IN THE COURT OF COMMON PLEAS
FOR FRANKLIN COUNTY, OHIO

MADELINE MOE, et al. Plaintiffs, v. DAVID YOST, et al. Defendants.	Case No. _____ Judge _____ PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION PRECEDED BY TEMPORARY RESTRAINING ORDER IF NECESSARY AND MEMORANDUM IN SUPPORT

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION PRECEDED BY TEMPORARY RESTRAINING ORDER IF NECESSARY

Pursuant to Civ. R. 65, Plaintiffs Madeline, Michael, and Michelle Moe, and Grace, Garrett, and Gina Goe (collectively "Plaintiffs"), move this Court for a preliminary injunction to enjoin enforcement of Ohio's recently enacted ban against gender-affirming health care for minors (the "Health Care Ban,") consisting of Sections 3109.054, 3129.01-3129.06, 3313.5319, and 3335.562 of the Ohio Revised Code, contained in H.B. 68, before the Health Care Ban takes effect on April 24, 2024. If the Court is not able to issue a preliminary injunction in time to take effect by April 24, Plaintiffs also move for a TRO to issue on April 24, enjoining the Health Care Ban until a Preliminary Injunction is issued.

The Health Care Ban prohibits physicians from providing gender-affirming medication to patients under the age of eighteen. If the Ban is permitted to take effect on April 24, 2024, it will have devasting consequences on the health and well-being of Ohio transgender youth, who will

be deprived of access to the medical profession's standard of care treatment for gender dysphoria, a serious medical condition, for which there is no effective alternative treatment.

As supported by the accompanying Memorandum, its attached affidavits, and the Complaint, emergency injunctive relief is necessary to prevent the irreparable harm that will occur if H.B. 68 goes into effect on April 24.

Respectfully submitted,

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IN THE COURT OF COMMON PLEAS
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MADELINE MOE, et al. Plaintiffs, v. DAVID YOST, et al. Defendants.	Case No. _____ Judge _____ MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION PRECEDED BY TEMPORARY RESTRAINING ORDER IF NECESSARY

MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION PRECEDED BY TEMPORARY RESTRAINING ORDER IF NECESSARY

Table of Contents

INTRODUCTION

This lawsuit challenges the constitutionality of House Bill 68 ("H.B. 68"), which bans medical interventions when, and only when, they are provided to transgender adolescents to treat gender dysphoria. Gender dysphoria is a serious condition that, when left untreated, causes severe harm to patients. The prohibited interventions are evidence-based and medically necessary care essential to the health and well-being of transgender adolescents. For Parent Plaintiffs Michael and Michelle Moe, this care has allowed their twelve-year-old transgender daughter, Madeline, to thrive and be her true self. Before treatment, Madeline wanted to die so she could come back as a girl. Now, with the benefit of treatment, she is successful and happy in school and in her community. Parent Plaintiffs Gina and Garrett Goe want the same for their twelve-year-old transgender daughter, Grace. She has been living happily as a girl for most of her life, and the prospect of being unable to access the medical care that she will soon need threatens to push the entire Goe family out of their loving and supportive community.

H.B. 68 overrides the informed decision-making of the Parent Plaintiffs. Rather than allowing loving and caring parents, along with the adolescents' treating physicians, to make considered decisions about when and whether to pursue medical care for their adolescent children's gender dysphoria, the law makes one decision for every parent and family in Ohio: starting April 24, 2024, no adolescent may begin receiving this care. This government intrusion into private family decision-making violates four separate provisions of the Ohio Constitution. First, it violates the Health Care Freedom Amendment ("HCFA") in Article I, Section 21, because it "prohibits the purchase of health care." Second, it violates the Equal Protection Clause in Article I, Section 2, because it discriminates on the basis of sex. Third, it violates the Due Course of Law provision in Article I, Section 16, because it infringes on parents' rights to direct their children's

medical care. Fourth, it violates the one-subject rule in Article II, Section 15(D) because H.B. 68 is not one, but two, entirely separate acts: the Health Care Ban, and an unrelated act regulating sports.

These are more than bare constitutional injuries. The Health Care Ban endangers the health and wellbeing of transgender adolescents, including Plaintiffs Grace Goe and Madeline Moe, and it forces Parent Plaintiffs to make an unbearable decision: leave their homes and communities in Ohio, or watch their children suffer needlessly. This court should preliminarily enjoin the Ohio Attorney General and State Medical Board from enforcing the Health Care Ban before it goes into effect on April 24, 2024, to prevent these irreparable injuries.

FACTUAL BACKGROUND

I. The Healthcare Ban Was Passed Only After Being Logrolled With A Restriction On Interscholastic Sports Participation

As its title states, H.B. 68 comprises two distinct Acts regulating two distinct subject matters (respectively, the "Health Care Ban" or the "Ban," and the "Sports Prohibition"). H.B. 68 expressly provides:

> To enact [multiple sections] of the Revised Code to enact the Saving Ohio Adolescents from Experimentation (SAFE) Act regarding gender transition services for minors, and to enact the Save Women's Sports Act to require schools, state institutions of higher education, and private colleges to designate separate single-sex sports teams and sports for each sex.

2024 Sub.H.B. No. 68. [1]

In relevant part, the Health Care Ban prohibits physicians from providing gender-affirming health care—which it dubs "gender transition services"—to patients under the age of eighteen. That prohibition specifically forbids physicians from prescribing "a cross-sex hormone or puberty-

[1] This action challenges the enactment of H.B. 68 as a whole because it is a logrolled combination of the "Health Care Ban" and the "Sports Prohibition", and also specifically challenges the substance of the Health Care Ban.

blocking drug for a minor individual for the purpose of assisting the minor individual with gender transition." *Id.* (enacting R.C. 3129.02(A)(2)). It further forbids physicians from knowingly engaging in "conduct that aids or abets in" such treatment. *Id.* (enacting R.C. 3129.02(A)(3)).

The Ban contains a limited exemption for preexisting care, applicable only to some patients. Under the exemption, a physician may "continue to prescribe cross-sex hormones or puberty-blocking drugs" to a minor patient if (a) the patient has been a continuous Ohio resident since the effective date of the law; and (b) the physician has both (1) "[i]nitiated a course of treatment for the minor individual prior to the effective date of this section that includes the prescription of a[n otherwise prohibited] cross-sex hormone or puberty-blocking drug[,]" and (2) "[d]etermined and documented in the minor individual's medical record that terminating the minor individual's prescription for the cross-sex hormone or puberty-blocking drug would cause harm to the minor individual." *Id.* (enacting R.C. 3129.02(B)). Many, if not all, physicians in Ohio with patients who are already undergoing puberty-delaying treatment have advised those patients that they interpret the exemption to prevent them from prescribing hormone therapy to patients who are currently on puberty blockers.[2]

The Health Care Ban includes penalties and enforcement mechanisms. Defendant Yost is authorized to "bring an action to enforce compliance" with the Health Care Ban, and the Defendant State Medical Board is instructed that any violation of the Health Care Ban "shall be considered

[2] As set forth in the expert affidavit of Dr. Corathers, a pediatric endocrinologist who has treated hundreds of youth and young adults with gender dysphoria in Ohio, the medical guidelines governing treatment for gender dysphoria dictate that clinicians and families consider how to initiate puberty after a period of time on puberty-delaying medication and after the adolescent matures. If puberty delaying medication is discontinued, endogenous puberty will begin. Most adolescents with gender dysphoria continue to experience severe distress and, after assessment, go on to receive hormone therapy, which allows them to go through a puberty consistent with their gender identity alongside their peers. See Corathers Aff. ¶¶ 26, 34, 55.

unprofessional conduct and subject to discipline[.]" *Id.* (enacting R.C. 3129.02(A)(2)–(3), 3129.05(A)).

When it was first introduced, H.B. 68 consisted solely of the Health Care Ban, with no mention of interscholastic sports. *See generally* H.B. No. 68, As Introduced version, 135th General Assembly (February 27, 2023). A separate bill introduced earlier that month, House Bill 6, contained what would become the "Sports Prohibition"—a series of restrictions on interscholastic girls' and women's sports at the grade school and collegiate levels. *See* H.B. No. 6, As Introduced version, 135th General Assembly (February 15, 2023). Four months later, on June 14, 2023, the contents of H.B. 6 were rolled into H.B. 68 as a second "Act" within that bill. *See Saving Ohio Adolescents from Experimentation Act: hearing on H.B. 68 before the H. Comm. on Public Health Policy*, 2023 Leg., 135th Sess. The combined H.B. 68 thus contains both the Health Care Ban *and* the Sports Prohibition.

The Sports Prohibition specifically requires that schools designate sex-segregated sports teams, and mandates that no school or interscholastic conference "shall knowingly permit individuals of the male sex to participate on athletic teams or in athletic competitions designated only for participants of the female sex." 2024 Sub.H.B. No. 68 (enacting R.C. 3313.5319). This portion of the bill is not subject to enforcement by the Attorney General or the State Medical Board. Instead, H.B. 68 creates private rights of action for damages and injunctive relief for "[a]ny participant who is deprived of an athletic opportunity," "[a]ny participant who is subject to retaliation or other adverse action," or "[a]ny school or school district that suffers any direct or indirect harm" as a result of a violation. *Id.* (enacting R.C. 3313.5139(E)(1)-(3)).

II. Gender-Affirming Care Is A Widely Accepted Form Of Health Care To Treat Minors With Gender Dysphoria.

A. Gender dysphoria is a serious medical condition

Gender dysphoria is the distress that results from an incongruence between a person's gender identity and their sex assigned at birth. Being transgender is not in itself a medical condition to be treated, but gender dysphoria is a serious medical condition, recognized in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., Text Revision. Corathers Aff. ¶¶ 26–27. A gender dysphoria diagnosis requires that the incongruence between a person's gender identity and designated sex has persisted for at least six months and is accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. *Id.* at ¶ 26. Untreated, gender dysphoria can result in not just decreased quality of life, but also debilitating anxiety, severe depression, self-harm, suicidal ideation, and suicide attempts. *Id.* at ¶ 27. Gender-affirming medical care improves mental health for the adolescents who require such care. *Id.* at ¶ 46.

B. Gender-affirming health care is the standard of care to treat gender dysphoria

The widely accepted standard of care for gender dysphoria includes the use, where appropriate, of puberty-delaying medication and/or hormone therapy. This treatment regimen is referred to as gender-affirming health care, or simply gender-affirming care. *See id.* at ¶¶ 37–47. (The text of the Health Care Ban instead uses the term "gender transition services.")

Every major medical organization in the United States recognizes the efficacy of gender-affirming medical care to treat adolescents with gender dysphoria and has issued an explicit statement opposing bans on this care. These organizations include The American Medical Association, The American Academy of Pediatrics, The American Psychiatric Association, The American College of Physicians, The American Academy of Family Physicians, The American

Academy of Child & Adolescent Psychiatry, The Endocrine Society, The Pediatric Endocrine Society, The World Professional Association for Transgender Health, and the United States Professional Association for Transgender Health, among many others. *Id.* at ¶ 74.

Gender-affirming care, including medical intervention for adolescents, is not a novel or experimental type of health care. Puberty-delaying medication has been prescribed for over twenty years, and hormone therapy has been available for decades. Antommaria Aff. ¶ ¶ 27, 28; Corathers Aff. ¶ ¶ 31, 71. The current version of the WPATH standards is Standards of Care Version 8 ("SOC-8"), published in 2022. SOC-8 provides guidelines for multidisciplinary care of transgender individuals, including children and adolescents, and describes criteria for medical treatment of gender dysphoria in adolescents and adults. Such treatment includes puberty-delaying medication and hormone treatment where medically indicated. Antommaria Aff. ¶ 29.

The Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, has also published a clinical practice guideline for the treatment of individuals with gender dysphoria ("Endocrine Society Guideline"), including pubertal suppression and sex hormone treatment. The Endocrine Society Guideline provides protocols for the medically necessary treatment of gender dysphoria similar to those outlined in the WPATH Standards of Care. *See id.* at ¶¶ 37, 42.

The SOC-8 and the Endocrine Society Guideline are both widely accepted. Antommaria Aff. ¶ 29. Clinicians throughout Ohio and throughout the country follow the SOC-8 and the Endocrine Society Guideline to diagnose and treat people with gender dysphoria. *See id.* at ¶ 36–42.

C. Gender-affirming health care is not "experimentation"

Contrary to the title of the Health Care Ban, ("Saving Ohio Adolescents from Experimentation") gender-affirming care is not experimental in either the colloquial sense

(because it is not new, novel, or unproven), or the technical sense. Experimental treatments are interventions that have shown some promise as a cure and are administered to advance knowledge for the potential benefit of *future* patients. In contrast, gender-affirming care is provided to benefit *individual* patients and the treatment is modified based on their individual responses. Antommaria Aff. ¶¶ 27-28. The quality of evidence supporting SOC-8 and the Endocrine Society Guideline is comparable to the support for guidelines that medical providers use to treat many other widely accepted conditions, including in the field of pediatrics. There are decades of studies—going back over 25 years—supporting the benefits of gender-affirming care where medically indicated, which is why it is the standard of care for gender dysphoria. Antommaria Aff. ¶¶ 27-29; Turban Aff. ¶¶ 12-21.

D. The Health Care Ban prohibits medication for gender dysphoria while permitting the same medication for other purposes

The Health Care Ban prohibits the use of well-established medications for gender dysphoria in transgender adolescents—including puberty-delaying treatment and hormone therapy—when these medications are provided "for the purpose of" assisting the minor individual with gender transition." Ohio Revised Code. § 3129.02(A)(2). But the Health Care Ban does not prohibit the use of these same medications for any other purpose. As one example, puberty-delaying medication is commonly used to treat conditions like precocious puberty. Corathers Aff. ¶¶ 30-31. The Health Care Ban prohibits puberty-delaying medication to treat a youth with gender dysphoria, but would permit the same medication for a youth with precocious puberty, simply because it would not be "for the purpose of assisting the minor individual with gender transition[.]" Ohio Revised Code. § 3129.02(A)(2).

Likewise, the Health Care Ban prohibits hormone therapy when prescribed "for the purpose of" treating a transgender adolescent's gender dysphoria but would allow that same

hormone therapy when prescribed to other patients. For example, non-transgender boys with delayed puberty or hypogonadism may be prescribed testosterone. *See* Corathers Aff. ¶ 33. Similarly, non-transgender boys who experience gynecomastia or overdevelopment of breast tissue may be treated to reduce breast tissue, and non-transgender girls with polycystic ovarian syndrome may be treated with hormone therapy to minimize undesired facial and body hair. *Id.*at ¶ 72. But transgender patients are denied these treatments for gender dysphoria.

E. The risks of gender-affirming health care treatments are comparable to those of other health care treatments

Puberty-delaying medications and gender-affirming hormones are prescribed only after a comprehensive psychosocial assessment by a qualified 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) ensures that, if co-occurring mental health conditions are present, they do not interfere with the accuracy of the diagnosis of gender dysphoria or impair the ability of the adolescent to assent to care. *See id.* at ¶¶ 54-60.

Unwanted side effects from gender-affirming hormone therapy are rare when treatment is provided, as they are, under clinical supervision. *See id.* at ¶¶ 62-65. But to the extent there is a risk, the side effects of puberty delaying treatment and hormone therapy are comparable when used to treat gender dysphoria and versus other conditions. *See id.* at ¶ 65. In each circumstance, doctors advise patients and their parents about the risks and benefits of treatment and tailor recommendations to the individual patient's needs. *See id.* at ¶¶ 64-65. For adolescents, parents consent to treatment and the patient gives their assent. *See id.* at ¶ 58.

III. The Ban Will Deprive Plaintiffs Of Necessary Health Care, Without Which They Will Suffer Great Harm.

A. Gender-affirming care is safe and effective at treating gender dysphoria

For youth with gender dysphoria who have not yet started puberty, there are no pharmaceutical interventions. *See* Corathers Aff. ¶ 53. Care for these children may include "social transition" which means supporting the child living consistently with their persistently expressed gender identity (for example, adopting a new name and pronouns or changes in clothing or hairstyle), along with supportive therapy. Under SOC 8 and the Endocrine Society Guideline, medical interventions may become medically necessary and appropriate when youth with gender dysphoria begins puberty. *See* Corathers Aff. ¶¶ 37-47.

1. Puberty-delaying medication

When a child with gender dysphoria enters endogenous puberty—becomes an adolescent—their body typically begins to develop in accordance with their sex designated at birth. *See* Corathers Aff. ¶ 25. Transgender girls, if not treated, develop facial hair, a pronounced Adam's apple, and a deepening voice. Transgender boys develop breasts and begin to menstruate. *Id*. For many transgender adolescents, this can cause extreme distress. *Id.*

For these individuals, puberty-delaying medication—known as gonadotropin-releasing hormone agonists ("GnRH agonists") and referred to in the Health Care Ban's text as "puberty-blocking drugs"—can minimize and potentially prevent the heightened gender dysphoria and the often permanent and unwanted physical changes that puberty would cause. For adolescents with gender dysphoria who are experiencing severe distress upon the onset of puberty, this provides a pause in these physiological changes that alleviates the worsening distress of progressing puberty. *Id.* at ¶ 32.

Treatment with puberty-delaying medication is part of the standard of care for treating gender dysphoria in adolescents. *Id.* at ¶ 31. In all cases, the precise treatment recommended for gender dysphoria will depend upon each patient's individualized considerations. *Id*. at ¶ 64. Under the Endocrine Society Guideline, adolescents may be eligible for puberty-delaying treatment if:

> "1. A qualified MHP [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, and
> - the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment.
>
> 2. 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,

3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment:

- agrees with the indication for GnRH agonist treatment,
- has confirmed that puberty has started in the adolescent (Tanner stage ≥G2/B2),[3]
- has confirmed that there are no medical contraindications to GnRH agonist treatment." *Id.* at ¶ 47.

Puberty-delaying medication has been shown to be safe and effective at treating gender dysphoria in adolescents and is associated with improved mental health outcomes that include significantly lower levels of anxiety, depression, disruptive behaviors, and suicidality and suicidal ideation, as well as improved global functioning (i.e., how well a person functions in their daily life). *Id.* at ¶¶ 37, 66 The use of puberty-delaying treatment after the onset of puberty can also eliminate or reduce the need for surgery later in life. *See id.* at ¶ 41

Puberty-delaying treatment does not permanently affect fertility and is reversible. *See id.* at ¶¶ 30, 54; Antommaria Aff. ¶ 44, 45. If it is stopped, there are no lasting effects of treatment, and puberty resumes on a timeline typical of their peers. Corathers Aff. ¶ 67.

2. Gender-affirming hormone therapy

For some adolescents, later in puberty, it may be medically necessary and appropriate to treat their gender dysphoria with gender-affirming hormone therapy (testosterone for transgender boys, and testosterone suppression and estrogen for transgender girls). Corathers Aff. ¶¶ 44-46. If puberty-delaying medications are withdrawn without any further medical interventions, then endogenous puberty resumes. *Id.* at ¶ 55. If gender-affirming hormone therapy follows the cessation of puberty-delaying medication, then that individual will develop secondary sex characteristics consistent with the individual's gender identity. *See id.* at ¶ 43. For adolescents who

are not prescribed puberty-delaying medication, the first medical intervention they receive may be hormone therapy. *Id.* at ¶ 44.

The psychological benefits of gender-affirming hormone treatment for adolescents with gender dysphoria include reduction of anxiety, depression, and suicidality, and improvements in life satisfaction. *Id.* at ¶ 46.

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

> "1. A qualified MHP [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 situation and functioning are stable enough to start sex hormone treatment,
> - the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,
>
> 2. And the adolescent:
>
> - has been informed of the (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,

3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:

- agrees with the indication for sex hormone treatment,
- has confirmed that there are no medical contraindications to sex hormone treatment." *Id.* at ¶ 47.

Through decades of clinical experience and research, gender-affirming hormone therapy has been shown to be safe and effective at treating gender dysphoria in adolescents. *See id.* at ¶ 66. Treatment with gender affirming hormone therapy is demonstrated to result in improvement in symptoms of gender dysphoria, depression, and anxiety in transgender youth, as well as improved psychological functioning among transgender young adults who receive treatment for gender dysphoria. *Id.* at ¶ 46.

B. Absent gender-affirming care, Plaintiffs will suffer significant harm

In the absence of intervention, the physical changes of puberty will progress. For a person with gender dysphoria, these changes can cause clinically significant distress. *See* Corathers Aff. ¶ 25. To not intervene, when gender-affirming medical care is indicated, thus causes significant harm to the patient in the form of increasing gender dysphoria associated with the development of secondary sex characteristics that do not match that person's gender identity. *Id.*

There is no evidence-based intervention other than gender-affirming medical care to effectively treat adolescent gender dysphoria. *See id.* at ¶ 37-48; Antommaria Aff. ¶ 50. Psychotherapy alone does not effectively treat gender dysphoria. Antommaria Aff. ¶ 50. Not only does withholding the medically indicated gender-affirming treatment from adolescents with gender dysphoria put them at risk of severe and irreversible harm to their health in the near

term, but also providing medical treatment in adolescence can reduce life-long gender dysphoria, possibly eliminating the need for surgical intervention in adulthood, and further can significantly improve mental health outcomes. Antommaria Aff. ¶ 42; Corathers Aff. ¶ 41.

Without treatment, transgender adolescents and young adults report several fold higher rates of depression, anxiety, suicidal ideation and suicide attempts, compared to their cisgender counterparts. Corathers Aff. ¶ 73. Over twenty years of clinical experience and research has shown that when transgender adolescents are able to access puberty-delaying medication and hormone therapy, their distress recedes, and their mental health improves. For many young people, this treatment is transformative, and they go from experiencing pain and suffering to thriving. *Id.* at ¶ 61.

If the Health Care Ban goes into effect, medical and mental health providers across Ohio will be left with no evidence-based treatments for their adolescent patients with gender dysphoria. Turban Aff. ¶ 18. Given the well-documented benefits of gender-affirming medical care, and the known harms of untreated adolescent gender dysphoria, banning this care will lead to substantial deterioration of mental health for adolescents diagnosed with gender dysphoria. For many of these patients, this is likely to include worsening suicidality. Corathers Aff. ¶ 73.

IV. The Plaintiffs

Madeline Moe is a twelve-year-old transgender girl. Michael Moe Aff. ¶ 4, 7. Madeline has been living as a girl in all aspects of her life since she was seven years old. Moe Aff. ¶ 17. She has been on pubertal suppression medication for a year to treat her diagnosed gender dysphoria, and she is thriving. Moe Aff. ¶ 14. Puberty-delaying medication has given her significant relief from her gender dysphoria: she no longer has to worry about going through a puberty that does not match her gender identity. Moe Aff. ¶ 15-16. Michelle and Michael Moe do not want their daughter to return to the self-harm and mental anguish she felt at six years old, when she said, "I want to

die and come back as a girl. Can't God just make me come back as a girl?" Moe Aff. ¶ 9. The Moe family wants to remain in their supportive and loving community in Ohio and to be able to access their daughter's need for hormone therapy so that she can grow into a healthy young woman. Moe Aff. ¶ 17-18.

Grace Goe is also a twelve-year-old transgender girl. Gina Goe Aff. ¶ 4, 7. Grace first told her parents, Gina and Garrett, that she was a girl at five years old, and was diagnosed with gender dysphoria at six years old. Goe Aff. ¶ 10-11. Since her parents allowed her to live as a girl—as her true self—in all aspects of her life, she has been the happiest and healthiest version of herself. Goe Aff. ¶ 12. That has been her life for the past six years. Goe Aff. ¶ 13. Now that she is twelve, her parents and doctor are monitoring her for the first signs of puberty to identify the right time to begin medication that will pause puberty temporarily. Goe Aff. ¶ 13. When puberty begins, Gina and Garrett want to be able to discuss these options with Grace and her doctor in Ohio and, if medically indicated, begin treatment so that she does not develop physical characteristics that do not match her gender identity. Goe Aff. ¶ 14. Grace's parents worry about her mental health and safety in the community if she is unable to start pubertal suppression and is thus outed as being transgender against her will. Goe Aff. ¶ 14-15. Although the Goe family has deep roots in Ohio and does not want to leave, they are considering moving, or even temporarily separating their family, to ensure that Grace can receive medical care when she needs it. Goe Aff. ¶16-17.

ARGUMENT

A party seeking a preliminary injunction "must ordinarily show that (1) there is a substantial likelihood that the plaintiff will prevail on the merits, (2) the plaintiff will suffer irreparable injury if the injunction is not granted, (3) no third parties will be unjustifiably harmed if the injunction is granted, and (4) the public interest will be served by the injunction." *Vineyard*

Fellowship v. Anderson, 2015-Ohio-5083, 53 N.E.3d 910, ¶ 11 (internal citation and quotation marks omitted). The factors to be considered for a temporary restraining order are the same, and the plaintiff must show that irreparable injury would be immediate in the absence of relief. *Coleman v. Wilkinson*, 147 Ohio App. 3d 357, 2002-Ohio-2021, 770 N.E.2d 637, ¶ 2; *see* Civ. R. 65(A). "In determining whether to grant injunctive relief, no one of the four preliminary injunction factors is dispositive; rather, the four factors must be balanced with 'flexibility which traditionally has characterized the law of equity.'" *AIDS Taskforce of Greater Cleveland v. Ohio Dep't of Health*, 2018-Ohio-2727, 116 N.E. 3d 874, ¶ 23. Where a plaintiff has shown "a high likelihood of irreparable harm," then "likelihood of success on the merits" is less critical. *Id.*

Regardless, Plaintiffs here satisfy all four prongs of the inquiry.

I. Plaintiffs Are Likely to Succeed on the Merits.

A. Plaintiffs are likely to succeed on their single-subject rule claim

H.B. 68 violates the Ohio Constitution's single-subject (or one-subject) rule, which imposes "a constitutional limitation on the legislative power of the General Assembly." *Rumpke Sanitary Landfill, Inc. v. State*, 128 Ohio St.3d 41, 2010-Ohio-6037, 941 N.E.2d 1161, ¶ 20. Article II, Section 15(D) of the Ohio Constitution provides: "No bill shall contain more than one subject, which shall be clearly expressed in its title." This rule "attacks logrolling by disallowing unnatural combinations of provisions in acts, *i.e.*, those dealing with more than one subject[.]" *In re Nowak*, 104 Ohio St.3d 466, 2004-Ohio-6777, 820 N.E.2d 335, ¶ 71 (quoting *State ex rel. Dix v. Celeste*, 11 Ohio St.3d 141, 143, 464 N.E. 2d 153 (1984)).[3] The result "is a more orderly and fair legislative process. By limiting each bill to one subject, the issues presented can be better grasped and more

[3] "Logrolling" is "the practice of combining and thereby obtaining passage for several distinct legislative proposals that would probably have failed to gain majority support if presented and voted on separately." *Nowak* at ¶ 31.

intelligently discussed." *State ex rel. Dix v. Celeste*, 11 Ohio St.3d 141, 143, 464 N.E.2d 153 (1984). Constitutional challenges to statutes under this rule are challenges "to the authority of the General Assembly to enact the bill," not to the underlying provisions of the bill. *Rumpke* ¶ 20. Nonetheless, even if a bill's two or more constituent parts are independently valid (e.g., are not otherwise unconstitutional), the impermissible combination of multiple acts in violation of the one-subject rule renders the entire bill unconstitutional.

H.B. 68's title announces its violation of the single-subject rule by "clearly express[ing]" two separate subjects: the "Saving Ohio Adolescents from Experimentation (SAFE) Act regarding gender transition services for minors, *and* … the Save Women's Sports Act to require schools, state institutions of higher education, and private colleges to designate separate single-sex teams and sports for each sex." 2024 Sub.H.B. No. 68 (emphasis added). This dual title is no accident: H.B. 68 jams two separate bills together as one, creating two Acts not even united by their title.

Adolescent health care and interscholastic sports are distinct subjects pertaining to two wholly independent spheres of life. The Health Care Ban restricts physicians' ability to provide certain treatments to adolescent patients—an issue that has no relation either to schools or to athletics. The Sports Prohibition dictates the operation of schools' and universities' athletic programs, which, likewise, has nothing to do with adolescent health care. Combining the two is an "unnatural combination[]" of distinct subjects into a single bill, in a brazen display of the "disunity of subject matter" that is the "polestar in assessing a violation of the one-subject rule." *Nowak* ¶ 71, ¶ 59.

The individual provisions of H.B. 68 underscore the distance between the Acts. To start, the Health Care Ban and the Sports Prohibition each have their own separate statutory definitions; indeed, neither Act uses any terms defined in the other Act. *See* 2024 Sub.H.B. No. 68 (enacting

R.C. 3129.01, containing definitions for the health care ban, and R.C. 3345.532, containing definitions for the sports restrictions). In other words, each Act can accomplish its objective with no mention of the subject matter of the other Act. Each Act also has its own enforcement mechanism, with no overlap between the degree or type of penalty. The Health Care Ban authorizes the Attorney General to bring an "action to enforce compliance," and provides that violations of some of its sections "shall be considered unprofessional conduct and subject to discipline by the applicable professional licensing board." *See id.* (enacting R.C. 3129.05). The Sports Prohibition, meanwhile, is to be enforced solely by private actions for damages or injunctive relief. *See id.* (enacting R.C. 3345.562). Again, this disconnect reveals that the Acts target entirely different conduct that will be barred through entirely different means. Finally, the General Assembly's findings in Section 2 pertain only to gender-affirming health care with no mention of interscholastic sports. *See id.* at Section 2. That is, again, unsurprising since the Sports Prohibition was logrolled on to the pre-existing bill that contained the Health Care Ban.

Though "[t]he one-subject provision does not require evidence of fraud or logrolling beyond the unnatural combinations themselves," the history of H.B. 68 reveals flagrant logrolling. *Nowak* ¶ 71. Each of H.B. 68's component bills—the Health Care Ban and the Sports Prohibition—failed to pass as a standalone bill. Senate Bill 132 from the 2021-2022 General Assembly session attempted to regulate interscholastic sports in the same fashion as the Sports Prohibition. *See* S.B. No. 132, As Introduced version, 134th General Assembly (March 16, 2021). And, like the Health Care Ban, House Bill 454 from that same legislative session would have banned gender-affirming care for adolescents. *See* H.B. No. 454, As Introduced version, 134th General Assembly (October 19, 2021). Both S.B. 132 and H.B. 454 failed to pass in the 2021-2022 session. But the combined bill encountered no such roadblocks; it cleared the Ohio House within

a week after they were joined together, and subsequently passed the Senate as well. *See* Ohio Legislative Service Commission, Final Analysis of Sub.H.B. No. 68, as passed by the General Assembly (2024), at 9. This maneuver is precisely what the single-subject rule is intended to prevent and the Court should enjoin enforcement of H.B. 68 because it plainly runs afoul of the Ohio Constitution

B. Plaintiffs are likely to succeed on their claim that H.B. 68 unconstitutionally restricts the sale and purchase of health care under Article I, Section 21 of the Ohio Constitution

Article I, Section 21 of the Ohio Constitution, the Health Care Freedom Amendment ("HCFA"), was enacted through a citizen-led ballot initiative in 2011. In relevant part, it provides:

> (B) No federal, state, or local law or rule shall prohibit the purchase or sale of health care or health insurance.
>
> (C) No federal, state, or local law or rule shall impose a penalty or fine for the sale or purchase of health care or health insurance.

The HCFA contains only a handful of limited exemptions: laws that were already "in effect as of March 19, 2010," laws affecting which services a health care provider is "*required to* perform or provide," the terms and conditions of government employment, or "any laws calculated to deter fraud or punish wrongdoing in the health care industry." Sec. 21(D) (emphasis added). By banning a single group of Ohioans from purchasing a specific category of medical treatment, H.B. 68 violates both Section 21(B) and 21(C), and none of the exemptions in Section 21(D) apply.

1. Article I, Section 21 protects Ohioans' right to make their own individual health care decisions

"In construing constitutional text that was ratified by direct vote, we consider how the language would have been understood by the voters who adopted the amendment." *City of Centerville v. Knab*, 162 Ohio St.3d 623, 2020-Ohio-5219, 166 N.E.3d 1167, ¶ 22. As with a statutory provision, courts are to begin "with the plain language of the text," and consider "how

the words and phrases would be understood by the voters in their normal and ordinary usage." *Id.* (citing *District of Columbia v. Heller*, 554 U.S. 570, 576-577 (2008)); *see also, e.g.*, *State ex rel. Sylvania Home Tel. Co. v. Richards*, 94 Ohio St. 287, 294, 114 N.E. 263 (1916) (in constitutional interpretation, "[i]t is the duty of the court to ascertain and give effect to the intent of the people, and the language used should be given its ordinary and reasonable meaning").

The text of the HCFA is simple, direct, and unambiguous. It forbids the General Assembly from prohibiting or penalizing "the purchase or sale of health care[.]" Art. I Sec. 21(B)-(C), where "health care" refers to medical treatment, procedures, diagnoses, and related services and items. This definition accords with contemporary definitions of "health care" (or "healthcare") from the 2011 passage of the HCFA[4] and is likewise consistent with the General Assembly's use of the term "health care" elsewhere in the Revised Code. In two separate provisions—one enacted before the HCFA and one enacted after—"health care" is similarly defined as "any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition or physical or mental health." R.C. 2135.01(G) (enacted in 2003); R.C. 1337.11(G) (enacted in 2013).

"Health care" is distinct from health insurance or insurance coverage, as evidenced by the HCFA's repeated use of the disjunctive phrase "health care or health insurance." *See Cowher v. Million*, 380 F.3d 909, 913 (6th Cir. 2004) ("[I]t is a basic principle of statutory construction that terms joined by the disjunctive 'or' must have different meanings because otherwise the statute or provision would be redundant."); *see also State ex rel. Liberty Council v. Brunner*, 125 Ohio St.3d

[4] *See, e.g.*, Merriam-Webster Online Dictionary (Feb. 19, 2010) Internet Archive https://web.archive.org/web/20100409025253/http://www.merriam-webster.com/dictionary/healthcare ("efforts made to maintain or restore health especially by trained and licensed professionals"); Dictionary.com (Mar. 4, 2011) Internet Archive https://web.archive.org/web/20110324080003/http://dictionary.reference.com:80/browse/healthcare ("the field concerned with the maintenance or restoration of the health of the body or mind" and "any of the procedures or methods employed in this field").

315, 2010-Ohio-1845, 928 N.E.2d 410, ¶ 57 (noting the then-prospective amendment's "general object or purpose of preserving freedom of choice in health care *and* health-care coverage") (emphasis added). The only Ohio court to interpret the substance of the HCFA took this view, explaining that "the use of the disjunctive 'or' renders the term [health care] separate and distinct from the purported target of the amendment – health insurance." *See* Decision and Entry Granting Temporary Restraining Order, *Preterm-Cleveland v. Yost*, Hamilton C.P. No. A2203203 ("*Preterm-Cleveland* TRO Decision," attached as Exhibit 1).

The plain text of the HCFA thus resolves its meaning. It exists not only to protect an individual's ability to select health insurance coverage, but also to ensure constitutional protection for an individual's right to select—and a provider's right to provide—particular health care services, procedures, and treatments. As the court explained in *Preterm-Cleveland*, "[t]he plain language of subsections B and C of the HCFA is simple and clear[.] …[A]s a result of the HCFA, the Ohio Constitution contains a direct recognition of the fundamental nature of the right to freedom in health care decisions." *Preterm-Cleveland* TRO Order at 12–13.

The background and circumstances of the HCFA's adoption only bolster this conclusion. *See City of Centerville* ¶ 22 (a court may "review the history of the amendment and the circumstances surrounding its adoption, the reason and necessity of the amendment, the goal the amendment seeks to achieve, and the remedy it seeks to provide to assist the court in its analysis"). The HCFA was enacted against the backdrop of a nationwide debate over the federal Affordable Care Act ("ACA"). The HCFA was itself an effort to reject or undercut portions of the ACA based on perceived governmental interference in the relationship between physician and patient.[5]

[5] *See generally, e.g.*, *Opponents of health care law continue petition drive*, WFMJ21, (June 25, 2010) https://www.wfmj.com/story/12709736/opponents-of-health-care-law-continue-petition-

Proponents of the HCFA made clear that they were "attempting to draw a line in the sand and say that the federal government shouldn't get any further in between doctors and patients."[6] A board member of the HCFA's proponent committee wrote in a national publication that the HCFA was about freedom to choose health care, not merely to choose how to pay for it: "It's about freedom – the freedom of Ohioans and others to make some of the most important personal decisions they can make about their choice of health care *and* how to pay for it" (emphasis added).[7] Likewise, the committee's campaign manager declared that "[h]ealth care decisions should be made between patients and doctors. Not politicians and bureaucrats."[8] He stated further that the amendment would "allow voters to have a choice this fall if health care decisions should be made by patients and doctors or politicians in Washington D.C."[9]

In fact, the HCFA was designed to protect not only the right to choose standard-of-care health care—such as the well-established care at issue here—but also the right to choose alternative and innovative medicine and treatment. HCFA proponents specifically intended the amendment to protect against efforts to penalize or punish disfavored forms of health care. As the Hamilton County court found in *Preterm-Cleveland*:

> Proponents of the HCFA argued that its passage would not 'further overcrowd our

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drive; *Obama health care foes score big court win*, CBS News (Aug. 12, 2011), available at https://www.cbsnews.com/news/obama-health-care-foes-score-big-court-win/

[6] Aaron Marshall, *Opponents of Issue 3 say amendment would interfere with many Ohio laws*, The Plain Dealer (Sept. 1, 2011), available at https://www.cleveland.com/open/2011/09/opponents_of_issue_3_say_amend.html.

[7] Ed Meese & Jack Painter, *Ohio's battle for health care freedom*, Politico (Nov. 7, 2011), available at https://www.politico.com/story/2011/11/ohios-battle-for-health-care-freedom-067727.

[8] Robert Wang, *Issue 3 low-key, but has long reach*, The Repository (Oct. 30, 2011), available at https://www.cantonrep.com/story/news/politics/elections/issues/2011/10/30/issue-3-low-key-but/42071877007/.

[9] Jo Ingles, *Ohio court says anti-Obamacare amendment can be on November ballot*, Reuters (Aug. 12, 2011), available at https://www.reuters.com/article/us-ohio-obamacare/ohio-court-says-anti-obamacare-amendment-can-be-on-november-ballot-idUSTRE77B50V20110812/

> prisons with those who pursue alternative medicine' and that under its provisions the state could not '*punish the purchase or sale of cutting-edge services, procedures, and coverage*.'

Preterm-Cleveland TRO Order at 14 n.11 (emphasis added) (citing Maurice Thompson, 1851 Center, *Passage of Issue 3 will protect liberty, restrain health care costs, and preserve health care choice and privacy*, available at https://www.healthpolicyohio.org/wp-content/uploads/2014/01/1851_issue3essay.pdf (Sept. 29, 2011)).

2. The Health Care Ban is unconstitutional under Article I, Section 21

The Health Care Ban violates the HCFA. Gender-affirming health care is "health care" within any reasonable understanding of that term—and so soundly within that understanding that it is both covered by the prevailing clinical practice guidelines and standards of care, and supported by every major American medical association. Turban Aff. ¶ 13. Because puberty-delaying medication and hormone therapy to treat gender dysphoria are "health care," these treatments are necessarily protected by the HCFA. By prohibiting the use of those medicines for the purpose of providing gender-affirming health care, the Ban restricts the sale and purchase of widely accepted treatments for gender dysphoria, a serious medical condition. *See* Ohio Const. Art. I Sec. 21(B). And by threatening physicians who provide gender-affirming health care with government enforcement actions and professional discipline from the State Medical Board, the Ban also "impose[s] a penalty" for the sale or purchase of health care. Ohio Const. Art. I Sec. 21(C). In short, the Health Care Ban is the Ohio General Assembly's effort to substitute its own judgment for that of Ohio adolescents, their parents, and physicians —thus infringing on individual "freedom of choice in health care." *State ex rel. Liberty Council v. Brunner*, 125 Ohio St.3d 315, 2010-Ohio-1845, 928 N.E.2d 410, ¶ 57. That is precisely what the HCFA was enacted to prevent.

Nor can the government evade the HCFA by summarily declaring gender-affirming health care to be "experimental," as the title of the Health Care Ban suggests. To start, gender-affirming

health care is not experimental because it is not novel or unproven. Antommaria Aff. ¶ 28. Experimental treatments are interventions that have shown some promise as a cure and are administered to advance knowledge for the potential benefit of *future* patients. In contrast, gender-affirming care is provided to benefit *individual* patients and the treatment is modified based on their individual responses. But there are already ample studies supporting the benefits of gender-affirming care where medically indicated, which is why it is not an "experiment." To the contrary, it has long been the standard of care to treat gender dysphoria. *Id.*

Moreover, as its proponents repeatedly stated, the HCFA was intended to protect a broad swath of medical care, including "cutting-edge services [and] procedures" and even "alternative medicine." *Preterm-Cleveland* TRO Order at 14 n.11 (internal citation omitted). The HCFA's protection thus extends well beyond widely accepted treatments like puberty-delaying medicine and hormone therapy. At bottom, the HCFA removes politicians' authority to draw arbitrary lines defining what is or is not an accepted medical treatment. All "health care" is protected by the HCFA's plain terms, with only limited, statutorily defined exceptions: most notably, restrictions that were already in place as of March 19, 2010, and "laws calculated to deter fraud or punish wrongdoing in the health care industry." Ohio Const. Art. I Sec. 21(D).

Neither exception applies here. First, H.B. 68 was passed long after March 19, 2010, so it was not a restriction in place at the time.

Second, the phrase "deter fraud or … wrongdoing in the health care industry" has no bearing on the provision of gender-affirming health care. While the terms "fraud" and "wrongdoing" are not defined in the HCFA, if the General Assembly could dictate via statute that a particular form of health care is tantamount to "fraud" or "wrongdoing," then the HCFA would provide no protection at all for "health care." Tellingly, H.B. 68 does not categorically define any

particular medical intervention as "fraud" or "wrongdoing," on its own, and the legislative findings are silent on those points. There is no specific intervention—pharmaceutical or surgical—that the Health Care Ban categorically proscribes in the State of Ohio. Rather, it prohibits a specific subset of patients—transgender adolescents with gender dysphoria —from purchasing health care to treat their medical diagnosis, while allowing all other Ohioans, of any age, to purchase those same interventions. And the Ban's prospective prohibition still allows physicians to continue providing gender-affirming health care to adolescent Ohio residents who are already receiving it, as well as to all adults. *See* 2024 Sub.H.B. No. 68 (enacting R.C. 3129.02(B)).

Moreover, the study and provision of gender-affirming health care to treat adolescents with gender dysphoria pre-dates the HCFA. *See* Antommaria Aff. ¶ 28 ("The first reference to the use of GnRH analogs for the treatment of gender dysphoria in the medical literature was in 1998, over 25 years ago."). That the HCFA didn't exclude it from protection shows that it was covered. "The [HCFA] drafters could have excluded existing and future regulation of the health care profession … but they did not." *Preterm-Cleveland* TRO Order at 13–14.

In sum, the Health Care Ban both prohibits and penalizes the purchase and sale of health care and is therefore unconstitutional under the plain text, ordinary meaning, and avowed purpose of the HCFA.

C. Plaintiffs are likely to succeed on their equal protection claim

Plaintiffs are likely to succeed on their equal protection claim because the Health Care Ban is a sex-based classification that fails to satisfy strict scrutiny, meaning it is not narrowly tailored to serve a compelling state interest. Ohio's Equal Protection Clause broadly proclaims that "[a]ll political power is inherent in the people." Ohio Const., Art. I, Section 2. As such, the "Government is instituted for [the people's] equal protection and benefit," meaning "[the people] have the right to alter, reform, or abolish the same, whenever they may deem it necessary; and no special

privileges or immunities shall ever be granted, that may not be altered, revoked, or repealed by the general assembly." *Id.* The Ohio Equal Protection Clause has both "unique language" and an independent "historical background." *Stolz v. J & B Steel Erectors, Inc.*, 155 Ohio St.3d 567, 2018-Ohio-5088, 122 N.E.3d 1228, ¶28-29 (Fischer, J., concurring) (noting that Ohio's Equal Protection Clause predates its federal counterparty by 17 years). While the U.S. Constitution focuses on "proscriptions against taking or denying benefits," i.e. a check against government action, the Ohio Constitution is fundamentally oriented toward greater protections and elevates equal protection to one of the "foundational reasons for the existence of state government." *League of Women Voters of Ohio v. Ohio Redistricting Comm.*, 167 Ohio St.3d 255, 2022-Ohio-65, 192 N.E.3d 379, ¶ 151 (Brunner, J., concurring). In light of this difference, the Ohio Supreme Court has noted that it "can and will interpret [the Ohio] Constitution to afford greater rights to [Ohio] citizens" since it is "not confined by the federal courts' interpretation of similar provisions in the federal Constitution." *State v. Mole*, 149 Ohio St.3d 215, 2016-Ohio-5124, 74 N.E.3d 368, ¶ 21; *see also id.* ¶ 23 (holding that "the guarantees of equal protection in the Ohio Constitution independently forbid" certain conduct, regardless of federal constitutional protections).

The Health Care Ban violates the Ohio Constitution's sweeping commands. By prohibiting treatment if and only if that treatment is deemed to facilitate a "gender transition"—defined as allowing the "social, legal, or physical changes" involved in allowing someone to identify as a gender "different from" the patient's "biological sex—H.B. 68 classifies on the basis of sex in multiple ways. Because sex is a suspect classification, the Ban is subject to strict scrutiny, which requires the government to show that it is narrowly tailored to advance a compelling governmental interest. H.B. 68 fails that test.

1. The Health Care Ban classifies based on sex

The Healthcare Ban facially classifies based on sex in three ways. First, it classifies based

on an adolescent's sex designated at birth. Second, it classifies based on the incongruence between a person's gender identity and their sex designated at birth. Third, it conditions treatment based on the government's preferences about a person's sex—namely, that they live and identify with their sex designated at birth.

First, the Health Care Ban is a sex-based classification because it facially classifies based on sex designated at birth: whether an individual adolescent can access a particular medical intervention depends on their designated sex. In other words, a person's sex designated at birth is the but-for cause of the Health Care Ban's prohibition. Treatment is prohibited only when it relates to "gender transition," which is the "process in which an individual goes from identifying with and living as a gender that corresponds to his or her biological sex to identifying with and living as a gender different from his or her biological sex." R.C. 3129.01(E). In each instance a physician must know and prohibit treatment based on whether an adolescent was designated male at birth or female at birth. Sex "plays an unmistakable" role when the government "penalizes a person identified as male at birth for traits or actions that it tolerates in [a person] identified as female at birth." *Bostock v. Clayton Cnty.*, 590 U.S. 644, 140 S. Ct. 1731, 207 L.Ed.2d 218, 659-663. That is precisely how the Ban operates. A person designated female at birth can obtain any medical intervention to affirm a female gender identity, regardless of whether it is to treat a medical diagnosis or for cosmetic purposes, but a person designated male at birth cannot, even with a diagnosis of gender dysphoria. *See* Corathers Aff. ¶ 72. That is precisely what the *Bostock* Court identified as a sex classification.

Second, the Ban classifies based on the incongruence between a person's sex designated at birth and their gender identity. Whether any medication or intervention is prohibited depends on whether the treatment is deemed consistent with the minor's designated sex at birth. "Gender

transition services" are defined by virtue of whether they "alter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex, or to instill or create physiological or anatomical characteristics that resemble a sex different from the individual's birth sex…[or] promote the development of feminizing or masculinizing features in the opposite sex." Sec. 3109.054(F). By drawing a line based on the incongruence between a person's sex designated at birth and gender identity, the Ban "unavoidably discriminates against persons with one sex identified at birth and another today." *Bostock*, 590 U.S. at 669.

Finally, by hinging the prohibition on whether a particular intervention is typical of what is expected of a person designated a particular sex at birth, the law imposes a government preference for gender conformity. This is a "form of sex stereotyping where an individual is required effectively to maintain [their] natal sex characteristics." *Boyden v. Conlin*, 341 F. Supp. 3d 979, 97 (W.D. Wis. 2018); *cf. Kadel v. Folwell*, 446 F. Supp. 3d 1, 14 (M.D.N.C. 2020) (rule discriminates based on sex if it "tethers [people] to sex stereotypes which, as a matter of medical necessity, they seek to reject"). Indeed, the Health Care Ban specifically allows treatment for intersex conditions, also described as disorders of sex or sexual development, thus allowing parents to consent to any treatment—pharmaceutical or surgical—that would tether their child to their "biological sex." R.C. 3129.04.

Because the Health Care Ban classifies based on sex in multiple ways, it must survive strict scrutiny. Under this standard, the state has the burden of demonstrating that the law passed is narrowly tailored to a compelling government interest. They cannot do so here.

2. Sex-based classifications are subject to strict scrutiny

Under the Ohio Constitution, sex is a suspect class. *See, e.g.*, *Adamsky v. Buckeye Loc. Sch. Dist.*, 73 Ohio St.3d 360, 362, 1995-Ohio-298, 653 N.E.2d 212 ("[A] suspect class … has been defined as one involving race, national origin, religion, or sex."); *In re A.W.*, 5th Dist. Knox No.

15CA3, 2015-Ohio-3463, ¶ 23 ("Suspect classes include race, sex, religion, and national origin[.]"), *aff'd in part, appeal dismissed in part on other grounds*, 147 Ohio St.3d 110, 2016-Ohio-5455, 60 N.E.3d 1264 (Mem), *reconsideration denied*, 147 Ohio St.3d 1414, 2016-Ohio-7455, 62 N.E.3d 186 (Table). Sex-based classifications are therefore subject to strict scrutiny under the Ohio Constitution. *See Arbino v. Johnson & Johnson*, 116 Ohio St.3d 468, 2007-Ohio-6948, 880 N.E.2d 420, at ¶ 64.[10]

3. The Health Care Ban cannot survive strict scrutiny because it is not narrowly tailored to advance a compelling state interest

None of the reasons set forth in H.B. 68's legislative findings justify singling out gender-affirming medical care for prohibition. And, in fact, the Health Care Ban undermines, rather than advances, the government's interest in protecting the health and safety of children. To survive strict scrutiny, the Health Care Ban must be narrowly tailored to serve a compelling state interest. *See Groch v. Gen. Motors Corp.*, 117 Ohio St.3d 192, 2008-Ohio-546, 883 N.E.2d 377, ¶ 155; *see also Rowitz v. McClain*, 2019-Ohio-5438, 138 N.E.3d 1241, ¶ 19 (10th Dist.). Strict scrutiny places a "heavy" burden of proof on the state—a burden the State cannot satisfy here. *Crowe v. Owens Corning Fiberglass*, 8th Dist. Cuyahoga No. 73206, 1998 WL 767622, *4 (Oct. 29, 1998), aff'd, 87 Ohio St.3d 204, 1999-Ohio16, 718 N.E.2d 923 (Mem).

a) The legislative findings reveal that the Ban is not supported by a compelling state interest

[10] That is a higher level of judicial scrutiny than similar classifications under the U.S. Constitution. Under the Fourteenth Amendment to the U.S. Constitution, "heightened scrutiny" applies to gender-based classifications, including those that purport to classify based on physical differences between the sexes. *See United States v. Virginia*, 518 U.S. 515, 555, 116 S.Ct, 2264, 135 L.Ed.2d 735 (1996) ("*VMI*"); *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 n.9, 102 S.Ct. 3331, 73 L.Ed. 1090 (1982). The Ohio Constitution must, at a minimum, provide the same protection, but it in fact goes beyond the level of protection provided under the U.S. Constitution. *See State v. Broom*, 146 Ohio St.3d 60, 2016-Ohio-1028, 51 N.E.3d 620, ¶ 55 ("The United States Constitution provides a floor for individual rights and civil liberties, but state constitutions are free to accord greater protections.").

To start, the Ban does not serve a compelling state interest. The legislative findings in Section 2 assert that the "state has a compelling government interest in protecting the health and safety of its citizens, especially vulnerable children." H.B. 68 (Sec. 2(A)). That is a compelling interest, but the Ban itself does not protect the health or safety of any minors, and in fact inflicts great harm transgender adolescents by depriving them of the only evidence-based medical care for gender dysphoria. Moreover, the legislative findings contained in the Health Care Ban are wholly unsupported by evidence, riddled with factual errors, and rest on misleading claims.

Evidence Base: There is ample evidence that gender-affirming medical care is both safe and effective at alleviating gender dysphoria in adolescents and young adults. Antommaria Aff. ¶¶ 27-29. Longitudinal and cross-sectional studies support the efficacy and effectiveness of puberty blockers and gender-affirming hormones for the treatment of adolescents with gender dysphoria, and experts in the field are confident regarding the positive mental health impacts of these treatments. Turban Aff. ¶ 35. Contrary to legislative finding (F), *see* H.B. 68 (Sec. 2(F)), longitudinal studies examining mental health before and after gender-affirming medical interventions have found that mental health is improved after treatment. Turban Aff. ¶ 35. Controlled cross-sectional studies compared those who accessed gender-affirming medical care to those who desired but did not access this treatment and found that people who accessed treatment had better mental health outcomes than those who did not. *Id.* These studies are well-accepted in medical research and often relied upon in medicine, especially when it is neither feasible nor ethical to conduct randomized controlled trials. *Id.* at ¶ 36. With respect to legislative finding (G) regarding the absence of randomized controlled trials for the provision of hormone therapy to adolescents with gender dysphoria, *see* H.B. 68 Sec. 2(G), randomized controlled trials are not feasible or ethical: the evidence supporting gender-affirming care is already so strong that it would

be difficult to recruit people to accept a placebo instead, and for pediatric populations, it is not considered ethical to randomize patients to placebo treatments when there is substantial evidence that active treatment confers important benefits. Turban Aff. ¶ 36. Moreover, the existing studies supporting the efficacy of care are supplemented by decades of clinical experience from experts around the world, and in Ohio, who have seen the substantial clinical benefits that their adolescent patients with gender dysphoria have experienced from gender-affirming medical treatment. Turban Aff. ¶ 36; Corathers Aff. ¶ 66, 69.

Efficacy: Gender-affirming medical care relieves gender dysphoria in adolescents and improves mental health outcomes. Turban Aff. ¶ 14. It is the only evidence-based intervention to treat gender dysphoria. *Id.* at ¶ 18. The legislative finding (E) that certain negative health outcomes are more common after gender-affirming surgery, *see* H.B. 68 (Sec. 2(E)), is misleading and irrelevant to the provision of puberty-delaying medications and hormone therapy to adolescents. First, surgery is a red herring. Plaintiffs are not seeking access to surgery, and the major multidisciplinary gender clinics in Ohio do not provide gender-affirming surgery to minors in Ohio. Corathers Aff. ¶ 69 n.9; *id.* at ¶ 75 n.12. Second, mental health improves following gender-affirming medical care for adolescents with gender dysphoria. Turban Aff. ¶ 34; Corathers Aff. ¶ 46. Third, transgender people face a range of stressors that affect their mental health, most prominently societal rejection based on being transgender, which can lead to elevated rates of mental health problems compared to cisgender people, even after receiving gender-affirming care. Turban Aff. ¶ 34. Banning gender-affirming medical care because it does not resolve all potentially co-occurring mental health diagnoses is no more logical than prohibiting psychiatric medications for treating depression or anxiety simply because all symptoms do not completely abate in every patient. *Id.* at ¶ 34. Similarly, legislative findings (N) and (O), *see* H.B. 68 (Secs. 2(N)-(O)) are

incorrect to the extent they claim there is a lack of sufficient studies or that risks outweigh benefits. *Id. at* ¶ 37. To the contrary: gender-affirming medical care is the standard of care for gender dysphoria precisely because, where medically-indicated, the benefits of providing treatment outweigh the risks, which include deteriorating mental health from allowing gender dysphoria to go untreated. *Id.* at ¶ 23.

Risks of Side Effects: There is nothing uniquely risky about the care provided to transgender minors to treat gender dysphoria when compared to any other type of health care. Notably, the endocrine treatments prohibited by the Ban are used to treat other conditions and carry comparable risks and side effects regardless of the indication for which they are prescribed. Corathers Aff. ¶¶ 70-72. Many of the potential risks and side effects of hormone therapy are the same or similar for cisgender and transgender patients. Corathers Aff. ¶ 65. Contrary to legislative finding (H) regarding the risks of gender-affirming hormone therapy, *see* H.B. 68 (Sec. 2(H)), the majority of potential side effects are tied to genetic and behavioral risk factors, not the medications themselves. *Id.* at ¶ 64. The risks and side effects of gender-affirming medical care are rare, manageable through clinical monitoring, and disclosed via informed consent. *Id.* at ¶ 58. Many people with gender dysphoria are on hormone therapy for decades and there is no evidence that negative health outcomes outweigh the substantial benefits. Corathers Aff. ¶ 71.

The Standards of Care: Prior to initiating gender-affirming care, the standards of care require a biopsychosocial mental health assessment, which can be extended for youth with complex mental health histories, autism, or other co-occurring diagnoses. Turban Aff. ¶ 33. Contrary to legislative finding (D), *see* H.B. 68 (Sec. 2(D)), which misrepresents the model of gender-affirming care, adolescents with gender dysphoria also receive evaluation and treatment for other co-occurring mental health conditions, which are considered alongside potential gender

dysphoria diagnoses. Turban Aff. ¶ 33. These assessments distinguish other mental health conditions from gender dysphoria and help determine whether gender-affirming medical interventions are appropriate. *Id.* Further, while psychotherapy can be very helpful for adolescents with gender dysphoria to help explore their gender identity and address other mental health conditions, there are no evidence-based psychotherapy protocols that effectively treat gender dysphoria itself. Turban Aff. ¶¶ 18, 33.

Pre-adolescents: Only at the onset of puberty do adolescent patients with gender dysphoria become candidates for gender-affirming medical care. Corathers Aff. ¶ 42. Once transgender youth begin puberty—the earliest point in time where a medical intervention might be considered—it is extremely rare for them to later identify as cisgender. Turban Aff. ¶ 23. Legislative finding (C), *see* H.B. 68 (Sec. 2(C)), is extraordinarily misleading in suggesting otherwise by referencing children who have not yet reached puberty. Turban Aff. ¶ 32. Because prepubertal children are not candidates for gender-affirming medical interventions under current guidelines, studies regarding prepubertal children and their likelihood of ultimately identifying as transgender should not be used to assess medical interventions that are provided only to adolescent patients. *Id.* at ¶ 22-25, 32.

Ultimately, the Health Care Ban does not serve a compelling government interest in protecting the health and well-being of minors because it does the opposite: it endangers minors by prohibiting the only evidence-based treatment for a serious medical condition. Turban Aff. ¶ 38; Corathers Aff. ¶¶ 73-76; Antommaria Aff. ¶¶ 50, 63.

The personal experiences of the Moe family illustrate how this treatment positively transforms the lives of the adolescents who need it: Madeline is a thriving twelve-year-old girl because she was able to access puberty-delaying medication when she needed it, and when her

parents and her doctors decided with her that such treatment was appropriate. Only puberty-delaying medication is capable of preventing Madeline from going through male puberty, which would immensely exacerbate her gender dysphoria. Only hormone therapy in the form of estrogen will allow her, at the appropriate time, to begin female puberty and continue to grow into a young woman. Depriving Madeline of this care will prevent her from continuing to live her life with her loving family in her supportive community. The Goe family wants that same opportunity for their daughter: they want Grace to avoid the debilitating symptoms of gender dysphoria and continue living her life as a girl. Grace is poised to start puberty at any time; when it happens, only puberty-delaying medication and later estrogen can bring her body into alignment with her gender. Rather than harming these adolescents, gender-affirming care has enabled them to thrive or provided them with hope for their futures. The Health Care Ban fails strict scrutiny because it endangers, rather than protects, transgender minors like Grace Goe and Madeline Moe.

b) The Health Care Ban is not narrowly tailored

Moreover, the Health Care Ban is not narrowly tailored to address the legislature's purported concerns about safety, efficacy, reversibility, or fertility with respect to surgical interventions, as set forth in legislative findings (E), (I), (J), (K), (L), and (N). *See* H.B. 68 (Sec. 2(E), (I)-(L), (N)). None of these findings have any bearing on the provision of puberty-delaying medication or hormone therapy, which are the most common interventions provided to minors. Surgical interventions are very rare. *See* Corathers Aff. ¶ 69 n.9. The Health Care Ban nonetheless prohibits the vast majority of care provided to transgender adolescents in the form of puberty-delaying medication or hormone therapy, neither of which implicate the concerns in those legislative findings about surgical frequency, outcomes, reversibility, or infertility. There is a profound disconnect between these legislative findings about surgery and the ban on puberty-delaying medication and hormone therapy. Medication and hormonal treatment do not invoke any

of those concerns, which are specific to surgical intervention.

Further, the exceptions in the Health Care Ban itself reveal the lack of narrow tailoring: none of the surgical interventions listed in the law are prohibited based on evidence of safety, efficacy, reversibility, or fertility: they are banned when provided "for the purpose of assisting an individual with gender transition" or to "alter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex." R.C. 3109.054(C). Under the Health Care Ban, surgeons in Ohio remain free to provide irreversible and sterilizing surgeries, regardless of the evidence for efficacy, to treat any "disorder of sex development." Antommaria Aff ¶ 56. The Health Care Ban explicitly protects a parent's right to make any decision that aligns with biological sex, but not treatment that departs from it: physicians are not prohibited from treating intersex conditions, also known as "disorder[s] of sex[ual] development," R.C. 3129.04(A) , or when an individual "does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a biological male or female." *id.*, R.C. 3129.04(B). The legislative findings are at odds with the contours of the Ban.

Contrary to the Ban's legislative findings, the provision of gender-affirming medical care is consistent with professional medical standards, developed based on rigorous review of existing evidence and comparable to the types of guidelines used to treat other conditions. Corathers Aff. ¶¶ 66-72; Turban Aff. ¶¶ 12-21; Antommaria Aff. ¶¶ 16-36. Peer-reviewed longitudinal and cross-sectional studies have shown that the treatments prohibited by the Ban are safe and effective, and the legislative findings greatly exaggerate the risks associated with the care. Antommaria Aff. ¶¶ 31-35. The overwhelming consensus of the medical community, based on research and clinical experience, is that gender-affirming medical care greatly improves the health and well-being of adolescent patients with gender dysphoria. Corathers Aff. ¶¶ 66-72; Turban Aff. ¶¶ 12-21;

Antommaria Aff. ¶¶ 16-36. This care reduces symptoms of anxiety, depression, and suicidality, and improves health outcomes for adolescent patients. Corathers Aff. ¶ 73; Turban Aff. ¶¶ 14-19; Antommaria Aff. ¶ 43.

D. Plaintiffs are likely to succeed on their due course of law claim

The Health Care Ban violates Article I, Section 16 of the Ohio Constitution by infringing the Parent Plaintiffs' fundamental right to seek appropriate medical care for their children. As such, it is subject to strict scrutiny—a standard it cannot satisfy. *See supra*, pp. 31-35.

1. The Parent Plaintiffs' due process claims are subject to strict scrutiny

Under the Ohio Constitution, parents have a "fundamental liberty interest … in the custody, care and control of their children." *In re S.H.*, 9th Dist. Medina No. 13CA0066-M, 2013-Ohio-4380, 2013 WL 5519847, ¶ 13 (Oct. 1, 2013). This interest extends to parents' right to make medical decisions for their children, including, "within reason, whether and what type of medical care the child will receive." *In re I.S.*, 2022-Ohio-3923, 199 N.E.3d 1130, ¶ 102 n.8, (8th Dist.). The U.S. Constitution is in accord. *See* supra, p. 31 n.10 (recognizing that state constitutional protections must, at a minimum, track analogous federal protections). As the U.S. Supreme Court has recognized, fundamental liberty interests include parents' rights to make decisions "concerning the care, custody, and control of their children," based on a "presumption" that "fit parents act in the best interests of their children." *Troxel v. Granville*, 530 U.S. 57, 66, 68, 120 S.Ct. 2054, 147 L.Ed.2d 49 (2000). Indeed, this right is "perhaps the oldest of the fundamental liberty interests recognized by [the] Court." *Id.* at 65; *see also Parnham v. J.R.*, 442 U.S. 584, 602, 99 S.Ct. 2493, 61 L.Ed.2d 101 (1979) (collecting cases).

Because any restriction of parents' rights in this area "infringe[s] upon a fundamental right," the restriction must satisfy strict scrutiny. *Stolz*, 155 Ohio St.3d 567, 2018-Ohio-5088, 122 N.E.3d 1228, ¶ 14; *see also Pre-Term Cleveland* TRO Order at 12 ("governmental action that

limits the exercise of a fundamental constitutional right is subject to the highest level of judicial scrutiny"). The government cannot "infringe certain 'fundamental' liberty interests at *all*, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest." *Reno v. Flores*, 507 U.S. 292, 302, 113 S.Ct. 1439, 123 L.Ed.2d 1 (1993); *see also Middleton v. City of Flint*, 92 F.3d 396, 404 (6th Cir. 1996) (where a fundamental right is burdened, government must show "a compelling state interest," and "that the plan is narrowly tailored to further" that interest). The Ban fails this standard.

2. The Health Care Ban cannot survive strict scrutiny

As discussed above and below, the Ban cannot survive any level of review, and thus necessarily fails the strict scrutiny that governs state intrusions into fundamental rights. In addition to the reasons discussed above, the Ban fails strict scrutiny because Ohio's chosen means are nowhere near the "least restrictive." *See Bernal v. Fainter*, 467 U.S. 216, 219, 104 S.Ct. 2312, 81 L.Ed.2d 175 (1984). Nothing about the Ban is narrowly tailored to *any* interest, compelling or not. Rather than address the Legislature's purported concerns, the Ban simply rules out *any* new courses of medical treatment for gender dysphoria in adolescents.

Moreover, where Ohio courts have deprived parents of this fundamental right, it has been in rare cases where "parents cannot or will not consent to" affirmatively *provide* treatment for a minor's significant (typically life-threatening) medical condition. *In re I.S.*, 2022-Ohio-3923, 199 N.E.3d 1130, ¶ 102 (8th Dist.); *see also In re S.H.*, 9th Dist. Medina No. 13CA0066-M, 2013-Ohio-4380, 2013 WL 5519847, ¶ 25 (noting that "the state that can intervene and *order* medical procedures for a child against their parents' wishes under certain circumstances") (emphasis added); *In re Willmann*, 24 Ohio App. 3d 191, 198-99, 493 N.E.2d 1380 (1st Dist. 1986) (appointing temporary custodian where parents disagreed with consensus of physicians and surgeons that son needed treatment for cancer). But there is no authority supporting the State's

authority to take this decision away from parents when the parents, the adolescent child, and medical professional are all aligned in the view that treatment will be beneficial.

3. The Health Care Ban fails any level of review

Although the Ban is properly subject to strict scrutiny, it ultimately fails any level of review. At minimum, the law's "classification [must] be rationally related to a legitimate government purpose." *Thorp v. Strigari*, 155 Ohio App.3d 245, 2003-Ohio-5954, 800 N.E.2d 392, ¶ 15. What this law does, however, is "so far removed from [the asserted] justifications that it [is] impossible to credit them." *Romer v. Evans*, 517 U.S. 620, 635, 116 S.Ct. 1620, 134 L.Ed.2d 855 (1996). Rather than protect children, the Ban harms them.

There is no rational basis to conclude that allowing adolescents with gender dysphoria to receive gender-affirming medical care that they, their parents, and their doctors agree is medically necessary "would threaten legitimate interests of [Ohio] in a way that" allowing other types of care "would not." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 448 105 S.Ct. 3249, 87 L.Ed.2d 313 (1985); *see also Eisenstadt v. Baird*, 405 U.S. 438, 452, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972) (health risks of birth control pills not a rational basis for banning access for unmarried people while allowing for married people). Even under rational basis review, the justifications for the Ban "ma[k]e no sense in light of how the [statute] treat[s] other [procedures] similarly situated in relevant respects." *Bd. of Trust. Of Univ. of Ala. V. Garrett*, 531 U.S. 356, 366 n.4, 121 S.Ct. 955, 148 L.Ed.2d 866 (2001). Notably, an improper motive for legislation "rises not from malice or hostile animus alone," but "may result as well from insensitivity caused by simple want of careful, rational reflection or from some instinctive mechanism to guard against people who appear to be different in some respects from ourselves." *Id.* at 374 (Kennedy, J., concurring). That is precisely the case here. Indeed, the entirety of H.B. 68—both the Health Care Ban and Sports Prohibition—is concerned with limiting rights for transgender people. Regardless of the intent

behind those two Acts, the targeting of transgender people for unique restrictions it is not a proper legislative purpose.

II. Plaintiffs Will Suffer Irreparable Harm Absent Injunctive Relief.

If permitted to go into effect, the Ban will inflict on Plaintiffs severe and irreparable harm for which no adequate remedy at law exists. To start, "[a] finding that a constitutional right has been threatened or impaired mandates a finding of irreparable injury as well." *Magda v. Ohio Elec. Comm.*, 58 N.E. 3d 1188, 2016-Ohio-5043, ¶ 38 (10th Dist.) (citing *Bonnell v. Lorenzo*, 241 F.3d 800, 809 (6th Cir. 2001)). As shown above, Plaintiffs are substantially likely to succeed in demonstrating that H.B. 68 violates four distinct provisions of the Ohio Constitution: the single-subject rule, the Health Care Freedom Amendment, the Equal Protection Clause, and the Due Course of Law provision. Those constitutional injuries constitute irreparable harm as a matter of law.

But the irreparable harm here is much more dire: allowing the Health Care Ban to go into effect will immediately deny patients life-saving medical care and force families to watch their children suffer or uproot their lives in Ohio. Grace Goe is twelve years old; she has been living as a girl since she was five. Goe Aff. ¶¶ 4,9. Her life as a girl is all she and her community know. As puberty approaches and her distress at the potential for permanent changes to her body increase, it is likely that the only way to preserve her health will be the puberty-delaying medication consistent with the medical standard of care, if recommended by her doctors. But the Health Care Ban prevents her from receiving that treatment, contrary to her wishes, her parents' considered judgment, and her doctors' recommendations. To undergo puberty inconsistent with her gender identity would be extraordinarily distressing: developing facial and body hair, a deepening voice, and an Adam's apple, would be profoundly disturbing. For transgender adolescents like Grace, the development of these unwanted sex characteristics exacerbates gender dysphoria and risks their

mental health, including increased anxiety and depression, and, potentially, suicidality. Corathers Aff. ¶ 73; Turban Aff. ¶¶ 14-19; Antommaria Aff. ¶ 43. If Grace is forced to develop these characteristics, they may be difficult, if not impossible to eliminate when she is an adult. Corrathers Aff. ¶ 41. But in the absence of an injunction, Grace will be forced to do exactly that, causing irreparable harm to her well-being.

Madeline Moe, meanwhile, has already been on puberty-delaying medication for approximately one year, and she and her parents anticipate that, at the appropriate time, they will want to consult with Madeline's doctors about whether hormone therapy is medically indicated for her gender dysphoria. Moe Aff. ¶ 17. Remaining on puberty-delaying medication indefinitely is not an option. Corathers Aff. ¶ 75. Her treating physician, however, has already informed Madeline and her parents that as a result of the Health Care Ban, while he can continue prescribing specific medications or treatments that have already commenced, he cannot prescribe hormone therapy in the form of estrogen, which would be the appropriate medication to treat her if her distress continues. Corathers Aff. ¶¶ 43-46. Absent injunctive relief, Madeline will be unable to continue the course of care recommended by her physician to treat her gender dysphoria, leading to risks of suicidality and self-harm. Moe Aff. ¶ 16. Being unable to start estrogen before she turns eighteen means that she will not develop as a young woman alongside her peers, and it is medically untenable for her to remain on puberty-delaying medication for such a prolonged period of time. But if she stops puberty-delaying medication without being able to begin hormone therapy, she will start male puberty. For the girl who had "want[ed] to die and come back as a girl," pleading with God to make her a girl, this would be profoundly disturbing. "Even the thought of growing facial and body hair, developing an Adam's apple, or her voice deepening distresses her." Moe Aff. ¶ 15. For Madeline, without injunctive relief, her distressing fear would become her reality.

Untreated, her gender dysphoria will lead to substantial deterioration of her mental health. For many patients, this is likely to include worsening suicidality. Corathers Aff. ¶ 73; Turban Aff. ¶¶ 14-19; Antommaria Aff. ¶ 43. Absent injunctive relief, Madeline will be deprived of the opportunity to benefit from the one effective treatment to reduce the anxiety, depression, and suicidality that stems from gender dysphoria, and to increase her potential for life satisfaction. *See id.*

III. No Third Parties Will Be Unjustifiably Harmed By The Requested Relief.

Injunctive relief will not result in any harm—let alone unjustifiable harm—to third parties. In stark contrast to the deeply personal and irreparable harms Plaintiffs face, an injunction would merely preserve the status quo while Plaintiffs pursue their claims. Prior to H.B. 68 and the Health Care Ban, physicians in Ohio were permitted to provide gender-affirming medical care to adolescents when parents provided informed consent, adolescents provided assent, and in the physicians' clinical judgment, such interventions were medically indicated to alleviate gender dysphoria. Such medical care was provided in accordance with rigorous guidelines, informed by decades of research and clinical experiences. Corathers Aff. ¶¶ 66-72; Turban Aff. ¶¶ 12-21; Antommaria Aff. ¶¶ 16-36. And, importantly, the decision about whether to provide such treatments ultimately rested with parents, not the State of Ohio. Ensuring that parents remain the decision-makers for their adolescent children's health care, and that health care remains available for adolescents cannot, in itself, cause unjustifiable harm to anyone. Moreover, even without H.B. 68 and the Health Care Ban, physicians and patients in Ohio can rely on the full range of professional and legal safeguards, such as professional practice standards and other protections against negligence and malpractice.

Nor would the government be unjustifiably harmed. H.B. 68's Health Care Ban is unconstitutional, for the reasons discussed above. The government can suffer no "unjustifiable"

harm or injury merely because an unconstitutional statute is enjoined. Nor is the government harmed by families—that is, parents, their adolescent children, and their physicians—making individualized decisions about the appropriate course of medical care for gender dysphoria.

IV. The Public Interest Weighs In Favor of Injunctive Relief.

"[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *G & V Lounge, Inc. v. Mich. Liquor Control Comm'n*, 23 F.3d 1071, 1079 (6th Cir. 1994). The public also has a strong interest in preventing discrimination against a vulnerable class of individuals, such as transgender adolescents. *See, e.g.*, *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217, 222 (6th Cir. 2016) (public interest weighed "strongly" against staying an injunction, when a stay would have allowed continued discrimination against a student based on gender identity). Injunctive relief from this Court would serve both of these interests.

Moreover, halting the Health Care Ban will serve the pressing interests of any number of transgender adolescents who, like Plaintiffs, fear the loss or deprivation of critical health care. As Governor DeWine explained when vetoing H.B. 68, "[m]any parents have told me that their child would be dead today if they had not received the treatment they received from an Ohio children's hospital. I have also been told, by those that are now grown adults, that but for this care, they would have taken their lives when they were teenagers." Gov. Mike DeWine, *Statement of the Reasons for the Veto of Substitute House Bill 68*, available at https://content.govdelivery.com/attachments/OHIOGOVERNOR/2023/12/29/file_attachments/2731770/Signed%20Veto%20Message%20HB%2068.pdf (Dec. 29, 2023).

Finally, as Governor DeWine also acknowledged, it is in the public interest for parents to be able to make health care decisions on behalf of their children: "Were I to sign [H.B. 68] or were [it] to become law, Ohio would be saying that the State, that the government, knows what is best medically for a child rather than the two people who love that child the most, their parents." *Id.*

H.B. 68 denies parents that autonomy and privacy, and the public thus has a strong interest in enjoining the statute.

V. The Injunction Should Issue Without Bond

This Court has broad discretion under Civ. R. 65(C) to waive the bond requirement. *See Vanguard Transp. Sys. Inc. v. Edwards Transfer & Storage Co., Gen. Commodities Div.*, 109 Ohio App.3d 786, 793, 673 N.E.2d 182 (10th Dist. 1996) (recognizing courts have discretion to issue preliminary injunctions without requiring bond). The Court should exercise that discretion here, where the relief sought will result in no monetary loss to Defendants. *See Molton Co. v. Eagle-Picher Indus.*, 55 F.3d 1171, 1176 (6th Cir. 1995) (affirming decision to waive bond because of "the strength of [the plaintiff's] case and the strong public interest involved"); *Preterm-Cleveland v. Yost*, 394 F.Supp.3d 796, 804 (S.D. Ohio 2019) (waiving bond).

CONCLUSION

For the foregoing reasons, Plaintiffs ask that this Court enter a temporary restraining order and/or preliminary injunction as follows:

1. Enjoining implementation and enforcement of H.B. 68 in its entirety, on the basis that it violates Article II, Section 15(D) of the Ohio Constitution; or
2. In the alternative, enjoining implementation and enforcement of H.B. 68's Health Care Ban, including its prohibition on the prescription of "cross-sex hormone[s] or puberty-blocking drug[s] for a minor individual for the purpose of assisting the minor individual with gender transition," its prohibition on "[e]ngag[ing] in conduct that aids or abets" in the same, its authorization of Defendant Yost to "bring an action to enforce compliance" with these restrictions, and its provision that any violation of these sections "shall be considered unprofessional conduct and subject to discipline by" the Defendant State Medical Board. *See* 2024 Sub.H.B. No. 68 (enacting R.C.

3129.02(A)(2)–(3); R.C. 3129.05(C); R.C. 3129.05(A)).

Respectfully submitted,

/s/ Freda J. Levenson

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**PHV motion forthcoming*

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CERTIFICATE OF SERVICE

I hereby certify that on March 26, 2024, the foregoing was electronically filed via the Court's e-filing system. I further certify that a copy of the foregoing was served by email upon the following parties:

DAVID YOST, Attorney General of Ohio
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STATE MEDICAL BOARD OF OHIO,
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I further certify that a copy of the foregoing was served by the clerk via certified mail and upon the following parties:

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/s/ Freda J. Levenson
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Exhibit 1

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PRETERM-CLEVELAND, *et al.*,	:	
	:	Case No.: A2203203
Plaintiffs,	:	
	:	
v.	:	Judge Christian A. Jenkins
	:	
DAVID YOST, *et al.*,	:	
	:	Decision and Entry
Defendants.	:	
	:	
	:	

I. Procedural Background

Plaintiffs filed their verified complaint, motion for a temporary restraining order and supporting affidavits on September 2, 2022. Plaintiffs seek an order enjoining the enforcement of Ohio's so-called "Heartbeat Act," which subjects medical providers to potential felony prosecution for performing abortions of intrauterine pregnancies after the detection of a fetal heartbeat, or approximately six weeks after the patient's last menstrual period ("LMP").[1]

Defendants David Yost, Bruce Vanderhoff, Kim Rothermel and Bruce Saferin filed their opposition on September 7, 2022.[2] One of the Prosecutor Defendants, Julia Bates of Lucas County, Ohio, filed a response to plaintiffs' motion on September 7, 2022 stating that she does not

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[1] 2019 Ohio Laws File 3 (Sub. S.B. 23), referred to herein as "S.B. 23."

[2] David Yost is Attorney General of Ohio. Bruce Vanderhoff is the Director of the Ohio Department of Health. Kim Rothermel is Secretary of the State Medical Board of Ohio. Bruce Saferin is Supervising Member of the State Medical Board of Ohio. These defendants are collectively represented by the Ohio Attorney General's Office and referred to herein as the "State Defendants." The remaining defendants are the county prosecutors in Ohio's six most populous counties where the clinics operated by plaintiffs are located, namely Cuyahoga County, Hamilton County, Franklin County, Montgomery County, Lucas County and Summit County, which collectively account for approximately 42 percent of Ohio's population. These defendants are referred to herein as the "Prosecutor Defendants."

object to the issuance of the requested relief. Plaintiffs filed a reply in support of their motion on September 8, 2022.

The Court heard arguments on plaintiffs' motion at a hearing on September 8, 2022. At the hearing, the State Defendants argued for the first time that this Court does not have jurisdiction because, at the time of the hearing, the Ohio Supreme Court had not yet granted plaintiffs' application for voluntary dismissal of the mandamus action they brought in the Ohio Supreme Court challenging S.B. 23 (Ohio S.Ct. Case No. 2022-0803). Plaintiffs responded that dismissal of the mandamus action is ministerial and a matter of right such that this Court could properly proceed. The remaining Prosecutor Defendants advised the Court that they do not object to the issuance of the requested temporary restraining order.

II. S.B. 23

S.B. 23 is a lengthy bill that amends and creates several sections of the Ohio Revised Code. Pertinent to this matter, S.B. 23 creates the following new provisions:

R.C. 2919.193

> (A) Except as provided in division (B) of this section, no person shall knowingly and purposefully perform or induce an abortion on a pregnant woman before determining in accordance with division (A) of section 2919.192 of the Revised Code whether the unborn human individual the pregnant woman is carrying has a detectable heartbeat.
>
> Whoever violates this division is guilty of performing or inducing an abortion before determining whether there is a detectable fetal heartbeat, a felony of the fifth degree. A violation of this division may also be the basis of either of the following:
>
> (1) A civil action for compensatory and exemplary damages;
>
> (2) Disciplinary action under section 4731.22 of the Revised Code.
>
> (B) Division (A) of this section does not apply to a physician who performs or induces the abortion if the physician believes that a medical emergency, as defined in section 2919.16 of the Revised Code, exists that prevents compliance with that division.

(C) A physician who performs or induces an abortion on a pregnant woman based on the exception in division (B) of this section shall make written notations in the pregnant woman's medical records of both of the following:

(1) The physician's belief that a medical emergency necessitating the abortion existed;

(2) The medical condition of the pregnant woman that assertedly prevented compliance with division (A) of this section.

For at least seven years from the date the notations are made, the physician shall maintain in the physician's own records a copy of the notations.

(D) A person is not in violation of division (A) of this section if the person acts in accordance with division (A) of section 2919.192 of the Revised Code and the method used to determine the presence of a fetal heartbeat does not reveal a fetal heartbeat.

R.C. 2919.195

(A) Except as provided in division (B) of this section, no person shall knowingly and purposefully perform or induce an abortion on a pregnant woman with the specific intent of causing or abetting the termination of the life of the unborn human individual the pregnant woman is carrying and whose fetal heartbeat has been detected in accordance with division (A) of section 2919.192 of the Revised Code.

Whoever violates this division is guilty of performing or inducing an abortion after the detection of a fetal heartbeat, a felony of the fifth degree.

(B) Division (A) of this section does not apply to a physician who performs a medical procedure that, in the physician's reasonable medical judgment, is designed or intended to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

A physician who performs a medical procedure as described in this division shall declare, in a written document, that the medical procedure is necessary, to the best of the physician's reasonable medical judgment, to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman. In the document, the physician shall specify the pregnant woman's medical condition that the medical procedure is asserted to address and the medical rationale for the physician's conclusion that the medical procedure is necessary to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

> A physician who performs a medical procedure as described in this division shall place the written document required by this division in the pregnant woman's medical records. The physician shall maintain a copy of the document in the physician's own records for at least seven years from the date the document is created.
>
> (C) A person is not in violation of division (A) of this section if the person acts in accordance with division (A) of section 2919.192 of the Revised Code and the method used to determine the presence of a fetal heartbeat does not reveal a fetal heartbeat.
>
> (D) Division (A) of this section does not have the effect of repealing or limiting any other provision of the Revised Code that restricts or regulates the performance or inducement of an abortion by a particular method or during a particular stage of a pregnancy.

III. Discussion

A. This Court has Subject Matter Jurisdiction.

Although not raised in their written submission, the State Defendants argued at hearing that this Court lacked subject matter jurisdiction under the "jurisdictional priority" rule because essentially the same case was then pending in a superior court (i.e., the Ohio Supreme Court). On September 12, 2022, the Ohio Supreme Court granted plaintiffs' application to voluntarily dismiss the mandamus action they had brought in the Ohio Supreme Court. Ohio S.Ct. Case Announcement 2022-3174.

The Supreme Court's dismissal should obviate the need to address the State Defendants' jurisdictional priority argument. However, because the issue raised by the State Defendants is jurisdictional, and in view of the fact that the original mandamus action was pending in the Supreme Court at the time this action was filed such that a question about the Court's jurisdiction could still theoretically be raised, the Court will address its jurisdiction.

The jurisdictional priority rule provides simply that, "as between state courts of concurrent jurisdiction, the tribunal whose power is first invoked by the institution of proper proceedings

acquires jurisdiction, to the exclusion of all other tribunals, to adjudicate upon the whole issue and to settle the rights of the parties." *State ex rel. Dunlap v. Sarko*, 135 Ohio St.3d 171, 2013-Ohio-67, 985 N.E.2d 450, ¶ 9 (holding that mandamus action filed first in the court of appeals had jurisdictional priority over subsequently filed mandamus action in the Ohio Supreme Court). Thus, under this rule it is immaterial which court is superior to the other, but rather where the matter was first filed.

Under Ohio's Constitution, a court of common pleas has "original jurisdiction over all justiciable matters and such powers of review of proceedings of administrative officers and agencies as may be provided by law." Ohio Constitution, Article IV, Section 4(B). A common pleas court "is a court of general jurisdiction, with subject-matter jurisdiction that extends to all matters at law and in equity that are not denied to it." *Ohio High School Athletic Ass'n v. Ruehlman*, 157 Ohio St.3d 296, 2019-Ohio-2845, 136 N.E.3d 436, ¶ 7 (citations omitted).

Plaintiffs in this case filed a complaint in mandamus with the Ohio Supreme Court on June 29, 2022, five days after the reversal of *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973) in *Dobbs v. Jackson*, 142 S.Ct. 2228, 213 L.Ed.2d 545 (2022).[3] Plaintiffs filed a motion for emergency stay at the same time. In response to plaintiffs' motion for emergency stay, the State Defendants argued before the Ohio Supreme Court that the mandamus action was not properly brought and that the Ohio Supreme Court "lacks original jurisdiction to entertain requests for prohibitory injunctions." Memorandum of Attorney General David Yost, *et al*. in Response to Motion for Emergency Stay at p. 5, filed in Ohio S.Ct. Case No. 2022-0803 June 30, 2022. [4] The State Defendants further argued that plaintiffs could not pursue mandamus relief in the Ohio

[3] A writ of mandamus is an order from a court issued in the name of the state to an inferior tribunal, public official or other body commanding the performance of an act. *See* R.C. 2731.01.

[4] The Court takes judicial notice of the filings in Ohio Supreme Court Case No. 2022-0803, publicly available at https://www.supremecourt.ohio.gov/Clerk/ecms/#/caseinfo/2022/0803.

Supreme Court because they "have an adequate remedy: they can pursue their constitutional challenges in lower courts, seeking declaratory and injunctive relief." *Id*. at 6. In short, the State Defendants took the position before the Supreme Court that plaintiffs' case should be before a court of common pleas like this Court as an action for declaratory judgment and injunctive relief.

The Supreme Court denied plaintiffs' motion for emergency stay without opinion on July 1, 2022. *See* Ohio Supreme Court Case Announcement #2, 2022-Ohio-2317.[5] The State Defendants then moved the Ohio Supreme Court on July 20, 2022 to dismiss the mandamus action arguing again that plaintiffs' claims should be brought in common pleas court as an action for declaratory judgment and injunctive relief. On September 2, 2022, plaintiffs consented in writing to the dismissal of their Ohio Supreme Court mandamus action by filing an application under Ohio Supreme Court Rule of Practice 4.05. Plaintiffs then filed a complaint for declaratory judgment and injunctive relief in this Common Pleas Court on September 2, 2022, as State Defendants argued they should. Nonetheless, at hearing the State Defendants objected. The State Defendants argued that case could not be considered in the court where they said it should be presented on the theories they argued were proper because the Ohio Supreme Court had not yet put on an entry granting the dismissal they requested and to which the plaintiffs had consented. Then on September 12, 2022, the Ohio Supreme Court granted the application for dismissal.[6]

The Court holds that it would have jurisdiction under the Ohio Constitution and pursuant to the jurisdictional priority rule even if the Ohio Supreme Court had not dismissed the mandamus action. *See State ex rel. Hasselbach v. Sandusky County Bd. of Elections*, 157 Ohio St.3d 433, 2019-Ohio-3751, 137 N.E.3d 1128, ¶9 ("[I]f the second case is not for the same cause of action,

[5] Publicly available at https://www.supremecourt.ohio.gov/rod/docs/pdf/0/2022/2022-ohio-2317.pdf.
[6] *See* September 12, 2022 Supreme Court Case Announcement #2, 2022-Ohio-3714, publicly available at https://www.supremecourt.ohio.gov/Clerk/ecms/#/caseinfo/2022/0803.

nor between the same parties, the former suit will not prevent the latter"). While the parties and basic subject matter in both cases are the same, the claims advanced and the relief sought differ. Plaintiffs sought mandamus relief before the Ohio Supreme Court, whereas this case is an action for declaratory judgment and injunctive relief. The standard applicable to plaintiffs' claims in this case is quite different from the standard applicable to a mandamus action and does not involve any question about the nature of the relief sought or whether it is available from the court in which the claims are pending. Thus, this Court has jurisdiction to adjudicate plaintiffs' claims regardless.

B. Plaintiffs Have Demonstrated that a Temporary Restraining Order Enjoining The Enforcement Of S.B. 23 Is Appropriate.

When ruling on a motion for temporary restraining order, the Court must consider whether: 1) the movant has shown a substantial likelihood of success on the merits; 2) the movant will suffer an irreparable injury; 3) a temporary restraining order could harm third parties; and 4) the interest of the public will be served by granting a temporary restraining order. *See City of Cincinnati v. City of Harrison*, 1st Dist. Hamilton No. C-090702, 2010-Ohio-3430, ¶8.

1. Plaintiffs are substantially likely to prevail on the merits.

The State Defendants take the position that plaintiffs' motion "turns entirely on the question of whether they are likely to succeed on the merits." State Defendants Memo. Opp. p. 7. The State Defendants make two arguments in support of their position: 1) plaintiffs, as abortion providers rather than patients, lack standing to assert a claim that there is a right to abortion under the Ohio Constitution; and 2) there is no such right to abortion under the Ohio Constitution. *Id*. at 8.

a) Plaintiffs have standing.

Plaintiffs are five corporations that provide reproductive health services, including abortion services, both surgical and medication, at eight locations throughout Ohio and a licensed physician

who is the medical director of plaintiff Planned Parenthood Southwest Ohio Region, which provides reproductive health services including abortion. Plaintiffs allege that they and/or their providers are threatened with criminal penalties, loss of their medical licenses, civil forfeiture and civil suits for potential violations of S.B. 23. They sue on behalf of their staff, officers, agents and patients. Complaint ¶¶ 9-14.[7]

At the September 8, 2022 hearing, counsel for the State Defendants argued that, because none of the individual patients affected by S.B. 23 have brought their own actions challenging its application, the Act is functioning as intended by permitting abortions beyond six weeks under its limited exceptions. In other words, the absence of claims by patients somehow validates the statute. To the contrary, the State Defendants' argument in this regard demonstrates the propriety of third party standing in this case.

The affidavits presented by plaintiffs recount the stories of patients seeking abortion services who were turned away as a result of S.B. 23, often under some of the most difficult circumstances imaginable. Dr. Liner's affidavit tells the story of a 25-year-old who needed chemotherapy for recurrent cancer, but could not obtain chemotherapy after discovering she was pregnant. She sought an abortion but was found to be eight weeks pregnant. Her medical provider was unwilling to provide documentation to support an exception to S.B. 23, so her only choice other than foregoing chemotherapy was to travel out of state for medical care. Liner Aff. ¶ 14. Dr. Liner also recounts the story of a patient with a desired pregnancy who discovered severe fetal anomalies in the second trimester (when most fetal anomalies are discovered). This patient, too, was forced to go out of state for medical care, thereby prolonging the pregnancy. Id. ¶ 5.

[7] The complaint is properly verified by the Affidavit of Dr. Sharon Liner. In support of their motion for a temporary restraining order, plaintiffs have also submitted the affidavits of Dr. Liner, David Burkons, M.D., Aeran Trick, LPN, Allegra Pierce, Dr. Adarsh Krishen, and W.M. Martin Haskell, M.D. These affidavits compile and recount the effect that S.B. 23 has had on abortion providers and patients.

Dr. Burkons describes a high-school-aged patient who ended up in the hospital on suicide watch after being turned away because of S.B. 23. Burkons Aff. ¶ 3. Dr. Burkons also explains that patients with ectopic pregnancies have reported being turned away from emergency rooms due to S.B. 23, with one case resulting in fallopian tube rupture requiring surgery rather than typical medical management. Id. ¶ 17. The providers in those cases were apparently concerned that intrauterine pregnancies might also be present and feared prosecution under S.B. 23 if they aborted such a pregnancy when intending to treat an ectopic pregnancy, which is specifically excepted from S.B. 23.

Aeran Trick, an LPN at Women's Med Center of Dayton, describes numerous patients who have experienced enormous distress – financial, emotional and employment-related – as a result of S.B. 23 and the need to arrange costly emergency travel to obtain medical care. Ms. Trick describes a 37 year-old patient with stage III melanoma whose oncologist would not treat her until her pregnancy was terminated. The patient was denied an abortion due to S.B. 23 and became inconsolable. Trick Aff. ¶ 6.

These stories continue at great length throughout the affidavits presented by plaintiffs. The argument advanced by counsel for the State Defendants that the failure of any of these pregnant women to come forward with claims somehow indicates that they are not aggrieved by the law is dubious at best. The State Defendants contend that "[a]n aggrieved patient could file suit . . . [n]othing stops any would-be patient from doing so." State Defendants' Memo. Opp. p. 29. As detailed in the affidavits, patients denied abortion services because of S.B. 23 are often under great distress from, for example, not being able to obtain treatment for life threatening cancers, or from fearing job loss and an inability to provide for their families because they must arrange travel out of state on short notice, often without the resources to do so. It is not surprising that individuals

dealing with such situations do not hire lawyers and file lawsuits, but rather focus their energies on their health, keeping their jobs, caring for their families or keeping up with their educational studies. Moreover, the circumstances that lead women to seek an abortion can be intensely private. It is understandable that many women would be reluctant to place the deeply personal details of their experiences in the public record, even under a pseudonym, in such a highly charged and divisive matter.

Decades of precedent have confirmed and other judges on this Court have held that "[t]hird party standing is available in circumstances like these." *See Planned Parenthood Southwest Ohio Region v. Ohio Dept. of Health,* Hamilton C.P. No. A 2101148 (Apr. 19, 2021) at 5. Ohio law clearly recognizes that there may be circumstances where third-party standing is appropriate. *See Util. Serv. Partners, Inc. v. Pub. Util. Comm.*, 124 Ohio St.3d 284, 2009-Ohio-6764, 921 N.E.2d 1038, ¶ 49 (citations omitted); *City of E. Liverpool v. Columbiana County Budget Comm'n*, 114 Ohio St.3d 133, 2007-Ohio-3759, 870 N.E.2d 705, ¶ 25; *Cincinnati City Sch. Dist. V. State Bd. of Educ.*, 113 Ohio App.3d 305, 314, 680 N.E.2d 1061 (10th Dist.1996); *Akron Ctr. for Reproductive Health v. N. Coast Christian Community*, 9th Dist. Summit No. 12414, 1986 Ohio App. LEXIS 7534, *7 (July 9, 1986). This is such a case. The Court is satisfied that the evidence presented at this stage of the proceedings sufficiently establishes circumstances that would hinder aggrieved patients from advancing the claims presented by plaintiffs on their behalf such that third party standing is appropriate.

b) There is a fundamental right to abortion under the Ohio Constitution.

For nearly 50 years it was settled law in the United States that there was a federal constitutional right to abortion. As a result of this long-established federal right, S.B. 23 was enjoined by a federal court from its effective date until the U.S. Supreme Court's reversal of *Roe*

in *Dobbs v. Jackson*, 142 S.Ct. 2228, 213 L.Ed.2d 545 (2022). Given this history and the supremacy of federal law in this area, it is not surprising that there is limited caselaw directly addressing whether the Ohio Constitution and its unique language protect the right to abortion.

Neither party has provided the Court with any authority addressing this issue since the U.S. Supreme Court's decision in *Dobbs*, and the Court has been unable to locate any. However, in 1993 Ohio's Tenth District Court of Appeals expressly recognized in the abortion context that "the Ohio Constitution confers greater rights than are conferred by the United States Constitution." *Preterm Cleveland v. Voinovich*, 89 Ohio App.3d 684, 691, 627 N.E.2d 570, 575 (10th Dist.1993).[8] The Tenth District concluded that:

> In light of the broad scope of "liberty" as used in the Ohio Constitution, it would seem almost axiomatic that the right of a woman to choose whether to bear a child is a liberty within the constitutional protection. This necessarily includes the right of a woman to choose to have an abortion so long as there is no valid and constitutional statute restricting or limiting that right.

Id. at 691-692.[9] The Tenth District then considered whether a statute requiring physicians to provide patients seeking an abortion with information about the procedure, gestational age of the fetus and medical risks of carrying the pregnancy to term at least 24 hours prior to the procedure imposed an undue burden on the constitutional right to an abortion. Because *Roe* and *Planned*

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[8] Indeed, the Tenth District found it to be "obvious" that the Ohio Constitution can and does in several contexts "confer greater rights upon individuals (or greater restrictions upon the legislative power of the General Assembly) than are imposed by the United States Constitution." *Id.* at 689. This is consistent with established Ohio authority in numerous other contexts. *See e.g. Humphrey v. Lane*, 89 Ohio St.3d 62, 67, 728 N.E.2d 1039 (2000); *State v. Mole*, 149 Ohio St.3d 215, 2016-Ohio-5124, 74 N.E.3d 368, ¶ 21; *State v. Farris*, 109 Ohio St.3d 519, 2006-Ohio-3255, 849 N.E.2d 985, ¶ 48; *State v. Brown*, 99 Ohio St.3d 323, 2003-Ohio-3931, 792 N.E.2d 175, ¶ 7; *State v. Bode*, 144 Ohio St.3d 155, 2015-Ohio-1519, 41 N.E.3d 1156, ¶¶ 23-27; *Vail v. Plain Dealer Publishing Co.*, 72 Ohio St.3d 279, 280-82, 649 N.E.2d 182 (1995); *Simpkins v. Grace Brethren Church of Del.*, 149 Ohio St.3d 307, 2016-Ohio-8118, 75 N.E.3d 122, ¶ 61; *Arnold v. City of Cleveland*, 67 Ohio St.3d 35, 616 N.E.2d 163 (1993), paragraph one of the syllabus.

[9] The State Defendants' reliance on *Williams v. Marian Rapid Transit*, 152 Ohio St. 114, 87 N.E.2d 334 (1949) for the proposition that there is no right to abortion in the Ohio Constitution is misplaced. That case involved whether a child injured in an accident in utero could recover for personal those injuries and their effects after birth. Abortion was not at issue in any way, and the decision does nothing to inform the question of whether there is a right to abortion under the Ohio Constitution.

Parenthood v. Casey, 505 U.S. 833, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992) were then the law of the land, the court analyzed the restrictions under those precedents, but specifically noted that:

> This does not mean, as intimated in the dissenting and concurring opinion, that we are required to follow the undue-burden test of [*Casey*] to the Ohio Constitution, but only that we are not free to find constitutional a statute that violates the United States Constitution as interpreted by [*Casey*] on the basis that the Ohio Constitution is not violated, *but are free to find a statute to violate the Ohio Constitution, even though it does not violate the United States Constitution.*

Id. at 695, n. 9 (emphasis added). With the U.S. Supreme Court's reversal of *Roe*, this is precisely the situation in which the Court finds itself today – S.B. 23 does not violate the U.S. Constitution as recently interpreted in the *Dobbs* decision, but it may violate the Ohio Constitution. So far as this Court can tell, no Ohio court has directly addressed this issue, so this Court will.

Article I Section 16 of the Ohio Constitution (the "Due Course of Law Clause") provides that:

> All courts shall be open, and every person, for an injury done him in his land, goods, *person*, or reputation, shall have a remedy by due course of law, and shall have justice administered without denial or delay. Suits may be brought against the state, in such courts and in such manner, as may be provided by law.

(Emphasis added). Well-established Ohio law holds that this provision provides substantive and procedural due process rights. *See Stolz v. J & B Erectors, Inc.*, 155 Ohio St.3d 567, 2018-Ohio-5088, 122 N.E.3d 1228, ¶ 13 (citations omitted). Substantive due process jurisprudence provides that governmental action that limits the exercise of a fundamental constitutional right is subject to the highest level of judicial scrutiny. *See Sorrell v. Thevenir*, 69 Ohio St. 3d 415, 423, 633 N.E.2d 504 (1994).

No great stretch is required to find that Ohio law recognizes a fundamental right to privacy, procreation, bodily integrity and freedom of choice in health care decision making. In 2011, the Ohio Constitution was amended by popular referendum to adopt the Health Care Freedom

Amendment (Article I, Section 21) ("HCFA"). The plain language of subsections B and C of the HCFA is simple and clear:

> (B) No federal, state, or local law or rule shall prohibit the purchase or sale of health care or health insurance.
>
> (C) No federal, state, or local law or rule shall impose a penalty or fine for the sale or purchase of health care or health insurance.

The State Defendants argue that the HCFA was intended by its drafters to provide a legal basis for Ohio and Ohioans to undermine or avoid the federal Affordable Care Act, not to outlaw health care regulation in Ohio. They point to the language in subsection (D) providing in pertinent part that "[t]his section does not . . . affect any laws calculated to deter fraud *or punish wrongdoing* in the health care industry" to suggest that the Amendment does not render health care regulations unconstitutional. But this misses the point – as a result of the HCFA, the Ohio Constitution contains a direct recognition of the fundamental nature of the right to freedom in health care decisions.

The fact that no one has yet challenged any existing health care regulations under the HCFA does not negate the import of its plain language.[10] The HCFA does not define "health care," but the use of the disjunctive "or" renders the term separate and distinct from the purported target of the amendment – health insurance. Abortion, whether procedural or medication, clearly constitutes health care within the ordinary meaning of that term. Moreover, the drafters could

[10] A mandamus action was brought in the Ohio Supreme Court under the HCFA by several individuals who contended that pandemic-related mask requirements and other protective measures violated the HCFA and sought an order from the Court directing the Ohio Senate and its 33 members to "defend [the HCFA] against any passage of legislation which may possibly conflate, obfuscate or otherwise subvert the clarity of rights conveyed by [the HCFA]" and to "order the Ohio Attorney General to halt the operation of any public or private entity that is participating in the alleged constitutional violations within the state of Ohio." *State ex rel. Johnson v. Ohio State Senate*, 2022-Ohio-1912, 2022 Ohio LEXIS 1144, 2022 WL 2056247, ¶ 2. The Court dismissed the petition for lack of jurisdiction and, therefore, did not address the merits of petitioners' claims under the HCFA. *Id.* ¶ 13.

have excluded existing and future regulation of the health care profession, or even abortion specifically, but they did not.[11] Rather, the exception in subsection D is limited to fraud and the nebulous term, "wrongdoing," without providing any definitional or interpretive guidance. Wrongdoing is defined as "illegal or improper conduct." *Black's Law Dictionary* 1932 (11th Ed.2019). At the time of the HCFA's adoption in 2011, abortion had been constitutionally protected as the law of the land for nearly 40 years, and could hardly be considered "wrongdoing." Finally, S.B. 23 was adopted years after the HCFA such that the General Assembly was presumably aware of its provisions recognizing a fundamental constitutional right to choice in healthcare decisions.

This Court cannot simply ignore part of Ohio's Constitution because the Ohio Attorney General asserts it is not germane to this case. Nor must the Court defer to the General Assembly on questions of law such as those presented in this case, for "'[i]t is emphatically the province and duty of the judicial department to say what the law is.' Our function here is to determine whether the act transcends the limits of legislative power." *Adams v. DeWine*, __ Ohio St. 3d __, 2022-Ohio-89, ¶ 28 (rejecting Congressional district plan adopted by General Assembly in contravention of Ohio Constitutional amendment enacted by popular referendum); *citing Marbury v. Madison*, 5 U.S. 137, 177, 2 L. Ed. 60 (1803).

The HCFA represents an express constitutional acknowledgement of the fundamental nature of the right to freedom and privacy in health care decision making. Read together with other applicable sections of the Ohio Constitution, a clear and consistent recognition the

[11] Proponents of the HCFA argued that its passage would not "further overcrowd our prisons with those who pursue alternative medicine" and that under its provisions the state could not "punish the purchase or sale of cutting-edge services, procedures, and coverage." 1851 Center for Constitutional Law, "Passage of Issue 3 will protect liberty, restrain health care costs, and preserve health care choice and privacy," September 29, 2011, available at https://www.healthpolicyohio.org/tools/issue-3-the-health-care-freedom-amendment/.

fundamental nature of this right under Ohio law emerges. *See e.g. Planned Parenthood Southwest Ohio Region v. Ohio Dept. of Health*, Hamilton C.P. No. A 2100870, p. 6 (Jan. 31, 2022) ("Deprivation of reproductive autonomy falls squarely within the meaning of an injury done to one's person under the Ohio Constitution"), *citing Stone v. City of Stow*, 64 Ohio St. 3d 156, 160-163, 593 N.E.2d 294 (1992).[12] Accordingly, this Court recognizes a fundamental right to abortion under Ohio's Constitution.

Based on the limited record available to the Court on plaintiffs' motion for a temporary restraining order, the Court finds that S.B. 23 fails the strict scrutiny analysis applicable to enactments that impinge upon fundamental constitutional rights. S.B. 23 is not narrowly tailored to serve a compelling state interest. The record establishes that S.B. 23 effectively bans all or virtually all abortions after six weeks LMP. Plaintiffs' affidavits recount the stories of patient after patient unable to obtain abortion services after six weeks – when fetal embryonic cardiac activity typically begins – even when the exception for "a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman" should logically apply.[13]

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[12] *See also Steele v. Hamilton County Community Mental Health Bd.*, 90 Ohio St.3d 176, 180, 736 N.E.2d 10 (2000) ("personal security, bodily integrity, and autonomy are cherished liberties"); *Preterm-Cleveland v. Voinovich*, 89 Ohio App. 3d 684, 712, 627 N.E.2d 570 (10th Dist. July 27, 1993) (Petree, J. concurring in part and dissenting in part) ("Manifestly, a fundamental right to bodily integrity must be acknowledged as a necessary precondition to the enjoyment of our express guarantees of freedom in the Ohio Bill of Rights"); *Biddle v. Warren General Hospital*, 86 Ohio St.3d 395, 399-402, 1999-Ohio-115, 715 N.E.2d 518 (1999) (recognizing fundamental privacy interest in physician-patient relationship sufficient to support creation of entirely new species of tort claim for disclosure of confidential medical information).

[13] For example, the 25-year-old woman who had to miss chemotherapy appointments after discovering she was pregnant and was denied an abortion (Liner Aff. ¶ 14); the woman with an ectopic pregnancy who required surgery for a rupture suffered after being denied an abortion in an emergency room (Burkons Aff. ¶ 17); the woman with stage III melanoma who was denied an abortion in Ohio and was compelled to travel to Indiana for such care (Trick Aff. ¶ 6); the 39-year-old woman who was 13 weeks pregnant and had no amniotic fluid such that the pregnancy was not viable but whose physician would not perform an abortion because of S.B. 23 and instructed her to call the office if she developed a fever (Trick Aff. ¶ 13); the 16-year-old who was sexually assaulted by a family member and became pregnant who had to travel to Indiana for an abortion; and the minor victim of sexual assault who had to wait three weeks for an appointment for an abortion in Michigan because S.B. 23 prevented her from receiving care in Ohio (Krishen Aff. ¶ 21).

This is likely because S.B. 23 requires physicians who perform abortions after six weeks to create a document to be placed in the patient's medical records which must:

> Declare . . . that the medical procedure is necessary, to the best of the physician's reasonable medical judgment, to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman [and] specify the pregnant woman's medical condition that the medical procedure is asserted to address and the medical rationale for the physician's conclusion that the medical procedure is necessary to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

R.C. 2919.195(B)

Should the physician's medical judgment of "substantial risk" or "irreversible impairment" later be second guessed, he or she may be subject to prosecution for a fifth-degree felony (punishable by up to one year in prison), loss of licensure, civil forfeiture and civil liability. Thus, S.B. 23 potentially criminalizes rather than merely regulates the practice of medicine such that it should come as no surprise to anyone that many or most physicians are unwilling to perform abortions after six weeks even where an exception should apply.[14]

On the record before the Court on plaintiffs' motion for temporary restraining order, S.B. 23 is in effect a ban on abortion after six weeks LMP. The Court finds that such a ban is not narrowly tailored to serve a compelling state interest, and it therefore violates the Ohio Constitution.

c) S.B. 23 discriminates against pregnant women in violation of the Ohio Constitution's Equal Protection and Benefit Clause.

[14] The State Defendants declined to present any evidence on this point in opposition to plaintiffs' motion for temporary restraining order such that the record before the Court is limited to the verified complaint and its attachments and the supporting affidavits submitted by plaintiffs. The State Defendants will be afforded an opportunity to challenge plaintiffs' evidence, submit evidence of their own and create a complete evidentiary record at the preliminary injunction hearing.

Article I, Section 2 of the Ohio Constitution – the Equal Protection and Benefit Clause – provides as follows:

> All political power is inherent in the people. Government is instituted for their equal protection and benefit, and they have the right to alter, reform, or abolish the same, whenever they may deem it necessary; and no special privileges or immunities shall ever be granted, that may not be altered, revoked, or repealed by the general assembly."

Ohio Constitution, Article I, Section 2.

Although the Ohio Supreme Court often follows federal decisions in the equal protection area, there is no mandate to that effect. *See Preterm-Cleveland v. Voinovich* at 713 (Petree, J. concurring in part and dissenting in part). The weight of recent authority recognizes that Ohio's Equal Protection and Benefit Clause confers broader protection than its federal analogue. *See State v. Mole*, 149 Ohio St.3d 215, 2016-Ohio-5124, 74 N.E.3d 368, ¶ 23; *State v. Noling*, 149 Ohio St.3d 327, 2016-Ohio-8252, 75 N.E.3d 141, ¶ 11; *League of Women Voters of Ohio v. Ohio Redistricting Comm'n*, Slip Opinion No. 2022-Ohio-65, ¶ 151 (Brunner, J. concurring). Nonetheless, the State Defendants contend that S.B. 23 is not directed at women, but rather treats everyone the same.

In this Court's opinion, it would be intellectually incoherent to recognize a fundamental right to privacy, procreation, bodily integrity and freedom of choice in health care decision making, but hold that a law that limits only pregnant women in the exercise of such rights by effectively outlawing abortion does not discriminate against them based on the rationale that there is no one else who seeks or needs abortion services. But this is precisely what the State Defendants argue. This argument fundamentally, and perhaps purposely, mis-frames the issue and thereby the scope of protection afforded by the constitutional right at issue. *See Obergefell v. Hodges*, 576 U.S. 644, 671, 135 S.Ct. 2584, 2602, 192 L.Ed.2d 609 (2015) ("It is inconsistent with the approach this Court

has used in discussing other fundamental rights, including marriage and intimacy. *Loving* did not ask about a 'right to interracial marriage'; *Turner* did not ask about a 'right of inmates to marry'; and *Zablocki* did not ask about a 'right of fathers with unpaid child support duties to marry.' Rather each case asked about the right to marry in its comprehensive sense . . .").[15] Likewise in this case, women, and particularly pregnant women, are denied equal protection of the law with respect to the fundamental right to privacy, procreation, bodily integrity and freedom of choice in health care decision making by S.B. 23, which effectively denies them, and only them, access to a well-established, safe and potentially life-saving health care.

Thus, because it discriminates against women (and specifically pregnant women), with respect to the protection of a fundamental constitutional right, S.B. 23 is again subject to strict scrutiny analysis. *See Adamsky v. Buckeye Local Sch. Dist.*, 73 Ohio St.3d 360, 362, 1995-Ohio-298, 653 N.E.2d 212 (observing that a suspect class has traditionally been "one involving race, national origin, religion, or sex"). A statute subject to strict scrutiny is constitutional only if it "furthers a compelling governmental interest and the state's chosen means are narrowly tailored to advance that interest." *State v. Weber*, 163 Ohio St.3d 125, 2020-Ohio-6832, 168 N.E.3d 468, ¶ 17. Under strict scrutiny "the state must assume the heavy burden of proving that the legislation is constitutional." *Beatty v. Akron City Hospital*, 67 Ohio St.2d 483, 492, 424 N.E.2d 586 (1981).

As discussed above, S.B. 23 fails to survive strict scrutiny. The record demonstrates that S.B. 23 effectively bars virtually all abortions after six weeks LMP. As such it is clearly not narrowly tailored to serve – indeed, it seems incompatible with -- one of the stated purposes of

[15] The State Defendants argued at hearing that only rights "deeply rooted in the nation or state's history or tradition" should be recognized (Tr. p. 41) under *Washington v. Glucksberg*, 521 U.S. 702 (1997). This argument was rejected in *Obergefell,* 576 U.S. at 671 ("If rights were defined by who exercised them in the past, then received practices could serve as their own continued justification and new groups could not invoke rights once denied. This Court rejected that approach, both with respect to the right to marry and the rights of gays and lesbians") (citations omitted).

S.B. 23 (i.e., to protect women's health). The record is replete with evidence of women who have suffered and whose health has been placed in jeopardy as a result of S.B. 23. By way of yet another example, plaintiffs refer to the widely-publicized case of a ten-year-old rape victim who was six weeks and three days pregnant when she sought an abortion in Ohio.[16] This child was a victim of crime who should have had access to clearly needed health care in the form of abortion in her community. However, she was denied under S.B. 23 and forced to travel to Indiana.[17] Very soon such care will be unavailable in Indiana. It is already unavailable in Kentucky.[18] Thus, S.B. 23 clearly discriminates against pregnant women and places an enormous burden on them to secure safe and effective health care such that it violates Ohio's Equal Protection and Benefit Clause and is therefore unconstitutional.

2. Plaintiffs and their patients will suffer irreparable harm.

A finding that a constitutional right has been threatened or impaired mandates a finding of irreparable injury. *See Magda v. Ohio Elections Comm'n*, 2016-Ohio-5043, 58 N.E.3d 1188, ¶ 38 (10th Dist.); *citing Bonnell v. Lorenzo*, 241 F.3d 800, 809 (6th Cir.2001); *Elrod v. Burns*, 427 U.S. 347, 373, 96 S. Ct. 2673, 49 L. Ed. 2d 547 (1976). *See also Ohio Democratic Party v. LaRose*,

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[16]Vakil, Caroline, *10-year-old-girl denied abortion in Ohio*, (July 2, 2022), publicly available at https://thehill.com/policy/healthcare/3544588-10-year-old-girl-denied-abortion-in-ohio/ (accessed September 14, 2022).

[17] S.B. 23's denial of abortion after the detection of fetal cardiac activity is reminiscent of the law in Ireland prior to the country's popular referendum legalizing abortion in 2018. In a well-known case that spurred the referendum movement, a pregnant woman died of sepsis when a hospital refused to perform an abortion even though she was in the process of miscarrying because a fetal heartbeat could still be detected. https://www.usnews.com/news/best-countries/articles/2022-06-27/the-story-behind-irelands-abortion-ban-and-its-reversal

[18] The State Defendants do not directly address the reality of how S.B. 23 has operated, preferring instead to criticize plaintiffs' affidavits as second-hand anecdotes of no evidentiary value. (Tr. 44-45). However, on the record before the Court at this time it does not appear that these stories are mere aberrations. As noted above, the parties will have an opportunity to make a complete evidentiary record at the preliminary injunction hearing.

2020-Ohio-4664, 159 N.E.3d 852, ¶ 61 (irreparable harm presumed where a plaintiff demonstrates a threat or impairment to the constitutional right to vote).

The record provides ample facts reviewed above that support a finding of irreparable harm. In addition to those stories, consider the high school student whose pregnancy caused constant vomiting who ended up in the hospital on suicide watch after learning she could not obtain an abortion in Ohio. Burkons Aff. ¶ 9. Dr. Burkons reports that one patient inquired, "What do you want me to do . . . throw myself down the steps?" Burkons Aff. ¶ 10. Dr. Liner describes another woman who said she would terminate her pregnancy by drinking bleach, and reports that multiple women threatened to commit suicide after being denied abortion care. Liner Aff. ¶ 11. Plaintiffs have clearly satisfied the irreparable harm requirement.

3. Other factors weigh in favor of temporary injunctive relief.

There will be no harm to third parties if S.B. 23 is enjoined. In the absence of S.B. 23, plaintiffs may resume providing abortion services subject to the pre-existing limitations under Ohio law, much as they had for nearly 50 years. [19] Likewise, the public interest is served in numerous ways by enjoining S.B. 23. The public interest is clearly served when Ohioans needing health care are able to obtain it safely in their communities, without undue delay, stress, cost or travel. Women in need will be able to obtain safe and effective care from physicians exercising their medical judgment without fear of criminal prosecution. Suicides and unnecessary injuries and deaths of pregnant women who seeking abortion services from providers other than licensed

[19] *See e.g.* R.C. 2919.201 (generally prohibiting abortion when the probable post-fertilization age is 20 weeks or greater); R.C. 2919.10 (prohibiting abortion where the provider knows the pregnant woman is seeking the procedure because of a test result indicating Down Syndrome in the unborn child); R.C. 2919.15 (generally prohibiting "dismemberment" abortions); R.C. 2919.17 (generally prohibiting abortion after fetal viability).

professionals will be prevented. All of these are in the public interest, which is clearly advanced by suspending enforcement of S.B. 23.

C. The Relief Granted Is Limited To Enjoining Enforcement of S.B. 23.

The Court's Order today is limited to enjoining the enforcement of S.B. 23. Other provisions of Ohio law respecting abortion are unaffected by this order. Nor does this Court's Order affect any other orders respecting abortion in Ohio in effect from any other court of competent jurisdiction. Enforcement of S.B. 23 is enjoined, nothing more.

IV. Conclusion

For the foregoing reasons, the Court hereby orders that defendants, their employees, agents, and successors in office, and all those acting in concert with them, are hereby temporarily restrained and enjoined from enforcing S.B. 23 for the next 14 days, and from later taking any enforcement action premised on a violation of S.B. 23 that occurred while such relief is in effect. Because the relief granted to plaintiffs will not result in monetary loss to defendants, the Court hereby waives the bond requirement of Civ.R. 65(C).

So ordered.

Date: September 14, 2022

/s/ Christian A. Jenkins
Common Pleas Court Judge

IN THE COURT OF COMMON PLEAS
FOR FRANKLIN COUNTY, OHIO

MADELINE MOE, et al. Plaintiffs, v. DAVID YOST, et al. Defendants.	Case No. _____ Judge _____

EXPERT AFFIDAVIT OF
ARMAND H. MATHENY ANTOMMARIA, MD, PhD, FAAP, HEC-C

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armand.antommaria@gmail.com (Principal) (ID Verified)

E-Signature Notary: Theresa M Sabo (TMS)
March 25, 2024 11:50:07 -5:00 [B17D50CFF4FD] [65.60.211.87]
tess.sabo@gmail.com
I, Theresa M Sabo, did witness the participants named above electronically sign this document.

INTRODUCTION

I, Armand H. Matheny Antommaria, hereby declare and state as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. I am over 18 years old, of sound mind, and in all respects competent to testify.

2. I have actual knowledge of the matters stated herein.

3. In preparing this affidavit, I reviewed Ohio House Bill No. 68 (hereafter "the Ban"). In addition to this legislation and the materials cited herein, I have also relied on my years of research and other experience, as set out in my curriculum vitae (CV) (Exhibit A), in forming my opinions. The materials I have relied upon in preparing this affidavit are the same types of materials that experts in my fields of study regularly rely upon when forming opinions on subjects. 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 areas of expertise.

OVERVIEW

4. I am a pediatrician and bioethicist with extensive clinical and research experience. I am the author of 43 peer-reviewed articles, which have been published in high-impact journals including the *Journal of the American Medical Association* and *Annals of Internal Medicine,* and I direct the Ethics Center at Cincinnati Children's Hospital Medical Center. I have reviewed the Ban and submit this declaration to explain my disagreement with and concerns about its conclusions.

5. The Ban, among other restrictions, prohibits physicians from prescribing cross-sex hormones or puberty-blocking drugs to minor individuals for the purpose of "assisting the minor individual with gender transition," with an exception allowing physicians to continue prescribing these treatments in some cases. I will refer to cross-sex hormones as sex hormones or gender-

affirming hormones, puberty-blocking drugs as gonadotropin releasing hormone (GnRH) analogs, these treatments collectively as gender-affirming medical care, and the individuals to whom they are prescribed as minors or adolescents. The Ban prohibits physicians from providing this care under the threat of professional administrative and civil penalties, and enforcement by the Attorney General.

6. There is no sound medical or ethical basis for such a ban. Gender-affirming medical care is evidence-based and the evidence for it is comparable to the evidence for many other treatments in pediatrics. The potential benefits and risks of gender-affirming medical care are comparable to those of other forms of medical treatment treatment for which parents or legal guardians are capable of providing informed consent and minor adolescents are capable of providing assent.

7. As a result, the Ban puts clinicians in the untenable position of either following state law and violating their ethical duties to promote their patients' well-being and protect them from harm or facing professional administrative and civil penalties. Either outcome results in harm to patients.

BACKGROUND AND QUALIFICATIONS

8. I am the Director of the Ethics Center, the Lee Ault Carter Chair of Pediatric Ethics, and an Attending Physician in the Division of Hospital Medicine at Cincinnati Children's Hospital Medical Center ("Cincinnati Children's"). I am also a Professor in the Departments of Pediatrics and Surgery at the University of Cincinnati College of Medicine.

9. I received my medical degree from Washington University School of Medicine in St. Louis, Missouri in 2000. I received my PhD in Religious Ethics from The University of Chicago Divinity School in 2000. I completed my pediatrics residency at the University of Utah in 2003.

10. I have been licensed to practice medicine since 2001 and am currently licensed to practice medicine in Ohio. I have been Board Certified in General Pediatrics since 2004 and in Pediatric Hospital Medicine since the inception of this certification in 2019. I have been certified as a Healthcare Ethics Consultant since the inception of this certification in 2019.

11. I have extensive experience as a pediatrician and as a bioethicist. I have been in clinical practice since 2003 and 30% of my current effort is dedicated to caring for hospitalized patients. I was Chair of the Ethics Committee at Primary Children's Medical Center in Salt Lake City, Utah from 2005 to 2012 and have been Director of the Ethics Center at Cincinnati Children's since 2012. I regularly consult on the care of patients in the Transgender Health Clinic at Cincinnati Children's and participate in the Clinic's monthly multidisciplinary team meetings. I remain current with the medical and bioethics literature regarding the treatment of minors with gender dysphoria. I am also part of Cincinnati Children's team that cares for patients born with differences or disorders of sex development (DSD), also known as intersex traits. I chair Cincinnati Children's Fetal Care Center's Oversight Committee, which provides the Center recommendations on the use of innovative treatments and experimental interventions.

12. I am a member of the American Academy of Pediatrics (AAP), the American Society for Bioethics and Humanities (ASBH), the Association of Bioethics Program Directors, and the Society for Pediatric Research. I was a member of the AAP Committee on Bioethics from 2005 to 2011. I have also served as a member of ASBH's Clinical Ethics Consultation Affairs Committee from 2009 to 2014 and currently serve on its Healthcare Ethics Consultant Certification Commission.

13. I am the author of 43 peer-reviewed journal articles, 11 non-peer-reviewed journal articles, 6 book chapters, and 28 commentaries. My peer-reviewed journal articles have been

published in high-impact journals, including the *Journal of the American Medical Association* and *Annals of Internal Medicine.* I am also an author of 17 policy statements and technical reports, including 4 as lead author, by the AAP.

14. I am a member of *Pediatrics'* Executive Editorial Board and its Associate Editor for Ethics Rounds. I am an active peer reviewer for many medical journals, including the *American Journal of Bioethics* and the *Journal of Pediatrics*. I am chair of the National Library of Medicine's Literature Selection Technical Review Committee. I also review abstracts for meetings of professional organizations, including the Pediatric Academic Societies and ASBH. I was previously a member of the editorial boards of the *Journal of Clinical Ethics* and the *Journal of Medical Humanities.*

15. I have previously testified at deposition and trial in *Brandt et al. v. Griffin et al.*, United States District Court, Eastern District of Arkansas, Case No. 4:21-CV-00450; at deposition and trial in *Dekker et al. v. Weida et al.*, United States District Court, Northern District of Florida, Case No. 4:22-cv-00325; in the preliminary injunction phase and at deposition in *Boe et al. v. Marshall et al.*, United States District Court, Middle District of Alabama, Case No. 22-cv-00184; and at deposition in *Zayre-Brown v. North Carolina Department of Public Safety et al.*, United States District Court, Western District of North Carolina, Case No. 3:22-CV-01910. I have also previously testified in the preliminary injunction phase in *Doe et al. v. Abbott et al.*, District Court of Travis County, Texas, Case No. D-1-GN-22-000977. The cases in which I have authored reports but have not testified are listed in my CV (Exhibit A). I am being compensated at a rate of $400 per hour for preparation of expert declarations and reports, and for time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

THE TREATMENT OF GENDER DYSPHORIA IS SUPPORTED BY EVIDENCE COMPARABLE TO THE EVIDENCE FOR MANY OTHER MEDICAL TREATMENTS

Clinical Practice Guidelines

16. Medical professional organizations develop clinical practice guidelines to provide clinicians with helpful, evidence-based recommendations and improve patient care and outcomes. Clinical practice guidelines are developed using systematic processes to select and review scientific evidence. Guidelines typically rate the quality of the evidence and grade the strength of recommendations.[1] One widely used method of grading the quality of the evidence and the strength of recommendations is the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) system.[2]

17. Clinical practice has different goals and methods from research or experimentation. Clinical practice's goal is to benefit individual patients and its method is individualized decision-making. Research's goal is to contribute to generalizable knowledge and research is conducted using formal protocols that describe its objectives and procedures.[3] For example, a research study may have restrictive inclusion and exclusion criteria for participants in order to increase the investigators' ability to draw scientifically valid conclusions. A clinician may, however, recommend a treatment to a patient who would not have been eligible for the study because the clinician believes the treatment will benefit the patient. The clinician will subsequently make

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[1] American Academy of Pediatrics Steering Committee on Quality Improvement and Management. Classifying recommendations for clinical practice guidelines. *Pediatrics*. 2004;114(3):874-877.

[2] Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490.

[3] National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research.* U.S. Department of Health and Human Services; 1978.

recommendations about whether to modify or discontinue the treatment based on the patient's response to it.

18. GRADE states, "In the context of making recommendations, the quality ratings reflect the extent of our confidence that the estimates of an effect are adequate to support a particular decision or recommendation."[4] Quality of evidence is based on several factors including study design, risk of bias, consistency, and directness. GRADE distinguishes four levels of evidence: "high," "moderate," "low," and "very-low." These levels are relative to one another and "low" does not necessarily mean poor or inadequate. As discussed below, a recommendation in a clinical practice guideline may be based on "low" or "very low" quality evidence, not just "high" or "moderate" quality evidence.[5]

19. With respect to study design, randomized trials generally provide "high" quality evidence.[6] In a randomized trial, participants are randomly assigned to a treatment or a comparison group. The major benefit of a randomized trial is that it decreases the likelihood that any differences in the outcomes between the groups is the result of baseline differences between the groups rather than the result of the intervention.[7]

20. By comparison, observational studies generally constitute "low" quality evidence.[8] Observational studies include cross-sectional and longitudinal studies. In cross-sectional studies,

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[4] Balshem H, Helfand M, Schünemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):403.
[5] Balshem H, Helfand M, Schünemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406.
[6] Balshem H, Helfand M, Schünemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406.
[7] Browner WS, Newman TB, Cummings SR, et al. *Designing Clinical Research*. 5th ed. Wolters Kluwer; 2022.
[8] Balshem H, Helfand M, Schünemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406.

investigators collect data at a single point in time. A cross-sectional design permits investigators to examine potential associations between factors, but it cannot prove one factor caused the other. An example of a cross-sectional study related to gender-affirming medical care is Jack L. Turban and colleagues' analysis of data from the 2015 United States (US) Transgender Survey. The survey asked transgender adults, who were recruited through community outreach, about their demographics, past gender-affirming medical care, family support, and mental health outcomes. The investigators found that those who received pubertal suppression had lower odds of lifetime suicidal ideation compared to those who wanted treatment with pubertal suppression but did not receive it.[9] In longitudinal studies, researchers follow individuals over time, making continuous or repeated measures.[10] Examples of longitudinal studies include the studies of the associations between gender-affirming medical care and psychological outcomes discussed below.[11]

21. The labels "high" and "low" quality evidence can be misleading if the latter is used in the colloquial sense of poor or inadequate. While randomized controlled trials are described in the medical literature as "high" quality evidence and observational studies as "low" quality evidence, randomized controlled trials may not be feasible or ethical, may have intrinsic methodological limitations, or may be unavailable in some contexts. A particular quality of

[9] Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*. 2020;145(2):e20191725.
[10] Browner WS, Newman TB, Cummings SR, et al. *Designing Clinical Research*. 5th ed. Wolters Kluwer; 2022.
[11] See, for example, de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *J Sex Med*. 2011;8(8):2276-2283.

evidence as specified by the GRADE system does not necessarily entail a particular strength of recommendation; "low" quality evidence can be sufficient to justify strong recommendations.[12]

22. At times, it may be unethical to conduct randomized trials. For randomized trials to be ethical, clinical equipoise must exist; there must be uncertainty about whether the efficacy of the intervention or the control is greater. Otherwise, it would be unethical to knowingly expose trial participants to an inferior intervention or control. Trials must also be feasible; it would also be unethical to expose individuals to the risks of trial participation without the benefit of the trial generating generalizable knowledge. A randomized trial that is unlikely to find enough people to participate because they believe they might be randomized to an inferior intervention would be unethical because it could not produce generalizable knowledge due to an inadequate sample size.[13]

23. Clinical research focusing on children is less likely to use randomized trials than is clinical research for adults. Potential reasons for this disparity include the low prevalence of childhood disease, small market share for therapeutic agents in children, low level of National Institutes of Health funding, and difficulty enrolling children in research.[14]

24. The process for assessing the quality of the evidence is separate and distinct from the process for grading the strength of recommendations based on this evidence.[15] When making

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[12] Balshem H, Helfand M, Schünemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406; Swiglo BA, Murad MH, Schünemann HJ, et al. A case for clarity, consistency, and helpfulness: State-of-the-art clinical practice guidelines in endocrinology using the Grading of Recommendations Assessment, Development, and Evaluation system. *J Clin Endocrinol Metab*. 2008;93(3):666-673.

[13] Emanuel EJ, Wendler D, Grady C. What makes clinical research ethical? *JAMA*. 2000;283(20):2701-2711.

[14] Martinez-Castaldi C, Silverstein M, Baucher H. Child versus adult research: The gap in high quality study design. *Pediatrics*. 2008;122(1):52-57.

[15] Balshem H, Helfand M, Schünemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406.

recommendations, the authors of guidelines consider a variety of factors; the quality of the evidence is only one factor considered in making recommendations. Other considerations include the balance between desirable and undesirable outcomes, confidence and variability in patients' values and preferences, and resource use.[16] The GRADE system distinguishes "strong" and "weak" recommendations; if the authors are highly confident in the balance between desirable and undesirable consequences, they make a "strong" recommendation and, if they are less confident, a "weak" recommendation.[17] The larger the differences between the desirable and undesirable consequences and the smaller the variability in patient values and preferences, the more likely a "strong" recommendation is warranted. "Low" quality evidence may be sufficient to make a "strong" recommendation.[18]

25. Recommendations for pediatric care made by professional associations in clinical practice guidelines are seldom based on well-designed and conducted randomized controlled trials due to their rarity. Instead, recommendations are frequently based on observational studies or, if such studies are unavailable, expert opinion. The medical use of the term "expert opinion" in this context refers to the consensus of experts when studies are not available.

26. For example, of the 130 recommendations in the American Heart Association's (AHA's) guideline for Pediatric Basic and Advanced Life Support, only 1 (0.8%) is based on "high-quality evidence from more than 1 [randomized clinical trial]" and 3 (2.3%) on "moderate-

[16] Andrews JC, Schünemann HJ, Oxman AD, et al. GRADE guidelines: 15. Going from evidence to recommendation-determinants of a recommendation's direction and strength. *J Clin Epidemiol*. 2013;66(7):726-735.
[17] Andrews J, Guyatt G, Oxman AD, et al. GRADE guidelines: 14. Going from evidence to recommendations: The significance and presentation of recommendations. *J Clin Epidemiol*. 2013;66(7):719-725.
[18] Andrews JC, Schünemann HJ, Oxman AD, et al. GRADE guidelines: 15. Going from evidence to recommendation-determinants of a recommendation's direction and strength. *J Clin Epidemiol*. 2013;66(7):726-735.

quality evidence from 1 or more [randomized clinical trials]." The remainder of the recommendations were based on lower quality evidence. Among its 57 "strong" recommendations (both Class 1 and Class 3 Harm), 48 (84%) are based on "limited data" or "expert opinion."[19] Table 1 (Exhibit B).

Clinical Practice Guidelines for Gender-Affirming Medical Care for Minors

27. Gender-affirming medical care is not experimental in either the colloquial or the technical sense. The level of evidence supporting clinical practice guidelines recommendations regarding gender-affirming medical care for adolescents is comparable to the level of evidence supporting many other pediatric medical treatments.

28. Gender-affirming care for minors is not experimental in the colloquial sense of new, novel, or unproven. The first reference to the use of GnRH analogs for the treatment of gender dysphoria in the medical literature was in 1998, over 25 years ago.[20] Prospective observational trials of GnRH analogs began recruiting participants in 2000.[21] Evidence for this medical care will be discussed in greater detail below. Gender-affirming medical care is also not experimental in the

[19] Topjian AA, Raymond TT, Atkins D, et al. Part 4: Pediatric basic and advanced life support: 2020 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. *Circulation*. 2020;142(16 suppl 2):S469-S523. These clinical practice guidelines use different terminology than the GRADE approach for describing the quality of the evidence and the strength of recommendations.

[20] Cohen-Kettenis PT, van Goozen SH. Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. *Eur Child Adolesc Psychiatry*. 1998;7(4):246-248. See also Gooren L, Delemarre-van de Waal H. The feasibility of endocrine interventions in juvenile transsexuals. *J Psychol Human Sex*. 1996;8(4):69-74.

[21] de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *J Sex Med*. 2011;8(8):2276-2283.

technical sense; it is intended to benefit individual patients and is modified based on individual patients' responses.[22]

29. The Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, has published a clinical practice guideline for the treatment of gender-dysphoric/gender-incongruent persons, including pubertal suppression, sex hormone treatment, and surgery for gender confirmation.[23] Gender dysphoria is a medical diagnosis contained in the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders*. It is "a marked incongruence between one's experienced/expressed gender and their assigned gender" which is "associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning."[24] Gender-affirming medical care is also recommended by the World Professional Association for Transgender Health's (WPATH's) Standards of Care for the Health of Transgender and Gender Diverse People which is currently in its 8th version.[25] The treatments outlined in these guidelines are also endorsed by other medical professional associations including the American Academy of Family

[22] National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The *Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. U.S. Department of Health and Human Services; 1978.
[23] Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.
[24] American Psychiatric Association. Gender Dysphoria. In: *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed., text rev. American Psychiatric Publishing; 2022.
[25] Coleman E, Radix AE, Bouman WP, et al. Standards of care for the health of transgender and gender diverse people, version 8. *Int J Transgend Health*. 2022;23(Suppl 1):S1-S259.

Physicians,[26] the AAP,[27] the American College of Obstetricians and Gynecologists,[28] the American Medical Association,[29] the APA,[30] the American Psychological Association,[31] and the Pediatric Endocrine Society.[32]

30. The Endocrine Society clinical practice guideline includes 28 recommendations: 3 (11%) are based on "moderate" and 19 (68%) are based on "low" or "very low" quality evidence.

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[26] American Academy of Family Physicians. Care for the transgender and gender nonbinary patient. December 2023. Accessed February 12, 2024. Available at https://www.aafp.org/about/policies/all/transgender-nonbinary.html#:~:text=The%20American%20Academy%20of%20Family,patients%2C%20including%20children%20and%20adolescents.

[27] Rafferty J, Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence, Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*. 2018;142(4):e20182162.

[28] American College of Obstetricians and Gynecologists. ACOG Committee Opinion Number 823: Health care for transgender and gender diverse individuals. March 2021. Accessed February 12, 2024. Available at https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals/; American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice and Committee on Health Care for Underserved Women. Health care for transgender and gender diverse individuals: ACOG Committee Opinion, Number 823. *Obstet Gynecol*. 2021;137(3):e75-e88.

[29] American Medical Association. Removing financial barriers to care for transgender patients H-185.950. 2022. Accessed February 12, 2024. Available at https://policysearch.ama-assn.org/policyfinder/detail/H-185.950?uri=%2FAMADoc%2FHOD.xml-0-1128.xml; Madara JL. Letter to Mr. Bill McBride. April 26, 2021. Accessed February 12, 2024. Available at https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-26-Bill-McBride-opposing-anti-trans-bills-Final.pdf.

[30] American Psychiatric Association. Position statement on treatment of transgender (trans) and gender diverse youth. July 2020. Accessed February 12, 2024. Available at https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf.

[31] American Psychological Association. Transgender, gender identity, and gender expression non-discrimination. August 2008. Accessed February 12, 2024, Available at https://www.apa.org/about/policy/transgender.pdf.

[32] Endocrine Society and Pediatric Endocrine Society. Transgender health: Position statement. December 2020. Accessed February 12, 2024. Available at https://www.endocrine.org/-/media/endocrine/files/advocacy/position-statement/position statement transgender health_pes.pdf.

The remaining 6 (21%) recommendations are Ungraded Good Practice Statements.[33] Table 2 (Exhibit C).

31. The quality of the evidence supporting these recommendations is similar to the quality of the evidence supporting the recommendations in the AHA clinical practice guideline described above and in other Endocrine Society guidelines for the pediatric population. For example, none of the Endocrine Society's 84 recommendations in its two other guidelines that focus on the pediatric population guidelines on pediatric obesity and congenital adrenal hyperplasia is based on "high" quality evidence. Twenty-four (29%) of the recommendations are based on "moderate," and 49 (58%) on "low" or "very low" quality evidence. The remaining recommendations (11, 13%) are Ungraded Good Practice Statements.[34] Table 2 (Exhibit C).

32. With respect to GnRH analogs, the Endocrine Society specifically "suggest[s] that adolescents who meet diagnostic criteria for [gender dysphoria]/gender incongruence, fulfill criteria for treatment, . . . and are requesting treatment should initially undergo treatment to suppress pubertal development."[35] The evidence for this recommendation includes a longitudinal study of a group of 70 transgender adolescents who were evaluated using objective measures prior to both pubertal suppression and sex hormone treatment. The mean length of time between the start of pubertal suppression and sex hormone treatment was 1.88 years and ranged from 0.42 to

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[33] Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.

[34] Speiser PW, Arlt W, Auchus RJ, et al. Congenital adrenal hyperplasia due to steroid 21-hydroxylase deficiency: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2018;103(11):4043-4088; Styne DM, Arslanian SA, Connor EL, et al. Pediatric obesity-assessment, treatment, and prevention: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(3):709-757.

[35] Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3880.

5.06 years. The study showed statistically significant decreases in behavioral and emotional problems and depressive symptoms, and increases in general functioning.[36]

33. This is the same level of evidence as supports the use of GnRH analogs for the treatment of central precocious puberty which the Ban permits. Central precocious puberty is the premature initiation of puberty, before 8 years of age in people assigned female at birth and before 9 in people assigned male, by the central nervous system. The potential negative effects of precocious puberty include impairment of final adult height as well as antisocial behavior and lower academic achievement. There are no randomized trials evaluating the adult height of treated and untreated individuals. Most studies are observational and compare pretreatment predicted final height with actual final height. These studies have additional limitations including small sample sizes. This "low" quality evidence nonetheless is sufficient to support the use of GnRH analogs as treatment for central precocious puberty.[37] The Ban therefore subjects the use of GnRH analogs to a double standard. There are no randomized clinical trials for the use of GnRH analogs to treat precocious puberty or gender dysphoria, but the evidence is deemed sufficient for the former but not the latter.

34. The evidence supporting the guideline's recommendations regarding gender-affirming hormone treatment in adolescents include Annelou L. C. de Vries and colleagues' longer-term follow-up of individuals after pubertal suppression through sex hormone and gender-affirming surgical treatment. Participants' mean age at their initial assessment was 13.6 years and

[36] de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *J Sex Med.* 2011;8(8):2276-2283.
[37] Mul D, Hughes IA. The use of GnRH agonists in precocious puberty. *Eur J Endocrinol.* 2008;159(Suppl 1):S3-S8.

their mean age at their final assessment was 20.7 years. The researchers report the resolution of gender dysphoria and improvement in psychological functioning.[38]

35. As a result of these studies and healthcare providers' subsequent experience, randomized, placebo-controlled trials (trials that compare pharmacological treatment to no pharmacological treatment) of gender-affirming medical care are currently unethical. Potential investigators do not have equipoise between pharmacological treatment and no pharmacological treatment; they believe that pharmacological treatment is superior. It is also highly unlikely that a sufficient number of participants would enroll in randomized controlled trials for them to be informative.[39]

36. Even if such studies could be conducted ethically, they would provide a lower quality of evidence because of intrinsic limitations in their design. For example, it would be impossible to blind/mask the investigators or the participants to whether the participants were receiving the active treatment or a placebo. They would know if participants were in the intervention or the control arm of the study due to the physical changes in their bodies, or the lack

[38] See de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*. 2014;134(4):696-704. Additional longitudinal studies of the psychosocial effects of pubertal suppression to treat gender dysphoria include Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M. Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *J Sex Med.* 2015;12(11):2206-2214 and Carmichael P, Butler G, Masic U, et al. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One.* 2021;16(2):e0243894.

[39] Chew D, Anderson J, Williams K, May T, Pang K. Hormonal treatment in young people with gender dysphoria: A systematic review. *Pediatrics*. 2018;141(4):e20173742; Reisner SL, Deutsch MB, Bhasin S, et al. Advancing methods for US transgender health research. *Curr Opin Endocrinol Diabetes Obes*. 2016;23(2):198-207.

thereof, over time. This might bias their perception of the outcomes and lower the rating of the study's quality.[40]

OFF-LABEL USE DOES NOT SUPPORT A BAN

37. The fact that GnRH analog and gender-affirming hormone treatment are not approved by the US Food and Drug Administration (FDA) for the treatment of gender dysphoria does not support a ban. Off-label use of FDA-approved medications is legal, common, and often evidence-based. FDA approval is not required for each and every use of a medication. Once the FDA has approved a medication for one indication,[41] thereby agreeing that it is safe (i.e., its benefits outweigh its potential risks) and effective for this intended use, as is the case with the medications at issue here, prescribers are generally free to prescribe it for other indications.[42] The AAP Committee on Drugs states, "[i]t is important to note that the term 'off-label' does not imply an improper, illegal, contraindicated, or investigational use" and "[t]he administration of an approved drug for a use that is not approved by the FDA is not considered research and does not

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[40] Browner WS, Newman TB, Cummings SR, et al. *Designing Clinical Research*. 5th ed. Wolters Kluwer; 2022; Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490.

[41] According to the FDA, an indication includes several factors: the particular disease or condition or the manifestation or symptoms of the disease or condition for which the drug is approved; whether the drug is approved for treatment, prevention, mitigation, cure, or diagnosis; and the population, including age group, for which the drug is safe and effective. U.S. Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research, Center for Biologics Evaluation and Research. Indications and Usage Section of Labeling for Human Prescription Drug and Biological Products Content and Format: Guidance for Industry. July 2018. Accessed February 12, 2024. Available at https://www.fda.gov/files/drugs/published/Indications-and-Usage-Section-of-Labeling-for-Human-Prescription-Drug-and-Biological-Products-%E2%80%94-Content-and-Format-Guidance-for-Industry.pdf. A medication approved for the treatment of asthma in adults would, for example, be prescribed off label if used to treat a different disease, like pneumonia, or a different age group, like children.

[42] U.S. Food & Drug Administration. Understanding Unapproved Use of Approved Drugs "Off Label." February 5, 2018. Accessed February 12, 2024. Available at https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label.

warrant special consent or review if it is deemed to be in the individual patient's best interest." It further states "in no way does a lack of labeling signify that therapy is unsupported by clinical experience or data in children."[43] There are several reasons why, even if there is substantial evidence of safety and efficacy for a new indication, a sponsor may not seek FDA approval for it. These reasons include that seeking approval may not be economically beneficial for the sponsor.[44]

38. "Off-label" use of drugs is common in many areas of medicine, including pediatrics. A recent study of children's hospitals found that in 28.1% of encounters, at least one off-label drug was prescribed. Examples of medications used off-label in this study included: albuterol, which is used to treat asthma; morphine, which is used to treat pain; and lansoprazole (Prevacid®), which is used to treat gastroesophageal reflux.[45] The rate of off-label use may be significantly higher in certain age groups, categories of drugs, and clinical settings.[46]

GENERALLY APPLICABLE PRINCIPLES OF INFORMED CONSENT APPLY TO PEDIATRIC GENDER-AFFIRMING MEDICAL CARE

Principles of Informed Consent

39. Before performing any medical intervention, a healthcare provider must generally obtain an adult patient's informed consent. Informed consent is a process in which the provider discloses information, elicits the patient's preferences, offers medical advice, and seeks explicit authorization. In order to participate in the informed consent process, a patient must have medical decision-making capacity. If an adult patient lacks capacity, a proxy decision-maker is generally

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[43] Frattarelli DA, Galinkin JL, Green TP, et al. Off-label use of drugs in children. *Pediatrics*. 2014;133(3):563-567. Quotations appear on pages 563, 565, and 564 respectively.
[44] Wittich CM, Burkle CM, Lanier WL. Ten common questions (and their answers) about off-label drug use. *Mayo Clin Proc*. 2012;87(10):982-990.
[45] *See* Yackey K, Stukus K, Cohen D, Kline D, Zhao S, Stanley R. Off-label medication prescribing patterns in pediatrics: An update. *Hosp Pediatr*. 2019;9(3):186-193.
[46] Maltz LA, Klugman D, Spaeder MC, Wessel DL. Off-label drug use in a single-center pediatric cardiac intensive care unit. *World J Pediatr Congenit Heart Surg*. 2013;4(3):262-266.

appointed. The healthcare provider's disclosure should include the nature of the intervention and the reasons for it, as well as its potential benefits, risks, and alternatives, including the alternative of not undergoing the intervention. The patient or the patient's proxy must understand and appreciate this information and express a decision. For the informed consent to be valid, the authorization must be voluntary. Exceptions to the requirement to obtain informed consent exist, such as in the case of an emergency.[47]

40. Medical decision-making and informed consent in pediatrics is more complex than in adult medicine because it involves both minor patients and their parents or legal guardians. Parents and guardians are afforded substantial, but not unlimited, discretion in making medical decisions for their minor children based on their assessment of the individual child's best interest. They generally care about their children and best understand their children's unique needs.[48]

41. Healthcare providers also have an ethical obligation to include children in medical decision-making to the extent that it is developmentally appropriate. For example, a provider examining a toddler for a possible ear infection should not ask a toddler for permission to look in the child's ear because the provider intends to look even if the child says no. The provider could, however, ask the toddler which ear the child would like to have looked in first. As a minor becomes older, the minor should participate more actively in medical decision-making and the minor's assent should be sought. In early adolescence, individuals typically have developed a sense of identity, individual values and preferences, and are developing medical decision-making capacity. Capacity entails the ability to (i) understand the indications and the potential benefits, risks, and

[47] Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 6th ed. Oxford University Press; 2009.
[48] Diekema DS. Parental refusals of medical treatment: The harm principle as threshold for state intervention. *Theor Med Bioeth.* 2004;25(4):243-264.

alternatives to a treatment, including declining treatment; (ii) appreciate the implications of a treatment decision for their own lives; (iii) evaluate the potential benefits and risks; and (iv) express a preference.[49] Adolescents generally possess comparable medical decision-making capacity to adults. Louis A. Weithorn and Susan B. Campbell, for example, found that 14-year-olds performed similarly to adults with respect to their ability to understand and reason about treatment information.[50]

42. The current treatment paradigm for treating gender dysphoria in minors is consistent with general ethical principles instantiated in the practices of informed consent and assent. The Endocrine Society clinical practice guideline extensively discusses the potential benefits, risks, and alternatives to treatment, and its recommendations regarding the timing of interventions are based in part on the treatment's potential risks and the adolescent's decision-making capacity. The guideline recommends that the informed consent process for GnRH analogs and sex hormones include a discussion of the implications for fertility and options for fertility preservation. The Endocrine Society clinical practice guideline also advises delaying gender-affirming hormone treatment, which results in partly irreversible physical changes, until an adolescent is developmentally capable of providing informed consent.[51] Lieke J. J. J. Vrouenraets

[49] Katz AL, Webb SA, Committee on Bioethics. Informed consent in decision-making in pediatric practice. *Pediatrics*. 2016;138(2):e20161485; Kon AA, Morrison W. Shared decision-making in pediatric practice: A broad view. *Pediatrics*. 2018;142(Suppl 3):S129-S132.
[50] Weithorn LA, Campbell SB. The competency of children and adolescents to make informed treatment decisions. *Child Dev*. 1982;53(6):1589-1598.
[51] See Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.

and colleagues found most adolescents with gender dysphoria have sufficient medical decision-making capacity to make decisions regarding GnRH analogs.[52]

Gender-Affirming Medical Care's Benefits, Risks, and Alternatives

43. The potential benefits of gender-affirming medical care include improved physical and psychological outcomes. Starting pubertal suppression in early puberty prevents adolescents with gender dysphoria from developing secondary sex characteristics inconsistent with their gender identity, which can be extremely distressing for them, and that may be difficult, if not impossible, to eliminate once the characteristics have fully developed. Sex hormone therapy results in the development of secondary sex characteristics consistent with an individual's gender identity. Potential psychological benefits include increased quality of life and decreased depression, suicidal ideation and suicide attempts, and anxiety.[53]

44. As with all medical treatments, gender-affirming medical care entails risks. One of the potential risks is negative effects on fertility, but this risk should not be overstated. GnRH analogs do not, by themselves, permanently impair fertility. Children with central precocious puberty are routinely treated with GnRH analogs and have typical fertility in adulthood.[54] These medications are also used for fertility preservation in individuals being treated for cancer.[55]

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[52] Vrouenraets LJJJ, de Vries ALC, de Vries MC, van der Miesen AIR, Hein IM. Assessing medical decision-making competence in transgender youth. *Pediatrics*. 2021;148(6):e2020049643.

[53] See, for example, Baker KE, Wilson LM, Sharma R, Dukhanin V, McArthur K, Robinson KA. Hormone therapy, mental health, and quality of life among transgender people: A systematic review. *J Endocr Soc*. 2021;5(4):1-16.

[54] Lazar L, Meyerovitch J, de Vries L, Phillip M, Lebenthal Y. Treated and untreated women with idiopathic precocious puberty: Long-term follow-up and reproductive outcome between the third and fifth decades. *Clin Endocrinol* (Oxf). 2014;80(4):570-576.

[55] Valsamakis G, Valtetsiotis K, Charmandari E, Lambrinoudaki I, Vlahos NF. GnRH analogues as a co-treatment to therapy in women of reproductive age with cancer and fertility preservation. *Int J Mol Sci*. 2022;23(4):2287.

45. While treatment for gender dysphoria with gender-affirming hormones may impair fertility, this is not universal and may also be reversible. There are transgender men who became pregnant while on or after discontinuing testosterone therapy.[56] Transgender men and women are also capable of producing eggs and sperm respectively both during and after the discontinuation of gender-affirming hormone treatment.[57]

46. Additionally, the clinical practice guidelines discussed above recommend that healthcare providers offer individuals considering gender-affirming medical care methods to potentially preserve their fertility.[58]

47. The risk of infertility is also not unique to treatment for gender dysphoria. For example, parents and legal guardians consent to the treatment of medical conditions for their minor children, including some nonmalignant rheumatologic disorders and hematologic conditions, which may impair fertility.[59]

48. While transgender adolescents have higher rates of depression, anxiety, suicidal ideation, and suicide attempts, there are no studies indicating that those higher rates are caused or

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[56] Light AD, Obedin-Maliver J, Sevelius JM, Kerns JL. Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstet Gynecol*. 2014;124(6):1120-1127.
[57] Leung A, Sakkas D, Pang S, Thornton K, Resetkova N. Assisted reproductive technology outcomes in female-to-male transgender patients compared with cisgender patients: A new frontier in reproductive medicine. *Fertil Steril.* 2019;112(5):858-865; de Nie I, van Mello NM, Vlahakis E, et al. Successful restoration of spermatogenesis following gender-affirming hormone therapy in transgender women. *Cell Rep Med.* 2023;4(1):100858.
[58] Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.
[59] Delessard M, Saulnier J, Rives A, Dumont L, Rondanino C, Rives N. Exposure to chemotherapy during childhood or adulthood and consequences on spermatogenesis and male fertility. *Int J Mol Sci*. 2020;21(4):1454; Blumenfeld Z. Chemotherapy and fertility. *Best Pract Res Clin Obstet Gynaecol*. 2012;26(3):379-390; Hirshfeld-Cytron J, Gracia C, Woodruff TK. Nonmalignant diseases and treatments associated with primary ovarian failure: An expanded role for fertility preservation. *J Womens Health (Larchmt)*. 2011;20(10):1467-1477.

exacerbated by gender-affirming medical care.[60] Rather, contributing factors include conflict between one's appearance and identity, stigma, and rejection.[61] As discussed above, the available evidence indicates that gender-affirming care improves, rather than worsens, psychological outcomes.

49. Finally, not knowing all potential harmful effects associated with a medication is not a sufficient reason for the FDA to not approve a medication, let alone for a state to ban it. The FDA requires post-marketing surveillance of medications' adverse effects because the clinical trials on which the approvals are based cannot identity all possible side effects.[62]

50. In determining whether the benefits of treatment outweigh the risks, medical providers and patients must also consider the potential alternatives including not providing or receiving the treatment. As stated above, prior to the initiation of gender-affirming medical care, many individuals with gender dysphoria have significant, unresolved symptoms that treatment improves. Without medical treatment, these symptoms would persist. The assertion that psychotherapy alone is sufficient to treat gender dysphoria in adolescents is only supported by anecdotal evidence.[63]

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[60] Haas AP, Eliason M, Mays VM, et al. Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *J Homosex.* 2011;58(1):10-51.
[61] Bauer GR, Scheim AI, Pyne J, Travers R, Hammond R. Intervenable factors associated with suicide risk in transgender persons: A respondent driven sampling study in Ontario, Canada. *BMC Public Health.* 2015;15:525.
[62] U.S. Food & Drug Administration. Postmarketing Surveillance Programs. April 2, 2020. Accessed February 12, 2024. Available at https://www.fda.gov/drugs/surveillance/postmarketing-surveillance-programs.
[63] See, for example, Levine SB. Transitioning back to maleness. *Arch Sex Behav.* 2018;47(4):1295-1300.

The Risks and Benefits of Gender-Affirming Medical Care are Comparable to Those of Other Medical Care to which Parents and Guardians May Consent

51. Medical care for minors can require weighing potential benefits and risks in the face of uncertainty. There is nothing unique about gender-affirming medical care that justifies singling out this medical care for prohibition based on concern for adolescents' inability to assent or parents or guardians' inability to consent. Medical decisions regarding treatment for gender dysphoria should continue to be left to the discretion of adolescents, their parents or guardians, and their healthcare providers.

52. The potential risks of gender affirming medical care are comparable to the risks parents and adolescents are permitted to assume in numerous other treatment decisions, including decisions explicitly authorized by this legislation. As described above, parents can choose treatments that have some chance of damaging their children's gonads and impairing their fertility. Individuals with some types of DSDs, such as complete androgen insensitivity syndrome, are treated with sex hormones, which have comparable risks to the use of these treatments in persons with gender dysphoria.[64] Parents of children with some types of DSDs may even choose to have their children's gonads removed due to the possible elevated risk of malignancy, which causes infertility.[65] It is also my understanding that the Ban permits gender-affirming medical treatment of individuals with DSDs, which has similar risks to the use of this treatment in individuals who do not have DSDs.

53. As discussed above, the potential benefits of gender-affirming medical care, including improved psychological outcomes, frequently outweigh the potential risks.

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[64] Lanciotti L, Cofini M, Leonardi A, Bertozzi M, Penta L, Esposito S. Different clinical presentations and management in complete androgen insensitivity syndrome (CAIS). *Int J Environ Res Public Health*. 2019;16(7):1268.

[65] Abacı A, Çatlı G, Berberoğlu M. Gonadal malignancy risk and prophylactic gonadectomy in disorders of sexual development. *J Pediatr Endocrinol Metab*. 2015;28(9-10):1019-1027.

Potential Regret Does Not Support a Ban

54. Patients experiencing regret as a result of any medical treatment is profoundly unfortunate and such individuals should be provided support and additional treatment as needed. Patients expressing regret over having received a certain kind of medical care, gender-affirming or other medical care, however, does not justify banning that medical care.

55. While there are individuals who received gender-affirming medical care as minors who express regret, the available studies report that rates of regret regarding gender-affirming medical care are very low. For example, Chantal M. Wiepjes and colleagues report that 0.6% of transgender women and 0.3% of transgender men experienced regret.[66] Similarly, R. Hall and colleagues report regret was specifically documented in 1.1% of adult gender-diverse patients.[67] Banning gender-affirming medical care to prevent regret in a small minority of patients would result in harm to the majority of patients who benefit. The potential for regret should nonetheless be disclosed in the informed consent process, and support and services should be provided to individuals who experience regret.

56. The potential for regret is also not unique to gender-affirming medical care. Ironically, at the same time that Ohio prohibits gender-affirming medical care for minors, the statute expressly allows doctors to perform irreversible genital surgeries on infants and children with DSDs at ages when they are unable to meaningfully participate in medical decision-making. The evidence base for these surgeries is poor and they are highly controversial when performed at

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[66] Wiepjes CM, Nota NM, de Blok CJ, et al. The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in prevalence, treatment, and regrets. *J Sex Med.* 2018;15(4):582-590. This study analyzes all individuals who presented to the clinic, whether they presented as minors or adults. Regret was assessed in individuals who had undergone gender-affirming surgery that included removal of the gonads. This surgery was only performed on adults.

[67] Hall R, Mitchell L, Sachdeva J. Access to care and frequency of detransition among a cohort discharged by a UK national adult gender identity clinic: Retrospective case-note review. *BJPsych Open*. 2021;7(6):e184.

such an early age.[68] Parents of children who have undergone feminizing genitoplasty and hypospadias repair have experienced regret over their decisions.[69] For example, Rachel S. Fisher and colleagues found that 38% of caregivers of infants with congenital adrenal hyperplasia reported some level of regret about their child's genital surgery.[70]

THE INCREASED PREVALENCE OF GENDER-AFFIRMING CARE DOES NOT SUPPORT A BAN

57. The increased number of transgender individuals and those receiving medical treatment does not justify a ban. The causes of these changes are likely to be multifactorial including increased social acceptance of transgender individuals and availability of gender-affirming medical care.[71] Changes in demographics are not unique to gender dysphoria and have been seen in other conditions such as autism spectrum disorder and childhood-onset type 1 diabetes.[72] These changes are a justification for further research on gender-affirming medical care rather than prohibiting these treatments and thereby preventing further research on them.

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[68] Jesus LE. Feminizing genioplasties: Where are we now? *J Pediatr Urol*. 2018;14(5):407-415; Frader J, Alderson P, Asch A, et al. Health care professionals and intersex conditions. *Arch Pediatr Adolesc Med*. 2004;158(5):426-428.

[69] Fisher RS, Espeleta HC, Baskin LS, et al. Decisional regret about surgical and non-surgical issues after genitoplasty among caregivers of female infants with CAH. *J Pediatr Urol*. 2022;18(1):27-33; Vavilov S, Smith G, Starkey M, Pockney P, Deshpande AV. Parental decision regret in childhood hypospadias surgery: A systematic review. *J Paediatr Child Health*. 2020;56(10):1514-1520.

[70] Fisher RS, Espeleta HC, Baskin LS, et al. Decisional regret about surgical and non-surgical issues after genitoplasty among caregivers of female infants with CAH. *J Pediatr Urol*. 2022;18(1):27-33.

[71] Wiepjes CM, Nota NM, de Blok CJM, et al. The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in prevalence, treatment, and regrets. *J Sex Med*. 2018;15(4):582-590.

[72] Christensen DL, Maenner MJ, Bilder D, et al. Prevalence and characteristics of autism spectrum disorder among children aged 4 years - Early Autism and Developmental Disabilities Monitoring Network, seven sites, United States, 2010, 2012, and 2014. *MMWR Surveill Summ*. 2019;68(2):1-19; DIAMOND Project Group. Incidence and trends of childhood type 1 diabetes worldwide 1990-1999. *Diabet Med*. 2006;23(8):857-866.

TREATMENT PROTOCOLS IN EUROPE DO NOT SUPPORT A BAN

58. Some have pointed to the actions of European health authorities as support for banning gender-affirming medical care.[73] It is difficult to evaluate some of these actions because the relevant material is not available in official English translations. While several of these authorities have conducted systematic reviews of the evidence, none have developed a formal clinical practice guideline. While both systematic reviews and clinical practice guidelines ideally grade the quality of the evidence, only clinical practice guidelines make recommendations and grade their strength. Of the documents by European health authorities that do make treatment recommendations, none rate the quality of the evidence and the strength of the recommendations.

59. Critically, none of the European health authorities has prohibited gender-affirming medical care as does Ohio. The authorities instead emphasize the importance of multidisciplinary evaluation and treatment, including psychological care, and the need for additional research. Even though Sweden has called for the provision of gender-affirming medical care within the research context, the Swedish National Board of Health and Welfare states that doing so "does not

[73] The relevant documents include the following: Socialstyrelsen. Vård av barn och ungdomar med könsdysfori: Nationellt kunskapsstöd med rekommendationer till profession och beslutsfattare. December 2022. Accessed February 12, 2024. Available at https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-12-8302.pdf; Socialstyrelsen: The National Board of Health and Welfare. Care of children and adolescents with gender dysphoria: Summary of national guidelines. December 2022. Accessed February 12, 2024. Available at https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf; Palveluvalikoima. Medical treatment methods for dysphoria associated with variations in gender identity in minors recommendation. June 16, 2020. Accessed February 12, 2024. Available at https://palveluvalikoima.fi/documents/1237350/22895008/Summary minors en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary minors en+(1).pdf?t=1631773838474; The Cass Review. Independent review of gender identity services for children and young people: Interim report. February 2022. Accessed February 12, 2024. Available at https://cass.independent-review.uk/publications/interim-report/.

necessarily imply the use of randomized controlled trials,"[74] acknowledging that other study designs are appropriate to evaluate gender-affirming medical care. The European documents do not support the claims that gender-affirming medical care should be banned.

THE MEDICAL CARE BAN UNDERMINES THE INTEGRITY OF THE MEDICAL PROFESSION

60. The Ban violates the integrity of the medical profession and coerces medical professionals to violate their integrity and ethical duties. The medical profession has processes by which it evaluates treatments and determines whether they are safe and effective. The Ban intervenes in these processes replacing medical professionals' judgement with the judgment of the legislature.

61. Healthcare providers have an ethical obligation to promote their patients' well-being and to protect them from harm. When providers believe that the potential benefits of gender-affirming medical care outweigh the potential risks for a particular patient, prohibiting them from providing this treatment forces them to violate their ethical obligations to their patients or risk losing their licenses and incurring financial penalties. While the ability to continue to prescribe gender-affirming medical care to Ohio residents currently receiving treatment may mitigate some of the harmful consequences of the Ban, it does not obviate its fundamental medical and ethical shortcomings.

CONCLUSION

62. Treating adolescents with gender dysphoria with gender-affirming medical care under clinical practice guidelines, like the Endocrine Society's, is evidence-based; its potential benefits outweigh its potential risks for many patients; and these risks are well within the range of

[74] Socialstyrelsen. Care of children and adolescents with gender dysphoria: Summary. 2022. Accessed June 28, 2023. Available at https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf.

other medical decisions that adolescents and their parents or guardians have the discretion to make in consultation with their healthcare professionals.

63. Based on my research and experience as a pediatrician and bioethicist, there is no sound medical or ethical basis to prohibit healthcare professionals from providing gender-affirming medical care to minors. Doing so puts clinicians in the untenable position of having to harm their patients and violate their integrity and ethical obligations due to the threat of administrative and civil penalties.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Armand H. Matheny Antommaria
Signed on 2024/03/25 11:50:07 -5:00

ARMAND H. MATHENY ANTOMMARIA, MD, PhD

Signed at:
Franklin County, Ohio

03/25/2024

Sworn to and subscribed before me this _____day of March, 2024

Signed on 2024/03/25 11:50:07 -5:00

Notary Public

NOTARY PUBLIC STATE OF OHIO

Theresa M Sabo
Commission # 2016-RE-619622
Electronic Notary Public
State of Ohio
My Comm Exp. Nov 28, 2026

Notary Stamp 2024/03/25 08:50:07 PST B17D5ICFF4FD

Notarial act performed by audio-visual communication

EXHIBIT A

Curriculum Vitae

Last Updated: February 11, 2024

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1987-1989	MD	Washington University School of Medicine
1998-2000		Saint Louis, MO
1989-2000	PhD	The University of Chicago Divinity School (Religious Ethics) Chicago, IL
2000-2003	Resident	University of Utah (Pediatrics) Salt Lake City, UT
2005-2006	Certificate	Conflict Resolution Certificate Program, University of Utah Salt Lake City, UT

BOARD CERTIFICATION

2019 Pediatric Hospital Medicine, American Board of Pediatrics
2019 Healthcare Ethics Consultant-Certified, Healthcare Ethics Consultation Certification Commission
2004 General Pediatrics, American Board of Pediatrics

PROFESSIONAL LICENSES

2012-Present	Doctor of Medicine, Ohio
2006-2010	Alternative Dispute Resolution Provider Mediator, Utah
2001-2014	Physician and Surgeon, Utah
2001-2014	Physician and Surgeon Controlled Substance, Utah

PROFESSIONAL EXPERIENCE

Full Time Positions

2019-Present *Professor*
Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Department of Surgery

2019-Present *Professor of Clinical-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Surgery

2017-Present *Professor*
Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Division of Pediatric Hospital Medicine

2017-Present *Professor of Clinical-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Pediatrics

2016-2017 *Associate Professor of Clinical-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Pediatrics

2012-2017 *Associate Professor*
Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Division of Pediatric Hospital Medicine

2012-Present *Lee Ault Carter Chair in Pediatric Ethics*
Cincinnati Children's Hospital Medical Center

2012-2016 *Associate Professor-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Pediatrics

2010-2012 *Associate Professor of Pediatrics* (with Tenure)
University of Utah School of Medicine, Salt Lake City, UT
Divisions of Inpatient Medicine and Medical Ethics

2010-2012 *Adjunct Associate Professor of Medicine*
University of Utah School of Medicine, Salt Lake City, UT
Division of Medical Ethics and Humanities

2004-2010 *Assistant Professor of Pediatrics* (Tenure Track)
University of Utah School of Medicine, Salt Lake City, UT
Divisions of Inpatient Medicine and Medical Ethics

2004-2010 *Adjunct Assistant Professor of Medicine*
University of Utah School of Medicine, Salt Lake City, UT
Division of Medical Ethics and Humanities

2003-2004 *Instructor of Pediatrics* (Clinical Track)
University of Utah School of Medicine, Salt Lake City, UT
Divisions of Inpatient Medicine and Medical Ethics

2003-2004 *Adjunct Instructor of Medicine*
University of Utah School of Medicine, Salt Lake City, UT
Division of Medical Ethics

Part Time Positions

2023-Present *Expert Witness,* Report
Voe et al. v. Mansfield et al., United States District Court, Middle District of North Carolina. Case No. 1:23-CV-00864

2023-Present *Expert Witness,* Report and Deposition
Zayre-Brown v. North Carolina Department of Public Safety et al., United States District Court, Western District of North Carolina, Case No. 3:22-CV-01910

2023-Present *Expert Witness,* Report
Poe et al. v. Drummond et al., United States District Court, Northern District of Oklahoma, Case No. 4:23-cv-00177

2023-Present *Expert Witness*, Report
L.W. et al. v. Skrmetti et al., United States District Court, Middle District of Tennessee, Case No. 3:23-cv-00376.

2022-2023 *Expert Witness,* Reports, Deposition, and Testimony
Dekker et al. v. Weida et al., United States District Court, Northern District of Florida, Case No. 4:22-cv-00325

2022- Present *Expert Witness,* Report, Deposition, and Testimony
Boe et al. v. Marshall et al., United States District Court, Middle District of Alabama Northern Division, Case No. 22-cv-00184

2022 *Expert Witness,* Report
Walker et al. v. Marshall et al., United States District Court, Middle District of Alabama Northern Division, Case No. 2:22-cv-00167

2022-Present *Expert Witness,* Report and Testimony
Doe et al. v. Abbott et al., District Court of Travis County, Texas , Case No. D-1-GN-22-000977

2021-2022 *Expert Witness*, Reports, Deposition, and Testimony
Brandt et al. v. Griffin et al., United States District Court, Eastern District of Arkansas, Case No. 4:21-CV-00450-JM-1

2021 *Consultant*
Proctor & Gamble, Cincinnati, OH

2019 *Consultant*
Sanofi Genzyme, Cambridge, MA

2018-Present *Consultant*
Center for Conflict Resolution in Healthcare, Memphis, TN

2017-2020 *Consultant*
Amicus Therapeutics, Cranbury, NJ

2017 *Expert Witness,* Report
Klickovich v. Tristate Arthritis & Rheumatology et al., Commonwealth of Kentucky, Boone Circuit Court, Civil Action No. 16-CI-01690

2017 *Consultant*
Sarepta Therapeutics, Cambridge, MA

2014 *Consultant*
Genzyme, A Sanofi Company, Cambridge, MA

Editorial Experience

Editorial Board

2020-Present *Pediatrics,* Associate Editor for Ethics Rounds and Member of the Executive Editorial Board

2015-2020 *Journal of Clinical Ethics*

2009-2020 *Journal of Medical Humanities*

Guest Academic Editor

2017 *PLOS|ONE*

Ad Hoc Reviewer: *Academic Medicine, Academic Pediatrics, AJOB Primary Research, American Journal of Bioethics, American Journal of Law & Medicine, American Journal of Medical Genetics, American Journal of Transplantation, Archives of Disease in Childhood, BMC Medical Ethics, BMJ Open, Canadian Journal of Bioethics, CHEST, Clinical Transplantation, European Journal of Human Genetics, European Journal of Pediatrics, Frontiers in Genetics, Hospital Medicine, International Journal of Health Policy and Management, International Journal of Nursing Studies, Journal of Adolescent and Young Adult Oncology, Journal of Clinical Ethics, Journal of Empirical Research on Human Research Ethics, Journal of General Internal Medicine, Journal of Healthcare Leadership, Journal of Hospital Medicine, Journal of the Kennedy Institute of Ethics, Journal of Law, Medicine & Ethics, Journal of Medical Ethics, Journal of Medical Humanities, Journal of Medicine and Life, Journal of Palliative Care, Journal of Pediatrics, Journal of Pediatric Surgery, Mayo Clinic Proceedings, Medicine, Healthcare and Philosophy, Molecular Diagnosis & Therapy, New England Journal of Medicine, Patient Preference and Adherence, Pediatrics, Pediatrics in Review, Personalized Medicine, PLOS|ONE, Risk Management and Healthcare Policy, Saudi Medical Journal, SSM - Qualitative Research in Health,* and *Theoretical Medicine and Bioethics*

SCHOLASTIC AND PROFESSIONAL HONORS

2023	*Digital Health Award,* Bronze Medal in the Digital Health Media/Publications category for *Pediatric Collections: Ethics Rounds: A Casebook in Pediatric Bioethics Part II*, Health Information Resource Center, Libertyville, IL
2021	*Hidden Gem Award,* Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2019-2022	*Presidential Citation,* American Society for Bioethics and Humanities, Chicago, IL
2016	*Laura Mirkinson, MD, FAAP Lecturer,* Section on Hospital Medicine, American Academy of Pediatrics, Elk Grove Village, IL
2016, 2018	*Certificate of Excellence*, American Society for Bioethics and Humanities, Glenview, IL
2013, 2016	*Senior Resident Division Teaching Award,* Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2012	*Role Model*, Quality Review Committee, Primary Children's Medical Center, Salt Lake City, UT
2011	*Member*, Society for Pediatric Research, The Woodlands, TX
2011	*Presidential Citation*, American Society for Bioethics and Humanities, Glenview, IL
2009	*Role Model*, Quality Review Committee, Primary Children's Medical Center, Salt Lake City, UT
2008	*Nominee,* Physician of the Year, Primary Children's Medical Center, Salt Lake City, UT
2005-2006	*Fellow,* Medical Scholars Program, University of Utah School of Medicine, Salt Lake City, UT
1995-1997	*Doctoral Scholar*, Crossroads, A Program of Evangelicals for Social Action, Philadelphia PA

1989-1992 *Fellow*, The Pew Program in Medicine, Arts, and the Social Sciences, University of Chicago, Chicago, IL

ADMINISTRATIVE EXPERIENCE

Administrative Duties

2023-Present *Chair,* Literature Selection Technical Review Committee, National Library of Medicine, Bethesda, MD
2019-Present *Chair,* Oversight Committee, Cincinnati Fetal Center, Cincinnati, OH
2014-Present *Chair*, Ethics Committee, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2012-Present *Director*, Ethics Center, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2012-Present *Chair,* Ethics Consultation Subcommittee, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2010 *Co-Chair,* Ethics Subcommittee, Work Group for Emergency Mass Critical Care in Pediatrics, Centers for Disease Control and Prevention, Atlanta, GA
2009 *Chair*, Ethics Working Group, H1N1 and Winter Surge, Primary Children's Medical Center, Salt Lake City, UT
2005-2012 *Chair*, Ethics Committee, Primary Children's Medical Center, Salt Lake City, UT
2005-2012 *Chair*, Ethics Consultation Subcommittee, Primary Children's Medical Center, Salt Lake City, UT
2003-4 *Chair*, Clinical Pertinence Committee, Primary Children's Medical Center, Salt Lake City, UT

Professional & Scientific Committees

Committees

2023-Present *Member,* Expert Committee, Humanitarian Access Program, Alnylam Pharmaceuticals, Cambridge, MA
2021 *Member*, EMCO Capacity Collaboration, Ohio Hospital Association, Columbus, OH
2020-2021 *Member*, Allocation of Scarce Resources Work Group, Ohio Hospital Association, Columbus, OH
2020-Present *Member,* Literature Selection Technical Review Committee, National Library of Medicine, Bethesda, MD
2020 *Member*, Crisis Standards of Care Workgroup, The Health Collaborative, Cincinnati, OH
2019-Present *Member,* Healthcare Ethics Consultant Certification Commission, Oak Park, IL
2019 *Member,* Expert Panel, Pediatric Oncology End-of-Life Care Quality Markers, Institute for Cancer Outcomes & Survivorship, University of Alabama at Birmingham, Birmingham, AL
2018 *Member,* Resource Planning and Allocation Team Implementation Task Force, Ohio Department of Health, Columbus, OH
2012-Present *Member*, Gaucher Initiative Medical Expert Committee, Project HOPE, Millwood, VA
2009-2014 *Member,* Clinical Ethics Consultation Affairs Committee, American Society for Bioethics and Humanities, Glenview, IL

2005-2011 *Member,* Committee on Bioethics, American Academy of Pediatrics, Oak Park, IL

Data Safety and Monitoring Boards

2019-Present *Member,* Data and Safety Monitoring Board, Sickle Cell Domestic Trials, National Heart, Lung, and Blood Institute, Bethesda, MD

2018-2019 *Member,* Standing Safety Committee for P-188-NF (Carmeseal-MD™) in Duchenne Muscular Dystrophy, Phrixus Pharmaceuticals, Inc., Ann Arbor, MI

2017-Present *Member*, Observational Study Monitoring Board, Sickle Cell Disease Observational Monitoring Board, National Heart, Lung, and Blood Institute, Bethesda, MD

2016-2018 *Member,* Observational Study Monitoring Board, Long Term Effects of Hydroxyurea in Children with Sickle Cell Anemia, National Heart, Lung, and Blood Institute, Bethesda, MD

Reviewer

2020-Present *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting

2020 *Grant Reviewer,* The Croatian Science Foundation, Hvatska zaklada za znanost (HRZZ)

2018 *Book Proposal Reviewer*, Elsevier

2018-2019 *Category Leader,* Religion, Culture, and Social Sciences, American Society for Bioethics and Humanities Annual Meeting

2017 *Timekeeper,* American Society for Bioethics and Humanities Annual Meeting

2017-Present *Abstract Reviewer,* Pediatric Academic Societies Annual Meeting

2016-2021 *Workshop Reviewer*, Pediatric Academic Societies Annual Meeting

2016 *Grant Reviewer*, Innovation Research Incentives Scheme, The Netherlands Organisation for Health Research and Development

2016-2017 *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting

2014, 2016 *External Peer Reviewer*, PSI Foundation, Toronto, Ontario, Canada

2014 *Member,* Scientific Committee, International Conference on Clinical Ethics and Consultation

2013 *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting

2013 *Reviewer*, Open Research Area Plus, Agence Nationale de la Research, Deutsche Forschungsgemeinschaft, Economic and Social Research Council, National Science Foundation, and Organization for Scientific Research

2011-2012 *Abstract Reviewer,* Pediatric Academic Societies Annual Meeting

2011-2013 *Workshop Reviewer*, Pediatric Academic Societies Annual Meeting

2011-2014 *Abstract Reviewer*, Pediatric Hospital Medicine Annual Meeting

2011-2012 *Religious Studies Subcommittee Leader,* Program Committee, American Society for Bioethics and Humanities Annual Meeting

2010 *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting

Other

2023 *Member,* Student Paper Committee, American Society for Bioethics and Humanities

2021 *Timekeeper,* American Society for Bioethics and Humanities Annual Meeting

2021 *Mentor,* Early Career Advisor Professional Development Track, American Society for Bioethics and Humanities.

2021 *Mentor,* Early Career Advisor Paper or Project Track, American Society for Bioethics and Humanities.

2109 *Mentor*, Early Career Advising Program, American Society for Bioethics and Humanities

2018 *Passing Point Determination*, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission

2018 *Member*, Examination Committee, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission

2018 *Item Writer*, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission

UNIVERSITY COMMUNITY ACTIVITIES

Cincinnati Children's Hospital Medical Center

2023-Present *Member*, Artificial Intelligence Governance Council

2023-Present *Member,* Executive Committee, Discover Together Biobank

2020-Present *Member*, Faculty Diversity and Inclusion Steering Committee

2020-Present *Member*, Medical Management of COVID-19 Committee

2020-2021 *Member,* Caregiver Refusal Team

2020-2021 *Member,* COVID-19 Vaccine Allocation Committee

2020 *Member*, Personal Protective Equipment Subcommittee of the COVID-19 Steering Committee

2018-2019 *Member,* Planning Committee, Center for Clinical & Translational Science & Training Research Ethics Conference

2017-Present *Member*, Donor Selection Committee

2017-2020 *Member,* Employee Emergency Fund Review Committee

2017 *Member,* Root Cause Analysis Team

2016-2017 *Member,* Planning Committee, Center for Clinical & Translational Science & Training Research Ethics Conference

2015-2019 *Member,* Destination Excellence Medical Advisory Committee

2015-Present *Member,* Disorders of Sexual Development Case Review Committee

2015-2019 *Member,* Destination Excellence Case Review Committee

2014-2018 *Member,* Genomics Review Group, Institutional Review Board

2014-2017 *Member,* Center for Pediatric Genomics Leadership Committee

2013-2017 *Member,* Genetic Testing Subcommittee, Health Network

2013-2016 *Member,* Schwartz Center Rounds Planning Committee

2013-2014 *Member*, Genomics Ad Hoc Subcommittee, Board of Directors

2012-Present *Member,* Cincinnati Fetal Center Oversight Committee

2012-Present *Member,* Ethics Committee
2012-Present *Member,* G-23
2012-2016 *Member,* Integrated Solid Organ Transplant Steering Committee

University of Utah
2009-2012 *Member,* Consolidated Hearing Committee

University of Utah School of Medicine
2010-2012 *Member,* Medical Ethics, Humanities, and Cultural Competence Thread Committee
2008-2010 *Member,* Fourth Year Curriculum Committee

University of Utah Department of Pediatrics
2010-2011 *Member,* Planning Committee, 25th Annual Biological Basis of Children's Health Conference, "Sex, Gender, and Sexuality"
2009-2012 *Member,* Medical Executive Committee
2005-2012 *Member,* Retention, Promotion, and Tenure Committee
2004-2012 *Interviewer,* Residency Program
2003-2012 *Member,* Education Committee

Intermountain Healthcare
2009-2012 *Member,* System-Wide Bioethics Resource Service
2009-2012 *Member,* Pediatric Guidance Council

Primary Children's Medical Center
2012-2012 *Member,* Shared Accountability Organization Steering Committee
2009 *Member*, H1N1 and Winter Surge Executive Planning Team
2005-2010 *Member,* Continuing Medical Education Committee
2005-2010 *Member*, Grand Rounds Planning Committee
2003-2012 *Member*, Ethics Committee

ACTIVE MEMBERSHIPS IN PROFESSIONAL SOCIETIES
2012-Present Association of Bioethics Program Directors
2011-Present Society for Pediatric Research
2000-Present American Academy of Pediatrics
1999-Present American Society of Bioethics and Humanities

FUNDING
Past Grants
2015-2019 "Better Outcomes for Children: Promoting Excellence in Healthcare Genomics to Inform Policy."
Percent Effort: 9%
National Human Genome Research Institute
Grant Number: 1U01 HG008666-01
Role: Investigator

2015-2016 "Ethics of Informed Consent for Youth in Foster Care"
Direct Costs: $10,000
Ethics Grant, Center for Clinical and Translational Science and Training
University of Cincinnati Academic Health Center
Role: Co-Investigator

2014-2015 "Extreme Personal Exposure Biomarker Levels: Engaging Community Physicians and Ethicists for Guidance"
Direct Costs: $11,640
Center for Environmental Genetics
University of Cincinnati College of Medicine
Role: Investigator

2014-2015 "Child, Adolescent, and Parent Opinions on Disclosure Policies for Incidental Findings in Clinical Whole Exome Sequencing"
Direct Costs: $4,434
Ethics Grant, Center for Clinical and Translational Science and Training,
University of Cincinnati Academic Health Center
Role: Principal Investigator

2013-2014 "Better Outcomes for Children: GWAS & PheWAS in eMERGEII"
Percent Effort: 5%
National Human Genome Research Institute
Grant Number: 3U01HG006828-0251
Role: Investigator

2004-2005 "Potential Patients' Knowledge, Attitudes, and Beliefs Regarding Participating in Medical Education: Can They be Interpreted in Terms of Presumed Consent?"
Direct Costs: $8,000
Interdisciplinary Research in Applied Ethics and Human Values, University Research Committee, University of Utah
Role: Principal Investigator

TEACHING RESPONSIBILITIES/ASSIGNMENTS

Course and Curriculum Development

2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100.

Course Lectures

2018, 2021 Introduction to Biotechnology, "Ethics and Biotechnology" and "Clinical Ethics," BIOL 3027, University of Cincinnati, Taught 1 time per year, Taken by undergraduate students, Enrollment 25.

2018-Present	Biomedical Ethics, "Conscientious Objection in Healthcare" and "Ethical Issues in the Care of Transgender Adolescents," MEDS 4035 & MEDS 4036, University of Cincinnati College of Medicine, Taught 1 time per year, Taken by senior undergraduate students, Enrollment 52.
2016	Foundations of Healthcare Ethics and Law, "Clinical Ethics," HESA 390, Xavier University.
2014-Present	Physicians and Society, "Transfusion and the Jehovah's Witness Faith," "Obesity Management: Ethics, Policy, and Physician Implicit Bias," "Embryos and Ethics: The Ethics of Designer Babies," "Ethics and Genetic Testing," and "Ethics and Direct to Consumer Genetic Testing," 26950112 and 26950116, University of Cincinnati School of Medicine, Taken by first and second year medical students, Enrollment 100.
2014-Present	Ethical Issues in Health Care, "Ethical Issues in Managing Drug Shortages: The Macro, Meso, and Micro Levels," HESA 583, College of Social Sciences, Health, and Education Health Services Administration, Xavier University, Taken by health services administration students, Enrollment 25.
2009	Physical Diagnosis II, Internal Medicine 7160, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100
2003-2012	Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by fourth year medical students, Enrollment 100.

Small Group Teaching

2024	Clinical Ethics Consortium Tutorial B, BETH 731B, Harvard Medical School, Taught 1 time, Taken by Master of Science in Bioethics students.
2018-Present	Ethics in Research, GNTD 7003-001, University of Cincinnati School of Medicine, Taught 1 time per year, Taken by fellows, MS, and PhD students, Enrollment 110.
2007	Physical Diagnosis I, Internal Medicine 7150, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100.
2003-2012	Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by fourth medical students, Enrollment 100.
2003	Pediatric Organ System, Pediatrics 7020, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100.

Graduate Student Committees

2018-2022	*Chair,* Scholarship Oversight Committee, William Sveen, Pediatric Critical Care Fellowship, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2018-2020	*Member*, Scholarship Oversight Committee, Anne Heueman, Genetic Counseling, University of Cincinnati, Cincinnati, OH
2017-2019	*Chair*, Scholarship Oversight Committee, Bryana Rivers, Genetic Counseling, University of Cincinnati, Cincinnati, OH
2013-2015	*Mentor*, Sophia Hufnagel, Combined Pediatrics/Genetics Residency, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2013-2015	*Co-Chair,* Scholarship Oversight Committee, Andrea Murad, Genetic Counseling, University of Cincinnati, Cincinnati, OH

2013-2014 *Member*, Scholarship Oversight Committee, Grace Tran, Genetic Counseling, University of Cincinnati, Cincinnati, OH

2011-2012 *Chair,* Scholarship Oversight Committee, Kevin E. Nelson, MD, PhD, Pediatric Inpatient Medicine Fellowship, University of Utah, Salt Lake City, UT

Continuing Education Lectures

2008 Choosing Healthplans All Together (CHAT) Exercise Facilitator, 18th Annual Intermountain Medical Ethics Conference, "Setting Priorities for Healthcare in Utah: What Choices are We Ready to Make?," Salt Lake City, Utah, October 3.

2007 *Speaker*, Infant Medical Surgical Unit, Primary Children's Medical Center, "Withholding and Withdrawing Artificial Nutrition and Hydration: Can It Be Consistent With Care?," Salt Lake City, Utah, September 6.

2007 *Faculty Scholar-in Residence,* Summer Seminar, "The Role of Religion in Bioethics," Utah Valley State College, Orem, Utah, May 1.

2006 *Workshop Leader,* Faculty Education Retreat, "Publications and Publishing in Medical Education," University of Utah School of Medicine, Salt Lake City, Utah, September 15.

2006 *Breakout Session,* 16th Annual Intermountain Medical Ethics Conference, "Donation after Cardiac Death: Evolution of a Policy," Salt Lake City, Utah, March 28.

Other Educational Activities

2008 *Instructor*, Contemporary Ethical Issues in Medicine and Medical Research, Osher Lifelong Learning Institute, University of Utah, "Religion and Bioethics: Religiously Based Demands for and Refusals of Treatment," Salt Lake City, Utah, February 7.

2007 *Speaker*, Biology Seminar, Utah Valley State College, "Is He Dead?: Criteria of the Determination of Death and Their Implications for Withdrawing Treatment and Recovering Organs for Transplant," Orem, Utah, September 21.

PEER-REVIEWED JOURNAL ARTICLES

1. Armand H. Matheny Antommaria. (Forthcoming) "Decision Making for Adolescents with Gender Dysphoria." *Perspectives in Biology and Medicine*.
2. Erica K. Salter, D. Micah Hester, Lou Vinarcsik, Armand H. Matheny Antommaria, Johan Bester, Jeffrey Blustein, Ellen Wright Clayton, Douglas S. Diekema, Ana S. Iltis, Loretta M. Kopelman, Jay R. Malone, Mark R. Mercurio, Mark C. Navin, Erin Talati Paquette, Thaddeus Mason Pope, Rosamond Rhodes, and Lainie F. Ross. (2023) "Pediatric Decision Making: Consensus Recommendations." *Pediatrics.* 152: e2023061832. PMID: 37555276.
3. William N. Sveen, Armand H. Matheny Antommaria, Stephen Gilene, and Erika L. Stalets. (2023) "Adverse Events During Apnea Testing for the Determination of Death by Neurologic Criteria: A Single Center, Retrospective Pediatric Cohort." *Pediatric Critical Care Medicine.* 24: 399-405. PMID: 36815829.
4. Erica K. Salter, Jay R. Malone, Amanda Berg, Annie Friedrich, Alexandra Hucker, Hillary King, and Armand H. Matheny Antommaria. (2023) "Triage Policies at U.S. Hospitals with Pediatric Intensive Care Units." *AJOB Empirical Bioethics.* 14: 84-90. PMID: 36576201.

5. Armand H. Matheny Antommaria, Elizabeth Lanphier, Anne Housholder, and Michelle McGowan. (2023) "A mixed methods analysis of requests for religious exemptions to a COVID-19 vaccine requirement." *AJOB Empirical Bioethics.* 14: 15-22. PMID: 36161802.
6. Anne C Heuerman, Danielle Bessett, Armand H. Matheny Antommaria, Leandra. K. Tolusso, Nicki Smith, Alison H. Norris, and Michelle L. McGowan. (2022). "Experiences of reproductive genetic counselors with abortion regulations in Ohio." *Journal of Genetic Counseling*. 31: 641-652. PMID: 34755409.
7. Armand H. Matheny Antommaria and Ndidi I. Unaka. (2021) "Counterpoint: Prioritizing Health Care Workers for Scarce Critical Care Resources is Impractical and Unjust." *Journal of Hospital Medicine.* 16: 182-183. PMID 33617445.
8. Gregory A. Grabowski, Armand H. Matheny Antommaria, Edwin H. Kolodny, and Pramod K. Mistry. (2021) "Gaucher Disease: Basic and Translational Science Needs for More Complete Therapy and Management." *Molecular Genetics and Metabolism*. 132: 59-75. PMID: 33419694.
9. Armand H. Matheny Antommaria, Laura Monhollen, and Joshua K. Schaffzin. (2021) "An Ethical Analysis of Hospital Visitor Restrictions and Masking Requirements During the COVID-19." *Journal of Clinical Ethics.* 32: 35-44. PMID 33416516.
10. Armand H. Matheny Antommaria. (2020) "The Pediatric Hospital Medicine Core Competencies: 4.05 Ethics." *Journal of Hospital Medicine.* 15(S1): 120-121.
11. Armand H. Matheny Antommaria, Tyler S. Gibb, Amy L. McGuire, Paul Root Wolpe, Matthew K. Wynia, Megan K. Applewhite, Arthur Caplan, Douglas S. Diekema, D. Micah Hester, Lisa Soleymani Lehmann, Renee McLeod-Sordjan, Tamar Schiff, Holly K. Tabor, Sarah E. Wieten, and Jason T. Eberl for a Task Force of the Association of Bioethics Program Directors. (2020) "Ventilator Triage Policies During the COVID-19 Pandemic at U.S. Hospitals Associated With Members of the Association of Bioethics Program Directors." *Annals of Internal Medicine.* 173: 188-194. PMID: 32330224.
12. Armand H. Matheny Antommaria. (2020) "Conflicting Duties and Reciprocal Obligations During a Pandemic." *Journal of Hospital Medicine.* 15: 284-286. PMID: 32379030.
13. Mary V. Greiner, Sarah J. Beal, and Armand H. Matheny Antommaria. (2020) "Perspectives on Informed Consent Practices for Minimal-Risk Research Involving Foster Youth." *Pediatrics*. 145: e20192845. PMID: 32156772.
14. Jennifer deSante-Bertkau, Michelle McGowan, and Armand H. Matheny Antommaria. (2018) "Systematic Review of Typologies Used to Characterize Clinical Ethics Consultations." *Journal of Clinical Ethics.* 29: 291-304. PMID: 30605439.
15. Andrew J. Redmann, Melissa Schopper, Armand H. Matheny Antommaria, Judith Ragsdale, Alessandro de Alarcon, Michael J. Jutter, Catherine K. Hart, and Charles M. Myer. (2018) "To Transfuse or Not to Transfuse? Jehovah's Witnesses and Postoperative Hemorrhage in Pediatric Otolaryngology." *International Journal of Pediatric Otorhinolaryngology*. 115: 188-192. PMID: 30368384.

16. Armand H. Matheny Antommaria, Kyle B. Brothers, John A. Myers, Yana B Feygin, Sharon A. Aufox, Murray H. Brilliant, Pat Conway, Stephanie M. Fullerton, Nanibaá A. Garrison, Carol R. Horowitz, Gail P. Jarvik, Rongling Li, Evette J. Ludman, Catherine A. McCarty, Jennifer B. McCormick, Nathaniel D. Mercaldo, Melanie F. Myers, Saskia C. Sanderson, Martha J. Shrubsole, Jonathan S. Schildcrout, Janet L. Williams, Maureen E. Smith, Ellen Wright Clayton, and Ingrid A. Holm. (2018) "Parents' Attitudes toward Consent and Data Sharing in Biobanks: A Multi-Site Experimental Survey." *AJOB Empirical Bioethics.* 9: 128-142. PMID: 30240342.
17. Armand H. Matheny Antommaria and Cynthia A. Prows. (2018) "Content Analysis of Requests for Religious Exemptions from a Mandatory Influenza Vaccination Program for Healthcare Personnel." *Journal of Medical Ethics.* 44: 389-391. PMID: 29463693.
18. Armand H. Matheny Antommaria. (2017) "May Medical Centers Give Nonresident Patients Priority in Scheduling Outpatient Follow-Up Appointments?" *Journal of Clinical Ethics.* 28: 217-221. PMID: 28930708.
19. Andrea M. Murad, Melanie F. Myers, Susan D. Thompson, Rachel Fisher, and Armand H. Matheny Antommaria. (2017) "A Qualitative Study of Adolescents' Understanding of Biobanks and Their Attitudes Toward Participation, Re-contact, and Data Sharing." *American Journal of Medical Genetics: Part A.* 173: 930-937. PMID: 28328120.
20. Saskia Sanderson, Kyle Borthers, Nathaniel Mercaldo, Ellen Wright Clayton, Armand Antommaria, Sharon Aufox, Murray Brillant, Diego Campos, David Carrell, John Connolly, Pat Conway, Stephanie Fullerton, Nanibaa Garrison, Carol Horowitz, Gail Jarvik, David Kaufman, Terrie Kitchner, Rongling Li, Evette Ludman, Cahterine McCarty, Jennifer McCormick, Valerie McManus, Melanie Myers, Aaron Scrol, Janet Williams, Martha Shrubsole, Jonathan Schildcrout, Maureen Smith, and Ingrid Holm. (2017) "Public Attitudes Towards Consent and Data Sharing in Biobank Research: A Large Multisite Experimental Survey in the US." *The American Journal of Human Genetics*. 100: 414-427. PMID: 28190457.
21. Maureen E. Smith, Saskia C Sanderson, Kyle B Brothers, Melanie F Myers, Jennifer McCormick, Sharon A Aufox, Martha J Shrubsole, Nanibaá A Garrison, Nathaniel D Mercaldo, Jonathan S Schildcrout, Ellen Wright Clayton, Armand H. Matheny Antommaria, Melissa Basford, Murray Brilliant, John J Connolly, Stephanie M Fullerton, Carol R Horowitz, Gail P Jarvik, Dave Kaufman, Terrie Kitchner, Rongling Li, Evette J Ludman, Catherine McCarty, Valerie McManus, Sarah C Stallings, Janet L Williams, and Ingrid A Holm. (2016) "Conducting a Large, Multi-Site Survey about Patients' Views on Broad Consent: Challenges and Solutions." *BMC Medical Research Methodology.* 16: 162. PMID: 27881091.
22. Angela Lorts, Thomas D. Ryan, Armand H. Matheny Antommaria, Michael Lake, and John Bucuvalas. (2016) "Obtaining Consensus Regarding International Transplantation Continues to be Difficult for Pediatric Centers in the United States." *Pediatric Transplantation.* 20: 774-777. PMID: 27477950.
23. Sophia B. Hufnagel, Lisa J. Martin, Amy Cassedy, Robert J. Hopkin, and Armand H. Matheny Antommaria. (2016) "Adolescents' Preferences Regarding Disclosure of Incidental Findings in Genomic Sequencing That Are Not Medically Actionable in Childhood." *American Journal of Medical Genetics Part A*. 170: 2083-2088. PMID: 27149544.

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4. Susan Bratton and Armand H. Matheny Antommaria. (2010) "Dead Donor Rule and Organ Procurement: The Authors Reply." *Pediatric Critical Care Medicine.* 11: 314-315.

5. Armand H. Matheny Antommaria and Joel Frader. (2009) "Policies of Children's Hospitals on Donation After Cardiac Death Reply." *Journal of the American Medical Association.* 302: 845.

Case Reports

Armand H. Matheny Antommaria. (2002) "Case 4.9: Inappropriate Access to a Celebrity's Medical Records." In *Ethics and Information Technology: A Case-Based Approach to a Health Care System in Transition*, James G. Anderson and Kenneth W. Goodman, 79-80. New York: Springer-Verlag.

Book Reviews

1. Armand H. Matheny Antommaria. (In Press) Review of *Mormonism, Medicine, and Bioethics,* by Courtney S. Campbell. *Mormon Studies Review.*
2. Armand H. Matheny Antommaria. (2023) Review of *Disability's Challenge to Theology: Genes, Eugenics, and the Metaphysics of Modern Medicine* by Devan Stahl. *Hastings Center Report.* 53(2): 44-45.
3. Armand H. Matheny Antommaria. (2021) Review of *When Harry Became Sally: Responding to the Transgender Moment,* by Ryan T. Anderson. *Journal of Medical Humanitie.s* 42: 195-199. PMID 31808021.
4. Armand H. Matheny Antommaria. (2012) Review of *The Ethics of Organ Transplantation*, by Steven J. Jensen, ed., *Journal of the American Medical Association.* 308: 1482-1483.
5. Armand H Matheny Antommaria. (2012) Review of *The Soul of Medicine: Spiritual Perspectives and Clinical Practice*, by John R. Peteet and Michael N. D'Ambra, ed., *Journal of the American Medical Association*. 308: 87.
6. Armand H. Matheny Antommaria. (2009) Review of *Conflicts of Conscience in Health Care: An Institutional Compromise,* by Holly Fernandez Lynch. *American Journal of Bioethics*. 9: 63-64.
7. Armand H. Matheny Antommaria. (2008) Review of *A Practical Guide to Clinical Ethics Consulting: Expertise, Ethos, and Power*, by Christopher Meyers. *American Journal of Bioethics*. 8: 72-73.
8. Armand H. Matheny Antommaria. (2004) Review of *Children, Ethics, and Modern Medicine*, by Richard B. Miller. *American Journal of Bioethics.* 4: 127-128.
9. Armand H. Matheny Antommaria. (2002) Review of *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*, by Thomasine Kushner and David Thomasma, ed. *American Journal of Bioethics*. 2: 70-71. PMID: 22494193.
10. Armand H. Matheny Antommaria. (1999) Review of *Human Cloning: Religious Responses*, by Ronald Cole-Turner, ed. *Prism.* 6 (March/April): 21.
11. Armand H. Matheny Antommaria. (1999) Review of *Christian Theology and Medical Ethics: Four Contemporary Approaches*, by James B. Tubbs, Jr. *Journal of Religion*. 79 (April): 333-335.
12. Armand H. Matheny Antommaria. (1997) Review of *Body, Soul, and Bioethics*, by Gilbert C. Meilaender. *Prism*. 4 (May/June): 28.

Newspaper Articles

1. W. Bradley Poss and Armand H. Matheny Antommaria. (2010) "Mass casualty planning must incorporate needs of children." *AAP News*. 31 (July): 38.
2. Robert Murray and Armand H. Matheny Antommaria. (2010) "Pediatricians should work with school nurses to develop action plans for children with DNAR orders." *AAP News*. 31 (May): 30.
3. Armand H. Matheny Antommaria. (2009) "Addressing physicians' conscientious objections in health care." *AAP News*. 30 (December): 32.

UNPUBLISHED POSTER PRESENTATIONS

1. Armand H. Matheny Antommaria. (2018) "Ethical Issues in the Care of International Patients: A Case Study." International Conference on Clinical Ethics and Consultation, Oxford, United Kingdom.
2. Jill S Sweney, Brad Poss, Colin Grissom, Brent Wallace, and Armand H Matheny Antommaria. (2010) "Development of a Statewide Pediatric Pandemic Triage Plan in Utah." Pediatric Academic Societies Annual Meeting, Vancouver, Canada. E-PAS20103713.147.
3. Christopher G. Maloney, Armand H. Matheny Antommaria, James F. Bale, Thomas Greene, Jian Ying, Gena Fletcher, and Rajendu Srivastava. (2010) "Why Do Pediatric Interns Violate the 30 Hour Work Rule?" Pediatric Academic Societies Annual Meeting, Vancouver, Canada. E-PAS20101500.596.
4. Armand H. Matheny Antommaria and Edward B. Clark. (2007) "Resolving Conflict through Bioethics Mediation." 3rd International Conference on Ethics Consultation and Clinical Ethics, Toronto, Canada.
5. Elizabeth Tyson, Tracy Hill, Armand Antommaria, Gena Fletcher, and Flory Nkoy. (2007) "Physician Practice Patterns Regarding Nasogastric Feeding Supplementation and Intravenous Fluids in Bronchiolitis Patients." Pediatrics Academic Societies Annual Meeting, Toronto, Canada. E-PAS2007:61300.

ORAL PRESENTATIONS

Keynote/Plenary Lectures

International

1. 2021, *Panelist*, Partnership for Quality Medical Donations, Charitable Access Programming for Rare Diseases, "Ethical Issues," Webinar, April 6.
2. 2017, *Invited Speaker*, Spina Bifida Fetoscopic Repair Study Group and Consortium, "Ethics of Innovation and Research in Fetal Surgery," Cincinnati, Ohio, October 26.
3. 2014, *Invited Speaker,* CIC 2013 CCI: Canadian Immunization Conference, "Condition-of-Service Influenza Prevention in Health Care Settings," Ottawa, Canada, December 2.
4. 2014, *Invited Speaker*, National Conference of the Chinese Pediatric Society, "A Brief Introduction to Pediatric Research and Clinical Ethics," Chongqing, China, September 12.

National

1. 2020, *Panelist*, Children's Mercy Bioethics Center, "Ethical Issues in the COVID Pandemic at Children's Hospitals," Webinar, March 2.
2. 2019, *Invited Speaker*, North American Fetal Therapy Network (NAFTnet), "Ethics of Innovation," Chicago, Illinois, October 12.

3. 2019, *Panelist,* National Society of Genetic Counselors Prenatal Special Interest Group, "Fetal Intervention Ethics," Webinar, September 12.
4. 2017, *Invited Participant,* American College of Epidemiology Annual Meeting, Preconference Workshop, "Extreme Personal Exposure Biomarker Levels: Guidance for Study Investigators," New Orleans, Louisiana, September 24.
5. 2016, *Invited Speaker,* American Academy of Pediatrics National Conference & Exhibition, Joint Program: Section on Hospital Medicine and Section on Bioethics, "Resource Allocation: Do We Spend Money to Save One Patient with Ebola or Over a 1,000?" San Francisco, California, October 23.
6. 2016, *Invited Speaker*, 26th Annual Specialist Education in Extracorporeal Membrane Oxygenation (SEECHMO) Conference, "Ethical Issues in ECMO: The Bridge to Nowhere," Cincinnati, Ohio, June 5.
7. 2015, *Invited Speaker,* Extracorporeal Life Support Organization (ELSO) 26th Annual Conference, "ECMO-Supported Donation after Circulatory Death: An Ethical Analysis," Atlanta, Georgia, September 20.
8. 2014, *Invited Speaker*, Pediatric Evidence-Based Practice 2014 Conference: Evidence Implementation for Changing Models of Pediatric Health Care, "Ethical Issues in Evidence-Based Practice," Cincinnati, Ohio, September 19.
9. 2014, *Invited Speaker,* 6th Annual David Kline Symposium on Public Philosophy: Exploring the Synergy Between Pediatric Bioethics and Child Rights, "Does Predictive Genetic Testing for Adult Onset Conditions that Are Not Medically Actionable in Childhood Violate Children's Rights?" Jacksonville, Florida, March 6.
10. 2010, *Invited Speaker,* Quest for Research Excellence: The Intersection of Standards, Culture and Ethics in Childhood Obesity, "Research Integrity and Religious Issues in Childhood Obesity Research," Denver, Colorado, April 21.
11. 2010, *Invited Speaker*, Symposium on the Future of Rights of Conscience in Health Care: Legal and Ethical Perspectives, J. Reuben Clark Law School at Brigham Young University and the Ave Maria School of Law, "Conscientious Objection in Clinical Practice: Disclosure, Consent, Referral, and Emergency Treatment," Provo, Utah, February 26.
12. 2009, *Invited Speaker*, Pediatric Organ Donation Summit, "Research Findings Regarding Variations in Pediatric Hospital Donation after Cardiac Death Policies," Chicago, Illinois, August 18.
13. 2008, *Meet-the-Experts*, American Academy of Pediatrics National Conference & Exhibition, "Physician Refusal to Provide Treatment: What are the ethical issues?" Boston, Massachusetts, October 11.
14. 2008, *Invited Conference Faulty*, Conscience and Clinical Practice: Medical Ethics in the Face of Moral Controversy, The MacLean Center for Clinical Medical Ethics at the University of Chicago, "Defending Positions or Identifying Interests: The Uses of Ethical Argumentation in the Debate over Conscience in Clinical Practice," Chicago, IL, March 18.
15. 2007, *Symposium Speaker*, Alternative Dispute Resolution Strategies in End-of-Life Decisions, The Ohio State University Mortiz College of Law, "The Representation of Children in Disputes at the End-of-Life," Columbus, Ohio, January 18.
16. 2005, *Keynote Speaker*, Decisions and Families, *Journal of Law and Family Studies* and The University of Utah S.J. Quinney College of Law, "Jehovah's Witnesses, Roman Catholicism, and Calvinism: Religion and State Intervention in Parental, Medical Decision-Making," Salt Lake City, Utah, September 23.

Regional/Local

1. 2024, *Case Expert Commentator*, Center for Bioethics Clinical Ethics Consortium, Harvard Medical School, "Can he be his mother's keeper?", Boston, Massachusetts, February 2.
2. 2023, *Speaker*, Yale Ethics Program, Yale School of Medicine, "Gender-Affirming Care," New Haven, Connecticut, March 8.
3. 2021, *Panelist*, Pediatric Residency Noon Conference, University of Tennessee Health Science Center, "Bioethics Rounds Ethical Issues in the Care of Transgender Adolescents," Memphis, Tennessee, September 21.
4. 2020, *Keynote Speaker*, 53rd Annual Clinical Advances in Pediatrics, "Referral to a Fetal Care Center: How You Can Help Patients' Mothers Address the Ethical Issues," Kansas City, Kansas, September 16.
5. 2019, *Speaker,* Patient and Family Support Services, Primary Children's Hospital, "Ethical Issues in the Care of Trans Adolescents," Salt Lake City, Utah, December 5.
6. 2019, *Speaker,* Evening Ethics, Program in Medical Ethics and Humanities, University of Utah School of Medicine, "Patients, Parents, and Professionals: Ethical Issues in the Treatment of Trans Adolescents," Salt Lake City, Utah, December 4.
7. 2019, *Speaker,* Pediatric Hospital Medicine Board Review Course, "Ethics, Legal Issues, and Human Rights including Ethics in Research," Cincinnati, Ohio, September 8.
8. 2019, *Speaker,* Advances in Fetology, "Evolving Attitudes Toward the Treatment of Children with Trisomies," Cincinnati, Ohio, September 6.
9. 2019, *Speaker,* Half-Day Ethics Training: Ethics Consultation & Ethics Committees, "Navigating the Rapids of Clinical Ethics Consultation: Intake, Recommendations, and Documentation," Salt Lake City, Utah, June 1.
10. 2019, *Speaker*, Scientific and Ethical Underpinnings of Gene Transfer/Therapy in Vulnerable Populations: Considerations Supporting Novel Treatments, BioNJ, "What Next? An Ethical analysis of Prioritizing Conditions and Populations for Developing Novel Therapies," Cranbury, New Jersey, March 7.
11. 2018, *Panelist*, Periviability, 17th Annual Regional Perinatal Summit, Cincinnati, Ohio, October 12.
12. 2018, *Speaker,* Regional Advance Practice Registered Nurse (APRN) Conference, "Adults are Not Large Children: Ethical Issues in Caring for Adults in Children's Hospitals," Cincinnati, Ohio, April 26.
13. 2018, *Speaker*, Southern Ohio/Northern Kentucky Sigma Theta Tau International Annual Conference, "Between Hope and Hype: Ethical Issues in Precision Medicine," Sharonville, Ohio, March 2.
14. 2017, *Speaker*, Advances in Fetology 2017, "Ethics of Innovation and Research: Special Considerations in Fetal Therapy Centers," Cincinnati, Ohio, October 27.
15. 2016, *Speaker*, End-of-Life Pediatric Palliative Care Regional Conference, "Ethical/Legal Issues in Pediatric Palliative Care," Cincinnati, Ohio, September 15.
16. 2016, *Speaker*, 26th Annual Bioethics Network of Ohio (BENO) Conference, "When Does Parental Refusal of Medical Treatment for Religious Reasons Constitute Neglect?" Dublin, Ohio, May 29.
17. 2014, *Speaker,* Cincinnati Comprehensive Sickle Cell Center Symposium: Research Ethics of Hydroxyurea Therapy for Sickle Cell Disease During Pregnancy and Lactation, "Ethical Issues in Research with Pregnant and Lactating Women," Cincinnati, Ohio, October 30.

18. 2014, *Speaker,* Advances in Fetology 2014, "The 'Miracle Baby' and Other Cases for Discussion," Cincinnati, Ohio, September 26.
19. 2014, *Speaker,* Advances in Fetology 2014, "'Can you tell me …?': Achieving Informed Consent Given the Prevalence of Low Health Literacy," Cincinnati, Ohio, September 26.
20. 2014, *Panelist*, Center for Clinical & Translational Science & Training, Secrets of the Dead: The Ethics of Sharing their Data, Cincinnati, Ohio, August 28.
21. 2014, *Speaker,* Office for Human Research Protections Research Community Forum: Clinical Research … and All That Regulatory Jazz, "Research Results and Incidental Findings: Do Investigators Have a Duty to Return Results to Participants," Cincinnati, Ohio, May 21.
22. 2013, *Opening Presentation*, Empirical Bioethics: Emerging Trends for the 21st Century, University of Cincinnati Center for Clinical & Translational Science & Training, "Empirical vs. Normative Ethics: A Comparison of Methods," Cincinnati, Ohio, February 21.
23. 2012, *Videoconference,* New York State Task Force on Life and the Law, "Pediatric Critical Care Triage," New York, New York, March 1.
24. 2011, *Presenter,* Fall Faculty Development Workshop, College of Social Work, University of Utah, "Teaching Ethics to Students in the Professions," Salt Lake City, Utah, November 14.
25. 2011, *Speaker,* 15th Annual Conference, Utah Chapter of the National Association of Pediatric Nurse Practitioners, "Ethical Issues in Pediatric Practice," Salt Lake City, Utah, September 22.
26. 2011, *Speaker*, Code Silver! Active Shooter in the Hospital, Utah Hospitals & Health Systems Association, Salt Lake City, Utah, March 21.
27. 2009, *Speaker,* Medical Staff Leadership Conference, Intermountain Healthcare, "The Ethics of Leadership," Park City, Utah, October 30.
28. 2008, *Speaker*, The Art and Medicine of Caring: Supporting Hope for Children and Families, Primary Children's Medical Center, "Medically Provided Hydration and Nutrition: Ethical Considerations," Salt Lake City, Utah, February 25.
29. 2005, *Speaker*, Utah NAPNAP (National Association of Pediatric Nurse Practitioners) Chapter Pharmacology and Pediatric Conference, "Immunization Update," Salt Lake City, Utah, August 18.
30. 2005, *Keynote Speaker,* 17th Annual Conference, Utah Society for Social Work Leadership in Health Care, "Brain Death: Accommodation and Consultation," Salt Lake City, March 18.
31. 2004, *Continuing Education Presentation*, Utah NAPNAP (National Association of Pediatric Nurse Practitioners), "Febrile Seizures," Salt Lake City, Utah, April 22.
32. 2004, *Speaker,* Advocacy Workshop for Primary Care Providers, "Ethics of Advocacy," Park City, Utah, April 3.
33. 2002, *Speaker,* 16th Annual Biologic Basis of Pediatric Practice Symposium, "Stem Cells: Religious Perspectives," Deer Valley, Utah, September 14.

Meeting Presentations

<u>International</u>

1. 2023, *Speaker*, International Conference on Clinical Ethics and Consultation, "Addressing Ethical and Conceptual Issues in Gender-Affirming Medical Care Outside of the Hospital," Rome, Italy, June 8.

2. 2018, *Speaker*, International Conference on Clinical Ethics and Consultation, "A Systematic Review of Typologies Used to Characterize Clinical Ethics Consultations," Oxford, United Kingdom, June 21.

National

1. 2023, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "Addressing Restrictions on Gender-Affirming Medical Care in New Spaces: State Houses and Courtrooms," Baltimore, Maryland, October 13.
2. 2023, Kelsey S. Ryan, Rakhi Gupta Bassuray, Leela Sarathy, Sharon Ostfeld, Armand H. Matheny Antommaria, Erin Rholl, Steven R. Leuthner, and Christy L. Cummings. *Workshop Presenter,* Pediatric Academic Societies Annual Meeting, "How Can Newborn Toxicology Testing be Equitable?" Washington, DC, April 30.
3. 2022, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "A Mixed Methods Analysis of Requests for Religious Exemptions to a COVID-19 Vaccine Requirement." Portland, Oregon, October 27.
4. 2022, *Panelist,* American Society for Bioethics and Humanities Annual Meeting, Pediatric Ethics Affinity Group, "When Ethical Healthcare Is Prohibited By Law, How Do We Respond?" Portland, Oregon, October 27.
5. 2022, *Speaker,* APPD/PAS Fellow Core Curriculum Workshop, Pediatric Academic Societies Annual Meeting, "From Idea to Implementation: Navigating the Ethical Landscape of Pediatric Clinical Research," Denver, Colorado, April 22.
6. 2021, *Panelist,* Pediatric Endocrine Society Annual Meeting, Difference of Sex Development Special Interest Group, Virtual Conference, April 29.
7. 2020, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Is This Child Dead? Controversies Regarding the Neurological Criteria for Death," Virtual Conference, October 17.
8. 2020, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Contemporary Ethical Controversy in Fetal Therapy: Innovation, Research, Access, and Justice," Virtual Conference, October 15.
9. 2020, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "K-12 Schools and Mandatory Public Health Programs During the COVID-19 Pandemic," Virtual Conference, October 15.
10. 2019, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Ethical Issues in Translating Gene Transfer Studies Involving Children with Neurodegenerative Disorders," Pittsburgh, Pennsylvania, October 26.
11. 2019, *Moderator,* Pediatric Academic Societies Annual Meeting, Clinical Bioethics, Baltimore, Maryland, April 28.
12. 2018, *Presenter,* American Society for Bioethics and Humanities Annual Meeting, "Looking to the Past, Understanding the Present, and Imaging the Future of Bioethics and Medical Humanities' Engagement with Transgender Health," Anaheim, California, October 19.
13. 2018, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Should Vaccination Be a Prerequisite for Sold Organ Transplantation?" Anaheim, California, October 18.
14. 2018, Lindsey Douglas, Armand H. Matheny Antommaria, Derek Williams. *Workshop Presenter*, Pediatric Hospital Medicine Annual Meeting, "IRB Approved! Tips and Tricks to Smooth Sailing through the Institutional Review Board (IRB)." Atlanta, Georgia, July 20.

15. 2018, Alan Schroeder, Armand H. Matheny Antommaria, Hannah Bassett, Kevin Chi, Shawn Ralston, Rebecca Blankenburg. *Workshop Speaker,* Pediatric Hospital Medicine Annual Meeting, "When You Don't Agree with the Plan: Balancing Diplomacy, Value, and Moral Distress," Atlanta, Georgia, July 20.
16. 2018, Alan Schroeder, Hannah Bassett, Rebecca Blankenburg, Kevin Chi, Shawn Ralston, Armand H. Matheny Antommaria. *Workshop Speaker,* Pediatric Academic Societies Annual Meeting, "When You Don't Agree with the Plan: Balancing Diplomacy, Value, and Moral Distress," Toronto, Ontario, Canada, May 7.
17. 2017, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Tensions in Informed Consent for Gender Affirming Hormone Therapy and Fertility Preservation in Transgender Adolescents," Kansas City, Missouri, October 19.
18. Lindsey Douglas, Armand H. Matheny Antommaria, and Derek Williams. 2017, *Workshop Leader,* PHM[Pediatric Hospital Medicine]2017, "IRB Approved! Tips and Tricks to Smooth Sailing through the Institutional Review Board (IRB) Process," Nashville, Tennessee, July 21.
19. 2016, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "Ethical Challenges in the Care of International Patients: Organization, Justice, and Cultural Considerations," Washington, DC, October 9.
20. 2015, *Coauthor,* The American Society of Human Genetics Annual Meeting, "Adolescents' Opinions on Disclosure of Non-Actionable Secondary Findings in Whole Exome Sequencing," Baltimore, Maryland, October 9.
21. 2012, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "A Public Health Ethics Analysis of the Mandatory Immunization of Healthcare Personnel: Minimizing Burdens and Increasing Fairness," Washington, DC, October 21.
22. Armand H. Matheny Antommaria, Valerie Gutmann Koch, Susie A. Han, Carrie S. Zoubul. 2012, *Moderator*, American Society for Bioethics and Humanities Annual Meeting, "Representing the Underrepresented in Allocating Scarce Resources in a Public Health Emergency: Ethical and Legal Considerations," Washington, DC, October 21.
23. 2012, *Platform Presentation,* Pediatric Academic Societies Annual Meeting, "Qualitative Analysis of International Variation in Donation after Circulatory Death Policies and Rates," Boston, Massachusetts, April 30. Publication 3150.4.
24. 2011, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "The Intersection of Policy, Medicine, and Ethics during a Public Health Disaster: Special Considerations for Children and Families," Minneapolis, Minnesota, October 13.
25. Armand H. Matheny Antommaria and Joel Frader. 2010, *Workshop Leader,* Pediatric Academic Societies Annual Meeting, "Conscientious Objection in Health Care: Respecting Conscience and Providing Access," Vancouver, British Columbia, Canada. May 1. Session 1710.
26. 2009, *Workshop Leader,* American Society for Bioethics and Humanities Annual Meeting, "Advanced Clinical Ethics Consultation Skills Workshop: Process and Interpersonal Skills," Washington, DC, October 15.
27. 2009, *Platform Presentation*, Pediatric Academic Societies Annual Meeting, "Qualitative Analysis of Donation after Cardiac Death Policies at Children's Hospitals," Baltimore, Maryland, May 2. Publication 2120.6.

28. 2008, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "Qualitative Analysis of Donation After Cardiac Death (DCD) Policies at Children's Hospitals," Cleveland, Ohio, October 26.
29. 2007, *Participant,* Hamline University School of Law Biennial Symposium on Advanced Issues in Dispute Resolution, "An Intentional Conversation About Conflict Resolution in Health Care," Saint Paul, Minnesota, November 8-10.
30. *2007*, *Speaker,* American Society of Bioethics and Humanities Annual Meeting, "Bioethics Consultation and Alternative Dispute Resolution: Opportunities for Collaboration," Washington, DC, October 21.
31. 2007, *Speaker,* American Society of Bioethics and Humanities Annual Meeting, "DNAR Orders in Schools: Collaborations Beyond the Hospital," Washington, DC, October 18.
32. Armand H. Matheny Antommaria and Jeannie DePaulis. 2007, *Speaker,* National Association of Children's Hospitals and Related Institutions Annual Meeting, "Using Mediation to Address Conflict and Form Stronger Therapeutic Alliances," San Antonio, Texas, October 9.
33. 2006, *Speaker,* American Society of Bioethics and Humanities Annual Meeting, "Bioethics Mediation: A Critique," Denver, Colorado, October 28.
34. 2005, *Panelist,* American Society of Bioethics and Humanities Annual Meeting, "How I See This Case: 'He Is Not His Brain,'" Washington, DC, October 20.
35. 2005, *Paper Presentation,* Pediatric Ethics: Setting an Agenda for the Future, The Cleveland Clinic, "'He Is Not His Brain:' Accommodating Objections to 'Brain Death,'" Cleveland, Ohio, September 9.
36. 2004, *Speaker,* American Society for Bioethics and Humanities Spring Meeting, "Verification and Balance: Reporting Within the Constraints of Patient Confidentiality," San Antonio, Texas, March 13.
37. 2002, *Panelist*, American Society for Bioethics and Humanities Annual Meeting, "'Who Should Survive?:' Mental Retardation and the History of Bioethics," Baltimore, Maryland, October 24.

Invited/Visiting Professor Presentations

1. 2013, Visiting Professor, "How to Listen, Speak and Think Ethically: A Multidisciplinary Approach," Norton Suburban Hospital and Kosair Children's Hospital, Louisville, Kentucky, May 22.
2. 2010, Visiting Professor, Program in Bioethics and Humanities and Department of Pediatrics, "What to Do When Parents Want Everything Done: 'Futility' and Ethics Facilitation," University of Iowa Carver College of Medicine, Iowa City, Iowa, September 10.

Grand Round Presentations

1. 2023, Harvey and Bernice Jones Lecture in Pediatric Ethics, "Too Far or Not Far Enough? Assessing Possible Changes in Determining Death and Procuring Organs," Arkansas Children's Hospital, Little Rock, November 16.
2. 2019, David Green Lectureship, "Establishing Goals of Care and Ethically Limiting Treatment," Primary Children's Hospital, Salt Lake City, Utah, December 5.
3. 2018, "The Ethics of Medical Intervention for Transgender Youth," El Rio Health, Tucson, Arizona, September 29.

4. 2018, Pediatrics, "Patient Selection, Justice, and Cultural Difference: Ethical Issues in the Care of International Patients," Cleveland Clinic, Cleveland, Ohio, April 10.
5. 2018, Bioethics, "Reversibility, Fertility, and Conflict: Ethical Issues in the Care of Transgender and Gender Nonconforming Children and Adolescents," Cleveland Clinic, Cleveland, Ohio, April 9.
6. 2017, Heart Institute, "'Have you ever thought about what you would want if god forbid you became sicker?': Talking with adult patients about advance directives," Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, October 16.
7. 2017, Pediatrics, "Respectful, Effective Treatment of Jehovah's Witnesses," with Judith R. Ragsdale, PhD, MDiv and David Morales, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, March 14.
8. 2017, Pediatrics, "Ethical Dilemmas about Discharging Patients When There Are Disagreements Concerning Safety," Seattle Children's Hospital, Seattle, Washington, January 19.
9. 2015, Pediatrics, "'Nonbeneficial' Treatment: What must providers offer and what can they withhold?," Greenville Health System, Greenville, South Carolina, May 10.
10. 2014, Advance Practice Providers, "Common Ethical Issues," Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, August 13.
11. 2014, Respiratory Therapy, "Do-Not-Resuscitate (DNR) Orders," Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, July 15.
12. 2013, Heart Institute, "No Not Months. Twenty-Two *Years*-Old: Transiting Patients to an Adult Model of Care." Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, October 21.
13. 2013, Division of Neonatology, "This Premature Infant Has a *BRCA1* Mutation!?: Ethical Issues in Clinical Whole Exome Sequencing for Neonatologists." Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, October 11.
14. 2013, Department of Pediatrics, "Adults are Not Large Children: Ethical Issues in Caring for Adults in Children's Hospitals," Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, February 26.
15. 2012, "Mandate or Moratorium?: Persisting Ethical Controversies in Donation after Circulatory Death," Cedars-Sinai Medical Center, Los Angeles, California, May 16.
16. 2011, Division of Pediatric Neurology Friday Lecture Series, "Inducing or Treating 'Seizures' with Placebos: Is It Ever Ethical?," University of Utah, Salt Lake City, Utah, October 7.
17. 2011, Department of Surgery, "DNR Orders in the OR and other Ethical Issues in Pediatric Surgery: Case Discussions," Primary Children's Medical Center, Salt Lake City, Utah, October 3.
18. 2009, Department of Pediatrics, "What to Do When Parents Want Everything Done: 'Futility' and Bioethical Mediation," Primary Children's Medical Center, Salt Lake City, Utah, September 17.
19. 2008, Division of Pulmonology and Critical Care, "Futility: May Clinicians Ever Unilaterally Withhold or Withdraw Medical Treatment?" Utah Valley Regional Medical Center, Provo, Utah, April 17.
20. 2007, Division of Otolaryngology-Head and Neck Surgery, "Advance Directives, Durable Powers of Attorney for Healthcare, and Do Not Attempt Resuscitation Orders: Oh My!," University of Utah School of Medicine, Salt Lake City, Utah, June 20.

Outreach Presentations

1. 2019, *Panelist*, Cincinnati Edition, WVXU, "The Ethics of Human Gene Editing," Cincinnati, Ohio, June 13.
2. 2019, *Speaker,* Adult Forum, Indian Hill Church, "Medical Ethics," Indian Hill, Ohio, March 24.
3. 2016, *Speaker,* Conversations in Bioethics: The Intersection of Biology, Technology, and Faith, Mt. Washington Presbyterian Church, "Genetic Testing," Cincinnati, Ohio, October 12.
4. 2008, *Speaker,* Science in Society, Co-sponsored by KCPW and the City Library, "Death Choices," Salt Lake City, Utah, November 20.
5. 2003, *Panelist,* Utah Symposium in Science and Literature, "The Goodness Switch: What Happens to Ethics if Behavior is All in Our Brains?" Salt Lake City, Utah, October 10.
6. 2002, *Respondent*, H. Tristram Englehardt, Jr. "The Culture Wars in Bioethics," Salt Lake Community College, Salt Lake City, Utah, March 29.

Podcasts

1. 2021, "Ethics of COVID Vaccines in Kids," PHM from Pittsburgh, August 12.
2. 2020, COVID Quandaries: Episode 1, "Is Getting Sick Just Part of the Job?" Hard Call, October 6.

EXHIBIT B

TABLE 1: Level (Quality) of Evidence and Class (Strength) of Recommendation[1] and in 2020 American Heart Association Guideline for Pediatric Basic and Advanced Life Support

	Class 1 (Strong) Benefit >>> Risk	Class 2a (Moderate) Benefit >> Risk	Class 2b (Weak) Benefit >= Risk	Class 3 No Benefit (Moderate) Benefit = Risk	Class 3 Harm (Strong) Risk > Benefit	Total
Level A	1 (0.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.8%)
Level B-R (Randomized)	1 (0.8%)	2 (1.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (2.3%)
Level B-NR (Nonrandomized)	5 (3.8%)	9 (6.9%)	3 (2.3%)	0 (0.0%)	2 (1.5%)	19 (14.6%)
Level C-LD (Limited Data)	24 (18.5%)	22 (16.9%)	21 (16.2%)	1(0.8%)	2 (1.5%)	70 (53.8%)
Level C-EO (Expert Opinion)	22 (16.9%)	9 (6.9%)	6 (4.6%)	0 (0.0%)	0 (0.0%)	37 (28.5%)
Total	53 (40.8%)	42 (32.3%)	30 (23.1%)	1 (0.8%)	4 (3.1%)	130 (100%)

1. Level (Quality) of Evidence

Level A

- High-quality evidence from more than 1 [Randomized Controlled Trial (RCT)]
- Meta-analyses of high-quality RCTs
- One or more RCTS corroborated by high-quality registry studies

Level B-R (Randomized)

- Moderate-quality evidence from 1 or more RCTS
- Meta-analyses of moderate-quality RCTs

Level B-NR (Nonrandomized)

- Moderate-quality evidence from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies
- Meta-analyses of such studies

Level C-LD (Limited Data)

- Randomized or nonrandomized observational or registry studies with limitations of design or execution
- Meta-analyses of such studies
- Psychological or mechanistic studies in human subjects

Level C-EO (Expert Opinion)

- Consensus of expert opinion based on clinical experience

Topjian AA, Raymond TT, Atkins D, et al. Part 4: Pediatric basic and advanced life support: 2020 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. Circulation. 2020;142(16 suppl 2):S469-S523.

EXHIBIT C

TABLE 2: Strength of Recommendation and Quality of Evidence in Recommendations Made by the Endocrine Society

Strength of the Recommendation/ Quality of the Evidence[1]	Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons	Pediatric Obesity-Assessment, Treatment, and Prevention	Congenital Adrenal Hyperplasia Due to Steroid 21-Hydroxylase Deficiency
Strong|High	0 (0)[2]	0 (0)	0 (0)
Strong|Moderate	3 (11)	4 (13)	18 (33)
Strong|Low	5 (18)	6 (20)	13 (25)
Strong|Very Low	2 (7)	1 (3)	1 (2)
Weak|High	0 (0)	0 (0)	0 (0)
Weak|Moderate	0 (0)	0 (0)	2 (4)
Weak|Low	9 (32)	5 (17)	4 (7)
Weak|Very Low	3 (11)	12 (40)	7 (13)
Ungraded Good Practice Statement[3]	6 (21)	2 (7)	9 (17)
Either Low or Very Low	19 (68)	24 (80)	25 (46)
Total	28	30	54

[1] Quality of the Evidence
High: "Consistent evidence from well-performed RCTs [Randomized Controlled Trials] or exceptionally strong evidence from unbiased observational studies"
Moderate: "Evidence from RCTs with important limitations (inconsistent results, methodological flaws, indirect or imprecise evidence), or unusually strong evidence from unbiased observational studies"
Low: "Evidence for at least one critical outcomes from observational studies, from RCTs with serious flaws, or indirect evidence"
Very Low: "Evidence for at least one of the critical outcomes from unsystematic clinical observations or very indirect evidence"
See Swiglo BA, Murad MH, Schünemann HJ, et al. A case for clarity, consistency, and helpfulness: State-of-the-art clinical practice guidelines in endocrinology using the grading of recommendations, assessment, development, and evaluation system. *J Clin Endocrinol Metab.* 2008;93(3):666-73.

[2] n (%)

[3]Ungraded Good Practice Statement: "Direct evidence for these statements was either unavailable or not systematically appraised and considered out of the scope of this guideline. The intention of these statements is to draw attention to these principles." See Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.

Guidelines:

Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.

Styne DM, Arslanian SA, Connor EL, et al. Pediatric obesity-assessment, treatment, and prevention: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(3):709-757.

Speiser PW, Arlt W, Auchus RJ, et al. Congenital adrenal hyperplasia due to steroid 21-hydroxylase deficiency: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2018;103(11):4043-4088.

IN THE COURT OF COMMON PLEAS
FOR FRANKLIN COUNTY, OHIO

MADELINE MOE, et al. Plaintiffs, v. DAVID YOST, et al. Defendants.	Case No. _____ Judge _____

EXPERT AFFIDAVIT OF SARAH D. CORATHERS, M.D.

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E-Signature 1: Sarah Corathers (SDC)
March 22, 2024 17:51:06 -5:00 [30F42C915E1B] [202.90.68.2]
sarah.corathers@mac.com (Principal)

E-Signature Notary: Theresa M Sabo (TMS)
March 22, 2024 17:51:06 -5:00 [932FDBB18A74] [65.60.211.87]
tess.sabo@gmail.com
I, Theresa M Sabo, did witness the participants named above electronically sign this document.

EXPERT AFFIDAVIT OF SARAH D. CORATHERS, MD

INTRODUCTION

I, Sarah D. Corathers, hereby declare and state as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. The purpose of this affidavit is to provide my expert opinions on: (1) the clinical practice and treatment protocols for treating transgender adolescents with gender dysphoria including the provision of pubertal suppression treatment and hormone therapy; (2) the risk and benefit analysis of the endocrine interventions to treat adolescents with gender dysphoria as compared with other pediatric endocrine treatments; and (3) the severe risk of harm to adolescents with gender dysphoria of withholding or withdrawing this medical treatment where such treatment is medically necessary.

3. I have actual knowledge of the matters stated in this affidavit and have collected and cited relevant literature concerning the issues that arise in this litigation in the body of the affidavit.

4. In preparing this affidavit, I reviewed Ohio House Bill 68 (hereinafter "HB68"), as well as materials listed in the attached Bibliography (**Exhibit B.**) I also relied on my scientific education and training, my research experience, my knowledge of the scientific literature in the pertinent fields, and my clinical experience treating adolescents with gender dysphoria, as set out in my curriculum vitae (**Exhibit A.**)

5. The materials I have relied upon in preparing this affidavit are the same types of materials that experts in my field regularly rely upon when forming opinions on these subjects.

6. 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.

BACKGROUND AND QUALIFICATIONS

7. I received my medical degree from Wright State University in 2002. I completed my residency in Internal Medical and Pediatrics at the University of Cincinnati and Cincinnati Children's Hospital between 2002-2006. I was the Chief Resident in Internal Medicine at the University of Cincinnati from 2006-2007. I completed a four-year combined Fellowship in Adult and Pediatric Endocrinology between 2009-2013 at the University of Cincinnati and Cincinnati Children's Hospital. Beginning in 2013, I was an Assistant Professor, Department of Pediatrics, Division of Endocrinology, at Cincinnati Children's Hospital. I became an Associate Professor in the Department of Pediatrics, Division of Endocrinology, in 2019. Since 2022, I have been the Clinical Director in the Division of Pediatric Endocrinology at Cincinnati Children's Hospital overseeing clinical operations and quality. Notably, the Division of Endocrinology at Cincinnati Children's Hospital was recognized by U.S. News and World Reports as #3 in the nation for Diabetes and Endocrinology in 2022-2023 and #1 in the nation for Diabetes and Endocrinology in the 2023-2024 rankings, the same year Cincinnati Children's Hospital was also recognized as the #1 Best Children's Hospital in the nation. As of March 1, 2024, I am Associate Chief of Staff, Ambulatory Medicine at Cincinnati Children's Hospital.

8. I have been licensed to practice medicine in the state of Ohio since September 2006.

9. I have extensive experience working with children with endocrine disorders, and I am an expert in the treatment of children with hormone or metabolic health concerns including hypogonadism and in the treatment of adolescents with gender dysphoria. I have been treating patients with gender dysphoria since 2013. I also treat children and adolescents with other endocrine disorders including type 1 diabetes, Turner syndrome, and survivors of childhood

cancers with lifelong hormone deficiencies.

10. I am a member of the American Academy of Pediatrics, the Pediatric Endocrine Society, and the Endocrine Society.

11. I currently see patients at the Endocrinology Clinic at Cincinnati Children's Hospital, where I also serve as the Clinical Medical Director.

12. I am a member of the inter-disciplinary transgender medicine team at Cincinnati Children's Hospital (the "Living with Change Center for Transgender Health"), where I routinely engage in care coordination with colleagues in Adolescent Medicine, Gynecology, Mental Health, and other allied health fields in the care of children, adolescents, and young adults with gender dysphoria.

13. I am currently directly involved in the treatment of approximately 200 transgender youth and young adults from Ohio and surrounding areas and have consulted as a member of the interdisciplinary gender team providing care to many more over the past decade.

14. I supervise the education of pediatric endocrinology fellows in care of transgender and gender non-conforming youth through didactic lectures and clinical practice.

15. I have published over 60 peer reviewed articles on endocrine disorders and treatments. Among those, I have published on topics that include: interdisciplinary care for transgender and gender non-conforming youth, shared decision making about gender-affirming hormone therapy, hormonal contraceptive choices for transgender adolescents and adults, and bone health among transgender youth undergoing pubertal suppression. I have also published an invited commentary about developing effective hormonal treatment paradigms for transgender youth. In addition, I am a contributing author on the International Turner Syndrome Clinical Practice Guidelines (2017; 2024 update in press), which reflect grading of available evidence and

recommendations for care including estrogen hormone replacement.

16. As part of my practice, I am familiar with the latest medical science and treatment protocols related to gender dysphoria and Differences of Sexual Development (DSDs).

17. I have never been deposed or testified at trial.

18. I am being compensated at a rate of $300 per hour. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

GENDER IDENTITY AND GENDER DYSPHORIA

19. A person's gender identity refers to a fundamental inner sense of self as female, male, a combination of both, or neither distinctly male nor female.

20. Everyone has a gender identity and one's understanding of it may develop over time.

21. Sex is usually assigned at birth based upon observation of external physical attributes.

22. Most people have a gender identity that aligns with the sex they were designated at birth based on their external genitalia.[1] People whose sex designated at birth aligns with their gender identity are cisgender.

23. A transgender person is someone who has a gender identity that differs from the

[1] The terms "sex designated at birth" or "sex assigned at birth" are more precise than the term "biological sex" because all the physiological aspects of a person's sex are not always aligned with each other. For example, some people with intersex characteristics may have chromosomes typically associated with males but genitalia typically associated with females. *See* Hembree, W.C., et al., *Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline*. J. Clin. Endocrinol. & Metab., 2017. **102**: 3869 3903, 3875, https://academic.oup.com/jcem/article/102/11/3869/4157558 (hereafter "Endocrine Guideline") ("Biological sex, biological male or female: These terms refer to physical aspects of maleness and femaleness. 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.")

person's sex designated at birth.

24. Transgender people have always existed, although the number of people who we know to be transgender has increased in recent times with increased visibility and alongside advances in modern medical treatments.[2]

25. Gender dysphoria describes the significant emotional distress that stems from the incongruence between a person's gender identity and sex designated at birth, and/or body characteristics. A person can experience gender dysphoria at any age, but among adolescents it is often associated with distress at physical changes associated with the development of secondary sexual characteristics during puberty such as breast development, voice deepening, growth and thickening of facial and body hair or testicular enlargement that are inconsistent with a person's gender identity.

26. Gender dysphoria is also a diagnosis in the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders ("DSM V"). In order to be diagnosed with gender dysphoria, the incongruence between a person's gender identity and designated sex 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. There are two separate diagnoses for gender dysphoria, one for gender dysphoria in childhood and the other for gender dysphoria in adolescence and adulthood.

27. Being transgender is not itself a mental health condition; however, stigma, bullying, and untreated gender dysphoria can lead to severe anxiety, depression, and suicidality.[3] Mental

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[2] Carswell, J.M., Lopez, X., and Rosenthal, S.M., *The evolution of adolescent gender-affirming care: An historical perspective*. Horm. Res. Paediatr., 2022. **95**(6): p. 649-656.

[3] Spack, N.P., et al., *Children and adolescents with gender identity disorder referred to a pediatric medical center.* Pediatr., 2012. **129**(3): p. 418-25; Olson, K.R., et al., *Mental Health of Transgender Children Who Are Supported in Their Identities.* Pediatr., 2016. **137**(3): p.

health and psychosocial support are essential components of care for transgender and gender diverse people as detailed in the Endocrine Society Clinical Care Guideline.

MECHANISM OF PUBERTY AND PUBERTY RELATED MEDICATIONS

28. Puberty is the process of physical changes driven by hormone activation of pulsatile signals from the hypothalamus in the brain, Gonadotropin Releasing Hormone (GnRH), to stimulate the pituitary gland to produce Luteinizing Hormone (LH) and Follicle Stimulating Hormone (FSH). Subseqently, LH and FSH signal the gonads: ovaries make estrogen and testes make testosterone. Estrogen and testosterone hormones are in turn responsible for a pubertal growth spurt, and, respectively, breast development and menarche, or testicular enlargement and sperm production.

29. Pubertal onset typically ranges between the ages of 8-12 for people designated female at birth and between 9 and 14 for people designated male at birth. There are five stages of pubertal development, known as "Tanner stages."

30. Common variations in puberty are precocious puberty, which describes onset earlier than expected, e.g. "early bloomer", and constitutional delay of growth and puberty, e.g. "late bloomer." GnRH agonists are medications that interrupt the pulsatile pattern of GnRH secretion through down regulation of receptors to lower LH and FSH levels, which would otherwise stimulate the gonads of pubertal adolescents and adults to produce estrogen and testosterone. The impact is a reversible suppression of the hypothalamic-pituitary-gonadal hormone axis, which in essence causes puberty to be paused during the course of the treatment. When the medication is discontinued, the pulsatile action of GnRH resumes the hormone signalling cascade and puberty resumes.

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e20153223.

31. GnRH agonists are the standard of care for the treatment of children with central precocious puberty, which is a condition where pubertal development begins early due to premature activation of the hypothalamic-pituitary-gonadal axis.[4] They have been used for treating precocious puberty for decades. Additional indications for GnRH agonist medications are to protect fertility during certain cancer treatments, for endometriosis, and for prostate cancer.

32. Treatment with GnRH agonists is also part of the standard of care for treating gender dysphoria in adolescents. As with other conditions, the GnRH agonists work in gender dysphoric patients by reversibly suppressing the hypothalamic-pituitary-gonadal hormone axis and pausing secondary sex characteristic development. For gender dysphoric adolescents who are experiencing severe distress upon the onset of puberty, this pause alleviates worsening distress that occurs as puberty progresses.

33. Other hormonal treatments that endocrinologists and other pediatricians might prescribe include testosterone, estrogen, and medicines that block the action or supress the production of androgens. Adolescents with constitutional delay of growth and puberty may benefit from hormone therapy to "jump start" endogenous puberty, to more closely match development with peers.[5] Adolescents with medical conditions that result in hypogonadism, such as Turner sydrome or Klinefelter syndrome, may need hormone treatment with estrogen or testsoterone to initiate and support ongoing pubertal development.

34. Hormone therapy is also prescribed to transgender adolescents with gender dysphoria to help bring their bodies into alignment with their gender identity and match their peers' pubertal developments. For transgender boys, this is through testosterone and menstural supression

[4] Popovic, J., et al., *Gonadotropin-releasing hormone analog therapies for children with central precocious puberty in the United States.* Front Pediatr., 2022. **10**: p. 968485.

and for transgender girls this is through estrogen and testosterone suppression.

35. Endocrinologists, including pediatric endocrinologists, have extensive experience in the type of hormone management that treatment of gender dysphoria entails.

36. When treating patients with hormone therapy for gender dysphoria whether pubertal suppression or gender-affirming hormones clinicians follow the evidence-based protocols discussed below.

TREATMENT PROTOCOLS FOR GENDER DYSPHORIA

37. When appropriately treated, gender dysphoria can be effectively managed. I currently treat hundreds of transgender youth and young adults in accordance with the Endocrine Society Clinical Practice Guideline. The Endocrine Society is a professional organization of more than 18,000 endocrinologists. These guidelines have been endorsed by the American Academy of Pediatrics and the Pediatric Endocrine Society.

38. For transgender youth, the development of secondary sexual characteristics associated with endogeneous puberty can be very distressing and contribute to and severely exacerbate gender dysphoria.

39. Treatment with GnRH agonists temporarily suppresses endogenous puberty, which enables transgender youth to socially present in their affirmed gender, provides more time for gender identity exploration, and preserves an opportunity to proceed in the future to puberty that matches (is congruent with) their gender identity.

40. It is critical to understand that non-intervention in the context of gender dysphoria is not benign since in the absence of intervention, distressing physical changes of endogenous puberty will progress.

41. By preventing permanent physical changes in puberty, transgender adults experience less dysphoria later in life because they can have body alignment that more closely

matches their gender identity. For example, preventing the voice deepening that would occur due to exposure to testosterone during puberty enables a transgender female to maintain a voice quality in a higher pitch as an adult. Preventing development of breasts due to exposure to estrogen in puberty can alleviate the need for a transgender male to undergo top surgery as an adult.

42. Under the Endocrine Society Clinical Practice Guideline, transgender adolescents with gender dysphoria may be eligible for pubertal suppression if:

- A qualified mental health provider 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 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 through the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
    - Agrees with the indication for 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.

43. For the subset of adolescents who initiate GnRH agonist treatment to pause puberty and who then maintain insistent, persistent, consistent gender identity incongruent with sex designated at birth, a second stage of medical treatment is initiation of gender affirming hormones (estrogen or testosterone) to induce puberty consistent with gender identity.

44. For adolescents and adults who do not begin medical treatment until after puberty has started or substantially progressed, gender affirming hormone therapy (estrogen and testosterone suppression or testosterone and menstrual suppression) may be the first medical intervention.

45. Feminizing effects of estrogen include breast growth, redistribution of body fat, and decrease in terminal hair growth. Masculinizing effects of testosterone include deepening of voice, increased muscle mass, and increase in facial and body hair growth.

46. Treatment with gender affirming hormone therapy (estrogen or testosterone) is demonstrated to result in improvement in symptoms of gender dysphoria, depression, and anxiety in prospective observational studies of transgender youth,[6] as well as improved psychological functioning among transgender young adults who receive treatment for gender dysphoria.[7]

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[6] *See* Chen, D., et al., *Psychosocial functioning in transgender youth after 2 Years of hormones*. N. Engl. J. Med., 2023. **388**(3): p. 240-250. Prospective study of 315 participants between 12 to 20 years of age from four clinics in the United States after gender affirming hormone therapy with either estrogen or testosterone. Overall, there was improvement across appearance congruence (degree to which physical traits align with gender) and psychosocial functioning (depression, anxiety, life satisfaction).

[7] See longitudinal outcome data from young adults, de Vries, A.L., et al., *Young adult psychological outcome after puberty suppression and gender reassignment.* Pediatr., 2014. **134**(4): p. 696-704. Longitudinal outcome study of 55 young transgender individuals followed in "Dutch model" assessed at mean age 13.6 years, 16.7 years, and 20.7 years. Improvement observed in symptoms of gender dysphoria, depression, anxiety, and social-educational functioning.

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

- A qualified mental health professional has confirmed:
  - The presence 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 situation and functioning are stable enough to start sex hormone treatment,
  - The adolescent has sufficient mental capacity to estimate that 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 (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), and the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent through the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal induction:
  - Agrees with the indication for sex hormone treatment,
  - Has confirmed that there are no medical contraindications to sex hormone treatment.

48. I often meet transgender teens who wear binders to minimize the appearance of breast tissue and/or oversized clothing to hide aspects of their body shape that they do not like as changes related to puberty occur; often they do not make eye contact when asked to talk about their feelings related to gender. After starting gender affirming treatment, they are visibly more comfortable and confident with increasing engagement with me during each subsequent visit. As gender affirming treatment continues, adolescents often tell me that they feel more like themselves,

that they are more active with peers, and frequently experience improved school performance. I am witness to the progression of pained and tearful early visits to head nods of affirmation and smiles in response to asking how things are going as they begin to experience puberty changes consistent with their gender embodiment goals. In my experience, the physical changes from gender affirming hormone therapy are accompanied by noticeable positive impact on mood and wellbeing. While mental health care is an essential component of treatment, there is simply no mental health intervention that in isolation can accomplish the kind of affirming physical changes that medical interventions allow for these adolescents. And as noted above, any adolescent who begins medical intervention for gender dysphoria has already been in the care of a mental health professional who signs off on the appropriateness of treatment.

MY CLINICAL PRACTICE TREATING TRANSGENDER YOUTH AND YOUNG ADULTS WITH GENDER DYSPHORIA AT CINCINNATI CHILDREN'S HOSPITAL

49. I am currently a provider to hundreds of youth and young adults with gender dysphoria at the Endocrinology Clinic at Cincinnati Children's Hospital, which is a part of the Cincinnati Children's Gender Program, "Living with Change Center for Transgender Health". I have specialized training, expertise, and experience to describe the use of puberty pausing medications (GnRH agonist) and gender-affirming hormone treatment for adolescents and young adults with gender dysphoria.

50. The Gender Program includes an interdisciplinary team that meets monthly and is available for specialty referrals. The Program provides comprehensive care, including both medical and mental health evaluation and treatment.

51. The initial intake visit, as well as the follow up visits with an endocrinologist for evaluation of gender dysphoria, all include a history and physical exam, review of mental health records, anticipatory guidance around topics of growth, bone health, and puberty.

52. Puberty is described as a progression through 5 stages, Tanner 1 through Tanner 5. Tanner 1 is pre-pubertal, without any hormonal or physical changes. Tanner 5 describes completion of adult hormone levels and secondary sexual characteristics.

53. Medical treatment with a GnRH agonist, often referred to as a puberty blocker, is considered when it is medically indicated for an adolescent with gender dysphoria at Tanner 2 or Tanner 3 stages of puberty never before Tanner Stage 2. There are no hormonal or medical interventions indicated for pre-pubertal youth, i.e. those who have not started puberty.

54. If medical treatment with a GnRH agonist is considered to pause pubertal progression, I discuss with the patient and their family the Endocrine Society guidelines for care of transgender youth. Specifically, we discuss indications for puberty blockers, as well as the risks, benefits, limitations, and potential side effects, including considerations for fertility and bone health. Puberty blockers are safe, reversible, and recognized as an important tool to decrease gender dysphoria by preventing further secondary sexual characteristics that are incongruent with identity. We review options to optimize bone health while on puberty blockers, including maintaining adequate Vitamin D levels, calcium intake, and weight bearing exercises. I provide anticipatory guidance on options for injectable or implantable GnRH agonist, the insurance approval process, and longer-term options for hormone affirming treatment later.

55. Discussion of the potential side effects of pubertal suppression are familiar and common because they are the same side effects when used to treat other conditions like precocious puberty. Though the timeline for pausing puberty can come later for a transgender adolescent than for a precocious puberty patient, gender dysphoria patients are generally on pubertal suppression for shorter periods of time than my precocious puberty patients who may begin suppression as early as three years old. Additionally, the duration that an adolescent maintains on pubertal

suppression is limited. For example, a patient receiving pubertal suppression to treat gender dysphoria will either discontinue that treatment and resume endogenous puberty or more often, initiate gender affirming hormonal therapy to initiate puberty consistent with gender identity around age 14, similar to the timing of puberty of peers.

56. When discussing treatment with gender affirming hormones (estrogen or testosterone) I describe the approach to slowly titrate doses to mimic changes of the cadence of endogenous puberty. I review the expected physical changes associated with hormones and the timeframe those changes are most often experienced. I review which aspects of hormone treatment are fully reversible, partly reversible, and not reversible (e.g. with testosterone treatment, increased acne is fully reversible, changes in hair pattern and muscle mass are partly reversible, and voice deepening is not reversible). I review with families the impact of hormones on growth and adult height prediction. I review the impact of hormones on future fertility and the need for reliable contraception (e.g., even though testosterone therapy can decrease fertility, it is not in and of itself reliable contraception and it is possible for transmasculine patients on testosterone to become pregnant both intentionally and unintentionally). During these discussions referral for fertility preservation is offered before initiating gender affirming hormone treatment. Family medical history is reviewed for any conditions that might predispose to higher risk of side effects with exogenous hormone therapy (e.g. increased risk of blood clots) and counseling is provided on smoking avoidance for everyone. I advise on types and frequency of laboratory testing to monitor safety of hormone levels. Lastly, I review that the treatment is entirely voluntary and that the individual can elect to slow down pace of dose titration or discontinue treatment at any time.

57. The potential side effects from hormone therapy are comparable when used to treat patients with gender dysphoria and when used for other purposes. A difference is the potential

impact on fertility, which is thoroughly discussed with patients and fertility preservation is offered. Treatment for gender dysphoria is not the only pediatric condition whose treatment may impact fertility. Many of the adolescents I treat for pediatric cancers, intersex conditions and some other conditions also have treatments that may impair their fertility and as physicians we discuss this impact with them, their parents/guardians, and other relevant providers.

58. Before prescribing a GnRH agonist medication or gender affirming hormone therapy as treatment for gender dysphoria, I obtain written and verbal informed consent from the parent(s) and assent from the adolescent patient. Furthermore, I review a letter from a mental health professional that confirms the individual's diagnosis of gender dysphoria, and that the mental health provider supports proceeding with medical treatment.

59. Prior to the initiation of medical treatment, we perform blood work and imaging (e.g. bone age x-ray, bone density testing) to provide a baseline for continual monitoring.

60. Prescriptions for puberty blockers require prior authorization from insurance companies, which often takes weeks or months to obtain. Therefore, there is time for families to reflect on the decision further before initiating treatment.

61. After initiating a medical treatment, routine follow-up visits occur at 6-month intervals thereafter for ongoing monitoring of how treatment is impacting symptoms of gender dysphoria. Witnessing the dramatic and positive transformation of transgender adolescents who are thriving after starting gender affirming care is among the most rewarding aspects of my career. After initiation of gender affirming care, transgender teens often express feeling less anxious, with improved symptoms of depression and decreased distress related to gender dysphoria.

INCIDENCE AND MANAGEMENT OF RISKS AND SIDE EFFECTS OF TREATMENT

62. Estrogen treatment can be delivered via a transdermal patch or an oral pill. The patch allows for more gentle dose escalation and avoids first-pass metabolism in the liver that oral

estrogens require, therefore it is often a preferred approach for inducing puberty in girls.[8] The most common side effect is skin irritation due to the adhesive on the patch, in which case we can try an alternative brand or switch to an oral formulation if necessary. Hormone levels can be measured with laboratory tests with goal to maintain estradiol levels between 100-200 pg/mL (menstruating women will experience variation in estradiol levels between 40-400 pg/mL throughout a usual monthly cycle). Transdermal estrogen doses or comparable oral Estrace doses used for physiologic induction of puberty or treatment of hypogonadism are far lower than pharmacologic doses of ethinyl estradiol used in oral contraceptive pills, which have a higher rate of thrombo-embolic (blood clot) events particularly in patients over the age of 35 years, and in the context of concurrent hypertension, and with smoking.

63. Testosterone can be delivered via an injection, by topical gel, or oral tablet. Treatment with injections is the most common as it offers the advantage of flexible dosing, can be administered once a week or every other week, and is least expensive. Topical treatment is more difficult to titrate for induction of puberty but may be an effective choice once an individual has reached a steady dose and is willing to apply a daily medication. Topical formulations can transfer to other people, so it is very important to wash hands and avoid physical contact until after the medication is completely dry. Oral testosterone formulations are relatively new on the market in the United States, require twice daily dosing, and are often cost prohibitive. Oral agents are metabolized through the liver similar to oral estrogen, therefore closer monitoring of liver function

[8] See Gravholt, C.H., et al., *Clinical practice guidelines for the care of girls and women with Turner Syndrome: Proceedings from the 2016 Cincinnati International Turner Syndrome Meeting.* Eur. J. Endocrinol., 2017. **177**(3): p. G1-G70 for detailed description of protocols for adjusting estrogen doses and potential side effects in girls with premature ovarian insufficiency related to Turner syndrome, a condition in which individuals are missing a portion of an entire X chromosome.

tests is required. All individuals treated with testosterone are monitored for levels (male range 300-1000 ng/dL) and for elevated hemoglobin levels since testosterone promotes erythrocytosis or increased red blood cells. If the hemoglobin or hematocrit level are too high, a decrease in dose or adjustment in timing of dose is necessary to reduce risk of a thrombo-embolic event (blood clot). Risk of blood clots are higher among individuals who smoke, so counseling to avoid tobacco, vaping, e-cigarettes is always provided.

64. The majority of potential side effects from hormone therapy are tied to genetic and behavioral risk factors and not the medications themselves, and much of the counseling therefore involves helping to ensure appropriate clinical oversight of treatment and ongoing monitoring of overall health.

65. Moreover, many of the potential risks and side effects of hormone therapy are the same or similar for cisgender and transgender patients. For example, when prescribing testosterone for a cisgender adolescent male with delayed puberty or hypogonadism, there is a risk of elevated hemoglobin levels, and so such patients are counseled and monitored in the same way that transgender male patients who are prescribed testosterone are counseled and monitored. Similarly, because estrogen can increase the risk of breast cancer for both cisgender and transgender females, I ask detailed family medical history questions before prescribing exogenous estrogen. Transgender females with no known increased risk of breast cancer are encouraged to follow the same breast cancer screening guidelines as for those designated female at birth.

PUBERTY-DELAYING TREATMENT AND GENDER-AFFIRMING HORMONES ARE SAFE AND EFFECTIVE TREATMENTS FOR TRANSGENDER ADOLESCENTS AND YOUNG ADULTS

66. Based upon my education, training, and clinical experience, puberty pausing treatment and gender-affirming hormones are safe, effective, and beneficial treatment options for adolescents and young adults with gender dysphoria.

67. GnRH agonist medications cause a temporary pause in puberty. When the medication is discontinued, the effects are reversible, and hormone signals related to endogenous puberty restart. Physiologically, a temporary pause in puberty for transgender adolescents is akin to peers who experience constitutional delay of growth and puberty, e.g. "late bloomers" who catch up over time.

68. The timing of initiation of gender affirming hormones and cadence of dose titration is adjusted to meet patient goals and maintain safety parameters based upon laboratory monitoring. In my clinical experience, the overwhelming majority of adolescents and young adults who experience support from their families and pursue medical treatment for gender dysphoria are thriving at subsequent visits. It is gratifying to hear about the confidence to play a lead role in a the school play, pick out a dress for prom, or to feel secure in making decisions for their lives comparable to age matched peers.

69. In a decade of practice, rates of discontinuation of gender affirming treatment amongst my patient panel are rare, and lower than published rates. It is worth contextualizing that literature around rates of regret vary and may include external factors such as lack of family support, societal stigma, or internal factors such as uncertainty about gender identity.[9] Ongoing

[9] *See* Wiepjes, C.M., et al., *The Amsterdam cohort of gender dysphoria study (1972-2015): Trends in prevalence, treatment, and regrets*. J. Sex. Med., 2018. **15**(4): p. 582-590. Retrospective study of 6,793 individuals evaluated in the Dutch model gender identity clinic between 1972-2015 describing demographic and prescribing trends over time. Authors report low rates of regret (under 1%) for subset of individuals who elected to undergo surgery as part of their gender transition. (Of note, surgery is not performed on minors by any children's hospital in the state of Ohio.) *See also* Turban, J.L., et al., *Factors leading to "Detransition" among transgender and gender diverse people in the United States: A mixed-methods analysis*. LGBT Health., 2021. **8**(4): p. 273-280. Secondary analysis of survey data from 27,715 transgender and gender diverse adults. Among those identified as detransitioning, a majority (82.5%) reported external driving factors including family and societal stigma; less frequently (15.9%) internal factors including fluctuations or uncertainty regarding gender identity reported.

research is needed to optimize the safety and efficacy of interventions offered to transgender adolescents and young adults, including better understanding the reasons for those that experience regret. But this is not unique to the treatment of transgender adolescents or young adults with gender dysphoria and in all of medicine, more research is important for better understanding treatment outcomes and minimizing negative outcomes including regret.

TREATMENTS FOR GENDER-AFFIRMING CARE ARE SIMILAR TO TREATMENTS FOR OTHER PEDIATRIC CONDITIONS

70. Hormone replacement treatment is a cornerstone of the field of Endocrinology. Insulin is used to treat type 1 diabetes, hydrocortisone is used to treat adrenal insufficiency, and estrogen and testosterone are used to treat hypogonadism. There is nothing unique about undergoing hormone treatment to sustain one's health; it is a common practice in many non-transgender patients, including minors, for reasons unrelated to treatment of gender dysphoria. Compared to other hormone treatments that endocrinologists routinely prescribe, estrogen and testosterone have a relatively wide safety profile. For example, insulin, a required medication for treatment of type 1 diabetes, can cause severe hypoglycemia, seizure, and death if given in excess. Similarly, steroid replacement is life sustaining for people with adrenal insufficiency, but higher doses of steroids can cause weight gain, hypertension, diabetes, and osteoporosis.

71. Many people with gender dysphoria have been on hormone therapy for decades and there is no evidence of any negative health outcomes that would outweigh the substantial benefit of the treatment. Likewise, many non-transgender individuals undergo hormone treatment for treatment of hypogonadism most of their lives, and it is well-managed.[10] This includes conditions

[10] Asscheman, H., et al., *A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones*. Eur. J. Endocrinol., 2011 Apr. **164**(4): p. 635-42. doi: 10.1530/EJE-10-1038.

such as Turner syndrome, Klinefelter syndrome, premature ovarian failure, and sequelae following cancer treatments.

72. Other common examples in pediatric endocrinology of treatment with hormone therapy for social emotional or gender affirming purposes in cisgender population include use of testosterone to jump start puberty in boys with constitutional delay of growth and puberty to better match peers, and use of estrogen and androgen receptor blockers for girls with polycystic ovarian syndrome (PCOS) to minimize undesired facial and body hair. In puberty, some boys will experience gynecomastia or breast development. The condition is often temporary, but if it does not resolve, can be distressing and cisgender boys will seek treatment to reduce breast tissue.

HARMS OF WITHHOLDING OR TERMINATING TREATMENT FOR TRANSGENDER ADOLESCENTS AND YOUNG ADULTS WITH GENDER DYSPHORIA

73. Without treatment, transgender adolescents and young adults report several-fold higher rates of depression, anxiety, suicidal ideation, suicide attempt, and self-harm without lethal intent, compared to their cisgender counterparts. Transgender youth in unsupportive homes have worse mental health outcomes than those in supportive ones; failure to obtain treatment when medically indicated because of unsupportive caregivers also leads to worse outcomes.[11] In my own clinical practice and in review of available literature, I've observed negative mental health outcomes improve with supportive social structure (family, school), and interdisciplinary treatment from medical and mental health providers.

74. At the current time, synthesis of the best available evidence by medical professional

[11] Spack N.P, Edwards-Leeper L, Feldmain HA, et al. *Children and adolescents with gender identity disorder referred to a pediatric medical center. Pediatr*., 2012. **129**(3): p. 418-425; Olson K.R., et al., *Mental health of transgender children who are supported in their identities*. Pediatrics., 2016. **137**: p. 1-8.

organizations including the American Academy of Pediatrics, the American Medical Association and the Endocrine Society favor continuing access to the spectrum of gender affirming care from an interdisciplinary team. The Ohio Children's Hospital Association strongly advocated for Governor DeWine to veto HB68 based on the catastrophic impact on a small but high-risk population of children.[12]

75. In preparation for HB68 legislation enactment, our clinical care has already been adversely impacted. The team has spent dozens of hours in care coordination ensuring that patients have access to visits before April 24, 2024 and/or have referrals to providers in other states. I have already had to compromise the standard of care offered to families that live outside of the State of Ohio as I will not be able to offer ongoing follow up for Kentucky residents, even though many live closer to Cincinnati Children's hospital than some Ohio residents given our location at the border of the two states. For continuous Ohio residents who do not yet meet criteria to initiate GnRH agonist or gender affirming hormone therapy, I am already in the untenable position of offering substandard medicine with substantial geographic barriers to care. For example, in the ordinary course, for my patients who are candidates for pubertal suppression, I would continue to meet with and monitor those patients until they met the criteria to initiate treatment, i.e. demonstrate Tanner 2 puberty development. At that time, I would then counsel the patient and their family about the risks and benefits of treatment and, after the parents consent and the patient assent, begin a course of treatment. Because of HB68, I cannot provide that care to those patients, who will now have to travel out of state to see a clinician for that monitoring and to initiate that treatment. Furthermore, the wording of the legacy clause indicates that established patients that

[12] Lashutka, N., *Media statement regarding Ohio General Assembly passage of Sub. HB 68*, Ohio Gen. Hosp. Assoc. Press Room, 2023 Dec. 15. https://ohiochildrenshospitals.org/press-room/media-statement-regarding-ohio-general-assembly-passage-of-sub-hb-68/.

have started GnRH agonist or gender affirming hormone therapy and are continuous Ohio residents may continue therapy. The conjunction "or" is incredibly problematic as it implies that youth that are on puberty blockers but not yet gender affirming care cannot initiate that next step in treatment with their established care providers in Ohio. Prolonged pubertal blockade beyond the typical age range for the onset of puberty is detrimental to bone health and social, emotional development. The law as written is simply bad medicine and will result in predictable and serious physical and psychological harms to an already vulnerable population.

76. Withholding pubertal suppression and gender affirming hormone therapy from transgender youth when it is medically indicated is extremely harmful. I am already beginning to see the negative impact for families as I explain the legal implications HB68 will have on the care that I will no longer be able to provide for their child. Transgender youth do not understand why adults they have never met are interfering in their ability to access health care, and they feel threatened, unwelcome, and targeted. Families that do not have the financial means to travel to other states are under tremendous stress as the legal landscape is creating additional layers of burden.

77. In summary, denying treatment will not cause an adolescent to stop being transgender, it will only exacerbate distress from lack of access to established treatments. As a medical provider it is devastating and goes against my ethical obligations to my patients to be legally prohibited from offering services that are safe, effective, and beneficial to transgender youth.

Sarah Corathers
Signed on 2024/03/22 17:51:05 -5:00

SARAH CORATHERS, MD

Signed at:
Franklin
_____,Ohio
County

Sworn to and subscribed before me this 03/22/2024 day of March, 2024

Signed on 2024/03/22 17:51:05 -5:00

Notary Public

NOTARY PUBLIC
STATE OF OHIO

Theresa M Sabo
Commission # 2016-RE-619622
Electronic Notary Public
State of Ohio
My Comm Exp. Nov 28, 2026

Notary Stamp 2024/03/22 14:51:06 PST

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Notarial act performed by audio-visual communication

EXHIBIT A

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Cincinnati, Ohio 45219
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Sarah.corathers@cchmc.org

Education

Bachelor of Arts, Barnard College, Columbia University (1992-1996)

Art History Major, graduated with departmental honors

Doctor of Medicine, Wright State University (1998-2002)

Passed Step 1 USMLE June 2000; Passed Step 2 September 2001, Passed Step 3 July 2004

Residency, Internal Medicine and Pediatrics (2002-2006)

University of Cincinnati and Cincinnati Children's Hospital Medical Center (CCHMC)

Fellowship, Adult and Pediatric Endocrinology (2009-2013)

University of Cincinnati and Cincinnati Children's Hospital, Divisions of Endocrinology

Quality Improvement (QI) Training

Cincinnati Children's Hospital: Intermediate Improvement Science Series (August 2010-January 2011);
Advanced Improvement Methods (September 2014- May 2015)
Academic Pediatric Association: Advancing Implementation and QI Science (Seminar, 5/2018; 4/2019)

Academic Appointments

Associate Chief of Staff, Ambulatory, Cincinnati Children's (March 2024-)
Clinical Director, Division of Pediatric Endocrinology, Cincinnati Children's (January 2022-)
Associate Professor, Dept of Pediatrics, Division of Endocrinology, Cincinnati Children's (06/2019-)
Assistant Professor, Dept of Pediatrics, Divisions of Endocrinology, Cincinnati Children's (07/2013- 06/2019)
Secondary appointment, James M. Anderson Center for Health System Excellence, (07/2013--)
Director, Quality Scholars Program, Cincinnati Children's (9/2017-3/2024)
Chief Resident, Internal Medicine, University of Cincinnati (07/2006-06/2007)

Licensing and certification

American Board of Pediatrics, Board Certified, 10/2006
American Board of Internal Medicine, Board Certified, 8/2007
Pediatric Endocrinology, Diabetes and Metabolism, Board Certified, 11/2013; MOC in progress
Adult Endocrinology, Diabetes and Metabolism, Board Certified, 10/2013; MOC in progress
State Medical Board of Ohio, License 35.088645, Expiration date 4/1/2025

Awards and Honors

Cincinnati Magazine Top Doctor, 2016--2024
Cincy Magazine, Best Doctor, 2016--2023
Venue Media and LEAD magazine, Comprehensive Healthcare Leadership Award, August 2016
Service Quality Award 2015, Permanente Journal, "Effective Follow up for Depression and or Suicidal Ideation in Adolescents with Diabetes."
Ohio Patient Safety Institute, Best Practice Award, "Depression Screening in the Diabetes Center", 2013
Alpha Omega Alpha Honor Society Member

Updated 2.1.2024

Clinical Service

Clinical Expertise and Activities

Based on dual training in pediatric and adult endocrinology, my interests and experience are in the care of adolescents and adults with endocrine conditions across the lifespan. Areas of clinical concentration include type 1 diabetes, Turner syndrome, transgender health, and successful transition to adult care.

Clinical Director: Oversee the clinical operations and quality improvement portfolio of the Division of Pediatric Endocrinology. Notable accomplishments in the past year include improving access (reduce 3rd next available from mean of 43 days to 24 days, achieve consistent clinic visits for established patients), expand to Mobile Care Clinic, two additional satellite locations, and launch e-visit for diabetes, recognition as top performing ambulatory division for Patient and Family Experience (2023), USNWR Division ranking tied for #1 in the nation (2023).

Diabetes Transition Program Development: Led development of a transition policy and registry to track transition planning and transfers to adult care (2013-2014). In collaboration with Seattle Children's Hospital, developed and implemented a patient reported readiness assessment tool, READDY (2013-2018) that is translated into 5 languages and used internationally (2021--). Increased transition planning from 10% to > 85% for ages 16-18 and > 90% of over age 19 (2018- ongoing). Expanded depression screening and referral for mental health services to people over age 18 (2019), partner with adult receivership programs.

Leadership in Quality Improvement (QI): Engagement with institution-wide Psychosocial Screening task force, the Health Equity Network at Cincinnati Children's (2021-ongoing) and coordinating Division of Endocrinology initiatives with the Type 1 Diabetes Exchange national collaborative (T1Dx-QI). Cincinnati Children's Diabetes Center was one of the first North American centers to join the International Diabetes Registry SWEET (2019). The Division of Endocrinology at Cincinnati Children's Hospital consistently ranks highly in USNWR, most recently 1st in the nation in 2023 and 3rd in 2022.

Clinical improvement activities include: implementation of depression screening and appropriate referral for youth with diabetes (2011- present), increasing timely insulin administration in hospitalized patients with cystic fibrosis related diabetes (2014-2015), decreasing loss to follow of congenital hypothyroid patients (2014-2018), development of diabetes registry with selection of quality metrics and data capture strategies (2015-2016), integration of patient reported outcomes into clinical care (2016- current), development of care gap reports (2017-current). Current work includes expanding uptake of diabetes technology and sharing diabetes device data between visits to address and reduce health equity gaps. Across all ages and public and private insurance coverage, increasing continuous glucose monitor use rates > 80%, while cutting disparity gaps in half (2019- ongoing). Through ConnecT1D project, mean HbA1c for Healthvine Medicaid cohort with T1D improved from 9.4% to 8.8% (2022--).

Research and Scholarly Activities

Research and Scholarly Activities

I am a board-certified pediatric and adult endocrinologist, with advanced training in quality improvement (QI) methods. The intersection of my research and clinical interests includes psychosocial aspects of diabetes management, mechanisms to promote successful transition between adult and pediatric health care systems, and health system-based interventions to improve care delivery and patient outcomes. As Clinical Director, I lead an interdisciplinary QI team at Cincinnati Children's Division of Endocrinology and direct the Quality Scholars Program in the James M. Anderson Center for Health Systems Excellence. Nationally, I serve as a faculty leader for the Type 1 Diabetes Exchange Learning Collaborative (T1DX-QI), a network of 50+ centers throughout the United States. Funded research projects focus on ambulatory safety, diabetes self-management support, use of patient reported outcomes to inform productive clinical interactions, QI initiatives to achieve excellent and equitable outcomes for youth with type 1 diabetes.

Updated 2.1.2024

Grants and Contracts

Current Research Support

Helmsley Charitable Trust, Corathers (PI) 02/1/2022-01/31/2025
ConnecT1D: reinforcing connections between patients, the clinic and community partners to achieve excellent and equitable glycemic and psychosocial outcomes for young people with type 1 diabetes (T1D).
The objective of this 2.6-million-dollar diabetes clinic innovation grant is development of a more efficient, proactive care delivery model for T1D that supports patients and families through access to diabetes technology, more frequent communication between visits, and establishing a unified clinical information system infrastructure for diabetes devices to interface with the electronic medical record.
Role: PI, current year effort 20%

R01DK121295-01, NIH/NIDDK, Modi/Driscoll (co-PIs) 04/01/19- 03/31/24
Diabetes Journey: From Systematic Screening to Intervention
The objective of this study is to use patient reported outcomes (e.g., adherence barriers) to guide the integration of a novel tailored intervention into clinical care to improve adherence, A1C, and HRQOL.
Role: Co-Investigator, current year effort 8%

Unitio /Helmsley Charitable Trust, Corathers/Rioles (co-PIs) 03/2016 – 06/2025
Type 1 Diabetes Exchange Learning Collaborative
The primary aim is to develop a multi-site national quality improvement collaborative for type 1 diabetes with a focus on outcomes amongst adolescent and young adult population.
Role: Co-Investigator, Clinical Faculty leader, current year percent effort 5%

Completed Research Support

R18 HS026644-01, DHHS/AHRQ, Walsh (PI) 09/30/18 - 09/29/23
Ambulatory Pediatric Safety Learning Lab
The specific aims of this longitudinal study are to reduce harm due to medication errors and treatment delay in two conditions (diabetes and autism spectrum disorder) through redesign of the processes for medication dose adjustment of insulin and prompt management of serious illness at home.
Role: Site PI, co-investigator

Place Outcomes Award, Cincinnati Children's Hospital 01/2020-12/2022
AID-T1D (Artificial Intelligence Decision Support in Type 1 Diabetes)
The aim of this research is to determine feasibility and efficacy of using artificial intelligence software to guide glucose pattern review and insulin dose titration at and between clinical encounters.
Role: Primary Investigator

Helmsley Charitable Trust, DiMeglio (PI) 02/2017 - 06/2019
Strategies to Enhance New CGM Use in Early Childhood (SENCE)
The objective of this multi-site study is to compare the efficacy and safety of CGM alone and CGM in combination with a family behavioral intervention with a control group using blood glucose monitoring.
Role: Site PI

R01 DK069486, NIH/NIDDK, Dolan (PI) 07/2017 - 06/2019
Self-Management of Type 1 Diabetes during Adolescence
The aims include 1) examination of the trajectories of glycemic control 2) test a model of modifiable risk on glycemic control 3) identify subgroups and profiles of risk factors and 4) characterize the impact on glycemic control on precursor measures of kidney, eye, and cardiovascular complications.
Role: Co-investigator

Unitio /Helmsley Charitable Trust, Anhalt (PI) 03/2016 - 06/2018
Type 1 Diabetes Exchange Learning Collaborative
The primary aim is to develop a multi-site national quality improvement collaborative for type 1 diabetes.
Role: Co-Investigator, Faculty leader

Unitio /Helmsley Trust, Margolis/Britto (Co-PIs) 08/2014 - 07/2015
A Collaborative Chronic Care Network for Type-I Diabetes: Design Phase
Role: Co-Investigator

Publications

Peer Review Articles as a listed author

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2. Huber, A., Jacobson E., **Corathers, S.**, and Tomer, Y. Joint susceptibility to autoimmune diabetes and thyroiditis: from epidemiological observations to gene function. Endocr Rev. 2008; Oct 29(6):697-725. PMID 18776148
3. Hillman JB, **Corathers SD**, Wilson SE. Pediatricians and screening for obesity with body mass index: does level of training matter? Public Health Rep. 2009; Jul-Aug; 124(4):561-7 PMID 19618793
4. **Corathers S.**, Falciglia, M. The role of hyperglycemia in acute illness: supporting evidence and its limitations, Nutrition 2010; Sept 22. PMID 20869205
5. Lotstein, D, Seid, M, Klingensmith, G, Case, D, Lawrence, J, Pihoker, C, Dabelea, D, Mayer-Davis, E, Gilliam, L, **Corathers, S**, Imperatore, G, Dolan, L, Anderson, A, Bell, R, Waitzfelder, B for the SEARCH for Diabetes in Youth Study Group. Transition from Childhood to Adult Care for Youth with Type 1 Diabetes in Adolescence. Pediatrics, 2013 Apr;131 (4): e1062-70. PMID 23530167
6. **Corathers, S.**, Peavie, S, Salehi, M. Complications of Diabetes Therapy. Endocrinol Metab Clin North Am, 2013. 42(4): p. 947-70. PMID 24286957
7. **Corathers, S**, Kichler, J, Jones, N, Houchen, A, Jolly, M, Morwessel, N, Dolan, L, Hood, K. Improving Depression Screening for Adolescents with Diabetes. Pediatrics, 2013. 132(5) PMID 24127480
8. Powell, P., **Corathers, S.**, Raymond, J., Streisand, R. New Approaches to Providing Individualized Diabetes Care in the 21st Century. Curr Diabetes Rev. 2015 Apr 21. PMID 25901504
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11. Beal, S., Riddle, I., Kichler, J., Duncan, A., Houchen, A., Casnellie, L., Woodward, J., **Corathers, S.** Transition readiness across different clinic populations: The influence of chronic condition and individual characteristics. Acad Pediatr. 2016 Sept-Oct; 16(7):660-7. PMID: 27345693
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13. Garvey KC, Foster NC, Agarwal S, DiMeglio LA, Anderson BJ, **Corathers SD**, Desimone ME, Libman IM, Lyons SK, Peters AL, Raymond JK, Laffel LM. Health care transition preparation and experiences in a US national sample of young adults with type 1 diabetes. Diabetes Care December 2016. PMID: 2800779
14. **Corathers, S.,** Kichler, J, Mara, C. Psychosocial Patient-Reported Outcomes in Pediatric and Adolescent Diabetes: A Review and Case Example. Curr Diab Rep. 2017. PMID: 28508255

Updated 2.1.2024

15. Matlock, K., Yayah Jones, N., **Corathers, S.**, Kichler, J. Clinical and psychosocial factors associated with suicidal ideation in adolescents with type 1 diabetes mellitus. J Adolesc Health 2017 Oct; 61(4):4710477 PMID: 28732716
16. Wakefield, C., Mehta, P., **Corathers, S.**, Geller, J., Gelfand, J., Olowukure, O., Marsh, R. A First Report of Secondary Hemophagocytic Lymphohistiocytosis Associated with Papillary Thyroid Cancer. J Pediatr Hematol Oncol. 2018 Mar;40 (2): e97-98. PMID: 29087969
17. Agarwal, S., Raymond, J., Isom, S., Lawrence, J., Klingensmith, G., Pihoker, C, **Corathers, S**, Saydah, S., D'Agostino,R., Dabelea, D. Transition from Pediatric to Adult Care for Young Adults with Type 2 Diabetes: The SEARCH for Diabetes in Youth Study. Diabetic Medicine Vol 35, Issue4, April 2018, Pages 504-512. PMID 29377258.
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19. Varni, J, Delatmater, A, Hood, K, Raymond, J, Driscoll, K, Wong, J, Adi, S, Yi-Frazier, J, Grishman, E, Faith, M, **Corathers, S.**, Kichler, J, Miller, J, Doskey, E, Aguirre, V, Heffer,R, Wilson, D. Diabetes symptoms predictors of health-related quality of life in adolescents and young adults with type 1 or type 2 diabetes. Qual Life Res, 2018 May 21. PMID: 29785681
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25. **Corathers, S.**, Mara CA., Chundi PK., Kichler JC. Depression and Suicide Screening in Adolescents with Type 1 Diabetes: 5-Years of Implementation and Outcomes. J Am Acad Child Adolesc Psychiatry. 2019 Feb 22 PMID: 30802493
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32. **Corathers, SD**, Yi-Frazier JP, Kichler JC, Gilliam LK, Watts G, Houchen A, Beal S. Development and Implementation of the Readiness Assessment of Emerging Adults with Type 1 Diabetes Diagnosed in Youth (READDY) Tool. Diabetes Spectr. 2020 Feb;33(1):99-103. PMID: 32116461
33. **Corathers, SD**, DeSalvo, DJ., Therapeutic Inertia in Pediatric Diabetes: Challenges and Strategies to Overcome Acceptance of the Status Quo. Diabetes Spectr. 2020 Feb;33(1):22-30. PMID:32116450
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65. Roberts, A., **Corathers, S.,** Rapaport, R., Rompicherla, S., Majidi, S., Rioles, N., Ebekozien, O., Malik, F. Depression Rates in Youth with Type 1 Diabetes During the COVID-19 Pandemic: Data from the T1D Exchange Quality Improvement Collaborative. *Submitted to 01.2024*

Peer Review Articles as a member of a collaboration or study group

1. Dubose SN et al, **collaborating contributor of the Type 1 Diabetes Exchange Clinic Network** (recruited research subjects), Obesity in Youth with Type 1 Diabetes in Germany, Austria and the United States. J Pediatr. 2015 Sep; 167(3):627-32 PMID: 26164381
2. Fair C et al, **collaborating contributor of the International and Interdisciplinary Heath Care Transition Research Consortium** (developed research plan, served as member of writing group). International and Interdisciplinary Identification of Health Care Transition Outcomes. JAMA Pediatr. 2016 Mar; 170(3):205-11. PMID: 26619178
3. Craig et al, **collaborating contributor of the Type 1 Diabetes Exchange** (recruited research subjects), Prevalence of Celiac Disease in 52,721 Youth with Type 1 Diabetes: International Comparison across Three Continents. Diabetes Care. 2017 Aug; 40(8):1034-1040. PMID 28546222
4. Gravholt et al, **collaborating author of International Turner Syndrome Consensus Group**, (reviewed literature, participated in international consensus meeting, member of writing group for transition and adult care sections), Clinical Practice Guidelines for the care of girls and women with Turner Syndrome: proceedings from the 2016 Cincinnati International Turner Syndrome Meeting. European Journal of Endocrinology 2017 Sep;177(3) PMID 28705803
5. Miller KM, et al. **collaborating contributor of the Type 1 Diabetes Exchange** (recruited research subjects), Longitudinal Changes in Continuous Glucose Monitoring Use Among Individuals with Type 1 Diabetes: International Comparison in the German and Austrian DPV and U.S. T1D Exchange Registries. Diabetes Care. 2019 Oct. PMID: 31672703

Updated 2.1.2024

6. Mizokami-Stout KR, et al. **Collaborating contributor of the Type 1 Diabetes Exchange** (recruited research subjects) Contemporary Prevalence of Diabetic Neuropathy in Type 1 Diabetes: Findings from the T1D Exchange. Diabetes Care. 2020 Apr;43(4):806-812. Epub 2020 Feb 6. Diabetes Care. 2020. PMID: 32029635
7. A Randomized Clinical Trial Assessing Continuous Glucose Monitoring (CGM) Use with Standardized Education with or without a Family Behavioral Intervention Compared with Fingerstick Blood Glucose Monitoring in Very Young Children with Type 1 Diabetes. **Collaborating author and contributor to Strategies to Enhance New CGM Use in Early Childhood (SENCE) Study Group.** Diabetes Care 2021 Feb; 44(2):464-472. PMID: 33334807
8. The COVID-19 Pandemic Affects Seasonality, With Increasing Cases of New-Onset Type 1 Diabetes in Children, From the Worldwide SWEET Registry. **Collaborating contributor of the SWEET study group.** Diabetes Care.2022 Sept. PMID 36166593
9. Twelve-month psychosocial outcomes of continuous glucose monitoring with behavioral support in parents of young children with type 1 diabetes. **Collaborating contributor to Strategies to Enhance New CGM Use in Early Childhood (SENCE) Study Group.** Diabet Med. 2023 Aug;40(8). PMID: 37083018.
10. Demographic, Clinical, Management, and Outcome Characteristics of 8,004 Young Children with Type 1 Diabetes. **Collaborating contributor of the Type 1 Diabetes Exchange.** Diabetes Care. 2024 Feb. PMID: 38305782.

Book chapters and other publications (non-peer reviewed)

1. **Corathers, S**. Collaboration is Key to Developing Effective Hormonal Treatment Paradigms for Transgender Youth. (Letter to Editor) J Adolesc Health. 2018 Apr; 62 (4):361-362 PMID: 29571433
2. **Corathers, S.,** Gerstle, M., Casnellie, L., Pater, C., Trotman, G. Transitioning from Pediatric to Adult Care in Endocrinology: A Clinical Handbook, chapter, Transition Considerations for Turner Syndrome. Springer Publishing. April 2019.
3. Backeljauw P, **Corathers S**. Chapter: The Turner Syndrome Resource Center – an Interdisciplinary approach to the Care of Girls and Women with Turner Syndrome. Book, Turner Syndrome Pathophysiology, Diagnosis, and Treatment. Patricia Fechner, Editor. Springer Publishing. March, 2020

Quality review of Publications

1. Lotstein, D, Seid, M, Klingensmith, G, Case, D, Lawrence, J, Pihoker, C, Dabelea, D, Mayer-Davis, E, Gilliam, L, **Corathers, S,** Imperatore, G, Dolan, L, Anderson, A, Bell, R, Waitzfelder, B for the SEARCH for Diabetes in Youth Study Group. Transition from Childhood to Adult Care for Youth with Type 1 Diabetes in Adolescence. Pediatrics, 2013 Apr;131(4):e1062-70. PMID 23530167
   - Contributing author to manuscript that describes transition outcomes for a cohort in the SEARCH for diabetes in youth study. Primary findings include increased odds of poor glycemic control among participants who transition to adult care compared to those who remain in pediatric care, highlighting need for supports when moving to adult care. Total citations 219: 2023 (25); 2022 (23); 2021 (24); 2020 (21); 2019 (20); 2018 (24); < 2019 (105).

2. **Corathers, S.,** Kichler, J, Jones, N, Houchen, A, Jolly, M, Morwessel, N, Dolan, L, Hood, K. Improving Depression Screening for Adolescents with Diabetes. Pediatrics, 2013. 132(5): p. e1395-402. PMID 24127480
   - This manuscript describes a feasible, reliable implementation of routine depression screening for adolescents with a chronic condition. I was the author on the paper, and subsequently led similar efforts across the T1Dx-QI collaborative. Total citations 97: 2023 (10); 2022 (6); 2021 (19); 2020 (14); 2019 (13); < 2019 (34).

Updated 2.1.2024

3. **Corathers, S.**, Schoettker, P., Clements, M., List, B., Mullen, D., Ohmer, A., Shah, A., Lee, J. Health-System-Based Interventions to Improve Care in Pediatric and Adolescent Type 1 Diabetes. Curr Diab Rep (2015) September 15:91. PMID 26374568
    - This manuscript describes a system-based approach to improving outcomes for type 1 diabetes and integrates work accomplished during a year-long design project funded by the Type 1 Diabetes Exchange to create a learning health system for diabetes. I was the lead author of the paper, and workgroup lead from the QI/Patient Reported Outcomes group. Total citations 15: 2023 (2); 2022 (2); 2021 (4); 2020 (3); 2018 (3); 2017 (1).

4. **Corathers, S.** Kichler, J., Fino, N. Lang, W. Lawrence, J., Raymond, J., Yi-Frazier, J., Dabelea, D. MD, PhD, Liese, A. Saydah, S., Seid, M., Dolan, L. High health satisfaction among emerging adults with diabetes: factors predicting resilience. Health Psychology. October 2016. PMID: 27736152
    - Manuscript reframes the study of emerging adults with diabetes from one of pre-determined risk factors and morbidity to instead evaluate features associated with positive health outcomes. A novel health resilience model is used to identify modifiable factors associated with higher satisfaction of health care and overall health amongst a cohort of emerging adults participating in the SEARCH for diabetes in youth study. I conceived of the research plan and led the writing group. Total citations 15: 2023 (3); 2022 (3); 2020 (5) 2019 (1); 2018 (3).

5. Gravholt et al, **collaborating author of International Turner Syndrome Consensus Group**, Clinical Practice Guidelines for the care of girls and women with Turner Syndrome: proceedings from the 2016 Cincinnati International Turner Syndrome Meeting. European Journal of Endocrinology 2017 Sep;177(3) PMID 28705803
    - This guideline represents an updated international consensus for diagnosis and treatment of Turner syndrome. I reviewed literature, participated in international consensus meeting that was hosted in Cincinnati, Ohio and served as a member of writing groups for transition and adult care sections. Total citation: 705: 2023 (128); 2022 (122); 2021 (143); 2020 (127); 2019 (124); < 2019 (58).

6. **Corathers, S.,** Kichler, J, Mara, C. Psychosocial Patient-Reported Outcomes in Pediatric and Adolescent Diabetes: A Review and Case Example. Current Diabetes Rep.2017 Jul;17(7):45 PMID: 28508255
    - This manuscript provides a framework for selection and integration of patient reported outcomes (PRO) into routine diabetes care to promote meaningful clinical interactions in real time. I led the conception and writing of the paper and I and my co-authors have been invited to speak nationally on this topic. Total citations: 18; 2023 (3); 2022 (3); 2021 (1); 2020 (4); 2019 (5); 2018 (2)

7. Pihoker, C., Forsander, G., Fantahun, B., Virmani, A., **Corathers, S.**, Benitez-Aguirre, P., Fu, J. Maahs, D. ISPAD Clinical Practice Consensus Guidelines 2018: The delivery of ambulatory diabetes care to children and adolescents with diabetes. Pediatric Diabetes. Vol 19, Oct 2018. PMID: 30144259
    - This guideline provides international standards of care for youth with diabetes based upon evidence and consensus of the International Society for Pediatric and Adolescent Diabetes. I was also involved in the updated guidelines published in 2022. Total citations: 69; 2023 (7); 2022 (16); 2021 (18); 2020 (19); 2019 (8); < 2019 (1).

Abstracts

1. Hillman, J.B., **Corathers, S.D**, Wilson, S.E. The Impact of Provider Level of Training on Screening and Treatment of Pediatric Overweight. Pediatric Academy Society Annual Meeting, Poster Session, May 2007, Boston, MA.
2. **Corathers, S.** Lucky, A. Komlos, M, Tamai, J., Tamura, D., Khan, S., Digiovanna, J., Kraemer, K., Stenger, P. Increased bone mineral density provides clue to elusive diagnosis of trichothiodystrophy. Pediatric Endocrine Society/Pediatric Academic Society, Poster Session, April 2011, Denver, CO.
3. **Corathers, S.,** Salehi, M. Virilization and hypertension resolved after oophorectomy: case report of ovarian Leydig cell tumor. Endocrine Society, Poster Session, June 2011, Boston, MA.
4. **Corathers, S.,** Yayah Jones, NH. Crawford, P., Houchen, A., Morwessel, N., Dolan, L., Hood, K. Outpatient screening for depression: Feasibility and outcomes in adolescents with type 1 diabetes. American Diabetes Association, Moderated Poster Session, June 2012, Philadelphia, PA.
5. Kudel, I., Kichler, J., Hood, K., **Corathers, S**. Psychometric analysis of the Children's Depression Inventory short form in adolescents with type 1 diabetes. Society for Behavioral Medicine, Poster Session, March 2013, San Francisco, CA.
6. **Corathers, S.** Kichler, J., Beavers, D., Dabelea, D., Lawrence, JM., Liese, A., Raymond, J., Saydah, S., Seid, M., Yi-Frazier, J., Dolan, L. for the SEARCH for Diabetes in Youth Study Group. Improving Health Outcomes in Emerging Adults with Diabetes. American Diabetes Association, Poster Session, June 2013, Chicago, IL.
7. **Corathers, S.,** Houchen, A., Cafasso, M., D'Alessio, D., Hennard, C., Horewitz, D., Klein, D., Dolan, L. Bridging the Gap in Transition from Pediatric to Adult Health Care for Adolescents and Young Adults (AYA): A Diabetes Pilot Program. Fifth Annual Health Care Transition Research Consortium, Poster Session, October 2013, Baylor University, Houston, Tx.
8. **Corathers, S.**, Beal, S., Kichler, J., Houchen, A. Readiness for transition to adult care in adolescents and young adults (AYA): a comparison of youth with and without type 1 diabetes (T1D). International Society for Pediatric and Adolescent Diabetes, Moderated Poster Session, September 2014, Toronto, Canada.
9. **Corathers, S.,** Beal, S., Yi-Frazier, J., Kichler, J., Houchen, A., Pihoker, C. Confirmatory factor analysis of a novel transition to adult care readiness assessment tool for adolescents and young adults (AYA) with type 1 diabetes (T1D). International Society for Pediatric and Adolescent Diabetes, Moderated Poster Session, September 2014, Toronto, Canada.
10. Fair,C., Javalkar, K., Betz, C., Okumura, M., Wood, D., LeComte, J., Jan, S., Maslow, G., Bozik, K., Porter, J., **Corathers, S.,** Tolleson-Rinehart, S., Shah, P., Woodward, J., Ferris, T., Ferris, R., Ferris, M. on behalf of the HCTRC. Health Care Transition Outcomes: A Delphi Stage 3 Survey. Sixth Annual Health Care Transition Research Consortium, Poster Session, October 2014, Baylor University, Houston, Tx.
11. Beal, S. J., Riddle, I., Kichler, J., Duncan, A., Houchen, A., Casnellie, L., **Corathers, S.** Transition Readiness among Teens – Differences by Chronic Condition. Sixth Annual Healthcare Transitions Research Consortium, Poster Session, October 2014, Baylor College of Medicine, Houston, TX.
12. Matlock, K., Yayah Jones, N., Kichler, J., **Corathers, S.** Clinical and Psychosocial Factors Associated with Suicidal Ideation in Adolescents with Type 1 Diabetes Mellitus. Pediatric Academic Society, Poster Session, April 2015, San Diego, CA.
13. Smego, A., Lawson, S., Courter, J., Warden, D., **Corathers, S.** Decreasing the Time to Insulin Administration for Hospitalized Patients with Cystic Fibrosis-Related Diabetes. Pediatric Academic Society, Poster Session, April 2015, San Diego, CA.
14. **Corathers, S.,** Beal, S., Kichler, J., Casnellie, L., Backeljauw, P. Personal health knowledge and preparation for transition to adult care in adolescents with Turner Syndrome (TS). Pediatric Academic Society, Poster Session, April 2015, San Diego, CA.

Updated 2.1.2024

15. Alexander, C., Ellsworth, S., Melvin, P., Kichler, J., **Corathers, S.,** Yayah Jones, N., Houchen, A., Jolly, M. Effective Screening and Follow up for Depression and Suicidal Ideation in Adolescents with Diabetes Mellitus. The 27th Annual National Forum on Quality Improvement in Healthcare, Poster Session, December 2015, Orlando, Fl.
16. Garvey, K., Foster, N., Laffel, L., DiMeglio, L., Agarwal, S., Desimone, M., Libman, I., Lyons, S., Peters, A., Anderson, B., **Corathers, S.,** Miller, K., Beck, R. Health Care Transition Preparation and Experience in a US National Sample of Young Adults with Type 1 Diabetes. International Diabetes Federation, Poster Session, December 2015, Vancouver, CA
17. Conard, L., **Corathers, S.,** Lawlis, S. & Restle, H. Improving Standardization of Care in Trans* Clinic. WPATH Symposium, Poster Session, June 2016, Amsterdam, Netherlands.
18. Ikomi, C, Alexander, C, Mallon, D, Dykes, D, Anderson, V, Davis, B, Jolly M, Gahl, J, Ellsworth, S, **Corathers, S,** Crimmins, N. Improving Screening for Celiac Disease in Patients with New-Onset Type 1 Diabetes. International Society for Pediatric and Adolescent Diabetes, Poster Session, October 2016, Valencia, Spain.
19. **Corathers, SD,** Kichler, JC, Mara, C. Implementation of patient reported outcomes (PROs) through quality improvement methods to enhance patient care. International Society for Pediatric and Adolescent Diabetes, Moderated Poster Session, October 2016, Valenica, Spain.
20. Remiker, A., Chuang, J, **Corathers, S,** Rutter, M, Ho, Brian, Rutter, M, Gelfand, M, Trout, A, Geller, J. Differentiated thyroid cancer outcomes in the pediatric/adolescent population: a longitudinal review from a single center. ASPHO, Poster Session, April 2017, Montreal, Quebec.
21. Malik, F, Stafford, J, Klingensmith, G, Dabelea, D, Lawrence, J, Mayer-Davis, E, Sayday, S, **Corathers, S**, Reboussin, B, Pihoker, C. Receipt of Recommended Clinical Tests for Youth and Young Adults with Type 1 Diabetes: Associations with Glycemic Control and Satisfaction with Care. American Diabetes Association, Poster Session, June 2017, San Diego, California.
22. Boyle, C, Foster, N, Scheer, K, Anhalt, H, Shah, A, Lee, J, **Corathers, S**. Funnel Plots for Statistical Quality Control in a Large, Multi-Site Registry. Society of Clinical Trials, Poster Session, May 2017. Liverpool, UK.
23. Krishnamurthy, M, Blunden, C, **Corathers, S,** Sheanon, N. Diazoxide-responsive Hyperinsulinism in an Infant with Sotos Syndrome. Pediatric Endocrinology Society, Poster Session, April 2017, Orlando, Florida.
24. Warning, A, Rohan, J, McGrady, M, Pendley, Delamater, J, **Corathers, S.,** Drotar, D., Dolan, L. Changes in Depressive Symptoms over Time Differ between Males and Females with Type 1 Diabetes. Society of Pediatric Psychology, Poster Session, April 2017, Portland, OR.
25. Mallon, D., Crimmins, N., Ikomi, C., **Corathers, S.,** Dykes, D., Gahl, J., Jolly, M. Improving Celiac Screening for Children with Type 1 Diabetes and Lessons from False Positive Serology. National American Society for Pediatric Gastroenterology, Hepatology, and Nutrition, Poster Session, November 2017, Las Vegas, NV.
26. Wood, J, Boyle, C, Quinn, M, Wong, J, Haller, M, Nelson, B, Shatz, D, Tamborlane, W, Fox, L, Prahalad, P, **Corathers, S,** Maahs, D, Alonso, T, DeSalvo, D, Wadwa, P, DiMeglio, L, Impact of Target HbA1c Change in Pediatric Participants in the T1D Exchange Clinic Registry. American Diabetes Association, Poster Session, June 2018, Orlando, FL.
27. Majidi, S, Jolly, M, Alonso, G, Buckingham, D, Cabrera, A, Clements, M, Garrity, A, Gibbs, K, Click, B, ong, K, Kamboj, M, Lambert, K, Lee J, Nadkarni, P, McDonough, R, Ohmer, A, Rioles, N, Stanek, K, Thomas, S, Weinstock R, **Corathers S.** Incorporating Depression Screening into Diabetes Clinics across the T1DX Learning Collaborative. American Diabetes Association, Poster Session, June 2018, Orlando, FL.
28. Shah, A., **Corathers, S.,** Alonso, G, Buckingham, D, Cabrera, A, Clements, M, DeSalvo D, Kamboj, M, Lambert K, Mehta, S, Ohmer, A, Rioles, N, Sonabend, R, Lee, J. Establishment of the Type 1 Diabetes Exchange QI Learning Collaborative (T1DX-LC). American Diabetes Association, Poster Session, June 2018, Orlando, FL.

Updated 2.1.2024

29. Agarwal, S. Hirshfeld, E., Garrity, A., Shah, A., **Corathers, S.,** Weinstock, R., Lambert, K., Bobik, C., Cabrera, A., Rioles, N., Lee, J. Comparison of adult and pediatric resources for type 1 diabetes among T1D exchange centers. American Diabetes Association, Poster Session, June 2018, Orlando, FL.
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31. Kichler, J., Monaghan, M., **Corathers, S.,** Hilliard, M. Protective Factors in Emerging Adulthood: Reliability and Validity of a New Measure of Diabetes Strengths and Resilience. Society of Pediatric Psychology Annual Conference, New Orleans, April 2019.
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33. Hilliard, Monaghan, **Corathers,** Kichler, Protective Factors in Emerging Adulthood: Reliability and Validity of a New Measure of Diabetes Strengths and Resilience, Society of Pediatric Psychology Annual Conference, New Orleans, 2019
34. Lipstein, E. **Corathers, S.** I couldn't see a downside: Adolescent and Parent Decision-making about gender-affirming hormone therapy. Pediatric Academic Society, Baltimore, April 2019
35. Kamoun, C., Khoury, J., Crimmins, N., **Corathers, S.** Opportunities for Enhanced Type 1 Diabetes Transition Preparation. Pediatric Academic Society, Baltimore, April 2019.
36. Quinn, M., Bailey, R., Foster, N., Simmons, J., Eyth, E., Rodriguez, H., **Corathers, S.,** Levy, C., Sheanon, N., Wasserman, R., Seiple, D., Sparling, D., Adkins, D., Albanese, A., DeSalvo, D. Diabetes Management Supplies in Youth with Type 1 Diabetes: Don't Leave Home Without Them! American Diabetes Association, San Francisco, June 2019
37. Cabrera, A., Alonso, G., **Corathers, S.,** Lee, J., Prahalad, P., Rioles, N. Assessing Data Availability and Benchmarking Performance of Quality Measures for the T1D Exchange Improvement Collaborative, American Diabetes Association, San Francisco, June 2019
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40. Yao, M. Alexandrou, E., Arora, S., Biery, M., Jones, R., Nasomyont, N., Petrovic, E., Seitz, S., Sylvester, A., Chundi, P., Mostajabi, F., Redel, J., **Corathers, S.** Outpatient Quality of Life Screening: Feasibility and outcomes in parents of children 2-7 with T1D. International Society of Adolescent and Pediatric Diabetes (ISPAD), Boston, November 2019.
41. Noor, N., Rioles, N., **Corathers, S.,** Majid, S., McDonough, R., Polsky, S., Greenfield, M., Obrynba, K., Ebekozien, O., DeSalvo, D. Patient Demographics and clinical outcomes among type 1 diabetes patients using continuous glucose monitors: real world evidence from a large US Collaborative. American Diabetes Association (ADA), Virtual meeting, June 2020.
42. McDonough, R., Thomas, S., Rioles, N., Ebekozien, O., **Corathers, S.,** Jolly, M, Lee, J., Garrity, A., Prahalad, P., Kamboj, M., Buckingham, D., Alonso, T. Reducing lost-to-follow rates in the T1D Exchange Quality Improvement Collaborative (T1DX-QI). American Diabetes Association (ADA), Virtual meeting, June 2020.
43. Ebekozien, O., Rioles, N., DeSalvo D., Gallagher, K., Lee, J.M, McDonough, R., Obrynba, K., Prahalad, P., Thomas, S., Weinstock, R.S., **Corathers, S.** Improving Continuous Glucose Monitoring (CGM) Use across Ten National Centers: Results from the T1D Exchange Quality Improvement Collaborative (T1DX-QI). American Diabetes Association (ADA), Virtual meeting, June 2020.

Updated 2.1.2024

44. Improving Diabetes Care Through Population Health Studies: Insights from the largest U.S Population Based T1D Cohort. ISPAD virtual conference, October 2020.
45. Patient demographics and clinical outcomes among type 1 diabetes (T1D) patients using Continuous Glucose Monitors (CGMs): real world evidence from a large U.S. collaborative. ISPAD virtual conference, October 2020.
46. Multi-site quality improvement project: improving Continuous Glucose Monitor (CGM) uptake across ten U.S Centers. ISPAD virtual conference, October 2020.
47. Deconstructing Diabetes Strengths: Factor Analysis of the Diabetes Strengths and Resilience Measure for Young Adults (DSTAR-YA). Carreon, S., Iturralde, E., Monaghan, M., Kichler, J., Raymond, J., **Corathers, S.**, Hilliard, M. Virtual Society of Pediatric Psychology Annual Conference, April 2021.
48. Bone Marrow Adipose Tissue Assessment in Transgender Youth Undergoing Pubertal Suppression: A Pilot Study. Nasomyont, N., Meisman, A., Ecklund, K., Vajapeyam, S., Cecil, K., Tkach, J., Altaye, M., **Corathers, S.** Conard, L,, Kalkwarf, H., Dolan, L, Gordon, C. Pediatric Endocrine Society virtual meeting April 2021.
49. Challenges to Telemedicine Transition During Covid-19; Insights From 21 Us Diabetes and Endocrinology Clinics, oral presentation at 14th International Conference on Advanced Technologies & Treatments for Diabetes (ATTD 2021) virtual conference June 2-5, 2021.
50. Transition of Care in Type 1 diabetes and Association with Student and Employment Status. Majidi, S., Roberts, A., Suerken, C., Reboussin, B., Malik, F., Marcovina, S., **Corathers, S.**, Reynolds, K., Imperatore, G, Wadwa, P., Pihoker, C. American Diabetes Association Virtual Scientific Sessions, June 25-29, 2021.
51. Insulin Pump Use and Glycemic Control Among Patients With Type 1 Diabetes: Trends From The T1Dx-QI Cohort. Noor N, McDonough R, Carlson E, Mekhoubad A, Hsieh S, Demeterco-Berggren C, Majidi S, Desimone M, De-Tutu S, Obrynba K, Ebekozien O, **Corathers S**. Poster at American Diabetes Association Virtual Scientific Sessions; June 25-29, 2021.
52. HbA1c trends in the T1D Exchange Quality Improvement Collaborative (T1DX-QI) 2017-2020. Ebekozien O, Noor N, Jones NH-Y, Alonso GT, Desimone M, Izquierdo R, **Corathers S**, DeSalvo DJ, Gandhi K, Odugbesan O, Prahalad P, Clements M. Poster at American Diabetes Association Virtual Scientific Sessions; June 25-29, 2021.
53. Six Habits: Quality Metrics to Support Glycemic Outcomes in Type 1 Diabetes. Lee, J., Garrity, A., Hirschfeld, E., Thomas, I., Rioles, N., Ebekozien, O., **Corathers, S.** Poster at American Diabetes Association Virtual Scientific Sessions: June 25-29, 2021.
54. Lavik, A.R, Jones, N.H.Y, Rompicherla, S, Greenfield, M, Chen, J, Polsky, S, Alonso G. T, **Corathers, S**, Blackman, S, Gallagher, M. P, Demetero-Berggren, C, Garrity, A, Ebekozien, O. Diabetic ketoacidosis rates rose among patients with type 1 diabetes during U.S. COVID-19 peaks with highest burden on non-Hispanic Blacks. ePoster at the 47th ISPAD 2021 virtual Annual Conference.
55. Muthuvel, G., Brady, P., Daraiseh, N., Khoury, J., Tellez, S., **Corathers, S.**, Using Artificial Intelligence Decision Support to Enhance Care for Type 1 Diabetes, ePoster at the 47th ISPAD 2021 virtual Annual Conference.
56. H. Nelson, S.D. Corathers, P.W. Brady, E. Kirkendall, R.M. Ruddy, T.B. Wetterneck, K.E. Walsh. Ambulatory Patient Safety Learning Lab: Failure modes and effects analysis for management of type 1 diabetes during illness, ePoster at the 47th ISPAD 2021 virtual Annual Conference.
57. Tellez, S., Brady, P., Daraiseh, N., Khoury, J., Muthuvel, G., **Corathers, S.**, Evaluation of an Enhanced Care Intervention Using an Artificial Intelligence-Guided Decision Tool in Children and Emerging Adults with Type 1 Diabetes. Accepted for ePoster at Advanced Technologies and Treatments for Diabetes annual conference, Barcelona, Spain, April 27-30, 2022.
58. **Corathers, S.** et al. Implementation of Psychosocial Screening in Diabetes Centers. American Diabetes Association, New Orleans, June 2022.

Updated 2.1.2024

59. Noor, N, Ebekozien, O, Vendrame, F, Jacobsen, L, Weinstock, R, Gallagher, M.P, **Corathers, S**, Accacha, S, Prahalad, P, Rapaport, R. Continuous glucose monitor derived Glycemic Outcomes Among Real-Time CGM vs. Flash CGM users in a Multi-Center EMR Database for People with T1D. ATTD, Berlin, Germany, February, 2023.
60. Williford, D. N., McGrail, M., Flynn, E., Buschhaus, S., Winning, A., Beckmann, E., Burstein, E., Yayah Jones, N-H., **Corathers, S.,** Crosby, L. E., & Modi, A. C. *Toward a deeper understanding of social capital: A family-centered approach to measurement development.* Abstract accepted for presentation at the Society of Pediatric Psychology Annual Conference, Chicago, IL. April, 2023.
61. Samantha Roberge, MD; Sarah **Corathers**, MD; Rula Kanj, MD; Nat Nasomyont, MD. 10-Year Retrospective Chart Review of Ordering Practices of Laboratory and Imaging Surveillance for Gender Diverse Youth During Pubertal Suppression Therapy, Abstract accepted for Pediatric Endocrine Society, San Diego, California, May 2023.
62. Malik, F, Cases, J, Hillard, M, Lyons, S, Jacobsen, L, Roberts, A, Mucci, A, Agarwal, S, Demeterco-Berggren, C, Alonso, T, Ebekozien, O, **Corathers, S.** Health Care Transition Practices in the T1D Exchange Quality Improvement Collaborative. Poster Presentation at the 83rd ADA Scientific Sessions, San Diego, California, June 2023.
63. Murray, A., Hottor, S., Bimpeh, Y., Ojilong, J., Sun, Q., **Corathers, S.**, Yayah-Jones, N. Reduction of Diabetes-Related Hypoglycemia in Children and Adolescents with Type 1 Diabetes in Ghana. ISPAD, Rotterdam, The Netherlands, October 2023.
64. Roberge, S., **Corathers, S.**, Roberge, T., Nasomyont, N., "Determinants of Bone Mass Accrual in Transgender and Gender Diverse Youth undergoing Pubertal Suppression Therapy." Submitted to USPATH, Westminster, Colorado, November 2023.
65. Yayah-Jones, N., Grant, A., **Corathers, S.**, Smith, L., Kelly, J., Riley, A., Wiliford, D., Fazio, C., Kaplan, K., Howell, A. EDICT: Equity in Diabetes Care and Transformation. T1Dx-QI National Meeting, NYC, NY, November 2023.
66. **Corathers, S.**, Desai, R., Deisinger, A., Jones, R., Kaplan, K., Jolly, M., Grant, A., Kichler, J. Sustained QI Implementation of a Transition Preparation Program for Adolescents and Emerging Adults with Type 1 Diabetes. T1Dx-QI National Meeting, NYC, NY, November 2023.
67. **Corathers, S.**, Yayah Jones, N., Smith, L., Brady, P., Grant, A., Howell, A. Tellez, S., Muthuvel, G., Kelly, J., Noh, Y., Riley, A., Town, M. ConnecT1D: Reinforcing connections between patients, clinic, and community partners. T1Dx-QI National Meeting, NYC, NY, November 2023.

Teaching and Mentoring

Teaching

1. Direct clinical teaching of teaching medical students, residents, fellows on the endocrine inpatient service at Cincinnati Children's Hospital Medical Center 4 weeks/year as well as precepting of endocrine fellows and residents in outpatient clinics on a weekly basis.
2. Academic courses, lectures, grand rounds, professor rounds, participation in firms:
    a. CCHMC, Intermediate Improvement Science Series, Creating a Portfolio: Integrating Improvement into the Daily Work of Pediatric Endocrinology, February 2023.
    b. CCHMC, Department of Pediatrics Grand Rounds, Innovations and Achievements from Recent Place Outcomes Research Awards, (June 2022)
    c. CCHMC, Division of Endocrinology Grand Rounds, Living with Change, Care Delivery for transgender and Gender Expansive Youth, (Feb 2021)
    d. CCHMC, NRSA Fellowship, Integrating Improvement Methods into Clinical Care and Research, (May 2020)
    e. University of Cincinnati, Diabetes Day Symposium, Childhood into Adolescence with Diabetes, (Nov 2019)

f. CCHMC, Division of Psychology, Adherence Center Grand Rounds, Division of Behavioral Medicine and Clinical Psychology, Loss to Follow-Up: An Indicator of Health Care Delivery Adherence? (July 2019)
g. CCHMC, Division of Endocrinology Fellowship Core Curriculum: Hyperglycemic Hyperosmolar Syndrome (July 2013-2023); Hypocalcemia nuts and bolts (July 2013-2016)
h. University of Cincinnati, CCHMC combined endocrinology grand rounds: Glycemic Targets for Individuals and Patient Health (September 2017); Transition Preparation (October 2015); Transition to Transfer: (November 2015)
i. University of Cincinnati, College of Medicine Intersession Careers in Quality Improvement Panel (Feb 2018)
j. University of Cincinnati, Child and Adolescent Development, Undergraduate Psychology Course. Type 1 diabetes: Psychosocial considerations for children, adolescents, emerging adults and their families (November 2015)
k. Endocrine nurse lecture series: Thyroid cancer (September 2014); Routine screening and prevention of diabetes co-morbidities (January 2011)
l. Mini-Medical College, University of Cincinnati, "Type 1 diabetes across the lifespan" (October 2014)
m. Internal Medicine Residency Ambulatory long block curriculum, University of Cincinnati (June 2016, June 2015, June 2014)
n. Department of Pediatrics Residency noon conference (Cis Puberty and Trans Puberty Blocking September 2017, Hypocalcemia nuts and bolts June 2014)
o. Ohio Patient Safety Institute Best Practice Webinar (September 2014)
p. Division of Infectious Diseases University of Cincinnati Grand Rounds: Management of hormone therapy for transgender adults (July 2012)

3. Participation in patient and family educational activities
   a. Speaker, Friends for Life Conference, Getting the Most out of your Automated Insulin Delivery System, College Park, MD, October 2022.
   b. Speaker, PFLAG, Living with Change, Endocrinology Care for Transgender and Gender Expansive Youth and Adults, December 2021
   c. Speaker, Children with Diabetes National Conference, Friends for Life, "Transition from Pediatric to Adult Care", July 2018
   d. Planning committee member and speaker at JDRF community outreach summits (Nov 2019, Nov 2017, Nov 2016, Nov 2015, March 2015, March 2013)
   e. Speaker at Turner Syndrome community outreach events (May 2017, May 2015, May 2014, May 2012)
   f. Speaker and event coordinator, Building Bridges for a Successful Future with Diabetes, family outreach program (February 2014)
4. Listing of teaching materials developed:
   a. Pediatric Endocrine Society Webinar Series for Fellows on Quality Improvement (3/2021)
   b. American Board of Pediatrics Roadmap project website video resources, Talking About Emotional Health (09/2020). The full set of videos and associated guides are on the Roadmap webpage at: https://www.abp.org/foundation/roadmap
      Direct link to my video on talking to teens with diabetes about depression: https://fast.wistia.net/embed/channel/til9iwsorj?wchannelid=til9iwsorj&wvideoid=3bl9aqh8ur
   c. Virtual lecture for pediatric residents on Endocrinology rotation, "Thyrotoxicosis and Hyperthyroidism in Adolescents" (4/2020)
   d. Content review and editing of American Board of Pediatrics Roadmap materials for maintenance of certification module, Emotional Health and Resilience for Patients and Families with Chronic Pediatric Conditions, (12/2019)

e. "Demystifying MOC Part 4, Quality Improvement for Endocrinologists" National Webinar for Pediatric Endocrine Society (11/2019)
f. Type 1 Diabetes Exchange Depression Screening Change Package (2018) Depression Screening on 2019 : Nov Learning Session | Trello
g. Depression Screening on 2019 : Nov Learning Session | Trello
h. "Future with Diabetes" transition materials for patients (2014-2015)
i. "Diabetes and Alcohol" resource materials (2016)
j. Diabetes transition readiness assessment curriculum development for diabetes team (2015-2018)
k. "Talking T1D" electronic book resource for adolescents and young adults developed in with graduate students at University of Cincinnati professional writing course, published on JDRF website, http://jdrf.org/swo/2016/01/15/talking-t1d-ebook/ (01/2016)

5. Evidence of teaching excellence: Fellow ratings of teaching performance in an anonymous survey in four categories (support/latitude of management; accurate information/fosters problem solving skills; encourages self-learning/provides mentoring; treats with respect/provides feedback) using a seven-point scale (range 1-7, maximum =7). Scores for the last 8 years were:

2014: 6.55 (Division mean = 6.43, median = 6.45, range = 6.98-5.880)
2015: 6.56 (Division mean = 6.49, Median = 6.47; range = 6.96-5.89)
2016: 6.61 (Division mean = 6.46, Median = 6.46; range = 6.96-5.34)
2017: 6.67 (Division mean = 6.35, median = 6.18, range = 6.83-5.78)
2019: 6.61 (Division mean = 6.66, median = 6.64, range = 6.93 – 6.41)
2020: 6.68 (Division mean = 6.72, median = 6.75, range = 7.00 - 6.55)
2021: 6.79 (Division mean = 6.73, median = 6.77, range = 6.98 - 6.50)
2022: 6.77 (Need to obtain Division mean, median, range data)

Mentoring

Fellows and Students

As Director of the Quality Scholars Program, I participate in the scholarly oversight committee of each scholar.

Within the Division of Endocrinology, past mentees:

1. Dr. Alison Smego, (clinical and research mentor, 2014-2017). Dr. Smego was recognized for excellence during poster sessions of the Pediatric Academic and Pediatric Endocrine Society meeting and published her QI project, "Decreasing the Time to Insulin Administration for Hospitalized Patients with Cystic Fibrosis Related Diabetes" in journal Hospital Pediatrics 2018.
2. Dr. Kristal Matlock, (clinical and research mentor, 2015-2018). Dr. Matlock presented nationally and published, "Clinical and psychosocial factors associated with suicidal ideation in adolescents with type 1 diabetes mellitus" in the Journal of Adolescent Health in 2017. In addition, Dr. Matlock completed formal QI coursework and presented an oral presentation at national Endocrine Society meeting and subsequently published, "Untreated Congenital Hypothyroidism Due to Loss to Follow-Up: Developing Preventative Strategies through Quality Improvement", in the Journal of Pediatric Endocrinology and Metabolism in 2018.
3. Dr. Alissa Roberts, visiting Endocrinology Fellow from Seattle Children's for clinical transition medicine elective (March 2017)
4. Riley Brock, Undergraduate Student in SURF program (Summer 2017), completed project on shared decision- making regarding use of diabetes related technology amongst adolescents.
5. Dr. Jacob Redel, (clinical mentor, 2016-2018). Dr. Redel led a QI Prevnar/Pneumovax immunization initiative for patients with diabetes. As chief fellow, Dr. Redel coached a team composed of first year fellows led by Dr. Michael Yao to reliably address parental worry in parents of young children

with diabetes and detailed a method for applying QI training in sub-specialty fellowship setting published in Medical Education in 2019.

6. Dr. Eirene Alexandrou, Endocrinology Fellow (clinical mentor, 2017-2020). Dr. Alexandrou completed a QI project on screening for anxiety symptoms among girls and women with Turner Syndrome published in Hormone Research Paediatrics in 2022.
7. Dr. Nat Nasomyont, (clinical and research mentor, 2017--2020). Dr. Nasomyont completed a prospective pilot study of bone health outcomes amongst youth with gender dysphoria treated with puberty blockers.
8. Dr. Priscilla Rodas, Endocrinology Fellow (clinical mentor, 2019-2022). Dr. Rodas completed a QI project on uploading diabetes devices prior to and between clinic visits.
9. Dr. Andrew Lavik, (research mentor, 2019-2022), was a RISE award recipient as a pediatric resident, for project, "Utilization of a condition-specific registry to improve patient-reported and health-related outcomes in children with type 1 diabetes." During fellowship, Dr. Lavik completed research with T1Dx-QI about DKA concurrent with COVID-19 with results published in JCEM 2022.
10. Dr. Samantha Roberge, (research mentor, 2022--). Dr. Roberge is working on developing a curriculum for transgender health and a research project evaluated bone health outcomes among youth that receive GnRH agonist treatment. Dr. Roberge has an abstract accepted for Pediatric Endocrine Society in 2023.
11. Dr. Hailee Delsart, (research mentor, 2022--). Dr. Delsart is a member of the Pediatric Ambulatory Safety Learning Lab AHRQ sponsored research project. Dr. Delsart is leading work developing and conducting simulation scenarios for diabetes sick day management. She is a co-author on a publication in Pediatric Quality and Safety on "Safer Type 1 Diabetes Care at Home".

Division of Endocrinology faculty peer mentorship:

1. Dr. Sarah Lawson (QI mentorship, collaborator). I coached Dr. Lawson during an improvement methodology course (I2S2, 2015-2016) that built upon work of Dr. Smego to reduce time to insulin administration, resulted in redesign of insulin ordering process to increase timeliness and safety across the institution. Dr. Lawson has gone on to fundamentally restructure care delivery for new onset diabetes from an inpatient to a Day Hospital model (2016-2017) and develop protocols for timely insulin ordering and administration throughout the institution.
2. Dr. Nancy Crimmins (QI mentorship, collaborator). I assisted Dr. Crimmins and Dr. Daniel Mallon to develop a clinical algorithm for screening of Celiac Disease amongst new onset and established diabetes patients (2015-2017). This work has been presented at national and international meetings and helps support innovative inter-disciplinary clinical care for dual diagnosis patients.
3. Dr. Halley Wasserman (mentorship). I meet with Dr. Wasserman monthly to discuss current research and clinical projects, and coach on professional and career development.
4. Dr. Nana Hawa-Yayah Jones (QI mentorship, collaborator). I coached Dr. Jones during an improvement methodology course (RCIC with Dr. Matlock, 2014-2015) that led to a reliable process to prevent loss to follow up for children with congenital hypothyroidism, which is a model for other conditions within the division of endocrinology. I am a collaborator with Dr. Jones in partnership with community health to identify interventions for population of youth at high risk of diabetes complications (2017-ongoing). Through the Health Equity Network, and ConnecT1D, Dr. Jones has led implementation of screening for social determinants of health in diabetes clinic, and further systematically identifying, and addressing health equity gaps for youth with diabetes.

Service and Leadership

Service:

Professional Organization Memberships

- American Diabetes Association, Member

- Pediatric Endocrine Society, Member and Quality Improvement Committee Member
- International Society of Pediatric and Adolescent Diabetes, Member
- Endocrine Society, Member
- American Academy of Pediatrics, Member, Former Chair of Resident Section

Local Committee Involvement:

- Place Outcomes Grant Reviews (2017, 2021)
- Standard care algorithm pilot, type 1 diabetes and celiac disease (November 2015--2017)
- Member, CCHMC and University of Cincinnati transition to adult care teams (2013--2017)
- Project lead, Improving transition between pediatric and adult diabetes care (2013--)
- Project lead, Improving depression screening for diabetes patients (2011--2016)
- Patient Reported Outcomes Institutional Governance Committee for CCHMC (2018--)
- COVID-19 matrix for annual review (2020)
- Institutional Ambulatory Access Steering Committee (2022-2023)
- Institutional Psychosocial Screening and Response Taskforce (2022--)
- Institutional Adult Care Taskforce (2023--)
- Institutional Digital Care Transformation Taskforce (2023--)

National/International Distinguished Activities:

- Speaker, Pediatric Endocrine Society, Workshop, How to Start and Sustain QI, San Diego, California, May 2023.
- Speaker, International Society for Pediatric and Adolescent Diabetes (ISPAD), ConnecT1D: reinforcing connections between patients, clinic, and community to achieve excellent and equitable outcomes. Rotterdam, The Netherlands, October 2023.
- Speaker, ISPAD, Transition Workshop, Secrets of Successful Transition: Readiness and Receivership, Rotterdam, The Netherlands, October 2023.
- International Turner Syndrome Guidelines Committee, Aarhus, Denmark, June 2023.
- National Webinar sponsored by USNWR Making a Difference for Kids with Type 1 Diabetes: Advances and Challenges, March 2023.
- Guest Speaker (virtual due to Covid-19) BDC Endocrinology Grand Rounds, Applying Lessons from Community Pediatrics In Pursuit of Equity in Type 1 Diabetes, April 2022.
- Guest Speaker (virtual due to Covid-19), Diabetes, Research and Training Center (DRTC) Seminar Vanderbilt University, Patient Reported Outcomes: Using Clinic Based Screening and Intervention to Inform Diabetes Care, Feb 2021
- Speaker, European Society Pediatric Endocrinology, Condition Specific Tools for Transition Care: Lessons from Turner Syndrome Models, September 2018, Athens, Greece
- Type 1 Diabetes Exchange Learning Collaborative national meeting organizer and presenter, May 2018, Cincinnati, Ohio
- Speaker, Pediatric Endocrine Society, "Quality Improvement in Endocrinology", May 2018, Toronto, Canada
- Speaker, NIDDK/ADA workshop, "Patient Reported Outcomes that Matter to Providers", Nov 2017, Bethesda, Maryland
- Visiting Professor, "Integrating Improvement into Daily work of Pediatric Endocrinology" University of Michigan, September 2017, Ann Arbor, Michigan
- Speaker, American Diabetes Association, "Patient Reported Outcomes- Using Clinic Based Screening and Intervention to Inform Diabetes Care", June 2017
- Speaker, American Diabetes Association, "Getting to Goal in Pediatric Type 1 Diabetes" June 2016

Updated 2.1.2024

- Speaker, American Diabetes Association, "Design and Validation of Diabetes Transition Preparation Readiness Skills Measure" June 2016
- Speaker, Health Care Transition Research Consortium, "One Year Outcomes of Planned Transition of Pediatric to Adult Diabetes Care". Houston, TX. September 2015
- Speaker, Society of Adolescent Health and Medicine, "Transitioning Trans patients". Los Angeles, California, March 2015
- International Turner Syndrome Consensus Guideline Delegate, July 2016

Data Safety and Monitoring Board Participation

- 4T Study of remote patient monitoring in dose changes for newly diagnosed children with T1D
- Reduce Study is a national clinical trial for young adults that aims to reduce diabetes distress.

Manuscripts Reviewed:

- JAMA Network Open 2022 (1)
- Diabetes Spectrum 2015 (1) 2016 (1)
- Pediatrics 2014 (1) 2015 (1) 2016 (1) 2017 (2)
- Journal of Health Psychology 2014 (1)
- Lancet Journal of Diabetes and Endocrinology 2014 (2)
- Journal of Diabetes Science and Technology 2016 (1)
- Pediatric Diabetes 2016 (2) 2017 (2) 2019 (1) 2020 (5) 2021 (2) 2022 (2)
- Diabetes Care 2018 (1) 2022 (2)
- The Permanente Journal 2017 (1)
- Journal of Adolescent Health 2017 (1) 2018 (1)
- Endocrine Practice 2017 (1)
- Diabetic Medicine 2020 (2) 2023 (1)
- Journal of American Medical Informatics 2020 (1)
- Diabetes Research and Clinical Practice 2020 (1)
- Journal of Clinical Endocrinology and Metabolism 2020 (1)
- Canadian Journal of Diabetes 2020 (1) 2021 (1)
- Diabetes Technology and Therapeutics 2022 (1)

Participation in department recruitment activities:

- Participated in recruitment of endocrinology fellows and faculty candidates annually.
- Participated in interviews for faculty members in divisions of adolescent medicine, behavioral medicine and clinical psychology, hematology and oncology, emergency medicine, gastroenterology, critical care.

Participation in local activities that benefit the institution:

- Speaker, IHI Open House, Integrating Improvement into Academic Medicine (May 2017)
- Speaker, Chronic Care Webinar with Jennifer Lail and Donna Claes, (May 2017)
- Speaker at the Ohio Valley Chapter, Society of Adolescent Health, "Cases in Transgender Care; Inter-disciplinary panel discussion", (November 2017)
- Speaker at Southwest Ohio Professional Transgender Conference, Endocrine Care for Transgender Adults (November 2015)

Community activities:

- Board member of SW Ohio JDRF chapter (July 2014-2020)
- Team Captain, American Diabetes Association, Step Out to Stop Diabetes Walk (2010-2013)
- Volunteer, Children's International Summer Village, Peace Education Program (2022--)

Updated 2.1.2024

Leadership:

Local:

1. Clinical Director, Division of Pediatric Endocrinology (2021--)
2. Director, Quality Scholars Program (2017--2024)
3. Director, Diabetes Transition Program (2013-2023)
4. Co-President, WIMS, (Women in Medicine and Science) with Dr. Jennifer O'Toole (2020-2023)
5. Physician lead, USNWR Endocrinology division reporting team (2014--)
6. Physician lead, condition outcome improvement team, type 1 diabetes (March 2014-2019)
7. Completed CORE leadership training program- Class VI (2017-2018)

National:

8. Diabetes Expert Panel for the National Committee for Quality Assurance (NCQA) (2020--)
9. Faculty lead, Type 1 Diabetes Exchange, Learning Network Quality Improvement Initiative (2015--)
10. Advisory board member, Type 1 Diabetes Outcome Program, JDRF national initiative (2016-2017)
11. Clinical advisory board member, College Diabetes Network (2015-2019)
12. Advisory board member, Turner Syndrome Network, clinical centers of excellence (2017-2020)
13. Pediatric Endocrine Society, MOC-QI Committee Member (2018-2024)

International:

1. Data Publications and Presentation Committee (DPPC) board member, SWEET international diabetes network (4/2021--)

EXHIBIT B

Bibliography

1. Carswell, J.M., X. Lopez, and S.M. Rosenthal, The Evolution of Adolescent Gender-Affirming Care: An Historical Perspective. Horm Res Paediatr, 2022. 95(6): p. 649-656.
2. Chen, D., et al., Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. N Engl J Med, 2023. 388(3): p. 240-250.
3. de Vries, A.L., et al., Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics, 2014. 134(4): p. 696-704.
4. Gaudino, R., et al., Current clinical management of constitutional delay of growth and puberty. Ital J Pediatr, 2022. 48(1): p. 45.
5. Gravholt, C.H., et al., Clinical practice guidelines for the care of girls and women with Turner syndrome: proceedings from the 2016 Cincinnati International Turner Syndrome Meeting. Eur J Endocrinol, 2017. 177(3): p. G1-G70.
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11. Wiepjes, C.M., et al., The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets. J Sex Med, 2018. 15(4): p. 582-590.

IN THE COURT OF COMMON PLEAS
FOR FRANKLIN COUNTY, OHIO

MADELINE MOE, et al. Plaintiffs, v. DAVID YOST, et al. Defendants.	Case No. _____ Judge _____

EXPERT AFFIDAVIT OF JACK TURBAN, M.D.

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jack.turban@gmail.com (Principal)

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tess.sabo@gmail.com
I, Theresa M Sabo, did witness the participants named above electronically sign this document.

EXPERT AFFIDAVIT OF JACK TURBAN, M.D.

INTRODUCTION

I, Jack Turban, M.D., hereby declare and state as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. 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.

3. In preparing this affidavit, I reviewed Ohio H.B. 68 (hereafter "the medical care ban"). In addition to that legislation and the materials cited herein, I have also relied on my years of research and other experience, as set out in my curriculum vitae (**Exhibit A**) in forming my opinions. The materials I have relied upon in preparing this affidavit are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject, and particular studies that I rely upon are included in the bibliography (**Exhibit B**). 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.

BACKGROUND AND QUALIFICATIONS

4. I am currently an Assistant Professor of Child & Adolescent Psychiatry at the University of California, San Francisco (UCSF) School of Medicine, where I am also Affiliate Faculty at the Philip R. Lee Institute for Health Policy Studies. As a member of the faculty at UCSF, I serve as director of the Gender Psychiatry Program in the Division of Child & Adolescent Psychiatry. I also serve as an attending psychiatrist in the adult LGBT psychiatry clinic, and in the eating disorders program. I conduct research focusing on the determinants of mental health among

transgender youth and teach medical students, psychology trainees, psychiatry residents, and child and adolescent psychiatry fellows.

5. I received my undergraduate degree in neuroscience from Harvard College. I received both my MD and Master of Health Science degrees from Yale University School of Medicine. I completed residency training in general psychiatry in the combined Massachusetts General Hospital / McLean Hospital residency training program (Harvard Medical School) and fellowship training in child and adolescent psychiatry at Stanford University. I am board certified in psychiatry by The American Board of Psychiatry and Neurology.

6. My research focuses on the mental health of transgender youth and gender dysphoria. While at Yale, I was awarded the Ferris Prize for my thesis entitled "Evolving Treatment Paradigms for Transgender Youth." In 2017, I received the United States Preventative Health Services Award for Excellence in Public Health, based on my work related to the mental health of transgender youth. I have lectured on the mental health of transgender youth at Yale School of Medicine, UCSF, Stanford University, and The Massachusetts General Hospital (a teaching hospital of Harvard Medical School). I have given grand rounds presentations around the country and have presented nationally and internationally on topics related to the mental health of transgender people and people experiencing gender dysphoria.

7. I have served as a manuscript reviewer for numerous professional publications, including *The Journal of The American Medical Association (JAMA)*, *JAMA Pediatrics*, *JAMA Psychiatry*, *The Journal of The American Academy of Child & Adolescent Psychiatry*, *Pediatrics*, *Annals of Internal Medicine, The Journal of Child Psychology and Psychiatry, The Journal of Adolescent Health*, *Academic Psychiatry, Journal of Autism and Developmental Disorders,* and *The American Journal of Public Health*. I have served as lead author for textbook chapters on the

mental health of transgender youth, including for *Lewis's Child & Adolescent Psychiatry: A Comprehensive Textbook* and the textbook of The International Academy for Child & Adolescent Psychiatry and Allied Professionals. I am co-editor of the textbook *Pediatric Gender Identity: Gender-Affirming Care for Transgender and Gender Diverse Youth* and a contributing editor for *the Journal of the American Academy of Child & Adolescent Psychiatry*.

8. I have published extensively on the topic of transgender youth, including nine articles in peer-reviewed journals within the past two years.

9. In the last four years, I have been retained as an expert and provided testimony in the following cases: *K.C. v. Individual Members of Medical Licensing Board of Indiana, et al.*, No. 1:23-CV-00595 (S.D. Ind. 2023) (deposition); *Poe v. Drummond*, No. 4:23-CV-00277 (N.D. Okla. 2023) (declaration); *Poe et al. v. Labrador et al.*, No. 1:23-CV-269 (D. Idaho 2023) (deposition); *L.W. et al. v. Skrmetti et al.*, No. 3:23-CV-00376 (M.D. Tenn. 2023) (declaration); *Regino v. Staley*, No. 2:23-CV-00032 (E.D. Cal. 2023) (declaration); *PFLAG, Inc. et al. v. Abbott et al.*, Cause No. D-1-GN-22-002569 (459th Judicial District, Travis County, Texas 2022) (evidentiary hearing); *Brandt et al. v. Griffin et al.*, No. 4:21-CV-450 (D. Ark. 2021) (deposition and trial testimony); *Hecox et al. v. Little et al.*, No. 1:20-CV-184 (D. Idaho 2020) (declaration).

10. I am being compensated at an hourly rate of $400 per hour for preparation of expert affidavits and reports, and for time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

SUMMARY OF OPINIONS

11. In this declaration, I cite relevant literature to support my opinions that: (1) gender-affirming medical interventions improve mental health outcomes for adolescents with gender dysphoria when medically indicated; (2) adolescents who experience gender dysphoria at the onset

of puberty rarely come to identify with their sex assigned at birth; (3) regret among individuals receiving medical treatment for gender dysphoria is uncommon; and (4) the legislative findings that accompanied the medical care ban contained numerous misstatements of the relevant literature regarding gender identity and gender dysphoria and were incorrect with respect to the scientific and medical evidence regarding the safety and efficacy of gender-affirming medical care for adolescent gender dysphoria.

GENDER-AFFIRMING MEDICAL INTERVENTIONS IMPROVE MENTAL HEALTH OUTCOMES FOR ADOLESCENTS WITH GENDER DYSPHORIA WHEN MEDICALLY INDICATED

12. The medical care ban is not supported by data and runs counter to the widely accepted views of the mainstream medical community. Existing research shows gender-affirming medical treatments for adolescents with gender dysphoria are consistently linked to improved mental health, and denial of such care is expected to lead to adverse mental health outcomes, including, in some instances, worsening suicidality.

13. All of the major medical organizations in the United States have highlighted the importance of gender-affirming medical care for adolescents with gender dysphoria and have issued explicit statements opposing bans on this care. These organizations include The American Medical Association, The American Academy of Pediatrics, The American Psychiatric Association, The American College of Physicians, The American Academy of Family Physicians, The American Academy of Child & Adolescent Psychiatry, The Endocrine Society, The Pediatric Endocrine Society, The World Professional Association for Transgender Health, and the United States Professional Association for Transgender Health, among many others.[1]

[1] For a list of statements, please see Turban, J. L., Kraschel, K. L., & Cohen, I. G. (2021). Legislation to criminalize gender-affirming medical care for transgender youth. *JAMA*, *325*(22), 2251-2252.

14. A substantial body of evidence links gender-affirming medical interventions to improved mental health outcomes for adolescents with gender dysphoria, who, without treatment, experience higher levels of depression, anxiety, and suicidality. While each of these studies as with all studies in medicine has strengths and limitations, and no one study design can answer all questions regarding an intervention, taken together, these studies indicate that gender-affirming medical care improves mental health for adolescents who require such care.

15. Peer-reviewed cross-sectional and longitudinal studies[2] have found that pubertal suppression is associated with a range of improved mental health outcomes for adolescents with gender dysphoria, including statistically significant improvements in internalizing psychopathology (*i.e.*, anxiety and depression), externalizing psychopathology (*e.g.*, disruptive behaviors), global functioning, and suicidality.[3] For example, in the realm of cross-sectional studies, Turban et al. *Pediatrics* 2020 found that, after controlling for a range of other variables,

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[2] A note on methodology: cross-sectional studies examine mental health at a single point in time. For example, van der Miesen et al. 2020 *Journal of Adolescent Health* compared, at a single time point, those who accessed pubertal suppression with those who desired but had not accessed it. van der Miesen, A.I.R., Steensma, T.D., de Vries, A.L.C., *et al*. (2020). Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *Journal of Adolescent Health*, 66(6), 699-704. Longitudinal studies examine multiple time points (e.g., looking at levels of suicidality before and after gender-affirming medical care).

[3] 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.R., Steensma, T.D., de Vries, A.L.C, *et al*. (2020). Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *Journal of Adolescent Health*, 66(6), 699-704; and 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.

those who accessed pubertal suppression had lower odds of lifetime suicidal ideation than those who desired but were unable to access this intervention during adolescence.[4] A similar study by van der Miesen et al. in the *Journal of Adolescent Health* compared 272 adolescents who had not yet received pubertal suppression with 178 adolescents who had been treated with pubertal suppression.[5] Those who had received pubertal suppression had statistically significant lower "internalizing psychopathology" scores (a measure of anxiety and depression). Longitudinal studies have yielded similar results.[6]

16. Peer-reviewed research studies have likewise found improved mental health outcomes following gender-affirming hormone treatment (*e.g.*, estrogen or testosterone) for individuals with gender dysphoria, including adolescents. These include statistically significant improvements in internalizing psychopathology (*e.g.*, anxiety and depression), general well-being, and suicidality.[7] For example, Chen et al. followed a cohort of 315 transgender youth receiving

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[4] 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.

[5] van der Miesen, A.I.R., Steensma, T.D., de Vries, A.L.C., *et al*. (2020). Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *Journal of Adolescent Health*, 66(6), 699-704.

[6] See for example, de Vries, A.L., McGuire, J.K., Steensma, T.D., *et al.* (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696-704; and Costa, R., Dunsford, M., Skagerberg, E., Holt, V., *et al.* (2015). Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *Journal of Sexual Medicine*, 12(11), 2206-2214.

[7] See for example, Chen, D., Berona, J., Chan, Y.M., *et al.* (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England Journal of Medicine*, 388(3), 240-250; 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; 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

gender-affirming hormone treatment and found improvements in anxiety, depression, and life satisfaction.[8] In that study, parallel-process models were used to show that appearance congruence tracked along with improvements in mental health, indicating that physical changes from gender-affirming hormone treatment were the cause of improved mental health. 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.[9] Cross-sectional studies comparing those who accessed gender-affirming hormones during adolescence to those who did not access these interventions have similarly linked access to gender-affirming hormone treatment during adolescence to lower odds of suicidality.[10]

17. Overall, as summarized above, existing peer-reviewed published research studies consistently link gender-affirming medical interventions to improved mental health for individuals with gender dysphoria, including adolescents.

López de Lara, D., Pérez Rodríguez, O., Cuellar Flores, I., *et al.* (2020). Psychosocial Assessment in Transgender Adolescents. *Anales de Pediatría (English Edition)*, 93(1), 41-48.

[8] Chen, D., Berona, J., Chan, Y.M., *et al.* (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England Journal of Medicine*, 388(3), 240-250.

[9] 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.

[10] See for example, Turban, J.L., King, D., Kobe, J., *et al.* (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*, 17(1):e0261039; and Green, A.E., DeChants, J.P., Price, M.N., *et al.* (2022). Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *Journal of Adolescent Health*, 70(4), 643-649.

18. There are no evidence-based interventions, other than gender-affirming medical care, that treat adolescent gender dysphoria. There are no evidence-based psychotherapy protocols that have been shown to effectively treat gender dysphoria. In other words, though the H.B. 68 lawmakers quarrel with the strength of the studies that demonstrate the efficacy of gender-affirming medical interventions, there are *no studies of any kind* indicating improved health outcomes from psychotherapy alone to treat gender dysphoria.[11] And what clinical experience has shown is that psychotherapy alone, without medical intervention where indicated, does not improve gender dysphoria. Under the medical care ban, medical and mental health providers would be left with no evidence-based treatment approaches to support their adolescent patients with gender dysphoria. This would be a devastating situation for adolescents and their parents, physicians, and other mental health providers who care for them.

19. In the past, some clinicians have described psychotherapeutic strategies that aimed to result in youth with gender dysphoria identifying with their sex assigned at birth, hoping such approaches would alleviate gender dysphoria.[12] Such practices, termed "gender identity conversion efforts," have subsequently been linked to adverse mental health outcomes, including suicide attempts.[13] In addition to being harmful, there is no peer-reviewed research to suggest that

[11] Of note, some adolescents with gender dysphoria may also have other co-occurring conditions that should be treated with psychotherapy (*e.g.,* obsessive compulsive disorder should be treated with exposure and response prevention therapy), but these treatments for co-occurring conditions should not be confused with treating gender dysphoria.

[12] Meyer-Bahlburg, H.F. (2002). Gender Identity Disorder in Young Boys: A Parent-and Peer-Based Treatment Protocol. *Clinical Child Psychology and Psychiatry*, 7(3), 360-376.

[13] Turban, J.L., Beckwith, N., Reisner, S.L., & Keuroghlian, A.S. (2020). Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. *JAMA Psychiatry*, 77(1), 68-76.

these gender identity conversion efforts are successful in changing a person from transgender to cisgender. Gender identity conversion efforts have been labelled unethical by major medical organizations including The American Medical Association[14] and The American Academy of Child & Adolescent Psychiatry.[15] The United Nations has called for an end to the practice worldwide.[16]

20. The studies supporting the efficacy of gender-affirming care have had substantially long follow-up periods, particularly when compared to other commonly used medications in pediatrics. For example, one study by deVries et al. in the journal *Pediatrics* examined mental health outcomes a mean 5.9 years after starting pubertal suppression.[17] Turban et al. 2022 *PLoS One*, which found associations between access to gender-affirming hormone treatment during adolescence and better mental health outcomes, similarly examined mental health outcomes a mean six to seven years after starting gender-affirming hormones.[18] To put this into context, a major study used by the FDA to approve the medication lurasidone for bipolar depression in

[14] American Medical Association (2018). Health Care Needs of Lesbian, Gay, Bisexual and Transgender and Queer Populations. H-160.991. *Available at* https://policysearch.ama-assn.org/policyfinder/detail/gender%20identity?uri=%2FAMADoc%2FHOD.xml-0-805.xml.

[15] American Academy of Child & Adolescent Psychiatry (2018). Conversion Therapy. *Available at* https://www.aacap.org/AACAP/Policy Statements/2018/Conversion Therapy.aspx.

[16] United Nations (2020). Practices of so-called "conversion therapy." *Available at* https://digitallibrary.un.org/record/3870697?ln=en&v=pdf.

[17] de Vries, A.L., McGuire, J.K., Steensma, T.D., *et al.* (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696-704.

[18] Turban J.L., King D., Kobe J., *et al.* (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*. 17(1):e0261039.

children and adolescents followed study participants for six weeks.[19] If the state were to ban all medications that lack at least a decade of long-term follow up studies, that would require banning a substantial proportion of FDA-approved and relied-upon medications.

21. Given the well-documented benefits of gender-affirming medical care outlined above, and the known harms of untreated adolescent gender dysphoria, banning this care is expected to lead to substantial deterioration of mental health for adolescents diagnosed with gender dysphoria. For many of these patients, this is likely to include worsening suicidality.[20] A recent qualitative study of 273 parents of transgender youth identified that bans on gender-affirming care led to substantial concerns that their children would have worsening mental health and be at an increased risk of death from suicide.[21] These parents implored lawmakers to leave critical decisions about gender-affirming medical interventions to families and their medical providers.[22] While parent-report-only studies (*i.e.*, those that do not include the perspectives of patients themselves) should be interpreted with caution, these findings closely align with the other patient-report studies mentioned earlier and thus warrant serious concern. Another qualitative study of 103 healthcare providers who care for transgender youth similarly identified substantial concerns that

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[19] DelBello, M.P., Goldman, R., Phillips, D., *et al.* (2017). Efficacy and Safety of Lurasidone in Children and Adolescents with Bipolar I Depression: A Double-Blind, Placebo-Controlled Study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(12), 1015-1025.

[20] See, for example, Green, A.E., DeChants, J.P., Price, M.N., *et al.* (2022). Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *Journal of Adolescent Health*, 70(4), 643-649 and other studies cited above.

[21] Kidd, K.M., Sequeira, G.M., Paglisotti, T., *et al.* (2021). "This Could Mean Death for My Child": Parent Perspectives on Laws Banning Gender-Affirming Care for Transgender Adolescents. *Journal of Adolescent Health*, 68(6), 1082-1088.

[22] *Id.*

such bans would lead to worsening mental health and increased risk of suicide for adolescents with gender dysphoria.[23]

ADOLESCENTS WHO EXPERIENCE GENDER DYSPHORIA AT THE ONSET OF PUBERTY RARELY COME TO IDENTIFY WITH THEIR ASSIGNED SEX AT BIRTH

22. Though the terms "children" and "adolescents" are sometimes used synonymously in common parlance, these terms have specific and distinct meanings in the context of child and adolescent psychiatric research. In this field, "child" and "children" refer to minors who have not yet reached the earliest stages of puberty (*i.e.,* Tanner Stage 2). The terms "adolescent" and "adolescents" refer to minors who have begun puberty. Studies of prepubertal children (who are not candidates for gender-affirming medical interventions under any existing clinical guidelines) cannot be conflated with studies of adolescents (who, depending on several factors, may be candidates for various forms of gender-affirming medical interventions).

23. This distinction is vital in the realm of "desistence" studies (*i.e.*, studies that aim to assess how many young people who identify as transgender will later identify as cisgender). The suggestion that a majority of transgender minors affected by this law will come to identify with their assigned sex at birth inappropriately relies on studies of gender diverse *prepubertal* children, which have, in the past, shown that many of these children will not grow up to be transgender. These studies do not apply to transgender minors who have reached puberty (*i.e.*, "adolescents"). Once a transgender youth begins puberty, it is rare for them to later identify as cisgender.[24]

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[23] Hughes, L.D., Kidd, K.M., Gamarel, K.E., *et al.* (2021). "These Laws Will Be Devastating": Provider Perspectives on Legislation Banning Gender-Affirming Care for Transgender Adolescents. *Journal of Adolescent Health*, 69(6), 976-982.

[24] See for example de Vries, A.L., McGuire, J.K., Steensma, T.D., *et al.* (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696-704; and Turban, J.L., de Vries, A.L.C., & Zucker, K. (2018). Gender Dysphoria and Gender Incongruence. In Martin A., Bloch M.H., & Volkmar F.R. (Editors): *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook, Fifth Edition*. Philadelphia: Wolters Kluwer. This

Furthermore, physicians and families must weigh the low risk of a future cisgender identification against the often substantial risk of deteriorating mental health due to active gender dysphoria. Under existing medical guidelines, any minor who is considering gender-affirming medical or surgical interventions must first work with a mental health professional to conduct a complete biopsychosocial evaluation, which includes ensuring that an adolescent and their parents understand the complexity of this decision. Such evaluations are designed to minimize regret rates.

24. Any study regarding prepubertal children and their likelihood of ultimately identifying as transgender should not be used to assess the interventions targeted by the medical care ban, namely, pubertal suppression, hormone therapy, and gender-affirming surgery, since none of these interventions are provided to prepubertal patients with gender dysphoria under current medical guidelines.[25]

25. Further, the utility of "desistence" studies even for assessing the likelihood that prepubertal children will persist in a transgender identity has been questioned due to their reliance on an outdated diagnosis of "gender identity disorder in children," which did not require a child to identify as a sex different than their sex assigned at birth. This diagnosis likely captured many cisgender "tomboys" or cisgender boys with feminine interests like dresses or dolls, who never identified as transgender and, thus, unsurprisingly did not identify as transgender when followed up with later in life. In contrast, the diagnosis of "gender dysphoria in children" requires one to not merely have gender atypical interests and behaviors; one must identify as a gender different

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textbook chapter provides comments from the directors of two of the oldest and most established gender clinics in the world.

[25] 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.

than one's sex assigned at birth. This is a vital distinction. While the diagnostic category of "gender identity disorder" would capture many cisgender children, the diagnostic category of "gender dysphoria," by definition, does not.[26] Of note, a recent study by Princeton professor Dr. Kristina Olson et al. found that the vast majority of prepubertal transgender children continued to identify as transgender over a five-year follow-up period.[27]

REGRET AMONG INDIVIDUALS RECEIVING MEDICAL TREATMENT FOR GENDER DYSPHORIA IS UNCOMMON

26. De-transition and transition regret are distinct concepts, and transition regret is uncommon. Given that de-transition has heterogeneous definitions, I caution against interpreting papers that use the term without clarifying how the phrase is being used.

27. The term "de-transition" is used inconsistently in literature and may sometimes refer to simply the stopping of medical interventions. But discontinuation of gender-affirming medical interventions does not always coincide with a change in understanding of one's gender identity or with transition-related regret. Rather, transgender adolescent patients who discontinue gender-affirming medical interventions may do so because of external factors (*e.g.*, pressure from family, societal rejection, harassment by peers). For example, a substantial number of currently identified transgender people (13.1%) have "de-transitioned" at some point in their life, with the

[26] The desistance studies have also been criticized for a range of other methodological limitations. Olson, K.R. (2016). Prepubescent Transgender Children: What We Do and Do Not Know. *Journal of the American Academy of Child & Adolescent Psychiatry*, 55(3), 155-156.

[27] Olson, K. R., Durwood, L., Horton, R., *et al.* (2022). Gender Identity 5 Years After Social Transition. *Pediatrics*, 150(2):e2021056082. Additionally, while one may ask if a social transition increases likelihood of "persistence," another study from this group (Rae et al. *Psychological Sciences*) found that social transition does not increase gender incongruence. Rae JR, Gülgöz S, Durwood L, *et al.* (2019). Predicting Early-Childhood Gender Transitions. *Psychological Sciences* 30(5), 669-681.

majority (82.5%) citing external factors like family rejection, societal stigma, or harassment.[28] Given that these people *currently* identify as transgender, it highlights that many people who "de-transition" choose to transition again in the future.

28. Studies focused specifically on regret, as opposed to the broad heterogeneous category of "de-transition," indicate that regret is extremely rare. In 2018, Amsterdam's VUMC Center of Expertise on Gender Dysphoria published the rates of regret among their cohort of 6,793 transgender patients who had undergone gender-affirming medical and/or surgical interventions.[29] Among transgender women with gender dysphoria who underwent gender-affirming surgery, 0.6% experienced regret. Among transgender men with gender dysphoria who underwent gender-affirming surgery, 0.3% experienced regret. Several of those who experienced regret were classified as having "social regret" rather than "true regret," defined in the study as still identifying as transgender but deciding to reverse their gender-affirming surgery due to factors like "the loss of relatives [being] a large sacrifice." The study also reported that only 1.9% of adolescents who started pubertal suppression did not choose to go onto gender-affirming hormones. In a second study of 143 transgender adolescents who started pubertal suppression, five adolescents (3.5%) decided not to proceed with further gender-affirming medical treatments.[30] One of these

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[28] Turban, J.L., Loo, S.S., Almazan, A.N., & Keuroghlian, A.S. (2021). Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. *LGBT Health,* 8(4), 273-280.

[29] Wiepjes, C.M., Nota, N.M., de Blok, C.J., *et al.* (2018). The Amsterdam Cohort of Gender Dysphoria Study (1972 2015): Trends in Prevalence, Treatment, and Regrets. *The Journal of Sexual Medicine*, 15(4), 582-590.

[30] Brik, T., Vrouenraets, L.J.J.J., de Vries, M.C., *et al.* (2020). Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria. *Archives of Sexual Behavior*, 49(7), 2611-2618.

adolescents noted that pubertal suppression helped them to better understand their gender identity, and they ultimately identified with their sex assigned at birth. One birth-assigned female had ongoing chest dysphoria but chose to live with a female gender expression regardless, though was dreading further breast development and menstruation. One stopped due to unspecified "psychosocial reasons" but continued to identify as transgender. One identified as gender non-binary and felt they no longer needed treatment. One came to identify with his sex assigned at birth. There was no indication that any of these adolescents *regretted* pubertal suppression; rather, this study shows that the treatment served its goal of allowing adolescents more time to better understand their gender identity before being assessed for additional treatment. Cases of initiating then discontinuing gender-affirming hormones like estrogen or testosterone appear to be uncommon, largely at the case report level.[31] In one of these case reports, a patient similarly noted that a trial of estrogen helped them to better understand their gender identity, which had evolved to non-binary, and they did not regret initiating estrogen therapy.[32] Though there have been scattered and difficult-to-confirm social media reports of people regretting gender-affirming medical care (as with any form of medical treatment), this must be considered in the context of the 1.4 million transgender people in the United States alone.[33] The largest study to date that aimed to identify people who specifically started then stopped gender-affirming medical interventions

[31] A case report is a publication in which clinicians report on what occurred with a single patient.

[32] Turban, J.L., Carswell, J., & Keuroghlian, A.S. (2018). Understanding Pediatric Patients Who Discontinue Gender-Affirming Hormonal Interventions. *JAMA Pediatrics*, 172(10), 903-904.

[33] Flores, A.R., Herman, J.L., Gates, G.J., *et al.* (2016). How Many Adults Identify as Transgender in the United States? The Williams Institute, UCLA School of Law. *Available at* https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Adults-US-Aug-2016.pdf.

identified 100 individuals from around the world.[34] 34% of participants were from outside the United States. In this study, the average age of having started any gender-affirming medical intervention was 21.9 years, suggesting that these individuals were primarily cared for in the adult model of care, not the pediatric model of care, the latter of which requires a comprehensive biopsychosocial mental health assessment designed to minimize regret rates. Among these participants who had discontinued gender-affirming hormones, 34% reported that transition was "a necessary part of their journey" (*i.e.*, important for coming to better understand themselves and their gender identity). 67.7% reported they were helped in some way by gender-affirming medical care. While it is important to ensure that people are adequately supported in the rare instances of stopping gender-affirming medical interventions,[35] it is essential to contextualize this small number of cases among the 1.4 million transgender people in the U.S. alone, as well as the complexities of their experiences, which do not universally indicate regret.

29. All treatments in medicine carry risks, benefits, and side effects. It is essential that parents, adolescents, and their doctors be able to work together to weigh these factors and choose a path forward that is *most likely* to improve a young person's health, including their mental health. If the government were to ban all medical treatments with potential adverse side effects or the possibility of regret, it would ban essentially of all medicine. As one example, the vast majority of people who take the antibiotic penicillin find that their infections resolve; however, a small number of people will experience Stevens-Johnson syndrome (SJS) or toxic epidermal necrolysis (TEN)

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[34] Littman, L. (2021). Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. *Archives of Sexual Behavior*, 50(8), 3353-3369.

[35] Turban, J.L., Brady, C., & Olson-Kennedy, J. (2022). Understanding and Supporting Patients With Dynamic Desires for Gender-Affirming Medical Interventions. *JAMA Network Open*, 5(7): e2224722.

from the medication rare and potentially fatal conditions in which the person's skin detaches.[36] Morality rates from SJS/TEN are as high as 50%. The cholesterol-lowering medication atorvastatin (known to many under the brand name Lipitor) is one of the most commonly prescribed medications in the U.S., given its potential to lower cholesterol and subsequently reduce the risk of a heart attack. However, a small number of people will experience rhabdomyolysis as a side effect a potentially fatal form of muscle breakdown that can cause kidney damage. Though both these medications carry a serious risk of adverse side effects, they help the vast majority of people, and thus should not be—and are not banned. The responsibility of the clinician is to inform patients about these risks, benefits, and potential side effects, and work with patients and families to identify the best course of action. Gender-affirming care is not unique in carrying risks, side effects, or the possibility of regret.

30. While there is undoubtedly a small number of people who start gender-affirming medical interventions and later stop them, many people stop medical interventions for reasons other than a change in transgender identification, and among those small minority, an even smaller minority appear to regret the treatment. As with all medical interventions, gender-affirming medical interventions cannot claim a 100% success rate. However, for the vast majority of adolescents, these interventions improve mental health. Accordingly, it is dangerous to take the only evidence-based treatment option away from families and physicians as they work together to examine existing evidence and their individual case to determine what pathway is most likely to result in favorable mental health outcomes for an adolescent.

[36] Lee, E.Y., Knox, C., & Phillips, E.J. (2023). Worldwide Prevalence of Antibiotic-Associated Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis: A Systematic Review and Meta-analysis. *JAMA Dermatology*, 159(4), 384-392.

THE LEGISLATIVE FINDINGS FOR THE MEDICAL CARE BAN ARE FACTUALLY INCORRECT AND UNSUPPORTED BY THE RELEVANT LITERATURE

31. I have reviewed the legislative findings that accompanied the medical care ban. They contain numerous misstatements of the relevant literature regarding gender identity and gender dysphoria, as well as the scientific and medical evidence for the safety and efficacy of gender affirming medical care in adolescents. In addition to the general opinions offered above, I specifically address findings (C), (D), (E), (F), (G), (N), and (O) below.

32. As set forth in paragraphs 23-26 above, and contrary to legislative finding (C), the statement that "the vast majority of children who are gender nonconforming or experience distress at identifying with their biological sex come to identify with their biological sex in adolescence or adulthood, thereby rendering most medical health care interventions unnecessary" is extraordinarily misleading. As set forth in greater detail earlier in this declaration, prepubertal children are not candidates for gender-affirming medical interventions under current guidelines. Furthermore, once a transgender youth begins puberty (*i.e.*, the earliest time point at which a gender-affirming medical intervention would potentially be considered), it is extremely rare for them to later identify as cisgender.[37] Any study regarding prepubertal children and their likelihood of ultimately identifying as transgender should not be used to assess the medical interventions targeted by the medical care ban, namely, pubertal suppression and gender-affirming hormones,

[37] See Turban, J.L., de Vries, A.L.C., & Zucker, K. (2018). Gender Dysphoria and Gender Incongruence. In Martin A., Bloch M.H., & Volkmar F.R. (Editors): *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook, Fifth Edition*. Philadelphia: Wolters Kluwer. This textbook chapter provides comments from the directors of two of the oldest and most established gender clinics in the world.

since none of these interventions are provided to prepubertal patients under current medical guidelines.[38]

33. Contrary to legislative finding (D), it is not the case that "Scientific studies show that individuals struggling with distress at identifying with their biological sex often have already experienced psychopathology, which indicates these individuals should be encouraged to seek mental health care services before undertaking any hormonal or surgical intervention." First, this statement implies a misrepresentation of the model of gender-affirming care for adolescent gender dysphoria. The current standards of care require a biopsychosocial mental health assessment prior to initiating gender-affirming medical interventions for minors.[39] As the WPATH Standards of Care note, this biopsychosocial assessment is often extended "for youth with more complex mental health presentations (e.g., complicating mental health histories), co-occurring autism spectrum characteristics, or an absence of experienced childhood gender incongruence."[40] Such mental health assessments exist to distinguish other mental health conditions from gender dysphoria and to determine if gender-affirming medical interventions may be appropriate or not. Second, as discussed above, while psychotherapy can be very helpful for adolescents with gender dysphoria to help explore their gender identity and address comorbid conditions (e.g., major depressive

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38 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. *Journal of Clinical Endocrinology & Metabolism*, 102(11), 3869-3903.

39 Coleman, E., Radix, A.E., Bouman, W.P., *et al.* (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, 23(Suppl 1), S1-S259.

40 *Id.*

disorder, generalized anxiety disorder), there are no evidence-based psychotherapy protocols that effectively treat gender dysphoria itself.

34. The legislative finding (E) that "Suicide rates, psychiatric morbidities, and mortality rates remain markedly elevated above the background population after inpatient gender reassignment surgery has been performed" is misleading. First, mental health improves following gender-affirming medical care for adolescents with gender dysphoria, an effect mediated by an increase in congruence between participants' gender identities and their physical bodies.[41] Second, transgender people face a range of stressors that affect their mental health, most prominently societal rejection based on being transgender. Though gender-affirming medical interventions improve mental health, they cannot eliminate societal discrimination, and thus even after intervention, many transgender people still suffer elevated rates of mental health problems compared to cisgender people.[42] Additionally, while gender-affirming medical interventions may improve mental health by improving certain aspects of gender dysphoria (e.g., improved voice dysphoria with testosterone), it cannot necessarily improve all domains of gender dysphoria (e.g., testosterone has minimal impact on chest tissue and thus generally does not relieve chest dysphoria). This reality of mental health challenges even with gender-affirming care is not a valid argument against the provision of gender-affirming care. To draw a simple analogy, I have many patients with depression and anxiety whose symptoms improve with psychiatric medications, but

[41] Chen, D., Berona, J., Chan, Y.M., *et al.* (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England Journal of Medicine*, 388(3), 240-250.

[42] It is worth noting, however, that some studies of adolescents with gender dysphoria who received gender-affirming medical care while in very accepting communities had mental health outcomes on par with the general population. de Vries, A.L., McGuire, J.K., Steensma, T.D., *et al.*. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696-704.

do not completely abate. This, of course, does not mean that the medications were not effective in improving symptoms, nor that we should ban these treatments. Legislative finding (D) appears to be a distorted reading of studies like Dhejne et al.'s study from 2011, which found that those who had gender-affirming surgery had a 19-fold increased odds of suicidality when compared to the general population.[43] That study is not evidence that gender-affirming care is ineffective or that it increases suicide risk. As the authors of that study explained in their discussion: "It is therefore important to note that the current study is only informative with respect to transsexual persons health after sex reassignment; no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism. In other words, the results should not be interpreted such as sex reassignment per se increases morbidity and mortality. Things might have been even worse without sex reassignment. As an analogy, similar studies have found increased somatic morbidity, suicide rate, and overall mortality for patients treated for bipolar disorder and schizophrenia. This is important information, but it does not follow that mood stabilizing treatment or antipsychotic treatment is the culprit."[44] Of note, a more recent study that compared those who accessed gender-affirming surgery to those who desired such surgeries but were unable to access them found that those who accessed surgery had lower odds of suicidality.[45]

35. Contrary to legislative finding (F), it is not the case that with respect to "puberty-blocking drugs" there is a "lack of any long-term longitudinal studies evaluating the risks and

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[43] Dhejne, C., Lichtenstein, P., Boman, M., *et al.* (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*, 6(2):e16885.

[44] *Id.*

[45] Almazan, A.N., & Keuroghlian, A.S. (2021). Association Between Gender-Affirming Surgeries and Mental Health Outcomes. *JAMA Surgery*, 156(7), 611-618.

benefits of using these drugs for the treatment of such distress or gender transition." There are over a dozen studies evaluating the efficacy and effectiveness[46] of puberty blockers and gender-affirming hormones for the treatment of adolescents with gender dysphoria.[47] These studies can be roughly delineated into two categories: uncontrolled longitudinal studies and controlled cross-sectional studies. Uncontrolled longitudinal studies (*e.g.*, Chen et al. *New England Journal of*

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[46] Efficacy refers to studies looking at an intervention under "ideal circumstances" (e.g., in a research clinic), whereas effectiveness studies look at the impact of an intervention under "real world" conditions (*i.e.,* in the general community practice setting).

[47] Such studies include: 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; de Vries, A.L., McGuire, J.K., Steensma, T.D., *et al.* (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696-704; Costa, R., Dunsford, M., Skagerberg, E., *et al.* (2015). Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *The Journal of Sexual Medicine*, 12(11), 2206-2214; 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; Kaltiala, R., Heino, E., Työläjärvi, M., *et al.* (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry*, 74(3), 213-219; López de Lara, D., Pérez Rodríguez, O., Cuellar Flores, I., *et al.* (2020). Psychosocial assessment in transgender adolescents. *Anales de Pediatría (English Edition)*, 93(1), 41-48; van der Miesen, A.I.R., Steensma, T.D., de Vries, A.L.C., *et al.* (2020). Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *Journal of Adolescent Health*, 66(6), 699-704; Kuper, L.E., Stewart, S., Preston, S., *et al.* (2020). Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy. *Pediatrics*, 145(4):e20193006; 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; Green, A.E., DeChants, J.P., Price, M.N., *et al.* (2021). Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *Journal of Adolescent Health*, 70(4), 643-649; Turban, J.L., King, D., Kobe, J., *et al.* (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*, 17(1): e0261039; Tordoff, D.M., Wanta, J.W., Collin, A., *et al.* (2022). Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Network Open*, 5(2):e220978; Chen, D., Berona, J., Chan, Y.M., *et al.* (2023). Psychosocial functioning in transgender youth after 2 years of hormones. *New England Journal of Medicine*, 388(3), 240-250.

Medicine 2023[48] and deVries et al. *Pediatrics* 2014[49]) have examined mental health before and after gender-affirming medical interventions and found that mental health is improved after treatment. Controlled cross-sectional studies (e.g., van der Miesen et al. *Journal of Adolescent Health*[50] and Turban et al. *PLoS One*[51]) have compared those who accessed gender-affirming medical care to those who desired but did not access this treatment and found that those who accessed treatment had better mental health outcomes. These two types of study designs offer complementary information that make experts in this field confident regarding the mental health benefits of these treatments. The results of these studies are additionally supplemented by decades of clinical experience from experts around the world who care for adolescents with gender dysphoria who have likewise documented and shared the substantial clinical benefits that their adolescent patients with gender dysphoria have experienced from gender-affirming medical treatment.

36. With respect to legislative finding (G) regarding the absence of randomized controlled trials for the provision of hormone therapy to adolescents with gender dysphoria, there are many controlled cross-sectional studies and uncontrolled longitudinal cohort studies, both of which are well-accepted in medical research and often relied upon in medicine. Randomized

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[48] Chen, D., Berona, J., Chan, Y.M., *et al.* (2023). Psychosocial functioning in transgender youth after 2 years of hormones. *New England Journal of Medicine*, 388(3), 240-250.

[49] de Vries, A.L., McGuire, J.K., Steensma, T.D., *et al.* (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696-704.

[50] van der Miesen, A.I.R., Steensma, T.D., de Vries, A.L.C., *et al.* (2020). Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *Journal of Adolescent Health*, 66(6), 699-704.

[51] Turban, J.L., King, D., Kobe, J., *et al.* (2022). Access to gender affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*, 17(1):e0261039.

controlled trials are not always feasible or ethical in medicine. It is true that randomized controlled trials provide valuable information and strong evidence of causation that other studies do not. Randomized controlled trials are not feasible in the realm of gender-affirming medical care for adolescent gender dysphoria in particular. Because of the existing body of literature linking gender-affirming medical care to improved mental health outcomes for adolescents with gender dysphoria, it would be extraordinarily difficult to recruit people to participate in studies, knowing they could be randomized to receive no treatment. Particularly for vulnerable and pediatric populations, it is not considered ethical to randomize patients to placebo treatments when there is substantial evidence that active treatment confers important benefits. Thus, a randomized controlled trial of gender-affirming medical care for adolescent gender dysphoria would be unlikely to be approved by an Institutional Review Board (IRB), the ethical boards at universities that decide if research is allowed to proceed.[52] Moreover, such a study could not be blinded because of the physical effects of the treatment: those in the control group for either pubertal suppression or hormone therapy would, based on their continued progress (or not) through endogenous puberty and based on their development of gender-affirming secondary sex characteristics (or not) would know whether they had been provided a placebo or the intervention. Additionally, there have been no randomized controlled trials of using psychotherapy alone to treat gender dysphoria, as the state seems to suggest.

[52] Of note, an RCT was recently conducted in Australia among adults with gender dysphoria to examine the impact of testosterone therapy. Nolan, B.J., Zwickl, S., Locke, P., *et al.* (2023). Early Access to Testosterone Therapy in Transgender and Gender-Diverse Adults Seeking Masculinization: A Randomized Clinical Trial. *JAMA Network Open*, 6(9):e2331919. The RCT found that those randomized to immediate testosterone therapy had better mental health outcomes than those randomized to the clinic's regular waitlist. Given that minors are a vulnerable group that generally warrants stricter protection under IRB review, it is unlikely that such an RCT would be approved for adolescent patients.

37. For these reasons, as well as those listed throughout this declaration, legislative findings (N) and (O) are incorrect to the extent they claim there is a "lack of studies showing that the benefits of such extreme interventions outweigh the risks" or that the "risks of gender transition services far outweigh any benefit at this stage of clinical study on these services." The relevant literature is to the contrary.

CONCLUSION

38. In summary, gender-affirming medical care for adolescent gender dysphoria, when medically indicated, is supported by a substantial body of peer-reviewed scientific evidence that has been collected over more than a decade. Though these treatments, like all medical treatments, carry potential risks and side effects, these potential risks must be weighed against the benefits of treatment and the risks of not providing treatment. There is nothing anomalous about the risks and side effects of treatment for gender dysphoria that would warrant singling out this care for prohibition. It is essential that physicians be able to work with adolescents and their families to weigh potential benefits against potential risks and side effects and provide the care that is appropriate for a given adolescent and their family. Banning these medical interventions would leave physicians without any evidence-based treatments for adolescent gender dysphoria, which, when left untreated, has been linked to dramatic adverse mental health outcomes, including suicidality. For these reasons, all relevant major medical organizations (The American Medical Association, The American Academy of Pediatrics, The American Psychiatric Association, The American Academy of Child & Adolescent Psychiatry, The Endocrine Society, and The Pediatric Endocrine Society, to name a few) oppose bans on gender-affirming medical care for adolescents with gender dysphoria.

Jack Turban
Signed on 2024/03/22 18:41:18 -5:00

JACK L. TURBAN, MD, MHS

Signed at:

Franklin ,Ohio

County

03/22/2024

Sworn to and subscribed before me this day of March, 2024

Signed on 2024/03/22 18:41:18 -5:00

Notary Public

NOTARY PUBLIC
STATE OF OHIO

Theresa M Sabo
Commission # 2016-RE-619622
Electronic Notary Public
State of Ohio
My Comm Exp. Nov 28, 2026

Notary Stamp 2024/03/22 15:41:18 PST

Notarial act performed by audio-visual communication

EXHIBIT A

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ACADEMIC APPOINTMENTS

University of California, San Francsisco School of Medicine San Francisco, CA. September 2022-Present
Assistant Professor of Child & Adolescent Psychiatry and Affiliate Faculty in the Philip R. Lee Institute for Health Policy Studies. Responsibilities include directing the Gender Psychiatry Program and serving as an attending psychiatrist in the adult gender and sexual minority clinic, and in the eating disorders clinic, as well as research focusing on the determinants of mental health among transgender and gender diverse youth and the teaching of medical students, residents, and fellows.

EDUCATION & TRAINING

Stanford University School of Medicine Palo Alto, CA July 2020-June 2022
Fellow in Child & Adolescent Psychiatry. Fellow in child and adolescent psychiatry. Research focused on pediatric gender identity and LGBTQ mental health. Served as administrative chief fellow 2021-2022.

Massachusetts General Hospital & McLean Hospital Boston, MA July 2017 – May 2020
Integrated Adult, Child, & Adolescent Psychiatry Resident. Resident physician in the integrated adult, child, and adolescent psychiatry program. Research focused on pediatric gender identity and LGBT mental health.

Yale School of Medicine New Haven, CT. August 2012- May 2017
Doctor of Medicine & Master of Health Science with honors. Clinical rotations included inpatient pediatrics, inpatient child psychiatry, inpatient adolescent psychiatry, residential adolescent psychiatry, psychiatric consult liaison service, clinical neuromodulation, neurology clinics, and neurosurgery. Completed award-winning masters' thesis as a Howard Hughes Medical Institute (HHMI) medical research fellow on evolving treatment paradigms for transgender youth.
Clerkship Grades: All Honors
USMLE: Step 1 (252), Step 2 (256)

Harvard University Cambridge, MA September 2007- May 2011
B.A. Neurobiology magna cum laude with a secondary in the Dramatic Arts. Coursework included clinical neuroscience, systems neurobiology, visual neuroscience, positive psychology, neurobiology of behavior, CNS regenerative techniques, neuroanatomy, vertebrate surgery, and extensive coursework in dramatic theory and practice. International study included Spanish language (Alicante, Spain), stem cell biology (Shanghai, China), and studying how visual art may be used as a window into the mechanisms of neural processing (Trento, Italy). Honors thesis completed at The Massachusetts Eye & Ear Infirmary studying inner-ear development and regeneration. GPA: 3.8/4.0

RESEARCH EXPERIENCE

The Fenway Institute Boston, MA 2017-Present
Post-doctoral Research Fellow. Currently using data from the National Transgender Discrimination Survey to determine the adult mental health correlates of recalled childhood experiences including exposure to conversion therapy and access to gender-affirming hormonal interventions. PIs: Timothy Wilens, Alex Keuroghlian, & Sari Reisner

Stanford Division of Child & Adolescent Psychiatry Palo Alto, CA 2020-2022
Post-doctoral Resaerch Fellow. Estabished the Stanford Evaluation of Gender Affirmation (SEGA) study, which examines the impact of gender-affirming medical and surgical interventions on the mental health of transgender and gender diverse youth. Mentors: Dr. David Hong & Dr. Tandy Aye

McLean Institute for Technology in Psychiatry Belmont, MA. 2017-2020
Post-doctoral Research Fellow. Conducted cross-sectional studies that examine the associations between geosocial "hook-up apps," internalizing psychopathology, and compulsive sexual behavior. Utilizing the TestMyBrain platform. PI: Laura Germine

Yale Program for Research on Impulsivity & Impulse Control Disorders New Haven, CT 2016-2019

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Pre-doctoral Research Fellow. Conducted a studies of US military veterans who had recently returned from deployment, studying rates and comorbidities of those veterans who exhibit compulsive sexual behavior facilitated by social media. PI: Marc Potenza MD/PhD

Yale Child Study Center New Haven, CT 2015-2017
Pre-doctoral Research Fellow. Conducted a study to evaluate pediatric attending and medical student knowledge regarding transgender pediatric patient care. Additionally studied participants' personal ethical views regarding pubertal blockade and cross-sex hormone therapy for adolescent patients. PI: Timothy VanDeusen MD

Yale Department of Dermatology New Haven, CT 2015-2016
HHMI Medical Research Fellow. Studied the potential molecular mediators of Langerhans Cell-mediated UVB-induced epidermal carcinogenesis. Techniques included transgenic mouse models of chronic UV exposure, epidermal sheet preparations, immunohistochemistry, confocal microscopy, flow cytometry, Bioplex analysis, quantitative PCR and tissue culture. PI: Michael Girardi MD

Yale Department Laboratory Medicine New Haven, CT 2012-2014
Pre-doctoral Research Fellow. Employed mass spectrometry to compare metabolite profiles of recurrent tumor versus radiation-induced necrosis following Gamma Knife Radiosurgery for brain metastases, working to identify novel biomarkers for non-invasive imaging techniques. PI: Tore Eid MD/PhD

Yale Department of Neurosurgery New Haven, CT 2012-2012
Pre-doctoral Research Fellow. Developed a database of patients who received gamma knife radiosurgery or whole brain radiation for the treatment of brain metastases. This database is designed to evaluate the relative risks of radiation-induced necrosis following these two treatment modalities. PI: Veronica Chiang MD

Eaton-Peabody Laboratory Cambridge, MA 2009-2011
Undergraduate Rearch Fellow. Worked at the Massachusetts Eye and Ear Infirmary laboratory, studying stem cells of the inner ear and working toward cochlear hair cell regeneration. PI: Albert Edge PhD

LEADERSHIP

UCSF Child & Adolescent Psychiatry Grand Rounds Committee San Francisco, CA. 2023-Present
Member. Works with with committee to select and work with grand rounds speakers for the weekly child and adolescent psychiatry grand rounds series.

UCSF Child & Adolescent Psychaitry Fellowship Selection Committee San Francisco, CA 2022-Present
Member. Conducts interviews for applications to the UCSF child and adolescent psychiatry fellowship training program, sits on selection committee, works on recruitment efforts.

The Upswing Fund 2020-Present
Scientific Advisory Board. Member of the scientific advisory board of a $15M charitable fund to support adolescent minority mental health during the COVID19 pandemic. Funded by Melinda Gates's Panorama Global.

Stanford Medicine Diversity Cabinet LGBTQ+ / Sexual and Gender Minority Subcommittee 2021-2022
Member. Working to improve Stanford School of Medicine in all aspects relevant to sexual and gender minorities including curriculum, clinical care, and employee support.

Stanford Pediatric Gender Journal Club 2021-2022
Founder. Organizing a monthly journal club focusing on the latest research relevant to the care of transgender and gender diverse youth.

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MGH Psychiatry Gender Lab Meetings Boston, MA 2019-2020
Founder. Established monthly lab meetings for those in the MGH psychiatry department to discuss ongoing research regarding transgender mental health.

Yale School of Medicine Cultural Competence Committee New Haven, CT 2012-2017
Chair. Worked with individual course directors to develop course material on cultural competence. Authored case studies on handling pediatric patient sexuality (Professional Responsibility Course), authored a pre-clinical lecture on LGBT healthcare (Ob/Gyn Module), and lectured on transgender pediatric patient care (Pediatrics Clinical Clerkship).

Dean's Advisory Committee on LGBTQ Affairs (Yale School of Medicine) New Haven, CT 2016-2017
Member. Served on the advisory committee to the Dean of Yale School of Medicine, advising on issues related to LGBTQ affairs.

Yale HIV Dermatology Roundtable New Haven, CT 2014-2017
Founder. Eighty percent of patients suffering from HIV face a dermatologic manifestation of their disease. Struck by these patients' experience of stigma, I organized a bi-monthly interdisciplinary roundtable to improve research, education, and clinical care in HIV dermatology. Interventions have included primary care provider training on the treatment of genital warts and improved referral systems for cutaneous malignancies.

Yale Gay & Lesbian Medical Association New Haven, CT 2013-2017
President. Led a group of medical students focused on supporting careers in medicine for LGBT individuals. Organized mixers with LGBT organizations from other graduate schools and with LGBT faculty. Coordinated trips to GLMA national conferences. Worked with the medical school administration to create an LGBT faculty advisor position.

VOLUNTEER WORK & ADVOCACY

American Academy of Child & Adolescent Psychiatry "Break the Cycle" 2017-2017
Event Coordinator. Worked with Dr. Andres Martin to coordinate a fundraising indoor cycling event for the AACAP *Break The Cycle* fundraising campaign to fight children's mental illness.

Yale Hunger & Homelessness Auction New Haven, CT 2012-2014
Logistics Co-Chair. Organized a group of ten students to coordinate entertainment, donations, and event logistics for the Yale annual charity auction. All proceeds for the auction go to support local charities.

Yale School of Medicine Admissions Committee New Haven, CT 2015-2017
Interviewer. Served as a full voting member of the admissions committee. Responsibilities include student interviewing, recruitment, and organizing LGBT-focused activities for admitted students.

Harvard College Admissions New Haven, CT 2012-2020
Interviewer. Interviewing students from the Boston area for admission to Harvard College.

SELECTED PEER REVIEWED PUBLICATIONS: ORIGINAL RESEARCH

Turban J.L., Dolotina B., Freitag T.M., King D., Keuroghlian A.S. Age of realization of transgender identity and mental health outcomes among transgender and gender diverse adults. *Journal of Adolescent Health.* 72(6): 852-859.

Turban J.L., Dolotina B., King D., Keuroghlian A.S. (2022) Sex assigned at birth ratio among transgender and gender diverse adolescents in the United States. *Pediatrics*. 150(3):e2022056567.

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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.

Passell E., Rutter L.A., **Turban J.L.**, Scheuer L., Wright N., Germine L. (2021) Generalized Anxiety Disorder Symptoms are Higher Among Same- and Both-Sex Attracted Individuals in a Large, International Sample. *Sexuality Research and Social Policy*. [ePub ahead of print]

Lewis, J. M., Monico, P. F., Mirza, F. N., Xu, S., Yumeen, S., **Turban, J. L.**, Galan A., & Girardi, M. (2021). Chronic UV radiation–induced RORγt+ IL-22–producing lymphoid cells are associated with mutant KC clonal expansion. *Proceedings of the National Academy of Sciences*, 118(37).

Turban J.L., King, D., Li, J.L., Keuroghian, A.S. (2021) Timing of Social Transition for Transgender and Gender Diverse Youth, K-12 Harassment, and Adult Mental Health Outcomes. *Journal of Adolescent Health*. 69(6), 991-998.

Turban J.L., Loo, S. S., Almazan, A. N., Keuroghlian, A.S. (2021) Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. *LGBT Health*. 8(4), 273-280.

Turban, J. L., Passell E, Scheer L, Germine L. (2020) Use of Geosocial Networking Applications Is Associated With Compulsive Sexual Behavior Disorder in an Online Sample. *The Journal of Sexual Medicine*. 17(8), 1574-1578.

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.

Turban, J. L., Shirk, S. D., Potenza, M. N., Hoff, R. A., & Kraus, S. W. (2020). Posting Sexually Explicit Images or Videos of Oneself Online Is Associated With Impulsivity and Hypersexuality but Not Measures of Psychopathology in a Sample of US Veterans. *The Journal of Sexual Medicine*, *17*(1), 163-167.

Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*, *77*(1), 68-76.

Acosta, W., Qayyum, Z., **Turban, J. L.**, & van Schalkwyk, G. I. (2019). Identify, engage, understand: Supporting transgender youth in an inpatient psychiatric hospital. *Psychiatric Quarterly*, 90(3), 601-612.

Turban, J. L., King, D., Reisner, S. L., & Keuroghlian, A. S. (2019). Psychological Attempts to Change a Person's Gender Identity from Transgender to Cisgender: Estimated Prevalence Across US States, 2015. *American Journal of Public Health*, 109(10), 1452-1454.

Turban, J. L., Winer, J., Boulware, S., VanDeusen, T., & Encandela, J. (2018). Knowledge and attitudes toward transgender health. *Clinical Teacher*, *15*(3), 203-207.

Turban, J. L., Potenza, M. N., Hoff, R. A., Martino, S., & Kraus, S. W. (2017). Psychiatric disorders, suicidal ideation, and sexually transmitted infections among post-deployment veterans who utilize digital social media for sexual partner seeking. *Addictive Behaviors*, 66, 96-100.

Turban J. L.*, Lu, A. Y*., Damisah, E. C., Li, J., Alomari, A. K., Eid, T., ... & Chiang, V. L. (2017). Novel biomarker identification using metabolomic profiling to differentiate radiation necrosis and recurrent tumor following Gamma Knife radiosurgery. *Journal of Neurosurgery*, 127(2), 388-396.

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Kempfle, J. S., **Turban, J. L.,** & Edge, A. S. (2016). Sox2 in the differentiation of cochlear progenitor cells. *Scientific Reports*, 6, 23293.

SELECTED PEER REVIEWED PUBLICATIONS: COMMENTARY, REVIEWS, & PERSPECTIVES

Turban J.L., Anderson T.M., Spetz J. Gender Identity and Ethnoracial Disparities in Conversion Effort Exposure. American Journal of Public Health. [Invited Commentary, Accepted for Publication]

Turban, J.L., Dolotina, B., Freitag, T.M., King, D., Keuroghlian, A.S. (2023) Rapid-Onset Gender Dysphoria Is Not a Recognized Mental Health Diagnosis. Journal of Adolescent Health. 73(6): 1163-1164.

Lerario, M.P., Fusunyan, M., Stave C.D., Roldan, V., Keuroghlian, A.S., **Turban, J.L.,** Perez, D.L., Maschi, T., Rosendale,
N. (2023) Functional neurologic disorder and functional somatic syndromes among sexual and gender minority people: a scoping review. Journal of Psychosomatic Research. 174: 111491.

Lerario, M. P., Rosendale, N., Waugh, J. L., **Turban, J.L.,** & Maschi, T. (2023). Functional Neurological Disorder Among
Sexual and Gender Minority People. Neurologic Clinics. 41(4): 759-781.

Chen A, Cohen I.G., Kraschel K., **Turban J.L.**. Legal & Ethical Perspectives on Criminalization of Standard of Care Medical Practices. *Cell Reports Medicine*.

Turban J.L., Brady C., & Olson-Kennedy J. Understanding & Supporting Patients with Dynamic Desires for Gender-affirming Medical Interventions. *JAMA Network Open*.

Dolotina B. **& Turban J.L.** "Phantom Networks" Prevent Children & Adolescents from Obtaining the Mental Health Care They Need. *Health Affairs*. 41(7).

Turban J.L., Kamceva M, Keuroghlian A.S. Pharmacologic Considerations for Transgender and Gender Diverse People. *JAMA Psychiatry*. 79(6): 629-630.

Dolotina B. & **Turban J.L.**. (2022) A multipronged, evidence-based approach to improving mental health among transgender and gender diverse youth. *JAMA Network Open*. 5(2): e220926.

Turban J.L., Almazan A.N., Reisner S.L., Keuroghlian A.S. (2022) The importance of non-probability samples in minority health research: lessons learned from studies of transgender and gender diverse mental health. *Transgender Health*. [ePub ahead of print]

Turban J.L., Kraschel K.L., Cohen, G.C. (2021) Legislation to Criminalize Gender-affirming Medical Care for Transgender Youth. *JAMA*. 325(22), 2251-2252.

Liu M., **Turban J.L.**, Mayer K.H. (2021) The US Supreme Court and Sexual and Gender Minority Health. *American Journal of Public Health*. 111(7), 1220-1222.

Suto, D.J., Macapagal, K., **Turban, J.L.** (2021) Geosocial Networking Application Use Among Sexual Minority Adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*. 60(4), 429-431.

Turban, J. L., Keuroghlian, A. S., & Mayer, K. H. (2020) Sexual Health in the SARS-CoV-2 Era. *Annals of Internal Medicine*. 173(5), 387-389.

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Suozzi, K., **Turban, J.L.,** & Girardi, M. (2020). Focus: Skin: Cutaneous Photoprotection: A Review of the Current Status and Evolving Strategies. *The Yale Journal of Biology and Medicine*, *93*(1), 55.

Malta, M., LeGrand, S., **Turban, J.L.**, Poteat, T., & Whetten, K. (2020). Gender-congruent government identification is crucial for gender affirmation. *The Lancet Public Health*. 5(4), e178-e179.

Turban J.L. (2019). Medical Training in the Closet. *The New England Journal of Medicine*, *381*(14), 1305.

Turban, J. L., & Keuroghlian, A. S. (2018). Dynamic gender presentations: understanding transition and" de-transition" among transgender youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, 57(7), 451-453.

Turban, J. L., Carswell, J., & Keuroghlian, A. S. (2018). Understanding pediatric patients who discontinue gender-affirming hormonal interventions. *JAMA Pediatrics*, *172*(10), 903-904.

Turban, J. L. (2018). Potentially Reversible Social Deficits Among Transgender Youth. *Journal of Autism and Developmental Disorders*, 48(12), 4007-4009.

Turban, J. L., & van Schalkwyk, G. I. (2018). "Gender dysphoria" and autism spectrum disorder: Is the link real?. *Journal of the American Academy of Child & Adolescent Psychiatry*, *57*(1), 8-9.

Turban, J. L., & Ehrensaft, D. (2018). Research review: gender identity in youth: treatment paradigms and controversies. *Journal of Child Psychology and Psychiatry*, *59*(12), 1228-1243.

Turban J. L., Genel, M. (2017) Evolving Treatment Paradigms for Transgender Patients. *Connecticut Medicine*, 81(8), 483-486.

Turban, J., Ferraiolo, T., Martin, A., & Olezeski, C. (2017). Ten things transgender and gender nonconforming youth want their doctors to know. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(4), 275-277.

Turban, J. L. (2017). Transgender Youth: The Building Evidence Base for Early Social Transition. *Journal of the American Academy of Child and Adolescent Psychiatry*, 56(2), 101.

Turban J. L., Martin A. (2017) Book Forum: Becoming Nicole. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(1): 91-92.

TEXTBOOKS AND TEXTBOOK CHAPTERS

Forcier, M., Van Schalkwyk, G., **Turban, J. L.** (Editors). Pediatric Gender Identity: Gender-affirming Care for Transgender & Gender Diverse Youth. Springer Nature, 2020.

Challa M., Scott C., **Turban J.L.** Epidemiology of Pediatric Gender Identity. In Forcier, M., Van Schalkwyk, G., **Turban, J. L.** (Editors). Pediatric Gender Identity: Gender-affirming Care for Transgender & Gender Diverse Youth. Springer Nature, 2020.

Turban J.L., Shadianloo S. Transgender & Gender Non-conforming Youth. In Rey, J.M. (Editor): IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva. International Association of Child and Adolescent Psychiatry and Allied Professionals, 2018.

Turban, J. L., DeVries, A.L.C., Zucker, K. Gender Incongruence & Gender Dysphoria. In Martin A., Bloch M.H., Volkmar F.R. (Editors): Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook, Fifth Edition. Philadelphia: Wolters Kluwer 2018.

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INVITED GRAND ROUNDS PRESENTATIONS

Turban JL. Research Updates: Supporting the Mental Health of Transgender & Gender Diverse Youth, UCSF Child Psychiatry and Behavioral Sciences Grand Rounds, 2024.

Turban JL. Transgender Youth Mental Health. Maudsley Hospital / Kings College London Grand Rounds, 2023.

Turban JL. Resaerch Updates: Supporting the Mental Health of Transgneder and Gender Diverse Youth. Department of Behavioral Health, Wake Forest School of Medicine / Atrium Health, 2023.

Turban JL. Supporting the Mental Health of Transgender and Gender Diverse Youth. Child & Adolescent Psychiatry Grand Rounds, Long Island Jewish Medical Center / Zucker Hillside, 2023.

Turban JL. Suicidality in Sexual and Gender Minority Youth. Psychiatry Grand Rounds, Boston Children's Hospital, 2023.

Turban JL. Opinion Writing to Promote Public Health & Evidence-Based Public Policy. Medical Education Grand Rounds, The University of Vermont Larner College of Medicine, 2022.

Turban JL. Research Updates: Supporting the Mental Health of Transgender & Gener Diverse Youth. Division of Child & Adolescent Psychiatry Grand Rounds, Stanford University School of Medicine, 2022.

Turban JL. Supporting Transgender & Gender Diverse Youth: Research Updates & Treatment Paradigms. Department of Psychiatry Grand Rounds, University of Nebraska Medical Center, 2022.

Turban JL. Supporting the Mental Health of Transgener & Gender Diverse Youth. Department of Pediatrics, Division of Behavioral Health Grand Rounds, University of Utah, 2022.

Turban JL. Gender Diverse Youth: Treatment Paradigms & Research Updates. Psychiatry Grand Rounds, Thomas Jefferson University, 2021.

Turban JL. Supporting Gender Diverse Youth Throughout Development. Child Psychiatry Grand Rounds, Georgetown, 2021.

Turban JL. Understanding Pediatric Gender Identity through Childhood and Adolescence. Grand Rounds, Institute of Living, 2021.

Turban JL. Evolving treatment paradigms for transgender youth. Pediatric Grand Rounds, Albany Medical Center, 2021.

Turban JL. Evolving Treatment Paradigms for Transgender Youth. Psychiatry Grand Rounds, McLean Hospital (Harvard Medical School), 2021.

Turban JL. Einstein Psychiatry Grand Rounds: Evolving Treatment Paradigms for Transgender Youth. Psychiatry Grand Rounds, Einstein Medical Center, 2021.

Turban JL. COVID19 and Pediatric Mental Health. Pediatrics Grand Rounds, Stanford University School of Medicine, 2021.

Turban JL. Evolving Treatment Paradigms for Transgender Youth. Psychiatry Grand Rounds, Beth Israel Deaconess

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Medical Center (Harvard Medical School), 2020.

ADDITIONAL INVITED PRESENTATIONS

Turban JL. Supporting the Mental Health of Transgender & Gender Diverse Youth. West Virginia Rural Health Equity Summit, Wheeling, West Virginia, 2023.

Turban JL. Suicide Prevention for LGBTQ+ Youth. National Institues of Health, Bethesda, 2023.

Turban JL. NAMI LGBTQ+ Mental Health Roundtable Discussion. National Alliance on Mental Illness, San Francisco, 2023.

Turban JL. Supporting the Mental Health of Transgender & Gender Diverse Youth. United Nations NGO Committee on Mental Health, United Nations, 2023.

Turban JL. Research Updates: Gender-affirming Care for Transgender Youth. MUSC LGBTQ+ Health Equity Summit, Medical University of South Carolina, 2022.

Turban JL. Keynote: Supporting The Mental Health of Transgender & Gender Diverse Youth. Edythe Kurz Educational Institute Conference, Westchester, 2022.

Turban JL, Peters B, Olson-Kennedy J. Gender-Affirming Care: Through a Medical, Surgical, and Mental Health Lens. Critical Issues in Child & Adolescent Mental Health Conference, San Diego, 2022.

Turban JL. Improving Mental Health Outcomes for Transgender and Gender Diverse (TGD) Youth Through Gender-affirming Care. National LGBTQIA+ Health Education Center, The Fenway Institute, 2022.

Turban JL. Combatting anti-trans legislation through science, data, and writing. State of Queer Mental Health Conference by The Mental Health Association of San Francisco, Online, 2021.

Turban JL. Updates on LGBTQ Mental Health. Annual Psychiatric Times World CME Conference, Online, 2021.

Turban JL. Imbasciani LGBTQ Health Equity Lecture: Evolving Treatment Paradigms for Transgender and Gender Diverse Youth. University of Vermont Larner College of Medicine, Burlington, 2021.

Turban JL. The Emergence of Gender-affirming Care for Transgender & Gender Diverse Youth, United Nations NGO Committee on Mental Health, Oral Presentation, Online, 2021.

Turban JL. Keynote – Transgender & Gender Diverse Youth: Research Updates. Stony Brook Transgender Health Conference, Online, 2021.

Turban JL. Opinion Writing on Sensitive Topics. Harvard Media & Medicine Course, Live Lecture, Online, 2021.

Turban JL. Gender affirming care for transgender and gender diverse youth: what we know and what we don't. University of Texas Pride Health Institute, Oral Presentation, Online, 2020.

Turban JL. Q&A on Transgender Youth Mental Health. PEOPLE in Healthcare at University of Toledo, Oral Presentation, Online, 2020.

Turban JL, Pagato S, Gold J, Broglie J, Naidoo U, Alvarado A. Innovation of Student Mental Health during COVID19. Panel to the People, Oral Presentation, Online, 2020.

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Turban JL, Belkin B, Vito J, Campos K, Scasta D, Ahuja A, Harris S. Discussion on Abomination: Homosexuality and the Ex-Gay Movement. Panelist, The Association of LGBTQ+ Psychiatrists Virtual Session, Oral Presentation, Online, 2020.

Turban JL. Is Grindr affecting gay men's mental health? Oral Presentation, UCLA & AETC Coping with Hope, Online, Oral Presentation, 2020.

Turban JL, Hall TM, Goldenberg D, Hellman R. Gay Sexuality and Dating. Moderator, The Association of LGBTQ+ Psychiatrists Virtual Session, Oral Presentation, Online, 2020.

CONFERENCE PRESENTATIONS & ABSTRACTS

Turban JL. A Systematic Approach for Understanding Gender Identity Evolution. Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Oral Presentation, Toronto, 2022.

Turban JL. Transgender Youth: Evolving Gender Identities and "Detransition." Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Session Chair of Oral Symposium, Toronto, 2022.

Turban JL, Gold J, Hartselle S, Yen J. From The New York Times to the Big Screen: Communicating With the Public Through Opinion Writing, Publishing, Social Media, and Consulting for Film and TV. Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Session Chair of Oral Symposium, Online, 2021.

Turban JL. Creating Change through Opinion Writing in Child & Adolescent Psychiatry. Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Oral Presentation, Online, 2021.

Turban JL, Giedinghagen A, Janssen A, Myint M, Daniolos P. Transgender Youth: Understanding "De-transition," Non-linear Gender Trajectories, and Dynamic Gender Identities. Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Session Chair of Oral Symposium, Online, 2021.

Turban JL. A framework for understanding dynamic gender identities through internal and external factors. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2021.

Turban JL, Geosocial networking application use among birth-assigned male adolescents. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2021.

Turban JL. LGBTQ Families and the US Supreme Court. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentations, Online, 2021.

Turban JL, King D, Kobe J, Reisner SL, Keuroghlian AS. Access to Gender-affirming Hormones during Adolescence and Mental Health Outcomes among Transgender Adults. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Poster, Online, 2021.

Turban JL. Gender Identity Conversion Efforts: Quantitative Perspectives. Annual Meeting of The American Psychiatric Association, Oral Presentation, Online, 2021.

Turban JL. For Worse: Negative Aspects of Social Media for LGBT Youth. Oral Presentation, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2020.

Turban JL. Hookup App Use among Gay and Bisexual Males: Sexual Risk and Associated Psychopathology. Oral Presentation, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Online, 2020.

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Turban JL. Communicating with the Public: From The New York Times to The Big Screen. Oral Presentation, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Online, 2020.

Turban JL, McFarland C, Walters O, Rosenblatt S. An Overview of Best Outpatient Practice in the Care of Transgender Individual. Oral Presentation, Annual Meeting of the American Psychiatric Association, Philadelphia, 2020. [Accepted, but cancelled due to COVID19]

Turban JL, Lakshmin P, Gold J, Khandai C. #PsychiatryMatters: Combating Mental Health Misinformation Through Social Media and Popular Press. Oral Presentation, Annual Meeting of the American Psychiatric Association, Philadelphia, 2020. [Accepted, but cancelled due to COVID19]

Turban JL. The Pen and the Psychiatrist: Outreach and Education Through the Written Word. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Chicago, 2019.

Turban JL. For Better and For Worse: Gender and Sexuality Online, Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Chicago, 2019.

Turban JL. Gender Diverse Young Adults: Narratives and Clinical Considerations, Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Chicago, 2019.

Turban JL. Transgender Youth: Controversies and Research Updates, Oral Presentation, Annual Meeting of the American Psychiatric Association, San Francisco, 2019.

Turban JL, Beckwith N, Reisner S, Keuroghlian A. Exposure to Conversion Therapy for Gender Identity Is Associated with Poor Adult Mental Health Outcomes among Transgender People in the U.S. Poster Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Seattle, 2018.

Shirk SD, **Turban JL**, Potenza M, Hoff R, Kraus S. Sexting among military veterans: Prevalence and correlates with psychopathology, suicidal ideation, impulsivity, hypersexuality, and sexually transmitted infections. Oral Presentation, International Conference on Behavioral Addictions, Cologne, Germany, 2018.

Turban JL. Gender Identity and Autism Spectrum Disorder. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Washington D.C., 2017.

Turban JL. Tackling Gender Dysphoria in Youth with Autism Spectrum Disorder from the Bible Belt to New York City. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent psychiatry, Washington D.C., 2017.

Turban JL. Affirmative Protocols for Transgender Youth. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Washington D.C., 2017.

Turban, JL. Evolving Management of Transgender Youth. Oral Presentation, Klingenstein Third Generation Foundation Conference, St Louis, 2017.

Turban, JL, Potenza M, Hoff R, Martino S, Kraus S. Clinical characteristics associated with digital hookups, psychopathology, and clinical hypersexuality among US military veterans. Oral Presentation, International Conference on Behavioral Addictions, Haifa, Israel, 2017.

Lewis J, Monaco P, **Turban JL**, Girardi M. UV-induced mutant p53 ketatinocyte clonal expansion dependence on IL-22 and RORγT. Poster, Society of Investigative Dermatology, Portland, 2017.

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Turban JL, Winer J, Encandela J, Boulware S, VanDeusen T. Medical Student Knowledge of and Attitudes toward Transgender Pediatric Patient Care. Abstract, Gay & Lesbian Medical Association, St Louis, 2016.

Turban JL, Lu A, Damisah E, Eid T, Chiang V. Metabolomics to Differentiate Radiation Necrosis from Recurrent Tumor following Gamma Knife Stereotactic Radiosurgery for Brain Metastases. Oral Presentation, 14th Annual Leksell Gamma Knife Conference, New York City, 2014

Turban JL, Lewis J, Girardi M. UVB-induced HMGB1 and extracellular ATP increase Langerhans cell production of IL-23 implicated in ILC3 activation. Poster, Society of Investigative Dermatology, Scottsdale, 2016

Turban JL, Lewis J, Girardi M. Characterization of cytokine pathways associated with Langerhans cell facilitation of UVB-induced epidermal carcinogenesis. Poster, American Society of Clinical Investigation, Chicago, 2016.

Lewis J, **Turban JL**, Girardi M, Michael Girardi. Langerhans cells and UV-radiation drive local IL22+ ILC3 in association with enhanced cutaneous carcinogenesis. Poster, Society of Investigative Dermatology, Scottsdale, 2016.

Sewanan L, Zheng D, Wang P, Guo X, Di Bartolo I, Marukian N, **Turban JL**, Rojas-Velazques D, Reisman A. Reflective Writing Workshops Led By Near Peers During Third-Year Clerkships: A Safe Space for Solidarity, Conversation, and Finding Meaning in Medicine. Poster & Workshop, Society of General Internal Medicine, New Haven and Hollywood, 2016.

AWARDS & HONORS

Top Peer Review Service, Annals of Internal Medicine (2022)
Stanford Child & Adolescent Psychiatry Chief Fellow (2021-2022)
Wasserman Award for Advocacy in Children's Mental Health (2021)
Top Manuscript of The Year - *Pediatrics* (2020)
American Psychiatric Association Child & Adolescent Psychiatry Fellowship (2019-2021)
Ted Stern Scholarship and Travel Award (2019)
Editor's Pick for Best Clinical Perspectives Manuscript – *Journal of The American Academy of Child & Adolescent Psychatry* (2018)
SciShortform Project: Best Shortform Science Writing, Columns & Op-Eds (2018)
Ted Stern Scholarship and Travel Award (2018)
Medaris Grant (2018)
Editor's Pick for Best Clinical Perspectives Manuscript – *Journal of The American Academy of Child & Adolescent Psychatry* (2017)
United States Preventative Health Services Award for Excellence in Public Health (2017)
NBC Pride 30 Innovator (2017)
Ferris Thesis Prize, Yale School of Medicine (2017)
Parker Prize, Yale School of Medicine (2017)
Howard Hughes Medical Institute Medical Research Fellowship (2015-2016)
American Academy of Child and Adolescent Psychiatry Life Members Mentorship Grant (2016)
Student Scholarship, Gender Conference East (2016)
Farr Award for Excellence in Research (2016)
Yale Office of International Medical Education Grant, Buenos Aires, Argentina (2016)
Yale Office of International Medical Education Grant, VU Medical Center, The Netherlands (2016)
Yale Summer Research Grant (2012)
AIG International Scholar, Harvard College (2007-2011)
Harvard International Study Grant, Alicante, Spain (2008)
David Rockefeller International Study Grant, Shanghai, China (2009)

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PROFESSIONAL MEMBERSHIPS & COMMITTEES

American Medical Association, Member
American Psychiatric Association, Member
American Academy of Child & Adolescent Psychiatry, Member
American Psychiatry Association, Council on Communications
American Academy of Child & Adolescent Psychiatry, Media Committee
American Academy of Child & Adolescent Psychiatry, Chair of Subcomittee on Interfacing with the Media
World Professional Association for Transgrender Health, Member
US Professional Association for Transgender Health, Member
US Professional Association for Transgender Health, Research Committee
Athlete Ally, Affiliate Scholar
Psychiatric Times, Editorial Board
Alpha Omega Alpha (AOA) Honor Medical Society, Member
NCAA Committee on Competitive Safeguards and Medical Aspects of Sports, Member

ACADEMIC JOURNAL SERVICE & AD HOC PEER REVIEW

PLoS One, Academic Editor
JAACAP, Contributing Editor
JAACAP, Guest Editor
JAMA, Peer Reviewer
JAMA Pediatrics, Peer Reviewer
JAMA Psychiatry, Peer Reviewer
JAMA Network Open, Peer Reviewer
Annals of Internal Medicine, Peer Reviewer
Pediatrics, Peer Reviewer
Journal of the American Academy of Child & Adolescent Psychiatry, Peer Reviewer
JAACAP Open, Peer Reviewer
Journal of Child Psychology and Psychiatry, Peer Reviewer
Journal of Adolescent Health, Peer Reviewer
Academic Psychiatry, Peer Reviewer
Journal of Autism and Developmental Disorders, Peer Reviewer
American Journal of Public Health, Peer Reviewer
Perspectives on Psychological Science, Peer Reviewer
Transgender Health, Peer Reviewer
Journal of Clinical Medicine, Peer Reviewer
Brain Sciences, Peer Reviewer
Social Science & Medicine, Peer Reviewer
Sexual Health, Peer Reviewer
Women, Peer Reviewer

EXHIBIT B

BIBLIOGRAPHY

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.

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.

Almazan, A.N., & Keuroghlian, A.S. (2021). Association Between Gender-Affirming Surgeries and Mental Health Outcomes. *JAMA Surgery*, 156(7), 611-618.

American Academy of Child & Adolescent Psychiatry (2018). Conversion Therapy. *Available at* https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx.

American Medical Association (2018). Health Care Needs of Lesbian, Gay, Bisexual and Transgender and Queer Populations. H-160.991. *Available at* https://policysearch.ama-assn.org/policyfinder/detail/gender%20identity?uri=%2FAMADoc%2FHOD.xml-0-805.xml.

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IN THE COURT OF COMMON PLEAS
FOR FRANKLIN COUNTY, OHIO

MADELINE MOE, et al. Plaintiffs, v. DAVID YOST, et al. Defendants.	Case No. _____ Judge _____

AFFIDAVIT OF MICHAEL MOE IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

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March 21, 2024 17:01:12 -5:00 [A76FA21387E0] [65.60.211.87]
tess.sabo@gmail.com
I, Theresa M Sabo, did witness the participants named above electronically sign this document.

AFFIDAVIT OF MICHAEL MOE IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Michael Moe, having first been duly cautioned and sworn, declare as follows:

1. I am over the age of 18 and competent to make this affidavit.

2. My name for the purposes of the above-captioned action is Michael Moe, a pseudonym.[1] I am a Plaintiff in this action. I offer this Affidavit in support of Plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction. I have personal knowledge of the facts set forth in this Affidavit and could and would testify competently to those facts if called as a witness.

3. I, along with my wife Michelle Moe, am next friend of my minor child, Madeline Moe.

4. I am an Ohio resident. I live in Hamilton County with my wife, our daughter Madeline who is 12 years old, and her sibling.

5. Madeline is smart, outgoing, and has had the same tight-knit group of friends since kindergarten. She loves to play sports, including volleyball, basketball, and track. She also like to play Roblox and watch videos of other kids playing video games.

6. My wife and I love our daughter, support her, and want her to be able to be herself.

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

8. Throughout her childhood, Madeline had been drawn to "girly" things. She preferred feminine clothes, enjoyed painting her nails, and styled her hair with headbands or towels

[1] Michelle, Madeline, and Michael are pseudonyms. My wife, my daughter (who is a minor), and I are proceeding under pseudonyms to protect our privacy and ourselves from discrimination, harassment, and violence, as well as retaliation for seeking to protect our rights.

to appear as though she had long hair. If she wore male clothing outside of the house, she would run upstairs and change into a dress when she got home. In preschool, whenever boys and girls were separated, she always wanted to go to the girl's side.

9. First grade, when Madeline was six years old, was a really tough year for her. She would refuse to get out of the car at school. Madeline would tell us, "I want to die and come back as a girl. Can't God just make me come back as a girl?" It got so bad that she would try to hurt herself.

10. We did everything we could to get help for Madeline. We called Cincinnati Children's Hospital Medical Center, specifically the Living with Change Center, because we wanted to know more about how best to support her. Madeline's school also provided a therapist so that she could discuss her feelings.

11. In April 2018, when Madeline was six years old, we met with a doctor at Cincinnati Children's, who diagnosed our daughter with gender dysphoria. In hindsight, that made sense to us. Madeline had been trying to tell us for a long time that she was a girl.

12. On the last day of first grade, Madeline told us, "This is it. I'm Madeline." As soon as we told Madeline that she was our daughter and treated her that way in every aspect of her life, we got our child back.

13. Madeline continued to receive therapy from when she was six years old until the present.

14. About a year ago, when Madeline was 11, she started puberty. Her endocrinologist prescribed her with a pubertal suppressing implant to delay the changes of male puberty. Before prescribing histrelin, her endocrinologist explained the risks and benefits to me, my wife, and Madeline. With my support and her mother's support, and with Madeline also wanting to do so,

Madeline received an implant in early 2023. Madeline regularly gets blood tests to monitor her hormone levels. The implant will need to be replaced every one to two years.

15. It was amazing to see how Madeline became more comfortable once she began living as the girl she is, and how happy and authentic she is now. Not having to worry about going through male puberty, and having her body change in ways that do not match her identity as a girl, allows her to be herself and thrive in every part of her life. She is really happy that she doesn't have to go through male puberty. The thought of growing facial and body hair, developing an Adam's apple, or her voice deepening distresses her.

16. This medical treatment has given Madeline significant relief from her gender dysphoria. We are very concerned about Madeline's mental and physical health if she cannot continue receiving this treatment. Madeline has struggled with thoughts of self-harm before starting puberty blockers, and we are worried about her risk of suicidality and self-harm if she loses access to that care.

17. Madeline has been living as a girl in all aspects of her life since she was seven years old: she is insistent, persistent, and consistent about her true self. In 2020, when Madeline was eight years old, her mother and I had her birth certificate amended to reflect her new name and gender marker. She is now 12, and her endocrinologist has told us that she will be a good candidate for hormone therapy, if that is what she wants and we as her parents agree. Madeline does want to start estrogen at the right time because she wants to go through puberty as a girl and be a woman when she grows up. All her mother and I want for her is to be a happy, healthy person, which for Madeline means living and being the girl and eventually woman that she knows herself to be.

18. I have lived in Ohio my entire life. This is my home and my family's home. We are part of a large and supportive community, and one that has been very welcoming of Madeline. We

do not want to leave Ohio, or to have to drive hours away to another state to obtain medical care for our daughter. However, those may be our only options if this law goes into effect and Madeline can no longer get the care she needs in Ohio. It is not an option for our family to not support Madeline as our daughter, or for Madeline to not be the girl that she is.

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

[redacted]
Signed on 2024/03/21 17:01:12 -5:00
MICHAEL MOE

Sworn to or affirmed before me and subscribed in my presence in Franklin County, Ohio

on this 03/21/2024 day of [illegible], 2024.

Signed on 2024/03/21 17:01:12 -5:00

NOTARY PUBLIC STATE OF OHIO

Theresa M Sabo
Commission # 2016-RE-619622
Electronic Notary Public
State of Ohio
My Comm Exp. Nov 28, 2026

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IN THE COURT OF COMMON PLEAS
FOR FRANKLIN COUNTY, OHIO

MADELINE MOE, et al. Plaintiffs, v. DAVID YOST, et al. Defendants.	Case No. _____ Judge _____

AFFIDAVIT OF GINA GOE IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

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March 22, 2024 09:41:08 -5:00 [AD02FF565343] [65.60.211.87]
tess.sabo@gmail.com
I, Theresa M Sabo, did witness the participants named above electronically sign this document.

AFFIDAVIT OF GINA GOE IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Gina Goe, having first been duly cautioned and sworn, declare as follows:

1. I am over the age of 18 and competent to make this affidavit.

2. My name for the purposes of the above-captioned action is Gina Goe, a pseudonym.[1] I am a Plaintiff in this action. I offer this Affidavit in support of Plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction. I have personal knowledge of the facts set forth in this Affidavit and could and would testify competently to those facts if called as a witness.

3. I, along with my husband Garrett Goe, am next friend of my minor child, Grace Goe.

4. I am an Ohio resident. I live in Franklin County, Ohio with my husband, our daughter Grace, who is 12 years old, and Grace's siblings.

5. Grace is strong, grounded, and happy. She loves sports, especially running and soccer, and she likes to do art with her friends. She also likes to bake cakes and collect fossils and crystals.

6. My husband and I love our daughter, support her, and want her to be able to be herself.

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

[1] Garrett, Grace, and Gina are pseudonyms. My husband, my daughter (who is a minor), and I are proceeding under pseudonyms to protect our privacy and ourselves from discrimination, harassment, and violence, as well as retaliation for seeking to protect our rights.

8. When Grace was a toddler, she insisted on wearing dresses at home and was drawn to interests more typically associated with girls.

9. When she was five years old, Grace began telling us that she was a girl. Her father and I began asking her questions, without insisting either way. Around that same time, when she started kindergarten, Grace began getting very upset when she could not leave the house as her true self, meaning dressing and being treated like a girl.

10. Grace was very persistent in telling us that she was a girl. My husband and I began to conduct our own research. We contacted the THRIVE Program at Nationwide Children's Hospital because we wanted to know more about how best to support Grace.

11. In 2018, when Grace was six years old, our family started meeting with a pediatric psychiatrist at the THRIVE Program, who diagnosed my daughter with gender dysphoria. Grace has continued to see that psychiatrist for the past six years.

12. At around the same time, during the summer between kindergarten and first grade, Grace changed her name and pronouns, and started living in the world as her true self. She has been the happiest and healthiest version of herself ever since.

13. Grace has lived as a girl in all aspects of her life since she was six years old. She is persistent, consistent, and insistent that she is a girl. She is now 12. Grace's doctors are closely monitoring her for the first signs of puberty to identify the right time to begin medication that will pause puberty temporarily. In January 2024, at our last THRIVE appointment, Grace's doctor recommended that we come in every six months to evaluate whether puberty had started. Her next appointment is in July 2024. When she has started puberty, my husband and daughter and I, along with her doctors, hope to discuss which medications are a good fit for her.

14. If Grace is unable to pause puberty, and begins developing male physical characteristics, I am worried about her mental health and well-being. It would be devastating for her to live in a body that does not match her true self as a girl.

15. I am also worried about Grace's physical safety. We are so proud of Grace for telling us who she is and for being her true self, and I am concerned for her safety as a transgender girl. Many people in my daughter's life only know her as Grace, and it should be her choice who she tells about being transgender, and when. Without the ability to pause puberty, she is at risk of being outed as transgender against her will.

16. My family has deep roots in Ohio. We are active members of our Christian faith community and are surrounded by a supportive network of family, friends, and colleagues. We do not want to move our children out of Ohio or have to drive five hours away to Michigan to obtain medical care for Grace.

17. We have considered moving to another state to get the care that Grace needs, but this would require moving Grace and her siblings out of the schools and community where they are thriving. We have deep friendships and a community surrounding and supporting us, and moving would be like ripping the roots out of our community. Only my husband is working at the moment, so moving would be a financial hardship, as would routine travel out of state. If we moved, we would also need to find new jobs and start all over in a new community. But if this law goes into effect, moving out of state may be our only option. My husband and I have even discussed separating our family, with Grace and I moving to another state to live with my sister and Grace's aunt. It is not an option for our family to not support Grace as our daughter, or for Grace to not be the girl that she is.

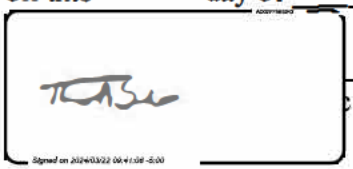
I declare under penalty of perjury that the foregoing is true and correct.

[redacted]

Gina Goe

Sworn to or affirmed before me and subscribed in my presence in Franklin County, Ohio

on this 03/22/2024 day of _____, 2024.



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