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SUPREME COURT OF TEXAS
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No. _________________

IN THE SUPREME COURT OF TEXAS

THE STATE OF TEXAS, *et al.*,

Appellants,

v.

LAZAROE LOE, *et al.*;

Appellees.

On Direct Appeal from the
201st Judicial District of Travis County, Texas
No. D-1-GN-23-003616

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To the Honorable Chief Justice and Justices of the Supreme Court of Texas:

INTRODUCTORY STATEMENT

Senate Bill 14 ("SB14"), a law that bans medical treatment for minors with gender dysphoria, is scheduled to take effect September 1, 2023. On August 25, 2023, after two full days evidentiary hearings, the trial court enjoined SB14's enforcement after finding (among other things) that (1) SB14 likely violates the Texas Constitution, (2) Appellees will suffer probable, imminent, and irreparable injury unless Appellants are enjoined from enforcing SB14, (3) it was necessary to enter a temporary injunction to maintain the status quo, and (4) the temporary injunction should remain in effect while the merits are examined. Just over an hour after the trial court issued the temporary injunction order, Appellants filed a direct appeal to this Court, which automatically superseded the order. Through this motion, Appellees request emergency relief to preserve the status quo, once again.

SB14 will inflict irreparable harm on Texas parents, children, and healthcare providers if it goes into effect and each day that it is enforced. Appellees are asking the Court to consider this harm when deciding whether to *temporarily* enjoin SB14's enforcement while considering this appeal. Without a temporary injunction, Texas adolescents with gender dysphoria will lose access to safe, effective courses of medical treatment. Halting, delaying, or not receiving such treatment will force these adolescents to experience unwanted—and in some cases irreversible—physical and

psychological effects that will worsen over time. Texas parents will lose the ability to plan, direct, and provide for their children's medical needs related to gender dysphoria. Texas physicians who provide this care will be forced to either violate their professional oaths and disregard their patients' medical needs or put their medical licenses and livelihoods at risk. These are not merely possible harms. Absent an injunction, they are certain, and they compound daily.

With this Motion, Appellees request entry of a temporary order reinstating the trial court's temporary injunction, pursuant to this Court's inherent authority and Texas Rule of Appellate Procedure 29.3 ("Rule 29.3"). This order will preserve the status quo and protect the parties' rights until the disposition of the appeal in this matter. *Appellees respectfully request a ruling on this Motion by this Thursday, August 31, 2023—the day before SB14 is scheduled to take effect.*

DESCRIPTION OF THE PARTIES

Appellees, who were plaintiffs at the trial-court level, are as follows: seven parents of transgender minor children (Lazaro Loe, Mary Moe, Matthew Moe, Nora Noe, Sarah Soe, Steven Soe, and Gina Goe, collectively, "Parent Appellees"),[1] asserting claims individually and on behalf of their children; the respective transgender minor children of these parents (Luna Loe, Maeve Moe, Nathan Noe,

[1] The Parent Appellees and Minor Appellees are all proceeding under pseudonym, pursuant to the trial court's order. App. B (Agreed Protective Order Regarding Pseudonyms).

Samantha Soe, and Grayson Goe, collectively, "Minor Appellees"); PFLAG, asserting claims on behalf of its members, which include all of the Parent Appellees; three Texas-licensed physicians providing or facilitating medical treatment for gender dysphoria to adolescents in Texas (Dr. Richard Ogden Roberts III, Dr. David L. Paul, and Dr. Patrick W. O'Malley, collectively, "Physician Appellees"), asserting claims as individuals and on behalf of their patients; and GLMA, asserting claims on behalf of its members, which include all of the Physician Appellees.

Appellants, who were defendants at the trial-court level, are the State of Texas, the Office of the Attorney General of Texas, John Scott in his official capacity as Provisional Attorney General of Texas,[2] the Texas Medical Board, and the Texas Health and Human Services Commission.

FACTUAL AND PROCEDURAL BACKGROUND

On August 15-16, 2023, the trial court heard Appellees' Application for a Temporary Injunction. App. C at 1. Following an evidentiary hearing that included testimony from fact and expert witnesses for both sides, as well as the admission of hearing exhibits for both sides, the trial court issued an order on August 25, 2023, granting Appellees' Application for Temporary Injunction (the "Temporary

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[2] John Scott was subsequently replaced as Provisional Attorney General by Angela Colmenero on July 14, 2023.

Injunction Order"). *Id.* at 2. The Temporary Injunction Order is challenged in the direct appeal to this Court. App. D ("Appellants' Notice of Appeal") at 1.

I. SB14 was signed into law and threatens to categorically ban necessary and lifesaving medical treatment to transgender adolescents in Texas.

On May 19, 2023, the Legislature passed SB14, categorically banning the provision of necessary and often lifesaving medical treatment to transgender adolescents in Texas. Governor Greg Abbott signed SB14 into law on June 2, 2023. Absent sustained injunctive relief from this Court, SB14 will take effect on September 1, 2023 and will irreparably harm Appellees and the hundreds of other similarly situated Texas families and their medical providers.

SB14 categorically bans medical treatment of gender dysphoria for minors in Texas. Under the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5"), gender dysphoria is the clinically significant distress that some transgender people experience as a result of the incongruence between their gender identity and their sex assigned at birth. It is a serious medical condition that, if left untreated, can result in severe and negative health outcomes. Gender dysphoria is only experienced by transgender individuals.

SB14 achieves a categorical ban by prohibiting 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). Specifically, SB14 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," "supraphysiologic doses of testosterone to females," "supraphysiologic doses of estrogen to males," and various surgeries, including "mastectom[ies]" (the "Prohibited Care"). *Id.*

SB14 prohibits the provision of such 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." *Id.* Under SB14, the provision of the exact same medical treatments is permitted for *any* other purpose, including but not limited to precocious puberty or "a medically verifiable genetic disorder of sex development," which are specifically identified as exceptions under SB14. *Id.*

SB14 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).

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

SB14 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 adolescents. SB14 § 2 (proposed Tex. Health & Safety Code §§ 161.704, 161.705); *id*. § 3 (proposed Tex. Hum. Res. Code § 32.024). It also grants the Appellant 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 proposed Section 161.702 of the Texas Health and Safety Code, which addresses the Prohibited Care. SB14 § 2 (proposed Tex. Health & Safety Code § 161.706).

II. Appellees sued to block SB14 from taking effect.

On July 12, 2023, Appellees filed suit, seeking declaratory relief and temporary and permanent injunctions to prevent the devastating and irreparable harms that would befall Appellees and hundreds of similarly situated Texas families and their medical providers if SB14 takes effect. App. A. (Pls.' Verified Original Pet. for Declaratory J. and Appl. for Temporary and Permanent Injunctive Relief, hereinafter referred to as "the Petition"). The Petition asserts five causes of action, including that enforcement of SB14 violates Appellees' rights under the Due Course of Law Clause and both the Equal Rights Provision and the Equal Rights Amendment of the Texas Constitution. App. A at 60-69. In their Petition, Appellees request a temporary injunction blocking Appellants from enforcing or implementing SB14, declaratory judgment that SB14 is unconstitutional, and a permanent injunction restraining the enforcement of SB14. *Id.* at 70-71.

III. The trial court entered a temporary injunction in Appellees' favor.

A. Appellees presented extensive evidence to the trial court.

At the evidentiary hearing on August 15-16, 2023, Appellees presented evidence demonstrating that Appellants' enforcement of SB14 will cause severe, irreparable, and ongoing harms to Appellees and other similarly situated transgender adolescents, their parents, and medical providers that provide care prohibited under SB14 to transgender adolescents in Texas. Appellees presented expert testimony showing that the medical care prohibited by SB14 is medically necessary and part

of the standard course of care for gender dysphoria in adolescents, App. E (Temporary Inj. Hr'g Tr., Rep.'s R. vol. 1, 51:21-24, 53:25-54:3, 62:18-23, 82:24-83:15, 89:11-90:4, 94:11-14, 95:6-11, 129:8-130:7), and that the withholding, interruption, or delay of the provision of this medically necessary treatment for gender dysphoria will cause "intensification of [] gender dysphoria" and can cause "worsening depression and anxiety" and "increased thoughts of suicidality or self-harm," in addition to causing "a devastating setback in their gender dysphoria care and their overall health" and "significantly deteriorating mental health," *id.* (vol. 1, 62:22-63:1, 95:6-97:3, 128:18-129:7).

(1) Expert Witnesses

The trial court heard expert testimony that treatments for gender dysphoria are safe, effective, and widely accepted in the medical community.

Dr. Aron Janssen, a Child and Adolescent Psychiatrist at the Ann and Robert H. Lurie Children's Hospital of Chicago, Assistant Professor of Psychiatry at Northwestern University Feinberg School of Medicine, and founder and former director of the Gender and Sexuality Service at NYU Langone Medical Center, was qualified by the trial court as an expert on the study, assessment, diagnosis, and treatment of gender dysphoria. App. E (vol. 1, 35:6-19, 38:1-8). Dr. Janssen testified that the World Professional Association of Transgender Health (WPATH) and the Endocrine Society Guidelines for the care of gender dysphoria are evidence-based

and viewed by the medical and mental health profession as "the guidelines that we should all be striving to achieve in our clinical care." *Id.* (vol. 1, 44:21-46:7). These guidelines have been recognized as best practices by the "American Medical Association, the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, the American Academy of Pediatrics, [and] the American Psychological Association," amongst others. *Id.* (Rep.'s R. vol. 1, 46:8-16). The care recommended by both the Endocrine Society Guideline and the WPATH Standards of Care includes providing puberty blockers or gender-affirming hormone therapy to treat individuals with gender dysphoria. *Id.* (vol. 1, 47:12-18). Dr. Janssen testified that this medical care is both safe and effective. *Id.* (vol. 1, 63:16-19). Based on his clinical experience and published, peer-reviewed, and evidence-based studies, the use of puberty blockers and hormone therapy to treat gender dysphoria leads to improvement in mental health symptoms, improvement in distress, improvement in gender dysphoria, and to "improvements in functioning" for patients. *Id.* (vol. 1, 55:14-19, 56:13-57:5. In fact, not providing treatment when an adolescent has gender dysphoria can result in severe risks for the adolescent's mental health, including the development of anxiety, depression, and an increased risk of suicide. *Id.* (vol. 1, 62:10-63:1).

Dr. Daniel Shumer, a Pediatric Endocrinologist at Mott Children's Hospital University of Michigan, Associate Professor at the University of Michigan Medical

School, the Medical Director of the Child and Adolescent Gender Clinic at Mott Children's Hospital, and the Medical Director of the Comprehensive Gender Services Program at Michigan Medicine, University of Michigan, was qualified by the trial court as an expert on the provision, protocols, and treatment of gender dysphoria in adolescents, and the field of pediatric endocrinology. *Id.* (vol. 1, 74:7-76:11). Dr. Shumer testified that no hormonal or medical interventions are provided before the onset of puberty to treat gender dysphoria. *Id.* (vol. 1, 76:25-77:6). Adolescents with gender dysphoria who have started puberty may benefit from GnRH agonists, known as puberty blockers or puberty suppression, which temporarily pause the development of secondary sex characteristics that increase gender dysphoria and prevent the long-term harm of developing those unwanted characteristics. *Id.* (vol. 1, 79:8-24, 80:22-82:23). Puberty suppression is reversible, safe, effective, and not experimental. *Id.* (vol. 1, 82:20-83:15, 87:6-9). Puberty suppression is also used to treat precocious puberty and in children with cancer prior to chemotherapy to preserve fertility, among other conditions. *Id.* (vol. 1, 83:16-84:2). Older adolescents may benefit from hormone therapy, which is also used by pediatric endocrinologists to treat other conditions where adolescents are unable to make appropriate amounts of testosterone or estrogen. *Id.* (vol. 1, 87:10-89:10). Hormone therapy is safe, effective, and not experimental. *Id.* (vol. 1, 89:11-90:4, 94:11-14). Based on his clinical experience, Dr. Shumer testified that pubertal

suppression and hormone treatment improve patients' lives: "the true reward is watching patients who maybe initiated care feeling hopeless and helpless graduating from care as someone who is maybe going off to college, going to law school, getting married, starting a family, with a life that they didn't dream possible and their parents didn't dream possible before initiating care." *Id.* (vol. 1, 94:15-95:5, 97:9-19). Dr. Shumer testified that the risks of not providing treatment when medical indicated include persisting or intensifying gender dysphoria and deteriorating mental health. *Id.* (vol. 1, 95:12-97:3). Dr. Shumer also testified that "weaning off" care will not mitigate the harm: "There's no protocol or recommendation about withdrawing care that's working slowly, so that would be experimental." *Id.* (vol. 1, 97:4-8).

Dr. Johanna Olson-Kennedy, a medical doctor double board-certified in Pediatrics and Adolescent Medicine, an Associate Professor in Pediatrics at the University of Southern California, and the Medical Director of the Center for Transyouth Health and Development at Children's Hospital Los Angeles, was qualified by the trial court as an expert on the study, research, and treatment of gender dysphoria. *Id.* (vol. 1, 108:22-112:7). Dr. Olson-Kennedy testified that transgender people have been using hormones and surgery to treat gender dysphoria for decades; that puberty-delaying medications, which have been used for almost 50 years, have also been used in adolescents with gender dysphoria since the 1990s; and that surgery, while rare in adolescents, most commonly includes chest

masculinization surgery. *Id.* (vol. 1, 112:8-113:23). For adolescents with gender dysphoria at the onset of puberty, it is highly likely that their gender dysphoria will persist. *Id.* (vol. 1, 114:22-115:4, 123:23-125:12). There is a large body of research that gender-affirming medical care improves mental health in multiple ways. *Id.* (vol. 1, 115:5-20, 116:22-117:22). There are no randomized controlled trials in this area because it would be unethical to withhold care from one patient population in such a trial, and it would not be methodologically sound. *Id.* (vol. 1, 115:21-116:21). But existing studies show that puberty blockers improve mental health, which Dr. Olson-Kennedy has also observed in her clinical experience, *id.* (vol. 1, 117:23-120:6), and the same is true for hormone therapy, *id.* (vol. 1, 120:7-122:11), as well as surgery, *id.* (vol. 1, 122:12-123:8). Dr. Olson-Kennedy also testified that while some individuals detransition, it is very rare (perhaps 2%), and more frequently related to external factors like loss of health insurance or other outside pressure. *Id.* (vol. 1, 125:13-126:25). An even smaller number of people—perhaps 1%—regret their medical treatment. *Id.* (vol. 1, 127:1-20). None of the European studies referenced by Appellants' experts recommend banning treatment or coverage of treatment for adolescents with gender dysphoria. *Id.* (vol. 1, 127:21-128:7). There are no studies demonstrating that psychotherapy alone can address gender dysphoria if medical interventions are indicated. *Id.* (vol. 1, 128:11-17). Delaying medical treatment for gender dysphoria when it is medically indicated leads to significant

mental health deterioration, including the potential for increased suicidality. *Id.* (vol. 1, 128:18-129:7). By contrast, Dr. Olson-Kennedy testified that the mental health benefits of this care are "profound" and enable adolescents to be "thriving" and "have sunshine in their lives." *Id.* (vol. 1, 130:8-131:5).

(2) Fact Witnesses: Plaintiff Parents and Minors

Appellee Parents Lazaro Loe, Mary Moe, Sarah Soe, and Gina Goe testified to the irreparable harms their transgender children and families would face without an injunction. Appellee Minor Nathan Noe testified to the harm he and his family will face if SB14 takes effect.

Sarah Soe, the mother of now fifteen-year-old transgender girl Samantha Soe, described the severe mental health struggles her daughter and family faced before Samantha received medical treatment for gender dysphoria that she fears will resume if SB14 takes effect. Samantha—who had been crying herself to sleep every night—came out as transgender to Sarah and her husband Steven around the sixth grade but did not start medical treatment for gender dysphoria until about two years later. App. E (vol. 1, 199:11-24, 206:10-14). During this period, Sarah and Samantha's father, Steven Soe, grew increasingly worried about how withdrawn and sad Samantha seemed. *Id.* (vol. 1, 201:16-202:2). One morning, while Steven was on a call with Samantha's school counselor, the counselor got a "red flag alert" on the computer that Samantha's computer was being used to search "how to kill yourself." *Id.* (vol.

1, 202:3-18). Following this terrifying incident, Sarah and Steven took Samantha to a psychiatrist who prescribed her antidepressants and she began regular therapy. *Id.* (vol. 1, 203:4-15). Samantha continued to struggle, eventually seeing a specialist who formally diagnosed her with gender dysphoria. *Id.* (vol. 1, 203:15-204:21). The specialist recommended puberty blockers to give the family and Samantha time to consider her course of treatment for gender dysphoria. *Id.* (vol. 1, 204:19-205:12). After starting puberty blockers, Sarah observed that Samantha's mental health was "stabilizing" and that Samantha was not "crying at night anymore" and was improving at school. *Id.* (vol. 1, 205:13-21). A year after starting puberty blockers, Samantha began hormone therapy. *Id.* (vol. 1, 206:15-18). After Samantha started hormone therapy, Sarah noticed that Samantha was "smiling more and seeming more open and outgoing," that she started to make new friends, and that she "just seemed a lot happier." *Id.* (vol. 1, 206:19-207:7). If SB14 goes into effect, Sarah is "very afraid" that Samantha would once again be at risk of suicide. *Id.* (vol. 1, 208:1-2, 208:6-17). Sarah testified, "I think if [Samantha's] medical care was taken from her, I would be afraid that she would kill herself." *Id.* (vol. 1, 208:16-17).

Grayson Goe similarly had a history of mental health issues, including suicidal ideation, before receiving medical treatment for gender dysphoria. *Id.* (vol. 1, 31:17-22). When Gina Goe, Grayson's mother, weighed the risks of him starting hormone therapy, she described it as follows: "with a history of suicidal ideation . . .

for me as a parent of my son, I'm deciding between strong mental problems that may lead to suicide or a deep voice and some body hair and not being able to have children . . . I'm going to choose life." *Id.* (vol. 1, 31:17-22). Since Grayson started hormone therapy, Gina notes that Grayson leaves his room and has become more confident, social, and that "things have changed for the better." *Id.* (vol. 1, 31:10-15). Gina fears that, if Grayson cannot continue taking testosterone, things "will just be completely reversed." *Id.* (vol. 1, 31:16).

Gina testified that SB14 "completely hinders my ability [and right] as a parent to make medical decision on a whole for my kid" and that she now has "fractured medical care" for Grayson. *Id.* (vol. 1, 31:23-32:13). Gina does not know what she and Grayson will do if SB14 takes effect; she has attempted to look into care for him in Colorado but there is a waiting list so "there's going to be a gap in his medical care." *Id.* (vol. 1, 32:14-33:4).

Twelve-year-old transgender girl Luna Loe first told her father, Lazaro Loe, that she was a girl around age five. *Id.* (vol. 1, 143:3-6). Lazaro had some initial fears about the challenges Luna would face as a transgender person. *Id.* (vol. 1, 145:8-13). But he saw how much "more joyful" Luna was when they accepted her and allowed her to express herself in girls' clothing, long hair, and feminine nicknames—"it was like she was half a person before, but as we started to accept her more, she just changed. She did better in school and was just happier." *Id.* (vol. 1, 145:15-22). Luna

was diagnosed with gender dysphoria at age six by a child psychologist. *Id.* (vol. 1, 145:23-146:23). Luna expressed a lot of anxiety about going through male puberty, and eventually started puberty blockers at age eleven under the care of a pediatric endocrinologist she had started seeing a year prior. *Id.* (vol. 1, 148:6-149:6). Lazaro describes puberty blockers as an "obviously lifesaving kind of care" for Luna. *Id.* (vol. 1, 150:2-4).

Lazaro testified that if Luna was unable to continue taking puberty blockers it would be devastating and mentally distressing for both of them. *Id.* (vol. 1, 151:12-152:3). "[I]t's incredibly distressing . . . to have to think about . . . your child having to suffer. . . a reversal of [] something that clearly she wants and needs." *Id.* (vol. 1, 151:19-23). Lazaro worries about Luna's mental health and the physical changes that she would experience if forced to cease or disrupt puberty blockers. *Id.* (vol. 1, 151:12-152:3). Lazaro has struggled to come up with a plan for what to do if SB14 takes effect; he describes that it has "already had a chilling effect on the medical community [in Texas] that provides this kind of treatment." *Id.* (vol. 1, 152:4-13).

Mary Moe and Matthew Moe are the parents of a nine-year-old transgender girl, Maeve Moe. Maeve was diagnosed with gender dysphoria and has been living as a girl for many years. *Id.* (vol. 1, 214:23-215:19). Mary notes that, because Maeve has not started puberty, she is not yet receiving any medical care for her gender dysphoria. *Id.* (vol. 1, 217:19-22; 215:20-216:1). Mary testified that doctors in Texas

told her they would not treat Maeve and her gender dysphoria because of SB14. *Id.* (vol. 1, 218:4-8). As a result, Mary and her children have relocated outside of Texas, leaving Matthew in their family home in Texas, to allow Maeve to "go to the doctor and talk about whatever she feels the need to have a conversation with her doctor about." *Id.* (vol. 1, 218:9-18). The changes associated with male puberty are "absolutely terrifying to Maeve" according to Mary. *Id.* (vol. 1, 217:1-5). Mary testified that "SB 14 prevents Maeve from going to the doctor whenever she needs to just to check how her body's changing, to have a conversation with the doctor to ease her anxiety [around puberty starting]." *Id.* (vol. 1, 217:25-218:3).

Mary desires to return her family to Texas where she grew up and where her family and community live. *Id.* (vol. 1, 218:19-219:1). Mary testified to the hardship of having to move away from her husband: "It sucks. It absolutely sucks. We are a family that sits down to dinner four times a week . . . I have not been away from my husband this long since we got married. He's my best friend. I got married because I wanted to do this together with him, and now I feel divided because I've got to protect my children and put their emotional, physical, and mental health first and foremost." *Id.* (vol. 1, 219:2-16).

Nathan Noe is a sixteen-year-old transgender boy who has been taking testosterone for almost two years. *Id.* (vol. 2, 11:1-17, 19:19-21). When Nathan started puberty, he would isolate himself and would not participate in events with

his family: it felt like "something wrong was happening" to him. *Id.* (vol. 2, 11:18-12:15). When Nathan recognized that he was a transgender boy, "it made a lot of sense what the feelings that I had been experiencing – you know, what that meant," and he experienced relief and joy when his family and people around him started using male pronouns for him and treating him as a boy. *Id.* (vol. 2, 12:16-13:19, 15:21-17:9). After many conversations with his parents and his doctors, eventually Nathan began hormone therapy when he was about fourteen. *Id.* (vol. 2, 17:10-18:7). Nathan testified that testosterone "just really improved my life to a point where gender dysphoria almost doesn't bother me as much as it did . . . people were really able to see me as the me that I saw myself as. And having a body that aligned with that was – it felt like a weight being lifted." *Id.* (vol. 2, 18:8-22). Nathan's entire life has improved now that people see him as a boy, and he is "able to just go about [his] life as a teenage boy." *Id.* (vol. 2, 18:23-19:18). Hormone therapy has given Nathan "freedom . . . to live [his] life without having gender dysphoria as a heavy weight on [him]." *Id.* (vol. 2, 21:12-22). Being unable to take testosterone would deprive him of "this medicine" that, in his words, "just really saved [his] life." *Id.* (vol. 2, 19:22-20:18).

(3) Fact Witnesses: Physician Plaintiffs

Appellee Physicians Dr. Paul and Dr. Roberts testified to the impact SB14 has had on their ability to practice medicine and on their patients. Dr. Roberts is a double

board-certified Pediatric Endocrinologist licensed in Texas who practices at a large children's hospital in Houston. App. E (vol. 1, 161:11-17, 162:11-13). Approximately 10-20% of Dr. Roberts' clinical time is spent providing medical treatment to youth with gender dysphoria. *Id.* (vol. 1, 164:7-13). Dr. Roberts testified that if SB14 were to go into effect and he were to continue treating his transgender patients consistent with evidence-based medicine, he could lose his license. *Id.* (vol. 1, 169:23-170:2). If SB14 goes into effect, he would be forced to "abandon patients" with which he has "established relationships." *Id.* (vol. 1, 170:3-7). Because of SB14, Dr. Roberts has spent the last month telling his patients he may "not be able to see them come September 1." *Id.* (vol. 1, 170:5-15). Dr. Roberts testified that if SB14 goes into effect, he anticipates that the gender dysphoria of his patients will increase, and it may increase depression and anxiety amongst these patients. *Id.* (vol. 1, 169:12-19).

Dr. Paul is a Texas-licensed, board-certified Pediatric Endocrinologist. *Id.* (vol. 1, 173:25-174:5). His practice includes providing gender-affirming medical care to patients that are Medicaid and CHIP recipients. *Id.* (vol. 1, 178:1-6). He first started treating adolescents with gender dysphoria while serving in the Air Force and working as a Pediatric Endocrinologist on a military base in San Antonio when a transgender adolescent was referred to him. *Id.* (vol. 1, 175:11-176:3). Dr. Paul testified, "I recognize that if these youth do not receive standard of care science-

based help as they undergo gender transition, that it can be life threatening. It can be threatening to their entire life existence, affecting every single aspect of their life." *Id.* (vol. 1, 176:20-25). Dr. Paul testified that SB14 "will strip me of providing this standard of care consensus-approved treatment from 20 U.S. medical organizations . . . It's the only care in my practice that is being removed." *Id.* (vol. 1, 185:18-22). Dr. Paul also testified that SB14's weaning provision will not mitigate harm: "It'll worsen it. There's no such thing as weaning in the healthcare provision for this population. There's no guideline. There's no studies. There's no science . . . there's no science or publication or guideline to say how to" withdraw puberty blockers or hormones in the manner SB14 requires. *Id.* (vol. 1, 187:19-188:10).[3]

(4) Fact Witnesses: Organizational Plaintiffs

Brian Bond, the CEO of PFLAG National—the first and largest organization for LGBTQ+ individuals and their families with over 1,500 members in Texas—testified to the impact of SB14 on the members of PFLAG. App. E (vol. 1, 153:20-22, 154:16-22, 158:16-21). PFLAG's mission is "to create a caring, just, and affirming world for LGBTQ+ individuals and those who love them." *Id.* (vol. 1, 154:23-155:12). Mr. Bond testified that PFLAG members include Texas families with transgender children receiving gender-affirming medical treatment, including

[3] As Appellees' expert Dr. Shumer also testified: "There's no protocol or recommendation about withdrawing care that's working slowly, so that would be experimental." *Id.* (vol. 1, 97:4-8).

Appellee Parents and Minors. *Id.* (vol. 1, 158:22-159:9). When asked about the impact of SB14 on PFLAG members, Mr. Bond testified that it is "terrifying" and "very disruptive" for his members, and that PFLAG member families are trying to figure out if they need to move, can afford to move, and what the law means for their ability to care for their children. *Id.* (vol. 1, 159:24-160:10).

Alex Sheldon, the Executive Director of GLMA—the oldest and largest association for LGBTQ+ and allied health professionals in the country—testified to the impact of SB14 on GLMA members and their ability to provide care to their patients. *Id.* (vol. 1, 191:6-7, 191:17-19). GLMA's mission is to both advocate for and advance LGBTQ+ health equity, and to promote equality for LGBTQ+ and allied health professionals in their work. *Id.* (vol. 1, 191:20-21). Mx. Sheldon testified that GLMA members include the Physician Appellees along with other Texas healthcare providers that currently provide gender-affirming medical care for minors. *Id.* (vol. 1, 195:6-13). Mx. Sheldon testified that if SB14 goes into effect it will be "devastating" on GLMA members that provide gender-affirming medical care to minors in Texas and that such members would "would be putting their medical licenses on the line in order to save the lives of their patients." *Id.* (vol. 1, 195:24-196:7). Mx. Sheldon noted that many members "have said that they might be forced to leave the state and practice elsewhere." *Id.* (vol. 1, 195:24-196:12).

B. The trial court issued a detailed, well-reasoned Temporary Injunction Order.

Based on Appellees' Application for Temporary Injunction, the testimony and evidence presented at the temporary-injunction hearing, the arguments of counsel, and the applicable authorities, the trial court found "sufficient cause to enter a Temporary Injunction against Defendants [Appellants]" and entered a detailed, well-reasoned Temporary Injunction Order. App. C at 2.

The trial court found that, "unless Defendants [Appellants] are immediately enjoined from enforcing the Act, Plaintiffs [Appellees] will suffer probable, imminent, and irreparable injury in the interim" and that "[s]uch injury . . . cannot be remedied by an award of damages or other adequate remedy at law." *Id.* at 2, 4. The trial court thus ordered that Appellants were "*immediately enjoined and restrained from* implementing or enforcing the Act." *Id.* at 5 (emphasis added).

The trial court concluded that there was a substantial likelihood that Appellees would succeed on the merits of each of their claims that SB14 violates the Texas Constitution. The trial court specifically found the following:

(1) SB14 likely violates Parent Appellees' fundamental rights under Article I, Section 19 of the Texas Constitution.

- SB14 "likely violates Article I, Section 19 . . . by infringing upon the fundamental right of parents to make decisions concerning the care, custody, and control of their children." *Id.* at 2.

- This fundamental right includes "the right of parents to give, withhold, and withdraw consent to medical treatment for their children" and to "seek and to follow medical advice to protect the health and wellbeing of their minor children." *Id.*
- SB14's "prohibitions on providing evidence-based treatment for adolescents with gender dysphoria stands directly at odds with parents' fundamental right to make decisions concerning the care of their children." *Id.* at 2-3.
- SB14 strips Parent Appellees and PFLAG members "of the right to seek, direct, and provide medical care for their children" and "denies their parents, including Parent Plaintiffs and PFLAG parent members, the ability to obtain necessary and in some circumstances, lifesaving medical care treatment" for their children. *Id.* at 3.
- The evidence presented at the hearing demonstrated that SB14 "threatens the health and wellbeing of adolescents with gender dysphoria" rather than protects it, and SB14 is "not narrowly tailored to serve a compelling government interest . . . [and] lacks even a rational relationship to any legitimate government interest." *Id.*

(2) SB14 likely violates Physician Appellees' constitutional rights under Article I, Section 19 of the Texas Constitution.

- SB14 "likely violates Article I, Section 19 of the Texas Constitution by infringing upon Texas physicians' right of occupational freedom." *Id.*
- SB14 specifically "deprives Texas physicians of a vested property right in their medical licenses" and requires "Texas medical providers, including the physician Plaintiffs and health professional members of GLMA, to disregard well-established, evidence-based clinical practice guidelines, and their training and oaths, thereby significantly and severely compromising the health of their patients with gender dysphoria or, alternatively, to risk their livelihoods." *Id.*
- SB14 subjects physicians to discipline if they "provide their transgender adolescent patients with medically necessary treatment" and for "treating a patient according to generally accepted standards of care." *Id*. SB14 is "clearly arbitrary and its effect as a whole is so unreasonably burdensome that it is oppressive." *Id.*

(3) SB14 likely discriminates against Minor Appellees because of their sex, sex stereotypes, and transgender status in violation of Article I, Sections 3 and 3a of the Texas Constitution.

- SB14 "likely violates Article I, Sections 3 and 3a of the Texas Constitution by discriminating against transgender adolescents with gender dysphoria because of their sex, sex stereotypes, and transgender status." *Id.* at 3-4.
- SB14 infringes on the guarantees of equality under the law by enacting a "discriminatory and categorical prohibition on evidence-based medical treatments for transgender youth which remains available to cisgender youth." *Id.* at 4.
- Specifically, the treatments prohibited under SB14—such as puberty-blockers and hormone therapy—are prohibited "*only* when used to treat an adolescent for gender dysphoria" even though the same or similar risks exist regardless of the condition for which such treatment is prescribed. *Id.*
- SB14 "is not justified by any legitimate state purpose, let alone a compelling one" and "was passed because of, and not in spite of, its impact on transgender adolescents, depriving them of necessary, safe, and effective medical treatment." *Id.*

With those findings in place, the trial court "immediately enjoined and restrained" Appellants and their agents, officers, employees, attorneys, and others

from "implementing or enforcing" SB14 until "all issues in this lawsuit are finally and fully determined." *Id.* at 5. "[S]uch restraint encompasses but is not limited to:

> (1) enjoining and restraining the State of Texas, Office of the Attorney General of the State of Texas, Angela Colmenero, in her official capacity as Provisional Attorney General, and any successor Attorney General from filing an action to enforce the Act, whether directly through authority provided by proposed Section 161.706 of Texas Health and Safety Code, or indirectly through authority provided by the Texas Medical Practice Act or otherwise;
>
> (2) enjoining and restraining the State of Texas and Texas Medical Board from taking action to implement or enforce the Act, including investigating a complaint, referring a complaint to the Office of the Attorney General, revoking the license or other authorization to practice medicine of a physician, refusing to admit to examination or refuse to issue a license or renewal license to a person based on the Act, whether directly through authority provided by proposed Sections 164.052(a)(24) or 164.0552 of Texas Occupations Code, or indirectly through authority provided by the Texas Medical Practice Act or otherwise;
>
> (3) enjoining and restraining the State of Texas and Texas Health and Human Services Commission from (a) withholding public money from being used, granted, paid, or distributed to any health care provider, medical school, hospital, physician, or any other entity, organization, or individual that provides or facilitates the provision of a procedure or treatment based on the Act, and (b) withholding or otherwise limiting reimbursement of or coverage for prohibited care under the Act by Medicaid and/or CHIP insurance plans."

Id. at 5-6.

The trial court explained that the temporary injunction ordered was "necessary to maintain[] the status quo and should remain in effect while this [c]ourt, and potentially the Third Court of Appeals and the Supreme Court of Texas, examine the parties' merits and jurisdictional arguments." *Id.* at 5.

C. Appeal of Temporary Injunction Order.

Appellants filed a notice of accelerated interlocutory appeal directly to this Court under Section 51.014(a)(4) of the Texas Civil Practice and Remedies Code and Section 22.001(c) of the Texas Government Code, which automatically superseded the trial court's Temporary Injunction Order.[4] App. D at 1.

ARGUMENT AND AUTHORITIES

I. This Court should use its inherent powers and equitable authority under Rule 29.3 to reinstate a temporary injunction on the terms set forth by the trial court.

Rule 29.3 authorizes appellate courts to "make any temporary orders necessary to preserve the parties' rights until disposition of the appeal." Tex. R. App. P. 29.3. Preservation of the status quo is at the heart of Rule 29.3. Appellees ask this Court to exercise its inherent powers and its authority under Rule 29.3 to issue a temporary order reinstating the terms of the temporary injunction issued by the trial court, which preserves the status quo in this case, protects Appellees' rights, and prevents irreparable and immediate harms to Appellees.

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[4] In their direct appeal, Appellants also seek review of the trial court's denial of their Plea to the Jurisdiction ("Plea"). App. D at 1. Under Texas Government Code 22.001(c), "an appeal may be taken to the supreme court only if the appeal was first brought to the court of appeals," except that "[a]n appeal may be taken directly to the supreme court from *an order of a trial court granting or denying an interlocutory or permanent injunction on the ground of the constitutionality of a statute of this state*." Tex. Gov. Code 22.001(c) (emphasis added). This limited grant of jurisdiction will likely be addressed in Appellants' Statement of Jurisdiction. The Plea should not be addressed as part of the Court's consideration of this motion.

A. A temporary injunction is necessary to preserve the status quo.

Rule 29.3 "broadly empower[s this Court] to preserve parties' rights when necessary," granting the Court "great flexibility in preserving the status quo based on the unique facts and circumstances presented." *In re Geomet Recycling LLC*, 578 S.W.3d 82, 89 (Tex. 2019). Based on the facts and circumstances of this case, temporary injunctive relief of the same scope as issued by the trial court is necessary to preserve the status quo.

Although the trial court's temporary injunction was superseded when Appellants filed their direct appeal, Rule 29.3 authorizes an appellate court to issue its own temporary order effectively continuing that injunction pending resolution of the appeal in order "to preserve the status quo and prevent irreparable harm." *In re Tex. Educ. Agency*, 619 S.W.3d 679, 680 (Tex. 2021). And the "status quo" is "the last, actual, peaceable, non-contested status which preceded the pending controversy." *In re Newton*, 146 S.W.3d 648, 651 (Tex. 2004) (quotation marks and citation omitted) (emphasis added). Permitting Appellants to enforce the unconstitutional changes threatened by SB14 would alter and disrupt the status quo in a manner detrimental to the lives of many Texans.

The prohibitory temporary injunction issued by the trial court against Appellants preserves the status quo in this case, and this Court should issue an order enjoining Appellants from the actions outlined in the trial court's temporary

injunction to similarly preserve the status quo. The trial court found that the temporary injunction is necessary to maintain the *status quo*. App. C at 5. Currently, adolescents with gender dysphoria are lawfully able to access the medical care deemed necessary by medical professionals to treat their gender dysphoria; parents are lawfully able to choose and consent to the provision of such care for their children; and providers are lawfully able to prescribe and facilitate such care. If SB14 goes into effect, this *status quo* would be suddenly and irrevocably altered. The minor Appellees would suddenly be prohibited from securing medical treatment that they may have been getting for years. Physicians would suddenly be prohibited from providing ongoing treatment.

Appellate courts have the authority to effectively reinstate a lower court's temporary injunction to preserve the status quo. In *In re Texas Education Agency*, the appellants filed an interlocutory appeal that "automatically suspended enforcement of the trial court's order," which included a temporary injunction. 619 S.W.3d at 683. As this Court noted, "[i]nstead of preserving the status quo, however, suspension of the temporary injunction would . . . have the contradictory effect of permitting the status quo to be altered, because if compliance with the injunction were not required," the plaintiff's rights and position "could be changed from 'the last, actual, peaceable non-contested status [that] preceded the pending controversy.'" *Id.* at 683-84. In such circumstances, temporary relief under Rule 29.3

is appropriate even if that temporary order has the "same practical effect as denying supersedeas of the trial court's injunction." *Id*. at 680; s*ee also In re Abbott*, 645 S.W.3d 276, 282 (Tex. 2022).

Appellate courts have exercised and continue to exercise their authority under Rule 29.3 to preserve the *status quo*. *See Texas Health & Human Servs. Comm'n v. Sacred Oak Med. Ctr. LLC*, No. 03-21-00136-CV, 2021 WL 2371356, at *1, *5 (Tex. App.—Austin June 9, 2021, no pet.) (In reinstating a temporary injunction under Rule 29.3, the court addressed *In re Texas Education Agency* and explained that "[t]he Texas Supreme Court recently confirmed that courts of appeals have the power to provide relief from the State's automatic right to supersedeas under Rule 29.3," even if procedural rules would prevent the trial court from issuing a counter-supersedeas order, if the suspension of the temporary injunction would "have the contradictory effect of permitting the status quo to be altered."); *see also In re Newton*, 146 S.W.3d at 651 (explaining "that the continuation of illegal conduct cannot be justified as preservation of the status quo").

Under these same principles, in *In re Abbott*, this Court denied requested mandamus relief from the court of appeals' reinstatement of a trial court's temporary injunction under Rule 29.3 to maintain the status quo for the parties. 645 S.W.3d at 283. After the State's appeal superseded a district court's injunction barring the Texas Department of Family and Protective Services from enforcing an unlawfully

adopted rule requiring child abuse investigations into the provision of gender-affirming medical care, the court of appeals reinstated that suspended injunction under Rule 29.3. *See Abbott v. Doe*, 2022 WL 837956 (Tex. App.—Austin Mar. 21, 2022, pet. granted). The district court concluded that such investigations had not taken place before adoption of the rule, the rule changed the status quo, and the temporary injunction restored that status quo. *Id.* at *1. The court of appeals thus reinstated the temporary injunction, noting its own authority under Rule 29.3 "to maintain the status quo and preserve the rights of all parties." *Id.* at *2. And this Court held that the court of appeals' order protecting the plaintiffs was within the court of appeals' Rule 29.3 power. *See In re Abbott*, 645 S.W.3d at 683-84.

The Court should exercise its Rule 29.3 authority here and enter injunctive relief on the terms set forth by the trial court because it is the only way to preserve the status quo while the merits are being considered in this matter.

B. Reinstating the trial court's temporary injunction is necessary to protect Appellees' rights and prevent irreparable harm.

Appellate courts also have "the power to preserve a party's right to judicial review of acts that it alleges are unlawful and will cause it irreparable harm." *Sacred Oak*, 2021 WL 2371356, at *5. Specifically, "Rule 29.3 provides a mechanism by which [this Court] may exercise the scope of [its] authority over parties, including [its] inherent power to prevent irreparable harm to parties properly before [it] pursuant to [its] appellate jurisdiction in an interlocutory appeal." *Tex. Educ.*

Agency, 609 S.W.3d at 578. *See also Geomet*, 578 S.W.3d at 90 (noting "the authority of a court of appeals to prevent irreparable harm to parties that have properly invoked its appellate jurisdiction in an interlocutory appeal"). Here, reinstatement of a temporary injunction is necessary to protect the rights of Appellees, who would suffer irreparable and immediate harms in the absence of such a temporary injunction.

In this way, this case is like *Texas Education Agency* and *Sacred Oak.* In *Texas Education Agency*, the plaintiff-appellee was concerned that failure to issue an order under Rule 29.3 to preserve the status quo "could delay remedial measures designed to protect students and improve academic achievement." 619 S.W.3d at 690. And in *Sacred Oak*, the plaintiff-appellee faced irreparable harm from the suspension of its license and continued closure. 2021 WL 2371356, at *8. In both instances, this Court entered a temporary injunction, pursuant to its inherent powers and authority under Rule 29.3, to protect the plaintiffs-appellees' rights and prevent irreparable harm while the appeals were considered.

Like *Texas Education Agency* and *Sacred Oak*, this case presents "compelling circumstances that require the Court to reinstate the trial court's temporary injunction to preserve the parties' rights." *Sacred Oak Med. Ctr. LLC*, 2021 WL 2371356, at *7 (quotations omitted). As the trial court found, "unless Defendants are immediately enjoined from enforcing [SB14], Plaintiffs will suffer probable,

imminent, and irreparable injury in the interim." App. C at 4. Reinstating a temporary injunction is therefore necessary to prevent immediate, ongoing, and irreparable harm to Appellees. Indeed, the trial court recognized that enforcement of SB14 will cause myriad irreparable harms to Appellees, including: the loss of access to safe, effective, and medically necessary treatment for transgender adolescents experiencing gender dysphoria; significantly and severely compromising the health and wellbeing of transgender adolescents experiencing gender dysphoria, including forcing such patients to experience unwanted and unbearable changes to their body; the loss of a parent's ability to direct their child's medical treatment; destabilizing the family unit, including forcing families to leave Texas, travel regularly out of state, and/or choose indefinite family separation; depriving Texas physicians of the right to occupational freedom and their vested property interests in their medical licenses; forcing Texas physicians to either violate their oath by disregarding the patients' medical needs and inflicting needless suffering, or putting their medical license and livelihood at risk; and exacerbating health disparities for transgender adolescent patients who receive Medicaid and Children' Health Insurance Program coverage and who will lose that coverage if SB14 goes into effect. App. C at 4-5. These harms are not static but compound in their severity and likelihood every day an injunction is not in place.

The unconstitutional law at issue here presents Appellees with an impossible choice. For the Parent Appellees and their minor children, as well as other PFLAG members, they must either cease medical treatment for gender dysphoria—care which for many has been lifesaving—or leave their homes and communities to continue to legally access such care i another state. Physician Appellees and other GLMA members must decide whether to violate their oaths taken as physicians and disregard their patients' medical needs, undoubtedly inflicting suffering, or violate SB14 and put their medical licenses and livelihoods at risk.

The deprivation of medical care mandated by SB14 is irreparable harm that cannot be compensated or measured under a pecuniary standard. No price can be put on the physical, social, psychological, and not yet fully known harms that will undoubtably occur if the Minor Appellees are forced to go without medically-necessary care for gender dysphoria. There is no standard of compensation that can measure these certain and—in some instances—irreversible harms, both physical and psychological, that flow from forcing a transgender adolescent to experience an undesired puberty against their wishes, the wishes of their parents, and against the professional recommendations of their healthcare providers. *See, e.g., Bowen v. City of New York*, 476 U.S. 467, 483 (1986) (a risk of suffering "a severe medical setback" is an irreparable injury). An injunction blocking SB14's enforcement is

necessary to allow Minor Appellees to maintain continuity of their medically-necessary care in Texas and prevent these otherwise certain harms.

Of note, in denying mandamus relief in *In re Abbott*, this Court found no abuse of the appellate court's discretion in issuing an injunction pursuant to Rule 29.3 to protect the Doe family from further harmful action by the Defendants. *In re Abbott*, 645 S.W.3d at 283. Appellees are identically situated to the Doe family in the imminent and irreparable harm they face from enforcement of SB14.

Appellees have also satisfied their burden of showing irreparable injury warranting injunctive relief because SB14 infringes their constitutional rights, including the Parent Appellees' right of parental autonomy, the Minor Appellees' equality rights, and the Physician Appellees' property and occupational freedom rights. "[T]he denial of a constitutionally guaranteed right …, as a matter of law, inflicts an irreparable injury." *Iranian Muslim Org. v. City of San Antonio*, 615 S.W.2d 202, 208 (Tex. 1981) (citing *Henry v. Greenville Airport Commission*, 284 F.2d 631, 633 (4th Cir. 1960) for the proposition "that a court has no discretion to deny relief by a temporary injunction where a violation of a constitutional right is clearly established."); *Elrod v. Burns*, 427 U.S. 347, 373 (1976) (noting that loss of constitutional "freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury").

Absent relief from this Court, that same imminent, irreparable harm that led the trial court to issue its injunction will persist while this appeal is pending. An order from this Court reinstating a temporary injunction on the terms set forth by the trial court would do Appellants "no harm whatsoever," as any interest they may claim "in enforcing an unlawful (and likely unconstitutional)" statute "is illegitimate." *BST Holdings, L.L.C. v. Occupational Safety & Health Admin., U.S. Dep't of Lab.*, 17 F.4th 604, 618 (5th Cir. 2021); *see also Doe v. Ladapo*, No. 4:23CV114-RH-MAF, 2023 WL 3833848, at *16 (N.D. Fla. June 6, 2023) ("Adherence to the Constitution is always in the public interest.").

C. Facial injunctive relief is necessary to maintain the status quo and preserve the Appellees' rights.

Temporary relief that effectively reinstates the trial court's injunction against the implementation and enforcement of SB14 is necessary to preserve the parties' rights. This Court has been clear that 29.3 relief is limited "to that which is necessary to preserve *the parties'* rights." *In re Abbott*, 645 S.W.3d at 282. Here, an injunction barring enforcement of SB14 solely against the parties would fail to preserve the parties' rights, both practically and legally.

A court's preservation of the status quo necessarily turns on an assessment of the "unique facts and circumstances presented." *Geomet*, 578 S.W.3d at 89. *See also*, *e.g.*, *Huynh v. Blanchard*, No. 12-20-00198-CV, 2021 WL 3265549, at *8 (Tex. App.—Tyler July 30, 2021, pet. granted) (affirming grant of permanent injunction

that completely shuttered commercial operation, as opposed to merely decreasing its scope to abate a nuisance, because a "more narrow injunction is not economic or feasible, nor would it be equitable to do so…" given the parties' conduct and credibility). Here, the structure and function of SB14 means that only an injunction facially barring its enforcement can sufficiently maintain the status quo and protect the parties' interests during the pendency of the litigation. While SB14 imposes serious and irreparable harms on transgender adolescents and their parents like the Family Appellees and PFLAG members, the mechanism for barring their medically necessary care is a prohibition directed at and enforced against healthcare providers and institutions, including through the loss of public funds. *Cf. City of Austin v. Thompson*, 219 S.W.2d 57, 59 (Tex. 1949) (a prohibition of the expenditure of public funds to pay the expense of something has "the same practical effect" as a prohibition against the things itself). As a result, an injunction specific to the Appellees only would be practically unworkable and fail to provide meaningful protection.

First, physicians, health care providers, and institutions face significant penalties and funding restrictions for failing to comply with SB14. As Plaintiffs testified, this is already causing providers to end the provision of gender-affirming medical care in anticipation of the bill's effective date. App. E (vol. 1, 152:4-13, 159:24-160:10, 169:7-170:15, 218:4-18; vol. 2, 19:22-20:18); *see also* William

Melhado, "'Unbearable': Doctors treating trans kids are leaving Texas, exacerbating adolescent care crisis," The Texas Tribune (July 17, 2023), available at https://www.texastribune.org/2023/07/17/texas-gender-affirming-care-doctors-hospitals/; Ariel Worthy, "Texas Children's Hospital to end gender-affirming care by September 1," Houston Public Media (May 25, 2023), available at https://www.houstonpublicmedia.org/articles/news/health-science/2023/05/25/452850/texas-childrens-hospital-end-gender-affirming-care-by-september-1; Julian Gill, "Texas Children's to discontinue transgender care in coming months, CEO email says," The Houston Chronicle (May 24, 2023), available at https://www.houstonchronicle.com/news/houston-texas/health/article/ceo-texas-children-s-discontinue-trans-care-18117681.php. As a result of these sanctions, "[a] serious chilling effect on access to care is likely to follow, for what doctor or medical institution will continue to offer such care to minors, with the threat of serious sanctions on the horizon?" *Koe v. Noggle*, No. 1:23-CV-2904-SEG, 2023 WL 5339281, at *29 (N.D. Ga. Aug. 20, 2023). A plaintiff-specific injunction will not shield their health care providers or institutions from SB14's sanctions. As a result, "[c]omplete relief will only obtain upon an injunction with a broader sweep"—one that "will mitigate the fears" of providers "and in turn alleviate the [Plaintiffs'] consequent harms." *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Hum. Servs.*, 485 F. Supp. 3d 1, 63 (D.D.C. 2020).

Second, while members of both PFLAG and GLMA would technically be shielded from SB14's harms by a party-specific injunction, *see Warth v. Seldin*, 422 U.S. 490, 515 (1975), and therefore able to access and provide the medical treatments SB14 prohibits, the same practical limitations would apply. PFLAG members would "would have to establish their current membership in the organization to a series of providers, and this could give rise to factual disputes," *Koe*, 2023 WL 5339281, at *30, the resolution of which would occur at the hands of providers who remain under the threat of serious sanctions if they make the wrong call. GLMA members themselves would be shielded from those sanctions for providing or facilitating the provision of gender-affirming medical treatments, but the institutions where they work and the colleagues with whom they work would not, thereby risking the loss of public funding including Medicaid. Without a facial injunction, PFLAG and GLMA members' protection would be nominal at best.

Finally, the Family Plaintiffs are proceeding under pseudonym in order to protect their privacy interests. App. B. Taking advantage of party-specific injunctive relief to access medical treatments for their children would inherently involve identifying themselves as plaintiffs to a host of medical providers, administrative staff, and others involved in the provision or facilitation of and payment for those treatments, thereby undermining the purpose of proceeding anonymously in the first place. *See Koe*, 2023 WL 5339281 at *30 ("it would be administratively

burdensome, if possible at all, to fashion an injunction that would allow them to secure relief without compromising their anonymity"); *see also*, *e.g.*, *In re Does 1-10*, 242 S.W.3d 805, 820 (Tex. App.—Texarkana 2007, no pet.) (explaining in the First Amendment context that the right to speak anonymously, though not absolute, "would be of little practical value if there was no concomitant right to remain anonymous after the speech is concluded").

Moreover, as a legal matter, in a facial constitutional challenge, the only way to provide Appellees meaningful relief from an unconstitutional law is to enjoin it in its entirety. In a facial challenge, "the challenging party contends that the statute, by its terms, always operates unconstitutionally." *Texas Workers' Comp. Comm'n v. Garcia*, 893 S.W.2d 504, 518 (Tex. 1995). Appellees allege and the trial court found that they are likely to succeed on their claims that SB14 is facially unconstitutional. As a result, permitting enforcement of SB14 in any manner continues the infringement of Appellees' rights. *See, e.g., Mulholland v. Marion Cnty. Elec. Bd.*, 746 F.3d 811, 819 (7th Cir. 2014) ("We have not encountered before the idea of facial unconstitutionality as applied only to a particular plaintiff. Facial unconstitutionality as to one means facial unconstitutionality as to all, regardless of the fact that the injunctive portion of the judgment directly adjudicated the dispute of only the parties before it."); *see also Doe v. City of Albuquerque*, 667 F.3d 1111, 1127 (10th Cir. 2012) (explaining that "where a statute fails the relevant

constitutional test…it can no longer be constitutionally applied to anyone”). A facial injunction is necessary because when a law conflicts with rights guaranteed by Article I, the Texas Constitution declares that the law is void. *See City of Beaumont v. Bouillion*, 896 S.W.2d 143 (Tex. 1995). Equitable remedies are the established and appropriate means of redress in a constitutional challenge precisely because “[a] law that is declared void has no legal effect,” and if that is the case, it cannot be enforced against anyone without furthering the constitutional violation.

Granting a facial injunction here is not a matter of attempting to extend relief to “any and all persons” who are not parties to this lawsuit, *In re Abbott*, 645 S.W.3d at 283, but a matter of ensuring that the parties’ rights are meaningfully protected throughout the pendency of the litigation. “[T]he mere fact that nonparties might be affected by a facial injunction does not bar the Court from issuing one. That is, a statewide injunction is appropriate where its scope is principally measured by the extent of the violation established . . . and by that which is necessary to protect the interests of the parties[.]” *Koe*, 2023 WL 5339281, at *29. As the Eighth Circuit recognized in assessing the propriety of temporary relief that facially enjoined enforcement of Arkansas’s ban on gender-affirming care for minors, there is simply not a “more narrowly tailored injunction that would remedy Plaintiffs’ injuries.” *Brandt by & through Brandt v. Rutledge*, 47 F.4th 661, 672 (8th Cir. 2022); s*ee also K. C. v. Individual Members of Med. Licensing Bd. of Indiana*,

No. 123CV00595JPHKMB, 2023 WL 4054086, at *14 (S.D. Ind. June 16, 2023) (granting statewide relief and enjoining the enforcement of a law banning gender-affirming care for minors "against any provider, as to any minor"); *Hecox v. Little*, 479 F. Supp. 3d 930, 988 (D. Idaho 2020), *aff'd*, No. 20-35813, 2023 WL 1097255 (9th Cir. Jan. 30, 2023), and *aff'd*, No. 20-35813, 2023 WL 5283127 (9th Cir. Aug. 17, 2023) (district court granted statewide injunction of Idaho law excluding transgender girls and women from participating in women's sports teams because law was likely unconstitutional).

CONCLUSION AND PRAYER

Appellees respectfully ask this Court to grant this Motion and issue an order providing temporary injunctive relief on the terms set forth by the trial court until the disposition of the appeal. Such an order is necessary to preserve the status quo and Appellees' rights. Appellees further request that this Court rule on this emergency motion on or before **August 31, 2023**, prior to SB14's September 1, 2023 effective date. Finally, Appellees further request that this Court grant any and all other relief to which they may be entitled.

Respectfully Submitted,

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COUNSEL FOR APPELLEES

CERTIFICATE OF COMPLIANCE

Pursuant to Texas Rule of Appellate Procedure 9.4(i)(3), I certify that this Motion contains 9927 words, excluding the portions of the brief exempted by Rule 9.4(i)(1).

/s/ Kennon Wooten
Kennon Wooten

CERTIFICATE OF CONFERENCE

Pursuant to Texas Rule of Appellate Procedure 10.1(a)(5), I certify that, on August 27, 2023, I conferred with Appellants' counsel via email regarding this Motion and Appellants' counsel stated that Appellants are opposed to this Motion.

/s/ Kennon L. Wooten
Kennon L. Wooten

CERTIFICATE OF SERVICE

I certify that, on August 28, 2023, Appellees electronically served a true and correct copy of the foregoing Motion on the following counsel for Appellants, through the electronic-filing manager in the electronic-filing system.

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APPENDIX INDEX

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APPENDIX A

7/12/2023 5:08 PM
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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;	§	IN THE DISTRICT COURT OF
	§	201ST, DISTRICT COURT
Plaintiffs,	§	TRAVIS COUNTY, TEXAS
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.	§	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,

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[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

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[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;

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[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

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[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.

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[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.

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[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.

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[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

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[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.

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[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*.

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[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

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[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

[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:

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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.

Lazaro Loe

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

Lazaro Loe

Exhibit
2

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

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.

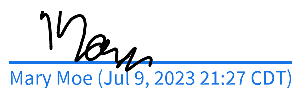
20. My husband will continue to live in our house in Texas and I will keep my residency and professional license in Texas. Texas is our home. My husband and I want to continue to live and raise our children in the communities they have spent their whole lives in. We hope that once this law is struck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

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]

[REDACTED]

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

Nora Noe

Exhibit 5

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

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] [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

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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.

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[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.

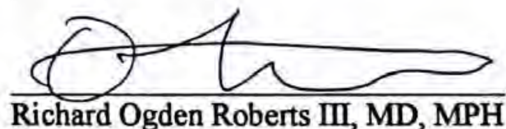
38. For patients currently on gender-affirming medical treatment as of June 1, 2023, my concerns are not alleviated by the provision in SB 14 that allows for some patients to have a "wean off" period of gradually decreasing their existing regimens for puberty-blocking medication or hormones. While tapering 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

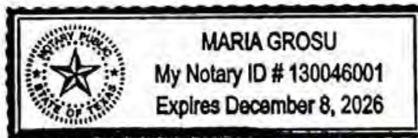
JURAT

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

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.

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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.

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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

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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

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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.

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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
Signed on 2023/07/11 16:07:08 -6:00

David Leo Paul, M.D.

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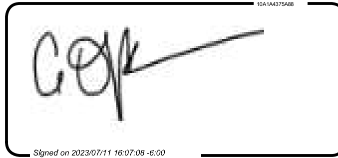
JURAT

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

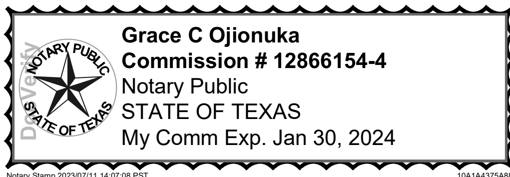


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Exhibit
10

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.

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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

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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

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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

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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

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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

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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

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Exhibit
11

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

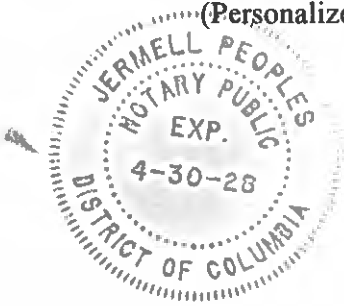
Notary Verification

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

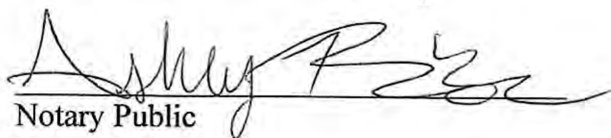
State of North Carolina)
)
County of Mecklenburg)

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.

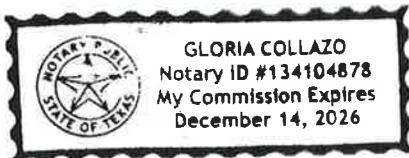
JURAT

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 Public

Exhibit
14

CAUSE NO.

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

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

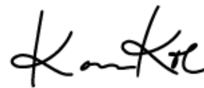
impacts them as it prohibits coverage of this evidence-based, necessary care, even if medically indicated, which they cannot afford otherwise.

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] [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]

[REDACTED]

Exhibit 15

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 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 10 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)

<u>Non-Peer Reviewed Articles</u>

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

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

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

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

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

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

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

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

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

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

Editorial Comment

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

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

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

Erratum

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

Journal Articles

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

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

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

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

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

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

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

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

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

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

11. Strang JF, Meagher H, Kenworthy L, de Vries AL C, Menvielle E, Leibowitz S, Janssen A, Cohen-Kettenis P, **Shumer DE**, Edwards-Leeper L, Pleak RR, Spack N, Karasic DH, Schreier H, Balleur A, Tishelman A, Ehrensaft D, Rodnan L, Kuschner ES, Mandel F, Caretto A, Lewis HC, Anthony LG: Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents, *Journal of Clinical Child and Adolescent Psychology*.47(1): 105-115, 01/2018. PM27775428

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

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

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

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

Letters

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

Letters to editor

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

Notes

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

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

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

EXHIBIT B

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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. <u>Qualifications</u>

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.

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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

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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

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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.

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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

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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.

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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.

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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. <u>Gender Dysphoria and Its Diagnostic Criteria</u>

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.

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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:

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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

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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.

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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. <u>Assessment and Treatment of Gender Dysphoria in Children</u>

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).

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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.

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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).

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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).

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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-

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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

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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

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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

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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

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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

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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

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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.

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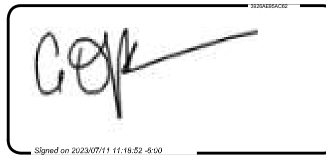
JURAT

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

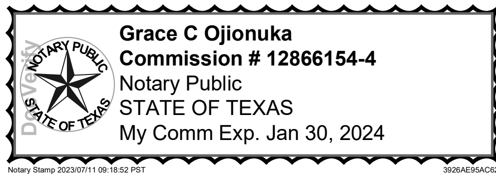


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EXHIBIT A

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.
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9. Connors J., Irastorza, I., Janssen A., Kelly, B., "Child and Adolescent Medicine," The Equal Curriculum: The Student and Educator Guide to LGBTQ Health, editors Lehman J., et al. November 2019.
10. Janssen, A., et. al., "Gender and Sexual Diversity in Childhood and Adolescence," Dulcan's Textbook of Child and Adolescent Psychiatry, 3rd edition, editor Dulcan, M., (in press)
11. Busa S., Wernick J, Janssen, A., "Gender Dysphoria," The Encyclopedia of Child and Adolescent Development, DOI: 10.1002/9781119171492. Wiley, December 2020.

Invited Academic Seminars/Lectures

1. April 2006: "How to Talk to a Gay Medical Student" – presented at the National AAMC Meeting.
2. March 2011: "Kindling Inspiration: Two Model Curricula for Expanding the Role of Residents as Educators" – workshop presented at National AADPRT Meeting.
3. May 2011: Janssen, A., Shuster, A., "Sex Matters: Identity, Behavior and Development," Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.
4. March 2012: Janssen, A., Lothringer, L., "Gender Variance in Children and Adolescents," Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.
5. June 2012: Janssen, A., "Gender Variance in Childhood and Adolescence," Grand Rounds Presentation, Woodhull Department of Psychiatry
6. October 2012: "Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations." Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting.
7. March 2013: "Gender Variance in Childhood and Adolescence," Sexual Health Across the Lifespan: Practical Applications, Denver, CO.
8. October 18th, 2013: "Gender Variance in Childhood and Adolescence," Grand Rounds Presentation, NYU Department of Endocrinology.

9. October, 2014: GLMA Annual Conference: "Theory of Mind and Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning ASD," Invited Presentation
10. October 2014: New York Transgender Health Conference: "Mental Health Assessment in Gender Variant Children," Invited Presentation.
11. November, 2014: Gender Spectrum East: "Affirmative Clinical Work with Gender-Expansive Children and Youth: Complex Situations."
12. October 2015: "Gender Dysphoria and Complex Psychiatric Co-Morbidity," LGBT Health Conference, Invited Speaker
13. October 2015: "Transgender Health Disparities: Challenges and Opportunities," Grand Rounds, Illinois Masonic Department of Medicine
14. November 2015: "Autism and Gender Variance," Gender Conference East, Invited Speaker
15. February 2016: "Working with Gender Variant Youth," New York State Office of Mental Health State Wide Grand Rounds, Invited Speaker
16. March, 2016: "Working with Gender Variant Youth," National Council for Behavioral Health Annual Meeting, Invited Speaker
17. March 2016: "Gender Variance Among Youth with Autism: A Retrospective Chart Review and Case Presentation," Working Group on Gender, Columbia University, Invited Speaker.
18. September, 2016: "Best Practices in Transgender Mental Health: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth," DeWitt Wallace Institute for the History of Psychiatry, Weill Cornell.
19. October, 2016: "LGBTQ Youth Psychiatric Care," Midwest LGBTQ Health Symposim
20. October, 2016: "Gender Fluidity and Gender Identity Development," NYU Health Disparities Conference.
21. February, 2017: "Best Practices in Transgender Mental Health," Maimonides Grand Rounds
22. March, 2017: "Transgender Health: Challenges and Opportunities," Invited speaker, Center for Disease Control STD Prevention Science Series.
23. September 2017: "Autism and Gender Dysphoria," Grand Rounds, NYU Department of Neurology.
24. November 2017: "Consent and Assent in Transgender Adolescents," Gender Conference East.
25. November 2017: "Transgender Mental Health: Challenges and Opportunities," Grand Rounds, Lenox Hill Hospital.
26. April 2018: "Gender Trajectories in Childhood and Adolescent Development and Identity," Sex, Sexuality and Gender Conference, Harvard Medical School.
27. September 2019: "Social and Psychological Challenges of Gender Diverse Youth," Affirmative Mental Health Care for Gender Diverse Youth, University of Haifa.
28. October 2019: "Best Practices in Transgender Mental Health," Grand Rounds, Rush Department of Psychiatry.
29. February 2020: "The Overlap of Autism and Gender Dysphoria," Grand Rounds, Northwestern University Feinberg School of Medicine Department of Psychiatry
30. February 2020: "Gender Dysphoria and Autism," Grand Rounds, University of Illinois at Chicago Department of Psychiatry
31. September 2021: "Gender Diversity and Autism," Grand Rounds, Kaiser Permanente Department of Pediatrics

32. October 2021: Gender Dysphoria and Autism," Grand Rounds, Case Western Reserve University Department of Psychiatry.

Selected Invited Community Seminars/Lectures

1. April 2012: "Gender and Sexuality in Childhood and Adolescence," Commission on Race, Gender and Ethnicity, NYU Steinhardt Speakers Series.
2. February 2013: "Supporting Transgender Students in School," NYC Independent School LGBT Educators Panel, New York, NY.
3. June 2013: "LGBT Health," Presentation for Neuropsychology Department
4. August 2013: "Chronic Fatigue Syndrome: Etiology, Diagnosis and Management," invited presentation.
5. September 2013: Panelist, "LGBTQ Inclusive Sex Education."
6. April 2015: Transgender Children, BBC News, BBCTwo, invited expert
7. January 2016: Gender Dysphoria and Autism – Ackerman Podcast - http://ackerman.podbean.com/e/the-ackerman-podcast-22-gender-dysphoria-autism-with-aron-janssen-md/
8. February 2016: "Best Practices in Transgender Mental Health," APA District Branch Meeting, Invited Speaker.
9. May 2016: "Best Practices in Transgender Mental Health," Washington D.C., District Branch, APA, Invited Speaker
10. July 2016: "Transgender Youth," Union Square West
11. November 2017: "Understanding Gender: Raising Open, Accepting and Diverse Children," Heard in Rye, Conversations in Parenting.
12. January 2018: "The Emotional Life of Boys," Saint David's School Panel, Invited Speaker
13. June 2018: "Supporting Youth Engaged in Gender Affirming Care," NYU Child Study Center Workshop.
14. October 2018: "Medicine in Transition: Advances in Transgender Mental Health," NYCPS HIV Psychiatry and LGBT Committee Meeting.
15. October 2018: "Understanding Gender Fluidity in Kids," NYU Slope Pediatrics.
16. October, 2021: Issues of Ethical Importance: Health Care for Pediatric LGBTQ+ Patients, American Medical Association, Invited Talk

Major Research Interests

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

Research Studies

Study Title	IRB Study#	Dates
Suicide Attempts Identified in a Children's Hospital Before and During COVID-19	2021-4428	2/26/21-present
Lurie Children's Sex & Gender Development Program Clinical Measure Collection	2019-2898	2019-present

Adolescent Gender Identity Research Study (principal investigator) - unfunded	s15-00431	4/15-5/19
Co-Occurrence of Autism Spectrum Disorders and Gender Variance: Retrospective Chart Review (principal investigator) - unfunded	s14-01930	10/14-5/19
Expert Consensus on Social Transitioning Among Prepubertal Children Presenting with Transgender Identity and/or Gender Variance: A Delphi Procedure Study (principal investigator) - unfunded	s13-00576	3/16-5/19
Co-Occurrence of ADHD/Gender Dysphoria (principal investigator) - unfunded	s16-00001	1/16-5/19
PICU Early Mobility- unfunded	s16-02261	12/16-5/19
Metformin for Overweight and Obese Children and Adolescents with Bipolar Spectrum Disorders Treated with Second-Generation Antipsychotics – Funded by PCORI	s16-01571	8/16-5/19

Other

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

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

Selected Media Appearances:

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

EXHIBIT B

Bibliography

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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.

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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. <u>Previous Testimony</u>

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. <u>Compensation</u>

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. <u>Bases for Opinions</u>

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

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[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]

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[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]

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[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]

* * *

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

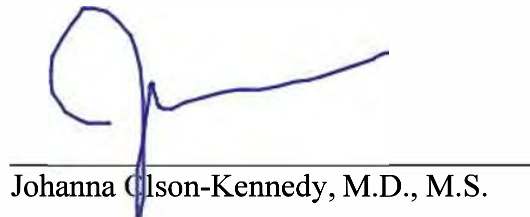
of puberty. It is well documented and studied, through years of clinical experience, observational scientific studies, and even some longitudinal studies. It is also the accepted standard of care by all major medical organizations in the United States.

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.

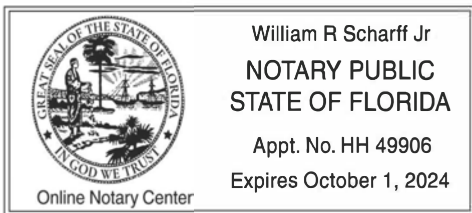
JURAT

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

<u>EXHIBIT A</u>

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**

REFEREED JOURNAL ARTICLES:

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.

5. Belzer ME, Naar-King S, **Olson J**, Sarr M, Thornton S, Kahana SY, Gaur AH, Clark LF; Adolescent Medicine Trials Network for HIV/AIDS Interventions. The use of cell phone support for non-adherent HIV-infected youth and young adults: an initial randomized and controlled intervention trial. AIDS Behav. 2014 Apr;18(4):686-96. doi: 10.1007/s10461-013-0661-3. PubMed PMID: 24271347; PubMed Central PMCID: PMC3962719.

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.

12. **Olson-Kennedy J**,** Cohen-Kettenis PT, Kreukels BP, Meyer-Bahlburg HF, Garofalo R, Meyer W, Rosenthal SM. Research priorities for gender nonconforming/transgender youth: gender identity development and biopsychosocial outcomes. Curr Opin Endocrinol Diabetes Obes. 2016 Apr;23(2):172-9. doi: 10.1097/MED.0000000000000236. PMID: 26825472; PMCID: PMC4807860.

13. **Olson-Kennedy J**,** Okonta V, Clark LF, Belzer M. Physiologic Response to Gender-Affirming Hormones Among Transgender Youth. J Adolesc Health. 2018 Apr;62(4):397-401. doi: 10.1016/j.jadohealth.2017.08.005. Epub 2017 Oct 19. PMID: 29056436; PMCID: PMC7050572.

14. **Olson-Kennedy J****, Warus J*, Okonta V, Belzer M, Clark LF. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. JAMA Pediatr. 2018 May 1;172(5):431-436. doi: 10.1001/jamapediatrics.2017.5440. PMID: 29507933; PMCID: PMC5875384.

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.

16. 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.

17. **Olson-Kennedy J****, Chan YM, Garofalo R, et al. Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study. JMIR Res Protoc. 2019;8(7):e14434. Published 2019 Jul 9. doi:10.2196/14434; PMID: 31290407

18. Rider, G. N., Berg, D., Pardo, S. T., **Olson-Kennedy, J**., Sharp, C., Tran, K. M., Calvetti, S., & Keo-Meier, C. L. (2019). Using the Child Behavior Checklist (CBCL) with transgender/gender nonconforming children and adolescents. *Clinical Practice in Pediatric Psychology, 7*(3), 291–301. https://doi.org/10.1037/cpp0000296

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.

23. **Olson-Kennedy J**,** Streeter LH*, Garofalo R, Chan YM, Rosenthal SM. Histrelin Implants for Suppression of Puberty in Youth with Gender Dysphoria: A Comparison of 50 mcg/Day (Vantas) and 65 mcg/Day (SupprelinLA). Transgender health. 2021 February;6(1):36-42. PMID:33644320; PubMed Central PMCID: PMC7906230; DOI:10.1089/trgh.2020.0055.

24. Millington K, Finlayson C, **Olson-Kennedy J**, Garofalo R, Rosenthal SM, Chan YM. Association of High-Density Lipoprotein Cholesterol With Sex Steroid Treatment in Transgender and Gender-Diverse Youth. JAMA pediatrics. 2021 May 1;175(5):520-521. PMID: 33587098; PMCID: PMC7885095; DOI: 10.1001/jamapediatrics.2020.5620.

25. Chen D, Abrams M, Clark L, Ehrensaft D, Tishelman AC, Chan YM, Garofalo R, **Olson-**

Kennedy J, Rosenthal SM, Hidalgo MA. Psychosocial Characteristics of Transgender Youth Seeking Gender-Affirming Medical Treatment: Baseline Findings from the Trans Youth Care Study. The Journal of adolescent health: official publication of the Society for Adolescent Medicine. 2021 June;68(6):1104-1111. PMID: 32839079; PMCID: PMC7897328; DOI: 10.1016/j.jadohealth.2020.07.033.

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27. Millington, K., et al. (2022). "The effect of gender-affirming hormone treatment on serum creatinine in transgender and gender-diverse youth: implications for estimating GFR." Pediatr Nephrol **37**(9): 2141-2150. PMID: 35083530

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31. Ashley F, Tordoff D, **Olson-Kennedy J**, Restar A, (2023) Randomized-controlled trials are methodologically inappropriate in adolescent transgender healthcare, International Journal of Transgender Health, DOI: 10.1080/26895269.2023.2218357

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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

3. Forcier M, **Olson J****, Transgender and Gender Nonconforming Youth, AM:STARs Hot Topics in Adolescent Health: Adolescent Medicine State of the Art Reviews, 25(2), August 2014 American Academy of Pediatrics Section on Adolescent Health; PMID: 27132320

4. **Olson J**,** Transgender Youth and Young Adults. In: Neinstein's Adolescent and Young Adult Health Care: A Practical Guide, 6th edition, Lippincott Williams and Wilkins, 2015

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.

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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:

1. Beharry M*, **Olson J**,** Men and the Morning After, poster presented at the Society for Adolescent Health and Medicine, Toronto, 2010.

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

11. **Olson J**, Gender Non-conforming Children and Transgender Adolescents, EDGY Conference, Los Angeles, CA, 2015

12. **Olson J**, Gender Non-conforming Children and Transgender Teens, Chico Trans Week, Stonewall Alliance Center of Chico, Chico, CA, 2015

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
32. **Olson-Kennedy J,** Feminizing Hormone Therapy, Gender Infinity, Houston Texas, 2016
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
38. **Olson-Kennedy J,** Beyond Male and Female; Approach to Youth with Non-Binary Gender Identities; Gender Odyssey, Seattle, WA, 2016

39. **Olson-Kennedy J,** Puberty Suppression; What When and How?; Gender Odyssey, Seattle, WA, 2016

40. **Olson-Kennedy J,** Care of Gender Nonconforming Children and Adolescents, Southeastern Transgender Health Summit, Asheville, North Carolina, 2016

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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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.

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Filing Code Description: Petition
Filing Description: PLAINTIFFS' VERIFIED ORIGINAL PETITION FOR DECLARATORY JUDGMENT AND APPLICATION FOR TEMPORARY AND PERMANENT INJUNCTIVE RELIEF
Status as of 7/12/2023 7:23 PM CST

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APPENDIX B

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D-1-GN-23-003616

CAUSE NO. D-1-GN-23-003616

LAZARO LOE, *et al.*,	§	**IN THE DISTRICT COURT OF**
***Plaintiffs*,**	§	
v.	§	**TRAVIS COUNTY, TEXAS**
THE STATE OF TEXAS, *et al.*,	§	
	§	**201st JUDICIAL DISTRICT**
***Defendants*.**	§	

AGREED PROTECTIVE ORDER REGARDING PSEUDONYMS

In order to preserve the anonymity of Plaintiffs Lazaro Loe, Luna Loe, Mary Moe, Matthew Moe, Maeve Moe, Nora Noe, Nathan Noe, Sarah Soe, Steven Soe, Samantha Soe, Gina Goe, and Grayson Goe (hereinafter, "Family Plaintiffs"), and the anonymity of any other minors and their parents who may testify about medical procedures or treatments implicated by SB 14 (hereinafter, "Pseudonymous Witnesses"), and to protect against the disclosure of any and all information that would divulge, either directly or indirectly, the true identities of the Family Plaintiffs or the Pseudonymous Witnesses, the Court hereby finds and orders as follows:

WHEREAS, Plaintiffs Luna Loe, Maeve Moe, Nathan Noe, Samantha Soe, and Grayson Goe (hereinafter, "Minor Plaintiffs") are all transgender minors who have been diagnosed with gender dysphoria;

WHEREAS, the remaining Family Plaintiffs are parents of one of the Minor Plaintiffs;

WHEREAS, the Family Plaintiffs brought this action under their respective pseudonyms to protect their identities from public disclosure;

WHEREAS, the parties to this action ("Parties") may call minors and/or their parents to testify about medical procedures or treatments implicated by Senate Bill 14—the legislation at issue in the above-referenced action ("this Action");

WHEREAS, the Parties jointly request that this Court issue a protective order to protect the identities and highly intimate and personally identifiable information of Family Plaintiffs and Pseudonymous Witnesses throughout this Action;

WHEREAS, exposing the identities of the Family Plaintiffs and Pseudonymous Witnesses would reveal information otherwise protected by law;

WHEREAS, this Court finds good cause exists for issuance of an appropriately tailored protective order governing this Action;

IT IS HEREBY ORDERED that any person subject to this Order—including without limitation any of the Parties, their representatives, agents, experts, and consultants—will adhere to the following terms:

1. The Family Plaintiffs are permitted to bring this action pseudonymously to protect their identities from public disclosure;

2. The Family Plaintiffs and Pseudonymous Witnesses have an interest in protecting the identities of minors, particularly as it relates to the minors' personal health information;

3. In all publicly filed documents, the Family Plaintiffs and Pseudonymous Witnesses shall be identified pseudonymously;

4. All documents filed with this Court in this Action that contain the legal names of any of the Family Plaintiffs and Pseudonymous Witnesses or contain information that identifies any of the Family Plaintiffs and Pseudonymous Witnesses, directly or indirectly, shall be filed under seal using the appropriate mechanisms under Rule 76a;

5. Upon request, the Parties—through each side's respective counsel—will disclose the legal names of Family Plaintiffs and Pseudonymous Witnesses to the other side's counsel;

6. Counsel for the Parties may only disclose the Family Plaintiffs' and Pseudonymous Witnesses' identities to (a) their agents, (b) the Parties to this Action who are individual persons, (b) for each Party to this Action that is not an individual person, a single designated representative for that Party, and (c) to any experts retained by the Parties in this Action. In each instance, the disclosure shall be made only to the extent necessary to litigate this Action;

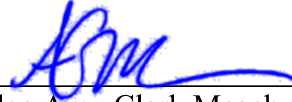
7. Individuals to whom disclosure of the Family Plaintiffs' or Pseudonymous Witnesses' identities is made shall not further disclose the Family Plaintiffs' or Pseudonymous Witnesses' identities;

8. Every individual to whom disclosure of the Family Plaintiffs' or Pseudonymous Witnesses' identities is made shall read and be bound by this Order. Counsel for the Parties shall secure signed copies of the form attached hereto as Exhibit A from every individual to whom disclosure is made under paragraphs 4 and 5 of this Order and shall make the signed copies available to the other side's counsel upon request;

9. Under no other circumstances shall any Party or any other person publicly disclose the Family Plaintiffs' or Pseudonymous Witnesses' identities, either directly or indirectly, without written consent from the counsel for the Family Plaintiffs or Pseudonymous Witnesses who are the subject of the contemplated disclosure; and

10. If any specific issues related to nondisclosure of the Family Plaintiffs' or Pseudonymous Witnesses' identities arise during the course of this Action, the Parties shall seek to resolve those issues without court intervention. If the Parties cannot agree, they shall seek further clarification from the Court.

Signed this __9th__ day of August, 2023.



Judge Amy Clark Meachum
PRESIDING JUDGE

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*signed with permission

CAUSE NO. D-1-GN-23-003616

LAZARO LOE, ***et al.*****,**	§	**IN THE DISTRICT COURT OF**
Plaintiffs**,** **v.**	§	**TRAVIS COUNTY, TEXAS**
THE STATE OF TEXAS, ***et al.*****,**	§	**201st JUDICIAL DISTRICT**
Defendants**.**	§	

Exhibit A to the Agreed Protective Order

I hereby acknowledge that I, ________________________________[NAME], ________________________________ [POSITION AND EMPLOYER], am about to receive the legal name and/or other identifying information about a person proceeding under pseudonym in the above-entitled action. I certify that I understand that this information is provided to me subject to the terms and restrictions of the Agreed Protective Order Regarding Pseudonyms ("Agreed Protective Order") filed in this action. I have received a copy of the Agreed Protective Order; I have read the Agreed Protective Order; and I agree to be bound by the terms of the Agreed Protective Order.

DATED:________________________ BY: ________________________________
[Signature]

APPENDIX C

COPY

Filed in The District Court
of Travis County, Texas

AR AUG 25 2023
At 2:22 P M.
Velva L. Price, District Clerk

CAUSE NO. D-1-GN-23-003616

LAZARO LOE, ***et al.*****,** ***Plaintiffs*****,**	§	**IN THE DISTRICT COURT OF**
v.	§	**TRAVIS COUNTY, TEXAS**
THE STATE OF TEXAS, ***et al.*****,** ***Defendants*****.**	§	**201st JUDICIAL DISTRICT**

TEMPORARY INJUNCTION ORDER

On August 15 and 16, 2023, the Court held an evidentiary hearing on the Application for Temporary Injunction included within Plaintiff's Verified Original Petition ("Application") filed by Plaintiffs 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. ("PFLAG"); Richard Ogden Roberts III, M.D.; David L. Paul, M.D.; Patrick W. O'Malley, M.D.; American Association of Physicians for Human Rights, Inc., d/b/a GLMA: Health Professionals Advancing LGBTQ Equality ("GLMA") (collectively, "Plaintiffs") against Defendants the State of Texas, the Office of the Attorney General of Texas, John Scott, in his official capacity as Provisional Attorney General[1] ("Attorney General"), the Texas Medical Board, and Texas Health and Human Services Commission (collectively, "Defendants").

[1] Plaintiffs' Verified Original Petition for Declaratory Judgment and Application for Temporary and Permanent Injunctive Relief sued John Scott, in his capacity as Provisional Attorney General due to the Articles of Impeachment against Ken Paxton passed by the Texas House of Representatives on 5/27/2023, which resulted in the suspension of the exercise of Ken Paxton's duties in the Office of Attorney General. On July 12, 2023, Angela Colmenero succeeded John Scott as Provisional Attorney General of Texas.

In their Application, Plaintiffs seek to temporarily restrain and enjoin Defendants, their officers, agents, servants, employees, attorneys, and all persons in active concert and participation with Defendants, from implementing and enforcing the act commonly known as Senate Bill 14, passed by the 88th Texas Legislature, Regular Session, and signed by the Governor on June 2, 2023 ("Act"). The Act prohibits the provision of certain medical treatments and procedures to transgender adolescents in Texas by various amendments to the Health and Safety Code, the Occupations Code, and Human Resources Code. Act §§ 1-9 (adding Subsection (g) to Section 62.151 of the Health and Safety Code; Subchapter X to Chapter 161 of the Health and Safety Code; Subsection (pp) to Section 33.024 of the Human Resources Code; Section 164.052(a)(24) of the Occupations Code; Section 164.0552 to Subchapter B, Chapter 164 of the Occupations Code).

Having considered the testimony and evidence admitted at the hearing, the arguments of counsel, and the applicable authorities, this Court finds sufficient cause to enter a Temporary Injunction against Defendants. Plaintiffs state a valid cause of action against Defendants and have a probable right to the declaratory and permanent injunctive relief they seek in this lawsuit. There is a substantial likelihood that Plaintiffs will prevail after a trial on the merits. Furthermore, unless Defendants are immediately enjoined from enforcing the Act, Plaintiffs will suffer probable, imminent, and irreparable injury in the interim.

FINDINGS

I. Likelihood of Success

A. The Court finds the Act likely violates Article I, Section 19 of the Texas Constitution by infringing upon the fundamental right of parents to make decisions concerning the care, custody, and control of their children. This fundamental right includes the right of parents to give, withhold, and withdraw consent to medical treatment for their children. This fundamental right also includes the right to seek and to follow medical advice to protect the health and wellbeing of their minor children. The Act's prohibitions on providing evidence-based treatment for adolescents with gender dysphoria stands directly at odds with parents' fundamental right to make decisions

concerning the care of their children. Furthermore, the Act 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 for their children. The evidence before the Court does not support the conclusion the Act protects the health or wellbeing of minors. Instead, the evidence demonstrates that the Act threatens the health and wellbeing of adolescents with gender dysphoria. Specifically, the Act denies their parents, including Parent Plaintiffs and PFLAG parent members, the ability to obtain necessary and in some circumstances, lifesaving medical treatment for these children. The Court finds the Act is not narrowly tailored to serve a compelling government interest. Furthermore, the Court finds the Act lacks even a rational relationship to any legitimate government interest.

B. The Court further finds the Act likely violates Article I, Section 19 of the Texas Constitution by infringing upon Texas physicians' right of occupational freedom. The Act deprives Texas physicians of a vested property interest in their medical licenses. The Act requires Texas medical providers, including the physician Plaintiffs and health professional members of GLMA, to disregard well-established, evidence-based clinical practice guidelines, and their training and oaths, thereby significantly and severely compromising the health of their patients with gender dysphoria or, alternatively, to risk their livelihoods. The Act mandates revocation of licenses, along with a panoply of other disciplinary actions (including actions available to some Defendants through existing enforcement provisions of the Texas Medical Practice Act) if physicians provide their transgender adolescent patients with medically necessary treatment. The Act interferes with the professional relationship among medical providers, adolescent patients, and the patients' parents. Further, it subjects physicians to discipline for treating a patient according to generally accepted standards of care. The Act is clearly arbitrary and its effect as a whole is so unreasonably burdensome that it is oppressive.

C. The Court further finds that the Act likely violates Article I, Sections 3 and 3a the Texas Constitution by discriminating against transgender adolescents with gender dysphoria because of

their sex, sex stereotypes, and transgender status. The Act infringes upon the Texas Constitution's guarantees of equality under the law by enacting a discriminatory and categorical prohibition on evidence-based medical treatments for transgender youth which remains available to cisgender youth. Puberty-delaying treatment, hormone therapy, and chest surgery may be administered to treat minors with a variety of conditions other than gender dysphoria. However, the Act does not prohibit the same medical treatments for minors with all medical conditions; rather, it prohibits the treatments *only* when used to treat an adolescent for gender dysphoria, even though the risks of the treatments are similar, if not the same, regardless of the condition for which they are prescribed. In short, the Court finds that the Act is not justified by any legitimate state purpose, let alone a compelling one. The Act was passed because of, and not in spite of, its impact on transgender adolescents, depriving them of necessary, safe, and effective medical treatment. Further, the Act interferes with and overrides the clinical and evidence-based judgment of medical providers and the decision-making of parents, who provide informed consent.

II. Likelihood of Irreparable Harm

A. It is clear to the Court that, unless Defendants are immediately enjoined from enforcing the Act, Plaintiffs will suffer probable, imminent, and irreparable injury in the interim. Such injury, which cannot be remedied by an award of damages or other adequate remedy at law, includes:

(i) the loss of access to safe, effective, and medically necessary treatment for transgender adolescents experiencing gender dysphoria;

(ii) significantly and severely compromising the health and wellbeing of transgender adolescents experiencing gender dysphoria, including forcing such patients to experience unwanted and unbearable changes to their body;

(iii) the loss of a parent's ability to direct their child's medical treatment;

(iv) destabilizing the family unit, including forcing families to leave Texas, travel regularly out of state, and/or choose indefinite family separation;

(v) depriving Texas physicians the right of occupational freedom and their vested property interests in their medical licenses;

(vi) forcing Texas physicians to either violate their oath by disregarding the patient's medical needs and inflicting needless suffering, or putting their medical license and livelihood at risk; and

(vii) exacerbating health disparities for transgender adolescent patients who receive Medicaid and Children's Health Insurance Program (CHIP) coverage and who will lose that coverage if the Act goes into effect.

III. Balancing of the Equities

Defendants were provided notice of the causes of action, the Application, and participated in the hearing. The balance of the equities favors Plaintiffs. The threatened injury to Plaintiffs substantially outweighs the harm, if any, that Defendants would suffer from having to forestall enforcement of the Act, pending resolution of this case.

The Temporary Injunction being entered by the Court today is necessary to maintains the status quo and should remain in effect while this Court, and potentially the Third Court of Appeals and the Supreme Court of Texas, examine the parties' merits and jurisdictional arguments.

IT IS HEREBY ORDERED, ADJUDGED, and DECREED:

A. Until all issues in this lawsuit are finally and fully determined, Defendants and their respective officers, agents, servants, employees, and attorneys, as well as any individuals or entities in active concert with them, directly or indirectly under their control, or participating with them, who receive actual notice of the Order by personal service or otherwise, are immediately enjoined and restrained from implementing or enforcing the Act, and such restraint encompasses but is not limited to:

(1) enjoining and restraining the State of Texas, Office of the Attorney General of the State of Texas, Angela Colmenero, in her official capacity as Provisional Attorney General, and any successor Attorney General from filing an action to

enforce the Act, whether directly through authority provided by proposed Section 161.706 of Texas Health and Safety Code, or indirectly through authority provided by the Texas Medical Practice Act or otherwise;

(2) enjoining and restraining the State of Texas and Texas Medical Board from taking action to implement or enforce the Act, including investigating a complaint, referring a complaint to the Office of the Attorney General, revoking the license or other authorization to practice medicine of a physician, refusing to admit to examination or refuse to issue a license or renewal license to a person based on the Act, whether directly through authority provided by proposed Sections 164.052(a)(24) or 164.0552 of Texas Occupations Code, or indirectly through authority provided by the Texas Medical Practice Act or otherwise;

(3) enjoining and restraining the State of Texas and Texas Health and Human Services Commission from (a) withholding public money from being used, granted, paid, or distributed to any health care provider, medical school, hospital, physician, or any other entity, organization, or individual that provides or facilitates the provision of a procedure or treatment based on the Act, and (b) withholding or otherwise limiting reimbursement of or coverage for prohibited care under the Act by Medicaid and/or CHIP insurance plans.

B. Defendants shall provide notice of this Temporary Injunction to their officers, agents, servants, employees, and attorneys, and those persons in active concert or participation with them.

C. Plaintiffs' bond is set at $100. The clerk of this Court shall issue a Temporary Injunction in conformity with the law and the terms of this Order.

D. All parties may be served with notice of this Temporary Injunction in any matter provided under Rule 21a of the Texas Rules of Civil Procedure.

E. This Temporary Injunction shall not expire until judgment in this case is entered or this case is otherwise dismissed by this Court.

F. A trial on the merits is preferentially set before the Honorable Maria Cantú Hexsel, Judge of the 53rd Judicial District Court of Travis County, Texas on May 6, 2024, at 9:00 AM.

SIGNED on the 25th day of August, 2023.

Judge Maria Cantú Hexsel
PRESIDING JUDGE

APPENDIX D

CAUSE NO. D-1-GN-23-003616

LAZARO LOE, et al., *Plaintiffs*,	§	IN THE DISTRICT COURT OF
	§	
	§	
	§	
v.	§	TRAVIS COUNTY, TEXAS
	§	
	§	
STATE OF TEXAS, et al., *Defendants.*	§	
	§	201st JUDICIAL DISTRICT

DEFENDANTS' NOTICE OF ACCELERATED INTERLOCUTORY APPEAL

Defendants the State of Texas, Office of the Attorney General, Angela Colmenero, in her official capacity as Provisional Attorney General of Texas, the Texas Medical Board, and the Texas Health and Human Services Commission (collectively, "Defendants") appeal the Court's Orders granting Plaintiffs' Application for Temporary Injunction and denying Defendants' Plea to the Jurisdiction.

Defendants are entitled to an interlocutory appeal pursuant to Tex. Civ. Prac. & Rem. Code §§ 51.014(a)(4), (8), which allow for immediate appeals from orders granting temporary injunctions and denying pleas to the jurisdiction. Defendants appeal to the Texas Supreme Court pursuant to Tex. Gov't Code § 22.001(c), which provides for direct appeals to the Texas Supreme Court when a trial court grants an interlocutory injunction on the ground of the constitutionality of a statute of this state. This is an accelerated appeal as provided by Tex. R. App. P. 28.1. This is not a parental termination or child protection case, as defined in Tex. R. App. P. 28.4.

Pursuant to Tex. Civ. Prac. & Rem. Code § 51.014(b), all further proceedings in this court are stayed pending resolution of Defendants' appeal. Upon filing of this instrument, the August 25, 2023, Order Granting Plaintiffs' Application for Temporary Injunction is superseded pursuant to Tex. Civ. Prac. & Rem. Code § 6.001(b) and Tex. R. App. P. 29.1(b). Pursuant to Tex. Civ. Prac. & Rem. Code § 6.001, as governmental officers and entities, Defendants are not required to file a

supersedeas bond for court costs. Defendants' appeal is therefore perfected upon the filing of the notice of appeal.

Respectfully submitted.

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Provisional Attorney General

BRENT WEBSTER
First Assistant Attorney General

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Deputy First Assistant Attorney General

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Acting Deputy Attorney General for Civil Litigation

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COUNSEL FOR DEFENDANTS

CERTIFICATE OF SERVICE

I hereby certify that on August 25, 2023, a true and correct copy of the foregoing document was served via File and Serve Texas to all counsel of record.

/s/Johnathan Stone
JOHNATHAN STONE
Assistant Attorney General

APPENDIX E

1 REPORTER'S RECORD
VOLUME 1 OF 2 VOLUMES
2 TRIAL COURT CAUSE NO. D-1-GN-23-003616

3 LAZARO LOE, individually and as parent and next friend of 4 LUNA LOE, a minor; MARY MOE and MATTHEW, individually 5 and as parent and next friends of MAEVE MOE, a 6 minor; NORA NOE, individually and as parent 7 and next friend of NATHAN NOE, a minor; SARAH SOE and 8 STEVEN SOE, individually and as next friends of SAMANTHA 9 SOE, a minor; GINA GOE, individually and as parent 10 and next friend of GRAYSON GOE, a minor; PFLAG, INC.; 11 RICHARD OGDEN ROBERTS III, M.D., on behalf of himself 12 and his patients; DAVID L. PAUL, M.D., on behalf of 13 himself and his patients; PATRICK W. O'MALLEY, M.D., 14 on behalf of himself and his patients; and AMERICAN 15 ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS, INC. d/b/a 16 GLMA; HEALTH PROFESSIONALS ADVANCING LGBTQ+ EQUALITY,	)	IN THE DISTRICT COURT
17 v. 18	)	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS; OFFICE 19 OF THE ATTORNEY GENERAL OF TEXAS; JOHN SCOTT, in his 20 official capacity as Provisional Attorney 21 General; TEXAS MEDICAL BOARD; and TEXAS HEALTH AND 22 HUMAN SERVICES COMMISSION	)	201ST JUDICIAL DISTRICT

23 ---

24 HEARING ON APPLICATION FOR TEMPORARY INJUNCTION
AND PLEA TO THE JURISDICTION
25

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1 On the 15th day of August, 2023, the following
2 proceedings came on to be heard in the above-entitled
3 and numbered cause before the Honorable Maria Cantú
4 Hexsel, Judge presiding, held in Austin, Travis County,
5 Texas;
6 Proceedings reported by machine shorthand.
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1 **A P P E A R A N C E S**

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1 **I N D E X**

2 **VOLUME 1 OF 2**

3 **HEARING ON APPLICATION FOR TEMPORARY INJUNCTION AND PLEA TO THE JURISDICTION**

4 **AUGUST 15, 2023**

5

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13 By Ms. Leskin	25			1
14 ARON JANSSEN, M.D.				
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18 JOHANNA OLSON-KENNEDY, M.D.				
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21 By Ms. Leskin	142			1
22 BRIAN BOND				
By Ms. Pollard	153			1

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By Ms. Pollard	172			1
SHELDON, ALEX				
By Ms. Pollard	190			1
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1	Curriculum Vitae of Michael Laidlaw, M.D.	12	12	1
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3

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6	Curriculum Vitae of Colin Wright, Ph.D.	12	12	1
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1 **PROCEEDINGS**

2 THE COURT: All right. Then let's go on
3 the record in Cause No. D-1-GN-23-3616. Today is
4 August 15th, 2023, and we are here on both a temporary
5 injunction and plea to the jurisdiction in the case
6 referenced. I would ask those attorneys present to make
7 their appearances for our record beginning with you,
8 Ms. Wooten.
9 MS. WOOTEN: Thank you, Your Honor. Good
10 morning. As stated, my name is Kennon Wooten. I'm a
11 partner at Scott Douglass & McConnico representing
12 plaintiffs pro bono in this matter. And if you'll
13 permit, I'll announce the other people --
14 THE COURT: Sure.
15 MS. WOOTEN: -- appearing for plaintiffs.
16 At counsel table for plaintiffs are Lori Leskin and
17 Allissa Pollard from Arnold & Porter, which is also
18 involved pro bono in this matter. In addition, we have
19 from Lambda Legal Defense and Education Fund, Inc. Karen
20 Loewy and Omar Gonzalez-Pagan. And last but certainly
21 not least, we have Harper Seldin from ACLU Foundation.
22 THE COURT: Thank you. For the defense?
23 MR. STONE: Johnathan Stone for
24 defendants.
25 MS. DYER: Heather Dyer for defendants.

1 MR. ELDRED: Charles Eldred for
2 defendants.
3 THE COURT: All right. Thank you. Again,
4 I will state for our record that there is no recording,
5 broadcasting, or photographing admitted -- or permitted
6 in this proceeding, and that would count both in this
7 courtroom as well as the overflow courtroom in 8C. It
8 is punishable by contempt if I find anyone has recorded
9 or photographed or broadcast from our proceeding, but
10 otherwise, you're all welcome in the gallery. Thank
11 you.
12 All right. So would we like to admit some
13 evidence? I know we discussed that.
14 MS. WOOTEN: Yes, Your Honor.
15 THE COURT: Okay. So I understand there
16 may be some evidence we can admit if you'd like to go
17 ahead with that offer, Ms. Wooten.
18 MS. WOOTEN: The parties conferred and
19 identified 14 agreed exhibits. They are all loaded into
20 Box. The exhibits consist of the eight exhibits
21 defendants have identified for this hearing, and those
22 are marked as D-1 through D-8. In addition, there are
23 six of the exhibits that plaintiffs have identified for
24 the hearing, and those are marked P-1, P-2, P-3, P-5,
25 P-8, and P-11. At this time I'm offering the exhibits

1 marked as P-1, P-2, P-3, P-5, P-8, and P-11 into
2 evidence.
3 THE COURT: Mr. Stone, as I understand it,
4 those are agreed to.
5 MR. STONE: Yes, Your Honor, those are
6 agreed to.
7 THE COURT: So I will admit P-1, 2, 3, 5,
8 8, and 11.
9 *(Plaintiffs' Exhibits 1, 2, 3, 5, 8,*
10 *and 11 admitted)*
11 THE COURT: And Mr. Stone, do you at this
12 time -- would you like to offer D-1 through D-8?
13 MR. STONE: Yes, Your Honor.
14 THE COURT: And I assume, Ms. Wooten,
15 those are agreed to.
16 MS. WOOTEN: Yes, Your Honor.
17 THE COURT: Thank you. D-1 through D-8
18 are admitted.
19 *(Defendants' Exhibits 1 through 8*
20 *admitted)*
21 THE COURT: All right. So if we would
22 like to begin with some opening statements.
23 MS. WOOTEN: Yes, Your Honor. We do have
24 one more administrative matter that we believe may be
25 helpful for the proceedings. Last night plaintiffs'

1 counsel provided defendants' counsel with a list of our
2 witnesses and the order in which we anticipate
3 presenting them, and I do have a copy for Your Honor and
4 the court reporter if I may have permission to approach.
5 THE COURT: Yes. Go ahead. Thank you.
6 Anything else, Ms. Wooten, before we begin with opening
7 statements?
8 MS. WOOTEN: No, Your Honor.
9 THE COURT: All right. Give me one more
10 second just to pull up a couple -- where would you like
11 to do opening from? The lectern or the --
12 MS. LOEWY: Whichever Your Honor would
13 prefer.
14 THE COURT: I'm kind of a fan of the
15 lectern, so if you'd like to do that, that would be
16 great. Just give me one other second to get my time
17 calculator up. And, of course, you can run any
18 exhibits -- well, how is that going to work?
19 *(Discussion off the record)*
20 THE COURT: Do you have a PowerPoint or
21 something that you'd like to run?
22 MS. LOEWY: No, Your Honor.
23 THE COURT: Okay. Then I'm going to leave
24 that alone for now so I don't mess anything up. Give me
25 one other second just to do this. All right. Please go

1 ahead.

2 **PLAINTIFFS' OPENING STATEMENTS**

3 MS. LOEWY: Thank you, Your Honor. Good
4 morning. My name is Karen Loewy. I'm here for the
5 plaintiffs.

6 When a child develops a serious health
7 condition, parents generally want nothing more than to
8 make their child feel better and help them grow into
9 happy, healthy people and so will work with their
10 child's healthcare providers to figure out what is going
11 on and determine what course of care will be medically
12 necessary for that child.

13 Physicians and other healthcare providers
14 will use their training and judgment to prescribe
15 treatments in accordance with established standards of
16 care to meet that child's treatment needs, help parents
17 understand their options and their risks, and enable
18 parents to make decisions about what their child's
19 course of care will be.

20 For transgender young people in Texas and
21 their parents and their healthcare providers, the
22 ability to take these ordinary steps is at significant
23 risk because of Senate Bill 14. Gender dysphoria is a
24 serious health condition experienced only by transgender
25 people characterized by the clinically significant

1 distress caused by the incongruence between their gender
2 identity and the sex they were assigned at birth.
3 Evidence-based comprehensive clinical
4 practice guidelines recommend certain medical treatments
5 for gender dysphoria. And adolescents who experience
6 gender dysphoria in Texas right now have access to those
7 treatments. But SB 14 categorically bars the very
8 medical treatments accepted as necessary, effective, and
9 even lifesaving from being provided to minors for the
10 purpose of treating gender dysphoria.
11 SB 14 at its core prohibits physicians and
12 healthcare providers from prescribing, providing, or
13 performing certain medical treatments to minors, namely
14 puberty blockers, hormone therapy, and surgery, solely
15 if those treatments are being provided to treat gender
16 dysphoria. The rest of the bill incorporates that
17 prohibition in a variety of ways; one, by requiring the
18 Board of Medical Examiners to deny or revoke the medical
19 license of any physician who provides the prohibited
20 treatments and imposing other penalties; two,
21 prohibiting any form of state funding being paid to any
22 provider or entity that provides or facilitates the
23 prohibited treatments; three, barring coverage and
24 reimbursements for prohibited treatments under Medicaid
25 and the child health plan; and four, empowering the

1 attorney general to bring enforcement actions against
2 any person the attorney general has reason to believe
3 is, has, or will violate the prohibition.
4 SB 14 threatens the health and well-being
5 of transgender adolescents in Texas, their parents'
6 autonomy to make decisions about their medical care, and
7 the licenses and livelihoods of healthcare providers who
8 have been and want to continue caring for them in
9 accordance with the recognized course of treatment for
10 gender dysphoria. In doing so, SB 14 violates
11 plaintiffs' constitutional rights. It violates parents'
12 fundamental rights to parental autonomy under Article 1
13 Section 19, which includes the right to seek medical
14 care for their child and make judgments about what care
15 that child should receive. Parents do not sacrifice
16 these rights simply because their child is transgender.
17 SB 14 also deprives transgender youth of
18 the Texas Constitution's promises of equality and equal
19 rights by discriminating against them on the bases of
20 sex and transgender status. By its plain terms, whether
21 a minor can receive certain medical treatment turns on
22 their sex assigned at birth or on whether they are
23 transgender. SB 14 singles out transgender minors and
24 excludes them only from accessing medically necessary
25 care.

1 Finally, SB 14 deprives physicians of
2 their vested property interests and their medical
3 licenses and infringes the rights of all healthcare
4 providers' occupational liberty without due course of
5 law. SB 14 requires that physicians lose their licenses
6 for treating their patients in accordance with
7 established standards of care and undermines healthcare
8 providers' ability to fulfill the obligations of their
9 profession.
10 Today the Court will hear from families
11 and healthcare providers who will be directly harmed if
12 SB 14 goes into effect on September 1st as well as from
13 experts who will establish that the treatments it
14 prohibits are safe, effective, and part of the
15 established course of care for gender dysphoria and will
16 address the serious harms to transgender youth from
17 cutting off and denying that care.
18 Plaintiffs seek temporary injunctive
19 relief to ensure that the transgender youth of Texas can
20 continue to receive medically necessary care in their
21 own communities, that their parents can continue to make
22 decisions about that care, and that their doctors and
23 other health professionals can continue to provide that
24 care without threatening their medical licenses or state
25 funding.

1 These families and providers have stated
2 viable claims that SB 14 is facially unconstitutional
3 against the state defendants charged with its
4 enforcement, claims on which they have a probable right
5 to relief as every trial court considering similar
6 wholesale bans on medically necessary healthcare for
7 transgender minors has concluded. Enjoining SB 14 from
8 going into effect while this Court assesses its
9 constitutionality is necessary to maintain the
10 status quo and shield transgender youth, their families,
11 and their healthcare providers from harm. Thank you.
12 THE COURT: Thank you. For the defense?
13 **DEFENDANTS' OPENING STATEMENTS**
14 MS. DYER: May it please the Court. Good
15 morning, Your Honor. I'm Heather Dyer for the
16 defendants.
17 We are here today because plaintiffs claim
18 that Senate Bill 14, which is the state's bipartisan
19 prohibition on puberty blockers, cross-sex hormones, and
20 surgeries for the treatment of gender dysphoria in
21 minors, violates the Texas Constitution. To make it
22 more concise for the Court, defendants will refer to
23 prohibited medication and surgeries throughout this
24 hearing as prohibited treatment.
25 As you know, defendants have filed a plea

1 to the jurisdiction requesting dismissal of plaintiffs'
2 claims, and plaintiffs seek to enjoin the enforcement of
3 Senate Bill 14 during the pendency of this suit. At the
4 outset, defendants would note that since a question of
5 jurisdiction has been raised, that issue should be
6 decided before turning to the merits and subjecting
7 defendants, who are entitled to sovereign immunity, to
8 further litigation.
9 However, with regards to the
10 jurisdictional question, Senate Bill 14 simply does not
11 violate the Constitution, and plaintiffs have failed to
12 allege sufficient facts that it does. Consequently,
13 defendants retain their immunity to suit, and this Court
14 lacks subject matter jurisdiction.
15 With respect to plaintiffs' first
16 constitutional claims, the due course of law clause does
17 not protect a parent's interests in providing medical
18 treatment that is prohibited by the law, nor does it
19 protect a physician's interests in providing medical
20 treatment to a patient that is prohibited by the law.
21 At best, it protects a citizen's interest in lawful
22 common callings, but the prohibited treatment is not a
23 common calling and will no longer be lawful on
24 September 1st.
25 With respect to plaintiffs' second

1 constitutional claim, the statute does not deny or
2 abridge equality under the law on the basis of sex. It
3 classifies based on the medical purpose for which the
4 treatment is being offered, not sex. It treats persons
5 of both biological sex the exact same.
6 With respect to plaintiffs' third
7 constitutional claim, the statute does not treat
8 similarly situated people differently. It prohibits
9 certain treatment for gender dysphoria, yes, but persons
10 with gender dysphoria are not similarly situated to
11 others. And Texas courts do not create suspect classes.
12 Suspect classes are listed in the Constitution itself.
13 While sex is listed, persons with gender dysphoria are
14 not.
15 Even if plaintiffs could identify a
16 plausible claim, Senate Bill 14 would still not violate
17 the Texas Constitution because it not only passes
18 rational basis, but it also passes strict scrutiny. It
19 passes strict scrutiny for two primary reasons, the
20 first being the State has a compelling interest in
21 safeguarding the physical and psychological well-being
22 of a minor. In *Prince v. Massachusetts* the Supreme
23 Court of the United States stated a democratic society
24 rests upon the health and well-rounded growth of young
25 people into full maturity as citizens. That is

1 precisely what SB 14 was designed and enacted to
2 protect.
3 The evidence will show in this hearing
4 that sex is biological and immutable. However, gender
5 identity is not. It can change over time. It can
6 change going through puberty. And it can also change
7 based on social circumstances and environments. Gender
8 dysphoria is a psychological condition, not an endocrine
9 condition where a person's biological sex does not match
10 the perception of their gender. There are no physical
11 medical tests for gender dysphoria.
12 Plaintiffs contend the scientific studies
13 and medical association opinions on these prove that
14 these prohibited treatments are safe and effective.
15 However, that is simply not the case, or at least it is
16 not an established fact. The evidence throughout this
17 hearing will show the prohibited treatment will result
18 in irreversible consequence for these minors. The
19 consequences, to name a few, range from bone density
20 problems, diminished cognitive ability, to
21 sterilization. The risks associated with the prohibited
22 treatment vastly outweighs any potential benefit,
23 especially when you consider that gender identity by
24 definition can change. Conversely, therapy has no
25 risks. It is indisputably the only treatment that is

1 entirely safe, effective, and devoid of dangerous side
2 effects.
3 Further, nothing in Senate Bill 14
4 prohibits individuals from receiving the care they seek
5 to receive once they are of the age of 18. This law was
6 enacted only to protect minors from scientifically
7 unfounded treatment. The evidence will show that the
8 State's restrictions on prohibited treatment is the
9 least restrictive means of achieving that interest
10 because the risks vastly outweigh any potential benefit,
11 and a safe and effective alternative, being therapy,
12 already exists.
13 The second reason Senate Bill 14 passes
14 strict scrutiny and necessarily a rational basis review
15 is because the State has a compelling interest in
16 preventing medical procedures for which there is no
17 informed consent. The evidence will show that a human
18 brain is not even fully developed until you are in your
19 mid twenties. Children under the age of 18 cannot
20 understand or appreciate the impact that these
21 prohibited treatments will have on their life in the
22 long term.
23 Plaintiffs claim that prohibited treatment
24 is reversible and that it does not cause infertility.
25 However, the very standards they rely on in their

1 complaint note that a consequence of the treatment is
2 partially irreversible, and a side effect of treatment
3 includes potential loss of fertility. The evidence
4 throughout this hearing will show that the prohibited
5 treatment is in fact irreversible and does lead to
6 infertility.
7 Just as an example, once a biological girl
8 has a bilateral mastectomy, or a top surgery as it's
9 often referred to, her breasts will never function the
10 same again, and she will never be able to breastfeed her
11 children one day should that be something she chooses to
12 do. That is simply not something that a 13-, 14-, or
13 15-year-old can understand or appreciate at that stage
14 in their life.
15 Children are albeit focused on what makes
16 them happy in the moment, as they should be, but they do
17 not have the brain development nor the maturity to make
18 an informed decision to consent to these treatments that
19 have lifelong altering impacts. Because they cannot
20 give informed consent to the prohibited treatment, a ban
21 on such treatment until they are of legal age passes
22 strict scrutiny and a rational basis review.
23 Plaintiffs cannot meet their burden to
24 show they are likely to succeed on the merits, nor will
25 they be able to show that there's imminent irreparable

1 harm to meet the standard necessary for a temporary
2 injunction. Accordingly, defendants respectfully
3 request this Court deny plaintiffs' motion for a
4 temporary injunction and grant defendants' plea to the
5 jurisdiction. Thank you.
6 THE COURT: Thank you, Ms. Dyer.
7 All right. Ms. Wooten, who would you like
8 to call as your first witness?
9 MS. LESKIN: Your Honor, we call Gina Goe.
10 THE COURT: Say the name one more time.
11 MS. LESKIN: Gina Goe.
12 THE COURT: Okay.
13 MS. LESKIN: Ms. Goe is proceeding under
14 pseudo- -- is a plaintiff proceeding under pseudonym.
15 THE COURT: Yes. Yes. I just wanted to
16 make sure I heard the right name. Just one second.
17 MS. LESKIN: And if Your Honor would
18 indulge me, can I proceed from this location?
19 THE COURT: If that's more comfortable for
20 you, that's fine.
21 MS. LESKIN: Thank you, Your Honor.
22 THE COURT: Hello, Ms. Goe. If you'll
23 step forward here, I'll swear you in. If you will raise
24 your right hand for me.
25 *(Witness sworn)*

1 THE COURT: All right. If you can make
2 your way around and up to this witness stand, and just
3 make sure -- the sweet spot is about six inches from the
4 mic. Thank you.
5 MS. LESKIN: Thank you, Your Honor.
6 **GINA GOE**,
7 having been first duly sworn, testified as follows:
8 **DIRECT EXAMINATION**
9 BY MS. LESKIN:
10 Q. Good morning.
11 A. Good morning.
12 Q. Will you tell us your name, please?
13 A. Gina Goe.
14 Q. And Ms. Goe, do you live in Texas?
15 A. Yes.
16 Q. Which county in Texas do you live in?
17 A. McLennan County.
18 THE COURT: And ma'am, you can be seated.
19 If you're going to stay at counsel table, you can --
20 MS. LESKIN: Thank you, your Honor.
21 THE COURT: -- be seated to question the
22 witness. Go ahead.
23 Q. (BY MS. LESKIN) Are you a member of PFLAG?
24 A. Yes.
25 Q. Tell me about your family, Ms. Goe.

1 A. We're just a family living life. We live in a
2 small town. It's my husband and Grayson and myself and
3 our two cats and a dog.
4 Q. And Grayson is your son?
5 A. Yes.
6 Q. Tell me about Grayson.
7 A. I think Grayson's pretty amazing. He's funny.
8 He's smart. He's very curious, so he, like, engages in
9 learning about things a lot on his own, like, taught
10 himself to play the ukulele and wood whittle, and he
11 likes video games.
12 Q. And how old is Grayson?
13 A. 15.
14 Q. What sex was Grayson assigned at birth?
15 A. Female.
16 Q. And what gender does Grayson identify today?
17 A. Male.
18 Q. How did Grayson -- when did Grayson tell you
19 that he identified as male?
20 A. I think it was when he was about 11.
21 Q. Tell me about that conversation.
22 A. I don't remember exactly how the conversation
23 went, but he told me that he felt like he was a boy.
24 Q. And prior to Grayson telling you that he felt
25 like he was a boy, had you noticed anything about

1 Grayson's mental health?
2 A. I mean, yeah, we were dealing with some
3 depression and anxiety, and he was having some trouble
4 in school with grades and so forth, so we were, like,
5 trying to address that as well.
6 Q. How were you addressing that?
7 A. So I took him to a psychologist, and then later
8 on he saw a psychiatrist, and the psychiatrist
9 prescribed medication for depression.
10 Q. Did you find that the medication that Grayson
11 took was helping his depression?
12 A. Somewhat. It seems to take a while to find,
13 like, just the right thing that works, but he was laying
14 around less but still spending time in the room and
15 still being somewhat moody.
16 Q. Did there come a time that you believed you
17 needed to do more for Grayson?
18 A. I felt like that all the time, actually. One
19 of the things that I noticed that I was concerned about
20 was his lack of confidence in himself. And as a mom, I
21 didn't really know what to do about it. I was trying to
22 do everything I was supposed to with, you know, getting
23 proper medical care.
24 Q. After Grayson told you that he felt like he was
25 a boy, did you take any additional steps to treat him?

1 A. Yeah. So I tried to locate, like, a physician
2 that was friendly to the LGBT community so that we could
3 discuss this. And I didn't want it to be dismissed. I
4 wanted it to be a conversation. And so we saw his
5 primary and talked to her about it, and she, like,
6 initiated referrals to endocrinology and adolescent
7 medicine.
8 Q. And at some point was Grayson diagnosed with
9 gender dysphoria?
10 A. Yeah. The adolescent medicine doctor did that.
11 Q. And what was the next step in Grayson's
12 treatment that you discussed with the adolescent
13 doctor -- the adolescent medicine doctor?
14 A. We talked about putting him on birth control to
15 take and manage his menstrual cycle.
16 Q. And why was it -- why did you consider birth
17 control for Grayson?
18 A. I have, like, personal experience with it and
19 felt that it's relatively safe. And if -- if you take
20 the right thing and you take it properly, then it does a
21 pretty good job of managing the bleeding. So that was
22 really important to us because for Grayson, a menstrual
23 cycle is very distressing. Like, in the very beginning,
24 like even with the first one, I was like -- it was odd
25 for me to see him so upset about it. I didn't really

1 understand, but he was very distressed. And so managing
2 that is a really important step in part of his care.
3 Q. Once you started Grayson on birth control, did
4 you notice any changes in his mental health?
5 A. I could tell that he felt empowered because --
6 like, being in control of something that he didn't
7 previously have control over. So it seemed like him
8 taking the birth control and it doing a pretty good job
9 managing the menstrual cycle was very helpful.
10 Q. Was there anything else you were doing during
11 this time to affirm Grayson?
12 A. Yes. So we -- we tried with the pronouns.
13 It's a -- it's an awkward change. Like, it's gotten
14 better over time for us. But he was still in school, so
15 I got him, like, a binder to help with that, and that
16 did help him feel a little better. And then we just
17 acknowledged how he felt, and we -- I asked questions
18 a lot, and we talked about things. And I asked him
19 about changing his name because I feel like that helps
20 the pronoun change happen a little easier. And he
21 really took his time picking a name and finally settled
22 on it just a few months ago I think. I don't remember
23 exactly, but it's fairly recent when the name was
24 decided.
25 Q. And as you were deciding a name and using

1 proper pronouns, did you continue to notice a change in
2 Grayson?
3 A. Yeah. I think just being a support and him
4 knowing that I'm there for him and he doesn't have to
5 hide who he is from me -- I mean, I might not a hundred
6 percent understand all the time, but I'm there to
7 support him, and I will do what I can to figure out the
8 best way to do that.
9 Q. Did there come a time when you determined that
10 Grayson needed more medical treatment?
11 A. Yeah. We had talked about -- kind of early on
12 when we first saw the adolescent medicine doctor, we had
13 talked about puberty blockers, and I had never heard of
14 them before, but I guess at the stage of development he
15 was at, those weren't an option. So once we got -- the
16 goal was to get the periods under control and then later
17 talk about testosterone treatment. The facility that we
18 see those physicians at does not offer that care, so I
19 had to do some digging to find a place that would give
20 us that option.
21 Q. Did you understand that there were risks
22 putting Grayson on testosterone?
23 A. Yes. So, I mean, I assumed that in the
24 beginning, but I didn't know the extent to which the
25 risk is until we talked to the doctor at the clinic

1 where he receives that care. That was our first visit
2 with them. And she went into great deal about the ones
3 that are reversible and the ones that aren't reversible.
4 And I just -- I really felt that with any medication
5 there's -- there's a risk. And as a parent, I have to
6 weigh the risks with the benefits. And for this
7 particular treatment, the benefits far outweigh the
8 risks.
9 Q. How so?
10 A. So if he doesn't continue on the testosterone,
11 I worry that, like, the mental aspect of -- the things
12 that have changed for the better, like, he's more
13 confident. He comes out of his room. He socializes.
14 And that was -- when he first came out of his room, I
15 was like, Are you okay? Like, you're out of your room.
16 So I'm afraid that will just be completely reversed.
17 And, you know, with a history of suicidal
18 ideation, you're talking about, for me as a parent of my
19 son, I'm deciding between strong mental problems that
20 may lead to suicide or a deep voice and some body hair
21 and not being able to have children. Like, life, death;
22 I'm going to choose life.
23 Q. What is your concern if the ban under Senate
24 Bill 14 goes into effect?
25 A. I would say my biggest concern or issue is that

1 it completely hinders my ability as a parent to make
2 medical decisions on a whole for my kid. That aspect of
3 who he is is part of his medical care, and I won't be
4 allowed to do anything about it, so now I have fractured
5 medical care for my son. Am I going to be allowed to
6 talk to the adolescent medicine doctor? I already know
7 if it goes into effect that the clinic we were going to
8 won't even see him for other gender-affirming care that
9 doesn't involve medicine. So it's just insulting to
10 take away a parent's right to do that. I don't -- I
11 didn't do it by myself. We have a slew of doctors that
12 are very good at what they do, and Grayson is part of
13 the decision-making as well.
14 Q. Do you have a plan for what to do if SB 14 goes
15 into effect?
16 A. No. I mean, I don't know what I would do. I
17 mean, I would -- I would probably first go through,
18 like, a grieving process, I would expect. I would be
19 very upset. It's -- I -- I could go out of state or I
20 could attempt to find care outside of Texas, and I have
21 reached out to a Colorado facility, but there's, like, a
22 waiting list. So in the meantime, prior to me being
23 able to take him there, there's going to be a gap in his
24 medical care. And I don't even know how much that might
25 cost. I know it's going to take away time from my job,

1 and I don't know if my insurance would cover the cost of
2 that. I don't know how much the medication would be.
3 So it's -- it's probably cost prohibitive for me to be
4 able to do that.
5 Q. If Grayson had to wait until he turned 18 to
6 continue testosterone, what do you think would happen?
7 A. I mean, I think he would lose that confidence
8 that he's built. He would feel -- I imagine he would
9 feel defeated. Like, we went through so much to get
10 here, and we've only been -- he's only been taking it
11 for a short time, and I've already seen benefits. So
12 all that work and all that effort and all the stress,
13 like, okay, you get to have it again. Like, it's that
14 rug that's ripped out from underneath you.
15 Q. Thank you.
16 THE COURT: Thank you, ma'am.
17 Mr. Stone or Ms. Dyer?
18 MR. ELDRED: No questions, Your Honor.
19 THE COURT: All right. Thank you.
20 Thank you, ma'am. You are done on the
21 witness stand.
22 THE WITNESS: Thank you.
23 THE COURT: I think if you'll go back out
24 this way. Thank you.
25 Next witness for the plaintiffs?

1 MR. GONZALEZ-PAGAN: Thank you,
2 Your Honor. I'm Omar Gonzalez-Pagan for the plaintiffs.
3 We would call Dr. Aron Janssen to the stand, please.
4 THE COURT: All right. Dr. Janssen. Good
5 morning, sir. If you'll step forward and raise your
6 right hand for me.
7 *(Witness sworn)*
8 THE COURT: You can make your way up to
9 the witness stand.
10 **ARON JANSSEN, M.D.**
11 having been first duly sworn, testified as follows:
12 **DIRECT EXAMINATION**
13 BY MR. GONZALEZ-PAGAN:
14 Q. Good morning, Dr. Janssen.
15 A. Good morning.
16 Q. Can you please state your name for the record
17 and spell it out for the court reporter?
18 A. Aron Janssen, A-r-o-n, J-a-n-s-s-e-n.
19 THE COURT: One second, sir.
20 *(Discussion off the record)*
21 MR. GONZALEZ-PAGAN: Your Honor, if I may,
22 I'm just authenticating one of the exhibits.
23 THE COURT: Okay.
24 MR. GONZALEZ-PAGAN: I don't believe we
25 are going to spend much time with it. I can use the

1 Elmo.
2 THE COURT: Well, I want to make sure if
3 there's any other presentation, that it's set up to do
4 it, so if you'll bear with me.
5 *(Discussion off the record)*
6 Q. (BY MR. GONZALEZ-PAGAN) Dr. Janssen, what is
7 your profession?
8 A. I'm a child, adolescent, and adult
9 psychiatrist.
10 Q. Where are you currently employed?
11 A. I'm currently employed at the Ann and Robert H.
12 Lurie Children's Hospital of Chicago. I'm also an
13 associate professor of psychiatry at the Northwestern
14 University Feinberg School of Medicine.
15 Q. Prior to your role at Lurie Children's
16 Hospital, where did you work?
17 A. I was a psychiatrist at NYU Langone Medical
18 Center, and I was also the founder and director of the
19 Gender and Sexuality Service there.
20 Q. How would you describe your practice?
21 A. My role is mixed into a few different types. I
22 do clinical care primarily with gender diverse and
23 transgender youth as well as administrative and research
24 work.
25 Q. You mentioned that you do clinical care with

1 gender diverse and transgender youth. What is the
2 clinical care that you provide to those patients?
3 A. I provide primary mental health support and
4 assessments for transgender and gender diverse youth.
5 Q. Are there any particular conditions that you
6 treat them for?
7 A. I have done a fair amount of research and
8 publishing in co-occurring mental health disorders among
9 transgender youth, and so that is a particular niche of
10 my clinical care.
11 Q. Do you treat them for gender dysphoria?
12 A. I treat them for gender dysphoria, yes.
13 Q. And what percentage of your current clinical
14 practice is gender diverse and transgender adolescents?
15 A. Approximately 95 percent.
16 Q. Are there any clinical guidelines that you
17 utilize?
18 A. I utilize the World Professional Association of
19 Transgender Health Standards of Care, on its 8th
20 version.
21 Q. And how long have you been working with
22 patients with gender dysphoria?
23 A. I founded my gender clinic in 2011. I had
24 worked with transgender and gender diverse youth and
25 young adults prior to that, but that's when I started my

1 clinic.
2 Q. You said you also spend your time doing
3 research. What are the areas of study that you
4 research?
5 A. I study the overlap between co-occurring mental
6 health disorders and gender dysphoria as well as suicide
7 prevention and systems of care.
8 Q. Have you published any scholarly articles
9 related to this -- to the treatment of gender dysphoria?
10 A. I have.
11 Q. Have those publications been in peer-reviewed
12 journals?
13 A. They are.
14 Q. You also mentioned that you rely on the WPATH
15 Standards of Care Version 8. Do you have any role in
16 the publication or development of these standards of
17 care?
18 A. I was one of the co-authors of that standard.
19 Q. If you can look at the screen, it's showing
20 what's been already admitted as Exhibit 5. Do you
21 recognize this document?
22 A. That is my curriculum vitae.
23 Q. Does this curriculum vitae accurately reflect
24 your professional background and experience?
25 A. It does.

1 MR. GONZALEZ-PAGAN: Your Honor, at this
2 time I will ask that Dr. Janssen as a child and
3 adolescent psychiatrist and a researcher be qualified as
4 an expert on the study, assessment, diagnosis, and
5 treatment of gender dysphoria.
6 THE COURT: Is there any objection?
7 MS. DYER: No, Your Honor. No objection.
8 THE COURT: Thank you. So designated.
9 Q. (BY MR. GONZALEZ-PAGAN) Dr. Janssen, we
10 mentioned gender dysphoria as a condition that you
11 treat. What is gender dysphoria?
12 A. Gender dysphoria is a diagnosis within the
13 DSM-V. There's actually two different diagnoses, gender
14 dysphoria in children and gender dysphoria in
15 adolescents and adults. And what it describes is the
16 distress and impairment in functioning that's resultant
17 from the discordance between one's sex assigned at birth
18 and one's gender identity.
19 Q. I just want to clarify some terms for the
20 record and the Court. You mentioned the term gender
21 identity. What does gender identity mean?
22 A. Gender identity is simply the innate and
23 deeply-held sense of gender.
24 Q. And you also made reference to sex assigned at
25 birth. What does that mean?

1 A. Sex assigned at birth is typically based on
2 phenotypic appearance. So the genitalia primarily is
3 what is used to determine sex assigned at birth.
4 Q. Are there multiple sex characteristics?
5 A. There are.
6 Q. Is gender identity one of those
7 characteristics?
8 A. Gender identity is one of the characteristics
9 of sex, yes.
10 Q. What does the term transgender mean?
11 A. Transgender is an umbrella term to describe
12 individuals who have a discordance between their sex
13 assigned at birth and their gender identity.
14 Q. And you mentioned that there were two
15 particular diagnoses, one gender dysphoria in children
16 and one gender dysphoria in adolescents and adults that
17 are used in this country. Is there anyplace where those
18 diagnoses are contained or documented?
19 A. They are documented within the *Diagnostic and*
20 *Statistical Manual* or the DSM-V as we refer to it.
21 Q. And who publishes the *Diagnostic and*
22 *Statistical Manual*?
23 A. It's published by the American Psychiatric
24 Association. It's the primary guide by which we use to
25 make diagnoses in the field of mental health.

1 Q. Can you summarize the diagnostic criteria for
2 gender dysphoria under the DSM?
3 A. Well, it's important to note that the
4 diagnostic criteria for gender dysphoria for children
5 requires more diagnostic criteria to be positive in
6 order to make that diagnosis, but the elements are
7 shared between them, and that includes, one, a sense of
8 identity -- a deeply-held sense of identity that is
9 discordant from the sex assigned at birth, but there's a
10 number of factors, including relationship to the body,
11 social relationships, and sense of self as it comes to
12 gender and that there is clinically significant distress
13 or impairment and that these symptoms are lasting six
14 months or more.
15 Q. Who makes the diagnosis of gender dysphoria?
16 A. Primarily it is going to be a qualified and
17 licensed mental health professional or medical
18 professional within the United States. The WPATH or
19 World Professional Association of Transgender Health
20 Standards of Care recommend that that person have
21 licensure to practice, experience in working with gender
22 diverse youth, and expertise in the field.
23 Q. How is gender dysphoria diagnosed in children
24 and adolescents?
25 A. It's important to note that this is an

1 individualized process and that the standard assessment
2 is going to depend upon when you've seen the patient,
3 what the family circumstances are. But in general what
4 we are establishing is what is the history of this
5 child's gender identity, what is the history of this
6 child's relationship to their body, what are the social
7 contexts of this child's life, what are the family
8 influences. We want to understand are there
9 co-occurring mental health diagnoses, what they are, and
10 how they might impact the ability to understand gender
11 or the ability to understand potential interventions.
12 And we are gathering information from multiple
13 informants, including the child themselves, any parents
14 or caregivers or legal decision-makers for that child,
15 and ideally members from the child's school or other
16 community.
17 Q. Does the fact that a child or an adolescent
18 exhibits gender non-conforming behavior or expression
19 mean that they have gender dysphoria?
20 A. It does not.
21 Q. Is being transgender a mental disorder?
22 A. It is not.
23 Q. Is gender identity something that somebody can
24 voluntarily change to be congruent with their sex
25 assigned at birth?

1 A. It is not.
2 Q. Have there been efforts in the field of
3 psychiatry or psychology to try to change a transgender
4 person's gender identity to be congruent with their sex
5 assigned at birth?
6 A. Unfortunately, there have been a lot of
7 unsuccessful and harmful efforts to endeavor to do that.
8 Q. You mentioned that there have been some efforts
9 that have been harmful. Have there been any medical --
10 have any medical or mental health groups taken any
11 positions on such efforts?
12 A. There have been a number of medical
13 organizations that have made statements opposing the use
14 of reparative or conversion therapy for sexual
15 orientation and gender identity. These include but are
16 not limited to the American Psychiatric Association, the
17 American Academy of Child and Adolescent Psychiatry, the
18 American Medical Association, the American Academy of
19 Pediatrics, the American Psychological Association, just
20 to name a few.
21 Q. Is there an understanding of what causes
22 someone to have a particular gender identity?
23 A. We need more research to be able to give you a
24 definitive answer to that question, but the
25 preponderance of published data we have on this supposes

1 that it's likely a -- there's biological influence to
2 gender identity.
3 Q. Does the fact that someone's understanding of
4 their gender identity can change over time mean that
5 their gender identity has changed?
6 A. It's a universal developmental task to
7 understand one's identity when it comes to gender over
8 time. All of us have gender identities that evolve over
9 time. It doesn't mean that our core sense of who we are
10 has changed, but our understanding, our contexts can
11 evolve over time.
12 Q. Once an adolescent hits the onset of puberty,
13 is it likely that they would desist from their gender
14 identity?
15 A. I think we have to pause for a second and talk
16 about what desistance and persistence means because it's
17 very specific. The group of researchers that were
18 initially doing work in understanding and treating with
19 medicine transgender youth and youth with gender
20 dysphoria and what was previously in the DSM-IV, gender
21 identity disorder, defined the term desistance as a
22 child who met criteria for what was then called gender
23 identity disorder or gender identity disorder not
24 otherwise specified in childhood.
25 And by the time they hit Tanner stage 2 of

1 puberty or adolescence, if they no longer met criteria
2 for that diagnosis, those kids were referred to as
3 desisters. Those that persisted, so those kids that did
4 have the diagnosis of gender identity disorder in
5 childhood, hit adolescence and continued to have that
6 diagnosis of gender dysphoria or what was then gender
7 identity disorder, those kids persist almost universally
8 throughout adulthood.
9 Q. Dr. Janssen, you've worked at two major
10 institutions in two large states in different parts of
11 the country. Do you have an awareness of the practices
12 of other child and adolescent psychiatrists and other
13 mental health professionals outside those institutions?
14 A. Given my role within the American Academy of
15 Child and Adolescent Psychiatry, I've had the privilege
16 to attend conferences all over the country and all over
17 the world as well as present at numerous academic
18 institutions, and so I've had plenty of opportunities to
19 get a sense of how this field is practiced in multiple
20 settings.
21 Q. Are there any best practice guidelines
22 recognized within the medical and mental health fields
23 for the treatment of patients with gender dysphoria?
24 A. In my experience, most mainstream medical
25 professionals look to the WPATH Standards of Care.

1 Q. And how long has WPATH been issuing standards
2 of care?
3 A. Since approximately 1979.
4 Q. And you mentioned Version 8 of the WPATH
5 Standards of Care. Is that the most recent version?
6 A. It is the most recent version.
7 Q. When was that published?
8 A. 2022.
9 Q. Are you familiar with the process that was used
10 to develop the WPATH Standards of Care 8?
11 A. I am.
12 Q. What are the WPATH Standards of Care based on?
13 A. The standards of care are based upon a review
14 of the scientific -- the scientific literature in the
15 field as well as clinical consensus from experts within
16 the field.
17 Q. Besides the WPATH Standards of Care, are there
18 any other guidelines that medical professionals use to
19 treat patients with gender dysphoria?
20 A. The most commonly other cited guidelines are
21 the Endocrine Society Clinical Practice Guidelines.
22 Q. And are you familiar with those guidelines?
23 A. I am.
24 Q. Do those guidelines also make recommendations
25 regarding the treatment of adolescents?

1 A. They do.
2 Q. How are the WPATH Standards of Care and the
3 Endocrine Society guidelines viewed within the medical
4 and mental health professional communities?
5 A. They're viewed as the guidelines that we should
6 all be striving to achieve in our clinical care with
7 these individuals.
8 Q. Are there any -- have any medical or mental
9 health professional groups recognized these guidelines
10 as best practices?
11 A. They have, and these include but are not
12 limited to the American Medical Association, the
13 American Academy of Child and Adolescent Psychiatry, the
14 American Psychiatric Association, the American Academy
15 of Pediatrics, the American Psychological Association,
16 just to name a few.
17 Q. In your experience, are the WPATH Standards of
18 Care and the Endocrine Society Guidelines practice --
19 recommended practices followed by other clinicians?
20 A. All the clinicians I've had an opportunity to
21 meet with strive to follow those guidelines, yes.
22 Q. In these Clinical Practice Guidelines, are the
23 recommendations for the treatment of gender dysphoria
24 the same across age ranges?
25 A. There are different recommendations for

1 treatment based upon age.
2 Q. Do the recommendations for treatment also
3 differ based on the stage of development of the patient?
4 A. The recommendations for prepubertal youth are
5 going to be different for those for adolescents which
6 will be different for those for adults.
7 Q. What treatments are recommended for prepubertal
8 children with gender dysphoria?
9 A. There are no medical recommendations for
10 prepubertal youth with gender dysphoria. The treatment
11 is therapy and social support.
12 Q. And what are the treatments that are
13 recommended for adolescents with gender dysphoria?
14 A. For individuals with -- for adolescents with
15 gender dysphoria, we're still recommending therapy for
16 some folks and social supports, and for those for whom
17 it is medically indicated, one would consider puberty
18 blockers or hormones.
19 Q. Do the standards of care that you named specify
20 what should be included in an assessment of an
21 adolescent patient?
22 A. It does.
23 Q. What is that?
24 A. As I had mentioned earlier, the assessment is a
25 comprehensive approach that has not defined specific --

1 it doesn't have a cookbook of how you're supposed to do
2 it, so it allows for individualized approaches based
3 upon an individual's training, experience, time working
4 with the families, et cetera. But in essence, all of
5 the components are going to be similar. How you get to
6 those components is going to change, but that means
7 you're going to do a diagnostic assessment, that you're
8 qualified to make a diagnosis of gender dysphoria and
9 that the symptoms are present and persistent across time
10 and to significant impairments in functioning, that
11 you're doing a diagnostic assessment for any other
12 co-occurring mental health conditions and understanding
13 how those co-occurring mental health conditions impact
14 either the gender dysphoria or the patient's
15 functioning, that you're doing an assessment of the
16 social context in which that child lives, the family
17 context, and school context in which that child is
18 experiencing, and understanding the potential risks,
19 benefits, and alternatives of whatever the proposed
20 intervention is, whether that's therapy alone, whether
21 that is puberty blockers, whether that's hormones, or
22 whether that's surgery.
23 And most importantly is to recognize that
24 a family is an integral part of the assessment. We are
25 engaging parents from the beginning to understand their

1 experiences and their observations of their child and
2 making sure, given they are the medical decision-makers
3 for their child, that they have an understanding of the
4 potential interventions that may be recommended.
5 Q. Are there any psychiatric comorbidities that
6 are common in gender dysphoric patients?
7 A. We would anticipate any minoritized group that
8 faces stigma to experience higher rates of depression
9 and anxiety. And that's something that we see in
10 elevated rates with kids with gender dysphoria. We also
11 see increased rates of suicidal ideation, eating
12 disorders, suicidal ideation. But I also think it's
13 important to know when we follow these kids
14 longitudinally, those presenting for care, the most
15 common co-occurring diagnosis among kids with gender
16 dysphoria is no diagnosis at all.
17 Q. You mentioned minoritized youth. Do you have
18 an understanding of why these co-occurring mental health
19 issues are common among patients with gender dysphoria?
20 A. I think there's a number of reasons. Number
21 one, stigma and bias itself. Having to live in an
22 identity that is constantly invalidated or rejected or
23 criticized can lead to increased stress, anxiety,
24 depression. The experience of gender dysphoria itself,
25 your experience with your body rejecting your sense of

1 identity, the discomfort you feel every day, the
2 constant buzzing of anxiety and worry that can be
3 incredibly distracting can be in and of itself quite
4 harmful.
5 Q. Does having anxiety affect an individual's
6 understanding of their gender identity?
7 A. It would be highly unusual for anxiety to
8 impact anybody's capacity to understand their sense of
9 self.
10 Q. What about depression?
11 A. It would be highly unusual for it to impact it
12 in that way.
13 Q. Does the presence of anxiety, depression, or
14 other psychiatric co-occurring conditions affect the
15 capacity of an individual to provide informed consent or
16 assent to medical care?
17 A. Well, first, again, it's the parents who are
18 providing the informed consent. But for the child who's
19 providing an informed assent, it would be highly unusual
20 for any psychiatric diagnoses to impact the capacity to
21 consent. Even among our most psychiatrically-ill
22 patients with chronic psychotic disorders or bipolar
23 disorder, most of the time they retain the capacity to
24 consent to almost all of their medical care.
25 Q. And you mentioned both consent and assent. Can

1 you explain to the Court the difference between informed
2 consent and assent?
3 A. Yeah. I think we want to make sure that the
4 care that we're providing is patient and family
5 centered; right? So even though legally it is the
6 parents who are providing the consent for any treatment,
7 we are not going to make a recommendation if that
8 adolescent can't also understand the intervention that
9 they are agreeing to. That is the difference between
10 assent and consent.
11 We need to -- the process is the same;
12 right? We are understanding the child's ability to
13 understand the risks, benefits, and alternatives of an
14 intervention as well as the risks, benefits, and
15 alternatives of not intervening, that we're assessing
16 the capacity to understand what the intervention is
17 actually going to do and whether or not that's realistic
18 as well as that of the parents.
19 Q. Dr. Janssen, are you familiar with SB 14?
20 A. I am.
21 Q. Are the medical treatments for adolescents with
22 gender dysphoria that are recommended by the Clinical
23 Practice Guidelines prohibited by SB 14?
24 A. They are.
25 Q. How do these medical interventions that we have

1 been discussing alleviate gender dysphoria in
2 adolescents?
3 A. It alleviates it on a number of different
4 levels. First we see relief from the gender dysphoria
5 itself. We see kids who -- as an example, one of the
6 kids that I saw who had an incredible amount of distress
7 every time menstruation would occur, then being able to
8 access puberty blockers and knowing that they had
9 control over their body, that their period was no longer
10 going to come, just created a sense of relief and hope
11 and an ability to understand and think about what their
12 future life might look like as opposed to having a
13 foreshortened sense of self, a foreshortened sense of
14 their future. I've had kids describe having access to
15 this medical care as lifesaving and that it increases
16 functioning in a significant and positive way.
17 Q. In your experience, what are some of the
18 consequences of not providing treatment for gender
19 dysphoria -- medical treatment for gender dysphoria when
20 such treatment is medically indicated?
21 A. Well, first, gender dysphoria is a diagnosis.
22 It's a serious diagnosis. And if we have a treatment
23 for it and we're not able to access that treatment, we
24 would anticipate the symptoms and the functioning
25 resultant from that diagnosis would worsen and

1 intensify.
2 The second major part that's really
3 important to note is that the unwanted puberty will
4 continue to progress over time. And what that means for
5 a transgender youth is that your body will be changing,
6 and your body will be changing into a way that is
7 unaligned with your gender identity, and that can have
8 lifelong consequences. In the moment you see distress
9 from these changes, but it also means that if patients
10 are going to wait until adulthood to transition
11 medically, it makes it much more difficult and much more
12 unsafe in their communities.
13 Q. Dr. Janssen, one argument that some of the
14 defendants' designated experts have made is that
15 providing medical care for adolescents diagnosed with
16 gender dysphoria essentially ensures that they will
17 persist in their transgender identity. What is your
18 response to that?
19 A. There's no evidence to support that assertion.
20 Q. Is there any evidence that psychotherapy alone
21 is sufficient to resolve an adolescent's gender
22 dysphoria if medical treatment is indicated?
23 A. There is no evidence to suggest that.
24 Utilization of psychotherapy alone has been used for a
25 long time without alleviation of distress. I think it's

1 also important to note that delaying care that is
2 medically necessary leads to worse outcomes in the long
3 term for these adolescents as well.
4 Q. Is there any evidence that addressing or
5 resolving a co-occurring condition on its own leads to a
6 resolution of a person's gender dysphoria?
7 A. There's no evidence to suggest that. And
8 similarly as to my last statement, if you delay
9 treatment for gender dysphoria in order to treat the
10 co-occurring mental health diagnoses, it tends to delay
11 improved outcomes.
12 Q. We've talked a little bit about the assessment
13 and diagnosis of gender dysphoria. Can you tell me a
14 little bit about the role of the mental health
15 professional in deciding whether to undergo
16 gender-affirming medical care?
17 A. There's a number of different factors that are
18 involved that a mental health provider participates in.
19 One is in that assessment process that has all the
20 elements that we've talked about, is the diagnosis
21 present, does the child understand the intervention and
22 understand the risks and benefits of the intervention as
23 well as the risks and benefits of not engaging in the
24 intervention, understanding that co-occurring mental
25 health diagnoses and whether or not they're impacting

1 the capacity to consent, understanding the social
2 context and the family context in which those
3 individuals live, and making a recommendation based upon
4 medical necessity for any further interventions.
5 Q. In order to conduct this informed
6 consent/assent process to discuss the risks and benefits
7 of treatment, do you have to be aware of the research in
8 this area?
9 A. You do, yes.
10 Q. Are you familiar with the body of research
11 regarding the efficacy of gender-affirming medical
12 treatments to treat gender dysphoria?
13 A. I am.
14 Q. In your opinion, what does the body of research
15 tell us about the efficacy of puberty-delaying
16 medications to treat gender dysphoria in adolescents?
17 A. We see improvement in gender dysphoria. We see
18 improvement in distress. We see improvement in mental
19 health symptoms.
20 Q. How does this accord with your clinical
21 experience?
22 A. It's much drier than my clinical experience.
23 In my clinical experience, I see all those things, yes,
24 but you also see things that don't make it into
25 peer-reviewed journals, like a sense of relief, an

1 ability to take ten minutes in the morning to go to
2 school as opposed to two hours because it took that
3 amount of time to find that one outfit that feels like I
4 can leave the house and people are going to recognize me
5 for who I am as opposed to making assumptions about how
6 I look. It is being able to imagine a future that can
7 be actualized and make decisions for themselves. It is
8 about having the confidence to go to the restroom, to
9 not worry about menstruation when that's a rejection of
10 their sense of self. There's a number of really
11 profound impacts of these interventions that don't make
12 it into the dry medical journals as we read them.
13 Q. In your opinion, what does the body of research
14 tell us about the efficacy of hormones to treat gender
15 dysphoria in adolescents?
16 A. When we see adolescents with gender dysphoria
17 able to have increased body congruence, when their body
18 starts to change in accordance to their gender identity,
19 we see improvements in functioning. We see improvements
20 in mental health outcomes. We see improvements in core
21 gender dysphoria symptoms.
22 Q. And how does that accord with your clinical
23 experience?
24 A. Again, in a much drier way. We see kids who
25 are able to live full lives as a result of these

1 treatments, as we heard earlier, kids who are able to
2 leave their rooms, kids who are able to engage in social
3 relationships, kids who are able to function, which is
4 really what we're aiming for, is how do we improve
5 functioning for these kids.
6 Q. In your opinion, what does the body of research
7 tell us about the efficacy of surgery to treat gender
8 dysphoria?
9 A. For those for whom it is clinically indicated,
10 it is a highly effective intervention and in some cases
11 is actually curative of gender dysphoria. We see
12 improvements in gender dysphoria. We see improvements
13 in mental health outcomes. We see improvements in
14 functioning.
15 Q. How common is surgery for gender dysphoric
16 patients under 18?
17 A. It's highly rare.
18 Q. Are there any particular types of surgeries
19 that are more common than others?
20 A. More commonly adolescents would be accessing
21 top surgery or chest masculinization surgery.
22 Q. And how does the research that you've just
23 discussed accord with your clinical experience?
24 A. It's aligned with the clinical experience. We
25 see adolescents who are able to live their lives fully,

1 who have improved outcomes, who feel more confident.
2 The number of conversations I've had with transgender
3 boys and young adolescent boys who take hours every
4 morning to get the binder just right, to find that way
5 of tucking their shirt in that allows them to feel
6 confident without their chest giving them away, to have
7 them leave the house and talk about this just sense of
8 relief, I can go to gym class and I can participate, I
9 can go swimming, there's just an intense improvement
10 that we see among these kids.
11 Q. Some of the State's designated experts have
12 argued that the provision of puberty-delaying
13 medications is a one-way road to further medical
14 interventions. What is your response to that?
15 A. There's no evidence to suggest that's the case.
16 And in my clinical experience, I've had a number of
17 youth who will start puberty blockers who opt to
18 discontinue it because they felt aligned with their
19 gender identity.
20 Q. Is there any evidence that puberty-delaying
21 medications access -- or act as some type of switch that
22 children will go on to persist in their transgender
23 identity?
24 A. There's no evidence to suggest that. In fact,
25 the data we have from transgender youth who were

1 followed in the community, their identity persists
2 independent of whether or not they had access to gender
3 dysphoria treatment such as puberty blockers. The
4 recommendations that we require -- the requirements that
5 we have for individuals to access puberty-blocking
6 medications is quite high. It's a very high bar in
7 order to reach recommendations for proceeding with this
8 treatment, and so it's not surprising that most of those
9 youth will go on to have persistent gender identity --
10 persistent gender dysphoria that requires other medical
11 care.
12 Q. Some of the State's designated experts argue
13 that mental health professionals believe that a patient
14 suffers gender dysphoria solely based on the patient's
15 self-report and that they really don't scrutinize and
16 take it at face value. What is your response to that?
17 A. I mean, it's a little diminishing of the field
18 of psychiatry and mental health in general. Self-report
19 is a part of all medical history taking. It's an
20 important element to be able to hear what the patient's
21 experience is, but it's one component of an assessment.
22 It's not the entirety of the assessment. We're always
23 looking at multiple layers, not just what the patient is
24 saying but how we are saying it and how it accords to or
25 discords to the experience that parents and teachers

1 have about those same incidents and experiences.
2 Q. Some of the State's designated experts discuss
3 a theory that an increase in the number of transgender
4 boys in late adolescence presenting to gender clinics
5 for treatment of gen- -- for gender dysphoria is a
6 result of peer pressure or social contagion. What is
7 your response to that?
8 A. I think it's a little reductive, and it's
9 certainly not in accordance with my clinical experience.
10 I have patients who talk about their experiences for
11 years and years and years of distress, a sense of
12 differentness that they had a hard time articulating.
13 And once they found a community of support where they
14 had the language and the tools and the mirror to be able
15 to see this makes sense, this explains my differentness,
16 this is exactly it, there's an experience of coming out,
17 of talking about it. And so to an outside observer it
18 may look like I went on a website and now I'm
19 transgender or to a parent this seems like it could come
20 out of nowhere, but most of the time these are years of
21 developmental tasks, years of distress, years of
22 exploration that children find in order to get to a
23 sense of self.
24 Q. You mentioned websites. Some of the State's
25 designated experts have suggested that the fact that

1 some adolescents find communities online with other
2 transgender adolescents suggest that it's proof that
3 social contagion is a reason to explain the prevalence
4 of gender dysphoria. What is your response to that?
5 A. They have the relationship backwards.
6 Minoritized youth seek out affinity spaces, whether
7 that's with race, ethnicity, interests, hobbies, gender
8 identity, sexual orientation, and it's not uncommon for
9 like to seek out like. And it's from these groups that
10 often kids have the most amount of social support that
11 they can get. It doesn't create a gender identity.
12 Q. Some of the State's designated experts argue
13 that adolescents based on their brain development lack
14 the mental capacity to assent to this medical care.
15 What is your response to that?
16 A. I have two responses to that. One, it's not
17 true. And we have lots of evidence. As an example, in
18 Europe the age of consent is 16 in most of the
19 countries. We recognize that children have the capacity
20 to assent in all types of medical care here in the
21 United States. This seems like it is a bit of a
22 Heilmeier (phonetic). Yeah.
23 Q. Some of the State's designated experts opine
24 that parents and caregivers of transgender adolescents
25 are unable to provide informed consent because there's

1 no full accounting of all the potential risks associated
2 with these medical interventions. What is your response
3 to that?
4 A. If we expected parents to have a full
5 accounting not only of the known risks but of the
6 unknown risks, we would never have any medicine that we
7 would be able to practice in the field of pediatrics.
8 There's no single intervention. Not even Tylenol has a
9 full accounting of the potential risks.
10 Q. I would like to get into it a little bit and
11 ask you about the harms that people may experience for
12 not having access to care. You talked a little bit
13 about this earlier. But can you tell me about what
14 effect the lack of access to gender-affirming medical
15 interventions has for transgender people with gender
16 dysphoria?
17 A. It's a highly individualized experience, but it
18 has profound impact. To be told that we know that
19 there's medically necessary and clear standard of care
20 that would make your life better and improve care for
21 your gender dysphoria and you can't have access to it,
22 you're going to have intensification of the gender
23 dysphoria. It would not be uncommon to see worsening
24 depression and anxiety. Sometimes it would not be
25 uncommon to see increased thoughts of suicidality or

1 self-harm as well as a foreshortened sense of a future.
2 I've had a number of patients -- you know,
3 I practice in Illinois. We have the opportunity to make
4 recommendations for this treatment there. And even the
5 patients I see in Illinois feel targeted and stigmatized
6 and wonder why -- why are people targeting me in this
7 way? What have I done? And that can have a real
8 profound impact. We see -- in communities where these
9 kinds of laws are passed, you see increased searches for
10 suicide attempts and methods of suicide attempts after
11 these laws are passed.
12 Q. Dr. Janssen, in your opinion, is the provision
13 of gender-affirming medical interventions to treat
14 gender dysphoria in adolescents experimental?
15 A. It is not experimental.
16 Q. Is it safe?
17 A. It is safe.
18 Q. Is it effective?
19 A. It is effective.
20 Q. Thank you, Dr. Janssen.
21 MR. GONZALEZ-PAGAN: No further questions
22 at this time.
23 THE COURT: Thank you, sir. Do you have
24 cross for this witness?
25 MS. DYER: Yes.

1 THE COURT: About how long?
2 MS. DYER: I would estimate maybe 10,
3 15 minutes at most.
4 THE COURT: All right. Go ahead.
5 **CROSS-EXAMINATION**
6 BY MS. DYER:
7 Q. Good morning, Dr. Janssen. Thank you for
8 coming.
9 A. Good morning.
10 Q. I have just a few questions. I shouldn't take
11 too much longer. I'm not trying to beat the horse. So
12 first -- let me see. You testified that you treat
13 minors with gender dysphoria; correct?
14 A. That is correct.
15 Q. Okay. And have you ever prescribed puberty
16 hormone blockers or is that something you refer
17 different patients to?
18 A. I refer patients.
19 Q. Okay. And when -- have you ever referred a
20 patient on their very first visit to see you?
21 A. I don't have my records in front of me, but
22 that would be highly unusual.
23 Q. After about how many visits would you say on
24 average? Again, nothing specific about any of your
25 patients obviously, but just on average, how often --

1 how long does it take you?
2 A. It's going to be really individualized and
3 dependent on context. Given my niche in the field of
4 working with kids with co-occurring mental health
5 diagnoses and gender dysphoria, generally my assessments
6 are going to be a little bit longer. But I'm also
7 providing opinions sometimes for folks who have been in
8 care with established professionals for years, so I have
9 a lot of information, so in those cases it will take
10 less time than to do a full thorough assessment because
11 there's so much information that's already been
12 gathered.
13 Q. Okay. And you've mentioned a thorough
14 assessment. About how long does it take you to conduct
15 one of those for, let's say, a brand-new patient?
16 A. First of all, I don't have, like, a nice answer
17 for you because it really is dependent upon the
18 clinically presenting symptoms.
19 Q. Would you say something along the lines of
20 15 minutes, 30 minutes, to five hours? I'm just trying
21 to get an idea, not necessarily something specific.
22 A. Sure. I mean, again, it depends upon the
23 complexity of the situation, what are the details of the
24 co-occurring mental health conditions. Typically I'm
25 taking three to five hours as an initial assessment over

1 a period of a few visits before I make any
2 recommendations.
3 Q. Okay. And you said that gender identity was
4 innate; correct?
5 A. Yes.
6 Q. Okay. Are you familiar with the American
7 Academy of Pediatrics policy statement regarding gender
8 identity?
9 A. I am familiar that they have one. I'd have to
10 see it in front of me to comment on it.
11 Q. If I told you that it says that gender identity
12 develops over time and yet for some people gender
13 identity can be fluid, how would you respond to that?
14 A. I think that it's aligned with what I discussed
15 in terms of how people understand and express their
16 gender identity can change and evolve over time. That
17 core sense of gender identity isn't something that is
18 changeable.
19 Q. Okay. And then let me see. You testified that
20 social media -- or I can't remember the exact phrasing
21 counsel used for that, but that social media and social
22 contagion is not something that had a direct impact or
23 it broke it down to be too big of an issue where,
24 you know, it wasn't directly the cause of it. Is that
25 your -- a correct assessment of your testimony?

1 A. I'm not sure I understood.
2 Q. I know. I'm sorry. I guess what I'm trying to
3 say is from my understanding of your testimony, you said
4 that social media was not necessarily the cause of the
5 influx of individuals you've seen that are now
6 transgender boys. Is that correct?
7 A. I would say that there's no evidence to suggest
8 that social media is the cause of increased rates of
9 gender dysphoria.
10 Q. Would you say it's a contributing factor?
11 A. I don't think there's evidence to support that.
12 Q. Okay. Have you seen social media impact or
13 social contagion impact any other mental health
14 diagnoses?
15 A. I have seen it, yes.
16 Q. In what other mental health diagnoses?
17 A. Tics in particular.
18 Q. Okay. And why do you think that in tics in
19 particular social media can be an impact but in gender
20 dysphoria it's not?
21 A. What I would clarify is to say that media
22 impacts all mental health disorders as well as social
23 contexts, social relationships, family relationships.
24 Part of what we're doing in an assessment is to
25 understand how those social impacts influence a child's

1 sense of self and the reasons they're coming to a sense
2 of self and the reason they are making recommendations
3 or wishing for particular interventions. There's a
4 difference between having a social media experience or a
5 social context influence one's sense of self versus
6 having to create a diagnosis de novo. That's the part
7 that is not present.
8 Q. So would you say that social media does impact
9 potentially a gender identity and gender dysphoria
10 diagnosis?
11 A. I would say that my clinical experience is that
12 by and large kids having access to peers who share their
13 experiences has a really profound positive influence on
14 their experience of self.
15 Q. Okay. And let's see. You had testified
16 that -- oh, you testified that you're very familiar with
17 the research in this area of gender identity and in
18 gender dysphoria diagnoses; correct?
19 A. Yes.
20 Q. Are you familiar with the Bränström study? I
21 may be mispronouncing that, but it's got a few accents
22 on it.
23 A. I would have to see it in front of me. I'm not
24 the best with names.
25 Q. Okay. It was a peer-reviewed -- if I told you

1 it was a peer-reviewed study that was conducted and
2 happened through the American Journal of Psychiatry,
3 have you -- if I told you that they had to issue a
4 correction about their study, does that ring any bells
5 about the study itself?
6 A. I have a bell that is ringing, but part of what
7 I'm going to do in terms of studies is review all of the
8 study to make sure I'm understanding it before I can
9 comment with any specificity on it.
10 Q. Absolutely. If I told you that they -- that
11 they did in fact issue a correction this year and they
12 said that their study did not support a finding of
13 improved mental health in post-surgeries for patients
14 that have gone through plastic surgery for these things,
15 how would you respond to that?
16 A. I would say our job --
17 MR. GONZALEZ-PAGAN: Objection,
18 Your Honor. At this point counsel is testifying. If
19 she wants to ask him about the study, she can show him
20 the study.
21 MS. DYER: Your Honor, I was asking a
22 hypothetical.
23 THE COURT: I'm going to overrule the
24 objection. If you can answer, Dr. Janssen.
25 A. Part of our job as physicians, particularly in

1 this field, is to recognize the full body of evidence
2 and clinical experience and look to the guidelines, the
3 gold standard within the field for support and guidance
4 in terms of appropriate next step. If we look at the
5 broad evidence, the scientific peer-reviewed literature,
6 we would say that the impact of surgery on gender
7 dysphoria is positive and leads to improvement.
8 Q. And would you consider peer-reviewed studies to
9 be the gold standard?
10 A. I would consider peer-reviewed studies to be
11 the gold standard, yes, but it's a component, not the
12 only component.
13 Q. And lastly, I noted that you testified that
14 it's a parent who provides the informed consent. Did I
15 understand that correctly?
16 A. In most cases it is the parent providing the
17 informed consent process. There are occasions in which
18 it is the State or other actors within the child's
19 family.
20 Q. Absolutely. Their guardian. I should have
21 clarified that. And you mentioned that the adolescents
22 assent to that. You didn't use the word informed
23 consent; you used assent. Is that correct?
24 A. That's correct.
25 Q. And you also testified that you're familiar

1 with the WPATH standards -- correct? -- and that you
2 actually assisted in their creation also?
3 A. That is correct.
4 Q. If I told you that the WPATH standard expressly
5 states that informed consent must come from a minor, how
6 would you respond to that based on your testimony?
7 A. The document is the World Professional
8 Association of Transgender Health, and so it encompasses
9 recommendations and adjusts for individuals in the
10 United States but also throughout the world. Many
11 different countries have different ages of majority for
12 capacity to make medical decisions. As I mentioned, in
13 Europe the age at which patients consent to their
14 medical care is 16, which is still recognized as a
15 minor.
16 Q. Okay. And -- oh, lastly, with regards to
17 the -- I call -- I refer to it as WPATH, if that's okay.
18 The WPATH standards claim that a qualified mental health
19 diagnosis must be done. Is that correct? Or is that --
20 are you familiar?
21 A. It depends on the context.
22 Q. In order to receive puberty blockers, cross-sex
23 hormones, you mentioned that a mental health assessment
24 was done on children.
25 A. A diagnosis of gender dysphoria is required to

1 access care. It is not necessary for that person to be
2 a mental health professional. It could be other medical
3 professionals that can give that diagnosis.
4 Q. So would you say that an endocrinologist can
5 make a gender dysphoria diagnosis?
6 A. I would.
7 Q. And what about a family care practitioner?
8 A. I would.
9 Q. Okay.
10 MS. DYER: I have nothing further,
11 Your Honor.
12 THE COURT: All right. Do you have
13 redirect?
14 MR. GONZALEZ-PAGAN: No redirect,
15 Your Honor.
16 THE COURT: All right. Thank you,
17 Dr. Janssen.
18 THE WITNESS: Thank you.
19 THE COURT: You're done on the stand.
20 Ladies and gentlemen, we're going to go
21 ahead and take a morning break. It is 10:25. I would
22 like to get started again at 10:40, and we are on break
23 and off the record until then.
24 *(Recess taken)*
25 THE COURT: For the plaintiff, who's the

1 next witness?
2 MS. WOOTEN: Your Honor, next on the list
3 is Dr. Shumer. As a matter of housekeeping, although we
4 discussed invoking the rule yesterday, we did not do
5 that on the record.
6 THE COURT: Okay. Yes, we did. So as
7 discussed yesterday, we will invoke the rule in this
8 case, which means that any witness that is not an expert
9 is precluded from being in the courtroom during the
10 testimony. So I don't think we've had an issue to this
11 point, but yes, officially for our record the rule has
12 been invoked.
13 And so, Dr. Shumer, come on up. Good
14 morning, sir.
15 THE WITNESS: Good morning.
16 THE COURT: If you'll raise your right
17 hand for me.
18 *(Witness sworn)*
19 THE COURT: Go ahead and make your way up
20 there.
21 If you'll make sure that green light is
22 on.
23 MR. SELDIN: Yes, Your Honor. Good
24 morning.
25

1 **DANIEL SHUMER, M.D.**,
2 having been first duly sworn, testified as follows:
3 **DIRECT EXAMINATION**
4 BY MR. SELDIN:
5 Q. Good morning, Dr. Shumer.
6 A. Good morning.
7 Q. Could you please state your name for the record
8 and spell it for the court reporter?
9 A. Daniel Shumer, D-a-n-i-e-l, S-h-u-m-e-r.
10 Q. And what is your profession?
11 A. I'm a pediatric endocrinologist.
12 Q. And could you please summarize for the Court
13 your formal education and training?
14 A. I attended medical school at the Feinberg
15 School of Medicine at Northwestern University.
16 Afterwards I was a pediatrics resident at Vermont
17 Children's Hospital at the University of Vermont and
18 also a chief resident there. I was then a fellow in
19 pediatric endocrinology at Boston Children's Hospital.
20 Concurrent with that fellowship I received a master's of
21 public health from the T.H. Chan School of Public Health
22 at Harvard University.
23 Q. And what current positions do you hold?
24 A. I'm a pediatric endocrinologist at Mott
25 Children's Hospital University of Michigan. I am an

1 associate professor at the medical school of University
2 of Michigan. I'm the medical director of the Child and
3 Adolescent Gender Clinic at Mott Children's Hospital and
4 the medical director of the Comprehensive Gender
5 Services Program at Michigan Medicine, which is how
6 healthcare is organized for transgender adult and
7 pediatric patients.
8 Q. And over the course of your career, about how
9 many adolescents have you provided gender-affirming care
10 to?
11 A. Approximately 400.
12 Q. Have you conducted research on the treatment of
13 gender dysphoria in adolescents?
14 A. I have.
15 Q. Have you published peer-reviewed articles on
16 the treatment of gender dysphoria in adolescents?
17 A. Yes.
18 Q. And we're displaying on the screen what's been
19 pre-marked and pre-admitted as Plaintiffs' Exhibit 8.
20 Do you recognize this document?
21 A. I do.
22 Q. What is it?
23 A. It's my CV.
24 Q. And does this exhibit accurately reflect your
25 education, training, and experience?

1 A. It does.
2 MR. SELDIN: Your Honor, at this time,
3 pursuant to Rule 702, I would move to qualify Dr. Shumer
4 as an expert witness on the nature of gender dysphoria,
5 the provision, protocols, and treatment of gender
6 dysphoria in adolescents, and the field of pediatric
7 endocrinology.
8 THE COURT: Any objection?
9 MR. STONE: No objection, Your Honor.
10 THE COURT: All right. Thank you. So
11 designated.
12 Q. (BY MR. SELDIN) And Dr. Shumer, were you in
13 the courtroom when Dr. Janssen was testifying earlier
14 about gender dysphoria?
15 A. Yes, I was.
16 Q. And what is gender dysphoria?
17 A. Gender dysphoria is distress caused by a
18 disconnect between one's gender identity and assigned
19 sex at birth which is lasting for more than six months
20 in duration and also causing significant impairment in
21 one's life or functioning.
22 Q. And how is gender dysphoria diagnosed?
23 A. It's diagnosed by a mental health or medical
24 provider.
25 Q. And is any medical treatment provided for

1 gender dysphoria prior to the onset of puberty?
2 A. Prior to the onset of puberty, there's no
3 hormonal intervention or medical intervention that would
4 be required or recommended. Prior to the onset of
5 puberty, the treatment of gender dysphoria involves
6 supportive care and potentially psychotherapy.
7 Q. And taking a step back, Dr. Shumer, what is
8 puberty?
9 A. Puberty is the process -- a life process when a
10 person transitions from childhood to adulthood.
11 Q. And is there a clinical term used to describe
12 the onset of puberty?
13 A. Puberty can be described by the visual
14 appearance of a person going through puberty, and that
15 is oftentimes referred to in medicine as Tanner staging.
16 So Tanner, who was a doctor that came up with this
17 system of observation, described that by observation of
18 breast buds or testicular enlargement or other factors,
19 you can describe how far someone is in puberty.
20 So, for example, at Tanner stage 1 there
21 would be no visible evidence that someone has started
22 puberty. Tanner stage 2 would be the first stage that
23 you could see visible evidence that a person has started
24 puberty, such as development of breast buds or
25 testicular enlargement. If someone's at Tanner stage 5,

1 that would mean that they've completed the process of
2 puberty.
3 Q. And at what age do people typically reach
4 Tanner stage 2?
5 A. There's a wide range of normal, but on average
6 about age 11.
7 Q. And do you use any guidelines in your practice
8 as a pediatric endocrinologist?
9 A. Specific to the treatment of gender dysphoria,
10 yes. I use the World Professional Association for
11 Transgender Health Version 8 and the Endocrine Society
12 Clinical Practice Guidelines.
13 Q. And does the Endocrine Society issue guidelines
14 other than the ones you just referenced for the
15 treatment of gender dysphoria?
16 A. They do.
17 Q. And do you rely on those in your practice as
18 well?
19 A. Yes.
20 Q. And the evidence in the Endocrine Society
21 guideline for the treatment of gender dysphoria, is that
22 comparable to the evidence and other guidelines used in
23 pediatric medicine?
24 A. Yes. Any medical problem that requires
25 guidelines inherently is a complex issue. Otherwise, it

1 wouldn't need a guidelines written to describe how
2 management should go. So all of the Endocrine Society
3 Guidelines, for example, are based on similar evidence.
4 Q. And Dr. Shumer, what are the types of treatment
5 that you provide for adolescents that have been
6 diagnosed with gender dysphoria?
7 A. Sorry. Can you repeat that?
8 Q. Sorry. What are the types of medical treatment
9 that you provide for adolescents that have been
10 diagnosed with gender dysphoria?
11 A. So an adolescent with gender dysphoria that has
12 started puberty, so is at Tanner stage 2, may benefit
13 from intervention with GnRH agonists, which are
14 oftentimes referred to as puberty blockers or pubertal
15 suppression. Older adolescents may benefit from
16 hormonal intervention such as testosterone or estrogen.
17 Q. And what is the goal of treatment for gender
18 dysphoria in adolescents?
19 A. The goal of treatment is similar to the goal of
20 treatment for any medical problem, to improve health.
21 Specific to the treatment of gender dysphoria, it's to
22 reduce the dysphoria in order to help to allow a young
23 person to have the happiest, healthiest life that they
24 can have.
25 Q. And in your clinical practice, what is the

1 informed consent or assent process like?
2 A. Similar to other informed consent process
3 throughout medicine, an informed consent process
4 involves first explaining what the condition is that's
5 being diagnosed, what the treatment options for that
6 condition are, how those treatment options work, how the
7 treatment options may be provided to the patient, how
8 they're taken, what we're expecting will happen if a
9 patient takes those medications, what are the potential
10 benefits that might be achieved or what are our goals of
11 treatment, what are some potential side effects of
12 medication, what are alternatives to treatment. And
13 also, in so doing, the provider is assessing
14 understanding from the patient themself and from the
15 parent answering questions and then ultimately making a
16 decision about next steps in care.
17 Q. And is that process unique to the informed
18 consent or process for the treatment of gender
19 dysphoria?
20 A. No. It's the same for any medical intervention
21 that I'd be providing.
22 Q. And first you mentioned GnRH agonists or
23 pubertal suppression. When might puberty blockers be
24 medically indicated for an adolescent with gender
25 dysphoria?

1 A. It may be indicated if someone has started
2 puberty and, as puberty has started, gender dysphoria
3 has persisted or intensified. And in that case we might
4 expect that as puberty continues, the child would
5 develop more secondary sex characteristics, those
6 differences that help to identify men versus women; so
7 for men, deeper voice, more body hair, more facial hair,
8 body shape changes; for women, breast shape changes,
9 body shape changes, skin softening. Those secondary sex
10 characteristics are different between males and females
11 due to different hormones.
12 GnRH agonists arrest the progression of
13 the production of those hormones. And so in doing that,
14 the child -- if puberty is causing distress, that
15 distress would be alleviated. But also, by never
16 developing the secondary sex characteristics associated
17 with the unwanted puberty, in the long term that person
18 would not have to carry those secondary sex
19 characteristics with them for the rest of their life,
20 which would have the potential for long-term harm.
21 Q. And are those the goals of puberty suppression
22 for the treatment of gender dysphoria in adolescents?
23 A. Ultimately the goal is to improve gender
24 dysphoria and delay decision-making about hormonal
25 interventions until middle adolescence, and the -- that

1 goal is accomplished by preventing progression of an
2 unwanted puberty.
3 Q. And Dr. Shumer, how does puberty suppression
4 work?
5 A. I think it's first important to understand how
6 puberty works. So puberty starts in an area of the
7 brain called the hypothalamus, which starts making a
8 hormone called GnRH in pulses. Those pulses then
9 inspire the pituitary gland to make two other hormones,
10 luteinizing hormone and follicle stimulating hormone, LH
11 and FSH. And it's those hormones that tell the gonads,
12 testes or ovaries, to make testosterone or estrogen.
13 So GnRH agonists are actually the same
14 hormone that is being made in pulses by the
15 hypothalamus, but when given as a steady dose interferes
16 with those pulses, with the outcome that there's no LH
17 and FSH production, and hence, no production of
18 testosterone or estrogen. So it sort of turns off
19 puberty at the source.
20 Q. And is puberty suppression reversible?
21 A. Yes. So when GnRH agonists are used, they are
22 arresting the progress of puberty. And then if they
23 were withdrawn, then puberty picks up where it left off.
24 Q. Based on your knowledge, your research, and
25 your clinical experience, would you say that the use of

1 puberty suppression to treat gender dysphoria in
2 adolescents is safe?
3 A. Yes.
4 Q. And based on your knowledge of the research and
5 your clinical experience, would you say that the use of
6 puberty suppression is effective for the treatment of
7 gender dysphoria?
8 A. I would.
9 Q. And what's the basis for your opinion that
10 these treatments are safe and effective?
11 A. Those opinions are based on the extensive
12 available evidence related to the use of GnRH agonists
13 for the treatment of gender dysphoria and also my
14 clinical experience working with young people with
15 gender dysphoria.
16 Q. And in your practice as a pediatric
17 endocrinologist, do you treat any other conditions with
18 pubertal suppression?
19 A. Yes. The most common condition that we use
20 GnRH agonists is for something called precocious
21 puberty, which is puberty that occurs too young.
22 Q. Are there conditions other than precocious
23 puberty where GnRH agonists may be indicated?
24 A. They're sometimes used in children with cancer
25 prior to chemotherapy to preserve fertility, and they

1 may be used for adult indications related to the
2 menstrual cycle or for men with prostate cancer.
3 Q. And what are the side effects of pubertal
4 suppression?
5 A. The most common side effect of GnRH agonists
6 would be pain at the injection site if we're using
7 injectable Lupron, that sometimes people could have
8 headaches after administration. I think that -- when I
9 think about side effects of GnRH agonists, I think it's
10 important to think about, well, what are the side
11 effects or consequences of stopping puberty.
12 So in someone with precocious puberty, we
13 would be using GnRH agonists up until the average time
14 that puberty starts, but it's different when we're using
15 it for gender dysphoria. In gender dysphoria, we're not
16 stopping puberty that's too early; we're stopping a
17 puberty that is the wrong puberty for the individual.
18 And so because we're delaying puberty longer than what
19 would be typically expected, the consequences of
20 delaying puberty would include changes to perhaps the
21 timing of the growth spurt and the timing of bone
22 density accrual, which is why we use GnRH agonists for a
23 limited time as we're considering next steps.
24 The other side effect that I would mention
25 is about six people out of the many thousands of people

1 that have been prescribed GnRH agonists have had
2 elevated endocranial pressure, which would be a reason
3 to stop the medication.
4 Q. And you spoke -- you mentioned bone density as
5 a potential issue when delaying puberty. Can you talk
6 about how that's managed in your clinical practice?
7 A. Yes. So how I explain it to patients is that
8 every year our bones get stronger. So from a
9 five-year-old to a six-year-old to a seven-year-old,
10 every year our bones get stronger. And then when we go
11 through puberty, our bones get a lot stronger. So
12 puberty is, therefore, important for this bone density
13 spurt.
14 Now, if you're using medication like GnRH
15 agonists to delay puberty, every year your bones will
16 get stronger still; right? Say you use GnRH agonists at
17 age 12. Your bones -- your bone density at age 13 will
18 be stronger, but it won't be as strong as if we didn't
19 use the GnRH agonists and you were going through puberty
20 and achieving that bone density spurt. That bone
21 density spurt will happen for you after the GnRH
22 agonists are either withdrawn or we start providing
23 hormones like testosterone or estrogen. Everyone must
24 go through puberty at some point in some direction in
25 order to have that bone density spurt that allows adults

1 to have stronger bones than children.
2 Q. And does pubertal suppression have an effect on
3 fertility?
4 A. GnRH agonists themselves do not affect
5 fertility. One must go through some of your endogenous
6 puberty to achieve fertility, but suppressing puberty or
7 delaying puberty does not impact one's fertility.
8 Q. Are the side effects and risks of pubertal
9 suppression different when treating, for example,
10 precocious puberty as opposed to gender dysphoria?
11 A. Only with respect to those differences that I
12 mentioned with regards to delaying things like the
13 growth spurt and bone density accrual. Otherwise, the
14 medication works exactly the same regardless of the
15 indication that's being used.
16 Q. And for your patients who use puberty
17 suppression to treat central precocious puberty, about
18 how long are they on puberty blockers?
19 A. It would be used from the diagnosis of
20 precocious puberty up until an age of average puberty.
21 So that could vary based on when precocious puberty --
22 what age precocious puberty is diagnosed, but most often
23 two to three years.
24 Q. And how does that compare to the amount of time
25 that your patients who are treated with pubertal

1 suppression for gender dysphoria are on puberty
2 blockers?
3 A. For gender dysphoria, it may be comparable or
4 it may be less time compared to people with precocious
5 puberty.
6 Q. Do you consider the use of puberty suppression
7 to treat gender dysphoria in adolescents to be
8 experimental?
9 A. I do not.
10 Q. Earlier you mentioned hormone therapy as
11 another potential treatment for gender dysphoria in
12 adolescents. When might hormone therapy be medically
13 indicated?
14 A. Hormones may be indicated for an older
15 adolescent who is having gender -- who is diagnosed with
16 gender dysphoria and an element of that dysphoria is
17 related to not progressing through puberty in
18 concordance with the gender identity, not developing the
19 secondary sex characteristics in concordance with the
20 gender identity, and allowing that development of
21 secondary sex characteristics would improve that
22 distress.
23 Q. And so what is the goal of providing hormone
24 therapy to treat gender dysphoria in adolescents?
25 A. At its core, it's again to improve health and

1 functioning of the individual. But specifically we're
2 using hormones like testosterone or estrogen to mimic
3 the normal rise of testosterone or estrogen in other
4 people of that gender. So if someone is being
5 prescribed testosterone, we're dosing the testosterone
6 in order to raise the testosterone level up into the
7 normal range for a young person that age. In so doing,
8 very predictably, the development of secondary sex
9 characteristics would follow similar to other young men
10 that age; and similarly with estrogen, using estrogen,
11 dosing estrogen to mimic the normal rise of estrogen in
12 other young women, young women that age, and then
13 predictably expecting the development of secondary sex
14 characteristics similar to other young women, women that
15 age.
16 Q. And in your practice as a pediatric
17 endocrinologist, do you treat other conditions with
18 hormone therapy using estrogen or testosterone?
19 A. Yes. Those are two very common medications
20 used by pediatric endocrinologists.
21 Q. What conditions might you use them for?
22 A. Testosterone would be used for a boy or young
23 man that's not able to make his own testosterone or not
24 able to make enough testosterone. Specific conditions
25 could include someone that has had bilateral testicular

1 loss or testicular torsion. Klinefelter syndrome is a
2 condition that commonly requires supplemental
3 testosterone. We use estrogen for women -- or girls
4 that don't make their own estrogen or don't make enough
5 estrogen. Examples could include ovarian insufficiency.
6 Turner syndrome is a condition where the ovaries are
7 underdeveloped and don't make enough estrogen, but
8 really any condition where puberty doesn't go as
9 planned, as normal, due to a challenge or difficulty
10 making testosterone or estrogen.
11 Q. And based on your knowledge of the research and
12 your clinical experience, would you say that hormone
13 therapy used to treat gender dysphoria in adolescents is
14 safe?
15 A. Yes.
16 Q. And based on your knowledge, your research, and
17 your clinical experience, would you say that the use of
18 hormone therapy is effective for the treatment of gender
19 dysphoria in adolescents?
20 A. I would.
21 Q. And what's the basis for your opinion that
22 these treatments are safe and effective?
23 A. Those opinions are based on the extensive
24 evidence outlining the use of these medications, the
25 evidence based on the treatment of gender dysphoria and

1 other conditions used to treat these medications, but
2 specifically efficacy data specific to outcomes
3 improving after treatment with hormones to treat gender
4 dysphoria.
5 Q. Are there side effects or risks associated with
6 using hormone treatment in adolescents with gender
7 dysphoria?
8 A. As with any medical intervention, there are
9 potential side effects of both testosterone and
10 estrogen. How I think about side effects of
11 testosterone, for example, would be, well, what are the
12 side effects or the consequences of having a normal male
13 testosterone level? Men and women, by virtue of having
14 different hormone levels, have different risks for
15 different things.
16 An example that I find easy to wrap my
17 head around is going bald. So if a trans boy or man
18 never took testosterone, his chance of going bald would
19 be very low. On testosterone his chance of going bald
20 would be very similar, say, to other men in his family.
21 For estrogen, an example that is easy for
22 me to wrap my head around is related to breast cancer.
23 A person with breasts intrinsically has a higher risk
24 for breast cancer than a person without breasts. Some
25 men develop breast cancer, but it's very rare. If a

1 trans woman never took estrogen, her risk for breast
2 cancer would be very low. But on estrogen and
3 subsequent development of -- with subsequent development
4 of breasts, she would be at higher risk for breast
5 cancer than if she never took the estrogen, it turns out
6 probably not as high as cisgender women but high enough
7 that anyone with breasts, whether it's endogenous
8 production of estrogen or taking estrogen, should follow
9 the same mammogram screening as any other woman.
10 Q. Are there risks to fertility associated with
11 hormone treatment for gender dysphoria in adolescents?
12 A. I was going to just back up and add one other
13 comment to the last question. I think that in addition
14 to what would be side effects of having a normal
15 testosterone or estrogen level, we think, well, what
16 would be consequences of having an excessively high
17 testosterone or an excessively high estrogen level?
18 We know that our goal in using
19 testosterone or estrogen is to bring that level up to
20 what's normal. But if someone has an excessively high
21 testosterone level, that wouldn't be healthy. So I
22 think about a baseball player abusing testosterone to
23 hit more home runs. That person would be at higher risk
24 for high red blood cell count, high blood pressure. And
25 so when I'm dosing testosterone, I'm avoiding bringing a

1 testosterone level to an excessively high level,
2 similarly to how I would be monitoring for that in using
3 testosterone in other conditions.
4 For estrogen, an excessively high estrogen
5 level, I would be concerned about a higher risk for
6 blood clotting, and so when using estrogen for gender
7 dysphoria or any other condition, I would be dosing
8 appropriately and monitoring.
9 Q. Thank you, Dr. Shumer. I apologize for cutting
10 you off. My next question was going to be about are
11 there risks to fertility associated with the use of
12 hormone treatment in adolescents with gender dysphoria.
13 A. I think fertility is a really important topic
14 to talk about with anyone we're considering prescribing
15 testosterone or estrogen. The first thing that I always
16 like to point out is that neither testosterone nor
17 estrogen should be considered birth control, that I've
18 had patients and there are many patients every day on
19 testosterone that become pregnant. There are many
20 patients on estrogen that have participated in causing a
21 pregnancy. That being said, if you're on an appropriate
22 dose of testosterone or estrogen, it is less likely that
23 you would ovulate or have a normal sperm count.
24 If a patient on testosterone or on
25 estrogen desired fertility, what I would advise them is

1 to withdraw from the medication, wait for the menses or
2 the testosterone level in their body to return to
3 normal, and then attempt to achieve fertility. If they
4 were still having challenges with fertility, they would
5 be recommended to see a fertility expert.
6 There is probably a subset of people that
7 if they are taking testosterone or estrogen for a long
8 enough period of time may have reduction in their
9 fertility, but also there's a big -- there's variability
10 in fertility in people in the first place. So I think
11 that going into the decision regarding testosterone or
12 estrogen, this type of discussion is important to have.
13 Q. And are there steps that patients can take if
14 preserving fertility is a particular priority for them?
15 A. It's recommended to discuss fertility
16 preservation prior to starting testosterone or estrogen
17 for the reasons I outlined. However, also I -- I hope
18 that you get the sense that I would also not consider
19 testosterone or estrogen the end of the story for
20 someone's fertility, that it's -- that because there may
21 be some impact on fertility, fertility preservation
22 conversations should be -- should be discussed.
23 Q. And do pediatricians provide or prescribe other
24 medications that may bear on fertility?
25 A. Yes. We have to have conversations about

1 fertility when prescribing other medications.
2 Specifically, some chemotherapeutic agents have more
3 significant risk for fertility than testosterone or
4 estrogen, and, you know, important conversations are had
5 with patients and families prior to the initiation of
6 those medications.
7 Q. So conversations about fertility are not unique
8 to the provision of hormone treatment to treat
9 adolescents with gender dysphoria?
10 A. That's correct.
11 Q. And do you consider hormone therapy to be an
12 experimental treatment for gender dysphoria in
13 adolescents?
14 A. I do not.
15 Q. In your clinical experience, what are the
16 benefits of gender-affirming medical care like pubertal
17 suppression and hormone treatment?
18 A. I think that as a pediatrician, you know, I
19 became a pediatrician in order to promote health in
20 children. The experience of meeting a family who is
21 entering the clinic for the first time, maybe feeling
22 scared, anxious, maybe even a bit ashamed, and leaving
23 that visit feeling hopeful and prideful is just such a
24 rewarding experience for me. But the true reward is
25 watching patients who maybe initiated care feeling

1 hopeless and helpless graduating from care as someone
2 who is maybe going off to college, going to law school,
3 getting married, starting a family, with a life that
4 they didn't dream possible and their parents didn't
5 dream possible before initiating care.
6 Q. Are you familiar with SB 14?
7 A. I am.
8 Q. And does SB 14 prohibit the care that we've
9 just been discussing for the treatment of gender
10 dysphoria in adolescents?
11 A. It does.
12 Q. And are there risks of not providing treatment
13 when it is deemed medically indicated for an adolescent
14 with gender dysphoria?
15 A. There are.
16 Q. And what are those risks?
17 A. A person with gender dysphoria that is not
18 treated, I would be concerned that the gender dysphoria
19 would persist or potentially intensify, and that may
20 lead to negative health and mental health outcomes.
21 Q. And what are the risks of terminating treatment
22 for adolescents with gender dysphoria when such
23 treatment has been medically indicated?
24 A. That's quite concerning to me. A patient that
25 is on treatment that's working for something that has

1 been a significant challenge for them who is then told
2 that they can no longer continue the treatment that has
3 been helpful to them I would imagine could have a
4 devastating setback in their gender dysphoria care and
5 their overall health.
6 Q. And so in your expert opinion, what are the
7 effects of stopping pubertal suppression in an
8 adolescent with gender dysphoria who has a medical need
9 for that treatment?
10 A. Stopping pubertal suppression would allow the
11 dysphoria-inducing puberty to resume, which would
12 have -- would carry a risk of deterioration in gender
13 dysphoria and health.
14 Q. And in your expert opinion, what are the
15 effects of stopping gender-affirming hormone treatment
16 in an adolescent who has a medical need for that
17 treatment?
18 A. If a patient is taking testosterone or estrogen
19 and seeing positive impacts related to the development
20 of those secondary sex characteristics, stopping that
21 medication would mean no longer continuing to develop
22 those secondary sex characteristics and allowing the
23 body to make the hormones associated with the unwanted
24 puberty, which I would imagine for many folks would have
25 a negative impact on their health.

1 Q. And do you have to imagine that or have you
2 seen that in your clinical experience?
3 A. I have seen that in my clinical experience.
4 Q. And can that harm be mitigated by withdrawing
5 care more slowly?
6 A. There's no protocol or recommendation about
7 withdrawing care that's working slowly, so that would be
8 experimental.
9 Q. And in your clinical experience -- based on
10 your clinical experience, can you tell us why this care
11 is so important for the patients that you treat?
12 A. It really provides an opportunity to live the
13 life that the patient deserves. I think that patients
14 that come to care, patients with gender dysphoria, are
15 some of the most courageous and resilient people that I
16 know, but they're really suffering from a condition that
17 has a highly effective treatment. And providing that
18 treatment can be invaluable in order to allow that child
19 to achieve their full potential in life.
20 MR. SELDIN: No more questions at this
21 time.
22 THE COURT: Thank you. Any questions from
23 the defense?
24 MR. STONE: Yes, Your Honor, just a few.
25 MS. WOOTEN: Your Honor, if there's no

1 objection, may I give the witness some water?
2 THE COURT: There should be some right
3 there. I'm sorry.
4 MS. WOOTEN: Okay.
5 THE COURT: Yeah, he's got -- I'm not that
6 mean.
7 MS. WOOTEN: Thank you, Your Honor.
8 THE WITNESS: Thank you.
9 THE COURT: Go ahead.
10 MR. STONE: Thank you, Your Honor.
11 **CROSS-EXAMINATION**
12 BY MR. STONE:
13 Q. Doctor, Senate Bill 14 doesn't ban
14 psychotherapy or counseling for minors with gender
15 dysphoria, does it?
16 A. It does not.
17 Q. Psychotherapy is a treatment for gender
18 dysphoria in minors, isn't it?
19 A. It's one of the potential treatments for
20 someone with gender dysphoria, yes.
21 Q. You said you treated about 400 kids for gender
22 dysphoria; right?
23 A. Yes.
24 Q. Have you ever prescribed cross-sex hormones for
25 the treatment of gender dysphoria to a child who was 11?

1 A. I have not.
2 Q. 12?
3 A. Yes.
4 Q. 13?
5 A. Yes.
6 Q. 14?
7 A. Yes.
8 Q. Of the 400 adolescents that you've treated for
9 gender dysphoria, approximately how many of them had top
10 surgery as a minor?
11 A. Approximately 5 percent.
12 Q. Of the 400 adolescent patients that you've
13 treated for gender dysphoria, approximately how many had
14 bottom surgery as a minor?
15 A. I believe zero.
16 Q. Why is it that only 5 percent of the 400
17 adolescents that you've treated for gender dysphoria --
18 minors that you've treated for gender dysphoria have had
19 top surgery?
20 A. I think it's a complicated question to answer,
21 but specific in Michigan, insurance companies cover top
22 surgery to treat gender dysphoria over 18. So patients
23 that may benefit from top surgery under 18 would be
24 paying out of pocket, and that would be prohibitive for
25 some families. Also, the -- not all trans boys desire

1 or require top surgery. So we have a small -- a group
2 of people that may desire and require top surgery, but
3 not all of those people are able to get it.
4 Q. If money wasn't a factor, would you recommend
5 more of the adolescents that you treat for gender
6 dysphoria for top surgery?
7 A. I think it would be --
8 MR. SELDIN: Objection, calls for
9 speculation.
10 MR. STONE: It --
11 THE COURT: Well, hold on. If you can try
12 and rephrase that.
13 Q. (BY MR. STONE) Doctor, of the 400 adolescents
14 that you have treated for gender dysphoria, do you
15 believe that more than 5 percent of them could benefit
16 from top surgery as a -- while they were still a minor?
17 A. Remember that there's two groups of patients
18 that we're considering here. One group has received
19 GnRH agonists in early puberty, so that group of
20 patients -- one of the beauties of using GnRH agonists
21 in early puberty is that they wouldn't have developed
22 breasts that would require surgery. So that group of
23 patients, zero percent of them would need top surgery.
24 Patients that came to care later who developed breasts
25 prior to the initiation of a medical intervention, I

1 would say the majority of them do have chest dysphoria
2 as part of their distress and may benefit from chest
3 surgery, but that's not uniformly true.
4 Q. So of -- I'm asking about the 400 percent. Is
5 your answer of the 400 -- I'm sorry -- patients. So is
6 your answer yes, that there's more than 5 percent that
7 you think could benefit from top surgery as a minor?
8 A. Yes.
9 Q. Do you think all of them could benefit from top
10 surgery as a minor that fall within that second category
11 you just discussed?
12 A. No.
13 Q. Why not?
14 A. Because for some people chest dysphoria is
15 not -- not a significant source of distress. For other
16 people in describing the potential risks, potential
17 benefits, and alternatives for top surgery wouldn't
18 choose to have it.
19 Q. Of the 400 adolescents that you've treated for
20 gender dysphoria, how many of them subsequently
21 desisted?
22 A. What do you mean by "desisted"?
23 Q. What do you mean when -- how do you understand
24 the word "desist" in the context of gender dysphoria to
25 mean?

1 A. To me it's a word that's most commonly used to
2 describe a prepubertal person who has a difference in
3 gender identity that at the time of puberty no longer
4 identifies as that gender or no longer carries a
5 diagnosis of gender dysphoria. So in my practice I
6 don't typically see prepubertal youth, so I would have a
7 hard time answering that question.
8 Q. Okay. So what term would you use for somebody
9 who has taken puberty blockers and cross-sex hormones
10 and then subsequently stops because they feel like their
11 gender identity aligns with their biological sex?
12 A. Right. So the number of people in that
13 scenario would be extremely low.
14 Q. I'm not asking the number. I'm asking what
15 would you call them. Is there a term that you have?
16 A. I think your description is how I would
17 describe that.
18 Q. Okay. Of the 400 adolescents that you've
19 treated for gender dysphoria, approximately how many of
20 them have subsequently stopped taking the treatment that
21 you prescribed to them because they determined that
22 their gender identity aligned with their biological sex?
23 A. So I would say that one of the goals of GnRH
24 agonists is to allow that to happen before making a
25 decision for initiation of a cross-sex hormone. I would

1 say the number of people that have started pubertal
2 suppression and then stopped pubertal suppression I
3 would put in the range of about 10. And people who have
4 stopped hormones because they identify as a gender
5 that's more aligned with their biologic sex, I would say
6 about two.
7 Q. So a total of -- that was percentage or the
8 number of patients?
9 A. Number.
10 Q. Number. So 12 out of the 400?
11 A. Stopped either GnRH agonists or hormones
12 because of a change in their understanding of their
13 gender identity more aligned with their sex assigned at
14 birth.
15 Q. Doctor, is gender identity immutable and fixed?
16 A. Yes.
17 Q. How many genders are there?
18 A. Gender is not something that I think about in
19 terms of how many there are. Gender is a concept of
20 oneself as male, female, or maybe neither one of those
21 categories fits one's -- fits one's experience.
22 Q. So it's male, female, or neither?
23 MR. SELDIN: Objection, Your Honor,
24 misstates testimony.
25 THE COURT: Sustained. Next question.

1 Q. (BY MR. STONE) Doctor, I want you to assume
2 for the purposes of this hypothetical that gender
3 identity is not immutable and fixed. Would that change
4 your assessment as to whether or not the potential --
5 the risks outweigh the potential benefits for the
6 treatment of gender dysphoria in adolescents and
7 specifically with respect to cross-sex hormones?
8 A. No. I think that our job would be to try to
9 understand what characteristics of a person would be
10 helpful in predicting their future gender identity, and
11 in using those clinical skills, working with patients
12 and families, understand what potential interventions
13 may or may not be helpful.
14 Q. Following along with the same hypothetical that
15 gender identity is not immutable and fixed, would it
16 change your assessment as to whether or not the risks
17 outweigh the benefits of performing surgeries on minors
18 for the treatment of gender dysphoria?
19 A. If gender identity was not fixed and immutable,
20 I would want to understand the probability that
21 someone's gender identity would continue to align with
22 the desire for the surgery and then use that in a
23 risk-benefit analysis with the patient and family.
24 Q. Informed consent is necessary from an
25 adolescent themselves prior to starting cross-sex

1 hormones; right?
2 A. Yes.
3 Q. And informed consent from the patient, that is
4 the adolescent, is necessary prior to performing a
5 surgical procedure --
6 A. I'm sorry. I think I misunderstood your last
7 question. Can you repeat it?
8 Q. Yeah. I asked if informed consent is necessary
9 from the adolescent patient prior to prescribing
10 cross-sex hormones.
11 A. So in our country the only people that can
12 provide an informed consent are adults. So when
13 prescribing medical interventions with youth, the term
14 that we use is informed assent.
15 MR. STONE: Your Honor, I would like to
16 show a demonstrative, so I'm going to go back to the
17 table if that's okay.
18 THE COURT: Sure.
19 Q. (BY MR. STONE) Doctor, you testified earlier
20 about the Endocrine Society Guidelines; right?
21 THE COURT: Hold on, Mr. Stone.
22 *(Discussion off the record)*
23 THE COURT: All right. Go ahead,
24 Mr. Stone.
25 MR. STONE: I apologize, Your Honor.

1 THE COURT: That's okay.
2 Q. (BY MR. STONE) Doctor, can you see the
3 highlighted portion on your screen? 2.4. Can you see
4 2.4 on your screen?
5 A. I'm with ya.
6 Q. Okay. Would you agree with me that the
7 Endocrine Society Guidelines state that for the
8 prescribing of cross-sex hormones, prior to it, the
9 provider has to confirm the persistence of gender
10 incongruence and the patient must have sufficient mental
11 capacity to give informed consent, which most
12 adolescents have by the age of 16? Is that what 2.4
13 says?
14 A. It does.
15 Q. Okay. So same question. Do adolescents with
16 gender dysphoria have to provide informed consent prior
17 to having a surgical procedure performed for the
18 treatment of their gender dysphoria?
19 A. Yes, so I think we're using this word "informed
20 consent" -- there's a bit of semantics here. Legally
21 informed consent in our country is something that
22 someone over 18 legally is allowed to do. I think that
23 in the Endocrine Society Guidelines, clearly what
24 they're meaning is that the person is informed of the
25 risks, benefits, and alternatives.

1 So regardless, yes, a person that is
2 receiving any medical intervention should be aware of
3 what the medication or intervention is, what the risks
4 and potential benefits are, what the goals are of that
5 intervention, what the alternatives are. If we want to
6 legally call that informed consent or assent, the idea
7 remains the same.
8 Q. So when you use -- earlier when you were
9 testifying that informed consent is not necessary from a
10 minor prior to prescribing cross-sex hormones, the minor
11 patient, you meant legally; is that -- is that correct?
12 MR. SELDIN: Objection, misstates
13 testimony.
14 THE COURT: If you'll rephrase the
15 question, Mr. Stone. I don't --
16 Q. (BY MR. STONE) I guess I'm not understanding.
17 Could you explain to me, what is the significance of the
18 law with respect to whether or not informed consent is
19 needed from a minor prior to beginning cross-sex
20 hormones for gender dysphoria?
21 MR. SELDIN: Objection, Your Honor. He's
22 not an expert on the law in this instance.
23 THE COURT: Sustained.
24 MR. STONE: Well --
25 THE COURT: Sustained. Next question.

1 MR. STONE: Pass the witness, Your Honor.
2 THE COURT: Okay. Any redirect?
3 MR. SELDIN: None, Your Honor. Thank you.
4 THE COURT: All right. Dr. Shumer, thank
5 you.
6 THE WITNESS: Thank you.
7 THE COURT: You're done on the witness
8 stand.
9 From the plaintiffs, the next witness?
10 MS. WOOTEN: Your Honor, the next witness
11 is Dr. Olson-Kennedy.
12 THE COURT: Okay. Dr. Olsen-Kennedy, if
13 you'll please step forward and raise your right for me.
14 *(Witness sworn)*
15 THE COURT: Please make your way.
16 **JOHANNA OLSON-KENNEDY,**
17 having been first duly sworn, testified as follows:
18 **DIRECT EXAMINATION**
19 BY MR. GONZALEZ-PAGAN:
20 Q. Good morning, Dr. Olson-Kennedy.
21 A. Good morning.
22 Q. Can you please state your name for the record
23 and spell it out for the court reporter?
24 A. Johanna Olson-Kennedy. J-o-h-a-n-n-a. Last
25 name is hyphenated, O-l-s-o-n hyphen K-e-n-n-e-d-y.

1 Q. Doctor, what is your profession?
2 A. I am a medical doctor.
3 Q. What type of doctor?
4 A. I am double board certified in pediatrics and
5 adolescent medicine.
6 Q. And where are you currently employed?
7 A. I am an associate professor at the University
8 of Southern California in pediatrics and also the
9 medical director of the Center for Transyouth Health and
10 Development at Children's Hospital in Los Angeles.
11 Q. And how would you describe your practice?
12 A. My practice is basically split between clinical
13 care of adolescents with gender dysphoria and young
14 adults with gender dysphoria, and the other part of it
15 would be research.
16 Q. About how many patients with gender dysphoria
17 have you treated over your career?
18 A. Over the past 17 years, probably between 11 and
19 1200.
20 Q. You mentioned that you treat both adolescents
21 and young adults, but do you also treat prepubertal
22 patients?
23 A. I have prepubertal patients that I see within
24 the context of my clinic, but medical interventions are
25 not appropriate nor warranted for prepubertal children.

1 Q. What are the treatments that you provide to
2 patients with gender dysphoria, adolescent patients with
3 gender dysphoria?
4 A. So adolescents and young adults, again, as we
5 heard from prior witnesses, puberty suppressive
6 medications as well as gender-affirming hormones.
7 Q. Are there any clinical guidelines that you
8 utilize in your practice?
9 A. Also similar to the previous folks that were up
10 here, I utilize the World Professional Association of
11 Transgender Health Standards of Care Version 8 and the
12 endocrine guidelines.
13 Q. And you mentioned that you spend your time
14 doing both clinical care and research. What are the
15 areas of study that you research?
16 A. My research is about the impact of medical
17 interventions on physiologic and mental health of youth
18 with gender dysphoria.
19 Q. And have you published any of this research in
20 scholarly articles?
21 A. I have.
22 Q. And have these been in peer-reviewed journals?
23 A. Yes, they have.
24 Q. About how many peer-reviewed articles have you
25 published pertaining to the treatment of gender

1 dysphoria?
2 A. Over 20.
3 Q. Have you ever served as a principal
4 investigator?
5 A. I have and I do currently.
6 Q. And in what study do you serve as a principal
7 investigator?
8 A. So my current study that I am the principal
9 investigator on is a foresight study that is funded by
10 the National Institutes of Health. It has been going on
11 since 2015. And we received an extension of that grant
12 in 2020 to continue it for another five years.
13 Q. About how many manuscripts have you published
14 as a result of this longitudinal study?
15 A. I'm not sure of the exact number. I think
16 around 25, something like that.
17 Q. On the screen is what has been admitted as
18 Plaintiffs' Exhibit 11. Do you recognize this document?
19 A. I do.
20 Q. What is it?
21 A. That's my CV.
22 Q. Does that CV accurately reflect your
23 professional background and experience?
24 A. Yes, it does.
25 MR. GONZALEZ-PAGAN: Your Honor, at this

1 time I would ask that Dr. Olson-Kennedy as a
2 pediatrician, adolescent medicine doctor, and clinical
3 researcher be qualified as an expert on the study,
4 research, and treatment of gender dysphoria.
5 THE COURT: Any objection?
6 MR. ELDRED: No, Your Honor.
7 THE COURT: Thank you. So designated.
8 Q. (BY MR. GONZALEZ-PAGAN) Doctor, I would like
9 to back up a little bit and ask about some of the
10 history pertaining to gender-affirming medical care.
11 How long has the use of hormones to treat gender
12 dysphoria been around?
13 A. So we synthesized hormones in the late 1920s
14 and early 1930s. And around that same time they were
15 starting to be utilized for changing bodies in people
16 with what we now call gender dysphoria. It was not
17 called gender dysphoria back then. But trans people
18 were utilizing synthetic hormones during that time
19 period shortly after they were synthesized.
20 Q. And how long has the use of surgery to treat
21 gender dysphoria been around?
22 A. I think the first surgery that at least is
23 documented was in about 1940. I'm not exactly sure the
24 exact date.
25 Q. But it's been around for decades?

1 A. It has been around for decades.
2 Q. And how long has the use of puberty-delaying
3 medications to treat gender dysphoria been around?
4 A. So the use of GnRH analogues specifically for
5 blocking puberty in youth with gender dysphoria began in
6 the Netherlands in the 1990s.
7 Q. And how long have puberty-delaying medications
8 been around to treat any condition?
9 A. We're getting close to about 50 years now for
10 using central puberty blockers for other indications
11 that we heard of like central precocious puberty,
12 endometriosis, prostate cancer, other medical
13 indications.
14 Q. When it comes to minors, are there any
15 surgeries that are more commonly provided?
16 A. I think that the most common surgery that would
17 be provided for youth with gender dysphoria who are
18 minors would be chest surgery, chest masculinization
19 surgery, or top surgery as it's colloquially referred
20 to.
21 Q. And is surgery common in adolescents with
22 gender dysphoria?
23 A. No.
24 Q. Just for the edification of those of us here,
25 can you tell us a little bit about how people begin to

1 understand their gender identity?
2 A. So this is a highly individualized process for
3 people whose gender identity is not aligned with their
4 assigned sex at birth. So there are some people that
5 are able to understand, organize, and verbalize about
6 their gender identity being different in early
7 childhood, but a lot of people might not have language
8 for it. They might not feel safe talking about it or a
9 variety of other things.
10 I really look to -- I think one of the
11 largest surveys that has asked these questions of the
12 trans population was the U.S. Transgender Health Survey,
13 and it came out in 2015. They asked this question.
14 There were about 27,000 respondents. And they asked
15 this question: When did you first know that your gender
16 was different from what was on your birth certificate?
17 And about 60 percent of the respondents said age 11 or
18 younger, and the vast majority were at age 21 or
19 younger. I think there was about 6 percent who really
20 did not have those feelings until after age 21, but
21 60 percent at age 11 or younger.
22 Q. When someone presents to you for a
23 puberty-delaying medication, for example, does that
24 demonstrate that their gender dysphoria is likely to
25 persist?

1 A. Yes. If they have started their puberty
2 process, it is highly likely that their gender dysphoria
3 is going to persist and their gender identity will be
4 something other than their assigned sex at birth.
5 Q. We talked a little bit about how long these
6 gender-affirming medical treatments have been provided.
7 Has gender-affirming medical care been studied
8 throughout these decades?
9 A. Yes, it has.
10 Q. Are you familiar with the body of research that
11 exists pertaining to the treatment of gender dysphoria?
12 A. Yes, I am.
13 Q. What are the type of studies out there
14 assessing the efficacy of treatment for gender dysphoria
15 in adolescents?
16 A. So all kinds of studies ranging from case
17 reports to cross-sectional studies, observational
18 longitudinal studies, prospective longitudinal studies.
19 All kinds of study designs have looked at the impact of
20 treatment.
21 Q. In your answer, you did not mention randomized
22 clinic -- randomized controlled trials. Can you tell us
23 why?
24 A. So the study design for a randomized controlled
25 trial requires that participants be randomly chosen to

1 either be in a treatment arm or an untreated arm. So in
2 a study that's looking at the impact of medical care for
3 gender dysphoria, it is highly unlikely that anyone
4 would make a decision to participate in a study where
5 they might be randomized to not getting treatment. It's
6 gender dysphoria that's driving people to come for
7 treatment, so it's unlikely that someone would be open
8 to the idea of not receiving that treatment.
9 So from an ethical perspective there are
10 problems. But I also think, you know, as a scientist,
11 as a researcher, there are flawed things that can happen
12 when a study is randomized blindly, which means that
13 both the participant and the researcher don't know
14 whether or not they're getting the intervention. And so
15 clearly you're not going to be able to have blinding or
16 masking of the intervention because if someone's not
17 getting the intervention, they're going to know that
18 they're not experiencing those changes that come with
19 the intervention arm. And so you have a
20 methodologically flawed study that is not going to give
21 you the answers that you need.
22 Q. When looking at the entire body of research,
23 assessing the efficacy of medical treatments for gender
24 dysphoria in adolescents, what does this body of
25 research look at?

1 A. The body of research that exists looks at
2 mental health aspects, improvement of these mental
3 health symptoms over time, specifically around
4 depression, anxiety, quality of life, psychological
5 well-being, functioning, body esteem, body image. A
6 whole variety of different things have been looked at in
7 the existing literature.
8 Q. And what do these measures or metrics tell us
9 about the efficacy of treatment for gender dysphoria?
10 A. The body of literature demonstrates that
11 treatment improves people's mental health.
12 Q. How so?
13 A. So across all of these domains, so what we've
14 seen is from different studies across the world that
15 there is improvement in psychological functioning.
16 There's a decrease in depression symptoms. There's a
17 decrease in anxiety symptoms. Some studies have
18 demonstrated an improvement in gender dysphoria. Other
19 studies have demonstrated an improvement in body esteem,
20 a large variety that include all of those things I
21 talked about, and I'm probably missing some of them as
22 well.
23 Q. Are there any particular studies that you would
24 point to that specifically assess the efficacy of
25 puberty blockers as treatment for gender dysphoria in

1 adolescents?
2 A. Yeah, there are a lot of studies. I think that
3 for me a couple of studies stand out from the
4 Netherlands published in 2011. The Netherlands -- there
5 is a team of researchers in the Netherlands who really
6 introduced this idea of using puberty blockers for
7 gender dysphoria so that young people did not have to go
8 through the distressing experience of the wrong puberty.
9 They published on their earliest cohort of young people
10 who went on puberty blockers in 2011 and demonstrated
11 indeed that those people had better psychological
12 functioning than prior to starting.
13 There was another study that came out in
14 2015. It came out from the UK. The first author was
15 Rosalia Costa. And in this study they looked at people
16 who had the treatment arm of just mental health therapy
17 versus the treatment arm of mental health therapy and
18 puberty blockers. And what they demonstrated is that
19 over time the group that had mental health therapy and
20 puberty blockers increased -- continued to increase over
21 the course of the study in mental health domains that we
22 discussed earlier.
23 The last one that I would bring up because
24 I think it's an important study is also from the
25 Netherlands. The first author is Vandermaesen. I think

1 it was published in 2019. And that group tried to
2 create an uncontrolled treatment arm like we're talking
3 about in randomized controlled trials by -- they had to
4 use two separate cohorts, but one was individuals who
5 were just referred for care in their clinic, and the
6 other one was people who had undergone treatment
7 already. And they replicated their findings that the
8 group who had received intervention had better mental
9 health than the group who was showing up for care.
10 Q. How does the research that you just discussed
11 regarding puberty blockers compare to your clinical
12 experience?
13 A. This aligns with my clinical experience. I've
14 been doing gender care for 17 years and using blockers
15 within my practice for that amount of time. It is -- I
16 just think it's important to recognize that the number
17 of people who engage in care in and around or before the
18 time their puberty starts is extraordinarily low. It's
19 just a very small part of across the board people who
20 show up for care.
21 But people who have this opportunity to
22 only go through one puberty that is aligned with their
23 gender, it is a trajectory changer for them. They do
24 not have to overcome some of the things that no matter
25 how much intervention you have, no matter how many

1 hormones or surgery, you're not going to be able to walk
2 back some of those permanent changes of endogenous
3 puberty. So for people who have access to puberty
4 blockers, their life is just different because of that,
5 and their mental health is intact. It's the same as
6 their peers that are not trans.
7 Q. Turning to hormones, are there any particular
8 studies that you would point to that specifically assess
9 the efficacy of treatment of adolescents with hormone
10 therapy for gender dysphoria?
11 A. Also yes. I would say I look to the original
12 cohort that I talked about that the Dutch have been kind
13 of reporting on over time. In 2014 they put out a
14 manuscript that looked at that cohort that we were just
15 talking about after puberty blockers, hormones, and
16 surgery and demonstrated that that group of people had
17 eradication of their gender dysphoria, that their
18 psychological functioning was even better than it had
19 been at prior time points, and also that for some of
20 those young people, their mental health and
21 psychological functioning was actually better than the
22 Dutch population as a whole. So that was a report out
23 on their cohort.
24 There was a study that was a different
25 kind of a design that looked at -- it was an online

1 study, so it accessed trans people online and divided
2 that group into people who wanted access to
3 gender-affirming hormones and didn't have it versus
4 people who did have access to gender-affirming hormones
5 and demonstrated a higher rate of suicidality and
6 anxiety in people who were not able to access that care.
7 And then the third study, I'll just point
8 to my own team. We published an article in the
9 *New England Journal of Medicine* earlier this year, and
10 this was data that reported out after 24 months of
11 gender-affirming hormones, also demonstrating a decrease
12 in depression, anxiety, and an improvement in
13 psychological well-being, which included positive affect
14 and patient satisfaction.
15 And those are probably the three studies
16 that I think have different study designs that are
17 important.
18 Q. And how does the research that you just
19 discussed regarding hormone therapy compare to your
20 clinical experience?
21 A. I just really appreciate what my colleague
22 said, that research has a definitive dryness to it that
23 does not provide the depth and fabric of the experience
24 of people within my clinical practice. And so,
25 you know, the young people that I take care of are a

1 great -- a great source of joy for me, and they also --
2 I just had a person last week who said I just want you
3 to know something, that if you had not allowed me and
4 helped shepherd me through these interventions, I really
5 don't think I would be here today. And that's really a
6 meaningful thing and not the first time that I've heard
7 that. I've heard that hundreds of times over the last
8 17 years that I've been doing this work. So we don't
9 sometimes capture the depth and personal experiences of
10 people in a research context, but it aligns around
11 symptoms of mental health.
12 Q. I'm going to ask you a little bit about
13 surgery. Is there research evaluating the efficacy of
14 surgical treatments for gender dysphoria?
15 A. Yes.
16 Q. What does that research tell us?
17 A. That body of research demonstrates similar
18 findings to what we were just talking about. Surgical
19 interventions demonstrate very good outcomes across
20 multiple mental health domains and very low levels of
21 regret.
22 Q. Are there any particular studies looking at the
23 efficacy of chest surgery in adolescents?
24 A. Yes.
25 Q. What do these studies show?

1 A. The studies looking at chest surgery, in
2 particular for trans masculine individuals, demonstrate
3 very improved mental health, across multiple domains of
4 mental health, and very low regret rates, little to
5 none.
6 Q. And have you published research pertaining to
7 the efficacy of chest surgery in adolescents?
8 A. I have.
9 Q. Some of the State's designated experts point to
10 the limitations that some of these studies have to say
11 that they do not prove that gender-affirming medical
12 interventions are efficacious. What is your response to
13 that?
14 A. I disagree.
15 Q. Why?
16 A. I think that, you know, research is a body,
17 very much like a human body, and we look at -- the
18 congregation of all this data together over multiple
19 decades has demonstrated that interventions are
20 efficacious, desirable, and have good outcomes for
21 people. And so I just disagree with that assessment.
22 That aligns with our clinical experience as well.
23 Q. There's been some discussion throughout the day
24 about desistance. Are you familiar with the term
25 desistance?

1 A. Yes.
2 Q. Based on the literature, what does this term
3 refer to?
4 A. I've often seen desistance utilized in
5 children, in prepubertal children. The bulk of the data
6 that talks about desistance really has to do with people
7 who have not yet started puberty.
8 Q. Some of the defendants' designated experts
9 suggest that as many as 98 percent of minors with gender
10 dysphoria come to identify with their sex assigned at
11 birth and that therefore medical interventions to treat
12 gender dysphoria in adolescents are inappropriate. What
13 is your response to that?
14 A. I think probably the first thing to do is
15 separate out these cohorts because not only are the
16 diagnostic criteria different in prepubertal children
17 than they are for adolescents and adults, and that's
18 important because the criteria that define gender
19 dysphoria in prepubertal children are really related
20 most specifically to the kinds of things that people
21 like and do and want to wear and play with. But for --
22 once people move into postpubertal or peripubertal age,
23 the criteria are different, and they have to do with
24 people's bodies.
25 And so when we look at that early data,

1 which is what most people are referring to when they're
2 talking about these high rates of desistance, has to do
3 with children who may, for example, like different kinds
4 of clothes and toys and things like that. Many of those
5 participants in those studies did not meet -- go on to
6 meet criteria that we utilize when we determine
7 treatment. And so that is -- whether or not somebody
8 has gender -- also these studies were done before we had
9 the terminology gender dysphoria and the criteria were
10 different. But as they're progressing in age and
11 development, we have different sets of criteria for
12 them.
13   Q.   Are you familiar with the term detransition?
14   A.   I am.
15   Q.   What do the -- what do you understand this term
16 to mean?
17   A.   I understand detransition to mean somebody who
18 discontinues medical treatment and may or may not go
19 back to living as their assigned sex at birth.
20   Q.   What are some of the reasons that may lead
21 someone to detransition?
22   A.   In the research that's looked at detransition,
23 there's a variety of reasons that somebody might
24 detransition. The majority of those reasons have to do
25 with something outside of the individual's experience.

1 It doesn't have to do with their own sort of changing or
2 understanding of their identity; it has to do with
3 outside pressures.
4 So some people -- for example, in the
5 small handful of people in my practice that have
6 detransitioned, it's related to how people are
7 perceiving them, inability to access services, losing
8 health insurance. And people have moved in and out of
9 detransition and transition. And so there are a very,
10 very small number of people who detransition because
11 they come to affiliate more with their designated sex at
12 birth.
13 Q. About what percent of people who detransition
14 do so because they come to identify as their sex
15 assigned at birth?
16 A. In -- so probably the largest study that looked
17 at this was -- was Jack Turban's study. And I think
18 that the numbers of people that -- so I have to go
19 backwards on the number, so forgive me for a minute.
20 But I think it's about 2 percent of people who said it
21 was related to their sense of self.
22 Q. Does the fact that some people -- around
23 2 percent of the people who detransitioned; is that
24 right?
25 A. 2 percent of all people who transitioned.

1 Q. So does the fact that there may be up to
2 2 percent of people that may detransition mean that
3 gender-affirming medical care is ineffective or
4 experimental?
5 A. No.
6 Q. And does the fact that someone detransitioned
7 mean that they were not receiving gender-affirming
8 medical care?
9 A. No.
10 Q. What percentage of people who receive
11 gender-affirming medical treatment experience regret
12 over their medical treatment?
13 A. Very small. I think about 1 percent.
14 Q. And if someone regrets treatment, does that
15 mean that they no longer identify as transgender?
16 A. Not necessarily.
17 Q. So we're talking about a Venn diagram of
18 2 percent and 1 percent of people who will detransition
19 and regret their treatment; is that right?
20 A. That's very small.
21 Q. Shifting gears a little bit, some of the
22 State's designated experts have pointed to reports from
23 government entities in other countries, specifically in
24 England, Finland, and Sweden, as demonstrating a lack of
25 evidence of the effectiveness of gender-affirming

1 medical interventions for adolescents. Are you familiar
2 with these arguments?
3 A. I am.
4 Q. Do any of the reports from any of these
5 countries recommend banning the treatment or its
6 coverage for adolescents?
7 A. They do not.
8 Q. And to your knowledge, are any of these reports
9 peer-reviewed?
10 A. Not to my knowledge, no.
11 Q. We've talked about the efficacy -- the research
12 regarding the efficacy of hormone treatments and
13 surgical treatments for gender dysphoria. Is there any
14 research demonstrating that the use of psychotherapy
15 alone is sufficient to treat a person's gender dysphoria
16 if medical interventions are indicated?
17 A. No.
18 Q. What is the effect of delaying treatment for
19 gender dysphoria when it is medically indicated?
20 A. So I can tell you from my perspective, because
21 I certainly have families that come in to talk about and
22 understand and learn more about interventions. And what
23 I have seen unfortunately more than one time is that
24 when somebody needs intervention but they don't have
25 access to it, their mental health deteriorates and not

1 insignificantly. So many times somebody will re- -- a
2 family will reengage in services after someone has been
3 hospitalized for, you know, a suicide attempt or just
4 significantly deteriorating mental health. And it is --
5 it's always -- it's always sad to me that people have to
6 engage in services through a distress perspective, but
7 that does happen occasionally.
8 Q. Doctor, as a clinician operating in this space
9 for over 17 years and a researcher, do you consider the
10 use of puberty-delaying medications to treat gender
11 dysphoria in adolescents to be experimental?
12 A. No.
13 Q. Is it safe?
14 A. Yes.
15 Q. Is it effective?
16 A. Yes.
17 Q. As a clinician and researcher, do you consider
18 the use of hormone therapy to treat gender dysphoria in
19 adolescents to be experimental?
20 A. No.
21 Q. Is it safe?
22 A. Yes.
23 Q. Is it effective?
24 A. Yes.
25 Q. As a clinician and researcher, do you consider

1 surgical treatment for gender dysphoria to be
2 experimental?
3 A. No.
4 Q. Is it safe?
5 A. Yes.
6 Q. Is it effective?
7 A. Yes.
8 Q. You know, we've talked a lot today about
9 research and statistics that surround the treatment for
10 gender dysphoria, particularly in your testimony. As a
11 healthcare provider, can you tell us a bit about why
12 this care is so important for the patients that you
13 treat?
14 A. When I reflect back to when I started this work
15 17 years ago, I think as a -- you know, the care had
16 been provided at my institution since the early '90s. I
17 remember that we used to really celebrate when our
18 patients graduated high school. Now I feel like because
19 of access to services being more available, people are
20 finishing college. They're going to graduate school.
21 They're becoming doctors. They're becoming lawyers.
22 They're becoming filmmakers. People are really thriving
23 in their life, and they're able to sort of -- I just --
24 I reflect on families that say I'm so glad that my kid
25 just has normal teenage problems or normal young adult

1 problems. It is really profound. It is why I have
2 continued my career in this work, because people who
3 could not imagine a future are thriving, and they really
4 just -- they just have sunshine in their lives, and
5 that's really important, and people deserve that.
6 Q. Thank you, Dr. Olson-Kennedy.
7 MR. GONZALEZ-PAGAN: No more questions at
8 this time, Your Honor.
9 THE COURT: All right. Thank you. Is
10 there a cross-examination for this witness?
11 MR. ELDRED: Yes, Your Honor, but I do see
12 the time.
13 THE COURT: Yes. Okay. I just wanted to
14 double-check that. All right. It's 12:00 o'clock.
15 We'll be on our lunch break until 1:30 at which time
16 we'll resume with questions for you, Dr. Kennedy.
17 All right. We're in recess until 1:30.
18 MR. ELDRED: Your Honor, can we get a time
19 before we recess?
20 THE COURT: Yes. Give me one second.
21 Everyone else is excused but the attorneys.
22 *(Lunch recess taken)*
23 THE COURT: And Dr. Olson-Kennedy, you can
24 come back up to the stand. Thank you. All right.
25 We'll resume then with cross-examination.

1 MR. ELDRED: Thank you, Judge.
2 **CROSS-EXAMINATION**
3 BY MR. ELDRED:
4 Q. Good afternoon, Dr. Olson-Kennedy. My name is
5 Charlie Eldred. I'm with the Texas Attorney General's
6 Office. How are you?
7 A. I'm good. Thank you.
8 Q. I first want to ask about a study I think you
9 wrote called "Chest Reconstruction and Chest Dysphoria
10 in Transmasculine Minors and Young Adults: Comparisons
11 of Nonsurgical and Postsurgical Cohorts." Did you write
12 that study?
13 A. I did.
14 Q. And I'm assuming that study was about
15 mastectomy surgery or something called top surgery or
16 chest reconstruction; is that correct?
17 A. That's correct.
18 Q. And did it study minors getting this surgery as
19 young as 13 years old?
20 A. The youngest was 13.
21 Q. Did you conclude it was safe and effective for
22 a 13-year-old to get the surgery?
23 A. That's not what the study was really about.
24 The study was really about the impact of surgery on
25 chest dysphoria, but chest surgery is safe, yes.

1 Q. For 13-year-olds?
2 A. Yes.
3 Q. Okay. Next topic. Did I hear you say you've
4 treated approximately 2,000 patients?
5 MR. GONZALEZ-PAGAN: Objection.
6 A. Around 1100.
7 Q. (BY MR. ELDRED) I apologize. Thank you. What
8 percentage of your patients have you treated for five
9 years or more?
10 A. I don't know the exact number offhand because
11 people graduate out of my care when they're 25.
12 Probably about 50 percent, maybe 60 percent.
13 Q. Okay.
14 A. That's an estimate, though.
15 Q. And so you don't treat people who are over 25;
16 is that -- is that correct?
17 A. That's correct.
18 Q. New topic. Do you agree with me that gender
19 identity can change spontaneously?
20 A. I don't know what you mean by that.
21 Q. Well, I think you said 6 percent of people --
22 and correct me if I'm wrong -- 6 percent of people over
23 21 -- I'm sorry -- 6 percent of people who have a -- who
24 have gender dysphoria or have a feeling that their
25 gender identity is different than their biological sex,

1 I think you said 6 percent come to that feeling over the
2 age of 21. Is that true?
3 MR. GONZALEZ-PAGAN: Objection, misstates
4 testimony.
5 MR. ELDRED: Well, I'm asking if it's
6 true.
7 THE COURT: Hold on. I'll overrule the
8 objection if you can answer.
9 A. In that study, 6 percent of the respondents
10 said that they realized their gender was different from
11 their sex assigned at birth after the age of 21.
12 Q. (BY MR. ELDRED) Okay. So before the age of
13 21, they did not have that realization?
14 A. I don't know the specifics beyond that number.
15 Q. Okay. So are you denying that gender identity
16 can change in people?
17 A. In trans and non-binary people, their gender
18 unfolds. Their process of their identification of their
19 gender is different than people whose gender identity
20 matches their assigned sex at birth.
21 Q. So is that a yes?
22 A. Can you repeat the question again?
23 Q. I think I asked -- I'll try it again.
24 THE COURT: I can -- I can repeat it.
25 MR. ELDRED: Thank you, Judge.

1 THE COURT: So are you denying that gender
2 identity can change in people?
3 A. I don't think that it changes. It unfolds for
4 people.
5 Q. (BY MR. ELDRED) And you see unfolding as
6 different from changing?
7 A. Yes.
8 Q. Can the unfolding process occur well into
9 adulthood?
10 A. Yes.
11 Q. Okay. I've got two more topics. The next one
12 is: Isn't it true there's no physical tests that you
13 can run on somebody to see if they have gender
14 dysphoria?
15 A. To date that is correct.
16 Q. And is it also true that gender identity does
17 not have a physical manifestation that you can test?
18 A. As science stands right now, no.
19 Q. As opposed to, say, diabetes. If I have
20 diabetes, you can figure that out with physical tests;
21 is that true?
22 A. That's correct.
23 Q. It doesn't matter whether I think I have
24 diabetes or not. Whether I have diabetes or not is
25 going to be determined by a physical test; is that true?

1 A. That's correct.
2 Q. But gender dysphoria and gender identity is the
3 opposite of that; isn't that true?
4 A. Gender dysphoria is defined by a set of
5 criteria that one can go through and answer and then
6 make that determination. A professional can make that
7 determination for somebody. The experience of having an
8 incongruent gender identity from your sex assigned at
9 birth, right now there is not a physical test to prove
10 or disprove that experience.
11 Q. And I think that leads to my last topic. I've
12 heard -- I think -- I can't remember if you said it, but
13 do you agree gender dysphoria is diagnosed by certical
14 med- -- certified medical professionals? Let me try
15 that again.
16 Gender dysphoria is diagnosed by certified
17 mental professionals. Did I say that right?
18 A. Gender dysphoria is diagnosed by licensed
19 mental or medical professionals.
20 Q. And are you one of those?
21 A. I am.
22 Q. And we've heard testimony that gender dysphoria
23 is a condition of distress. We've heard details about
24 the kind of distress. But it has to last for six
25 months; isn't that true?

1 A. It has to have been ongoing for at least six
2 months before a formal diagnosis can be made.
3 Q. So if I -- if one of your patients is only --
4 if they report to you they've had distress for four
5 months, can you diagnose them as having gender dysphoria
6 and start treating them?
7 A. Well, they don't -- they would not meet
8 criteria for a diagnosis of gender dysphoria if they've
9 only been experiencing those symptoms for four months.
10 Q. Would you start treating them anyway or would
11 you wait two months?
12 A. It's very hard to say given their specifics and
13 their life history. I think that there's -- there are
14 so many questions that I would have for someone in that
15 situation, but I have had situations like that and I
16 have not started treatment.
17 Q. But you have started treatment before six
18 months of a reported dysphoria?
19 A. No, it's extraordinarily rare. By the time
20 that someone gets to a medical facility, we're very much
21 the last stop for people. They've been experiencing
22 symptoms for a year and oftentimes much longer than
23 that. So I can't recall for sure if I've ever had one
24 person with that, but I don't think so, because I don't
25 provide that diagnosis if somebody has been experiencing

1 those kinds of symptoms and experiences less than six
2 months.
3 Q. But you don't personally believe that drug
4 treatment should wait for six months after a report of
5 gender dysphoria; isn't that true?
6 A. I'm not sure what you mean. It's -- when
7 people come to my door, that's a very different --
8 people have been experiencing gender dysphoria for
9 usually much longer than six months.
10 Q. Have you ever said that people should not be
11 required to prove their gender to a therapist before
12 embarking on a phenotypic gender transition?
13 A. No person can prove their gender to anyone.
14 Q. My -- will you answer my question, though,
15 please?
16 A. I don't remember.
17 Q. Would it refresh your recollection if I showed
18 it to you on your Facebook page?
19 A. Absolutely.
20 MR. GONZALEZ-PAGAN: Objection,
21 Your Honor. I think it should be shown to counsel.
22 MR. ELDRED: I'm sorry, Judge. I should
23 have --
24 THE COURT: Yeah, you can show it to him
25 then.

1 MR. ELDRED: I should have asked for
2 permission as well.
3 THE COURT: Yes.
4 MR. ELDRED: Where would you like me to
5 go?
6 THE COURT: Well, I would show it to him
7 first.
8 MR. ELDRED: Okay.
9 MR. GONZALEZ-PAGAN: Your Honor, I see a
10 cut-out here from an image. It's unclear to me if it's
11 from Facebook or any other website. It's not -- I
12 cannot even see where the provenance of that is.
13 THE COURT: I'll let you show it to her
14 and let's just go from there.
15 MR. ELDRED: Yes, Your Honor.
16 A. Yes, this looks like something I wrote.
17 MR. ELDRED: Okay. Do you mind if I just
18 ask her right here?
19 THE COURT: Sure. That's fine.
20 MR. ELDRED: Just so we can read it
21 together.
22 Q. (BY MR. ELDRED) So you wrote: People should
23 not be required to prove their gender -- I'm sorry.
24 People should not be required to prove
25 their gender to a therapist before embarking on a

1 phenotypic gender transition.
2 A. That's right.
3 Q. Do you agree with that or --
4 A. Yes.
5 Q. Okay. So is it true to say you don't actually
6 believe people need six months of non -- of therapy --
7 let me try that again.
8 You don't believe people should have six
9 months of reported gender dysphoria before you'd start
10 treating them with drugs?
11 A. I don't think people should have to prove their
12 gender because no one can do that.
13 Q. So that's a yes; right?
14 MR. GONZALEZ-PAGAN: Objection,
15 Your Honor, asked and answered.
16 THE COURT: Sustained. Next question.
17 MR. ELDRED: Okay. I'll pass the witness.
18 THE COURT: Thank you, sir. Any redirect?
19 MR. GONZALEZ-PAGAN: Very briefly,
20 Your Honor.
21 THE COURT: Okay.
22 **REDIRECT EXAMINATION**
23 BY MR. GONZALEZ-PAGAN:
24 Q. Doctor, you were just asked some questions
25 about a comment you had posted pertaining to having

1 somebody not needing to prove their gender. That is
2 different from making a diagnosis of gender dysphoria;
3 is that correct?
4 A. That's correct.
5 Q. Okay. You were not saying that somebody
6 needed -- need not meet the criteria for gender
7 dysphoria in order to access medical treatment?
8 A. Can you ask -- there are so many negatives in
9 these questions.
10 Q. In that statement -- in that statement, you did
11 not say that somebody did not need to meet the criteria
12 for a gender dysphoria diagnosis in order to access
13 medical treatment?
14 A. That's correct.
15 Q. Thank you.
16 MR. GONZALEZ-PAGAN: No more questions,
17 Your Honor.
18 THE COURT: Thank you, sir.
19 Thank you, Dr. Olsen-Kennedy. You are
20 excused from the witness stand.
21 Counsel for plaintiff, who would you like
22 to call next?
23 MS. WOOTEN: Thank you, Your Honor.
24 Counsel for plaintiffs announces Lazaro Loe will be our
25 next witness.

1 THE COURT: All right. Thank you. We'll
2 go and retrieve him.
3 MS. LESKIN: And again, Your Honor,
4 Mr. Loe is a plaintiff proceeding under a pseudonym
5 pursuant to the protective order.
6 THE COURT: All right. Thank you.
7 Hello, Mr. Loe. If you'll step here, I'll
8 swear you in, and then you can take the witness stand.
9 If you'll raise your right hand for me.
10 *(Witness sworn)*
11 THE COURT: All right. You can make your
12 way around up to this chair here. There should be some
13 water there for you as well.
14 All right. Go ahead.
15 **LAZARO LOE**,
16 having been first duly sworn, testified as follows:
17 **DIRECT EXAMINATION**
18 BY MS. LESKIN:
19 Q. Good afternoon. Can you tell us your name,
20 please?
21 A. Hi. Can you hear me okay?
22 Q. Yes.
23 A. My name is Lazaro Loe.
24 Q. And Mr. Loe, do you live in Texas?
25 A. I do. I live in Bexar County.

1 Q. Are you a member of PFLAG?
2 A. I am.
3 Q. Tell us a little bit about your family.
4 A. Well, I have a daughter named Luna. She's
5 12 years old. She's transgender. Around age five, five
6 or -- well, about five, she told us that she was a girl.
7 And, you know, at first it was pretty difficult for me
8 to accept that. But, you know, there was a lot of
9 indication that -- as we researched it more, that it
10 wasn't just a phase, and so we started to affirm her and
11 her identity as a girl through clothing and hairstyles
12 and things like this.
13 Q. So let's back up just a little bit.
14 A. Uh-huh.
15 Q. What sex was Luna assigned at birth?
16 A. She was born a boy.
17 Q. And you said that at age five she told you she
18 felt like a girl.
19 A. Yes.
20 Q. How did she express that to you?
21 A. I think initially she told my wife first, but
22 she was always -- I mean, I had tried to get her into
23 soccer and things that I'm into and more boys things
24 like building things or whatever, and she never really
25 was interested in those things. I mean, she liked

1 Frozen and girls things and pink and those kinds of
2 things. Her proclivities were towards more feminine
3 things, I suppose.
4 Q. And just because she liked pink and Frozen, did
5 that mean that she couldn't also be a boy?
6 A. No, but, I mean, it was deeper than that
7 because, I mean, I think that seeing her -- there was,
8 like, an awkward period I think from the time that,
9 you know, she could first speak until she was probably
10 in first grade that she -- she just -- like a lot of
11 strange things that were happening in school with regard
12 to, like, her feeling uncomfortable in certain types of
13 clothing and just kind of -- it was hard to describe,
14 but it was -- she was pretty emphatic about that
15 expression of, you know, that she was a girl. I mean,
16 when she opened up to me about it, you know, I was kind
17 of initially hoping that it might just be a phase, but,
18 I mean, she was very -- she never wavered in that -- in
19 that aspect of herself.
20 Q. You've mentioned that at first you resisted
21 when Luna told you she was a girl. What do you mean by
22 that, that you resisted?
23 A. I don't think I wanted to fully accept that it
24 was -- that it was true. I mean, I was kind of hoping
25 that it was something that she would grow out of and

1 that -- I mean, I think that it was okay for her to like
2 Frozen and all these other things. We allowed those
3 things. We didn't not allow them. But, you know, it
4 took -- it took me a while to realize that -- to really
5 see her as she truly is.
6 Q. And how did that change affect Luna, your
7 change in accepting her?
8 A. I think that change was -- was tremendous
9 because, I mean, I think that once I -- I mean, I think
10 a lot of it had to do with the fear as a parent when you
11 realize that, you know, the life of a transgender
12 person, especially a kid, would be -- the road would be
13 pretty difficult. So I was hoping that it wasn't true
14 because of that, because of the challenges that she
15 would face in life. But as we started to allow her to
16 be -- to express herself more as -- the way that she
17 wanted in terms of clothing and hairstyles and
18 alternative nicknames and things like that, she just was
19 so much more joyful. I mean, it was like she was half a
20 person before, but as we started to accept her more, she
21 just changed. She did better in school and she was just
22 happier.
23 Q. At some point did you choose to seek care,
24 medical care for Luna?
25 A. We did. So her mother and I, we -- we sought

1 out a child psychologist, and we had several
2 appointments with her around age six.
3 Q. Why so early?
4 A. Well, because, you know, as we -- we -- like I
5 said, we had a few kind of difficult years where we were
6 trying to -- struggled to figure out what exactly was
7 going on. And as -- as we started to kind of put the
8 pieces together, I think we wanted some kind of third
9 party opinion on what we were doing to make sure we were
10 doing the right thing.
11 Q. And what did -- did the professional make any
12 diagnosis of Luna?
13 A. She did. I think that within the first few
14 sessions that we had with her -- I mean, I know -- I
15 remember distinctly after the very first one that after
16 we had our sort of meet and greet with the doctor, that
17 you know, we left the room and she spent, you know, the
18 session with Luna and, you know, immediately afterwards
19 the doctor said, well, you know, your daughter is a
20 girl. I mean, she had expressed it very completely in
21 the session and has always expressed it that way to us.
22 But, I mean, I think the official, you know, diagnosis
23 was gender dysphoria.
24 Q. So what was the next step in caring for Luna
25 and supporting Luna at that point?

1 A. I mean, I think that -- you know, that those
2 initial consultations with the child psychologist were
3 very reassuring to us because we felt like we were kind
4 of on the right path as parents, and we could see the
5 very obvious results with regard to her academic
6 performance and her just -- her joyfulness and happiness
7 because, you know, the sort of years prior had been
8 a lot more difficult. So all that we did really was,
9 you know, let her grow her hair long, and I remember
10 going to Target and I kind of had donated all of her
11 boys clothes and uniforms and things like that and
12 purchased, you know, like 300 bucks' worth of clothing
13 at Target for her and, you know --
14 Q. How did she react to that?
15 A. She was super happy, you know. It was a very
16 joyful experience.
17 Q. At some point in time, did you come to
18 investigate medical treatment for Luna?
19 A. I mean, I think it's been an ongoing thing for
20 us. I mean, I like to read a lot, so, you know, I think
21 even prior to meeting with the child psychologist I
22 started reading books and reading about this issue and
23 what the proper course of care would be. So we started
24 having discussions early on about, you know, medical
25 interventions, which didn't happen until much later. I

1 mean, you know -- but yes, I mean, we did -- we did talk
2 about that with her.
3 Q. When you say you talked about it with her, with
4 Luna?
5 A. With Luna, yes.
6 Q. And did you involve any medical doctors in
7 those conversations?
8 A. We did. Yeah, we did. Around age ten we
9 sought out treatment at a clinic and got a referral to a
10 pediatric endocrinologist where she had several
11 appointments prior to any medications being
12 administered. So after meeting and consulting with,
13 you know, this team of doctors, we decided -- and with
14 Luna, of course, that she would start puberty blockers
15 at age 11?
16 Q. At age 11.
17 A. Uh-huh.
18 Q. So how long was it then from the first time
19 Luna told you she identified as a girl until you started
20 her on puberty blockers?
21 A. I mean, the first time that she expressed that
22 to us, she was -- I mean, I would say she was probably
23 around age five, so it was, you know, about six years.
24 Q. What was the purpose of starting Luna on
25 puberty blockers, is your understanding of starting her

1 on puberty blockers?
2 A. I mean, I think it was -- it was very -- very
3 obvious, and, you know, Luna has obviously expressed,
4 you know, a desire to have a more feminine appearance
5 and body and was -- had a lot of anxiety around,
6 you know, going through puberty as her biological sex.
7 Q. When you say she had anxiety, what did she tell
8 you?
9 A. I mean, I think it's just -- you know, it's --
10 she would just say that -- I mean, I can't remember
11 exactly, you know, the things that she would have said,
12 but, you know, it's just -- I think it was more of a
13 positive expression of a desire to have -- you know, to
14 affirm her, like her physical appearance and how she
15 feels on the inside, like who she is.
16 Q. Have you ever discussed with Luna whether to
17 stop puberty blockers?
18 A. We have. I mean, I think every time that,
19 you know, we have a doctor's appointment we make it
20 clear that, you know, if she ever felt any anxiety -- or
21 any discomfort with continuing the care, that, you know,
22 it wasn't anything that she was -- she's a willing --
23 she's the one who really is wanting this treatment for
24 herself, you know, and as parents also, you know,
25 because we realize that we want the best possible

1 outcomes for her, you know, as an adult, and, you know,
2 we think that this is obviously a lifesaving kind of
3 care for her, that this is the right treatment for --
4 you know, for who she is.
5 Q. How long has Luna been on puberty blockers at
6 this point?
7 A. I would say a little -- not quite a year and a
8 half, about a -- you know, a little bit over a year.
9 Q. Have you had any discussions with Luna and her
10 doctors about if there's any other medical treatments
11 that would -- that may come along?
12 A. Yes, we have. We -- you know, we've talked to
13 her doctor several times about starting hormone therapy,
14 but she's not a candidate until she's 13.
15 Q. When you say hormone therapy, you mean starting
16 her on estrogen?
17 A. Yes.
18 Q. And have you started to investigate any of the
19 risks associated with taking estrogen?
20 A. We have. I mean, we've had several -- I mean,
21 Luna is always present as -- you know, as is her mother
22 and I, like in, you know, all the appointments, or at
23 least one of the -- one of us has been there, but Luna
24 is always there for every one of her appointments. And
25 we've had several discussions with the doctor about it,

1 and she's, you know, pretty thorough in explaining,
2 you know, exactly what will happen and, you know, kind
3 of what the risks are, but she -- she understands that
4 and she wants to continue with the treatment.
5 Q. What do you think would be the -- well, strike
6 that.
7 Luna has not yet started estrogen;
8 correct?
9 A. She has not.
10 Q. And she is continuing to take puberty blockers?
11 A. She is.
12 Q. What do you see as the potential impact on Luna
13 if she was not able to take puberty blockers?
14 A. I think it would be devastating because, I
15 mean, one of the conversations that we've had with the
16 doctor in light of everything that's been going on,
17 you know, here in the state is obviously the mental
18 distress that it would create and just the -- as a
19 parent, I mean, I think it's incredibly distressing to,
20 like -- to have to think about, you know, your child
21 having to suffer, you know, these kinds of -- like a
22 reversal of, like, something that clearly she wants and
23 needs. I mean, I think that it would -- she would
24 change from a really happy, joyful, kind person into --
25 you know, I think she would become withdrawn. And I

1 would be worried about her mental health actually, not
2 to mention the physical changes that she would
3 experience that she's -- that she doesn't want, so...
4 Q. Have you made any plans for what to do if SB 14
5 goes into effect?
6 A. I mean, we're already struggling with that now
7 because, I mean, the law has already had a chilling
8 effect on the medical community here that provides this
9 kind of treatment. So I think as far as our family is
10 concerned, we're still trying to come up with a plan for
11 how we would continue the treatment, which obviously
12 we're going to do somehow, but we don't really know
13 exactly what that's going to look like yet.
14 Q. How has Luna reacted to what's going on?
15 A. She's very upset about it all. I mean, I think
16 it's confusing for a 12-year-old to try to figure out
17 why, you know, so many people would hate, you know,
18 people like her. I mean, she doesn't understand. She
19 thinks they're stupid, actually.
20 Q. Thank you very much.
21 MS. LESKIN: No further questions.
22 THE COURT: All right. Thank you. Any
23 cross?
24 MR. ELDRED: No questions, Judge.
25 THE COURT: All right. Thank you.

1 Mr. Loe, you're excused from the witness stand. I would
2 head back to that door.
3 THE WITNESS: All right. Thank you.
4 THE COURT: Thank you. All right. From
5 the plaintiffs, which witness is next, just in case
6 Ms. Gould needs to grab them?
7 MS. WOOTEN: Brian Bond, Your Honor.
8 THE COURT: Okay. Mr. Bond, if you'll
9 step forward and raise your right hand.
10 *(Witness sworn)*
11 THE COURT: All right. Make your way up
12 to the witness stand.
13 **BRIAN BOND**,
14 having been first duly sworn, testified as follows:
15 **DIRECT EXAMINATION**
16 BY MS. POLLARD:
17 Q. Mr. Bond, would you please state your full name
18 for the record?
19 A. Brian Bond. My pronouns are he/him/his.
20 Q. And how are you employed?
21 A. I am the executive director now transitioning
22 title-wise to CEO for PFLAG National.
23 Q. And is PFLAG a party in this case?
24 A. Yes, it is.
25 Q. Is PFLAG bringing this lawsuit on behalf of its

1 members?
2 A. Yes, it is.
3 Q. And you mentioned that you're in the midst of
4 transitioning titles. How long did you hold the role of
5 executive director of PFLAG?
6 A. Four years. I started February of 2019.
7 Q. And are your responsibilities now under your
8 new title as CEO essentially the same as they were as
9 executive director?
10 A. Exactly the same.
11 Q. All right. And what are those
12 responsibilities?
13 A. I have the fiduciary responsibility for the
14 organization. I manage the team of the organization.
15 And I set the strategy for the organization.
16 Q. Mr. Bond, what is PFLAG?
17 A. PFLAG is the first and largest organization for
18 LGBTQ+ individuals and their families. We were started
19 in 1973 by a mom, a schoolteacher, math. And it's made
20 up of truly for me the most amazing individuals, parents
21 that want nothing more than for their kids to be safe
22 and to thrive.
23 Q. And what is PFLAG's mission?
24 A. Excuse me. I'm sorry.
25 Q. No. Go ahead.

1 A. PFLAG's mission is to create a caring, just,
2 and affirming world for LGBTQ+ individuals and those who
3 love them.
4 THE COURT: If you'll slow down just a
5 little bit, Mr. Bond.
6 THE WITNESS: I'm sorry.
7 THE COURT: That's okay.
8 THE REPORTER: Repeat that to make sure I
9 got it.
10 A. Our mission is to create a caring, just, and
11 affirming world for LGBTQ+ individuals and those who
12 love them.
13 Q. (BY MS. POLLARD) And what -- is it your job as
14 CEO to make sure that PFLAG achieves that mission?
15 A. Absolutely.
16 Q. And what kind of work does PFLAG do in order to
17 achieve the mission?
18 A. We have three basic pillars. By the way, this
19 is our 50th -- this is our 50th anniversary. Slow down,
20 I know. This is our 50th anniversary. Our pillars are
21 support, education, and advocacy.
22 Q. And how is supporting access to
23 gender-affirming medical care for minors consistent with
24 PFLAG's mission?
25 A. It's important for our mission, for our

1 parents, for our families, for them to be able to come
2 to chapter meetings to hear from other parents, to know
3 that the journey they are on -- that they're not alone,
4 that they're loved, and to affirm them.
5 Q. As the executive director and now CEO, do you
6 make decisions about whether PFLAG participates in
7 litigation?
8 A. Yes.
9 Q. And why did you decide to participate in this
10 litigation?
11 A. Because this is really important for our
12 families here in Texas.
13 Q. Does PFLAG have bylaws?
14 A. Yes, it does.
15 MS. POLLARD: Your Honor, I would like to
16 show what has been pre-admitted as Plaintiffs' Exhibit 3
17 to the witness.
18 THE COURT: Go ahead.
19 Q. (BY MS. POLLARD) All right. Mr. Bond, do you
20 recognize this document?
21 A. Yes.
22 Q. And what is it?
23 A. Those would be our bylaws.
24 Q. Does it appear to be a true and accurate copy
25 of your bylaws?

1 A. Yes, it does.
2 Q. And does this appear to be the most recent
3 version of your bylaws?
4 A. Yes, it does.
5 Q. Okay. Thank you very much. That is all of my
6 questions that document.
7 Is PFLAG a membership organization?
8 A. Yes, it is.
9 Q. How do people become members of PFLAG?
10 A. So people can join PFLAG by either joining the
11 national office -- through the national office or they
12 can join through one of the chapters, one of the 350
13 plus chapters across the country. By the way, I would
14 add you don't have to be a member of PFLAG to go to one
15 of our support meetings. It's open to everyone.
16 Q. And so if someone becomes a member through the
17 local chapter, that makes them also a member of the
18 national organization?
19 A. That is correct.
20 Q. Is the role of members contained within PFLAG's
21 bylaws?
22 A. Yes, it is.
23 Q. And as the executive director, now CEO, how do
24 you stay informed of what PFLAG members are
25 experiencing?

1 A. There's multiple platforms for that. First of
2 all, I'm very accessible. They can get to me directly,
3 and many do. We have an RDs council, regional directors
4 council, one for this area. These are volunteers who
5 are in contact constantly with our chapters. There's
6 obviously the chapter meetings. There are various
7 social media private Facebook places for people to
8 convene. I have staff directly assigned to this region.
9 All that information ends up back up with me at some
10 level.
11 Q. And how does PFLAG track its membership?
12 A. Through our database.
13 Q. And how many members does PFLAG currently have?
14 A. About 350,000 supporting members across the
15 country.
16 Q. And how many Texas chapters do you have?
17 A. We have 18 chapters here in Texas, from El Paso
18 to Beaumont and everywhere in between.
19 Q. And how many members do you have in your Texas
20 chapters?
21 A. We have over 1500 right now.
22 Q. And are families with transgender children who
23 are receiving gender-affirming medical treatment among
24 those 1500 members?
25 A. Yes, they are.

1 Q. How do you know that?
2 A. Because I hear from them. They're terrified
3 right now.
4 Q. Are you familiar with the families who are
5 plaintiffs in this lawsuit?
6 A. Yes.
7 Q. And do you know that they are -- whether they
8 are PFLAG members?
9 A. I do, from their declarations, yes.
10 Q. What kind of support does PFLAG provide to
11 Texas members with transgender children?
12 A. There's constant support going on at the local
13 level through our chapters in our support group
14 meetings, education. And then from the national office
15 there's various newsletters that we would send out
16 specifically in Texas. And then there's a large array
17 of publications that would be germane to Texas as well
18 as anywhere in the country.
19 Q. And is that support ongoing?
20 A. Yes.
21 Q. All right. Are you familiar with a law known
22 as SB 14?
23 A. Yes.
24 Q. If SB 14 is allowed to go into effect, how
25 would it impact PFLAG members in Texas with transgender

1 children?
2 A. It's already starting to impact my members, my
3 families here in the state. I'm hearing from members of
4 our organization who are trying to figure out if they
5 need to move, if they can even afford to move, what this
6 means from care -- for care for their kid. All these
7 folks are wanting to do is try to make sure that their
8 kids can thrive and be treated equally. And this is
9 very disruptive right now, terrifying in fact for my
10 members.
11 Q. Thank you, Mr. Bond.
12 MS. POLLARD: I'll pass the witness,
13 Your Honor.
14 THE COURT: All right. Thank you. Any
15 cross-examination?
16 MR. ELDRED: No, Your Honor.
17 THE COURT: Thank you. All right.
18 Mr. Bond, you're done on the witness stand.
19 Your next witness?
20 MS. WOOTEN: Your Honor, the next witness
21 is Dr. Richard Ogden Roberts, III.
22 THE COURT: Okay. Dr. Ogden Roberts, if
23 you'll step forward and raise your right hand for me.
24 *(Witness sworn)*
25 THE COURT: Take your place on the witness

1 stand.

2 **RICHARD OGDEN ROBERTS, III**,

3 having been first duly sworn, testified as follows:

4 **DIRECT EXAMINATION**

5 BY MS. POLLARD:

6 Q. Dr. Roberts, would you please state your full

7 name for the record?

8 A. I am Richard Ogden Roberts, III.

9 Q. And what is your role in this case?

10 A. I am a plaintiff in this case.

11 Q. And what is your profession?

12 A. I'm a pediatric endocrinologist.

13 Q. And are you licensed to practice in Texas?

14 A. I am, yes.

15 Q. And where are you currently employed?

16 A. I work at a large children's hospital in

17 Houston, Texas.

18 Q. And are you here today in your personal

19 capacity?

20 A. Yes.

21 Q. Can you describe for us your educational

22 background?

23 A. I received a bachelor's of science in commerce

24 from the University of Virginia in 2007. I hold a

25 master's of public health in epidemiology from Tulane in

1 2010. And then I graduated from medical school back at
2 the University of Virginia with my MD degree in 2014.
3 Q. And with respect to training, where did you
4 perform your residency?
5 A. I did a residency in categorical or general
6 pediatrics at UCLA in Los Angeles.
7 Q. And did you also complete a fellowship?
8 A. I did. My fellowship was at the University of
9 Colorado in the Barbara Davis Center in Aurora or
10 Denver, Colorado.
11 Q. And are you board certified?
12 A. I am. I am double board certified in general
13 pediatrics and pediatric endocrinology.
14 Q. Are you currently a member of any professional
15 organizations?
16 A. Yes. I'm a member of the American Academy of
17 Pediatrics, the Pediatric Endocrine Society, WPATH and
18 by extension USPATH, and GLMA.
19 Q. Dr. Roberts, what led you to pursue a career in
20 medicine?
21 A. I think like many people who go into the field,
22 I went into it out of a desire to leave a mark on the
23 world and to help people.
24 Q. And at a high level, for those of us who aren't
25 doctors, can you describe your current practice?

1 A. Sure. I, like several of the other witnesses
2 you have heard, spend time in a variety of different
3 settings. The majority of my practice is clinical, so I
4 spend time seeing patients, but I also have
5 administrative duties within my section and educational
6 duties as well.
7 Q. And what is the patient population that you
8 see?
9 A. I see obviously pediatric patients, so from
10 birth until young adulthood, with endocrine conditions
11 generally, including gender dysphoria.
12 Q. How many patients with gender dysphoria have
13 you treated?
14 A. Throughout training and my current clinical
15 practice, I estimate I've seen over 200 patients with
16 gender dysphoria.
17 Q. And in what settings do you treat patients with
18 gender dysphoria?
19 A. In clinical settings, so a doctor's office.
20 Patients come in to see me and I spend time with them.
21 Q. Are there other physicians that work as a part
22 of your practice?
23 A. Yes. I am a pediatric endocrinologist, but
24 this care encompasses several other subspecialties, so I
25 work alongside mental health professionals,

1 psychologists, and psychiatrists, Dr. O'Malley of whom
2 is also a plaintiff on this case. I have partners
3 within the field of pediatric endocrinology, Dr. David
4 Paul. There's an adolescent medicine physician who we
5 work with. And we have a social worker to help some
6 other needs.
7 Q. What portion of your practice is related to
8 providing medical treatment to youth with gender
9 dysphoria?
10 A. In terms of my clinical time, it breaks down to
11 probably 10 to 20 percent of the time I have dedicated
12 to see patients that is allotted to the treatment of
13 gender dysphoria.
14 Q. What does the remainder of your practice relate
15 to?
16 A. General pediatric endocrinology. So I see
17 patients with Type 1 diabetes, growth disorders, puberty
18 disorders, thyroid disease, cancer, amongst others.
19 Q. Do you consider providing gender-affirming
20 medical care to youth an important part of your
21 practice?
22 A. Absolutely.
23 Q. Why is that?
24 A. I didn't become a pediatric endocrinologist to
25 be a gender specialist. I discovered pediatric

1 endocrinology through my third and fourth year of
2 medical school and really enjoyed the breadth of
3 practice that it offered. And I would say over the
4 course of my training, both medical school and then as a
5 resident and fellow, experiences with gender-diverse
6 individuals, both children and adults, caused me or
7 allowed me to see the need that existed and sometimes
8 the dearth of providers that were there able to provide
9 that care, and it grew out of that.
10 Q. What types of medical treatments do you provide
11 for patients with gender dysphoria?
12 A. I'm a pediatric endocrinologist, so I provide
13 puberty-blocking hormones that you've heard about
14 already as well as hormone therapies for youth with
15 gender dysphoria.
16 Q. And if I use the term gender-affirming medical
17 care, will you understand that to refer to the
18 puberty-delaying medications and the hormone therapies
19 that you mentioned in the context of gender dysphoria?
20 A. Yes.
21 Q. Do you provide any medical treatment for gender
22 dysphoria to patients before they reach puberty?
23 A. No. As you've heard before, there's no medical
24 therapy necessary for gender diversity before the onset
25 of puberty.

1 Q. Are any of your transgender patients on
2 Medicaid?
3 A. I believe so, yes, although I don't
4 specifically track which insurance programs my patients
5 have when they see me.
6 Q. And are any of your patients on the Children's
7 Health Insurance Program or CHIP?
8 A. The same answer. I believe so, yes.
9 Q. And regarding the use of puberty-delaying
10 medications and hormone therapies, do you also provide
11 those same treatments to cisgender patients?
12 A. Yes. Those therapies are common practice or
13 common medications for a pediatric endocrinologist to
14 provide under other indications for cisgender patients.
15 Q. Is there a specific diagnosis that has to be
16 made before you begin providing gender-affirming medical
17 care to a transgender patient?
18 A. Yes. Patients must meet criteria per the DSM-V
19 of gender dysphoria.
20 Q. And how do you determine if a patient is
21 developmentally and emotionally ready to undergo
22 treatment?
23 A. Yeah. As you've heard, the practice of
24 medicine is a complex practice in which physicians get
25 to know the patients that are in front of them and the

1 families that come to them. The ability to assess
2 capacity is an ability that every physician learns
3 throughout their medical training --
4 MR. STONE: Your Honor, objection. This
5 witness is now talking about what every physician
6 learns. He's not designated as an expert. Under
7 Rule 701, he can offer a lay opinion, but it has to be
8 based on his personal perceptions. And in this case,
9 because this is a witness who's not designated as an
10 expert but is a fact witness, we object to this
11 testimony about what other physicians would do.
12 THE COURT: Well, what I'm going to do is
13 repeat the question, okay?
14 THE WITNESS: Sure.
15 THE COURT: And how do you determine if a
16 patient is developmentally and emotionally ready to
17 undergo treatment?
18 So I'm going to overrule the objection and
19 let you answer that question.
20 A. I would say that I use the skills that have
21 been developed through a rigorous medical training to
22 assess patients and their ability to understand and
23 consent to therapies proposed to them.
24 Q. (BY MS. POLLARD) And are their families
25 involved or their guardians involved in that process?

1 A. Absolutely.
2 Q. In what situations do you provide
3 gender-affirming medical care to a transgender patient
4 under 18 without the consent of their parent or
5 guardian?
6 A. I have never.
7 Q. And in what situations would you provide
8 gender-affirming medical care to a transgender patient,
9 again under 18, without the assent of that patient?
10 A. Again, I have never.
11 Q. Do you utilize any clinical guidelines in your
12 treatment of patients with gender dysphoria?
13 A. Yes. I utilize the WPATH Standards of Care
14 Version 8 and the Endocrine Society Clinical Practice
15 Guidelines.
16 Q. Does every transgender patient you see receive
17 some sort of medical treatment for gender dysphoria?
18 A. No, not necessarily.
19 Q. And can you give us an example of when it might
20 be the case that they would not receive medical
21 treatment?
22 A. Sure. This care is very individualized. And
23 there are times when patients come to me having met a
24 criteria for gender dysphoria, lasting over a period of
25 six months, who may not be ready to start hormone

1 therapies for a number of reasons. I can think of a
2 recent patient who was assigned female at birth and
3 plays hockey and wants to continue to be able to play
4 hockey and fears that if he -- his gender identity is
5 male -- starts testosterone therapy, he may no longer be
6 able to play the sport that he likes to play.
7 Q. And are you aware of a law known as SB 14?
8 A. Yes.
9 Q. Have you seen any evidence of the impact of
10 SB 14 on your patients?
11 A. Yes.
12 Q. If SB 14 is allowed to go into effect, what
13 impacts would it have on the health of your patients
14 with gender dysphoria?
15 A. I anticipate that patients with gender
16 dysphoria, if SB 14 were to go into effect in this
17 state, would increase their dysphoria and may increase
18 other mental health aspects such as their depression or
19 anxiety.
20 Q. Have any of your transgender patients attempted
21 suicide before coming to see you?
22 A. Unfortunately, yes.
23 Q. If SB 14 were to go into effect and you were to
24 continue treating your transgender patients consistent
25 with evidence-based medicine, what risks would that

1 carry?
2 A. I would lose my license.
3 Q. In your view, how does SB 14 comport with your
4 ethical obligations as a doctor?
5 A. SB 14, if it were to go into effect, would make
6 me abandon patients with whom I have established
7 relationships.
8 Q. And how does that impact you personally as a
9 physician?
10 A. Well, that's terrible. You know, I went into
11 medicine to connect with people and to help people. I
12 spent the last month telling people that I may in fact
13 not be able to see them come September 1. It would be
14 heart-wrenching to lose these patients and the
15 relationships that we've established over years.
16 Q. Thank you very much, Doctor.
17 MS. POLLARD: I'll pass the witness.
18 THE COURT: Cross-examination?
19 MR. STONE: Yes, Your Honor, just a
20 couple.
21 **CROSS-EXAMINATION**
22 BY MR. STONE:
23 Q. Doctor, do you obtain informed consent from
24 adolescent patients for whom you're treating them for
25 gender dysphoria prior to beginning cross-sex hormones?

1 A. Mr. Stone, I obtain informed assent from my
2 adolescent patients and informed consent from their
3 parent or guardian before starting cross-sex hormone
4 therapy, yes.
5 Q. Have any of your patients attempted suicide
6 after -- for whom you're treating for gender
7 dysphoria -- let me start again.
8 Have any of your adolescent patients for
9 whom you're treating them for their gender dysphoria
10 condition -- have any of them attempted suicide after
11 beginning a treatment course in puberty blockers or
12 cross-sex hormones?
13 A. Not that I'm aware of.
14 Q. Do you understand SB 14 is requiring you to
15 wean your current patient population off of puberty
16 blockers and cross-sex hormones over a period of time?
17 A. I understand that SB 14 allows a provision for
18 some patients to be weaned off of their medications.
19 Q. When you say some patients, what do you mean by
20 that?
21 A. I believe the wording of SB 14 states that if a
22 patient has had -- started therapy before -- and I can't
23 remember the exact date, but there is a date in there --
24 and had more than 12 mental health sessions prior to
25 starting hormone therapy of any kind, including puberty

1 blockers, at least six months before starting therapy,
2 that they may qualify for a wean.
3 MR. STONE: I'll pass the witness,
4 Your Honor.
5 THE COURT: Any redirect?
6 MS. POLLARD: No, Your Honor.
7 THE COURT: All right. Thank you,
8 Dr. Ogden Roberts. You are done on the witness stand.
9 The next witness for plaintiffs?
10 MS. POLLARD: Your Honor, plaintiffs would
11 like to call Dr. David Paul.
12 THE COURT: Okay. Dr. Paul, if you could
13 step forward and raise your right hand for me.
14 **DAVID L. PAUL, M.D.**
15 having been first duly sworn, testified as follows:
16 **DIRECT EXAMINATION**
17 BY MS. POLLARD:
18 Q. Dr. Paul, would you please state your name for
19 the record?
20 A. David Leo Paul.
21 Q. And Dr. Paul, are you a party to this
22 proceeding?
23 A. Yes, I am.
24 Q. What party is that?
25 A. I'm a plaintiff.

1 Q. And what is your occupation?
2 A. I'm a physician.
3 Q. And would you walk us through your educational
4 background?
5 A. So I attended Trinity University from '77 to
6 '80 for undergrad and then University of Texas Health
7 Science Center San Antonio for medical school from 1980
8 to '84.
9 Q. And where did you complete your residency?
10 A. At Wilford Hall United States Air Force Medical
11 Center in San Antonio at Lackland Air Force Base
12 from '84 to '87.
13 Q. And did you complete a clinical fellowship?
14 A. I did pediatric endocrine training for three
15 years from '90 to '93 at the University of California in
16 San Francisco.
17 Q. How long did you serve in the Air Force,
18 Dr. Paul?
19 A. Four years of reserve and then 28 years of
20 active duty.
21 Q. And when did you retire from service?
22 A. In 2012.
23 Q. And what -- at what rank did you retire?
24 A. Lieutenant colonel.
25 Q. Are you currently licensed to practice medicine

1 in Texas?
2 A. Yes, I am.
3 Q. And are you currently board certified in any
4 medical specialties?
5 A. In pediatric endocrinology.
6 Q. And are you a member of any professional
7 organizations?
8 A. GLMA, Pediatric Endocrine Society, the
9 Endocrine Society.
10 Q. And where are you currently employed?
11 A. At a large children's hospital in Texas.
12 Q. Are you here today in your personal capacity?
13 A. Yes, I am.
14 Q. Do you currently work in a clinical capacity?
15 A. Yes, I do, full time.
16 Q. And how would you describe your current
17 practice?
18 A. Busy. Much enjoyed. I spend six months a year
19 as a hospitalist endocrinologist, so I take care of
20 children that are sick in the hospital caring for all
21 sorts of endocrine conditions. And then six months a
22 year I'm working in the clinic setting.
23 Q. And as an endocrinologist, what types of
24 conditions do you treat?
25 A. So as Dr. Roberts said, it's a tremendous

1 variety, but any glandular disorder, pubertal disorders,
2 diabetes. Diabetes is a large portion of pediatric
3 endocrine care. And again, on the inpatient side, a
4 whole host of endocrine disorders, including thyroid
5 cancer.
6 Q. Do you treat patients with gender dysphoria?
7 A. I do.
8 Q. Are some of your patients with gender dysphoria
9 under the age of 18?
10 A. Yes.
11 Q. How did you first come to treat adolescents
12 with gender dysphoria?
13 A. So in 2007 I was at the military base in
14 San Antonio as a pediatric endocrinologist in the
15 Air Force, and I was referred a patient -- excuse me --
16 from the adolescent clinic in that facility who came to
17 them as a gender-identified child -- an adolescent who
18 was assigned male sex at birth. She was getting
19 estrogen on her own from a pharmacy out of Europe and on
20 tremendous doses of estrogen.
21 Adolescent medicine didn't really know
22 what to do. That was a very new human experience for
23 them to help care for. So they recognized the
24 endocrinologists were involved around the world and the
25 country, and so they referred her to me, and I took over

1 her care. I saw her, and we contracted for me to be
2 part of her healthcare, to take over her
3 gender-affirming hormone care.
4 Q. Today would you say that care -- providing
5 medical care for patients with gender dysphoria makes up
6 a relatively small portion of your practice?
7 A. Yes, it is a small portion, perhaps 5 percent.
8 Q. And given that, why is providing medical care
9 to youth with gender dysphoria important to you?
10 A. So I had already understood back then that
11 there was a considerable mental health morbidity
12 associated with gender dysphoria and with patients who
13 experience transgender identity. And then after I took
14 care of the young lady I spoke to you about for a couple
15 years, she was approaching adulthood, and then I lost
16 track of her. She stopped coming back to see me. A
17 couple years after that, her sister sent me an email --
18 found me and sent me an email stating that she had
19 committed suicide.
20 So I recognize that if these youth do not
21 receive standard of care science-based help as they
22 undergo gender transition, that it can be
23 life-threatening. It can be threatening to their entire
24 life existence, affecting every single aspect of their
25 life. And it dawned on me that I had the skills to

1 provide this care. I already had the training within
2 the endocrine exposure that I had. And these children
3 needed care. So I decided from that moment forward I
4 was going to be caring for children who were gender --
5 had gender dysphoria and who identified as transgender.
6 Q. Dr. Paul, what kinds of medical care do you
7 provide to adolescents with gender dysphoria?
8 A. So yes, adolescents, which would be children
9 who have onset of puberty or thereafter, if they have --
10 if they identify as a gender opposite to the sex that --
11 to the gender that they were given at birth, which is
12 based on their genitalia at birth, and then they go into
13 puberty and their secondary sexual development traverses
14 down the pathway that is diametrically opposite to the
15 gender that they identify as, I will pro- -- I will
16 offer and go through the counseling to help them
17 understand puberty suppression therapy using GnRH
18 agonists. Later in adolescence the concept of hormone
19 replacement therapy will come into play, which I can
20 provide under the proper circumstances.
21 Q. And if I use the term gender-affirming medical
22 care today, will you understand it to refer to the
23 puberty-delaying medications and hormone therapy
24 provided to youth with gender dysphoria?
25 A. Yes.

1 Q. Do you provide gender-affirming medical care to
2 patients who are on Medicaid?
3 A. I do know that, yes.
4 Q. And do you provide gender-affirming medical
5 care to patients who are on CHIP?
6 A. Yes.
7 Q. Can you tell us how the gender-affirming
8 medical care that you provide has affected your
9 adolescent patients?
10 A. I am almost weekly amazed at the outcomes, the
11 positive outcomes from the children and adolescents that
12 I care for who have gender dysphoria and who identify as
13 transgender. They are probably the most impressive
14 positive outcomes of all the patients I see. They are
15 the most highly motivated. They faithfully take their
16 medicines like none of the other patients that I see.
17 They actually have a tremendous change in
18 how they feel about themselves, their self-esteem, their
19 ability to interact with other peers, their academic
20 performance, their family life. Every single corner of
21 their life is dramatically changed, and I have seen this
22 and heard their stories, even before they have any
23 physical body changes, just knowing that they have the
24 care provided to them, that they don't see that care
25 going away. This was before SB 14. They know that the

1 hormone -- or that the puberty suppression is engaged
2 and their bodies are not going to continue to physically
3 change down the pathway that is opposite to how they
4 want their bodies to be. And then the hormone
5 therapies, they're circulating. They know it's going to
6 provide the secondary sexual development that goes along
7 with how they identify. They are beaming at the thought
8 of what is going to come in the future.
9 Q. Do you also provide puberty-delaying medication
10 or -- let's start with just puberty-delaying medication.
11 Do you also provide puberty-delaying medication to youth
12 who are not transgender?
13 A. I do, yes.
14 Q. And do you also provide hormone therapy to
15 youth who are not transgender?
16 A. I do, yes, and -- yes, I do.
17 Q. Can you give us an example of circumstances in
18 which you would provide puberty-delaying medication to a
19 cisgender patient?
20 A. The most common again that's been talked about
21 before is precocious puberty. That therapy has been
22 around since the mid 1980s. And I've been using puberty
23 suppression, GnRH analogues, ever since it first came on
24 the market for precocious puberty. But it's also used,
25 as was stated before, to suppress puberty to help

1 preserve fertility in cancer patients who are getting
2 gonadotoxic drugs, and then also patients who have a
3 variety of rheumatological disorders or excessive
4 bleeding disorders -- uterine bleeding disorders.
5 We actually use puberty suppression in
6 children for short stature to help -- with growth
7 hormone therapy to attempt as best as possible to help a
8 youth to reach a normal adult height. And that's a
9 pretty common practice. So there's a whole host of
10 reasons in other children that are cisgender that we use
11 puberty suppression therapy for.
12 Q. And can you give us an example of circumstances
13 in which you would provide hormone therapy to a
14 cisgender patient?
15 A. Yes. The most commonly are children that have
16 what we call hypogonadism where they're not capable of
17 making the hormone -- the sex hormone they need to
18 undergo puberty, and we will re- -- we will provide
19 hormone replacement therapy for them.
20 There's also treatments we may provide for
21 cisgender children who have secondary sexual development
22 against their gender identity. For example, we have
23 cisgender males, again, assigned male at birth, raised a
24 male, identify as a male, undergo male puberty and then
25 start having breast development. We have cisgender

1 females who will develop sometimes pathological causes
2 of virilization of the body, including facial hair,
3 deepening of the voice, and enlargement of the clitoris
4 that we will actually provide hormone therapy for
5 sometimes as part of that treatment. And then, of
6 course, many of them will get surgical therapy as well
7 to remove, for example, breast tissue in cisgender
8 males. So hormone therapies are used in cisgender
9 patients as well under different circumstances.
10 Q. Do you provide any medications to your
11 transgender patients that you don't also provide to
12 cisgender patients?
13 A. I do not.
14 Q. Is there a particular diagnosis that you
15 require before providing any gender-affirming medical
16 care to a transgender patient?
17 A. I'm sorry. The first part of that was do I
18 require a diagnosis?
19 Q. Is there a particular medical diagnosis that
20 you require before providing gender-affirming medical
21 care to a transgender patient?
22 A. Yes, that they have gender dysphoria according
23 to the DSM-V criteria.
24 Q. And do you require the consent of a parent or
25 guardian before initiating gender-affirming medical care

1 for your patients?
2 A. 100 percent of the time, yes.
3 Q. And what does the informed consent process
4 involve in your practice?
5 A. Once a diagnosis is established, the patient
6 and par- -- legal guardians will, of course, ask and be
7 allowed to ask as many questions as they need to ask to
8 have a full understanding. So I disclose all the
9 pertinent things I need to tell them about how the --
10 how I made the diagnosis, for example, what the
11 treatments are available for them under that diagnosis
12 of gender dysphoria, the potential benefits, which
13 outweigh, but still discuss the potential known and
14 possibly unknown risks, short term and long term.
15 I make sure that they have complete
16 voluntary ability to ask for this treatment. I inform
17 them of any alternative therapies that might be
18 available for them to consider. And then I leave the
19 final decision for puberty suppression or hormone
20 therapy to the legal guardian as the consenting
21 individual and then, of course, make sure that the
22 adolescent has full capacity and understands and is
23 mentally capable of assenting to that care.
24 Q. And in what situations would you provide -- or
25 do you provide gender-affirming medical care to a

1 patient under 18 without the informed consent of their
2 parent or guardian?
3 A. Never.
4 Q. In what situations do you provide
5 gender-affirming medical care to one of your patients
6 under 18 without the assent of the patient?
7 A. Never.
8 Q. And you mentioned SB 14 already. How are --
9 how would SB 14 affect your ability to practice medicine
10 if it were to go into effect?
11 A. To practice the medicine for transgender
12 patients?
13 Q. Yes.
14 A. It would halt that care completely.
15 Q. In your view, how does SB 14 comport with
16 medical standards of care for transgender youth?
17 MR. STONE: Your Honor, this is not an
18 expert witness. They're asking him for his -- to
19 provide a medical opinion to the Court that I think is
20 more properly an expert witness opinion. Like I said
21 earlier -- it's a similar objection that I had with the
22 last witness. Under 701, he can talk about his personal
23 perceptions, but he's not qualified and has not been
24 proven up or proffered as an expert in this case.
25 MS. POLLARD: May I respond, Your Honor?

1 THE COURT: If you can rephrase, I think
2 that would be fine.
3 MS. POLLARD: Great.
4 THE COURT: Okay.
5 Q. (BY MS. POLLARD) Dr. Bond, in your view, how
6 does SB 14 comport with how you view the med- -- your
7 medical obligations?
8 A. Well, I feel that both puberty suppression and
9 hormone replacement therapy for this population of
10 youth, this vulnerable population, is well established
11 in standard of care. It has been reviewed extensively
12 by --
13 MR. STONE: Objection, Your Honor. Now
14 we're going into the standard of care and his belief
15 about the standard of care. He has not been proven up
16 as an expert to talk about the standard of care. I
17 think this is beyond the scope of what he can testify to
18 as a fact witness.
19 THE COURT: Do you have a response?
20 MS. POLLARD: He's talking about his own
21 view of medicine that he practices regularly as he's
22 already seen and how it impacts his practice and his
23 view of his own professional obligations. It's very
24 specific to the doctor himself.
25 THE COURT: Right. So I'm going to

1 overrule the objection. I realize -- I don't
2 necessarily need the expert designation under 701. He's
3 a doctor. So if he -- he can testify about his
4 understanding.
5 But that's where we need to limit it, to
6 what your understanding is and how it affects your
7 patient care.
8 THE WITNESS: Yes.
9 THE COURT: Okay.
10 THE WITNESS: Yes, Your Honor.
11 A. Probably -- to be short, it's established care
12 all over the country, around the world. There's data to
13 support it. There's science to support it. There's
14 outcomes to support it. That I have seen in my personal
15 practice in particular, across the board my patients
16 have done profoundly well and have had no adverse side
17 effects.
18 This bill -- this law will strip me of
19 providing this standard of care consensus-approved
20 treatment from 20 U.S. medical organizations, remove my
21 ability to provide that care. It's the only care in my
22 practice that is being removed. It is not being
23 removed -- I have colleagues around the country who
24 provide the same care under the same training --
25 MR. STONE: Objection, Your Honor. Now

1 he's -- again, he's talking about colleagues around the
2 country and what other people are doing. This just is
3 not limited to him.
4 THE COURT: Okay. I'll sustain that.
5 Let's go ahead and ask the next question, please.
6 MS. POLLARD: Your Honor, to clarify, are
7 you sustaining the objection only with respect to the
8 last portion of the answer where he said colleagues
9 around the country?
10 THE COURT: Correct. And remember,
11 there's not a jury here, so I know what to do.
12 MS. POLLARD: Thank you, Your Honor. I
13 was hoping it might encourage others in their propensity
14 for interrupting my questions and the witness' answers.
15 THE COURT: That's all right. Go ahead to
16 the next question, please.
17 Q. (BY MS. POLLARD) Have any of your patients or
18 their families expressed concerns to you about SB 14?
19 A. Yes, many.
20 Q. What are those concerns?
21 A. That after all this time of receiving the care
22 and seeing the positive outcomes for their children,
23 they're going to lose this care, and they just don't
24 know what to do. They don't know where to go. They
25 can't get this care in the state of Texas, so I feel

1 that I am having to abandon them. And under the ethics
2 of abandonment, I have to make sure they can get care
3 elsewhere, but they actually can't get care elsewhere
4 because the whole state of Texas will be banned.
5 So they're fearful. The anxiety levels
6 are profound. And they're having to figure out how
7 they're going to change schooling and jobs and whatnot
8 in order to get this care if they can get this care.
9 Some of them are worried about the concept of having to
10 cross the border, which, of course, Texas is close to
11 Mexico, where that care can be available. It's a rather
12 dangerous undertaking, but some people are feeling
13 that's the only place they can go.
14 Q. And are you concerned about the effect on
15 transgender adolescents if SB 14 goes into effect?
16 A. I'm very concerned about the deterioration of
17 their mental and their physical health and their social
18 interactions and their achievements, yes.
19 Q. Do you think that the SB 14 weaning provision
20 will mitigate the harm of withdrawing that care?
21 A. It'll worsen it. There is no such thing as
22 weaning in the healthcare provision for this population.
23 There's no guideline. There's no studies. There's no
24 science. You can't even wean GnRH agonists to suppress
25 puberty. It's an on or off treatment. The only way

1 that the SB 14 says for me in my private practice -- in
2 my practice to wean them is if it's safe and medically
3 appropriate, and yet there's no science or publication
4 or guideline to say how to do that. The only way I
5 could do that would be to ask the parent: How's it
6 going with this weaning? Is it working out for you? Is
7 it showing positive outcomes towards your child's health
8 to wean them off therapy? This is as I think through
9 what's going to happen, and it has no rationale to it
10 whatsoever.
11 Q. What are your under- -- what is your
12 understanding --
13 A. In fact, can I say one more?
14 Q. Absolutely.
15 A. The reason that was put in there is because the
16 State recognizes there's dangers to stopping this
17 medication, and they recognize that there's a section of
18 the population on this care --
19 MR. STONE: Objection, Your Honor. This
20 witness does not have -- they have not established --
21 THE COURT: Okay. Just make the
22 objection, Mr. Stone, and I'll rule.
23 MR. STONE: Lack of personal knowledge.
24 THE COURT: All right. Thank you.
25 Objection sustained. If you can ask a different

1 question.
2 Q. (BY MS. POLLARD) As a pediatrician who's
3 practiced for 40 years, how do you feel about the
4 possibility that the law might prevent you from
5 providing gender-affirming medical care for your
6 transgender patients?
7 A. How do I personally feel?
8 Q. How do you personally feel?
9 A. Well, I personally feel about as angry as I've
10 ever felt. Sad. Bewildered. Although I fully see this
11 type of behavior towards the LGBTQ+ community around the
12 world, so it's not like I don't realize what's
13 happening, but I'm still bewildered. I don't understand
14 why these vulnerable children can't be left to be
15 themselves. Anxious. Worried. I've lost one child
16 that I took care of who was transgender. I don't want
17 any other child to even have a detriment in their life
18 story going forward, much less to lose them from this
19 planet.
20 Q. Thank you very much, Dr. Paul.
21 MS. POLLARD: I'll pass the witness.
22 THE COURT: Mr. Stone, any
23 cross-examination?
24 MR. STONE: No questions, Your Honor.
25 Thank you.

1 THE COURT: All right. Thank you.
2 Dr. Paul, you're excused from the witness stand. Thank
3 you.
4 All right. Where to next? Oh, wait. Let
5 me see. Yeah, where to next?
6 MS. POLLARD: All right. Plaintiffs call
7 Alex Sheldon.
8 THE COURT: All right. Please step
9 forward and raise your hand.
10 *(Witness sworn)*
11 THE COURT: All right. Go ahead and make
12 your way up to the witness stand.
13 **ALEX SHELDON**,
14 having been first duly sworn, testified as follows:
15 **DIRECT EXAMINATION**
16 BY MS. POLLARD:
17 A. Can you hear me okay?
18 Q. I can.
19 A. Great.
20 Q. Mx. Sheldon, would you please state your name
21 for the record?
22 A. Yes. It's Alex Sheldon, and I use they/them
23 pronouns.
24 Q. Mx. Sheldon, where are you currently employed?
25 A. I work at GLMA.

1 Q. And is GLMA a plaintiff in this case?
2 A. Yes, we are.
3 Q. And is GLMA bringing this case on behalf of its
4 members?
5 A. Yes, we are.
6 Q. What is your role at GLMA?
7 A. I am the executive director.
8 Q. And how long have you held that role?
9 A. Just about a year now.
10 Q. And what are your responsibilities as the
11 executive director at GLMA?
12 A. I set the strategy for the organization in
13 accordance with our mission. I oversee our day-to-day
14 operations. I manage our staff. I am the key liaison
15 to our board of directors. And I have general budgetary
16 and fiscal oversight.
17 Q. What is GLMA?
18 A. We are the oldest and largest association of
19 LGBTQ+ and allied health professionals in the country.
20 Q. And what is GLMA's mission?
21 A. Our mission is dual-fold. We both advocate to
22 advance LGBTQ+ health equity, and we promote equality
23 for LGBTQ+ and allied health professionals in their work
24 and educational institutions.
25 Q. As executive director, is it part of your job

1 to ensure that GLMA achieves its mission?
2 A. It sure is.
3 Q. How does GLMA work to achieve its mission?
4 A. We work through research, advocacy, and
5 education, but our main role is to bring to bear the
6 vast expertise of our multidisciplinary health
7 professional membership in each of those areas.
8 Q. As the executive director, do you make
9 decisions about whether GLMA participates in litigation?
10 A. Yes.
11 Q. And did you make that decision for this case?
12 A. I did, yes.
13 Q. And why did you decide that GLMA would
14 participate in this case?
15 A. Well, as an LGBTQ+ health equity organization,
16 it's incumbent on us and me in particular to stay
17 abreast of the political landscape that governs care,
18 the provision of healthcare for the LGBTQ+ community.
19 And when we heard that this harmful legislation was
20 moving forward in Texas, and elsewhere but in Texas, we
21 knew that, one, it would potentially restrict access to
22 care for trans young people in the state; and not only
23 that, that it would tie the hands of our health
24 professional members. They would either be forced to
25 comply with the law and therefore abandon care and

1 endanger the lives of their patients like our members
2 have attested to so far, or they would -- if they chose
3 to continue to act in accordance with their extensive
4 training and with evidence-based care and continue that
5 care for young people, they would potentially risk
6 losing their medical licenses or risk other disciplinary
7 actions. So we knew that it would drastically undermine
8 their medical expertise, their professional ethical
9 obligations as well as their occupational freedom, so we
10 felt compelled to act.
11   Q.   And why does GLMA support access to
12 gender-affirming medical care for minors?
13   A.   We support access to care because we know that
14 it is evidence-based lifesaving care, and we act in
15 accordance with the expertise of our medical membership.
16   Q.   And I'm going to move to a different topic for
17 a moment. Does GLMA have bylaws?
18   A.   We do.
19   Q.   All right. I'd like to show you what has been
20 marked as Plaintiffs' Exhibit 2. As the executive
21 director, are you familiar with GLMA's bylaws?
22   A.   Sorry. Just one second. Yes, I am.
23   Q.   And does this appear to be -- does Exhibit 2
24 appear to be a true and correct copy of GLMA's bylaws?
25   A.   Yes, it does.

1 Q. And does this appear to be the most recent
2 version of your bylaws?
3 A. Indeed it does.
4 Q. Those are all of the questions I have about
5 that document.
6 Is GLMA a membership organization?
7 A. Yes, we are.
8 Q. How do people become members of GLMA?
9 A. Through a membership form that is online --
10 excuse me -- and by paying membership dues.
11 Q. Who can be a member of GLMA?
12 A. Anyone can be a member of GLMA, but we mostly
13 have members who are health professionals, and we also
14 have a designation for members who are LGBTQ+ health
15 equity supporters.
16 Q. How many members does GLMA currently have?
17 A. Just about 1,000 members nationwide.
18 Q. And what is the role of members within GLMA's
19 organization?
20 A. As I said, our members bring to bear their vast
21 expertise in health profession -- health professions and
22 our research, advocacy, and education initiatives, but
23 their role primarily is to advance our mission through
24 their own work and to -- they can cast an advisory vote
25 to inform our strategy. And also they contribute to our

1 annual conference through submitting sessions for
2 educational purposes.
3 Q. And is the role of members addressed within
4 GLMA's bylaws?
5 A. It is, yes.
6 Q. Does GLMA have members who work in Texas?
7 A. Yes, we do.
8 Q. Do any of your Texas members currently provide
9 gender-affirming medical care for minors?
10 A. Yes, they do.
11 Q. And does that include the three physician
12 plaintiffs in this case?
13 A. Yes. Dr. Paul, Dr. Roberts, and Dr. O'Malley.
14 Q. As executive director, are there ways that you
15 keep up with what the GLMA members are experiencing?
16 A. Yeah, absolutely. Well, first, we -- I'm very
17 accessible to our members through our annual conference
18 as well as other ways in which I interact with our
19 members very, very often. And also, since some of this
20 legislation has moved forward, we have started to
21 convene gender-affirming care providers from throughout
22 the country on a biweekly basis virtually, and that also
23 includes members in Texas.
24 Q. If SB 14 is allowed to go into effect, how
25 would it impact GLMA members providing gender-affirming

1 medical care to youth in Texas?
2 A. I think it would have a devastating effect.
3 From what we've heard already from testimony today, it
4 would put -- it would truly tie the hands of our health
5 professional membership. They really would be putting
6 their medical licenses on the line in order to save the
7 lives of their patients. And as folks have attested to
8 today, they got into these provisions to help people and
9 to save lives. And if they can't do that, then they are
10 no longer fulfilling their professional obligation. And
11 many of them have said that they might be forced to
12 leave the state and practice elsewhere.
13 Q. Thank you very much.
14 A. Thank you.
15 MS. POLLARD: Pass the witness.
16 THE COURT: Thank you. Any questions?
17 MS. DYER: No questions.
18 THE COURT: All right. Thank you. You
19 may be excused from the witness stand.
20 Uh-oh. Did we break it?
21 MS. WOOTEN: Sorry, Your Honor.
22 THE COURT: That's okay.
23 MS. WOOTEN: Are you ready for the next
24 witness or would you like to take a break?
25 THE COURT: Well, let me check in with

1 Ms. Crain.
2 THE REPORTER: We can go a little bit
3 longer.
4 THE COURT: I try to make it at least till
5 3:10 or 3:15 so that our afternoon isn't too long. So
6 I'd say let's get started.
7 MS. WOOTEN: Thank you, Your Honor. The
8 next witness plaintiffs are going to call is Sarah Soe.
9 THE COURT: All right. Thank you.
10 MR. STONE: Your Honor, I believe this is
11 their last witness for today. So I just wanted to let
12 you know that we are trying to reach one of our
13 witnesses to see if we can get them here in time to be
14 able to keep going potentially this afternoon if that's
15 okay.
16 MS. WOOTEN: Yes. And Your Honor, we're
17 also trying to reach one of our witnesses to see if it's
18 at all possible to get that witness here.
19 THE COURT: Okay.
20 MS. WOOTEN: So perhaps we'll confer
21 during the break.
22 THE COURT: That should work out
23 perfectly. Thank you.
24 MS. LESKIN: And Your Honor, Ms. Soe is
25 also a plaintiff proceeding under pseudonym.

1 THE COURT: Understood. Thank you.
2 Hello. Come on up here and I'll swear you
3 in before you take the witness stand. If you'll raise
4 your right hand for me.
5 *(Witness sworn)*
6 THE COURT: You can make your way around
7 and up to this witness chair.
8 **SARAH SOE**,
9 having been first duly sworn, testified as follows:
10 **DIRECT EXAMINATION**
11 BY MS. LESKIN:
12 Q. Can you tell us your name, Ms. Soe?
13 A. Yes. Sarah Soe.
14 Q. And Ms. Soe, you live in Texas?
15 A. Yes.
16 Q. What county do you live in?
17 A. Hays County.
18 Q. Are you a member of PFLAG?
19 A. Yes, I am.
20 Q. Tell us a little bit about your family.
21 A. Well, there's me. There's my husband, Steven.
22 And we've been married 18 years. There's my older
23 daughter and a younger daughter, so Stephanie and
24 Samantha.
25 Q. And we're here today to talk a little bit about

1 Samantha. So can you tell us a little bit about her?
2 A. Yeah. She's -- she's a really bright kid.
3 She's played soccer for a number of years, loves soccer,
4 learning how to play guitar, likes to read, a pretty
5 good student, loves choir and really doing really well
6 in choir.
7 Q. How old is Samantha?
8 A. 15.
9 Q. What sex was Samantha assigned at birth?
10 A. Male.
11 Q. And what gender does Samantha identify with
12 today?
13 A. Female.
14 Q. How did you learn that Samantha identifies as
15 female?
16 A. Well, so a number of years ago, probably like
17 when Samantha was around like fifth, sixth grade, she
18 had been crying herself to sleep every night pretty --
19 pretty much not -- we didn't really know why. She just
20 wasn't really talking about it. And I usually would go
21 in to tuck her into bed, and I would just sit on the bed
22 and we'd talk, and -- and one night she said to me,
23 "Mom, I think I'm transgender." And -- yeah. So I
24 just -- you know, that's when.
25 Q. And what was your reaction when Samantha told

1 you she thought she was transgender?
2 A. I -- I said I love you. I -- I think I just --
3 just wanted her to know that I'm -- I'm there. I'm
4 always going to be her mom. And so I just said, okay,
5 well, you know, you're young, so you have lots of time
6 to think about, you know, who you're going to be and
7 things like that. So -- so I just kind of tried to
8 reassure her that, you know, I'm there for her and that
9 it's okay.
10 Q. Did you make any -- take any steps to talk to
11 any of Samantha's medical providers?
12 A. Oh. Well, so after -- after Samantha first
13 told me, then we -- Samantha, you know, told my husband,
14 and I asked Samantha before her wellness check, her
15 annual wellness check that she does on her birthday -- I
16 asked would she feel comfortable talking to our family
17 pediatrician about -- about how she's feeling about her
18 gender. And the pediatrician -- Samantha said yes, she
19 felt comfortable. So we talked to the pediatrician
20 about that. And the pediatrician did ask like,
21 you know, do you feel like you need a referral to a
22 specialist or anything at this time? And Samantha said
23 she did not feel like she needed to. And so -- and so
24 we just -- you know, we let it -- we let that sit. And
25 she -- over the next -- course of the next year, we --

1 she did say at that point, at the next year's wellness
2 check, that she did feel like she would like to speak to
3 someone else about how she was feeling.
4 Q. So I want to just talk a little bit about that
5 one-year time period then. Samantha told you she didn't
6 want to go see a specialist at that time. Did you do
7 anything as a family to support her in her gender
8 identity?
9 A. Yes. So she had told us that she wanted us to
10 use a new name, a female name, and so we started to do
11 that in our household. We told -- she wanted to tell
12 her schoolteachers and, of course, we supported what she
13 had to say. And she started using a new gender. She --
14 the female and non-binary kind of gender so that she --
15 she was kind of in a transition I think.
16 And we -- we actually -- because she had
17 been crying, you know, before, we -- we took her to a
18 therapist. She was starting to get counseling just to
19 have someone to talk to. The school -- we also talked
20 with the school counselor, and the school counselor
21 talked to our -- meanwhile we had done a bunch of
22 research -- right? -- on our own, just reading
23 everything we could to try and educate ourselves about
24 how to support our child. And that was helpful I think
25 for us, but she was seeming more and more depressed.

1 She was becoming more withdrawn. And so she quit
2 playing soccer, which had been with a boys team.
3 And so one day actually -- I'm very close
4 to her, and I felt like something didn't feel right.
5 She had been feeling sad and not really engaging very
6 much. And I had a bad feeling, you know, like when
7 you're -- you just have not a good feeling in your heart
8 about what's -- how things feel. And she went to
9 school. She was very quiet. And I was about to head
10 off to work, but I asked my husband could he give the
11 school a call, you know, just to have the school
12 counselor just check in on her because we had already
13 been in touch with the counselor a lot. So my husband
14 did. And this was like still in the morning. And as he
15 was on the phone with the school counselor, the school
16 counselor got an alert, a red flag alert on her computer
17 that said that my child Samantha's computer alerted them
18 because she had been searching how to kill yourself.
19 So -- so I didn't go to work and I went to
20 my child's school and I got her. And we -- you know,
21 after we talked with the counselor and the counselor was
22 like, okay, you -- like, do you have a -- do you have a
23 plan? And like, is it okay for us to release you? My
24 child and I went home together, and we just talked and
25 we talked. And I think at that point I kind of knew

1 things probably needed to change, that we couldn't
2 really keep going on like this. Things felt like they
3 were getting worse for her.
4 Q. As her -- as her mom, were you scared for her?
5 A. Oh, yeah. Yeah, no, I mean, I could see in my
6 child's eyes that things were not right. And yeah, I
7 was scared for her.
8 Q. What was the next step that you took? You said
9 things had to change, so what did you do?
10 A. Well, we actually -- we went back to our
11 pediatrician, and she suggested we go have our daughter
12 see a psychiatrist, so we found a psychiatrist, and our
13 daughter started going to the psychiatrist. And then at
14 the next -- and she started taking some antidepressants
15 and doing talk therapy. And then at the next wellness
16 check, which was, you know, a year later, I guess, I
17 asked my child -- and the doctor asked the child, like,
18 you know, would you like a referral, I guess following
19 up, and we said yes. Yeah. And we talked about that as
20 a family. We kind of had done our own research, so we
21 kind of knew that that was possibly what might happen,
22 but yes, we said yes, please do give us a referral.
23 Q. Before you got that referral, you mentioned
24 that Samantha had started talk therapy and I think you
25 said antidepressants.

1 A. Yes.
2 Q. Did that help?
3 A. I think it -- it might have helped a little
4 bit, I think probably, but it I guess brought home to me
5 just how serious things were.
6 Q. Did you meet with a specialist?
7 A. Yes. It took a while because there was -- I
8 think it was like three or four months before we could
9 get in. So, you know, we did meet with a specialist.
10 The specialist was really, really nice. She spent more
11 than an hour with us just getting to know our child and
12 finding about their history and things like that. And
13 she told us what some of the risks were, which we kind
14 of knew, you know, that there could be some impacts like
15 bone loss, bone density loss potentially for certain
16 things. Yeah.
17 Q. Let me just stop you one second. When you say
18 risks, risks of what?
19 A. Oh, okay. So -- yeah. So we talked about
20 options for, like, how to treat gender dysphoria, which
21 is -- which is what our child was diagnosed with.
22 And -- and one of the options that the doctor laid out
23 for us was that before we would do any kind of hormonal
24 sort of treatment, which my child was sort of asking
25 about, that really at this time we would put a pause.

1 And so she suggested puberty blockers as a temporary
2 kind of let's kind of see how things go kind of measure
3 and explained to us what a course of treatment may look
4 like, you know, given how -- our daughter's own
5 particular case. And because our child had had some
6 mental health challenges, you know, she had said we
7 really want to give you lots of time to meet with your
8 therapist and try to make sure that you are healthy.
9 And so -- so we -- we -- we did start the puberty
10 blockers fairly soon. Our child had entered puberty,
11 and so that was sort of time to sort of give her time to
12 kind of think about things and us.
13 Q. And did you see an impact on Samantha after she
14 started puberty blockers?
15 A. Yeah. I think she felt -- I think she felt
16 better. I think she was doing a little better at school
17 and doing better, like, with her friends and things.
18 Things were -- were a little bit better. She wasn't
19 crying at night anymore. But -- and her mental health
20 was sort of stabilizing, and we didn't have some of the
21 other scares that we had had.
22 Q. And you mentioned that the next step would be
23 hormone therapy. Did you have conversations -- at what
24 point did you have conversations with your doctor about
25 hormone therapy?

1 A. I think in the initial consultation when we
2 talked about gender dysphoria, she mentioned that that
3 was one of the treatments that they do eventually offer.
4 It wasn't something that we were necessarily going to do
5 right away. We knew that. But -- yeah, I'm trying to
6 think back here. I think she -- she mentioned it, but
7 it was my child really who had mentioned it a few
8 different times. And so my child had asked her doctor
9 about it and the doctor responded.
10 Q. How long was it before -- from the time that
11 Samantha first told you she identified as a girl until
12 you started her on puberty blockers?
13 A. I think it had to have been probably two years
14 I'm going to say.
15 Q. And then how -- at some point did you start her
16 on hormone therapy?
17 A. Yes, we did. We started a little more than a
18 year after starting the puberty blockers.
19 Q. Did you see any change in Samantha's mental
20 health after she started the hormone therapy?
21 A. Yeah. So --
22 Q. What did you see?
23 A. Well, it was -- it was good. So she -- she
24 started to -- she had been starting to make some new
25 friends in choir, which was the treble choir, and she

1 just kind of felt really good about being in there,
2 included. She, like, just started smiling more and
3 seeming more open and outgoing. She found some friends
4 who were accepting. And she had some teachers who were
5 also accepting that I think made her feel safe and cared
6 for. And yeah, she -- she stopped crying at night and I
7 think just seemed a lot happier.
8 Q. You mentioned the conversations with your
9 doctors about starting hormone therapy. Was the
10 decision to start Samantha on hormone therapy an easy
11 one for you?
12 A. So that's like -- so that's an easy and a hard
13 question. So it was hard because the doctor did say,
14 you know, there are some risks like -- like what I
15 mentioned, the bone density loss, or potential
16 infertility. There are some, like, potential negatives.
17 But it was also not a hard decision because I felt like
18 my child's life was in danger. And my job as a
19 parent -- as a mom, but as a parent probably -- is to
20 keep my child safe, and I would do anything to keep my
21 child safe.
22 And our child was, you know, talking about
23 threats of suicide, was cutting herself on her leg with
24 razors. If -- if she was not moving in the right
25 direction, if she was starting to move in the wrong

1 direction, I think I would be very afraid that she would
2 be at risk for suicide. So seeing how positively she
3 responded to having a body that was trying to look like
4 she felt like she was, that meant a lot to me, and I --
5 what matters most to me is keeping my child safe.
6 Q. What concerns do you have if SB 14 goes into
7 effect?
8 A. I -- well, I made a promise to my child that I
9 would keep her safe no matter what. So I will -- I will
10 do what I need to do as a mom to keep my child safe. I
11 will take my child out of state if I need to. If I have
12 to pay an exorbitant amount out of pocket for the
13 medical care that she needs, which is -- which is the
14 standard of care, I will do those things, and I will
15 find a way, because that's my job, is to keep my child
16 safe. I think if her medical care was taken from her, I
17 would be afraid that she would kill herself.
18 Q. You mentioned that you would take your child
19 out of state. Is your desire to stay in Texas?
20 A. Yes. So I own a home here with my -- with my
21 husband, and we both have jobs here in Texas. And my
22 job is the job I expect to retire with. So I have no
23 intention of leaving. I have eight chickens at home and
24 five cats and two dogs, and, you know, I have citrus
25 trees in my backyard, and I don't want to leave any of

1 them. But, you know, I'll leave my chickens behind if
2 it takes -- if it means helping my child.
3 MS. LESKIN: Pass the witness, Your Honor.
4 THE COURT: Any questions for this
5 witness?
6 MS. DYER: No questions.
7 THE COURT: All right. Thank you.
8 Thank you. Your time on the stand is
9 done, and you can head back out to that door.
10 We're going to take our afternoon break.
11 And if we can be back by 3:35, we'll resume then at that
12 time. And just in case -- I forgot to mention earlier,
13 if there's anybody new in the gallery, there's no
14 recording, broadcasting, or photography, so please keep
15 that in mind. All right. We're on break.
16 *(Recess taken)*
17 THE COURT: And who do you officially
18 call?
19 MS. WOOTEN: Your Honor, we call Mary Moe.
20 THE COURT: Okay.
21 MS. WOOTEN: And if the Court will allow,
22 we would be grateful for a time check before her
23 testimony begins.
24 THE COURT: Sure. Give me one second.
25 Two hours and 28 minutes remaining for the plaintiff.

1 And I guess on the defense there's just been about 11
2 additional minutes used, so I'll have -- I can update
3 that I think later today.
4 MS. WOOTEN: Thank you, Your Honor.
5 THE COURT: Okay. I take that back. I
6 forgot to add the last 15 minutes from the past witness.
7 Let's see. So about two hours and ten minutes.
8 MS. WOOTEN: Thank you, Your Honor.
9 MS. LESKIN: And, Your Honor, Ms. Moe is
10 also a plaintiff proceeding under pseudonym.
11 THE COURT: Correct. Thank you.
12 If you can step forward here, I'll swear
13 you in before you take the stand. If you will raise
14 your right hand for me.
15 *(Witness sworn)*
16 THE COURT: You can make your way around
17 there and up to this chair. There's water there. And
18 it's good to be about five or six inches from the mic.
19 MS. LESKIN: May I proceed, Your Honor?
20 THE COURT: Yes. Please go ahead.
21 MS. LESKIN: Thank you.
22 **MARY MOE**,
23 having been first duly sworn, testified as follows:
24 **DIRECT EXAMINATION**
25 BY MS. LESKIN:

1 Q. Can you introduce yourself to us, please?
2 A. Yes, ma'am. My name is Mary Moe.
3 Q. Ms. Moe, do you live in Texas?
4 A. I'm in transition right now. I have a house in
5 Montgomery County that I would like to return to.
6 Q. And we'll talk a little bit more about that.
7 Are you a member of PFLAG?
8 A. Yes, ma'am.
9 Q. Tell me about your family.
10 A. My husband, Matthew, and I have been married
11 for 10 years. We have two beautiful children, one
12 precious little trans girl and one cis boy.
13 Q. And we're here, as you know, to talk about your
14 daughter.
15 A. Yes.
16 Q. And her name is Maeve?
17 A. Maeve.
18 Q. Tell us a little bit about Maeve.
19 A. Oh, Maeve is bright. Since the time she was
20 born, she loved dancing. She loved twirling. She has a
21 love for learning, extremely intelligent. By the time
22 she was 18 months she was doing sight words already. So
23 prior to kindergarten we had her tested to see where she
24 was academically because she was just excelling in every
25 aspect, and at that point she was reading at a third

1 grade level.
2 Q. And how old is Maeve now?
3 A. Maeve is nine, about to be ten. She would
4 prefer that I tell people that she's ten because
5 she's --
6 Q. Almost ten.
7 A. She's reached the mark. Yes.
8 Q. And what sex was Maeve assigned at birth?
9 A. Maeve was assigned male at birth.
10 Q. And what gender does Maeve identify as today?
11 A. Maeve identifies as a girl.
12 Q. When did Maeve tell you that she identified as
13 a girl?
14 A. By the time she could talk, she showed a
15 preference for feminine things. We tried to pump the
16 brakes as much as we could. And whenever we were
17 pumping the brake, she would make statements like, "Will
18 I ever like girl things -- or "Will I ever like boy
19 things?" So it wasn't that she necessarily said I'm a
20 girl, but there were so many things that happened along
21 that journey over time that pointed us in that
22 direction.
23 Q. And did there come a time when Maeve actually
24 told you she was a girl?
25 A. She said she would -- she -- she has reached

1 that point, absolutely. But she was really young
2 whenever she started to transition, and so she would say
3 I like girly things, I'm a girl, I'm a girl -- I don't
4 know the exact words that she would use whenever she
5 first -- whenever we first discovered that she was
6 trans, because it was more like I like girly things, I
7 like hanging out with my friends, because she always
8 hung out with the girls. She would put shirts on her
9 hair to make long hair.
10 Q. Did there come a time when you thought it
11 was -- you saw it was more than just preferring girl
12 things and more that she identified as a girl?
13 A. Yes.
14 Q. And how did that come to pass?
15 A. We went through a really rough -- rough period
16 where she was starting to lose sleep at night. She was
17 begging and pleading, Will I ever like boy things? Will
18 I ever fit in with the boys? One day I'll like boy
19 things. But she kept on getting disappointed whenever
20 it didn't happen. She started avoiding eye contact with
21 people. She started biting her nails till they bled.
22 And her love of learning just plummeted. Her love of
23 learning -- she would just say I don't care. And it
24 seemed like we weren't listening to her, so why -- why
25 the hell was she going to listen to us on some of these

1 things?
2 Q. Did there come a time when you accepted that
3 she was a girl?
4 A. Yes.
5 Q. When that was?
6 A. It's been a process. It wasn't -- it wasn't
7 overnight. I mean, it started out with getting pink
8 socks, and it progressed into me and my husband debating
9 for six months on the back porch if we were going to get
10 her a pink bike because we were worried about bullies.
11 Q. When you -- did you buy Maeve that pink bike?
12 A. Yes.
13 Q. How did she react when you got that pink bike
14 for her?
15 A. She lit up. She lit up. She just sparkled.
16 Q. How else did you continue to support her as she
17 was working this through?
18 A. Whenever she started biting her nails and
19 losing sleep and -- you know, this was going on for
20 weeks at this point. I decided to talk to her
21 pediatrician as well as I sought counseling for her.
22 Q. And what did the doctors tell you?
23 A. The doctors described a situation called gender
24 dysphoria and encouraged me to look into it a little bit
25 more.

1 Q. And how old was Maeve at that point?
2 A. She was about five.
3 Q. Did you look into gender dysphoria more?
4 A. Absolutely.
5 Q. How did you do that?
6 A. I started researching wherever I could,
7 whatever I could get my hands on essentially. And I was
8 very cautious on what sources I was getting my
9 information from because there was a lot of
10 misinformation out there. It was a very confusing
11 situation, so talking to the professionals and reaching
12 out to friends and family that have medical background
13 to add some additional guidance was incredibly helpful.
14 Q. At some point was Maeve diagnosed with gender
15 dysphoria?
16 A. Yes.
17 Q. And who made that diagnosis?
18 A. She has that diagnosis from a therapist as well
19 as from a doctor.
20 Q. Have you ever attempted to investigate medical
21 treatment for Maeve to treat her gender dysphoria?
22 A. We've looked into our options, but we're not
23 there yet.
24 Q. So Maeve has not yet received medical
25 treatment?

1 A. No.
2 Q. What have you done to support Maeve and her
3 gender dysphoria?
4 A. To support Maeve, I have let her grow her hair
5 out. I've let her wear what she's comfortable in. I
6 let her present herself how she feels. We do touch base
7 with a gender doctor because her dysphoria creeps up at
8 times. She's starting to see her body change, and it
9 makes her very uncomfortable, and we go back to those
10 sleepness nights whenever she's seeing those changes.
11 Did I answer the question?
12 Q. Yeah.
13 A. Okay.
14 Q. You said that her dysphoria creeps up. What is
15 she seeing that's causing her dysphoria to creep up?
16 A. She has recently started getting some hair
17 under her armpit, and it makes her uncomfortable the
18 more -- the longer it grows.
19 Q. Have you talked with Maeve about the potential
20 for medical treatment?
21 A. Yes.
22 Q. And tell me about those conversations with
23 Maeve.
24 A. I have explained that there are -- there's
25 medicine out there that can just pause puberty to buy us

1 some more time, because if -- if she goes through a
2 testosterone journey in puberty, she will develop facial
3 hair. She'll get that Adam's apple. She'll get chest
4 hair. And at this point those ideas are absolutely
5 terrifying to Maeve.
6 Q. How so?
7 A. She starts -- if she starts seeing her body
8 change in these ways, that's all she can see. All she
9 can see is gender. She forgets to look at her books and
10 focus on her friends and her love of learning.
11 Q. When you and people around you treat Maeve as
12 the little girl that she is, how does she react?
13 A. She flourishes. She eats it up. She soaks it
14 in.
15 Q. You mentioned that you have not yet started
16 medical care for Maeve, but you've talked to the doctors
17 about it?
18 A. Briefly. Briefly.
19 Q. And is there a reason you haven't started
20 medical treatment yet?
21 A. We're just not there. She has not reached
22 Tanner 2 at this point.
23 Q. So as of right now, how does SB 14 affect you
24 and your family?
25 A. Oh. SB 14 prevents Maeve from going to the

1 doctor whenever she needs to just to check how her
2 body's changing, to have a conversation with the doctor
3 to ease her anxiety.
4 Q. Have doctors told you that, that they wouldn't
5 treat her and her gender dysphoria --
6 A. Yes.
7 Q. -- here in Texas?
8 A. Yes.
9 Q. What has your family done to prepare in case
10 SB 14 goes into effect?
11 A. A week ago, two weeks ago, I relocated with my
12 children out of state, and my husband is still down
13 here.
14 Q. And what was the purpose of relocating out of
15 state?
16 A. So that my child can go to the doctor and talk
17 about whatever she feels the need to have a conversation
18 with her doctor about.
19 Q. Is it your desire to return to Texas?
20 A. I would like to. I grew up here. I have
21 family. We have family. We have friends, the kids,
22 their neighborhood. I sat there and held my little boy
23 last night as he was crying because we don't live in a
24 big neighborhood where he can ride his bike anymore.
25 Yeah, I would like to return to Texas, but Texas has

1 become very ugly towards me and my family.
2 Q. You said that you relocated with your children.
3 Where is your husband?
4 A. My husband is still in our home in Montgomery.
5 Q. And how has that separation impacted your
6 family?
7 A. It sucks. It absolutely sucks. We are a
8 family that sits down to dinner four times a week. My
9 husband is the Cub Scout leader of my little boy's
10 Cub Scout group. Going to Cub Scouts with mom is not
11 going to be the same. I have not been away from my
12 husband this long since we got married. He's my best
13 friend. I got married because I wanted to do this
14 together with him, and now I feel divided because I've
15 got to protect my children and put their emotional,
16 physical, and mental health first and foremost.
17 Q. You said you left Texas at least temporarily to
18 allow Maeve to be able to talk to her doctor.
19 A. Uh-huh.
20 Q. What is your concern if Maeve is not able to
21 get medical treatment, to get puberty blockers at the
22 appropriate time?
23 A. As I've said before, you know, whenever her
24 body's changing and she is not able to talk to doctors
25 about what's going on with her body, gender becomes the

1 forefront and everything else goes to the side. And I
2 just want her to be a kid. My husband and I both
3 want -- just want her to be a kid.
4 MS. LESKIN: Pass the witness, Your Honor.
5 THE COURT: Any questions for this
6 witness?
7 MS. DYER: No questions.
8 THE COURT: All right. Thank you,
9 Ms. Moe. Your time on the stand is done. And you may
10 exit back through that door. Thank you.
11 All right. So is it my understanding that
12 at this time we'll have a witness out of order?
13 MR. ELDRED: Yes.
14 THE COURT: All right. And who would that
15 be, Mr. Eldred?
16 MR. ELDRED: Dr. Colin Wright.
17 THE COURT: Okay. Dr. Wright, if you will
18 step forward, I will swear you in.
19 *(Witness sworn)*
20 THE COURT: All right. You can make your
21 way around and up to the witness stand.
22 Go ahead.
23 MR. ELDRED: Thank you, Your Honor.
24 **COLIN WRIGHT**,
25 having been first duly sworn, testified as follows:

1 **DIRECT EXAMINATION**
2 BY MR. ELDRED:
3 Q. Will you please state and spell your name?
4 A. My name is Colin Wright, C-o-l-i-n,
5 W-r-i-g-h-t.
6 Q. What is your profession?
7 A. I'm an evolutionary biologist, and I'm a fellow
8 at the Manhattan Institute.
9 Q. What is an evolutionary biologist?
10 A. It's somebody who studies how life evolved over
11 the planet from simple beginnings to the diversity of
12 life we have today.
13 Q. And what is your academic background?
14 A. So I'm specialized as an evolutionary
15 behavioral ecologist. I study the evolutionary
16 significance of behavior. I have over 30 papers
17 published on this topic. One component of education
18 that's involved in that is having a firm grounding in
19 biological sex because this is the sort of underpinning
20 for some of the largest sex differences we see in nature
21 in terms of behavior. And I've also been publishing
22 articles in medical journals on the biology of sex and
23 in peer-reviewed academic books.
24 Q. What degrees do you hold?
25 A. I have a Ph.D. in evolutionary biology from

1 UC Santa Barbara and then a bachelor's of science in
2 evolution, ecology, and biodiversity from UC Davis.
3 Q. Do you have any postdoctorate work?
4 A. I do. I spent two years as an Eberly research
5 fellow at Penn State.
6 Q. What did you study there?
7 A. I studied evolutionary behavioral ecology of
8 social insects.
9 Q. And where do you work now?
10 A. I'm currently at the Manhattan Institute.
11 Q. Have you ever testified as an expert before?
12 A. No.
13 Q. Are you familiar from your -- pardon me. From
14 your knowledge, experience, training, and education, are
15 you familiar with the concept of biology of the male and
16 female sex?
17 A. Very familiar.
18 Q. And we may have gone over this a little bit
19 already, but just explain your education and training
20 that makes you familiar with that concept.
21 A. Yes. So it's a foundational concept in my
22 field of evolutionary behavioral ecology. If you're
23 studying the evolutionary significance of behavior, one
24 of the main things you're going to want to look at is
25 what males and females are and have a knowledge about

1 what that is across a broad spectrum of species because
2 that's going to help you design experiments, to execute
3 them, and ensure that you're not confusing certain
4 individuals for others when you're formulating your
5 hypotheses and testing ideas, then just sort of an
6 academic understanding of biology of sex and how this
7 applies universally across the entire plant and animal
8 kingdom.
9 Q. And tell us a little bit -- have you published
10 in the biology -- have you published on the biology of
11 male and female sex?
12 A. I have, for medical journals and in an academic
13 textbook.
14 Q. And just give us a taste of about how many
15 articles and what they've been about.
16 A. So I have an article in the *Irish Journal of*
17 *Medicine*, and this is just outlining what the biological
18 basis of male and females are, their gametes, the type
19 of gamete they produce. And then I have an academic
20 chapter in a book by the academic publisher Routledge,
21 so it's peer-reviewed book chapter. And this just gives
22 a very broad overview of what biological sex is,
23 you know, universally, how humans developed, what sex is
24 in humans, and then sort of going through a lot of
25 common misconceptions about biology of sex and why they

1 don't hold -- hold weight.
2 Q. Have you given any presentations on the subject
3 of male and female biological sex?
4 A. I have at conferences and summits and some
5 universities.
6 Q. Have you formed any research yourself on the
7 biology of male and female sex?
8 A. Not active research on it, but it's definitely
9 a component of, you know, my background knowledge for
10 when I'm designing experiments on any organism. I think
11 it's relevant the fact that, you know, biological sex is
12 defined the same way across all of life, whether it's
13 plants or animals. And so having specific research in,
14 say, human sex isn't going to give you any more insight
15 into what sex is than if you're studying things like
16 ants or wasps or any other animal that has males and
17 females.
18 MR. ELDRED: Your Honor, his CV has
19 already been admitted as Exhibit 4.
20 THE COURT: All right. Thank you.
21 MR. ELDRED: And we'd like to offer him at
22 this time as an expert on the subject of biological sex.
23 THE COURT: Any objection?
24 MR. GONZALEZ-PAGAN: Your Honor, if I can
25 conduct a brief voir dire.

1 THE COURT: That will be allowed.

2 **VOIR DIRE EXAMINATION**

3 BY MR. GONZALEZ-PAGAN:

4 Q. Dr. Wright, you mentioned your degrees are in
5 evolutionary biology; is that right?

6 A. Yeah, evolution, ecology, and biodiversity and
7 then evolution, ecology, and marine biology at
8 Santa Barbara.

9 Q. And following your studies and your two-year
10 postdoctoral fellowship, you have not worked in
11 academia; correct?

12 A. I left formally academia in 2020, but I've been
13 publishing as an independent scholar.

14 Q. You obtained your Ph.D. in 2018; is that
15 correct?

16 A. Yes.

17 Q. And following your studies and two-year
18 postdoctoral fellowship which ended in 2020, you have
19 not conducted any original research; is that right?

20 A. I've written academic papers that are in
21 peer-reviewed journals about the topic of what
22 biological sex is.

23 Q. You referred to one article in a peer-reviewed
24 journal and you said it was the *Irish Journal of*
25 *Medicine*; is that correct?

1 A. I believe that's the title of the journal,
2 yeah.
3 Q. Yeah. That was a -- that was a letter to the
4 editor with one citation; is that right?
5 A. Yes.
6 Q. Okay. So it wasn't an original article of
7 research, and it wasn't peer-reviewed; is that correct?
8 A. It was peer-reviewed. It's a peer-reviewed
9 journal.
10 Q. Are letters to the editor peer-reviewed?
11 A. Yes.
12 Q. You're not a medical doctor; right?
13 A. I am not.
14 Q. You're not a mental health professional?
15 A. Nope.
16 Q. And you provide no healthcare services of any
17 kind?
18 A. I do not.
19 Q. All of your original peer-reviewed publications
20 relate to the study of insects and other arthropods; is
21 that correct?
22 A. That is correct, but as far as it pertains to
23 the biology of sex. Again, sex is defined the same way
24 across all of life, so I could be a botanist and it
25 would still be as relevant.

1 Q. Sure. You have no peer-reviewed publications
2 relating to gender dysphoria aside from this one letter
3 to the editor?
4 A. No, that is not my field. It is not in gender
5 dysphoria.
6 Q. You have no peer-reviewed publications relating
7 to transgender people?
8 A. That's not my area of expertise and not why I'm
9 here.
10 Q. And you have conducted no original research
11 relating to gender dysphoria; is that right?
12 A. That's correct.
13 Q. And no original research relating to
14 transgender people?
15 A. That's correct.
16 Q. And there are species that change sex; is that
17 correct?
18 A. There are some, yes.
19 MR. GONZALEZ-PAGAN: Your Honor, at this
20 time -- Your Honor, at this time we would object to this
21 witness. We don't understand the relevance of this
22 witness.
23 THE COURT: Well, let me ask,
24 Mr. Eldred -- so I tried to look back. It's an expert
25 on biological sex?

1 MR. ELDRED: Yes, Your Honor. We think
2 it's -- under Rule 702, it's a -- he's qualified as an
3 expert in knowledge, skill, experience, training, or
4 education in that topic, and it's useful to you because
5 biological sex is mentioned in the statute. And again,
6 he's not going to be testifying about things like gender
7 dysphoria, just describe what biological sex is, which I
8 think is important to understand to understand how the
9 statute works.
10 THE COURT: And as I understood it,
11 Dr. Wright, it's a Ph.D. in evolutionary biology and a
12 bachelor of science in evolution ecology? Did I get
13 that right?
14 THE WITNESS: So the Ph.D. -- it's a long
15 title. The Ph.D. is in evolution, ecology, and marine
16 biology. And then my BS is evolution, ecology, and
17 biodiversity.
18 THE COURT: I'm going to allow the
19 designation of this expert. You can continue your
20 examination, Mr. Eldred.
21 MR. ELDRED: Thank you.
22 **CONTINUED DIRECT EXAMINATION**
23 BY MR. ELDRED:
24 Q. What is biological sex?
25 A. So at root, biological sex refers to the type

1 of reproductive strategy that an individual has. So in
2 what are called anisogamous species, these are species
3 that reproduce by fusing two gametes of different sizes.
4 The individual that produces the larger-sized gamete is
5 called the female. The one who produces the smaller
6 gamete or sperm is called the male. This is
7 fundamentally what biological sex means. It refers to
8 these reproductive strategies rooted in the type of
9 gamete that they have the function to produce.
10 Q. Would you say that biological sex is binary?
11 A. Biological sex is binary because there are only
12 two gamete types. There's just sperm and there's ova.
13 So -- so yes. So there's only two options for an
14 individual to have with respect to sex, and that is
15 either male or female. There's no third sex. There's
16 no third gamete, which would be the requirement for
17 there to be a third sex or more.
18 Q. Is there any sort of transitional gamete
19 between a sperm and an egg?
20 A. Not even close. They are widely different in
21 sizes. And there's never been a third intermediate
22 gamete found in any species. And there's reasons,
23 evolutionarily speaking, why that this is a stable
24 strategy that has evolved independently many times
25 across many different organisms.

1 Q. And when you say species, are you including
2 humans in that?
3 A. Yeah, humans, any species that has two
4 different sized gametes.
5 Q. Insects as well?
6 A. All -- all animals and many plants.
7 Q. Okay. How do you determine the biological sex
8 of an individual?
9 A. So this is an important point to make about
10 sort of some confusion on terminology. A lot of people,
11 when they talk about how sex is determined, they
12 conflate this with how sex is defined. As a
13 biologist -- so it's a -- in developmental biology, for
14 instance, when we talk about how sex is determined,
15 we're talking about the mechanisms that cause an embryo
16 to eventually develop into a male or a female, but that
17 is very different from how sex is defined, which is
18 based on the types of gamete that they can or would
19 produce.
20 So there are many different organisms,
21 different species that determine sex in a different way,
22 such as -- alligators, for instance, they do it
23 environmentally by temperature. But regardless of how
24 sex is determined mechanistically and caused, the
25 definition of sex across all of life, all plants,

1 animals, is going to be rooted in those binary
2 distinction between gametes.
3 Q. Is it correct to say that in humans that
4 biological sex is assigned?
5 A. I don't prefer that term because I think that
6 suggests that it's sort of an arbitrary designation,
7 that it's --
8 MR. GONZALEZ-PAGAN: Objection,
9 Your Honor. This is outside the scope of what
10 biological sex is.
11 MR. ELDRED: It's not --
12 THE COURT: I'll ask -- well, hold on.
13 Hold on. Let me just take a look. I'll overrule the
14 objection. I think you were completing your answer.
15 A. Yes. I think that it suggests there's
16 ambiguity or that it's an arbitrary designation. I tend
17 to say that sex is observed and recorded. That's --
18 yeah, that's what I should say.
19 Q. (BY MR. ELDRED) So would you say biological
20 sex is a spectrum?
21 A. I would not say it's a spectrum because that
22 would require to have a sort of spectrum of gamete sizes
23 running all the way from the size of a sperm, which is
24 very tiny, to the size of an ovum, which is very large.
25 So no, sex is not a spectrum. It's a -- there's two

1 poles which correspond to either producing sperm or
2 producing ova.
3 Q. I want to show you a demonstrative. We'll pull
4 it up.
5 THE COURT: Yeah, if you've got a
6 demonstrative, I'd prefer you show it to the other side
7 first.
8 MR. GONZALEZ-PAGAN: I'm unclear on the
9 relevance of this exhibit, Your Honor, but --
10 THE COURT: Sure.
11 MR. ELDRED: We're not offering it as an
12 exhibit, just a demonstrative --
13 THE COURT: Okay.
14 MR. ELDRED: -- just to help the
15 testimony.
16 THE COURT: Okay.
17 MR. ELDRED: Oh, there it is.
18 Q. (BY MR. ELDRED) What is that?
19 A. So this is a figure that I created sort of in
20 response to this idea that sex is a spectrum and why
21 that's sort of a misleading way to talk about the
22 biology of sex, because sex doesn't come in degrees.
23 You know, people aren't just degrees of maleness and
24 femaleness. For the vast majority of people, they are
25 just either male or female, much like when you flip a

1 coin, you're either -- you get heads or tails and it
2 doesn't come in degrees. There is a very small
3 percentage of people who have intersex conditions whose
4 genitalia appears sexually ambiguous.
5 Q. I'm going to cut you off for just a second.
6 A. Yeah.
7 Q. What do the numbers mean on the demonstrative
8 exhibit up there you created?
9 A. So those are just the percentage of the
10 population that fall into these buckets of males and
11 females and to be considered intersex, although the
12 intersex category -- much more of those individuals in
13 that white box are also either male or female if you
14 just sort of investigate a little bit more about --
15 regarding their gonads.
16 Q. Well, explain a little bit more about intersex.
17 What does it mean by intersex?
18 A. So intersex refers to individuals whose
19 genitalia appears ambiguous at birth or there's a
20 mismatch between sort of your internal reproductive
21 organs and your external phenotype.
22 Q. Does the existence of intersex prove that
23 there's a spectrum of biological sex?
24 A. No, it doesn't, because intersex people, they
25 don't have reproductive organs that are sort of

1 organized around the production of a new third type of
2 gamete that it would require for there to be another --
3 a third sex. Anyone -- to the degree that sexual
4 ambiguity actually exists in humans -- again, sexual
5 ambiguity is not a third sex. There's still only two
6 sexes that a human can actually be.
7 Q. How do chromosomes fit into this conversation?
8 A. So in humans, mammals, and birds, and other
9 organisms as well, chromosomes are a sex-determining
10 mechanism if they have sex chromosomes. These are the
11 causes of an individual's sex. They have certain genes
12 that reside on them that cause the embryo to develop
13 down the pathway that results in a male or a female.
14 But as I mentioned earlier, how sex is determined,
15 whether through chromosomes or environment, that doesn't
16 define an individual's sex. So it wouldn't be
17 completely accurate to say that, you know, your
18 chromosomes define your sex or that XX equals female or
19 XY equals male. It really just comes down to the types
20 of gametes that you have the function to produce.
21 Q. Is it true there's more than two different type
22 of chromosomes -- sex chromosomes for humans?
23 A. So there's, broadly speaking, two sex
24 chromosomes, X and Y chromosomes, but those can vary in
25 bodies differently. Some individuals can have different

1 collections of chromosomes. They're called sex
2 chromosome aneuploidies. So, for instance, someone with
3 Klinefelter syndrome has XXY chromosomes. This doesn't
4 mean that they're a third sex because, again,
5 chromosomes are just a cause of an individual's sex.
6 People with Klinefelter have a Y chromosome. And if
7 they have an active gene on there called the SRY gene,
8 that makes them 100 percent male. They develop into
9 males. These differences in sex chromosomes, whether
10 it's XX, XY, XYY, et cetera -- there's several different
11 combinations people can have -- those represent
12 variation within the two sexes. They're not sort of
13 additional sexes beyond male and female.
14 Q. I asked you about chromosomes. How about
15 secondary sex characteristics such as facial hair in
16 men, body shape of female, genitals and breasts and
17 things like that? How does that fit into this
18 conversation?
19 A. Yeah. None of those define the sex of an
20 individual. Those are downstream consequences of an
21 individual's sex. So if you're biologically male and
22 you have testes, you produce higher levels of
23 testosterone. If you're a female, you have ovaries.
24 Those produce higher levels of estrogen. Each sex --
25 both has testosterone and estrogen, just in different

1 concentrations. But those sort of hormonal mixtures
2 that you get when they surge during puberty, they will
3 create the sort of sex-related secondary sex
4 characteristics that we tend to see. Males, they grow
5 taller. They get more facial hair, more body hair.
6 Generally their voice deepens. Women -- females, they
7 grow breasts.
8 So these are traits that are, again, a
9 downstream consequence of sex, but they do not define an
10 individual's sex in any way. You can't modify, say,
11 someone's breasts and make them, you know, more male or
12 female depending on the size that you make them. These
13 are just sort of related to sex, but they don't define
14 an individual's sex.
15 Q. And just to clarify, when you say if you modify
16 someone's breasts it doesn't make them more or less
17 female or male, you're talking about biological sex
18 female and biological sex male; is that right?
19 A. Yes. Yeah. You can modify secondary sex
20 characteristics. That doesn't change what sex you are.
21 Q. So when people say there are more than two
22 biological sexes, do you agree?
23 A. No, I don't, because that would require a third
24 type of gamete. Most people who make that claim are
25 confused about the distinction between how sex is

1 determined with chromosomes and how sex is defined,
2 which leads people to say that there's, like, six sexes
3 because there's sort of six viable types of chromosome
4 combinations people can have, but that's not
5 scientifically accurate.
6 Q. Okay. Are there degrees of biological maleness
7 or biological femaleness? Like, can someone be more
8 biological male than someone else?
9 A. No, because, again, sex is rooted in the type
10 of gamete that your primary sex organs are organized
11 around to produce. So in order for you to have a degree
12 of maleness and femaleness that's somewhere in between,
13 you'd need to have -- you know, to produce some sort of
14 intermediate gamete that doesn't exist.
15 MR. ELDRED: Judge, I'd like to show
16 another demonstrative.
17 THE COURT: Okay.
18 Q. (BY MR. ELDRED) What is this diagram on the
19 screen?
20 A. So this is a distribution of height among males
21 and females in humans.
22 Q. Did you make this diagram?
23 A. I did not.
24 Q. Okay. Do you know who did make the diagram?
25 MR. GONZALEZ-PAGAN: Your Honor --

1 THE COURT: Hold on.
2 MR. GONZALEZ-PAGAN: -- counsel just
3 represented that he made the diagram.
4 THE COURT: Hold on. Let's just get to
5 the bottom of it. Who made the graph?
6 THE WITNESS: This is -- I pulled it off a
7 paper, an academic paper. I'm not exactly sure which
8 one. I'm sorry.
9 THE COURT: I don't know that we need to
10 use it, Mr. Eldred.
11 MR. ELDRED: Okay. I apologize, Judge.
12 THE COURT: Okay. No worries.
13 Q. (BY MR. ELDRED) Is it true that males and
14 females -- let me be more clear -- that humans with
15 biological sex male and humans with biological sex
16 female have overlapping height distributions?
17 A. They have overlapping distributions in height
18 and many other different characteristics that are sort
19 of sex related or that sex influences but not sex
20 itself.
21 Q. And does that prove anything about whether
22 biological sex is a spectrum?
23 A. No, it doesn't, because -- you know, I'd like
24 to reference that distribution. I think that's
25 important. Because a lot of people will say sex is a

1 spectrum based on secondary sex characteristics, like
2 breast size, for instance, how tall individuals are, the
3 amount of facial hair. But really when you see the
4 distribution, these are just sort of overlapping
5 distributions and traits between males and females, but
6 these traits don't define an individual's sex. So if
7 you have a bimodal distribution like in that previous
8 slide, as you go from one side to the other, you
9 don't -- you just get more higher or lower proportions
10 of males and females that fall into those sort of
11 distributions, but that doesn't mean that the sex is
12 changing as you're going from right to left or
13 vice versa on a graph like that.
14 Q. Did you read Dr. Shumer's report submitted in
15 this case?
16 A. I did.
17 Q. And I'm just going to read part of it to you.
18 It's in Paragraph 27. Sex is comprised of several
19 components, including, among others, internal
20 reproductive organs, external genitalia, chromosomes,
21 hormones, gender identity, and secondary sex
22 characteristics. Do you agree with that statement?
23 A. I do not disagree -- or sorry. I do disagree
24 with that.
25 Q. Why do you disagree?

1 A. I think it just completely misconstrues what
2 biological sex actually is because the sex of an
3 individual, not just in humans but across, again, all
4 animals and plants, is related to the type of gamete
5 that you have the function to produce or would produce.
6 I would say that when he said internal sex
7 characteristics, if he's referring to gonads, then that
8 would be accurate. But other things like chromosomes,
9 again, these are upstream causes of sex. Secondary sex
10 characteristics, they're called secondary sex
11 characteristics for a reason, because they are only
12 downstream related effects of one's sex. And the
13 hormones are an example of sort of the downstream
14 consequence of one's sex either. You know, those are
15 sex-related traits, but they do not constitute what
16 sex -- the sex of an individual.
17 Q. In Paragraph 32, Dr. Shumer said gender
18 identity, like other components of sex, has a strong
19 biological foundation. Do you have any opinion on that,
20 whether that's accurate?
21 A. You know, I'm not an expert on gender identity,
22 so I would actually like to not comment on that one.
23 Q. Okay. Fair enough.
24 MR. ELDRED: Bear with me just one second,
25 Your Honor, please.

1 THE COURT: Uh-huh.
2 MR. ELDRED: I'll pass the witness,
3 Your Honor.
4 THE COURT: Thank you, Mr. Eldred.
5 Cross?
6 MR. GONZALEZ-PAGAN: Thank you,
7 Your Honor.
8 THE COURT: Are you going to need the
9 screen?
10 MR. GONZALEZ-PAGAN: I will, Your Honor.
11 THE COURT: Okay. We just want to make
12 sure. If you do, it needs to be either plugged in at
13 the lectern or plugged in your laptop, whatever it is
14 you want to show.
15 MR. GONZALEZ-PAGAN: Oh, I'm --
16 THE COURT: They'll take care of it for
17 you?
18 MR. GONZALEZ-PAGAN: Yes.
19 THE COURT: Got it.
20 **CROSS-EXAMINATION**
21 BY MR. GONZALEZ-PAGAN:
22 Q. Dr. Wright, you testified that reproduction --
23 sex is defined based on reproductive capacity and
24 production of gametes across all animal species; is that
25 right?

1 A. It's defined by not whether you can actually
2 produce gametes but if you have the function to, which
3 would be rooted -- related to the type of gonads that
4 you have that would normally produce them.
5 Q. Sure. And sorry. It takes --
6 A. And it's universal, yes.
7 Q. Yes. And I need to go back a little bit. My
8 biology training as a major takes a little while to kick
9 in.
10 There are animal species that reproduce
11 without gametes; is that right?
12 A. Absolutely. Yes, there are.
13 Q. That includes aphids within your field of
14 entomology?
15 A. Yes. They reproduce by budding off of one
16 another, parthenogenesis.
17 Q. And to clarify, you're not offering any
18 opinions on the biological basis of gender identity?
19 A. No.
20 Q. You're not offering any opinions on the
21 biological basis of gender dysphoria?
22 A. No.
23 Q. You say that individuals who say that sex is
24 defined by anything other than gametes or the capacity
25 to produce gametes are mistaken; is that correct?

1 A. Yes.
2 Q. Okay. Would it surprise you to learn that some
3 of the State's designated experts have testified both in
4 court and to the Legislature that sex is defined by
5 chromosomes?
6 A. I'm not surprised, but that is an incorrect
7 assessment. Sex is not defined by an individual's
8 chromosomes. It's determined by them.
9 Q. Would you agree then that your views shared
10 today about sex are not universally accepted within the
11 scientific community?
12 A. I think there's a lot of people who have
13 misconceptions about sex in the scientific community,
14 but I think if you get to the researchers who are
15 studying the evolution of sex in a fundamental way,
16 there's -- there's no disagreement about what
17 constitutes an individual's sex.
18 Q. But my question was were your views accepted
19 within -- universally accepted within the scientific
20 community.
21 A. I think a vast majority if polled would agree
22 with me.
23 Q. And what's the basis for that statement?
24 A. This has been a longstanding discovery of basic
25 biology for a very long time, hundreds of years.

1 Q. And you have not published in the area of sex
2 determination or what it means to be a biological sex in
3 scientific literature; is that right?
4 A. I've written peer-reviewed book chapters on
5 what sex is across all of -- all of life, yes.
6 Q. This is one book that was published this year
7 that includes, among others, Michael Biggs and other
8 authors, all of whom are opponents of gender-affirming
9 medical care; is that correct?
10 A. I was asked to write a chapter about the
11 biological basis of sex, and so that's what I -- what I
12 wrote about.
13 MR. GONZALEZ-PAGAN: Can we pull up
14 Plaintiffs' Exhibit 48, please?
15 THE COURT: It's not been admitted. Are
16 you going to admit it through him?
17 MR. GONZALEZ-PAGAN: Well, I'm going to
18 show it as a demonstrative, Your Honor, just like the
19 other ones.
20 THE COURT: Okay. As long as we make sure
21 we're clear about that and that it's a demonstrative as
22 opposed to --
23 MR. GONZALEZ-PAGAN: Yes. Not a --
24 pre-marked non-admitted exhibit, Plaintiffs' Exhibit 48.
25 THE COURT: Got it. P-48, not an admitted

1 exhibit.
2 Q. (BY MR. GONZALEZ-PAGAN) Do you recognize this
3 document?
4 MR. ELDRED: How is this a demonstrative,
5 Your Honor? I don't understand.
6 A. Um --
7 THE COURT: Well, hold on.
8 A. -- not immediately, no.
9 MR. GONZALEZ-PAGAN: Well, it's an
10 impeachment, Your Honor. He states that his views are
11 universally shared. This is a peer-reviewed article
12 that I'll show shows otherwise.
13 THE COURT: Which might be appropriate to
14 use, but if you've got a hard copy maybe so that he can
15 see the whole thing, that would be the way to do it.
16 MR. GONZALEZ-PAGAN: We're happy to
17 provide the witness with a hard copy, Your Honor.
18 THE COURT: I'm sorry?
19 MR. GONZALEZ-PAGAN: We're happy to
20 provide the witness with a hard copy.
21 THE COURT: Sure.
22 MR. GONZALEZ-PAGAN: And it is in the Box.
23 THE COURT: Is there a hard copy?
24 MS. DYER: It is in the Box?
25 MR. GONZALEZ-PAGAN: Yes.

1 MS. DYER: Oh. Was it updated yesterday?
2 MR. GONZALEZ-PAGAN: It was updated
3 earlier today.
4 MS. DYER: Oh, I didn't know there was any
5 additions to the Box.
6 MR. STONE: Were there other updates today
7 to the Box?
8 MR. GONZALEZ-PAGAN: Your Honor, if I may,
9 just to pause the time.
10 THE COURT: Yeah, let's go off the record.
11 *(Discussion off the record)*
12 THE COURT: And Dr. Wright has a copy of
13 P-48. Just give him an opportunity to kind of look
14 through it before you ask him some questions.
15 MR. GONZALEZ-PAGAN: Thank you,
16 Your Honor.
17 A. All right. I think I've read articles that are
18 very similar in scope to this one before that make
19 similar claims, so I think I can address your questions.
20 Q. (BY MR. GONZALEZ-PAGAN) Thank you. Having
21 reviewed Exhibit Plaintiffs' 48, which hasn't been
22 admitted, have -- would you dispute that some scientists
23 believe that sex is multifaceted?
24 A. I believe some scientists are mistaken about
25 what biological sex is, yes.

1 Q. Sex can have multiple meanings; is that
2 correct?
3 A. I mean, if we're going to say sex can be an act
4 with intercourse, that's one other use of the word sex.
5 But if we're talking about the sex of an individual,
6 what sex a person is, that has a very specific meaning
7 in biology.
8 Q. Is it your understanding that the sex on a
9 birth certificate or a driver's license has to always be
10 consistent with -- or a college application has to
11 always be consistent with somebody's genitalia and their
12 production of gametes?
13 MR. ELDRED: Objection. This is outside
14 the scope of his expertise.
15 THE COURT: I'll sustain that objection,
16 if you have another question.
17 MR. GONZALEZ-PAGAN: Sure.
18 Q. (BY MR. GONZALEZ-PAGAN) You earlier testified
19 that sex -- biological sex can be bimodal; is that
20 correct?
21 A. I do not think sex is bimodal. It is binary.
22 Q. Would you agree that some sex characteristics
23 are multimodal?
24 A. Some sex-related characteristics can be bimodal
25 and perhaps multimodal. I would need specific examples.

1 But again, those are downstream consequences of sex.
2 They don't define an individual's sex.
3 Q. And again, aside from the letter to the editor
4 and the chapter in the book that was published this year
5 by individuals that harbor views against the provision
6 of gender-affirming medical care, you have not published
7 or researched in the area of what biological sex means?
8 A. Outside of the publications I have on the
9 topic, there are no additional ones.
10 Q. You would agree that having a credential alone
11 is insufficient to offer expert opinions on the subject;
12 is that right?
13 A. Absolutely.
14 Q. Yet your opinions today are based solely on
15 your understanding as an evolutionary biologist?
16 A. It's based on my understanding of the biology,
17 again, the universal characteristics that unite all
18 males and females across the plant and animal kingdom,
19 not simply just looking at humans.
20 Q. Let me ask you this. Do you believe that being
21 transgender is a delusion?
22 THE COURT: Is a what?
23 MR. ELDRED: Objection. This is
24 outside --
25 THE COURT: I'm sorry. I didn't

1 understand.
2 MR. GONZALEZ-PAGAN: A delusion.
3 THE COURT: A delusion. Okay. And your
4 objection?
5 MR. ELDRED: I'm sorry. What was the
6 question again?
7 MR. GONZALEZ-PAGAN: Do you believe that
8 being transgender is a delusion?
9 MR. ELDRED: I think that's outside -- I
10 object that it's outside the scope of what he's been
11 offered as his expertise.
12 MR. GONZALEZ-PAGAN: It goes to bias,
13 Your Honor.
14 THE COURT: I'll overrule the question, if
15 you can answer.
16 A. What do you mean by transgender?
17 Q. (BY MR. GONZALEZ-PAGAN) Do you believe that
18 being transgender is a delusion?
19 A. I would need to know how you're defining the
20 term whether I can make a claim on that. If you're
21 asking me whether I believe someone who is one sex who
22 believes they are actually the other sex despite the
23 type of gamete that they can or would produce, I would
24 say that that specific belief would be a delusional
25 belief if they're actually identifying as the sex that

1 they are empirically not.
2 MR. GONZALEZ-PAGAN: Let's show Exhibit --
3 Plaintiffs' Exhibit 51, which has not been admitted to
4 the record.
5 THE COURT: So as a demonstrative. As a
6 demonstrative, P-51.
7 Q. (BY MR. GONZALEZ-PAGAN) Do you see it on your
8 screen?
9 THE COURT: You should see it both places,
10 but whichever works best.
11 MS. POLLARD: Your Honor, may I approach
12 to retrieve the laptop?
13 THE COURT: Yes.
14 Q. (BY MR. GONZALEZ-PAGAN) Do you recognize this?
15 A. I do.
16 Q. It is a screen capture of an Instagram post by
17 @swipewright on April 10, 2022; correct?
18 A. That looks like what it is, yes.
19 Q. And @swipewright is your Instagram account; is
20 that right?
21 A. It's my Twitter and Instagram.
22 Q. And on this post on April 10th, 2022, you
23 stated in part: The medical establishment has somehow
24 convinced itself that it's more conducive to a
25 delusional person's mental health to have all society

1 participate in their delusion than to bring them in
2 touch with reality.
3 Is that what you wrote?
4 MR. ELDRED: Objection, Judge. This is
5 not a demonstrative exhibit. This is outside the scope
6 of his expertise. His opinions outside the scope of his
7 expertise should not be admissible. He's not testifying
8 as just some guy with opinions. He's testifying as an
9 expert on biological sex. And what he thinks about --
10 this opinion on this tweet has nothing to do with his
11 opinion on biological sex.
12 THE COURT: Well, you've put him up as an
13 expert, and so I guess this potentially goes to bias,
14 but I need you to offer the exhibit, sir, in order to
15 move forward with it.
16 Q. (BY MR. GONZALEZ-PAGAN) Is that what you
17 wrote, Dr. Wright?
18 A. That is what I wrote.
19 MR. GONZALEZ-PAGAN: Your Honor, at this
20 time I would move for the admission of Exhibit --
21 Plaintiffs' Exhibit 51.
22 THE COURT: All right. And then your
23 objection?
24 MR. ELDRED: Yes, Your Honor. Same
25 objection. This is not relevant to the witness'

1 testimony. This is just something he wrote on Twitter,
2 not within his expertise. He's not here testifying
3 about his opinions on things. It's also hearsay.
4 THE COURT: All right. The objection is
5 overruled and P-52 [sic] is admitted.
6 *(Plaintiffs' Exhibit 51 admitted, as*
7 *clarified later by the Court on Page 255)*
8 Q. (BY MR. GONZALEZ-PAGAN) In this post, you're
9 referring to transgender people; correct?
10 A. I'm referring to anyone who identifies with a
11 biological sex that they are empirically not. So to the
12 degree that a transgender person believes incorrectly
13 that they are the opposite sex, that is the target of
14 this tweet.
15 Q. And by bringing them in touch with reality, you
16 mean having transgender people live in accordance with
17 their birth sex based on their genitalia?
18 A. No. I would say that they just need to
19 understand that their sex cannot literally be changed.
20 So I'm okay with trans people choosing to medically
21 transition if they would like to for adults, for
22 instance, but I think it's important that they
23 understand that you can't literally become the opposite
24 sex merely by changing a host of secondary sex
25 characteristics. So when I say in touch with reality,

1 that's what I mean, that they need to understand what
2 their sex is and that they're only making cosmetic
3 changes.
4 Q. Previously you stated that even asking a person
5 what their pronouns are is a form of indoctrination.
6 MR. ELDRED: Objection, Judge. This is
7 not part of his expertise. In fact, he's already
8 testified he does not know anything about -- he's not
9 testifying as an expert on gender identity.
10 THE COURT: I'll sustain that objection,
11 if you have another question.
12 Q. (BY MR. GONZALEZ-PAGAN) Do you believe that
13 being asked what pronouns somebody uses makes kids
14 transgender?
15 MR. ELDRED: Objection. Same objection,
16 Judge. This is outside of his expertise. He's not an
17 expert on gender identity.
18 MR. GONZALEZ-PAGAN: Your Honor, it goes
19 to his bias. He's never even published in this area.
20 THE COURT: Well, I think we're -- I don't
21 know that we need anything more on that. So for saving
22 time, I'm going to sustain the objection.
23 MR. GONZALEZ-PAGAN: Thank you,
24 Your Honor.
25 THE COURT: Do you have any other

1 questions?

2 MR. GONZALEZ-PAGAN: In that case, no more

3 questions, Your Honor.

4 THE COURT: Okay. Any redirect,

5 Mr. Eldred?

6 MR. ELDRED: Can I have one second to

7 consult?

8 THE COURT: Sure.

9 MS. WOOTEN: Your Honor, while they're

10 conferring, as a housekeeping matter, I believe that on

11 the record it was stated --

12 MR. ELDRED: Your Honor, can we have

13 housekeeping matters when we're ready to discuss them,

14 please?

15 THE COURT: Well, if they're busy, let's

16 wait.

17 MR. ELDRED: No questions, Judge.

18 THE COURT: All right. Thank you,

19 Mr. Eldred.

20 Dr. Wright, you are done on the witness

21 stand. You may be excused.

22 THE WITNESS: Thank you.

23 THE COURT: All right. Is this -- is

24 there another witness for today or --

25 MR. ELDRED: We do not have one today.

1 THE COURT: Okay. All right. Just wanted
2 to make sure. We can go ahead -- unless there's
3 something else we need to take up on the record.
4 MS. WOOTEN: One matter, Your Honor. I
5 believe it was stated on the record that Exhibit P-52
6 was admitted. It's P-51 that was admitted.
7 THE COURT: Okay. I thought I heard 52,
8 but thank you. So the correction is there's no P-52,
9 and P-51 is admitted.
10 Anything else we need to take up on the
11 record before we go off?
12 MS. WOOTEN: No, Your Honor.
13 THE COURT: Okay. All right. We can go
14 off the record.
15 *(Court adjourned)*
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1 **REPORTER'S CERTIFICATE**

2

3 THE STATE OF TEXAS)

4 COUNTY OF TRAVIS)

5 I, Chavela V. Crain, Official Court

6 Reporter in and for the 53rd District Court of Travis

7 County, State of Texas, do hereby certify that the above

8 and foregoing contains a true and correct transcription

9 of all portions of evidence and other proceedings

10 requested in writing by counsel for the parties to be

11 included in this volume of the Reporter's Record, in the

12 above-styled and numbered cause, all of which occurred

13 in open court or in chambers and were reported by me.

14 I further certify that this Reporter's Record of

15 the proceedings truly and correctly reflects the

16 exhibits, if any, offered in evidence by the respective

17 parties.

18 WITNESS MY OFFICIAL HAND this the 20th day of

19 August, 2023.

20

/s/ Chavela V. Crain

21 Chavela V. Crain
Texas CSR 3064, RMR, CRR

22 Expiration Date: 10/31/2024
Official Court Reporter

23 53rd District Court
Travis County, Texas

24 P.O. Box 1748
Austin, Texas 78767

25 (512) 854-9322 *

1 REPORTER'S RECORD
VOLUME 2 OF 2 VOLUMES
2 TRIAL COURT CAUSE NO. D-1-GN-23-003616

3 LAZARO LOE, individually and as parent and next friend of 4 LUNA LOE, a minor; MARY MOE and MATTHEW, individually 5 and as parent and next friends of MAEVE MOE, a 6 minor; NORA NOE, individually and as parent 7 and next friend of NATHAN NOE, a minor; SARAH SOE and 8 STEVEN SOE, individually and as next friends of SAMANTHA 9 SOE, a minor; GINA GOE, individually and as parent 10 and next friend of GRAYSON GOE, a minor; PFLAG, INC.; 11 RICHARD OGDEN ROBERTS III, M.D., on behalf of himself 12 and his patients; DAVID L. PAUL, M.D., on behalf of 13 himself and his patients; PATRICK W. O'MALLEY, M.D., 14 on behalf of himself and his patients; and AMERICAN 15 ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS, INC. d/b/a 16 GLMA; HEALTH PROFESSIONALS ADVANCING LGBTQ+ EQUALITY, 17	)	IN THE DISTRICT COURT
v. 18	)	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS; OFFICE 19 OF THE ATTORNEY GENERAL OF TEXAS; JOHN SCOTT, in his 20 official capacity as Provisional Attorney 21 General; TEXAS MEDICAL BOARD; and TEXAS HEALTH AND 22 HUMAN SERVICES COMMISSION	)	201ST JUDICIAL DISTRICT

23 ---

24 HEARING ON APPLICATION FOR TEMPORARY INJUNCTION
AND PLEA TO THE JURISDICTION

25 ---

1 On the 16th day of August, 2023, the following
2 proceedings came on to be heard in the above-entitled
3 and numbered cause before the Honorable Maria Cantú
4 Hexsel, Judge presiding, held in Austin, Travis County,
5 Texas;
6 Proceedings reported by machine shorthand.
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1 **I N D E X**

2 **VOLUME 2 OF 2**

3 **HEARING ON APPLICATION FOR TEMPORARY INJUNCTION AND PLEA TO THE JURISDICTION**

4 **AUGUST 16, 2023**

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1 **PROCEEDINGS**
2 THE COURT: As I understand it, we're
3 going to resume with your case-in-chief. Who would you
4 like to call as your next witness?
5 MS. WOOTEN: Your Honor, we'd like to call
6 Nathan Noe, Mr. Noe. And he is a 16-year-old minor
7 proceeding under pseudonym.
8 THE COURT: Okay.
9 MS. WOOTEN: So I just wanted to tell the
10 Court that to ensure you're aware of it.
11 THE COURT: Thank you very much.
12 Hello. Mr. Noe, if you'll come right up
13 here with me and I'll swear you in, and then you can
14 take the witness stand, okay? Right here is fine. And
15 if you'll raise your right hand.
16 *(Witness sworn)*
17 THE COURT: All right. You can make your
18 way around the court reporter and up to this chair here.
19 There is some water here if you need some, okay?
20 MR. SELDIN: Your Honor, may I?
21 THE COURT: Yes, you may.
22 **NATHAN NOE**,
23 having been first duly sworn, testified as follows:
24 **DIRECT EXAMINATION**
25 BY MR. SELDIN:

1 Q. Good morning, Nathan.
2 A. Good morning.
3 Q. Are you Nathan Noe?
4 A. Yes, I am.
5 Q. Is that your legal name?
6 A. No, it is not.
7 Q. Why are you using a pseudonym in this case?
8 A. Today I'm using a pseudonym because we think
9 that it would be safer for me and my family to not be
10 publicly identified as a transgender person and the
11 family of a transgender person. And I also would like
12 to continue to be able to not have to disclose the fact
13 that I'm transgender publicly, to everybody I mean.
14 Q. And do you live in Texas?
15 A. I do.
16 Q. What county do you live in?
17 A. We live in Williamson County.
18 Q. And who do you live with?
19 A. Currently I live with my mother and my father,
20 my two younger siblings, and my elderly grandmother.
21 Q. Do you have pets?
22 A. I do. I have seven pets.
23 Q. We won't make you name them all. Does your
24 family belong to PFLAG?
25 A. Yes.

1 Q. And how old are you?
2 A. I'm 16 years old.
3 Q. And what grade are you in?
4 A. This year I'm a junior.
5 Q. And where are you supposed to be today?
6 A. Today is supposed to be my second day of
7 high school.
8 Q. And what do you do when you're not in school?
9 A. I like writing a lot. I like gardening. I
10 participated in choir, and I swim.
11 Q. And when you were born, what sex were you
12 assigned at birth?
13 A. I was assigned female at birth.
14 Q. And growing up, how did it feel for -- well,
15 let me take a step back. How would you describe your
16 gender identity today?
17 A. I'm male.
18 Q. And growing up, how did it feel for you when
19 people saw you as a girl?
20 A. When I was a very young child, gender didn't
21 really have much bearing in my life and my identity. I
22 was kind of just a child rather than a girl child or a
23 boy child. When I got a bit older, like 10, 11, that's
24 when I started puberty, and gender became, like, a part
25 of my life. It was -- it felt jarring to be perceived

1 as a female, and I couldn't necessarily describe why at
2 the beginning. It felt like something was wrong with me
3 or, you know, wrong with -- something wrong was
4 happening to me, and I couldn't describe that.
5 Q. And how did that feeling that you couldn't
6 describe -- how did that manifest for you in your life?
7 A. I isolated myself a lot. I didn't like,
8 you know, being seen by people because I knew that they
9 would see me as a girl, and so I sort of -- I didn't
10 really participate in events with my family. I kept to
11 myself, and I kind of -- I just -- I felt really badly
12 about myself. And I didn't, like, really enjoy doing
13 the activities I enjoyed before.
14 Q. It sounds like it was hard.
15 A. Yes, it was.
16 Q. Did there come a time when you began to figure
17 out where maybe that discomfort came from?
18 A. Yes. I realized that I might not be a girl
19 when I was about 11 or 12. I had sort of always known
20 that transgender people existed, but I didn't really
21 ever, you know, connect that idea to myself until at
22 that point in time. Once I did realize, it kind of
23 clicked. You know, it made a lot of sense what the
24 feelings that I had been experiencing -- you know, what
25 that meant, and it made everything sort of like, oh,

1 this is, you know, what's going on with me right now.
2 Q. And did there come a time when you told anyone
3 that you thought you might be a boy?
4 A. Yes. A few months after I, you know, made that
5 realization, I talked to my mom about it. I told her
6 that I think that I might, you know, not be a girl and I
7 might want to try using a different name, different
8 pronouns, stuff like that.
9 Q. And what was her reaction?
10 A. Her first reaction was, you know, wanting to
11 obviously do the best thing for me, make sure that,
12 you know, everything -- that I was safe. She knew that
13 transgender people faced a lot more issues, you know,
14 discrimination as well as mental health issues, that she
15 wanted to help me deal with the best that I could, so we
16 signed up for like a mental health counselor as well as
17 talking to my primary care doctor. But she also just --
18 you know, we made sure to have a lot more conversations
19 so that we could figure out what the best thing was.
20 Q. And after that first conversation --
21 THE COURT: One second, sir. Yes?
22 MR. STONE: Your Honor, we have two people
23 in the waiting room on Zoom, and I think they're our
24 experts. I know the rule's been invoked, but they are
25 expert witnesses, and we're wondering if they could be

1 let in so that they could watch this testimony since it
2 might be relevant to some of their testimony later.
3 THE COURT: Okay. Let's just make sure.
4 Grossman MD and -- okay.
5 MR. SELDIN: Your Honor, if I may, we
6 don't object to having them be admitted, but if we could
7 just confirm on the record that they don't have anyone
8 in the room with them given --
9 THE COURT: Sure. Yeah. I guess go ahead
10 and let them in and I'll just talk to them for a second.
11 Excuse us. Let me do this.
12 Good morning, Dr. Laidlaw. I'm waiting
13 for Dr. Grossman's audio to connect so I can speak with
14 both of you at the same time. One second.
15 DR. LAIDLAW: Thank you.
16 THE COURT: I don't know if she's just not
17 paying attention. Yeah. Of course, she's not going to
18 hear me. I don't know if you can text her, Mr. Stone.
19 It may just be a matter of -- yeah, if you can message
20 her maybe.
21 Dr. Laidlaw, I guess I can start with you.
22 I need to confirm that you don't have anyone else in the
23 room with you at this time.
24 DR. LAIDLAW: That is correct.
25 THE COURT: And sir, just a reminder that

1 there's no -- no recording or broadcasting or any
2 photography of our proceedings. Understood?
3 DR. LAIDLAW: Understood.
4 THE COURT: All right. Thank you.
5 MR. STONE: Your Honor, I sent
6 Dr. Grossman -- I sent Dr. Grossman an email, and I'm
7 trying to find her cell phone number. I'll text her.
8 THE COURT: Oh, sure. Sure. I guess -- I
9 just don't want to interrupt you again.
10 MR. STONE: Your Honor, maybe we can just
11 remove her from the room.
12 THE COURT: Sure.
13 MR. STONE: And once I'm able to reach out
14 to her and get ahold of her, we can revisit it.
15 THE COURT: That's fine.
16 MR. STONE: I apologize.
17 THE COURT: Can you go ahead and move her
18 back?
19 Okay. All right. And let me do one more
20 thing because I don't like that. Okay. Go ahead.
21 Q. (BY MR. SELDIN) Nathan, we were just chatting
22 a minute ago before we were interrupted. After you
23 first told your mom that you were a boy, were there
24 steps that you and your family took to affirm your
25 gender identity?

1 A. The first steps that we took were, you know, as
2 well as, you know, more conversations with the rest of
3 my family, to just talk about what this meant. What
4 those first steps looked like was just, you know,
5 getting a haircut. I wore different clothes. The name
6 that I was using, I changed that to be the name that I
7 currently use and is my legal name, you know, using
8 different pronouns. At this time it was during
9 quarantine, so the only people that I was pretty much
10 consistently in contact with were my family, so
11 everybody in my family started using my new name and
12 pronouns.
13 THE COURT: Nathan, can you scoot up just
14 a little bit?
15 THE WITNESS: Oh, sorry.
16 THE COURT: No, that's okay. Just a
17 little bit closer.
18 THE WITNESS: Is that good?
19 THE COURT: Yeah, I think so.
20 Q. (BY MR. SELDIN) And how did it feel to have
21 your family see you and treat you like the boy that you
22 are?
23 A. I would say that it was an immediate positive
24 shift. I -- if I had been, you know, reserved and
25 isolated before, I was able to, you know, really again

1 participate and, you know, talk with people I cared
2 about. I felt more comfortable just doing the things I
3 like doing because I didn't have to focus on this,
4 you know, issue that was going, you know, unrecognized.
5 I -- it felt really positive, and it was I think -- I
6 felt like I lit up whenever somebody would use my name
7 or the correct pronouns. Or, you know, if we went to a
8 restaurant and someone called me "sir," I would just
9 have the best day ever.
10 Q. And did there come a time when you sought
11 medical care related to your gender?
12 A. Yeah. In those conversations, like I said
13 before, that I had with my family, we talked about what
14 the right steps would be. When I first realized I was
15 transgender, I knew that I would eventually want to
16 pursue, you know, medical care, be that in the form of
17 surgeries or taking hormones. The decision that we had
18 to make was when it would be appropriate to start that.
19 Like I said, we talked to my primary care doctor, and I
20 received a gender -- a diagnosis of gender dysphoria
21 from him. And he referred us after a while to a
22 specialist who specialized in gender-affirming care,
23 hormone replacement therapy, and that was when I was
24 about 14.
25 We talked with her, had appointments where

1 we discussed, you know, what starting these hormones
2 would look like physically as well as making sure that I
3 was ready to do that. And I believe it was
4 November 16th of 2021 when I was 14 when I started
5 taking testosterone.
6 Q. You remember the exact date that you started?
7 A. Yes, I do. It was a very big day for me.
8 Q. How did it feel?
9 A. If socially transitioning was a big change,
10 then being on testosterone just really improved my life
11 to a point where gender dysphoria almost doesn't bother
12 me as much as it did at this point in my life. That was
13 during about my freshman year, halfway through. And
14 everyone around me could tell there was a shift from the
15 beginning of the year to the end of the year. I felt
16 like people were really able to see me as the me that I
17 saw myself as. And having a body that aligned with that
18 was -- it felt like a weight being lifted almost.
19 You know, my voice changed and I was able to sound the
20 way I wanted to sound, and I -- a lot of -- I just -- I
21 felt better about myself. I was more able to do the
22 things I loved again.
23 Q. And so how would you compare, you know, how you
24 felt about yourself and your mental health before and
25 after you started testosterone?

1 A. Well, before I started testosterone I -- I
2 struggled a lot. I still had to -- gender dysphoria
3 took up a lot of my time that I would have otherwise
4 been able to do other things. I struggled to focus on
5 my schoolwork. You know, everything that I did felt
6 like it was a little bit off even when I was being
7 referred to with my correct name and pronouns, just
8 because I knew that some people wouldn't see me as my
9 correct gender.
10 After starting testosterone, I just didn't
11 have to deal with that burden as much anymore,
12 especially, you know, publicly. The people around me
13 just knew me as a boy, and that was all I wanted. I
14 started my sophomore year having been on testosterone
15 and having transitioned, and it felt like I was less
16 stressed about everything else. I was able to just go
17 about my life as a teenage boy the way that I had really
18 wanted to.
19 Q. So for how long have you been on testosterone
20 at this point?
21 A. At this point, it has almost been two years.
22 Q. How would you feel if you had to stop taking
23 that medication?
24 A. Well, unfortunately, my -- the specialist who I
25 referred to earlier, her practice was shut down this

1 May -- or this last May because of the threat of,
2 you know, what was going on. And so I still had some of
3 my medicine from, you know, previous refills, but the
4 prescription is no longer, you know -- I don't have that
5 anymore. And we weren't -- we didn't -- weren't able to
6 communicate with her because, you know, she was no
7 longer working there. We set up another appointment in
8 Houston that just recently happened, but they were also
9 not able to fill my prescription because of, you know,
10 what was happening.
11 And it feels -- I feel very helpless, and
12 it makes me feel like I am going to have to go back into
13 a place mentally speaking that I was really
14 uncomfortable in, and I don't want to do that. I want
15 to be able to, you know, continue to focus on my
16 high school and eventually graduate and not have to deal
17 with not being on this medicine that's just really saved
18 my life, I would say.
19 Q. What would it mean for your family if you
20 couldn't access the medical care that you need in Texas?
21 A. That would mean that we would have to travel
22 out of state to get the care that I need, which would be
23 very difficult for a lot of reasons. Like I said
24 before, my parents care for my littler siblings and my
25 grandmother, so leaving periodically to go get a

1 prescription and then do the blood work that is
2 associated with it would leave them to have to deal with
3 that, as well as it would be disruptive to my life and
4 my parents' life. I would have to miss school and work
5 to go get this work done.
6 Q. Nathan, do you like living in Texas?
7 A. I do like living in Texas. I've lived here
8 since I was like one or two. I love the weather here.
9 I like the wildflowers. I love -- I love living in
10 Texas. I really don't want to have to leave my home
11 because of this.
12 Q. If you could describe the impact that this
13 medical treatment has had on your life in one word, what
14 would it be?
15 A. I'd say freedom. I feel free to live my life
16 without having gender dysphoria as a heavy weight on me.
17 And I also feel free to, you know, be perceived the way
18 I want to without people, you know, questioning me or
19 asking to hear my story. I'm able to just -- I'm free
20 to do the things I like doing without having to focus on
21 other things. I just have that freedom. I have that
22 ability now.
23 Q. Thank you, Nathan.
24 MR. SELDIN: We will pass the witness.
25 THE COURT: Thank you. Cross-examination?

1 MR. ELDRED: No questions, Your Honor.
2 THE COURT: All right. Thank you, sir.
3 Thank you, Nathan. You're done on the
4 witness stand. You can circle back around and head to
5 the door that you came in. Thank you.
6 Next witness?
7 MS. WOOTEN: Your Honor, we have no other
8 witnesses.
9 THE COURT: Okay. Thank you. Do you rest
10 at this time?
11 MS. WOOTEN: Yes, we do, Your Honor.
12 THE COURT: Thank you. All right.
13 Mr. Stone, let's try, I guess, dealing with having
14 Dr. Grossman back in and check on that, and then we'll
15 have you call your first witness.
16 MS. POLLARD: Your Honor?
17 THE COURT: Yes.
18 MS. POLLARD: Can we get access to the
19 back room while you're doing that?
20 THE COURT: Sure. It looks like she might
21 be away from her computer. Were you going to call
22 Laidlaw first?
23 MR. STONE: Yes.
24 THE COURT: Okay. Well, I'll be on the
25 lookout to see once she gets back. And we can

1 probably -- I guess we can -- do you want to pin
2 Dr. Laidlaw, Ms. Gould, and see if -- or actually, if
3 you'll unmute, sir, and see if once you talk if that
4 puts you -- should we do that?
5 DR. LAIDLAW: Okay. I just turned off
6 mute.
7 THE COURT: Okay. Yeah, I'd rather it pin
8 to him, or even that's better than the other. That
9 works, Tiffaney. That's okay.
10 All right. So Mr. Stone, who would you
11 like to call as your first witness?
12 MR. STONE: Yes, Your Honor. Our first
13 witness is Michael Laidlaw.
14 THE COURT: Okay. Make sure you've got
15 the mic or whoever's going to question the witness has
16 the mic so that -- all right. Dr. Laidlaw, if you'll
17 please raise your right hand. I'm going to switch this
18 to me so you know who's talking. If you'll raise your
19 right hand for me.
20 *(Witness sworn)*
21 THE COURT: You can put your hand down.
22 And I'm going to put this camera on the attorneys and
23 maybe -- let me try and Zoom in just a little bit so
24 that hopefully that helps. Okay. All right. Hold on.
25 What happened? There. Okay. All right. Go ahead.

1 MR. STONE: Thank you, Your Honor.
2 **MICHAEL K. LAIDLAW, M.D.**
3 having been first duly sworn, testified as follows:
4 **DIRECT EXAMINATION**
5 BY MR. STONE:
6 Q. What is your name?
7 A. Michael Laidlaw.
8 Q. What degrees do you hold?
9 A. I have a bachelor's degree in biology, a
10 concentration in molecular cell biology, a medical
11 doctor degree. I've completed residencies in internal
12 medicine and endocrinology and have taken board
13 certifications for both.
14 Q. And are you actually board certified?
15 A. Board certified endocrinologist, correct.
16 Q. Are you currently licensed to practice
17 medicine?
18 A. Yes, in the state of California.
19 Q. How long have you been practicing medicine as
20 an endocrinologist?
21 A. As an endocrinologist, I started in private
22 practice in 2006 through current, so about 17 years.
23 Q. Do you hold any privileges at any hospitals?
24 A. I'm on staff here at the Sutter Roseville
25 Medical Center.

1 Q. What academic appointments have you held?
2 A. I trained in an academic institution, but I
3 have not held any academic seats or anything of the
4 sort.
5 Q. Have you published at all in the area of
6 endocrinology?
7 A. Yes, I have.
8 Q. Just generally, what have you published in the
9 field of endocrinology?
10 A. I published an article in the *American Journal*
11 *of Bioethics* about puberty blockers, cross-sex hormones
12 for treatment of gender dysphoria. I've had a couple of
13 letters to the editor accepted in our main endocrinology
14 journal regarding similar topics. And I've written
15 other articles for the lay public.
16 Q. Have you ever testified before as an expert in
17 the subject of endocrinology?
18 A. Yes.
19 Q. Approximately how many times?
20 A. I want to say three. I can't think offhand,
21 something like that.
22 Q. How many times have you testified as an expert
23 in endocrinology on the subject of gender dysphoria
24 treatments in minors -- for minors?
25 A. Yeah. Testifying in court or by Zoom, two

1 times, I believe.
2 THE COURT: Hold on, Dr. Laidlaw. Just
3 hold on for me for a second.
4 Dr. Grossman, if you can hear us.
5 It's like she's in court, so I need her to
6 sit down.
7 MR. STONE: Yes, Your Honor.
8 THE COURT: If you can hear us, I need you
9 to stay put. It's distracting to have you walking
10 around. And I also want to make sure there's nobody
11 else in the room with you. Is that correct? Okay.
12 You're on mute, but I think I read your lips to say
13 that's correct. Okay. It just needs to be like you're
14 in the courtroom. So if you're here, I need you to stay
15 put, okay? Thank you.
16 Sorry about that. Go ahead.
17 MR. STONE: No problem. Your Honor,
18 Dr. Laidlaw's CV has been previously admitted as
19 Defendants' Exhibit 1. And at this time defendants
20 proffer Dr. Laidlaw as an expert on research, study, and
21 practice of endocrinology.
22 THE COURT: Any objection?
23 MR. SELDIN: Your Honor, can we do a brief
24 voir dire?
25 THE COURT: Briefly.

1 MR. STONE: Your Honor, will this count
2 against their time?
3 THE COURT: Yeah, it counts against them.
4 MR. STONE: Okay.
5 **VOIR DIRE EXAMINATION**
6 BY MR. SELDIN:
7 Q. Dr. Laidlaw, you have not performed any primary
8 research regarding gender dysphoria; correct?
9 A. That's correct.
10 Q. You have not performed any primary research
11 regarding transgender people; correct?
12 A. That's correct.
13 Q. You have not performed any primary research
14 regarding gender identity; correct?
15 A. That's correct.
16 Q. And none of your publications pertaining to
17 gender dysphoria are based on original research;
18 correct?
19 A. If you're talking about using human subjects in
20 research, that's correct.
21 Q. And you're not a member of WPATH; correct?
22 A. Correct.
23 Q. And you don't participate in WPATH conferences?
24 A. Correct.
25 Q. And you are not a surgeon; correct?

1 A. Correct.
2 Q. And you're not a mental health provider?
3 A. Correct.
4 MR. SELDIN: Your Honor, we would ask that
5 Dr. Laidlaw's testimony be limited to endocrinology.
6 THE COURT: As I understand it, the
7 request is research, study, and practice of
8 endocrinology; correct?
9 MR. STONE: That is correct, Your Honor.
10 So what they're asking for is already what we're --
11 THE COURT: Right.
12 MR. STONE: It sounds like we're in
13 agreement.
14 THE COURT: So I'll go ahead and designate
15 Dr. Laidlaw as an expert in research, study, and
16 practice of endocrinology. Okay.
17 MR. STONE: Thank you, Your Honor.
18 THE COURT: Go ahead, Mr. Stone.
19 **CONTINUED DIRECT EXAMINATION**
20 BY MR. STONE:
21 Q. Dr. Laidlaw, what is endocrinology?
22 A. Endocrinology is the study of glands and
23 hormones, diagnosing disorders with those, looking at
24 hormone imbalances or structural problems with glands.
25 Q. How do you diagnose endocrine disorders?

1 A. Endocrine disorders are diagnosed, if we're
2 talking about hormone imbalances, primarily through
3 laboratory tests, blood tests, urine tests, so forth.
4 Structural problems with glands are tested through
5 imaging generally, such as ultrasound or MRI. Tissue
6 can be sampled using biopsy techniques.
7 Q. Is gender dysphoria an endocrine disorder?
8 A. Gender dysphoria is not an endocrine disorder.
9 It is a psychological disorder found in the *Diagnostic*
10 *and Statistical Manual of Mental Health Disorders V*.
11 MR. SELDIN: Your Honor, we would object.
12 We just asked to limit his testimony to endocrinology,
13 which they agreed to.
14 MR. STONE: Your Honor, I just asked him
15 if it was an endocrine disorder.
16 THE COURT: Yeah. Overruled. I think
17 he's answered. Next question.
18 Q. (BY MR. STONE) Is gender dysphoria a condition
19 that can be treated by endocrinologists?
20 A. Gender dysphoria is -- currently has different
21 sets of recommendations throughout the world. Some
22 places in Europe favor psychological treatment. Some
23 advocacy --
24 THE COURT: Hold on. Now we're getting --
25 A. -- organizations such as WPATH --

1 THE COURT: Hold on, Dr. Laidlaw. Now
2 we're getting past. You asked him the question if it
3 was related to, but I don't think it's within his area
4 of expertise to talk about how it's treated around the
5 world.
6 MR. STONE: Understood, Your Honor.
7 THE COURT: Okay.
8 MR. STONE: I'm just trying to lay a
9 predicate --
10 THE COURT: Sure.
11 MR. STONE: -- that gender dysphoria is --
12 right. Thank you, Your Honor.
13 THE COURT: All right.
14 Q. (BY MR. STONE) Okay. Dr. Laidlaw --
15 A. Yeah.
16 Q. -- is -- is gender dysphoria a condition that
17 is treated within the field of endocrinology?
18 A. It is not an endocrine condition per se. There
19 are endocrinologists who use hormones to treat this
20 condition.
21 Q. How is gender dysphoria different from an
22 endocrine disorder?
23 A. Gender dysphoria is elicited, the diagnosis,
24 through psychological methods --
25 MR. SELDIN: Your Honor, the witness is

1 talking --
2 A. -- whereas endocrine conditions --
3 THE COURT: Hold on, Dr. Laidlaw.
4 A. -- are --
5 THE COURT: Hold on, Dr. Laidlaw. I have
6 to deal with an objection. State your objection for the
7 record, please.
8 MR. SELDIN: Objection, Your Honor. The
9 witness is being offered for endocrinology. He's been
10 talking about gender dysphoria, which he's already
11 established is a psychiatric diagnosis outside of his
12 field.
13 THE COURT: So I'm willing to let him
14 answer this specific question. What happens is he then
15 continues on to areas that I think go outside of what we
16 designated him for.
17 MR. STONE: Well, Your Honor, he just
18 testified that gender dysphoria is a condition that
19 endocrinol- -- some endocrinologists treat using
20 endocrinology. So I think this falls within the
21 practice of endocrinology if it's a condition that
22 endocrinologists treat.
23 THE COURT: Sure. But I think the
24 question is does he do it, does he treat gender
25 dysphoria as an endocrinologist. And if he doesn't, I

1 don't know -- well --
2 MR. STONE: He's an expert, Your Honor.
3 We're not asking about what he does. We're asking
4 about -- he's testifying as an expert in the field of
5 endocrinology.
6 THE COURT: Okay. Understood. But I
7 think that we're getting a little far afield when we
8 start talking -- well, let's go ahead and start again
9 and begin with a new question. I understand his
10 designation, and I'm willing to let him testify. I'm
11 the one that gets to decide the weight and the
12 credibility of the evidence, so I'd rather get through
13 it, okay? So go ahead.
14 Q. (BY MR. STONE) Doctor, can you describe to me
15 the endocrine treatments that are -- that some providers
16 provide -- some endocrinologists provide for the
17 treatment of gender dysphoria in minors?
18 A. Sure. Some endocrinologists are providing
19 hormones referred to as puberty blockers and other
20 hormones referred to as cross-sex hormones, meaning
21 testosterone for natal females and estrogen or similar
22 for natal males.
23 Q. What are puberty blockers?
24 A. Puberty blockers are medications which affect a
25 gland in the brain called the pituitary. They block the

1 normal signaling of the pituitary to the gonads, be it
2 testicles of natal males or ovaries of natal females,
3 such that those organs are unable to produce their
4 hormones, estrogen for the female ovary or testosterone
5 for the male gonad, testicle. And such as it is, if
6 this occurs during the time of normal pubertal
7 development, it will halt the progression of puberty.
8 Q. How old are minors -- well, at what stage
9 during puberty would an endocrinologist prescribe --
10 would some endocrinologists prescribe puberty blockers
11 to a minor for the treatment of gender dysphoria?
12 A. In the Endocrine Society Guidelines, they
13 recommend beginning at Tanner stage 2, which is a stage
14 of pubertal development. It's divided into five, with 1
15 being pre-pubertal and 5 being full adulthood. So
16 Tanner stage 2 is the earliest stage of puberty this can
17 occur, as early as age eight for girls or age nine for
18 boys.
19 Q. How long are puberty blockers prescribed to
20 minors for the treatment of gender dysphoria generally?
21 A. I've seen it can be for a few months to several
22 years.
23 Q. What is the goal of prescribing puberty
24 blockers to minors for the treatment of gender
25 dysphoria?

1 A. The goals have shifted over time. Initially it
2 was a time to help -- the thought was to help alleviate
3 the distress from gender dysphoria and give the child
4 time to fully recognize their gender identity. I think
5 it's become over time a method to prevent normal
6 pubertal development and the prevention of both
7 secondary and primary sex characteristic development
8 during puberty.
9 Q. Are you familiar with the Endocrine Society?
10 A. Yes. I am a member.
11 Q. What is the Endocrine Society?
12 A. The Endocrine Society is a group of
13 professionals, medical doctors, scientists, and so forth
14 who hold conferences, have journals, and contribute to
15 the field of medical endocrinology and basic science of
16 endocrinology.
17 Q. Has the Endocrine Society published guidelines
18 for endocrinologists on the treatment of gender
19 dysphoria in minors?
20 A. Yes, two that I'm aware of, in 2009 and 2017.
21 Q. Are you familiar with those guidelines?
22 A. Yes.
23 Q. What are the potential benefits of providing
24 puberty blockers to minors for the treatment of gender
25 dysphoria?

1 A. Potential benefits are allegedly to alleviate
2 gender dysphoria to give a patient time to recognize
3 their maybe true gender identity.
4 Q. Have you -- have you evaluated the scientific
5 research and literature on the effectiveness of puberty
6 blockers for the treatment of gender dysphoria in
7 minors?
8 A. Yes. I've spent the last several years looking
9 into this.
10 Q. What does the scientific literature and
11 research say about the effectiveness of puberty blockers
12 for the treatment of gender dysphoria in minors?
13 A. There's limited data on this, which is
14 low-quality evidence. Systematic reviews have shown
15 that there's limited evidence in the short or long term
16 for efficacy or safety.
17 Q. What are the risks of providing puberty
18 blockers to minors for the treatment of gender
19 dysphoria?
20 A. There's multiple risks for providing puberty
21 blockers to halt normal puberty, one being that puberty
22 is the time of rapid development of bone and increased
23 bone density. What happens is that bone density,
24 instead of increasing rapidly, will flatline. That
25 leaves a person at future risk for osteoporosis,

1 fractures of the hip, and so forth. There are changes
2 to the brain which happen under the influence of the sex
3 hormones which will be blocked.
4 There are -- most concerningly I feel is
5 that stopping normal puberty at an early Tanner stage as
6 recommended by the Endocrine Society, Tanner stage 2,
7 will be before fertility is established, before
8 menstrual cycle function and ovulation in female and
9 sperm development of male, which means that continuing
10 on to cross-sex hormones will lock this person in an
11 undeveloped state and will remain infertile.
12 Most of the patients in studies from
13 de Vries and the Dutch have shown that patients who
14 start on puberty-blocking medications, the overwhelming
15 majority go on to cross-sex hormones and then surgeries,
16 which are permanently sterilizing procedures of the
17 gonads.
18 Q. Are puberty blockers reversible?
19 A. Some aspects of puberty blockers are
20 reversible; some aspects are not reversible.
21 Q. What aspects of puberty blockers are not
22 reversible?
23 A. The effects that I described on bone are not
24 immediately reversible. In other words, if medication
25 is stopped and the person is allowed to progress through

1 puberty, they've lost time for bone development. I
2 would add that the development with relationship to
3 their peers is time lost that can't be gained. And then
4 there are unknown effects on brain development.
5 Q. Have you evaluated the scientific literature
6 and research on the safety of puberty blockers for the
7 treatment of gender dysphoria in minors?
8 A. I have. One thing to recognize is that these
9 medications are not FDA approved specifically for gender
10 dysphoria, so there are no FDA type of safety studies
11 that have ever been done. Again, the evidence that has
12 been presented is low-quality evidence. Systematic
13 reviews have not been able to establish safety in the
14 short or long term for these medications specifically
15 for gender dysphoria.
16 Q. Are you aware of any ongoing FDA safety studies
17 on the -- on puberty blockers for the treatment of
18 gender dysphoria in minors?
19 A. I am not aware.
20 Q. Are you aware if any of the manufacturers of
21 puberty blockers that are used for the treatment of
22 gender dysphoria in minors have requested FDA approval?
23 A. Not that I'm aware of.
24 Q. In your opinion, do the potential benefits
25 outweigh the risks of providing puberty blockers to

1 minors for the treatment of gender dysphoria?
2 A. No. The potential benefits do not outweigh the
3 risks.
4 Q. What is the likelihood that a minor taking
5 puberty blockers for gender dysphoria will be harmed?
6 A. The likelihood depends on the length of time
7 that they've taken the medication and whether or not
8 they continue to cross-sex hormones. If they take it
9 for a limited period of time, the harm will be minimal.
10 The longer they take the medications, the greater the
11 harm that's produced.
12 Q. I want to go back to the last question. I
13 skipped -- I skipped a question. Why do you think that
14 the -- that the risks of providing puberty blockers to
15 minors for the treatment of gender dysphoria outweighs
16 any potential benefits?
17 A. I think you have a group of medications which
18 hasn't been -- for this particular condition hasn't been
19 researched properly. There's lack of controlled
20 studies, for example. There is -- the evidence base is
21 poor in terms of quality of existing studies.
22 Therefore, one can see that the risks -- and there are
23 numerous risks already on the labeling for this
24 medication and risks that we know, as I've said, for
25 brain, bone development, and other unknown risks,

1 certainly fertility, that we know simply from endocrine
2 practice, that the risks, both known and unknown, exceed
3 the benefits.
4 Q. In your opinion, are puberty blockers a safe
5 and effective treatment for gender dysphoria?
6 A. No.
7 Q. Why not?
8 MR. SELDIN: Objection, Your Honor.
9 THE COURT: Yeah, sustained. Treatment of
10 gender dysphoria, he doesn't treat it.
11 MR. STONE: Your Honor, I --
12 THE COURT: Next question, Mr. Stone. I'm
13 happy to read it back to you.
14 MR. STONE: Then, Your Honor, I would like
15 to take this witness on -- I would like to --
16 THE COURT: Offer of proof?
17 MR. STONE: -- make an offer of proof,
18 Your Honor.
19 THE COURT: All right.
20 MR. STONE: Sorry.
21 THE COURT: That's okay. Go ahead.
22 MR. STONE: Okay.
23 **OFFER OF PROOF**
24 BY MR. STONE:
25 Q. Doctor, why do you believe puberty blockers are

1 not a safe and effective treatment for gender dysphoria?
2 A. This is through my examination of the medical
3 literature and my knowledge and experience as an
4 endocrinologist dealing with conditions produced by
5 these medications called hypogonadotropic hypogonadism.
6 Q. And Doctor, what is the basis for your
7 opinions --
8 MR. STONE: That's the end of my offer of
9 proof.
10 THE COURT: Understood. Thank you.
11 MR. STONE: Thank you, Your Honor.
12 **CONTINUED DIRECT EXAMINATION**
13 BY MR. STONE:
14 Q. Doctor, what is --
15 MR. SELDIN: Your Honor --
16 THE COURT: Hold on.
17 MR. SELDIN: We would object, Your Honor.
18 We don't believe that proffer is sufficient. The
19 question was whether he treats gender dysphoria.
20 THE COURT: Well, it's just an offer of
21 proof, so it's sort of outside of this. So go ahead.
22 Q. (BY MR. STONE) Doctor, what is the basis for
23 your -- the expert opinions that you've given about the
24 risks and potential benefits of puberty blockers for
25 minors today in the treatment of gender dysphoria?

1 A. They're based on my knowledge of endocrinology,
2 of endocrine conditions, through training, through
3 experience, and also a review of the literature and
4 systematic evidence-based reviews.
5 Q. Dr. Laidlaw, what are cross-sex hormones?
6 A. Cross-sex hormones are hormones given in high
7 dosages to -- which are higher than what's expected for
8 the natal sex. For example, a female would be given --
9 a natal female given testosterone as a cross-sex
10 hormone, a natal male given estrogen or similar as a
11 cross-sex hormone.
12 Q. Dr. Laidlaw, how are cross-sex hormones used in
13 the treatment of gender dysphoria by endocrinologists,
14 some endocrinologists?
15 A. These hormones are used by some
16 endocrinologists to -- in place of the hormone that is
17 produced natively. In other words, a testicle will
18 produce testosterone unless inhibited. In this case,
19 estrogen would be given to help produce what we call
20 secondary sex characteristics in a natal male, for
21 example, gynecomastia or to develop breast tissue,
22 changes that may be feminizing to the skin, for example,
23 or a change in body habitus, fat distribution due to
24 estrogen. If we're talking about testosterone effects,
25 secondary sex characteristic effects may include growth

1 of hair on the face or chest or back, which we call
2 hirsutism, deepening of the voice, change in musculature
3 as examples.
4 Q. What age does the Endocrine Society recommend
5 prescribe -- endocrinologists prescribe cross-sex
6 hormones to minors for the treatment of gender
7 dysphoria?
8 A. They have a general recommendation of around
9 age 16, though it may be lower in certain circumstances.
10 Q. How long -- how long would a minor be
11 prescribed cross-sex hormones by some endocrinologists
12 for the treatment of gender dysphoria?
13 MR. SELDIN: Objection, Your Honor.
14 A. The potential is for it to be indefinite.
15 THE COURT: Hold on, Dr. Laidlaw.
16 A. Lifelong.
17 THE COURT: Hold on. Sorry. Do you want
18 to state your objection?
19 MR. SELDIN: Your Honor, he's speaking to
20 the practices of others in the field he said he doesn't
21 practice in.
22 THE COURT: I think the way the question
23 is worded is fine, so I'm going to overrule the
24 objection.
25 I'm sorry, Dr. Laidlaw, if you'll

1 continue.
2 A. Yeah. I was saying that the potential is for
3 this to be a lifelong or near lifelong treatment.
4 Q. (BY MR. STONE) What are the potential benefits
5 of prescribing cross-sex hormones to minors for the
6 treatment of gender dysphoria according to the endocrine
7 society?
8 A. Stated potential benefits are allowing a person
9 to have an appearance congruence or a similarity in
10 appearance that's opposite to their natal sex with the
11 goal of helping to alleviate psychosocial stress that
12 occurs with gender incongruence.
13 Q. Have you reviewed the scientific research and
14 what it says about the effectiveness of cross-sex
15 hormones for the treatment of gender dysphoria in
16 minors?
17 A. Yes.
18 Q. What does the scientific literature and
19 research say about the effectiveness of cross-sex
20 hormones for the treatment of gender dysphoria in
21 minors?
22 A. There have been a number of systematic reviews
23 on this topic, the NICE systematic reviews, McMaster's,
24 which have shown that there is limited evidence for
25 safety and effectiveness in the short or long term for

1 adolescents. WPATH said they could not do a systematic
2 evidence review and so has no comprehensive data on
3 this.
4 Q. How much -- well, let me stop. What is the --
5 what is the goal of prescribing cross-sex hormones to
6 minors for the treatment of gender dysphoria?
7 A. The goal is to provide appearance congruence or
8 try to provide some physical changes which allow the
9 natal male, for example, to have an appearance that is
10 congruent with a natal female and vice versa and such as
11 it is to make the person feel comfortable in their -- in
12 their body and within society.
13 Q. Would it be helpful to the Court to
14 illustrate -- to illustrate the difference here in terms
15 of hormones between those naturally occurring and those
16 prescribed?
17 A. I believe it would be.
18 Q. Have you -- in your declaration, did you create
19 or provide an illustration that showed the difference
20 between naturally occurring hormones and those
21 prescribed for the treatment of gender dysphoria in
22 minors?
23 A. Yes, I did.
24 MR. SELDIN: Your Honor, we would just ask
25 that we be directed to the page --

1 THE COURT: Sure.
2 MR. SELDIN: -- and just be allowed the
3 opportunity to look at it before it's displayed.
4 MR. STONE: It's D-10.
5 THE COURT: Okay.
6 MS. WOOTEN: Your Honor, it's not a marked
7 exhibit, so we're hunting.
8 THE COURT: It is in the Box in case that
9 helps. Is it just that one page, Mr. Stone?
10 MR. STONE: Yeah, it's just -- it's just
11 this one page.
12 THE COURT: Let me --
13 MR. STONE: Do you want me to find it in
14 the expert report?
15 MR. SELDIN: Yes.
16 MR. STONE: Okay.
17 MR. SELDIN: That'll be sufficient.
18 THE COURT: It says Figure 4, so Figure 4
19 in the expert report.
20 THE WITNESS: It's Page 48.
21 MR. SELDIN: Your Honor, it's fine. Thank
22 you. We appreciate your patience.
23 THE COURT: Thank you. No worries.
24 Okay. Go ahead, Mr. Stone.
25 Q. (BY MR. STONE) Dr. Laidlaw, do you recognize

1 the image that we're displaying on the screen?
2 A. Yes, I do. This is a chart that I produced.
3 Q. What is this chart of?
4 A. So what I'm showing here is levels of natal
5 female testosterone. You can see across the bottom,
6 zero being the lowest, 1,000 being the highest. And at
7 the -- on the left-hand side there are three different
8 conditions, endocrine conditions, and also the reference
9 range for normal females, normal meaning not having any
10 endocrine condition.
11 Q. What is PCOS?
12 A. PCOS is polycystic ovarian syndrome. It's a
13 condition of natal females where there are higher than
14 normal levels of testosterone.
15 Q. And how do you treat PCOS?
16 A. So PCOS can lead to things such as hirsutism,
17 problems with fertility. It's treated by different
18 methods. Some are hormonal. Some are metabolic such as
19 treatment with Metformin.
20 Q. What is an -- I see endo -- endo tumor. What
21 is an endo tumor?
22 A. So tumors can develop either -- in the
23 endocrine glands primarily that produce -- overproduce
24 testosterone or similar androgens. So what I'm showing
25 here is that the normal -- normal range for adult female

1 testosterone, depending on the lab, is somewhere between
2 10 and 50. That's in blue. Polycystic ovarian syndrome
3 may be somewhere between, say, 50 and 150. You can see
4 with endocrine tumors, the levels can be much higher, on
5 the order of 150 to 1,000, and these are serious
6 conditions that often require -- always require
7 treatment and sometimes surgeries.
8 Q. And last, I see female to male transition, but
9 where -- let me start over. Where are you getting that
10 figure for the FtM transition from?
11 A. This is from the Endocrine Society Guidelines
12 2017.
13 Q. And what -- what are you showing in this
14 illustration of female to male transition testosterone
15 levels?
16 A. So you can see here that the levels are
17 somewhere recommended to be between 300 and 1,000, which
18 is calculated about six to 100 times higher than natal
19 female levels and on the order of endocrine tumors.
20 Q. Why is that significant?
21 A. It's significant because we recognize that high
22 levels of testosterone is a unique endocrine disorder,
23 which we call hyperandrogenism, and there are multiple
24 health effects that occur because of hyperandrogenism.
25 And this is a condition that endocrinologists would

1 diagnose and treat, but what strikes me is that this
2 condition is being deliberately generated through
3 endocrine treatment of gender dysphoria.
4 Q. Dr. Laidlaw, what are the potential risks of
5 providing puberty blockers to minors for the treatment
6 of gender dysphoria? I'm sorry. Strike that. Strike
7 that. We're not talking about puberty blockers.
8 Let me start again. Dr. Laidlaw, what are
9 the potential risks of providing cross-sex hormones to
10 minors for the treatment of gender dysphoria?
11 A. Sure. There's cardiovascular risk.
12 Dr. Irwig's review has shown increased risk of
13 myocardial infarction and death due to cardiovascular
14 disease in both sexes from cross-sex hormones. If we
15 stick with natal females using testosterone, there is
16 changes that can occur in the labeling of testosterone
17 such as blood clots, which can be deadly, changes in
18 cholesterol such as lowered HDL.
19 There are permanent changes of hair
20 growth, which we call hirsutism, permanent deepening of
21 the voice, changes -- direct changes to reproductive
22 organs such as atrophy of the vagina, of the uterus,
23 polycystic ovaries. If testosterone is given,
24 testosterone I would add also given to natal females
25 during normal pubertal development will stop native

1 pubertal development, so it will lead to infertility.
2 If the pelvis hasn't developed fully under the influence
3 of estrogen, it will halt pelvic development causing it
4 to be -- decrease the size -- the ultimate size of the
5 inlet -- pelvic inlet and outlet and could eventually
6 cause obstruction or it's a risk for obstruction of
7 labor.
8 In the male, there is increased risk of
9 thromboembolism or blood clots, which could be deadly,
10 five times increase in the Irwig paper. Gynecomastia or
11 abnormal production of breast tissue, they found in one
12 study 46 times increased risk of breast cancer of the
13 male, which is ordinarily -- or natal male, which is
14 ordinarily a rare condition. Sexual dysfunction,
15 impotence, infertility. And again, if this is given
16 during normal pubertal development, you will have a
17 halting of penile growth, testicular development,
18 infertility.
19 Q. Thank you, Doctor. And a slightly different
20 question: Other than what you've already covered, what
21 other -- are there any other potential risks to taking
22 testosterone on a long-term or lifelong basis?
23 A. Other risks -- and I've written about this in
24 my declaration -- is that with the ordinarily high doses
25 of testosterone being recommended, the closest example

1 in the literature is anabolic steroid use. They found
2 changes such as hyperactivity, aggressiveness, reckless
3 behavior. 23 percent or so had met DSM criteria for
4 major depression, mood disorders, mania. Something like
5 8 percent had psychosis. So there are physical effects,
6 which are concerning, lifelong cardiovascular, as well
7 as mental health side effects.
8 Q. Doctor, you mentioned sterilization a moment
9 ago; right?
10 A. I believe I said infertility.
11 Q. Infertility. Sorry.
12 A. I may have said leading to sterilization. I
13 don't recall.
14 Q. How -- how does -- how can potential -- how can
15 cross-sex hormones potentially lead to infertility?
16 A. Sure. So infertility of the female, if there's
17 disruption of normal menstruation and ovulation, the
18 person will be infertile. If there's -- and I don't
19 think this is known yet, but puberty blockers followed
20 by cross-sex hormones could permanently damage the
21 ovaries from what is known from pathology studies of
22 patients who had their ovaries removed and there's
23 polycystic changes and other changes. Same thing with a
24 male. Puberty blockers stopping progression of normal
25 testicular development and adding on cross-sex hormones,

1 it causes infertility in the short term. In the long
2 term there's potential for sterility. And then, as I
3 said, the studies starting with puberty blockers to
4 cross-sex hormones to surgeries, which the majority in
5 the de Vries series had gone on to do, led to ultimate
6 sterilization by removal of gonads.
7 Q. Have you reviewed the scientific literature and
8 research about the safety of cross-sex hormones for the
9 treatment of gender dysphoria in minors?
10 A. Yes.
11 Q. What does the scientific literature and
12 research say about the safety of providing cross-sex
13 hormones to minors for the treatment of gender
14 dysphoria?
15 A. Similarly, systematic reviews of the evidence
16 such as the NICE review and other similar reviews have
17 shown poor-quality evidence, lack of controlled studies,
18 lack of long-term studies establishing safety of
19 cross-sex hormones for the treatment of gender dysphoria
20 for adolescents.
21 Q. In your opinion, do the potential benefits
22 outweigh the risks of providing cross-sex hormones to
23 minors for the treatment of gender dysphoria?
24 MR. SELDIN: Objection, Your Honor. It's
25 outside the scope.

1 THE COURT: Well, he does say in his
2 opinion, which I understand to be in this area. So I'm
3 going to overrule the objection and let him answer the
4 question.
5 A. In my opinion, based on my experience,
6 training, and review of the literature, the benefits do
7 not outweigh the risks for cross-sex hormones for
8 adolescents.
9 Q. (BY MR. STONE) Are cross-sex hormones
10 reversible?
11 A. Some aspects are; some are not. Some are
12 unknown. For example, permanent side effects of
13 testosterone, if a person decides to detransition or
14 regrets their decision, they're left with some degree of
15 beard growth on the face or hair on other parts of the
16 body that aren't easily changed, permanent changes in
17 deepening of the voice that to my knowledge has -- there
18 are no treatments or it's very limited. For males, it
19 can be very discomforting if they regret their decision
20 to have gynecomastia or increased breast tissue that can
21 be either uncomfortable or particularly having to be
22 reversed by breast reduction surgery, which can be
23 painful and costly and difficult.
24 Q. Doctor, are you familiar with the WPATH?
25 A. Yes.

1 Q. Have you reviewed the WPATH Standard of Care
2 Version 8?
3 A. Yes.
4 Q. Doctor, what is informed consent in the
5 practice of endocrinology?
6 A. In the practice of endocrinology, particularly
7 if we're giving -- prescribing medications, which is
8 what we would most often do, it's the practice of
9 informing the patient about risks and benefits of the
10 medication side effects, risks and benefits of not
11 taking the medication, risks and benefits of not -- of
12 the alternatives to not taking the medication, and also
13 understanding the capacity of a person -- a patient to
14 provide informed consent.
15 Q. Doctor, have you reviewed the WPATH guidelines
16 about obtaining informed consent or assent from a minor
17 for the treatment -- for the use of puberty blockers or
18 cross-sex hormones?
19 A. Yes.
20 Q. Would it assist you if we -- if I showed you to
21 refresh your recollection a copy of the WPATH's
22 guidelines on obtaining informed consent or assent from
23 a minor for the use of puberty blockers or cross-sex
24 hormones?
25 A. That would be helpful.

1 MR. STONE: Your Honor, at this time we'd
2 like to display on the screen Plaintiffs' Exhibit 26.
3 THE COURT: Okay.
4 MR. STONE: Page 63.
5 THE COURT: Which is not in evidence --
6 MR. STONE: It's not in evidence.
7 THE COURT: -- but just as a
8 demonstrative.
9 MR. STONE: But it's in the Box.
10 THE COURT: Okay. Give me one second.
11 All right. Go ahead.
12 MR. STONE: Thank you, Your Honor.
13 Q. (BY MR. STONE) Doctor, do you see the first
14 sentence at the very bottom of the right hand? I think
15 we're zooming in on it.
16 THE COURT: What page are you on,
17 Mr. Stone?
18 MR. STONE: I'm on Page 63.
19 THE COURT: Okay. Thank you.
20 Q. (BY MR. STONE) The very first sentence at the
21 bottom on the right-hand column, "The following
22 questions may be useful." Do you see it on the screen?
23 Okay.
24 A. Yes.
25 Q. Doctor, do you see the sentence on the screen

1 "The following questions may be useful to consider in
2 assessing a young person's emotional and" -- it
3 continues on -- "cognitive readiness to assent or
4 consent to specific gender-affirming treatment"?
5 A. Yes.
6 Q. I want to ask you about each of these four
7 questions. The first, do you see it on the screen? Can
8 the young person think carefully into the future and
9 consider the implications of a partially or fully
10 irreversible intervention? Do you see that on the
11 screen?
12 A. Yes, I do.
13 Q. Doctor, in your opinion, can a minor think
14 carefully and -- into the future and consider the
15 implications of taking puberty blockers and cross-sex
16 hormones?
17 A. Given the long-term limited data on this and
18 certainty of certain types of risks, especially that are
19 lifelong, such as fertility complications, sexual
20 dysfunction, cardiovascular function, I would say no.
21 Q. Second question: Does the young person have --
22 do you see on the screen where it says: Does the young
23 person have sufficient self-reflective capacity to
24 consider the possibility that gender-related needs and
25 priorities can develop over time and gender-related

1 priorities at a certain point in time might change?
2 A. I think that a young person would have limited
3 capacity to do so. They tend to, because of their age
4 of development, prefer immediate gratification and can't
5 perceive the long-term consequences or the possibility
6 that their gender identity might change over time, so I
7 would say they don't have that capacity.
8 Q. For the third question: In your opinion, do
9 young people to some extent -- have they thought
10 through --
11 MS. DYER: Sorry.
12 Q. (BY MR. STONE) Sorry. Let me -- okay. Let me
13 just read it. Do you see on the screen where it says:
14 Has the young person to some extent thought through the
15 implications of what they might do if their priorities
16 around gender do change in the future? Do you see that
17 on the screen?
18 A. I do. I think it's again going to be very
19 limited. You know, a 13-year-old may not be thinking
20 about breastfeeding at age 28 or, you know, a
21 12-year-old, 11-year-old male may not be thinking about
22 what it's like to be the father of a child. They simply
23 don't have the experience, maturity, or development to
24 comprehend those big changes that occur in adult life.
25 Q. All right. Last question on this.

1 MR. STONE: And I think we're almost done,
2 Your Honor.
3 Q. (BY MR. STONE) Do you see on the screen where
4 it says: Is the young person able to understand and
5 manage the day-to-day short- and long-term aspects of a
6 specific medical treatment? Do you see that on the
7 screen?
8 A. Yes.
9 Q. What is your opinion about minors and their
10 capacity to provide this informed consent or assent to
11 the specific topic with respect to puberty blockers and
12 cross-sex hormones?
13 A. It's difficult for -- medication adherence is a
14 difficult general problem even for adults. But my
15 experience with, say, even young people who have
16 diabetes, adhering to taking insulin every day and on a
17 regular basis can be quite difficult. And so I presume
18 this type of treatment, which can involve regular
19 injections, daily medications, would be difficult for
20 the young person to appreciate how to stay on a regimen
21 and continue their course.
22 Q. Dr. Laidlaw, did you have an oppor- -- have you
23 had an opportunity to review the declarations submitted
24 in this case?
25 A. Yes.

1 Q. Have you had an opportunity to review the
2 declaration submitted by Dr. Shumer?
3 A. Yes.
4 Q. What -- what opinions, if any, do you have
5 about the declaration submitted by Dr. Shumer?
6 A. I disagree with him on a number of key issues.
7 I believe I pointed those out in my declaration.
8 Q. Okay.
9 MR. STONE: Okay. Your Honor, we pass the
10 witness.
11 THE COURT: All right. Thank you,
12 Mr. Stone. Let's go ahead and take our morning break.
13 It's 10:15. We'll try and resume back at 10:30. And
14 we're in recess until 10:30, and we'll continue with
15 you, Dr. Laidlaw, as soon as we're back. But you're
16 welcome to turn off your microphones and videos on our
17 Zoom and be back at 10:30, which -- I don't know exactly
18 where you are. I think you're in California, so it's
19 still early, but 10:30 Texas time. Thank you.
20 THE WITNESS: Okay. Thank you.
21 *(Recess taken)*
22 THE COURT: Just for any new visitors, a
23 quick reminder, there's no recording, broadcasting, or
24 any photography inside the courtroom. Thank you very
25 much. I think we are ready to proceed.

1 Dr. Laidlaw, are you ready to proceed?
2 Oh, if you'll unmute yourself, sir.
3 THE WITNESS: Yes.
4 THE COURT: Okay. Perfect. Thank you.
5 **CROSS-EXAMINATION**
6 BY MR. SELDIN:
7 Q. Dr. Laidlaw, good morning.
8 A. Good morning.
9 Q. Less than 5 percent of your endocrinology
10 practice is treating patients under 18; correct?
11 A. Correct.
12 Q. And puberty blockers, testosterone, and
13 estrogen are all prescribed by endocrinologists to
14 adolescents to treat other endocrine conditions;
15 correct?
16 A. Yes.
17 Q. And in those cases, endocrinologists will
18 review the risks and benefits of those medications for
19 those conditions with their patients; correct?
20 A. Yes, they should.
21 Q. Earlier you referenced Figure 4 in your
22 testimony from your declaration; is that right?
23 A. Yes.
24 Q. And this is a chart that you created; correct?
25 A. Correct.

1 Q. And Figure 4 doesn't include -- well, Figure 4
2 includes what you refer to as the normal female range of
3 testosterone; is that correct?
4 A. It's, to be clear, the reference range for
5 females without an endocrine condition affecting their
6 testosterone.
7 Q. And Figure 4 doesn't include the normal male
8 range for testosterone; correct?
9 A. That's correct. They have not indicated that.
10 Q. And you testified earlier that you reviewed
11 Dr. Shumer's report; correct?
12 A. Yes.
13 Q. And Dr. Shumer in his report testified that the
14 goal of treatment of gender dysphoria in adolescents is
15 to raise testosterone levels to the range appropriate
16 for their age and stage of development as compared to
17 males who are not transgender; correct?
18 A. That's their goal, but they don't have evidence
19 to support those numbers.
20 Q. What is the normal male range for testosterone?
21 A. Roughly 300 to 1,000 based -- depending on the
22 lab.
23 Q. And your chart includes what you would call the
24 FtM transition range from, it looks like, to about 300
25 to 1,000; is that correct?

1 A. Yes.
2 Q. So would you say then that also corresponds to
3 what you would call the normal male range for
4 testosterone?
5 A. Normal natal male reference range.
6 Q. Earlier you testified about a concern about
7 abuse of testosterone and you compared it to the use of
8 anabolic steroids in athletes; correct?
9 A. Yes.
10 Q. And so that concern would not apply to raising
11 testosterone levels in accordance with Endocrine Society
12 Guidelines to what you call the normal male natal range;
13 correct?
14 A. Are you saying specifically raising natal
15 female levels to 300 to 1,000?
16 Q. Let me rephrase. Earlier you talked about a
17 concern about testosterone being overprescribed and
18 compared it to the use of anabolic steroids in athletes;
19 correct?
20 MR. STONE: Objection, Your Honor. This
21 misstates prior testimony. Specifically, the question
22 was about the long-term use, and he said it was
23 analogous to -- the closest analogy in the literature
24 was to anabolic steroids. He didn't say
25 overprescribing, any of like the loaded language they're

1 using.
2 THE COURT: If you can rephrase. I don't
3 know that he said it was over- -- well, I don't -- if
4 you'll rephrase.
5 Q. (BY MR. SELDIN) Dr. Laidlaw, earlier you
6 testified about a concern about the use of testosterone
7 over time being comparable to the use of anabolic
8 steroids by athletes; correct?
9 A. High dose testosterone.
10 Q. And when you say high dose testosterone, you
11 meant in excess of the normal female range of
12 testosterone as indicated by your chart; correct?
13 A. That's correct.
14 Q. Not in excess of the levels indicated by the
15 FtM transition level on your chart; correct?
16 A. That could be in addition to it. In other
17 words, levels could be potentially higher than 1,000,
18 depending on how it's given, but that's the
19 recommendation of the Endocrine Society is the range I
20 have there.
21 Q. When you treat natal males, or as you call
22 them, as the term that you're using, what is the goal
23 reference range that you use for a normal testosterone
24 level?
25 A. Typically, again, depending on the lab,

1 somewhere between 300 and 1,000, taking into account age
2 and risks of treatment.
3 Q. And Dr. Laidlaw, you testified earlier you
4 don't treat gender dysphoria in adolescents; correct?
5 A. That's correct.
6 Q. Dr. Laidlaw, you believe that minors who
7 experience gender dysphoria have a false belief that
8 they are the opposite sex; correct?
9 A. They may have a false belief that they're -- or
10 that they could become the opposite sex.
11 Q. And you believe that minors with gender
12 dysphoria have a delusion and are part of a charade when
13 they live in accordance with their gender identity;
14 correct?
15 A. If they live in accordance with their gender
16 identity, they may be convinced that they can become the
17 opposite sex, which is not medically possible.
18 Q. You believe that minors with gender dysphoria
19 who live in accordance with their gender identity are
20 engaged in a form of impersonation or play acting;
21 correct?
22 A. They may be influenced to it by adults through
23 social transition or hormones to acquire stereotypical
24 mannerisms of the opposite sex, but they can't truly
25 become the opposite sex.

1 MR. SELDIN: Your Honor, if I could just
2 have a brief moment.
3 THE COURT: Uh-huh.
4 MR. SELDIN: Your Honor, we have no
5 further questions. We pass the witness.
6 THE COURT: All right. Any redirect,
7 Mr. Stone?
8 MR. STONE: Yes, just a little bit,
9 Your Honor.
10 THE COURT: Okay.
11 **REDIRECT EXAMINATION**
12 BY MR. STONE:
13 Q. Going back to Figure No. 4, Dr. Laidlaw, what
14 is the significance of a biological female receiving
15 testosterone at the levels that you indicated in the
16 figure?
17 A. There's a reason we have established laboratory
18 what I'm calling reference ranges, so say a normal
19 minimum and a normal maximum. In this case we're
20 talking about testosterone. For some types of things,
21 let's say sodium, to my knowledge you can check that in
22 the lab, and the reference range is similar or nearly
23 identical for males and females, as far as I know. But
24 when you're talking about sex-specific hormones, the
25 ranges are very different, and there's a reason for

1 that, because that person's body is meant to have a
2 certain level of hormone to continue normal function, to
3 develop normally through puberty, and excesses or very
4 low levels of hormones will lead to medical conditions.
5 And so in the female, high levels of testosterone beyond
6 the normal reference range cause a medical condition,
7 endocrine condition, we call hyperandrogenism. And this
8 is being deliberately induced iatrogenically, is the
9 term I would use, through medical treatments for gender
10 dysphoria.
11 Q. Doctor, what is gender identity?
12 MR. SELDIN: Objection, Your Honor.
13 MR. STONE: Your Honor, they opened the
14 door to this with their cross-examination. They
15 specifically read him statements. They asked him about
16 gender identity and his thoughts on --
17 THE COURT: All right, all right,
18 all right.
19 MR. STONE: Okay.
20 THE COURT: Let's just ask him what his
21 opinion is about what gender identity means.
22 MR. STONE: Thank you, Your Honor.
23 Q. (BY MR. STONE) What is your opinion --
24 A. Sure.
25 Q. Go ahead.

1 A. In the DSM-V, which I referenced earlier,
2 gender identity is a social psychological concept
3 distinct from biologic sex, which has to do with a
4 person's internal feeling of being male or female or on
5 a spectrum of male to female or some other gender
6 identity.
7 Q. What is your opinion on whether there's a
8 biological basis for gender identity?
9 MR. SELDIN: Objection, Your Honor.
10 MR. STONE: Your --
11 THE COURT: Hold on. I'll overrule the
12 objection and let him answer if he can.
13 A. The problem with saying there's a biological
14 basis, this is an ongoing area of investigation.
15 They've done some limited studies, for example
16 autopsies, of brains to look for evidence of a gender
17 identity caused by biology that had some limited studies
18 on genetics to look for this. But importantly, there is
19 no brain study, there is no imaging, there is no blood
20 test, there is no chromosome test, there is no genetic
21 test which can definitively show diagnostically the
22 gender identity of a given person. So there is no
23 biological physical method to confirm the gender
24 identity.
25 Q. And I just have I think two more questions.

1 What is -- in your opinion, can biological sex change
2 over time?
3 A. When we say biological sex change over time,
4 what I would say is that, one, there are two -- sex is
5 binary. Physical sex is binary, male and female. A
6 male cannot change into a female or female into a male
7 by current medical technology.
8 Q. And last question: Do you believe that in your
9 opinion that gender identity can change over time?
10 A. Yes, gender identity can change over time.
11 MR. SELDIN: Your Honor --
12 A. This is --
13 MR. SELDIN: -- we would object.
14 THE COURT: Hold on. Let's let the
15 objection get on the record.
16 MR. SELDIN: Your Honor, we would object.
17 This is outside the scope of his testimony on cross and
18 redirect.
19 THE COURT: I'll overrule the objection.
20 Finish your answer, Dr. Laidlaw.
21 A. There's a couple of ways of knowing this. One
22 is what we call the desistance rate. In other words,
23 most --
24 THE COURT: Well, hold on.
25 A. -- children 12 --

1 THE COURT: Hold on. I think you've
2 answered the question. Is there a -- is there a next
3 question?
4 MR. STONE: Sure.
5 Q. (BY MR. STONE) What is the -- why is that your
6 opinion?
7 A. My opinion has to do with the desistant rate
8 and the people who exist who are called detransitioners
9 who once identified with one gender identity and have
10 changed to another.
11 MR. STONE: Pass the witness, Your Honor.
12 THE COURT: All right. Anything further?
13 MR. SELDIN: Your Honor, we have no
14 further questions, but we would move at this time to
15 admit P-26 into evidence.
16 THE COURT: Okay. P-26 was the WPATH
17 society No. 8?
18 MR. SELDIN: Yes.
19 MR. STONE: Your Honor, we object. This
20 is hearsay, and it's not admissible, under 803, I
21 believe, 15.
22 THE COURT: Did you -- but you used it
23 with this witness, Mr. Stone.
24 MR. STONE: I only used it, Your Honor, to
25 refresh his recollection and to show it to him. And

1 it's a -- or a learned treatise or guideline. Under
2 803.15 we can show it to a testifying person, but it
3 doesn't make it admissible. Specifically the rule
4 says -- 803.15 says -- I'm sorry. It's not 15. It's
5 18. 803.18, Statement in a Learned Treatise, Periodical
6 or Pamphlet: A statement in a treatise, periodical, or
7 pamphlet if the statement is called to the attention of
8 an expert witness on cross-examination or relied on by
9 the expert on direct examination and the publication is
10 established as a reliable authority by the expert's
11 admission or testimony, by another expert's testimony,
12 or by judicial notice, then, if admitted, the statement
13 may be read into evidence but is not received as an
14 exhibit.
15 That's what we did. We read portions of
16 it, but that doesn't make the document itself
17 admissible. It's still inadmissible hearsay. It's just
18 that we can read and ask questions from it.
19 THE COURT: A response?
20 MR. SELDIN: Your Honor, he didn't --
21 Mr. Stone did not lay the predicate for 803.15. He may
22 have used the words "refresh your recollection," but
23 there was no forgetting by Dr. Laidlaw in this respect.
24 Further, Dr. Laidlaw has relied upon it. He has
25 authenticated it. He's used it here today.

1 THE COURT: Right. So -- and there's not
2 a jury, so I'm going to overrule the objection and admit
3 P-26.
4 *(Plaintiffs' Exhibit 26 admitted)*
5 THE COURT: Okay. So Mr. Stone, your next
6 witness?
7 MR. ELDRED: It's Dr. Cantor. And we're
8 trying to get him to check in to Zoom.
9 THE COURT: Okay. We'll be on the lookout
10 for that. Dr. Laidlaw, you're welcome to stay put as
11 long as you turn off your microphone. You can also turn
12 off your video if you'd like. It's up to you.
13 MR. STONE: He just emailed us and said he
14 was getting on.
15 THE COURT: Okay. Perfect. I don't know
16 how long you're going to be with this witness or the
17 next one, but I do probably need to break about five
18 minutes to 12:00 just to get downstairs for a meeting.
19 MR. ELDRED: Yes, Your Honor.
20 MS. WOOTEN: Your Honor, while we're
21 waiting, if it's possible to confirm that the people
22 participating via Zoom, in addition to having no one in
23 the room, are not communicating with others via text or
24 otherwise.
25 THE COURT: Sure. I can do that. I don't

1 know -- did Grossman specifically leave us or was
2 that --
3 MS. DYER: Yes, Your Honor. Sorry. I
4 meant to explain. She had a conflict right at 11:00.
5 We thought we were going to get through the prior
6 witness a little bit faster, and so she cannot testify
7 any longer. We informed the plaintiffs.
8 THE COURT: Okay. Thank you very much,
9 Ms. Dyer. Is there anybody in? Oh, there they are.
10 There's Dr. Cantor. Yeah, it looks like Laidlaw is not
11 with us anymore.
12 Good morning, Dr. Cantor. This is the
13 judge. Can you hear me okay?
14 DR. CANTOR: Yes, I can. Thank you.
15 THE COURT: All right.
16 DR. CANTOR: Can you hear me?
17 THE COURT: Yes, I can, very well. Let me
18 just confirm with you that there's no one else present
19 in your room right now. Is that correct?
20 DR. CANTOR: That's correct.
21 THE COURT: And to the extent I guess --
22 the rule's been invoked. You have not communicated with
23 any of the other witnesses in this proceeding, have you?
24 DR. CANTOR: That is correct. I have not.
25 THE COURT: All right. Thank you, sir.

1 All right. Please go ahead.
2 MR. ELDRED: Thank you, Your Honor.
3 Dr. Cantor, I'm Charles Eldred.
4 THE REPORTER: Did you swear him in?
5 THE COURT: Oh, I didn't. I'm so sorry.
6 Dr. Cantor, I need to swear you in, if you'll please
7 raise your right hand.
8 *(Witness sworn)*
9 THE COURT: Thank you. And thank you,
10 Ms. Crain.
11 **JAMES CANTOR**,
12 having been first duly sworn, testified as follows:
13 **DIRECT EXAMINATION**
14 BY MR. ELDRED:
15 Q. All right. Dr. Cantor, I'm Charles Eldred with
16 the Attorney General's Office. I'll be questioning you
17 today on direct examination. Can you please state and
18 spell your name?
19 A. Dr. James, J-a-m-e-s, Cantor, C-a-n-t-o-r.
20 Q. What degrees do you hold?
21 A. I have a bachelor's degree in interdisciplinary
22 science concentrating in mathematics and physics, a
23 master's degree in psychology, and my doctoral degree in
24 clinical psychology with a dissertation in the
25 neurobiology of sexual function.

1 Q. And do you have any postdoctoral follow -- I'm
2 sorry. Do you have any postdoctoral fellowships?
3 A. Yes. I completed a postdoctoral fellowship
4 again in the development of human sexuality at the
5 Center for Addiction and Mental Health here in Canada.
6 Q. Where do you currently work?
7 A. I am currently the director of the Toronto
8 Sexuality Center.
9 Q. What academic appointments have you held?
10 A. I was first appointed as a postdoctoral fellow,
11 then assist professor, then associate professor of
12 medicine at the University of Toronto Medical School.
13 Q. And have you published peer-reviewed articles?
14 A. Yes, I have, somewhat over 50.
15 Q. And what kind of things have they been about?
16 A. Again, primarily the development of human
17 sexuality, concentrating really in the atypical
18 sexualities. They've spanned gender identity, sexual
19 orientation, and a group of atypical sexualities called
20 the paraphilias, which refer to highly atypical
21 interests that pertain to people who are sexually
22 aroused by things that are not just male or female.
23 Q. Okay. Have you ever testified as an expert
24 witness?
25 A. Yes, I have.

1 Q. About how many times and what about?
2 A. Oh, goodness. I've been involved one way or
3 another in about 35 cases. The majority of those have
4 been expert reports. Testimony has been in about half
5 of those. The questions are one way or another about
6 what is known about the science and the development of
7 usually -- of some atypical sexuality of question -- of
8 interest to the Court. Some of those have been about
9 pedophilia, some of those have been about other sexual
10 interests that can motivate sex offenses, and in the
11 past two years or so about the development of gender
12 identity and how to distinguish it from other atypical
13 sexualities.
14 Q. All right. Do you have clinical and scientific
15 expertise?
16 A. Yes, I do. Usually in forensic settings, the
17 typical question is related to malpractice, whether a
18 specific clinician correctly implemented a
19 well-established procedure in clinical science. So in
20 those types of expertise, it's very useful to have
21 somebody else who engages in a similar activity.
22 That's very different, however, from
23 today's proceedings and similar proceedings in other
24 jurisdictions where the question is not whether a
25 specific clinician correctly implemented a policy or

1 procedure. The question is over the validity of that
2 procedure itself that requires a very different kind of
3 expertise where you cannot use other people who engage
4 in that activity because it represents a conflict of
5 interest.
6 Q. All right.
7 A. To use a metaphor, you can't find out if
8 fortunetelling is accurate only by asking other
9 fortunetellers. You need people --
10 Q. Sir --
11 A. -- with expertise --
12 THE COURT: All right. Mr. Cantor, hold
13 on. Your attorney has another question. Hold on.
14 Q. (BY MR. STONE) I'm sorry. We're getting a
15 little bit into the substance of what you're going to
16 talk about, and I'm just trying to get your
17 qualifications right now.
18 A. Oh, sorry.
19 Q. That's okay. I probably asked you a bad
20 question. I meant to ask you this. Have you ever
21 personally treated patients with gender dysphoria?
22 A. Yes, I have.
23 Q. And can you talk about that just a little bit?
24 A. My license spans treating people ages 16 and
25 up, and these have -- such cases have varied between

1 people who have questions about their own gender
2 identity, what their decision is, whether medical
3 transition would be best for them, and people for whom
4 it's already clear and they're undergoing the transition
5 process and need support while doing.
6 Q. And do you have training and experience in
7 evaluating research methodologies?
8 A. Yes, quite a bit.
9 Q. What are the research methodologies and what is
10 your training and experience?
11 MR. GONZALEZ-PAGAN: Objection, compound.
12 A. Well --
13 THE COURT: Hold on, Dr. Cantor. I just
14 want the record to be clear. Do you have an objection?
15 MR. GONZALEZ-PAGAN: Objection, compound.
16 MR. ELDRED: I'll try again then.
17 THE COURT: Sure.
18 Q. (BY MR. ELDRED) Just briefly, generally what
19 are research methodologies?
20 A. Research methods are systematic procedures that
21 we use in order to answer specific questions, such as
22 whether certain features or characteristics cluster
23 together or how to predict outcomes given different
24 types of treatments that we might apply.
25 Q. And do you have training with evaluating

1 research methodologies?
2 A. Yes, I do, quite a bit.
3 Q. What is that training?
4 A. In most of the training programs I've been in,
5 it's actually been integrated into the rest of the
6 training programs, so understanding the full range of
7 what -- of the scientific methods that we can apply in
8 science to answer different kinds of questions. My
9 experience then includes applying that in many different
10 circumstances, for example, evaluating other researchers
11 who submit various manuscripts for publication in
12 peer-reviewed journals and evaluating the proposed
13 methods that a scientist would use when they, for
14 example, apply for granting for the funding in order to
15 perform a series of experiments.
16 Q. Have you ever served on the editorial board of
17 any peer-reviewed journals?
18 A. Yes, several. The most relevant ones are the
19 *Archives of Sexual Behavior* and the *Journal of Sex*
20 *Research*. Oh, I'm sorry. And I've also served as
21 editor-in-chief of *Sexual Abuse*, so I was in charge of
22 the peer-review system for that journal.
23 Q. That's the name of a journal?
24 A. Yes, it is. Actually, the full name of it when
25 I was editor was *Sexual Abuse: A Journal of Research and*

1 *Treatment*. It's since shortened its name. Now it's
2 just called *Sexual Abuse*.
3 Q. Thank you. And you said before you have
4 testified -- have you ever testified as an expert on
5 scientific research relating to the treatment of gender
6 dysphoria in minors?
7 A. Yes, I have.
8 Q. Can you list some of those cases?
9 A. The most recent one was last week in Georgia.
10 The name slips my mind. *Koe vs. Noggle*. The others are
11 listed on my CV.
12 MR. ELDRED: And Your Honor, his CV has
13 been previously admitted as Defendants' Exhibit 5.
14 THE COURT: Thank you.
15 MR. ELDRED: And at this time defendants
16 proffer Dr. Cantor as an expert on the scientific
17 research related to the treatment of gender dysphoria in
18 minors.
19 MR. GONZALEZ-PAGAN: A brief voir dire if
20 I can, Your Honor.
21 THE COURT: Sure. Mr. -- and I'm sorry.
22 MR. GONZALEZ-PAGAN: Gonzalez-Pagan.
23 THE COURT: -- Gonzalez-Pagan is going to
24 have a few questions for you, Dr. Cantor.
25 THE WITNESS: I understand.

1 **VOIR DIRE EXAMINATION**

2 MR. GONZALEZ-PAGAN:

3 Q. Dr. Cantor, you previously testified in the --

4 here in Texas last year in the *PFLAG v. Abbott* case; is

5 that correct?

6 A. Yes, it is.

7 Q. And in that case you testified that you have

8 not conducted any original scientific research on the

9 efficacy or safety on the medical treatment of gender

10 dysphoria; is that correct?

11 A. I haven't collected data specifically on such a

12 sample, that is correct.

13 Q. And you yourself have not conducted any

14 original scientific research on the safety and efficacy

15 of medical treatment of gender dysphoria in adolescents;

16 is that correct?

17 A. Mostly correct. The data that I have collected

18 myself would be indirectly relevant such as the

19 development of the brain, the development of various

20 facial features over the course of puberty, and the

21 development of sexual orientation, which is highly

22 integrated into the development of gender identity.

23 Q. But my question is: Have you conducted any

24 research regarding the treatment of gender dysphoria in

25 adolescents? Have you?

1 A. Not directly, no.
2 MR. GONZALEZ-PAGAN: Your Honor, we would
3 object to the expert being proffered on the evidence of
4 safety and efficacy provided by the research, but he can
5 speak to research methodologies, which clearly has been
6 established through the voir dire.
7 THE COURT: All right. Mr. Eldred, what I
8 have noted is scientific research related to treatment
9 of gender dysphoria of minors. Is that the subject
10 area?
11 MR. ELDRED: Yes, Your Honor, that's what
12 we offer -- that's what we are proffering him for.
13 THE COURT: And tell me again exactly what
14 you think he can testify about.
15 MR. GONZALEZ-PAGAN: Research
16 methodologies. If he wants to speak to the
17 methodologies used by any study, that would be certainly
18 within the -- we would concede that that would be
19 something within what's been established within the
20 voir dire.
21 THE COURT: As opposed to?
22 MR. GONZALEZ-PAGAN: To what the actual
23 research speaks to with regards to safety and efficacy
24 of treatment of gender dysphoria in minors.
25 THE COURT: Okay. So I understand the

1 distinction. Is there anything further you want to add
2 to that, Mr. Eldred?
3 MR. ELDRED: I don't think the distinction
4 has a difference because he's testifying about what the
5 research says about such things. He's an expert on that
6 kind of a topic.
7 THE COURT: All right. So I'm clear on
8 what I think -- I'm clear, so I'm going to go ahead and
9 allow the designation under the topics as you've stated,
10 Mr. Eldred, and so you can continue your examination.
11 MR. ELDRED: Thank you, Judge.
12 **CONTINUED DIRECT EXAMINATION**
13 BY MR. ELDRED:
14 Q. I want to start by just defining some terms. I
15 want to start with safe and effective. What is safe in
16 a clinical research context?
17 A. Within clinical research, we simultaneous -- to
18 answer any decision-making question, we need to -- we
19 need to assess the risk-to-benefit ratio of any given
20 treatment. We need to know -- or the decision-makers
21 need to know are the risks posed by any particular
22 treatment worth the potential benefits that might come
23 out of that treatment. So we assess safety relative to
24 potential benefit, and we assess benefit relative to the
25 potential safety.

1 So when we discuss safety, we discuss the
2 probable, the necessary, or the potential downsides that
3 would apply either to a person's physical health and
4 well-being or mental health and well-being. The flip
5 side to benefits are how it might improve a person's
6 physical objective functioning or how it might improve a
7 person's subjective account of their own mental health
8 status.
9 Q. And same question for effective. What is
10 effective in a clinical research context?
11 A. Effective would be if we have a reliable
12 indication of improvement in a person's either physical
13 or mental well-being. So there can sometimes be
14 disagreement over what counts as a benefit according to
15 an individual -- individual person's values, but in
16 order to demonstrate that something is effective, we
17 need to be able to show it in some reliable way. That
18 is, we need to be able to know that another treatment
19 provider or policymaker engaging in the same procedures
20 should be able to expect or should reliably expect to
21 get the same outcomes.
22 Q. Okay. I'm going to ask you about something
23 called the pyramid of evidence. Have you ever heard of
24 that?
25 A. Yes, I have.

1 Q. What is that?
2 A. It's ubiquitous really in clinical science and
3 in outcomes research. Not all research studies have the
4 same value. Some are more reliable than others. Some
5 provide results that are more ambiguous than others. So
6 the pyramid of evidence is a hierarchy describing the
7 various levels of evidence going from low-quality
8 evidence that are relatively uncertain or ambiguous up
9 through high-quality evidence that is highly reliable
10 and worth generalizing to other people.
11 MR. ELDRED: Judge, this is Defendants'
12 Exhibit 11. We would like to offer that in evidence,
13 the pyramid. It's a one-page diagram called Pyramid of
14 Standards of Evidence.
15 THE COURT: Any objection?
16 MR. GONZALEZ-PAGAN: Yes, Your Honor.
17 This is a graphic obtained from a random website called
18 OpenMD.com. It is hearsay. It is not authenticated.
19 We would object to it being entered into evidence.
20 THE COURT: Any response, Mr. Eldred?
21 MR. ELDRED: May I ask the doctor one more
22 question about it in response to that?
23 THE COURT: Sure.
24 Q. (BY MR. ELDRED) Doctor, you just heard
25 plaintiffs' counsel object to it that it comes from

1 OpenMD.com. I think I heard you say it's ubiquitous.
2 Can you explain? Go ahead.
3 A. That is correct. It is a standard hierarchy
4 that is ubiquitous throughout clinical science. I
5 picked this particular copy from this particular website
6 because it's not copyrighted. Exactly the same setup is
7 identifiable in any standard research textbook, and I
8 found the same hierarchy on the NIH websites.
9 MR. ELDRED: With that clarification, I'd
10 like to reoffer D-11 into evidence.
11 THE COURT: Any other --
12 MR. GONZALEZ-PAGAN: Your Honor, that
13 offer of proof does not attend to either of the
14 objections. It's both hearsay and it's not
15 authenticated.
16 MR. ELDRED: It's a learned treatise at
17 the very least. We can at least use it as a learned
18 treatise.
19 THE COURT: Well, I think we can use it as
20 a demonstrative.
21 MR. ELDRED: That's -- that -- I'm sorry.
22 That's fine too, Judge.
23 THE COURT: All right. D-11 is not --
24 MR. ELDRED: Do you have a copy of it?
25 THE COURT: It is not admitted. It is a

1 demonstrative.
2 Q. (BY MR. ELDRED) Do you see it on the screen?
3 A. I do see it, but now it started an echo on the
4 audio system.
5 Q. I think we fixed it. I'll try again. Do you
6 see it on the screen now?
7 A. Yes, I do.
8 Q. Great. And is that the pyramid of evidence you
9 were talking about?
10 A. Yes, it is.
11 Q. Okay. So there's a diagonal line on the left
12 side called quality. What is meant by that? Actually,
13 no --
14 A. It --
15 Q. Let me cut you off there. I'm sorry. Let me
16 try this again. Just give us a general picture of what
17 it is we're looking at right now, a big picture.
18 A. These, as I described, are the different types
19 of research methodologies that are available in
20 performing different kinds of systematic studies. The
21 general idea of quality is the reliability of the study;
22 that is, how well can we expect to be able to take the
23 results of the study and expect that somebody else
24 performing the same study would get the same results
25 because, of course, especially within clinical science,

1 the whole point is to be able to take a treatment that
2 was studied by one person and to be able to use that
3 with other people in order to have a good idea of what
4 kind of outcomes to expect.
5 The pyramid shape was chosen for this in
6 order to describe the number of studies that come out.
7 The lower-level studies are very, very common because
8 they are fast to perform and they are inexpensive to
9 perform. So the low-quality studies are very numerous
10 in the research literature exactly because or as a side
11 effect of their being easy to perform, but they're less
12 reliable. The more systematic and the more reliable
13 studies are harder to perform, take more time to
14 perform, and take much more thorough analysis, so there
15 are fewer of them.
16 So again, the shape of the pyramid is
17 meant as a reminder that you can't just take a vote of
18 studies. The high-quality studies are almost by
19 definition rarer than the easier studies which are
20 almost necessarily more numerous. Then at the top of
21 the pyramid are the systematic reviews which review all
22 the other studies beneath it assessing them according to
23 their relative qualities.
24 Q. Okay. And I see on the bottom there's another
25 arrow called information volume. Can you explain how

1 that relates to this diagram?
2 A. That again is a reference to the cheaper and
3 easier-to-conduct studies being more numerous. We can't
4 take a number of studies just as a vote and say
5 something along the lines of more studies show one thing
6 versus another thing because the studies vary in
7 quality, systematically vary in quality. We have to
8 assess them according to their research methods, not
9 according to how many studies found one thing versus how
10 many studies found another thing. As a metaphor, it
11 doesn't matter how many naked eye observations we have
12 once we have a high-powered telescope taking a
13 high-resolution picture.
14 Q. And I think I'm counting six different types of
15 studies in this pyramid. Do I have that right?
16 A. That's in this particular pyramid. Again, I
17 chose it because it didn't enumerate each of the
18 sublayers. There exist many, many more than just six
19 different types of studies. They tend to -- they tend
20 to cluster. And again, this one provided a sufficient
21 level of detail in order to understand the relative
22 qualities of the research studies that have been
23 conducted of the outcomes for transition of minors
24 without going into excessive detail talking about the
25 different kinds of other studies that could have been

1 done but have not been conducted.
2 Q. All right. Thank you. So I also see on the
3 right side of the pyramid is something called unfiltered
4 information and filtered information. Can you explain
5 those?
6 A. Certainly. Unfiltered information are the --
7 I'm sorry. I couldn't see if that meant an objection.
8 I just heard a voice.
9 Q. No. I'm sorry. I don't think there was one.
10 THE COURT: No. It must have just been a
11 little bit of an echo. Sorry about that. Go ahead.
12 A. No problem at all. The unfiltered information
13 are the original actual research studies. In some
14 fields, of course, you know, there are many, many
15 studies with many, many scientists working on them, and
16 they can be producing hundreds of studies, and it's not
17 realistic for somebody to be reading in detail every
18 single one of them. In other fields, they are slow
19 enough and small enough where that is possible.
20 The filtered information is then the
21 systematic method of making sure that somebody has
22 considered all of the relevant original studies. The
23 point of the apex, the systematic review, is to avoid
24 bias when somebody is trying to assess the other
25 studies. Especially in large fields when there are many

1 studies, there are opportunities for bias such as
2 cherry-picking, picking studies that come to one
3 conclusion but avoiding or ignoring the studies that
4 come -- that came to another conclusion. So the
5 filtered information are the systematic ways of making
6 sure that somebody has considered all of the relevant
7 original base unfiltered information.
8 Q. Okay. Let's start at the bottom. What is
9 background information and expert opinion?
10 A. Those would the hunches that the experts have,
11 the ideas, the hypotheses that experts come up with as
12 we're beginning to ask a question about any particular
13 research program. They're valuable because a person can
14 consider other kinds of research, analogous research in
15 related fields that give us an idea of what questions to
16 ask and what we might expect. But that's not yet at all
17 reliable because they're still only hypotheses and
18 guesses. Nobody's yet tested that kind of information.
19 Nobody's yet tried to verify whether those hunches or
20 hypotheses, which are often contradictory -- nobody's
21 yet tried testing if they're correct.
22 Q. Just for clarification, the expert opinion on
23 this chart is different than the expert opinion you're
24 offering now; is that true?
25 A. That is correct. Expert opinion in the legal

1 context is different from expert opinion within the
2 specifically scientific context.
3 Q. All right. So moving up to the next level, I
4 see case series and reports. What are those?
5 A. The case series and reports are generally
6 retrospective. It's when somebody wants an idea of what
7 kind of treatments might produce what kind of outcomes,
8 but it's not yet systematic. These, as I say, are
9 generally retrospective studies where somebody would go
10 through hospital records, for example, pull out cases of
11 specific diagnoses and see what happened amongst those
12 people. It gives -- it can give some idea of what to
13 expect if nothing is done, but because these are not
14 systematic, they're not yet ready for any kind of
15 generalization to other cases. We can't yet know if
16 there's some systematic bias such as people who go to
17 the hospital versus don't go to the hospital, so we have
18 a record of them versus don't have a record of them.
19 Q. Okay. The next level up is called
20 case-controlled studies. What does that signify?
21 A. Case-controlled studies are another type of
22 observational study. It's not an experiment where the
23 scientist has systematically assigned people to groups
24 to see what would happen. These would be people where
25 we get somebody with a particular condition and want to

1 compare them to people without that condition. So we
2 wouldn't be randomly assigning them. We would just be
3 comparing, you know, people, for example, who had smoked
4 with a group of people who have not smoked, but we
5 didn't assign who the smokers were and not. We're just
6 looking for patterns of what happens in different groups
7 of people or what makes different groups of people
8 different from each other. So we would look for -- I
9 guess I'll say the reverse of my prior example, if we
10 looked at people who developed lung cancer and looked
11 for features that they had in common with each other and
12 compared them with people who didn't develop lung cancer
13 and see how they were different from the people who did.
14 Q. Okay. How about cohort studies, the next level
15 up? What are those?
16 A. In cohort studies, we're now checking on a
17 single group of people but over time. We're looking to
18 see what happened, for example, before or after they
19 were exposed to a treatment or exposed to some not just
20 substance. So instead of just taking a look at them at
21 one point in time, we're taking the same group of people
22 and looking at them over several groups of time. So
23 it's another type of observational study that also gives
24 us correlational data but gives us an idea of what
25 changes over whatever period of time the study was.

1 Q. And above that I see randomized controlled
2 tests. What is that?
3 A. The RCTs, that's now -- we've now graduated
4 above the observational studies and now we're talking
5 the actual experimental studies. The experimental
6 studies and the randomized controlled trials are the
7 ones where we take a group of people, randomly assign
8 which ones are going to receive the experimental
9 treatment and which ones are going to receive either no
10 treatment or some other comparison treatment such as
11 treatment as usual, a placebo treatment, or some
12 other -- some other intervention. It's because we have
13 randomly assigned people to which groups they are we are
14 now able to decide -- or now able to conclude whether
15 the treatment we're talking about has caused the actual
16 effect.
17 In observational studies we only get
18 correlational data. We know what clusters with what,
19 but interpreting observational studies is necessarily
20 ambiguous. There's always more than one thing that can
21 explain why a correlation happened.
22 When we're randomizing the groups that
23 people are in in these experimental studies, including
24 the RCTs, we can now conclude that the treatment that we
25 gave is what caused whatever treatments, positive or

1 negative, in those specific people. So this, as I say,
2 is what gives us experimental data. This is the actual
3 test that can tell us -- that can differentiate for us
4 when the treatment is still near the experimental or has
5 been successfully passed by the experimental process.
6 Q. And at the very top -- I think you may have
7 talked a little bit about this already. What are
8 systematic reviews and meta-an -- analys- --
9 meta-analyses?
10 A. Meta-analyses.
11 Q. Sorry.
12 A. No problem at all. That wouldn't be the first
13 time that I too trip over some of the technical words.
14 The systematic reviews are again a way to
15 analyze all of the studies and all of the layers that
16 were beneath it. Again, especially in large fields with
17 many people, there are many, many studies, and
18 especially for very busy clinicians, it's not possible
19 to read and integrate every single one. So the purpose
20 of systematic reviews is to get the big picture of what
21 all of the other studies have shown, but as I say, to do
22 it in a systematic way that removes the potential for
23 bias. The biggest bias, as I mentioned, was
24 cherry-picking where people pick out the positive
25 studies but don't mention the studies where the

1 experiment failed.
2 Similarly, the other big bias that can
3 happen is when somebody looks at only part of a study or
4 only mentions -- holds different studies to a different
5 standard according to whether a person likes the
6 results, that is, holding the bar higher or lower
7 according to whether the conclusion of that study agreed
8 or disagreed with the scientist. So the process of a
9 systematic review is to make sure that all studies are
10 included, not just cherry-picking, and to make sure that
11 all studies are assessed, you know, with the same
12 criteria rather than, as I described, raising and
13 lowering the bar according to whether one likes the
14 studies.
15 The only difference between a systematic
16 review and a meta-analysis is that we would use a
17 meta-analysis when we are looking for a particular
18 number as the outcome, for example, what the optimal
19 dose of a drug might be, and it could be high, it could
20 be low, it could be somewhere in between. And a
21 systematic review is the same basic process, but that's
22 what we use for yes and no kinds of questions, does the
23 treatment work at all or not.
24 Q. And just briefly summarizing this, a systematic
25 review is of higher quality than the studies below it on

1 the chart; is that correct?
2 A. That is correct. It's a study, again, that it
3 doesn't collect its own data; it summarizes and gives us
4 a big picture of what all of the data ever reported has
5 in as unbiased a means as we have available.
6 Q. All right. What are surveys?
7 A. A survey -- and these days surveys are very,
8 very common because it's so easy to conduct a survey,
9 for example, on the Internet. Surveys can, you know,
10 help us give, you know -- help us produce hypotheses,
11 can help give us ideas, but they don't represent
12 evidence at all. Surveys don't appear on the pyramid of
13 evidence at all. As I say, they can give us a good idea
14 of questions to look at, but they don't represent any
15 kind of outcomes evidence.
16 Q. And did you review the declarations submitted
17 by the plaintiffs' experts in this case?
18 A. Yes, I did.
19 Q. Where would you say they fall on the pyramid of
20 evidence?
21 A. There were some mentions of some of the cohort
22 studies that exist, but the great majority of the
23 studies that were referred to were surveys.
24 Q. And surveys are not on the pyramid of evidence;
25 is that true?

1 A. That is correct. They don't count as medical
2 evidence, they don't count as outcome evidence, but the
3 conclusions of the experts depended largely on what
4 doesn't count as evidence. Anybody can take a survey if
5 they want to or not. In many of these surveys, they can
6 take the same survey over and over again. The purpose
7 of everything that's on the pyramid of evidence is that
8 it's systematic. And just a general survey over the
9 Internet of anybody who wants to take it, they have no
10 regular diagnosis, none of the facts on it are checked,
11 just doesn't count as systematic evidence at all.
12 Q. So it has uses, but it's not evidence. Is that
13 a fair -- a fair summary of surveying?
14 A. Yes, it is.
15 Q. And are you aware -- have there been surveys
16 conducted on the safety and efficacy of medical
17 interventions used on minors for the treatment of gender
18 dysphoria?
19 A. There have been claims of safety and
20 effectiveness that are based on -- based on survey --
21 based on surveys, but again, I wouldn't exactly call
22 them evidence because it's so easy for advocates or
23 people with one or another political persuasion to be
24 able to affect a survey. If, for example, one
25 advertised a survey on an Internet site or website or a

1 listserv of people -- a discussion group of a particular
2 mindset or of a particular bent, well, then the results
3 of the survey are going to reflect the people, you know,
4 with that -- with that bias. So if somebody just says
5 that I drank this kind of tea and I felt better
6 afterwards, therefore this tea is the cure for whatever
7 it is the person thought was wrong with them, well,
8 that's good for that person, but that just doesn't count
9 as medical evidence.
10 Q. It could be the start of a process for getting
11 to medical evidence about that, but it's not medical
12 evidence itself; is that true?
13 A. That's correct. If there are large groups of
14 people claiming that a nutritional supplement or a tea
15 or anything else helps them, it's worth investigating.
16 If there are people who tried several different things
17 and started reporting an effect, it's worth then
18 subjecting to systematic scrutiny, but it by itself
19 doesn't consist of a systematic piece of evidence.
20 Q. Let's move up the pyramid. Have there been any
21 case series and reports conducted on the safety and
22 efficacy of medical interventions used on minors for the
23 treatment of gender dysphoria?
24 A. Yes, there have been a handful published over
25 the years. But again, they generally came out with

1 ambiguous -- with ambiguous results but results that,
2 again, suggested that it was at least worth looking at
3 more systematically.
4 Q. Okay. Same question for case-controlled
5 studies. Have there been any case-controlled studies
6 conducted on the safety and efficacy of medical
7 intervention used on minors for the treatment of gender
8 dysphoria?
9 A. I am aware of one where people undergoing
10 transition were compared to people who didn't qualify
11 undergoing medical transition. That was a particularly
12 low-quality study because we can't tell, you know, what
13 changes, you know, what improvements and, you know, what
14 got worse amongst these people. We can't tell what was
15 attributable to the treatment itself and what's
16 attributable to the fact that the comparison group were
17 people who didn't qualify for transition. They were in
18 a poor mental health status to begin with.
19 THE COURT: Ms. Dyer, can you stop your
20 share screen? I just want to be able to see it larger.
21 Thank you. Sorry about that.
22 MR. ELDRED: No problem, Judge.
23 Q. (BY MR. ELDRED) The next level up is cohort
24 studies. Have there been any cohort studies conducted
25 on the safety and efficacy of medical interventions to

1 minors for the treatment of gender dysphoria?
2 A. Yes. There have been exactly 13, and these are
3 the 13 that I summarize in my own report. This is the
4 highest level study that so far has been conducted at
5 all for the medical transition of minors.
6 Q. And what's your summary of the 13?
7 A. There have been --
8 MR. GONZALEZ-PAGAN: Objection, calls
9 for --
10 A. -- roughly three clusters --
11 THE COURT: Hold on.
12 A. -- of results.
13 THE COURT: Hold on, Dr. Cantor.
14 A. There have been roughly four studies --
15 THE COURT: Hold on, Dr. Cantor. Hold on.
16 Hold on. What's the objection for the record?
17 MR. GONZALEZ-PAGAN: Objection,
18 Your Honor, calls for a narrative.
19 THE COURT: Well, let's go to a question.
20 I guess it does call for a narrative, Mr. Eldred. If
21 you can just rephrase and have him break it down.
22 MR. ELDRED: Sure.
23 Q. (BY MR. ELDRED) Can you break down what the 13
24 cohort studies showed about the safety and efficacy of
25 medical interventions used on minors for the treatment

1 of gender dysphoria?
2 A. Certainly. I outline such a breakdown as I
3 describe them in my report. There were four of them
4 which showed essentially no improvement at all. The
5 medical transition did not demonstrate any benefits to
6 the mental health status of the kids.
7 In another group, roughly half of the
8 studies, roughly six of them, there were some
9 improvements in some mental health parameters, but we
10 can't conclude that it was the intervention, that it was
11 the medical interventions itself that caused the
12 improvement because the people were getting
13 psychotherapy at the same time. That's what we call a
14 confound, because they were getting two kinds of
15 treatments, both medical treatment and mental health
16 treatment, at the same time. For the people who showed
17 benefits, we don't know if it was the medicalized
18 transition that caused the benefit or if it was that
19 they were in psychotherapy that produced the mental
20 health benefit.
21 And then there were two studies which were
22 designed in a way that allowed more direct comparison
23 trying to allocate how much of the improvement was due
24 to the medical interventions versus how much of the
25 improvement was due to the mental health interventions.

1 And both of those demonstrate -- and both of those
2 failed to demonstrate that the medical interventions
3 produced any more benefit than did the mental health --
4 the psychotherapeutic interventions.
5 Q. And are there any randomized --
6 A. Oh, I'm sorry. I left one out. And there was
7 one other very recent study that just did not indicate
8 whether the people were in psychotherapy at the same
9 time, so the results -- we can't assess whether the
10 medical interventions were superior because we don't
11 know how many were getting psychotherapy at the same
12 time.
13 Q. Thank you. Are there any randomized controlled
14 trials -- I'm sorry -- randomized controlled studies
15 conducted on the safety and efficacy of medical
16 intervention used on minors for the treatment of gender
17 dysphoria?
18 A. No. It's never been tried yet.
19 Q. Same question for systematic reviews.
20 A. There have now been several systematic reviews,
21 none conducted in the U.S. They've all been conducted
22 by the national public healthcare systems in Europe.
23 Q. And what do those --
24 A. I'm sorry. Again --
25 Q. Go ahead.

1 A. They've all been conducted by the national
2 healthcare systems in Europe, but they have not yet been
3 conducted by any groups in the U.S.
4 Q. And what do they show?
5 A. They all showed exactly the same thing, which,
6 again, is the purpose of a systematic review. The idea
7 of doing it systematically is that anybody engaging in
8 such a review should come out with the same result, and
9 these did. And they said essentially what I just did,
10 that there is no evidence to suggest that medicalized
11 interventions provides any benefits superior to the
12 mental health interventions.
13 Q. All right. I want to switch topics a little
14 bit. Oh, sorry. So can you summarize what the studies
15 show about the safety and efficacy of medical
16 interventions used on minors for the treatment of gender
17 dysphoria?
18 A. The safety issues are the well-reported -- are
19 relatively well-reported because they're objective and
20 they're physical. For example, one of the largest
21 downsides, one of the largest risks of medical
22 intervention is the sterility of the child. When a
23 child is subjected to puberty-suppressing drugs, what we
24 used to call chemical castration, when they go from a
25 pre-pubescent physical state and are then exposed to

1 cross-sex hormones, they are sterilized. That is,
2 of course, you know, the -- I hate to call it a risk to
3 safety because the outcomes are so definite. And the
4 others include problems in bone development, bone
5 health, as well as --
6 MR. GONZALEZ-PAGAN: Your Honor --
7 A. -- there are some indications of --
8 MR. GONZALEZ-PAGAN: -- I'm going to
9 object at this point.
10 A. -- changes in development.
11 THE COURT: Okay. Hold on.
12 A. It's because we have --
13 THE COURT: Hold on, Dr. Cantor.
14 MR. GONZALEZ-PAGAN: This is beyond the
15 scope. He is now talking about risks and benefits of
16 treatment, and he's here to talk about just --
17 THE COURT: We need to --
18 MR. GONZALEZ-PAGAN: -- the research.
19 THE COURT: We need to stick to the
20 systematic review.
21 Q. (BY MR. ELDRED) And I may have asked the
22 question poorly, Your Honor -- Doctor. Based on the
23 research that you've looked at, can you summarize any
24 conclusions about the safety and efficacy of medical
25 interventions used on minors for the treatment of gender

1 dysphoria?
2 A. Each of the systematic reviews came to the same
3 conclusion, that the evidence for benefits are
4 outweighed by the evidence of the risks of harm.
5 Q. Did McMaster University in Canada do a
6 systematic review?
7 A. I'm aware of some people from McMaster
8 University having conducted one at the request of a
9 hearing in Florida. I was tangentially involved, and I
10 also submitted a report at that same hearing, but I
11 wasn't otherwise involved in the rest of the hearing or
12 in that review. McMaster University itself is
13 significant because it is essentially home to
14 evidence-based medicine and the process for conducting
15 systematic reviews.
16 Q. All right. I'd like to move on to another
17 topic. According to the research that you reviewed, are
18 there different types of gender dysphoria?
19 A. Yes, there are.
20 Q. What are those types?
21 A. It's been well known really for almost -- over
22 a century at this point that more than one thing can
23 lead a person to feeling gender dysphoric. It's not
24 simply a -- it's unlike sexual orientation where
25 somebody is just attracted to men or women and the

1 subtypes are just different ways in which a person likes
2 to have sex.
3 Gender dysphoria is a symptom, and it can
4 result from any -- more than one different situations.
5 The best metaphor I have would be if somebody comes
6 in -- a patient comes in complaining of a headache. We
7 don't immediately diagnose the person with headache
8 disorder and send them to headache treatment. We find
9 out what causes the headache. It could be a migraine.
10 It could be a head injury. It could be an aneurysm. It
11 could be a brain tumor. What we do is according to what
12 causes the symptom we're observing.
13 With gender dysphoria, the major types
14 that have been well known for decades are -- we nickname
15 according to -- we nickname them or we classify them
16 according to when in life they kick in, either a
17 childhood onset gender dysphoria or adult onset gender
18 dysphoria.
19 The adult onset gender dysphoria almost
20 always are in men. There are virtually no cases of
21 biological females reporting adult onset gender
22 dysphoria. These are men who are attracted to women.
23 They refer to themselves as heterosexual. They're
24 unremarkable and fade into the background. They seem
25 heterosexual. But usually by middle age, you know,

1 they've decided that they've lived a heterosexual life
2 and that it's just not working for them. They
3 experience a sexual interest pattern that we call
4 autoandrophilia where they actually experience sexual
5 arousal to the image of themselves as female. For some
6 people it's just a kink and part of their sex life and
7 they're perfectly happy and healthy that way, but for
8 some people, just cross-dressing, just looking female in
9 the mirror isn't enough and they actually want to live
10 their life 24/7 as female. And the research shows if
11 they're otherwise mentally healthy, they do perfectly
12 fine having transitioned.
13 Q. I'm going to cut you off because this case is
14 about minors. So can you talk about --
15 A. And that's -- yeah. That's the other type.
16 Q. Yes.
17 A. I detail the adults really in order to
18 demonstrate the level of contrast between the two.
19 Q. Okay.
20 A. The childhood onset are kids who feel like
21 they're the opposite sex pretty much from the get-go.
22 They start reporting it prepubertally really since
23 childhood. The majority are still biologically male,
24 roughly three-quartersish, but there is a substantial
25 portion of them who are biologically female.

1 In those cohort studies -- there have been
2 11 of them -- the majority of them, you know,
3 three-quarters of them, 80 percent of them, stop feeling
4 gender dysphoric by puberty. Instead, when puberty
5 kicks in and they start experiencing sexual arousal and
6 sexual interest patterns, they realize instead they were
7 gay or lesbian. They were either effeminate boys. They
8 were tomboyish girls. But when puberty hits and they
9 start developing attractions and developing crushes on
10 other people, they realize that what made them feel like
11 not a regular boy or not a regular girl was just an
12 early manifestation of what will be their sexual --
13 their sexual orientation. In a minority of them, as I
14 say, roughly 20 percent, the feeling of gender dysphoria
15 does not go away.
16 Since -- in the past ten years or so,
17 really coinciding almost identically with the advent of
18 social media, a third group has started coming to
19 clinics, and these are completely unlike either of the
20 first two clinics. They do not report childhood gender
21 dysphoria like the childhood onset types. They're
22 majority female, and they have a completely different
23 mental health pattern, again, unlike the other two
24 groups. This is the group who now is the large, large
25 majority of people coming into clinics saying that they

1 feel unhappy with their gender and want to live in some
2 other way. Also unlike the other two types, they're
3 very frequently picking some neologism or some ambiguous
4 status such as being fluid or non-binary, unlike the
5 other two groups.
6 So where we have outcome studies on the
7 childhood onset type and we have outcome studies on the
8 adult onset type, we have absolutely no data, we have no
9 outcome studies on this -- what I'll call the adolescent
10 onset type even though they are now suddenly the large
11 majority of people coming into clinics.
12 Q. All right. Thank you. What is -- what does
13 desist mean in this field?
14 A. We use that word to refer -- originally we used
15 that word to refer to the child onset cases who ceased
16 to feel gender dysphoric over the course of puberty. As
17 I said, the majority of them, 80 percentish, cease to
18 feel gender dysphoric. We refer to them as the
19 desisters. And the minority of them who continued to
20 feel gender dysphoric during and after puberty we refer
21 to as the persisters.
22 Q. Does desist have a meaning with adolescent
23 onset -- I'm trying to -- adolescent onset gender
24 dysphoria?
25 A. Gender dysphoria. It seems to, but it's much

1 more ambiguous. As I say, we don't have any systematic
2 studies following up the adolescent onset type, so it's
3 tough to tell.
4 The cases that have come to attention are
5 the people -- the adolescent onset cases who have
6 started medicalized transition realized or decided that
7 it was a mistake and so they stopped or tried to reverse
8 the medicalized procedures they underwent. It's
9 perfectly reasonable to refer to them as desisters
10 because they're reporting that they no longer feel
11 gender dysphoric. The other term that is used very
12 commonly with them are detransitioners. Some people,
13 you know, choose one term or the other because sometimes
14 it's just the feelings that change, and for some people
15 there's been a medical process that they're trying to
16 reverse. And people use those words sometimes very
17 ambiguously, and it's tough to tell who should really be
18 called a desister --
19 MR. GONZALEZ-PAGAN: Your Honor --
20 A. -- versus who should be called a
21 detransitioner, but both are definitely on the table and
22 both are in play.
23 MR. ELDRED: Stop for a second.
24 THE COURT: Hold on.
25 MR. GONZALEZ-PAGAN: Your Honor, at this

1 point I would object to this line of inquiry. It is
2 beyond the scope of what he was qualified for. He was
3 qualified to speak about the research regarding the
4 safety and efficacy of the treatment of gender
5 dysphoria.
6 THE COURT: Treatment of gender dysphoria
7 in minors. Scientific research related to treatment of
8 gender dysphoria of minors. And --
9 MR. GONZALEZ-PAGAN: He's now speaking
10 about different types of gender dysphoria, the
11 desistance and what is desistance. This is beyond
12 safety and efficacy of treatment.
13 THE COURT: Well, but safety and efficacy
14 wasn't the specific --
15 MR. GONZALEZ-PAGAN: It's beyond the word
16 treatment.
17 THE COURT: Well, I'm going to overrule
18 the objection. I think -- but ask him a next question,
19 Mr. Eldred.
20 MR. ELDRED: We're almost done with this
21 topic.
22 THE COURT: Okay.
23 MR. ELDRED: And I'll try to ask the
24 questions better.
25 Q. (BY MR. ELDRED) What's the scientific research

1 say about the predictability of who will detransition or
2 desist?
3 A. That we can't do it with any kind of accuracy.
4 Several studies have attempted to, but other than some
5 small correlations, nobody's yet been able to identify a
6 reliable method of which people will persist and which
7 people will desist.
8 Q. Okay. Some of these studies about gender
9 dysphoria, do any of them talk about suicide and
10 suicidality?
11 A. Yes. That's been attempted to be measured in
12 very many of these studies, again, primarily the survey
13 studies.
14 Q. What's the difference --
15 A. The --
16 Q. -- between the two --
17 THE REPORTER: I couldn't hear.
18 A. The common misunderstanding --
19 THE COURT: Hold on. Hold on. Hold on,
20 Dr. Cantor. We're talking over each other.
21 Mr. Eldred, if you'll go ahead and restate
22 your question.
23 Q. (BY MR. ELDRED) Yeah. I'm sorry. I tried to
24 cut you off on Zoom, which is sometimes hard to do.
25 What's the difference between --

1 A. I can see the waving, but the picture I'm
2 seeing everybody in is small.
3 Q. Yeah. I'm sorry. When I wave my hand, I'm
4 trying to get you to stop.
5 What's the difference between suicide and
6 suicidality?
7 MR. GONZALEZ-PAGAN: Objection,
8 Your Honor, beyond the scope.
9 THE COURT: Well, I think the question was
10 what the research indicated with respect to suicide and
11 suicidality, but I guess if you'll phrase a next
12 question.
13 MR. ELDRED: Sure.
14 Q. (BY MR. ELDRED) From your research of -- you
15 already said that some of the research discusses suicide
16 and suicidality. Is that true?
17 A. That is correct.
18 Q. And what does the research say about the
19 difference between those two terms?
20 A. They are independent phenomena. Suicidality
21 is -- suicide refers to actual death and an actual
22 intent to die. The great majority -- this is well known
23 in psychology. The great majority of suicides are
24 impulsive, mostly in biological males, and mostly
25 middle-aged. Suicidality --

1 MR. GONZALEZ-PAGAN: Your Honor --
2 A. -- refers to suicidal ideation --
3 MR. GONZALEZ-PAGAN: -- again, beyond the
4 scope.
5 THE COURT: Hold on. Hold on. State your
6 objection.
7 MR. GONZALEZ-PAGAN: He's speaking now
8 about research about middle-aged men and suicidality.
9 THE COURT: I agree, it's probably a
10 little bit more than we need, but I'm going to overrule
11 the objection. And just try and ask a more specific
12 question, Mr. Eldred.
13 Q. (BY MR. ELDRED) Okay. What is suicidality
14 related to gender dysphoria in minors?
15 A. Suicidality --
16 Q. According to scientific research -- I
17 apologize.
18 THE REPORTER: I didn't hear the end.
19 A. Suicidality, unlike suicide, is --
20 THE COURT: Hold on. Sorry, Dr. Cantor.
21 THE WITNESS: That's no problem.
22 THE REPORTER: Start over.
23 MR. ELDRED: It's my fault. I've been
24 stopping and starting. I will try to ask the question
25 again.

1 Q. (BY MR. ELDRED) The scientific research that
2 you've described and study about gender dysphoria, as
3 you stated, discusses suicidality. And what does it say
4 about suicidality, what it is, and what else does it say
5 about it?
6 A. The studies have pertained to suicidality and
7 not suicide. It would be a mistake to generalize the
8 studies that have been conducted to say something about
9 suicide. They don't. They refer to people with, for
10 example, suicide ide- -- suicidal ideation. Suicidality
11 is not just a -- is not a preliminary form of suicide.
12 It's generally a sign of psychological distress and a
13 cry for help. That's been widely studied and widely
14 reported amongst minors, especially the adolescent onset
15 gender dysphoria, but it does not pose the great
16 potential for death the way that it's often discussed in
17 the media. It's a serious condition and it merits
18 mental health treatment, but it is not the -- it does
19 not imply if you don't give the person what they're
20 asking for they will kill themselves. That's not shown
21 by the research. As I say, it's a sign and it's an
22 indicator of profound and substantial psychological
23 distress, but the -- but it indicates that the person is
24 in need of psychotherapy for dealing with that distress
25 itself.

1 MR. ELDRED: Judge, may I have one moment
2 to consult with my co-counsel?
3 THE COURT: Certainly.
4 MR. ELDRED: All right, Judge. We're
5 ready for some more questions.
6 THE COURT: Go ahead.
7 Q. (BY MR. ELDRED) I'm going to switch gears a
8 little bit. From your knowledge of studying standards
9 of evidence and methodologies, what is an established
10 treatment?
11 A. That's a good question. It's really -- that
12 would be more of a subjective account of the
13 particular --
14 MR. GONZALEZ-PAGAN: Objection,
15 Your Honor. Dr. Cantor --
16 A. -- scientists that --
17 THE COURT: Hold on. Hold on, Dr. Cantor.
18 What's the objection?
19 MR. GONZALEZ-PAGAN: Again, beyond the
20 scope. This is beyond the scope of speaking to
21 treatment of gender dysphoria in minors. He's now
22 speaking to standard of care and how to establish one.
23 THE COURT: If you can ask a more specific
24 question, Mr. Eldred.
25 MR. ELDRED: Sure. I'll try.

1 Q. (BY MR. ELDRED) In the research you've been
2 talking about, do they -- do the studies talk about
3 established treatment of gender dysphoria in minors?
4 A. The studies themselves don't determine what's
5 established versus not. Whether a study is established
6 usually would be handled subjectively by a committee
7 that's evaluating the entire body of research, including
8 its safety and its efficacy.
9 Q. And the same question: Do these studies talk
10 about experimental treatments of gender dysphoria in
11 minors?
12 A. They would if any existed, but there have not
13 yet been any studies of the RCT or at the experimental
14 level.
15 Q. Is medical intervention for the treatment of
16 dysphoria in minors an experimental treatment?
17 A. Yes, it is. It has not yet been tested with
18 experimental studies, so it's necessarily still within
19 the experimental status.
20 Q. All right. We're almost done. Have you
21 assessed the clinical guidelines put out by WPATH?
22 A. Yes, I have.
23 MR. GONZALEZ-PAGAN: Objection,
24 Your Honor. He's speaking to the research, not to the
25 standard of care guidelines.

1 THE COURT: A response?
2 MR. ELDRED: Judge, I'll try to ask a
3 better question.
4 THE COURT: Okay.
5 MR. ELDRED: One moment, please. Sorry.
6 THE COURT: No worries.
7 MR. ELDRED: Thank you.
8 Q. (BY MR. ELDRED) Do the research studies that
9 you have looked at and have been talking about, do they
10 study -- do they support the conclusions reached by
11 WPATH about the treatment of gender dysphoria in minors?
12 A. When taken as a whole, no, they do not. The
13 contents of the WPATH guidelines engaged very much in
14 the cherry-picking that the systematic review process
15 was designed to prevent.
16 Q. How about the same question for the Endocrine
17 Society?
18 A. Similarly. The Endocrine Society conducted --
19 I hesitate to call it a systematic review. The review
20 consisted of exactly one study, and the study that they
21 reviewed was not at all about the safety of puberty
22 blockers.
23 MR. ELDRED: And I will pass the witness.
24 THE COURT: All right. Given the time,
25 I'm going to go ahead and take our lunch break at this

1 point, and we can expect to return at 1:30. Dr. Cantor,
2 we'll be on break for about an hour and a half, just
3 over that, so you're welcome to -- I'd probably stay
4 signed into the Zoom, maybe just turn off your camera
5 and your microphone during our lunch break.
6 THE WITNESS: Oh, I'm sorry. I forgot the
7 time zone. You said 1:30, so to me that'll be 2:30.
8 THE COURT: I believe so. I'm not sure
9 exactly where you are.
10 THE WITNESS: I'm sorry. I'm in Toronto,
11 which is Eastern Standard Time.
12 THE COURT: So about an hour and a half.
13 THE WITNESS: Yep.
14 THE COURT: All right.
15 MR. STONE: I just wanted to check that
16 Dr. Cantor would be available. When we talked to him
17 earlier, we thought that we'd be done by lunch.
18 Dr. Cantor, will you still -- will you be able to come
19 back?
20 THE WITNESS: Yes.
21 MR. GONZALEZ-PAGAN: Well --
22 THE COURT: Yeah, he kind of has to.
23 Sorry. Sorry. So yes, so we'll be on break until 1:30.
24 And again, you're welcome to turn off your microphone
25 and your camera during that time, okay?

1 THE WITNESS: Understood.
2 THE COURT: Thank you. All right. We're
3 excused for lunch. I'll be back at 1:30. Thank you.
4 *(Lunch recess taken)*
5 THE COURT: Dr. Cantor, are you ready to
6 proceed?
7 THE WITNESS: Yes, I am.
8 THE COURT: All right. To the extent we
9 have anybody new in the gallery, just a reminder no
10 recording, broadcasting, or any photography.
11 And so, Mr. Gonzalez-Pagan, it's your
12 turn.
13 MR. GONZALEZ-PAGAN: Thank you,
14 Your Honor. And if it's okay, I'll move over there.
15 THE COURT: Yes. That'll be fine. And
16 actually, let me -- well, I think he can still see you
17 on that camera.
18 MR. GONZALEZ-PAGAN: I'm in the corner.
19 THE COURT: All right. Go ahead.
20 **CROSS-EXAMINATION**
21 BY MR. GONZALEZ-PAGAN:
22 Q. Good afternoon, Dr. Cantor.
23 A. Good afternoon.
24 Q. Dr. Cantor, you have never diagnosed a child or
25 adolescent with gender dysphoria; is that correct?

1 A. Not child, but adolescents, yes.
2 Q. You testified at a hearing in Alabama; is that
3 right?
4 A. That's correct.
5 Q. At that hearing you testified -- when asked
6 have you -- you have never diagnosed a child or an
7 adolescent with gender dysphoria, you said no.
8 A. I don't recall the question specifically, but
9 what I'm pointing out is the distinction between child,
10 meaning prepubescent, versus adolescent teenager,
11 teenagehood. As I said, my license permits a diagnosis
12 of ages 16 and up. I don't remember the context around
13 that particular question.
14 Q. That's all right.
15 A. If they --
16 Q. There's no need to -- I have limited time, so I
17 appreciate the answer.
18 So then you would -- you would agree then
19 that you have never treated or diagnosed a child or
20 adolescent under 16 for gender dysphoria?
21 A. Correct.
22 Q. In your testimony earlier today, you discuss
23 instances in which you have purportedly served as an
24 expert; is that right?
25 A. Correct.

1 Q. You have never testified in a trial relating to
2 the treatment of gender dysphoria in minors; is that
3 correct?
4 A. I don't believe any of those cases have yet
5 gotten to the trial phase. The most advanced would be
6 the --
7 Q. A simple no is fine. You have testified at
8 only three hearings, one in Alabama, one in Georgia last
9 week, and one in Texas last year; is that right?
10 A. I would have to check my notes to be sure, but
11 that sounds about right.
12 Q. And the Court in Alabama found that your
13 testimony should be given very little weight; is that
14 correct?
15 A. I don't remember the details of the finding. I
16 think I was the only expert actually mentioned at all.
17 I can't speak to the judge's frame of mind, but it was
18 essentially me versus the entire medical establishment,
19 and the judge's comments were why he -- he needed to say
20 something about me in order to say why he was finding
21 essentially for the medical establishment. I don't
22 believe he said anything specifically about my
23 credibility.
24 Q. Understood. Notwithstanding your interest and
25 concern relating to medical treatment for gender

1 dysphoria in minors, you have not sought to conduct any
2 original research in this area; is that correct?
3 A. I haven't -- not in the sense that I collected
4 data on them directly, that's correct.
5 Q. And you have not sought to conduct and publish
6 a systematic review of the evidence pertaining to the
7 treatment of gender dysphoria; is that right?
8 A. Almost. What I have done -- not systematically
9 in the sense of a systematic review, but what I have
10 done exhaustively is to evaluate, for example, the --
11 Q. I understand, Dr. Cantor.
12 A. -- American Academy --
13 Q. I just want to speak to the question that's
14 asked.
15 MR. ELDRED: Objection.
16 THE COURT: Yeah, hold on. Hold on.
17 First of all, let's not talk over each other. And so I
18 think that if you can finish -- I'm going to let him
19 finish this specific answer, Mr. Gonzalez-Pagan, and
20 then we'll go from there.
21 But you were -- finish, Dr. Cantor.
22 A. But I do compare the contents, for example, the
23 policy of the American Academy of Pediatrics conducting
24 a peer-reviewed facts check of its claims against the
25 scientific literature.

1 Q. (BY MR. GONZALEZ-PAGAN) But you have not
2 yourself published a systematic review of the evidence;
3 is that correct?
4 A. That's correct.
5 Q. You pointed to the limitations of some of the
6 studies pertaining to the treatment of gender dysphoria
7 in adolescents in your testimony. Do you recall that?
8 A. Yes, I do.
9 Q. You would agree that every study has
10 limitations; right?
11 A. That's correct.
12 Q. None of the studies you discussed concluded or
13 showed that the provision of puberty blockers or hormone
14 therapy to treat gender dysphoria in adolescents is
15 harmful; is that correct?
16 A. No, I couldn't say that's correct. Many of the
17 studies, as I said, do point out the downsides, the
18 changes in bone density and so on and other objective
19 variables. What's questionable or what's -- what's
20 usually in debate is whether there's sufficient
21 documentation or objective documentation of benefit in
22 order to make those objectively shown harms worth it.
23 Q. Understood. I'm asking about the studies'
24 conclusions. None of them concluded that the provision
25 of medical treatment for gender dysphoria in adolescents

1 is harmful. Yes or no?
2 A. No, they -- they did conclude -- the ones that
3 were investigating safety of such -- certain blood
4 parameters, bone density, did denote the changes
5 themselves -- did denote the changes. They tend not to
6 make the subjective assessment that the, you know,
7 decrease in bone density is itself harmful. You know,
8 that's usually done by the candidates which then
9 interpret the evidence. The job of the study itself is
10 just to document changes in -- the example I'm using is
11 bone density.
12 Q. Sure. Studies have a discussion and a
13 conclusion usually when they're in peer-reviewed
14 literature; is that right?
15 A. Yes. That's the standard format.
16 Q. Okay. So my question is about the conclusion.
17 Did any of them conclude that the provision of
18 gender-affirming medical treatment for gender dysphoria
19 in minors is harmful?
20 A. Yes, I would say that that's a fair assessment,
21 they do conclude that.
22 Q. Which study concluded that?
23 A. Oh, goodness. I couldn't give the names of the
24 studies offhand, but I did include in my report, as I
25 said, summaries of exactly what they did say, the

1 systematic reviews that covered them -- the systematic
2 reviews that covered them, which in turn cited them, but
3 I couldn't tell you by name. I couldn't cite the study
4 off the top of my head -- such studies off the top of my
5 head.
6 Q. Isn't it true actually that all of the studies
7 concluded in some form that the provision of
8 gender-affirming medical treatment showed beneficial or
9 positive effects for the adolescents treated?
10 A. Those were different studies. Some of the
11 studies, as I say, were investigating the harms with
12 regard to specific physical parameters, and other
13 studies -- other studies tried looking at the benefits,
14 usually the mental health benefits. And the ones that
15 looked at harms, again, the objective physiological
16 parameters were indeed able to document the decreases in
17 physical health, and it's the studies that were trying
18 to look for potential benefits that were looking -- the
19 mental health parameters, which some claimed and some
20 did not claim that there were benefits. So I'm not --
21 as I say, I'm not exactly sure which study you're
22 referring to. The studies of harms are usually distinct
23 from the studies of benefits.
24 Q. Sure. Dr. Cantor, I'm asking about what
25 studies you're referring to because you never mentioned

1 any particular study, so I'm asking.
2 A. No, I cited the studies quite thoroughly in my
3 report. I'm just pointing out that I can't recall their
4 names off the top of my head. If you're asking me to
5 refer to my report to name them, I can do that.
6 Q. Sure. The cohort studies that you discussed
7 pertaining to the mental health benefits for seeking to
8 assess mental health benefits or efficacy of the
9 provision of medical treatment for gender dysphoria in
10 adolescents, these studies fall within the middle of the
11 so-called ubiquitous pyramid of evidence that you
12 discussed; is that right?
13 A. Yes. They're cohort studies.
14 Q. Is it your testimony that cross-sectional
15 peer-reviewed studies based on survey data are not valid
16 forms of evidence?
17 A. Not for outcomes of interventions, no.
18 Q. Dr. Cantor, you support the provision of
19 medical treatment for gender dysphoria in adults; is
20 that correct?
21 A. That is correct.
22 Q. The evidence pertaining to the provision of
23 medical treatment for gender dysphoria in adults is of
24 the same kind and level of evidence pertaining to the
25 provision of medical treatment for gender dysphoria in

1 adolescents; is that right?
2 A. It's of the same kind, but when the
3 interventions are aimed at an adult body, the risks are
4 lower.
5 Q. You do not dispute that there are medical
6 treatments that are provided to adolescents for which
7 there are no randomized controlled trials?
8 A. Such -- such interventions exist, yes. Again,
9 the basic decision-making process is risk to benefit.
10 So when there is a low-risk intervention, then we --
11 then it's permissible or it's legitimate to employ only
12 low-quality evidence of benefit. But when it's a high
13 risk of harm, such as sterilizing --
14 Q. Dr. Cantor --
15 A. -- a child --
16 THE COURT: Hold on.
17 MR. GONZALEZ-PAGAN: I'm on limited time.
18 I'm going to object --
19 THE COURT: Yeah. So Dr. Cantor, your
20 attorney will have a chance to ask things in more
21 detail, so if you could just stick to what
22 Mr. Gonzalez-Pagan -- they're worried about time. They
23 only have a certain amount of time, each side. So if
24 you can concentrate on just his question and answer
25 that.

1 THE WITNESS: I understand.
2 Q. (BY MR. GONZALEZ-PAGAN) Dr. Cantor, you have
3 testified that there is no study showing that
4 psychotherapy alone can resolve an adolescent's gender
5 dysphoria; is that right?
6 A. It depends on what somebody means by resolve.
7 Q. You testified here in Texas last year on this
8 very question I asked of you -- you have testified that
9 there is no -- I asked you: Are there any studies
10 showing that psychotherapy alone can resolve an
11 adolescent's gender dysphoria? Is that correct? And
12 you said that's correct. Do you recall that?
13 A. I can't say that I do in the sense that --
14 again, I'd need to know the context of the questions
15 around it. It's true in the sense that the person
16 doesn't -- a person who is genuinely gender dysphoric
17 doesn't cease to feel dysphoric. What usually can
18 happen is the person's distress which they are mistaking
19 to be gender dysphoria a person can come to realize
20 wasn't gender dysphoria to begin with.
21 Q. Dr. Cantor, you would agree that the
22 peer-reviewed process is an integral part of scientific
23 research; right?
24 A. Yes, that's fair.
25 Q. You discussed some purported systematic reviews

1 earlier today. Do you recall that?
2 A. Yes, I do.
3 Q. With the exception of a paper from Finland,
4 none of the purported systematic reviews that you
5 discussed have been subjected to the readers of external
6 peer review or been published in a peer-reviewed
7 scientific journal; is that right?
8 A. A systematic review conducted by the healthcare
9 system of a government typically does not. It's a
10 different means of assessing -- of assessing the
11 literature. For example, if the --
12 Q. So is that a no?
13 A. -- NIH was to --
14 Q. Dr. Cantor, were they --
15 A. Understood.
16 Q. Were they submitted to external peer review?
17 Yes or no?
18 A. So far as I know, it was the Swedish study that
19 was, the Ludvigsson.
20 Q. So just the Swedish study?
21 A. That's my recollection, yes.
22 Q. Counsel for defendants made reference to a
23 purported systematic review from McMaster University in
24 Canada. Do you recall that?
25 A. Yes, I do.

1 Q. This review was commissioned by the
2 administration of Governor DeSantis in Florida in
3 support of the rule prohibiting coverage for medical
4 treatment --
5 THE REPORTER: Can you start over, please?
6 THE COURT: Whoa, too fast.
7 MR. GONZALEZ-PAGAN: I apologize. That
8 was very fast.
9 THE COURT: Slow down.
10 MR. GONZALEZ-PAGAN: That's on me.
11 Q. (BY MR. GONZALEZ-PAGAN) Dr. Cantor, I'm going
12 to slow down for the court reporter before I get thrown
13 out of here.
14 A. I'm from New York. I have the same problem.
15 Q. This review was commissioned by the
16 administration of Governor DeSantis in Florida in
17 support of their rule prohibiting coverage for medical
18 treatment for gender dysphoria. Is that correct?
19 A. That's my understanding of it, yes.
20 Q. And you testified that you submitted a
21 declaration in relation to this matter?
22 A. To the general matter, not to that specific
23 review, yes.
24 Q. That rule was recently found to be
25 unconstitutional; is that right?

1 A. I -- that's a good question. I don't follow
2 each state's individual policy, but I seem to recall
3 such a thing being reported in the media.
4 Q. That review has never been submitted to
5 external peer review; is that right?
6 A. Not that I know of, no.
7 Q. And it has never been published in a scientific
8 or medical journal; is that right?
9 A. So far as I know, it hasn't.
10 Q. You said that systematic reviews account for
11 all the evidence. Do you recall that?
12 A. When properly conducted, that's their purpose,
13 yes.
14 Q. But systematic reviews are conducted and
15 authored by people who establish criteria of what
16 studies qualify for the review or not. Is that not
17 correct?
18 A. That is correct. The proper procedure would be
19 to register what those criteria are before conducting
20 the review itself.
21 Q. So none of the systematic reviews that you
22 discussed actually account for all the peer-reviewed
23 studies regardless of design pertaining to the medical
24 treatment for gender dysphoria. Would you agree with
25 that?

1 A. Sort of. Again, the criteria were to select
2 the best and most relevant ones and to take out the ones
3 that were irrelevant because, following the metaphor I
4 used before, once you have the results of the telescope,
5 there is no point to including the naked eye
6 observations.
7 Q. Understood. You mentioned that gender
8 dysphoria is a symptom. Do you recall that?
9 A. Yes.
10 Q. Gender dysphoria is a diagnosis under the
11 DSM-V; is that correct?
12 A. That's correct.
13 Q. There are two and only two diagnoses for gender
14 dysphoria under the DSM-V, gender dysphoria in children
15 and gender dysphoria in adolescents and adults; is that
16 right?
17 A. Yes, that's correct.
18 Q. In discussing the alleged types of gender
19 dysphoria, you mentioned adolescent onset gender
20 dysphoria as a third type; is that right?
21 A. That is correct.
22 Q. In support for your opinion in your
23 declaration, you have cited to an article by Lisa
24 Littman based on survey data; is that correct?
25 A. That is correct.

1 Q. This is the same kind of survey data that you
2 said earlier is not evidence; is that correct?
3 A. Not evidence of medical outcomes. It's
4 evidence of what features cluster together with what
5 features.
6 Q. Is there any case-controlled study, cohort
7 study, randomized controlled study, or systematic review
8 that you can cite as evidence for this so-called third
9 type of gender dysphoria?
10 A. There's -- there can't be. Again, for
11 diagnosis, that's about clustering, what features go
12 together with what features. The randomized clinical
13 trials and so on are to test the outcomes of a
14 particular intervention. We would use one set of
15 methodology to answer one kind of question and the other
16 set of methodology to answer the other kind of question.
17 Q. Dr. Cantor, you discussed some studies
18 pertaining to desistance. Do you recall that?
19 A. Yes, I do.
20 Q. In these studies that followed prepubertal
21 children that you discussed in relation to desistance
22 rates, none of the subjects of those studies were
23 diagnosed with gender dysphoria under the DSM-V; is that
24 right?
25 A. Correct. They were conducted before the DSM-V,

1 and they are part of the data on which the DSM-V was
2 based. It's -- the research literature is necessarily
3 one step ahead of the DSM-V.
4 Q. The subjects of those studies were diagnosed
5 with gender identity disorder under prior versions of
6 the DSM; is that right?
7 A. Yes, that's correct.
8 Q. And the diagnosis criteria for gender dysphoria
9 under the DSM-V differ from the diagnostic criteria for
10 gender identity disorder under those prior DSM versions;
11 is that right?
12 A. Right. That's the nature of how the system
13 works. The scientists publish the studies, and then the
14 committees that form the DSM form their decisions on the
15 basis of those studies, and then the studies going
16 forward use the DSM-V. And then the results of those
17 studies will be used to form the DSM-VI. As I say, the
18 results of the studies are necessarily one step ahead of
19 the DSM.
20 Q. Well, these studies are actually steps behind
21 the current DSM; is that right?
22 A. No. The DSM only knows what to do on the basis
23 of the studies that already exist, and so they form the
24 DSM criteria on the basis of the existing studies as a
25 suggestion for what to do in the next generation of

1 studies.
2 Q. The DSM-V criteria were changed to actually
3 make it stricter in order to avoid false-positives. Do
4 you know that?
5 A. Yes. That was part of the intent, yes, but the
6 DSM-V criteria -- all diagnostic criteria are a
7 committee decision in order to compromise together
8 several competing principles, and one of them is to
9 simultaneously create as many hits as possible, that is
10 to diagnose as many people as appropriate, without
11 overdiagnosing or underdiagnosing.
12 Q. Thank you, Dr. Cantor.
13 MR. GONZALEZ-PAGAN: No further questions
14 at this time, Your Honor.
15 THE COURT: All right. Thank you.
16 Mr. Eldred, some redirect?
17 MR. ELDRED: No, Your Honor.
18 THE COURT: All right. Thank you,
19 Dr. Cantor. We are done with you on the witness stand.
20 You may stay in the proceeding if you'd like and just
21 make sure and turn off your microphone, but you are also
22 welcome to leave.
23 THE WITNESS: Thank you very much.
24 THE COURT: Thank you. All right. Your
25 next witness?

1 MS. DYER: Defendants now call Katrina
2 Taylor to the stand.
3 THE COURT: And I'm sorry. Katrina?
4 MS. DYER: Katrina Taylor.
5 THE COURT: Taylor. Okay. Please step
6 forward, ma'am. You can step right up here and I'll
7 swear you in.
8 MS. TAYLOR: Okay.
9 THE COURT: If you'll raise your right
10 hand.
11 *(Witness sworn)*
12 THE COURT: You can make your way around
13 there up to this chair here. There should still be some
14 water if you need it.
15 **KATRINA TAYLOR**,
16 having been first duly sworn, testified as follows:
17 **DIRECT EXAMINATION**
18 BY MS. DYER:
19 Q. Good afternoon, Ms. Taylor. Could you state
20 your name and spell it for the record, please?
21 A. Yes. My name is Katrina Taylor. So my legal
22 name is Y-e-k-a-t-e-r-i-n-a, last name T-a-y-l-o-r. I
23 do go by Katrina colloquially.
24 Q. Perfect. And what degrees do you hold?
25 A. Yes. So I have a master's in counseling

1 psychology from St. Edward's University.
2 Q. And when did you obtain your master's?
3 A. I graduated in 2014.
4 Q. Perfect. And what type of clinical training
5 have you done?
6 A. I have done quite a bit of clinical training.
7 After graduation I completed a two-year integrative
8 training program focused on working with families and
9 couples, children, adolescents, family systems. And I
10 also have completed six years of psychoanalytic training
11 to be able to conduct psychoanalysis and intensive
12 psychoanalytic psychotherapy.
13 Q. And are you licensed in anything specifically?
14 A. Well, I am a licensed marriage and family
15 therapist in the state of Texas.
16 Q. Is Texas the only state you're currently
17 licensed in?
18 A. Yes.
19 Q. And what year did you receive that license?
20 A. I received my provisional license in 2015, and
21 I received my full license in 2017.
22 Q. Okay. And then you just testified that the
23 psychoanalytic psychotherapy -- would you consider that
24 your specialty inside the practice of family and
25 marriage therapy?

1 A. Yes. Yes, absolutely. That's the main lens
2 through which I view people and families and
3 development, correct.
4 Q. Okay. And do you teach anything related to the
5 field that you practice?
6 A. Yes. So I teach for my institute, which is the
7 Center for Psychoanalytic Studies in Houston. I
8 typically teach one class per year. I've done it the
9 last two years, and I have a class coming up this
10 academic year that I'll be teaching.
11 Q. Okay. And how many years would you say you've
12 been working as a psychoanalytic therapist? I guess we
13 can do the math with your licensure, but it's a little
14 easier just to ask you.
15 A. I would say psychoanalytically since 2017, but
16 I've been working clinically since 2014 in my pre-grad
17 internship. All together I have over 10,000 clinical
18 direct hours, clinical contact hours.
19 Q. Okay. And within those 10,000 hours, what
20 experience do you have treating patients with gender
21 dysphoria, both adolescent and/or adult?
22 A. I would say some experience, but it's not the
23 majority of my practice.
24 Q. In terms of treating adolescents, what
25 majority -- what portion of your practice is that?

1 A. Well, currently -- so there were not -- there
2 were no children or adolescents with gender dysphoria
3 for a long time. And it's only recently that we have
4 seen an influx of patients coming in with this
5 diagnosis. You know, I would say in the last few years
6 I've probably worked with about 30 children and
7 adolescents and their families.
8 Q. Specifically with --
9 A. With the gender dysphoria, yes.
10 Q. And just generally, what experience do you have
11 treating minors for psychological conditions generally,
12 not just gender dysphoria?
13 A. I have experience going all the way back to my
14 pre-grad internship working with minors, working with
15 their families.
16 Q. Okay. And have you done any research with
17 regards to this subject?
18 A. I have not myself conducted research, no.
19 Q. What research have you done, not yourself, but
20 have you looked into with regards to the topic?
21 A. I've done extensive research on this topic.
22 I've done a lot of reading. I'm a member of the Gender
23 Exploratory Therapy Association, and they have a lot of
24 research, webinars, resources, you know, on their
25 website in the private community that we have for the

1 therapists. So I've really delved into the writings on
2 the topic as well as psychoanalytic writings, which tend
3 to be not official research but more so clinical
4 writings, expanded case studies of working with gender
5 confusion in minors as well as adults.
6 MS. DYER: Your Honor, Ms. Taylor's CV is
7 Defendants' Exhibit 7. And at this time defendants
8 would proffer Ms. Katrina Taylor as an expert in
9 clinical psychotherapy and the diagnosis, treatment, and
10 care of gender dysphoria and other psychological
11 conditions.
12 MR. SELDIN: Your Honor, can I do a brief
13 voir dire?
14 THE COURT: Sure.
15 **VOIR DIRE EXAMINATION**
16 BY MR. SELDIN:
17 Q. Good morning. So you have not conducted any
18 original research on the treatment of gender dysphoria
19 in adolescents; is that correct?
20 A. That's correct.
21 Q. You haven't published any research on that
22 topic either?
23 A. That's correct.
24 Q. Has any of your training taken place in a
25 multidisciplinary clinic for the treatment of gender

1 dysphoria?
2 A. Specifically for the treatment of gender
3 dysphoria, no.
4 Q. And do you have any specialized training in
5 adolescent mental health?
6 A. Yes.
7 Q. What training is that?
8 A. That's the training through the Center for
9 Psychoanalytic Studies in Houston.
10 Q. And --
11 A. As well as in my master's program.
12 Q. Of the 30 children and adolescents that you say
13 you've treated in this area, how many of them -- or do
14 those children or adolescents have a gender dysphoria
15 diagnosis?
16 A. Some of them, yes. I have diagnosed them with
17 gender dysphoria. I have given them that diagnosis.
18 Some I have not.
19 Q. About how many of the 30?
20 A. That I have given a diagnosis to, I would say
21 about five.
22 MR. SELDIN: Your Honor, we would object
23 to the extent that this witness intends to offer expert
24 testimony on the treatment of gender and diagnosis --
25 diagnosis of gender dysphoria given that it's a very

1 small number and limited. Her clinical experience seems
2 to be mostly focused on psychoanalysis in adults.
3 THE COURT: Ms. Dyer, do you have any
4 other response or follow-up with this witness?
5 MS. DYER: Your Honor, I mean, she's a
6 qualified therapist who does treat these children,
7 including adolescents of all different types of
8 psychological conditions. And to the extent it could
9 help the Court in any capacity, I think she should be
10 designated as an expert.
11 MR. SELDIN: Your Honor, we would ask that
12 it be limited then to psychoanalysis and not the medical
13 treatment.
14 THE COURT: All right. So I'll accept the
15 designation with the caveat that it's related to the
16 psychoanalysis piece from this witness.
17 MR. SELDIN: Thank you, Your Honor.
18 THE COURT: All right. Go ahead.
19 **CONTINUED DIRECT EXAMINATION**
20 BY MS. DYER:
21 Q. Okay. Ms. Taylor, we're going to back up just
22 a little bit. So first can you explain to me how you
23 define and/or how you have been taught based on your
24 experience -- what is gender dysphoria?
25 A. So gender dysphoria is a feeling of not being

1 in the right body, a feeling of a fundamental
2 incompatibility with one's sexed body and that these
3 feelings should persist for six months or more.
4 Q. And how do therapists treat gender dysphoria in
5 minors?
6 A. Well, the current prevailing treatment is to
7 affirm, is to affirm the child or adolescent's belief
8 that they are of the opposite sex or that they are not
9 in the right body.
10 Q. And what would you say is the goal of therapy
11 to a minor for the treatment of gender dysphoria?
12 A. Well, I think it's important for us to say that
13 a minor is not separate from their family, that --
14 you know, in my training, in having a grounding in both
15 a family systems theory and a psychoanalytic theory, we
16 can't separate the child from the family because the
17 child lives with the family and the child is an integral
18 part of the family.
19 So when there is gender confusion -- and I
20 specify the difference between diagnosing with gender
21 dysphoria versus more of a gender confusion because I
22 think that's an important difference. But when there is
23 gender confusion or gender dysphoria, I see it as a
24 symptom for the family. The child is an identified
25 patient for the family, and there's something going on

1 in that family system that is awry, that is
2 dysfunctional that needs to be addressed.
3 Q. Would you say that therapy is safe -- is a safe
4 treatment for gender dysphoria in minors?
5 A. Yes, absolutely.
6 Q. And do you think it's an effective treatment
7 for gender dysphoria in minors?
8 A. Yes, absolutely.
9 Q. How -- I know you mentioned it earlier about
10 the gender confusion, but how does gender identity --
11 and that phrase is with regards to how you understand
12 it -- relate to a diagnosis of gender dysphoria?
13 A. Well, I don't -- I don't use the phrase gender
14 identity very much. I don't prefer to use it. Gender
15 identity, it's not an empirical statement. We have no
16 proof that there's such a thing as a gender identity. I
17 have come to see it as a personal or spiritual belief
18 about the self. Therefore, I don't agree that one can
19 have a gender identity that is fundamentally different
20 from one's sexed body. What is possible are feelings of
21 hatred, of revulsion for one's own body, whether it has
22 to do with sex and the sexed body or whether it has to
23 do, you know, with weight like we see in eating
24 disorders.
25 Q. And would you say there's a diversity of

1 opinion in the psychological realm with regard to
2 diagnosing and treating of gender dysphoria?
3 A. Unfortunately, no.
4 Q. Is that because everyone is -- you just
5 testified that everyone -- the current model is to
6 affirm. Is that the primary method that you're -- that
7 you're saying that that's why there's no diversity of
8 opinion?
9 A. Yes. By and large the current method is to
10 affirm. Clinicians who don't affirm or who put forth
11 different ways of thinking about children and families,
12 you know, more critical ways, more thoughtful ways,
13 they're often censored. They're often ostracized in
14 their therapeutic communities. I've experienced that
15 myself. And so a lot of people are afraid to say much.
16 And I think this is where the Gender Exploratory Therapy
17 Association of which I am a member is a very important
18 voice in this -- on this topic.
19 Q. And who is Diane Ehrensaft?
20 A. Yes. So she is a psychologist, and I believe
21 she's the founder and quite involved in the University
22 of San Francisco Child and Adolescent Gender Center,
23 Benioff Center. And so I've actually -- I have seen
24 Dr. Ehrensaft speak in person, and she came to our
25 institute back in 2019. She has some theories about how

1 gender develops in children which I believe to be
2 unfounded and go contrary to everything we know about
3 child development.
4 Q. What is she known for in the area of
5 psychology?
6 A. Well, one of the things she's known for -- I
7 don't know if a lot of people know this, but she was
8 involved in the Satanic panic, the accusations against
9 daycare teachers --
10 MR. SELDIN: Your Honor, we would object
11 to this being outside the scope.
12 THE COURT: Ms. Dyer?
13 MR. GONZALEZ-PAGAN: And inflammatory.
14 MS. DYER: To the extent that she's
15 talking about another opinion in the psychiatric
16 community with regards to treating the -- we can reframe
17 the question so we don't discuss the latter of the
18 response.
19 THE COURT: All right. So reframe the
20 question.
21 Q. (BY MS. DYER) Okay. With regards to
22 Ehrensaft's opinions on gender identity, can you explain
23 to me what her stance is on that?
24 A. So her stance is that children can know what
25 their so-called gender identity is in infancy,

1 toddlerhood, even going back to the womb. She has
2 spoken about sort of children rejecting gender
3 stereotypes and that that says something about them
4 having a gender identity that is opposite of their sexed
5 body. So, for example, she's spoken about a baby girl
6 ripping out a barrette, you know, from her hair and that
7 indicates that that baby girl is actually a baby boy.
8 Another example --
9 MR. SELDIN: Your Honor, we would object
10 at this point as a narrative answer to the question.
11 THE COURT: I'm more interested in her
12 opinions. I don't necessarily need to get into what she
13 might think about somebody else's.
14 MS. DYER: That's fine, Your Honor. I was
15 going to follow up with her opinion on that.
16 THE COURT: Okay. Then let's do that.
17 Q. (BY MS. DYER) Okay. Given what you've just
18 stated --
19 A. Right.
20 Q. -- what is -- do you share her opinions? Or
21 what are your opinions in response to that?
22 A. I absolutely do not share those opinions.
23 Again, there's no empirical basis for this. It's
24 pseudoscientific. It's pseudoreligious. It really
25 points to this idea of a personal or spiritual belief

1 about the self that, you know, when in the case of young
2 children is actually inculcated by the parents in my
3 opinion.
4 Q. Okay. And so let's shift gears just a little
5 bit. In terms of your direct clinical practice with
6 patients in adolescence, among the patients that you've
7 treated for either significant body hate, I think as you
8 phrased it earlier -- I'm sorry if I misspoke -- or
9 gender dysphoria, have you noticed any patterns amongst
10 them?
11 A. Yes. So some of the patterns I've noticed is
12 that these children and adolescents come from
13 dysfunctional families, that there can be marital
14 discord. Sometimes there's divorce. Sometimes when we
15 really dig into it, there is trauma in each of the
16 parents' or one of the parents' histories, you know, for
17 example, mental illness in the extended family,
18 suicidality in the extended family.
19 I have also noticed that these are parents
20 who have a permissive parenting style. You know, so we
21 have three parenting styles: authoritarian, permissive,
22 and authoritative. We know children do best with an
23 authoritative parenting style. These are quite
24 permissive parents. There is a sense of anything goes.
25 And these parents really struggle to set boundaries with

1 their children, to impose consequences for, you know,
2 negative behavior.
3 Q. And you mentioned trauma a minute ago. Is
4 underlying trauma something that adolescents or children
5 are quick to give you details about when you first meet
6 with them?
7 A. No.
8 Q. How many sessions would you say or hours -- I'm
9 not sure how long your sessions are -- would you say
10 that it takes for youth to open up to you about those
11 types of things?
12 A. It takes a while. It really depends on the
13 individual, you know, child or adolescent. I mean, I
14 would say we have to probably work together at least
15 eight to ten sessions to build up a sense of trust and
16 rapport before we can get into anything deeper.
17 Q. And roughly how long are your average sessions?
18 A. 50 minutes, five zero.
19 Q. Okay. And out of the individuals that you have
20 made a gender dysphoria diagnosis for, roughly --
21 without any specific details about the individuals, how
22 many generalized sessions have you taken to give them
23 that diagnosis?
24 A. I would say on average probably six to eight
25 sessions.

1 Q. Do you believe that a diagnosis could be made
2 during an initial assessment?
3 A. No, I don't believe it can be.
4 Q. And what's your basis for that belief?
5 A. One session is barely long enough to say hello.
6 It's certainly not long enough to delve into the
7 history, to understand the context of the presenting
8 symptoms, to get more of a sense of the family and the
9 family structure. And also, I -- when it comes to
10 children and adolescents, I prefer to meet with the
11 parents first to do either a parent meeting or to have
12 as many members of the family come in so I can observe
13 how they interact together. Then I would meet with the
14 child adolescent one on one and we'd have more sessions.
15 So it just really takes some time to get a feel for what
16 is happening there.
17 Q. Okay. So going directly to how you would treat
18 an individual, let's take one of the plaintiffs, for
19 example.
20 A. Sure.
21 Q. Have you reviewed the affidavits attached to
22 plaintiffs' complaint?
23 A. Yes.
24 Q. And so I will give you a brief summary to jog
25 your memory of which one we're discussing. In

1 particular, Sarah Soe, who's a plaintiff, that began --
2 or her parents -- began to express gender dysphoria
3 around the age of 12 and in her parents' affidavit
4 stated that she never fit the boy gender stereotypes.
5 That was a quote. Do you recall reading that affidavit?
6 A. Yes, I believe --
7 MR. SELDIN: Your Honor, we would object
8 to this line of questioning as it appears to be going
9 toward offering an opinion from the plaintiffs
10 specifically in this case, who she's --
11 THE COURT: And was that --
12 MR. SELDIN: -- never met.
13 THE COURT: I'm sorry. So complete that.
14 MR. SELDIN: We would object, Your Honor.
15 We appear to be leading down a path of asking questions
16 about offering expert opinions on plaintiffs that she's
17 never met.
18 THE COURT: Right.
19 MR. SELDIN: And so --
20 THE COURT: So she reviewed the affidavits
21 and you're going to ask her --
22 MS. DYER: What her line of psychotherapy
23 approach -- psychotherapeutic approach based on her
24 knowledge she would have recommended for that patient.
25 THE COURT: Based on the affidavits.

1 MS. DYER: Based on the affidavits.
2 THE COURT: I understand that context. So
3 I'm going to overrule the objection and let her ask the
4 question.
5 Q. (BY MS. DYER) So do you recall reading that
6 affidavit?
7 A. Yes, I believe so. So Sarah Soe, that's the
8 12-year-old girl -- right? -- who identifies as a,
9 quote, trans boy?
10 Q. Sarah Soe identifies as a trans girl, was a
11 bio- -- was born a biological boy.
12 A. Oh, right. And is that the one where the onset
13 began at age four?
14 Q. No. This --
15 MR. SELDIN: Objection, Your Honor. At
16 this point counsel appears to be testifying.
17 THE COURT: Yeah. I mean, if you've got a
18 more --
19 MS. DYER: I was just trying to clarify.
20 THE COURT: -- specific question for her --
21 MS. DYER: Yeah.
22 Q. (BY MS. DYER) Okay. Let's -- the second one
23 that you were referring to at the onset of four --
24 A. Yeah.
25 Q. -- would you like -- do you recall that one?

1 A. I do recall that one.
2 Q. Okay.
3 MS. DYER: Then can I -- is it okay if I
4 jump to that one?
5 THE COURT: Try that.
6 Q. (BY MS. DYER) Okay. So this was plaintiff
7 Maeve Moe. She's currently nine. And like you
8 mentioned --
9 MR. SELDIN: Objection, Your Honor, at
10 this point.
11 THE COURT: I mean --
12 MS. DYER: It's her --
13 THE COURT: Yeah, but you're -- well,
14 you're not supposed to be leading this witness.
15 MS. DYER: I'm sorry. I was just trying
16 to refresh her memory as to the exact affidavit
17 without --
18 MR. SELDIN: Your Honor, there's --
19 MS. DYER: -- being able to show it to
20 her.
21 MR. SELDIN: There's --
22 THE COURT: Hold on. We cannot talk over
23 each other.
24 MR. SELDIN: I apologize.
25 THE COURT: Okay. Let's get a question

1 out and then get me an objection and we'll deal with
2 that.
3 MS. DYER: Okay. I will reframe.
4 THE COURT: Don't start your answer yet.
5 Q. (BY MS. DYER) Hypothetically, if there was a
6 patient that came into your practice, given your years
7 of experience, who was roughly five years old, born a
8 biological boy and was expressing symptoms -- or
9 expressing things that they were interested in pink and
10 more feminine type things, how would you go about
11 treating or recommending treatment to that minor and/or
12 family members?
13 THE COURT: All right. Do you have an
14 objection?
15 MR. SELDIN: No, Your Honor.
16 THE COURT: All right. Answer that
17 question.
18 MR. SELDIN: I haven't been shot.
19 A. I would say let this boy wear pink. He is
20 still a boy.
21 Q. (BY MS. DYER) Is there any type of
22 psychotherapeutic specific type of treatment or
23 counseling you would offer to the family?
24 A. Well, I would work with -- with the family.
25 That's a very young age. That's an age when kids are

1 still in preschool. Maybe they're starting
2 kindergarten. That's an age of pretend play, of
3 dress-up, of -- you know, maybe one day he's a girl,
4 maybe another day he's a dog or a cat or a dinosaur.
5 And children are playing. Play is a way that children
6 learn about the world and figure out their own
7 identities and other people's identities. I would tell
8 the family to let him play.
9 I would say if the family is coming into
10 my office with this as a presenting issue and they are
11 concerned about their boy identifying as a girl, I would
12 again see it as an identified patient for the family.
13 What kind of distress is this child expressing for the
14 family? And I would probably meet with the parents for
15 quite a bit to understand more about their marriage,
16 what's happening in the family, you know, as a whole,
17 are there other siblings, does this child, for example,
18 feel like he's not getting enough attention and adopting
19 this kind of identity as a way to get more attention.
20 Q. And what would you say the overarching goal of
21 therapy is for any of your patients that have been
22 diagnosed with gender dysphoria or are suffering from
23 body hate?
24 A. I would say the overarching goal is to learn to
25 accept one's body, the body that the person was born

1 into. We all only ever get one body, to accept it, to
2 make peace with it, and to focus on what really matters
3 in life, which is work and love, so completing
4 schooling, figuring out a career that they would like to
5 pursue, and love, which includes romantic partnerships,
6 friends, family. Those are really what lead to healthy
7 psychological functioning in life.
8 Q. And have you seen positive -- I don't want to
9 say outcome -- I guess outcome is the right word --
10 positive improvement, however you would like to define
11 it, in the patients that you've been treating with
12 psychotherapeutic approaches that have gender dysphoria?
13 A. Well, maybe here we should clarify between
14 gender confusion and gender dysphoria.
15 Q. Yes. I apologize.
16 A. That's okay. I don't think every one of those
17 children meets a diagnosis for gender dysphoria. But if
18 they're showing up with gender confusion -- and again,
19 sometimes it could be gender dysphoria -- yes, I
20 absolutely have seen positive outcomes where they gain
21 insight, they are more able to put words to their
22 feelings, they're able to get to a place of accepting
23 their body, of being more comfortable with who they are,
24 and going through what can be a very difficult and scary
25 time, which is puberty, you know, learning to be able to

1 go through puberty with less distress.
2 Q. Is puberty something that causes your other --
3 different patients distress as well, not necessarily
4 adolescents suffering from gender dysphoria or body
5 hate?
6 A. Oh, yes, absolutely. Absolutely. Yeah.
7 Q. Do they have any kind of distress associated
8 with puberty?
9 A. I think a lot of children have distress
10 associated with puberty, especially girls. Girls going
11 through puberty, you know, go through a lot of unwanted
12 changes to their body, which are painful and can be
13 embarrassing, such as menstruation. I think it's very
14 common for girls to feel like they hate their body at
15 just that point in time that they're receiving unwanted
16 attention from boys and even men to want to hide and to
17 want to hide behind a trans identity, to take on this
18 trans boy identity as a way to escape the distress and
19 consequences of puberty.
20 Q. So potentially my last question: In your
21 opinion, do you think that therapy is in fact a safe and
22 effective treatment for minors with gender dysphoria?
23 A. Yes, absolutely.
24 MS. DYER: Can I have just one second to
25 confer?

1 THE COURT: Of course.
2 MS. DYER: Okay. At this time we will
3 pass the witness.
4 THE COURT: Thank you. Cross-examination?
5 MR. SELDIN: Your Honor, just one moment
6 to confer.
7 THE COURT: Sure.
8 MR. SELDIN: I will have brief cross.
9 THE COURT: Sure.
10 **CROSS-EXAMINATION**
11 BY MR. SELDIN:
12 Q. You testified that you belong to an
13 organization called the Gender Exploratory Therapy
14 Association; is that correct?
15 A. That's correct.
16 Q. You said that there are some writings that you
17 reviewed from them that inform your practice; is that
18 correct?
19 A. Correct.
20 Q. Have any of those writings been subjected to
21 randomized controlled trials validating their
22 recommendations?
23 A. I can't be sure if they have or not.
24 Q. Have they been subjected to any longitudinal
25 studies validating the recommendations?

1 A. I can't be sure.
2 Q. Have they been subjected to any cross-sectional
3 or any other kinds of research studies validating their
4 recommendations?
5 A. I can't be sure.
6 Q. Do you know if there's been any follow-up in
7 terms of outcomes for patients who have been treated in
8 accordance with those writings?
9 A. I am aware of clinical case studies. You know,
10 Lisa Marchiano is one writer. Alessandra Lemma is
11 another, Roberta D'Angelo, Robert Withers. They all
12 have written clinical case studies on their work with --
13 describing their work with patients. And some of those
14 papers do describe positive outcomes with patients.
15 Q. So those would be studies of individual
16 clinical --
17 A. Correct.
18 Q. -- patients, not large sets of people; correct?
19 A. Not large sets of people, correct.
20 Q. Would you agree that consent is principally a
21 parental function?
22 A. Yes.
23 Q. You testified that the -- that there's no
24 diversity of treatment in this area because the
25 prevailing treatment is to affirm a child's gender

1 identity; is that correct?
2 A. By and large --
3 Q. So --
4 A. -- yes.
5 Q. I didn't mean to cut you off. I'm sorry.
6 A. By and large. There's little diversity is how
7 I would put it.
8 Q. So the treatment that you're describing in your
9 practice would be outside of the mainstream of
10 prevailing standards of care; correct?
11 A. Correct.
12 Q. You testified earlier that you did not believe
13 a three-year-old had the capacity to understand their
14 gender identity; is that correct?
15 A. That's correct.
16 Q. Do you believe that a three-year-old who has
17 been assigned male at birth has an ability to know that
18 he is a boy?
19 A. Yes, a three-year-old has the ability to know
20 he is a boy because he is a boy.
21 Q. Based on his genitalia?
22 A. That is one marker of being a boy.
23 Q. Are there other markers of being a boy?
24 A. Boys behave differently from girls in terms of
25 their energy level, their activity levels.

1 Q. Earlier you testified that if a hypothetical
2 patient presented to you who was assigned a boy but
3 liked pink, you would say go ahead and let them like
4 pink; correct?
5 A. Correct.
6 Q. Is liking pink the kind of a sign of being a
7 boy or a girl like high energy level that you just
8 described or is it something different?
9 A. Liking pink or not liking pink is an interest.
10 Energy level is a behavior.
11 Q. Do you think that a three-year-old who's been
12 assigned female at birth has an ability to understand
13 that their gender identity may be something other than
14 female?
15 A. No.
16 Q. Earlier you talked about patterns that you had
17 seen in your practice. You also -- that would be based
18 on the five people or so that you have given a gender
19 dysphoria diagnosis to?
20 A. It would be based on the 30 people I have
21 worked with with some level of gender confusion.
22 MR. SELDIN: Your Honor, I may be done, if
23 I could just have a brief moment.
24 THE COURT: Sure.
25 MR. SELDIN: I apologize. Thank you.

1 Q. (BY MR. SELDIN) Of the 30 patients that you
2 just referenced, how many of them were minors?
3 A. I would say all of them except for maybe two.
4 The vast majority were minors.
5 Q. And about how old were they?
6 A. Ranging in age from 12 to 17.
7 Q. And of the five that you did diagnose with
8 gender dysphoria, about how old were they?
9 A. So some right around puberty, 12, 13, and some
10 a little bit older, adolescents, like 17.
11 MR. SELDIN: Your Honor, I have nothing
12 else for this witness. I pass the witness. Thank you.
13 THE COURT: Thank you. Any redirect?
14 MS. DYER: I have one quick question.
15 THE COURT: Sure.
16 MS. DYER: Maybe two, actually. Sorry.
17 **REDIRECT EXAMINATION**
18 BY MS. DYER:
19 Q. What would you say informed consent is in the
20 context of therapy for minors?
21 A. Informed consent is the parent agreeing --
22 allowing the therapist to treat the child and to treat
23 the family.
24 Q. And what risks are present in therapy for
25 minors?

1 MR. SELDIN: Objection, Your Honor. I
2 think this is outside the scope of cross.
3 MS. DYER: Respectfully, Your Honor, he
4 just asked about informed consent.
5 THE COURT: I'll allow it. Go ahead.
6 A. The risk of therapy for minors? I would say
7 there are few risks unless the therapist behaves
8 unethically and seeks to alienate the minor, turn them
9 against the family, or gives the family advice that is
10 ultimately harmful.
11 MS. DYER: Okay. I think that's it. Give
12 me just one second. Okay. We pass the witness.
13 THE COURT: Any other redirect -- or
14 cross-examination?
15 MR. SELDIN: None, Your Honor. Thank you.
16 THE COURT: Okay. All right. Ms. Taylor,
17 you're done on the witness stand. You may be excused.
18 All right. Next witness?
19 MR. STONE: At this time, Your Honor,
20 defendants call Dr. Hopewell, Dr. Alan Hopewell.
21 THE COURT: Hopewell. Okay. If
22 Dr. Hopewell's here, if you'll step forward, please. I
23 assume that's the man in the white coat.
24 MR. STONE: Yes, Your Honor.
25 THE COURT: If you'll raise your right

1 hand for me, sir.
2 *(Witness sworn)*
3 THE COURT: All right. You can make your
4 way around and up to this witness chair.
5 **C. ALAN HOPEWELL, PH.D.,**
6 having been first duly sworn, testified as follows:
7 **DIRECT EXAMINATION**
8 BY MR. STONE:
9 Q. Good morning, Dr. Hopewell.
10 THE COURT: Actually, we're in the
11 afternoon. Both of y'all said morning. I wanted to
12 remind you of the time you have left.
13 MR. SELDIN: Your Honor, the days go by
14 quickly.
15 MR. GONZALEZ-PAGAN: It's afternoon.
16 That's what I meant to say.
17 THE COURT: I don't know where y'all are
18 at, but I'm in the afternoon. Go ahead. Sorry.
19 MR. STONE: Thank you, Your Honor.
20 Q. (BY MR. STONE) Could you state your name for
21 the record?
22 A. My name is Clifford Alan, and that's A-l-a-n,
23 Hopewell.
24 Q. Dr. Hopewell, what degrees do you hold?
25 A. How many or which ones?

1 Q. Which ones?
2 A. I have a bachelor's degree in psychology from
3 Texas A&M University, which I was also commissioned at
4 the same time. I have a master's degree in clinical
5 psychology from what is now the University of North
6 Texas. I have a Ph.D. in clinical neuropsychology with
7 my minor in experimental --
8 MS. WOOTEN: Your Honor?
9 THE COURT: Hold on.
10 MS. WOOTEN: I'm not sure you administered
11 the oath.
12 THE COURT: Oh, my -- yes, I did. Yes, I
13 did.
14 MS. WOOTEN: Did we miss it?
15 THE COURT: I did administer the oath to
16 you.
17 THE WITNESS: Yes, ma'am.
18 MS. WOOTEN: I'm so sorry. We all missed
19 it. Thank you.
20 MR. SELDIN: We were distracted by the
21 white coat.
22 THE WITNESS: I'm also an expert in memory
23 testing.
24 MS. WOOTEN: Well, that's coming at the
25 end of today.

1 A. My third degree, I think -- I have to keep
2 track here -- is a Ph.D. in clinical psychology with a
3 minor in experimental. I forgot to mention my minor at
4 the A&M is in languages, in German. And then I have a
5 postdoctoral master's degree in clinical
6 psychopharmacology.
7 Q. (BY MR. STONE) Doctor, what year did you
8 obtain your Ph.D. in psychology?
9 A. 1978.
10 Q. Did you do a residency?
11 A. Yes.
12 Q. What was your residency in?
13 A. I was a resident at the University of Texas
14 Medical Branch, and the residency was in primarily
15 clinical psychology, but I went there specifically to
16 work in the division of neurosurgery in clinical
17 neuropsychology. I'm the first neuropsychologist
18 trained in the state of Texas.
19 Q. Doctor, do you hold any board certifications?
20 A. Yes.
21 Q. What are you board certified in?
22 A. In clinical neuropsychology. I was the first
23 board certified clinical neuropsychologist in Texas.
24 Q. Doctor, have you served in the military?
25 A. Yes.

1 Q. How long did you serve in the military and in
2 what branch?
3 A. United States Army, a total of 27 years. I had
4 both reserve and active duty service, and I retired as a
5 regular army officer.
6 Q. What was your rank when you retired?
7 A. Major.
8 Q. Did you achieve any awards or commendations
9 during your military service?
10 A. Yes, sir.
11 Q. What awards or commendations did you receive?
12 A. I received the Bronze Star Medal for medication
13 research and directing the brain injury services in Iraq
14 during the War on Terror. I was the senior brain injury
15 consultant for the United States Army during that period
16 of time. I also received two meritorious service
17 awards. One was for surviving -- for my working with
18 the assassination attempt at Fort Hood of which I'm a
19 survivor. And the other was for my -- again, my work
20 in -- at Fort Hood with organizing the brain injury
21 services, the neuropsychological laboratory. I have
22 extensive other Army awards, earning achievement for
23 helping them achieve the Joint Commission accreditation
24 at Fort Hood Darnall, things like that. The list is
25 pretty extensive.

1 Q. I want to follow up on something you just said.
2 What do you mean the assassination attempt at Fort Hood?
3 A. Well, Colonel Platoni and I were the two
4 targets of the assassination attempt there, but
5 fortunately we survived. I was in charge of some of the
6 survivor organization after that and -- I mean, we were
7 there during that assassination attempt.
8 Q. So you're saying the phrase assassination
9 attempt. Who -- who tried to perform -- or who was
10 attempting to carry out an assassination at Fort Hood?
11 Can you just clarify?
12 A. Well, it was a psychiatrist who worked with me,
13 Nidal Hasan.
14 Q. Okay.
15 A. And he was a colleague psychiatrist, and he
16 attempted to kill some of his colleagues. He killed,
17 of course, 13 people.
18 THE COURT: The Court's familiar with the
19 circumstances.
20 MR. STONE: Sorry, Your Honor. I was just
21 trying to --
22 THE COURT: That's okay. Just don't want
23 you to spend your time on it.
24 Q. (BY MR. STONE) Doctor, what states are you --
25 what states are you currently licensed to practice

1 psychology in?
2 A. I've been licensed in Texas since I think 1979.
3 I'm licensed by the Louisiana -- medical board in
4 Louisiana, although I allowed that to lapse when I kind
5 of retired. I'm semi-retired. And I'm currently
6 licensed by the Louisiana Psychological Board. I'm also
7 licensed in Missouri as a clinical neuropsychologist.
8 Q. What states have you previously been licensed
9 in that you are no longer licensed in the practice of
10 psychology?
11 A. When I taught at the medical school in
12 North Carolina I was, of course, licensed in
13 North Carolina. I was also licensed in New Hampshire.
14 I'm licensed by the medical prescription board in
15 New Mexico. And I was also licensed in Nevada. Again,
16 I'm semi-retired, so I've retired some of those
17 licenses.
18 Q. Have you ever held a DEA registration to
19 prescribe controlled substances?
20 A. Yes.
21 Q. When did you hold a DEA registration?
22 A. During my service at Carl Darnall Medical
23 Center at Fort Hood. So that was between 2006 and I
24 retired there in 2014. So when I left federal
25 service -- I was also a federal employee. When I left

1 federal service, I left that federal license and was
2 planning on retiring, so I never pursued a state
3 license.
4 Q. What experience do you have teaching in the
5 field of psychology?
6 A. Extensive. I've taught at two different
7 medical schools. I've taught at several universities as
8 adjunct professors, such as University of North Texas,
9 several schools with military psychology students, such
10 as Central Texas College and things like that.
11 Q. What professional awards and recognitions have
12 you received in the field of psychology?
13 A. I've -- gosh, I can't remember all. I've
14 been -- I was the clinical neuropsychologist for Texas
15 by the Texas Psychological Association. Probably the
16 most important one is I was selected to be a fellow of
17 the American Psychological Association, which is the
18 highest award they give other than outstanding -- you're
19 the outstanding guy in the world, I guess. But that's
20 the highest category they have, and that was based
21 mainly on my research on medication management and brain
22 injury in Iraq.
23 Q. How long have you been practicing clinical
24 psychology?
25 A. 50 years.

1 Q. What experience do you have with gender
2 dysphoria?
3 A. I was the chief resident at the University of
4 Texas Medical Branch on their sexual surgery team. We
5 also had specialized studies. Of course, that was a
6 long time ago, and so that was where some of the initial
7 studies by John Money, who's clinic was closed, but we
8 studied extensively John Hopkins models and John Money's
9 work at that. And we were part of the -- I also served
10 on the sexual surgery team at the medical branch. And
11 then since then I've dealt with it in my private
12 practice.
13 Q. What education and training do you have as it
14 relates to the psychological development of minors?
15 A. Well, that was an extensive part of our
16 training at University of North Texas, learning theory,
17 child theory. Then at the medical branch at Galveston,
18 my first rotation was in the division of child and
19 adolescent psychiatry. My second rotation was in the
20 department of pediatrics with pediatric children and
21 with some medical and sexual disorders. My third
22 assignment, again, was on the sexual treatment team.
23 And then, again, I specialized in the division of
24 neurosurgery and neuropsychology, and that overlaps
25 quite a bit with developmental issues of children, and

1 we had children who had various neurological illnesses
2 and injuries.
3 Q. Doctor, what -- what training and experience do
4 you have in the field of informed consent as it relates
5 to the practice of psychology and neuropsychology?
6 A. Well, like any psychologist, I'm bound to the
7 ethics of the American Psychological Association. And
8 I've been on many hospital committees and research
9 panels where we've had to adhere to those principles.
10 Probably the specialty association that I've had is the
11 president of the psychological association who followed
12 me as president of the Texas Psychological Association
13 was Melba Vasquez, and Melba was -- and I was on the
14 board. Melba was involved intricately in revamping the
15 APA ethical principles, and so we reviewed those
16 extensively at that time. I didn't -- I didn't do that
17 myself. She was doing that. But yeah, those are my
18 familiarity with those issues.
19 MR. STONE: At this time, Your Honor, we'd
20 like the Court to know that Dr. Hopewell's CV is
21 Defendants' Exhibit 6. And at this time we proffer
22 Dr. Hopewell as an expert in the practice of
23 neuropsychology and clinical psychology and as it
24 relates to informed consent.
25 THE COURT: Any objection?

1 MR. GONZALEZ-PAGAN: No objection,
2 Your Honor.
3 THE COURT: All right. So designated.
4 Q. (BY MR. STONE) Doctor, why is informed consent
5 important?
6 A. Primarily probably because of the old Latin
7 phrase *nolo nocere* damage. We -- the phrase means above
8 all do no harm. And informed consent in terms of both
9 the philosophical underpinnings, the American Medical
10 Association and the American Psychological Society -- or
11 American Psychological Association, those -- that has to
12 be our primary ethical duty is to do no harm to a
13 patient.
14 The other consideration is, if you read
15 the ethical guidelines of the APA, for example,
16 extensive issues on human dignity and working with the
17 person, and so the other component of that is that the
18 patient is informed and involved and is part of the
19 informed or treatment process, so treating the patient
20 with dignity and respect and helping them to be an
21 informed consumer of healthcare as well as being well
22 educated about problems or difficulties or potential
23 injuries.
24 And there's a third component which is
25 equally important, and that is informed decision-making,

1 to make a decision with information about what treatment
2 the individual will accept or be involved in.
3 Q. Doctor, are you familiar with the WPATH?
4 A. Yes.
5 Q. What is the WPATH?
6 A. Well, it's a quasi-professional organization
7 that is mostly an advocate for their positions. They're
8 interested in sexual medicine or sexual issues. And
9 they're -- it's an organization of a wide range of
10 people who can join to, you know, participate in their
11 issues.
12 Q. How is WPATH different from an organization
13 like the International Neuropsychological Association --
14 or Society?
15 A. Society. Oh, International Neuropsychological
16 Society, I am no longer a member because I'm not -- I
17 haven't been traveling overseas, but that's an
18 organization of the preeminent scientists in the world
19 who are involved with neuropsychology. I don't think
20 you can join if you don't have a Ph.D. I may be wrong
21 about that. But you have to demonstrate very strict
22 criteria to be a member.
23 WPATH will allow people to join if they're
24 just associated with the mental health field. And for
25 example, we hired a receptionist lately who we're

1 teaching to give -- proctor some of the tests because
2 she's allowed to do that by law. She would be eligible
3 to join because she's working in a mental health office.
4 So there aren't any real requirements like there are for
5 an organization like National Institute of Health or
6 International Neuropsychological Society.
7 Q. Are you familiar with the WPATH Standard of
8 Care Version 8?
9 A. I think that's related to informed consent or
10 something. You'll have to --
11 Q. Sure --
12 A. -- be specific.
13 Q. Sure. Are you familiar with the WPATH
14 Standards of Care?
15 A. I've read them, yes.
16 Q. Okay. I'm going to show you what has been
17 already admitted. This is Plaintiffs' Exhibit 26.
18 MR. STONE: Your Honor, if we --
19 THE COURT: Oh, sorry.
20 THE WITNESS: This is one of our Army eye
21 tests; correct?
22 THE COURT: It should be there too.
23 THE WITNESS: I see that.
24 THE COURT: Yeah, it's on them to make it
25 bigger.

1 MS. DYER: I'm trying.
2 MR. STONE: Can you Zoom in on this right
3 here?
4 Q. (BY MR. STONE) Doctor, I'm going to show you
5 Statement 6.12.C. And -- sorry. We're going to try to
6 highlight this to make it easier to read.
7 MS. DYER: I'm not going to do that.
8 MR. STONE: All right. I'm not going to
9 try to highlight.
10 Q. (BY MR. STONE) Doctor, can you see it on the
11 screen? I'm just going to read it so that you can
12 follow and tell me if I'm reading this correctly.
13 In most settings for minors, the legal
14 guardian is integral to the informed consent process.
15 If a treatment is to be given, the legal guardian, often
16 the parent/caregiver, provides the informed consent to
17 do so. In most settings assent is a somewhat parallel
18 process in which the minor and the provider communicate
19 about the intervention and the provider assesses the
20 level of understanding and intention.
21 Now, do you see where I -- do you see on
22 the screen where those two sentences are?
23 A. Yes, I read that.
24 Q. Okay. Now, I want to -- and I will try to read
25 slower. Let me go to the very bottom of the page of 63

1 and then going on to Page 64, and then I've got four
2 questions I'm going to be asking. So follow along and
3 tell me if I'm reading this correctly.
4 The following questions may be useful to
5 consider in assessing a young person's emotional and
6 cognitive readiness to assent or consent to a specific
7 gender-affirming treatment.
8 Do you see where I read that?
9 A. Yes.
10 Q. Okay. I want to go through each of these in
11 turn. The first one is: Can the young person think
12 carefully into the future and consider the implications
13 of a partially or fully irreversible intervention?
14 Do you see that?
15 A. Yes.
16 Q. Do you believe that adolescents can think
17 carefully into the future and consider the implications
18 of a partially or fully irreversible intervention like
19 puberty blockers, cross-sex hormones, or gender surgery?
20 A. Well, when you're speaking of adolescents,
21 we're talking, I presume, from 13 to 19, 18 -- well, 18.
22 13 to 18. So that's a wide range. And youngsters that
23 age will vary widely in what they can do. The best way
24 to answer that question is that even the most mature
25 18 -- 17-, 18-year-olds will have an extremely difficult

1 time -- and let's just look at this -- looking into the
2 future and considering the implications of things that
3 are irreversible. That's going to be very difficult if
4 not impossible. Young adolescents have a very difficult
5 time because of the nature of their brain organization.
6 And I remember we were here in Austin
7 probably two or three years ago and I pointed out -- you
8 look at the students -- I don't know which way the
9 university is. Wherever the university is, look at
10 those students, and probably half will change their
11 minds about their minors -- or majors by the time they
12 enter and leave.
13 So the answer to your question is that
14 could be very difficult at best to know, and worse for
15 the younger kids, depending on their maturity, and the
16 reason is because of the way the brain functions in
17 adolescents.
18 Q. Well, let's follow up on that. How does -- can
19 you explain us and the Court, how does the brain
20 function in adolescents?
21 A. In adolescents, the brain functions mainly
22 through the limbic system. The limbic system is only
23 part of the brain. The limbic system is the emotional
24 part of the brain. Everybody in here who has kids and
25 adolescents know what I'm talking about. And the

1 emotional part of the brain is wired into their
2 development, but the prefrontal areas of the frontal
3 cortex, the frontal lobes, have not yet developed yet.
4 Settled science; it's uncontestable. The neurology
5 shows that that part of the brain doesn't fully develop
6 until people are 23, 24, 25 years old.
7 So the answer to your question is that at
8 that stage of life, those youngsters are reasoning on an
9 emotional level. They're not able to -- the executive
10 functions of the brain are exactly what's pointed out
11 here, being able to plan, being able to make decisions,
12 being able to rationalize, and they're really not able
13 to do that yet.
14 Q. Doctor, would it be helpful if we put up an
15 illustrative of a human brain to talk about the
16 different portions of it and how they function?
17 A. If you'd like.
18 Q. Doctor, what -- what are we looking at here?
19 A. You're looking at a cross-section of a human
20 brain.
21 Q. And are you familiar with this particular image
22 of a cross-section of the human brain?
23 A. Yes.
24 Q. How are you familiar with it?
25 A. I provided it to you.

1 Q. Where did you get it from?
2 A. I don't know. One of my textbooks. We have --
3 again, for the medical students, we have hundreds of
4 these that we teach the medical students, mainly at this
5 point the psychiatric residents.
6 Q. Why don't we talk about -- I'd like to talk
7 about the different portions of what's shown on this
8 image. What is the amygdala?
9 A. The amygdala is a nucleus of cells which
10 processes fear and anxiety. And if you'll notice, it's
11 close to what's labeled up here the mammillary bodies
12 and the hippocampus. Those are memory centers of the
13 brain. And the reason I point that out is because
14 learning what hurts us and learning what is threatening
15 is absolutely critical to survival of both the species
16 as well as the individual. And so that area is tied
17 directly into the memory centers.
18 So if you put your hand on a hot stove and
19 get burned, you'll remember that. And those are -- the
20 green areas are basically what I mentioned before, the
21 emotional areas of the brain. Those have to develop
22 first because otherwise the child wouldn't survive. The
23 child wouldn't learn, you know, safety and wouldn't
24 learn, you know, to avoid dangerous things.
25 Q. So how does -- how does this change over time

1 as a child grows and goes through adolescence?
2 A. The rest of the brain develops. The frontal
3 part of the brain, which is to the left of the green
4 curve, is what's designated by neuroanatomists, to
5 include Vesalius. Vesalius demonstrated this as early
6 as the 16th century. So this is not new. Everybody
7 knows this for 400 years. It is the frontal area of the
8 brain. It comprises about one-third of the surface of
9 the brain, so it's massive. That's what makes us
10 humans.
11 And the gray area is the prefrontal area,
12 but those are the last areas to develop, partly just
13 because the brain takes a long time to develop and,
14 again, also partly because those aren't really necessary
15 for children. Children are learning on a more basic
16 level, so they have to learn these emotional things
17 first, and then later they'll learn -- with the
18 prefrontal area they'll learn calculus or they'll learn
19 history or something like that.
20 Q. So you kind of covered it, but I want to
21 specifically ask about it. What does the prefrontal
22 cortex do?
23 A. It does what you -- you've taken it off the
24 screen here. It does what you just asked me, make
25 decisions about future events, be able to rationalize,

1 be able to reason, and be able to weigh consequences of
2 things that are abstract. Jean Piaget was the Swiss
3 child psychiatrist in the '20s and '30s who laid the
4 foundation for child learning with his operational
5 stages of child development. There are four stages:
6 sensorimotor with the babies; preoperational, kids up to
7 seven and nine; concrete operations; and then abstract
8 operations. And with that area not being developed,
9 youngsters in the age that we're talking about are
10 basically concrete and preoperational. So they can
11 figure certain things, but they can't do the abstract
12 reasoning really. They can't form those more difficult
13 concepts.
14 And an example is -- I'll give you one
15 example. You can tell a youngster you have a headache.
16 What do you do for headaches? Everybody in here's done
17 it. You take an aspirin. And the aspirin will make you
18 feel better. But what will aspirin also do? It might
19 make your stomach bleed where you'll die because
20 aspirin's a blood thinner. The kid can't understand
21 that. The kid is just, oh, give me aspirin. And if my
22 head aches more, I'll take more aspirin and more aspirin
23 because it makes it feel better. So that's the
24 rationalization of a youngster because they're not able
25 to understand the more abstract or far-reaching

1 consequences of, well, there might be some dangerous
2 consequences to even an innocuous thing like
3 aspirin-taking.
4 Q. Okay. So I want to go back to the four -- the
5 questions of the four elements from the WPATH. So going
6 to the second question, does the young person have
7 sufficient self-reflective capacity to consider the
8 possibility that gender-related needs and priorities can
9 develop over time and gender-related priorities at a
10 certain point in time might change?
11 Do you see that on the screen?
12 A. I see it.
13 Q. Do you --
14 A. But frankly, I'm having a little bit of trouble
15 following that. I don't think most adolescents can. So
16 again, that's kind of the difficult rationalization that
17 they're requiring people to do or they expect people to
18 do I guess that youngsters probably have a hard time
19 with.
20 Q. Do you believe that minors have sufficient
21 self-reflective capacity to consider that their
22 gender-related needs and priorities can develop and
23 change over time such that they can provide consent or
24 assent to puberty blockers, cross-sex hormones, or
25 surgeries?

1 A. I don't think that's realistic.
2 Q. Why not?
3 A. They don't think like that.
4 Q. Why do -- why do you say they don't think like
5 that?
6 A. I just explained it. And I know how children
7 think. Again, children think concretely. And the
8 child's going to think, well, let's just -- you're
9 talking about adolescents. Anybody in here who's had a
10 wonderful, marvelous pubescent adolescence, raise your
11 hand. No. Everybody has a hard time in adolescence.
12 And you talk to an adolescent and you say, You're having
13 a hard time; here's something that'll fix it, and
14 they'll think that's wonderful. They'll just, yeah,
15 yeah, I feel bad; I'll fix that. They -- they don't
16 reflect on consequences or all the -- they don't know
17 all the ins and outs and all the implications. They're
18 just not able to do that really. And we all know that.
19 Q. What about number 3? Has the young person to
20 some extent thought through the implications of what
21 they might do if their priorities around gender do
22 change in the future?
23 Do you see that on the screen?
24 A. No. My -- my post-doc fellow told me
25 yesterday -- his son's in college. He goes to Tarrant

1 County Junior College. The kid's I guess 17. And the
2 kid was talking to him about he might want to go to
3 medical school, but if that doesn't work out, he'll be a
4 tattoo artist. So, you know, what -- come on. And
5 that's if your -- if your priorities change, they don't
6 do that kind of reasoning yet. Their reasoning is
7 pretty limited. And they're not able to -- if
8 priorities are going to change, it's very difficult for
9 them. So they, you know, come up with statements like
10 that. It's always later that you're able to rationalize
11 much better.
12 Q. What about number 4? Is the young person able
13 to understand and manage the day-to-day short- and
14 long-term aspects of a specific medical treatment?
15 A. Gosh, look at the psychiatric literature, which
16 I can't quote the number, probably hundreds of studies
17 on noncompliance with not only adolescents but adults.
18 We can't get adults to comply with diabetes treatment,
19 so, again, very difficult for children to do to,
20 you know, be fully compliant with a lot of things.
21 You know, kids -- well, one example is attention deficit
22 medications. It's very difficult sometimes to get the
23 kids to stay on their medications the way they're
24 supposed to. That's a -- that's a problem with
25 children.

1 Q. Let's go to Page 258. Okay. Doctor, do you
2 see on the screen where the WPATH has their criteria for
3 prescribing puberty-blocking agents?
4 A. This is what you've highlighted in yellow?
5 Q. I'm going to ask about that in a moment. I'm
6 just asking if you can see it on the screen.
7 A. Where it says puberty-blocking agents?
8 Q. Yes.
9 A. Yes, I see that.
10 Q. Okay. Under C, do you see where it says
11 demonstrates the emotional and cognitive maturity
12 required to provide informed consent/assent to the
13 treatment?
14 A. I see that, yes.
15 Q. Do you believe that minors can demonstrate the
16 emotional and cognitive maturity sufficient to provide
17 informed consent or assent to puberty blockers?
18 A. Let me assure you they don't know what puberty
19 blockers are. They could be told that that's going to
20 stop their puberty. That's not the whole story. They
21 don't -- no, they don't know that. And from what we
22 know of the effects of puberty agents, these agents
23 change the entire functioning of the brain. Everybody
24 in this room's had that because we all went through
25 puberty. And these are agents that normally are in like

1 testosterone and estrogen. That's their function.
2 That's what they do is change the nervous system and
3 brain. An adolescent doesn't understand that, doesn't
4 understand what it does, no.
5 Q. What about under E, informed of the
6 reproductive effects, including the potential loss of
7 fertility and the available options to preserve
8 fertility? Can a minor understand that sufficient to
9 give informed consent or assent to puberty blockers?
10 A. Well, I don't know. I think, yeah, you can
11 tell an adolescent you'll never have children, you'll be
12 sterilized, and I think they probably understand that to
13 some extent. But what does that mean? That not only
14 means you're not going to have children; that means loss
15 of, you know, a child in your later life. That means
16 all sorts of emotional things. That means loss of
17 familial things. I don't think they understand those
18 things.
19 So I think they -- I think they can get
20 the concept that I might never have kids, but when
21 you're -- when you're talking about informed consent,
22 again, let's look at the philosophical underpinning.
23 It's not just, oh, this isn't going to happen. That's
24 really being able to understand all the implications of
25 something.

1 And for example, I'm just going to pick
2 somebody at random, a female having a mastectomy because
3 she has breast cancer. Well, you don't just tell the
4 lady, well, you're just going to lose the breasts. The
5 other consequences are there's pain problems. There are
6 prosthetic problems. There are social problems. That's
7 what informed consent is, is understanding all of those
8 implications, not just, oh, it's going to be gone.
9 Q. I want to look at the criteria for hormonal
10 treatments. Sorry about all the highlighting. I did
11 that. Under C, do you see where it says demonstrates
12 the emotional and cognitive maturity required to provide
13 informed consent/assent to the treatment for hormonal
14 treatments?
15 A. Well, again, no, not really. You took the
16 slide down, but this is -- it's not my saying, but this
17 is the consensus of the scientific community with the
18 citation I had in that children this age are thinking
19 through the amygdala. And the amygdala is purely
20 emotional -- fear, anxiety, or emotional issues. So
21 that's not -- emotional and cognitive maturity is
22 completely the antithesis of amygdala. That's not what
23 the amygdala is.
24 Q. What about the -- number E, informed of the --
25 and this is similar to above, being informed of the

1 potential loss of fertility and available options for
2 preserving fertility before losing that opportunity. Do
3 you believe that a minor can appreciate the consequences
4 of that decision?
5 A. I think I've answered that. Again, I -- I
6 think -- I think an adolescent can probably understand
7 no, I won't have kids. In fact, I remember I was in
8 high school and one of my best friends was informed that
9 he had a medical problem, and I can't remember what it
10 was, and he would not have children. I clearly remember
11 the discussion. And so we understood that he would
12 never have children, but I don't think that you
13 understand the other implications, you know, around
14 that.
15 So yeah, you might be able to understand,
16 again, on a limited basis, yeah, I'm not going to have
17 kids, but my whole point is there are other implications
18 too that probably aren't understood. And we see this --
19 we see this with some of the people who have gone
20 through some of these procedures that -- we're seeing
21 more and more of those folks now who say I just didn't
22 understand fully what would happen to me as a
23 human being and, you know, expressing that in some of
24 their therapy or their communications.
25 Q. Lastly I want to talk about surgeries. And I

1 apologize if some of these questions are redundant, but
2 these are different procedures. Under C, do you see
3 where it says demonstrates emotional and cognitive
4 maturity required to provide informed consent/assent to
5 the treatment?
6 Do you believe that minors have the
7 emotional and cognitive maturity required to provide
8 informed consent or assent to surgical procedures for
9 the treatment of gender dysphoria?
10 A. Again -- again, not fully.
11 Q. Under F, it says -- do you see the criteria
12 where it says at least 12 months of -- before beginning
13 surgical procedures, they have to have at least
14 12 months of gender-affirming hormone therapy or longer
15 unless hormone therapy is either not desired or is
16 medically contraindicated?
17 Do you see that on the screen?
18 A. I see it, yes.
19 Q. Okay. So my question is: Do you think that if
20 a minor is taking cross-sex hormones for a year that --
21 would that change your analysis of whether or not they
22 are having emotional and cognitive maturity required to
23 provide informed consent or assent to a surgical
24 procedure?
25 A. Not really, no. It wouldn't change my opinion.

1 Q. Well, why not? If they're getting
2 testosterone, for example, wouldn't that -- that
3 hormonal development -- couldn't that play a role in
4 their development and maturity if they're not on --
5 couldn't that play a role in development and maturity?
6 A. Well, number one, that's not going to do
7 anything in terms of accelerating their executive
8 function process, so that's irrelevant. It's not going
9 to accelerate it. And number two, just a year is not
10 long enough to appreciate the full effects of some of
11 these medications. And we're now -- some of the recent
12 research is starting to document the side effects of
13 these medications as well as --
14 MR. GONZALEZ-PAGAN: Objection,
15 Your Honor, beyond the scope.
16 THE COURT: So the scope was related to
17 informed consent.
18 MR. STONE: Actually, we designated
19 Dr. Hopewell as an expert specifically on the practice
20 of neuropsychology and clinical psychology and on
21 informed consent. So to the extent that he's testifying
22 about neuropsychology and clinical psychology and the
23 practice thereof, I think this would fall within that.
24 But I don't have a whole lot of questions on that.
25 THE COURT: Sure.

1 MR. STONE: I mean, this is it.
2 THE COURT: Anything else?
3 MR. GONZALEZ-PAGAN: No, Your Honor. He's
4 talking about the effects of medical treatment, which we
5 would argue is beyond the scope.
6 THE COURT: Okay. Well, I guess let me go
7 ahead and let you finish your answer. And that question
8 specifically was: If they're getting testosterone, for
9 example, wouldn't that hormonal development -- couldn't
10 that play a role in their development and maturity if
11 they're not on -- couldn't that play a role in
12 development and maturity? Sorry.
13 MR. STONE: It's a bad question.
14 THE COURT: Which I think you may have
15 answered.
16 A. Well, I think I answered the first part of
17 that. The second part, as a neuropsychologist, as well
18 as a licensed prescriber, again, that's not enough time
19 for those medications to have their full effects. So
20 you're going to have a longer interval time to see some
21 of the consequences of them, and that plays a part in
22 decision-making. We had testimony -- well, I won't even
23 go into that. But we've had testimony similar to that
24 from people who say I was on these medications for a
25 long time, and it took me --

1 MR. GONZALEZ-PAGAN: Your Honor --
2 A. -- this long to understand it.
3 MR. GONZALEZ-PAGAN: Objection,
4 Your Honor.
5 THE COURT: Hold on. Hold on. We're not
6 doing very good question/answer, so let's ask the next
7 question.
8 Q. (BY MR. STONE) Doctor, is -- do you believe
9 that informed consent or assent is required from a
10 medical perspective from a minor for a procedure for
11 which there could be irreversible consequences?
12 A. That it's required?
13 Q. That -- yeah, required.
14 A. I think there are many instances where it's not
15 required. One example might be a blood transfusion
16 where the youngster may not want to or give assent, but
17 it's lifesaving. Did I understand your question
18 correctly?
19 Q. Sure. Let me rephrase it. In the context of
20 the treatment -- medical interventions for the treatment
21 of gender dysphoria, in your opinion is the -- just as
22 the WPATH requirements state, do you believe that
23 informed consent or assent from the minor is necessary
24 before beginning one of those treatments?
25 A. For sex dysphoria or -- I'm --

1 Q. Let me ask --
2 A. I'm not following the question I guess.
3 Q. Sure. So let me ask it differently. Do you
4 agree with the WPATH Standard of Care 8 that what we've
5 just been reviewing, that these are all things that a
6 clinician should be evaluating before beginning these
7 courses of treatment in terms of getting informed
8 consent or assent to that treatment from a minor?
9 A. Well, I agree that if it's possible, you should
10 get assent for any treatment, whether it's, you know,
11 sex related or anything else. The question I have is
12 what their capability is to do.
13 MR. STONE: Your Honor, pass the witness.
14 THE COURT: All right. Thank you. Can
15 we -- do we need -- okay. It's about 3:15, which is
16 usually when I take the afternoon break, so we're going
17 to do that and resume at 3:30.
18 MR. GONZALEZ-PAGAN: Thank you,
19 Your Honor.
20 THE COURT: And you can step off the
21 witness stand, Dr. Hopewell.
22 *(Recess taken)*
23 THE COURT: All right. Go ahead.
24 MR. GONZALEZ-PAGAN: Thank you,
25 Your Honor.

1 **CROSS-EXAMINATION**
2 BY MR. GONZALEZ-PAGAN:
3 Q. Good afternoon, Dr. Hopewell.
4 A. Good afternoon.
5 Q. My name is Omar Gonzalez-Pagan.
6 A. I'm sorry?
7 Q. Omar Gonzalez-Pagan is my name.
8 A. Pagan?
9 Q. Yes, Gonzalez-Pagan. Thank you. Dr. Hopewell,
10 have you diagnosed any patient under 18 for gender
11 dysphoria?
12 A. Yes.
13 Q. When?
14 A. I think we have a couple now.
15 Q. And have you treated any patient under 18 for
16 gender dysphoria?
17 A. Oh, yes.
18 Q. You do not have any peer-reviewed publications
19 relating to gender dysphoria; is that correct?
20 A. Now, I'd rather -- I'd rather use the term sex
21 dysphoria. Gender is a literary term. But no, I
22 haven't published on that.
23 Q. The diagnosis in the DSM-V is of gender
24 dysphoria; is that correct?
25 A. Well, they got it wrong.

1 THE COURT: All right. Well, we're
2 calling it gender dysphoria, Doctor. If you don't want
3 to use that term, that's fine, but he's going to use
4 that term.
5 THE WITNESS: Yeah. I'm a scientist, so I
6 try to use correct terms.
7 THE COURT: I don't need the extra
8 commentary. Let's get to the question.
9 Q. (BY MR. GONZALEZ-PAGAN) So have you conducted
10 any -- do you have any peer-reviewed publications
11 related to gender dysphoria?
12 A. No.
13 Q. Have you conducted any original research
14 relating to gender dysphoria?
15 A. No.
16 Q. You made reference to the capacity of children
17 and adolescents to consent to medical care. That was
18 your testimony; right?
19 A. Yes.
20 Q. Minor patients assent to care and their parents
21 or guardians consent to care; is that correct?
22 A. That's my understanding, yes.
23 Q. Medical treatment is provided to minor patients
24 for all kinds of medical conditions; is that right?
25 A. Yes, of course.

1 Q. Is it your testimony that no minor can assent
2 to medical treatment if such treatment has long-term
3 effects?
4 A. Well, I've already testified at length that
5 when you talk about minors, it's a wide period of time.
6 And I think that the AMA specifically answers that
7 question by saying that the assent needs to be tailored
8 to the child, to the developmental age, to the maturity,
9 to the understanding of the child. So I'm not going to
10 issue a blanket statement because the time period is too
11 long and children are different. Maybe I'm not
12 understanding your question.
13 Q. No. Thank you. That's very helpful. So you
14 would agree then that a minor can assent to medical
15 treatment when such treatment has long-term effects
16 depending on their developmental stage, maturity,
17 cognitive level?
18 A. Except I've already testified that minors don't
19 have the capacity to understand fully all the long-term
20 consequences of anything really.
21 Q. So given that minors cannot understand the
22 long-term consequences of anything really, does that
23 mean that they cannot assent to --
24 A. Really their assent's going to be --
25 Q. -- medical care --

1 A. Their assent's going to be --
2 Q. Let me finish my question.
3 THE COURT: Hold on. Hold on.
4 THE WITNESS: I'm sorry.
5 THE COURT: Hold on. We can't talk over
6 each other because Ms. Crain's going to get very upset
7 with us. So if you can finish your question.
8 MR. GONZALEZ-PAGAN: Thank you,
9 Your Honor.
10 THE COURT: Okay.
11 Q. (BY MR. GONZALEZ-PAGAN) If you'd please let me
12 finish my question before answering, I'll strive to do
13 the same as well. Thank you.
14 Is it your testimony then that a minor,
15 because they do not have the ability to comprehend
16 long-term effects, cannot assent to medical treatment if
17 such treatment has long-term effects?
18 A. I think that's basically correct. Again,
19 you're asking me a yes or no question, which is not
20 readily answerable with either yes or no, but certainly
21 the assent's limited. And with what I've testified
22 before, I -- I would basically say no because they don't
23 have the capacity to make those decisions or to form
24 that complete understanding.
25 Q. Are you aware of the body of literature

1 indicating that adolescents are capable of deliberative
2 decision-making in the presence of adults and when the
3 decision-making occurs over a protracted period of time?
4 A. I'm aware of some of it.
5 Q. You have testified in favor of bills similar to
6 SB 14; is that correct?
7 A. Yes.
8 Q. In your testimony before the Texas Legislature,
9 you said in reference to the provision of
10 gender-affirming medical care that it is -- quote, "This
11 is really a hysterical phenomenon," closed quote. Is
12 that right?
13 A. It is.
14 Q. You were deposed in a case *In the Interest of*
15 *J.A.D.Y. and J.U.D.Y.* in 2019; is that right?
16 A. I gave a deposition in 2019, but I think you're
17 using terms I don't know what --
18 Q. Sure.
19 A. -- what that is.
20 THE COURT: I think he's just using the
21 initials of the children. That's typically how the case
22 style works.
23 A. Okay. I think I know what you're referencing.
24 Q. (BY MR. GONZALEZ-PAGAN) You were deposed in
25 September of 2019 in relation to a custody matter?

1 A. To a what?
2 Q. A custody matter.
3 A. Yes.
4 Q. In that deposition when you were asked "Is it
5 possible for a person to be born one sex and want to
6 identify as the opposite sex at some point?" you
7 responded "That's not possible." Is that right?
8 A. What was the question again?
9 Q. "Is it possible for a person to be born one sex
10 and want to identify as the opposite sex at some point?"
11 Your response was "That's not possible."
12 A. Well, you can --
13 Q. Do you recall that testimony?
14 A. I don't remember specifically. But yeah, you
15 can identify with whatever you wish. I think my intent
16 was that you can't change your sex, which is not
17 possible, but people can identify with lots of different
18 things.
19 Q. In that deposition you testified, quote, "There
20 aren't transgender children," closed quote. And when
21 asked "Are there transgender adults?" you said "No."
22 A. You can't change your sex, no.
23 Q. In that deposition when asked "What's the
24 definition of a transgender individual?" you responded
25 "Well, I don't know. It's a meaningless term." Is that

1 consistent with your testimony?
2 A. That's -- after I discussed it with Dr. Zucker,
3 I agreed with him that that was essentially meaningless
4 because an individual can say whatever they wish. They
5 can identify however they wish, so it's meaningless.
6 Q. Are you aware that Dr. Zucker -- and you're
7 referring to Kenneth Zucker; is that right?
8 A. Right.
9 Q. And Dr. Zucker, who is in Canada at the Center
10 for Addiction -- used to head the Center for Addiction
11 and Mental Health in Canada; is that right?
12 A. That's the one that I spoke with, yes.
13 Q. Yes. Are you aware that he actually provided
14 gender-affirming medical treatment to adolescents after
15 the onset of adolescence -- of puberty?
16 A. Well, he can do whatever he wishes. I assume
17 he has done that. That doesn't change the fact of his
18 definition of it.
19 MR. GONZALEZ-PAGAN: No further questions,
20 Your Honor.
21 THE COURT: All right. Any further
22 redirect?
23 MR. STONE: Just a couple of follow-up
24 questions, Your Honor.
25 THE COURT: Okay.

1 **REDIRECT EXAMINATION**
2 BY MR. STONE:
3 Q. What did you mean when you said that the cases
4 were hysterical? I didn't quite catch the whole quote,
5 but something about cases being hysterical.
6 A. Well, all the evidence points to this recent
7 phenomenon which the -- I think the -- part of the term
8 now is rapid onset dysphoria as having a genuine
9 hysterical component. Admittedly, there are youngsters
10 who -- I'm trying to -- I'm trying to phrase this
11 correctly -- who genuinely have sexual disorders and
12 have had them, but we have -- this is not a unitary
13 phenomenon. Not everybody who walks in and says I have
14 back pain has all of a sudden back pain.
15 So we have different groups of children or
16 adolescents or adults who claim different problems for
17 different reasons. The evidence shows that a large
18 number of youngsters are being influenced by social
19 media, by peer pressure, things like that. And this has
20 gone in cycles in the United States. The last big cycle
21 which we had in Texas, which the Texas Legislature
22 investigated, was that of multiple personality disorder,
23 which resulted in hospitals being built essentially. So
24 there's a hysterical component to this issue that needs
25 to be acknowledged.

1 Q. Doctor, you testified earlier in response to a
2 cross-examination question that you treat patients who
3 are minors for gender dysphoria; right?
4 A. We -- we have a few. My practice is varied,
5 mostly to neurological issues. We also treat a number
6 of -- I say we; my staff. We treat a number of veterans
7 and veterans' families, and so we have -- at this moment
8 we have two or three youngsters with these kinds of
9 issues that we're -- that we're following and following
10 for different reasons. So it's not something that I've
11 never seen or never done. Again, I've served on a
12 sexual surgery team, but this was -- again, since
13 there's this component -- you never saw these kinds of
14 children, you know, more than 10 years ago or 15 years
15 ago. This is -- you know, just this surge has just
16 happened really since about 20 -- two thousand, I
17 guess -- 25.
18 Q. How do you treat those patients for gender --
19 minors for gender dysphoria?
20 A. Well, they're treated properly in terms of
21 80 percent have emotional difficulties. The testimony
22 earlier here alluded to that. So the primary treatment
23 and the primary treatment that's really recommended is
24 to address the emotional issues of the family and the
25 youngsters and explore what's best for them and what's

1 going to be helpful and also to treat any comorbid
2 emotional disorders.
3 70 percent -- the research has documented
4 that 70 percent of girls claiming that they want to
5 change sex and be a boy are -- that there's a large
6 autistic component, for example. That's a comorbid
7 disorder. So that's how we treat those youngsters, is
8 by working with all those disorders.
9 Q. Thank you.
10 MR. STONE: Pass the witness, Your Honor.
11 THE COURT: Anything further?
12 MR. GONZALEZ-PAGAN: Nothing further,
13 Your Honor.
14 THE COURT: All right. Dr. Hopewell, your
15 time on the stand is done.
16 THE WITNESS: Thank you, ma'am.
17 THE COURT: You are excused.
18 THE WITNESS: I'm sorry for talking over
19 people.
20 THE COURT: That's okay. I've just got
21 to -- I'm the referee.
22 All right. For defense, who's your next
23 witness?
24 MR. ELDRED: Dr. John Perrotti.
25 THE COURT: I'm sorry. The last name

1 again?
2 MR. ELDRED: Perrotti.
3 THE COURT: Perrotti. All right.
4 Dr. John. If you'll raise your right hand for me.
5 *(Witness sworn)*
6 THE COURT: All right. You can make your
7 way around up to this witness stand. Go ahead.
8 MR. ELDRED: Thank you.
9 **JOHN PERROTTI, M.D.**
10 having been first duly sworn, testified as follows:
11 **DIRECT EXAMINATION**
12 BY MR. ELDRED:
13 Q. Please state and spell your name.
14 A. Sure. J-o-h-n, P-e-r-r-o-t-t-i.
15 Q. How do you pronounce that last name?
16 A. Perrotti.
17 Q. Thank you. What is your profession?
18 A. Plastic surgery.
19 Q. Go ahead and pour yourself some water.
20 A. That's okay. I can wait.
21 Q. What degrees do you hold?
22 A. I hold a bachelor of science and an MD, medical
23 doctor.
24 Q. Where did you go to medical school?
25 A. New York Medical College.

1 Q. And what year did you graduate from medical
2 school?
3 A. 1991.
4 Q. What year did you -- or I'm sorry. Where did
5 you do your resident --
6 A. I did --
7 Q. -- residency?
8 A. I did two residences, the first in general
9 surgery at St. Vincent's Hospital in New York City, and
10 I did a subsequent plastic surgery residency at the
11 Cleveland Clinic, and I finished the second residency in
12 1998.
13 Q. Do you hold any board certifications?
14 A. American Board of Plastic Surgery
15 certification.
16 Q. Are you currently licensed to practice
17 medicine?
18 A. I am, in both New York and Florida.
19 Q. How long have you been practicing medicine as a
20 plastic surgeon?
21 A. Since -- well, subsequent to residency, since
22 1998. It's almost 25 years.
23 Q. What hospitals do you hold privileges at?
24 A. Currently I hold privileges at Lenox Hill
25 Hospital and its subsidiaries in New York and

1 Metropolitan Hospital also in New York.
2 Q. Have you ever held any academic appointments?
3 A. Assistant clinical professor of surgery at
4 New York Medical College.
5 Q. Do you still have that appointment?
6 A. Yes.
7 Q. Have you published in the area of plastic
8 surgery?
9 A. I have.
10 Q. What kind of things have you published?
11 A. I've published some reconstructive surgery
12 articles, some cosmetic or aesthetic surgery articles.
13 Q. Have you ever testified as an expert on the
14 subject of plastic surgery?
15 A. In general, yes.
16 Q. How many times?
17 A. I don't know.
18 Q. More than five?
19 A. Probably closer to ten.
20 Q. Okay. Do you have education and training
21 concerning obtaining informed consent to plastic
22 surgery?
23 A. Yes.
24 Q. What education and training do you have?
25 A. Well, informed consent is something that we

1 learn -- we learn it before residency -- before
2 residency while we're still in medical school by
3 shadowing the residents, but informed consent in the
4 surgical field is something that we learn day one in
5 internship and basically throughout the years of
6 surgical training, and it's something that surgeons do,
7 you know, every time that they operate or do a
8 procedure.
9 Q. And I think you may have answered this already,
10 but do you have experience with obtaining informed
11 consent for plastic surgery?
12 A. I do.
13 Q. And just tell us what that is.
14 A. What is -- what is my experience?
15 Q. Yes, sir.
16 A. Explaining the risks, benefits, and
17 alternatives, and limitations of surgical procedures or
18 interventions to patients, and I've been doing that for
19 almost 30 years.
20 Q. Have you performed any particular research on
21 obtaining informed consent for plastic surgery?
22 A. I have not -- I'm sorry. Could you repeat
23 that?
24 Q. Have you performed any research concerning
25 obtaining -- concerning -- concerning obtaining -- let

1 me try this again.
2 Have you performed any research on
3 obtaining informed consent to plastic surgery?
4 A. I have not.
5 Q. Okay.
6 MR. ELDRED: And Your Honor,
7 Dr. Perrotti's CV is Defendants' Exhibit 2. And at this
8 time we'd like to proffer him as an expert in the
9 practice of plastic surgery and informed consent in
10 plastic surgery.
11 THE COURT: Any objection?
12 MR. SELDIN: Can we have voir dire very
13 briefly, Your Honor?
14 THE COURT: Okay. Very briefly.
15 **VOIR DIRE EXAMINATION**
16 BY MR. SELDIN:
17 Q. Dr. Perrotti, good afternoon.
18 A. Good afternoon.
19 Q. Have you received any specialized training in
20 the treatment of gender dysphoria in adolescents?
21 A. I have not.
22 Q. Have you conducted any research on the safety
23 of surgical procedures to treat gender dysphoria in
24 adolescents?
25 A. I have not.

1 Q. Have you conducted any research on the efficacy
2 of surgical procedures to treat gender dysphoria?
3 A. I have not.
4 Q. Have you published any peer-reviewed research
5 on surgical procedures to treat gender dysphoria?
6 A. I have not.
7 Q. Have you ever provided surgery to treat gender
8 dysphoria in an adolescent?
9 A. I have not.
10 Q. Have you ever provided surgery -- have you ever
11 been a part of providing informed consent for surgery to
12 treat gender dysphoria in an adolescent?
13 A. I want to answer that question carefully. I --
14 if we're talking about gender-affirming procedures, then
15 the answer would be no. If we're talking about treating
16 transgender patients for issues that turn up which -- in
17 transgender surgery, then the answer would be yes.
18 MR. SELDIN: Your Honor, we would ask that
19 this -- we would proffer the -- proffer for this expert
20 is sufficient only for informed consent as to surgery
21 generally and not as to the outcomes of any particular
22 gender-affirming surgery.
23 THE COURT: Let me ask you this,
24 Dr. Perrotti. How much of your practice is plastic
25 surgery on minors?

1 THE WITNESS: Minors in general would
2 probably be somewhere around 10 percent.
3 THE COURT: All right. Because that's
4 where I think he could talk about that, but it's -- it
5 would be specific to that as opposed to -- so I guess I
6 just gave my ruling, which is --
7 MR. SELDIN: I'm happy to argue with you,
8 Your Honor, but I think you've ruled.
9 THE COURT: Just so that I'm clear on,
10 you know, sort of -- I mean, to the extent -- I mean,
11 he's -- I've understood his caveats about what he has
12 not -- has and has not done. And I think with respect
13 to informed consent, it's in the areas of -- in the area
14 of plastic surgery in minors, okay?
15 MR. SELDIN: Thank you, Your Honor.
16 THE COURT: Thank you. Not that I expect
17 you to agree with me, but...
18 MR. SELDIN: Very happy to.
19 THE COURT: All right, Mr. Eldred.
20 MR. ELDRED: Thank you.
21 **CONTINUED DIRECT EXAMINATION**
22 BY MR. ELDRED:
23 Q. What kind of surgical procedures -- what kind
24 of plastic surgical procedures are commonly offered for
25 the treatment of gender dysphoria?

1 A. There are several broad categories, one being
2 so-called top surgery or breast or chest surgery. The
3 second would be types of facial surgery. And the third
4 would be so-called bottom surgery or genital surgery.
5 Q. What's top surgery more specifically?
6 A. So top surgery describes surgery used to treat
7 the chest in gender dysphoria.
8 Q. What kind of surgical procedures are included
9 in top surgery?
10 A. So there's two broad categories, obviously.
11 One is for female to male and one is for male to female.
12 Male to female is one of the more common procedures.
13 That procedure is -- it's got several names, double
14 mastectomy, bilateral mastectomy.
15 Q. That's male to female or female to male?
16 A. That is female to male.
17 Q. Okay.
18 MR. ELDRED: Your Honor, may we approach?
19 Can counsel approach the bench?
20 *(Discussion off the record)*
21 THE COURT: Is it those three?
22 MS. DYER: May I approach the witness and
23 just give it to him?
24 THE COURT: Yes.
25 Q. (BY MR. ELDRED) Doctor, we're going to talk

1 about some of these procedures. Do you think it would
2 be beneficial to the Court when we talk about procedures
3 to show pictures of what they entail?
4 A. Yes.
5 Q. And did you send me some pictures of some of
6 these procedures -- well, send our office some pictures
7 of some of these procedures to help demonstrate what
8 we're talking about?
9 A. Yes.
10 Q. And would showing this picture -- let's start
11 with a double mastectomy. Would showing pictures of a
12 double mastectomy help the finder of fact, Her Honor,
13 demonstrate what you're talking about?
14 A. Yes.
15 Q. So I think we're showing you some pictures of
16 double mastectomies now that you sent us before from the
17 National Institutes of Health website. Do you recognize
18 those pictures?
19 A. Yes.
20 MR. ELDRED: And Your Honor, can you see
21 them?
22 THE COURT: Yes.
23 Q. (BY MR. ELDRED) And just for the record, we
24 have decided not to show these in the courtroom, but the
25 judge can see them and the witness can see them.

1 So why don't you just tell us what we're
2 looking at here.
3 A. Right. So before I tell you that, I'd just
4 like to say that there are several different ways and
5 procedures to do a double mastectomy or a top surgery,
6 and this is -- this is one of them. So these
7 photographs show preoperative images above with normal
8 healthy breast tissue and postoperative images below of
9 one of the post-mastectomy procedures.
10 Q. And when this procedure is done on a minor for
11 the purpose of gender dysphoria, are these pictures
12 equally demonstrative of what happens?
13 A. They are for one of the techniques that's used
14 to perform a double mastectomy.
15 Q. Can you describe the techniques?
16 A. Sure. There are several techniques. This
17 appears to show a technique where there's only a
18 periareolar incision. That means an incision around the
19 nipple. There's other surgeries that have more
20 extensive incisions. That depends on the patient's
21 anatomy, the amount of breast tissue that they have, the
22 amount of skin that they have. It's individualized to
23 the particular patient.
24 Q. And do minors who undergo this -- first of all,
25 have you performed this procedure on minors before?

1 A. I have not performed mastectomies on minors,
2 no.
3 Q. For any purpose?
4 A. For any purpose.
5 Q. Okay. Are these pictures of -- the after
6 pictures comparable to what a minor who received a
7 double mastectomy would appear?
8 MR. SELDIN: Objection, Your Honor. He's
9 just testified that he has not performed this procedure.
10 THE COURT: So I guess for my
11 clarification, these aren't -- these aren't necess- --
12 are these photos of your patients, Dr. Perrotti?
13 THE WITNESS: They are not.
14 THE COURT: Okay. But --
15 THE WITNESS: And -- I'm sorry.
16 THE COURT: No, that's okay. But they're
17 examples that you have located of mastectomies in -- but
18 not in minors -- or -- right? Or you don't know?
19 THE WITNESS: If I can clarify my answer.
20 THE COURT: Sure.
21 THE WITNESS: So I have not performed -- I
22 forget what your question was, if it was specific to
23 transgender surgery. I have not performed subcutaneous
24 mastectomies or bilateral mastectomies through a
25 periareolar approach for transgender patients, but I

1 have performed this procedure for other issues such as
2 gynecomastia, and I have performed them in minors under
3 18.
4 Q. (BY MR. ELDRED) Okay. All right. I don't
5 think we really -- why don't you just explain briefly
6 the ways you do a double mastectomy.
7 A. Okay. There's -- there's two ways. There's at
8 least two ways. One way is through a periareolar
9 approach as in this particular patient. That is where
10 the surgery is done with incisions around the nipple, no
11 other incisions, as can be seen in this photograph -- in
12 these photographs. Another more common I believe
13 procedure is a double incision where there's an incision
14 that's made underneath the breast as well as around the
15 nipple. And no, I have not performed that type of
16 mastectomy in minors.
17 Q. Okay. What are the potential long-term
18 complications of double mastectomy?
19 A. So the short-term complications to surgery,
20 which is bleeding, infection, wound healing problems,
21 and those are really all types of surgery and all
22 different techniques. The long-term complications of a
23 double mastectomy and particularly a double mastectomy
24 for transgender patients are long-term problems with
25 wound healing, long-term problems with contour

1 deformities. Depending on how the nipple is treated,
2 some of these procedures treat the nipple with a -- with
3 a free nipple graft where the nipple is removed and then
4 placed as a skin graft. Those patients can have
5 problems with nipple -- well, they do have problems with
6 nipple sensitivity. They can have problems with nipple
7 projection, nipple pigmentation, and other deformities
8 like that.
9 Q. Can this affect the breastfeeding function?
10 A. Certainly a mastectomy that removes the breast
11 tissue and/or devitalizes the nipple renders the patient
12 unable to breastfeed.
13 Q. How about the other top surgery, breast
14 augmentation? How do you perform that?
15 A. So breast augmentation is obviously performed
16 in the transgender population for male to female. And
17 no, I have not performed trans -- I have not performed
18 breast augmentation in transgender, but I certainly have
19 performed many, many breast augmentations. Breast
20 augmentation is basically through various incision
21 locations on the chest that basically a breast implant
22 is placed usually under the pectoralis muscle.
23 Q. And I think this is a dumb question, but if a
24 male gets a breast augmentation, can that male
25 breastfeed?

1 A. Of course not.
2 Q. Why not?
3 A. Because the male has no native breast tissue.
4 Q. Are there potential long-term complications of
5 breast augmentation?
6 A. So breast augmentation complications, the short
7 term, are the same that I previously mentioned. The
8 long-term complications are wound healing, infection,
9 what we call -- what's known as capsular contracture
10 where scar tissue forms around the implant. Scar tissue
11 always forms around an implant. Sometimes that implant
12 becomes problematic. Breast implants are known to
13 rupture. Breast implants are known to leak. So the
14 complications are -- the long-term complications are
15 almost specifically due to the implant themselves.
16 MR. ELDRED: And Judge, I think --
17 Q. (BY MR. ELDRED) Have you only -- I want to go
18 back to the double mastectomy picture. Have you looked
19 at just one picture? Or how many pictures have you
20 looked at?
21 A. I've only seen one. Well, the set. The one
22 set, yes.
23 MR. ELDRED: Can you show him the other
24 two sets?
25 MR. SELDIN: If we could just have an

1 identification of what number in Box we're at, please.
2 THE COURT: Sure. I'm assuming you're
3 wanting him to see D-15 and D -- oh.
4 MR. ELDRED: I believe D-13 -- one of them
5 has two sets and one of them has one set. I apologize.
6 MS. DYER: This is 14.
7 THE COURT: You're at 14, Ms. Dyer?
8 MS. DYER: Yes. D-13 was the initial one.
9 This is D-14. And I'll show him D-15 in just a moment.
10 THE COURT: Okay. I'm at D-14.
11 MR. ELDRED: Okay. I got you. I got you.
12 Q. (BY MR. ELDRED) Does D -- what does D-14 show,
13 the one you're looking at now?
14 A. So this is the other technique of double
15 mastectomy where there's two incisions. There's an
16 inframammary incision, which is in the breast crease,
17 and there are incisions around the nipple and most
18 likely free nipple grafts where the nipples are taken
19 off and they're replaced as skin grafts.
20 MR. ELDRED: And can you show him
21 Exhibit -- it's 16?
22 MS. DYER: 15.
23 MR. ELDRED: 15. I apologize.
24 THE COURT: I'm there.
25 A. And --

1 Q. (BY MR. ELDRED) What is -- what are we looking
2 at in D-15?
3 A. This is the same. This is the same as the
4 previous one where it's a double incision, double
5 mast- -- double mastectomy where there's the incision in
6 the inframammary crease below the breast and then
7 incision around the nipple. And you can see the nipple
8 has been resized, reshaped, and relocated.
9 Q. And in all three of these sets, D-13, D-14, and
10 D-15, are we seeing before and after pictures?
11 A. That's correct. The before pictures are above
12 and the after pictures are below.
13 Q. All right. Thanks. I'd like to move on --
14 what is facial feminization surgery?
15 A. So facial feminization surgery is performed on
16 male to female transgender patients basically to make
17 the -- give the face a more feminine procedure -- I'm
18 sorry -- appearance. These procedures -- there are
19 several procedures. They most often involve a surgery
20 on the forehead, surgery on the nose, surgery on the
21 jaw, surgery on the larynx.
22 Q. Are there potential complications of facial
23 feminization surgery?
24 A. The potential complications are the same as any
25 surgery, bleeding, infection, wound healing problems.

1 There's always -- in any type of structural surgery,
2 there's always contour deformities. Some of the
3 complications of rhinoplasties apply where there's both
4 structural complications as well as cosmetic
5 complications.
6 Q. Let's move on to bottom surgery. What are the
7 kinds of bottom surgery?
8 A. So bottom surgery entails phalloplasty for a
9 female to male or a vaginoplasty for a male to female.
10 Q. All right. What's a phalloplasty exactly?
11 A. So a phalloplasty is basically creation of a
12 penis and whatever other external genitalia for a trans
13 male patient.
14 Q. By trans male, you mean a female to male
15 person?
16 A. That's correct.
17 Q. I think we're looking at D-16 now.
18 MR. SELDIN: Your Honor, we would just
19 note our objection on the record to the extent these are
20 Wikipedia articles.
21 THE COURT: Sure. Hold on. Are you going
22 to ask to have them admitted, Mr. Eldred?
23 MR. ELDRED: No, Your Honor. I just want
24 to use the pictures -- let me set a little more of a
25 predicate.

1 Q. (BY MR. ELDRED) Did you send us pictures from
2 Wikipedia to show examples of phalloplasty and
3 vaginoplasty?
4 A. Yes.
5 Q. Even though they're Wikipedia, are they
6 demonstrative of those types of procedures?
7 A. Yes.
8 Q. So I'd like to show you and the judge --
9 MR. ELDRED: I think it's D-16. Is that
10 what it is?
11 THE COURT: It's actually D --
12 MR. ELDRED: And really we just want to
13 look at pictures. We don't want to read anything.
14 THE COURT: I guess as a demonstrative
15 that's fine, but your objection's noted.
16 MR. SELDIN: Thank you, Your Honor.
17 Q. (BY MR. ELDRED) And can you just -- again,
18 don't talk about the article itself. We're just looking
19 at the pictures. And describe what the pictures show
20 and how that demonstrates the phalloplasty procedure.
21 A. So the photographs basically show what a
22 phalloplasty looks like or at least in this particular
23 instance of this photograph. Phalloplasty is performed
24 most usually by taking a flap, which is a collection of
25 tissue, from a distant area. And most commonly it's

1 taken from the radial forearm as a radial forearm flap.
2 And that is used to form a penis where it's attached in
3 the location. And obviously the female genitalia are
4 removed.
5 Q. Can it also include a scrotum and testicles?
6 A. A scrotum can also be fashioned by using skin
7 grafts and/or scrotal implants, and phalloplasty also
8 can contain penile implant.
9 Q. And this again is probably a dumb question, but
10 if a patient receives this procedure, will that patient
11 have a functioning penis?
12 A. I think the jury is still out on that. The
13 literature is not really clear. I -- they can have a
14 functioning penis if they go through the steps of the
15 penile implants. And I'm assuming by functioning you
16 mean a sexual function.
17 Q. Okay. I apologize for this question, but would
18 that include -- if someone receives a phalloplasty, can
19 they ejaculate?
20 A. No. And also another important part of
21 phalloplasty is surgery and relocation of the urethra
22 where someone -- what's used to urinate. So from any
23 transgender surgery, the urethra needs to be lengthened
24 or shortened and/or repositioned.
25 Q. Okay. And does the phalloplasty surgery have

1 an effect on the female anatomy, the sexual anatomy of a
2 female?
3 A. I'm not sure I understand the question.
4 Q. If a female to male gets a phalloplasty, can
5 the patient still perform sexual function as a female?
6 A. The patient can't perform sexual function as a
7 female, no, but the patient can sometimes achieve
8 orgasm.
9 Q. Okay. What are potential complications of
10 phalloplasty?
11 A. So again, it's the short-term complications of
12 wound healing infection. With a phalloplasty there's
13 also a donor site, so there's long-term complications of
14 donor site -- donor site scarring. Any time there's a
15 flap that's moved to another location, there's always a
16 chance that that flap will not survive or that flap will
17 only partially survive. Because of what I mentioned
18 about the urethra and the urinary flow, there's
19 potential long-term complications of what's known as
20 urethral strictures or scar tissue in the urethra.
21 There's also urinary complications such as urinary tract
22 infections.
23 Q. All right. Let's look at D-17.
24 MR. SELDIN: Your Honor, we would have the
25 same set of objections.

1 THE COURT: And this is on 17?
2 MR. SELDIN: Just noting for the record.
3 THE COURT: Understood. Thank you. So
4 noted.
5 Q. (BY MR. ELDRED) And I'm sorry. I want to
6 stick with the phalloplasty for just a little bit
7 longer. How long is -- does the phalloplasty take? Is
8 it a one -- is it -- I'll stick with that. How long
9 does it take to complete a phalloplasty?
10 A. So phalloplasty is most likely a multistage
11 procedure and usually somewhere between two and three
12 stages.
13 Q. About how long in terms of months, weeks, years
14 does it take to complete the procedure?
15 A. Usually the first stage is done, then the
16 second stage is done at about six months after that, and
17 the third stage may not be done until a year afterwards.
18 Q. So what is a vaginoplasty?
19 A. So a vaginoplasty is so-called bottom surgery
20 for male to female. And a vaginoplasty is where the
21 penile tissue and the scrotal tissue is used to create a
22 vagina, also known as a neovagina.
23 Q. What's the difference between a vagina and a
24 neovagina?
25 A. I guess a neovagina is one that's constructed

1 or reconstructed for that matter.
2 Q. And does D-17 -- again, this is a Wikipedia
3 article. I don't want you to talk about the words or
4 anything, but there are some photographs in D-17. Are
5 those -- would those photographs help the judge
6 understand what this procedure is?
7 A. Yes. These photographs just show basically the
8 external appearance of a neovagina. They don't -- they
9 don't show obviously the inside of the vagina or
10 anything else like that.
11 Q. So this is an after picture?
12 A. That's correct.
13 Q. And I'm going to ask I think a dumb question
14 again, but if a patient gets a vaginoplasty, can that
15 patient get pregnant?
16 A. No.
17 Q. Why not?
18 A. Because the patient doesn't have a uterus.
19 Q. Does the patient have ovaries?
20 A. The patient does not have ovaries.
21 Q. How do you perform a vaginoplasty?
22 A. So the most common technique is what's called a
23 penile inversion technique where the actual skin of the
24 penis is removed and fashioned into a tube-like
25 structure that is then inserted between the ureter and

1 the rectum to form a vagina. This is often supplemented
2 with skin in the form of a skin graft taken from
3 somewhere else.
4 Q. And are there potential complications in a
5 vaginoplasty?
6 A. So the complications are -- for bottom surgery
7 in general, the complications are more significant.
8 There's the short-term complications, but for procedures
9 like this, there's much more serious long-term
10 complications. For vaginoplasty in particular, there's
11 problems with loss of depth, loss of girth. There's
12 problems with skin slough from the skin that's used to
13 create the inside of the vagina. There's problems with
14 a total loss of the vagina. There's what's called
15 fistulas, which are connections between the vagina and
16 the ureter and/or the rectum.
17 Q. And what's that?
18 A. That would be an abnormal connection between
19 the tissue of the vagina and the tissue of the ureter,
20 which is used for urination, or the rectum, which is
21 used for defecation.
22 Q. And when you said I think the loss of depth and
23 girth, can you explain that a little bit more?
24 A. Sure. This is -- this is other tissue that's
25 used to create a vagina. So with time, that tissue will

1 contract, particularly a skin graft, and that tissue
2 will lose its depth and will lose its girth. And that's
3 why after a vaginoplasty the patients need to use a
4 dilator to dilate the neovagina to keep it open, so to
5 speak.
6 Q. I think that's it for the pictures. So let's
7 move on to a new topic, informed consent. What is
8 informed consent in the context of plastic surgery?
9 A. So informed consent is explaining the risks,
10 benefits, alternatives, and also the limitations of a
11 particular surgical procedure or intervention.
12 Q. And why is it important?
13 A. It's important that the patient understands the
14 risks, what can go wrong, they understand what the
15 benefits are, what can be achieved, and that they
16 understand the limitations of what cannot be achieved
17 and also what the alternatives to those treatments are.
18 Q. And in general, how do you obtain an informed
19 consent to plastic surgery?
20 A. You would -- I obtain informed consent by
21 explaining the pertinent risks, alternatives, and
22 benefits, and limitations of a particular treatment.
23 Q. How do you obtain consent from a minor for
24 plastic surgery?
25 A. So there's been a lot of testimony today about

1 consent. The minor -- the minor has to agree to the
2 procedure, but legally it's the parents or the guardian
3 that give the actual permission for the procedure.
4 Q. Okay. Are you familiar with WPATH?
5 A. Yes.
6 Q. Have you reviewed their guidelines for informed
7 consent?
8 A. Yes.
9 Q. How long ago did you review them?
10 A. This week.
11 Q. Okay.
12 MR. ELDRED: I'd like to show what's
13 already been admitted, the WPATH guidelines that we've
14 been talking about a few times today.
15 THE COURT: P-26.
16 MR. ELDRED: Yes. Thank you. And if you
17 can go to Page 63, please. Can you Zoom in on those
18 four bullet points?
19 Q. (BY MR. ELDRED) And do you recognize what
20 we're -- I'm sorry. Do you recognize what we just put
21 up on the screen there?
22 A. Yes.
23 Q. What is that?
24 A. It's from the WPATH guidelines for
25 gender-affirming treatment. And I don't know if this

1 section is particularly for surgery or treatments in
2 general.
3 Q. And I don't want to beat a dead horse, but
4 let's look at the first bullet point. It says: Can a
5 young person think carefully into the future and
6 consider the implications of a partially or fully
7 irreversible intervention?
8 Do you think a minor can give informed
9 consent based on that definition of informed consent?
10 A. No.
11 Q. Why not?
12 A. Because a minor doesn't have the emotional and
13 cognitive ability to understand that these procedures --
14 and I didn't mention this before -- that these
15 procedures are irreversible.
16 Q. How so?
17 A. How --
18 Q. How so are they irreversible?
19 A. They're irreversible.
20 Q. Yes. How are they irreversible?
21 A. They're -- they're -- they're not reversible.
22 Once the breasts -- I'm sorry.
23 Q. That's too --
24 A. Once the breast -- once the breast tissue is
25 removed with a mastectomy of any type, that breast

1 tissue doesn't come back. That's -- that's
2 irreversible. Once the genitalia is changed, that
3 cannot -- that cannot be changed back.
4 I would say that a breast augmentation is
5 partially reversible because if it's a matter of just
6 putting implants in, those implants can be removed, but
7 then there's other issues with skin and scars and things
8 like that that may not be reversible.
9 Q. All right. Thank you. The next bullet point
10 reads: Does the young person have sufficient
11 self-reflective capacity to consider the possibility
12 that gender-related needs and priorities can develop
13 over time and that gender-related priorities at a
14 certain point in time might change?
15 Do you agree that's a good definition of
16 informed consent for plastic surgery?
17 A. I -- I think it's a good definition for the
18 gender-related part of plastic surgery, yes.
19 Q. Do you have any opinion about whether a
20 gender-related -- I'm sorry -- about gender-related
21 needs and priorities can change over time related to
22 plastic surgery?
23 A. You see, I -- I don't want to testify out of my
24 area of expertise. I'd like to stick to the surgery.
25 So as far as the surgery goes, that's a -- that's a good

1 definition related to the surgery.
2 Q. All right. Well, we'll skip gender stuff.
3 Let's go to number 4. Is the young person able to
4 understand and manage the day-to-day short- and
5 long-term aspects of a specific medical treatment? Is
6 that a good definition of informed consent with respect
7 to plastic surgery?
8 A. Yes.
9 Q. Can a young person -- can a young person give
10 informed consent to plastic surgery?
11 A. No.
12 Q. Why not?
13 A. Particularly in this item in number 4 because
14 they are unable to understand all the short- and
15 long-term aspects of these treatments and particularly
16 the more complicated procedures.
17 Q. All right. And can we go to Page 259 of this
18 exhibit? And do you see the heading Surgery followed by
19 A through F?
20 A. Yes.
21 Q. Are you familiar with this part of the WPATH
22 guidance?
23 A. Yes.
24 Q. And I'm going to go to number C: Can a minor
25 demonstrate the emotional and cognitive maturity

1 required to provide informed consent/assent for the
2 treatment?
3 A. So that's an important aspect of informed
4 consent, but I believe that minors cannot provide
5 informed consent for these treatments.
6 Q. And I'm reading part C under surgery. These
7 are kind of things that according to WPATH are kind of
8 definitions of informed consent. Would you agree?
9 A. Yes.
10 Q. Okay. Can minors -- I'm looking at number E
11 now. Can minors give informed consent to reproductive
12 effects including potential loss of fertility and
13 available options to preserve fertility?
14 A. So I don't believe that minors can give
15 confirmed -- informed consent to issues of fertility,
16 but certainly that's a vital aspect of the needed
17 informed consent.
18 MR. ELDRED: I'll pass the witness.
19 THE COURT: Thank you, Mr. Eldred.
20 MR. ELDRED: Wait. I'm sorry, Judge.
21 Wait.
22 THE COURT: Oh, no worries.
23 MR. ELDRED: I'm so sorry, Judge.
24 THE COURT: That's okay.
25 Q. (BY MR. ELDRED) Do plastic surgeons perform

1 breast augmentation surgeries on minors?
2 A. In general, no. In fact, the American Society
3 of Plastic Surgeons recommends that we don't do a breast
4 augmentation on patients under 18. And I believe that
5 FDA breast implants are also -- I'm sorry -- not FDA
6 breast implants, but breast augmentation is not approved
7 by the FDA for under 18 years old --
8 Q. Do you know --
9 A. -- for saline implants, and I believe it's 20
10 or even 22 for silicone implants.
11 Q. And do you know why it's not?
12 A. It's for all the same reasons that we
13 discussed, that minors don't have the emotional and
14 cognitive abilities to understand all the aspects of
15 breast augmentation surgery.
16 Q. All right.
17 MR. ELDRED: All right. Now I pass the
18 witness, Judge.
19 THE COURT: All right. Thank you.
20 Cross-examination?
21 **CROSS-EXAMINATION**
22 BY MR. SELDIN:
23 Q. Dr. Perrotti, you testified earlier that you
24 have performed periolar -- perioareolar mastectomies on
25 minors under 18 for treatment of gynecomastia; is that

1 correct?
2 THE REPORTER: Can you speak up?
3 MR. SELDIN: I'm sorry. I apologize.
4 Q. (BY MR. SELDIN) You have performed -- are you
5 familiar with the term keyhole surgery?
6 A. Yes.
7 Q. Is that another term for perioareolar?
8 A. Yes.
9 Q. So -- have you performed keyhole -- you
10 testified that you performed keyhole surgery on minors
11 under 18 to treat gynecomastia; correct?
12 A. Yes.
13 Q. And about how many times have you performed
14 that surgery?
15 A. I can't give you a number. I've been doing
16 that procedure since I was a resident in 1997 and '98,
17 so I don't know.
18 Q. In --
19 A. If I do several a year, if I do five or ten a
20 year and I've been doing them for 25 years, then I've
21 done hundreds.
22 Q. In persons under 18 or total?
23 A. Total.
24 Q. And about how many of those have been for
25 minors under 18 years old?

1 A. I don't know. I will say that the ones that
2 are under 18 are in that kind of 17- to 18-year age
3 because we most often wait till the development of the
4 gynecomastia is complete.
5 Q. But you have performed keyhole surgery on
6 minors age 17 or younger in your career; correct?
7 A. Yes.
8 Q. Okay. Did you obtain informed consent from the
9 parents in each of those cases?
10 A. If the minor -- if the minor was unable to give
11 their own consent, then it was the parent or the
12 guardian that gave consent, correct.
13 Q. So in each of those cases did you also obtain
14 informed assent from the minor?
15 A. If the minor didn't want the surgery, I
16 wouldn't do the surgery.
17 Q. So then the answer is yes, you obtained
18 informed consent and assent in each case?
19 A. Yes.
20 Q. And is keyhole surgery -- keyhole surgery in
21 minors is irreversible; correct?
22 A. It depends on what the surgery is for. If
23 keyhole surgery is done for a mastectomy, let's say, for
24 a transgender patient, that is essentially irreversible.
25 If a surgery is done for gynecomastia, depending on the

1 reason or why that patient developed gynecomastia -- and
2 remember, gynecomastia is a different -- it's kind of a
3 different operation. It's a different pathology.
4 Gynecomastia always contains breast tissue and fatty
5 tissue. So it's -- it's irreversible, but it's
6 certainly -- I don't know how to explain this. It
7 certainly can recur, let's say. So if they're forming
8 breast tissue for some reason, that can recur. And if
9 they're forming fatty tissue, that can recur.
10 Q. So is it your testimony then that when you
11 perform keyhole surgery in minors under 18 who are
12 cisgender and not transgender, there's a possibility
13 that you may have to do a second corrective surgery if
14 gynecomastia occurs?
15 A. That's always a possibility, yes.
16 Q. Dr. Perrotti, have you ever performed facial
17 feminization surgery on a transgender adolescent?
18 A. I have not.
19 Q. Okay. Have you performed facial feminization
20 surgery on a transgender adult?
21 A. I have not.
22 Q. And have you ever performed what you refer to
23 as bottom surgery on any individual?
24 A. I have not.
25 MR. SELDIN: Your Honor, if I could have a

1 moment.
2 Q. (BY MR. SELDIN) Dr. Perrotti, to your
3 knowledge, phalloplasty and other forms of bottom
4 surgery are extremely rare -- very rarely performed in
5 minors; is that correct?
6 A. I would agree with that.
7 Q. And the same true for facial feminization
8 surgery?
9 A. I don't know the specific answer to that. I
10 would say that it's less uncommon or more common than
11 genital surgery in minors.
12 Q. It's generally outside of your knowledge?
13 A. No, it's not outside of my knowledge. I can't
14 give you an exact number.
15 MR. SELDIN: Thank you, Your Honor.
16 Nothing further.
17 THE COURT: Thank you. Any other
18 redirect?
19 MR. ELDRED: One question.
20 **REDIRECT EXAMINATION**
21 BY MR. ELDRED:
22 Q. Have you ever treated an adult for
23 complications from prior gender-affirming surgery?
24 A. Yes.
25 MR. SELDIN: Objection, Your Honor. It's

1 outside the scope -- I apologize. Now that my mic is
2 on, objection, Your Honor. That's outside the scope of
3 cross.
4 MR. ELDRED: I believe he just asked about
5 his experience doing these surgeries.
6 MR. SELDIN: In minors with gender
7 dysphoria.
8 THE COURT: Right. Let me read your
9 question again.
10 MR. ELDRED: I believe that's my only
11 question, Judge.
12 THE COURT: Okay. So what is your
13 question?
14 MR. ELDRED: Have you ever treated an
15 adult for complications from prior gender-affirming
16 surgery? I guess I could say from -- performed on a
17 minor. Does that help?
18 MR. SELDIN: Your Honor --
19 THE COURT: Right. I think that's what
20 would take it back into his scope.
21 A. I have treated complications of surgery in
22 adults, but I can't say specifically whether the surgery
23 was done when they were minors or not.
24 Q. (BY MR. ELDRED) All right. Thank you,
25 Judge -- thank you, Your -- thank you, Doctor.

1 THE COURT: Any other further recross?
2 MR. SELDIN: Your Honor, no, thank you.
3 THE COURT: Okay. All right.
4 Dr. Perrotti, you're done on the witness stand. You're
5 excused.
6 THE WITNESS: Thank you.
7 THE COURT: Take care. All right. Any
8 additional witness for the State?
9 MR. GONZALEZ-PAGAN: Your Honor, if I may,
10 can we address a little bit of a cleanup matter before
11 moving on to fact witnesses to the extent that there are
12 any?
13 THE COURT: Sure.
14 MR. GONZALEZ-PAGAN: Specifically --
15 MR. STONE: And, Your Honor, we've got
16 two -- two very brief fact witnesses. We're going to
17 try to go as fast as we can to get through them.
18 THE COURT: Okay.
19 MR. GONZALEZ-PAGAN: Your Honor, under
20 Rule 902 as official publications, plaintiffs will be
21 moving for P-57 and P-58 to be admitted into evidence,
22 both publications by the Food and Drug Administration
23 related to off-label use, which has come up a number of
24 times during the testimony. And under Rule 90 -- 902.5,
25 their official publications are self-authenticating.

1 MR. STONE: Which number are they again?
2 THE COURT: 57 and --
3 MR. GONZALEZ-PAGAN: 57 and 58.
4 MR. STONE: Oh, sorry. Okay. Your Honor,
5 may I respond briefly?
6 THE COURT: Sure.
7 MR. STONE: For 57, this is a notice of
8 request for comment. So our first objection to this is
9 on relevance. This is just a call for public comment.
10 It has no relevance to this particular case. It's --
11 oh, right. So what they're -- they're also conflating
12 two different things. They're conflating, I believe,
13 Your Honor, authentication on how you authenticate a
14 document as opposed to its admissibility. And in this
15 case, like -- I'm not disputing the authenticity of this
16 document, but that doesn't -- just because it's
17 authenticated doesn't make it admissible.
18 And again, in this case, at least with
19 respect to 57, it's just a request for comment. There
20 appears to be some highlighting in it in here, so it
21 looks like they're trying to highlight something from a
22 request for comment related to a separate FDA drug
23 bulletin. So it looks like they're trying to get
24 something in that's buried within this document without
25 citing specifically to the original document. But in

1 any respect, Your Honor, we don't believe this is
2 relevant, and we don't believe that it passes the
3 hearsay exception, is subject to any kind of hearsay
4 exception.
5 THE COURT: So that's 57; right?
6 MR. STONE: 57, Your Honor.
7 THE COURT: A response on 57,
8 Mr. Gonzalez-Pagan?
9 MR. GONZALEZ-PAGAN: Yes, Your Honor. As
10 public records -- this is published by the FDA. It says
11 for the activities of the FDA. It passes -- there's
12 a -- it is an exception to hearsay under 803.8. What is
13 more, just because it's a notice for comment from the
14 FDA, it still lays out the FDA's official position when
15 it comes to off-label use. Your Honor can give it the
16 weight that the Court wants, but it is -- it is an
17 official governmental publication that the Court may
18 admit into evidence.
19 MR. STONE: No, Your Honor, that is
20 absolutely wrong. Under 803.8 it sets out the specific
21 criteria for what qualifies as a public record, and
22 there are elements of it. Number one, it has to -- the
23 statement or record from the public office must, one,
24 set out the office's activities; number two, a matter
25 observed while under a legal duty to report, but not

1 including, in a criminal case, a matter observed by law
2 enforcement personnel; or in a civil case or against the
3 government in a criminal case, factual findings from a
4 legally authorized investigation. That is not what --
5 that is not what this document is. It is absolutely not
6 subject to 803.8, the public records exception.
7 THE COURT: Okay.
8 MR. GONZALEZ-PAGAN: Just --
9 THE COURT: Hold on. The objection to 57
10 is sustained. What about 56?
11 MR. STONE: 58.
12 THE COURT: I mean 56. Wasn't it 56?
13 MR. GONZALEZ-PAGAN: 57 and 58.
14 Your Honor, I --
15 THE COURT: Oh, I'm sorry. I'm looking at
16 the wrong one.
17 MR. GONZALEZ-PAGAN: I -- I apologize. 57
18 and 58.
19 THE COURT: Okay.
20 MR. GONZALEZ-PAGAN: With regards to 57,
21 again, it sets out --
22 THE COURT: I've ruled,
23 Mr. Gonzalez-Pagan. We're done on that one.
24 MR. GONZALEZ-PAGAN: Understood.
25 THE COURT: 58.

1 MR. GONZALEZ-PAGAN: 58 is an official
2 guidance by the FDA administration. It again passes
3 muster under the public records hearsay exception. It
4 sets -- it's a record or a statement of a public office
5 that sets out the office's activities. It is a
6 disjunctive test. It is an "or," not an "and." And
7 therefore, any publication by an agency or public office
8 that sets out the office activities are acceptable like
9 rule-making or the office activities with regards to
10 guidance as to off-label use is a hearsay exception.
11 THE COURT: Mr. Stone?
12 MR. STONE: Yeah, absolutely. Your Honor,
13 this is not the record or statement of a public office
14 setting out the office's activities. I think that
15 that's pretty obvious. This isn't -- this isn't a
16 record or statement setting out the office's activities.
17 So this isn't describing what the FDA does, all right?
18 This is -- instead, this is an information sheet that
19 appears to be --
20 THE COURT: Guidance.
21 MR. STONE: -- guidance issued for IRBs
22 and from 1998.
23 THE COURT: All right. So on P-58, the
24 objection is overruled. So P-58 is in. P-57 is not.
25 MR. GONZALEZ-PAGAN: Thank you,

1 Your Honor. In that case, plaintiffs would move that
2 the Court take judicial notice of P-57 as an official
3 governmental publication pertaining to regulations.
4 MR. STONE: It's a request for comment.
5 THE COURT: I -- hold on. I'm not going
6 to take judicial notice of 57.
7 MR. GONZALEZ-PAGAN: Understood. Thank
8 you, Your Honor.
9 THE COURT: Okay. So fact witnesses.
10 MR. STONE: Your Honor, are we going to
11 have a hard stop at 5:00? Because it determines whether
12 or not we can -- if we hard stop at 5:00, I think we can
13 only call one of our remaining fact witnesses then.
14 THE COURT: Well, let -- tell me a little
15 bit about how long you think you have with either of
16 these fact witnesses.
17 MS. DYER: Your Honor, I only expect about
18 ten minutes, but I'm unsure if plaintiffs intend to use
19 any of their time on cross.
20 THE COURT: I think we can go ahead and do
21 it. I mean, I have permission from Ms. Crain and
22 Ms. Gould to stay a little after 5:00.
23 MS. DYER: I will do my best to be
24 efficient.
25 THE COURT: But, you know, I didn't ask,

1 but I apologize to the deputies, because that means they
2 have to stay after 5:00 too. So let's get going with
3 that then.
4 MS. DYER: Okay. Then the first fact
5 witness will be Emelie Schmidt.
6 THE COURT: All right. Ms. Schmidt, if
7 you can step forward, or is she --
8 MS. DYER: She is in the room in the back
9 based on the rule.
10 THE COURT: Got it. Hello, Ms. Schmidt,
11 if you'll step forward, please, I'll swear you in and
12 then you can take the stand. If you'll raise your right
13 hand for me.
14 *(Witness sworn)*
15 THE COURT: You can step around there and
16 up to this chair here. Go ahead.
17 **EMELIE SCHMIDT**,
18 having been first duly sworn, testified as follows:
19 **DIRECT EXAMINATION**
20 BY MS. DYER:
21 Q. Good afternoon, Emelie. How's it going? First
22 I will have you state your name for the record and spell
23 it, please.
24 A. Okay. Emelie Anne Schmidt, E-m-e-l-i-e,
25 A-n-n-e, S-c-h-m-i-d-t.

1 Q. And do you live in Texas, Emelie?
2 A. Yes, ma'am.
3 Q. Which county?
4 A. Harris.
5 Q. And do you live with anyone else or is it just
6 by yourself?
7 A. I live with my husband, and then I have a
8 renter on my first floor.
9 Q. Okay. And how long have you lived in Texas?
10 A. My whole life, so 24 years.
11 Q. I was about to ask how old you were, so
12 perfect. And what is your biological sex?
13 A. Female.
14 Q. And sitting here today, do you consider
15 yourself female or male?
16 A. Female.
17 Q. And describe to me your first experience with
18 the transgender world.
19 A. I was around 14 years old. And I was always a
20 tomboy growing up and I saw something on TLC. It was
21 about trans youth, and it said if you're a tomboy you
22 might actually be a boy. So I started looking on the
23 TLC Facebook page and I commented on a few things, and
24 that's where a few grown men who identified as women
25 contacted me privately and invited me into their

1 Facebook groups.
2 Q. And how did those groups transform you over the
3 next few years?
4 A. I posted that I was questioning and they
5 affirmed my gender at the time -- I guess my delusion.
6 They affirmed that I was male even though I'm not male.
7 And they just flooded me with a bunch of love and
8 support telling me that I'm handsome. And they told me
9 that my parents were evil because they wouldn't let me
10 start hormones or surgery. My parents are amazing, by
11 the way. They're not evil. But they made me truly hate
12 my parents even though they were wonderful. They also
13 sent me messages describing how to make HRT at home.
14 Q. Can you explain to me what --
15 THE REPORTER: Say it again. What at
16 home?
17 A. They taught me how to make hormone replacement
18 therapy at home, testosterone.
19 Q. (BY MS. DYER) And did you end up telling your
20 family -- you mentioned that, you know, they kind of
21 made you hate your parents. Did you tell your parents
22 that you were feeling this way?
23 A. I didn't feel comfortable telling them, but
24 they eventually found out through someone at my school.
25 Q. And did you tell people at your school?

1 A. I did. They found out through a kid's mom at
2 the school. My school never told my parents.
3 Q. But you did tell your school. Did you tell
4 your teachers to call you by your preferred pronouns,
5 name, et cetera?
6 A. Yes, ma'am.
7 Q. And they did that?
8 A. Yes. And they never notified my parents about
9 any of this, but they called me Jacob and he/him in the
10 classroom.
11 Q. And did you ever receive any -- I know you
12 mentioned a minute ago that you were angry at your
13 parents for not, but did you ever actually receive any
14 medication or surgeries?
15 A. I did not.
16 Q. And why was that?
17 A. At the time my parents didn't have insurance,
18 and my -- my mom said even if we had insurance she
19 wouldn't have let me because she felt deep down that --
20 she knew I was a girl because I was a girl, you know.
21 She said she would have supported me if she felt like
22 this is who I really was, but she knew that I wasn't.
23 Q. And when did you start questioning your
24 transgender status?
25 A. Around the time -- right after my 18th

1 birthday.
2 Q. And was there something that happened around
3 that time that made you start questioning that or was it
4 just like an ah-ha moment?
5 A. I started realizing that I didn't have any
6 friends in real life. All my friends were online, and
7 most of them were grown men online. And they were just
8 encouraging me to hate myself and hate my body. They
9 kept telling me my body was wrong and it needed fixing
10 with hormones and surgeries. And I just realized none
11 of my friends were in real life; I need to stop being
12 online all the time. And what really opened my eyes was
13 my mom took me on a trip to the beach, and she just
14 started telling me, hey, it's okay to be a girl and like
15 masculine things. It's okay to be a tomboy. And that's
16 when I really understood I could just be a tomboy. I
17 don't have to hate my body. I don't have to hate
18 myself.
19 Q. And now looking back on that chapter of your
20 life, how do you feel sitting here today?
21 A. I'm confident in my womanhood. I'm proud to be
22 a woman. And I regret that I spent so long hating my
23 femininity.
24 Q. And are you glad that you never received any
25 hormone replacement, puberty hormone blockers, or

1 surgeries?
2 A. I am eternally grateful that I never received
3 any of that treatment. I don't think I would be as
4 successful as I am today if I got those treatments. I
5 think if I got those treatments I would still be
6 depressed and anxious. I was never more depressed and
7 anxious as I was when I was surrounded by adults telling
8 me to hate my body in the trans community. They --
9 yeah.
10 Q. And that was going to be my last question
11 actually, was in terms of your mental health throughout
12 this process, you know, can you walk me through how you
13 were before you got involved in the community mental
14 health-wise, how you were during, and then after as
15 well?
16 A. I didn't have the best mental health just
17 before I was trans. I had a lot of anxiety and
18 depression just from my body growing up because I was
19 uncomfortable during puberty. But the trans community
20 latched onto these insecurities and they latched onto my
21 depression and anxiety and made it worse. I was the
22 most depressed, the most suicidal when I was in the
23 trans community. Once I got out of that community, I
24 was finally able to not be depressed and not be
25 suicidal. I was finally able to work on myself and love

1 myself for who I am.
2 MS. DYER: I have nothing further,
3 Your Honor.
4 THE COURT: Cross?
5 MS. LESKIN: Very briefly, Your Honor.
6 **CROSS-EXAMINATION**
7 BY MS. LESKIN:
8 Q. Hi, Ms. Schmidt. I just have a couple of
9 questions for you. No doctor ever diagnosed you with
10 general dysphoria; correct?
11 A. No, ma'am. It was all online and my school
12 hiding it from my parents.
13 Q. Right. But you've never been diagnosed with
14 gender dysphoria?
15 A. No, ma'am.
16 Q. And you never sought medical care for gender
17 dysphoria?
18 A. No, ma'am.
19 Q. And your parents did not decide one way or the
20 other to help you seek medical care for gender
21 dysphoria?
22 A. No, ma'am. And I'm glad they didn't.
23 Q. Okay. Thank you.
24 THE COURT: Anything further, Ms. Dyer?
25 MS. DYER: Nothing further.

1 THE COURT: Ms. Schmidt, you're done on
2 the witness stand. Thank you very much.
3 THE WITNESS: Thank you.
4 THE COURT: Next witness?
5 MS. DYER: Yes. The last witness the
6 State will call is Soren Aldaco.
7 THE COURT: Aldaco?
8 MS. DYER: Uh-huh.
9 THE COURT: Okay. I just want to say it
10 right. All right. Are they out there?
11 MS. DYER: Yes.
12 THE COURT: Okay. I just wanted to make
13 sure.
14 All right. If you'll step forward, I'll
15 swear you in.
16 THE WITNESS: Where should I step?
17 THE COURT: Here.
18 THE WITNESS: Okay.
19 THE COURT: If you'll raise your right
20 hand.
21 *(Witness sworn)*
22 THE COURT: All right. You can make your
23 way around there and up to this chair, please.
24 Go ahead.
25

1 **SOREN ALDACO**,
2 having been first duly sworn, testified as follows:
3 **DIRECT EXAMINATION**
4 BY MS. DYER:
5 Q. Good afternoon, Soren. First things first.
6 We're going to have you state your name and spell it for
7 the record.
8 A. I'm Soren Aldaco, S-o-r-e-n, A-l-d-a-c-o.
9 Q. And you live in Texas -- or do you live in
10 Texas? I'm sorry.
11 A. I do.
12 Q. Okay. What county do you live in?
13 A. I live in Tarrant. Or I -- well, I grew up in
14 Tarrant. I live in Travis County.
15 Q. Okay. And have you lived in Texas your whole
16 life?
17 A. Yeah.
18 Q. And how old are you?
19 A. I am 21 years old.
20 Q. Are you in school right now?
21 A. I am in school.
22 Q. What are you studying?
23 A. I study humanities, which is an honors program
24 where we make our own major.
25 Q. And is this -- is it through a university?

1 A. Yeah, it's through UT. And I more specifically
2 am interested in how we define normal and come to
3 develop identities.
4 Q. Okay. And what is your biological sex?
5 A. Female.
6 Q. And today do you consider yourself to be male
7 or female sitting here?
8 A. Female.
9 Q. Okay. And I'd like you to describe your first
10 kind of introduction, experience, however you want to
11 phrase it, with the transgender community and world.
12 A. Well, I always felt different from my peers,
13 but I was first introduced to trans identity through the
14 Internet via some friends who identified that way.
15 Q. Okay. And had you ever had -- had you been
16 diagnosed with any other mental health conditions or
17 anything else before you had been introduced to the
18 trans community?
19 A. I was diagnosed with ADHD at age six, and then
20 I acquired diagnoses after the trans identification.
21 Q. And around what age did the trans
22 identification come?
23 A. Well, I sort of played with the idea of gender
24 starting at 11, but I didn't really, like, solidly
25 identify as transgender until after age 15 when a

1 psychiatrist started to medically -- or medicalize those
2 thoughts.
3 Q. So tell me about that experience with the
4 psychiatrist.
5 A. Well, I was -- I went to the hospital for a
6 psychiatric episode at age 15. And when I was in there,
7 they put my chosen name on the door but had my legal
8 name on the records. And while speaking to the
9 psychiatrist, he asked me about that incongruence
10 between the name on my door and my records. And I told
11 him that was just the name I went by, and he pushed for
12 further explanation and I told him that was just the
13 name I went by. And he pushed for further explanation
14 and offered the idea that people didn't identify with
15 their biological sex, told me that was like normal and I
16 was safe to admit to him. And I told him -- asked him
17 whether or not our conversation was confidential and
18 essentially felt pressured to tell him that I was trans
19 as he, you know, recommended.
20 Q. Had you ever called yourself trans before that
21 time?
22 A. I had called myself a trans boy, but I also,
23 like, was calling myself a girl in online video games at
24 that time and was okay with people addressing me and
25 viewing me as female.

1 Q. And is that when you -- when did you get
2 your -- like, a gender dysphoria diagnosis if you got
3 one?
4 A. I don't know if he diagnosed me with that at
5 the time because I haven't seen my records, but I got my
6 first gender dysphoria diagnosis while seeing a
7 therapist, and it was only I believe after she had
8 written me a letter for my mastectomy.
9 Q. Okay. So let's go back a little bit to when
10 you were at the hospital for your psychiatric episode.
11 What was kind of the timeline between that and when --
12 and these recommendations later down the line?
13 A. So that was at age 15 shortly before my 16th
14 birthday. I began seeing a therapist for, like,
15 developmental problems. I was diagnosed with autism,
16 major depressive disorder, social rejection and
17 exclusion, and general anxiety, and OCD is a subset of
18 autism, that March I believe. And then at age 17 after
19 attending a transgender youth support group for a couple
20 of years, I was prescribed testosterone by a
21 psychiatrist in that support group who prescribed
22 hormones for many children and adults in that support
23 group. And then age 18 I was written a letter by the
24 therapist. And age 19, about a month after my 19th
25 birthday, I had a mastectomy. And then less than six

1 months later I medically and ideologically
2 detransitioned.
3 Q. Okay. And I want to go back to when you were
4 prescribed the hormones. How did the hormones make you
5 feel?
6 A. Well, I felt good right after I took them, like
7 especially because they were like a steroid and made my
8 body sort of feel like very engaged, almost like a high
9 of sorts. But over time I started having a lot of joint
10 pain. I would feel very hot on the hormones, like a lot
11 of menopausal-like symptoms. I felt like a lot of brain
12 fogs. The hormones would wane, and my natural hormone
13 cycle would attempt to, you know, come back. And
14 eventually, like, I just -- it felt, like, gross. Like,
15 I mean, I was happy that I was being affirmed, but I
16 think it was just that. Like, I was happy I was being
17 affirmed, but the actual mode of affirmation was, like,
18 very detrimental to my health overall. Like, I was on
19 11 different medications to manage the symptoms of those
20 hormones, and I was also just like tired all the time
21 and not engaging in any of my interests. I quit playing
22 softball. I stopped playing cello. Like, I was just
23 sort of obsessed with this identity even though my body
24 was, like, falling apart.
25 Q. And tell me a little bit more about when you

1 had the double mastectomy.
2 A. So I had the mastectomy in June of 2021. And
3 shortly after, like within three or four days, I noticed
4 significant bruising underneath my bandages. And I
5 called to talk to the emergency physician line, sent
6 them photos, and they just sort of said, oh, bruising is
7 normal, it can happen, which I sort of knew. I mean,
8 it's a surgery; right? But it felt very wrong in my
9 body.
10 At the post-op appointment when the nurse
11 took off my sutures and my holsters that were holding my
12 nipple grafts on, she said I've never seen bruising like
13 that before but didn't go and get a physician. I
14 continued to let them know that the bruising was getting
15 worse. I sent them photos of bruising on my flanks that
16 I had researched and found out was called Grey Turner's
17 sign. And I kept telling them something was wrong.
18 And it culminated on June 23rd I believe
19 when I called up to the same emergency physician line
20 and got the same doctor I spoke to before. I sent him
21 photos, and he told me I don't know what's wrong here,
22 but at the time my nipple grafts were peeling off. I
23 looked like I had breasts again. And I went to UT
24 Southwestern where they cut my incisions back open under
25 my arms and inserted drains. They had to put like a

1 Q-tip in and aggressively knock out blood clots. And
2 the top surgeon or the, you know, plastic surgeon who
3 did these mastectomies at the hospital actually refused
4 to see me because he didn't want to manage those
5 complications, so I was seen by the breast oncology
6 team.
7 Q. Okay. And you mentioned that six months later
8 you started to detransition. Did I hear that correctly?
9 A. Yeah, I stopped the hormones first because they
10 made my body feel awful, but then shortly after I
11 realized that after stopping the hormones I had no other
12 choice but to be fine. Like, I had to keep going. And
13 I realized, like, that actually wasn't bad for me.
14 Like, I learned to be resilient throughout my life by
15 becoming resilient to that. And then I realized that I
16 had been sold, like, the lie that that was the only way
17 forward when in fact it was not the only way forward,
18 and it caused me a lot of other problems on top of the
19 ones that I was already experiencing.
20 Q. And what kind of things do you still -- what
21 kind of side effects do you still have today from those
22 treatments?
23 A. Well, from those treatments I specifically have
24 a lot of chest pain. Like, I was supposed to give a
25 speech to my university welcoming the new faculty

1 yesterday, and I, like, had to take some time before I
2 went up on stage because I was getting, like, random,
3 like, zaps along my scar line and up through the tissue
4 where they had to, you know, use the Q-tips and such.
5 I still experience, like, vaginal
6 dysfunction, like in terms of, like, emptying my
7 bladder, in terms of, like, engaging in sex. It's
8 really painful. And I'm just generally disinterested.
9 I have bumps on my clitoris.
10 And I also just, like, generally have some
11 endocrinological issues. I was diagnosed with
12 hypothyroidism after starting the testosterone. I also
13 struggle with what I suspect could be like hypoglycemia,
14 like, related to my hormone -- regulation of my other
15 hormones. And then I also was diagnosed with idiopathic
16 hypersomnia afterwards on top of chronic fatigue. So
17 I'm just like tired all the time as if, like, you know,
18 my hormones are still struggling to, like, you know,
19 keep me going. That's what they do.
20 Q. In terms of your mental health, how do you feel
21 today?
22 A. I feel relatively good. Like, I have emotions,
23 which I didn't really experience on testosterone. Like,
24 I was just very blocked off and disconnected with my
25 body, which I suspect was part of the issue all along.

1 But now, like when I have negative emotions, I see them
2 as part of my beautiful colorful human existence. Like,
3 I have learned to be resilient and fortified, which is
4 what I really honestly needed all along to realize that
5 as I felt distressed, that it was just temporary, that
6 it was momentary, that I also experienced a lot of joy
7 in other ways. And that's kind of what I focus on now
8 is the joy.
9 I used to look at my body in terms of,
10 like, you know, thinking that I might be too fat or --
11 this morning I was a little bit upset at, like, how my
12 jeans fit because they fit better when I was on
13 testosterone; right? But that is part of the underlying
14 issue that I'm getting at, that it was just the way that
15 women -- in my case, you know, we are taught to hate
16 ourselves from a really young age. I mean, I was
17 exposed to pornography way too young, and I feel like
18 that was part of what contributed to this idea that I
19 needed to be thin. And that's what testosterone did to
20 me, was it gave me control over my body.
21 Q. And looking back, how effective would you say
22 were the hormone therapies at getting you to the place
23 you -- the peace you have today? Do you think you could
24 have gotten it if you had stayed on them?
25 A. No, because I just had a slew of other

1 problems. Like, I have way more peace just letting my
2 body be what it is and figuring out the mental side of
3 it now today than I ever did on testosterone.
4 Q. Do you wish you had never had taken hormones or
5 had the surgery?
6 A. Yeah, I really do.
7 MS. DYER: Nothing further, Your Honor.
8 THE COURT: All right. Cross-examination?
9 **CROSS-EXAMINATION**
10 BY MS. LESKIN:
11 Q. Good afternoon, Ms. Aldaco. On July 21st of
12 this year, you filed a lawsuit; correct?
13 A. I do think it was July 21st. I can't give you
14 the exact date, but yes.
15 Q. Okay. And in that lawsuit, you named the
16 doctor that you described, the mental health provider
17 you saw while you were hospitalized; correct?
18 A. Yes.
19 Q. And you're suing that doctor for breaching the
20 standard of care by, among other things, improperly
21 assessing, diagnosing, and/or counseling you regarding
22 your gender identity; right?
23 A. Yes.
24 Q. And that doctor did not prescribe any
25 medication to you; correct?

1 A. Yes.
2 Q. You also in that lawsuit filed -- name the
3 doctor who prescribed the testosterone to you; correct?
4 A. He wasn't a doctor, but yes.
5 Q. Okay. The medical professional who gave --
6 prescribed testosterone to you; correct?
7 A. Yes.
8 Q. And you are suing him for breaching the
9 standard of care in prescribing you hormone treatment
10 without performing a proper biopsychosocial evaluation
11 and without parental consent; correct?
12 A. I'm not entirely sure. I don't know the exact
13 verbiage.
14 Q. Sure.
15 MS. LESKIN: Can we pull up Exhibit P-75,
16 please? And if we can go to Paragraph -- Paragraph 70
17 of that. Let's bring up the first page first.
18 Q. (BY MS. LESKIN) Do you recognize this
19 document?
20 A. Yes.
21 Q. And this is the complaint you filed; correct?
22 A. Yes.
23 Q. Okay.
24 MS. LESKIN: So can we go to Paragraph 70,
25 please? I'm sorry. I have the wrong paragraph.

1 Paragraph 76 and 77.
2 Q. (BY MS. LESKIN) And Paragraph 77 is Count 3,
3 and that is a count against Del Scott Perry; correct?
4 A. Yes.
5 Q. And Mr. Perry was the medical professional who
6 prescribed testosterone to you; right?
7 A. Yes.
8 Q. And in Paragraph 77, you list a number of items
9 that you are alleging Mr. Perry was negligent and
10 grossly negligent; correct?
11 A. Yes.
12 Q. And you also named Doc- -- the therapist who
13 wrote your letter prior to your mastectomy; correct?
14 A. Yes.
15 Q. And you are suing that doctor for authoring and
16 signing a deceptive letter containing numerous material
17 falsehoods and recommending your mastectomy; correct?
18 A. She was not a doctor, but yes.
19 Q. And you're alleging that Ms. Wood breached the
20 standard of care to you in providing that letter;
21 correct?
22 A. I'm not sure the exact verbiage.
23 Q. Sure. Let's pull up Paragraph 89, please. And
24 you're alleging that Dr. Wood breached that duty of care
25 to you and thus committed negligence and gross

1 negligence in numerous ways, including but not limited
2 to authoring and signing a deceptive letter; correct?
3 MS. DYER: Objection, Your Honor,
4 relevance.
5 THE COURT: Overruled.
6 A. Duty of care, yes.
7 Q. (BY MS. LESKIN) And finally, you have named in
8 this lawsuit the doctor who performed your mastectomy;
9 correct?
10 A. Yes.
11 Q. And among other things, you are alleging that
12 he violated the standard of care to you; correct?
13 A. Yes, I believe she violated her duty of care.
14 Q. And that the doctor breached the standard of
15 care in failing to perform an adequate biopsychosocial
16 evaluation in anticipation of the surgery; correct?
17 A. The duty of care, yes.
18 Q. Thank you.
19 THE COURT: Any further re- --
20 MR. GONZALEZ-PAGAN: Just a second.
21 MS. LESKIN: Oh, excuse me.
22 THE COURT: Okay.
23 MS. LESKIN: Sorry, Your Honor.
24 THE COURT: That's okay.
25 MS. LESKIN: If you'll give me one moment,

1 Your Honor. Your Honor, we would offer P-75 into
2 evidence.
3 THE COURT: Any objection?
4 MS. DYER: Yes, objection. Why does her
5 lawsuit have any relevance on this case? Her testimony
6 speaks for itself.
7 THE COURT: Well, I think -- I guess the
8 cross-examination -- I'll -- I'll take judicial notice
9 of P-75. I don't think it needs to be in evidence.
10 MS. LESKIN: Thank you, Your Honor.
11 THE COURT: Okay. Any redirect?
12 MS. DYER: Just a couple of quick
13 questions.
14 THE COURT: Sure.
15 **REDIRECT EXAMINATION**
16 BY MS. DYER:
17 Q. I'm sorry. I just have a couple more questions
18 for you.
19 A. Sure.
20 Q. Are you a lawyer?
21 A. No.
22 Q. Did you write the lawsuit that was just taken
23 judicial notice of?
24 A. No.
25 Q. And do you wish you had received psychotherapy

1 instead of hormones?
2 A. Proper psychotherapy, absolutely, yes.
3 MS. DYER: Nothing further.
4 THE COURT: Any other?
5 MS. LESKIN: No, Your Honor.
6 THE COURT: Okay. All right. Ms. Aldaco,
7 you are done on the witness stand. You may be excused.
8 Mr. Stone, Ms. Dyer, Mr. Eldred, any other
9 witness at this time?
10 MR. STONE: No further witnesses,
11 Your Honor. The defendants rest our case-in-chief.
12 THE COURT: Okay. I need to give
13 Ms. Crain a little bit of a break before we continue, so
14 we can go off the record.
15 *(Discussion off the record)*
16 THE COURT: Okay. We're back on the
17 record. It's 5:43. We have concluded evidence. The
18 State has rested. We -- the Court can forego closing
19 arguments at this time. And although I have not given
20 the attorneys a final decision on exactly what I'm
21 anticipating needs to be -- or is allowed to be filed,
22 they will hear from me tomorrow morning on the
23 plaintiffs' response to the plea to the jurisdiction
24 that the State has filed and whatever briefing schedule
25 relates to that.

1 Is there anything else we need to put on
2 the record at this time?
3 MS. WOOTEN: No, Your Honor. Thank you.
4 MR. STONE: No, Your Honor. Thank you.
5 THE COURT: All right. Thank you. We can
6 go off the record.
7 *(Court adjourned)*
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1 **REPORTER'S CERTIFICATE**

2

3 THE STATE OF TEXAS)

4 COUNTY OF TRAVIS)

5 I, Chavela V. Crain, Official Court

6 Reporter in and for the 53rd District Court of Travis

7 County, State of Texas, do hereby certify that the above

8 and foregoing contains a true and correct transcription

9 of all portions of evidence and other proceedings

10 requested in writing by counsel for the parties to be

11 included in this volume of the Reporter's Record, in the

12 above-styled and numbered cause, all of which occurred

13 in open court or in chambers and were reported by me.

14 I further certify that this Reporter's Record of

15 the proceedings truly and correctly reflects the

16 exhibits, if any, offered in evidence by the respective

17 parties.

18 WITNESS MY OFFICIAL HAND this the 20th day of

19 August, 2023.

20

/s/ Chavela V. Crain

21 Chavela V. Crain

Texas CSR 3064, RMR, CRR

22 Expiration Date: 10/31/2024

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23 53rd District Court

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