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No. ___

In the Court of Appeals for the Fifth Judicial District Dallas Texas

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DALLAS, TEXAS
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Clerk Pro Tem

IN RE: THE STATE OF TEXAS,
Relator-Intervenor.

On Petition for Writ of Mandamus
to the Fifth Court of Appeals, Dallas

PETITION FOR WRIT OF MANDAMUS

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Table of Contents

Index of Authorities

Page(s)

Texas Cases

Texas Statutes

Texas Regulations

Constitutional Provisions

Federal Cases

Federal Statutes

Texas Rules

Treatises

Other Authorities

Record References

The mandamus record is cited as "MR.XX."

Statement of the Case

Nature of the Case:	Lopez sued CMC to enjoin it from discontinuing the provision of puberty blockers and hormone therapy to new pediatric patients for the treatment of gender dysphoria.
Trial Court:	County Court at Law No. 2, Dallas County The Hon. Melissa Bellan Cause No. CC-22-02427-B
Trial Court Disposition:	The trial court issued an Order Granting Agreed Temporary Injunction, denied State's Plea to the Jurisdiction, and issued an Order Granting Lopez's Motion to Strike the State's Intervention.

Statement of Jurisdiction

This Court has jurisdiction over this mandamus action pursuant to Tex. Const., art. V, § 6(a), Tex. Gov't Code §§ 22.201(f), 22.221(b), 25.0591(a)(2), and Tex. R. App. P. 52.

Issues Presented

1. The Attorney General has the authority to represent the State in matters where the State is a party and in suits involving constitutional challenges to state law. The State is a mandatory party in Lopez's suit because she seeks a judgment binding both CMC and UTSW. Lopez's suit also implicitly challenges the constitutionality of state child abuse laws. Did Respondent abuse her discretion when she struck the State's intervention after finding that the Attorney General lacked the authority to intervene and a justiciable or legal interest in the outcome of Lopez's suit?

2. Lopez lacks standing to bring a declaratory judgment action against CMC for allegedly violating the Texas Medical Practice, the Hospital Licensing Law, and its Bylaws. Lopez also lacks standing to bring a claim under Section 1557 because she has suffered no injury. Does Respondent lack jurisdiction over Lopez's claims where Lopez does not have standing to bring actions under the Texas Medical Practice Act, Texas Hospital Licensing Law, CMC's Bylaws, and Section 1557?

Statement of Facts

Lopez is employed by UTSW as an assistant Professor in Pediatrics and as an attending physician. MR.576. Lopez holds privileges to practice pediatric endocrinology at CMC. *Id.* at 577. Lopez participated the Gender Education and Care, Interdisciplinary Support ("GENECIS") program, which was jointly run by UTSW and CMC, and among other things, provided puberty blockers and hormone therapy (collectively "PBHT") to pediatric patients for the treatment of gender dysphoria. *Id.* at 576, 580-81.

On or about November 18, 2021, UTSW allegedly informed Lopez that she could continue to provide puberty blockers and hormone therapy for existing patients, but that it was discontinuing these services for *new* pediatric patients for the treatment of gender dysphoria. *Id.* 520-21.

On March 16, 2022, Lopez filed a Petition to Take a Rule 202 Pre-suit Deposition ("Rule 202 Petition") of Podolsky, UTSW Medical Center President, and Warner, UTSW Medical Center Executive Vice President for Health System Affairs. *Id.* at 79. Lopez argued that these depositions were necessary because she did "not know whom or what to file against or whom to enjoin." MR.90. Lopez argued that "[w]homever that person is, or whatever entity or office is behind this illegal conduct, their actions can only be *ultra vires*." *Id.* at 89.

On March 28, 2022, UTSW and CMC issued a statement announcing that they had jointly made the decision to discontinue the provision of PBHT to new pediatric patients for the treatment of gender dysphoria and to unbrand the GENECIS program. *Id.* at 669. The announcement noted that UTSW and CMC would continue to provide psychiatric care and evaluations to new pediatric patients with gender dysphoria. *Id.* at 669-70. The statement acknowledges that "it is evident the debate over the appropriate age of consent for hormone treatment calls for additional medical reviews and study." *Id.* at 670.

On April 11, 2022, Respondent held a hearing on Lopez's Rule 202 Petition. MR.398. Lopez's counsel stated during the hearing that "one party who might be a party, we don't know, might be the Governor of Texas." *Id.* at 435; 13:7-14. Lopez's counsel further explained that "if Governor Abbott is dipping his toe in this topic and enforcing things through intimidation, threats, coercion, whatever, he's acting outside his defined authority, as far as separation of powers go, and that is a recognized grounds to sue the Governor under an *ultra vires* action." *Id.* at 547; 125:15-21. Finally, Lopez's counsel stated:

> If the Governor, or the Attorney General, or anyone else engaged in a conspiracy to cause this policy to be implemented, it would be a conspiracy, the purpose of which or the result of which is the violation of a statute. And. . . such a conspiracy is actionable. . . . But if the Attorney General's office and others engaged in a conspiracy that interfere with Dr. Lopez's treatment with her

> patients with the medical standard of care with medically necessary modalities, then it's possible that that conspiracy would be actionable, and in no way implicates sovereign immunity.

MR.476-77; 54:22-55:12.

Lopez took the stand during the hearing and testified that she "was told [by UTSW officials] that. . . they had to remove the GENECIS brand. . . [a]nd, again, that was still because they had received pressure from the Governor's office, and that they had no choice. *Id.* at 519; 97:6-12. Lopez also testified that "at the meeting [with UTSW officials it] was discussed that they had continued to get pressure from the Governor's office, and they had no choice. It's a state institution. They could not continue to provide puberty suppression and hormone therapy for transgender youth, and they had to stop care for new patients. . .." *Id.* at 521; 99:1-6.

On April 13, 2022, Podolsky and Warner wrote affidavits stating that their decision, on behalf of UTSW, to remove GENECIS branding and suspend the provision of PBHT to new pediatric patients for the treatment of gender dysphoria was made jointly with CMC. MR.377-80. They swore that no third-party entity or individual forced or directed them to make this decision. *Id.*

Nonetheless, on April 14, 2022, Respondent granted Lopez's Rule 202 Petition and ordered that the depositions of the Podolsky and Warner should take place within 14 days. MR.398-400.

On April 22, 2022, Podolsky and Warner sought an emergency stay and mandamus relief before this Court from Respondent's Order Granting Lopez's Rule 202 Petition. *Id.* at 1, 561. The same day, this Court entered an Order Granting Podolsky and Warner's Emergency Motion to Stay Respondent's Order Granting Lopez's Rule 202 Petition. *Id.* at 574.

On May 11, 2022, Lopez filed an Application for Temporary Restraining Order, Temporary Injunction, and Plaintiff's Original Petition for Permanent Injunction and Declaratory Relief. *Id.* at 575. Lopez noted in the filing that the Rule 202 Petition was a related proceeding. *Id.* at 575. Lopez's Original Petition, in large part, consists of allegations copied almost verbatim from Lopez's Rule 202 Petition, but swapping out UTSW and replacing it with CMC. *Compare* App'x 575-98, *with* 79-97. Lopez's Original Petition repeats the allegation in Lopez's Rule 202 Petition that state officials were privately exerting their influence to shut down the GENECIS program. MR.586.

On May 12, 2022, Respondent, after a hearing, entered a Temporary Restraining Order against CMC and anyone acting in concert with it who received actual notice of the Temporary Restraining Order. *Id.* at 910-12. Respondent's Temporary Restraining Order ordered CMC, and therefore necessarily UTSW, to permit Lopez to provide PBHT to new pediatric patients for the treatment of gender dysphoria. *Id.*

UTSW and CMC complied with the TRO. MR.377-80, 669-70; 1129. Lopez immediately resumed providing PBHT to new pediatric patients for the treatment of gender dysphoria. *Id.*

On May 16, 2022, Lopez nonsuited her Rule 202 Petition. *Id.* at 913.

On May 17, 2022, the State filed a Petition in Intervention intervening in Lopez's suit against CMC. *Id.* at 917.

On May 18, 2022, Lopez filed Special Exceptions and a Motion to Strike the State's Intervention, arguing that it had no legal or equitable grounds for intervening. *Id.* at 925.

On May 23, 2022, Respondent entered an Order Granting Agreed Temporary Injunction against CMC, even though the State, who was bound by the Order, was not a signatory to the agreement, nor had it been conferred with. MR.951-53. The same day, Lopez filed an Answer and Counterclaim against the State. *Id.* at 942. Lopez's counterclaims sought declaratory judgment declaring that the provision of PBHT to pediatric patients for the treatment of gender dysphoria is not child abuse, is not unlawful, and that the public policy with respect to its provision is not dictated by the Governor or Attorney General. *Id.* Lopez also, incongruously, sought sanctions against the Attorney General for intervening. *Id.* at 948.

On June 3, 2022, without conferring with the parties on their availability, Lopez scheduled a hearing on her Special Exceptions and Motion to Strike the State's Intervention for June 17, 2022. *Id.* at 963. The same day, CMC filed an Original Answer, Special Exceptions, and a Plea to the Jurisdiction. MR.954.

On June 13, 2022, the State appealed Respondent's Order Granting Agreed Temporary Injunction because it was not consulted, nor did it consent, to the temporary injunction. *Id.* at 1017.

On June 14, 2022, the State filed an Amended Petition in Intervention, a Plea to the Jurisdiction, and a response to Lopez's Motion to Strike the State's Intervention (arguing that it was mooted by the amended filing). *Id.* at 1022-57.

On June 16, 2022, Lopez filed Amended Special Exceptions and Motion to Strike the State's Intervention largely repeating the same arguments previously raised. *Id.* at 1058.

On June 17, 2022, Respondent held a hearing on Lopez's Motion to Strike the State's Intervention. MR.1088. Lopez nonsuited her counterclaims during the hearing. *Id.* at 1089.

On July 7, 2022, Respondent signed an Order Granting Lopez's Motion to Strike the State's Intervention. *Id.* at 1088-89.

On July 13, 2022, the State appealed Respondent's Order Granting Lopez's Motion to Strike the State's Intervention. MR.1102.

Summary of the Argument

The State, through UTSW, jointly decided with CMC to discontinue the provision of PBHT to new pediatric patients for the treatment of gender dysphoria. Shortly thereafter, Lopez filed a Rule 202 Petition wherein she indicated her intent to conduct discovery in preparation for a suit against the State. The State responded by asserting sovereign immunity. Instead of addressing the State's sovereign immunity, Lopez nonsuited the Rule 202 Petition and filed suit against CMC seeking enjoin it, and necessarily UTSW, from discontinuing the provision of PBHT to new pediatric patients for the treatment of gender dysphoria. Lopez has sought, and obtained, temporary orders to this effect, and has since noticed the depositions of UTSW officials—all while avoiding having to address the State's sovereign immunity.

The State is mandatory party to Lopez's suit because its interests are prejudiced. Yet, when the State intervened to defend those interests, Respondent granted a motion striking its intervention. This is Court should reverse Respondent's ruling and permit the State to intervene where it is a mandatory party, and it has both a legal and equitable interests in the outcome of the Lopez's suit.

Additionally, Respondent lacks jurisdiction over Lopez's claims because Lopez lacks standing to bring a private cause of action for alleged violations of the Medical Practice Act and the Texas Hospital Licensing Law. Lopez lacks a cognizable injury, that is an adverse employment action as defined by the CMC Bylaws, that would entitle her to notice and a hearing pursuant to those Bylaws. Finally, Lopez lacks standing to bring a Section 1557 claim because her alleged injuries, a hypothetical disciplinary action by the Texas Medical Board or a medical malpractice suit, are pure speculation. Lopez cannot identify a single physician who has ever been sued for malpractice in Texas or disciplined by the Texas Medical Board for declining to provide PBHT to a minor for the treatment of gender dysphoria after the physician's employer and hospital chose to discontinue those services. Even if her injuries weren't pure speculation, she cannot bring a claim for discrimination on the basis of "gender identity" under Section 1557.

STANDARD OF REVIEW

To obtain mandamus relief, the relator must show that the respondent abused its discretion, and no adequate appellate remedy exists. *In re Turner*, 591 S.W.3d 121, 124 (Tex. 2019) (orig. proceeding). A court abuses its discretion if it acts without subject-matter jurisdiction, *In re Crawford & Co.*, 458 S.W.3d 920, 929 (Tex. 2015)

(orig. proceeding) (per curiam), and if it misinterprets or misapplies the law, *In re Dawson*, 550 S.W.3d 625, 628 (Tex. 2018) (orig. proceeding) (per curiam).

ARGUMENT

I. Respondent abused her discretion when she struck the State's intervention after finding that the Attorney General lacked the authority to intervene and a justiciable equitable or legal interest in the outcome of Lopez's suit. (Issue 1)

The Texas Constitution authorizes the Attorney General to "represent the State in all suits and pleas in the Supreme Court of the State in which the State may be a party. . . and to perform such other duties as may be required by law." Tex. Const. art. IV, § 22. The "other duties" clause permits the Legislature to assign other duties to the Attorney General. *El Paso Elec. Co. v. Tex. Dep't of Ins.*, 937 S.W.2d 432, 438 (Tex. 1996); *see also, e.g., Brady v. Brooks*, 89 S.W. 1052, 1055 (Tex. 1905) (noting the district and county attorneys' constitutional duties do not deprive the Legislature of "the authority to empower the Attorney General to bring suits on behalf of the state"). The Attorney General may prosecute and defend "all actions in which the state is interested before the supreme court and courts of appeals." Tex. Gov't Code § 402.021.

"The Attorney General, as the chief legal officer of the State, has broad discretionary power in conducting his legal duty and responsibility to represent the

state." *Terrazas v. Ramirez*, 829 S.W.2d 712, 721–22 (Tex. 1991). "In matters of litigation the Attorney General is the officer authorized by law to protect the interests of the State, and even in matters of bringing suit the Attorney General must exercise judgment and discretion, which will not be controlled by other authorities." *Bullock v. Escobedo*, 583 S.W.2d 888 (Tex. App.—Austin 1979, writ ref'd n.r.e.) (quoting *Charles Scribner's Sons v. Marrs*, 262 S.W. 722, 727 (Tex. 1924)) (cleaned up). The Legislature, in the General Appropriations Act, provided that, "[e]xcept as otherwise provided by the Constitution or general or special statutes. . . the Attorney General shall have the primary duty of representing the State in the trial of civil cases." 87th Leg., R.S., S.B. 1, art. IX-74, §16.01(a)(1) (2021).

An intervenor is not required to secure a court's permission to intervene in a cause of action. *Guar. Fed. Sav. Bank v. Horseshoe Operating Co.*, 793 S.W.2d 652, 657 (Tex. 1990). An intervenor need only show a "justiciable interest in a pending suit to intervene in the suit as a matter of right." *In re Union Carbide Corp.*, 273 S.W.3d 152, 154 (Tex. 2008). "A party has a justiciable interest in a lawsuit, and thus a right to intervene, when his interests will be affected by the litigation." *Jabri v. Alsayyed*, 145 S.W.3d 660, 672 (Tex. App.—Houston [14th Dist.] 2004, no pet.) (citing *Law Offices of Windle Turley P.C. v. Ghiasinejad*, 109 S.W.3d 68, 71 (Tex. App.—Fort Worth 2003, no pet.)).

Intervention is proper so long as (1) the intervenor would be able to defeat some part of the recovery if the action had been brought against it; (2) intervention will not complicate the case by an excessive multiplication of the issues; and (3) intervention is almost essential to effectively protect the intervenor's interest. *Guar. Fed. Sav. Bank v. Horseshoe Operating Co.*, 793 S.W.2d 652, 657 (Tex. 1990) (citing *Inter-Continental Corp. v. Moody,* 411 S.W.2d 578, 589 (Tex.Civ.App.—Houston [1st Dist.] 1966, writ ref'd n.r.e.). "The interest asserted by the intervenor may be legal or equitable." *Id.* at 657 (citation omitted).

A. The State is a mandatory party in Lopez's suit because it seeks to permanently enjoin both CMC and the State to prevent them from discontinuing the provision of PBHT to new pediatric patients for the treatment of gender dysphoria. (Issue 1)

The Attorney General is authorized to represent the State in all civil suits where it is a party. Tex. Const. art. IV, § 22. In declaratory judgment actions, "all persons who have or claim any interest that would be affected by the declaration *must be made parties*." Tex. Civ. Prac. & Rem. Code § 37.006(a) (emphasis added). The Texas Rules of Civil Procedure provide that the joinder of a party is mandatory if:

> (1) in his absence complete relief cannot be accorded among those already parties, or
>
> (2) he claims an interest relating to the subject of the action and is so situated that the disposition of the action in his absence may

> (i) as a practical matter impair or impede his ability to protect that interest or
>
> (ii) leave any of the persons already parties subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations by reason of his claimed interest.

Tex. R. Civ. P. 29(a) (formatting added).

The State is a mandatory party in Lopez's suit because UTSW will be bound by a favorable outcome for Lopez and forced to continue the provision of PBHT to new pediatric patients for the treatment of gender dysphoria. Lopez seeks an injunction "that permanently enjoins CMC *and anyone in active concert or participation with CMC*" from discontinuing the provision of PHBT to new pediatric patients for the treatment of gender dysphoria. MR.589-90 (emphasis added). Both of Respondent's temporary orders bind CMC and "*any individual or entity acting in concert with them*, who received notice of the Orders through personal service or otherwise. . . from enforcing any policy or limitation that restricts or prohibits gender affirming endocrinology care, including specifically pubertal suppression or hormonal therapy." *See id.* at 911, 952 (emphasis added). The services at issue in the injunction were offered jointly by CMC (who operates the facilities) and UTSW (who employs the physicians). *Id.* at 669. Both CMC and UTSW are bound by Respondent's temporary orders because CMC cannot provide PBHT services to pediatric patients for

the treatment of gender dysphoria at its facilities without UTSW employees to provide those services; consequently, a permanent injunction directing CMC to continue to provide these services necessarily extends to UTSW.[1] MR.377-80, 669-70; 1129.

Put differently, if the State is *not* a mandatory party, as Lopez claims, then Respondent cannot use CMC as a proxy to enjoin UTSW, Lopez's employer, from discontinuing the provision of PBHT to new pediatric patients for the treatment of gender dysphoria. Tex. Civ. Prac. Rem. Code § 37.006(a) ("a declaration does not prejudice the rights of a person not a party to the proceeding."). Lopez's insertion of the "any individual or entity in active concert or participation with CMC" language in the temporary orders and request for a permanent injunction demonstrates that she is aware that without that language, which necessarily enjoins UTSW, these orders would have no effect. UTSW has the unilateral power to decide that its employees may no longer provide PBHT to new pediatric patients for the treatment of gender dysphoria, even if CMC were to decide that such services are available at its facilities from physicians employed by someone other than UTSW.[2]

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[1] Most Texas hospitals do not directly employ the physicians due to the history of Texas' law governing the corporate practice of medicine.

[2] Lopez would not be impacted by an order that had the effect of requiring CMC to contract with a different employer for physicians to provide these services, since Lopez is employed by UTSW.

Thus, the State is a *mandatory* party to Lopez's suit because UTSW is necessarily affected by the outcome and Respondent's ruling striking the State's intervention is an abuse of discretion. *See Bradco Oil & Gas Co. v. Rowan*, 437 S.W.2d 58, 60 (Tex. Civ. App.—Houston [1st Dist.] 1968, no writ) (persons having a joint interest are "indispensable parties.").

Additionally, the State should be permitted to intervene where Lopez, through clever pleading, seeks to enjoin the State and conduct discovery on UTSW officials without having address the State's entitlement to sovereign immunity.[3] Lopez testified that UTSW officials told her that they were discontinuing PBHT services for new pediatric patients for the treatment of gender dysphoria due to pressure from state officials. MR.519, 97:6-12; 521, 99:1-6. Lopez's attorneys repeatedly indicated an intent to sue the State because state actors allegedly conspired to close the GENECIS program, blustering that they would easily overcome sovereign immunity because the actions were allegedly *ultra vires*. *See e.g.*, *id*. at 435, 13:7-14; 435, 13:7-14; 437, 15:12-20; 476-77, 54:22-55:12; 547, 125:15-21. But, when the State asserted sovereign immunity, brought a mandamus action before this Court, and ob-

[3] CMC may be entitled to sovereign immunity from Lopez's claims because private entities can qualify as "state actors" when the government acts jointly with them, *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 941-42 (1982), but CMC has not yet raised this defense. MR.958-59.

tained an emergency stay after Respondent permitted Lopez to proceed with Podolsky and Warner's deposition; Lopez backpedaled and nonsuited the Rule 202 proceedings. *See id.* at 1, 398-400, 561, 574, 913. Lopez instead file this suit, copying and pasting the factual allegations from the Rule 202 Petition and swapping UTSW for CMC. *Compare* App'x 575-98, *with* 79-97. In doing so, Lopez has successfully been able to enjoin UTSW and schedule depositions for Podolsky, Warner, and several other UTSW officials, all without having to address the issue of sovereign immunity. *Id.* at 911, 952, 1090-95. And, if Lopez is successful at trial, she will be able to permanently enjoin the State without the State being permitted to appear as a party to defend itself and assert its entitlement to sovereign immunity. This Court should permit the State to intervene in this matter to assert its entitlement to sovereign immunity *before* Respondent enjoins its actions and permits Lopez to conduct discovery on UTSW officials.

B. Lopez's suit implicitly challenges the constitutionality of state child abuse laws, and the Attorney General has the authority to intervene in constitutional challenges to state laws. (Issue 1)

The Attorney General is authorized to intervene in lawsuits where the constitutionality of a statute is challenged. Tex. Gov't Code § 402.010; *see also* Tex. Civ. Prac. & Rem. Code § 37.006(b) (stating that the Attorney General "is entitled to be

heard" in declaratory judgment actions seeking to declare a statute unconstitutional); *Abbott v. Mexican Am. Legislative Caucus, Tex. House of Representatives*, No. 22-0008, 2022 WL 2283221, at *10 (Tex. June 24, 2022). "The purpose of this statute is to provide the attorney general with the opportunity to be heard on issues important to the laws of the state—the laws the attorney general's office is charged with defending and enforcing." *In re State*, 489 S.W.3d 454, 454–55 (Tex. 2016) (Willett, J., concurring) (quoting *In re State*, No. 04-14-00282-CV, 2014 WL 2443910, at *2 (Tex. App.—San Antonio May 28, 2014, no pet.) (mem. op.)). "For this reason, both the Texas Constitution and the Texas Government Code prohibit a court from rendering a judgment holding a statute unconstitutional until the Attorney General has been given notice of the challenge and has had a reasonable opportunity to inform the court of the State's position on the matter." *T.L. v. Cook Children's Med. Ctr.*, 607 S.W.3d 9, 33 n.16 (Tex. App.—Fort Worth 2020, pet. denied). The language of this statute reflects "the Legislature's unqualified command that the State's chief legal officer be afforded the opportunity to defend the constitutionality of Texas law." *In re State*, 489 S.W.3d at 455 (Willett, J., concurring).

Texas Family Code Chapter 261 provides for the reporting and investigation of abuse or neglect of a child. *See* Tex. Fam. Code §§ 261.001–.505; *see also* Tex. Penal Code § 22.04 (providing for the offense of injury to a child). Section 261.001

defines abuse through a broad and nonexclusive list of acts and omissions. Tex. Fam. Code § 261.001(1). Subsection 261.001(1)(A) identifies "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." Subsection 261.001(1)(B) provides that "causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning" is abuse. Subsection 261.001(1)(C) includes as abuse a "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child." And Subsection 261.001(1)(D) includes "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child." The Attorney General has interpreted these child abuse laws as applying, in some cases, to the provision of puberty blockers and hormone therapy to minors. *See* Tex. Att'y Gen. Op. KP-0401, 2022 WL 579379 (Feb. 18, 2022).

In *Jane Doe v. Abbott* (*Doe*), the plaintiffs brought, among other things, a declaratory judgment action seeking to enjoin the Department of Family and Protective Services (DFPS) from investigating and enforcing state child abuse laws relating to

the provision of PBHT to minors. *See* MR.430, 8:6-17; *In re Abbott*, 645 S.W.3d 276, 279 (Tex. 2022).

Similarly, Lopez implicitly challenges the State's child abuse laws as they relate to the provision of PBHT to minors. *See* MR.585. Lopez has called *Doe* a related proceeding.[4] MR.470, 48:17-18. In the Rule 202 Petition hearing, Lopez's counsel argued that DFPS's enforcement of state child abuse laws would be harmful "for physicians like Dr. Lopez, because it subjects them to potential criminal penalties." *Id.* at 430; 8:6-17. Respondent's Orders enjoining the State, through UTSW's relationship with CMC, prohibits it from enforcing any policy or limitation that restricts or prohibits the provision of PBHT to minors for the treatment of gender dysphoria, which directly implicates DFPS and *Doe*. *See id.* at 911, 952. Indeed, Lopez brought a counterclaim *explicitly* challenging the constitutionality of the State's child abuse laws before nonsuiting it with barely a whimper during the hearing to strike the State's intervention.[5] MR.946-48. Lopez intends to obtain a ruling that implicitly challenges the constitutionality of the State's child abuse laws; consequently, the Attorney General is authorized to intervene to defend the constitutionality of those

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[4] Lopez's counsels recently issued a press release offering a $1 million bounty (in legal services) for physician or parent of a patient at CMC or UTSW who are criminally charged with child abuse relating to the provision of PBHT to minors. MR.1494.

[5] This is a pattern. Lopez made similar braggadocio claims about how easily she would state a claim against the State and defeats its entitlement to sovereign immunity during the hearing on her Rule 202 Petition—only to nonsuit a few weeks later.

laws and Respondent's ruling striking the State's intervention was an abuse of discretion.

C. The State should be permitted to intervene on public policy grounds where Lopez is abusing the judicial process by bringing a frivolous suit to harass and annoy her perceived political enemies. (Issue 1)

Lopez's suit asserts the following claims: (1) that CMC is engaged in the corporate practice of medicine; (2) that CMC restricted her staff privileges without the due process afforded in its Bylaws; and (3) that CMC's decision to discontinue PBHT services for pediatric patients for the treatment of gender dysphoria has caused Lopez to unlawfully discriminate against her own patients on the basis of sex and gender identity. MR.588-90.

As discussed *infra*, these are frivolous claims because Lopez has no standing to bring them. *Compare id.* at 575-590 (near total absence of legal citations in the alleged facts and "causes of actions" sections), *with* 590-96 (numerous legal citations in the sections requesting a temporary restraining order and temporary injunction).

Lopez is using her frivolous suit to target private citizens and entities for harassment. To date, Lopez has subpoenaed records from the Republican Party of Texas, Natalie Cato, Save Texas Kids, the Texas Hospital Association, and the Texas Medical Association. *Id.* at 965-106. Lopez has also noticed the depositions of

a Kelly Neidert, a University of North Texas college student, and Natalie Cato, President of Save Texas Kids. MR.1080-86. Upon information and belief, Lopez has also requested deposition dates for the Matt Rinaldi, Party Chair of the Republican Party of Texas. None of these individuals and entities has anything to do with CMC's Bylaws, its purported corporate practice of medicine, or whether its decision has caused Lopez to unlawfully discriminate against her own patients. The only reasonable explanation for why these individuals and entities have been targeted for discovery by Lopez is that she perceives them to be political enemies.

This Court should permit the State to intervene in Lopez's suit on public policy grounds so that it may put an end to Lopez's continued harassment and abuse of those who dare to publicly criticize or disagree with her.

II. Respondent lacks jurisdiction over Lopez's claims where Lopez does not have standing to bring actions under the Texas Medical Practice Act, Texas Hospital Licensing Law, CMC's Bylaws, and Section 1557. (Issue 2)

Subject-matter jurisdiction is "never presumed and cannot be waived." *Tex. Ass'n of Bus. v. Tex. Air Ctr. Bd.*, 852 S.W.2d 440, 443–44 (Tex. 1993). "Subject-matter jurisdiction is a multiple choice question with only two answers: yes or no." *City of Anson v. Harper*, 216 S.W.3d 384, 390 (Tex. App.—Eastland 2006, no pet.). The question of whether a trial court has subject-matter jurisdiction is a matter of law, and appellate courts review that issue *de novo*. *Texas Dep't of Parks & Wildlife v.*

Miranda, 133 S.W.3d 217, 226 (Tex. 2004). "[A] court cannot render a binding judgment concerning matters over which it lacks subject-matter jurisdiction." *In re City of Dallas*, 501 S.W.3d 71, 73 (Tex. 2016) (per curiam).

Standing "is an essential and unchanging part of the case-or-controversy requirement." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992). Plaintiffs, as the party invoking federal jurisdiction, bear the burden of establishing three essential elements: (1) "an injury in fact; that is, the invasion of a legally protected interest that is concrete and particularized and actual or imminent;" (2) "a causal connection between the injury and the conduct complained of;" and (3) "a showing that it is likely, not merely speculative, that the injury will be redressed by a favorable decision." *Id.* at 560–61. To allege standing to seek prospective relief a plaintiff must allege that the defendant either (1) poses an imminent threat of harm or (2) is currently inflicting harm. *City of Los Angeles v. Lyons*, 461 U.S. 95, 111 (1983); *Friends of the Earth, Inc. v. Laidlaw Envt. Servs., Inc.*, 528 U.S. 167, 184-85 (2000). Because "Texas's test for constitutional standing parallels the federal test for Article III standing," Texas courts "look to federal standing jurisprudence for guidance" unless specifically contradicted by state law. *Pike v. Tex. EMC Mgmt.*, LLC, 610 S.W.3d 763, 776 (Tex. 2020).

To establish injury in fact, a plaintiff must show that he or she suffered "an invasion of a legally protected interest" that is "concrete and particularized" and "actual or imminent, not conjectural or hypothetical." *Spokeo, Inc. v. Robins*, 578 U.S. 330, 339 (2016), as revised (May 24, 2016) (quoting *Lujan*, 504 U.S. at 560, 112 S.Ct. 2130).

A. Lopez lacks standing to bring claims under the Texas Medical Practice Act and Texas Hospital Licensing Act because they do not permit private causes of action. (Issue 2)[6]

Lopez believes that to state a claim under the Act she simply has to show that CMC violated a state law. See MR.872, 43:1-7; 894-95, 65:9-66:5. Respondent apparently agrees. *See* MR.887, 58:17-18.

They are both wrong. This mistake is a fundamental error of law.

The Declaratory Judgment Act is not a grant of jurisdiction, but merely a procedural device for deciding cases already within a court's jurisdiction. *Texas Med. Res., LLP v. Molina Healthcare of Texas, Inc.*, 620 S.W.3d 458, 471 (Tex. App.—Dallas 2021, pet. granted) (citing *Chenault v. Phillips*, 914 S.W.2d 140, 141 (Tex. 1996));

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[6] In the alternative, even if this Court were to find that the lack of a private cause of action is not jurisdictional, it is still reversible error by Respondent grant an injunction in the absence of a cause of action. *Butnaru v. Ford Motor Co.*, 84 S.W.3d 198, 204 (Tex. 2002) ("To obtain a temporary injunction, the applicant must plead and prove three specific elements: (1) *a cause of action against the defendant*; (2) a probable right to the relief sought; and (3) a probable, imminent, and irreparable injury in the interim.") (emphasis added) (citing *Walling v. Metcalfe*, 863 S.W.2d 56, 57 (Tex. 1993)).

Taylor v. State Farm Lloyds, Inc., 124 S.W.3d 665, 668–69 (Tex. App.—Austin 2003, pet. denied); *see also*, *Youngblood v. Zaccaria*, 608 S.W.3d 134, 137 n.1 (Tex. App.—San Antonio 2020, pet. denied) (stating that "[w]hile sometimes termed a cause of action colloquially, declaratory relief under the [Act] is more precisely a type of remedy that may be obtained with respect to a cause of action or other substantive right . . .").

A person who does not have standing to bring an affirmative cause of action for violation of a law may not seek a declaratory judgment that the opposing party has broken that law. *See Davis v. Hendrick Autoguard, Inc.*, 294 S.W.3d 835, 840 (Tex. App.—Dallas 2009, no pet.) (plaintiff had no standing to seek declaratory judgment for violation of statute having no private right of action); *see also Tex. Med. Ass'n v. Aetna Life Ins. Co.*, 80 F.3d 153, 158–59 (5th Cir. 1996) (physician plaintiffs could not bring a declaratory judgment action because the Texas Department of Insurance had exclusive authority to enforce the law); *see also Molina Healthcare of Texas*, 620 S.W.3d at 471 (citing *Reid v. Aransas Cnty.*, 805 F. Supp. 2d 322, 339 (S.D. Tex. 2011) ("[A] plaintiff cannot use the [Act] to create a private right of action where none exists.")); *see also e.g.*, *Reliable Ambulance Serv. v. Mercy Hosp. of Laredo*, No. 04-02-00188-CV, 2003 Tex. App. LEXIS 10934, at *5 (Tex. App.—San Antonio Aug. 20, 2003, pet. denied) (dismissing claim for unfair competition based on

alleged violation of anti-kickback provision of Social Security Act); Tex. Occ. Code §§ 102.009, 102.010 (explaining that action for violation of Texas anti-kickback statute may be instituted by attorney general, county attorney, or district attorney).

i. There is no private cause of action for alleged violations of the Texas Medical Practice Act. (Issue 2)

Under the "corporate practice of medicine" doctrine contained in the Texas Medical Practice Act, the practice of medicine is restricted to licensed physicians. *See* Tex. Occ. Code § 164.052(a)(17) (prohibiting physicians from directly or indirectly aiding or abetting in the practice of medicine by a person, partnership, association, or corporation that is not licensed to practice medicine by the Texas Medical Board.); *see also* § 165.156; § 155.001; 22 Tex. Admin. Code § 177.17(a) (noting the general prohibition on the corporate practice of medicine and enumerating exceptions). Specifically, the Medical Practice Act "prohibits a corporation comprised of lay persons, which employs licensed physicians to treat patients, from receiving a fee." *Fite v. Emtel, Inc.*, No. 01-07-00273-CV, 2008 WL 4427676, at *6 (Tex. App.—Houston [1st Dist.] Oct. 2, 2008, pet. denied) (citing *Gupta v. Eastern Idaho Tumor Inst., Inc.*, 140 S.W.3d 747, 752 (Tex. App.—Houston [14th Dist.] 2004, pet. denied). "The purpose of [the prohibition on the corporate practice of medicine] is to preserve the vitally important doctor-patient relationship and prevent possible

abuses resulting from lay control of corporations employing licensed physicians to practice medicine." *Gupta*, 140 S.W.3d at 752.

Only the Texas Medical Board and the Attorney General have the authority to enforce the Medical Practice Act in civil, criminal, and administrative proceedings. Tex. Occ. Code §§ 165.001–165.160. There is no private cause of action for violations of the Medical Practice Act, including claims alleging the corporate practice of medicine. *See Hosp. Internists of Austin, P.A. v. Quantum Plus, LLC*, No. 1:18-CV-466-RP, 2019 WL 1922051, at *4 (W.D. Tex. Jan. 23, 2019) (dismissing a declaratory judgment claim because that there is no private cause of action involving the corporate practice of medicine claims).

In *Cassidy v. TeamHealth, Inc.*, two doctors and medical societies representing other specialists sought a declaratory judgment that certain healthcare systems were violating the Medical Practice Act by engaging in the corporate practice of medicine. No. 01–0800324 CV, 2009 WL 2231217, at *1 (Tex.App.—Houston [1st Dist.] July 23, 2009 no pet.) (mem. op.). The First Court of Appeals held that the plaintiffs lacked standing because "[t]he Medical Practice Act does not create a private cause of action, and appellants may not use the [Declaratory Judgment Act] to create a quasi-cause of action to enforce the Medical Practice Act." *Id.* at *6 (citations omitted).

Like the doctors in *Cassidy*, Lopez seeks a decision declaring that CMC is engaged in the corporate practice of medicine. And, just like the doctors in *Cassidy*, she lacks standing because she cannot bring a declaratory judgment claim involving the alleged corporate practice of medicine where there is no underlying private cause of action for such claims. *See GuideOne Ins. Co. v. Cupps*, 207 S.W.3d 900, 904 (Tex. App.—Fort Worth 2006, pet. denied) (holding that, where a plaintiff brings a claim that is not subject to judicial review, "the trial court lacks subject matter jurisdiction and must dismiss the claims."). Consequently, this Court should find that Respondent lacks subject matter jurisdiction over Lopez's corporate practice of medicine claims because there is no private cause of action for such claims.

ii. There is no private cause of action alleged violations of the Texas Hospital Licensing Law. (Issue 2)

The Texas Hospital Licensing Law provides that hospitals must provide certain process when renewing, modifying, or revoking staff privileges. Tex. Health & Safety Code § 241.101(c) (stating that the due process procedures must meet the requirements of 42 U.S. C. § 11101, *et. seq.*). Specifically, hospitals subject to the Texas Hospital Licensing Law must provide medical staff with, at a minimum, written notice and, upon request, a hearing. 42 U.S.C. § 11112; *see also* § 11151 (defining a professional review activity as activity by a health care entity with respect to the determining or modifying the scope or conditions of a physician's privileges.).

The Texas Health and Human Services Executive Commissioner, Department of State Health Services, the Attorney General, and district and county attorneys are the only individuals with the authority to enforce the provisions of the Texas Hospital Licensing Law in civil, criminal, and administrative proceedings. *See* Tex. Health & Safety Code §§ 241.051-60 ("Enforcement" Subsection); *but see also* § 241.056 (making an exception to the rule permitting injunctive suits by persons harmed by a hospital patient transfer).

In *Park*, a hospital restricted an emergency room physician's staff privileges by requiring him to consult with the on-call pediatrician or another emergency room physician for all pediatric patients due to concerns about his care and treatment of three pediatric patients. *Park v. Mem'l Health Sys. of E. Texas*, 397 S.W.3d 283, 286 (Tex. App.—Tyler 2013, pet. denied). The physician brought suit against the hospital alleging, among other things, that it engaged in the corporate practice of medicine in violation of the Texas Medical Practice Act and failed to afford him the due process required by the Hospital Licensing Law. *Id.* The Twelfth Court of Appeals held that both statutes, "although binding on hospitals, do not create a [private] right of action in favor of physicians against hospitals that fail to comply. Enforcement is statutorily placed in the hands of the state and its agencies. Accordingly, existing

Texas law does not provide relief for [the physician plaintiff's] alleged damages pursuant to these statutes." *Id.* at 293 (cleaned up).

Lopez's suit suffers from the same incurable defects as the physician plaintiff in *Park*. Only the State can enforce violations of the Texas Medical Practice Act and Hospital Licensing Law. *Id.* Lopez lacks standing because there is no private cause of action for violations of either statute. *Id.* Consequently, this Court should find that Respondent lacks jurisdiction over Lopez's claims that CMC violated the Texas Hospital Licensing Law in the absence of a private cause of action for such alleged violations.

B. Lopez lacks standing to bring a due process claim under CMC's Bylaws because no adverse action was taken against her privileges. (Issue 2)

Physicians do not have a vested property right in their staff privileges at a hospital. *Holston v. Sloan*, 620 S.W.2d 255, 255 (Tex. Civ. App.—El Paso 1981, no writ); *Kinnard v. United Reg'l Health Care Sys.*, 194 S.W.3d 54, 55 (Tex. App.—Fort Worth 2006, pet. denied). Procedural rights created in a medical organization's bylaws may constitute, in some circumstances, contractual rights in favor of a doctor with staff privileges. *Marlin v. Robertson*, 307 S.W.3d 418 (Tex. App.—San Antonio 2009, no pet.); *East Texas Medical Center Cancer Institute v. Anderson*, 991 S.W.2d 55 (Tex. App.—Tyler 1998, pet. denied). But Lopez identifies no such contractual rights

here. CMC's bylaws provide certain "procedural rights of review" whenever an "adverse action" is taken against the practitioner. MR.1444-56. These rights of review include notice and a right to request a hearing. MR.1446. But a "limitation or restriction of clinical privileges imposed equally on all Practitioners with the same or similar Clinical Privileges" is *not* an adverse action under CMC's Bylaws. MR.1445.

Lopez lacks standing because, per CMC's Bylaws, she has not experienced an adverse action (an "injury") that might entitle her to notice and a hearing. CMC's Bylaws state that "[a]ny limitation or restriction of Clinical Privileges imposed equally on all Practitioners with the same or similar Clinical Privileges" is *not* an adverse action and does not entitle impacted physicians to notice and a hearing, much less any further process. MR.1445. In this case, CMC and UTSW jointly decided to discontinue PBHT for new pediatric patients for the treatment of gender dysphoria. MR.520-21. The decision was not specific to Lopez. *Id*. It applied equally to all practitioners with endocrinology privileges. *Id*. at 669. Thus, the decision was not an "adverse action" against Lopez's privileges entitling her procedural rights of review under CMC's Bylaws. MR.1445.

This Court should find that Lopez lacks standing because she has not experienced an injury, specifically an adverse action as defined by CMC's Bylaws. The

decision to discontinue the provision of PBHT to new pediatric patients for the treatment of gender dysphoria applied equally to all providers with endocrinology privileges at CMC. It is not an "adverse action" as to Lopez, so it does not trigger CMC's Bylaws' procedural rights of review.

C. Lopez lacks standing to bring a Section 1557 claims because her purported injuries are wholly speculative. (Issue 2)

Section 1557 of the Patient Protection and Affordable Care Act (ACA) prohibits discrimination and the denial of benefits on the basis of race, color, national origin, sex, age, or disability "under any health program or activity, any part of which is receiving Federal financial assistance." 42 U.S.C. § 18116(a). Section 1557 expressly incorporates four federal civil rights statutes, which outline the protected grounds of discrimination: race, color, and national origin (under Title VI); sex (under Title IX); age (under the ADEA); and disability (under the Rehabilitation act). *Id.*; *see also Joganik v. E. Texas Med. Ctr.*, No. 6:19-CV-517-JCB-KNM, 2021 WL 6694455, at *6 (E.D. Tex. Dec. 14, 2021), *report and recommendation adopted*, No. 6:19-CV-00517, 2022 WL 243886 (E.D. Tex. Jan. 25, 2022). Plaintiffs bringing a Section 1557 claim must plead a corresponding civil rights statute predicate. *Id.* (citing *Se. Pa. Transp. Auth. v. Gilead Scis., Inc.*, 102 F. Supp. 3d 688, 696 (E.D. Pa. 2015) (holding that the standard and burden of proof for a discrimination claim under Section 1557 changes

depending upon the type of discrimination alleged and should be drawn from the relevant statute listed in 42 U.S.C. § 18116(a)).

A Section 1557 claim for discrimination on the basis of sex dictates that Title IX is the relevant statute. *See* 42 U.S.C. § 2000e-5(g) (Title IX remedies provision); *Cannon v. Univ. of Chi.*, 441 U.S. 677, 709 (1979) (holding private right of action under Title IX for injunctive or equitable relief existed); s*ee also Rumble v. Fairview Health Servs.*, Case No. 14-CV-2037 (SRN/FLN), 2015 WL 1197415, at *7 n. 3 (D. Minn. Mar. 16, 2015) (concluding that Section 1557 provides a private right of action because each incorporated statute does so).

i. Lopez lacks standing to bring a Section 1557 claim.

Lopez is not alleging third-party, organizational, or class representative standing; instead, she contends that she has standing because CMC and UTSW's joint decision to discontinue the provision of PBHT to new pediatric patients for the treatment of gender dysphoria is forcing her to violate the standard of care and therefore exposes her to medical malpractice lawsuits and disciplinary action by the Texas Medical Board. MR.587; 892-93, 63:18-64:5. Specifically, Lopez claims that 41% of these hypothetical patients "will commit suicide."[7] *Id.* at 867, 68:2-3.

[7] This claim—to put it mildly—is outré. Lopez can simply refer these potential patients to other providers in the Dallas area who prescribe PBHT to pediatric patients for the treatment of gender dysphoria, and these patients can still receive psychiatric care and support at CMC. MR.669-70, 1391-92.

Lopez's purported injuries are entirely speculative. She has not and cannot cite to a single case in Texas where a medical malpractice judgment or a disciplinary order by the Texas Medical Board was entered against a physician who failed to provide PBHT to a pediatric patient for the treatment of gender dysphoria when those services had been jointly discontinued by both their employer and the hospital. This Court need go no further in determining that Lopez lacks standing because her purported injuries are pure conjecture.

Lopez's purported injuries are also hypothetical because she cannot show that treating gender dysphoria in pediatric patient without the use of PBHT *violates* the standard of care such that it would subject her to disciplinary action by the Texas Medical Board of malpractice claims from patients. CMC and UTSW's joint statement announcing their decision acknowledged that "it is evident the debate over the appropriate age of consent for hormone treatment calls for additional medical reviews and study." *Id.* at 670. UTSW added that the decision was made because of the "growing concern in the medical community about our limited understanding of the long-term effects—both psychological and physical—on children who receive this treatment. We considered that there have been controlled trials that have clearly delineated the effectiveness and safety of these treatments." MR.1391-92. And, unlike with puberty blockers for the treatment of precocious puberty, PBHT are not

FDA approved for the treatment of gender dysphoria in youth.[8] MR.1391-92. The media has widely reported that PBHT on pediatric patients is controversial a subject of debate among health care professionals. *See id.* at 1108-1214. This disagreement within the medical community is similarly borne out in the expert reports filed in the related cases challenging state child abuse laws. *See id.* at 1215-1390. Earlier this month, the Federal Drug Administration issued a warning that puberty blockers can cause pseudotumor cerebri in pediatric patients, including headache, papilledema, blurred or loss of vision, diplopia, pain behind the eye or pain with eye movement, tinnitus, dizziness and nausea. MR.1496.

Accordingly, this Court should find that Lopez lack standing to bring a Section 1557 claim against CMC because her purported injuries are nothing more than pure conjecture.

ii. Alternatively, *Bostock* did not extend gender identity discrimination protections to Title IX.

Section 1557 provides an individual shall not be "excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance." 42

[8] The FDA has not approved *any* PBHT drugs for the treatment of gender dysphoria in pediatric patients. Lopez prescribes and administers off-label drugs like Lupron, which is used to chemically castrate sex offenders, to her pediatric patients for the treatment of gender dysphoria.

U.S.C. § 18116(a). Section 1557 does not employ the terms "sex," "sexual orientation," or "gender identity." See *id*. Instead, Section 1557 expressly incorporates Title IX, which prohibits discrimination "on the basis of sex." See *id*.; 20 U.S.C. § 1681(a).

In *Bostock*, the Supreme Court held that Title VII's "because of ... sex" terminology should be read to prohibit "gender identity" discrimination. *Bostock v. Clayton Cnty., Georgia*, 140 S. Ct. 1731 (2020). However, *Bostock* does not prohibit gender identity discrimination under Section 1557's definition of "sex." Importantly, for purposes of this case, Section 1557 incorporates standards from Title IX, not Title VII, and the two statutes use different language and set out different statutory schemes. *See Neese v. Becerra*, No. 2:21-CV-163-Z, 2022 WL 1265925 (N.D. Tex. Apr. 26, 2022) (related pending case); *cf*, *Tennessee v. United States Dep't of Educ.*, No. 3:21-CV-308, 2022 WL 2791450, at *21 (E.D. Tenn. July 15, 2022); *contra Joganik v. E. Tex. Med. Ctr.*, No. 6:19-CV-517-JCB-KNM, 2021 WL 6694455, at *10 (E.D. Tex. Dec. 14, 2021), r*eport and recommendation adopted*, 2022 WL 243886 (E.D. Tex. Jan. 25, 2022); *Tovar v. Essential Health*, 342 F. Supp. 3d 947, 953 (D. Minn. 2018); *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 949–50 (W.D. Wis. 2018); *Prescott v. Rady Child.'s Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1098-1100 (S.D. Cal. 2017); *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 616

(4th Cir. 2020), *as amended* (Aug. 28, 2020), *cert. denied* 141 S. Ct. 2878 (with Justices Thomas and Alito noting that they would have granted the petition for writ of certiorari).

Courts construes statutory text to give effect to the ordinary public meaning conveyed when Congress enacted the statute. *See New Prime Inc. v. Oliveira*, 139 S. Ct. 532, 539 (2019); ANTONIN SCALIA & BRYAN A. GARNER, READING LAW: THE INTERPRETATION OF LEGAL TEXTS §§ 6–7 (2012). The Court must instead "read the statute as a whole, so as to give effect to each of its provisions without rendering any language superfluous." *Bustamante-Barrera v. Gonzales*, 447 F.3d 388, 397 (5th Cir. 2006) (emphasis added); *Janvey v. Golf Channel, Incorporated*, 487 S.W.3d 560, 570 (Tex. 2016). The terms of a statute bear their ordinary meaning unless (1) the Legislature has supplied a different meaning by definition, (2) a different meaning is apparent from the context, or (3) applying the plain meaning would lead to absurd results." *Hardy v. Communication Workers of America Local 6215 AFL-CIO*, 536 S.W.3d 38, 45 (Tex. App.—Dallas, 2017). To determine a statutory term's common, ordinary meaning, Texas courts typically look first to its dictionary definitions and then consider the term's usage in other statutes, court decisions, and similar authorities. *Id.* (citing *Texas State Board of Examiners of Marriage and Family Therapists v. Texas Medical Association*, 511 S.W.3d 28, 35 (Tex. 2017)).

Courts cannot interpret "sex" in isolation. *United States v. Morton*, 467 U.S. 822, 828 (1984). Congress enacted Title IX in 1972. 20 U.S.C. § 1681. At that time, "sex" was commonly understood to refer to physiological differences between men and women—particularly with respect to reproductive functions. *See, e.g., Sex*, AMERICAN HERITAGE DICTIONARY 1187 (1976) ("The property or quality by which organisms are classified according to their reproductive functions."); *Sex*, WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 2081 (1971) ("The sum of the morphological, physiological, and behavioral peculiarities of living beings that subserves biparental reproduction with its concomitant genetic segmentation and recombination which underlie most evolutionary change ...."); *Sex*, 9 OXFORD ENGLISH DICTIONARY 578 (1961) ("The sum of those differences in the structure and function of the reproductive organs on the ground of which beings are distinguished as male and female, and of the other physiological differences consequent on these."). Indeed, *Bostock* itself "proceed[ed] on the assumption that 'sex' ... refer[ed] only to biological distinctions between male and female." 140 S. Ct. at 1739.

Title IX presumes sexual dimorphism in section after section, requiring equal treatment for each "sex." *See, e.g.*, 20 U.S.C. § 1681(a)(8) (stating if father-son or

mother-daughter activities are provided for "one sex," reasonably comparable activities shall be provided for "the other sex."); 20 U.S.C. § 1681(a)(2) (requiring same in school admissions context). And Courts have long interpreted Title IX to prohibit federally funded education programs from treating men better than women (or vice versa). *See, e.g., N. Haven Bd. of Educ. v. Bell*, 456 U.S. 512, 530 (1982); *Cannon v. Univ. of Chi.*, 441 U.S. 677, 680 (1979). As written and commonly construed, Title IX operates in binary terms—male and female—when it references "sex."

Title IX's ordinary public meaning remains intact until changed by Congress. *See Cochise Consultancy, Inc. v. U.S. ex rel. Hunt*, 139 S. Ct. 1507, 1512 (2019) ("In all but the most unusual situations, a single use of a statutory phrase must have a fixed meaning."). As noted above, the ordinary public meaning of "sex" turned on reproductive function when Congress enacted Title IX. Legislators tried to amend Title IX to include "gender identity" on multiple occasions, but those attempts failed. *See, e.g.*, H.R. 1652, 113th Cong. (2013); S. 439, 114th Cong. (2015). By contrast, Congress *has* enacted hate-crimes legislation with enhanced penalties for crimes motivated by "gender identity," *See* 18 U.S.C. § 249(a)(2); 34 U.S.C. § 12291 (b)(13)(A) (prohibiting discrimination in certain funding programs based on "gender identity," separately from "sex"). The Texas Supreme Court has not held that Bostock extended "gender identity" protections

Though Courts sometimes apply the legal standards used in Title VII cases to decide Title IX cases—*see, e.g., Canutillo Indep. Sch. Dist. v. Leija*, 101 F.3d 393, 404 (5th Cir. 1996)—that is appropriate only where Title IX and Title VII are identical in the sense material to the case. But Section 1557 and Title IX are not identical to Title VII in every material instance. Title VII makes it unlawful for an employer to make certain decisions "*because of*" certain factors, including "sex." 42 U.S.C. § 2000e-2(a)(1)(emphasis added); *see Bostock*, 140 S. Ct. at 1738. By contrast, Title IX prohibits "discrimination *on the basis of sex*." 20 U.S.C. § 1681(a) (emphasis added). These phrases are not synonymous.

Courts must give full effect to the difference in word choice. *RepublicBank Dallas, N.A. v. Interkal, Inc.*, 691 S.W.2d 605, 607 (Tex. 1985); Henry J. Friendly, *Mr. Justice Frankfurter and the Reading of Statutes*, BENCHMARKS 224 (1967) ("[W]hen Congress employs the same word, it normally means the same thing, when it employs different words, it usually means different things").

As the *Bostock* Court explained, "only the words on the page constitute the law adopted by Congress and approved by the President." *Bostock*, 140 S. Ct. at 1738. If this Court failed to acknowledge the different phrases Title VII and Title IX employ, then it "would risk amending [the] statutes outside the legislative process reserved for the people's representatives." *Id.* The Supreme Court used a "but-for"

causation analysis to decide *Bostock* based on Title VII's text, which bars discrimination "*because of*" sex. *See id.* at 1739. Since Title IX prohibits "*on the basis of sex*," the Court should not reflexively adopt *Bostock*'s but-for causation analysis. 20 U.S.C. § 1681(a).

If a health-care provider applies the same rules to both male and female, and refuses to prescribe the identical hormone therapy regardless of the sex of the patient who asks for it, then it is impossible to see how the provider has discriminated "on the basis of sex." 20 U.S.C. § 1681(a). To hold otherwise would effectively amend the text of Title IX by converting its prohibition on "sex" discrimination into a statute that outlaws discrimination on account of gender identity—which is exactly what *Bostock* said it was not doing. *See Bostock*, 140 S. Ct. at 1746–47 ("We agree that homosexuality and transgender status are distinct concepts from sex.").

This Court should find that *Bostock* was a narrow ruling that did not create a new claim for gender identity discrimination under Section 1557 where one none previously existed.

III. The State has no adequate remedy by appeal.

Mandamus will not issue where there is an adequate remedy by appeal is well-settled. *Walker v. Packer*, 827 S.W.2d 833, 840 (Tex. 1992).

Absent mandamus relief, the State will be prejudiced. The State, through UTSW, is enjoined by Respondent's temporary orders from discontinuing the provision of PBHT to new pediatric patients for the treatment of gender dysphoria. CMC and Lopez agreed to the temporary injunction that necessarily bound UTSW without conferring with the State. Lopez also seeks to conduct discovery on UTSW and depose its officials, without the State being permitted to assert sovereign immunity from suit. If Lopez is ultimately successful, she will obtain a permanent injunction that enjoins the State to continue to provide PBHT to new pediatric patients for the treatment of gender dysphoria at UTSW. Thus, the State's interest are prejudiced by Lopez's suit. Absent mandamus relief, the State will continue to be enjoined without the ability to defend its interests until Respondent enters a Final Judgment.

PRAYER

The Court should issue a writ of mandamus directing Respondent to withdraw her Order Granting Agreed Temporary Injunction and Order Granting Lopez's Motion to Strike the State's Intervention, and to further enter an order dismissing Lopez's claims.

Respectfully submitted,

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MANDAMUS CERTIFICATION

Pursuant to Texas Rule of Appellate Procedure 52.3(j), I certify that I have reviewed this petition and that every factual statement in the petition is supported by competent evidence included in the appendix or record. Pursuant to Rule 52.3(k)(1)(A), I certify that every document contained in the appendix is a true and correct copy.

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Certificate of Service

On August 3, 2022, this document was served on the counsels for the Real Parties in Interests.

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Certificate of Compliance

Microsoft Word reports that this brief contains 9,278 words, excluding the portions of the brief exempted by Rule 9.4(i)(1).

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No. ___

In the Court of Appeals for the Fifth Judicial District Dallas Texas

IN RE: THE STATE OF TEXAS,
Relator-Intervenor.

On Petition for Writ of Mandamus
to the Fifth Court of Appeals, Dallas

APPENDIX TO RELATOR-INTERVENOR'S PETITION FOR WRIT OF MANDAMUS

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APPENDIX

	Daniel K. Podolsky, M.D. and John J Warner, M.D.	
O	Lopez's Answer and Counterclaim Against State	942-950
P	Order Granting Agreed Temporary Injunction Order	951-953
Q	CMC's Special Exceptions, Plea to the Jurisdiction, and Original Answer	954-962
R	Lopez's Notice of Hearing on Special Exceptions and Motion to Strike State's Intervention	963-964
S	Lopez's Notice of Intention to Request Production of Documents from Non-Party the Republican Party of Texas	965-973
T	Lopez's Notice of Intention to Request Production of Documents from Non-Party Natalie Cato	974-982
U	Lopez's Notice of Intention to Request Production of Documents from Non-Party Save Texas Kids	983-991
V	Lopez's Notice of Intention to Request Production of Documents from Non-Party the Texas Hospital Association	992-999
W	Lopez's Notice of Intention to Request Production of Documents from Non-Party the Texas Medical Association	1000-1007
X	Lopez's Notice of Intention to Request Production of Documents from Non-Party UTSW	1008-1016
Y	State's Notice of Appeal re: Order Granting Agreed Temporary Injunction	1017-1021
Z	State's Plea to the Jurisdiction	1022-1032
AA	State's Response to Lopez's Special Exceptions and Motion to Strike State's Intervention	1033-1037
BB	State's First Amended Petition in Intervention	1038-1057
CC	Lopez's Amended Special Exceptions and Motion to Strike State's Intervention	1058-1079
DD	Lopez's Deposition Notice for Kelly Neidert	1080-1083
EE	Lopez's Deposition Notice for Natalie Cato	1084-1087

FF	Ordering Granting Lopez's Motion to Strike State's Intervention	1088-1089
GG	Lopez's Deposition Notice for John J. Warner, M.D.	1090-1092
HH	Lopez's Deposition Notice for Daniel K. Podolsky, M.D.	1093-1095
II	Lopez's Deposition Notice for Stephen Skapek, M.D.	1096-1098
JJ	Lopez's Notice of Deposition for Dai H. Chung, M.D	1099-1101
KK	State's Notice of Appeal re: State's Plea to the Jurisdiction	1102-1107
LL	Lena Wilson, *What Are Puberty Blockers*, N.Y. Times (May 11, 2021)	1108-1111
MM	Abigail Shrier, *Top Trans Doctors Blow the Whistle on 'Sloppy' Care*, Common Sense (Oct. 4, 2021)	1112-1122
NN	Laura Edwards-Leeper & Erica Anderson, *The mental health establishment is failing trans kids*, WaPo (Nov. 24, 2021)	1123-1127
OO	Marin Wolf & Lauren McGaughy, Doctor at heart of fight over trans you care says she is racing against time, Dallas Morn. News (May 19, 2022)	1128-1134
PP	Emily Bazelon, *The Battle Over Gender Therapy*, N.Y. Times (June 24, 2022)	1135-1159
QQ	Connor Boyd, *Every trans child treated on NHS in past decade will have medical record scrutinised to see how many regret transitioning*, Daily Mail (June 30, 2022)	1160-1209
RR	Lindsey Tanner, *Trans kids' treatment can start younger, new guidelines say*, ABC News (June 15, 2022)	1210-1214
SS	Declaration and Report of James Cantor, PhD	1215-1347
TT	Declaration and Report of Michael Laidlaw, M.D.	1348-1390
UU	UTSW Statement on Genecis Program	1391-1392
VV	CMC's Bylaws	1393-1456
WW	CMC Rules and Regulations	1457-1493
XX	Lopez's Counsel's Press Release	1494-1496

YY	FDA Label	1497-1498

No. _____

In the Fifth Court of Appeals
at Dallas, Texas

In re Daniel K. Podolsky, M.D. and John J. Warner, M.D.
Relators,

Hon. Melissa Bellan,
Respondent

Ximena Lopez, M.D.,
Real Party in Interest

University of Texas Southwestern Medical Center and Children's Medical Center,
Other Interested Parties.

Original Proceeding from County Court at Law No. 2, Dallas County, Texas, Trial Court No. CC-22-01316-B, Hon. Melissa Bellan, Presiding

PETITION FOR WRIT OF MANDAMUS

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Emergency Temporary Relief Requested by ____ am/pm, April 27, 2022

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Table of Contents

Appendix

1. Order Granting Ximena Lopez, M.D.'s Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202
2. Texas Rules of Civil Procedure 202

Index of Authorities

Cases:

Constitutions and Statutes:

Statement of the Case

Nature of the Underlying Proceeding:	Ximena Lopez, M.D. filed a Rule 202 Petition to investigate potential claims against Relators Daniel K. Podolsky, M.D. and John J. Warner, M.D., President and Executive Vice President, respectively, at the University of Texas Southwestern Medical Center, related to a decision that changed the medical services provided by that institution. MR.3-22. Relators responded with a plea to the jurisdiction based on immunity and opposition to the Rule 202 Petition. MR.206-247.
Respondent:	Hon. Melissa Bellan, County Court at Law No. 2, Dallas County, Texas
Respondent's Challenged Actions:	The trial court did not rule on Relators' plea to the jurisdiction and thus could not have determined its jurisdiction to order Rule 202 depositions. MR.323 (numbered paragraph 6). The trial court found the benefit of the depositions outweighed the burden and ordered the depositions of Drs. Podolsky and Warner essentially within 14 days. MR.322, 324.

Statement of Jurisdiction

Section 22.221(b) of the Texas Government Code confers jurisdiction on a Court of Appeals to issue "all writs of mandamus" against a judge of a statutory county court in its appellate district. Tex. Gov't Code § 22.221(b); *see* Tex. Const. art. V, § 6(a). This Court's district includes Dallas County, where the respondent is the presiding judge of County Court at Law No. 2. Tex. Gov't Code §§ 22.201(f), 25.0591(a)(2).

Issues Presented

Issue 1: Sovereign or governmental immunity means that courts have no jurisdiction over governmental actors unless the Legislature has clearly and unambiguously waived that immunity. Rule 202 of the Texas Rules of Civil Procedure permits certain pre-suit depositions but only to the extent that they would be allowed in the anticipated or potential suit. Thus, if governmental immunity bars that suit, Rule 202 cannot compel pre-suit deposition. Here, Relators are governmental actors—President and Executive Vice President of the University of Texas Southwestern Medical Center, an arm of the State. Instead of first determining the immunity question, a prerequisite to a Rule 202 deposition of a potentially immune party, Respondent ordered Relators' Rule 202

depositions without any answer to that initial question. Did the trial court clearly abuse its discretion, for which no adequate appellate remedy exists, by not first answering the immunity question before ordering Relators' Rule 202 deposition?

Issue 2: A Rule 202 deposition must occur in a court that would have jurisdiction over the anticipated or potential suit. In a case implicating sovereign immunity, that jurisdictional analysis includes whether the claimant overcame immunity. Here, the Rule 202 Petition's claim of *ultra vires* acts—the corporate practice of medicine and discrimination—did not overcome Relators' immunity. Did the trial court abuse its discretion, for which there is no adequate remedy by appeal, by ordering Relators' depositions when their immunity had not been overcome?

Issue 3: A Rule 202 deposition to investigate a claim can only occur where the likely benefit of the discovery outweighs the burden or expense of the procedure. Before Respondent ruled, the public record included information about who made the decisions related to the governmental program in question and why. Dr. Lopez knows who to sue and what to sue for, providing a very limited benefit for any pre-suit depositions.

When compared to the burden on Relators, that benefit did not outweigh the burden. Did the trial court abuse its discretion, for which there is no adequate remedy by appeal, by ordering Relators depositions?

To the Honorable Court of Appeals for the Fifth District of Texas:

Relators Daniel K. Podolsky, M.D. and John J. Warner, M.D. seek mandamus relief to correct the trial court's clear abuse of discretion in ordering their depositions (1) before confirming that it had subject matter jurisdiction, (2) in a Rule 202 proceeding where it did not have jurisdiction, and (3) in a situation where, due to the publicly available information, the benefit of the depositions did not outweigh the burden. Relators have no adequate remedy by appeal. By separate emergency motion, Relators also seek temporary relief from those depositions, ordered to occur by April 28, 2022.

Introduction and Summary of the Argument

The underlying Rule 202 proceeding purportedly seeks discovery of certain information about who decided, on behalf of the University of Texas Southwester Medical Center to change certain treatments available to gender-dysphoric pediatric patients at Children's Medical Center clinics. Ximena Lopez, M.D. wants to see if she has claims against Daniel K. Podolsky, M.D., John J. Warner, M.D., UT Southwestern, and Children's Medical Center. MR.14 and 322. But how to best treat gender dysphoria, which has become politically charged, has little to do with this

mandamus proceeding, which seeks a determination of procedural issues surrounding the trial court's Rule 202 order. Should the trial court have determined its jurisdiction *before* it ordered the Rule 202 depositions to occur? Did the trial court have jurisdiction? And did the benefit of the Rule 202 depositions outweigh their burden, particularly given the publicly available information? The answers to those procedural questions have little to do with the substance of treatment for gender-dysphoric pediatric patients or any potential problems from the UT Southwestern decisions.

Instead, the procedural issues are immunity and mechanics of a Rule 202 proceeding. Sovereign immunity protects the citizens of Texas from bearing the costs of litigation. Those costs come not only in the monetary costs associated with litigation—e.g., hiring lawyers, paying experts, and paying court costs—but also with the practical costs from taking public officials away from their job duties. Dr. Podolsky is the President of UT Southwestern Medical Center. MR.301. Dr. Warner is the Executive Vice President for Health System Affairs at UT Southwestern Medical Center and has recently become the Chief Executive Officer of the UT Southwestern Health System. MR.303. They

have important jobs running a large public medical institution and, preparing for and sitting for Rule 202 depositions, takes them away from those responsibilities. And being Rule 202 depositions, "[t]here are practical as well as due process problems with demanding discovery from someone before telling them what the issues are." *In re Jorden*, 249 S.W.3d 416, 423 (Tex. 2008).

Sovereign immunity implicates a court's subject-matter jurisdiction—without a waiver of immunity, a court has no power over the immune parties. Even in a Rule 202 proceeding, the trial court "*must* have subject matter jurisdiction over the anticipated action." *In re City of Dallas*, 501 S.W.3d at 73 (emphasis in original, cleaned up). Thus, "*before* addressing the merits of pre-suit discovery," a court must determine whether it has jurisdiction over the claim the party wants to investigate. *Id.* (emphasis added). A Rule 202 proceeding cannot investigate potential suits over which the trial court would not have jurisdiction. *In re Doe (Trooper)*, 444 S.W.3d 603, 608 (Tex. 2014). That limitation includes pre-suit investigations over "potential claims that are otherwise barred by sovereign immunity." *Combs v. Tex. Civil Rights Project*, 410 S.W.3d 519, 535 (Tex. App.—Austin 2013, pet. denied). Here, the trial court ordered

the depositions of Drs. Podolsky and Warner without ever answering the jurisdictional question. MR.323. At a minimum, that cart-before-the-horse approach was reversibly wrong—a court must determine jurisdiction before ordering Rule 202 depositions. And Relators' jurisdictional challenge was correct: the trial court did not have jurisdiction over Dr. Lopez's potential future claims of purported *ultra vires* claims involving the corporate practice of medicine, which was inapplicable to Relators, and discrimination against patients, which Dr. Lopez lacked standing to pursue. Relators have no adequate remedy by appeal from the trial court's refusal to determine jurisdiction.

On the substance of the Rule 202 proceeding, the trial court abused its discretion in determining that the benefit of the depositions outweighed the burden. Publicly available information answered the questions that Dr. Lopez has about who made the decisions she disagrees with and the effects of those changes. She needed to discover no additional information in order to sue to stop Relators' alleged *ultra vires* acts, to enjoin Relators, UT Southwestern, or Children's Medical Center from discontinuing the treatment in question for new pediatric patients, and the alleged discrimination resulting from the changes—if any of

those claims are actionable. Any other information sought is unnecessary to bring her purported claims, and ordinary discovery during a lawsuit can answer her other concerns. With the information available and the burden on these public officials, the trial court abused its discretion by ordering these depositions. Relators have no adequate remedy by appeal.

Statement of Facts

UT Southwestern faculty physicians provide pediatric care at the hospitals and clinics owned by Children's Medical Center of Dallas. MR.207. That care included certain services previously coordinated under the Gender Education and Care, Interdisciplinary Support, or GENECIS, program. *Id*. Under that program, UT Southwestern physicians provided care to pediatric patients who are diagnosed with gender dysphoria. MR.7. But, as Dr. Lopez admits, GENECIS and the care provided under that brand, particularly puberty suppression and hormone therapy for minors, became "a political wedge issue," including some politicians' concerns that some of the treatments were child abuse. MR.11-12.

Considering the political controversy as well as other states' outright bans of hormone therapy for gender dysphoria for minors, UT

Southwestern, along with Children's Medical Center, decided to suspend the initiation of hormone therapy treatment for new pediatric patients. MR.207-208. *See also*, Joint Statement from Children's Health and UT Southwestern, March 28, 2022, p. 1 (available at https://www.utsouthwestern.edu/newsroom/articles/year-2022/gender-dysphoria-care.html. Care for existing patients remained unchanged MR.208. New patients and families could still receive a broad array of gender-affirming treatment, including psychiatric care considered foundational to gender transition and other front-line services to evaluate potential gender dysphoria. *Id*. And new patients and families seeking puberty suppression or hormone therapy would still "have access to outside practitioners not affiliated with a public institution that is ultimately accountable to the state…." *Id*.

These program changes closed no clinics—even though use of the GENECIS brand stopped. MR.208-209. But GENECIS, as a brand, was "a lightning rod for the controversy," so UT Southwestern and Children's Medical Center decided to remove that branding, which allowed patients to receive care "in a more protective environment." MR.208. UT

Southwestern and Children's Medical Center "continue to accept new patients referred for potential gender dysphoria." MR.209.

UT Southwestern and Children's Medical Center jointly believed that "a failure to act would put the entire program in jeopardy." MR.207-208. They feared the failure to act could be the "catalyzing" event that "would lead to banning the treatments statewide," leaving patients and families with no place to turn for that treatment—as had "already occurred in two states" with similar legislative bans pending in many more states. Drs. Podolsky and Warner, as the decision makers acting on behalf of UT Southwestern, jointly with Children's Medical Center, that made the changes to the services provided. MR.301, 303.

Dr. Lopez was not satisfied with the explanation for the changes to GENECIS and certain treatments offered to new patients and believes that the Governor or the Governor's office exerted political pressure on UT Southwestern to "stop clinicians from providing gender-affirming care." MR.12. She claims that changes to certain services interferes with her independent medical judgment and constitutes discrimination. MR.12-13. To answer some of her questions about the seissues, she filed a verified Rule 202 petition to take the depositions of Drs. Podolsky and

Warner. MR.3-177. She believes whoever ordered the changes to these services provided by UT Southwestern faculty at Children's Medical Center committed an *ultra vires* act and is subject to injunctive relief as well as a declaratory judgment. MR.13. She sought pre-suit discovery from Drs. Podolsky and Warner on the topics of (1) who made the decision to change the services, (2) whether any other governmental officials communicated with and demanded changes to the services, (3) "the medical, ethical, and legal basis for such limitations," (4) an explanation for why the changes are not discriminatory, and (5) the legal authority for the changes. MR.14. She served her petition on UT Southwestern, Children's Medical Center, and Drs. Podolsky and Warner, all potentially adverse parties. MR.14-15.

The adverse parties responded and objected to the pre-suit discovery requests. MR.179-190, 206-231, 233-247, 249-276. Very generally, UT Southwestern and Drs. Podolsky and Warner filed pleas to the jurisdiction, opposed the Rule 202 depositions, and objected to the topics and document-production requests. MR. 206-231, 233-247, 249-276. Children Medical Center objected to the lack of evidence supporting

pre-suit discovery as well as objecting to the document-production requests. MR.179-190.

Around 4:30 pm on April 8, 2022, the Friday before a Monday hearing, Dr. Lopez replied, responded to the jurisdictional pleas and the oppositions to her Rule 202 discovery. MR.286-295. She claimed entitlement to discovery on the jurisdictional pleas. MR.288-289. And she persisted that the decision to make changes to the services was *ultra vires* and discriminatory. MR.289-291. And she claimed that she met her burden to depose Drs. Podolsky and Warner pre-suit. MR.291-292.

The trial court heard the Rule 202 petition and took the matter under advisement. The transcript from the hearing, while requested, is not yet available. In addition to arguments and statements from counsel, Dr. Lopez testified at the hearing. After discussing her credentials and the GENECIS program as well as the treatment of adolescents with gender dysphoria, she testified that, during a May 2021 meeting, she was told that Dr. Podolsky had received a call from the Governor and that GENECIS was being shut down. She claimed she asked to meet with Dr. Podolsky to discuss the issue and the decision's effect on her patients. In a July 2021 meeting, Dr. Lopez stated she learned that UT Southwestern

was discussing the issue with legal but that they were still receiving pressure from the Governor and other legislators. In this meeting, Dr. Lopez learned UT Southwestern and Children's Medical Center were removing the GENECIS branding to remove all visibility of the care provided. According to Dr. Lopez, a final meeting occurred in November 2021, where Dr. Lopez learned that they were shutting the program down due to pressure. Dr. Lopez testified that she does not know who was ultimately making the decisions.

At the end of the hearing, the trial court took the matter under advisement and welcomed additional briefing. *See* MR.335. Drs. Podolsky and Warner decided to answer the main question presented from Dr. Lopez's testimony: who on behalf of UT Southwestern ultimately made the decisions to make changes to the services. MR.297. They submitted affidavits identifying themselves as the sole decision makers on behalf of UT Southwestern and that the decision was made jointly with Children's Health, as explained in the Joint Statement made by UT Southwestern and Children's Health. MR.301-304. They reiterated their position that, with this sworn testimony, there was no need for the pre-suit depositions. MR.298. They also explained why Dr. Lopez did not have standing to

assert a discrimination claim on behalf of patients and that the changes to the services were not discriminatory because it treated all new patients the same. MR.298-299. And they argued that the statutory anti-discrimination authority Dr. Lopez relied upon did not apply to the practice of medicine. MR.299.

UT Southwestern also provided a post-hearing letter brief that explained why merely alleging a discriminatory act did not necessarily amount to an *ultra vires* act to circumvented sovereign immunity. MR.308. UT Southwestern explained that Dr. Lopez was not the subject of discrimination and lacked standing to assert a claim on behalf of her patients. MR.309. And the changes to the services treated all persons the same, so that it did not amount to discrimination. MR.309-310. Finally, UT Southwestern argued that Drs. Podolsky's and Warner's disclosure that they were the decision makers on behalf of UT Southwestern mooted the Rule 202 petition.

Dr. Lopez moved to strike to the affidavits and post-submission briefing because Drs. Podolsky and Warner were not subject to cross examination and because evidence at the hearing had closed. MR.314-316. She also claimed that these statements waived immunity. MR.316-

317. Alternatively, she moved to re-open the evidence to cross examine these witnesses. MR. 317. Drs. Podolsky and Warner responded in opposition to this motion. MR.335-337.

The trial court never ruled on the Motion to Strike. But the trial court granted the Rule 202 petition and ordered the depositions of Drs. Podolsky and Warner. MR.322-324. The trial court required counsel for the parties to confer within three days to schedule the depositions and further ordered the depositions to occur remotely within 14 days of the order, or by April 28, 2022. MR.323-324. The trial court made clear that it did not "explicitly or implicitly" rule on the jurisdictional pleas. MR.323. On the objections to the deposition subjects, the trial court denied the objections but allowed the assertion of privileges to specific questions. MR.327-329. The trial court denied the document requests because it found that Dr. Lopez "is entitled to a deposition *or* D[eposition on]W[ritten]Q[uestions], but not a duces tecum or other document request in addition to the deposition." MR.330. The trial court also denied objections to Dr. Lopez's affidavit because the issue became moot considering her testimony at the hearing. MR.333.

Argument

A. Standard of Review

Parties seeking mandamus must show the trial court abused its discretion and that they have no adequate remedy by appeal. *In re Prudential Ins. Co.*, 148 S.W.3d 124, 135-136 (Tex. 2004); *Walker v. Packer*, 827 S.W.2d 833, 839-840 (Tex. 1992) (orig. proceeding). A trial court has no discretion to determine the law or apply the law to facts. *In re Prudential*, 148 S.W.3d at 135. An abuse of discretion occurs when a trial court acts "without reference to guiding rules or principles or in an arbitrary or unreasonable manner." *In re Garza*, 544 S.W.3d 836, 840 (Tex. 2018) (per curiam).

"[A] court cannot render a binding judgment concerning matters over which it lacks subject-matter jurisdiction." *In re City of Dallas*, 501 S.W.3d 71, 73 (Tex. 2016) (per curiam). Even in a Rule 202 proceeding, a court "must have subject-matter jurisdiction over the anticipated action." *In re DePinho*, 505 S.W.3d 621, 622 (Tex. 2016) (per curiam). Thus, a trial court has no discretion to order a Rule 202 deposition before determining if it has jurisdiction. *In re City of Dallas*, 501 S.W.3d at 74 (vacating trial

court's order authorizing pre-suit depositions and requiring the court "to first determine its jurisdiction").

The question of whether a trial court has subject-matter jurisdiction is a matter of law, and appellate courts review that issue de novo. *Texas Dep't of Parks & Wildlife v. Miranda*, 133 S.W.3d 217, 226 (Tex. 2004). That legal question includes whether a party has alleged facts affirmatively establishing subject-matter jurisdiction and whether any evidence establishes jurisdictional facts. *Id*. After a party challenges jurisdiction, the court determines whether the alleged facts demonstrate subject-matter jurisdiction, looking to the facts alleged, construed in favor of the pleader, as well as any evidence from the parties. *Miranda*, 133 S.W.3d at 226-227; *City of El Paso v. Heinrich*, 284 S.W.3d 366, 378 (Tex. 2009). If the pleadings are insufficient but curable, the pleader can amend; if not curable, the court should grant the jurisdictional challenge without the opportunity to amend. *Miranda*, 133 S.W.3d at 226-227.

Appellate courts review an order granting Rule 202 depositions for an abuse of discretion. *Patton Boggs LLP v. Moseley*, 394 S.W.3d 565, 568-569 (Tex. App.—Dallas 2011, no pet.). But improperly ordering a Rule 202 deposition when the benefits do not outweigh the burden is an

abuse of discretion. *In re Hewlett Packard*, 212 S.W.3d 356, 364 (Tex. App.—Austin 2006) ("We hold that Dell has not established that the benefit of the requested depositions outweighs the potential burden or expense of the procedure as required by [R]ule 202…Therefore, the trial court abused its discretion in granting [the Rule 202 petition].").

B. The Trial Court Abused Its Discretion by Granting the Rule 202 Petition Before Determining Jurisdiction (Issue 1)

1. Relators Are Employees of a Governmental Unit

The University of Texas Southwestern Medical Center is part of The University of Texas System and under the management and control of its board of regents. Tex. Educ. Code § 74.101. A university system is a state agency. Tex. Gov't Code 572.002(10)(B). Thus, UT Southwestern "enjoys sovereign immunity unless the [L]egislature expressly waives sovereign immunity." *Pulkrabek v. Univ. of Tex. Southwestern Med. Ctr.*, No. 05-14-01341-CV, 2016 WL 3004476, 2016 Tex. App. Lexis 5559 *3 (Tex. App.—Dallas 2016, no pet.).

No one disputes that Drs. Podolsky and Warner are employees of UT Southwestern. Dr. Lopez described Dr. Podolsky as "the President of UTSW." MR.12. Drs. Podolsky and Warner are high-ranking employees of UT Southwestern. MR.210 (describing both "as faculty physician

employees of UT Southwestern), 216-217 (describing Dr. Podolsky as "President of UT Southwestern" and Dr. Warner as "EVP for Health System Affairs and the CEO of UT Southwestern Health System"); MR.301 (identifying Dr. Podolsky "as the President of UT Southwestern Medical Center" and Dr. Warner as Executive Vice President for Health System Affairs and…Chief Executive Officer of the UT Southwestern Health System"); MR.303 (same).

2. Relators Are Immune from Suit Absent a Valid Waiver of Their Immunity

Claims against state officials in their official capacity are just a suit against the state. *Texas A&M Sys. v. Koseoglu*, 233 S.W.3d 835, 844-845 (Tex. 2007). An employee's jurisdictional plea "invoke[es] sovereign immunity from suit held by the government itself." *Id*. The Tort Claims Act's election of remedies provision immunizes governmental employees acting in their official capacities. *See* Tex. Civ. Prac. & Rem. Code § 101.106(e)-(f). The State and its agencies cannot be sued absent a valid legislative waiver of immunity. *Miranda*, 133 S.W.3d at 224. Such immunity "deprives a trial court of subject-matter jurisdiction." *Combs v. Tex. Civil Rights Project*, 410 S.W.3d 529, 533 (Tex. App.—Austin 2013, pet. denied). While Dr. Lopez attempted to circumvent this immunity by

alleging *ultra vires* acts by State officials, Drs. Podolsky and Warner's jurisdictional plea raised the immunity question, thereby raising a potential problem with subject-matter jurisdiction. *Miranda*, 133 S.W.3d at 225-227.

3. Rule 202 Petitions Against Governmental Actors Face Heightened Requirements

A Rule 202 proceeding "is not an end itself; rather, it is in aid of a suit which is anticipated and ancillary to the anticipated suit." *In re Wolfe*, 341 S.W.3d 932, 933 (Tex. 2011) (cleaned up). Thus, Rule 202 "prevent[s] an end-run around discovery limitations" by "restrict[ing] discovery…to the same as if the anticipated suit or potential claim had been filed." *Id.* (cleaned up). Thus, governmental entities and their employees "are protected from pre-suit depositions to the same extent they would be protected from the same depositions in the contemplated underlying proceedings." *Combs*, 410 S.W.3d at 535. A Rule 202 petition against a governmental entity "must…set forth specific facts demonstrating that, at least potentially, the petitioner has been injured by governmental actions as well as that a claim for those injuries would not be barred by sovereign immunity." *Id.* In other words, the claim the

petitioner wishes to investigate must be one for which sovereign immunity would not bar the claim.

4. The Trial Court Abused Its Discretion by Refusing to Rule on the Jurisdictional Issues and Failing to Confirm the Existence of Jurisdiction to Grant the Rule 202 Petition

Despite jurisdictional pleas from Drs. Podolsky and Warner MR.206-231 (as well as from UT Southwestern MR.241-276), the trial court did not determine jurisdiction—at all—before granting the Rule 202 depositions:

> [A]ny plea to the jurisdiction has not been heard or determined, explicitly or implicitly, and any such plea remains pending before the Court. The Court will consider whether it must exercise its discretion to permit targeted discovery before hearing such a plea...The Court…GRANTS, the Petitioner's request and orders that the [P]etitioner may take the depositions of Daniel K. Podolsky, M.D. and John J. Warner, M.D…The Court orders that the depositions of Dr. Podolsky and Dr. Warner shall be taken remotely within fourteen (14) days of this Order.

MR.323. That was wrong: a court, in the face of a jurisdictional challenge, cannot grant relief without assuring that it has jurisdiction.

"Subject-matter jurisdiction is essential to a court's power to decide a case." *In re City of Dallas*, 501 S.W.3d at 73 (cleaned up). "[F]or a party to properly obtain Rule 202 pre-suit discovery, the court *must* have

subject-matter jurisdiction over the anticipated action." *Id*. The Supreme Court has vacated a Rule 202 order and remanded the case to the trial court to first determine its subject-matter jurisdiction before ordering Rule 202 discovery. *Id*. at 74 ("Accordingly, we grant relator's petition, and…direct the county court to vacate its order authorizing depositions and to first determine its jurisdiction….").

Drs. Podolsky and Warner raised the jurisdictional issue, requiring the trial court to first determine whether it had jurisdiction. MR.214-221. Even if they had not, courts are "duty-bound to determine [their] jurisdiction regardless of whether the parties have questioned it." *In re City of Dallas*, at 73. Thus, "before addressing the merits of [a] claim to pre-suit discovery," a court "must determine whether [it] has jurisdiction over the potential claim [petitioner] seeks to investigate." *Id*. Rule 202 "cannot be used, for example, to investigate a potential federal antitrust suit or patent suit, which can be brought only in federal court." *In re Doe (Trooper)*, 444 S.W.3d 603, 608 (Tex. 2014).

The trial court's order notes that the jurisdictional pleas were not set for hearing on the day of the Rule 202 hearing. MR.323. But that hearing was set a mere ten days before it occurred. MR.197. That was

five days before Relators appeared in the lawsuit. MR.206. Given this timing, they could not set it for hearing before the Rule 202 proceeding. Regardless, the trial court still needed to assure itself that it had jurisdiction to act. The trial court abused its discretion by not determining it had jurisdiction before granting the Rule 202 petition and ordering Relators' depositions.

5. Relators Have No Adequate Remedy by Appeal

Drs. Podolsky and Warner do not have an adequate remedy by appeal. If they are deposed, the Rule 202 proceeding will be over. They will lose the right to have a court determine whether immunity precludes that discovery. A trial court's order compelling a Rule 202 deposition before determining its jurisdiction is an abuse of discretion for which no there is no adequate remedy by appeal. *See In re City of Dallas*, 501 S.W.3d at 73 (conditionally granting mandamus in this exact context). Even if Dr. Lopez later amended her Rule 202 petition to assert substantive claims, that would not cure the procedural error here—a court must determine its subject-matter jurisdiction and power to act *before* it rules. Even in the amended petition context, Drs. Podolsky and Warner could ultimately prevail because immunity bars the claims

against them. That possible result only proves that they will have lost the immunity's protection from the Rule 202 depositions without mandamus relief.

C. The Trial Court Did Not Have Jurisdiction for the Underlying Claims (Issue 2)

1. A Rule 202 Petition Must Be in a Court with Jurisdiction

As discussed, a Rule 202 proceeding must occur in a court with subject-matter jurisdiction, which means the court must have jurisdiction over the anticipated action. *In re DePinho*, 505 S.W.3d 621, 624 (Tex. 2016) (per curiam); *In re Doe (Trooper)*, 444 S.W.3d at 608. That jurisdictional analysis includes concepts of ripeness, whether a claim presents a sufficiently concrete injury to be justiciable, and mootness, whether a live claim exists between the parties, the court has power to act, and the decision would not be an impermissible advisory opinion. *Electric Reliability Council of Tex., Inc. v. Panda Power Generation Infrastructure Fund, Inc.*, 619 S.W.3d 628, 634-635 (Tex. 2021); *In re DePinho*, 505 S.W.3d at 624.

"Standing is [another] a component of subject-matter jurisdiction." *Brown v. Todd*, 53 S.W.3d 297, 305 n.3 (Tex. 2001). The standing

question asks whether the claimant "alleged personal injury fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief." *Meyers v. JDC/Firethorne, Ltd.*, 548 S.W.3d 477, 485 (Tex. 2018). The plaintiff must be personally injured, i.e., "he, himself (rather than a third party or the public at large)[] suffered the injury." *Heckman v. Williamson Cty.*, 369 S.W.3d 137, 155 (Tex. 2012).

And, as discussed, a court does not have subject-matter jurisdiction against a governmental official unless the Legislature expressly waived sovereign immunity. Standing, ripeness, mootness, and sovereign immunity deprived the trial court of subject-matter jurisdiction, thereby requiring the trial court to deny the Rule 202 petition.

2. Dr. Lopez Asserted No Potential Claim Within the Trial Court's Subject-Matter Jurisdiction

Dr. Lopez relies on the potential to assert an *ultra vires* claim against government officials in an attempt to avoid the bar of sovereign immunity. That type of claim "seek[s] to compel a government official to comply with statutory or constitutional provisions…." *Combs*, 410, S.W.3d at 536. Such suits can only be "brought against the state actors in the official capacity.". *Heinrich*, 284 S.W.3d at 373. That type of claim

ultimately requires allegations and proof that the government official acted without legal authority or failed to perform a ministerial act. *Creedmoor-Maha Water Supply Corp. v. Tex. Comm'n on Environmental Quality*, 307 S.W.3d 505, 512 (Tex. App.—Austin 2010, no pet.). That type of claim is also limited to prospective or injunctive relief and cannot seek retroactive relief. *Heinrich*, 284 S.W.3d at 374-377.

First, the scope of services that a public academic medical institution provides are just the types of decisions one would expect a President and Executive Vice President to make. Thus, the decision in question, at face value, is within the scope of Drs. Podolsky and Warner's duties at UT Southwestern. These sorts of discretionary decisions about what services to provide are not *ultra vires*—no matter how much Dr. Lopez disagrees with those judgment decisions. *See Texas Health Huguley, Inc. v. Jones*, 637 S.W.3d 202, 211-214 (Tex. App.—Fort Worth 2021, no pet.) (discussing the discretion that hospitals have to grant, deny, or limit privileges for physicians to practice in the facility and the very limited role of the judicial system to second guess those decisions).

Second, Dr. Lopez has not alleged that Relators failed to perform a ministerial act. MR.3-22; 286-293. That means their conduct could only

amount to *ultra vires* if, and only if, it were illegal. Dr. Lopez posits two possibilities—the bar on the corporate practice of medicine and discrimination. The trial court did not have subject-matter jurisdiction over either of Dr. Lopez's potential *ultra vires* claims.

Third, Dr. Lopez alleed interference with her independent medical judgment in violation of the rules against the corporate practice of medicine. *See* MR.12-13; 289. But the provisions cited deal with "health organizations," not individual physicians, like Drs. Podolsky and Warner. *See* 22 Tex. Admin. Code § 177.5; Tex. Occupations Code § 162.001(b). Indeed, the prohibition against the corporate practice of medicine prevents corporate entities and non-physicians from practicing medicine and bars acts that make it appear as though a corporate entity or non-physician is practicing medicine. *See generally*, 22 Tex. Admin Code § 177.17(a) (discussing the doctrine's contours). It is inapplicable to another physician.

Beyond that fundamental problem with Dr. Lopez's purported claim of corporate practice of medicine, those health organizations are not state governmental units like UT Southwestern. *Id*. Indeed, those corporate-practice-of-medicine provisions do not create a private cause of

action for Dr. Lopez—the most that can occur is that the Texas Medical Board "may impose an administrative penalty...or revoke [a health organization's] certification." 22 Tex. Admin. Code § 177.12(b). That limited act by another branch of government is not a waiver of sovereign immunity that would allow Dr. Lopez to sue for a violation of the corporate-practice-of-medicine rules. In fact, an academic institution, such as UT Southwestern, is one of the listed exceptions to the doctrine. 22 Tex. Admin. Code §§ 177.17(b)(24)(A), 172.8; Tex. Occupations Code § 155.104(b)(4)(B).

At some level, medical facilities face limitations. They must decide what services to provide—will they provide obstetrics and gynecology, orthopedics, pediatrics, and so on. But merely because a facility elects not to provide a particular type of care does not mean that it engaged in the corporate practice of medicine. Nothing about the changes made to the services offered at Children's Medical Center prohibits Dr. Lopez from providing what she deems medically appropriate care. The changes made only said not here—just like some hospitals and other facilities have decided (before recent legislative changes) to not provide abortions. Indeed, even with the changes to the services, patients and families could

receive hormone therapy from outside practitioners unaffiliated with a public institution accountable to the State. MR.208. Drs. Podolsky and Warner "weighed the momentum of opposition to hormone therapy for gender dysphoria minors—and efforts to curtail it—against the unquestioned need for other gender-affirming care and decided to focus on those important services." *Id*.

Fourth, Dr. Lopez's discrimination allegation fares no better. She asserted that the changes "force[d] [her] to engage in illegal discrimination." MR.13. She also asserted that "withhold[ing] medically appropriate treatment" was "patently discriminatory and illegal." MR.17. She also "knows that the restriction being mandated to her is discriminatory as it is a distinction based on gender identity." MR.289. She claims that such discrimination is illegal under Section 106.001 of the Texas Civil Practices & Remedies Code. MR.290.

But Dr. Lopez never asserted that UT Southwestern, Dr. Podolsky, or Dr. Warner discriminated against *her*. Her allegations limit the claimed discrimination to the potential patients who she may determine would benefit from puberty suppression or hormone therapy. Dr. Lopez has no standing to assert a claim of discrimination on behalf of her

patients. "A plaintiff must be personally injured…." *Heckman*, 369 S.W.3d 155. The Texas "Constitution opens the courthouse doors only to those who have or are suffering an injury." *Id*. The concepts of standing apply to *ultra vires* claims. *Meyers*, 548 S.W.3d at 484-489. Because Dr. Lopez made no claim of discrimination against her, she alleged no *ultra vires* discrimination claim against Drs. Podolsky and Warner and did not overcome their sovereign immunity.

Dr. Lopez asserts the decision to change the services "forces her to engage in illegal discriminatory conduct." MR.13. To the contrary, "all new patients are treated the same regardless of gender." MR.309. Irrespective of a patient's sex, gender identity, or gender expression, UT Southwestern faculty at Children's Medical Center provide certain treatment to new patients with gender dysphoria but not certain other treatment. The treatment options for all new patients are identical—no discrimination based on sex occurred.

Claiming that a decision to stop providing a particular treatment or service is discrimination would mean that a public medical institution such as UT Southwestern could never stop providing a type of care if it affected a protected class. A decision to stop providing obstetrics and

gynecology would affect women, but it is not discrimination against women. By Dr. Lopez's logic, it is discrimination to provide specialized care affecting only one of the biological sexes (like gynecology) because that care makes a distinction about the care provided based on gender. That is not discrimination. And neither is a decision to only provide certain treatments but not other treatments. All new patients from the time he decision was made have the same treatment options.

In her pre-hearing pleadings, Dr. Lopez claimed that discrimination based on gender identity is illegal, citing the Supreme Court of the United States' recent decision in *Bostock v. Clayton County, Georgia*. 140 S.Ct. 1731, 1741-42, 207 L.Ed.2d 218 (2020). But that decision interpreted a federal employment statute, which is inapplicable here because Dr. Lopez claimed no gender-identity discrimination in *her* employment. At the hearing, she relied on this Court's recent decision in *Tarrant County Coll. Dist. v. Sims*, 621 S.W.3d 323 (Tex. App.—Dallas 2021, no pet.). But, like *Bostock*, that case is about alleged sexual-orientation discrimination in employment under Section 21.051 of the Texas Labor Code—another issue that Dr. Lopez never alleged about *her* employment. *Id*. at 326-327, 329.

Instead, Dr. Lopez asserts the change in services "discriminate[s] *against patients based on their gender identity*." MR.13. But Dr. Lopez demonstrated no standing to assert a discrimination claim on behalf of her patients. Nothing in her petition, reply, or testimony established that standing.

Dr. Lopez incorrectly relies on Section 106.001 of the Texas Civil Practice & Remedies Code, which prohibits discrimination. MR.290. Beginning with the most obvious problem with that reliance, the Legislature only waived sovereign immunity allowing "the person aggrieved by the violation or threatened violation" to sue for preventative relief and attorney's fees if ultimately successful. Tex. Civ. Prac. & Rem. Code § 106.002. The waiver of immunity only applies to the person aggrieved. In a different context, the Supreme Court of Texas explained that "aggrieved" requires that the person show a justiciable interest in the controversy. *Hooks v. Tex. Dep't. of Water Resources*, 611 S.W.2d 417, 419 (Tex. 1981). The Supreme Court has also held that an affected or aggrieved person must show "how he [or she] has been injured or damaged other than as a member of the general public." *Scott v. Bd. of Adjustment*, 405 S.W.2d 55, 56 (Tex. 1966). But Dr. Lopez alleged no

discrimination, or injury, to herself. Thus, she is not the aggrieved person for which the Legislature waived sovereign immunity.

Dr. Lopez's Reply claimed "she [wa]s aggrieved" because the decision affected "her practice and exposes her to liability" under the anti-discrimination statute she relies upon. MR.290. But that concept of being "aggrieved" eviscerates the concept of standing. Under Dr. Lopez's logic, she is an aggrieved person only because she claims she may have potential future liability for allegedly violating the statute. But the statute's aggrieved person is the one suffering the violation or threated violation, not the potential violator. Tex. Civ. Prac. & Rem. Code § 106.002(a). Concepts of standing defeat Dr. Lopez's claim of potential future liabilities because standing requires a showing of an injury that is "both a concrete and particularized and actual or imminent injury, not conjectural or hypothetical." *Data Foundry, Inc. v. City of Austin*, 620 S.W.3d 692, 696 (Tex. 2021). Injury must be "likely as opposed to merely speculative." *Id*.

Dr. Lopez suffered no particularized, concrete injury because she has no right to practice medicine in a manner outside of the rules of the facility where she works. *Texas Health Huguley*, 637 S.W.3d at 211-214.

And her exposure to potential liability is too speculative—conjectural and hypothetical because, at this point, no one lodged a claim against her for discrimination.

Indeed, a potential claim's lack of ripeness is a justification for the denial of a Rule 202 petition. *In re DePinho*, 505 S.W.3d at 624-625. Ripeness "emphasizes the need for a concrete injury for a justiciable claim to be presented." *Robinson v. Parker*, 353 S.W.3d 753, 755 (Tex. 2011). A case is not ripe if the claimed "concrete injury can be made only on contingent or hypothetical facts, or upon events that have not yet come to pass." *Id*. at 756 (cleaned up). Thus, a trial court should have denied a Rule 202 petition where the potential claim centered around the omission of one party from a patent application—something that might hypothetically occur in the future. *In re DePinho*, 505 S.W.3d at 625. Any hint of an injury to Dr. Lopez relies on speculation about hypothetical events that may—or may not—occur. That fails the ripeness standard.

Aside from Dr. Lopez's lack of standing as an aggrieved person, the decision does not meet the discrimination prohibited by Section 106.001. The first two discriminatory acts are about a refusal to issue or revocation or suspension of a license, permit, or certificate. Tex. Civ. Prac. & Rem.

Code § 106.001(a)(1)-(2). Nothing about the changed services concerns the issuance, revocation, or suspension of a license. The third discriminatory act is a refusal "to permit the person to use facilities open to the public…." Tex. Civ. Prac. & Rem. Code § 106.001(a)(3). That provision is not about the treatments provided by a medical center. Indeed, no specific treatment is "open to the public" and subject to a person's use—all medical treatment is ultimately prescribed by a doctor, assuming the facility offers that treatment to patients with a particular diagnosis. Medical treatment is not "a facilit[y] open to the public."

The fourth, fifth, and sixth options are perhaps the closest options, but none of them address this situation. The fourth is refusing to permit a person "to participate in a program owned, operated, or managed" by the state. Tex. Civ. Prac. & Rem. Code § 106.001(a)(4). The fifth is the refusal to grant a benefit to a person. Tex. Civ. Prac. & Rem. Code § 106.001(a)(5). And the sixth is imposing an unreasonable burden on a person. Tex. Civ. Prac. & Rem. Code § 106.001(a)(6). UT Southwestern and Children's Medical Center's "program" for new gender dysphoric patients is the same for all patients. UT Southwestern and Children's Medical Center allow any minor gender dysphoric patients to participate

in that program. They have not "refused" participation in the program merely because they altered elements of the treatment provided. The same is true for item five—Relators did not refuse "to grant a benefit" by altering the services provided and not offering puberty suppression or hormone therapy to new patients. The "benefits" available to all new patients remain the same. And any burden on the gender-dysphoric patients was not unreasonable. In fact, Drs. Podolsky and Warner acted to preserve this care considering the risks of a statewide ban on hormone therapy or a ban on all gender-affirming care. MR.207-209.

The final prohibited discriminatory act is a "refus[al] to award a contract to the person." Tex. Civ. Prac. & Rem. Code § 106.001(a)(7). But medical treatment is not awarding a contract to any person. None of the statute's discriminatory acts prohibited by this statute covers medical treatment, particularly when the available treatment to all new patients is the same.

Dr. Lopez broadly proclaims that the change in treatment options constitutes *ultra vires* acts. While it is true that an *ultra vires* claim could overcome sovereign immunity, Dr. Lopez ignores other basic principles of subject-matter jurisdiction that defeat her allegations of *ultra vires*. The

corporate-practice-of-medicine claim ignores that Relators are physicians and that UT Southwestern is excepted from that doctrine. And Dr. Lopez's discrimination arguments are not her injuries or are too speculative. Those problems deprived the trial court of subject-matter jurisdiction over Dr. Lopez's claim. An *ultra vires* claim that fails to state a claim does not overcome sovereign immunity and cannot justify Rule 202 depositions. *Combs*, 410 S.W.3d at 537-538. Using the words "*ultra vires*" does not mean that Dr. Lopez had standing or ripeness or that Relators' conduct was outside their job duties or illegal. The trial court reversibly erred by granting the Rule 202 petition when it did not have subject-matter jurisdiction.

3. Relators Have No Adequate Remedy by Appeal, Particularly because the Trial Court Did Not Rule on the Jurisdictional Issue

Ordinarily, the grant or denial of a jurisdictional plea by a governmental unit would be ripe for an interlocutory appeal. Tex. Civ. Prac. & Rem. Code § 51.014(a)(5). And many Rule 202 disputes implicating sovereign immunity come up as dual interlocutory appeals and mandamus proceedings. *E.g., City of Dallas v. Dallas Companion Animal Project*, No. 05-18-00453-CV, 2018 Tex. App. Lexis 8787 *1-2 and

*8-*9 (Tex. App.—Dallas 2018) (involving an interlocutory appeal on the immunity issue and a mandamus of the Rule 202 issue) *dismissed as moot* No. 19-0016, 2019 Tex. Lexis 1260 (Tex. 2019); *City of Dallas v. Russell*, No. 05-18-8784, 2018 Tex. App. Lexis *1, *15 (Tex. App.—Dallas 2018) (involving interlocutory appeal of the immunity issue and mandamus of the Rule 202 issue). But an interlocutory appeal could not occur here because the trial court did not rule on the immunity issue and failed to confirm it had subject-matter jurisdiction. That failure deprives Relators of an adequate remedy by appeal because they have no interlocutory appeal without a ruling on the immunity issue.

This Court has previously held that a party's failure to overcome immunity in a Rule 202 proceeding left "no adequate remedy by appeal" because the opportunity to appeal after the deposition had occurred "compromised" procedural and substantive rights to avoid the deposition and associated duces tecum. *City of Dallas v. Russell*, 2018 Tex. App. Lexis 8784 at *15. In that case, the failure to overcome the bar of immunity meant the trial court should have denied the Rule 202 petition, subject to reversal on mandamus, so that the appellate court did not need to rule on the jurisdictional plea. *Id. See also In re Dallas Cty. Hosp. Dist.*,

No. 05-14-00249-CV, 2014 WL 1407415, 2014 Tex. App. Lexis 3542 *8-*9 (Tex. App.—Dallas 2014) (holding the trial court abused its discretion when the trial court had no "basis for concluding that [the claimant's] potential claim would not be barred by sovereign immunity").

The trial court lacked subject-matter jurisdiction over Dr. Lopez's potential claims. She suffered no injury, and any potential injury that she might have was not ripe. Dr. Lopez did not allege an *ultra vires* act that could overcome sovereign immunity. Drs. Podolsky and Warner have no adequate remedy by appeal. This Court should grant mandamus relief to correct the trial court's abuse of discretion.

D. The Trial Court Abused Its Discretion by Finding the Benefit of the Discovery Outweighed the Burden or Expense (Issue 3)

1. Rule 202 Depositions Are Not for Routine Use

"Rule 202 depositions are not now and never have been intended for routine use." *In re Jorden*, 249 S.W.3d 416, 423 (Tex. 2008). Rule 202 allows a pre-suit deposition to preserve testimony but only if the trial court finds "allowing…the requested deposition may prevent a failure or delay of justice in an anticipated suit." Tex. R. Civ. P. 202.1(a) and 202.4(a)(1). Dr. Lopez does not seek to preserve testimony. MR.3-22. And

the trial court did not make a failure-or-delay-of-justice finding. MR.322-324. The only other time that Rule 202 permits pre-suit depositions is "to investigate a potential claim" but only if the trial court finds "the likely benefit of allowing…the requested deposition…outweighs the burden or expense of the procedure." Tex. R. Civ. P. 202.1(b) and 202.4(a)(2). The trial court made this finding, MR.322, but that was an abuse of discretion.

Rule 202 depositions have practical and due process problems, particularly "demanding discovery from someone before telling them what the issues are." *In re Jorden*, 249 S.W.3d at 423. Sovereign-immunity issues compound the burden on governmental officials having to sit for pre-suit depositions—after all, part of the benefit of such immunity is to allow those officials to avoid depositions and to continue their work on behalf of the public. That is why Rule 202 claimants must overcome sovereign immunity to take the pre-suit deposition just like they would in a regular suit against the government. *City of Dallas v. Dallas Black Fire Fighters Ass'n*, 353 S.W.3d 547, 554 (Tex. App.—Dallas 2022, no pet.).

2. Any Benefit to Dr. Lopez Is Minimal: She Knows Who to Sue and What For

With the disclosure of Drs. Podolsky and Warner as the decision makers at UT Southwestern, Dr. Lopez knows who to sue. That moots her need for a deposition to investigate "who" made the decision. A moot issue is not the proper subject of an order compelling a Rule 202 deposition. *See Glassdoor, Inc. v. Andra Grp., L.P.*, 575 S.W.3d 523, 530-531 (Tex. 2019) (holding Rule 202 petition was moot because limitations had expired); *In re Tobolowsky*, No. 05-19-00073-CV, 2020 WL 6143676, 2020 Tex. App. Lexis 8306 *13 (Tex. App.—Dallas 2020) (same).

Dr. Lopez objects that this disclosure occurred without cross examination. MR.314-315. That position ignores this disclosure occurred under oath. MR.301-304. And even if what Dr. Lopez hypothetically suspects is true—that others may have exerted political influence over that decision—her suspicion does not change the fact Drs. Podolsky and Warner decided, on behalf of UT Southwestern, to change the services provided. Dr. Lopez says she wants injunctive relief, and if she can prove entitlement to it, she can obtain an injunction against Relators and UT Southwestern. She also purports to want a declaratory judgment—she now knows who her opponent for that proceeding should be. Her objection

also ignores her own testimony from the hearing that emphasized, on multiple occasions, that she did not know "who" ultimately made the decision. Relators considered her testimony and then answered her question.

As for her claims, her Reply made clear that she knew change is services were "discriminatory as it [wa]s a distinction based on gender identity." MR.289. She also knew that "discrimination because of sex is unconstitutional and illegal." MR.290. And she claimed to know that "discrimination based on gender identity is occurring." *Id*. The only unknown "is who is the one violating 106.001." *Id*. The identities of Drs. Podolsky and Warner as the decision makers answer that "who" question and obviate the need for the first subject of the Rule 202 deposition. MR.14.

Dr. Lopez's second topic was who communicated with UT Southwestern about limits on hormone therapy. *Id*. That topic—now that the decision makers are known—is irrelevant, at least for the purpose of a pre-suit deposition. Regardless of the answers, Dr. Lopez knows who to sue and, if she can obtain an injunction, she and the issuing court know who to enter it against. Even if she fervently insists others made the

decision, Relators' admission of decision-maker status allows Dr. Lopez to sue them for whatever claims she has. That ordinary discovery in a lawsuit might reveal the involvement of others is of no moment—limitations is not close to expiration, so she can join the others if she discovers their involvement in the ordinary course of a lawsuit. *Compare In re Johnston*, No. 06-10-00095-CV, 2010 WL 3930603, 2010 Tex. App. Lexis 8165 *12 (Tex. App.—Texarkana 2010). Only something extraordinary justifies pre-suit discovery.

The final three topics all address potential defenses to a substantive lawsuit—the medical, ethical, and legal basis for such limitations; why the limitation is not discriminatory; and what legal authority justified the limitation. MR.14. UT Southwestern and Children's Medical Center have publicly provided information that that delivers insight into those topics. MR.207-209. Additionally, other public information, including news articles, provides further information on those topics. *Id.* Regardless, a Rule 202 proceeding should not be used to pre-try an opponent's defenses—if so, pre-suit depositions would be the rule, not the limited exception. *In re Jorden*, 249 S.W.3d at 423. Indeed, the "legal basis" and "legal authority" issues are fraught with privilege problems—

as non-lawyers, Drs. Podolsky and Warner would have no answer to the legality topics without talking to lawyers about those issues, which would be protected by privilege. And, at least to Dr. Lopez, she already "knows" that the change to the medical treatment is supposedly discriminatory, limiting any potential benefit from deposing Relators on these topics. MR.289-290.

In short, with the disclosure that Drs. Podolsky and Warner were the decision makers on behalf of UT Southwestern, pre-suit discovery has limited benefit to Dr. Lopez, especially considering the information already in the public record about why the decisions were made. Such a limited benefit to the depositions cannot overcome the burden of the depositions. *See In re Caraway*, No. 02-05-00359-CV, 2007 WL 1879768, 2007 Tex. App. Lexis 5131 *16-*18 (Tex. App.—Fort Worth 2007) (concluding limited benefit to deposition in light of known facts based on judicial notice).

3. The Burden on Relators Was Great

Relators are high ranking executives at a very large public medical institution, who have important roles in operating that institution. They are also government employees, who should not have to incur the burden

of a deposition. Indeed, the public good is served by having these executives perform their job duties instead of sitting for unnecessary depositions. This great burden outweighed any benefit from the depositions.

4. The Trial Court Imposed No Limitations on the Depositions

Many courts, when looking at the burden, also evaluate limitations the trial court imposed on the deposition. Here, the trial court imposed no limitations. MR.322-324. Other courts have imposed time limits. *See In re Johnston*, 2010 Tex. App. Lexis 8165 at *13 (considering the trial court's limitation of the deposition to one hour in analyzing the benefit versus burden). Here, the trial court also denied Relators' privilege objections to the "legal" topics—despite the attorney-client privilege issues likely to pervade that topic. MR.326-331. After all, even Dr. Lopez testified that, during one meeting, she learned that legal was being consulted about the decision. While the trial court allowed privilege assertions to be lodged in the deposition, that ruling still burdens Relators, having to assert privilege during their pre-suit depositions for seemingly privileged topics, which will prolong any deposition.

A trial court abuses its discretion by compelling a Rule 202 deposition when the benefit does not outweigh the burden. *In re Hewlett Packard*, 212 S.W.3d at 364; *In re Campos*, No. 02-07-00197-CV, 2007 WL 2013057, 2007 Tex. App. Lexis 5485 *9-*10 (Tex. App.—Fort Worth 2007). Here, the benefit was slight with what Dr. Lopez already knows and what is publicly available. That did not outweigh the burden to Relators.

5. Relators Have No Adequate Remedy on Appeal

Like the other issues raised in this appeal, Drs. Podolsky and Warner have no adequate remedy by appeal to cure the trial court's abuse of discretion. If the benefit of the Rule 202 depositions did not outweigh the burden, then Dr. Lopez cannot conduct pre-suit discovery—the rule only allows it when the benefit outweighs the burden. Tex. R. Civ. P. 202.4. Without mandamus, Relators will permanently lose their right to avoid the Rule 202 depositions altogether. *In re Hewlett Packard*, 212 S.W.3d at 364.

Prayer

Relators Daniel K. Podolsky, M.D. and John J. Warner, M.D., therefore, pray that the Court grant them temporary relief and stay the depositions until after the Court decides this mandamus proceeding, grant their Petition for Writ of Mandamus, vacate the order granting Dr. Lopez's Rule 202 Petition and compelling Relators' deposition, and dismiss the underlying case for lack of subject-matter jurisdiction. Relators also pray partial relief where appropriate. Relators further pray for the recovery of their court costs as well as for such other relief as may be appropriate.

Respectfully submitted,

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Counsel for Relators
Daniel K. Podolsky, M.D. and
John J. Warner, M.D.

RULE 52.3(J) CERTIFICATION

I certify that I have reviewed the foregoing Petition for Writ of Mandamus and have concluded that every factual statement in the petition is within my personal knowledge and true and correct or is supported by competent evidence included in the Appendix or Mandamus Record.

C. TIMOTHY REYNOLDS

Certificate of Compliance

Relying on the word count feature in Microsoft Word that is a part of the suite of programs within Microsoft Office 365 Business, I certify that this computer-generated document contains 8,513 words, excluding the caption, identities of parties and counsel, table of contents, index of authorities, statement of the case, statement of jurisdiction, statement regarding oral argument, signature, proof of service, certification, certification of compliance, and appendix. The text for the body of this document is in 14-point Century Schoolbook, and any footnotes are in 12-point Century Schoolbook.

/s/ David M. Walsh IV

_____

David M. Walsh IV

Certificate of Service

I certify that on April 22, 2022, I served a complete copy of this Petition for Writ of Mandamus on all counsel of record through the e-filing system.

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/s/ David M. Walsh IV

David M. Walsh IV

CAUSE NO. CC-22-01316-B

IN RE XIMENA LOPEZ, M.D., *Petitioner*,	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

ORDER GRANTING XIMENA LOPEZ M.D.'S
PETITION TO TAKE DEPOSITION BEFORE SUIT
PURSUANT TO TEXAS RULE OF CIVIL PROCEDURE 202

On April 11, 2022, this Court heard argument and received evidence in support of Petitioner Ximena Lopez, M.D.'s Petition to Take Deposition Before Suit Pursuant to TEXAS RULE OF CIVIL PROCEDURE 202. The Court has reviewed the voluminous pleadings and exhibits filed in this matter as well as evidence submitted to the Court through live testimony. As supported by the foregoing, the Court makes the following findings:

1. Dr. Lopez seeks the requested discovery for purposes to investigate a potential claim under Rule 202.1(b).

2. Dr. Lopez has sufficiently pled her request.

3. It is within the contemplation of Dr. Lopez that she may have at least potentially a claim against Dr. Podolosky, Dr. Warner, or UT Southwestern Medical Center.

4. Pursuant to Rule 202.4(a)(2), the Court finds that the likely benefit of allowing Dr. Lopez to obtain the requested discovery outweighs the burden or expense of the procedure.

5. ~~The Court finds Rule 202.5 states that "depositions authorized by this rule are governed by the rules applicable to depositions of nonparties in a pending suit." Rule 205.1 governs depositions of nonparties in a pending suit and authorizes "by obtaining a court order under Rule...202" that a court may order both an oral deposition under 205.1(a) and "a request for production of documents or tangible things... served with a notice of deposition" under 205.1(c). The Court therefore finds that it may order the production of documents and tangible things in addition to an oral deposition as permissible relief under Rule 202.~~

6. On April 11, 2022, no plea to the jurisdiction was noticed for hearing or properly before the Court. As such, any plea to the jurisdiction filed has not been heard or determined, explicitly or implicitly, and any such plea remains pending before the Court. The Court will consider whether it must exercise its discretion to permit targeted discovery before hearing such a plea when those matters are properly set for the Court's determination.

The Court therefore GRANTS the Petitioner's request and orders that the petitioner may take the depositions of Daniel K. Podolsky, M.D. and John J. Warner, M.D. ~~The Court additionally orders that the following requested documents shall be produced:~~

~~1.~~ All documents to or from the Governor, the Office of the Governor, or any member of the Executive Branch of the State of Texas regarding, discussing, or pertaining in any way to gender-affirming care provided at UTSW or Children's Medical Center (including but not limited to the GENECIS program or Dr. Ximena Lopez) and dated January 1, 2020 through the present. Production is to include all responsive electronically stored or created documents/files and all meta-data related thereto.

3. All documents to or from any member or agent of a member of the Legislative Branch of the State of Texas regarding, discussing, or pertaining in any way to gender-affirming care provided at UTSW or Children's Medical Center (including but not limited to the GENECIS program or Dr. Ximena Lopez) and dated January 1, 2020 through the present. Production is to include all responsive electronically stored or created documents/files and all meta-data related thereto.

3. All documents sent by or to any officer, director, or employee of UTSW or Children's regarding, discussing, or pertaining in any way to any actual or potential restriction on, discontinuation, termination, or modification of, or change to any gender-affirming care (or policies related thereto) provided at UTSW or Children's Medical Center (including but not limited to the GENECIS program or Dr. Ximena Lopez) and dated January 1, 2020 through the present. Production is to include all responsive electronically stored or created documents/files and all meta-data related thereto.

The Court denies without prejudice the request for other documents sought in the Petition.

The Court orders that the depositions of Dr. Podolsky and Dr. Warner shall be taken remotely within fourteen (14) days of this Order. The Court orders that within three (3) days of this Order, counsel for Dr. Podolsky and Dr. Warner and counsel for Dr. Lopez shall confer and determine a mutually agreeable date for the deposition within that ten day time period. Upon determining a mutually agreeable date, the Court orders that counsel for Dr. Lopez shall send a notice of the deposition as required by TEXAS RULE OF CIVIL PROCEDURE 199.2. If counsel

for Dr. Podolsky and Dr. Warner and counsel for Dr. Lopez are unable to determine a mutually agreeable date within three days of this order, counsel for Dr. Lopez shall notify the Court, and the Court will select a date within that ten day time period. ~~The Court finds that no additional protections are necessary other than the protections already provided by Rule 199.~~ ujb

Date: April 14, 2022

Melissa J Bellan
HON. MELISSA BELLAN

Tex. R. Civ. P. 202.1

The State and Federal rules are current through March 20, 2022.

TX - Texas Local, State & Federal Court Rules > TEXAS RULES OF CIVIL PROCEDURE > PART II. RULES OF PRACTICE IN DISTRICT AND COUNTY COURTS > SECTION 9. Evidence and Discovery > B. DISCOVERY > Rule 202. Depositions Before Suit or to Investigate Claims

Rule 202.1. Generally.

A person may petition the court for an order authorizing the taking of a deposition on oral examination or written questions either:

(a) to perpetuate or obtain the person's own testimony or that of any other person for use in an anticipated suit; or

(b) to investigate a potential claim or suit.

End of Document

Tex. R. Civ. P. 202.2

The State and Federal rules are current through March 20, 2022.

TX - Texas Local, State & Federal Court Rules > TEXAS RULES OF CIVIL PROCEDURE > PART II. RULES OF PRACTICE IN DISTRICT AND COUNTY COURTS > SECTION 9. Evidence and Discovery > B. DISCOVERY > Rule 202. Depositions Before Suit or to Investigate Claims

Rule 202.2. Petition.

The petition must:

(a) be verified;

(b) be filed in a proper court of any county:

(1) where venue of the anticipated suit may lie, if suit is anticipated; or

(2) where the witness resides, if no suit is yet anticipated;

(c) be in the name of the petitioner;

(d) state either:

(1) that the petitioner anticipates the institution of a suit in which the petitioner may be a party; or

(2) that the petitioner seeks to investigate a potential claim by or against petitioner;

(e) state the subject matter of the anticipated action, if any, and the petitioner's interest therein;

(f) if suit is anticipated, either:

(1) state the names of the persons petitioner expects to have interests adverse to petitioner's in the anticipated suit, and the addresses and telephone numbers for such persons; or

(2) state that the names, addresses, and telephone numbers of persons petitioner expects to have interests adverse to petitioner's in the anticipated suit cannot be ascertained through diligent inquiry, and describe those persons;

(g) state the names, addresses and telephone numbers of the persons to be deposed, the substance of the testimony that the petitioner expects to elicit from each, and the petitioner's reasons for desiring to obtain the testimony of each; and

(h) request an order authorizing the petitioner to take the depositions of the persons named in the petition.

End of Document

Tex. R. Civ. P. 202.3

The State and Federal rules are current through March 20, 2022.

TX - Texas Local, State & Federal Court Rules > TEXAS RULES OF CIVIL PROCEDURE > PART II. RULES OF PRACTICE IN DISTRICT AND COUNTY COURTS > SECTION 9. Evidence and Discovery > B. DISCOVERY > Rule 202. Depositions Before Suit or to Investigate Claims

Rule 202.3. Notice and Service.

(a) Personal Service on Witnesses and Persons Named. At least 15 days before the date of the hearing on the petition, the petitioner must serve the petition and a notice of the hearing—in accordance with Rule 21a—on all persons petitioner seeks to depose and, if suit is anticipated, on all persons petitioner expects to have interests adverse to petitioner's in the anticipated suit.

(b) Service by Publication on Persons Not Named.

(1) Manner. Unnamed persons described in the petition whom the petitioner expects to have interests adverse to petitioner's in the anticipated suit, if any, may be served by publication with the petition and notice of the hearing. The notice must state the place for the hearing and the time it will be held, which must be more than 14 days after the first publication of the notice. The petition and notice must be published once each week for two consecutive weeks in the newspaper of broadest circulation in the county in which the petition is filed, or if no such newspaper exists, in the newspaper of broadest circulation in the nearest county where a newspaper is published.

(2) Objection to Depositions Taken on Notice by Publication. Any interested party may move, in the proceeding or by bill of review, to suppress any deposition, in whole or in part, taken on notice by publication, and may also attack or oppose the deposition by any other means available.

(c) Service in Probate Cases. A petition to take a deposition in anticipation of an application for probate of a will, and notice of the hearing on the petition, may be served by posting as prescribed by *Section 33(f)(2) of the Probate Code*. The notice and petition must be directed to all parties interested in the testator's estate and must comply with the requirements of *Section 33(c) of the Probate Code* insofar as they may be applicable.

(d) Modification by Order. As justice or necessity may require, the court may shorten or lengthen the notice periods under this rule and may extend the notice period to permit service on any expected adverse party.

End of Document

Tex. R. Civ. P. 202.4

The State and Federal rules are current through March 20, 2022.

TX - Texas Local, State & Federal Court Rules > TEXAS RULES OF CIVIL PROCEDURE > PART II. RULES OF PRACTICE IN DISTRICT AND COUNTY COURTS > SECTION 9. Evidence and Discovery > B. DISCOVERY > Rule 202. Depositions Before Suit or to Investigate Claims

Rule 202.4. Order.

(a) Required Findings. The court must order a deposition to be taken if, but only if, it finds that:

(1) allowing the petitioner to take the requested deposition may prevent a failure or delay of justice in an anticipated suit; or

(2) the likely benefit of allowing the petitioner to take the requested deposition to investigate a potential claim outweighs the burden or expense of the procedure.

(b) Contents. The order must state whether a deposition will be taken on oral examination or written questions. The order may also state the time and place at which a deposition will be taken. If the order does not state the time and place at which a deposition will be taken, the petitioner must notice the deposition as required by Rules 199 or 200. The order must contain any protections the court finds necessary or appropriate to protect the witness or any person who may be affected by the procedure.

End of Document

Tex. R. Civ. P. 202.5

The State and Federal rules are current through March 20, 2022.

TX - Texas Local, State & Federal Court Rules > TEXAS RULES OF CIVIL PROCEDURE > PART II. RULES OF PRACTICE IN DISTRICT AND COUNTY COURTS > SECTION 9. Evidence and Discovery > B. DISCOVERY > Rule 202. Depositions Before Suit or to Investigate Claims

Rule 202.5. Manner of Taking and Use.

Except as otherwise provided in this rule, depositions authorized by this rule are governed by the rules applicable to depositions of nonparties in a pending suit. The scope of discovery in depositions authorized by this rule is the same as if the anticipated suit or potential claim had been filed. A court may restrict or prohibit the use of a deposition taken under this rule in a subsequent suit to protect a person who was not served with notice of the deposition from any unfair prejudice or to prevent abuse of this rule.

End of Document

Automated Certificate of eService

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Associated Case Party: University of Texas Southwestern Medical Center

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No. _____

In the Fifth Court of Apealls
at Dallas, Texas

In re Daniel K. Podolsky, M.D. and John J. Warner, M.D.
Relators,

Hon. Melissa Bellan,
Respondent

Ximena Lopez, M.D.,
Real Party in Interest

University of Texas Southwestern Medical Center and Children's Medical Center,
Other Interested Parties.

Original Proceeding from County Court at Law No. 2, Dallas County, Texas, Trial Court No. CC-22-01316-B, Hon. Melissa Bellan, Presiding

MANDAMUS RECORD

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Counsel for Relators

Oral Argument Requested

Emergency Temporary Relief Requested by 12 pm, April 27, 2022

1. Verified Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202

CC-22-01316-B

CAUSE NO. _____

IN RE XIMENA LOPEZ, M.D., *Petitioner*,	IN THE COUNTY COURT AT LAW NO. ____ DALLAS COUNTY, TEXAS

VERIFIED PETITION TO TAKE DEPOSITION BEFORE SUIT PURSUANT TO TEXAS RULE OF CIVIL PROCEDURE 202

> "It is UT Southwestern's policy to **prohibit discrimination** on the basis of sexual orientation, gender identity, or gender expression."
>
> - UT SOUTHWESTERN MEDICAL CENTER, "Non-Discrimination Policy".

> "(c) **A health organization may not interfere with, control, or otherwise direct a physician's professional judgment** in violation of the Act, Board rules, or any other provision of law.... **A physician retains independent medical judgment and discretion in providing and supervising care to patients.** A health organization **may not discipline** a physician for reasonably advocating for patient care."
>
> - 22 T.A.C. § 177.5

For over a decade, Ximena Lopez, M.D. has provided compassionate, non-discriminatory, gender-affirming care at UT Southwestern Medical Center ("UTSW"), utilizing her independent medical judgment as to what is in the best interest of her patients. Recently, however, the administration at UTSW has instructed her that she cannot utilize her independent medical judgment to provide gender-affirming care to specific patients solely on the grounds of the patient's gender identity. That edict is patently prohibited discrimination. It is illegal. And it potentially exposes Dr. Lopez to legal liability. The only question is: who is dictating this illegal policy and why?

It is the answers to these questions that will inform if and against whom Petitioner Ximena Lopez, M.D. has claims giving rise to a potential right to declaratory and injunctive relief. To investigate these claims, Dr. Lopez files this Petition to Take Deposition Before Suit Pursuant to TEXAS RULE OF CIVIL PROCEDURE 202 seeking the depositions of Respondents Daniel K. Podolsky, M.D., John Warner, M.D., and University of Texas Southwestern Medical Center

("UTSW") to investigate potential claims she may have and future relief to which she may be entitled. In support of this Petition, Dr. Lopez will show as follows:

I.
Factual Basis for the Petition

A. Dr. Lopez, the Highly Credentialed Physician.

Dr. Lopez is a highly respected, trained, and decorated pediatric endocrinologist who teaches medical students and treats patients at UTSW and Children's Medical Center in Dallas, Texas. Born in El Paso, Texas, Dr. Lopez attended medical school at Universidad La Salle Medical School in Mexico City. Knowing that she wanted to help provide medical care for children, Dr. Lopez chose to do her residency in pediatrics at the University of Illinois at Chicago. Following her residency, Dr. Lopez pursued her Fellowship training in Pediatric Endocrinology at Harvard Medical School and Massachusetts General Hospital in Boston, Massachusetts. She then spent three years as a Clinical Research Fellow in Endocrinology at the Joslin Diabetes Center at Harvard Medical School.

In 2010, Dr. Lopez was hired by UTSW as an Assistant Professor in Pediatrics to teach medical students and as a Pediatric Endocrinology attending physician to care for patients at UTSW and Children's Medical Center. In 2018, Dr. Lopez became an Associate Professor of Pediatrics at UTSW and continued to provide clinical care to patients. In 2022, the Pediatric Endocrine Society also recognized Dr. Lopez's excellence in the field by selecting her as the recipient of the Pediatric Endocrine Society Clinician Award. This award is only given when a physician, like Dr. Lopez, is widely acknowledged by his or her peers as possessing exemplary clinical acumen, knowledge, and expertise. Throughout her career, Dr. Lopez has been engaged in academic endeavors, including obtaining research grants from the National Institutes of Health, serving as a principal investigator in clinical trials, providing lectures nationally and internationally, and publishing numerous peer reviewed articles, book chapters, and abstracts.

This is Dr. Lopez on paper; her *curriculum vitae*. But what defines Dr. Lopez–what makes her so important to her patients and this community–is what she does with that medical training and knowledge and how she exercises that qualified independent medical judgment. With compassion and care, Dr. Lopez has become a respected leader in an important medical field and, for her patients, a life-saving hero.

B. Dr. Lopez, the Life-Saving Hero.

In 2006, during her fellowship training in Boston, Dr. Lopez was exposed to a group of marginalized and discriminated-against patients who needed medical care: transgender patients and their families. Dr. Lopez was introduced to Dr. Norman Spack, a pediatric endocrinologist at Boston Children's Hospital, where he co-founded the hospital's Gender Management Service (GeMS) clinic in February 2007. GeMS was the first major program in the U.S. to focus on gender-diverse and transgender adolescents. Dr. Lopez learned of the difficulties for Dr. Spack and GeMS's patients, and how through the multi-disciplinary approach used at GeMS, patients' lives were transformed for the better. A 2017 feature in *D Magazine* about Dr. Lopez and her life-changing work shared how Dr. Lopez carried that experience with her and ultimately helped create the Gender Education and Care, Interdisciplinary Support ("GENECIS") clinic at UTSW as the first clinic in the Southwest to provide gender-affirming care to gender-diverse and transgender adolescents:

Health & Medicine

Faces of Change

At Children's Health, home to the Southwest's only pediatric transgender treatment clinic, kids find their true selves.

By Peter Simek | October 1, 2017 | 9:00 am

View Gallery

Dr. Ximena Lopez began her career researching Type 2 diabetes, but a fellowship assisting at the country's first pediatric transgender treatment clinic, in Boston, changed everything. Six years later, she founded the GENECIS program at Children's Health in Dallas.

Jill Broussard and Elizabeth Lavin

> "Dr. Ximena Lopez didn't expect her life to be transformed by a fellowship at Massachusetts General Hospital. This was in 2007. The pediatric endocrinologist had begun her career researching Type 2 diabetes, but she found herself in Boston assisting at the country's first pediatric transgender treatment clinic. The stigma around the treatment of transgender children was still strong, despite the pressing need and life-or-death stakes. A recent study found that 30 percent of transgender

> youth report at least one suicide attempt, and 42 percent report a history of self-injury, such as cutting. One kid in Boston still stands out for Lopez.
>
> 'The patient's mother found that no one was willing to treat this child,' she says. 'For me, that was a revealing experience. I knew nothing about it. And this patient told us his story. He was a perfectly normal kid, and he got all the medical support to be himself.'
>
> After she moved to Children's in Dallas and joined the faculty of UT Southwestern Medical Center, in 2012, she founded the GENECIS program, the first treatment clinic in the Southwest for children with gender dysphoria."[1]

The *D Magazine* article discusses the families and lives that Dr. Lopez has transformed with her compassionate care and how these families often tell Dr. Lopez:

> "***You are my hero.***
>
> ***You are saving my kid's life.***
>
> ***We don't know what we would do without you.***"[2]

The importance of this work in saving children's lives is no overstatement. As recently as September 21, 2021–less than 6 months ago–Dallas Children's Medical Center, the location of the GENECIS clinic, pushed back against fringe protestors and publicly noted how the care provided by Dr. Lopez and others at the GENECIS clinic helps combat the high suicide rate among children with gender dsyphoria:

> "With a suicide attempt rate of up to 41% for children and adolescents with gender dysphoria, there is a need for comprehensive care for these youth," Dallas Children's Medical Center told *Dallas Express* in an email interview. "Given the significant suffering and extraordinarily high suicide rate in these children, offering a comprehensive, multidisciplinary approach is needed to help treat this medical problem."[3]

The care provided by Dr. Lopez and the GENECIS clinic has a life-saving impact by utilizing gender-affirming care that is the "gold standard" of care for patients with gender dysphoria.

---

[1] Peter Simek, "Faces of Change", D MAGAZINE (October 1, 2017) (available online at: https://www.dmagazine.com/publications/d-magazine/2017/october/pediatric-transgender-treatment-clinic-genecis-childrens-health/)

[2] *Id.*

[3] Edgar James, "Dallas Children's Medical Center Responds to Allegations of Wrongdoing", THE DALLAS EXPRESS (available online https://dallasexpress.com/dallas-childrens-medical-center-responds-to-allegations-of-wrongdoing/)

C. The GENECIS Model and Understanding the Gender-Affirming Care.

The GENECIS clinic was the first of its kind in the Southwest. Nowhere else in Texas or in surrounding states could patients get the treatment they received at the GENECIS clinic. Patients from all over the Southwest came to the GENECIS clinic.

Dr. Lopez and the GENECIS clinic follow a gender-affirming care model that is the recommended standard of care of the World Professional Association of Transgender Health ("WPATH"), as well as The Endocrine Society, the world's oldest and largest organization of scientists devoted to hormone research. WPATH publishes specific standards of care establishing the procedures for gender-affirming care,[4] and The Endocrine Society publishes similar Clinical Practice Guidelines.[5] Together, these are recognized globally as "best practices" in the treatment of gender dsyphoric/gender-incongruent persons. These best practices are universally medically-accepted and are appropriately relied upon by Dr. Lopez in exercising her independent medical judgment on how to treat her patients.

It is important to understand what gender-affirming care is and what it is not.

The gender-affirming model of care affirms diversity in gender identity and assists individuals in defining, exploring, and actualizing their gender identity, allowing for exploration without judgments or assumptions. This does not mean that all youth need to undergo medical intervention; indeed, this is often not the case. Gender-affirming care is highly individualized and focuses on the needs of each individual by including psychoeducation about gender and sexuality (appropriate to age and developmental level), parental and family support, social interventions, and gender-affirming medical interventions.

Social interventions, which are considered reversible (meaning that if gender identity shifts in the future, these decisions can be adapted), are often attempted in a step-wise manner. For example, children may first begin to use a new name or pronouns in the home, and if this feels positive and eases distress, they may start to do so in other environments, such as school. Social transition may also involve use of different clothing or engagement in new activities, such as

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[4] *See* Exhibit A, THE WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People" 7th Version, (available online at: https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf).

[5] *See* Exhibit B, Hembree, Wylie C, et al., " Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline" J CLIN ENDOCRINOL METAB, November 2017, 102(11):3869–3903.

transferring to a new camp or sports league, that are more congruent with the child's gender identity. Social interventions have been found to lower the rates of depression and anxiety in gender-incongruent children.

Pubertal suppression, also considered fully reversible, allows for a "pause" on puberty and for further development of gender identity. This pubertal suppression, as practiced at the GENECIS clinic and by Dr. Lopez, utilizes gonadotropin-releasing hormone ("GnRH") agonists that block sex hormones, like testosterone and estrogen. ***Importantly***, GnRH puberty suppression is a medical treatment that has been used safely since the 1970s to deal with a variety of medical issues, such as "precocious" puberty—that is, early onset puberty. In precocious puberty, it is important to pause puberty because it can adversely impact the physical growth of the child, the child's self-esteem, and cause conditions such as depression because of the social impact. GnRH puberty suppression is well known to be safe and reversible. There is no creation of risk by utilizing it in gender-affirming care, and as such it is part of WPATH and The Endocrine Society's standards of care. In gender-affirming care, delaying puberty to promote physical development that is consistent with a child's gender identity is associated with better mental health outcomes, improved functioning, and life satisfaction.

Once adolescence is reached, hormone therapy can be considered. Hormone therapy involves administering estrogen or testosterone to match a patient's hormone levels to their gender identity. Similar to pubertal suppression, hormone therapy can make gender dysphoria less severe, reduce psychological and emotional distress, improve psychological and social functioning, and improve quality of life. For example, if testosterone hormone therapy is started before the changes of female puberty begin, female secondary sex characteristics, such as the development of breasts, can be avoided. Also like pubertal suppression, hormone therapy is considered safe and effective. Hormone therapy, as practiced by Dr. Lopez and the GENECIS clinic, is typically begun at the age of 16, and whether and when to start such treatment involves a thorough process of discussion and consultation between the patient, the patient's family, and the patient's care provider, such as Dr. Lopez.

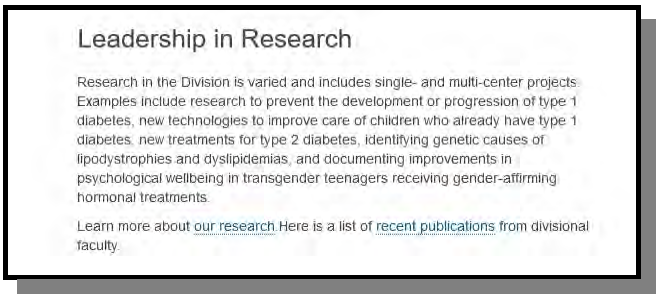
Importantly, as practiced by Dr. Lopez and the GENECIS clinic, what "gender-affirming" care of children is ***NOT*** is surgical "sex change". As Dr. Lopez and the GENECIS clinic only see children and adolescents, surgery is not indicated as part of the standard of care. If someone does wish to surgically transition later in life, that is handled elsewhere. Dr. Lopez and the GENECIS clinic instead help children go through the difficulty of youth and puberty in the most affirming and

compassionate way by using safe, reversible methods that give children the space to resolve their identity in their time.

D. The GENECIS Clinic and Dr. Lopez Find Success and Acclaim.

Since its founding, the GENECIS clinic has been a highly regarded leader in care. As the face of the clinic, Dr. Lopez has developed a positive, international reputation as an expert in gender-affirming care. She has received several national awards and is frequently invited to speak at conferences and symposiums about best practices in gender affirming care, including a 2017 TED Talk on treating transgender youth.

Dr. Lopez has been published in many peer review journals on the topic, and, in addition to treating patients at the GENECIS clinic, Dr. Lopez and the clinic's work have generated important research relied upon in the field internationally. Indeed, as of March 2021, UTSW was advertising on its webpage that UTSW is a leader in research in, among other things, "improvements in psychological wellbeing in transgender teenagers receiving gender-affirming hormonal treatments."

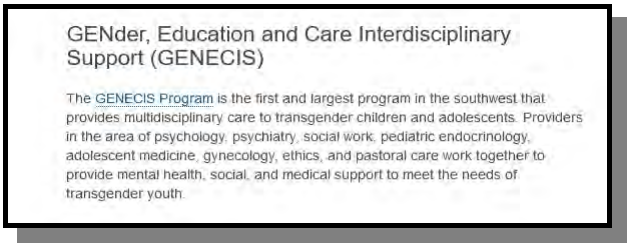


Leadership in Research

Research in the Division is varied and includes single- and multi-center projects. Examples include research to prevent the development or progression of type 1 diabetes, new technologies to improve care of children who already have type 1 diabetes, new treatments for type 2 diabetes, identifying genetic causes of lipodystrophies and dyslipidemias, and documenting improvements in psychological wellbeing in transgender teenagers receiving gender-affirming hormonal treatments.

Learn more about our research. Here is a list of recent publications from divisional faculty.

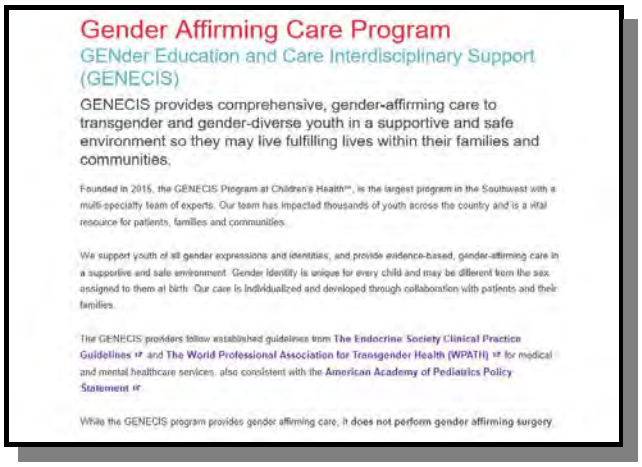
As recently as March of 2021, UTSW proudly included on its website that the GENECIS clinic was the first and largest program in the Southwest.



GENder, Education and Care Interdisciplinary Support (GENECIS)

The GENECIS Program is the first and largest program in the southwest that provides multidisciplinary care to transgender children and adolescents. Providers in the area of psychology, psychiatry, social work, pediatric endocrinology, adolescent medicine, gynecology, ethics, and pastoral care work together to provide mental health, social, and medical support to meet the needs of transgender youth.

Likewise, UTSW's affiliated Children's Medical Center advertised the importance of the GENECIS clinic:



Gender Affirming Care Program

GENder Education and Care Interdisciplinary Support (GENECIS)

GENECIS provides comprehensive, gender-affirming care to transgender and gender-diverse youth in a supportive and safe environment so they may live fulfilling lives within their families and communities.

Founded in 2015, the GENECIS Program at Children's Health™, is the largest program in the Southwest with a multi-specialty team of experts. Our team has impacted thousands of youth across the country and is a vital resource for patients, families and communities.

We support youth of all gender expressions and identities, and provide evidence-based, gender-affirming care in a supportive and safe environment. Gender identity is unique for every child and may be different from the sex assigned to them at birth. Our care is individualized and developed through collaboration with patients and their families.

The GENECIS providers follow established guidelines from The Endocrine Society Clinical Practice Guidelines and The World Professional Association for Transgender Health (WPATH) for medical and mental healthcare services, also consistent with the American Academy of Pediatrics Policy Statement.

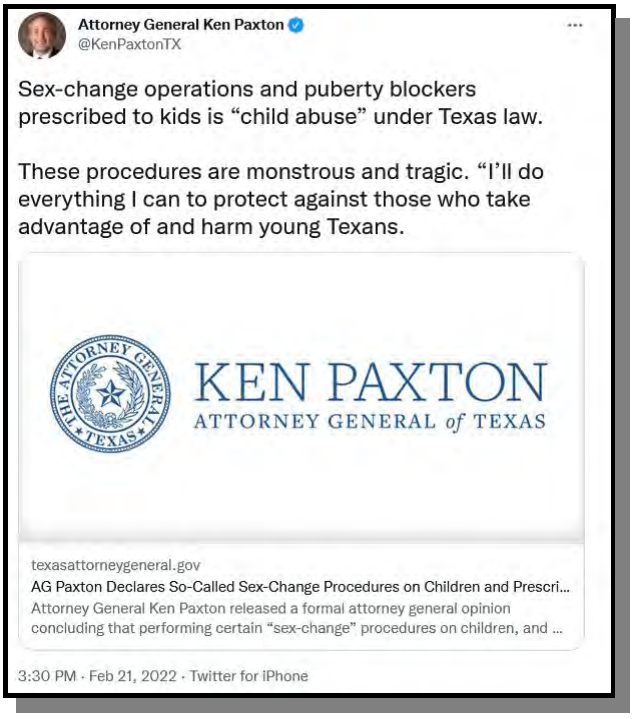
While the GENECIS program provides gender affirming care, it does not perform gender affirming surgery.

Simply stated, Dr. Lopez and the GENECIS clinic were a well-regarded academic and clinical feather in the cap of UTSW, and UTSW promoted what Dr. Lopez was doing as a leader in gender-affirming care. Then something changed, and the issue of providing care to children struggling with gender dsyphoria and gender incongruity became a political hot-button issue.

E. Gender-affirming Care Becomes a Political Wedge Issue.

Since 2017, certain members of the Texas Legislature have targeted transgender Texans. The 2017 legislative session caused immense strife over what was called "the Bathroom Bill", which ultimately failed. In 2021, the Texas Legislature considered a bill which would explicitly classify some gender-affirming care as child abuse. That bill failed as well.

Infirmed by the conceit of flaccid convictions, Governor Greg Abbott and Attorney General Ken Paxton publicly vowed to not give up. On February 21, 2022, Attorney General Ken Paxton released Opinion No. KP-0401 which addressed "Whether certain medical procedures performed on children constituted child abuse." Included in that letter was Attorney General Paxton's conclusion that puberty suppression medication *could* constitute child abuse. That same day Attorney General Paxton tweeted:



The following day, on February 22, 2022, Governor Abbott sent a letter to the Commissioner of the Texas Department of Family and Protective Services ("DFPS") demanding that DFPS

investigate the parents of children receiving puberty-blocking drugs and insisting that medical providers need to report such parents who seek such medication to DFPS for child abuse.

It is clear from Governor Abbott that this issue is a political one, not a medical one. His top political strategist Dave Carney told reporters "Running on the controversial transgender rule is a '75% to 80% winner' for Abbott."[6] As a result of these political machinations, patients needing the care provided by Dr. Lopez and the GENECIS clinic have unfortunately become victims of the partisan political demagoguery practiced by Governor Abbott and Attorney General Paxton.

While Governor Abbott and Attorney General Paxton were pursuing such tactics publicly, behind closed doors Governor Abbott was trying to exert influence privately to shut down transgender care and came after the GENECIS clinic. In a recently published New York Times article, Dr. John Warner is quoted as saying on a recorded phone call, "We received a reach [sic] from the Governor also requesting information about the clinic... And with that came an expectation that something different would occur."

This representation is consistent with what UTSW told Dr. Lopez directly: either the Governor or the Governor's office has exerted political pressure on UTSW to close the GENECIS clinic and to stop clinicians from providing gender-affirming care.

F. GENECIS is shut down and Dr. Lopez is told she is not able to exercise her independent clinical judgment.

Recently, UTSW officially shut down the GENECIS clinic and removed any reference to it from its website. Dr. Podolsky, the President of UTSW, has visited with various groups, including legislators, making claims as to the reasons for approving the shuttering of GENECIS and limiting the use of puberty suppressing medications and hormone therapy. Dr. Lopez, in meetings with UTSW administration, has been told that she cannot provide any new patients with puberty suppressing medication or hormone therapy. She has been told she can provide the medication to patients already receiving such medications, but she is to deny any new requests, even if Dr. Lopez believes that such medication is medically-indicated and would be beneficial to the patient. In other words, Dr. Lopez's "independent medical judgment and discretion in providing and supervising care to patients" is being "interfered with or controlled" in violation of 22 T.A.C. § 177.5 and various

[6] Alison Durkee, "Texas Gov. Abbott's Campaign Calls Transgender 'Child Abuse' Rule A Political 'Winner'", Forbes, March 2, 2022.

other statutory prohibitions against the corporate practice of medicine. Such imposed limitations are themselves illegal.

It is clear that the limitations imposed by UTSW on Dr. Lopez are targeted to discriminate against patients based on their gender identity. It is **not** the case that UTSW has elected to discontinue the use of gonadotropin-releasing hormone ("GnRH") agonists hospital-wide. On the contrary, those medications can and still are being used on patients with precocious puberty. GnRH is an available treatment at UTSW when a physician determines it is medically appropriate treatment for someone with precocious puberty; GnRH is **not** available treatment at UTSW when a physician determines it is medically appropriate treatment for someone with gender dsyphoria. That is naked discrimination because of gender identity. Thus, the purpose behind the imposed limitation is illegal and outside anyone's legal authority to enforce. It is, under the law, *ultra vires*.

II.
Why Discovery is Needed and Claims Needed to be Investigated

Someone, some entity, or some office is illegally attempting to interfere with or control Dr. Lopez's independent medical judgment. Someone, some entity, or some office is attempting to force Dr. Lopez to engage in illegal discriminatory conduct. Whomever that person is, or whatever entity or office is behind this illegal conduct, their actions can only be *ultra vires*. No one, from the Governor, to the board of UTSW, down to the Chair of Pediatrics at UTSW, acts within the law in forcing Dr. Lopez to limit her medical judgment in an illegal manner. Absent some publicly unknown legal basis for the actions, Dr. Lopez believes the acts to be *ultra vires* but she cannot know for sure until she knows who is doing it, and under what legal authority.

Because there is ***likely*** *ultra vires* conduct, Dr. Lopez has the legal right to file a lawsuit and seek prospective relief, including injunctive relief to enjoin the limitations imposed on her independent medical judgment or being stopped from providing medically appropriate treatment to her patients, as well as relief under the Texas Declaratory Judgment Act to define Dr. Lopez's rights and the legality of the discriminatory limitations.

Dr. Lopez does not know whom or what to file suit against or whom to enjoin. Suing the proper party may give rise to different immunity or other legal burdens. Therefore, Dr. Lopez needs to depose individuals with relevant knowledge, including Daniel K. Podolsky, M.D. and John Warner, M.D., to determine:

1. What person, entity, or office is seeking to impose limitations on Dr. Lopez's independent medical judgment to provide puberty-suppressing medications and hormone therapy to new patients;

2. Whether and which governmental official or government office communicated with UTSW and demanded such limitations be enforced by UTSW or Children's;

3. The medical, ethical, and legal basis for such limitations;

4. Why the limitation is not discriminatory; and

5. Upon what legal authority the limitation is being imposed.

It is not possible without conducting a 202 deposition to accurately obtain this information prior to filing a lawsuit. In order to do that, Dr. Lopez needs to investigate and determine that the appropriate claims are brought against the appropriate parties. Thus, in order to investigate whether potential claims exist and prevent a failure of justice, as well as to comply with the pleading requirements to investigate claims in good faith before they are filed, Dr. Lopez must be permitted to be able to discover such information through a 202 deposition.

III.
Potentially Adverse Parties to be Served

The following entities and persons should be served as they likely have an adverse interest in this proceeding:

A. UT Southwestern Medical Center
c/o Daniel Podolsky, MD, President
5323 Harry Hines Blvd.
Dallas, Texas 75390

B. Children's Medical Center Dallas
c/o Christopher J. Durovich, President
1935 Medical District Dr.
Dallas, Texas 75235

C. Daniel K. Podolksy, MD
5323 Harry Hines Blvd.
Dallas, Texas 75390

D. John J. Warner, MD
5939 Harry Hines Blvd #935
Dallas, Texas 75235

IV.
Jurisdiction and Venue

This Court has jurisdiction over any witnesses or potential parties, as all reside or have their principal offices in Texas. This Court has jurisdiction under Rule 202 to hear this matter.

This Application is filed in Dallas County, Texas where venue of any suit arising from this investigation may lie. Venue is proper in Dallas County under Texas Civil Practices & Remedies Code 15.002(a)(1) because Dallas County is the county in which all or a substantial portion of the claims arose.

V.
This Case is Not Removable to Federal Court

A 202 proceeding is not a claim or civil action and is not removable to federal court, regardless of the nature of the potential claim being investigated.[7]

[7] *See Texas v. Real Parties in Interest*, 259 F.3d 387, 394 (5th Cir. 2001) (202 proceeding is not removable); *In re Enable Commerce, Inc.*, 256 F.R.D. 527, 533 (N.D. Tex. 2009) (202 proceeding does not allege a claim); *Linzy v. Cedar Hill Indep. Sch. Dist.*, 2001 U.S. Dist. LEXIS 11845, *5 (N.D. Tex. Aug. 8, 2001) aff'd on other grounds, 37 Fed. Appx. 90, 2002 WL 1021883, at *2 (5th Cir. May 9, 2002) (holding that a Rule 202 petition is not a "civil action" for purposes of establishing claims subject to removal even when the underlying claim would be a federal question under 28 U.S.C. § 1331; *Mayfield-George v. Texas Rehab Comm'n*, 197 F.R.D. 280, 283 (N.D. Tex. 2000) (a Rule 202 petition sought depositions of respondents' employees to investigate whether petitioners could bring causes of action against Respondents under the Texas Tort Claims Act, 28 U.S.C. § 1983, Titles VII and IX of the Civil Rights Act of 1964, and Title II of the Americans with Disabilities Act; respondents removed the Rule 202 petition to the federal district court pursuant to 28 U.S.C. § 1441(b) and petitioners sought remand; the court held "the Petition is not a 'civil action' under § 1441(b) because it asserts no claim or cause of action upon which relief can be granted. ... It is merely a petition for an order authorizing the taking of a deposition for use in an anticipated suit, maybe with federal question jurisdiction, maybe not; it is a request for discovery, nothing more."); *Sawyer v. E.I. du Pont de Nemours & Co.*, No. CIV.A. 06-1420, 2006 WL 1804614, *2 (S.D. Tex. June 28, 2006) (noting the Rule 202 petition "is simply a request for discovery that may or may not eventually lead to federal claims over which this Court would have subject matter jurisdiction, and it therefore belongs where it was filed—in state court"); *Davidson v. S. Farm Bureau Cas. Ins. Co.*, No. H-05-03607, 2006 WL 1716075 (S.D. Tex. 2006).

VI.
The Maslovian Defense of Sovereign Immunity Does Not Foreclose the Relief Sought under Rule 202

Psychologist Abraham Maslow famously said "I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail." As Petitioner's claims may be against a governmental entity or employee, Petitioner expects that the Respondents will claim–as they always do–that there is no jurisdiction because of sovereign immunity. Lawyers representing governmental entities are conditioned to cry out sovereign immunity in response to all legal matters; it is their only hammer, so they treat everything as a nail.

However, the Courts have already resolved this issue and held that sovereign immunity or pleas to the jurisdiction asserting such immunity are not a bar to relief to investigate claims against governmental entities. The leading case on this point is *Combs v. Tex. Civil Rights Project*, 410 S.W.3d 529, 531 (Tex. App.–Austin 2013, pet. denied). In that case, the Texas Civil Rights Project sought a 202 deposition of Susan Combs, Texas Comptroller of Public Accounts, and the Office of the Comptroller of Public Accounts to investigate potential claims concerning a data-security incident. The State Defendants filed a plea to the jurisdiction, contending that the requested pre-suit depositions were barred by sovereign immunity.

> Nevertheless, a petition under rule 202 is ultimately a petition that asserts no substantive claim or cause of action upon which relief can be granted. A successful rule 202 petitioner simply acquires the right to obtain discovery—discovery that may or may not lead to a claim or cause of action. In addition, rule 202, like all the rules of civil procedure, was fashioned by the Texas Supreme Court as a means of "obtain[ing] a just, fair, equitable and impartial adjudication of the rights of litigants under established principles of substantive law." *City of Dallas v. Dallas Black Fire Fighters Ass'n*, 353 S.W.3d 547, 554 (Tex.App.-Dallas 2011, no pet.) (citing Tex. R. Civ. P. 1). Consequently, a proceeding under rule 202 "is not a separate independent lawsuit, but is in aid of and incident to an anticipated suit." We cannot agree that a rule 202 petition is itself a "suit," nor can we agree that all rule 202 proceedings involving governmental entities are "suits" that seek to control state action, as the State Defendants contend. Consequently, we conclude that pre-suit depositions of governmental entities under rule 202 are not, in wholesale, barred by immunity.[8]

[8] *Combs v. Tex. Civ. Rights Project*, 410 S.W.3d 529, 534 (Tex. App.–Austin 2013, pet. denied.).

The Dallas Court of Appeals agreed with this conclusion of the Austin Court of Appeals as recently as 2018.[9]

Thus, it is incorrect to say sovereign immunity prohibits a Rule 202 deposition or that potential plaintiffs have to file a suit before getting discovery from the State or an employee of the State. As both the Austin Court and Dallas Court make clear, a petitioner need only assert facts showing that a potential claim would exist that would permit the petitioner to obtain discovery if suit was filed.

Dr. Lopez, as set forth above, asserts that a person or entity who has sought to control her independent medical judgment and to require her to withhold medically appropriate treatment because of patently discriminatory and illegal grounds due to the patient's gender identity. She further asserts that the person or entity doing so would be engaged in an *ultra vires* act. That is, an action that is not authorized by law and is in fact in violation of the law and constitutional protections. Upon discovery that her independent medical decision making is being interfered with, and controlled in a discriminatory or illegal manner, Dr. Lopez will have a right to seek injunctive relief to prohibit such limitations in the future.

The Austin Court of Appeals acknowledged in *Combs* that such an allegation of *ultra vires* conduct was sufficient to support a Rule 202 petition:

> A suit seeking to compel a governmental official "to comply with statutory or constitutional provisions" is an *ultra vires* suit and therefore is not protected by sovereign immunity. *City of El Paso v. Heinrich*, 284 S.W.3d 366, 372 (Tex.2009). Suits alleging "ultra vires" or unconstitutional conduct by a governmental official are not barred by sovereign immunity because they "do not seek to alter government policy but rather to enforce existing policy." *Id.* Further, because these suits are not considered to be suits against the state, they must be brought against the state actors in their official capacity. *Id.* at 373. To assert a valid *ultra vires* claim, the plaintiff must allege, and ultimately prove, that the official acted without legal authority or failed to perform a purely ministerial act. *Creedmoor–Maha Water Supply Corp.*, 307 S.W.3d at 515. The ultra vires exception to sovereign immunity permits only prospective declaratory or injunctive relief restraining *ultra vires* conduct, as opposed to retroactive relief. *Heinrich*, 284 S.W.3d at 374–77.[10]

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[9] *See In re City of Dallas*, 2018 WL 5306925 (Tex. App.–Dallas 2018) (holding "Pre-suit depositions of governmental entities are not, in wholesale, barred by immunity either. In a case involving governmental immunity, the rule 202 petition must be sufficiently specific to demonstrate a basis for overcoming governmental immunity. The rule 202 petition must set forth specific facts demonstrating that, at least potentially, the petitioner has been injured by actions that would amount to a claim which would not be barred by governmental immunity.")

[10] *Combs*, 410 S.W.3d at 537.

As the Texas Civil Rights Project was alleging that Comptroller Combs violated privacy laws when she unintentionally released citizens' information, the *Combs* Court acknowledged that such an allegation of illegal conduct is *ultra vires* conduct that, as plead, could authorize a 202 petition over any concern of immunity:

> Upon review of the Plaintiffs' petition, we determine that it (1) complies with the pleading requirements of subsection (e) of rule 202, and (2) sufficiently alleges actions that, if true, at least potentially demonstrate *ultra vires* conduct committed by Combs in her official capacity. *See Creedmoor–Maha Water Supply Corp.*, 307 S.W.3d at 516 (explaining that in reviewing jurisdiction based on *ultra vires* claims, reviewing court should determine whether facts pled and not negated would constitute violations of relevant constitutional provisions or exceed authority under relevant statutory provisions). Specifically, the Plaintiffs' rule 202 petition sufficiently alleges that Combs, in her official capacity, disclosed personal information without statutory authority and in violation of the Texas Constitution.[11]

Notably, the *Combs* Court ultimately ruled against the Texas Civil Rights Project after resolving all of the above issues in its favor for a simple reason: the *remedy* sought by the Texas Civil Rights Project was restrospective as the invasion of privacy occurred in the past. *Ultra vires* actions permit only declaratory or injunctive relief—the relief that would be sought by Dr. Lopez as set forth above.

Because Dr. Lopez is investigating an *ultra vires* action that would give rise to declaratory and injunctive relief, that *ultra vires* action precludes the assertion of a defense of immunity to this 202 proceeding.

VII.
Request for Deposition and Document Production

Through this Petition, Dr. Lopez seeks the depositions of the following two individuals:

1. Daniel K. Podolksy, MD
   5323 Harry Hines Blvd.
   Dallas, Texas 75390

2. John J. Warner, MD
   5939 Harry Hines Blvd #935
   Dallas, Texas 75235

From these witnesses, the subject matter that Dr. Lopez seeks to elicit is:

[11] *Id.*

1. what person, entity, or office is seeking to impose limitations on Dr. Lopez's independent medical judgment to provide puberty-suppressing medications and hormone therapy to new patients;

2. whether and which governmental official or government office communicated with UTSW and demanded such limitations be enforced by UTSW or Children's;

3. the medical, ethical, and legal basis for such a limitation;

4. why the limitation is not discriminatory; and

5. upon what legal authority the limitation is being imposed.

Dr. Lopez also requests that the Court order the issuance of a subpoena requiring the production from Podolsky, Warner, and UTSW to produce any and all documents related to the following categories at least three (3) days prior to the first deposition:

1. any and all documents or correspondence, including emails or texts, from the Governor, the Office of the Governor, or any member of the Executive Branch of the State of Texas relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care;

2. any and all documents or correspondence, including emails or texts, from any member or agent of a member of the Legislative Branch of the State of Texas relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care;

3. any and all documents or correspondence, including emails or texts, between any employee of UTSW relating to the discontinuation of the GENECIS clinic, Dr. Lopez, or restrictions on gender-affirming care;

4. any and all documents or correspondence, including emails or texts, from any advocacy group relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care;

5. any and all documents or correspondence, including emails or texts, from any professional medical society or trade association relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care;

6. any and all documents reflecting any medical controversy regarding the provision of puberty suppression medications and/or hormone therapy to treat gender dysphoria; and

7. all public statements made about Dr. Lopez or the GENECIS clinic.

Dr. Lopez needs the above referenced information to properly evaluate a number of issues in order to determine whether she has a claim and, if so, against whom, as well as numerous issues related to the legal authority of individuals to limit her ability to provide gender-affirming care or potential criminal exposure she faces by complying with the limitations to be imposed upon her. Further, if *ultra vires* acts are occurring, Dr. Lopez needs to know against whom she should seek injunctive or declaratory relief. The likely benefits of these depositions and discovery outweigh the burden of the expense of the procedure, as Dr. Lopez has no other way to acquire this information. Dr. Lopez needs to be able to determine the viability of her claims and who will be a proper party to the suit so that she can file suit against the appropriate parties, evaluate potential immunity issues, and meet her burden under the TEXAS RULES OF CIVIL PROCEDURE with respect to properly investigating her claims before filing.

If Dr. Lopez is denied this information pre-suit, then the courts and parties will expend resources and time in answering and pursuing motions to resolve issues that can be resolved pre-suit by deposition. The cost or burden on the deponents is minimal. The burden of having to sit for a deposition is not itself a factor that precludes a 202 deposition, for if it was, Rule 202 would not exist. Further, the requested information is necessary to prevent a failure or delay of justice because claims Dr. Lopez may have that warrant injunctive relief are time sensitive and, if she complies with an unlawful order, she may be exposed to criminal prosecution in the near future.

VIII.
REQUEST FOR HEARING

After service of this Petition and notice, Rule 202.3(a) requires that the Court hold a hearing on the petition. Therefore, Petitioner requests that the Court set the hearing as early as possible, under Rule 202, so that justice may be done and no prejudice comes to the claims of Petitioner from delay.

IX.
PRAYER

Petitioner respectfully requests that the Court set a date for hearing on this Petition without delay, and that after the hearing, find that allowing the Petitioner to take the requested deposition(s) and acquire the requested documents prevents a failure or delay of justice and that the likely benefit outweighs the burden of proceeding. Petitioner additionally requests that the Court order the oral

deposition of Podolsky, the oral deposition of Warner, and the production of documents listed in this Petition and for such other relief to which Petitioner may show herself entitled.

Respectfully submitted,

/s/ Charla G. Aldous

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ATTORNEYS FOR PETITIONER XIMENA LOPEZ, M.D.

VERIFICATION OF XIMENA LOPEZ, M.D.

STATE OF TEXAS	§
	§
COUNTY OF DALLAS	§

BEFORE ME, the undersigned notary, on this day personally appeared XIMENA LOPEZ, M.D., the affiant, whose identity is known to me. After I administered an oath, affiant testified as follows:

"My name is XIMENA LOPEZ, M.D. I am capable of making this Verification. I have read the VERIFIED PETITION TO TAKE DEPOSITION BEFORE SUIT PURSUANT TO TEXAS RULE OF CIVIL PROCEDURE 202, Section I. The facts stated in it are within my personal knowledge and are true and correct."

XIMENA LOPEZ, M.D.

SWORN TO AND SUBSCRIBED BEFORE ME, by XIMENA LOPEZ, M.D. on this 16th day of March, 2022.

ELIZABETH ANN DAVILA
Notary ID #124248313
My Commission Expires
May 2, 2023

Notary Public in and for the State of Texas

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

www.wpath.org

Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health

7th Version

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

Standards of Care

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The World Professiona Association for Transgender Health

7th Version[1] | www.wpath.org

1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

Table of Contents

Purpose and Use of the Standards of Care

The World Professional Association for Transgender Health (WPATH)[1] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[2] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the *SOC*.

The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

1 Formerly the Harry Benjamin International Gender Dysphoria Association

2 *Standards of Care (SOC), Version 7* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

II

Global Applicability of the Standards of Care

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens, or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender nonconforming people in these settings are forced to be hidden, and therefore may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world – even in areas with limited resources and training opportunities – can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culturally and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.

III

The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV
Epidemiologic Considerations

Formal epidemiologic studies on the incidence[3] and prevalence[4] of transsexualism specifically or transgender and gender nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one's gender identity – is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European

3 **incidence**—the number of new cases arising in a given period (e.g., a year)
4 **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974), the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1968 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (for example, Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically-supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.

V

Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1-1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender nonconforming individuals has come of age – many of whom have benefitted from different therapeutic approaches – they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a "transition," because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that is comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatments options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- Offline and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[5] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

5 Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.

4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

2. Gender dysphoria emerged or worsened with the onset of puberty;

3. Any co-existing 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;

4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, monitoring, and risks for puberty suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

VII
Mental Health

Transsexual, transgender, and gender nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the *SOC* focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); or psychotherapy unrelated to gender concerns or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

Tasks Related to Assessment and Referral

1. Assess gender dysphoria

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in person or online contact with other transsexual, transgender, or gender nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses.

Mental health professionals with the competencies described above (hereafter called "a qualified mental health professional") are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider's health care team.

2. Provide information regarding options for gender identity and expression and possible medical interventions

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

3. Assess, diagnose, and discuss treatment options for co-existing mental health concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat co-existing mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. The presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these co-existing mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

4. If applicable, assess eligibility, prepare, and refer for hormone therapy

The *SOC* provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost the client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant co-existing mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

5. If applicable, assess eligibility, prepare, and refer for surgery

The *SOC* also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are considering surgery to be both psychologically prepared (for example, has made a fully informed

decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The *SOC* do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated with a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

- Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and other Health Professionals

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

Tasks Related to Psychotherapy

1. Psychotherapy is not an absolute requirement for hormone therapy and surgery

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy – although highly recommended – is not a requirement.

The *SOC* do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all

phases of exploration of gender identity, gender expression, and possible transition – not just prior to any possible medical interventions. Third, clients differ in their abilities to attain similar goals in a specified time period.

2. Goals of psychotherapy for adults with gender concerns

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

3. Psychotherapy for transsexual, transgender, and gender nonconforming clients, including counseling and support for changes in gender role

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill prepared to accommodate and respect transgender, transsexual, and gender nonconforming people. Psychotherapy can also aid in alleviating any co-existing mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging – often more so than the physical aspects. Because changing

gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender nonconforming people will present for care without ever having been related to or accepted in the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fear about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

4. Family therapy or support for family members

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise to work with family members, or to sources of peer support (e.g., online or offline support networks of partners or families).

5. Follow-up care throughout life

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

6. Etherapy, online counseling, or distance counseling

Online or etherapy has been shown to be particularly useful for people who have difficulty accessing competent psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, etherapy may be a useful modality for psychotherapy with transsexual, transgender, and gender nonconforming people. Etherapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005) but not all; the international situation is even less defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of etherapy is available, caution in its use is advised.

Mental health professionals engaging in etherapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to etherapy has been published (Fraser, 2009b).

Other Tasks of the Mental Health Professional

1. Educate and advocate on behalf of clients within their community (schools, workplaces, other organizations) and assist clients with making changes in identity documents

Transsexual, transgender, and gender nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006) (Currah & Minter, 2000). This role may involve consultation with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.

2. Provide information and referral for peer support

For some transsexual, transgender, and gender nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

Culture and its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the *SOC* have grown out of a Western tradition and may need to be adapted depending on the cultural context.

Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with or inexperienced in working with transsexual, transgender, and gender nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.

Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

VIII
Hormone Therapy

Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria (Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009).

Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

Criteria for Hormone Therapy

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the *SOC*. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *Standards of Care* outlined in section VI);
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the *SOC*, the presence of co-existing mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.

Informed Consent

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (see also Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

Relationship between the Standards of Care and Informed Consent Model Protocols

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The *SOC* are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the *SOC*). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of co-existing mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and decreased percentage of body fat compared to muscle mass.

- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fact compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months[C]	variable
Increased muscle mass/strength	6-12 months	2-5 years[D]
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

[A] Adapted with permission from Hembree et al.(2009). *Copyright 2009, The Endocrine Society*.
[B] Estimates represent published and unpublished clinical observations.
[C] Highly dependent on age and inheritance; may be minimal.
[D] Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/ strength	3-6 months	1-2 years[C]
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years[D]
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

[A] Adapted with permission from Hembree et al. (2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Significantly dependent on amount of exercise.
[D] Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy – with the possible exception of voice deepening in FtM persons – can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, co-morbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaberi, 2006; Ettner, Monstrey, & Eyler, 2007).

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	Venous thromboembolic disease[A] Gallstones Elevated liver enzymes Weight gain Hypertriglyceridemia	Polycythemia Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	Hypertension Hyperprolactinemia or prolactinom[A]	Elevated liver enzymes Hyperlipidemia
Possible increased risk with presence of additional risk factors[B]	Type 2 diabetes[A]	Destabilization of certain psychiatric disorders[C] Cardiovascular disease Hypertension Type 2 diabetes
No increased risk or inconclusive	Breast cancer	Loss of bone density Breast cancer Cervical cancer Ovarian cancer Uterine cancer

[A] Risk is greater with oral estrogen administration than with transdermal estrogen administration.
[B] Additional risk factors include age.
[C] Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of co-morbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.

2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).

3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.

4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.

5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.

6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.

1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1-6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the *SOC* (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

2. Hormone therapy following gonad removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and co-morbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

3. Hormone maintenance prior to gonad removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens,* below).

4. Initiating hormonal feminization/masculinization

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

Preventive care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

Risk assessment and modification for feminizing hormone therapy (MtF)

There are no absolute contraindications to feminizing therapy *per se*, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Risk assessment and modification for masculinizing hormone therapy (FtM)

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Co-morbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Cattrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (Physicians' Desk Reference, 2011), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Clinical Monitoring during Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with co-morbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

Efficacy and risk monitoring during feminizing hormone therapy (MtF)

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range, and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Efficacy and risk monitoring during masculinizing hormone therapy (FtM)

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of pressure, weight, pulse, and skin; and heart and lung exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or econonomic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

Regimens for feminizing hormone therapy (MtF)

Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular those resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen reducing medications ("anti-androgens")

A combination of estrogen and "anti-androgens" is the most commonly studied regimen for feminization. Androgen reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.

- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).

- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.

- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer III et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer III et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

Regimens for masculinizing hormone therapy (FtM)

Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecenoate, available outside the United States, results in lower serum testosterone levels than non-oral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2-4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecenoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

Bioidentical and compounded hormones

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

IX
Reproductive Health

Many transgender, transsexual, and gender nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals – including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons – should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing the production of mature

gametes (Payer, Meyer III, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignances that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to make eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.

X

Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients.

2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the *SOC*; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication – style, voice, choice of language, etc. – is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissinger, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice and communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and non-verbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice and

communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI
Surgery_

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage

& Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the *SOC*. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve "ideal" results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversibile, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the male-to-female (MtF) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);

2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;

3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the female-to-male (FtM) patient, surgical procedures may include the following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;

2. Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The *SOC* do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

Criteria for breast/chest surgery (one referral)

Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and ovariectomy in FtM patients and for orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled.
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
6. 12 continuous months of living in a gender role that is congruent with their gender identity;

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be

conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruysse, 2009).

Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dsyphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called "chest reconstruction") is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or "male chest contouring" procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, ovariectomy (salpingo-oophorectomy), vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and

unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled "purely aesthetic," these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

XII
Postoperative Care and Follow-up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long

distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

XIII
Lifelong Preventive and Primary Care

Transsexual, transgender, and gender nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such

as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions

of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hiltebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the Standards of Care to People Living in Institutional Environments

The *SOC* in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the *SOC* can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess

and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have co-existing mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A "freeze frame" approach is not considered appropriate care in most situations (Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV

Applicability of the Standards of Care to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPES1/ESPE2 Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to *DSD* during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the "disorder" label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term *DSD* in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Rationale for Addition to the SOC

Previously, individuals with a DSD who also met the *DSM-IV-TR's* behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a "Gender Identity Disorder - Not Otherwise Specified." They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization – which explicitly differentiates between gender dysphoric individuals with and without a DSD – is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the *SOC*.

Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals – during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered – the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.

Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam – both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, in press). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010). However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, in press). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, in press).

Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the *SOC*. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).

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APPENDIX A
GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the *SOC* are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite* – and, some would argue, the more recent term *transgender* – have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Bioidentical hormones: Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

Bioidentical compounded hormone therapy (BCHT): Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

Crossdressing (transvestism): Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

Disorders of sex development (DSD): Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

Female-to-Male (FtM): Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Gender dysphoria: Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Gender identity: A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

Gender identity disorder: Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender nonconforming: Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression: Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

Genderqueer: Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

Male-to-Female (MtF): Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Natural hormones: Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

Sex: Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte,

2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Sex reassignment surgery (gender affirmation surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized.

Transphobia, internalized: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through femininizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

APPENDIX B
OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

Risks of Feminizing Hormone Therapy (MtF)

Likely increased risk:

Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal route of estradiol administration, which is recommended for patients at higher risk of VTE.

Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

Possible increased risk:

Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

Other side effects of feminizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

Risks of anti-androgen medications:

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the *SOC*. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

Risks of Masculinizing Hormone Therapy (FtM)

Likely increased risk:

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

Possible increased risk:

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing**,** may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall.

- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

Other side effects of masculinizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.
- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

APPENDIX C
SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the *SOC*, the criteria put forth in the *SOC* for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

Criteria for Feminizing/Masculinizing Hormone Therapy (one referral or chart documentation of psychosocial assessment)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well-controlled.

Criteria for Breast/Chest Surgery (one referral)

Mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

Hysterectomy and ovariectomy in FtM patients and orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or phalloplasty in FtM patients and vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);

6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

APPENDIX D
EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who underwent sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer III, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment was not recorded. Study participants who were taking testosterone had typically being doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p<.001$). (A similar analysis was not done for genital surgery). In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 2000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990). Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E
DEVELOPMENT PROCESS FOR THE STANDARDS OF CARE, VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial *SOC* "work group" was established in 2006. Members were invited to examine specific sections of *SOC, Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the *SOC* as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International Journal of Transgenderism (IJT)*. Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1-4) in 2009, making them available for discussion and debate.

After these articles were published, a *Standards of Care* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of *SOC, Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision – both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion – and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of *SOC, Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized it was circulated among the broader *SOC* Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revision. Two additional drafts were created and posted on the Google website for consideration by the broader *SOC* Revision Committee and the International Advisory Group. Upon completion of these three iteratations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

The plans are to disseminate this version of the *SOC* and invite feedback for further revisions. The WPATH Board of Directors decides the timing of any revision of the *SOC*.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;

2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;

3. Working meeting of the Writing Group;

4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7* Revision Committee, and WPATH Board of Directors;

5. Costs of printing and distributing *Standards of Care, Version 7* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

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Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

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*Cosponsoring Associations: American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.

Objective: To update the "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," published by the Endocrine Society in 2009.

Participants: The participants include an Endocrine Society–appointed task force of nine experts, a methodologist, and a medical writer.

Evidence: This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation approach to describe the strength of recommendations and the quality of evidence. The task force commissioned two systematic reviews and used the best available evidence from other published systematic reviews and individual studies.

Consensus Process: Group meetings, conference calls, and e-mail communications enabled consensus. Endocrine Society committees, members and cosponsoring organizations reviewed and commented on preliminary drafts of the guidelines.

Conclusion: Gender affirmation is multidisciplinary treatment in which endocrinologists play an important role. Gender-dysphoric/gender-incongruent persons seek and/or are referred to endocrinologists to develop the physical characteristics of the affirmed gender. They require a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender. Hormone treatment is not recommended for prepubertal gender-dysphoric/gender-incongruent persons. Those clinicians who recommend gender-affirming endocrine treatments—appropriately trained diagnosing clinicians (required), a mental health provider for adolescents (required) and mental health

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Abbreviations: BMD, bone mineral density; DSD, disorder/difference of sex development; DSM, Diagnostic and Statistical Manual of Mental Disorders; GD, gender dysphoria; GnRH, gonadotropin-releasing hormone; ICD, International Statistical Classification of Diseases and Related Health Problems; MHP, mental health professional; VTE, venous thromboembolism.

professional for adults (recommended)—should be knowledgeable about the diagnostic criteria and criteria for gender-affirming treatment, have sufficient training and experience in assessing psychopathology, and be willing to participate in the ongoing care throughout the endocrine transition. We recommend treating gender-dysphoric/gender-incongruent adolescents who have entered puberty at Tanner Stage G2/B2 by suppression with gonadotropin-releasing hormone agonists. Clinicians may add gender-affirming hormones after a multidisciplinary team has confirmed the persistence of gender dysphoria/gender incongruence and sufficient mental capacity to give informed consent to this partially irreversible treatment. Most adolescents have this capacity by age 16 years old. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to age 16 years, although there is minimal published experience treating prior to 13.5 to 14 years of age. For the care of peripubertal youths and older adolescents, we recommend that an expert multidisciplinary team comprised of medical professionals and mental health professionals manage this treatment. The treating physician must confirm the criteria for treatment used by the referring mental health practitioner and collaborate with them in decisions about gender-affirming surgery in older adolescents. For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient. We suggest maintaining physiologic levels of gender-appropriate hormones and monitoring for known risks and complications. When high doses of sex steroids are required to suppress endogenous sex steroids and/or in advanced age, clinicians may consider surgically removing natal gonads along with reducing sex steroid treatment. Clinicians should monitor both transgender males (female to male) and transgender females (male to female) for reproductive organ cancer risk when surgical removal is incomplete. Additionally, clinicians should persistently monitor adverse effects of sex steroids. For gender-affirming surgeries in adults, the treating physician must collaborate with and confirm the criteria for treatment used by the referring physician. Clinicians should avoid harming individuals (via hormone treatment) who have conditions other than gender dysphoria/gender incongruence and who may not benefit from the physical changes associated with this treatment. **(*J Clin Endocrinol Metab* 102: 3869–3903, 2017)**

Summary of Recommendations

1.0 Evaluation of youth and adults

1.1. We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or the ICD for diagnostic purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕◯◯)

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕◯)

2.0 Treatment of adolescents

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕◯◯)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 |⊕⊕◯◯)

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕◯◯)

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 |⊕⊕◯◯).

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕◯◯◯)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 |⊕⊕◯◯)

3.0 Hormonal therapy for transgender adults

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕◯)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment. (1 |⊕⊕⊕◯)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕◯◯)

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕◯◯◯)

4.0 Adverse outcome prevention and long-term care

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕◯◯)

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 |⊕⊕◯◯)

4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕◯◯)

4.4. We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕◯◯)

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for non-transgender females. (2 |⊕⊕◯◯)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕◯◯◯)

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

5.0 Surgery for sex reassignment and gender confirmation

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕◯◯)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕◯◯◯)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕◯◯).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕◯◯◯)

Changes Since the Previous Guideline

Both the current guideline and the one published in 2009 contain similar sections. Listed here are the sections contained in the current guideline and the corresponding number of recommendations: Introduction, Evaluation of Youth and Adults (5), Treatment of Adolescents (6), Hormonal Therapy for Transgender Adults (4), Adverse Outcomes Prevention and Long-term Care (7), and Surgery for Sex Reassignment and Gender Confirmation (6). The current introduction updates the diagnostic classification of "gender dysphoria/gender incongruence." It also reviews the development of "gender identity" and summarizes its natural development. The section on clinical evaluation of both youth and adults, defines in detail the professional qualifications required of those who diagnose and treat both adolescents and adults. We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional. We recommend against puberty blocking followed by gender-affirming hormone treatment of prepubertal children. Clinicians should inform pubertal children, adolescents, and adults seeking gender-confirming treatment of their options for fertility preservation. Prior to treatment, clinicians should evaluate the presence of medical conditions that may be worsened by hormone depletion and/or treatment. A multidisciplinary team, preferably composed of medical and mental health professionals, should monitor treatments. Clinicians evaluating transgender adults for endocrine treatment should confirm the diagnosis of persistent gender dysphoria/gender incongruence. Physicians should educate transgender persons regarding the time course of steroid-induced physical changes. Treatment should include periodic monitoring of hormone levels and metabolic parameters, as well as assessments of bone density and the impact upon prostate, gonads, and uterus. We also make recommendations for transgender persons who plan genital gender-affirming surgery.

Method of Development of Evidence-Based Clinical Practice Guidelines

The Clinical Guidelines Subcommittee (CGS) of the Endocrine Society deemed the diagnosis and treatment of individuals with GD/gender incongruence a priority area for revision and appointed a task force to formulate evidence-based recommendations. The task force followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines (1). A detailed description of the grading scheme has been published elsewhere (2). The task force used the best available research evidence to develop the recommendations. The task force also used consistent language and graphical descriptions of both the strength of a recommendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕◯◯◯ denotes very low–quality evidence; ⊕⊕◯◯, low quality; ⊕⊕⊕◯, moderate quality; and ⊕⊕⊕⊕, high quality. The task force has confidence that persons who receive care according to the strong recommendations will derive, on average, more benefit than harm. Weak recommendations require more careful consideration of the person's circumstances, values, and preferences to determine the best course of action. Linked to each recommendation is a description of the evidence and the

values that the task force considered in making the recommendation. In some instances, there are remarks in which the task force offers technical suggestions for testing conditions, dosing, and monitoring. These technical comments reflect the best available evidence applied to a typical person being treated. Often this evidence comes from the unsystematic observations of the task force and their preferences; therefore, one should consider these remarks as suggestions.

In this guideline, the task force made several statements to emphasize the importance of shared decision-making, general preventive care measures, and basic principles of the treatment of transgender persons. They labeled these "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.

The Endocrine Society maintains a rigorous conflict-of-interest review process for developing clinical practice guidelines. All task force members must declare any potential conflicts of interest by completing a conflict-of-interest form. The CGS reviews all conflicts of interest before the Society's Council approves the members to participate on the task force and periodically during the development of the guideline. All others participating in the guideline's development must also disclose any conflicts of interest in the matter under study, and most of these participants must be without any conflicts of interest. The CGS and the task force have reviewed all disclosures for this guideline and resolved or managed all identified conflicts of interest.

Conflicts of interest are defined as remuneration in any amount from commercial interests; grants; research support; consulting fees; salary; ownership interests [*e.g.*, stocks and stock options (excluding diversified mutual funds)]; honoraria and other payments for participation in speakers' bureaus, advisory boards, or boards of directors; and all other financial benefits. Completed forms are available through the Endocrine Society office.

The Endocrine Society provided the funding for this guideline; the task force received no funding or remuneration from commercial or other entities.

Commissioned Systematic Review

The task force commissioned two systematic reviews to support this guideline. The first one aimed to summarize the available evidence on the effect of sex steroid use in transgender individuals on lipids and cardiovascular outcomes. The review identified 29 eligible studies at moderate risk of bias. In transgender males (female to male), sex steroid therapy was associated with a statistically significant increase in serum triglycerides and low-density lipoprotein cholesterol levels. High-density lipoprotein cholesterol levels decreased significantly across all follow-up time periods. In transgender females (male to female), serum triglycerides were significantly higher without any changes in other parameters. Few myocardial infarction, stroke, venous thromboembolism (VTE), and death events were reported. These events were more frequent in transgender females. However, the quality of the evidence was low. The second review summarized the available evidence regarding the effect of sex steroids on bone health in transgender individuals and identified 13 studies. In transgender males, there was no statistically significant difference in the lumbar spine, femoral neck, or total hip BMD at 12 and 24 months compared with baseline values before initiating masculinizing hormone therapy. In transgender females, there was a statistically significant increase in lumbar spine BMD at 12 months and 24 months compared with baseline values before initiation of feminizing hormone therapy. There was minimal information on fracture rates. The quality of evidence was also low.

Introduction

Throughout recorded history (in the absence of an endocrine disorder) some men and women have experienced confusion and anguish resulting from rigid, forced conformity to sexual dimorphism. In modern history, there have been numerous ongoing biological, psychological, cultural, political, and sociological debates over various aspects of gender variance. The 20th century marked the emergence of a social awakening for men and women with the belief that they are "trapped" in the wrong body (3). Magnus Hirschfeld and Harry Benjamin, among others, pioneered the medical responses to those who sought relief from and a resolution to their profound discomfort. Although the term transsexual became widely known after Benjamin wrote "The Transsexual Phenomenon" (4), it was Hirschfeld who coined the term "transsexual" in 1923 to describe people who want to live a life that corresponds with their experienced gender vs their designated gender (5). Magnus Hirschfeld (6) and others (4, 7) have described other types of trans phenomena besides transsexualism. These early researchers proposed that the gender identity of these people was located somewhere along a unidimensional continuum. This continuum ranged from all male through "something in between" to all female. Yet such a classification does not take into account that people may have gender identities outside this continuum. For instance, some experience themselves as having both a male and female gender identity, whereas others completely renounce any gender classification (8, 9). There are also reports of individuals experiencing a continuous and rapid involuntary alternation between a male and female identity (10) or men who do not experience themselves as men but do not want to live as women (11, 12). In some countries, (*e.g.*, Nepal, Bangladesh, and Australia), these nonmale or nonfemale genders are officially recognized (13). Specific treatment protocols, however, have not yet been developed for these groups.

Instead of the term transsexualism, the current classification system of the American Psychiatric Association uses the term gender dysphoria in its diagnosis of persons who are not satisfied with their designated gender (14). The current version of the World Health Organization's ICD-10 still uses the term transsexualism when diagnosing adolescents and adults. However, for the ICD-11, the World Health Organization has proposed using the term "gender incongruence" (15).

Treating persons with GD/gender incongruence (15) was previously limited to relatively ineffective elixirs or creams. However, more effective endocrinology-based treatments became possible with the availability of testosterone in 1935 and diethylstilbestrol in 1938. Reports of individuals with GD/gender incongruence who were treated with hormones and gender-affirming surgery appeared in the press during the second half of the 20th century. The Harry Benjamin International Gender Dysphoria Association was founded in September 1979 and is now called the World Professional Association for Transgender Health (WPATH). WPATH published its first Standards of Care in 1979. These standards have since been regularly updated, providing guidance for treating persons with GD/gender incongruence (16).

Prior to 1975, few peer-reviewed articles were published concerning endocrine treatment of transgender persons. Since then, more than two thousand articles about various aspects of transgender care have appeared.

It is the purpose of this guideline to make detailed recommendations and suggestions, based on existing medical literature and clinical experience, that will enable treating physicians to maximize benefit and minimize risk when caring for individuals diagnosed with GD/gender incongruence.

In the future, we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols. Specifically, endocrine treatment protocols for GD/gender incongruence should include the careful assessment of the following: (1) the effects of prolonged delay of puberty in adolescents on bone health, gonadal function, and the brain (including effects on cognitive, emotional, social, and sexual development); (2) the effects of treatment in adults on sex hormone levels; (3) the requirement for and the effects of progestins and other agents used to suppress endogenous sex steroids during treatment; and (4) the risks and benefits of gender-affirming hormone treatment in older transgender people.

To successfully establish and enact these protocols, a commitment of mental health and endocrine investigators is required to collaborate in long-term, large-scale studies across countries that use the same diagnostic and inclusion criteria, medications, assay methods, and response assessment tools (*e.g.*, the European Network for the Investigation of Gender Incongruence) (17, 18).

Terminology and its use vary and continue to evolve. Table 1 contains the definitions of terms as they are used throughout this guideline.

Biological Determinants of Gender Identity Development

One's self-awareness as male or female changes gradually during infant life and childhood. This process of cognitive and affective learning evolves with interactions with parents, peers, and environment. A fairly accurate timetable exists outlining the steps in this process (19). Normative psychological literature, however, does not address if and when gender identity becomes crystallized and what factors contribute to the development of a gender identity that is not congruent with the gender of rearing. Results of studies from a variety of biomedical disciplines—genetic, endocrine, and neuroanatomic—support the concept that gender identity and/or gender expression (20) likely reflect a complex interplay of biological, environmental, and cultural factors (21, 22).

With respect to endocrine considerations, studies have failed to find differences in circulating levels of sex steroids between transgender and nontransgender individuals (23). However, studies in individuals with a disorder/difference of sex development (DSD) have informed our understanding of the role that hormones may play in gender identity outcome, even though most persons with GD/gender incongruence do not have a DSD. For example, although most 46,XX adult individuals with virilizing congenital adrenal hyperplasia caused by mutations in *CYP21A2* reported a female gender identity, the prevalence of GD/gender incongruence was much greater in this group than in the general population without a DSD. This supports the concept that there is a role for prenatal/postnatal androgens in gender development (24–26), although some studies indicate that prenatal androgens are more likely to affect gender behavior and sexual orientation rather than gender identity *per se* (27, 28).

Researchers have made similar observations regarding the potential role of androgens in the development of gender identity in other individuals with DSD. For example, a review of two groups of 46,XY persons, each with androgen synthesis deficiencies and female raised, reported transgender male (female-to-male) gender role changes in 56% to 63% and 39% to 64% of patients, respectively (29). Also, in 46,XY female-raised individuals with cloacal

Table 1. Definitions of Terms Used in This 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.
Cisgender: This means not transgender. An alternative way to describe individuals who are not transgender is "non-transgender people."
Gender-affirming (hormone) treatment: See "gender reassignment"
Gender dysphoria: This is the distress and unease experienced if gender identity and designated gender are not completely congruent (see Table 2). In 2013, the American Psychiatric Association released the fifth edition of the DSM-5, which replaced "gender identity disorder" with "gender dysphoria" and changed the criteria for diagnosis.
Gender expression: This refers to external manifestations of gender, expressed through one's name, pronouns, clothing, haircut, behavior, voice, or body characteristics. Typically, transgender people seek to make their gender expression align with their gender identity, rather than their designated gender.
Gender identity/experienced gender: This refers to one's internal, deeply held sense of gender. For transgender people, their gender identity does not match their sex designated at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices. Unlike gender expression (see below), gender identity is not visible to others.
Gender identity disorder: This is the term used for GD/gender incongruence in previous versions of DSM (see "gender dysphoria"). The ICD-10 still uses the term for diagnosing child diagnoses, but the upcoming ICD-11 has proposed using "gender incongruence of childhood."
Gender incongruence: This is an umbrella term used when the gender identity and/or gender expression differs from what is typically associated with the designated gender. Gender incongruence is also the proposed name of the gender identity–related diagnoses in ICD-11. Not all individuals with gender incongruence have gender dysphoria or seek treatment.
Gender variance: See "gender incongruence"
Gender reassignment: This refers to the treatment procedure for those who want to adapt their bodies to the experienced gender by means of hormones and/or surgery. This is also called gender-confirming or gender-affirming treatment.
Gender-reassignment surgery (gender-confirming/gender-affirming surgery): These terms refer only to the surgical part of gender-confirming/gender-affirming treatment.
Gender role: This refers to behaviors, attitudes, and personality traits that a society (in a given culture and historical period) designates as masculine or feminine and/or that society associates with or considers typical of the social role of men or women.
Sex designated at birth: This refers to sex assigned at birth, usually based on genital anatomy.
Sex: This refers to attributes that characterize biological maleness or femaleness. The best known attributes include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics.
Sexual orientation: This term describes an individual's enduring physical and emotional attraction to another person. Gender identity and sexual orientation are not the same. Irrespective of their gender identity, transgender people may be attracted to women (gynephilic), attracted to men (androphilic), bisexual, asexual, or queer.
Transgender: This is an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment.
Transgender male (also: trans man, female-to-male, transgender male): This refers to individuals assigned female at birth but who identify and live as men.
Transgender woman (also: trans woman, male-to female, transgender female): This refers to individuals assigned male at birth but who identify and live as women.
Transition: This refers to the process during which transgender persons change their physical, social, and/or legal characteristics consistent with the affirmed gender identity. Prepubertal children may choose to transition socially.
Transsexual: This is an older term that originated in the medical and psychological communities to refer to individuals who have permanently transitioned through medical interventions or desired to do so.

exstrophy and penile agenesis, the occurrence of transgender male changes was significantly more prevalent than in the general population (30, 31). However, the fact that a high percentage of individuals with the same conditions did not change gender suggests that cultural factors may play a role as well.

With respect to genetics and gender identity, several studies have suggested heritability of GD/gender incongruence (32, 33). In particular, a study by Heylens *et al.* (33) demonstrated a 39.1% concordance rate for gender identity disorder (based on the DSM-IV criteria) in 23 monozygotic twin pairs but no concordance in 21 same-sex dizygotic or seven opposite-sex twin pairs. Although numerous investigators have sought to identify specific genes associated with GD/gender incongruence, such studies have been inconsistent and without strong statistical significance (34–38).

Studies focusing on brain structure suggest that the brain phenotypes of people with GD/gender incongruence differ in various ways from control males and females, but that there is not a complete sex reversal in brain structures (39).

In summary, although there is much that is still unknown with respect to gender identity and its expression, compelling studies support the concept that biologic factors, in addition to environmental factors, contribute to this fundamental aspect of human development.

Natural History of Children With GD/Gender Incongruence

With current knowledge, we cannot predict the psychosexual outcome for any specific child. Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence (20, 40). In adolescence, a significant number of these desisters identify as homosexual or bisexual. It may be that children who only showed some gender nonconforming characteristics have been included in the follow-up studies, because the DSM-IV text revision criteria for a diagnosis were rather broad. However, the persistence of GD/gender incongruence into adolescence is more likely if it had been extreme in childhood (41, 42). With the newer, stricter criteria of the DSM-5 (Table 2), persistence rates may well be different in future studies.

1.0 Evaluation of Youth and Adults

Gender-affirming treatment is a multidisciplinary effort. After evaluation, education, and diagnosis, treatment may include mental health care, hormone therapy, and/or surgical therapy. Together with an MHP, hormone-prescribing clinicians should examine the psychosocial impact of the potential changes on people's lives, including mental health, friends, family, jobs, and their role in society. Transgender individuals should be encouraged to experience living in the new gender role and assess whether this improves their quality of life. Although the focus of this guideline is gender-affirming hormone therapy, collaboration with appropriate professionals responsible for each aspect of treatment maximizes a successful outcome.

Diagnostic assessment and mental health care

GD/gender incongruence may be accompanied with psychological or psychiatric problems (43–51). It is therefore necessary that clinicians who prescribe hormones and are involved in diagnosis and psychosocial assessment meet the following criteria: (1) are competent in using the DSM and/or the ICD for diagnostic purposes, (2) are able to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) are trained in diagnosing psychiatric conditions, (4) undertake or refer for appropriate treatment, (5) are able to do a psychosocial assessment of the patient's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) regularly attend relevant professional meetings.

Because of the psychological vulnerability of many individuals with GD/gender incongruence, it is important that mental health care is available before, during, and sometimes also after transitioning. For children and adolescents, an MHP who has training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis, because assessing GD/gender incongruence in children and adolescents is often extremely complex.

During assessment, the clinician obtains information from the individual seeking gender-affirming treatment. In the case

Table 2. DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults

A. A marked incongruence between one's experienced/expressed gender and natal gender of at least 6 mo in duration, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender
   4. A strong desire to be of the other gender (or some alternative gender different from one's designated gender)
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender)
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
   1. The condition exists with a disorder of sex development.
   2. The condition is posttransitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (*e.g.*, penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

Reference: American Psychiatric Association (14).

of adolescents, the clinician also obtains information from the parents or guardians regarding various aspects of the child's general and psychosexual development and current functioning. On the basis of this information, the clinician:

- decides whether the individual fulfills criteria for treatment (see Tables 2 and 3) for GD/gender incongruence (DSM-5) or transsexualism (DSM-5 and/or ICD-10);
- informs the individual about the possibilities and limitations of various kinds of treatment (hormonal/surgical and nonhormonal), and if medical treatment is desired, provides correct information to prevent unrealistically high expectations;
- assesses whether medical interventions may result in unfavorable psychological and social outcomes.

In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues. Literature on postoperative regret suggests that besides poor quality of surgery, severe psychiatric comorbidity and lack of support may interfere with positive outcomes (52–56).

For adolescents, the diagnostic procedure usually includes a complete psychodiagnostic assessment (57) and an assessment of the decision-making capability of the youth. An evaluation to assess the family's ability to endure stress, give support, and deal with the complexities of the adolescent's situation should be part of the diagnostic phase (58).

Social transitioning

A change in gender expression and role (which may involve living part time or full time in another gender role that is consistent with one's gender identity) may test the person's resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports. It assists both the individual and the clinician in their judgments about how to proceed (16). During social transitioning, the person's feelings about the social transformation (including coping with the responses of others) is a major focus of the counseling. The optimal timing for social transitioning may differ between individuals. Sometimes people wait until they start gender-affirming hormone treatment to make social transitioning easier, but individuals increasingly start social transitioning long before they receive medically supervised, gender-affirming hormone treatment.

Criteria

Adolescents and adults seeking gender-affirming hormone treatment and surgery should satisfy certain criteria before proceeding (16). Criteria for gender-affirming hormone therapy for adults are in Table 4, and criteria for gender-affirming hormone therapy for adolescents are in Table 5. Follow-up studies in adults meeting these criteria indicate a high satisfaction rate with treatment (59). However, the quality of evidence is usually low. A few follow-up studies on adolescents who fulfilled these criteria also indicated good treatment results (60–63).

Recommendations for Those Involved in the Gender-Affirming Hormone Treatment of Individuals With GD/Gender Incongruence

1.1. We advise that only trained MHPs who meet the following criteria should diagnose GD/gender incongruence in adults: (1) competence in using the DSM and/or the ICD for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or ICD for diagnostic

Table 3. ICD-10 Criteria for Transsexualism

Transsexualism (F64.0) has three criteria:
1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatments.
2. The transsexual identity has been present persistently for at least 2 y.
3. The disorder is not a symptom of another mental disorder or a genetic, DSD, or chromosomal abnormality.

Table 4. Criteria for Gender-Affirming Hormone Therapy for Adults

1. Persistent, well-documented gender dysphoria/gender incongruence
2. The capacity to make a fully informed decision and to consent for treatment
3. The age of majority in a given country (if younger, follow the criteria for adolescents)
4. Mental health concerns, if present, must be reasonably well controlled

Reproduced from World Professional Association for Transgender Health (16).

purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

Evidence

Individuals with gender identity issues may have psychological or psychiatric problems (43–48, 50, 51, 64, 65). It is therefore necessary that clinicians making the diagnosis are able to make a distinction between GD/gender incongruence and conditions that have similar features. Examples of conditions with similar features are body dysmorphic disorder, body identity integrity disorder (a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow wrong or inappropriate) (66), or certain forms of eunuchism (in which a person is preoccupied with or engages in castration and/or penectomy for

Table 5. Criteria for Gender-Affirming Hormone Therapy for Adolescents

Adolescents are eligible for GnRH agonist treatment if:

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

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 $\geq$G2/B2),
- has confirmed that there are no medical contraindications to GnRH agonist treatment.

Adolescents are eligible for subsequent sex hormone treatment if:

1. A qualified MHP 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.

Reproduced from World Professional Association for Transgender Health (16).

reasons that are not gender identity related) (11). Clinicians should also be able to diagnose psychiatric conditions accurately and ensure that these conditions are treated appropriately, particularly when the conditions may complicate treatment, affect the outcome of gender-affirming treatment, or be affected by hormone use.

Values and preferences

The task force placed a very high value on avoiding harm from hormone treatment in individuals who have conditions other than GD/gender incongruence and who may not benefit from the physical changes associated with this treatment and placed a low value on any potential benefit these persons believe they may derive from hormone treatment. This justifies the good practice statement.

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕◯◯)

Evidence

In most children diagnosed with GD/gender incongruence, it did not persist into adolescence. The percentages differed among studies, probably dependent on which version of the DSM clinicians used, the patient's age, the recruitment criteria, and perhaps cultural factors. However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence (20). If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty (40). Social transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.

This recommendation, however, does not imply that children should be discouraged from showing gender-variant behaviors or should be punished for exhibiting such behaviors. In individual cases, an early complete social transition may result in a more favorable outcome, but there are currently no criteria to identify the GD/gender-incongruent children to whom this applies. At the present time, clinical experience suggests that persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty.

Values and preferences

The task force placed a high value on avoiding harm with gender-affirming hormone therapy in prepubertal children with GD/gender incongruence. This justifies the strong recommendation in the face of low-quality evidence.

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕◯)

Remarks

Persons considering hormone use for gender affirmation need adequate information about this treatment in general and about fertility effects of hormone treatment in particular to make an informed and balanced decision (67, 68). Because young adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormonal interventions, consent and protocol education should include parents, the referring MHP(s), and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding the future fertility of adolescents or adults beginning gender-affirming treatment.

Treating early pubertal youth with GnRH analogs will temporarily impair spermatogenesis and oocyte maturation. Given that an increasing number of transgender youth want to preserve fertility potential, delaying or temporarily discontinuing GnRH analogs to promote gamete maturation is an option. This option is often not preferred, because mature sperm production is associated with later stages of puberty and with the significant development of secondary sex characteristics.

For those designated male at birth with GD/gender incongruence and who are in early puberty, sperm production and the development of the reproductive tract are insufficient for the cryopreservation of sperm. However, prolonged pubertal suppression using GnRH analogs is reversible and clinicians should inform these individuals that sperm production can be initiated following prolonged gonadotropin suppression. This can be accomplished by spontaneous gonadotropin recovery after

cessation of GnRH analogs or by gonadotropin treatment and will probably be associated with physical manifestations of testosterone production, as stated above. Note that there are no data in this population concerning the time required for sufficient spermatogenesis to collect enough sperm for later fertility. In males treated for precocious puberty, spermarche was reported 0.7 to 3 years after cessation of GnRH analogs (69). In adult men with gonadotropin deficiency, sperm are noted in seminal fluid by 6 to 12 months of gonadotropin treatment. However, sperm numbers when partners of these patients conceive are far below the "normal range" (70, 71).

In girls, no studies have reported long-term, adverse effects of pubertal suppression on ovarian function after treatment cessation (72, 73). Clinicians should inform adolescents that no data are available regarding either time to spontaneous ovulation after cessation of GnRH analogs or the response to ovulation induction following prolonged gonadotropin suppression.

In males with GD/gender incongruence, when medical treatment is started in a later phase of puberty or in adulthood, spermatogenesis is sufficient for cryopreservation and storage of sperm. *In vitro* spermatogenesis is currently under investigation. Restoration of spermatogenesis after prolonged estrogen treatment has not been studied.

In females with GD/gender incongruence, the effect of prolonged treatment with exogenous testosterone on ovarian function is uncertain. There have been reports of an increased incidence of polycystic ovaries in transgender males, both prior to and as a result of androgen treatment (74–77), although these reports were not confirmed by others (78). Pregnancy has been reported in transgender males who have had prolonged androgen treatment and have discontinued testosterone but have not had genital surgery (79, 80). A reproductive endocrine gynecologist can counsel patients before gender-affirming hormone treatment or surgery regarding potential fertility options (81). Techniques for cryopreservation of oocytes, embryos, and ovarian tissue continue to improve, and oocyte maturation of immature tissue is being studied (82).

2.0 Treatment of Adolescents

During the past decade, clinicians have progressively acknowledged the suffering of young adolescents with GD/gender incongruence. In some forms of GD/gender incongruence, psychological interventions may be useful and sufficient. However, for many adolescents with GD/gender incongruence, the pubertal physical changes are unbearable. As early medical intervention may prevent psychological harm, various clinics have decided to start treating young adolescents with GD/gender incongruence with puberty-suppressing medication (a GnRH analog). As compared with starting gender-affirming treatment long after the first phases of puberty, a benefit of pubertal suppression at early puberty may be a better psychological and physical outcome.

In girls, the first physical sign of puberty is the budding of the breasts followed by an increase in breast and fat tissue. Breast development is also associated with the pubertal growth spurt, and menarche occurs ~2 years later. In boys, the first physical change is testicular growth. A testicular volume ≥4 mL is seen as consistent with the initiation of physical puberty. At the beginning of puberty, estradiol and testosterone levels are still low and are best measured in the early morning with an ultrasensitive assay. From a testicular volume of 10 mL, daytime testosterone levels increase, leading to virilization (83). Note that pubic hair and/or axillary hair/odor may not reflect the onset of gonadarche; instead, it may reflect adrenarche alone.

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment (Table 5), and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕◯◯)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty (Tanner stages G2/B2). (2 |⊕⊕◯◯)

Evidence

Pubertal suppression can expand the diagnostic phase by a long period, giving the subject more time to explore options and to live in the experienced gender before making a decision to proceed with gender-affirming sex hormone treatments and/or surgery, some of which is irreversible (84, 85). Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains (86).

Another reason to start blocking pubertal hormones early in puberty is that the physical outcome is improved compared with initiating physical transition after puberty has been completed (60, 62). Looking like a man or woman when living as the opposite sex creates difficult

barriers with enormous life-long disadvantages. We therefore advise starting suppression in early puberty to prevent the irreversible development of undesirable secondary sex characteristics. However, adolescents with GD/gender incongruence should experience the first changes of their endogenous spontaneous puberty, because their emotional reaction to these first physical changes has diagnostic value in establishing the persistence of GD/gender incongruence (85). Thus, Tanner stage 2 is the optimal time to start pubertal suppression. However, pubertal suppression treatment in early puberty will limit the growth of the penis and scrotum, which will have a potential effect on future surgical treatments (87).

Clinicians can also use pubertal suppression in adolescents in later pubertal stages to stop menses in transgender males and prevent facial hair growth in transgender females. However, in contrast to the effects in early pubertal adolescents, physical sex characteristics (such as more advanced breast development in transgender boys and lowering of the voice and outgrowth of the jaw and brow in transgender girls) are not reversible.

Values and preferences

These recommendations place a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm from early pubertal suppression.

Remarks

Table 6 lists the Tanner stages of breast and male genital development. Careful documentation of hallmarks of pubertal development will ensure precise timing when initiating pubertal suppression once puberty has started. Clinicians can use pubertal LH and sex steroid levels to confirm that puberty has progressed sufficiently before starting pubertal suppression (88). Reference ranges for sex steroids by Tanner stage may vary depending on the assay used. Ultrasensitive sex steroid and gonadotropin assays will help clinicians document early pubertal changes.

Irreversible and, for GD/gender-incongruent adolescents, undesirable sex characteristics in female puberty are breasts, female body habitus, and, in some cases, relative short stature. In male puberty, they are a prominent Adam's apple; low voice; male bone configuration, such as a large jaw, big feet and hands, and tall stature; and male hair pattern on the face and extremities.

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕◯◯)

Evidence

Clinicians can suppress pubertal development and gonadal function most effectively via gonadotropin suppression using GnRH analogs. GnRH analogs are long-acting agonists that suppress gonadotropins by GnRH receptor desensitization after an initial increase of gonadotropins during ~10 days after the first and (to a lesser degree) the second injection (89). Antagonists immediately suppress pituitary gonadotropin secretion (90, 91). Long-acting GnRH analogs are the currently preferred treatment option. Clinicians may consider long-acting GnRH antagonists when evidence on their safety and efficacy in adolescents becomes available.

During GnRH analog treatment, slight development of secondary sex characteristics may regress, and in a later phase of pubertal development, it will stop. In girls, breast tissue will become atrophic, and menses will stop. In boys, virilization will stop, and testicular volume may decrease (92).

An advantage of using GnRH analogs is the reversibility of the intervention. If, after extensive exploration of his/her transition wish, the individual no longer desires transition, they can discontinue pubertal suppression. In subjects with

Table 6. Tanner Stages of Breast Development and Male External Genitalia

The description of Tanner stages for breast development:
1. Prepubertal
2. Breast and papilla elevated as small mound; areolar diameter increased
3. Breast and areola enlarged, no contour separation
4. Areola and papilla form secondary mound
5. Mature; nipple projects, areola part of general breast contour

For penis and testes:
1. Prepubertal, testicular volume <4 mL
2. Slight enlargement of penis; enlarged scrotum, pink, texture altered, testes 4–6 mL
3. Penis longer, testes larger (8–12 mL)
4. Penis and glans larger, including increase in breadth; testes larger (12–15 mL), scrotum dark
5. Penis adult size; testicular volume > 15 ml

Adapted from Lawrence (56).

precocious puberty, spontaneous pubertal development has been shown to resume after patients discontinue taking GnRH analogs (93).

Recommendations 2.1 to 2.3 are supported by a prospective follow-up study from The Netherlands. This report assessed mental health outcomes in 55 transgender adolescents/young adults (22 transgender females and 33 transgender males) at three time points: (1) before the start of GnRH agonist (average age of 14.8 years at start of treatment), (2) at initiation of gender-affirming hormones (average age of 16.7 years at start of treatment), and (3) 1 year after "gender-reassignment surgery" (average age of 20.7 years) (63). Despite a decrease in depression and an improvement in general mental health functioning, GD/gender incongruence persisted through pubertal suppression, as previously reported (86). However, following sex hormone treatment and gender-reassignment surgery, GD/gender incongruence was resolved and psychological functioning steadily improved (63). Furthermore, well-being was similar to or better than that reported by age-matched young adults from the general population, and none of the study participants regretted treatment. This study represents the first long-term follow-up of individuals managed according to currently existing clinical practice guidelines for transgender youth, and it underscores the benefit of the multidisciplinary approach pioneered in The Netherlands; however, further studies are needed.

Side effects

The primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization (which can theoretically be reversed with sex hormone treatment), compromised fertility if the person subsequently is treated with sex hormones, and unknown effects on brain development. Few data are available on the effect of GnRH analogs on BMD in adolescents with GD/gender incongruence. Initial data in GD/gender-incongruent subjects demonstrated no change of absolute areal BMD during 2 years of GnRH analog therapy but a decrease in BMD *z* scores (85). A recent study also suggested suboptimal bone mineral accrual during GnRH analog treatment. The study reported a decrease in areal BMD *z* scores and of bone mineral apparent density *z* scores (which takes the size of the bone into account) in 19 transgender males treated with GnRH analogs from a mean age of 15.0 years (standard deviation = 2.0 years) for a median duration of 1.5 years (0.3 to 5.2 years) and in 15 transgender females treated from 14.9 (±1.9) years for 1.3 years (0.5 to 3.8 years), although not all changes were statistically significant (94). There was incomplete catch-up at age 22 years after sex hormone treatment from age 16.6 (±1.4) years for a median duration of 5.8 years (3.0 to 8.0 years) in transgender females and from age 16.4 (±2.3) years for 5.4 years (2.8 to 7.8 years) in transgender males. Little is known about more prolonged use of GnRH analogs. Researchers reported normal BMD *z* scores at age 35 years in one individual who used GnRH analogs from age 13.7 years until age 18.6 years before initiating sex hormone treatment (65).

Additional data are available from individuals with late puberty or GnRH analog treatment of other indications. Some studies reported that men with constitutionally delayed puberty have decreased BMD in adulthood (95). However, other studies reported that these men have normal BMD (96, 97). Treating adults with GnRH analogs results in a decrease of BMD (98). In children with central precocious puberty, treatment with GnRH analogs has been found to result in a decrease of BMD during treatment by some (99) but not others (100). Studies have reported normal BMD after discontinuing therapy (69, 72, 73, 101, 102). In adolescents treated with growth hormone who are small for gestational age and have normal pubertal timing, 2-year GnRH analog treatments did not adversely affect BMD (103). Calcium supplementation may be beneficial in optimizing bone health in GnRH analog–treated individuals (104). There are no studies of vitamin D supplementation in this context, but clinicians should offer supplements to vitamin D–deficient adolescents. Physical activity, especially during growth, is important for bone mass in healthy individuals (103) and is therefore likely to be beneficial for bone health in GnRH analog–treated subjects.

GnRH analogs did not induce a change in body mass index standard deviation score in GD/gender-incongruent adolescents (94) but caused an increase in fat mass and decrease in lean body mass percentage (92). Studies in girls treated for precocious puberty also reported a stable body mass index standard deviation score during treatment (72) and body mass index and body composition comparable to controls after treatment (73).

Arterial hypertension has been reported as an adverse effect in a few girls treated with GnRH analogs for precocious/early puberty (105, 106). Blood pressure monitoring before and during treatment is recommended.

Individuals may also experience hot flashes, fatigue, and mood alterations as a consequence of pubertal suppression. There is no consensus on treatment of these side effects in this context.

It is recommended that any use of pubertal blockers (and subsequent use of sex hormones, as detailed below) include a discussion about implications for fertility (see recommendation 1.3). Transgender adolescents may

want to preserve fertility, which may be otherwise compromised if puberty is suppressed at an early stage and the individual completes phenotypic transition with the use of sex hormones.

Limited data are available regarding the effects of GnRH analogs on brain development. A single cross-sectional study demonstrated no compromise of executive function (107), but animal data suggest there may be an effect of GnRH analogs on cognitive function (108).

Values and preferences

Our recommendation of GnRH analogs places a higher value on the superior efficacy, safety, and reversibility of the pubertal hormone suppression achieved (as compared with the alternatives) and a relatively lower value on limiting the cost of therapy. Of the available alternatives, depot and oral progestin preparations are effective. Experience with this treatment dates back prior to the emergence of GnRH analogs for treating precocious puberty in papers from the 1960s and early 1970s (109–112). These compounds are usually safe, but some side effects have been reported (113–115). Only two recent studies involved transgender youth (116, 117). One of these studies described the use of oral lynestrenol monotherapy followed by the addition of testosterone treatment in transgender boys who were at Tanner stage B4 or further at the start of treatment (117). They found lynestrenol safe, but gonadotropins were not fully suppressed. The study reported metrorrhagia in approximately half of the individuals, mainly in the first 6 months. Acne, headache, hot flashes, and fatigue were other frequent side effects. Another progestin that has been studied in the United States is medroxyprogesterone. This agent is not as effective as GnRH analogs in lowering endogenous sex hormones either and may be associated with other side effects (116). Progestin preparations may be an acceptable treatment for persons without access to GnRH analogs or with a needle phobia. If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see adult section).

Remarks

Measurements of gonadotropin and sex steroid levels give precise information about gonadal axis suppression, although there is insufficient evidence for any specific short-term monitoring scheme in children treated with GnRH analogs (88). If the gonadal axis is not completely suppressed—as evidenced by (for example) menses, erections, or progressive hair growth—the interval of GnRH analog treatment can be shortened or the dose increased. During treatment, adolescents should be monitored for negative effects of delaying puberty, including a halted growth spurt and impaired bone mineral accretion. Table 7 illustrates a suggested clinical protocol.

Anthropometric measurements and X-rays of the left hand to monitor bone age are informative for evaluating growth. To assess BMD, clinicians can perform dual-energy X-ray absorptiometry scans.

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule (see Table 8) after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years (Table 5). (1 |⊕⊕◯◯)

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕◯◯◯)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment (Table 9). (2 |⊕⊕◯◯)

Table 7. Baseline and Follow-Up Protocol During Suppression of Puberty

Every 3–6 mo
Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo
Laboratory: LH, FSH, E2/T, 25OH vitamin D
Every 1–2 y
Bone density using DXA
Bone age on X-ray of the left hand (if clinically indicated)

Adapted from Hembree *et al.* (118).

Abbreviations: DXA, dual-energy X-ray absorptiometry; E2, estradiol; FSH, follicle stimulating hormone; LH, luteinizing hormone; T, testosterone;

Table 8. Protocol Induction of Puberty

Induction of female puberty with oral 17β-estradiol, increasing the dose every 6 mo:
- 5 μg/kg/d
- 10 μg/kg/d
- 15 μg/kg/d
- 20 μg/kg/d
- Adult dose = 2–6 mg/d
- *In postpubertal transgender female adolescents, the dose of 17β-estradiol can be increased more rapidly:*
  - 1 mg/d for 6 mo
  - 2 mg/d

Induction of female puberty with transdermal 17β-estradiol, increasing the dose every 6 mo (new patch is placed every 3.5 d):
- 6.25–12.5 μg/24 h (cut 25-μg patch into quarters, then halves)
- 25 μg/24 h
- 37.5 μg/24 h
- Adult dose = 50–200 μg/24 h
- *For alternatives once at adult dose, see Table 11.*
- *Adjust maintenance dose to mimic physiological estradiol levels (see Table 15).*

Induction of male puberty with testosterone esters increasing the dose every 6 mo (IM or SC):
- 25 mg/m^2/2 wk (or alternatively, half this dose weekly, or double the dose every 4 wk)
- 50 mg/m^2/2 wk
- 75 mg/m^2/2 wk
- 100 mg/m^2/2 wk
- Adult dose = 100–200 mg every 2 wk
- *In postpubertal transgender male adolescents the dose of testosterone esters can be increased more rapidly:*
  - 75 mg/2 wk for 6 mo
  - 125 mg/2 wk
- *For alternatives once at adult dose, see Table 11.*
- *Adjust maintenance dose to mimic physiological testosterone levels (see Table 14).*

Adapted from Hembree *et al.* (118).

Abbreviations: IM, intramuscularly; SC, subcutaneously.

Evidence

Adolescents develop competence in decision making at their own pace. Ideally, the supervising medical professionals should individually assess this competence, although no objective tools to make such an assessment are currently available.

Many adolescents have achieved a reasonable level of competence by age 15 to 16 years (119), and in many countries 16-year-olds are legally competent with regard to medical decision making (120). However, others believe that although some capacities are generally achieved before age 16 years, other abilities (such as good risk assessment) do not develop until well after 18 years (121). They suggest that health care procedures should be divided along a matrix of relative risk, so that younger adolescents can be allowed to decide about low-risk procedures, such as most diagnostic tests and common therapies, but not about high-risk procedures, such as most surgical procedures (121).

Currently available data from transgender adolescents support treatment with sex hormones starting at age 16 years (63, 122). However, some patients may incur potential risks by waiting until age 16 years. These include the potential risk to bone health if puberty is suppressed

Table 9. Baseline and Follow-up Protocol During Induction of Puberty

Every 3–6 mo
- •Anthropometry: height, weight, sitting height, blood pressure, Tanner stages

Every 6–12 mo
- •In transgender males: hemoglobin/hematocrit, lipids, testosterone, 25OH vitamin D
- •In transgender females: prolactin, estradiol, 25OH vitamin D

Every 1–2 y
- •BMD using DXA
- •Bone age on X-ray of the left hand (if clinically indicated)

BMD should be monitored into adulthood (until the age of 25–30 y or until peak bone mass has been reached).
For recommendations on monitoring once pubertal induction has been completed, see Tables 14 and 15.

Adapted from Hembree *et al.* (118).

Abbreviation: DXA, dual-energy X-ray absorptiometry.

for 6 to 7 years before initiating sex hormones (*e.g.*, if someone reached Tanner stage 2 at age 9-10 years old). Additionally, there may be concerns about inappropriate height and potential harm to mental health (emotional and social isolation) if initiation of secondary sex characteristics must wait until the person has reached 16 years of age. However, only minimal data supporting earlier use of gender-affirming hormones in transgender adolescents currently exist (63). Clearly, long-term studies are needed to determine the optimal age of sex hormone treatment in GD/gender-incongruent adolescents.

The MHP who has followed the adolescent during GnRH analog treatment plays an essential role in assessing whether the adolescent is eligible to start sex hormone therapy and capable of consenting to this treatment (Table 5). Support of the family/environment is essential. Prior to the start of sex hormones, clinicians should discuss the implications for fertility (see recommendation 1.5). Throughout pubertal induction, an MHP and a pediatric endocrinologist (or other clinician competent in the evaluation and induction of pubertal development) should monitor the adolescent. In addition to monitoring therapy, it is also important to pay attention to general adolescent health issues, including healthy life style choices, such as not smoking, contraception, and appropriate vaccinations (*e.g.*, human papillomavirus).

For the induction of puberty, clinicians can use a similar dose scheme for hypogonadal adolescents with GD/gender incongruence as they use in other individuals with hypogonadism, carefully monitoring for desired and undesired effects (Table 8). In transgender female adolescents, transdermal 17β-estradiol may be an alternative for oral 17β-estradiol. It is increasingly used for pubertal induction in hypogonadal females. However, the absence of low-dose estrogen patches may be a problem. As a result, individuals may need to cut patches to size themselves to achieve appropriate dosing (123). In transgender male adolescents, clinicians can give testosterone injections intramuscularly or subcutaneously (124, 125).

When puberty is initiated with a gradually increasing schedule of sex steroid doses, the initial levels will not be high enough to suppress endogenous sex steroid secretion. Gonadotropin secretion and endogenous production of testosterone may resume and interfere with the effectiveness of estrogen treatment, in transgender female adolescents (126, 127). Therefore, continuation of GnRH analog treatment is advised until gonadectomy. Given that GD/gender-incongruent adolescents may opt not to have gonadectomy, long-term studies are necessary to examine the potential risks of prolonged GnRH analog treatment. Alternatively, in transgender male adolescents, GnRH analog treatment can be discontinued once an adult dose of testosterone has been reached and the individual is well virilized. If uterine bleeding occurs, a progestin can be added. However, the combined use of a GnRH analog (for ovarian suppression) and testosterone may enable phenotypic transition with a lower dose of testosterone in comparison with testosterone alone. If there is a wish or need to discontinue GnRH analog treatment in transgender female adolescents, they may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see section 3.0 "Hormonal Therapy for Transgender Adults").

Values and preferences

The recommendation to initiate pubertal induction only when the individual has sufficient mental capacity (roughly age 16 years) to give informed consent for this partly irreversible treatment places a higher value on the ability of the adolescent to fully understand and oversee the partially irreversible consequences of sex hormone treatment and to give informed consent. It places a lower value on the possible negative effects of delayed puberty. We may not currently have the means to weigh adequately the potential benefits of waiting until around age 16 years to initiate sex hormones vs the potential risks/harm to BMD and the sense of social isolation from having the timing of puberty be so out of sync with peers (128).

Remarks

Before starting sex hormone treatment, effects on fertility and options for fertility preservation should be discussed. Adult height may be a concern in transgender adolescents. In a transgender female adolescent, clinicians may consider higher doses of estrogen or a more rapid tempo of dose escalation during pubertal induction. There are no established treatments yet to augment adult height in a transgender male adolescent with open epiphyses during pubertal induction. It is not uncommon for transgender adolescents to present for clinical services after having completed or nearly completed puberty. In such cases, induction of puberty with sex hormones can be done more rapidly (see Table 8). Additionally, an adult dose of testosterone in transgender male adolescents may suffice to suppress the gonadal axis without the need to use a separate agent. At the appropriate time, the multidisciplinary team should adequately prepare the adolescent for transition to adult care.

3.0 Hormonal Therapy for Transgender Adults

The two major goals of hormonal therapy are (1) to reduce endogenous sex hormone levels, and thus reduce

the secondary sex characteristics of the individual's designated gender, and (2) to replace endogenous sex hormone levels consistent with the individual's gender identity by using the principles of hormone replacement treatment of hypogonadal patients. The timing of these two goals and the age at which to begin treatment with the sex hormones of the chosen gender is codetermined in collaboration with both the person pursuing transition and the health care providers. The treatment team should include a medical provider knowledgeable in transgender hormone therapy, an MHP knowledgeable in GD/gender incongruence and the mental health concerns of transition, and a primary care provider able to provide care appropriate for transgender individuals. The physical changes induced by this sex hormone transition are usually accompanied by an improvement in mental well-being (129, 130).

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕◯)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment (Table 10). (1 |⊕⊕⊕◯)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕◯◯)

Evidence

It is the responsibility of the treating clinician to confirm that the person fulfills criteria for treatment. The treating clinician should become familiar with the terms and criteria presented in Tables 1–5 and take a thorough history from the patient in collaboration with the other members of the treatment team. The treating clinician must ensure that the desire for transition is appropriate; the consequences, risks, and benefits of treatment are well understood; and the desire for transition persists. They also need to discuss fertility preservation options (see recommendation 1.3) (67, 68).

Transgender males

Clinical studies have demonstrated the efficacy of several different androgen preparations to induce masculinization in transgender males (Appendix A) (113, 114, 131–134). Regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism (135). Clinicians can use either parenteral or transdermal preparations to achieve testosterone values in the normal male range (this is dependent on the specific assay, but is typically 320 to 1000 ng/dL) (Table 11) (136). Sustained supraphysiologic levels of testosterone increase the risk of adverse reactions (see section 4.0 "Adverse Outcome Prevention and Long-Term Care") and should be avoided.

Similar to androgen therapy in hypogonadal men, testosterone treatment in transgender males results in increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire (137).

Table 10. Medical Risks Associated With Sex Hormone Therapy

Transgender female: estrogen
Very high risk of adverse outcomes:
•Thromboembolic disease
Moderate risk of adverse outcomes:
•Macroprolactinoma
•Breast cancer
•Coronary artery disease
•Cerebrovascular disease
•Cholelithiasis
•Hypertriglyceridemia
Transgender male: testosterone
Very high risk of adverse outcomes:
•Erythrocytosis (hematocrit > 50%)
Moderate risk of adverse outcomes:
•Severe liver dysfunction (transaminases > threefold upper limit of normal)
•Coronary artery disease
•Cerebrovascular disease
•Hypertension
•Breast or uterine cancer

Table 11. Hormone Regimens in Transgender Persons

Transgender females[a]	
Estrogen	
Oral	
Estradiol	2.0–6.0 mg/d
Transdermal	
Estradiol transdermal patch (New patch placed every 3–5 d)	0.025–0.2 mg/d
Parenteral	
Estradiol valerate or cypionate	5–30 mg IM every 2 wk 2–10 mg IM every week
Anti-androgens	
Spironolactone	100–300 mg/d
Cyproterone acetate[b]	25–50 mg/d
GnRH agonist	3.75 mg SQ (SC) monthly 11.25 mg SQ (SC) 3-monthly
Transgender males	
Testosterone	
Parenteral testosterone	
Testosterone enanthate or cypionate	100–200 mg SQ (IM) every 2 wk or SQ (SC) 50% per week
Testosterone undecanoate[c]	1000 mg every 12 wk
Transdermal testosterone	
Testosterone gel 1.6%[d]	50–100 mg/d
Testosterone transdermal patch	2.5–7.5 mg/d

Abbreviations: IM, intramuscularly; SQ, sequentially; SC, subcutaneously.

[a]Estrogens used with or without antiandrogens or GnRH agonist.

[b]Not available in the United States.

[c]One thousand milligrams initially followed by an injection at 6 wk then at 12-wk intervals.

[d]Avoid cutaneous transfer to other individuals.

In transgender males, testosterone will result in clitoromegaly, temporary or permanent decreased fertility, deepening of the voice, cessation of menses (usually), and a significant increase in body hair, particularly on the face, chest, and abdomen. Cessation of menses may occur within a few months with testosterone treatment alone, although high doses of testosterone may be required. If uterine bleeding continues, clinicians may consider the addition of a progestational agent or endometrial ablation (138). Clinicians may also administer GnRH analogs or depot medroxyprogesterone to stop menses prior to testosterone treatment.

Transgender females

The hormone regimen for transgender females is more complex than the transgender male regimen (Appendix B). Treatment with physiologic doses of estrogen alone is insufficient to suppress testosterone levels into the normal range for females (139). Most published clinical studies report the need for adjunctive therapy to achieve testosterone levels in the female range (21, 113, 114, 132–134, 139, 140).

Multiple adjunctive medications are available, such as progestins with antiandrogen activity and GnRH agonists (141). Spironolactone works by directly blocking androgens during their interaction with the androgen receptor (114, 133, 142). It may also have estrogenic activity (143). Cyproterone acetate, a progestational compound with antiandrogenic properties (113, 132, 144), is widely used in Europe. 5α-Reductase inhibitors do not reduce testosterone levels and have adverse effects (145).

Dittrich *et al.* (141) reported that monthly doses of the GnRH agonist goserelin acetate in combination with estrogen were effective in reducing testosterone levels with a low incidence of adverse reactions in 60 transgender females. Leuprolide and transdermal estrogen were as effective as cyproterone and transdermal estrogen in a comparative retrospective study (146).

Patients can take estrogen as oral conjugated estrogens, oral 17β-estradiol, or transdermal 17β-estradiol. Among estrogen options, the increased risk of thromboembolic events associated with estrogens in general seems most concerning with ethinyl estradiol specifically (134, 140, 141), which is why we specifically suggest that it not be used in any transgender treatment plan. Data distinguishing among other estrogen options are less well established although there is some thought that oral routes of administration are more thrombogenic due to the "first pass effect" than are transdermal and parenteral routes, and that the risk of thromboembolic events is dose-dependent. Injectable estrogen and sublingual

estrogen may benefit from avoiding the first pass effect, but they can result in more rapid peaks with greater overall periodicity and thus are more difficult to monitor (147, 148). However, there are no data demonstrating that increased periodicity is harmful otherwise.

Clinicians can use serum estradiol levels to monitor oral, transdermal, and intramuscular estradiol. Blood tests cannot monitor conjugated estrogens or synthetic estrogen use. Clinicians should measure serum estradiol and serum testosterone and maintain them at the level for premenopausal females (100 to 200 pg/mL and <50 ng/dL, respectively). The transdermal preparations and injectable estradiol cypionate or valerate preparations may confer an advantage in older transgender females who may be at higher risk for thromboembolic disease (149).

Values

Our recommendation to maintain levels of gender-affirming hormones in the normal adult range places a high value on the avoidance of the long-term complications of pharmacologic doses. Those patients receiving endocrine treatment who have relative contraindications to hormones should have an in-depth discussion with their physician to balance the risks and benefits of therapy.

Remarks

Clinicians should inform all endocrine-treated individuals of all risks and benefits of gender-affirming hormones prior to initiating therapy. Clinicians should strongly encourage tobacco use cessation in transgender females to avoid increased risk of VTE and cardiovascular complications. We strongly discourage the unsupervised use of hormone therapy (150).

Not all individuals with GD/gender incongruence seek treatment as described (*e.g.*, male-to-eunuchs and individuals seeking partial transition). Tailoring current protocols to the individual may be done within the context of accepted safety guidelines using a multidisciplinary approach including mental health. No evidence-based protocols are available for these groups (151). We need prospective studies to better understand treatment options for these persons.

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕○○○)

Evidence

Transgender males

Physical changes that are expected to occur during the first 1 to 6 months of testosterone therapy include cessation of menses, increased sexual desire, increased facial and body hair, increased oiliness of skin, increased muscle, and redistribution of fat mass. Changes that occur within the first year of testosterone therapy include deepening of the voice (152, 153), clitoromegaly, and male pattern hair loss (in some cases) (114, 144, 154, 155) (Table 12).

Transgender females

Physical changes that may occur in transgender females in the first 3 to 12 months of estrogen and antiandrogen therapy include decreased sexual desire, decreased spontaneous erections, decreased facial and body hair (usually mild), decreased oiliness of skin, increased breast tissue growth, and redistribution of fat mass (114, 139, 149, 154, 155, 161) (Table 13). Breast development is generally maximal at 2 years after initiating hormones (114, 139, 149, 155). Over a long period of time, the prostate gland and testicles will undergo atrophy.

Although the time course of breast development in transgender females has been studied (150), precise information about other changes induced by sex hormones is lacking (141). There is a great deal of variability among individuals, as evidenced during pubertal development. We all know that a major concern for transgender females is breast development. If we work with estrogens, the result will be often not what the transgender female expects.

Alternatively, there are transgender females who report an anecdotal improved breast development, mood, or sexual desire with the use of progestogens. However, there have been no well-designed studies of the role of progestogens in feminizing hormone regimens, so the question is still open.

Our knowledge concerning the natural history and effects of different cross-sex hormone therapies on breast

Table 12. Masculinizing Effects in Transgender Males

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	—[a]
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	—[b]
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157), Wierckx *et al.* (158).

[a] Prevention and treatment as recommended for biological men.

[b] Menorrhagia requires diagnosis and treatment by a gynecologist.

Table 13. Feminizing Effects in Transgender Females

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y[a]
Scalp hair	Variable	—[b]
Voice changes	None	—[c]

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157).

[a]Complete removal of male sexual hair requires electrolysis or laser treatment or both.

[b]Familial scalp hair loss may occur if estrogens are stopped.

[c]Treatment by speech pathologists for voice training is most effective.

development in transgender females is extremely sparse and based on the low quality of evidence. Current evidence does not indicate that progestogens enhance breast development in transgender females, nor does evidence prove the absence of such an effect. This prevents us from drawing any firm conclusion at this moment and demonstrates the need for further research to clarify these important clinical questions (162).

Values and preferences

Transgender persons have very high expectations regarding the physical changes of hormone treatment and are aware that body changes can be enhanced by surgical procedures (*e.g.*, breast, face, and body habitus). Clear expectations for the extent and timing of sex hormone–induced changes may prevent the potential harm and expense of unnecessary procedures.

4.0 Adverse Outcome Prevention and Long-Term Care

Hormone therapy for transgender males and females confers many of the same risks associated with sex hormone replacement therapy in nontransgender persons. The risks arise from and are worsened by inadvertent or intentional use of supraphysiologic doses of sex hormones, as well as use of inadequate doses of sex hormones to maintain normal physiology (131, 139).

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕○○)

Evidence

Pretreatment screening and appropriate regular medical monitoring are recommended for both transgender males and females during the endocrine transition and periodically thereafter (26, 155). Clinicians should monitor weight and blood pressure, conduct physical exams, and assess routine health questions, such as tobacco use, symptoms of depression, and risk of adverse events such as deep vein thrombosis/pulmonary embolism and other adverse effects of sex steroids.

Transgender males

Table 14 contains a standard monitoring plan for transgender males on testosterone therapy (154, 159). Key issues include maintaining testosterone levels in the physiologic normal male range and avoiding adverse events resulting from excess testosterone therapy, particularly erythrocytosis, sleep apnea, hypertension, excessive weight gain, salt retention, lipid changes, and excessive or cystic acne (135).

Because oral 17-alkylated testosterone is not recommended, serious hepatic toxicity is not anticipated with parenteral or transdermal testosterone use (163, 164). Past concerns regarding liver toxicity with testosterone have been alleviated with subsequent reports that indicate the risk of serious liver disease is minimal (144, 165, 166).

Transgender females

Table 15 contains a standard monitoring plan for transgender females on estrogens, gonadotropin suppression, or antiandrogens (160). Key issues include avoiding supraphysiologic doses or blood levels of estrogen that may lead to increased risk for thromboembolic disease, liver dysfunction, and hypertension. Clinicians should monitor serum estradiol levels using laboratories participating in external quality control, as measurements of estradiol in blood can be very challenging (167).

VTE may be a serious complication. A study reported a 20-fold increase in venous thromboembolic disease in a large cohort of Dutch transgender subjects (161). This increase may have been associated with the use of the synthetic estrogen, ethinyl estradiol (149). The incidence decreased when clinicians stopped administering ethinyl estradiol (161). Thus, the use of synthetic estrogens and conjugated estrogens is undesirable because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease. In a German gender clinic, deep vein thrombosis occurred in 1 of 60 of transgender females treated with a GnRH analog and oral

Table 14. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Male

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 3 mo until levels are in the normal physiologic male range:[a]
   a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. The target level is 400–700 ng/dL to 400 ng/dL. Alternatively, measure peak and trough levels to ensure levels remain in the normal male range.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. If the level is <400 ng/dL, adjust dosing interval.
   c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 wk of daily application (at least 2 h after application).
3. Measure hematocrit or hemoglobin at baseline and every 3 mo for the first year and then one to two times a year. Monitor weight, blood pressure, and lipids at regular intervals.
4. Screening for osteoporosis should be conducted in those who stop testosterone treatment, are not compliant with hormone therapy, or who develop risks for bone loss.
5. If cervical tissue is present, monitoring as recommended by the American College of Obstetricians and Gynecologists.
6. Ovariectomy can be considered after completion of hormone transition.
7. Conduct sub- and periareolar annual breast examinations if mastectomy performed. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

[a]Adapted from Lapauw *et al.* (154) and Ott *et al.* (159).

estradiol (141). The patient who developed a deep vein thrombosis was found to have a homozygous C677 T mutation in the methylenetetrahydrofolate reductase gene. In an Austrian gender clinic, administering gender-affirming hormones to 162 transgender females and 89 transgender males was not associated with VTE, despite an 8.0% and 5.6% incidence of thrombophilia (159). A more recent multinational study reported only 10 cases of VTE from a cohort of 1073 subjects (168). Thrombophilia screening of transgender persons initiating hormone treatment should be restricted to those with a personal or family history of VTE (159). Monitoring D-dimer levels during treatment is not recommended (169).

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 l⊕⊕○○)

Evidence

Estrogen therapy can increase the growth of pituitary lactrotroph cells. There have been several reports of prolactinomas occurring after long-term, high-dose estrogen therapy (170–173). Up to 20% of transgender females treated with estrogens may have elevations in prolactin levels associated with enlargement of the pituitary gland (156). In most cases, the serum prolactin levels will return to the normal range with a reduction or discontinuation of the estrogen therapy or discontinuation of cyproterone acetate (157, 174, 175).

The onset and time course of hyperprolactinemia during estrogen treatment are not known. Clinicians should measure prolactin levels at baseline and then at least annually during the transition period and every 2 years thereafter. Given that only a few case studies reported prolactinomas, and prolactinomas were not reported in large cohorts of estrogen-treated persons, the risk is likely to be very low. Because the major presenting findings of microprolactinomas (hypogonadism and sometimes gynecomastia) are not apparent in transgender females, clinicians may perform radiologic examinations of the pituitary in those patients whose prolactin levels persistently increase despite stable or reduced estrogen levels. Some transgender individuals receive psychotropic medications that can increase prolactin levels (174).

Table 15. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Female

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 mo.
   a. Serum testosterone levels should be <50 ng/dL.
   b. Serum estradiol should not exceed the peak physiologic range: 100–200 pg/mL.
3. For individuals on spironolactone, serum electrolytes, particularly potassium, should be monitored every 3 mo in the first year and annually thereafter.
4. Routine cancer screening is recommended, as in nontransgender individuals (all tissues present).
5. Consider BMD testing at baseline (160). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not compliant with hormone therapy.

This table presents strong recommendations and does not include lower level recommendations.

4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕○○)

Evidence

Transgender males

Administering testosterone to transgender males results in a more atherogenic lipid profile with lowered high-density lipoprotein cholesterol and higher triglyceride and low-density lipoprotein cholesterol values (176–179). Studies of the effect of testosterone on insulin sensitivity have mixed results (178, 180). A randomized, open-label uncontrolled safety study of transgender males treated with testosterone undecanoate demonstrated no insulin resistance after 1 year (181, 182). Numerous studies have demonstrated the effects of sex hormone treatment on the cardiovascular system (160, 179, 183, 184). Long-term studies from The Netherlands found no increased risk for cardiovascular mortality (161). Likewise, a meta-analysis of 19 randomized trials in nontransgender males on testosterone replacement showed no increased incidence of cardiovascular events (185). A systematic review of the literature found that data were insufficient (due to very low–quality evidence) to allow a meaningful assessment of patient-important outcomes, such as death, stroke, myocardial infarction, or VTE in transgender males (176). Future research is needed to ascertain the potential harm of hormonal therapies (176). Clinicians should manage cardiovascular risk factors as they emerge according to established guidelines (186).

Transgender females

A prospective study of transgender females found favorable changes in lipid parameters with increased high-density lipoprotein and decreased low-density lipoprotein concentrations (178). However, increased weight, blood pressure, and markers of insulin resistance attenuated these favorable lipid changes. In a meta-analysis, only serum triglycerides were higher at ≥24 months without changes in other parameters (187). The largest cohort of transgender females (mean age 41 years, followed for a mean of 10 years) showed no increase in cardiovascular mortality despite a 32% rate of tobacco use (161).

Thus, there is limited evidence to determine whether estrogen is protective or detrimental on lipid and glucose metabolism in transgender females (176). With aging, there is usually an increase of body weight. Therefore, as with nontransgender individuals, clinicians should monitor and manage glucose and lipid metabolism and blood pressure regularly according to established guidelines (186).

4.4. We recommend that clinicians obtain BMD measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕○○)

Evidence

Transgender males

Baseline bone mineral measurements in transgender males are generally in the expected range for their pretreatment gender (188). However, adequate dosing of testosterone is important to maintain bone mass in transgender males (189, 190). In one study (190), serum LH levels were inversely related to BMD, suggesting that low levels of sex hormones were associated with bone loss. Thus, LH levels in the normal range may serve as an indicator of the adequacy of sex steroid administration to preserve bone mass. The protective effect of testosterone may be mediated by peripheral conversion to estradiol, both systemically and locally in the bone.

Transgender females

A baseline study of BMD reported T scores less than −2.5 in 16% of transgender females (191). In aging males, studies suggest that serum estradiol more positively correlates with BMD than does testosterone (192, 193) and is more important for peak bone mass (194). Estrogen preserves BMD in transgender females who continue on estrogen and antiandrogen therapies (188, 190, 191, 195, 196).

Fracture data in transgender males and females are not available. Transgender persons who have undergone gonadectomy may choose not to continue consistent sex steroid treatment after hormonal and surgical sex reassignment, thereby becoming at risk for bone loss. There have been no studies to determine whether clinicians should use the sex assigned at birth or affirmed gender for assessing osteoporosis (*e.g.*, when using the FRAX tool). Although some researchers use the sex assigned at birth (with the assumption that bone mass has usually peaked for transgender people who initiate hormones in early adulthood), this should be assessed on a case-by-case basis until there are more data available. This assumption will be further complicated by the increasing prevalence of transgender people who undergo hormonal transition at a pubertal age or soon after puberty. Sex for comparison within risk assessment tools may be based on the age at which hormones were initiated and the length of exposure to hormones. In some cases, it may be

reasonable to assess risk using both the male and female calculators and using an intermediate value. Because all subjects underwent normal pubertal development, with known effects on bone size, reference values for birth sex were used for all participants (154).

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for those designated female at birth. (2 |⊕⊕◯◯)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕◯◯◯)

Evidence

Studies have reported a few cases of breast cancer in transgender females (197–200). A Dutch study of 1800 transgender females followed for a mean of 15 years (range of 1 30 years) found one case of breast cancer. The Women's Health Initiative study reported that females taking conjugated equine estrogen without progesterone for 7 years did not have an increased risk of breast cancer as compared with females taking placebo (137).

In transgender males, a large retrospective study conducted at the U.S. Veterans Affairs medical health system identified seven breast cancers (194). The authors reported that this was not above the expected rate of breast cancers in cisgender females in this cohort. Furthermore, they did report one breast cancer that developed in a transgender male patient after mastectomy, supporting the fact that breast cancer can occur even after mastectomy. Indeed, there have been case reports of breast cancer developing in subareolar tissue in transgender males, which occurred after mastectomy (201, 202).

Women with primary hypogonadism (Turner syndrome) treated with estrogen replacement exhibited a significantly decreased incidence of breast cancer as compared with national standardized incidence ratios (203, 204). These studies suggest that estrogen therapy does not increase the risk of breast cancer in the short term (<20 to 30 years). We need long-term studies to determine the actual risk, as well as the role of screening mammograms. Regular examinations and gynecologic advice should determine monitoring for breast cancer.

Prostate cancer is very rare before the age of 40, especially with androgen deprivation therapy (205). Childhood or pubertal castration results in regression of the prostate and adult castration reverses benign prostate hypertrophy (206). Although van Kesteren *et al.* (207) reported that estrogen therapy does not induce hypertrophy or premalignant changes in the prostates of transgender females, studies have reported cases of benign prostatic hyperplasia in transgender females treated with estrogens for 20 to 25 years (208, 209). Studies have also reported a few cases of prostate carcinoma in transgender females (210–214).

Transgender females may feel uncomfortable scheduling regular prostate examinations. Gynecologists are not trained to screen for prostate cancer or to monitor prostate growth. Thus, it may be reasonable for transgender females who transitioned after age 20 years to have annual screening digital rectal examinations after age 50 years and prostate-specific antigen tests consistent with U.S. Preventive Services Task Force Guidelines (215).

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

Evidence

Although aromatization of testosterone to estradiol in transgender males has been suggested as a risk factor for endometrial cancer (216), no cases have been reported. When transgender males undergo hysterectomy, the uterus is small and there is endometrial atrophy (217, 218). Studies have reported cases of ovarian cancer (219, 220). Although there is limited evidence for increased risk of reproductive tract cancers in transgender males, health care providers should determine the medical necessity of a laparoscopic total hysterectomy as part of a gender-affirming surgery to prevent reproductive tract cancer (221).

Values

Given the discomfort that transgender males experience accessing gynecologic care, our recommendation for the medical necessity of total hysterectomy and oophorectomy places a high value on eliminating the risks of female reproductive tract disease and cancer and a lower value on avoiding the risks of these surgical procedures (related to the surgery and to the potential undesirable health consequences of oophorectomy) and their associated costs.

Remarks

The sexual orientation and type of sexual practices will determine the need and types of gynecologic care required following transition. Additionally, in certain countries, the approval required to change the sex in a birth certificate for transgender males may be dependent on having a complete hysterectomy. Clinicians should help patients research nonmedical administrative criteria and

provide counseling. If individuals decide not to undergo hysterectomy, screening for cervical cancer is the same as all other females.

5.0 Surgery for Sex Reassignment and Gender Confirmation

For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role. The type of surgery falls into two main categories: (1) those that directly affect fertility and (2) those that do not. Those that change fertility (previously called sex reassignment surgery) include genital surgery to remove the penis and gonads in the male and removal of the uterus and gonads in the female. The surgeries that effect fertility are often governed by the legal system of the state or country in which they are performed. Other gender-conforming surgeries that do not directly affect fertility are not so tightly governed.

Gender-affirming surgical techniques have improved markedly during the past 10 years. Reconstructive genital surgery that preserves neurologic sensation is now the standard. The satisfaction rate with surgical reassignment of sex is now very high (187). Additionally, the mental health of the individual seems to be improved by participating in a treatment program that defines a pathway of gender-affirming treatment that includes hormones and surgery (130, 144) (Table 16).

Surgery that affects fertility is irreversible. The World Professional Association for Transgender Health Standards of Care (222) emphasizes that the "threshold of 18 should not be seen as an indication in itself for active intervention." If the social transition has not been satisfactory, if the person is not satisfied with or is ambivalent about the effects of sex hormone treatment, or if the person is ambivalent about surgery then the individual should not be referred for surgery (223, 224).

Gender-affirming genital surgeries for transgender females that affect fertility include gonadectomy, penectomy, and creation of a neovagina (225, 226). Surgeons often invert the skin of the penis to form the wall of the vagina, and several literatures reviews have reported on outcomes (227). Sometimes there is inadequate tissue to form a full neovagina, so clinicians have revisited using intestine and found it to be successful (87, 228, 229). Some newer vaginoplasty techniques may involve autologuous oral epithelial cells (230, 231).

The scrotum becomes the labia majora. Surgeons use reconstructive surgery to fashion the clitoris and its hood, preserving the neurovascular bundle at the tip of the penis as the neurosensory supply to the clitoris. Some surgeons are also creating a sensate pedicled-spot adding a G spot to the neovagina to increase sensation (232). Most recently, plastic surgeons have developed techniques to fashion labia minora. To further complete the feminization, uterine transplants have been proposed and even attempted (233).

Neovaginal prolapse, rectovaginal fistula, delayed healing, vaginal stenosis, and other complications do sometimes occur (234, 235). Clinicians should strongly remind the transgender person to use their dilators to maintain the depth and width of the vagina throughout the postoperative period. Genital sexual responsivity and other aspects of sexual function are usually preserved following genital gender-affirming surgery (236, 237).

Ancillary surgeries for more feminine or masculine appearance are not within the scope of this guideline. Voice therapy by a speech language pathologist is available to transform speech patterns to the affirmed gender (148). Spontaneous voice deepening occurs during testosterone treatment of transgender males (152, 238). No studies have compared the effectiveness of speech therapy, laryngeal surgery, or combined treatment.

Breast surgery is a good example of gender-confirming surgery that does not affect fertility. In all females, breast size exhibits a very broad spectrum. For transgender females to make the best informed decision, clinicians should delay breast augmentation surgery until the patient has completed at least 2 years of estrogen therapy, because the breasts continue to grow during that time (141, 155).

Another major procedure is the removal of facial and masculine-appearing body hair using either electrolysis or

Table 16. Criteria for Gender-Affirming Surgery, Which Affects Fertility

1. Persistent, well-documented gender dysphoria
2. Legal age of majority in the given country
3. Having continuously and responsibly used gender-affirming hormones for 12 mo (if there is no medical contraindication to receiving such therapy)
4. Successful continuous full-time living in the new gender role for 12 mo
5. If significant medical or mental health concerns are present, they must be well controlled
6. Demonstrable knowledge of all practical aspects of surgery (*e.g.*, cost, required lengths of hospitalizations, likely complications, postsurgical rehabilitation)

laser treatments. Other feminizing surgeries, such as that to feminize the face, are now becoming more popular (239–241).

In transgender males, clinicians usually delay gender-affirming genital surgeries until after a few years of androgen therapy. Those surgeries that affect fertility in this group include oophorectomy, vaginectomy, and complete hysterectomy. Surgeons can safely perform them vaginally with laparoscopy. These are sometimes done in conjunction with the creation of a neopenis. The cosmetic appearance of a neopenis is now very good, but the surgery is multistage and very expensive (242, 243). Radial forearm flap seems to be the most satisfactory procedure (228, 244). Other flaps also exist (245). Surgeons can make neopenile erections possible by reinervation of the flap and subsequent contraction of the muscle, leading to stiffening of the neopenis (246, 247), but results are inconsistent (248). Surgeons can also stiffen the penis by imbedding some mechanical device (*e.g.*, a rod or some inflatable apparatus) (249, 250). Because of these limitations, the creation of a neopenis has often been less than satisfactory. Recently, penis transplants are being proposed (233).

In fact, most transgender males do not have any external genital surgery because of the lack of access, high cost, and significant potential complications. Some choose a metaoidioplasty that brings forward the clitoris, thereby allowing them to void in a standing position without wetting themselves (251, 252). Surgeons can create the scrotum from the labia majora with good cosmetic effect and can implant testicular prostheses (253).

The most important masculinizing surgery for the transgender male is mastectomy, and it does not affect fertility. Breast size only partially regresses with androgen therapy (155). In adults, discussions about mastectomy usually take place after androgen therapy has started. Because some transgender male adolescents present after significant breast development has occurred, they may also consider mastectomy 2 years after they begin androgen therapy and before age 18 years. Clinicians should individualize treatment based on the physical and mental health status of the individual. There are now newer approaches to mastectomy with better outcomes (254, 255). These often involve chest contouring (256). Mastectomy is often necessary for living comfortably in the new gender (256).

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕◯◯)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕◯◯◯)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕◯◯).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕◯◯◯)

Evidence

Owing to the lack of controlled studies, incomplete follow-up, and lack of valid assessment measures, evaluating various surgical approaches and techniques is difficult. However, one systematic review including a large numbers of studies reported satisfactory cosmetic and functional results for vaginoplasty/neovagina construction (257). For transgender males, the outcomes are less certain. However, the problems are now better understood (258). Several postoperative studies report significant long-term psychological and psychiatric pathology (259–261). One study showed satisfaction with breasts, genitals, and femininity increased significantly and showed the importance of surgical treatment as a key therapeutic option for transgender females (262). Another analysis demonstrated that, despite the young average age at death following surgery and the relatively larger number of individuals with somatic morbidity, the study does not allow for determination of

causal relationships between, for example, specific types of hormonal or surgical treatment received and somatic morbidity and mortality (263). Reversal surgery in regretful male-to-female transsexuals after sexual reassignment surgery represents a complex, multistage procedure with satisfactory outcomes. Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for sexual reassignment surgery. We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment.

When a transgender individual decides to have gender-affirming surgery, both the hormone prescribing clinician and the MHP must certify that the patient satisfies criteria for gender-affirming surgery (Table 16).

There is some concern that estrogen therapy may cause an increased risk for venous thrombosis during or following surgery (176). For this reason, the surgeon and the hormone-prescribing clinician should collaborate in making a decision about the use of hormones before and following surgery. One study suggests that preoperative factors (such as compliance) are less important for patient satisfaction than are the physical postoperative results (56). However, other studies and clinical experience dictate that individuals who do not follow medical instructions and do not work with their physicians toward a common goal do not achieve treatment goals (264) and experience higher rates of postoperative infections and other complications (265, 266). It is also important that the person requesting surgery feels comfortable with the anatomical changes that have occurred during hormone therapy. Dissatisfaction with social and physical outcomes during the hormone transition may be a contraindication to surgery (223).

An endocrinologist or experienced medical provider should monitor transgender individuals after surgery. Those who undergo gonadectomy will require hormone replacement therapy, surveillance, or both to prevent adverse effects of chronic hormone deficiency.

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2. Respondent Children's Medical Center of Dallas' Objections to Ximena Lopez, M.D.'s Verified Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202

CAUSE NO. CC-22-01316-B

IN RE XIMENA LOPEZ, M.D., *Petitioner*,	§	IN THE COUNTY COURT AT LAW
	§	No. 2
	§	DALLAS COUNTY, TEXAS

RESPONDENT CHILDREN'S MEDICAL CENTER OF DALLAS'S OBJECTIONS TO XIMENA LOPEZ, M.D.'S VERIFIED PETITION TO TAKE DEPOSITION BEFORE SUIT PURSUANT TO TEXAS RULE OF CIVIL PROCEDURE 202 AND MOTION FOR PROTECTIVE ORDER

TO THE HONORABLE JUDGE OF SAID COURT:

Respondent Children's Medical Center of Dallas[1] ("CMCD") files the following Objections and Motion for Protective Order from Petitioner Ximena Lopez, M.D.'s ("Dr. Lopez's") Verified Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202 ("Petition"), and would respectfully show the Court the following:

INTRODUCTION

Dr. Lopez's Petition improperly seeks expansive pre-suit discovery that implicates documents and communications authored by or otherwise owned by CMCD. Dr. Lopez has failed to establish the evidentiary basis for her requested discovery, and her document requests are improper, overly broad, seek irrelevant information, and are otherwise objectionable. As more fully explained herein, CMCD respectfully requests that the Court deny Dr. Lopez's request for pre-suit discovery. Alternatively, to the extent the requested depositions are ordered to proceed, CMCD requests that the Court grant CMCD protection from Dr. Lopez's improper document requests.

[1] Incorrectly named as "Children's Medical Center Dallas."

BACKGROUND

Dr. Lopez is a pediatric endocrinologist who treats patients at The University of Texas Southwestern Medical Center ("UTSW") and CMCD. *See* Pet. at 2.[2] Dr. Lopez helped create the Gender Education and Care, Interdisciplinary Support ("Genecis") clinic[3], which provided gender-affirming care to gender-diverse and transgender adolescents. *Id.* at 3. Dr. Lopez alleges UTSW recently shut down the clinic. *Id.* at 10.

Dr. Lopez asserts she has been told by UTSW administration that she cannot provide any new patients with puberty suppressing medication or hormone therapy. *Id.* Dr. Lopez asserts "[s]he has been told she can provide the medication to patients already receiving such medications, but she is to deny any new requests, even if [she] believes that such medication is medically-indicated and would be beneficial to the patient." *Id.* Dr. Lopez contends her "independent medical judgment and discretion in providing and supervising care to patients" is being "interfered with or controlled" in violation of 22 Texas Administrative Code Section 177.5 and "various other statutory prohibitions against the corporate practice of medicine." *Id.* at 10-11. Dr. Lopez alleges that such imposed limitations are themselves illegal. *Id.* at 11.

Dr. Lopez alleges that "[s]omeone, some entity, or some office is illegally attempting to interfere with or control Dr. Lopez's independent medical judgment" and is "attempting to force Dr. Lopez to engage in illegal discriminatory conduct." *Id.* She asserts that "[w]homever that person is, or whatever entity or office is behind this illegal conduct, their actions can only be *ultra vires*." *Id.* Dr. Lopez contends that, because there is likely *ultra vires* conduct, she "has the legal right to file a lawsuit and seek prospective relief, including injunctive relief to enjoin the limitations

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[2] CMCD cites to Dr. Lopez's Petition solely for the purpose of setting forth the facts as alleged by Dr. Lopez in this Rule 202 proceeding. CMCD does not admit or concede the accuracy of Dr. Lopez's allegations or characterizations.

[3] Genecis served as a coordinating brand for the pediatric transgender services of CMCD and UTSW, however, it was never a standalone clinic.

imposed on her independent medical judgment or being stopped from providing medically appropriate treatment to her patients, as well as relief under the Texas Declaratory Judgment Act to define Dr. Lopez's rights and the legality of the discriminatory limitations." *Id.*

Dr. Lopez avers that she does not know whom or what to file suit against or whom to enjoin. *Id.* at 12. Accordingly, Dr. Lopez seeks to depose Dr. Podolsky and Dr. Warner, respectively, regarding the following topics:

> 1. what person, entity, or office is seeking to impose limitations on Dr. Lopez's independent medical judgment to provide puberty-suppressing medications and hormone therapy to new patients;
>
> 2. whether and which governmental official or government office communicated with UTSW and demanded such limitations be enforced by UTSW or Children's;
>
> 3. the medical, ethical, and legal basis for such a limitation;
>
> 4. why the limitation is not discriminatory; and
>
> 5. upon what legal authority the limitation is being imposed.

Id. at 16-17.

Dr. Lopez also requests that the Court order the issuance of a subpoena requiring Dr. Podolsky, Dr. Warner, and UTSW to produce any and all documents related to various categories at least three days before the first deposition. *Id.* at 17. Among other categories, Dr. Lopez seeks "any and all documents or correspondence, including emails or texts, between any employee of UTSW relating to the discontinuation of the GENECIS clinic, Dr. Lopez, or restrictions on gender-affirming care[,]" ("Document Request Number 3") and "any and all documents reflecting any medical controversy regarding the provision of puberty suppression medications and/or hormone therapy to treat gender dysphoria[.]" *Id.* ("Document Request Number 6"). Dr. Lopez has

identified CMCD, UTSW, Dr. Podolsky, and Dr. Warner as potentially adverse parties in this proceeding. *Id.* at 12-13.

The depositions sought by Dr. Lopez and her document requests seek information and documents that implicate CMCD's property and proprietary interests by virtue of CMCD's collaboration with UTSW regarding the operation of Genecis program. Therefore, CMCD objects to Dr. Lopez's discovery requests and moves for protection from the Court.

STANDARD OF REVIEW

Texas Rule of Civil Procedure 202 authorizes a person to petition a Court for an order authorizing a deposition in two limited circumstances—(1) "to perpetuate or obtain the person's own testimony or that of any other person for use in an anticipated suit"; or (2) "to investigate a potential claim or suit." TEX. R. CIV. P. 202.1. To obtain such a deposition under Rule 202, Dr. Lopez bears the burden to prove that: (1) allowing Dr. Lopez to take the requested depositions may prevent a failure or delay of justice in an anticipated suit, or (2) the likely benefit of allowing Dr. Lopez to take the requested depositions to investigate a potential claim outweighs the burden or expense of the procedure. TEX. R. CIV. P. 202.4(a).

The Texas Supreme Court has made clear that pre-suit discovery under Rule 202 "[is] not now and never ha[s] been intended for routine use." *In re Jorden*, 249 S.W.3d 416, 423 (Tex. 2008). "Rule 202 is not a license for forced interrogations," and "[c]ourts must strictly limit and carefully supervise pre-suit discovery to prevent abuse of the rule." *In re Wolfe,* 341 S.W.3d 932, 933 (Tex. 2011). Moreover, "[t]o prevent an end-run around discovery limitations that would govern the anticipated suit," the Texas Supreme Court has restricted pre-suit discovery under Rule 202 to be "'the same as if the anticipated suit or potential claim had been filed.'" *Id.* (quoting TEX. R. CIV. P. 202.5). In other words, if the pre-suit discovery sought under Rule 202 would not be permitted in the anticipated lawsuit, then the discovery should be denied. *Id.*

ARGUMENT AND AUTHORITIES

I. Dr. Lopez Fails to Establish the Evidentiary Basis for Her Requested Discovery.

Dr. Lopez's Petition fails to satisfy Rule 202's required evidentiary requirements. As noted above, Dr. Lopez has the burden to show that allowing her to take the requested depositions either (i) would prevent a failure or delay of justice in an anticipated suit, or (ii) that the likely benefit of the deposition outweighs the burden or expense of the procedure. *See, e.g.*, *In re Jorden,* 249 S.W.3d at 423; *DeAngelis v. Protective Parents Coal.*, 556 S.W.3d 836, 854 (Tex. App.—Fort Worth 2018, no pet.); *In re East*, 476 S.W.3d 61, 68 (Tex. App.—Corpus Christi 2014, no pet.). Dr. Lopez must present competent evidence to meet her burden. *See In re City of Dallas,* No. 05-18-00289-CV, 2018 WL 5306925, at *4 (Tex. App.—Dallas, Oct. 26, 2018, no pet.) ("It is an abuse of discretion for a trial court to order a rule 202 deposition when the party seeking the deposition fails to provide any evidence to meet the burden of establishing the facts necessary to support ordering a rule 202 deposition."); *In re East*, 476 S.W.3d at 68. Importantly, for the Rule 202 inquiry, ***verified pleadings and arguments of counsel are not considered competent evidence***. *See In re Noriega*, No. 05-14-00307-CV, 2014 WL 1415109, at *2 (Tex. App.—Dall. Mar. 28, 2014, orig. proceeding); *In re East*, 476 S.W.3d at 68 (collecting cases). The evidentiary finding cannot be implied from support in the record. *In re Does*, 337 S.W.3d 862, 865 (Tex. 2011).

Here, Dr. Lopez completely fails to provide any competent evidence—*i.e.*, evidence beyond her own verified pleading—that allowing the discovery she seeks would prevent a failure or delay of justice, or that the likely benefit of the discovery outweighs the burden or expense of the procedure. Dr. Lopez's request is nothing more than a fishing expedition that cannot validly serve as the basis for pre-suit discovery. Accordingly, because Dr. Lopez has failed to provide

legally sufficient justification for the requested pre-suit discovery, Dr. Lopez's Petition should be denied.

II. Dr. Lopez's Document Requests Are Improper, Overly Broad, Seek Irrelevant Information, and Are Otherwise Objectionable.

Even if Dr. Lopez could satisfy the strict requirements of Rule 202—which she cannot—Dr. Lopez's document requests are improper, overly broad, seek irrelevant information, and are otherwise objectionable. Because Dr. Lopez's overly broad requests would necessarily implicate documents created by CMCD or communications to or from CMCD employees, CMCD moves for protection to protect its confidentiality and proprietary interests.

A. Dr. Lopez's Document Requests Are Improper to the Extent They Seek Privileged Information.

Texas Rules of Civil Procedure state that a "person from whom discovery is sought, and any other person affected by the discovery request, may move within the time permitted for response to the discovery request for an order protecting that person from the discovery sought." TEX. R. CIV. P. 192.6(a). The trial court has broad discretion to enter an order "to protect the movant from undue burden, unnecessary expense, harassment, annoyance, or invasion of personal, constitutional, or property rights," including an order stating that the requested discovery, in its entirety, may not be sought. *Id.* at 192.6(b).

As noted above, Rule 202 expressly limits the scope of discovery to "the same as if the anticipated suit or potential claim had been filed." TEX. R. CIV. P. 202.5. Stated differently, if the pre-suit discovery sought under Rule 202 would not be permitted in the anticipated suit, then the discovery should be denied. *See In re Wolfe,* 341 S.W.3d at 933; *see also Rodriguez v. Cantu*, 581 S.W.3d 859, 868 (Tex. App.—Corpus Christi 2019, no pet.) ("Rule 202 was not intended to be

utilized as a means for obtaining otherwise unobtainable discovery"); *Combs v. Tex. Civil Rights Project*, 410 S.W.3d 529, 535 (Tex. App.—Austin 2013, pet. denied) (same).

Here, due to their expansive nature, Document Request Numbers 3 and 6 necessarily seek privileged and confidential information protected by the attorney-client privilege, the deliberative process privilege, and/or the medical committee and hospital committee privileges. Discovery that seeks privileged information exceeds the permissible scope of discovery and, thus, is not proper discovery. *See* TEX. R. CIV. P. 192.3(a). The Court should reject Dr. Lopez's attempt to obtain discovery under Rule 202 that she would not be able to obtain in the anticipated suit.

B. Dr. Lopez's Document Requests Are Overly Broad and Constitute an Impermissible Fishing Expedition.

Under Texas law, discovery requests must be reasonably tailored to include only matters relevant to the case. *In re Alford Chevrolet-Geo*, 997 S.W.2d 173, 180 (Tex. 1999) (citations omitted). The Texas Supreme Court has held that "[a]lthough the scope of discovery is broad, requests must show a reasonable expectation of obtaining information that will aid the dispute's resolution. Thus, discovery requests must be reasonably tailored to include only relevant matters." *In re CSX Corp.*, 124 S.W.3d 149, 152 (Tex. 2003) (internal quotation marks and citations omitted). Relevant matters within the permissible scope of discovery are those that are not privileged and are relevant to the subject matter of the pending action. TEX. R. CIV. P. 192.3(a). "The requesting party has the burden to tailor its requests for production narrowly." *Hernandez v. Abraham, Watkins, Nichols, Sorrels & Friend*, 451 S.W.3d 58, 67 (Tex. App.—Hous. [14th Dist.] 2014, pet. denied) (citing *In re Am. Optical Corp.*, 988 S.W.2d 711, 713 (Tex. 1998)). The Texas Supreme Court has repeatedly admonished that discovery may not be used as a fishing expedition. *See, e.g.*, *K Mart Corp. v. Sanderson*, 937 S.W.2d 429, 431 (Tex. 1996); *see also*

Dillard Dep't Stores, Inc. v. Hall, 909 S.W.2d 491, 492 (Tex. 1995) ("[R]equests for document production may not be used simply to explore." (citation omitted)).

Here, Document Request Number 3 seeks "any and all documents or correspondence, including emails or texts, between any employee of UTSW relating to the discontinuation of the GENECIS clinic, Dr. Lopez, or restrictions on gender-affirming care[.]" Pet. at 17. As noted above, such communications routinely involved CMCD employees due to CMCD's collaboration with UTSW in the operation of the Genecis program and provision of services. The expansive nature of this request would require UTSW to produce ***any*** document or communication to or from Dr. Lopez, or any document or communication merely referencing Dr. Lopez—regardless of any connection to the discontinuation of the Genecis program. The Request is also overly broad because it is not limited in time. Although UTSW would ultimately bear the burden and expense of locating and producing such responsive documents, the expansive nature of Dr. Lopez's requests undoubtedly implicate CMCD's property and proprietary interests because they seek the production of documents and communications authored by and/or created by CMCD employees.

Similarly, Document Request Number 6 seeks "any and all documents reflecting any medical controversy regarding the provision of puberty suppression medications and/or hormone therapy to treat gender dysphoria[.]" *Id.* The vague, speculative, and ambiguous nature of this request means that seemingly ***any*** document relating to the provision of puberty suppression medications and/or hormone therapy to treat gender dysphoria could potentially be responsive. This Request is also devoid of any limitation in time. As with above, the expansive nature of Dr. Lopez's requests undoubtedly implicate CMCD's property and proprietary interests because they seek the production of documents and communications authored by and/or created by CMCD employees.

The breadth of Dr. Lopez's requests run contrary to the purpose of Rule 202 and would constitute an abuse of the rule. As stated above, Dr. Lopez's Petition should be denied in its entirety. If the Court does permit Dr. Lopez to move forward with pre-suit discovery, her requests must, at a minimum, be narrowed and tailored.

C. Dr. Lopez's Discovery Requests Are Not Relevant.

Dr. Lopez's discovery requests fall outside the scope of permitted discovery because they are not relevant to the pending action. Discovery is only permitted into matters that are "relevant to the subject matter of the pending action." TEX. R. CIV. P. 192.3(a). In order to be relevant, the requested discovery must have a tendency to make the existence of a fact that is of consequence to the determination of the action more probable or less probable than it would be without the requested discovery. *See* TEX. R. EVID. 401.

Dr. Lopez's requested discovery does not meet the most fundamental threshold of relevance. Assuming Dr. Lopez has a valid basis to pursue pre-suit discovery—which she does not—the only issues in this Rule 202 proceeding are the five topics (excerpted above) on which Dr. Lopez seeks to depose Dr. Podolsky and Dr. Warner. *See* Pet. at 12. Documents or correspondence from advocacy groups (requested via Document Request Number 4), professional medical society or trade associations (requested via Document Request Number 5), or documents reflecting "any medical controversy" regarding the provision of puberty suppression medications and/or hormone therapy to treat gender dysphoria (requested via Document Request Number 6), *see* Pet. at 17, have ***no*** bearing whatsoever on the specific questions of who purportedly seeks to impose limitations on Dr. Lopez's independent medical judgment; whether or which governmental official demanded such purported limitations be enforced by UTSW or CMCD; the bases for such purported limitations; whether such purported limitations are discriminatory; or the legal authority

for such purported limitations. *Cf. id.* at 17. Dr. Lopez's discovery requests are neither relevant nor reasonably calculated to lead to lead to the discovery of admissible evidence.

D. Dr. Lopez's Document Requests Are Otherwise Objectionable.

CMCD objects to Dr. Lopez's document requests as overly broad, unduly burdensome, not properly limited in time and scope, and because they seek information that is neither relevant nor reasonably calculated to lead to the discovery of admissible evidence. CMCD also objects to Dr. Lopez's requests to the extent they seek documents that are subject to the attorney-client privilege, the deliberative process privilege, and/or the medical committee and hospital committee privileges. CMCD further objects to Dr. Lopez's document requests to the extent they seek the production of trade secret, confidential, and/or proprietary information for which she has not made the required foundational showing that such information is both relevant and necessary to the issues raised in this Rule 202 proceeding. Finally, CMCD objects to the extent the document requests are vague and ambiguous and fail to identify with reasonable and requisite certainty the information requested.[4]

CONCLUSION

Based on the foregoing, CMCD respectfully requests that the Court deny Dr. Lopez's Petition. To the extent the Court permits Dr. Lopez to depose Dr. Podolsky and/or Dr. Warner, CMCD requests that the Court grant its Motion for Protective Order. CMCD further requests that the Court award CMCD all other and further relief to which it may be justly entitled.

[4] In the event the Court permits Dr. Lopez to depose Dr. Podolsky and/or Dr. Warner, CMCD reserves all rights as an adverse party to lodge any of the objections set forth above, and any other applicable objections, during the deposition(s).

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document was electronically filed and served to the following on the 30th day of March 2022:

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3. Supplement to Verified Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202

CAUSE NO. CC-22-01316-B

IN RE XIMENA LOPEZ, M.D., *Petitioner*,	IN THE COUNTY COURT OF LAW NO. 2 DALLAS COUNTY, TEXAS

SUPPLEMENT TO VERIFIED PETITION TO TAKE DEPOSITION BEFORE SUIT PURSUANT TO TEXAS RULE OF CIVIL PROCEDURE 202

Attached as Exhibit A is the Affidavit of Ximena Lopez, M.D. in further support of her Verified Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202.

Respectfully submitted,

/s/ Charla G. Aldous

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* * *

Certificate of Service

I certify that this document is being served on all counsel of record via electronic mail on March 31, 2022.

/s/ Charla G. Aldous
Charla G. Aldous

AFFIDAVIT OF XIMENA LOPEZ, M.D.

STATE OF TEXAS *
*
COUNTY OF DALLAS *

Before the undersigned authority on this day personally appeared XIMENA LOPEZ, M.D., who, after being duly sworn on her oath, states as follows:

1. "My name is Ximena Lopez, M.D. I am over 18 years of age, of sound mind, and capable of making this declaration. I have personal knowledge of the facts stated herein and they are all true and correct. I have never been convicted of any crime involving moral turpitude.
2. On or about November 17, 2021, UT Southwestern Medical Center informed me that I would not be permitted to provide gender-affirming care to new patients.
3. Since that date, I have been advised that over 100 patients seeking gender-affirming care at UT Southwestern Medical Center have been turned away. My understanding is that a great majority of these patients were seeking pubertal suppression and hormone therapy for gender-affirming treatment. A number of these patients were seeking solely a consultation. I have not been allowed to treat or consult with these patients."

Further Affiant sayeth not.

Executed on this 30 day of March 2022.

XIMENA LOPEZ, M.D., AFFIANT

SUBSCRIBED AND SWORN TO BEFORE ME by the above-named Affiant on this 30TH day of March, 2022, to certify which witness my hand and seal.

ELIZABETH ANN DAVILA
Notary ID #124248313
My Commission Expires
May 2, 2023

NOTARY PUBLIC IN AND FOR THE STATE OF TEXAS

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4. Notice of Hearing on Petitioner Ximena Lopez, M.D.'s Verified Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202

CAUSE NO. CC-22-01316-B

IN RE XIMENA LOPEZ, M.D., *Petitioner*,	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

NOTICE OF HEARING ON PETITIONER XIMENA LOPEZ, M.D.'S VERIFIED PETITION TO TAKE DEPOSITION BEFORE SUIT PURSUANT TO TEXAS RULE OF CIVIL PROCEDURE 202

TO: ALL COUNSEL OF RECORD

Please allow this notice to confirm that a hearing regarding Ximena Lopez M.D.'s *Verified Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202* has been reset for **Monday April 11, 2022 at 1:30pm via CourtCall**. By service of this notice, all counsel are advised they will need to schedule their own appearances through CourtCall 24 hours prior to the hearing. To register an account and schedule your appearance, visit www.courtcall.com or dial (888) 882-6878.

Respectfully submitted,

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* * *

Certificate of Service

I certify that this document is being served on all counsel of record via electronic mail on April 1, 2022.

/s/ Charla G. Aldous
Charla G. Aldous

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5. Notice of Appearance of Counsel

CAUSE NO. CC-22-01316-B

		§	IN THE COUNTY COURT AT LAW
		§	
IN RE XIMENA LOPEZ, M.D.,		§	NO. 2
	Petitioner.	§	
		§	DALLAS COUNTY, TEXAS

NOTICE OF APPEARANCE OF COUNSEL

Please allow this to serve as notice to the court and counsel that Charles K. Eldred hereby files this Notice of Appearance as Counsel for Respondent, The University of Texas Southwestern Medical Center.

Respectfully submitted,

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CERTIFICATE OF SERVICE

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Associated Case Party: UT Southwestern Medical Center

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6. Respondents', Dr. Podolsky and Dr. Warner's, Plea to the Jurisdiction and Response in Opposition to Petitioner's Request for Pre-Suit Depositions and Documents Under Texas Rule of Civil Procedure 202

Cause No. CC-22-01316-B

In Re:	§	
	§	
PETITION OF XIMENA LOPEZ, M.D. TO TAKE DEPOSITION BEFORE SUIT PURSUANT TO TEXAS RULES OF CIVIL PROCEDURE RULE 202	§	IN THE COUNTY COURT AT LAW
	§	
	§	NO. 2
	§	
	§	DALLAS COUNTY, TEXAS

RESPONDENTS', DR. PODOLSKY AND DR. WARNER'S, PLEA TO THE JURISDICTION AND RESPONSE IN OPPOSITION TO PETITIONER'S REQUEST FOR PRE-SUIT DEPOSITIONS AND DOCUMENTS UNDER TEXAS RULE OF CIVIL PROCEDURE 202

"Rule 202 is not a license for forced interrogations. Courts must strictly limit and carefully supervise pre-suit discovery to prevent abuse of the rule. . . An improper order under Rule 202 may be set aside . . ."

-Texas Supreme Court[1]

"It is an abuse of discretion for a trial court to order a rule 202 deposition when the party seeking the deposition fails to provide any evidence to meet the burden of establishing the facts necessary to support ordering a rule 202 deposition."

-Dallas Court of Appeals[2]

TO THE HONORABLE JUDGE OF THE COURT:

Respondents Daniel K. Podolsky, M.D. ("Dr. Podolsky") and John J. Warner, M.D. ("Dr. Warner"), file this Plea to the Jurisdiction and Response in Opposition to the Rule 202 Petition to take Deposition Before Suit filed by Ximena Lopez, M.D. ("Dr. Lopez") which seeks improper pre-suit depositions and document production outside the bounds of Texas Rule of Civil Procedure 202, and they respectfully show the Court as follows:

1 *In re Wolfe*, 341 S.W.3d 932, 933 (Tex. 2011), *citing In re Jorden*, 249 S.W.3d 416, 420 (Tex. 2008).
2 *In re City of Dallas*, No. 05-18-00289-CV, 2018 WL 5306925 *4 (Tex. App. – Dallas Oct. 26, 2019, orig. proceeding).

I.
BACKGROUND STATEMENT

The University of Texas Southwestern Medical Center ("UT Southwestern"), one of the premier academic medical centers in the nation, integrates pioneering biomedical research with exceptional clinical care and education. With a faculty of more than 2,800, UT Southwestern physicians provide medical care in about 80 specialties to more than 105,000 hospitalized patients, nearly 370,000 emergency room cases, and oversee approximately 3 million outpatient visits a year. Dr. Podolsky is the President of UT Southwestern, Dr. Warner is the Executive Vice President for Health System Affairs and Chief Executive Officer of the UT Southwestern Health System, and both are UT Southwestern employees.

UT Southwestern faculty physicians provide pediatric patient care services at hospitals and clinics owned by Children's Medical Center of Dallas (Children's), including certain services formerly coordinated under the Gender Education and Care, Interdisciplinary Support ("GENECIS") program that forms the basis for the instant action. There is no mystery about the joint decisions by UT Southwestern and Children's to remove the GENECIS branding, with no changes to care for current patients, and to start referring new patients with a diagnosis of gender dysphoria to other providers for hormone therapy only. These decisions have been the subject of substantial media coverage and UT Southwestern and Children's have made joint public statements.[3]

In November 2021, in the face of legal challenges to hormone therapy as a component of care for minors treated for gender dysphoria gaining momentum in Texas and elsewhere, Children's and UT Southwestern suspended initiating hormone therapy treatment for new pediatric patients,

3 *See* March 28, 2022 Joint statement from Children's Health and UT Southwestern: Newsroom - UT Southwestern, Dallas, Texas, available at https://utsouthwestern.edu/newsroom/articles/year-2022/gender-dysphoria-care.html

believing that a failure to act would put the entire program in jeopardy. Effective November 18, 2021, pediatric endocrinology, psychiatry, and adolescent and young adult care services previously coordinated under the "GENECIS" brand went back to being managed through each specialty department, as they were before GENECIS. The care of existing patients was unchanged. New patients would still have continued access to the broader array of gender-affirming care, particularly the psychiatric care considered foundational to gender transition and other front-line services necessary for evaluation of potential gender dysphoria. *Id.*

In taking those actions, Children's and UT Southwestern weighed the momentum of opposition to hormone therapy for gender dysphoria for minors – and efforts to curtail it – against the unquestioned need for other gender-affirming care and decided to focus on those important services. Though the Children's pediatric endocrinology clinic discontinued enrollment of new patients into puberty suppression therapy for the indication of gender dysphoria, families and patients seeking hormone therapy continued to have access to outside practitioners not affiliated with a public institution that is ultimately accountable to the state and which, inevitably, must consider conflicting public viewpoints. *Id.*

Although GENECIS served as a coordinating brand for the Children's sub-specialty clinics providing these pediatric services, it was never a standalone clinic. After state legislative hearings in 2021 brought additional scrutiny of the care provided, the GENECIS brand became a lightning rod for the controversy over hormone therapy for gender dysphoria in minors. Children's and UT Southwestern made the joint decision to remove the branding so they could care for their patients in a more protective environment. In contrast to how this has been mischaracterized by Dr. Lopez, no

clinic has been closed, and Children's and UT Southwestern continue to accept new patients referred for potential gender dysphoria. *Id.*

In light of the heightened focus on gender-affirming care services, however, Children's and UT Southwestern jointly concluded that without some modifications in their provision of these treatments, they risked the possibility of having to shut down the program entirely - and catalyzing action that would lead to banning the treatments statewide – similar to prohibitions that have already occurred in two other states (with comparable legislation pending in many more). Indeed, a bill to that effect was filed in last year's regular session of the Texas Legislature. *Id.* To be clear: UT Southwestern physicians are currently providing gender-affirming care to both youths and adults. The Children's clinics providing care to youths experiencing or needing evaluation for gender dysphoria were never closed and have been actively accepting new patients. Children's clinics and UT Southwestern faculty physicians continue to provide evaluations for gender dysphoria in youths, continue to provide psychiatric care for gender transition, and continue coordination of these services. *Id*.

None of this information was hidden. All of it is in the public domain. Dr. Lopez does not need Rule 202 discovery to ascertain who made these decisions or why. More than sufficient information to bring a lawsuit is either already known to Dr. Lopez and to the public.[4] In her March 31, 2022 Affidavit, p. 2., Dr. Lopez states: "On or about November 17, 2021, UT Southwestern

4 *See* November 19, 2021 Dallas hospitals erase references to Genecis health care program for transgender children (dallasnews.com) available at https://www.dallasnews.com/business/health-care/2021/11/19/dallas-hospitals-erase-references-to-genecis-health-care-program-for-transgender-children/; Texas Youth Gender Clinic Closed Last Year Under Political Pressure - The New York Times (nytimes.com); Report: Before closure, UT Southwestern's clinic for transgender youth faced political pressure (dallasnews.com); UT Southwestern cites politics, media for changing care for transgender youth (dallasnews.com); Political pressure led to shutdown of Texas' largest gender-affirming care program (19thnews.org)

Medical Center informed me that I would not be permitted to provide gender-affirming care to new patients." Without accepting Dr. Lopez's statements as true, Dr. Lopez is clearly aware of who, what, and when she claims she was told. The putative parties are named in her Petition. Who else could Dr. Lopez possibly sue for the decisions she complains about other than UT Southwestern, UT Southwestern officials, or Children's -- the entities and individuals who made and implemented those decisions? Also fatal to her Rule 202 Petition, Dr. Lopez has not identified any possible cause of action over which a future trial court could exercise jurisdiction, depriving this Court of jurisdiction to order Rule 202 relief. And finally, as described in Respondents' Objections and Motion for Protective Order filed simultaneously herewith, Dr. Lopez has not introduced any evidence in support of her Rule 202 Petition to demonstrate that testimony needs to be preserved, or that the benefit of the onerous pre-suit discovery she seeks outweighs the burden to Respondents.

II.
INTRODUCTION AND SUMMARY OF ARGUMENT

Dr. Lopez's Rule 202 Petition seeks depositions and document production from Dr. Podolsky and Dr. Warner. Both are faculty physician employees of UT Southwestern currently and were at the time of the decisions upon which Dr. Lopez's bases her Petition. UT Southwestern is an institution of higher education and a governmental unit of the State of Texas. Dr. Lopez, also an employee of UT Southwestern, is a pediatric endocrinologist who treats patients at UT Southwestern and Children's. *See* Rule 202 Petition ("Petition") at p. 2.

Texas Rule of Civil Procedure 202 provides a vehicle for a person to petition a Court for an order authorizing a deposition in two limited circumstances—(1) "to perpetuate or obtain the person's own testimony or that of any other person for use in an *anticipated suit*"; or (2) "to investigate a *potential claim or suit*." TEX. R. CIV. P. 202.1 (emphasis added). Rule 202 is an

extraordinary remedy to be used rarely and the trial Court is to judiciously guard against overuse or improper use of the Rule by a Petitioner. *See In re Wolfe*, 341 S.W.3d at 933. Rule 202 does not permit pre-suit depositions to investigate facts that are already known to the Petitioner or that are in the public domain. Because the facts Dr. Lopez seeks leave to investigate are known to her or are already in the public sphere, there is no legal basis for Rule 202 pre-suit discovery.

In addition, Rule 202 does not permit pre-suit depositions to investigate potential claims where, as here, the trial Court would not have jurisdiction over any suit Petitioner may ultimately file. In this case, the trial Court lacks jurisdiction for the following reasons which independently and collectively demonstrate that Petitioner's request must be denied:

1. **As employees of the State, Respondents have immunity from suit and liability for any underlying anticipated or potential claims, nullifying this Court's subject matter jurisdiction, precluding the Court's ability to order the pre-suit discovery sought by Dr. Lopez, and entitling Respondents to have their Plea to the Jurisdiction granted.**
2. **Petitioner's attempts to allege *ultra vires* claims with no basis in law or fact do not entitle her to pre-suit discovery.**
    a. **The face of the Petition makes clear that any of the referenced decisions by Respondents were within the course and scope of their employment with the State in their official capacity and, therefore, were not *ultra vires* and do not divest Respondents of their immunity from suit.**
    b. **Petitioner's claim that UT Southwestern violated a prohibition against the "corporate practice of medicine" under 22 TAC § 177.5 giving rise to an *ultra vires* claim is baseless because that law does not apply to UT Southwestern or the Respondents.**
    c. **The bald assertion of a potential discrimination claim on behalf of putative pediatric patients with gender dysphoria does not create a justification for pre-suit discovery because such a claim cannot legally be asserted for the reasons stated below and is barred by sovereign immunity.**
3. **Petitioner's claim that UT Southwestern or Respondents violated a prohibition against the "corporate practice of medicine" under 22 TAC § 177.5 giving rise to a potential cause of action is baseless.**

a. **Respondents are physicians licensed to practice medicine, and no such prohibition could apply to them. 22 TAC § 177.5 does not apply to their employer UT Southwestern, a facility maintained and operated by the State.**

b. **In cases where § 177.5 is applicable unlike here, it does not create a private cause of action, but is enforced by the Texas Medical Board, and therefore could not provide the basis for an *anticipated suit* or a *potential claim or suit* by Dr. Lopez as required by Rule 202.**

c. **Even if UT Southwestern was not specifically excluded from the application of 22 TAC § 177.5 by statute, and it is, any such suit would still be prohibited by sovereign immunity.**

4. **Dr. Lopez makes no valid assertion of discrimination.**

a. **Petitioner has made no showing that gender dysphoria is a protected class. Rather, she confirms that gender dysphoria is a medical condition.**

b. **A medical facility's determination of the scope of services and treatment protocols it will provide prospectively to new patients, while maintaining continuity of care to existing patients is not actionable discrimination.**

c. **Dr. Lopez does not assert that she is being discriminated against and has no basis for any such assertion. She lacks standing to bring a discrimination claim on behalf of putative patients.**

5. **Petitioner's attempt to recast a potential a health care liability claim based on a supposed failure to meet the standard of care for new minor patients does not provide a valid basis for pre-suit discovery.**

a. **Rule 202 discovery is not allowed in an anticipated health care liability claim.**

b. **A healthcare liability claim could not be asserted against these physicians.**

6. **Petitioner's assertions that she seeks injunctive relief or declaratory judgment do not rescue a fatally flawed Rule 202 Petition. These are remedies, not causes of action. Petitioner has neither asserted nor described any potential claim or anticipated suit to support such relief.**

Petitioner has failed to show she needs the onerous pre-suit discovery requested. She has not met her burden under Rule 202. In addition, because the eventual trial court would lack jurisdiction over Dr. Lopez's purported claims for the reasons presented herein, this Court lacks jurisdiction to order a Rule 202 deposition. *Combs v. Tex. Civil Rights Project*, 410 S.W.3d 529, 538 (Tex. App.—

Austin, 2013 pet. denied). Respondents ask the Court to deny Dr. Lopez's Petition, to sustain their objections to the pre-suit discovery requests, and grant their Motion for Protective Order.[5]

III.
THE PETITION SHOWS PRE-SUIT DISCOVERY IS IMPROPER UNDER THE TERMS OF RULE 202

Rule 202 pre-suit discovery is not a typical discovery tool. Unlike normal discovery attendant to litigation that is automatically provided, pre-suit discovery must be denied unless the Petitioner carries the burden to prove they are entitled to it, which Dr. Lopez fails to do. *See In re Wolfe*, 341 S.W.3d at 933. Petitioner does not allege she seeks to take depositions of Drs. Podolsky and Warner because she needs to preserve their testimony. As a result, Petitioner must show that the likely benefit of allowing her to take the requested deposition to investigate potential claims outweighs the burden or expense to the Respondents. TEX. R. CIV. P. 202.4(a)(2). Pre-suit discovery first requires that a valid potential claim or anticipated suit exist. Tex. R. Civ. P. 202.1(a)-(b)[6]

As discussed in more detail in Section V below, the Rule 202 Petition shows that Dr. Lopez cannot carry her burden in this case. While no valid claim against any interested parties exists, which in itself prohibits the pre-suit discovery, Dr. Lopez seeks to force Respondents to engage in pre-suit discovery that is unnecessary. Dr. Lopez has averred no facts about how the benefit of allowing the depositions she seeks outweighs the burden to Drs. Podolsky and Warner. *See* Petition. She merely tracks the language of Rule 202 regarding the permissible reasons one might seek a pre-suit deposition. *Id*. Dr. Lopez fails to provide any competent evidence—evidence beyond her own pleading—that allowing the discovery would prevent failure or delay of justice, or that the likely

5 Respondent's Objections and Motion for Protective Order are filed simultaneously herewith and are incorporated by reference herein.

benefit of the discovery outweighs the burden or expense of the procedure. Her request is a bare fishing expedition that cannot validly serve as the basis for pre-suit discovery. *See In re Reassure America Life Ins. Co.*, 421 S.W.3d 165 (Tex. App.—Corpus Christi 2013) (discussing that a court has no discretion to order a Rule 202 deposition when the petitioner fails to provide the basis for the findings required to support order).

Given the size and complexity of UT Southwestern, the duties of the President and EVP, as well as the vital role Respondents play in the operation of the organization and its services to the community, Respondents' time is at a premium. The decisions about which Dr. Lopez now complains were made months ago, in November 2021. Her delay in seeking information belies any urgency. Lopez fails to demonstrate why or that she needs either deposition much less that she needs *both* depositions. She has wholly failed to carry her burden of showing that the (purported) necessity of the discovery outweighs the great burden and expense to Respondents and their employer, UT Southwestern. Moreover, the due process concerns for these physicians to be deposed without knowing the claims asserted against them is significant. The burden (indeed any burden) to Respondents cannot be outweighed by the benefit to Dr. Lopez because the information sought is unnecessary, already known to Dr. Lopez, or is otherwise in the public domain and therefore already available to Dr. Lopez.

IV.
PLEA TO THE JURISDICTION

1. Standard of Review

A plea to the jurisdiction challenges the court's authority to determine the subject matter of the controversy. *Bland Indep. Sch. Dist. v. Blue*, 34 S.W.3d 547, 553-54 (Tex. 2000). The purpose of a plea to the jurisdiction is to "defeat a cause of action without regard to whether the claims asserted

have merit." *Id*. At 554. As an initial matter, the plaintiff must "allege facts that affirmatively demonstrate the court's jurisdiction to hear the cause." *Tex. Ass'n of Bus. v. Tex. Air Control Bd.*, 852 S.W.2d 440, 446 (Tex. 1993). Whether a plaintiff has alleged facts that affirmatively establish subject-matter jurisdiction, and whether undisputed evidence of jurisdictional facts establish a trial court's jurisdiction, are both questions of law for the trial court to decide. *Tex. Dep't of Parks & Wildlife v. Miranda,* 133 S.W.3d 217, 226 (Tex. 2004).

The law requires that the Petitioner file her Rule 202 Petition in a "proper court" which means "a court with subject matter jurisdiction over the underlying dispute." *See Vestal v. Pistikopoulos*, 2016 Tex. App. LEXIS 7958, 2016 WL 4045081, at *1 (Tex. App. Waco, July 27, 2016, no pet.) (mem. op). A Rule 202 pre-suit deposition of State Defendants to investigate potential claims over which the trial court would lack jurisdiction is improper. *Combs,* 410 S.W.3d at 538. To determine whether a plaintiff demonstrated jurisdiction, the court looks to the facts alleged in the petition, construed in favor of the plaintiff, as well as any evidence submitted by the parties that is pertinent to the jurisdictional inquiry. *Miranda*, 133 S.W.3d at 226-27. If the pleadings do not contain sufficient facts to affirmatively demonstrate the trial court's jurisdiction, but do not affirmatively demonstrate incurable defects in jurisdiction, the issue is one of pleading sufficiency and the plaintiff should be afforded the opportunity to amend. *Id.* However, if the pleadings affirmatively negate the existence of jurisdiction, then a plea to the jurisdiction should be granted without allowing the plaintiffs an opportunity to amend. *Id.* If the defendant challenges the existence of jurisdictional facts, the trial court is required to consider relevant evidence to resolve the jurisdictional issue. *Heinrich*, 284 S.W.3d at 378.

A trial court abuses its discretion if it grants Rule 202 discovery when there is no evidence before the court "to provide a basis for concluding that [petitioner's] potential claim would not be barred by sovereign immunity (*emphasis added.)*" *In re Dallas County Hosp. Dist.,* 2014 WL 1407415 (Tex. App. – Dallas, Apr. 1, 2014, orig. proceeding). It is Dr. Lopez's burden to allege facts affirmatively establishing the trial court's jurisdiction. *See Tex. Ass'n of Bus. v. Tex. Air Control Bd.,* 852 S.W.2d at 446. Dr. Lopez has failed to put any allegations or evidence before the court of a cognizable claim or potential claim that, if true, would waive sovereign immunity; therefore, the court must deny and dismiss her Petition.

2. AS EMPLOYEES OF THE STATE, RESPONDENTS HAVE IMMUNITY FROM SUIT AND LIABILITY FOR ANY UNDERLYING ANTICIPATED OR POTENTIAL CLAIMS, NULLIFYING THIS COURT'S SUBJECT MATTER JURISDICTION, PRECLUDING THE COURT'S ABILITY TO ORDER PRE-SUIT DISCOVERY, AND ENTITLING RESPONDENTS TO HAVE THEIR PLEA TO THE JURISDICTION GRANTED.

When seeking discovery against a governmental unit via a Rule 202 petition, the petitioner must go beyond the pleading requirements of that rule. *Combs,* 410 S.W.3d at 536; *see* TEX. R. CIV. P. 202 (requiring only that the petitioner state the subject matter of the anticipated action and his interest in that action). Specifically, the petition must also set forth "specific facts demonstrating . . . [that] the petitioner has been injured by actions that would amount to a claim which would not be barred by sovereign immunity." *Id*. This is because sovereign immunity affords a governmental entity the same protections during this pre-suit process as it affords that entity after an action has been filed. *Id*. at 535. Rule 202 depositions may not be used to "investigate potential claims that are otherwise barred by sovereign immunity." All of Petitioner's deposition topics and document requests are related to decisions and actions by Dr. Podolsky and Dr. Warner in their positions as the President of UT Southwestern and EVP for Health System Affairs and CEO of the UT Southwestern

Health System, respectively. Any decisions and actions Dr. Lopez complains of were within the scope of their employment with UT Southwestern and would be part of their day-to-day administrative duties, decisions about changes to medical services for certain new pediatric patients.

Dr. Lopez's purported anticipated suit is against UT Southwestern, a governmental unit of the state of Texas, which has sovereign immunity. Dr. Podolsky and Dr. Warner, like their employer, UT Southwestern, are immune from suit. A suit against a state official in his official capacity is not a suit against the official personally. *Texas A&M Univ. Sys. v. Koseoglu*, 233 S.W.3d 835, 844-45 (Tex. 2007). It is fundamental that a suit against a state official is merely 'another way of pleading an action against the entity of which [the official] is an agent.'" *Id.* Because the real party in interest is the governmental unit, the suit "actually seeks to impose liability against the governmental unit rather than on the individual specifically named and 'is, in all respects other than name, ... a suit against the entity.'" *Id.; see also Tex. Natural Res. Conservation Comm'n v. IT–Davy,* 74 S.W.3d 849, 855–56 (Tex. 2002). Because a suit against government employees in their official capacity is a suit against the government itself, the employees may raise a plea to the jurisdiction. *See e.g. Friona ISD v. King*, 15 S.W.3d 653, 657, n. 3 (Tex. App. Amarillo 2000, no pet.) "When a state official files a plea to the jurisdiction, the official is invoking the sovereign immunity from suit held by the government itself." *See Koseoglu*, 233 S.W.3d at 844-45. To the extent Dr. Lopez's Petition contemplates some future suit against Dr. Podolsky or Dr. Warner, any such suit would in reality be a suit against UT Southwestern, the State, over which the Court lacks jurisdiction and cannot provide a basis for Rule 202 discovery.

Dr. Podolsky and Dr. Warner were employees of UT Southwestern, a governmental unit of the State of Texas as defined by Section 101.001 of the TEXAS CIVIL PRACTICE & REMEDIES CODE,

Chapter 312 of the TEXAS HEALTH & SAFETY CODE, and Chapter 61 of the TEXAS EDUCATION CODE, at the time any purported claim arose and were in all respects acting in their official capacity when involved in any of the actions or decisions referenced by Petitioner. Respondents are also immune from suit concerning any of Petitioner's potential claims, albeit insupportable claims under TEXAS CIVIL PRACTICE & REMEDIES CODE Section 101.106(e),(f) of the Tort Claims Act. The Court lacks subject-matter jurisdiction to order a deposition or the production of documents because Dr. Lopez's Rule 202 petition does not seek to investigate claims over which a future trial court would have subject matter jurisdiction and the Petition should be dismissed for lack of jurisdiction.

3. PETITIONER'S ATTEMPTS TO ALLEGE *ULTRA VIRES* CLAIMS WITH NO BASIS IN LAW OR FACT DO NOT ENTITLE HER TO PRE-SUIT DISCOVERY.

Dr. Lopez asserts that the decisions and actions she disagrees with were *ultra vires*, in a sham attempt to circumvent the sovereign immunity of UT Southwestern and the derivative immunity of the Respondents. *Ultra vires* claims cannot be brought against the State but can only be brought "against the state actors in their official capacity" because "'acts of officials which are not lawfully authorized are not acts of the State.'" *Heinrich*, 284 S.W.3d at 372–73.

a. The face of the Petition makes clear that any of the referenced decisions by Respondents were within the course and scope of their employment with the State in their official capacity and, therefore, were not *ultra vires* and do not divest Respondents of their immunity from suit.

In this case, the Head of the University and the Health System making decisions with Children's about services offered to current and new pediatric patients at clinics is not *ultra vires* – it is core to the job responsibilities of UT Southwestern leadership. Talking about such decisions with Children's or with other persons, entities or offices or other governmental officials or offices is squarely within the scope of Dr. Podolsky's and Dr. Warner's employment and within their regular

duties. Lopez's mischaracterization of these decisions and actions as "*ultra vires"* does not divest Dr. Podolsky and Dr. Warner of their immunity. Any decisions and actions about scope of medical services and any discussions with others about those services were an exercise of discretion performed in the Respondents' official capacity. Dr. Podolsky and Dr. Warner were undisputedly performing discretionary duties within the scope of their authority in good faith. *Ballantyne v. Champion Builders, Inc.*, 144 S.W.3d 417, 424 (Tex. 2004); *Joe v. Two Thirty Nine Joint Venture*, 145 S.W.3d 150, 164 (Tex. 2004).

When a petitioner complains of things that are within the discretion of the official, she has failed to plead a valid *ultra vires* claim. *Heinrich*, 284 S.W.3d at 372. To raise a valid *ultra vires* exception to sovereign immunity, Petitioner "must allege, and ultimately prove, that the officer acted without legal authority or failed to perform a purely ministerial act." *Id.* "[*U*]*ltra vires* suits do not attempt to exert control over the state—they attempt to reassert the control of the state" over the employee. *Id.* In sum, Dr. Lopez complaint concerning the use of medical and business discretion by UT Southwestern cannot form the basis for any *ultra vires* claim against Respondents.

In essence, Dr. Lopez asserts that she disagrees with UT Southwestern's discretionary and legal decision that certain services (puberty blocking medications) would no longer be offered to new pediatric patients and that new patients and their families seeking those services would be referred to other providers outside Children's clinics. Her purported cause of action amounts to no more than disagreement with Dr. Podolsky's and Dr. Warner's medical, business, and/or operational judgments and discretionary decisions made in their official capacities about medical services at Children's clinics staffed by UT Southwestern faculty physicians. This is no different than decisions a facility might make about treatments available for pediatric versus adult oncology patients, for

example; decisions about which medical specialties will be offered by a hospital; the scope of services an academic medical center will provide; or which infection control measures a hospital deems appropriate which are all also squarely within the authority of Drs. Podolsky and Warner and not *ultra vires*. *See e.g., Texas Health Huguley, Inc. v. Jones*, 637 S.W.3d 202 (Tex. App. – Fort Worth 2021, no pet.). Dr. Lopez's allegations do not come close to the assertion of facts necessary to show that Dr. Podolsky or Dr. Warner exercised their discretion without reference to or in conflict with the constraints of a law authorizing them to act, or that they otherwise failed to perform a purely ministerial act that did not allow for independent judgment, *Houston Belt & Terminal Ry. Co. v. City of Houston*, 487 S.W.3d 154, 163 (Tex. 2016).

Even taking Petitioner's allegations as true, her Rule 202 Petition seeks to investigate the exercise of administrative and medical judgment by the Respondents, which, by definition, are not *ultra vires*, but fall squarely within sovereign immunity applicable to UT Southwestern and by extension to official immunity for employees Dr. Podolsky and Dr. Warner. Because the Court would have no jurisdiction over the anticipated suit, the Court likewise lacks jurisdiction to grant Dr. Lopez' Rule 202 Petition.

b. Petitioner's claim that UT Southwestern violated a prohibition against the "corporate practice of medicine" under 22 TAC § 177.5 giving rise to an *ultra vires* claims is baseless because that law does not apply to UT Southwestern or the Respondents. .

Dr. Lopez attempts to skirt Dr. Podolsky's and Dr. Warner's sovereign immunity by claiming Respondents violated a state law prohibition on the corporate practice of medicine by supposedly interfering with her independent medical judgment and therefore these actions are "ultra vires." As discussed in Section V(2), 22 TAC § 177.5 does not apply to Dr. Podolsky or to Dr. Warner, nor

does it apply to their employer UT Southwestern. Therefore, 22 TAC § 177.5 cannot provide any basis an *ultra vires* claim against Dr. Podolsky or Dr. Warren to circumvent their immunity.

c. The bald assertion of a potential discrimination claim on behalf of putative pediatric patients with gender dysphoria does not create a justification for pre-suit discovery because such a claim cannot legally be asserted for the reasons stated below.

As discussed in Section V(3), Dr. Lopez has not asserted any actionable claim of discrimination. She has cited no authorities for the proposition that a diagnosis of gender dysphoria makes an individual part of a protected class. The entirety of the Petitioner's reference to discrimination revolves around the change in one single modality of treatment (puberty blocking medication) and only for new patients, as discussed in Section V(3). This does not provide a basis for an *ultra vires* claim that could defeat Dr. Podolsky's and Dr. Warner's official immunity.

V.
RESPONSE IN OPPOSITION TO RULE 202 PETITION

In the alternative, and without waiving any argument asserted in their Plea to the Jurisdiction, Drs. Podolsky and Warner file this Response in opposition to the Rule 202 Petition:

1. Standard of Review

Rule 202 contemplates two types of pre-suit depositions: (1) depositions to investigate a potential claim or suit that may never be filed, Tex. R. Civ. P. 202.1(b); and (2) depositions to preserve testimony when suit is anticipated, Tex. R. Civ. P. 202.1(a).[7] *See In re Denton*, 2009 WL 471524, at *1 (Tex. App. – Waco, Feb. 25, 2009, orig. proceeding)(mem. op.). When seeking deposition to preserve testimony, the petitioner has the burden to show that allowing her to take the sought deposition would prevent a failure or delay of justice in an anticipated suit. *See In re Hewlett Packard*, 212 S.W.3d 356, 363–64 (Tex. App.—Austin 2006, mand. denied). In addition, where, as

here, a petitioner seeks depositions to investigate potential claims, she must show that the likely benefit of allowing her to take the requested depositions outweighs the burden or expense of the procedure. *Id.* As stated by the Texas Supreme Court, the allegations in the petition must be more than "sketchy." *See In re Does*, 337 S.W.3d 862, 865 (Tex. 2011).

To obtain an order authorizing pre-suit depositions, the petitioner must make some effort to present the trial court with a basis for one of these required findings. *See id.* Dr. Lopez's Rule 202 Petition does not assert any reason the deposition testimony of Respondents must be preserved to prevent a delay or failure of justice. As stated above, all of the information Petitioner needs to file her lawsuit is known to her directly or is in the public sphere. Therefore, she cannot show that she needs the pre-suit discovery to prevent an injustice or to show that the necessity of the discovery outweighs the burden to Respondents. This alone provides the basis to dismiss the Rule 202 Petition.

Significantly, the Texas Supreme Court has made clear that Rule 202 depositions "*are not now and never have been intended for routine use*," precisely because they necessarily implicate the "practical as well as due process problems with demanding discovery from someone before telling him what the issues are." *In re Jorden*, 249 S.W.3d at 423 (emphasis added). Even more recently, the Supreme Court has stated that Rule 202 is not a license for forced interrogations, and emphasized that Courts must strictly limit and carefully supervise pre-suit discovery to prevent abuse of the rule. *In re Wolfe*, 341 S.W.3d 932. Thus, Rule 202 depositions should *not* be routinely granted, and require extraordinary circumstances demonstrating why a particular petitioner should be entitled to a special form of discovery not employed by the vast majority of plaintiffs who follow the normal course of seeking discovery after they have filed a lawsuit. To use the Rule 202 procedure is to risk

serious due process concerns for the respondent who is deposed without knowing the claims asserted against them.

2. PETITIONER'S CLAIM THAT UT SOUTHWESTERN OR RESPONDENTS VIOLATED A PROHIBITION AGAINST THE "CORPORATE PRACTICE OF MEDICINE" UNDER 22 TAC § 177.5 GIVING RISE TO A POTENTIAL CAUSE OF ACTION TO BE INVESTIGATED IS BASELESS.

a. Respondents are physicians licensed to practice medicine, and no such prohibition could apply to them. 22 TAC § 177.5 does not apply to their employer, UT Southwestern, a facility maintained and operated by the State.

Dr. Lopez claims that she needs to investigate who at UT Southwestern or Children's has supposedly violated 22 TAC § 177.5(c), which prohibits the corporate practice of medicine in Texas. Petition, p. 1. The corporate practice of medicine doctrine is a legal doctrine, which generally prohibits corporations, entities or non-physicians from practicing medicine. The prohibition on the corporate practice of medicine is based on numerous provisions of the Medical Practice Act, including §§ 155.001, 155.003, 157.001, 164.052(a)(8), (13), and 165.156. 22 Tex. Admin. Code 177.17. Found in Part 9 of The Medical Board Rules section of the Texas Administrative Code, § 177.5 applies only to organizations seeing a certificate under Texas Occupations Code § 162.001(b).

By its terms § 177.5 applies to entities, not individual physicians like Dr. Podolsky and Dr. Warner, who are both are licensed to practice medicine in the State of Texas. This provision cannot apply to Respondents, or to their exercise of medical and business judgment on behalf of UT Southwestern. Section 177.5 does not waive UT Southwestern's sovereign immunity as it does not apply to governments like UT Southwestern or to Dr. Podolsky or Dr. Warner in their official capacities. Rather, the provision applies to health organizations certified under section 162.001(b) of the Texas Occupations Code. UT Southwestern is not a "health organization" as defined by these statutes. In addition, the corporate practice of medicine principle does not apply to Respondents, or

even Dr. Lopez, as physician employees of UT Southwestern. *See* 22 Tex. Admin. Code §§ 177.17(b)(24)(A), 172.8; Tex. Occ. Code § 155.104(b)(4)(B). As there is no statutory proscription against the corporate practice of medicine that would apply to UT Southwestern. As § 177.5 does not apply to Respondents or to UT Southwestern, no potential claim or anticipated suit to be investigated can arise from the provision.

b. The "corporate practice of medicine doctrine" prohibited in § 177.5 does not create a cause of action for Dr. Lopez, but is enforced by the Texas Medical Board, and therefore could not provide the basis for an *anticipated suit* or a *potential claim or suit* as required by Rule 202.

Not only is UT Southwestern not a health organization subject to 22 TAC 177.5, any purported violation of the corporate practice of medicine doctrine, Medical Practice Act or other Texas Medical Board Rules would be investigated and enforced by the Texas Medical Board and there is no private cause of action Dr. Lopez could assert. *See generally* 22 TAC 161.2(5)-(6) (purpose and function of the TMB includes "investigate possible violations of the Medical Practice Act and the Board Rules;" and "discipline violators through appropriate legal action to enforce the Medical Practice Act and the Board Rules.") The only remedy for violations of the rule by a 162.001(b) health care organization (which, UT Southwestern is not) is the Texas Medical Board "may impose an administrative penalty against a health organization under Chapter 165 of the [Texas Occupations Code] or revoke a certification if in the board's determination the health organization is established, organized, or operated in contravention of or with the intent to circumvent any of the provisions of the Act or the board's rules." 22 Tex. Admin. Code § 177.12(b). This provision does not waive sovereign immunity. Because Dr. Lopez has no authority to enforce these provisions, there could be no waiver of immunity for any such action. Therefore, this Court should deny Dr. Lopez's Rule 202 petition for lack of subject matter jurisdiction. *See Combs*, 410

S.W.3d at 538 (vacating trial court's order granting rule 202 petition seeking to depose state defendants for lack of subject matter jurisdiction).

c. Even if UT Southwestern was not specifically excluded from the application of 22 TAC § 177.5 by statute, and it is, any such suit would still be prohibited by sovereign immunity.

For the reasons stated in the Plea to the Jurisdiction, UT Southwestern enjoys immunity from any suit for which there has been no waiver of immunity. Its employees, Dr. Podolsky and Dr. Warner, acting with the scope of their employment enjoy that immunity derivatively. Respondents are immune from suit for claims brought against them in their official capacity, they have official immunity, and they enjoy the immunity provided by Tex. Civ. Prac. & Rem. Code § 101.106. As there has been no waiver of immunity for any purported claims against the State for an alleged violation of § 177.5, even if this provision did not specifically exclude Respondents by its terms and even if Dr. Lopez, and not the TMB, could enforce the corporate practice of medicine doctrine, immunity would nevertheless attach and any such anticipated claim would not provide a basis for Rule 202 discovery.

3. DR. LOPEZ MAKES NO VALID ASSERTION OF DISCRIMINATION.

a. Petitioner has made no showing that a diagnosis of gender dysphoria is a protected class. Rather, she confirms that gender dysphoria is a medical condition.

Dr. Lopez essentially raises two potential claims in her Rule 202 Petition. The first purported claim is for "discrimination." Dr. Lopez alleges that by making changes to certain services offered to new patients at Children's clinics, UT Southwestern has discriminated against patients "due to . . . gender identity." *See* Petition, p. 15. But according to Dr. Lopez's own exhibits, "gender dysphoria" is defined as "the distress and unease experienced if gender identity and designated gender are not completely congruent" and carries a DSM-5 diagnosis from the American Psychiatric Association.

It is a medical diagnosis that individuals of all genders and gender identities could receive. *See* Petition, Exhibit B, p. 7. Meanwhile "gender identity" is "one's internal, deeply held sense of gender." *Id.* According to her own pleading, these two things are not the same. What UT Southwestern and Children's did was decide to continue certain treatments for current patients with a medical diagnosis, but to start referring new patients to other providers for one specific treatment modality no longer offered. That is not discrimination based on gender, gender identity, or any other protected status and Dr. Lopez cites no authority for such a preposterous position.

Moreover, Dr. Lopez's Petition demonstrates that all current patients are continuing on treatment plans, including puberty suppression or hormone blockers if they were already receiving them (p. 10). New patients diagnosed with gender dysphoria who want these medications are referred to other providers outside the Children's clinics that offer those treatments. *Id.* Dr. Lopez's Petition acknowledges that being an existing patient versus a new patient determines whether those services are available. *Id.* It is a very common occurrence for a hospital or physician to implement changes in services in this way because it ensures continuity of care for existing patients and poses no harm to new patients who can be referred out for services no longer offered. All existing patients are treated the same, regardless of gender, gender identity, or gender expression. All new patients are treated the same, regardless of gender, gender identity, or gender expression. Being a new patient is also not a protected status or activity under any anti-discrimination laws, and Lopez cites to none. What she ultimately seeks is this Court's permission to investigate medical and administrative decisions about operations of the hospital and clinical practices that she doesn't agree with, but that is not an actionable claim.

c. Dr. Lopez does not assert that she is being discriminated against and has no basis for any such assertion. She lacks standing to bring a discrimination claim on behalf of putative patients.

Dr. Lopez does not allege any discrimination against her, does not claim any adverse employment action by her employer, UT Southwestern, or any adverse action by Children's regarding her medical staff privileges. Dr. Lopez claims that she knows what the cause of action is – discrimination against patients "solely on the grounds of the patient's gender identity," which is baseless for the reasons outlined above. But she claims she needs Rule 202 discovery to determine whom to bring suit against for this purported discrimination against patients. Dr. Lopez lacks standing to assert a claim for discrimination on behalf of putative pediatric patients who supposedly want these medications that are no longer offered by Children's to new patients.

If the Petitioner lacks standing to bring the potential claim she seeks to investigate, the Court would abuse its discretion in granting the Rule 202 petition. *See In re Wolfe*, 341 S.W.3d at 932-933. "Standing is implicit in the concept of subject-matter jurisdiction, and subject-matter jurisdiction is essential to the authority of a court to decide a case." *In re Abbott*, 601 S.W.3d 802, 807 (Tex. 2020) (orig. proceeding). "Standing is specific to each individual plaintiff and to each of the plaintiff's individual claims." *In re UBS Fin. Servs. Inc.,* 2020 Tex. App. LEXIS 7972, 2020 WL 5902955, at *2 (Tex. App.—Houston [14th Dist.] Oct. 6, 2020, orig. proceeding). "Standing requires a concrete injury to the plaintiff and a real controversy between the parties that will be resolved by the court." *Id. citing Meyers v. JDC/Firethorne, Ltd.*, 548 S.W.3d 477, 484 (Tex. 2018). Questions of standing are reviewed de novo. *Beasley*, 598 S.W.3d at 240. Because it is an integral part of subject matter jurisdiction, standing can be neither presumed nor waived and may be raised for the first time on appeal. *Tex. Ass'n of Bus.*, 852 S.W.2d at 445. Unless standing is conferred by statute, a

plaintiff must demonstrate that he "possesses an interest in a conflict distinct from that of the general public, such that the defendant's actions have caused the plaintiff some particular injury." *Concerned Cmty. Involved Dev., Inc. v. City of Houston*, 209 S.W.3d 666, 670 (Tex. App. – Houston [14th Dist.] 2006, pet. denied). Dr. Lopez bears the burden to "allege facts affirmatively demonstrating the trial court's jurisdiction to hear the case." *Id. quoting, Tex. Ass'n of Bus.,* 852 S.W.2d at 445–46. She has failed to do so in this case. She has no anticipated claim of discrimination on behalf of patients.

4. Petitioner's attempt to recast a potential health care liability claim does not provide a valid basis for pre-suit discovery.

a. Rule 202 discovery is not allowed in an anticipated health care liability claim.

Although Dr. Lopez has no standing to bring a health care liability claim, the crux of her complaint is just that – an alleged deviation from the standards of care. Notably, her assertion is once again contradicted by her own pleading, which acknowledges "[n]ot all clinics offer puberty suppression" and whether such treatments are given is "influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings." Petition Ex. A, p. 19. A health care liability claim cannot be recast as another cause of action to avoid the requirements of Chapter 74 of the Texas Civil Practice & Remedies Code. *See Gormley v. Stover,* 907 S.W.2d 448, 449-50 (Tex. 1995). The gravamen of Dr. Lopez' anticipated claim meets the definition of a health care liability claim under Tex. Civ. Prac. & Rem. Code Ann. § 74.001(13); it is a health care liability claim and Rule 202 discovery is precluded. *In re Jorden*, 249 S.W.3d 416, 418 (Tex. 2008).

b. A healthcare liability claim could not be asserted against these physicians.

As more fully demonstrated in Respondents Plea, Respondents are also immune from suit concerning any potential healthcare liability claim. under TEXAS CIVIL PRACTICE & REMEDIES CODE

Section 101.106(e) and (f) of the Tort Claims Act.

5. Petitioner's assertions that she seeks injunctive relief or declaratory judgment do not rescue a fatally flawed Rule 202 Petition. These are remedies, not causes of action. Petitioner has neither asserted nor described any potential claim or anticipated suit to support such relief.

Simply referencing a generic potential entitlement to injunctive relief or declaratory judgment does not rescue an otherwise improper Rule 202 Petition. Dr. Lopez has failed to allege any underlying claim that could invoke the court's jurisdiction or support those remedies. The UDJA does not provide a trial court with jurisdiction; it is "merely a procedural device for deciding cases already within a court's jurisdiction." *Texas Dep't of Transp. v. Sefzik*, 355 S.W.3d 618, 621–22 (Tex. 2011). Simply put, Dr. Lopez must have a justiciable controversy that would be remedied by a declaratory judgment; she has identified none. In addition, the underlying action, must be one for which immunity has expressly been waived; it has not. *Sefzik*, 355 S.W.3d at 622. Dr. Lopez does not specify any provision of the UDJA that expressly waives immunity for any anticipated claim, as would be required to bring suit. As to the anticipated injunctive relief to be sought, an injunction is an equitable remedy not a cause of action. *See Brittingham v. Ayala*, 995 S.W.2d 199, 201 (Tex. App. – San Antonio, pet. denied). Any generic allegation that she "has claims giving rise to a potential right to declaratory and injunctive relief" is not enough to invoke Rule 202.

6. Dr. Lopez's Affidavit is "No Evidence"

Petitioner filed an Affidavit dated March 30, 2022 in support of her Petition. Respondents object to the Affidavit as it is based on speculation, is conclusory, and based on inadmissible hearsay. It amounts to no evidence, provides no support for the Petition, and should be stricken.

7. Respondents Object to the Individual Requests

The discovery requests themselves are overly broad, unduly burdensome, or otherwise improper and Respondents object to them in their Objections filed simultaneously herewith.

VI.
CONCLUSION & PRAYER

For all of the reasons set forth in this Plea and the response in opposition, Respondents Dr. Podolsky and Dr. Warner ask this Court to grant their plea to the jurisdiction and to deny Lopez's Rule 202 petition. Alternatively, and only to the extent that this Court orders the depositions of Respondents Dr. Podolsky and/or Dr. Warner to proceed, Respondents request pursuant to Texas Rule of Civil Procedure 202.4(b) that the Court's order issued contain express protections necessary to prevent undue burden as referenced in Respondents' Objections to Petitioner's Rule 202 Pre-Suit Deposition and Document Requests and Motion for Protective Order.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this, the 6th day of April 2022, a true and correct copy of the foregoing instrument has been forwarded to all counsel of record through the electronic filing manager.

/s/ C. Timothy Reynolds
C. Timothy Reynolds

7. Respondents', Dr. Podolsky and Dr. Warner, Objections to Petitioner's Rule 202 Pre-Suit Deposition and Document Requests and Motion for Protective Order

Cause No. CC-22-01316-B

In Re:		
PETITION OF XIMENA LOPEZ, M.D. TO TAKE DEPOSITION BEFORE SUIT PURSUANT TO TEXAS RULES OF CIVIL PROCEDURE RULE 202	§ § § § § § §	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

RESPONDENTS', DR. PODOLSKY AND DR. WARNER, OBJECTIONS TO PETITIONER'S RULE 202 PRE-SUIT DEPOSITION AND DOCUMENT REQUESTS AND MOTION FOR PROTECTIVE ORDER

TO THE HONORABLE JUDGE OF SAID COURT:

Respondents Dr. Podolsky and Dr. Warner simultaneously file the following Objections to requests contained within Petitioner Ximena Lopez, M.D.'s ("Dr. Lopez") Verified Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202 ("Petition") and Motion to Protective Order and would respectfully show the Court the following:

I.
INTRODUCTION AND SUMMARY OF ARGUMENT

Dr. Lopez's Petition seeks expansive pre-suit discovery that pursues documents and communications in the possession of UT Southwestern as well as the depositions of Dr. Podolsky and/or Dr. Warner. Dr. Lopez should be denied for the reasons demonstrated in Respondents' Plea to the Jurisdiction and Opposition to Petitioner's Rule 202 request ("Respondents' Plea and Response").[1] In addition, her requests are overly broad, not reasonably tailored to include only matters relevant to the case, and either constitute a fishing expedition or are otherwise

[1] Respondents', Dr. Podolsky and Dr. Warner, Plea to the Jurisdiction and Response in Opposition to Petitioner's Request for Pre-Suit Depositions and Documents Under Texas Rule of Civil Procedure 202 being filed simultaneously herewith is incorporated by reference.

objectionable. For all of the reasons set forth in the Plea and Response, Respondents Dr. Podolsky and Dr. Warner ask this Court to grant their plea to the jurisdiction and to deny Lopez's Rule 202 petition.

In the event that the Court grants Dr. Lopez's request and permits deposition(s) and/or document production, Drs. Podolsky and Warner submit these objections to her requests.

Alternatively, and only to the extent that this Court orders the depositions of Respondents Dr. Podolsky and/or Dr. Warner to proceed, Respondents request pursuant to Texas Rule of Civil Procedure 202.4(b) that the Court's order contain express protections necessary to prevent undue burden. In that circumstance, Respondents ask the court grant Respondents' protection by limiting the scope of depositions as well as the scope of the documents requested.

II.
BACKGROUND

Dr. Lopez's Rule 202 Petition seeks depositions and document production from Dr. Podolsky and Dr. Warner. Both are faculty physician employees of The University of Texas Southwestern Medical Center ("UT Southwestern") currently and were at the time of the decisions upon which Dr. Lopez bases her Petition. UT Southwestern is an institution of higher education and a governmental unit of the State of Texas. Dr. Podolsky is the President of UT Southwestern and Dr. Warner is the Executive Vice President (EVP) for Health System Affairs and the Chief Executive Officer (CEO) of the UT Southwestern hospitals.

Dr. Lopez, also an employee of UT Southwestern, is a pediatric endocrinologist who treats patients at UT Southwestern and Children's. Dr. Lopez seeks the depositions of Dr. Podolsky and/or Dr. Warner and certain documents prior to the depositions for the purported reason of investigating decisions and conversations related to a scope of services provided to pediatric

patients treated for gender dysphoria all of which are either known to Dr. Lopez or in the public domain, as more fully described in Respondents' Plea and Response.

As discussed therein, UT Southwestern faculty physicians provide pediatric patient care services at hospitals and clinics owned by Children's Medical Center of Dallas (Children's), including certain services formerly coordinated under the Gender Education and Care, Interdisciplinary Support ("GENECIS") program that forms the basis for the Rule 202 action. Effective November 18, 2021, pediatric endocrinology, psychiatry, and adolescent and young adult care services previously coordinated under the "GENECIS" brand started being managed through each specialty department. The care of existing patients was unchanged. New patients would still have continued access to the broader array of care, including psychiatric and other front-line services necessary for evaluation of potential gender dysphoria. *Id.* GENECIS served as a coordinating brand for the Children's sub-specialty clinics providing these pediatric services but was never a standalone clinic.

Texas Rule of Civil Procedure 202 provides a vehicle for a person to petition a Court for an order authorizing a deposition in two limited circumstances— (1) "to perpetuate or obtain the person's own testimony or that of any other person for use in an *anticipated suit*"; or (2) "to investigate a *potential claim or suit*." TEX. R. CIV. P. 202.1.

III.
STANDARD OF REVIEW

A court cannot grant such depositions unless Dr. Lopez can prove that: (1) allowing the requested depositions may prevent a failure or delay of justice in an anticipated suit, or (2) the likely benefit of allowing the requested depositions to investigate a potential claim outweighs the burden or expense of the procedure. Tex. R. Civ. P. 202.4(a).

The Texas Supreme Court has stated that Rule 202 is not a license for forced interrogations and emphasized that Courts must strictly limit and carefully supervise pre-suit discovery to prevent abuse of the rule. *In re Wolfe*, 341 S.W.3d 932 (Tex. 2011). Thus, Rule 202 depositions should *not* be routinely granted, and require extraordinary circumstances demonstrating why a particular petitioner should be entitled to a special form of discovery not employed by the vast majority of plaintiffs who follow the normal course of seeking discovery after they have filed a lawsuit. To use the Rule 202 procedure is to risk serious due process concerns for the respondent who is deposed without knowing the claims asserted against him.

IV.
OBJECTIONS

1. OBJECTIONS TO DOCUMENT REQUESTS

Dr. Lopez's request for this Court to issue a subpoena for documents implicates UT Southwestern's property and proprietary interests by virtue of UT Southwestern's affiliation agreement with Children's Medical Center of Dallas ("Children's") to provide UT Southwestern-employed faculty to provide services and treat patients at Children's clinics, including the clinics that were formerly coordinated under the brand GENECIS.

Therefore, Dr. Podolsky and Dr. Warner object to Dr. Lopez's discovery requests and move for protection from the Court. The deposition requests ask for topics that would invade attorney-client privilege, executive privilege, and seek to have deponents comment on legal theory and legal conclusions which are all improper for pre-suit discovery. As to the document requests, they seek privileged and confidential material, materials subject to attorney-client privilege, executive privilege, private patient information, and are vague. They are the epitome of a burdensome fishing expedition that have no place in pre-suit discovery, even if such discovery

were appropriate in this case. Respondents assert the following specific objections s to each of Dr. Lopez's document requests at page 17 of her Petition:

> **Request 1:** any and all documents or correspondence, including emails or texts, from the Governor, the Office of the Governor, or any member of the Executive Branch of the State of Texas relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care;
>
> > **Objections:** Respondents' object to this Request on the grounds that it seeks information which is neither relevant nor likely to lead to the discovery of admissible evidence. Respondents' also object to this Request on the grounds that it is overly broad, unduly burdensome and constitutes a fishing expedition of the type prohibited under *Loftin v. Martin*, 776 S.W.2d 145, 148 (Tex. 1989); *Texaco, Inc. v. Sanderson*, 898 S.W.2d 813 (Tex. 1995). Specifically, this Request is not properly limited in time. Finally, Respondents' object as they are not the custodian of these documents as the documents are the property of their employer.
>
> **Request 2:** any and all documents or correspondence, including emails or texts, from any member or agent of a member of the Legislative Branch of the State of Texas relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care;
>
> > **Objections:** Respondents' object to this Request on the grounds that it seeks information which is neither relevant nor likely to lead to the discovery of admissible evidence. Respondents' also object to this Request on the grounds that it is overly broad, unduly burdensome and constitutes a fishing expedition of the type prohibited under *Loftin v. Martin*, 776 S.W.2d 145, 148 (Tex. 1989); *Texaco, Inc. v. Sanderson*, 898 S.W.2d 813 (Tex. 1995). Specifically, this Request is not properly limited in time. Finally, Respondents' object as they are not the custodian of these documents as the documents are the property of their employer.
>
> **Request 3:** any and all documents or correspondence, including emails or texts, between any employee of UT Southwestern relating to the discontinuation of the GENECIS clinic, Dr. Lopez, or restrictions on gender-affirming care;
>
> > **Objections:** Respondents' object to this Request as overly broad and unduly burdensome as it is not limited in time. Further, this Request constitutes a fishing expedition of the type prohibited under *Loftin v. Martin*, 776 S.W.2d 145, 148 (Tex. 1989); *Texaco, Inc. v. Sanderson,* 898 S.W.2d 813 (Tex. 1995). Respondents' also object

to this Request on the grounds that it seeks information which is protected by the attorney/client privilege, attorney work product doctrine, was prepared in anticipation of litigation, and/or falls within the "communications" exemption afforded under Rule 192.5 or Rule 193.3 of the Texas Rules of Civil Procedure. Respondents' object to this Request in that it seeks information that would violate the peer review and/or medical committee privileges afforded to these Respondents under Texas Occupations Code, §160.001, et seq. and Texas Health and Safety Code, § 161.031 et seq; and/or 42 U.S.C., § 11101, et seq. Finally, Respondents' object as they are not the custodian of these documents as the documents are the property of their employer.

Request 4: any and all documents or correspondence, including emails or texts, from any advocacy group relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care;

Objections: Respondents' object to this Request on the grounds that it seeks information which is neither relevant nor likely to lead to the discovery of admissible evidence. Respondents' also object to this Request on the grounds that it is overly broad and constitutes a fishing expedition of the type prohibited under *Loftin v. Martin*, 776 S.W.2d 145, 148 (Tex. 1989); *Texaco, Inc. v. Sanderson*, 898 S.W.2d 813 (Tex. 1995). Specifically, this Request is not properly limited in time. Finally, Respondents' object as they are not the custodian of these documents as the documents are the property of their employer.

Request 5: any and all documents or correspondence, including emails or texts, from any professional medical society or trade association relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care;

Objections: Respondents' object to this Request on the grounds that it seeks information which is neither relevant nor likely to lead to the discovery of admissible evidence. Respondents' also object to this Request on the grounds that it is overly broad and constitutes a fishing expedition of the type prohibited under *Loftin v. Martin*, 776 S.W.2d 145, 148 (Tex. 1989); *Texaco, Inc. v. Sanderson*, 898 S.W.2d 813 (Tex. 1995). Specifically, this Request is not properly limited in time or scope. Respondents' object to this Request in that it seeks information that would violate the peer review and/or medical committee privileges afforded to these Respondents under Texas Occupations Code, §160.001, et seq. and Texas Health and Safety Code, § 161.031 et seq; and/or 42 U.S.C., § 11101, et seq. Finally, Respondents' object as they are not the custodian of these documents as the documents are the property of their employer.

Request 6: any and all documents reflecting any medical controversy regarding the provision of puberty suppression medications and/or hormone therapy to treat gender dysphoria; and

> **Objections:** Respondents' object to this Request on the grounds that it seeks information which is neither relevant nor likely to lead to the discovery of admissible evidence. Respondents' also object to this Request on the grounds that it is overly broad and constitutes a fishing expedition of the type prohibited under *Loftin v. Martin*, 776 S.W.2d 145, 148 (Tex. 1989); *Texaco, Inc. v. Sanderson*, 898 S.W.2d 813 (Tex. 1995). Specifically, this Request is not properly limited in time or scope. Respondents' further object to this Request on the grounds that it seeks information which is protected by the attorney/client privilege, attorney work product doctrine, was prepared in anticipation of litigation, and/or falls within the "communications" exemption afforded under Rule 192.5 or Rule 193.3 of the Texas Rules of Civil Procedure. Respondents' object to this Request in that it seeks information that would violate the peer review and/or medical committee privileges afforded to these Respondents under Texas Occupations Code, §160.001, et seq. and Texas Health and Safety Code, § 161.031 et seq; and/or 42 U.S.C., § 11101, et seq. Finally, Respondents' object as they are not the custodian of these documents as the documents are the property of their employer.

Request 7: all public statements made about Dr. Lopez or the GENECIS clinic.

> **Objections:** Respondents' object to this Request on the grounds that it seeks information which is neither relevant nor likely to lead to the discovery of admissible evidence. Respondents' also object to this Request on the grounds that it is overly broad and constitutes a fishing expedition of the type prohibited under *Loftin v. Martin*, 776 S.W.2d 145, 148 (Tex. 1989); *Texaco, Inc. v. Sanderson*, 898 S.W.2d 813 (Tex. 1995). Specifically, this Request is not properly limited in time or scope. Finally, Respondents' object as the requested information is already part of the Public Domain.

i. Petitioner Dr. Lopez is not Entitled to the Documents Requested.

Furthermore, Dr. Podolsky and Dr. Warner are being asked to provide documents on behalf of a third party – UT Southwestern and possible Children's. Respondents cannot be compelled to produce UT Southwestern's documents not in their possession just because they have access to

them. *In re Kuntz*, 124 S.W.3d 179, 184 (Tex. 2003) ("mere access to the relevant letters of recommendation does not constitute 'physical possession' of the documents under the definition of 'possession, custody, or control' set forth in Texas Rule of Civil Procedure 192.7(b)."); *In re Grand Jury Subpoena (Kent)*, 646 F.2d 963, 969 (5th Cir. 1981) ("The [employee's] subpoena, if upheld, would be illegal because it would direct her to produce documents not in her possession, custody, or control. Because [employee] had mere access, her compliance with the subpoena would have required that she illegally take exclusive possession of [her employer's] documents and deliver them to the grand jury."). In short, even if the Court concludes that Dr. Podolsky or Dr. Warner may be deposed under Rule 202, which Respondents deny, Dr. Lopez has not shown she is entitled to documents that belong to other entities in connection with that deposition.

Respondents' request that the court sustain its objections to Dr. Lopez's requests for documents.

2. OBJECTIONS TO DEPOSITION REQUESTS.

As asserted above, the deposition requests ask for topics that would invade attorney-client privilege, executive privilege, and seek to have deponents' comment on legal theory and legal conclusions which are all improper for pre-suit discovery. Respondents' assert the following specific objections to each of the following topics requested in page 16-17 of her Petition:

> **Request 1:** What person, entity, or office is seeking to impose limitations on Dr. Lopez's independent medical judgment to provide puberty-suppressing medications and hormone therapy to new patients;
>
> **Objections:** For the reasons stated in Respondents', Dr. Podolsky and Dr. Warner, Objections to Petitioners Pre-Suit Deposition and Document Request, Respondents' object as the requested topic is information already in the public domain. Further, Petitioner has failed to carry her burden to show (1) allowing the requested depositions may prevent a failure or delay of justice in an anticipated suit, or (2) the likely benefit of allowing the requested depositions to investigate a potential claim outweighs the burden or expense of the procedure. Tex. R. Civ. P. 202.4(a).

Request 2: Whether and which governmental official or government office communicated with UTSW and demanded such limitations be enforced by UTSW or Children's;

Objections: For the reasons stated in Respondents', Dr. Podolsky and Dr. Warner, Objections to Petitioners Pre-Suit Deposition and Document Request, Respondents' object as the requested topic is information already in the public domain. Further, Petitioner has failed to carry her burden to show (1) allowing the requested depositions may prevent a failure or delay of justice in an anticipated suit, or (2) the likely benefit of allowing the requested depositions to investigate a potential claim outweighs the burden or expense of the procedure. Tex. R. Civ. P. 202.4(a).

Request 3: The medical, ethical, and legal basis for such limitations;

Objections: For the reasons stated in Respondents', Dr. Podolsky and Dr. Warner, Objections to Petitioners Pre-Suit Deposition and Document Request, Respondents' object as the requested topic is simply asking the legal theories and legal conclusions of Respondents' which is not a proper factual inquiry under Rule 202.

Request 4: Why the limitation is not discriminatory; and

Objections: For the reasons stated in Respondents', Dr. Podolsky and Dr. Warner, Objections to Petitioners Pre-Suit Deposition and Document Request, Respondents' object as the requested topic is simply asking the legal theories and legal conclusions of Respondents' which is not a proper factual inquiry under Rule 202.

Request 5: Upon what legal authority the limitation is being imposed.

Objections: For the reasons stated in Respondents', Dr. Podolsky and Dr. Warner, Objections to Petitioners Pre-Suit Deposition and Document Request, Respondents' object as the requested topic is simply asking the legal theories and legal conclusions of Respondents' which is not a proper factual inquiry under Rule 202.

Respondents' also request that the court sustain its objections to Dr. Lopez's requests for depositions of Dr. Podolsky and Dr. Warner.

3. MOTION FOR PROTECTIVE ORDER IN THE EVENT DEPOSITION OR DOCUMENT PRODUCTION IS ALLOWED.

In the event that the Court grants Dr. Lopez's Rule 202 petition and permits depositions or requires document production Respondents' Dr. Podolsky and Dr. Warner move for protection from the Court. Respondents ask the Court to enter a protective order Pursuant to Tex. R. Civ. P. 192.6 which provides:

> (a) *Motion.* A person from whom discovery is sought, and any other person affected by the discovery request, may move within the time permitted for response to the discovery request for an order protecting that person from the discovery sought. A person should not move for protection when an objection to written discovery or an assertion of privilege is appropriate, but a motion does not waive the objection or assertion of privilege. If a person seeks protection regarding the time or place of discovery, the person must state a reasonable time and place for discovery with which the person will comply. A person must comply with a request to the extent protection is not sought unless it is unreasonable under the circumstances to do so before obtaining a ruling on the motion.
>
> (b) *Order.* ***To protect the movant from undue burden, unnecessary expense, harassment, annoyance, or invasion of personal, constitutional, or property rights, the court may make any order in the interest of justice and may--among other things--order that*:**
>
> (1) the requested discovery not be sought in whole or in part;
> (2) the extent or subject matter of discovery be limited;
> (3) the discovery not be undertaken at the time or place specified;
> (4) the discovery be undertaken only by such method or upon such terms and conditions or at the time and place directed by the court;
> (5) the results of discovery be sealed or otherwise protected, subject to the provisions of Rule 76a.
>
> Tex. R. Civ. P. 192.6(a)-(b)(emphasis added).

The Document and Deposition requests are overly broad, vague, unduly burdensome, and not properly limited in time and scope. Dr. Lopez seeks information which is neither relevant nor likely to lead to the discovery of admissible evidence and merely constitutes a prohibited fishing expedition. The information sought is subject to the attorney client privilege, executive privilege, and seeks to have deponents comment on legal theory and legal conclusions which is improper for pre-suit discovery and an improper inquiry for a purported fact witness.

As to the depositions, given the size of UT Southwestern, the duties of the President and EVP, as well as the vital role Respondents play in the operation of the organization and its services to the community, Respondents' time is at a premium. The decisions about which Dr. Lopez now complains were made months ago, in November 2021. Her delay in seeking information belies any urgency. Lopez fails to demonstrate why or that she needs the deposition of either Respondent much less that she needs *both* depositions. She has wholly failed to carry her burden of showing that the (purported) necessity of the discovery outweighs the great burden and expense to Respondents and their employer.

Moreover, the due process concerns for these physicians to be deposed without knowing the claims asserted against them is significant. The burden (indeed any burden) to Respondents cannot be outweighed by the benefit to Dr. Lopez because the information sought is unnecessary, already known to Dr. Lopez, or is otherwise in the public domain and therefore already available to Dr. Lopez.

To the extent the Court will allow pre-suit deposition testimony over Respondents' objections, Respondents seek a protective order. Specifically, given the limited nature of the inquiries and the burden to Respondents to give a deposition, Respondents ask the Court limit Lopez's depositions to two hours in total. Additionally, should the Court order production of documents as part of any such deposition, Respondents request such production be expressly limited to documents in the deponent's custody or control and limited in scope.

V.
CONCLUSION & PRAYER

For all of the reasons set forth, Respondents Dr. Podolsky and/or Dr. Warner ask this Court deny Dr. Lopez's Rule 202 petition and not allow pre-suit depositions or discovery.

Alternatively, and only to the extent that this Court orders the depositions of Respondents Dr. Podolsky and/or Dr. Warner to proceed, Respondents' request that the Court grant its Motion for Protective Order. Respondents request pursuant to Texas Rule of Civil Procedure 202.4(b) that the Court's order issued contain express protections necessary to prevent undue burden.[2] Specifically, Respondents request the Court limit Lopez's deposition to two hours of one deponent and limited in scope. Additionally, should the Court order production of documents as part of any such deposition, Respondents request such production be expressly limited to documents in each of their custody or control and subject to Respondents' objections herein.

Respectfully submitted,

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[2] This request is not a waiver of Respondent Dr. Podolsky's and Dr. Warner's jurisdictional arguments or their opposition to relief that Petition Dr. Lopez seeks. Instead, this request is made solely in the event the Court determines to allow such pre-suit discovery.

CERTIFICATE OF SERVICE

I hereby certify that on this, the 6th day of April, 2022, a true and correct copy of the foregoing instrument has been forwarded to all counsel of record through the electronic filing manager.

/s/ C. Timothy Reynolds
C. Timothy Reynolds

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Associated Case Party: UT Southwestern Medical Center

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8. Respondent, UT Southwestern's, Plea to the Jurisdiction and Response in Opposition to Petitioner's Request for Pre-Suit Deposition Under Texas Rule of Civil Procedure 202

CAUSE NO. CC-22-01316-B

	§	**IN THE COUNTY COURT OF LAW**
In re Ximena Lopez, M.D.,	§	
Petitioner.	§	**NUMBER 2**
	§	
	§	**DALLAS COUNTY, TEXAS**

RESPONDENT, UT SOUTHWESTERN'S, PLEA TO THE JURISDICTION AND RESPONSE IN OPPOSITION TO PETITIONER'S REQUEST FOR PRE-SUIT DEPOSITION UNDER TEXAS RULE OF CIVIL PROCEDURE 202

Respondent The University of Texas Southwestern Medical Center (potential adverse party "UT Southwestern") files this Plea to the Jurisdiction And Response In Opposition to Petitioner Ximena Lopez, M.D.'s ("Dr. Lopez") petition seeking pre-suit depositions and written discovery pursuant to Texas Rule of Civil Procedure 202.1(b) ("Petition"), and respectfully shows the Court as follows:

I. Background

Dr. Lopez is a physician and an employee of UT Southwestern. Dr. Lopez's specialty is pediatric endocrinology, which is the branch of medicine dealing with hormones in infants, children, and adolescents. UT Southwestern has a master services agreement with Children's Medical Center of Dallas ("Children's Medical Center"), whereby faculty physicians employed by UT Southwestern treat patients at Children's Medical Center. Pursuant to this agreement between UT Southwestern and Children's Medical Center, Dr. Lopez has provided medical care for pediatric patients at the Children's Medical Center Pediatric Endocrinology Clinic for many years.

Until November 2021, Dr. Lopez was the head of a program at Children's Medical Center called Gender Education and Care, Interdisciplinary Support, or "GENECIS." GENECIS was a

brand name for various types of "gender-affirming care" to minors who suffer from gender dysphoria, including psychiatry, endocrinology, and youth and adolescent care. Dr. Lopez describes "gender-affirming care" in her petition and attaches a document called "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People" (7th ed. 2011) ("SOC"), published by "The World Professional Association for Transgender Health" ("WPATH") which further describes some of the "gender-affirming care" treatment modalities.

According to Dr. Lopez's Petition and WPATH, there are five (5) aspects of "gender-affirming care."

1. Social interventions.

2. Puberty suppression of early-onset (or "precocious") puberty.

3. Puberty suppression to treat gender dysphoria.

4. Feminizing/masculinizing hormone therapy.

5. Surgical procedures.

Another modality of care omitted from Dr. Lopez's Petition is mental health care. Mental health care is a huge aspect of treatment for gender dysphoria in children and adolescents. For instance, mental health professionals "[d]irectly assess gender dysphoria in children and adolescents," "[p]rovide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties, and "[a]ssess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment)." SOP at 14.

In November 2021, UT Southwestern and Children's Medical Center made the joint decision (1) to end the use of the GENECIS brand, (2) to stop providing puberty-suppressing hormones to treat gender dysphoria to new patients, and (3) to stop providing feminizing and masculinizing hormone therapy to new patients. Patients already receiving puberty-suppressing hormones to treat gender dysphoria and feminizing and masculinizing hormone therapy may continue to receive that treatment, as Dr. Lopez acknowledges. Petition at 10 ("Dr. Lopez has been told she can provide [puberty suppressing medication and hormone therapy] to patients already receiving such medications"). Other "gender-affirming care," such as social interventions and mental health care, is still available to current and new patients. Surgery is not and has never been a treatment option for minor patients with gender dysphoria at UT Southwestern or performed by UT Southwestern physicians at Children's Medical Center.

Dr. Lopez alleges that ending the use of the GENECIS brand, and ceasing providing puberty suppressing hormones and feminizing and masculinizing hormone therapy (hereafter referred to collectively as "hormone therapy") to new pediatric patients as a treatment for gender dysphoria, are all illegal. She argues that these decisions and actions violate 22 Tex. Admin. Code § 177.5 and "other statutory prohibitions against the corporate practice of medicine." She further argues that "the limitations imposed by [UT Southwestern] on Dr. Lopez are targeted to discriminate against patients based on their gender identity" because "GnRH is an available treatment at [UT Southwestern] when a physician determines it is medically appropriate treatment for someone with precocious puberty; GnRH is **not** available treatment at [UT Southwestern] when a physician determines it is medically appropriate treatment for someone with

gender dysphoria." Petition at 11 (emphasis in original). Therefore, Dr, Lopez asserts not offering hormone therapy to new pediatric patients to treat gender dysphoria is *ultra vires*. *Id.*

She also alleges that these decisions were made because "either the Governor or the Governor's office exerted political pressure on UTSW to close the GENECIS clinic and to stop clinicians from providing gender-affirming care." Petition at 10. As previously explained, the latter phrase is inaccurate, and UTSW still provides "gender-affirming care" to current patients and new patients needing evaluation for gender dysphoria.

Dr. Lopez seeks a deposition under Rule 202 "to investigate" "who is dictating this illegal policy and why." Petition at 1. Similarly, she states, "Absent some publicly unknown legal basis for the actions, Dr. Lopez believes the acts to be *ultra vires* but she cannot know for sure until she knows who is doing it, and under what legal authority." Of course, she knows exactly who made the decision. As publicly known via joint press releases, it was a joint decision by UT Southwestern and Children's Medical Center. But Dr. Lopez suggests that unknown people, such as the Governor or Legislators, might have pressured UT Southwestern and Children's Medical Center into making that decision.

She states that UT Southwestern, Children's Medical Center, Daniel K. Podolsky, M.D., ("Dr. Podolsky") the President of UT Southwestern, and John Warner, M.D., ("Dr. Warner"), UT Southwestern's Executive Vice President for Health System Affairs and Chief Executive Officer of UT Southwestern Health System, are potentially adverse parties.

She argues that she needs to depose Dr. Podolsky and Dr. Warner to determine:

1. What person, entity, or office is seeking to impose limitations on Dr. Lopez's independent medical judgment to provide puberty-suppressing medications and hormone therapy to new patients;

2. Whether and which governmental official or government office communicated with UTSW and demanded such limitations be enforced by UTSW or Children's;

3. The medical, ethical, and legal basis for such limitation;

4. Why the limitation is not discriminatory; and

5. Upon what legal authority the limitation is being imposed.

Petition at 12, 16–17.

She also asks the Court to order the issuance of subpoena requiring Dr. Podolsky, Dr. Warner, and UT Southwestern to produce any and all documents related to the following categories at least three days before the first deposition:

1. any and all documents or correspondence, including emails or texts, from the Governor, the Office of the Governor, or any member of the Executive Branch of the State of Texas relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care;

2. any and all documents or correspondence, including emails or texts, from any member or agent of a member of the Legislative Branch of the State of Texas relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care;

3. any and all documents or correspondence, including emails or texts, between any employee of UTSW relating to the discontinuation of the GENECIS clinic, Dr. Lopez, or restrictions on gender-affirming care;

4. any and all documents or correspondence, including emails or texts, from any advocacy group relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care;

5. any and all documents or correspondence, including emails or texts, from any professional medical society or trade association relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care;

6. any and all documents reflecting any medical controversy regarding the provision of puberty suppression medications and/or hormone therapy to treat gender dysphoria; and

7. all public statements made about Dr. Lopez or the GENECIS clinic.

Petition at 17.

II. Summary of the Argument

The Court should deny Dr. Lopez's Rule 202 Petition for many reasons.

1. UT Southwestern retains its sovereign immunity. Dr. Podolsky and Dr. Warner, in their official capacities, also retain their sovereign immunity.

    A. Rule 202 depositions may not be used to investigate potential claims that are otherwise barred by sovereign immunity. Absent a statutory waiver of sovereign immunity, the Court cannot order a Rule 202 deposition. Moreover, Dr. Lopez lacks standing to complain about alleged discrimination against her potential patients.

    B. UT Southwestern is immune to *ultra vires* suits, and so is immune to the potential suit against it and a Rule 202 deposition. Suits alleging *ultra vires* conduct by a governmental official in his official capacity are not barred by sovereign immunity, but Dr Lopez has not stated an *ultra vires* claim against Dr. Podolsky or Dr Warner in their official capacities, so they retain their sovereign immunity.

2. Even if Dr. Lopez could overcome sovereign immunity, she has not met her burden of demonstrating entitlement to a Rule 202 deposition.

    A. She has not shown that the likely benefit of allowing her to take the requested deposition to investigate potential claims outweighs the burden or expense to UT Southwestern.

    B. She has not and cannot show that anyone has the power to direct UT Southwestern to end GENECIS or to stop offering hormone therapy to new patients diagnosed with gender dysphoria, so any deposition would not help her investigate her claim that UT Southwestern violated the law by doing so.

    C. She has no right to discover potential defendants' legal theories pre-suit.

    D. She has not submitted competent evidence to support the ordering of a Rule 202 deposition.

3. Even if she could overcome those obstacles, UT Southwestern would be entitled to a protective order limiting the deposition.

A. The court should not allow questioning on topics 3, 4, or 5 because that seeks information protected by the attorney-client privilege, and such information is only discoverable through contention interrogatories and requests for admissions, not depositions.

B. This court should limit the production of documents to documents that evidence any direction or attempted direction that UT Southwestern end GENECIS and stop providing hormone therapy to new patients, and the court should restrict the date range of responsive documents to a reasonable time period, not to exceed 6 months, before the decisions were implemented on November 18, 2021.

III. Plea to the Jurisdiction

A. Standard Of Review

A plea to the jurisdiction challenges the court's authority to determine the subject matter of the controversy. *Bland Indep. Sch. Dist. v. Blue*, 34 S.W.3d 547, 553-54 (Tex. 2000). The purpose of a plea to the jurisdiction is to "defeat a cause of action without regard to whether the claims asserted have merit." *Id.* at 554. As an initial matter, the plaintiff must "allege facts that affirmatively demonstrate the court's jurisdiction to hear the cause." *Tex. Ass'n of Bus. v. Tex. Air Control Bd.*, 852 S.W.2d 440, 446 (Tex. 1993). Whether a plaintiff has alleged facts that affirmatively establish subject-matter jurisdiction, and whether undisputed evidence of jurisdictional facts establish a trial court's jurisdiction, are both questions of law for the trial court to decide. *Tex. Dep't of Parks & Wildlife v. Miranda*, 133 S.W.3d 217, 226 (Tex. 2004).

When a defendant's plea to the jurisdiction challenges the plaintiff's pleadings, the court determines whether the plaintiff alleged facts that affirmatively demonstrate subject-matter jurisdiction. *Id.*; *City of El Paso v. Heinrich*, 284 S.W.3d 366, 378 (Tex. 2009). To determine whether a plaintiff demonstrated a court's jurisdiction, a court looks to the facts alleged in the petition, construed in favor of the plaintiff, as well as any evidence submitted by the parties that is

pertinent to the jurisdictional inquiry. *Miranda*, 133 S.W.3d at 226-27; *Cty. of Cameron v. Brown*, 80 S.W.3d 549, 555 (Tex. 2002). If the pleadings do not contain sufficient facts to affirmatively demonstrate the trial court's jurisdiction, but do not affirmatively demonstrate incurable defects in jurisdiction, the issue is one of pleading sufficiency and the plaintiffs should be afforded the opportunity to amend. *Miranda*, 133 S.W.3d at 226-27. However, if the pleadings affirmatively negate the existence of jurisdiction, then a plea to the jurisdiction should be granted without allowing the plaintiffs an opportunity to amend. *Id.* at 227.

B. Sovereign immunity

The common-law doctrine of sovereign immunity prohibits suits against the state unless the state consents and waives its immunity. Sovereign immunity from suit implicates a court's subject-matter jurisdiction. *Nazari v. State*, 561 S.W.3d 495, 500 (Tex. 2018). Immunity from suit is properly asserted in a plea to the jurisdiction. *Hous. Belt & Terminal Ry. Co. v. City of Hous.*, 487 S.W.3d 154, 160 (Tex. 2016).

Although the state may elect to waive its sovereign immunity, that policy decision belongs to the legislature. The legislature may waive the state's immunity by statute or by legislative resolution. If the legislature elects to waive immunity, it must do so by clear and unambiguous language. *Nazari*, 561 S.W.3d at 500; Tex. Gov't Code § 311.034.

C. Rule 202 depositions may not be used to investigate potential claims against governmental entities that are otherwise barred by sovereign immunity.

A court cannot allow pre-suit depositions when it would "not have jurisdiction to hear and determine the cause." *In re Wolfe*, 341 S.W.3d 932 (Tex. 2011) (per curiam). "The scope of discovery in depositions authorized by [Rule 202] is the same as if the anticipated suit or potential claim had been filed." Tex. R. Civ. P. 202.5. A petitioner "cannot obtain by Rule 202 what it would

be denied in the anticipated action." *Wolfe*, 341 S.W.3d at 933. As a result, a plea to the jurisdiction can be used to prevent pre-suit depositions sought "to investigate potential claims that are otherwise barred by sovereign immunity." *Combs v. Tex. Civil Rights Project*, 410 S.W.3d 529, 535 (Tex. App.—Austin 2013, pet. denied). Finally, when, as here, discovery is sought from a governmental entity, "[t]he petition must also set forth specific facts demonstrating that, at least potentially, the petitioner has been injured by actions that would amount to a claim which would not be barred by sovereign immunity." *In re Dallas Cty. Hosp. Dist.*, no. 05–14–00249–CV, 2014 WL 1407415 (Tex. App.—Dallas, Apr. 1, 2014, no pet. (orig. proceeding)) (citing *Combs v. Texas Civil Rights Project,* 410 S.W.3d at 536).

Dr. Lopez correctly notes that sovereign immunity does not automatically bar a Rule 202 deposition. But she fails to acknowledge governmental entities retain their sovereign immunity to Rule 202 depositions unless there is a waiver of sovereign immunity.

D. No waiver of sovereign immunity applies to this case.

Dr. Lopez never identifies any waiver of UT Southwestern's sovereign immunity that might apply. Moreover, no waiver of sovereign immunity applicable to her allegations is conceivable.

Dr. Lopez alleges that UT Southwestern violated 22 Tex. Admin. Code § 177.5. Petition at 10. That provision does not waive UT Southwestern's sovereign immunity for two reasons. First, it does not contain a waiver of sovereign immunity because it does not apply to state governmental units like UT Southwestern or Dr. Podolsky or Dr. Warner in their official capacities. That rule instead applies to health organizations certified under section 162.001(b) of the Texas Occupations Code. Second, neither the rule nor section 162.001(b) create a private right of action. Instead, the

only remedy for violations of the rule by 162.001(b) health care organizations (which, again, UT Southwestern is not) is that "the [Texas Medical Board] may impose an administrative penalty against a health organization under Chapter 165 of the [Texas Occupations Code] or revoke a certification if in the board's determination the health organization is established, organized, or operated in contravention of or with the intent to circumvent any of the provisions of the Act or the board's rules." 22 Tex. Admin. Code § 177.12(b). Thus, this rule does not waive sovereign immunity, and Dr. Lopez cannot use this as a basis for discovery under Rule 202.

Dr. Lopez also alleges that UT Southwestern has violated "other statutory prohibitions against the corporate practice of medicine." Petition at 10–11. But the corporate practice of medicine doctrine does not apply to physician employees of UT Southwestern like Dr. Lopez. *See* 22 Tex. Admin. Code §§ 177.17(b)(24)(A), 172.8; Tex. Occ. Code § 155.104(b)(4)(B). Consequently, there is no "statutory prohibition[] against the corporate practice of medicine" that could apply to UT Southwestern, and thus no waiver of UT Southwestern's sovereign immunity. Moreover, Dr. Lopez has no cause of action (or standing) to force UT Southwestern continue to offer particular treatments to particular patients.

Dr. Lopez also alleges that "the limitations imposed by [UT Southwestern] on Dr. Lopez are targeted to discriminate against patients based on their gender identity." Petition at 11. Even taking her framing of the matter as true, she has not identified any waiver of UT Southwestern's sovereign immunity, which is her burden.

Additionally, Dr. Lopez's claims do not fall within a Texas Tort Claims Act waiver of sovereign immunity in Chapter 101 of the Texas Civil Practices and Remedies code. To the extent

they could also be construed as health care liability claims, such claims do not permit Rule 202 depositions.

Finally, Dr. Lopez identifies no authority—and there is none—that gives her standing to complain about alleged discrimination against future potential patients (she agrees that the only changes are to services that apply prospectively to new patients, while maintaining continuity of care for existing patients). Therefore, the Court lacks jurisdiction over that complaint. "Standing is a constitutional prerequisite to suit. A court has no jurisdiction over a claim made by a plaintiff who lacks standing to assert it. Thus, if a plaintiff lacks standing to assert one of his claims, the court lacks jurisdiction over that claim and must dismiss it." *Heckman v. Williamson Cty.*, 369 S.W.3d 137, 150 (Tex. 2012) (citations omitted).

E. *Ultra vires* claims against UT Southwestern are barred by sovereign immunity, and Dr. Lopez has not stated any *ultra vires* claim against any official in his or her official capacity.

Dr. Lopez asserts that UT Southwestern's decisions that she challenges were *ultra vires*. But sovereign immunity bars *ultra vires* claims if asserted against a state agency like UT Southwestern. *City of El Paso v. Heinrich*, 284 S.W.3d 366, 372–73 (Tex.2009) (explaining that suits seeking to restrain illegal acts of state officials "cannot be brought against the state, which retains immunity, but must be brought against the state actors in their official capacity"). Instead, an *ultra vires* suit must lie against the allegedly responsible government actor in his official capacity, not a nominal, apex representative who has nothing to do with the allegedly *ultra vires* actions. *Hall v. McRaven*, 508 S.W.3d 232, 240 (Tex. 2017). But although Dr. Lopez names allegedly potential

parties in their official capacities (Dr. Podolsky and Dr. Warner), she has not in fact alleged *ultra vires* action, so they retain their sovereign immunity.[1]

Dr. Lopez's Petition fails to show that the depositions she seeks are to investigate potential *ultra vires* claims over which the Court would have jurisdiction. She fails to allege facts regarding a valid *ultra vires* claim. She does not and cannot claim that anyone, including Dr. Podolsky and Dr. Warner, had a ministerial duty to keep GENECIS active or to provide certain treatment to certain types of new patients. UT Southwestern and its officials have the authority to establish and disestablish programs and the authority to continue or discontinue certain kinds of care. Dr. Lopez has not alleged that anyone exceeded the bounds of that authority. She does allege that the actions she challenges are illegal for various reasons; she is incorrect.

As explained above, the challenged actions do not violate 22 Tex. Admin. Code § 177.5, statutory prohibitions on the corporate practice of medicine, or any anti-discrimination law—and Dr. Lopez lacks standing to complain about any supposed discrimination against her patients. The complained of actions simply do not fit in the *ultra vires* exception to immunity.

Because Dr. Lopez's claim does not fall within the *ultra vires* exception, the Court lacks subject-matter jurisdiction over the future claim and thus the Rule 202 petition. In *ultra vires* cases, courts must first construe the applicable law because "whether the [official's] conduct constitutes *ultra vires* action[] … that falls within an exception to governmental immunity depends on what the statute required of the [governmental entity]." *Sw. Bell Tel., L.P. v. Emmett*, 459 S.W.3d 578,

[1] *See* Drs. Poldosky and Warner's Response and argument that Dr. Lopez's incorrect *ultra vires* claims do not save her Rule 202 Petition, incorporated herein by reference.

583 (Tex. 2015); *see also Beeman v. Livingston*, 468 S.W.3d 534, 538 (Tex. 2015) ("whether [the state official's] actions were ultra vires depends on whether the statute required anything of him").

Only then can the Court decide whether the petitioner has pleaded facts for which immunity is waived. *See Hall v. McRaven*, 508 S.W.3d at 243 (affirming the grant of a plea to the jurisdiction where the Court, after examining the governing statutes and regulations, determined that the university chancellor acted within his discretion and did not violate a ministerial duty); *Hous. Belt & Terminal*, 487 S.W.3d at 163 (analyzing city official's duties under municipal ordinances and concluding jurisdiction was present); *Heinrich*, 284 S.W.3d at 377–80 (Tex. 2009) (analyzing the claims and the applicable law and concluding jurisdiction was present).

UT Southwestern and its officials did not violate a ministerial duty and acted within their discretion, so the challenged actions cannot be without legal authority or *ultra vires*. Therefore, Dr. Lope's *ultra vires* claim to support a Rule 202 petition must be dismissed for want of jurisdiction. *Sw. Bell Tel., L.P. v. Emmett*, 459 S.W.3d at 587–88.

* * *

UT Southwestern, and Dr. Podolsky and Dr Warner in their official capacities, have proven that they retain their sovereign immunity under the facts and law as pled in the Petition. The Court should grant their plea to the jurisdiction.

IV. Response in Opposition

Regardless of the status of UT Southwestern as a state agency with sovereign immunity, Dr. Lopez would still not be entitled to a Rule 202 deposition. To the extent the Court finds Dr. Lopez's Rule 202 Petition survives UT Southwestern's plea to the jurisdiction, UT Southwestern file its response in opposition, and respectfully show the Court as follows:

A. Standard Of Review

Rule 202 contemplates two types of pre-suit depositions: (1) depositions to investigate a potential claim or suit that may never be filed, Tex. R. Civ. P. 202.1(b); and (2) depositions to preserve testimony when suit is anticipated, Tex. R. Civ. P. 202.1(a). Dr. Lopez seeks the first kind of deposition.

If a petitioner seeks a deposition to investigate potential claims, she must show that the likely benefit of allowing her to take the requested deposition outweighs the burden or expense of the procedure. Tex. R. Civ. P. 202.4(a)(2). To obtain an order authorizing pre-suit depositions, the petitioner must make some effort to present the trial court with a basis for one of these required findings. *See In re Does*, 337 S.W.3d 862, 865 (Tex. 2011). The allegations in the petition must be more than "sketchy." *See id.*

Significantly, the Texas Supreme Court has made clear that Rule 202 depositions "are not now and never have been intended for routine use," precisely because they necessarily implicate the "practical as well as due process problems with demanding discovery from someone before telling him what the issues are." *In re Jorden*, 249 S.W.3d 416, 423 (Tex. 2008) (emphasis added). Even more recently, the Supreme Court has stated that Rule 202 is not a license for forced interrogations, and emphasized that Courts must strictly limit and carefully supervise pre-suit discovery to prevent abuse of the rule. *In re Wolfe*, 341 S.W.3d 932 (Tex. 2011). Thus, Rule 202 depositions should not be routinely granted, and require extraordinary circumstances demonstrating why a particular petitioner should be entitled to a special form of discovery not employed by the vast majority of plaintiffs who follow the normal course of seeking discovery after

they have filed a lawsuit. To use the Rule 202 procedure is to risk serious due process concerns for the respondent who is deposed without knowing the claims asserted against him.

B. The Court should deny Dr. Lopez's Petition because she failed to meet her burden.

Dr. Lopez's Petition is insufficient to meet the requirements of Rule 202. For the Court to order a pre-suit deposition for the purpose of investigating potential claims, she must show that the likely benefit of allowing her to take the requested deposition to investigate potential claims outweighs the burden or expense to the Respondent. Tex. R. Civ. P. 202.4(a)(2). Dr. Lopez cannot meet this burden.

It is undisputed that UT Southwestern and Children's Medical Center jointly made the decisions that Dr. Lopez claims are illegal. Dr. Lopez claims that she needs a pre-suit deposition to find out "who is dedicating this illegal policy and why?" Petition at 1. Similarly, she states, "Someone, some entity, or some office is illegally attempting to interfere with or control Dr. Lopez's independent medical judgment [by ending GENECIS and no longer offering hormone therapy to new patients as one treatment for gender dysphoria]." *Id.* at 2. And despite declaring that the decisions were "illegal," Dr. Lopez also states, "Absent some publicly unknown legal basis for the actions, Dr. Lopez believes the acts to be *ultra vires* but she cannot know for sure until she knows who is doing it, and under what legal authority." *Id.* at 11.

Thus, Dr. Lopez argues that she will benefit by finding out pre-suit (a) who dictated the challenged decisions; (b) why whoever dictated the challenged decision did so; and (c) to the extent that UT Southwestern and Children's Medical Center jointly made the decisions she challenges, why they did so and under what legal authority. The topics which she seeks to explore in a Rule

202 deposition, and the documents she seeks to be produced, are all geared towards finding these things out (although they do so in an overbroad fashion; *see* Part VI).

But Dr. Lopez will not get any benefit from finding out pre-suit (a) who dictated the challenged decisions; or (b) why whoever dictated the challenged decision did so because nobody—not even the Governor or Legislators—can "dictate" to UT Southwestern how to provide or not provide particular care outside of duly enacted state law. Dr. Lopez does not (because she cannot) show that anyone can "dictate" such decisions to UT Southwestern. Even if UT Southwestern, a state agency, receives political pressure, that would not be illegal. And in any event, UT Southwestern has already acknowledged publicly that it did consider the political pressure surrounding this issue as one factor. Nonetheless, even if UT Southwestern succumbed to political pressure, its decisions are its own, and no one else can possibly be liable for "dictating" those decisions to UT Southwestern. Dr. Lopez articulates no theory of liability or cognizable claim she could assert. Thus, finding out who supposedly "dictated" the decision and why will not benefit Dr. Lopez pre-suit.

Finding out pre-suit why UT Southwestern made the decisions she challenges, and under what legal authority, will also not benefit D. Lopez pre-suit except to the extent that it would benefit anybody who seeks a Rule 202 deposition. Of course, every potential plaintiff would like to find out a potential defendant's legal defenses before filing suit, but that's not our system, and Rule 202 depositions are not intended for routine use. Instead, plaintiffs routinely find out a defendant's legal defense *after* the defendant is sued. Dr. Lopez presents no reason why the routine litigation course needs to be modified here. Moreover, she already knows the "illegal policy" that she wants to challenge and who is responsible for it – both are described in detail and named in her Petition.

Furthermore, the idea that UT Southwestern needs to produce its legal reasoning justifying its decisions about the care it offers pre-suit is backwards (not to mention violative of attorney-client privilege). It is Dr. Lopez's burden to show that UT Southwestern violated the law, not UT Southwestern's burden to show that it did not.

Dr. Lopez can sue UT Southwestern and Children's Medical Center right now and allege that the decisions were *ultra vires* or otherwise illegal. Additional information will not benefit her, other than benefitting her in an obvious, routine ways that would unfairly disadvantage UT Southwestern in her future suit and do not justify a Rule 202 deposition.

UT Southwestern is burdened by having to prepare two of its top administrators for deposition (and taking them away from their many duties). The burden is increased when, as here, UT Southwestern has not seen Dr. Lopez's lawsuit or legal theories and has not had a chance to engage in discovery of its own. And producing documents for the deposition adds to the burden.

Ordering a Rule 202 deposition pre-suit for the purpose of discovering UT Southwestern's legal justifications for its decisions is tantamount to ordering UT Southwestern to write a motion for summary judgment in its favor before even seeing what the lawsuit is about. This is also an unfair burden on UT Southwestern.

Ordering a Rule 202 deposition would not benefit Dr. Lopez in any way relevant to the purpose of Rule 202 depositions, and would unfairly burden UT Southwestern. The Court should deny Dr. Lopez's Petition.

C. Dr. Lopez has not produced facts necessary to support her Petition.

Lopez has averred no facts about how the benefit of allowing the depositions she seeks outweighs the burden to UT Southwestern. Instead, she merely tracks the language of the Rule

202 regarding the permissible reasons one might seek a pre-suit deposition. Dr. Lopez fails to provide any competent evidence that the likely benefit of the discovery outweighs the burden or expense of the procedure. Neither her verification of her Petition nor her affidavit filed on March 31 contain any evidence to support a Rule 202 deposition.

* * *

Dr. Lopez cannot show, and has produced no evidence, that the benefit of a Rule 202 deposition is of sufficient investigative benefit to outweigh the burdens of taking Dr. Podolsky and Dr. Warner away from their duties in order to sit for unfair depositions on producing documents. The Court should deny Lopez's Rule 202 Petition.

V. Motion for protective order

Even if UT Southwestern did not retain its sovereign immunity, and even if Dr. Lopez had met her burden to show entitlement to a Rule 202 deposition, the Court should still limit her requested pre-suit discovery. If a court finds that the petitioner meets her burden, then the order issued "must state whether a deposition will be taken on oral examination or written questions … [and it] must contain any protections the court finds necessary or appropriate to protect the witness or any person who may be affected by the procedure." Tex. R. Civ. P. 202(b).

A. Dr. Lopez should not be allowed to ask questions about UT Southwestern's legal theories at a deposition.

UT Southwestern objects Topics 3, 4, and 5 because they seek discovery of legal contentions and the factual bases for those contentions (collectively, "contentions"). Discovery of contentions is not allowed via deposition. It is only allowed via requests for disclosure and via contention interrogatories, not depositions.

Discovery of contentions is separate and apart from general discovery because contentions are not relevant *evidence*. "In general, a party may obtain discovery regarding any matter that is not privileged and is *relevant to the subject matter of the pending action*." Rule 192.3(a) (emphasis added). Evidence is relevant if (a) it has any tendency to make a fact more or less probable than it would be without the evidence; and (b) the fact is of consequence in determining the action. Tex. R. Evid. 401. A party's contentions cannot possibly have any tendency to make any fact more or less probable than it would be without the contention. Thus, contentions are not relevant evidence and are not discoverable under general rules.

Instead, contentions are discoverable only under specific rules. And all of the specific rules governing the discovery of contentions assume that contentions are only discoverable via disclosure and contention interrogatories.

Rule 192.3(j) places contentions within the scope of discovery: "A party may obtain discovery of any other party's legal contentions and the factual bases for those contentions." But, as comment 5 clarifies, "Rule 192.3(j) makes a party's legal and factual contentions discoverable but does not require more than a *basic statement* of those contentions and does not require a marshaling of evidence [emphasis added]."

Rule 194.2(c) makes disclosable "the legal theories, and, in general, the factual bases of the responding party's claims or defenses (the responding party need not marshal all evidence that may be offered at trial)." And, as comment 2 clarifies, "Rule 194.2(c) [] permits a party further inquiry another's legal theories and factual claims than is often provided in notice pleadings. So-called 'contention interrogatories' are used for the same purpose. Such interrogatories are not properly used to require a party to marshal evidence or brief legal issues. Paragraph[] (c) [is]

intended to require disclosure of a party's basic assertions, whether in prosecution of claims or defenses [emphasis added]."

Rule 197.1 states, "An interrogatory may inquire whether a party makes a specific legal or factual contention and may ask the responding party to state the legal theories and to describe in general the factual bases for the party's claims or defenses, but interrogatories may not be used to require the responding party to marshal all of its available proof or the proof the party intends to offer at trial." Comment 1 specifies, "[I]nterrogatories that ask a party to state all legal and factual assertions are improper [emphasis added]," and, "As with requests for disclosure, interrogatories may be used to ascertain basic legal and factual claims and defenses but may not be used to force a party to marshal evidence [emphasis added]."

These specific provisions show that contentions are only discoverable via requests for disclosure and interrogatories in six ways.

1. Comment 2 to Rule 194.2(c) assumes that contentions are only discoverable via requests for disclosure and contention interrogatories. "Rule 194.2(c) [] permit[s] a party further inquiry another's legal theories and factual claims than is often provided in notice pleadings. So-called 'contention interrogatories' are used for the same purpose." It makes no sense to acknowledge that contentions are discoverable in two ways if they are also discoverable in other ways.

2. These specific contention discovery rules mandate that not "more than a basic statement of those contentions" is discoverable (Rule 192 cmt. 5), that "a party's basic assertions" are disclosable (Rule 194 cmt. 2), and that "As with requests for disclosure, interrogatories may be used to ascertain basic legal and factual claims and defenses" (Rule 197 cmt. 1). But questions at depositions are decidedly not limited to "basic" matters. It does not make sense to have specific

rules limiting discovery of contentions to "basic" matters if contentions may be also discovered at depositions, which are not so limited.

3. Moreover, these specific contention discovery rules also mandate that discovery of contentions "are not properly used to … brief legal issues." Rule 194.2(c), cmt. 2. But deponents can be asked question after follow-up question, and even hypothetical questions, limited only by time restraints. It makes no sense have a specific rule relieving parties from having to brief legal issues if those parties may be asked questions, follow-up questions, and hypothetical questions about a party's legal contentions at a deposition.

4. These specific contention discovery rules also mandate that discovery of contentions "does not require a marshaling of evidence" (Rule 192 cmt. 5), "are not properly used to require a party to marshal evidence" (Rule 194 cmt. 2), and "but may not be used to force a party to marshal evidence" (Rule 197 cmt. 1). There are no such limitations at depositions. It makes no sense to have specific rules relieving parties from having to marshal their evidence when responding to contention questions if contentions may be also discovered at depositions, which are not so limited.

5. Contentions that have been amended or supplemented are not admissible and may not be used for impeachment. "A disclosure under Rule 194.2(c) [allowing disclosure of contentions] [] that has been changed by an amended or supplemental response is not admissible and may not be used for impeachment." Rule 194.6. "An answer to an interrogatory inquiring about matters described in Rule 194.2(c) [] that has been amended or supplemented is not admissible and may not be used for impeachment." Rule 197.3. It makes no sense to have specific rules that contentions produced in response to a request for disclosure or a contention interrogatory are not admissible

and may not be used for impeachment if they are supplemented or amended, but that they are admissible and may be used for impeachment if made in a deposition, even if supplemented or amended. The lack of such a corresponding Rule further shows that contentions may not be discovered via deposition.

6. Responses to requests for disclosure, including disclosure of contentions, do not have to be verified. Neither do answers to contention interrogatories. Rule 197.2(d)(2). But answers at a deposition are under oath. Rule 199.5(b). It makes no sense that contentions produced in a response to a request for production or a contention interrogatory do not have to be under oath if contentions may also be obtained under oath at a deposition.

Reason number 6 exposes a fundamental problem with discovering a party's contentions at a deposition. Lawyers write responses to requests for disclosure and the answers to contention interrogatories, not parties. Lawyers are not deposed on their legal contentions, which, again, are not relevant evidence. If parties could make legal contentions, they wouldn't need lawyers. To depose a party on their lawyers' legal contentions—or for that matter, to cut out the middleperson and cross-examine the lawyer him- or herself at a deposition—is absurd, and preparing for such a deposition is impossible. Instead, the Rules make perfect sense: they require parties to state their contentions in response to a request for disclosure or a contention interrogatory instead. That is the very reasonable compromise agreed to in the 1999 revisions of the Rules for discovery.

In the alternative, should the Court disagree with UT Southwestern about the discoverability of contentions at a Rule 202 deposition, UT Southwestern asserts that preparing a witness to testify about Topics 3, 4, and 5 is unduly burdensome—in fact, impossible. The Court should not allow any questions on Topics 3, 4, and 5.

C. The Court should limit the production of documents to documents that show that that are relevant to the question of who "dictated" that UT Southwestern make the decisions Dr. Lopez challenges.

As noted, Dr. Lopez's theorizes that someone other than UT Southwestern and Children's Medical Center "dictated" the decisions that Dr. Lopez challenges. Yet her document requests numbered 1 through 5 seek all communications related to GENECIS, Dr. Lopez, or "gender-affirming care," including some documents from entities that cannot possibly have "dictated" UT Southwestern do anything, such as documents from "any advocacy group" and "any professional medical society." The Court should limit document production to documents that evidence that someone other than UT Southwestern and Children's Medical Center "dictated" the decisions Dr. Lopez challenges.

Not only are her requests not limited in scope, they are also not limited in time—for example the time leading up to when the changes to GENECIS and hormone therapy offered were implemented on November 18, 2021. As written, Dr. Lopez seeks "any and all documents … relating to … Dr. Lopez," from any time frame. As an example, documents responsive to request number 3 would include any UT Southwestern document related to Dr. Lopez—including performance reviews, normal business communications, her hiring and employment at UT Southwestern, and communications related to patients.

Document request number 6 seeks documents "reflecting any medical controversy regarding the provision of puberty suppression medications and/or hormone therapy to treat gender dysphoria." Document request number 7 seeks "all public statements made about Dr. Lope or the GENECIS clinic." Producing these documents cannot possibly advance Dr. Lopez's case for a Rule 202 deposition. Such documents do not concern whether someone other than UT

Southwestern and Children's Medical Center made the decisions Dr. Lopez challenges. The Court should deny Dr. Lopez's request that UT Southwestern produce those documents.

The burden of producing all the documents requested would outweigh any benefit of production. The "broad nature of the document requests" should indicate to this Court "that the benefit of allowing the discovery outweighs the burden or expense of the procedure." *DeAngelis v. Protective Parents Coal.*, 556 S.W.3d 836, 858 (Tex. App.—Fort Worth 2018, no pet.). The requests are so draconian that they would not be allowed in an actual lawsuit, and the time and expense of gathering the materials, vetting them for privileges, and producing them would far outweigh any benefit to determine whether someone "dictated" UT Southwestern's decision – which is neither illegal nor actionable by Dr. Lopez. *See DeAngelis*, 556 S.W.3d at 858.

VI. Conclusion and Prayer

UT Southwestern asks this Court to grant its plea to the jurisdiction and to dismiss Lopez's Rule 202 Petition. In the alternative, UT Southwestern requests that the Court deny Dr. Lopez's Rule 202 Petition because she has not shown entitlement to a pre-suit investigatory deposition. In further alternative, should the Court allow deposition and document production the Court should limit same as requested in Part V, above.

Date: April 6, 2022.

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CERTIFICATE OF SERVICE

I hereby certify that on April 6, 2022, a copy of the foregoing document has been served on

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9. Respondent Children's Medical Center of Dallas's Motion to Strike Affidavit of Ximena Lopez, M.D.

CAUSE NO. CC-22-01316-B

IN RE XIMENA LOPEZ, M.D., *Petitioner*,	§	IN THE COUNTY COURT AT LAW
	§	No. 2
	§	DALLAS COUNTY, TEXAS

RESPONDENT CHILDREN'S MEDICAL CENTER OF DALLAS'S MOTION TO STRIKE AFFIDAVIT OF XIMENA LOPEZ, M.D.

Respondent Children's Medical Center of Dallas[1] ("CMCD") files the following Motion to Strike Affidavit of Ximena Lopez, M.D. ("Dr. Lopez") offered as supplemental support of her Verified Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202 ("Petition"), and would respectfully show the Court the following:

INTRODUCTION

Dr. Lopez filed this Rule 202 proceeding on March 16, 2022, and has set this matter for hearing before this Court on April 11 via CourtCall. Dr. Lopez verified the Petition, indicating that she has read the Petition and that the facts stated within it are within her personal knowledge and are true and correct. *See* Pet. at 20 (Verification of Ximena Lopez, M.D.). CMCD filed Objections and a Motion for Protective Order in response to the Petition on March 30.

On March 31, Dr. Lopez filed a Supplement to the Petition that attached an Affidavit signed by Dr. Lopez "in further support of her [Petition]" ("Lopez Affidavit"). Supp. to Petition at 1. In the Affidavit, Dr. Lopez states that, on or about November 17, 2021, the University of Texas Southwestern Medical Center ("UTSW") informed her that she would not be permitted to provide

[1] Incorrectly identified as "Children's Medical Center Dallas."

gender-affirming care to new patients. *Id.* at 3 (Lopez Aff. at ¶ 2). The Affidavit further states the following:

> Since that date, I have been advised that over 100 patients seeking gender-affirming care at [UTSW] have been turned away. My understanding is that a great majority of these patients were seeking pubertal suppression and hormone therapy for gender-affirming treatment. A number of these patients were seeking solely a consultation. I have not been allowed to treat or consult with these patients.

Id. (Lopez Aff. at ¶ 3).

As explained below, because Dr. Lopez's Affidavit lacks foundation, is conclusory, and is based on inadmissible hearsay, it amounts to no evidence in support of the Petition. Therefore, the Court should strike Dr. Lopez's Affidavit.

ARGUMENT AND AUTHORITIES

A witness may testify to a matter "***only if*** evidence is introduced sufficient to support a finding that the witness has personal knowledge of the matter." TEX. R. EVID. 602 (emphasis added). Dr. Lopez's assertion that her "understanding" is "that a great majority of [the patients who were purportedly "turned away"] were seeking pubertal suppression and hormone therapy for gender-affirming treatment[,]" Lopez Aff. at ¶ 3, and that "[a] number of these patients were seeking solely a consultation[,]" *id.*, lacks foundation. Dr. Lopez cannot possibly have personal knowledge regarding the types of treatments, therapies, or consultations sought by ***over 100 patients*** with whom Dr. Lopez could not possibly have had a physician-patient relationship since—by Dr. Lopez's own allegation—the patients were "turned away" before Dr. Lopez could have treated them. *Id.* In the absence of any assertion demonstrating personal knowledge, the Court should strike Dr. Lopez's Affidavit as lacking foundation.

The same portions of Dr. Lopez's Affidavit are conclusory. "A conclusory statement is one that does not provide the underlying facts to support the conclusion." *Hodgkins v. Bryan*, 99 S.W.3d 669, 674 (Tex. App.—Hous. [14th Dist.] 2003, no pet.) (citation omitted). Because Dr.

Lopez has no personal knowledge regarding the types of treatments, therapies, or consultations sought by the patients referenced in her Affidavit, Dr. Lopez's assertions regarding these patients are conclusory. *See Ryland Grp., Inc. v. Hood*, 924 S.W.2d 120, 122 (Tex. 1996) (affiant's statement about his "understanding" was conclusory and did not raise a fact issue in analogous summary judgment context). Likewise, Dr. Lopez's assertion that she has not been allowed to treat or consult with such patients is conclusory because it assumes—in the absence of any personal knowledge—(a) that such patients sought treatment that necessarily required Dr. Lopez to specifically provide, and that (b) someone else has prevented Dr. Lopez from providing such treatment. Because Dr. Lopez has no evidence beyond her own subjective opinion or speculation regarding the treatment sought by the patients referenced above and whether Dr. Lopez was prevented from providing such treatment, the Court should strike Dr. Lopez's Affidavit because it is conclusory.

Finally, Dr. Lopez's Affidavit constitutes inadmissible hearsay. Hearsay is a statement, other than one made by the declarant while testifying at a trial or hearing, that a party offers in evidence to prove the truth of the matter asserted. TEX. R. EVID. 801(d). Dr. Lopez asserts she has "been advised that over 100 patients seeking gender-affirming care at [UTSW] have been turned away." Lopez Aff. at ¶ 3. This assertion characterizes an out-of-court statement—made by a person whom Dr. Lopez does not even identify—that is offered in evidence to prove that patients seeking gender-affirming care at UTSW have been "turned away." To the extent Dr. Lopez's "understanding" regarding the types of treatments, therapies, and consultations sought by the patients referenced above is based on the same out-of-court statement, these sentences similarly constitute inadmissible hearsay.

CONCLUSION

Based on the foregoing, CMCD respectfully requests that the Court strike Dr. Lopez's Affidavit. CMCD further requests that the Court award CMCD all other and further relief to which it may be justly entitled.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document was electronically filed and served to the following on the 7th day of April, 2022:

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10. Dr. Lopez's Reply to the Responses to Her 202 Petition

CAUSE NO. CC-22-01316-B

IN RE XIMENA LOPEZ, M.D., *Petitioner*,	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

DR. LOPEZ'S REPLY TO THE RESPONSES TO HER 202 PETITION

Petitioner Ximena Lopez, M.D. has not filed a lawsuit; Dr. Lopez has not asserted any legal claim against any particular person or entity. One might be excused for thinking she had if one only read the voluminous Responses riddled with legal arguments which would only have a place after a claim has been asserted. To be clear: Dr. Lopez's 202 Petition is "a request for discovery, nothing more."[1] Yet, despite this simple request for narrow answers to narrow questions, Children's Medical Center at Dallas ("CMC"), UT Southwestern ("UTSW"), and Drs. Podolsky and Warner filed over 80 pages of objections, responses, and "kettle logic"[2] about how the Court cannot allow any aspect of Dr. Lopez's simple request.

Borrowing from Queen Gertrude, the Respondents "doth protest too much, methinks."

There is one thing the Respondents do not contest in their kitchen-sink challenges to every other aspect of Dr. Lopez's Petition: the resolution of this matter is a life or death issue for transgender children. As CMC has publicly stated, 41% of children with gender dysphoria attempt suicide. Gender-affirming care can reduce that by 40%.[3] Simple math: out of 100 children, 16 fewer children attempt suicide when receiving gender-affirming care. Since the decision at issue, over 100 children seeking this care have been turned away by CMC. That is, statistically, at least 16 kids lives.

[1] *Mayfield-George v. Texas Rehab Comm'n*, 197 F.R.D. 280, 283 (N.D. Tex. 2000).

[2] In *The Interpretation of Dreams,* Sigmund Freud famously described what was coined "kettle logic": "The whole plea reminded one vividly of the defense put forward by the man who was charged by one of his neighbors with having given him back a borrowed kettle in a damaged condition. The defendant asserted first, that he had given it back undamaged; secondly, that the kettle had a hole in it when he borrowed it; and thirdly, that he had never borrowed a kettle from his neighbor at all."

[3] Carlisle, M. "Gender-Affirming Hormone Therapy for LGBTQ Youth Can Help Save Lives, Study Finds" TIME MAGAZINE, December 14, 2021, available at https://time.com/6128131/gender-affirming-hormone-therapy-study/

The dictate preventing Dr. Lopez from treating these children appears to be illegal and discriminatory, and it is costing children their lives. If actionable, Dr. Lopez will seek injunctive relief to prevent that policy in hopes of saving children as soon as she can identify who is responsible for the dictate and who needs to be enjoined.

This is a very narrow inquiry. Why on earth would health care providers oppose providing the answers? Why on earth would the State of Texas and the Attorney General so vociferously fight to prevent Dr. Lopez from knowing who is behind this policy? Why is the State of Texas and the Attorney General not joining on Dr. Lopez's side, demanding answers, and actively pursuing investigations about what appears to be a discriminatory (and thus *ultra vires)* policy that will cost lives? The Constitution of this State imposes on the State government the primary obligation to defend the lives of its citizens without regard to immutable characteristics. It is an abrogation of the State's obligations to instead use the State's fisc to shield such outrageous conduct.

So why are these Respondents so opposed to providing answers? Perhaps because they know what is happening is wrong.

Fortunately, the law allows citizens like Dr. Lopez to investigate if official misconduct is occurring and pursue claims if it is. That is, after all, why the Supreme Court promulgated Rule 202: to allow courts like this to permit parties to seek the truth. And in evaluating whether to allow this use of Rule 202, this Court must be always guided—as this Court routinely demonstrates it always is—by Rule 1:

> The proper objective of rules of civil procedure is to obtain a just, fair, equitable and impartial adjudication of the rights of litigants under established principles of substantive law. To the end that this objective may be attained with as great expedition and dispatch and at the least expense both to the litigants and to the state as may be practicable, these rules shall be given a liberal construction.

What could be a more obvious situation for application of Rule 1 then a liberal construction of Rule 202 that allows a party to pursue limited investigatory discovery to ensure that the proper parties are eventually brought before the Court in a meritorious suit?

Dr. Lopez files this Reply not to reiterate everything said in her Petition or to address every red herring raised by the Respondents in their Responses. But Dr. Lopez must address the Respondents' pleas to the jurisdiction and their various suggestions that she has not carrierd her burden.

I.
Response to the Pleas to the Jurisdiction

At the outset, it should be noted that neither UTSW nor Drs. Podolsky or Warner have provided written notice that their respective Pleas to the Jursidction have been set for hearing. As such, the Plea to the Jurisdiction is not before the Court until it is so set. Texas Rule of Civil Procedure 21(b) requires that any "application to the court for an order and notice of any hearing thereon, must be served upon all parties not less than three days before the time specified for the hearing, unless otherwise provided by these rules or shortened by the Court."

As no hearing has been set, the Pleas are not before the Court on April 11, 2022 when Dr. Lopez's Petition is set for hearing.

In her Petition, Dr. Lopez accurately predicted that the Respondents would make the same, lazy claims of sovereign immunity and lack of jurisdiction that are a fixture of every filing this Attorney General's office makes. In hopes of avoiding this much-abused defense, Dr. Lopez set forth the law acknowledged in *Combs v. Tex. Civ. Rights Project* and *In re City of Dallas* that clearly allows for pre-suit depositions under Rule 202 to investigate *ultra vires* claims against the State and State employees. The Respondents do not meaningfully contest that law. Instead, Respondents focus on instead arguing the merits of whether or not there is a potential future *ultra vires* claim. In so doing, both UTSW and Drs. Podolsky and Warner have plead their way into a box that requires the Court to allow discovery about whether *ultra vires* conduct has occurred.

Therefore, before the Court could even hear and rule on a plea to the jurisdiction, Dr. Lopez is entitled to tailored discovery about whether there has been ultra vires conduct in order to respond to the Plea.

The Supreme Court of Texas has been clear about the Court's broad discretion to allow discovery to respond to pleas to the jurisdiction:

> As we held in *Miranda*, trial courts considering a plea to the jurisdiction **have broad discretion** to allow "reasonable opportunity for targeted discovery"and to grant parties more time to gather evidence and prepare for such hearings.[4]

[4] *Mission Consol. Indep. Sch. Dist. v. Garcia*, 372 S.W.3d 629, 642–43 (Tex. 2012).

The reason courts enjoy such broad discretion is because the issue of jurisdiction or immunity is often tied to a factual dispute, as it is here. When the plea requires consideration of jurisdictional facts, the Court has to allow the parties to develop them in discovery and through a summary judgment procedure. Aand if the facts are disputed, the Court cannot grant the plea and the issue must be resolved by the fact-finder at trial.[5]

Here, the basis of the pleas to the jurisdiction is sovereign immunity. But whether or not there has factually been *ultra vires* conduct answers whether there is sovereign immunity.

- If there is *ultra vires* conduct, there is no sovereign immunity.
- If there is not *ultra vires* conduct, there may be sovereign immunity.

So the Court has to decide if there has been *ultra vires* conduct. That occurs when a state official acted without legal or statutory authority and in violation of the law.[6] Put another way, "*ultra vires* suits do not attempt to exert control over the state—they attempt to *reassert* the control of the state."[7]

The Court must first inquire whether there has been *ultra vires* conduct. Of course, that is the exact issue Dr. Lopez seeks to investigate. What Dr. Lopez knows is that someone is impermissibly restricting her medical judgment in violation of the law. Further, Dr. Lopez knows that the restriction being mandated to her is discriminatory as it is a distinction based on gender identity.

The United States Supreme Court case of *Bostock v. Clayton County, Georgia*[8] focused on whether discrimination based on gender identity was legal, and the Supreme Court held that discrimination based on gender identity was not legal because it is necessarily discrimination based on sex. So for courts interpreting discrimination claims, gender identity discrimination should be

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[5] *See e.g., Tex. Dept. of Parks & Wildlife v. Miranda*, 133 S.W.3d 217, 226-27 (Tex. 2004); *Suarez v. City of Tex. City,* 465 S.W.3d 623-33 (Tex. 2015); *Misson Consol. ISD v. Garcia*, 372 S.W.3d 629, 635 (Tex. 2012).

[6] *City of El Paso v. Heinrich*, 284 S.W.3d 366, 368 (Tex. 2009).

[7] *Id.*

[8] *Bostock v. Clayton Cty., Georgia*, 140 S. Ct. 1731, 1741–42, 207 L. Ed. 2d 218 (2020) (in demonstrating how discrimination based on gender identity is discrimination because of sex, the Supreme Court noted: "Or take an employer who fires a transgender person who was identified as a male at birth but who now identifies as a female. If the employer retains an otherwise identical employee who was identified as female at birth, the employer intentionally penalizes a person identified as male at birth for traits or actions that it tolerates in an employee identified as female at birth. Again, the individual employee's sex plays an unmistakable and impermissible role in the discharge decision.").

treated as sex discrimination.[9] Under both the Texas Constitution and statutory Texas law, discrimination because of sex is unconstitutional and illegal.

For instance, TEXAS CIVIL PRACTICE AND REMEDIES CODE § 106.001 prohibits discrimination because of sex by governmental officers or employees:

> (a) An officer or employee of the state or of a political subdivision of the state who is acting or purporting to act in an official capacity may not, because of a person's race, religion, color, sex, or national origin:...
>
> > (3) refuse to permit the person to use facilities open to the public and owned, operated, or managed by or on behalf of the state or a political subdivision of the state;
> > (4) refuse to permit the person to participate in a program owned, operated, or managed by or on behalf of the state or a political subdivision of the state;
> > (5) refuse to grant a benefit to the person;
> > (6) impose an unreasonable burden on the person.

This statute makes clear that there is a legislative intent to prohibit officers discriminating by not allowing people access to state resources because of sex or otherwise burdening them because of their sex, both of which happen when there is discrimination based on gender identity.

Importantly, this statute itself is a statutory waiver of immunity: "Section 106.002(b) provides for an express waiver of the State's governmental immunity to those prohibited acts listed in section 106.001."[10] The statute also allows perspective injunctive relief, just like an *ultra vires* claim.

So if some governmental official is discriminating because of sex/gender identity, then that governmental official does not enjoy sovereign immunity. That government official is also violating the law. Such conduct is essentially *ultra vires*. Furthermore, Dr. Lopez would have standing to bring a claim under the statute because she is aggrieved by such conduct insofar as it impacts her practice and exposes her to liability under that very statute. It is within Dr. Lopez's personal knowledge that discrimination based on gender identity is occurring. What is not known is who is the one violating 106.001? That is why discovery is needed.

The need for discovery is even highlighted in UTSW's own argument in support of its plea. In its brief, UTSW remarkably claims:

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[9] *Id.*

[10] *See, e.g., Richards v. Mena*, 907 S.W.2d 566 (Tex. App.–Corpus 1995).

> "UT Southwestern and its officials did not violate a ministerial duty and acted within their discretion, so the challenged actions cannot be without legal authority or *ultra vires*. Therefore, Dr. Lopez's *ultra vires* claim to support a Rule 202 petition must be dismissed for want of jurisdiction."

Huh? *Who* acted? *What* is the scope of "their" discretion? *Who* has a ministerial duty and *what* is the nature of those ministerial duties? *What* is the challenged "action"? What *claim* has Dr. Lopez asserted? UTSW makes these broad assertions as if anything in that vague statement has been proven. How is the Court supposed to analyze this assertion? What evidence from Respondents is before the Court that proves any of those assertions? None. Discovery must be permitted. Dr. Lopez cannot analyze or respond to such a vague cclaim which is precisely why discovery is needed.

Setting aside Rule 202, Dr. Lopez would be and is entitled to targeted discovery on the issue of whether *ultra vires* conduct occurred in order to respond to the Plea to the Jurisdiction.

Dr. Lopez requests that the Court allow such targeted discovery before any hearing is set on the Plea.

II.
Dr. Lopez has Met Her Burden

There is a purpose for an investigative deposition under Rule 202: because a party needs to know certain information. That is why Dr. Lopez filed this application.

Respondents claim that Dr. Lopez has failed to carry her burden of proof because she cannot provide the Court.... the very evidence Dr. Lopez is seeking to investigate. If a party was required to prove the elements of their claim with substantial proof as a pre-requisite to getting a 202 to investigate a claim, then the Rule would not exist.

As set forth above, Dr. Lopez has presented evidence that illegal conduct has occurred by a government official or employee. That should be sufficient to allow a 202 to determine who is behind it. If Dr. Lopez is not allowed to discover that, then she cannot file a lawsuit or pursue injunctive relief because she does not and cannot know who to request the Court to enjoin. Respondents go to great lengths to suggest that Dr. Lopez has no claim against UTSW as an institution. Without conceding that to be so, it does not mean she lacks viable claims against officers or employees of UTSW, the Governor's Office, or the Attorney General's office. But she has to have discovery to know who that is.

Respondents claim that Dr. Lopez has not provided this Court with evidence to prove that the deposition is necessary. What else could Dr. Lopez tell the Court? She has demonstrated illegal discrimination has occurred and that she does not know who is requiring it? She has stated she does not have any other way to figure it out. Indeed, Respondents underscore this in their Response by insisting on keeping a veil over who is behind it and what "influence" was used. Dr. Lopez has told the Court she cannot file a suit without knowing who the defendant would be. Again, what further evidence is needed to explain that?

Respondents claim Dr. Lopez has not shown that the benefits outweigh the burden. But Dr. Lopez has provided evidence that the failure to provide this care harms children, and that, so far, over 100 children have been turned away. Dr. Lopez has stated that when she knows the identity and reasons for this, she intends to pursue injunctive relief so these children can receive treatment they need to receive. What more benefit would the Court need to know then that children's lives are at stake? Dr. Lopez has noted for the Court that the only burden is sitting for a deposition, which itself cannot be a basis for claiming its too burdensome because if it was, then there would not be a 202 procedure since every 202 requires sitting for a deposition. What further evidence would be available to show the Court about the burden on the Respondent? If Dr. Lopez knows of no burden, how does she prove that other than by swearing to it?

Dr. Lopez is seeking narrow and limited information. Without it, this policy will remain unchallenged and will cost children's lives.

If 202 is not available for this purpose, what is the point of the rule? We should just discard it.

IX.
Prayer

If Respondents are going to pursue their pleas to the jurisdiction, Dr. Lopez requests she be allowed targeted discovery from Drs. Podolsky and Warner, including limited documents, in order to respond to the assertion of immunity and demonstrate evidence of *ultra vires* conduct.

If Respondents abandon their pleas to the jurisdiction, Dr. Lopez requests that the Court grant her 202 petition, order the requested depositions and production of documents, and such further relief to which she is entitled at law or equity.

Respectfully submitted,

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ATTORNEYS FOR PETITIONER XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing document was served on all counsel of record via the Court's e-filing system on April 8, 2022.

/s/ Brent R. Walker
BRENT R. WALKER

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Associated Case Party: UT Southwestern Medical Center

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Associated Case Party: UT Southwestern Medical Center

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11. Letter Enclosing Additional Briefing and Affidavits by Respondents, Dr. Podolsky and Dr. Warner

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April 13, 2022

Via E-file
Hon. Melissa Bellan
George L. Allen Sr. Courts Building
600 Commerce Street, 5th Floor West Tower
Dallas, Texas 75202

Re: Cause No. CC-22-01316-B; *In Re: Ximena Lopez, M.D. (Rule 202 Petition)*

Dear Judge Bellan:

On April 11 the Court heard evidence and arguments regarding the Rule 202 Petition filed by Petitioner, Dr. Ximena Lopez. At the close of the hearing, the Court advised that the parties could submit additional briefing if they so desired. On behalf of Respondents, Dr. Daniel Podolsky and Dr. John Warner, undersigned counsel submits the following:

At the recent hearing, the Petitioner, Dr. Lopez, and her counsel advised that the information they needed in order to investigate any potential claim, was the identity of the person, or persons who "dictated" that UT Southwestern and Children's Medical cease providing certain care starting November of 2021. After further consideration, we are providing those answers through the affidavits of Dr. Daniel Podolsky and Dr. John Warner, which are attached. As the Court and counsel will see, Dr. Podolsky and Dr. Warner affirmatively state unequivocally under oath that it was they, on behalf of UT Southwestern Medical Center, who made the decisions to: remove the GENECIS branding; suspend the provision of puberty suppression and hormone therapy to new pediatric patients for the diagnosis of gender dysphoria by UT Southwestern faculty physicians performing services at Children's Health Clinics; and that effective November 18, 2021, UT Southwestern faculty physicians performing services at Children's Health Clinics must begin referring new pediatric patients seeking puberty suppression and hormone therapy for the diagnosis of gender dysphoria to other providers outside of Children's Health and UT Southwestern.

Dr. Podolsky and Dr. Warner confirmed further that these decisions were made jointly with Children's Health as explained in the joint statement from Children's Health and UT Southwestern dated March 28, 2022, and that there were no third-party entities or individuals who made or directed them to make those decisions on behalf of UT Southwestern.

We respectfully submit that with the proffer of this information, there is no need for a Rule 202 deposition or other pre-suit discovery. As such, Respondents Dr. Podolsky and Dr. Warner, respectfully request that the Court deny Dr. Lopez' Petition for discovery under Rule 202. The forgoing notwithstanding, Respondents also ask the Court to deny Petitioner's request for additional reasons discussed below.

In her Reply in support of her 202 Petition (and at the hearing) Dr. Lopez argued for the first time that she is entitled to Rule 202 discovery to determine who, if anyone, committed an *ultra vires* act of "discrimination" that might preclude the Respondents or other state actors from prevailing on a Plea to The Jurisdiction. Dr. Lopez argued that Tex. Civ. Prac. & Rem. Code § 106.001, which prohibits a governmental officer or employee from performing seven specifically listed actions in a discriminatory manner based upon, among other things, sex, applies to her ability to prescribe puberty suppressing drugs as a UT Southwestern employee working in a Children's Medical Center clinic. Dr. Lopez's argument is that the hospitals' decision to stop providing this treatment to new pediatric patients for the diagnosis of gender dysphoria is discrimination on the basis of gender identity — which she argues is discrimination based on sex within the meaning of Section 106. This, she argued, would be an unlawful and therefore *ultra vires* act.

Dr. Lopez does not assert that she has been discriminated against on the basis of her sex or gender identity; instead, she claims that she would be forced to discriminate against future new patients at Children's Medical Center if she is not allowed to prescribe puberty suppressing drugs at those clinics. Section 106.001 is not applicable to our case because there is no action alleged by Dr. Lopez that is discriminatory against anyone based on their race, religion, color, sex or national origin. As Dr. Lopez has stated, she was told she could no longer provide puberty suppressing drugs to new pediatric patients who are diagnosed with gender dysphoria. Importantly, gender dysphoria is <u>not</u> synonymous with "sex" or "gender identity." Instead, it is a mental or psychological diagnosis or condition according to Dr. Lopez's own Petition. *See* Exhibit A to Petition "Standards of Care for the Health of Transexual, Transgender, and Gender Non-Conforming People." Her Petition defines gender dysphoria as: "**distress** that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth…" (emphasis added). Patients of any sex, gender identity or gender expression can be diagnosed with the condition of gender dysphoria. And all new pediatric patients at Children's Health with this psychological diagnosis who are seeking puberty suppression medication are treated the same – they are referred to providers outside UT Southwestern and Children's Health. Gender dysphoria is not a protected class and is not mentioned or encompassed within any protected class identified in Section 106.001 against whom discrimination is prohibited. Treatment offerings based on a medical diagnosis is not among the seven official actions listed and is certainly not discrimination. In short, this statute does not apply.

Additionally, Dr. Lopez has no standing to assert a 106.001 claim that would defeat Dr. Podolsky's and Dr. Warner's governmental immunity. As mentioned above, Dr. Lopez does not allege that anyone has discriminated against her. To try to make this statute work, she instead argues that she has been aggrieved by the "dictates" (from persons supposedly unknown to her) that prevent her from prescribing puberty suppressing drugs to new pediatric patients with gender dysphoria at Children's Medical Center. Respondents do not question Dr. Lopez's sincerity or passion for children with gender dysphoria; however, she presented no legal authority or evidence

demonstrating how she has been actionably or legally aggrieved. She argues that she is "aggrieved by such conduct insofar it impacts her practice and exposes her to liability under that very statute." (see, Dr. Lopez' Reply at pg. 5.) Dr. Lopez is speaking of a hypothetical or theoretical liability which has not occurred, and could not occur because, as discussed above, there has been no discrimination in any official action against any recognized protected class as those terms are defined in Section 106.001. Such a claim would not waive the sovereign immunity of Drs. Podolsky and Warner and therefore provides no basis for Rule 202 discovery.

Additionally, Dr. Lopez did not cite to or rely on any statutory provision or case law that applied 106.001 in the context of the practice of medicine. The prohibited official acts identified by the statute are the following:

1. Refuse to issue to the person a license, permit, or certificate;
2. Revoke or suspend the person's license, permit, or certificate;
3. Refuse to permit the person's use of facilities open to the public and owned, operated, or managed by or on behalf of the state or a political subdivision of the state;
4. Refuse to permit the person to participate in a program owned, operated, or managed by or on behalf of the state or a political subdivision of the state;
5. Refuse to grant a benefit to the person;
6. Impose an unreasonable burden on the person, or
7. Refuse to award a contract to the person.

In summary, this statute not applicable to Dr. Lopez's anticipated lawsuit because:

1. Gender dysphoria is a medical or psychological diagnosis/condition, not sex or other protected class;
2. Dr. Lopez does not have standing under Section 106.011 because she has not been discriminated against and is not otherwise actionably aggrieved;
3. The statute has not been applied or extended to the practice of medicine.

As stated in the joint statement from Children's Health and UT Southwestern from March 28, 2022, the decision was made to suspend initiating hormone treatment for new pediatric patients as it was believed that if they failed to do so that it would put the entire GENECIS program in jeopardy. (see the "Background Statement" of Respondents Plea to the Jurisdiction and Response in Opposition pgs 2-5 for further discussion.) As the attached affidavits from Dr. Podolsky and Dr. Warner affirm, it was they, on behalf of UT Southwestern, that made these decisions. Dr. Lopez disagrees with that decision, but she has not provided the Court sufficient basis to allow her the extraordinary relief of Rule 202 discovery for the reasons set forth in Respondents' Plea to the Jurisdiction, Opposition, and Motion for Protective Order.

Respectfully submitted,

C. Timothy Reynolds
timreynolds@steedlawfirm.com

CTR/cyh
Attachments: as stated
s:\docs\085\00114 podolsky\4-13-22 ltr to judge bellan re 202 pet ver. 3 (ems).docx

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AFFIDAVIT OF DANIEL K. PODOLSKY, M.D.

STATE OF TEXAS §
§
COUNTY OF DALLAS §

BEFORE ME, the undersigned authority, personally appeared Daniel K. Podolsky, M.D., who being by me duly sworn, deposed as follows:

1. My name is Daniel K. Podolsky, M.D. I am over the age of 18, of sound mind, and capable of making this affidavit. I have personal knowledge of the facts stated herein and affirm that they are all true and correct. I have never been convicted of any crime involving moral turpitude.

2. Since September 2008, I have been employed as the President of UT Southwestern Medical Center. Since March 2018, Dr. John J. Warner, M.D. has been employed as the Executive Vice President for Health System Affairs and since January 2022 he has also held the title of Chief Executive Officer of the UT Southwestern Health System.

3. On behalf of UT Southwestern Medical Center, Dr. Warner and I made the following decisions:

    a. To remove the GENECIS branding;
    b. To suspend the provision of puberty suppression and hormone therapy to new pediatric patients for the diagnosis of gender dysphoria by UT Southwestern faculty physicians performing services at Children's Health Clinics;
    c. Effective November 18, 2021, UT Southwestern faculty physicians performing services at Children's Health Clinics must begin referring new pediatric patients seeking puberty suppression and hormone therapy for the diagnosis of gender dysphoria to other providers outside of Children's Health and UT Southwestern.

4. The decisions described in Paragraph 3 above, were made jointly with Children's Health. *See* Joint Statement from Children's Health and UT Southwestern dated March 28, 2022.[1] There was no third-party entity or individual who made or directed me or Dr. Warner to make the decisions on behalf of UT Southwestern that are described in Paragraph 3 above.

[1] https://www.utsouthwestern.edu/newsroom/articles/year-2022/gender-dysphoria-care.html?msclkid=faac6293bb4e11ecb3e857d86a78dd0f

5. There are no documents or communications from or with a third-party entity, or individual, that instructed or directed me or Dr. Warner to make the decisions on behalf of UT Southwestern that are described in Paragraph 3 above.

Further Affiant sayeth not.

Daniel K. Podolsky MD

SWORN TO AND SUBSCRIBED before me by the above-named affiant on the 13th day of April 2022, to certify which witness my hand and seal.

STERLING M. MAYES
Notary Public, State of Texas
Comm. Expires 04-20-2025
Notary ID 5423473

Notary Public
In and for the State of Texas

My Commission Expires:
4/20/2025

AFFIDAVIT OF JOHN J. WARNER, M.D.

STATE OF TEXAS §
§
COUNTY OF DALLAS §

BEFORE ME, the undersigned authority, personally appeared John J. Warner, M.D., who being by me duly sworn, deposed as follows:

1. My name is John J. Warner, M.D. I am over the age of 18, of sound mind, and capable of making this affidavit. I have personal knowledge of the facts stated herein and affirm that they are all true and correct. I have never been convicted of any crime involving moral turpitude.

2. Since March 2018, I have been employed as the Executive Vice President for Health System Affairs at UT Southwestern Medical Center and since January 2022 I have also held the title of Chief Executive Officer of the UT Southwestern Health System. Since September 2008, Dr. Daniel K. Podolsky, M.D. has been employed as the President of UT Southwestern Medical Center.

3. On behalf of UT Southwestern Medical Center, Dr. Podolsky and I made the following decisions:

    a. To remove the GENECIS branding;
    b. To suspend the provision of puberty suppression and hormone therapy to new pediatric patients for the diagnosis of gender dysphoria by UT Southwestern faculty physicians performing services at Children's Health Clinics;
    c. Effective November 18, 2021, UT Southwestern faculty physicians performing services at Children's Health Clinics must begin referring new pediatric patients seeking puberty suppression and hormone therapy for the diagnosis of gender dysphoria to other providers outside of Children's Health and UT Southwestern.

4. The decisions described in Paragraph 3 above, were made jointly with Children's Health. *See* Joint Statement from Children's Health and UT Southwestern dated March 28, 2022.[1] There was no third-party entity or individual who made or directed me or Dr. Podolsky to make the decisions on behalf of UT Southwestern that are described in Paragraph 3 above.

[1] https://www.utsouthwestern.edu/newsroom/articles/year-2022/gender-dysphoria-care.html?msclkid=faac6293bb4e11ecb3e857d86a78dd0f

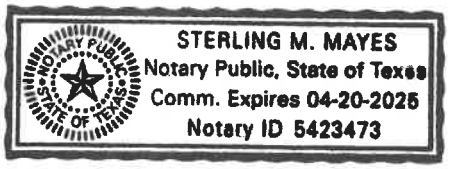
5. There are no documents or communications from or with a third-party entity or individual that instructed or directed me or Dr. Podolsky to make the decisions on behalf of UT Southwestern that are described in Paragraph 3 above.

Further Affiant sayeth not.

John J. Warner

John J. Warner MD

SWORN TO AND SUBSCRIBED before me by the above-named affiant on the 13th day of April 2022, to certify which witness my hand and seal.



Sterling M. Mayes

Notary Public
In and for the State of Texas

My Commission Expires:

4/20/2025

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Associated Case Party: UT Southwestern Medical Center

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12. Letter Enclosing Additional Briefing and Affidavits by Respondent, UT Southwestern

April 13, 2022

Via E-file
Hon. Melissa Bellan
George L. Allen, Sr Courts Building
600 Commerce Street, 5th Floor West Tower
Dallas, Texas 75202

Re: Cause No. CC-2201316-B; *In Re: Ximena Lopez, M.D. (202 Petition)*

Dear Judge Bellan:

On April 11, you heard Petitioner Dr. Ximena Lopez's Verified Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202 and Responses thereto. I represented The University of Texas Southwestern Medical Center ("UT Southwestern"). I file this post-hearing letter brief on behalf of UT Southwestern to address a single issue raised for the first time in Dr. Lopez's Reply brief—whether the Court should find that Dr. Lopez has sufficiently alleged a potential waiver of sovereign immunity under Chapter 106 of the Texas Civil Practice and Remedies Code.

Dr. Lopez argues that in November 2021, persons unknown to her "dictated" that UT Southwestern faculty providing services at Children's Medical Center clinics no longer provide puberty suppression to new pediatric patients for the diagnosis of gender dysphoria, while still providing that treatment to new patients for the diagnosis of precocious puberty. Among other allegations, she called that "naked discrimination because of gender identity," and argued that she needed the pre-suit deposition to find out who "dictated" UT Southwestern's November decisions. She did not provide any legal authority or argument in support of this position.

One of the arguments in UT Southwestern's Response was that sovereign immunity prevents Rule 202 depositions because Dr. Lopez had not identified either a possible cause of action that waives sovereign immunity or any possible *ultra vires* act. An allegation of "discrimination," without more, does not allege a cause of action that waives sovereign immunity or an *ultra vires* act.

In her Reply, among other things, Dr. Lopez argued that section 106.001 of the Texas Civil Practice and Remedies Code waives immunity for her potential claim of "discrimination." That statute provides:

> An officer or employee of the state or of a political subdivision of the state who is acting or purporting to act in an official capacity may not, because of a person's race, religion, color, sex, or national origin
>
> (1) refuse to issue to the person a license, permit, or certificate;
>
> (2) revoke or suspend the person's license, permit, or certificate;
>
> (3) refuse to permit the person to use facilities open to the public and owned, operated, or managed by or on behalf of the state or a political subdivision of the state;

(4) refuse to permit the person to participate in a program owned, operated, or managed by or on behalf of the state or a political subdivision of the state;

(5) refuse to grant a benefit to the person;

(6) impose an unreasonable burden on the person; or

(7) refuse to award a contract to the person.

Tex. Civ. Prac. & Rem. Code § 106.001.

She further argued that "because of a person's … sex" in section 106.001 means "because of a person's gender identity," citing *Bostock v. Clayton Cty., Georgia*, 140 S. Ct. 1731 (2020). In that case, the United States Supreme Court construed Title VII, a federal employment statute, and not Chapter 106 or any other law. There is no apparent reason that her counsel could not have made this argument in her Petition, instead of waiting until her Reply.

During the hearing, Dr. Lopez's counsel mentioned, for the first time, the Dallas Court of Appeals' decision in *Tarrant County Coll. Dist. v. Sims*, 621 S.W.3d 323 (Tex. App.—Dallas 2021, no pet.), and asserted that it supports her argument that section 106.001 applies to "gender identity" as well as "sex." While Dr. Lopez's counsel did not explain how it did so, the court in that case held, "[Section 21.001 of the Labor Code's] prohibition on discrimination 'because of … sex' [also] prohibit[ed] discrimination based on an individual's status as a homosexual or transgender person [citing *Bostock*]." *Id*. at 329. Again, there is no apparent reason that Dr. Lopez's counsel could not have argued this case in her Petition, instead of waiting until the end of a hearing, and then only in passing and without analysis.

The Court should reject Dr. Lopez's effort to fit her claim under Chapter 106 for five reasons.

First, Dr. Lopez has waived this argument by bringing it up for the first time in her Reply Brief and then orally at the hearing. Whether "because of a person's … sex" in section 161.001 also means "because of a person's gender identity" is an important question that should only be decided after full briefing, and not after considering only a few lines in a reply brief and an oral reference to another opinion interpreting and applying a totally different law. Dr. Lopez hid this argument from the Court, Respondents, and the public until it was too late to respond. In the alternative, the Court should order the parties to submit full and complete briefing in this issue. One would expect many *amicus* briefs on the issue of whether "sex" means "gender identity" or, in this case, whether "sex" also means pediatric patients with a medical diagnosis of gender dysphoria.

Second, even if section 161.001 were to apply to actions taken "because of a person's gender identity," no action has been taken against Dr. Lopez because of her gender identity, so she would lack standing and would not state a claim which overcomes sovereign immunity. To the extent Dr. Lopez is asserting that not providing puberty suppression to all new pediatric patients with a diagnosis of gender dysphoria exposes her to potential liability under section 161.001, that does not constitute discrimination at all, as explained below, because all new patients are treated the same regardless of gender. Dr. Lopez cites no authority or argument for this distorted interpretation, and Chapter 161 does not waive UT Southwestern's immunity from such a claim.

Third, section 106.001 does not apply to general discrimination, but only to seven types of official actions. A decision by a hospital to stop providing certain treatments to all new patients with a

specific diagnosis—regardless of the patient's sex, gender identity, or gender expression—is not discrimination and certainly does not fall into any of the seven prohibited actions listed in section 106.001. Dr. Lopez cites to no authority or argument applying section 106.001 to medical treatment at all, and counsel for UT Southwestern unsurprisingly found no caselaw on point.

Fourth, a hospital's decision to stop providing certain treatments to all new patients with a specific diagnosis is not a decision made "because of a person's gender identity," any more than a hospital's decision to cease providing certain treatments to new patients for breast cancer or testicular cancer are decisions made "because of a person's sex." Likewise, it makes no sense to say that a hospital or clinic that chooses to specialize in, say, care for males or care for females, somehow illegally makes that decision "because of a person's sex." Recognizing that she did not plead any potential claims that would waive UT Southwestern's sovereign immunity in her Petition, Dr. Lopez is now trying to fit a square peg (decisions about what treatments to provide all new patients with a particular diagnosis) in a round hole (an inapplicable state statute that prohibits seven specific actions based on protected characteristics). There is simply no legal authority to support her position—in Chapter 106, in any cases interpreting and applying that law, or any other law.

Fifth, this whole issue can now be avoided because Dr. Podolsky and Dr. Warner have provided the information under oath that Dr. Lopez claims she needs in order "to investigate a potential claim or suit" under Rule 202.1(b), thereby mooting her Petition. The Court should therefore deny Dr. Lopez's Rule 202 Petition, and Dr. Lopez should decide if she wants to file a lawsuit. Dr. Lopez will likely now assert she needs to depose Respondents about their affidavits. But any other questions Dr. Lopez has about the decisions she complains of belong in post-suit discovery, after she has put Respondents on notice of her actual claims.

Thank you for your attention to this matter.

Sincerely,

/s/ Charles K. Eldred
Charles K. Eldred
Attorney for Respondent The University of Texas Southwestern Medical Center

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Associated Case Party: XIMENA LOPEZ, M.D.,

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Associated Case Party: UT Southwestern Medical Center

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13. Dr. Lopez's Motion to Strike "Additional Briefing" with Attached Affidavits from Dr. Podolsky and Warner or, in the Alternative, Motion to Reopen the Evidence and Compel Their Attendance at Evidentiary Hearing for Cross-Examination

CAUSE NO. CC-22-01316-B

IN RE XIMENA LOPEZ, M.D., *Petitioner*,	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

DR. LOPEZ'S MOTION TO STRIKE "ADDITIONAL BRIEFING" WITH ATTACHED AFFIDAVITS FROM DR. PODOLSKY AND WARNER OR, IN THE ALTERNATIVE, MOTION TO REOPEN THE EVIDENCE AND COMPEL THEIR ATTENDANCE AT EVIDENTIARY HEARING FOR CROSS-EXAMINATION

> Cross-examination has long been regarded as the foremost weapon in the attorney's selective arsenal of trial tactics for the purpose of ascertaining the truth. A noted criminal prosecutor has written that cross-examination is the principal tool "for separating truth from falsehood, actual knowledge from hearsay, fact from imagination and opinion; it is the best technique, as one legal scholar wrote, 'for reducing exaggerated statements to their true dimensions.' ." Professor Wigmore has declared it "beyond any doubt the greatest legal engine ever invented for the discovery of truth."[1]

On April 11, this Court held a 3.5 hour long evidentiary hearing on Ximena Lopez, M.D.'s Application for a 202 Deposition that seeks the depositions of two witnesses, Daniel Podolsky, M.D. and John Warner, M.D. (the "UTSW Witnesses"). At that evidentiary hearing, Dr. Lopez testified regarding the reasons for and the life-or-death importance of her need to know the information sought in her request. Attorneys for Respondents had the opportunity to cross-examine Dr. Lopez if they thought her testimony misleading or less than truthful. They asked her no questions at all.

Prior to the hearing and at the hearing itself, Respondents offered the Court no evidence from the UTSW Witnesses. Rather, they argued the UTSW Witnesses should be immune from having to answer any questions at all.

After the close of evidence and at the conclusion of the hearing, the Court indicated that if a party needed to provide any supplemental briefing to provide the Court with additional legal authorities, those should be filed quickly because the Court intended to rule this week.

[1] *Collora v. Navarro*, 574 S.W.2d 65, 70 (Tex. 1978) (citing 5 Wigmore, Evidence s 1367 at 32 (Chadbourn rev. 1974)).

Despite the evidence being closed, counsel for the UTSW Witnesses attempted to use the Court's willingness to entertain supplemental briefing as a tactic to supplement the record by filing (presumably) attorney-drafted Affidavits signed by the UTSW Witnesses. They then claim "that with the proffer of this information, there is no need for a Rule 202 deposition or other pre-suit discovery." *UTSW Witnesses' Letter Brief* at 2.

This tactic is both legally infirm and transparently cowardly.

Why did the Respondents not bring these witnesses to the evidentiary hearing to make this "proffer of information"? Because unlike Respondents, counsel for Dr. Lopez would have cross-examined these witnesses and prevented them from playing the obvious attorney-parsing semantic games being played in the Affidavits. Instead, Dr. Podolsky and Dr. Warner are trying to escape cross-examination which the Texas Supreme Court has said, as noted in the beginning epigraph, is the greatest weapon for the purpose of ascertaining the truth. In so doing, Dr. Podolsky and Dr. Warner are trying to deny Dr. Lopez and this Court the opportunity to get full answers to the targeted issues addressed at length in the evidentiary hearing.

The Court does not need to indulge these craven tactics because the Affidavits are clearly untimely because the evidentiary record has already closed and must be struck. Furthermore, the "Additional briefing" is merely a rehash of issues covered at length during the hearing with no new additional legal authority. For these reasons, Dr. Lopez moves to strike the "Additional Briefing" of the UTSW Witnesses.

Alternatively, if the Court believes that the testimony of Drs. Podolsky and Warner would aid the Court in the resolution of the issues before it, Dr. Lopez would request that the Court reopen the evidence and set a new evidentiary hearing and compel the attendance of Drs. Podolsky and Warner so that Dr. Lopez may subject them to cross-examination, or what Prof. Wigmore called "beyond any doubt the greatest legal engine ever invented for the discovery of truth."

I.
Motion to Strike the UTSW's Witnesses "Additional Briefing"

The Court held an evidentiary hearing on Petitioner's Application for Rule 202 deposition. In evaluating this relief, the Court should consider the evidence on file before the hearing and properly tendered at the evidentiary hearing. When the Court invited supplemental briefing on authorities, it did not invite new evidence, nor could it. The evidentiary record was closed at the end of the hearing. That is the point of an evidentiary hearing.

The UTSW Witnesses did not seek leave to present new evidence or otherwise explain why the evidence they now seek to put into the record could not have been timely provided to the Court. Nor was supplemental briefing authorized that merely re-asserts the same arguments made pre-hearing and at the hearing, as the UTSW Witnesses' "Additional Briefing" does.

As such, Petitioner moves the Court to strike the UTSW Witnesses Additional Briefing, including specifically their attempt to add to the evidentiary record after the evidentiary hearing was closed.

II.
The UTSW Witnesses Have Waived Any Claim of Immunity or Burden to Provide Answers

It bears emphasizing that this Affidavit testimony offered from Drs. Podolsky and Warner after the hearing is completely inconsistent with the arguments at the hearing itself where the Respondents' lawyers argued for three hours that these two men are immune from ever having to answer any question about their decision. The Court correctly pointed out that governmental immunity applies to suits and does not mean immunity from discovery.[2] The Respondents did not have any authority saying otherwise, but they nonetheless asserted that the UTSW Witnesses had immunity so they cannot be compelled to answer for why they made the decisions they made. Likewise, the Respondents claimed it would be burdensome for Drs. Podolsky and Warner to have to answer questions about the issue in this matter.

Dr. Lopez does not believe any immunity protects the UTSW Witnesses from answering questions in discovery and there is no evidence of any burden to these doctors. However, by volunteering these Affidavits, the Court should find that the UTSW Witnesses have now equitably waived any claim of immunity or burden specifically with regards to having to provide answers on this topic.[3] But it cannot equitably be that the UTSW Witnesses can refuse to provide testimony on a topic when it is against their interests but then voluntarily provide testimony in a manner they perceive benefits their interests. Or, to borrow from the law of privilege, the UTSW Witnesses cannot use a (non-existent) claim of burden or immunity from discovery as "a shield and a sword":

---

[2] *See Tex. Dept. of Wildlife v. Miranda*, 133 S.W.3d 217, 224 (Tex. 2004) (noting that governmental immunity, if applicable, involves only immunity from suit and immunity from liability).

[3] That is not to say the Affidavits waive any other aspects of an applicable, valid claim for immunity.

after a partial disclosure is used as a sword to gain litigation advantage, it cannot then be used to shield the remainder.

III.
Alternative Motion to Reopen Evidence and Compel Testimony of the UTSW Witnesses at an Evidentiary Hearing

The Court has the sound discretion to reopen an evidentiary record following a hearing when the Court concludes additional evidence is needed.[4]

Respondents do not explain why they did not or could not have brought Dr. Podolsky or Dr. Warner to the evidentiary hearing. Nor do they explain why they could not have obtained and filed those Affidavits in advance of the hearing. By proceeding in the manner they have, the UTSW Witnesses have prevented Petitioner and the Court from cross-examining the witnesses or asking follow-up questions that may have shed further light on whether the Petition should be granted.

If the Court believes that the testimony from these UTSW Witnesses would be beneficial to the issues before the Court, then Dr. Lopez asks the Court to re-open the evidentiary record, set a new evidentiary hearing, and compel the attendance of Dr. Podolsky and Dr. Warner so that Petitioner may cross-examine them.

If the Court elects to open the evidence and hold an additional evidentiary hearing, Respondent respectfully requests that the Court hold such a hearing at its earliest availability as time is of the essence. Children's lives are at stake.

IV.
Prayer

If the Respondents want the Court to factor into its analysis the testimony of Dr. Podolsky and Dr. Warner, they should have brought the two witnesses to the evidentiary hearing and subject them to cross-examination like Dr. Lopez was. Their attempts to shield the doctors from cross-examination is both cowardly and inconsistent with the notions of fair play. Dr. Lopez respectfully requests that the Court strike the UTSW Witnesses' "Additional Briefing," including specifically the Affidavits of the UTSW Witnesses, or in the alternative, reopen the evidentiary record by setting a new evidentiary hearing and requiring these two witnesses to attend and be cross-examined so that the truth may be discovered.

---

[4] See Tex. R. Civ. P. 270. *See also Beavers v. Goose Creek Consol. I.S.D.*, 884 S.W.2d 932, 935 (Tex. App.–Waco, 1994), writ denied (Feb. 9, 1995)(court can agree to accept new evidence after a summary judgment hearing).

Respectfully submitted,

/s/ Charla G. Aldous

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* * *

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing document was served on all counsel of record via the Court's e-filing system on April 14, 2022.

/s/ *Brent R. Walker*
BRENT R. WALKER

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14. Order Granting Ximena Lopez, M.D.'s Petition to Take Depositions Before Suit Pursuant to Texas Rule of Civil Procedure 202

CAUSE NO. CC-22-01316-B

IN RE XIMENA LOPEZ, M.D., *Petitioner*,	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

ORDER GRANTING XIMENA LOPEZ M.D.'S
PETITION TO TAKE DEPOSITION BEFORE SUIT
PURSUANT TO TEXAS RULE OF CIVIL PROCEDURE 202

On April 11, 2022, this Court heard argument and received evidence in support of Petitioner Ximena Lopez, M.D.'s Petition to Take Deposition Before Suit Pursuant to TEXAS RULE OF CIVIL PROCEDURE 202. The Court has reviewed the voluminous pleadings and exhibits filed in this matter as well as evidence submitted to the Court through live testimony. As supported by the foregoing, the Court makes the following findings:

1. Dr. Lopez seeks the requested discovery for purposes to investigate a potential claim under Rule 202.1(b).

2. Dr. Lopez has sufficiently pled her request.

3. It is within the contemplation of Dr. Lopez that she may have at least potentially a claim against Dr. Podolosky, Dr. Warner, or UT Southwestern Medical Center.

4. Pursuant to Rule 202.4(a)(2), the Court finds that the likely benefit of allowing Dr. Lopez to obtain the requested discovery outweighs the burden or expense of the procedure.

5. ~~The Court finds Rule 202.5 states that "depositions authorized by this rule are governed by the rules applicable to depositions of nonparties in a pending suit." Rule 205.1 governs depositions of nonparties in a pending suit and authorizes "by obtaining a court order under Rule...202" that a court may order both an oral deposition under 205.1(a) and "a request for production of documents or tangible things... served with a notice of deposition" under 205.1(c). The Court therefore finds that it may order the production of documents and tangible things in addition to an oral deposition as permissible relief under Rule 202.~~

6. On April 11, 2022, no plea to the jurisdiction was noticed for hearing or properly before the Court. As such, any plea to the jurisdiction filed has not been heard or determined, explicitly or implicitly, and any such plea remains pending before the Court. The Court will consider whether it must exercise its discretion to permit targeted discovery before hearing such a plea when those matters are properly set for the Court's determination.

The Court therefore GRANTS the Petitioner's request and orders that the petitioner may take the depositions of Daniel K. Podolsky, M.D. and John J. Warner, M.D. ~~The Court additionally orders that the following requested documents shall be produced:~~

~~1.~~ All documents to or from the Governor, the Office of the Governor, or any member of the Executive Branch of the State of Texas regarding, discussing, or pertaining in any way to gender-affirming care provided at UTSW or Children's Medical Center (including but not limited to the GENECIS program or Dr. Ximena Lopez) and dated January 1, 2020 through the present. Production is to include all responsive electronically stored or created documents/files and all meta-data related thereto.

~~3.~~ All documents to or from any member or agent of a member of the Legislative Branch of the State of Texas regarding, discussing, or pertaining in any way to gender-affirming care provided at UTSW or Children's Medical Center (including but not limited to the GENECIS program or Dr. Ximena Lopez) and dated January 1, 2020 through the present. Production is to include all responsive electronically stored or created documents/files and all meta-data related thereto.

~~3.~~ All documents sent by or to any officer, director, or employee of UTSW or Children's regarding, discussing, or pertaining in any way to any actual or potential restriction on, discontinuation, termination, or modification of, or change to any gender-affirming care (or policies related thereto) provided at UTSW or Children's Medical Center (including but not limited to the GENECIS program or Dr. Ximena Lopez) and dated January 1, 2020 through the present. Production is to include all responsive electronically stored or created documents/files and all meta-data related thereto.

The Court denies without prejudice the request for other documents sought in the Petition.

The Court orders that the depositions of Dr. Podolsky and Dr. Warner shall be taken remotely within fourteen (14) days of this Order. The Court orders that within three (3) days of this Order, counsel for Dr. Podolsky and Dr. Warner and counsel for Dr. Lopez shall confer and determine a mutually agreeable date for the deposition within that ten day time period. Upon determining a mutually agreeable date, the Court orders that counsel for Dr. Lopez shall send a notice of the deposition as required by TEXAS RULE OF CIVIL PROCEDURE 199.2. If counsel

for Dr. Podolsky and Dr. Warner and counsel for Dr. Lopez are unable to determine a mutually agreeable date within three days of this order, counsel for Dr. Lopez shall notify the Court, and the Court will select a date within that ten day time period. ~~The Court finds that no additional protections are necessary other than the protections already provided by Rule 199.~~ MJB

Date: April 14, 2022

Melissa J Bellan
HON. MELISSA BELLAN

15. Order Overruling Respondents', Dr. Podolsky and Dr. Warner, 1) Objections to Petitioner's Rule 202 Pre-Suit Deposition and Document Requests; and 2) Motion for Protective Order

Cause No. CC-22-01316-B

In Re:		
PETITION OF XIMENA LOPEZ, M.D. TO TAKE DEPOSITION BEFORE SUIT PURSUANT TO TEXAS RULES OF CIVIL PROCEDURE RULE 202	§ § § § § § §	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

ORDER ON

RESPONDENTS', DR. PODOLSKY AND DR. WARNER, 1) OBJECTIONS TO PETITIONER'S RULE 202 PRE-SUIT DEPOSITION AND DOCUMENT REQUESTS; AND 2) MOTION FOR PROTECTIVE ORDER

Came on to be heard Respondents' Daniel K. Podolsky, M.D. ("Dr. Podolsky") and John J. Warner, M.D. ("Dr. Warner"): 1) Objections to the Deposition and Document Requests contained in Ximena Lopez, M.D.'s Verified Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202 ("Petition"); and 2) Dr. Podolsky's and Dr. Warner's Motion to Protective Order. After considering the arguments of counsel as well as the Petition and Supplement thereto and the requests for Depositions and documents contained therein, Respondents' Plea to the Jurisdiction, Respondents' Response in Opposition to the Petition, Respondents' Objections to Petitioner's Deposition and Document Requests, Respondents' Motion for Protective Order; Dr. Lopez' Reply, the exhibits submitted with those pleadings, and the and the authorities, the Court is of the opinion that:

Respondents' Objections to Petitioner's Requests for Depositions and Requests for documents are hereby Sustained, Overruled, or the Requests are Modified as follows:

I.

OBJECTIONS TO DEPOSITION REQUEST SUBJECT MATTER (Scope of Depositions)

Topic 1: What person, entity, or office is seeking to impose limitations on Dr. Lopez's independent medical judgment to provide puberty-suppressing medications and hormone therapy to new patients.

Objection 1: Overly Broad /Not Reasonably Tailored to Include Only Matters Relevant to the Case.

Court's Ruling: _____ Sustained ____✓____ Denied

Objection 2: Fishing Expedition and Unduly Burdensome.

Court's Ruling: _____ Sustained ____✓____ Denied

Objection 3: Invades Attorney-Client Privilege.

Court's Ruling: _____ Sustained ____✓____ Denied

✓ This ruling does not prevent the assertion of privileges during the deposition to specific questions.

Objection 4: Executive Privilege.

Court's Ruling: _____ Sustained ____✓____ Denied

✓ This ruling does not prevent the assertion of privileges during the deposition to specific questions.

Topic 2: Whether and which governmental official or government office communicated with UTSW and demanded such limitations be enforced by UTSW or Children's.

Objection 1: Overly Broad /Not Reasonably Tailored to Include Only Matters Relevant to the Case

Court's Ruling: _____ Sustained ____✓____ Denied

Objection 2: Fishing Expedition and Unduly Burdensome.

Court's Ruling: _____ Sustained ____✓____ Denied

Objection 3: Invades Attorney-Client Privilege.

Court's Ruling: _____ Sustained ✓ Denied

MR This ruling does not prevent the assertion of privileges during the deposition to specific questions.

Objection 4: Executive Privilege.

Court's Ruling: _____ Sustained ✓ Denied

MR This ruling does not prevent the assertion of privileges during the deposition to specific questions.

Topic 3: The Medical, Ethical, and Legal Basis for Such a Limitation.

Objection 1: Improperly Seeks Discovery of Legal Theories and Legal Conclusions.

Court's Ruling: _____ Sustained ✓ Denied

Objection 2: Overly Broad /Not Reasonably Tailored to Include Only Matters Relevant to the Case.

Court's Ruling: _____ Sustained ✓ Denied

Objection 3: Fishing Expedition and Unduly Burdensome.

Court's Ruling: _____ Sustained ✓ Denied

Objection 4: Invades Attorney-Client Privilege.

Court's Ruling: _____ Sustained ✓ Denied

MR This ruling does not prevent the assertion of privileges during the deposition to specific questions

Objection 5: Executive Privilege.

Court's Ruling: _____ Sustained ✓ Denied

This ruling does not prevent the assertion of privileges during the deposition to specific questions.

Topic 4: Why the limitation is not discriminatory.

Objection 1: Improperly Seeks Discovery of Legal Theories and Legal Conclusions.

Court's Ruling: _____ Sustained ✓ Denied

Objection 2: Overly Broad /Not Reasonably Tailored to Include Only Matters Relevant to the Case

Court's Ruling: _____ Sustained ✓ Denied

Objection 3: Fishing Expedition and Unduly Burdensome.

Court's Ruling: _____ Sustained ✓ Denied

Objection 4: Invades Attorney-Client Privilege.

Court's Ruling: _____ Sustained ✓ Denied

MP This ruling does not prevent the assertion of privileges to specific questions during the deposition

Objection 5: Executive Privilege.

Court's Ruling: _____ Sustained ✓ Denied

MP This ruling does not prevent the assertion of privileges to specific questions during the deposition

Topic 5: Upon what legal authority the limitation is being imposed.

Objection 1: Improperly Seeks Discovery of Legal Theories and Legal Conclusions.

Court's Ruling: _____ Sustained ✓ Denied

MP The deponents may answer to the extent they know

Objection 2: Overly Broad /Not Reasonably Tailored to Include Only Matters Relevant to the Case.

Court's Ruling: _____ Sustained ✓ Denied

Objection 3: Fishing expedition and Unduly Burdensome.

Court's Ruling: _____ Sustained ✓ Denied

Objection 4: Invades Attorney-Client Privilege.

Court's Ruling: _____ Sustained ✓ Denied

MP This ruling does not prevent the assertion of privileges to specific questions during the deposition

Objection 5: Executive Privilege.

Court's Ruling: _____ Sustained ✓ Denied

MP This ruling does not prevent the assertion of privileges to specific questions during the deposition.

II.

OBJECTIONS TO DOCUMENT PRODUCTION REQUESTS

REQUEST 1: Any and all documents or correspondence, including emails or texts, from the Governor, the Office of the Governor, or any member of the Executive Branch of the State of Texas relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care.

Objection 1: Documents Not in Drs. Podolsky or Warner's Possession, Custody or Control/Access to Documents via Employment is not Possession/Custody or Control. Tex. R. Civ. P. 192.3(b); 192.7(b); *In re Kuntz*, 124 S.W.3d 179, 180 (Tex. 2003); *In re Grand Jury Subpoena (Kent)*, 646 F.2d 963, 969 (5th Cir. 1981).

Court's Ruling: _____ Sustained _____ Denied

Objection 2: Overly Broad and Unduly Burdensome

Court's Ruling: _____ Sustained _____ Denied

Objection 3: Seeks information which is neither relevant nor likely to lead to the discovery of admissible evidence

Court's Ruling: _____ Sustained _____ Denied

Objection 4: Attorney-Client and work product.

Court's Ruling: _____ Sustained _____ Denied

Objection 5: Executive Privilege.

Court's Ruling: _____ Sustained _____ Denied

Objection 6: Private Patient Information– HIPAA, Right to Privacy; and to the extent it seeks information protected from discovery by the physician-patient privilege (TEX. R. EVID. 509) and/or the physician-patient communication privilege (TEX. OCCUPATIONS CODE § 159.002).

Court's Ruling: _____ Sustained _____ Denied

REQUEST 2: Any and all documents or correspondence, including emails or texts, from any member or agent of a member of the Legislative Branch of the State of Texas relating to the GENECIS clinic, Dr. Lopez, or gender-affirming care.

Objection 1: Documents Not in Drs. Podolsky or Warner's Possession, Custody or Control/Access to Documents via Employment is not Possession/Custody or Control. Tex.

As to the document requests, the Court finds that the Movant is entitled to a deposition or DWQ, but not a duces tecum or other document request in addition to the deposition.

REQUEST 7: All public statements made about Dr. Lopez or the GENECIS clinic.

Objection 1: Documents Not in Drs. Podolsky or Warner's Possession, Custody or Control/Access to Documents via Employment is not Possession/Custody or Control. Tex. R. Civ. P. 192.3(b); 192.7(b); *In re Kuntz*, 124 S.W.3d 179, 180 (Tex. 2003); In *re Grand Jury Subpoena (Kent)*, 646 F.2d 963, 969 (5th Cir. 1981).

Court's Ruling: _____ Sustained _____ Denied

Objection 2: Overly Broad and Unduly Burdensome.

Court's Ruling: _____ Sustained _____ Denied

Objection 3: Seeks information which is neither relevant nor likely to lead to the discovery of admissible evidence.

Court's Ruling: _____ Sustained _____ Denied

III.

MOTION FOR PROTECTIVE ORDER

IT IS FURTHER ORDERED, ADJUDGED and DECREED that Respondents Daniel K. Podolsky, M.D. and John J. Warner, M.D.'s Motion for Protective Order is hereby GRANTED in part and denied in part.

IT IS FURTHER ORDERED that all relief requested and not expressly granted herein is denied.

SIGNED this 14 day of April, 2022.

JUDGE PRESIDING

16. Order Denying Respondents', Dr. Podolsky and Dr. Warner, Objections to Petitioner's Affidavit

Cause No. CC-22-01316-B

In Re:

PETITION OF XIMENA LOPEZ, M.D. TO TAKE DEPOSITION BEFORE SUIT PURSUANT TO TEXAS RULES OF CIVIL PROCEDURE RULE 202	§ § § § § § § §	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

ORDER
SUSTAINING RESPONDENTS', DR. PODOLSKY AND DR. WARNER, OBJECTION TO PETITIONER'S AFFIDAVIT

THE COURT ORDERS the Respondents,' Dr. Podolsky and Dr. Warner, objection to Petitioner's affidavit IS ~~HEREBY~~: Moot because the court received and considered the live testimony during the 202 hearing.

SUSTAINED _____

OVERRULED _____

SIGNED this 14 day of April, 2022.

Melissa Le Bert
JUDGE PRESIDING

17. Dr. Daniel Podolsky and Dr. John Warner's Response to Plaintiff's Motion to Strike Additional Briefing

CAUSE NO. CC-2201316-B

IN RE: XIMENA LOPEZ, M.D.,	§	IN THE COUNTY COURT
	§	
Petitioner	§	AT LAW NUMBER TWO
	§	
	§	DALLAS COUNTY, TEXAS

DR. DANIEL PODOLSKY AND DR. JOHN WARNER'S RESPONSE TO PLAINTIFF'S MOTION TO STRIKE ADDITIONAL BRIEFING

Respondents Dr. Daniel Podolsky and Dr. John Warner respond to Petitioner's Motion to Strike Additional Briefing as follows:

As Petition points out in her Motion to Strike Respondents' Additional Briefing, at the hearing held on April 11, 2022, Petitioner testified that the reason she needs the depositions of Dr. Podolsky and Dr. Warner is to find out who was behind the "dictate" that prevents her from providing puberty-suppressing medications to any new adolescent patients diagnosed with gender dysphoria. While Dr. Podolsky and Dr. Warner presented briefing and arguments as to why they should be exempted from Dr. Lopez's request because of governmental immunity, they also presented briefing and arguments to show that the information Dr. Lopez sought was already in the public domain through the Joint Press Release by UT Southwestern and Children's Medical Center published in March of 2022, and as such the 202 deposition was not needed.

That notwithstanding, at the close of the hearing the Court advised that she would entertain any additional briefing. Thereafter, Respondents made the decision to provide Dr. Lopez the exact information she said at the hearing was necessary. Accordingly, Dr. Podolsky and Dr. Warner provided Affidavits stating it was they who made the decision, on behalf of UT Southwestern and jointly with Children's Health, that puberty-suppressing medications and hormone therapy, would be no longer allowed for new patients. Their Affidavits stated further that there were no third-party

entities or individuals who made or directed them to make those decisions. Petitioner now moves to strike those Affidavits because she was not allowed to cross examine Dr. Podolsky or Dr. Warner.

It is important to remember the purpose of the 202 deposition as expressed by Dr. Lopez and argued by her counsel: To find out who made the decision, so Dr. Lopez could determine who to include in a subsequent lawsuit. Dr. Lopez's counsel advised the Court that it was a very simple and straightforward request to Respondents, and that depositions could be completed in probably an hour. The Affidavits by Dr. Podolsky and Dr. Warner answer the question and provide Dr. Lopez the information she said she needed. If there is any need for cross examination, that can be done at any lawsuit on the merits that Dr. Lopez subsequently files. There is no reason for the Court to not consider the Affidavits of Dr. Podolsky and Dr. Warner, nor is there any reason to reopen evidence to compel further testimony from Dr. Podolsky or Dr. Warner.

Petitioner also moves to strike Respondents' additional briefing arguing that it merely reasserts the same arguments made pre-hearing and at the hearing. Respondents disagree.

At the hearing, Petitioner's lawyers argued that one of the reasons Dr. Podolsky's and Dr. Warner's plea to the jurisdiction should be denied is that Petitioner needs to discover if they had committed *ultra vires* acts by violating Tex. Civ. Prac. & Rem. Code, §106.001. That argument or authority was not included in Petitioner's Request for 202 Petition or her supplement to her Petition to take a 202 deposition. Instead, it was raised for the first time in Dr. Lopez's Reply, then argued at the oral hearing.

As permitted by the Court, Respondents provided a post-hearing letter brief to address Petitioner's arguments in which they relied upon Tex. Civ. Prac. & Rem. Code, §106.001. In that brief, Respondents demonstrated to the Court why that statutory provision was not applicable. The

arguments raised in Respondents' letter brief were in direct response to the arguments raised and discussed at the hearing, and there is no basis why the additional briefing should be excluded.

Accordingly, Respondents pray that Petitioner's Motion to Strike be denied and that the Court accept and consider Respondents' letter brief, with the attached Affidavits of Dr. Daniel Podolsky and Dr. John Warner.

Respectfully submitted,

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ATTORNEYS FOR RESPONDENTS
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JOHN J. WARNER, M.D.

CERTIFICATE OF SERVICE

I hereby certify that on April 15, 2022, a true and correct copy of the foregoing has been forwarded to all counsel of record through the electronic filing manager as follows:

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/s/ C. Timothy Reynolds
C. TIMOTHY REYNOLDS

VERIFICATION OF C. TIMOTHY REYNOLDS

STATE OF TEXAS	§
	§
COUNTY OF DALLAS	§

BEFORE ME, the undersigned notary, on this day personally appeared C. Timothy Reynolds, the affiant, whose identity is known to me. After I administered an oath, affiant testified as follows:

1. "My name is C. TIMOTHY REYNOLDS. I am over the age of 21 years, of sound mind, and capable of making this Affidavit. The facts stated in this affidavit are within my personal knowledge based on my personal experience with them, and they are true and correct. I am an attorney licensed to practice in the State of Texas and am a partner with the firm STEED DUNNILL REYNOLDS BAILEY STEPHENSON LLP."
2. I have received copies of various items from the Court file in this trial court through the efiling system when I was served with those documents, by obtaining them from the Dallas County website for court records, or by generating them on behalf of Drs. Podolsky and Warner. These items include (1) Real Party in Interest's Petition to Take Depositions Under Texas Rule of Civil Procedure 202, Relators' Plea to the Jurisdiction, (2) Relators' Objections to Depositions, Document Requests, and Motion for Protective Order, (3) Other Interested Parties' Responses to Real Party in Interest's Petition, (4) Real Party in Interest's Supplement to her Petition, (5) Real Party in Interest's Notice of Hearing on her 202 Petition, (6) Other Interested Party's Motion to Strike Real Party in Interest's Affidavit, (7) Real Party in Interest's Reply to Responses to her Petition, (8) Letters with Additional Briefing, (9) Real Party in Interest's Motion to Strike Additional Briefing, (10) Orders on the Petition, Objections, Motion for Protective Order, and (11) Relators' Response to Real Party in Interest's Motion to Strike. These items are items 1-17 in the Mandamus Record for the Petition for Writ of Mandamus in this matter. Those items in the Mandamus Record are true

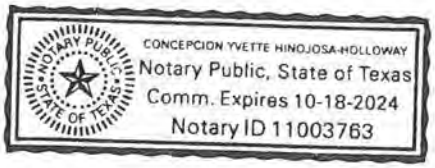
and correct copies of the documents that I obtained in this case or created as party of my representation of Drs. Podolsky and Warner.

3. I am one of the custodians of record for the law firm STEED DUNNILL REYNOLDS BAILEY STEPHENSON LLP and am familiar with the manner in which its records are created and maintained by virtue of my duties and responsibilities. The 338 pages of the Mandamus Record are the original records or exact duplicates of the original records. All of these records were received by STEED DUNNILL REYNOLDS BAILEY STEPHENSON LLP in the course of its representation of Dr. John Warner and Dr. Daniel Podolsky and were received or created at or near the time of each act, event, condition, opinion, or diagnosis set forth in the record. The records were received or created so that STEED DUNNILL REYNOLDS BAILEY STEPHENSON LLP could rely on the information within them. The records were provided by STEED DUNNILL REYNOLDS BAILEY STEPHENSON LLP by persons with knowledge of such matters set forth, and it is the regular practice of STEED DUNNILL REYNOLDS BAILEY STEPHENSON LLP to create or receive and rely on the accuracy of these types of documents in the regular course of its business. The records were kept in the course of regularly conducted business activity, and it is the regular practice of STEED DUNNILL REYNOLDS BAILEY STEPHENSON LLP to keep this type of record in the course of regular conducted business activity. It is the regular practice of STEED DUNNILL REYNOLDS BAILEY STEPHENSON LLP to receive, create, accurately keep, and rely on these types of records in its business activities."

Further, Affiant sayeth not.

C. TIMOTHY REYNOLDS

SWORN TO AND SUBSCRIBED BEFORE ME, by C. TIMOTHY REYNOLDS, on this 22 day of April, 2022.



Concepcion Yvette Hinojosa-Holloway
Notary Public in and for the State of Texas

Respectfully submitted,

/s/ David M. Walsh IV

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Certificate of Service

I certify that on April 22, 2022, I served a complete copy of this Mandamus Record on all counsel of record through the e-filing system.

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/s/ David M. Walsh IV

David M. Walsh IV

No. 05-22-00375-CV

In the Fifth Court of Appeals
at Dallas, Texas

In re Daniel K. Podolsky, M.D. and John J. Warner, M.D.
Relators,

Hon. Melissa Bellan,
Respondent

Ximena Lopez, M.D.,
Real Party in Interest

University of Texas Southwestern Medical Center and Children's Medical Center,
Other Interested Parties.

Original Proceeding from County Court at Law No. 2, Dallas County, Texas, Trial Court No. CC-22-01316-B, Hon. Melissa Bellan, Presiding

SUPPLEMENTAL MANDAMUS RECORD

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Oral Argument Requested

18. Transcript of Hearing on Plaintiff's Verified Petition to Take Deposition Before Suit Pursuant to Texas Rule of Civil Procedure 202

REPORTER'S RECORD
VOLUME 1 OF 1
COURT CAUSE NO. CC-22-01316-B

EX PARTE	)	IN THE COUNTY COURT
	)	
	)	
	)	
VS.	)	AT LAW NO. 2
	)	
	)	
XIMENA LOPEZ, M.D.,	)	
	)	
Petitioner.	)	DALLAS COUNTY, TEXAS
	)	
	)	

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202 PETITION HEARING

On the 11th day of April, 2022, the following proceedings came on to be heard in the above-entitled and numbered cause before the Honorable Judge Melissa Bellan, Judge presiding, held via Court Call in Dallas County, Texas;

Proceedings reported by machine shorthand.

COPY

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I N D E X
VOLUME 1 of 1
(202 PETITION HEARING)

P R O C E E D I N G S

(April 11, 2022)

(Proceedings held via videoconference)

THE COURT: There is no audio or video recordings at any proceeding from this courthouse.

We are here today on a 202 petition. I've got to say, I've never seen this many people show up for a 202.

This is a 202 petition. Generally, these are hearings that are based on the filings that are before the court. In this case, we have a whole lot of other action going on here. There have been some objections filed, there were also some witnesses served subpoenas, some of which may have been objected to.

We are going to start with the plaintiffs, who are the party who actually filed this request for a 202 in order to get some pre-suit discovery. When I looked at this file -- are we really pre-suit, or have we already started litigation. That's kind of what it looks like to the court.

This was filed by Aldous/Walker. Who will be taking the lead today? Mr. Walker, you will be? Okay. You can un-mute your phone line then.

MR. WALKER: Well, Your Honor, Brent Walker. So we represent Dr. Lopez, who actually is here

today, and if we get to the issue of the 202, since it is an evidentiary hearing, we have some brief testimony from Dr. Lopez we may want to put on the record.

Your Honor is right. We filed a request for a 202 deposition and some written discovery, which, as the courts routinely describe, it is just a request for a discovery and nothing more. And despite the fact we're just seeking a request for discovery, we received over 80 pages of various filings from three different groups of lawyers trying to resist our simple request for discovery. And our request for discovery was extremely narrow.

As I mentioned, we represent Dr. Lopez, who is a pediatric endocrinologist at UT Southwestern and Children's Medical Center here in Dallas. And Dr. Lopez has been doing this for many years. She's credentialed by the medical staff there to provide those services, and she has been doing so for well over a decade. And as part of her role as a pediatric endocrinologist, sometimes she sees patients who are transgender. She sees patients who are suffering from gender dysphoria. So part of her role as a pediatric endocrinologist is to treat those patients consistent with the standard of care. And we've attached to our petition for 202, two international publications that deal with the

appropriate standard of care to treat transgender adolescents. That actually is something that Children's Medical Center and UT Southwestern took immense pride in for many years. We included in our application a documentation showing that both Children's Medical Center and UT Southwestern publicly advertised the strength of the program they had there at their facilities to treat transgender adolescents how and by Dr. Lopez.

Now, they say that they follow those standards of care that we attached as Exhibit 2, and that's what Dr. Lopez did, and it's saving lives, and it has saved lives over the years. However, sometime in 2017, this all became a political football. And the court will recall, in the previous legislatures, we had issues with the Bathroom Bill, where there was a bunch of fight down in Austin about whether or not we were going to let transgender kids use different bathrooms. And then we had a fight, actually last session, about whether or not the state legislature was going to determine that gender-affirming care for transgender children constitutes child abuse. That measure failed, thankfully, and the legislature was the party that if we were going to be legislating about this topic, they were the ones obligated to do so, but that legislation

failed. Undeterred, our governor publicly stated that he would find other ways to put a stop to this. The attorney general passed -- or issued a letter in which he said, this is -- constitutes child abuse, and all people providing such care should be reported to CPS. And then the governor instructed CPS to investigate parents who have children who seek merely care for their children, and physicians like Dr. Lopez, who are just trying to do the best they can for their patients.

Now, that issue was actually subject to another lawsuit called Jane Doe versus Abbott, in which a temporary restraining order was issued by Judge Meachum down in Travis County, in which he found that -- having such a rule would be bad and harmful to children who are suffering from transgender or gender dysphoria, and also for physicians like Dr. Lopez, because it subjects them to potential criminal penalties.

Now, the same time this is all going down in Austin, what's not publicly known is behind the scenes somebody, we don't know, was exerting pressure on UT Southwestern to put a stop to the Genecis Program, which is the program that has been a internationally recognized feather in the cap of UT Southwestern that Dr. Lopez has worked at. And, so, the administration, or members of the administration at UT Southwestern,

came to Dr. Lopez and told her, you know, we're receiving pressure from the governor's office. There's a bunch of political noise on this. We have to stop providing this care. And Dr. Lopez pushed back and said, I can't do that. These are my patients. I have a duty to do no harm and to take care of these people. And so, a decision was ultimately made by whom? We don't know, and conveyed to Dr. Lopez that she is to not provide certain aspects of gender-affirming care, consistent with the standard of care that the institutions themselves publicly acknowledged, and that she should refrain from doing that for any new patients.

Now, it's important to understand what this care is that's at issue in this application. When a child is suffering from gender dysphoria, there are several components to that. There's a psychological component. It's recognized in the DSM as a psychological condition. But what you really have is a child who is trying to figure things out. A child who is working through issues. And gender-affirming care, the point behind it is, we want to affirm these children. We want to not force them into certain buckets. We don't want to tell them exactly what they can and can't do, and who they must be and who they shouldn't be. But what has been developed is a series

of treatment modalities, including puberty suppression. Now, why would you have puberty suppression for a transgender child? Well, as a child who is dealing with gender identity issues reaches the age of puberty, the psychological pressure upon them significantly increases because now, although they may be identifying as a male, for instance, they may be developing -- start developing breast or other female characteristics, or if they're a child that's identifying as a female, they might start growing a beard, or an Adam's apples, or something of that nature. And, so, what you can do is, you can provide, and the standard of care says you should provide these children puberty suppressions to delay the onset of puberty. Not forever, but to give the child some more time to work through these issues before the stigma of puberty sets in.

Now, this particular treatment, this gender -- puberty suppression treatment is something that is not new or specific as to children with gender dysphoria. On the contrary, there are all kinds of children, who don't suffer from any gender dysphoria, who identify as their same assigned sex at birth, who receive this puberty suppression medication because it's medically necessary for them. I actually know some children, children of my friends, who receive this

medication, not for anything to do with gender dysphoria, but because their child had premature puberty, and that can be bad for a child. And, so, part of what Dr. Lopez does, as a pediatric endocrinologist, is treat children who need to have puberty suppression for their own medical needs, because they have had precocious -- is what they call it -- precocious puberty.

So this medication is provided at UT Southwestern. This treatment modality is provided at UT Southwestern and has been provided for decades. And Dr. Lopez provides it currently to patients who are not suffering from gender dysphoria, but she is now being told that she cannot provide it to those who do have gender dysphoria. Now that's problematic. That's problematic both for the patients who need that treatment, but it's also problematic for Dr. Lopez because Dr. Lopez is a physician with duties to her patients, and she's being put in a position to deny treatment to patients because of their sex.

THE COURT: Okay. Mr. Walker, let me interrupt you for one second, because -- and I appreciate you giving me some of that background, because some of it I knew, but some of it I did not. Here is where we are. We're here on a 202, which is for

the ability to investigate whether a claim exists. What I am hearing, and the fact that I have all these folks here, and the fact that we're seeking all of these different folks who may have received subpoenas today. You know, the first thing that you have to establish to me is that we don't know for sure whether we have a claim. That's why we have to investigate. And what I'm hearing is, we have been told that treatments that we provide, under certain circumstances, we've now been told we can't apply it in other circumstances, even if we did before. And, so, my short sort of version of this to you is, how is it that we are trying to figure out whether we have a claim, when it sure sounds to me like you all have determined that you have a claim? So why are we going the 202 route?

MR. WALKER: Because we don't know against whom that claim needs to be asserted. We have the ability to pursue injunctive relief and declaratory judgment relief against parties who are interfering with Dr. Lopez's independent medical judgment. Under the administrative code, people, institutions, they cannot interfere with Dr. Lopez's independent medical judgment, and somebody is doing so. The question is, who?

Now, this is not just an idle question about we just want a name to put in defendant blank on a

lawsuit. It's much more than that because, as you're seeing here with the lawyers and all the pleadings, who we ultimately pursue a claim against, that is the person who makes this dictate. There's going to be some fairly substantial issues having to do with sovereign immunity, or, you know, with whether or not something is within their discretion, or within their ability. So one party who might be a party, we don't know, might be the governor of Texas. If it is, as was suggested to Dr. Lopez, that there was pressure coming from the governor of Texas, it could be that the governor of Texas dictated to UT Southwestern that they can no longer provide this treatment. That is not within the power of the governor of the State of Texas. It's a violation of separation of powers for him to do so, because the constitution places the ability to make decisions about the provision of healthcare in the hands of the legislature, not the governor.

So if this discovery shows up --

THE COURT: Hang on, Mr. Walker.

So I understand now that the position y'all are taking is not so much whether we have a claim, but who we may have a claim against. Can you run me through the parties or people that you are seeking discovery from in this 202? Because it may be a matter of, you

know, does the court believe that we have to start with one, see if there is a need for information from others? So can you start me out with giving me an understanding of who all we are seeking, either oral deposition or a deposition on written questions from, under Rule 202?

MR. WALKER: Certainly, Your Honor. We ask for two individuals. One is Dr. Podolsky and one is Dr. Warner. Now, Dr. Podolsky is the head of the medical school. And the reason why we're seeking his deposition is not for apex reasons, or anything of the sort. But it is Dr. Podolsky who told Dr. Lopez that he was under pressure from the governor's office. So what that means, we don't really know, and so we would like to inquire from Dr. Podolsky what that pressure was, and from whom it came, and so we can look at and evaluate whether or not there's a potential claim there. Dr. Warner is another -- I believe he's the chief medical officer. I could be wrong about that, but Dr. Warner also informed Dr. Lopez that she would not be able to provide this care to children, and there's all kinds of justification that were provided to -- public pressure pressure from the governor that there was questions about whether or not it was in the standard of care, various things like that. Now, we don't know who actually made the policy. We just know it was

communicated to Dr. Lopez that she could not do so. And, so, we were seeking very narrow depositions. We also sought some narrow document requests which is, you know, documents that show how this decision all became made. And we just want to know the very narrow question of who's responsible? Presumably, whoever is responsible is not ashamed of their ruling, and they can stand up and own it. And it may actually be the case that there's just one person. It may be the case that, you know, members of the board -- direct board of trustees of these institutions are a proper party. It could be that it's the governor. It could be that it's the attorney general. We know that the governor has publicly said that he was intending to accept this policy through his own means, and his political -- chief political advisor has publicly said this is a winning issue for the governor. And, so, if it's the governor, there maybe a claim against the governor. And then we would go through the whole issue about ultra vires and how you get to the governor. But that's not -- we can't answer that question today, because we don't know who the proper party is who enforced this limitation on Dr. Lopez.

THE COURT: Okay. And before we get any further there, who do I have today that is here

representing Dr. Podolsky? Please just make an appearance for me.

MR. REYNOLDS: This is Tim Reynolds. I represent both Dr. Podolsky and Dr. Warner. They were identified as potential adverse parties.

THE COURT: Thank you. I'm going to come back to you. I am trying to get the outline from Mr. Walker, and then we'll talk about each individual and what we may or may not be able to do today.

All right. Mr. Walker, outside of those two individuals, who else are we seeking discovery from under this 202?

MR. WALKER: Your Honor, in addition to the two individuals, which I would note that Rule 202, specifically -- the case law around 202 has said that you do not need to actually seek a deposition from the person who is a party. It can be from anyone. It doesn't have to be the target of a potential lawsuit. But in addition to seeking discovery from Dr. Podolsky and Dr. Warner on five narrow topics, we also ask for just written production of documents that have to do with correspondence, basically, with various entities about this whole decision making process. But other than two narrow depositions on five identified topics, depositions, I think, that can be done within an hour.

I think between those two people, we will have the universe as to how this decision will be made, and if we can get those documents before the deposition, they will assist us in being even more efficient in our time during the deposition.

THE COURT: Okay. Now outside of those two folks that we have talked about. I have several pleadings from various entities, and possibly some of those individuals. I will start with, you know, Children's Medical Center of Dallas has identified themselves as a respondent in this 202, and has filed what they're calling, objections to the request to take deposition before suit, under rule 202, and for a protective order.

So who do I have here today that is representing Children's Medical Center?

MS. PUIG: Your Honor, Yvonne Puig and Daphne Calderon. It's a pleasure to be before you again. We are here representing Children's Medical Center of Dallas.

THE COURT: Okay. Let me start with just a basic question which is, do you have standing to show up and file an objection as a respondent if you are not one of the parties that I've heard, yet, from Mr. Walker that he's seeking deposition from? I understand how you

all would be implicated in, you know, this overall question of who is enforcing a policy, and where did it come from. But let's just start with that legal issue of, how do you get before the court today?

MS. PUIG: Your Honor, we're before the court because if you look at the request, while no specific request for an individual was requested or served upon us, we are mentioned throughout, and there are documents that clearly touch on Children's Medical Center of Dallas. We're not here to argue them -- those objections today probably, but we would say they're overly broad, they're improper, and at least in one request, they're privilege. But we are here because we're clearly implicated from a four corners reading of the pleadings, but we are not here regarding a request for deposition of any individuals or representatives of our clients.

THE COURT: Okay. So, essentially, are you all in a position of, you know, we sometimes see this with third-party discovery where someone objects because their interests are also touched upon, even if they're not the party that discovery is sought from?

MS. PUIG: That is correct, Your Honor. Thank you.

THE COURT: So that's how I have Children's

Medical here.

And then let me pull up -- there is a plea to the jurisdiction. I think one of those was related to Dr. Podolsky, but then there is also one from UT Southwestern Medical Center. So who do I have today on behalf of UT Southwestern?

MR. ELDRED: Good afternoon, Your Honor. This is Charles Eldred with the Attorney General's Office on behalf of University of Texas Southwestern Medical Center. Erin Sine, the vice president of legal affairs of UT Southwestern is also here. Allene Evans, senior associate general counsel and managing attorney for healthcare for University of Texas Systems is also here.

THE COURT: So that's everybody from UT Southwestern. And just to short circuit this, is there anyone else here who's appearing that we haven't gotten an appearance from today?

MR. MALOUF: Steve Malouf for the Movant.

THE COURT: Thank you, Mr. Malouf. I just wanted to make sure we have a good record of everybody.

Okay, Mr. Walker, I'm going to circle back to you now so we can talk about the specifics here, and I think it is important for us to look at the issue of does 202 allow you to get a oral deposition and also

request documents, whether it only allows either an oral deposition or deposition on written questions? You know, the real question from my mind is, is a duces tecum valid?

Ms. Puig, I'm getting a duplicate attempt from you. I just want to make sure whether -- it looks like your audio was disconnected. I'm going to grant this, and then make sure we've got you in. It looks like her audio is disconnected. So let's just give it one second, unless Ms. Calderon tells us we can proceed, because they are both representing Children's.

MS. CALDERON: We can proceed, Your Honor.

THE COURT: Okay, Mr. Walker, let's get into these pockets, duces tecum, one or the other, and some authority to backup whichever position you're taking here.

MR. WALKER: Certainly, Your Honor. The Supreme Court has said that the scope of what's permissible under rule 202 is the same discovery that would be permitted if the lawsuit was filed. And 202 incorporates some prior rules, including rule 199 and rule 200, and rule 201. And so each of those different rules, which are about the process on how you take depositions, each of those rules incorporate the notion that you can request documents with that discovery

requests. And, so, under rule 199, which is incorporated in 202, there can be a request for documents under 199.5, and 199.3. Under Rule 200, there can also -- which is a deposition on written questions. As the court knows, that obviously can utilize documents. And 201 is a rule for requesting depositions. Basically, letter rogatory procedure, people in a foreign jurisdiction, and that also incorporates a request for documents. And, so, what 202 does is says, all of those rules can be utilized in a pre-suit scenario to investigate and anticipate -- or investigate more anticipation of a claim. And, so, I don't think it's terribly controversial that we would be able to, as part of the 202, to obtain documents as well --

THE COURT: Now, let's talk about -- I'm sorry to interrupt.

MR. WALKER: The O'Connor's says I can.

THE COURT: Well I guess the thing that matters is whether I end up saying you can.

MR. WALKER: Agreed.

THE COURT: Let's talk about, you said there are five, you know, specific topics, and that seems to be some of the complaints from the folks who have responded here is about the breath of those topics,

and, you know, obviously, then we also have a concern regarding a potential protective order. I don't know what your position on that may be. Obviously, it becomes easier if we are willing to consider a protective order on certain areas, but let me let you present what it is you want with the big swing of the bat, and then we'll see where we end up.

MR. WALKER: Certainly, Your Honor, this is a first for me. I actually thought my requests were fairly narrow, and usually I am overreaching. I don't think I was in this situation, because the topics that we were seeking, although from the responses you might think that we were seeking to discover an entire lawsuit. It is very narrow. The first category is the who. Who is imposing on this issue? The second one is whether a governmental official, the governor's office, the attorney general's office, some other office, communicated with UT Southwestern and made a demand about enforcing this policy? It seems like a pretty easy topic to answer.

The third one is, is the basis for that limitation. And the reason why we're asking that question is because that will inform the issue about whether or not there is a valid claim here, whether or not there is a claim that is being based upon some sort

of medical decision making from some entity that has the authority to make medical decision making, whether this is purely a political thing, whether this is something that was invested in the governor's office from the Texas Medical Board. I have any reason to think that's true. So we're just trying to figure out, okay, if you're doing this, what's your authority for doing it? That goes exactly to the issue about whether or not ultra vires actions have occurred, and there's no way for us to evaluate, you know, say it's Abbott, or Podolsky, or whoever. Okay, well, they're the person, but by what authority did they do this? That will inform whether or not an ultra vires action has occurred. And we don't know what authority they're asserting as the basis for imposing a limitation upon Dr. Lopez's medical judgment, and a discriminatory one at that.

The fourth category is why it's not discriminatory because it seems to be on the face. And under the United States Supreme Court precedent, it seems to be completely discriminatory on its face, and it's targeted only to those individuals who have gender identity issues, which the Supreme Court said is discrimination based on sex. So the question would be, okay, how does -- how is this not discriminatory? How

is this not going to put Dr. Lopez in a position where she could go to jail or be prosecuted by the Attorney General's Office, who is here today.

And the last one is, is -- actually, I guess it's somewhat duplicative. I said, let the legal authority of the limitations be imposed upon what authority? That's kind of redundant. So I guess three and five are kind of the same, basically. We just need to know who did it; why they did it; and what authority they had to do it? That seems pretty simple. We're not asking for, you know, anything beyond that. And then the documents are just -- the document requests are all tied to those same topics. We want to know, okay, do you have communication? Is that a letter that came from the governor's office? You know, is it a -- was UT Southwestern and Children's communicating with each other? I don't know.

How this all came about, we believe that a small set of documents will answer these questions. And, again, we don't need all the documents. We just need enough to answer this set of questions. So things that bear upon the five topics we're -- I guess four now -- that we're seeking, I think are discoverable. And I don't think that they should be subject to protective order, since as all their plea to the jurisdictions make

it clear, they're all governmental entities. So, why would the public -- why shouldn't the public know who is making this call and what they were saying? You know, I know our governor and attorney general proudly say that they stand and fight for these things. So why shouldn't communications from them be subject to public scrutiny? UT Southwestern is a state institution that provides patients to Children. So why should their decision making about whether or not they're going to provide care to transgender children or not, why shouldn't that be something that's subject to public scrutiny, because the public may think that that's a bad thing, and may want to tell our state institute no, no, we disagree. So we think all those topics are just narrowly cabined. There's a whole lot of other things we could get into, but we're not. And, so, we're jut trying to figure out these basic answers so we can file for a temporary restraining order, and then address the plea to the jurisdiction that are going to happen once we file the temporary restraining order.

THE COURT: That's what the court's concern here is, in part, is simply that it's clear to me that you all could attempt to file suit in a temporary restraining order against these entities. And as a result, depending on what the court ruled, and if I

allowed some discovery between the TRO if it was granted, and a TI, or just because you have a suit going if you started discovery, I imagine these would be the same issues that you would want to seek in that suit. But -- and I guess this comes back to what a judge once told me when I came in on a 202 and said, I just don't believe you that you're not going to file suit if I don't give you this 202. I think you've got what you need to file suit, and you're going to file suit regardless, is kind of a game of chicken between me and the judge. And this feels somewhat similar, with the exception of we know that there is some other party out there who must have communicated something, from your point of view. We don't know that for sure, but that's the argument you're making to me. And I thought I read in maybe one of these responses for the pleas that the hospitals are taking a slightly different position to what you represented here today. And, so, I just wanted to clarify that with them, because I thought I had read that part of the position in some of these documents is no, no, no, they misunderstand us. We didn't say that you couldn't do this. So is that the position from either UT Southwestern or Children's?

MR. REYNOLDS: Your Honor, may I speak to that? This is, again, Tim Reynolds for Dr. Podolsky and

Dr. Warner. I do not believe that, from my client's perspective, and I don't think I'm speaking out of turn of UT Southwestern. But there is -- the gender-affirmative care is still being provided. There is a limitations placed on it. Specifically, and without going too deep into the the actual medicine, I believe there's a limitation regarding the type of hormone therapy that can be provided. So, perhaps the court did misunderstand, or maybe we indicated something incorrectly, but I do not think there's a disagreement, but there is a limitation on some type of hormone therapy that can be provided.

THE COURT: That's what I wanted to clarify. So, thank you.

Is the Children's -- is that the same position from my folks here from Children's?

Looks like y'all may not be unable to un-mute yourselves there again. Let me un-mute Ms. Calderon.

Is that the same position from Children's?

MS. CALDERON: That is correct.

THE COURT: Thank you both.

I wanted to make sure I understood that we didn't have a fundamental disagreement. It is simply that there is a part of the gender-affirming care that

has either been stopped, or otherwise Dr. Lopez's position is that she's been directed not to provide that type of care.

Okay. Mr. Walker, what else do you want to fill the court in, as far as what it is that you want, and where we need it from, or want it from?

MR. WALKER: Certainly, Your Honor. And to clarify, it is -- she has been instructed that from new patients, that is patients that she didn't previously treat that are not ongoing patients. New patients, she cannot provide the items that are listed in the standard of care for those patients. The institutions are saying, oh, no, you're allowed to provide other kinds of care. And all they're referring to is you can send these children to a psychologist. The ones that are coming to the hospital, they're not coming to get psychologists. They already have psychologists. The point in time which people enter the hospital to try to get this gender-affirming care, they've already moved beyond the issue of psychologist. They are already patients that now need medical care. So the notion that is being expressed in the pleadings that no, no, no, you can still use psychology, but you just can't use anything that has to do with any of the hormonal treatment, that is puberty suppression or hormonal

treatment following puberty suppression. That's forbidden for any new patient. That's the essence of what this is. That's like saying you can treat cancer but, you know, you can't use radiation. I mean, what else are we going to do? No radiation of chemo, but I can take the cancer or the psychologist. That's the silliness of the argument they're making, Your Honor. There are -- been over a hundred patients that have came to this facility to try to get this care since it's been stopped, and they have been turned away, and these are patients who, without this type of care, studies -- the statistics show over 40 percent of them will try to commit suicide. So this is really serious. This isn't a small disagreement about the scope of gender-affirming care. Make no mistake, as the standard of care that we attached of both of the institutions, both of the groups that promulgate these standards of care made clear. They are saying we cannot perform the very gravamen of what this care is. So that is why Dr. Lopez, in effect, has nothing to provide these people who come to her seeking care, new patients, because anything that she would give them would be in the nature of the things she's supposed no longer can give. So, we need to know where these students are coming from.

So, I think the distinction that Mr.

Reynolds was trying to draw, is trying to set this up into an argument about, well, this is a dispute over the medicines. This isn't a dispute over medicines, and that is clear. The medicine was on their website as to what this care was. And, so, you know, the question needs to be, was this something that was enforced, externally, by someone in the government? And if so, that raises the issue about potential immunity issues. Was this a decision that was made by, you know, a board of trustee? That's an entirely different issue.

And, so, there has been plea to the jurisdictions filed in front of this court, and I don't know if the court has had the benefit of our reply, but the point we make in our reply is simply this: The law is abundantly clear that when somebody files a plea to the jurisdiction as UT Southwestern, and Dr. Podolsky, and Dr. Warner did, the court, before it's heard -- and those plea to the jurisdiction are not set for hearing today -- but before those pleas to the jurisdictions can be heard, the court can order discovery. Now what discovery would be needed in the plea to the jurisdiction? Well, it would be -- it would have to be discovery needed for the court to evaluate whether or not an ultra vires action occurred. That is -- that is something that --

THE COURT: But before we even get to that, I mean, there is also the issue that you have brought no claims for them to bring a plea to the jurisdiction about.

MR. WALKER: I would agree with that, Your Honor. It's sort of one of those things that they say it, and then we've got to do something with it. And, so, I would agree with Your Honor. I think you can deny the plea to the jurisdiction, insofar as there is no claim. Now, there is case law, and we cited it to the court. It's *Combs versus Texas Civil Rights Project*, and also Dallas Court of Appeals case, *In Re The City of Dallas*, that looks at this notion about whether or not there can be immunity -- sovereign immunity in the context of Rule 202. And, you know, the arguments that the institutions are making here is that we need to be able to provide you discovery proving that there's not an exception to immunity in order to get the discovery that we need. And in that case, there's a wonderful comment and opinion written by Judge Jones talking about requiring that exact type of thing. He says, "It should not be that a Rule 202 petitioner should be denied an opportunity to take discovery merely because he is presently unable to submit to the court the very type of evidence he seeks to discover."

So it's circular. We need to investigate this issue about whether an ultra vires action occurred, and that's the very issue that's subject to the plea to the jurisdiction.

And, so, I think the court has a decision to be made. If the court denies the plea to the jurisdiction, they have a right to an interlocutory appeal under Chapter 51. If the court grants the plea to the jurisdiction, we have a right to appeal. If the court grants the 202, my guess is there will be a mandamus. The third thing might be for the court to say, you know what, we need to know from the defendants are you going -- do you insist upon a ruling on your plea to the jurisdiction? If so --

THE COURT: So that's where I was going to start, because, as you pointed out, it is not set for hearing today, but I do want to hear from folks who filed a plea to the jurisdiction. And I believe, Mr. Eldred, you represent all of the parties that filed the pleas; is that right?

MR. ELDRED: No, Your Honor. Mr. Reynolds represents the doctors, who also filed pleadings.

THE COURT: I got the wrong box. You're right about him.

Mr. Reynolds, let me start with you as to

one, it is not set today, but are you urging the court to address the plea to the jurisdiction today?

MR. REYNOLDS: Let me answer the first one first, Your Honor. We believe it is set today. Our plea was included in our response to the pleadings to the court in response to petition. It is our position that we're not required to have filed a separate request for a hearing, but is part of our response, and, therefore, we believe properly before the court. So we do believe it's something the court can rule upon today. And to answer your second question, yes, I do believe we will request a hearing on our -- I'm sorry -- a ruling on our plea to the jurisdiction.

THE COURT: Okay. Well, then, I think that is where I need to start before we get any further into the weeds, because that plea to the jurisdiction may determine what we need to do next.

So, Mr. Reynolds, let me hear from you, and I'm hearing from you, but have not yet made a ruling about whether I think it is appropriately before the court, because there is a difference between raising some sort of defense for issue in a response, and an actual plea to the jurisdiction that requires notice and hearing. And, you know, just filing it as part of a response, unless you've got some case law to convince me

otherwise, is not necessarily how something gets before the court in a matter that it can be ruled upon by the court.

MR. REYNOLDS: Your Honor, in terms of notice, while we did not request a -- or file a request for a separate hearing, we did file our responsive pleadings last Thursday. I believe, maybe Wednesday, but within the three-day timeframe to give counsel appropriate notice of what we are arguing. We believe it's either ancillary or actually very germane to the issues that they are raising, and to our defenses. So, I'm not aware of any specific law saying we have to, or that we should have, or that we're precluded from arguing if we didn't. Again, for those reasons, we believe it is before the court, and something the court can rule upon today.

THE COURT: Obviously, jurisdiction is always into play. You know, the court can address jurisdiction on its own. It can be raised at any level. And, so, I will, you know, I'm going to hear you out on your arguments regarding that. But as you make those arguments, I do want you to try to interweave in there the issue that Mr. Walker has raised, which is the discovery that we would need in response to a plea to the jurisdiction is the same discovery that we are

seeking here.

MR. REYNOLDS: I Understand, Your Honor. And this is -- it would be very easy on this case to go beyond really what's before the court today. What's before the court is, are they entitled to obtain 202 discovery? It would be very easy to get into the medicine, whether or not the appropriate care is allowed to be given, and things such as that, but that's really beyond what we're talking about today. This is clearly, or could be a very emotional and even a political argument, but I do think it's very important that we stay focussed on this issue that the court has touched on is, number one, should these depositions go forward? The first issue -- the first part of that that we briefed, I think both we and UT Southwestern, is the issue of immunity. There doesn't seem to be any disagreement that the decision that was given to Dr. Lopez, or discussed with her, came from the UT administration. I mean, that's in the petition. They are state employees. Dr. Podolsky is the president. Dr. Warner is the vice president. I'm shortening their title, but they are the top of the food chain, if you will, at UT Southwestern. So the directives came from UT Southwestern. As such, they are governmental employees, and we believe, as such, they are immune from

not even -- well, not just from this issue, this 202 petition, but if there were a lawsuit to be filed, we believe they are protected from government immunity, because we do not believe that there's a potential valid claim against them. We believe they are entitled to immunity, not just in that defensive claim, but in this claim.

THE COURT: Mr. Reynolds.

MR. REYNOLDS: Yes.

THE COURT: The issue that I'm having there is that immunity applies to protect from claims. Immunity does not protect someone from discovery, and that's what we're seeking here. So, how are we -- how do you wrap that kernel up for me that they can't even ask us about this stuff because we have immunity from some potential claim, when what they've come to me and said, whether that bears that out or not, is that we're not necessarily looking to sue these parties if that they're the only parties that have the information we need to figure out who we need to sue. So I see a difference here between we may be immune from a claim that is brought, but that doesn't mean that we're immune from the discovery process.

MR. REYNOLDS: We believe, Your Honor, that a 202 petition has to allege or assert a potential claim

that they're investigating.

THE COURT: Hang on, Mr. Reynolds. There is blackletter case law that says it does not have to state a claim or a cause of action.

MR. REYNOLDS: Your Honor, that's one of the elements of a 202 is they have to identify that they're investigating a claim or lawsuit, and I'm paraphrasing.

THE COURT: That is correct, but they don't have to identify a particular claim. And, I mean, yes, we have to address this issue of governmental immunity. And, you know, you may argue to me that, look, governmental immunity is a giant King's X. There's not any available cause of action that could be brought that would fall outside of it, but I imagine when Mr. Walker responds here he's going to respond with something along the lines of, they're not necessarily immune from everything. There are exceptions. And, so, we can't just say, nope, you can't ask us anything because we might be addressing a potential claim that we might have immunity about.

MR. REYNOLDS: The issues that they've raised as potential claims we believe are claims that would not be valid had they been filed as a lawsuit. For example, they talk about this potentially elicit to

Dr. Podolsky and Dr. Warner is they committed ultra vires acts. If you read the face of the petition, the acts they're talking about is the change in a policy procedure protocol made on behalf of their employee -- I'm sorry -- employer, UT Southwestern. So those cannot be ultra vires acts. That's their action on behalf of their employer, a state entity. That's number one. They then talk about that they violated the corporate practice of medicine section 22, Texas admin code 177.5, as we have briefed to the court, that provision does not apply to the individuals, Dr. Podolsky and Dr. Warner. I know Mr. Eldred will weigh on that, because we believe, also, it does not apply, statutorily, to UT Southwestern.

The third reason they give us for a potential claim is discrimination. Dr. Lopez is a highly regarded, very well respected member of UT faculty, but she is not the subject herself of discrimination. I know they argue that her patients are being discriminated against. Number one, we disagree with that. We do not believe that what she's talking about, this medical diagnosis, is a class of persons against whom there is or can be discrimination, number one; and number two, as I mentioned, we don't believe she has standing to speak for those potential patients,

who they argue could be discriminated against. Those are the basis they have given the court in their petition of potential things they want to investigate, and maybe even file suit on. And we believe, since none of those would waive any sovereign immunity, we believe since there could not be a valid claim on those allegations or theories, then they should not be allowed to go forward with the 202 petition to investigate such claims.

THE COURT: So, again, let's wrap around on my first question which is, even if such claims maybe barred, do you agree with me or disagree with me that they can still be subject to discovery, even if it was third-party discovery?

MR. REYNOLDS: For ways to be pursued, Your Honor, I respectfully disagree. I think the 202 still has to identify a potentially valid claim to go forward. And the three claims that they've identified, we believe are not -- they do not waive governmental immunity, and, therefore, subject to our plea to the jurisdiction.

THE COURT: Okay.

Mr. Eldred, did you want to add to that?

MR. ELDRED: Sure, Your Honor. On page 8 and 9, there's a paragraph of UT Southwestern through the jurisdiction that I think may give y'all the law you

need on this issue.

"The scope of discovery and depositions authorized by rule 202 is the same as if the anticipated suit or potential suit have been filed, and the immunity aspect is that when discovery is sought from a governmental entity, the petition must also set forth specific facts demonstrating that, at least potentially, a petitioner has been injured by actions that would amount to a claim which would not be barred by sovereign immunity."

I'm quoting *In Re Dallas City Hospital*, which, in turn, quotes *Combs versus Texas Civil Rights Project*, which, by the way, Judge Jones' opinion of that opinion was a decent.

But any way, the immunity issue means that they do have to actually state a claim that is not barred by sovereign immunity. As Mr. Reynolds has said, they have not done so. In that respect, the rule 202 against the governmental entity is a little stricter than it is against a nongovernmental entity. And because they haven't stated the claim, we, UT Southwestern and the doctors in their official capacity, retained their sovereign immunity to a rule 202 deposition.

If I could add just one more thing. In

their reply and here today, Mr. Walker has said that this is just a request for discovery, nothing more. That's not true. It's a request for rule 202 discovery, which is not routinely granted. The opinion they've cited in their reply, that includes a federal case that was just distinguishing a rule 202 action from an actual legal claim. This is -- they are asking for more than just discovery. They're asking for pre-suit discovery. And, so, I just take issue with the way he's framed that issue.

THE COURT: Okay. Mr. Walker, do you want to respond on specifically the issue of, you know, does the court have to examine whether you could potentially succeed in making a claim, or if immunity with attached, and then the specific issue of, well, then, how do I carve out some discovery if that is, in fact, correct?

MR. WALKER: I think the court can look at both *In Re Dallas* and *Combs versus the Texas Civil Rights Project*. Those are both cases in which there was 202 discovery sought of an entity that said, hey, we're a governmental entity. We have sovereign immunity. And in both of those cases, the defendant was alleging a potential ultra vires act. They didn't know if there was one occurred. They were investigating ultra vires conduct. And both of those courts said it is

permissible to do that. But as the court said *In Re Combs*, it's tricky because, ordinarily under 202, you don't have to plead anything. You don't have to assert anything. All you have to show is that the applicant had a potential of being harmed, and then that would be enough to investigate a claim. But then you have all this case law that has to do with sovereign immunity. So how do you square that? And what the court said in Combs, which is in the majority opinion of Combs, after it states that it -- like all the rules of civil procedure, this was fashioned by the Supreme Court as a means of obtaining a just, fair, equitable, and impartial adjudication of the rights of the litigant under established principles of substantive law. An echo to rule 1, which kind of underscores the point of a 202. We want to try to be efficient here. So we want parties to have the information they need to file a lawsuit.

And the court went on to say, "That the pleading requirements of rule 202 on their face are less stringent than a normal -- than normally required to demonstrate a trial's court jurisdiction. As a practical manner, a party filing a 202 will often not have enough facts, or have enough information to allege facts that, if true, would establish the trial court's

jurisdiction. The tech position that we're in, if a party could sufficiently plead these factual allegations without violating rule 13, then it's likely the party could not demonstrate the need for a rule 202 deposition at all."

They're describing the exact issue the court is wrestling with. And when they evaluate through this, they say, when discovery from a governmental entity is sought under rule 202, it must set forth facts demonstrating, at least potentially, the petitioner has been injured by actions that would amount to a claim, which would not be barred by sovereign immunity.

So a potential that she could be harmed. That's not a real high burden. And what we have shown this court is Texas Civil Practice and Remedies Code 106.001 prohibits any employee of the state from discriminating based on sex, and discrimination, on gender identity, or sexual identity is discrimination based on sex.

And so this action, doesn't matter who made it. Doesn't matter if it's Podolsky, or Warner, or UT Southwestern, or Abbott, or Paxton, or whoever. Whoever made this is violating Texas law, Civil Practice and Remedies Code 106.001.

THE COURT: Mr. Walker. Hang on

Mr. Walker, because I thought that Mr. Reynolds made a good point on that which is, let's assume for a moment that that's true. That that's what happened, and that it is a violation of that provision. How does Dr. Lopez have standing to potentially bring that claim if she's not the actual party discriminated against? Because it would be the kids who can't get the treatment that would be, you know, the folks who are on the receiving end of a discriminatory policy.

MR. WALKER: Right. Two things, Your Honor. First of all, that's not the way the statute is written. It's not saying, only the person who is discriminated against. It says anyone who is aggrieved. And we assert that Dr. Lopez is very aggrieved by this decision making because it's affecting her ability to practice medicine independently. So we believe she is aggrieved. Secondarily to that, section 106.003 indicate that there are criminal penalties, penalties that could be prosecuted by Mr. Eldred tomorrow. There are criminal penalties if Dr. Lopez, as a state employee, discriminates against people by saying, I can't treat you because of your gender identity.

So this policy places her in a position to have to discriminate in violation of 106.003. The question is, who caused this policy? Because that's

what section 106.001 says is that, you know, an officer who establishes this policy, that's the party that we need to go after. And, so, Dr. Lopez is aggrieved, therefore, she has standing, and she's subject to criminal penalty. Therefore, she has standing if a lawsuit goes forth.

Any conduct by any individual we can conceive of who instituted this policy would be contrary to the law. It is, by definition, ultra vires. And we can get back into that box. But under this statute, it's discriminatory, therefore, it's ultra vires.

And contrary to what Mr. Reynolds said previously, section 171 of Texas Administrative Code, which is written by the Texas Medical Board, who is the legislatively granted authority to make these decisions, not the governor, not the medical school, not anyone else. The medical board. It is impermissible to infringe upon the independent medical judgment of a physician like Dr. Lopez. And that's true for any entity that is listed as a section 162.01 nonprofit health organization.

Now, if the court got in the weeds in the briefing, you would have seen both Mr. Reynolds and Mr. Eldred say that that doesn't apply to UT Southwestern. But here is the list promulgated by the State of Texas

that has all the institutions that are 162.001(b) nonprofit health organizations. And can the court guess what's on this page right here?

THE COURT: I'm going to guess it's UT Southwestern.

MR. WALKER: Yep. With the person that says -- the person who was on the application is Daniel Podolsky, the president. The person we're trying to depose here. And this statute says that if you're one of these institutions, which this is, then neither the institution nor its employee can interfere with the independent medical decision making of a physician like Dr. Lopez. That's a rule of the Texas Medical Board, who has the authority to make that rule. And the governor, the attorney general, Dr. Podolsky, Dr. Warner, UT Southwestern, Children's Medical Center, any of those institutions don't have the ability to controvert the rule making of a Texas Medical Board.

So my point is this, Your Honor. There are remedies out there that are not subject to any immunity that we can pursue. And I'd be happy to brief them and argue any one of them as soon as I know who would be the person that needed to be sued. As soon as we know that, all the other questions can be answered, then we can prove how a ultra vires is. Then we can prove who is

exceeding the scope of their authority. Then we can prove whether there's institutional liability or not. But why is it so hard to say who made this decision, who is the person? Because institutions don't make decisions. They are names on a piece of paper. The decisions are made by people. It could be groups of people. It could be one person. It could be a governor. It could be an attorney general. It could be a board. It could be a president, or a vice president, or chief medical officer. They're made by people, which is why these rules about what it costs to ultra vires actions, or what constitutes a violation of these different provisions focuses on the people who are doing the violations, because those are the people who do things that are outside the scope of their authority. An institution has no scope of authority. They don't do anything. It's just a name on paper. So these other people have limitations upon what they can do. And so the key is to figure out who the people are who are doing these things that are forbidden. And then those individuals are the people whose names would be on the the application for temporary restraining order. But before we get there and before the court can think about addressing sovereign immunity, it would have to tease out what is the nature of ultra vires claims, and can

Dr. Lopez present this court evidence to show that there is a potential ultra vires action against the party rooting for immunity. And that's a prerequisite for you deciding whether or not there's a plea to the jurisdiction that should be granted or not.

So, the point I was addressing earlier is the last avenue available for this court to say, you know what, the pleas to the jurisdiction are not set today. And contrary to what Mr. Reynolds told you about it being set today, this is a very common practice of the attorney general's office. They actually pulled this in the last litigation that we were involved in on behalf of Judge Jenkins where, on the eve of the hearing, they filed plea to the jurisdiction and then go, now the court has to handle this. Well, that's not so. It wasn't so in that case, and it wasn't so in the case I mentioned earlier today, Abbott versus Doe, which was related to this, that is the temporary restraining order having to do with CPS and whether or not people seeking care should be reported to CPS. Judge Meachum granted the temporary restraining order. The day before the TRO, what did the Attorney General's Office do? Filed plea to the jurisdiction, didn't set it for hearing, went up on appeal, and the State of Texas, on behalf of -- actually, the attorney general on behalf of

Governor Abbott argued that the trial court must have decided the plea to the jurisdiction, or was required to decide it prior to the TRO hearing. In the Houston -- excuse me -- the Austin Court of Appeals said, no, that's incorrect, just on March 9 of 2022. This was in the last month, said that that's not true. Just because you filed the plea to the jurisdiction doesn't mean a court has to answer it. And the court hasn't gone through the process that we need to be gone through for a plea to the jurisdiction. And in this instance, it's essential to note that the question of sovereign immunity is tied up in the underlying merits facts. And this is something that none of the defendants or -- excuse me -- the respondents had addressed, which is the Supreme Court's holding in a number of cases, including *Chambers versus Liberty -- Chamber of Liberty Counties Navigation District versus State*, which I think is the one that has to do with who has the right to farm oysters in the State of Texas.

In that particular case, the Supreme Court says, "We have recognized that the jurisdictional inquiry may unavoidably implicate the underlying substantive merits of the case when, as often happens in ultra vires claims, the jurisdictional inquiry in the merits inquiry are intertwined."

And, so, this particular case is an ultra vires case. There's no way to answer the jurisdictional question without answering the underlying merits question about whether or not an ultra vires act occurred. If an ultra vires occurred, there's no immunity. If it did not occur, it is immunity. So, this is an issue that's often decided, or can be decided, by the trier of fact at trial. So this court has the ability to order discovery on their request for a plea to the jurisdiction, which they're saying they want a ruling on. And if that is reviewed, if they mandamus that ruling on discovery, there is broad, broad discretion of a court to order discovery necessary to respond to a plea to the jurisdiction. So when it goes up to the Court of Appeals, the standard will be that Judge Bellan had very broad discretion to decide what discovery was necessary. And I would submit to the court that if the prerequisite, according to them, for me to get the 202 deposition is to demonstrate some form of a claim against any of these people who have objected to it, then I think a good way to find the answer to that question is to find -- is to depose Dr. Podolsky and Dr. Warner, and find out if the ultra vires act has occurred, and then I can respond to the plea to the jurisdiction. And then that would go up on a abuse of

discretion, which you had very broad discretion.

THE COURT: That is your alternative position, correct? Your first position is that you all, under 202, to be able to do discovery, because there maybe claims that would not be subject to immunity?

MR. WALKER: Yes. I believe that's -- all though I would be happy for the court to order the discovery to respond to the plea to the jurisdiction, it gets me to the same place. But, fortunately, through me, that's something that they plead themselves into. They have plead themselves into this quandary to which -- my client now has the right to the very discovery we're seeking in the 202 deposition to respond to the plea to the jurisdiction. That's how silly this whole opposition is. What doesn't make sense is why the attorney general is not on our side on this, and is not pursuing this matter on behalf of those who are being discriminated against. I don't understand why the attorney general is not there arguing for this, because it would be their burden to investigate this discrimination themselves.

THE COURT: Okay. And I do want to get a response from the parties who have raised pleas, because it does seem that we are in a bit of a snake eating its tail situation, which is if I consider the pleas, then I

also have to consider a request for discovery related to the pleas, and Mr. Walker is going -- whether he gets it or not, he's going to ask for, essentially, the same sort of discovery in order to determine whether this court could maintain jurisdiction over these parties. But the long and short of it is, is what I'm hearing is that they don't necessarily think that any of these named parties are ultimately who they want to have causes of action against. They need information from the folks who are within this pleading in order to figure out who those folks are. And, so, how could a plea to the jurisdiction necessarily be raised when they're telling the court, essentially, we don't think these folks are the ones we're going to end up with a cause of action against? We need information from these folks to figure out who we have a cause of action against, which then, of course, the court would have to address, or you all may raise then the issue of whether those parties have a proper plea to the jurisdiction, or if immunity applies. I mean, it does seem like we've boxed ourselves in a little bit here.

Mr. Reynolds, do you want to respond?

MR. REYNOLDS: Sure, Your Honor. For my clients' perspective, and I know this is apart of what UT Southwestern's position is as well, is if there's a

lawsuit filed against either UT Southwestern or Dr. Podolsky and/or Dr. Warner, then they would be entitled to the governmental's immunity.

The Combs case that Mr. Walker referenced earlier, It's also cited in our briefs numerous times, but it states, in looking at -- in deciding whether or not a 202 petition can go forward, what it says is, the petitioner must state specific facts to demonstrate that they have been injured by actions that would amount to a claim, which would not be barred by sovereign immunity.

That's exactly our position, Your Honor. If this claim goes forward, that is the ultimate lawsuit, not the 202. But, yet, to kind of backtrack into that. If it goes forward, the claims being asserted would be barred by sovereign immunity. And because they would be barred by sovereign immunity, then the 202 petition fails to sate facts that were pleaded outside of the sovereign immunity defense. And for that reason, we think it would be improper to either allow this to go forward. And, certainly, if it does go forward, then the immunity defenses would be raised against next level. But if you read the Combs Case, we believe that prevents this 202 from going forward, because they cannot assert a claim that is not subject to immunity.

MR. WALKER: There's key language there that --

THE COURT: Okay. Hang on, Mr. Walker. Hang on Mr. Walker.

MR. WALKER: -- that's the word, potentially.

THE COURT: Mr. Walker, before I come back to you, is there anyone else who wants to be heard on the plea to the jurisdiction issue and the things that we have just spoken about?

MR. MALOUF: I would like to address the court for just a moment.

(Speakers talking simultaneously)

THE COURT: I think I heard you first and you had your had raised. So, Mr. Malouf, let me hear from you, and then I'll here from anyone else.

MR. MALOUF: Your Honor, I understand my friend's, Mr. Reynolds, argument, but it's a bit (inaudible). I think what he said is that the physicians, whose depositions are being sought, would enjoy sovereign immunity. I don't agree with that, but I would address this question to Mr. Reynolds. If the governor, or the attorney general, or anyone else engaged in a conspiracy to cause this policy to be implemented, it would be a conspiracy, the purpose of

which or the result of which is the violation of a statute. And under *Berry versus Golden Life Coffee*, such a conspiracy is actionable. Immunity is not implicated through such because such a conspiracy would be outside the fairway of the officials' conduct, potentially depending on who the officials are. But if the attorney general's office and others engaged in a conspiracy that interfere with Dr. Lopez's treatment with her patients with the medical standard of care with medically necessary modalities, then it's possible that that conspiracy would be actionable, and in no way implicates sovereign immunity. You know, a government official is not immune, individually, to an action for conduct outside the scope of their authority. The State may be, because, after all, government official acts outside the scope of their authority. They're not acting on behalf of the State, and immunity wouldn't be waived, but we don't know that yet.

THE COURT: Right. You may have stated it much better than I was trying to earlier.

Mr. Reynolds, that is sort of what I was trying to get at, which is there are causes of action, or potential fact patterns, that would put us outside of these immunities that maybe in play here. And, so, how can the court prevent a party from getting the discovery

they need to find out whether they have a claim that might be subject to immunity? You're asking me to stop that before it even starts. And here, depending on what they ultimately allege, they either may plead themselves right into an immunity defense, or they may try very carefully to plead themselves outside of an immunity defense. But how is it that this court can kind of put the stop and put a cork in that before they had the opportunity to find out who maybe the party who has given this instruction, if, in fact, an instruction was given? We know there's a policy change here. But, you know, Mr. Malouf raised the issue of how would these individuals be subject to it? I imagine you're going to tell me it's because they are employees of the State, because you stated that earlier. But, again, I'm kind of stuck at this impasse of, well, you're telling me they can't ever succeed on any sort of claim. They're saying, well, we may have claims that fall outside of the immunity protections. Why would 202 not allow them to get that discovery so that they know whether they are pleading within or without immunity protection, and then you all would have a response or a plea to the jurisdiction on actual causes of action?

MR. REYNOLDS: May I respond, Your Honor.

THE COURT: Yes, please do.

MR. REYNOLDS: Sure. It goes back to what we talked about earlier. What they're required to do is plead specific facts to inform this court of the potential theories and causes of action they may pursue. What we have is allegations of ultra vires, potentially, to plead around immunity. But what they have told the court in their pleadings, the basis for the ultra vires, on their face, are not ultra vires. I mean, they've talked about the administration at UT giving a dictate to Dr. Lopez about the medicine she can provide, the medical care she can provide. Those are -- I don't think anyone would argue that UT, and Dr. Podolsky, Dr. Warner do not have the ability, as the university, as the healthcare system, to help dictate, control, and set parameters with their policy, and procedure, protocols of what their staff can provide.

THE COURT: Hang on, Mr. Reynolds, because that's the opposite of what you told me earlier. You told me, well, no, no, let's be clear. They can still provide things to current patients. It's that we're telling them that they can't provide this to any new patients. How is that not telling a physician what they can and can't provide to a patient?

MR. REYNOLDS: I'm not saying they can't. I'm saying that's part of what their -- they can do as a

-- whether it be a hospital institution, or medical staff, or faculty, they can set guidelines, parameters, protocol, what care they can provide to -- what the staff can provide to patients. They can do that, which is why if that decision has been made, it's based on -- it's made upon the authority that they have to direct, and dictate, and guide such care, and, therefore, it cannot be ultra vires.

THE COURT: How is that not violating the corporate practice of medicine statutes, or just simply the idea that they are dictating what kind of care a patient should receive outside of what the doctor believes the patient should receive? I mean, this isn't like, we won't give warm blankets. We'll only give room-temperature blankets. This is about whether certain children, who have certain needs, can be treated by these doctors at these institutions. And it has come down, as you all have explained it to me, as a policy which is, we will continue to provide this care for existing patients. So, it cannot be that we think that this care is harmful in some way, or that this care should never be used. The policy is, well, we can do it for the folks who are already under the umbrella, but we're not bringing anyone else in. How is that not a decision about medical care for a potential patient?

MR. REYNOLDS: It is. I don't disagree with that, Your Honor. Let me go back to something you said and we briefed extensively in our response, and I believe UT did as well, that the corporate practice of medicine doctrine does not apply to Dr. Podolsky, nor does it apply to UT Southwestern on the face of the statute. So we don't think that does apply.

THE COURT: And what is the basis of that? Is that the same as the section that Mr. Walker cited me to earlier that lists UT Southwestern?

MR. REYNOLDS: The section he referred to, Your Honor, I'm not sure. That's not in their brief. I may have to have him repeat that. The section they cite in the brief is 177.5.

THE COURT: Tell me what it is, what you are relying on for why that section does not apply to UT Southwestern or Dr. Podolsky?

MR. REYNOLDS: Well, certainly I can speak to Dr. Podolsky and Dr. Warner, because it talks about health organizations. They are not health organizations. They are individuals.

THE COURT: Okay. Let's talk about UT Southwestern. The section he cited, by the way, was 162.001(b). Is that correct, Mr. Walker?

MR. WALKER: That's correct, Your Honor.

And the way that you get there is what Mr. Reynolds just said is that a health organization may not interfere. Health organization is a defying term under 177.1, and it's defined as a folder of a certification under 162.00(b) under the Act. And this is the list of organizations that are 162.001(b), organizations, which includes UT Southwestern. So this statute -- or excuse me -- this regulation demonstratively applies to them. And the distinction that Mr. Reynolds just made is that it wouldn't apply to individuals. Again, that that is -- that's a farce, because it's always individuals who interfere, because organizations are not a thing. They are a paper. UT Southwestern cannot interfere with anyone's judgment. It's not a living being. Supreme Court has tried to give it rights under the election code, but it's not a living being that can actually interfere. And, so, it's always going to be people, themselves, who are acting presumably within the scope of their authority who are interfering. So this notion that this can't apply because the interference is being done by Dr. Podolsky, you know, that's a legal fiction. It, of course, can be that if Dr. Podolsky interferes with medical judgment, then he's violating this statute. It's outside of his legal authority in his position at UT Southwestern. It then becomes ultra vires. It's

outside the scope of his authority. It is ultra vires.

And, so, the notion that this doesn't apply to them is wrong on its face. Ut Southwestern said in their brief, well, there's another section that says that we're entitled to employ positions. Well, that's true. That's an entirely different subchapter of the statute. That has nothing to do with interfering with their medical judgment. It just says it's an exception to the rules that they can't employ physicians. They can, but they can't interfere with their judgment.

And, so, this provision absolutely applies to them. But even if it didn't, even if it didn't, what does unquestionably apply to them is 160 -- or 106.001 of the Civil Practice and Remedies Code, which is the discrimination statute. And they have not been able to provide this court with any argument about how this is not discriminatory. If a patient walks in Dr. Lopez's office today identifying as a male and saying, I need puberty suppression drugs, she can give it to them if they were born with XY chromosomes. If a patient identifying as a male walks into her office and says, I need puberty suppression drugs, but they were born with XY chromosomes, she cannot provide that care to them. And that is why the US Supreme Court said, just in the last two years, that is discrimination because of sex,

and that is prohibited under the state constitution and statute, which prohibits discrimination based on sex.

And, so, regardless of anything that Mr. Reynolds just said, whether it be covered under the TAP or not, it is discrimination and it's actionable.

THE COURT: Okay. Let me come back to Mr. Reynolds, because you had a couple of other points you wanted to make.

MR. REYNOLDS: Your Honor, the warranty of 106.002, Dr. Lopez then has the burden to show she has been aggrieved. We don't think she has done that. The discrimination they're talking about --

THE COURT: Stop. But this -- I mean, as Mr. Walker said earlier, this is potentially an evidentiary hearing. So, I have an affidavit. They could also try to get testimony. I hear you on the issue of they have to establish whether she has been aggrieved or not, but we haven't gotten far enough for me to know for sure we can't establish that. Let's put it that way. So, I mean, again, I keep circling back on the same issue, which is how is it that an entity or the parties that make decisions on behalf of an entity can be accepted from discovery that maybe necessary for a party to determine who the correct parties are that they need to go after? I mean, it's almost like we're trying

to hide behind a wall here and say, you know, we're not going to let you know who actually made the decision. And at the same time we're going to say, but you can't sue us for it, because we have immunity. And what I'm also hearing is because we have immunity, we also are immune from your discovery requests.

MR. REYNOLDS: That's essentially the argument, Your Honor, that based on what they've plead and what they're arguing, they cannot go forward with a lawsuit against UT Southwestern, Dr. Podolsky, Dr. Warner, whoever. Therefore, they cannot assert a valid claim, which is a requirement of a 202 petition.

THE COURT: I hear you.

MR. REYNOLDS: It's our position that Dr. Podolsky and Dr. Warner, my clients, they are -- anything they did regarding this change in policy, change in protocol, was done on behalf of -- or within the scope of their employment with UT Southwestern. Therefore, entitles them to governmental immunity. And because of that, then they shouldn't be allowed or subject to sit for a deposition in a case where they could not be a named defendant. I guess it could be named, but they'd be subject to immunity.

THE COURT: You're not arguing to me that they couldn't be fact witnesses in a case against

somebody else, are you?

MR. REYNOLDS: I'm not arguing that, Your Honor. I suppose the right context, they might be.

THE COURT: Just wanted to check.

Mr. Eldred, you had your hand up there for awhile. Let me let you jump in here.

MR. ELDRED: I'd like to set this up by first talking about Mr. Walker's list that he held up to the camera. That's not in evidence, and you should not consider it. If it were in evidence, I think what he's holding up is a list of 161.001(c) organization. And the ruling he's referring to only applies to 161.001(b) organizations. So, if he's holding up the list I think he's holding up, it's completely irrelevant, and it shows that -- Judge, I object to him trying to show you something on camera while I'm trying to talk to you.

THE COURT: I'm also not looking at what he's holding up, so. Yeah, I hear you. I mean, if it is included within the statutory language, of course, I can look at it. If your argument is it's outside of the evidence that's been provided, then that is something we'll have to address.

MR. ELDRED: It's outside the evidence. It's good enough reason to ignore what he's saying, but I'm telling you, UT Southwestern is 161.001(c)

organization, is not a 161.001(b) organization, which applies to nonprofit. Government is not a nonprofit. So that -- once -- and the administrative code that he'd been arguing about does not apply to 161.001(c). And the reason I start with that is because this gets into how can you get around sovereign immunity in a ultra vires claim? The way to get around sovereign immunity ultra vires claim is you have to actually state an ultra vires claim. You have to put out facts that show that what happened might have been ultra vires. They have not done that. Now, I'm trying to keep things in the right box, but they know that UT Southwestern and Children's Hospital have decided to make these decisions. We argue that's -- from the rule 202 perspective, there's no reason to have a rule 202 deposition to find out whether they made those decisions. They did make those decisions. Everyone knows they made those decisions. So whether or not they're allowed to make those decisions is one thing. We say they can. And the reason they can -- because they can, we have immunity. But whether they can or can't, it gets them to the next issue about whether there should be a 202 deposition to find out whether they were the ones who did it. Well, they already know who did it. So, that's not -- so is there an ultra

virus claim against other parties? I've heard the governor mentioned. I've heard the attorney general mentioned. In the pleadings, I've heard legislatures. They have not stated an ultra vires claim against any of those people because none of those people have authority to dictate these decisions to UT Southwestern and to Children's hospital. If the governor did pressure them or conspired with them, as Mr. Malouf put, that's not the ultra vires action. The governor is allowed to have opinions about these things. The governor is allowed to pressure people. So they have to state some sort of theory that shows the governor might have committed something ultra vires, or somebody might have committed something ultra vires. If you look at the request for documents, they even want documents from advocacy groups. Well, I don't think they're saying advocacy groups can dictate things -- can dictate treatment that's (inaudible) by UT Southwestern and Children's Hospital.

So, Your Honor, it is -- there is a confusing ball of immunity, ultra vires, and 202 standards all kind of blur together. At a minimum, you look at everything together, Dr. Lopez needs to state facts that show that she might have a claim that is not barred by sovereign immunity. She's not done so.

177.5, they keep talking about does not apply to UT Southwestern, despite Mr. Walker's un-filed list. The corporate practice of medicine, specifically, does not apply to UT Southwestern. We quoted that in our brief as the Texas Medical Board ruled in our plea to the jurisdiction. That's on page -- sorry page 10 of our plea to the jurisdiction has all you need from there. So when they complain that somebody has interfered with their medical -- with Dr. Lopez's medical judgment, not seeing a claim under either the rule or the corporate practice of medicine document. They haven't stated their claim yet. The other claim is discrimination, and they talk about *Bostock* was the interpretation of federal law. It did not and cannot interpret the state law. And if they're suing under federal law -- I don't know what they're suing under. They talked about --

THE COURT: Well, I mean, I think I can make that pretty simple for you. What they're telling me is if there is a constitutional protection for gender identity issues under the protection related to a party, you know, a party's sex, as previously been defined. Obviously, the State of Texas cannot make that more restrictive. They would have to follow those constitutional requirements.

MR. ELDRED: That is true as a matter of

federal law. It is absolutely untrue as a matter of state law. They're only trying to go under state law.

THE COURT: You're not really trying to argue with me that if there's a constitutional protection for these folks federally, that Texas can somehow say, you're not protected by the federal constitution here in Texas?

MR. ELDRED: No. What I am saying is Bostock was about the Civil Rights Act of 1964. It wasn't a constitutional case. Bostock says, "The Civil Rights Act of 1964 protects discrimination against gender identity."

Okay, that statute does. They have not brought up that statute. They're not claiming that anyone violated that statute. It would be very easy to claim that if they want to, but they have specifically not claimed that. The statutes they have claimed do not obtain gender identity elements at all. There's no ruling in Texas, or statute in Texas that prohibits what they call a discrimination, based on gender identity. Another interesting point is they seem to think that if there's a decision made about gender identity that's just automatically discrimination based (inaudible). Well, it's not. It's like saying that a decision made about treatment of breast cancer or testicular cancers

automatically gender discrimination. That's just not true. They need to plead some facts showing that this particular decision violates a statute of some kind. And Your Honor is correct. Under a regular rule 202, they don't necessarily have to spell out an entire cause of action. But when you throw in the immunity issue and ultra vires issue, they do. They need to show that there is a claim that's not barred by sovereign immunity. And that's from Combs versus -- the Combs case -- I can't think of the rest of the title of the case. The Combs case that they cited over and over again from 2013 from the Austin Court of Appeals. They have to plead that cause of action. There is no cause of action plead.

If I can say just a few more things. I don't know why he's talking about (inaudible) going to prosecute Dr. Lopez. I really don't understand where he's coming from there. So maybe he can explain it.

THE COURT: Well, the way I understood it had more to do with the fact that this decision, as it has been presented by the movant here today, I think that the way Mr. Walker had couched it, or the way I understood it is that because patients can be, if there are existing patients, provided these treatments for the purpose of their gender identity treatment, but new

patients for gender identity cannot be provided the same services. And on this other -- I guess the third hand that we don't have that a new patient who is seeking the same treatment for one of the other purposes, that is not gender identity related, still could be treated. That is how I understood Mr. Walker's argument about why this is discriminatory for this specific group, because if they came for one reason, they can get the treatment as a new patient. But if they come for the other reason, that existing patients are still getting treatment for, they cannot be provided treatment. So that is how I -- that's how I understood him to separate this issue out.

Whether that rises to the level of the discrimination, or that any of these statutes apply, is a different issue, but that is how I understood that argument.

Mr. Malouf, you've had your hand up for awhile.

MR. MALOUF: Just to be clear here, this isn't about medicine. In fact -- and it's apologetic UT Southwestern has said, well, we won't give it to you. We've terminated the program, the Genecis Program, and we won't give you the medication if you're a new patient, but we will refer you to an outside

endocrinologist who maybe willing or will be willing to do so. And, in fact, you know, the way Mr. Reynolds task it in his -- one of his motions or responses, he said this, though the Children's pediatric endocrinology clinic discontinued enrollment of new patients into puberty suppression therapy for the indication of gender dysphoria, families and patients seeking hormone therapy continue to have access to outside practitioners not affiliated with UT Southwestern that is ultimately accountable to the state, ultimately accountable to the state in which, inevitably, must consider conflicting public viewpoints. With all do deference to Mr. Eldred, since when did political considerations become a variable in the practice of medicine? For gosh sakes, for gosh sakes. And then they argue, well, you know, the medical school made the decision, and the medical school has the right to do so. No, it doesn't. I'm sorry. No, it doesn't. When it's discriminating, when it's engaged in the practice of medicine, based upon political considerations and not the best interests of the patient, as reasonably determined by a capable practitioner, practicing based upon best practices, then, no, they don't have the authority or the right, as a state institution, to do that. Independently of that, and even if they did, no one on this call believes for a

minute that this change in policy, as to medicine, the practice of medicine by Dr. Lopez was initiated by anything other than politics. We believe there maybe a claim that Dr. Lopez has against those people responsible for. And to make the argument that, you know, Dr. Podolsky or Dr. Warner made the decision, no one believes that. Certainly they implemented the decision. But by their own pleadings, by their own pleadings, they concede that the decision was politically motivated or made for political expediency.

So, with all due respect, Your Honor, we just want to take a couple of depositions.

THE COURT: Okay. Let me come back to Mr. Eldred.

MR. ELDRED: It doesn't state a claim that is not barred by immunity. The governor is allowed to have opinions. The hospitals, not just state hospitals, but all hospitals, are allowed to consider outside opinions. You, yourself, are allowed to consider outside opinions, but you're the one who makes the decisions, at the end of the day, if you succumb to pressure, or if the hospital succumbs to pressure. It doesn't mean it didn't make the decision. The hospital made the decision. And this goes back to why they need a 202 deposition. They know who made the decision.

They say they don't know who pressured them to make a decision. But that's not a cause of action. That's not a claim. It is not a claim that is not -- that it is not barred by immunity, because there is no waiver. In fact, we do actually expect our elected officials to have opinions about how the state agencies are run. There's -- it's not true that there's an exception for medical care. It's not true that Dr. Lopez, who is an employee of UT Medical -- I'm sorry -- of UT Southwestern. She's an employee of UT Southwestern and accepted from the corporate practice of medicine doctrine. It's not true that she can do whatever she wants without any supervision from the state, the hospital. It's just simply not true. Whether it's a good idea or not is a different issue. There is no cause of action for this. UT Southwestern maintains its immunity, so does Dr. Podolsky and Dr. Warner. And that's why a rule 202 deposition -- why we have immunity to it. It's also why, again, getting into the next question, rule 202 deposition should not be granted because they're not trying to find out anything that states a claim against anybody, except maybe UT Southwestern and Children's Medical. So, you know, it's -- there's lots of rhetorical points you can make about political interference with medicine. Legally, however,

it's not true that medicine is some sort of special part -- special thing that the state does that's not subject to state control, or to political control, ultimately. That's just not true. There's no cause of action for the governor, or the comp controller, or the railroad commission, or legislature, or anyone who puts some pressure on the state hospital to do something. They are allowed to do that. It's not their claim.

THE COURT: I'm a little shocked that's the position that you're taking today, but I fully understand why you're taking it.

Mr. Walker.

MR. WALKER: Your Honor, I refer to this as -- in the reply of Kettle logic, which is exactly what's going on here. You were told by Mr. Eldred, not ten minutes ago, that this was only a decision made by UT Southwestern, and it's impossible that the governor or the attorney general could have been involved in it because they have no authority to impose such obligation upon UT Southwestern. And that's exactly correct. They have no legal authority to do it. If they did it outside of their legal authority, then it is ultra vires. If Governor Abbott said, Dr. Podolosky, if you don't stop providing gender-affirming care, then I'm going to strip you of your connection with the school,

which is also something that's outside of authority, or threaten him in some way in which he had to interact -- had to do an act which is discriminatory on its face, that would be actionable. But, again, none of us know what it is, because they're keeping it from us, because a 202 is the thing that we have the right to do, under the case law, to find out the answer to that in question so we can respond to the ultra vires plea to the jurisdiction, like they're asserting here. There's no other way to respond to a plea to the jurisdiction. There's an ultra vires, and to get to the fact, which is why the Supreme Court said it's intertwined with the underlying merits, because whether or not there is a plea to the jurisdiction, an ultra vires claim, you have to go to the underlying merits, and you have to discover them.

But it is -- Mr. Eldred is clearly wrong about Bostock. It did not say that discrimination, based on gender identity, is in violation of the constitution. That's not what its holding said. What its holding was is that discrimination, based on sex, is prohibited. And what that case provides this court and every other court in this country, is the analytical framework in evaluating how a court is to look at the question of gender-identity discrimination. And what

the Supreme Court said is, using the typical rules and technique that judges use, that discrimination, based on gender identity, is, quote, because of sex. And that is because if you have two people who otherwise present the exact same way, but one has two X chromosomes and one has an XY, and you're discriminating against the one that is the XY, you're doing that because of sex. And so, therefore, it is the same thing as discrimination based on sex.

And, so, we do have a statute, unlike what Mr. Eldred told you, that an officer, or employee of the state, or of a political subdivision of the state who is acting or purporting to act in an official capacity, may not, because of a person's race, religion, color, or sex, do any of the following: In discrimination, based on gender identity, is discrimination because of sex. And that's what this statute says. If it's because of that, it is statutorily prohibited. So Mr. Eldred is completely wrong about Bostock, and it would apply in this instance as interpretative framework to determine what is discrimination based on sex. It's -- there's no distinction between gender identity when you're talking about discriminating. You're discriminating, based on their chromosomes -- chromosomes that they have. So that is discrimination based on sex. It violates the

statute. There's somebody who's violating the statute. They just don't want to let us figure out who it is.

THE COURT: Mr. Walker, even if we got there on that issue, one of the things that we have to establish is that Dr. Lopez was the aggrieved by that discrimination if the court were to find that it rises to that discrimination. So, how is it that we are establishing that portion? And then I need you to start moving into the extent that there is any testimony that you all are trying to get today, outside of the affidavits that have been provided, we need to start moving on here.

MR. WALKER: So, Your Honor, the aggrieved is one way to get the standing. That's 106.002, that she has a remedy for being aggrieved. And by the way, the courts have said this was an express waiver of the governmental immunity. This statute. It's an express waiver. So this notion that you have immunity from 106 is a farce. It's already been decided. This is an express waiver of immunity. But she also has standing under 106.003. Why is she aggrieved? Because she is a person who is an employee of the state, as they have repeatedly told you, who must violate section 106.001. She has to tell patients, if a patient comes into her office for -- this happens on occasion. They come in

for one thing, and then bring up another topic. And if they say, hey, I'm having -- I have gender dysphoria, can you help me with certain things, but I also would like to have puberty suppression. She has to tell them, I can not provide that to you because of what chromosomes you have. So, she is put in the position of having to, by this dictate, violate 106.003 and subject herself to criminal penalties because she is an employee of the state doing it. And so there's your standing right there. She's subject to criminal prosecution for complying with this dictate. And I call it a dictate because it's not a policy and procedure like Mr. Reynolds said. And how do we know that? Because Dr. Lopez had the discretion to provide this care to other people. And it's not a matter of discontinuing a line. It's not as if they said, hey, we're no longer going to have a cancer unit. We're going to get rid of all of our chemotherapy, and, blah, blah, blah, and we're not going to treat cancer in this hospital.

This is a case in which an established treatment modality that is within her credentials for the medical staff at UT Southwestern, Dr. Lopez can provide to people, but she has to discriminate who she gives that to, based on their -- what chromosomes they they were born with. And that's discrimination based

upon sex.

And, so, this was not a change in policy, because if they wanted to discontinue puberty suppression, I guess they could do that, but they have to alter her privileges that she received from the medical staff, and they'd have to discontinue that system, why? And they haven't done that. They just discriminated against a subset of people who may receive it.

So, as far as the evidence, I don't know -- if the court will pause for the (inaudible), we can call Dr. Lopez. I think 106.003, on its face, would provide her standing to -- because she's subject to a potential criminal penalty for violating statute. The evidence is clear that she's an employee of the state, and that she's in a position where she must discriminate based on gender, based on the admission of everyone here. So I think she is a party who has standing under 106.

THE COURT: Okay. What else do you need to put before the court today for me to go ponder and try to give y'all a ruling. And then I'm also going to need from you, Mr. Walker, to wrap up, because -- with what your request are. Because I know that at one point we kind of got down the train of, yeah, just give me the discovery under a plea of the jurisdiction, versus what

was originally here as the 202.

MR. WALKER: Yes, Your Honor. I think we probably do need to, based on the objections made by the defendants, we can call Dr. Lopez to address the issue about whether or not she knows the answer to this question, whether she needs the answer to this question in order to file a suit, and whether or not she's aware of any burden if we don't get this, or the people that have to be deposed under a narrow deposition. So I think Ms. Aldous was going to handle the question and answering of Dr. Lopez.

THE COURT: Ms. Aldous, are we ready to proceed with some testimony from Dr. Lopez?

It looks like you are on mute. I may have to un-mute you from here. Let me look.

MS. ALDOUS: Yes. Testing, one, two, three.

THE COURT: Dr. Lopez, will you say hello?

THE WITNESS: Hello. Thank you, Your Honor, for the opportunity to be able to be here and to speak.

THE COURT: Call your witness.

MS. ALDOUS: Yes, Your Honor. The movant calls Dr. Ximena Lopez.

THE COURT: Will you please raise your hand

for me?

(Witness sworn)

THE COURT: You can put your hand down. There is a little bit of a lag it sounds like in delivery. So, Ms. Aldous, make sure you wait for her to finish. And Ms. Lopez, you may have to pause for a moment to make sure Ms. Aldous has finished her question.

MS. ALDOUS: May I proceed, Your Honor.

THE COURT: You may.

XIMENA LOPEZ, M.D.

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. ALDOUS:

Q. Please tell us your name?

A. Ximena Lopez.

Q. And you are a medical doctor, or you not?

A. Yes, that is correct.

Q. And just briefly, Dr. Lopez --

THE COURT: Hang on one second. Hang on one second. I think that the delay may be coming on my end, but from my court reporter's face, I think she's hearing the same thing, which is -- Ms. Aldous, if you'll take a longer pause before your next question. We're getting her answer and then the beginning of your

question over top of it. So it's a delay on our end.

MS. ALDOUS: You bet.

Q. (BY MS. ALDOUS) Could you tell us, Dr. Lopez, where you went to medical school, and about your training after you graduated from medical school?

A. Yes. I went to medical school in Mexico City, where I'm originally from, and then I moved to Chicago to do my residency in pediatrics at the University of Illinois at Chicago. And then I moved to Boston, to Harvard Medical School, and Massachusetts General Hospital, where I did my training in pediatric endocrinology.

Q. Dr. Lopez, if you were going to describe to someone who is not in the healthcare profession what your specialty is, could you tell us how you would do so?

A. Yes. So I'm a pediatric endocrinologist. That means that I diagnose and treat conditions in children and adolescents that relate to hormonal conditions or treatments, that includes diabetes, puberty, gender dysphoria, growth problems.

Q. And Dr. Lopez, you have been here during the course of this hearing, and we have heard something about the Genecis Clinic. Can you tell the judge how you first became involved in caring for children who had

gender dysphoria.

A. Yes. So I started caring for my first transgendered patient ten years ago. Before that, I had a little bit of exposure to transgender care in my training at Harvard Medical School. And when I had my first patient, ten years ago, I really didn't have a significant amount of training or experience, but these cases are -- can be pretty desperate and life threatening. I had a patient who was nine years old and was suicidal, and this mother was desperate to give puberty suppressant for this child because he was at risk for suicide. So I engaged with other experts in Boston to start treating this single patient, realized there was nobody else that would treat this patient, and from then on I started, you know, getting more referrals because I was the only one in the southwest who would treatment for this patient. And soon after, I realized we needed a team of experts at Children's and UT Southwestern, and I started gathering what is now the Genecis Program.

MS. ALDOUS: Judge, I'm picking up about every fourth or fifth word. Am I the only one who's having that issue?

THE COURT: It's coming through okay for me. Is anyone else having any difficulties? And most

importantly, is my court reporter having difficulties?

THE COURT REPORTER: Judge, it's coming through fine for me.

THE COURT: Ms. ALDOUS if you're on a speakerphone that also maybe part of the problem. You may want to pick up that handset, and that may help some.

Q. (MS. ALDOUS) Dr. Lopez, I didn't hear all of your answer to my question, but have you told the court how you became interested in treating children who had gender dysphoria?

A. Yes, I did. I became interested because what one patient, one family showed up in my clinic, and they were in desperate need for care, and there was nobody else that could help them, and I trained myself, and that's how I started caring for these patients.

Q. And I think this may go without saying, Dr. Lopez, but do you feel quite patient about caring for these children?

A. I've been told I'm too passionate. It's a negative qualification somehow. I think -- I would have to say that every expert in the field, in my position, all my colleagues that do this across the country and the world, unfortunately, have become very passionate because these are very vulnerable children and families

that are very much discriminated against in different scenarios, including the medical field, and their community. And it's a natural thing for a pediatrician to become an advocate and passionate about these families, because you just want to help them. So, yes, I have to be.

Q. Dr. Lopez, are you currently -- I'm sorry, pause for a second.

Are you currently affiliated with UT Southwestern Medical Center here in Dallas?

A. Yes, I am.

Q. When did you first come to UT Southwestern?

A. In 2010.

Q. Since coming to UT Southwestern, have you held different titles at that institution? And if so, could you tell the judge what those have been?

A. I was hired as assistant professor in pediatrics. And in 2018, I was promoted to -- to associate professor in pediatric. And I was actually promoted because of the success and growth of the Genecis Program. And I've been the medical director and founder of the Genecis Program since 2014.

Q. All right. And does -- as far as your privileges are concerned at UT Southwestern, Dr. Lopez, have those privileges included a provision to treat

gender dysphoria with puberty suppression medication?

A. Well, the written privileges actually did not specify puberty suppression medication for any condition, but it's sort of the broad umbrella of endocrine conditions or treatments we provide in pediatric endocrinology. So we all -- all pediatric endocrinologist are assumed to be able to provide puberty suppression at my institution.

As far as there were privileges, all though I'm sure that it's specifically written like that.

MS. ALDOUS: Judge, I'm still hearing about every third word. Is it okay if I go to Mr. Walker's office and take his place and ask the questions from there? I think it might be easier.

THE COURT: Certainly. Go for it.

And while we're doing that --

MS. ALDOUS: I don't want to be confused with Mr. Walker, though.

THE COURT: That's okay.

And we've been going for quite a while here. Ms. Washington, do you need a five minute break while they reset which room they're in?

THE COURT REPORTER: That would be great, judge.

THE COURT: Let's take a five minute break,

and then we'll come back and get some more testimony from Dr. Lopez.

(A short recess was taken.)

THE COURT: Dr. Lopez, I'm going to turn you back over to Ms. Aldous, and she has some additional questions for you.

MS. ALDOUS: And Dr. Lopez, don't be concerned that you can't see. You're not on the video. We're doing that so we can hear your testimony more clearly. So just listen to what I have to say, and answer the questions without having to look at me while you're doing so, okay?

THE WITNESS: Sure. Thank you.

Q. (BY MS. ALDOUS) Okay. I didn't hear some of what you said in my earlier questions. So let me go back just a minute to make sure that our record is pretty clear.

You came to UT Southwestern, as I understand it, about ten years ago, did you not?

A. In 2010, so almost 12 years ago.

Q. And when you started practicing as an associate with UT Southwestern, what was the scope of your privileges at that time, Dr. Lopez?

A. So general pediatric endocrinology, which includes, really, the same things that I do now, which

is hormone treatment for children and adolescents in clinic, but also I cover the inpatient. So hospitalized patients at Children's Medical Center in Dallas, Plano, and also newborn care with endocrine issues at Parkland and Clement's UT Southwestern Hospital.

Q. And Dr. Lopez, was those privileges that you were granted at UT Southwestern and at Children's Medical Center, include the provision for you to treat children who had gender dysphoria with puberty suppression medication, if you deemed that to be appropriate in your best practices of medicine?

A. Well, I don't think that's written like as a specific for gender dysphoria, but it's not also like a specific written indication to use that for precocious puberty either, which is another reason to use puberty blockers, for example. It's just part of general pediatric endocrinology. So I will say, yes, but I don't think it's specifically written.

Q. All right. Well, let me ask it this way, Dr. Lopez. Is it safe to say that when you started at UT Southwestern, if you had a patient who came to you, and you made the diagnosis of gender dysphoria, you could use your best practice and medical judgment and the standard of care in the community to treat that patient as you deemed appropriate?

A. Yes, that is correct.

Q. And would you tell the judge how special is it, the relationship between you and your patients?

A. Well, this is -- this is really life-saving care. I can't emphasize more how life saving this is. Most of these patients who are transgender and suffer from having a gender identity that does not match the sex that they were assigned at birth suffer. And when puberty starts, that sort of distress worsens, and this is when we see a high incident of depression and suicidal risk during puberty, because having the physical puberty that does not match one's gender, can be very stressing and sends a message to that young person that their physical changes are not consistent with how they feel inside.

So, actually, I was going to say puberty suppressions, for example, for transgender adolescents started 30 years ago. It's not new anymore, okay? And it was started, precisely, because psychological and psychiatric care was not enough. It was simply not enough. And when we started the Genecis Program, the sort of critical piece of it was that we had support from psychiatry, because psychiatry of children said we have this patient. We see these patients. They're coming suicidal to emergency room every day, and we

don't have anything for them. We're not doing enough for them. And now we have years of data that shows that stopping the puberty that does not -- it's not consistent with how they feel inside, relieves a lot of the stress. And then when they became older adolescents and they want to go through the puberty that matches that gender identity, then they can receive hormone therapy that allows them to present to the outside world in the gender they have. And we have now years of data from our clinic that that relieves that distress, that depression, that high risk of suicide, and it becomes -- going to your point, Ms. Aldous, is that we see these kids thrive, and we see a decrease in suicide, and we see kids who are, you know, just thriving, and parents who are very, very happy with seeing their kids function again. So that's how special this treatment is. And there's really no good alternative, just psychological care alone is not enough.

Q. Now, Dr. Lopez, would it be fair to say that when you have been treating these children who have a condition called gender dysphoria, do you often see these families in a crisis mode when they come to you for help?

A. Always, always. I mean, I'm not a very -- I'm not sort of religious, but I've been to church, and what

it reminds is when people share their testimony at church and they cry, and they tell their story of how they came to accept Jesus, let's say. This is what I see, okay? All parents cry that first visit because they came to accept their child after a very long journey of battle, and denial, and difficulties trying to accept a child that they, you know -- it's a different child than they thought they had. No parent wants a transgender child. No parent wants a child that's at risk for discrimination and having a difficult life. So it's always, families are always in crisis. We actually do a lot of psychological testing on these families as part of our research study. And the quality of life of these parents is really, really low when they come in because of the distress that they're going through. This is having like a child with a chronic health condition. But the quality of life of their parents also improve as they go through the program as they see their child thrive.

Q. Okay. Dr. Lopez, I'm going to try to walk you through this fairly quickly, and I know you can talk about this all day long, and I completely understand your passion.

Could you tell Judge Bellan, were you instrumental in starting the Genecis Clinic or Program

at UT Southwestern?

A. Well I was the physician who saw the first patients. I created the team, and I requested the support from Children's and UT Southwestern to start a program, and I became the medical director of the program. So, yes.

Q. Did UT Southwestern, at that point, support you in this endeavor to form this Genecis Clinic to help these children who were in crisis?

A. A hundred percent.

Q. And did the folks at Children's Medical Center support you in this endeavor to create this safe haven for children who are in crisis from gender dysphoria?

A. Yes, a hundred percent.

Q. And you said -- I don't want to go into a lot of detail, Dr. Lopez. You said just a second ago, you were talking about the literature. Did the Genecis Program itself, did they undertake studies in an effort to help the treatment of children and adolescents with gender dysphoria, and were those studies actually published in peer review pediatric journals?

A. Yes, that is correct. We invite all our patients to participate in a study in which we perform serial psychometric testing about their mental health and wellbeing, and not just to the patient, the child,

but also to the parents. And we routinely, prospectively repeat those measures. And we've shown, and this has been published, that our main -- we have several studies, but our main study is published in the most reputable journal in pediatric medical literature, which is called 'The Pediatric,' which shows that a puberty suppression and hormone therapy improves mental health, depression, anxiety, dysphoria, and suicidal risk of transgender youth.

Q. I want to go to the topic, Dr. Lopez, when you first became aware that there was any talk about the Genecis Clinic or program being shut down. Could you tell Judge Bellan when you first heard anything about that?

A. Yes. This was in May of 2021. I received a request to meet with Dr. Stephen Skapek, who is the current, and has been at the time, chief of pediatrics at UT Southwestern, along with my boss, Kevin White. And so there was a meeting with the three of us, and it was an urgent meeting. So I got a call from 9:00 a.m. to meet at 10:00 a.m. very quickly. And Dr. Skapek told -- this was also news to my boss as well, to both of us, that the previous night, Dr. Podolsky, president of UT Southwestern, had received a call from the governor's office requesting to shut down our program, Genecis, to

stop care for all patients, and that -- so the next morning when they met with me, we had an emergent meeting at 7:00 a.m. to discuss this with UT Southwestern executives, and they decided that we needed to stop all care, including for existing patients, and they were asking me to help them transition those patients out. So that was the first time I heard about this. And this was completely news to me at the time.

Q. I've got to ask you this, Dr. Lopez, what did you think when you heard that news?

A. I was shocked because I did not understand the rational. This has been a very successful program. We've seen more than a thousand patients. We haven't had any case of patient -- their family being unhappy with their care. So I did not understand what was the medical rational, care rational? I really did not know how to react. We asked -- my reaction was, can I meet with Dr. Podolsky? I need to explain what we're doing. I don't think they understand the impact that this will have. We are the major program in the southwest, because we were the first one to start with the largest one. We have 600 existing patients if we stop care. This is going to affect these children's mental health. I need to speak with him. I need to make them understand what is the impact of this. That was my

reaction.

Q. To put it mildly, Dr. Lopez, did you push back a little bit on this decision that you were told that you had to stop the care of these patients you were caring for?

A. Yes. Both my boss and myself -- myself said, we need to meet with the legal team because we will put existing patients in medical abandonment, and we will not -- I said, I will not help with this because this goes against my oath of do no harm. I cannot help you with this. That's what I said.

Q. Were you allowed to meet with Dr. Podolsky to figure out why this decision had come about?

A. Never, no.

Q. Now, after that meeting in May, did you continue to see patients through the Genecis Clinic, Dr. Lopez?

A. So Dr. Skapek, who had called us for that meeting after -- when we said we will not help with this crazy idea. He said, okay, let me see what I can do, and then he called me a few days later and said, okay, it seems to be -- seems that this is more complicated than we thought. We're talking with legal, and they put kind of things on a hold. So I continued to see patients as usual, and see new patients as usual, until

November of 2021 when, officially, I was asked to stop care for new patients.

Q. Okay. We're going to get to the November meeting in just a second. But did you have another meeting with what I'll call the powers that be at UT Southwestern in July of 2021?

A. Yes. There was an intermittent meeting between May and November in July with -- because I requested to meet with Dr. Podolsky and they said, no. But, instead, they met -- they invited me to meet with Dr. John Warner, who is health services vice president at UT Southwestern. Andrew Lee is the medical school dean. And, again, Dr. Skapek, the chief of pediatrics, and my boss, (inaudible) White. And, at the time, in the meeting, they simply said they were still consulting with legal, things are complicated. We continued to get pressure from the governor, as well as other legislatures, that are inquiring about the Genecis Program, but we're -- we wanted to let you know that we're still receiving a lot of pressure.

Q. And I've got to ask you this, Dr. Lopez, since we've talked about the governor and other legislatures. Have you ever let politics dictate, in any manner whatsoever, how you treat a specific patient?

A. Never. Why would I? My oath is to the best

care to the patient, so I will do what I think is the best for the patient.

Q. Let's move to the meeting in July 2021. What were you told at that meeting about removal of the website for the Genecis Program or the Genesis Clinic?

A. So I was told that they needed to remove all disability of the care we provided, and that it was -- they had to remove the Genecis brand, which means they had to remove the website, the phone line, the e-mail, to make it seem like it didn't exist. And, again, that was still because they had received pressure from the governor's office, and that they had no choice.

Q. Did they give you time to let your patients know that this website would be taken down, and the clinic would be no more, the program would be no more?

A. No. I actually requested that they communicated this to the families before that was done, because existing patients would be confused and would think that their care was removed. But they still took down the website and all the contact without notifying families. They notified them after me putting a lot of pressure and requests a few weeks later.

Q. Now, Dr. Lopez, you obviously know the decision was made at UT Southwestern to remove the website relating to Genecis, to take down the phone numbers,

things of that nature, but do you have personal knowledge, and I'm not asking you if somebody told you, but do you have personal knowledge of who made that decision?

A. I do not.

Q. Okay. Now let's move to the meeting in November of 2021. Was that a meeting that had been set for some period of time? How were you notified that that meeting was going to happen?

A. No. I was called on the same day to have that meeting a couple of hours later. It was an urgent meeting.

Q. Who all was in that meeting?

A. In May?

Q. Who was there in November?

A. I'm sorry, November. I apologize.

No, November, I can't -- it was -- I can't remember how quickly it was called for that meeting. Might have been a few days. But in that meeting, it was, again, John Warner, health systems vice president, Andrew Lee; dean of the medical school, Stephen Skapek; chief of pediatrics, Erin Sine, who I believe is on this call, legal from UT Southwestern, and Karen White, my boss, and myself.

Q. What was discussed at that meeting, Dr. Lopez?

A. So at the meeting was discussed that they had continued to get pressure from the governor's office, and they had no choice. It's a state institution. They could not continue to provide puberty suppression and hormone therapy for transgender youth, and they had to stop care for new patients, and we had to remove the disability of the program, like I just said, and five weeks of continued care for existing patients, and we could provide psychosocial support for new patients.

I have to say, the main reasons why they came to see us is that psychosocial support, because that's the reason why we started the program because psychosocial support is not enough. The great majority of our patients already have their psychosocial support in the community. They come to us because of the -- because we provide puberty suppression and hormone therapy within standards of care.

Q. Dr. Lopez, during this meeting, November of 2021, did you or any of the participants there bring up the facts that the decision that you were being forced to -- the decision that was made that caused you to treat your gender dysphoria patients, that were new, different than the existing patients. Did that concern you?

With discrimination -- let me just cut to

the chase, Dr. Lopez. During that November meeting with Ms. Sine present, the vice president of legal, was it discussed that what UT Southwestern, or whomever was calling the shots on this, was forcing you to do was discrimination against transgender children and adolescents?

A. Yes, because that's the only patients I can treat. And I actually already saw outpatient recently that came to me with gender dysphoria asking for hormone therapy, and they know I do this. They know I can do this. I have every means to do this, and I had to tell them I couldn't, and that felt -- it didn't feel like I was doing the right thing, because I know I can give it to somebody else that's not transgender, and doesn't come from a gender identity issue.

Q. So someone -- a patient that has precocious puberty, you can give this therapy to, but if a patient comes to you with gender dysphoria and gender identity issues, you have been told you cannot give that very same therapy to, correct?

A. That is correct.

Q. And you heard in this hearing, Dr. Lopez, my partner, one of your lawyers, Mr. Walker, talking about criminal penalty for discriminating against patient. Do you have concerns that you could have personal exposure

if you tell patients that you cannot provide care to them because of their transgender identity?

A. Yes. This is also -- yes, because this is a group of population that's already discriminated against in the medical field. So if they know that I can give this same treatment to individuals who are not transgender, but not to them, because of their gender identity, yes. I am worried that I will be seen as someone who is discriminating against them.

Q. With criminal penalties attached, correct?

A. Yes.

Q. And let me ask you this, Dr. Lopez, have you thought about the fact that because you are not exercising your best medical judgment when treating patients who have come to UT Southwestern since November of 2021, and if you think they need this hormone suppressant therapy, but you can't give it to them, are you fearful you are violating your own standard of care and could be sued for that?

A. A hundred percent. A hundred percent, because it's not only my standard of care. All the legitimate medical societies support this standard of care and actually oppose any limitations to this care with discriminating.

Q. Now, do you have personal knowledge as to who

made this decision in November 2021 that you, as a pediatric endocrinologist, could not give puberty suppression meditation to children or adolescents that came to you suffering from gender dysphoria?

Do you know who ultimately made that decision, Dr. Lopez?

A. I don't have personal knowledge of who ultimately made that decision.

Q. Do you know if the dictate to shut down Genecis and to stop treating new patients for gender dysphoria was the result of an official order from the governor to UT Southwestern? Do you have personal knowledge of that?

A. I don't know.

Q. Do you know is there any way that you can, without the benefit of this discovery, if the court allows it, is there any other way for you to determine who made this decision that required you to stop using your best medical judgment in treating these children who are in crisis?

A. No.

Q. Did you see the ruling, Dr. Lopez, from Attorney General Paxton, whose lawyer -- two of his lawyers, I think. No, one of them is on the phone -- that gender-affirming care maybe considered child abuse?

A. Yes, I did.

Q. And have you had parents that come to you in distress thinking that they could be investigated by CPS, parents that have been distressed trying to get their kids the best medical care. They could be investigated by the government, and if they were receiving the very care you thought their children could receive, their children could be taken from their home, in addition to the other children in their home? Has that been a concern some of these parents have expressed to you?

A. Well, the distress is so high that they're not only crying, all of them in clinic for the last couple of months since that happened, but they're all trying to flee the state as refugees, like in a (inaudible) country, if they're able to. They're very distressed. They're trying to hide their kids as if they were -- I don't know. It's awful. It's criminal. It's awful.

Q. In fact, have some of the parents expressed to you they don't even want their children to go to school because they're afraid their teachers think they have to report them to CPS, and they could lose their children in their homes have they said that to you?

A. Yes. They're home schooling their kids. They're hiding them from their church. They're hiding

them from physicians. They don't want to take them to their general doctor, or they -- I had a patient with some stomach pain and they didn't want to go to the emergency room because they were afraid that the emergency room would call on them. I was trying to encourage them, you have to go.

So, yes, it's awful.

Q. This order that was issued by Attorney General Paxton, do you know the basis for that decision, or would you need this discovery in order to try to find out, to the best of your ability, who was behind making these decisions?

A. Yes, I think I would need that discovery.

Q. Do you know if the board of directors at Children's Medical Center made this decision to force you to not treat these patients in accordance with the standard of care?

A. I don't have any personal knowledge of that.

Q. Do you know if the board at UT Southwestern participated in this decision that required you to stop treating these children who were in crisis?

A. I do not know.

Q. And do you need this discovery so you can determine, in fact, who made this decision that caused you to discriminate, or potentially discriminate against

transgender children?

A. Yes, I do.

Q. Have you read in the newspaper articles and quotes, and various things, sometimes they said it's political pressure, sometimes they said it's patient privacy, sometimes they said it's medical controversy, other times they've said it's potential legal challenges. Have you heard these varying stories come out of UT Southwestern as to why this decision was made to discriminate against transgender children?

A. Yes, I did.

Q. And are you asking --

A. Yes. Sorry.

Q. Are you asking this court to allow this discovery so you can figure out why this decision was made?

A. Yes.

Q. And I don't want to go into this too much, but I do want to say this on the record. Has there been studies in the medical literature, Dr. Lopez, which have shown that over 41 percent of transgender youth attempt suicide?

A. Yes, that's very well known.

Q. And are you fearful that these patients that you cannot see are going to take their own lives because

of what UT Southwestern and whomever made this decision has done?

A. Unfortunately, and this is very scary, but I think kids are going to die. I can't put -- I'm not exaggerating. I'm not trying to be dramatic, but children are going to die because of these -- the limitation of gender-affirming care, meaning pubic suppression and hormone therapy are going to cause lives of transgender youth.

I want to point out one thing. There's a growing body of data. There's now 13 studies that support this care. There's no study that goes against this care. So there's really no medical reason to stop this care.

Q. Dr. Lopez, you filed an affidavit in this case, and you stated that the -- there have been over a hundred -- 100 patients that have been turned away because of this edit that was given to you by whomever did it. I want you to tell the court, did you ask someone in your group, a person that could keep track of this, to keep track of how many people called wanting this care? How many families were in crisis that wanted this care, but you had to refuse it, because of this decision?

A. Yes. We kept a log. I asked the front desk to

keep a log of the families who called and we had to deny care and not able -- and we were not able to see them because we could not do puberty suppression or hormone therapy. And that log as 98 patients.

Q. And have you personally reviewed that log, and was it taken in accordance with your direction?

A. Yes.

MS. ALDOUS: Let me look at my notes here. I think I'm pretty close to done.

Q. (BY MS. ALDOUS) Dr. Lopez, I'm going to ask you this. Was this an easy decision for you to make to file this motion for 202 depositions.

A. Of course, it was incredibly -- I've never -- I would have never wanted to be here. I need to concentrate in my work. I need to care for my patients. I'm spending way too much time on this, as everybody else, and I tried my best to restore care by trying to be rational, talking as a physician, as a scientist. I contacted our medical societies that oversee this care to contact the UT Southwestern leaders. They were not listening to me, to speak in the same medical terms, and it was a point it was -- there's no reason for medical dialogue, and there's no space for medical dialogue. So this is the only way out right now that, you know, I thought we had.

Q. Are you looking to find out, through this 202, any other form of discovery that the court grants? Are you trying to find out who made this decision, so that you can bring an action against them that hopefully will allow you to start caring for these children and adolescents again?

A. Yes, I am.

Q. Are you doing this for notoriety, or money, or any reason like that, Dr. Lopez?

A. No. I'm not doing this for money. I don't want any money from this. I just want these patients to get their care they want. They need.

Q. And have you received support, literally, internationally, for the stand that you're taking for your patients?

A. Yes, yes. I think all the individuals in the medical field that are knowledgeable about this care are aware of the political situation in Texas, and they're looking -- everybody, the families, the experts are looking for change, right; to do right for these families. So, yes, I've received -- I'm not exaggerating -- hundreds of messages of support from medical experts, presidents of medical physicians nationwide and worldwide for standing up for what's right for these kids.

Q. Last topic real quickly, Dr. Lopez. Do you know of any reason why it would be burdensome for Dr. Podolsky and Warner to just tell us why these decisions were made and who did it?

A. I mean, I don't know how -- I don't know how burdensome it is to them. I just know the burdens on these families is tremendous. Yeah.

Q. Do you just want to know whose decision this was so that you can seek intervention to stop it so you can treat your patients?

A. Yes.

MS. ALDOUS: I pass the witness, Your Honor.

THE COURT: Okay. Do we have any parties who have questions for Dr. Lopez?

MR. ELDRED: I do not have any questions at this time, Your Honor.

THE COURT: Okay.

Ms. Calderon has shook her head as no.

Ms. Sine, from UT Southwestern, do you have any questions?

MR. REYNOLDS: No, your Honor.

Ms. Sine is here as a party, not as an attorney. We don't have any questions.

THE COURT: All right. Well, I see

Mr. Walker walking back in, that must mean he wants his chair back.

MS. ALDOUS: He's lurching over me. He wants his space back.

THE COURT: Okay. Let him get settled in.

MR. WALKER: I've got good news.

THE COURT: What's your good news?

MR. WALKER: The nice thing about me having a minute, you were told earlier that no Texas court has said that discrimination, based on transgender status, quote, that it is discrimination, if you consider transgender status. That is actually not correct. There was a case out of the Dallas Court of Appeals on exactly one month ago, on March 11, 2021, called *Tarrant County College District versus Sims*, in which the Dallas Court of Appeals was looking at the Bostock opinion. And they said, "We conclude we must follow Bostock and read the Texas Humans Right Association Prohibition on discrimination -- not Texas Human Rights. The Texas Civil Rights Act prohibition discrimination, quote, because of sex, closed quote, as prohibiting discrimination, based on individual status as a homosexual or transgender person.

So the Dallas Court of Appeals made a holding that, with respect to the Human Rights Act, the

Texas Human Rights Act, is because of sex if you discriminate based on transgender status, and that's an opinion from one month ago today.

So I would submit that that holding is barring -- or is one that you have to -- this court must follow, because it's a holding of the Dallas Court of Appeals.

THE COURT: So that was March 11, 2022. Do you have either the court of appeals CV number, or a Westlaw cite? Do you have anything so that other folks can go find that?

MR. WALKER: Sure. So I got too excited, so I misstated the date. It's actually a year ago, March 10, 2021, *Tarrant County College District versus Sims*. The case cite is 621 S.W.3d 323, and it's an opinion of Justice Shank, who held that it's discriminatory to discrimination based because of sex to rely upon their transgender status, which, again, is exactly what the statute says. If it's because of sex, then it's prohibited, and transgender is because of sex.

The other thing, Your Honor, I wanted to bring to your attention is there's a case holding or a case -- Supreme Court case, *Mission Consolidated Independent School District versus Garcia*. The case cite is 372 S.W.3d 629, and it's a 2012 Texas Supreme

Court case, which stands for the proposition, among other things, that as we held in Miranda, which was the first case really on plea to the jurisdiction. The primary case. As we held in Miranda, trial courts considering a plea to the jurisdiction have broad discretion to allow reasonable opportunity for targeted discovery, and to grant parties more time to gather evidence and prepare for such hearing. So that was the Supreme Court indicating that the standard is broad discretion, that a court, such as this one, enjoys when considering a plea to the jurisdiction.

THE COURT: If only I did enjoy my discretion.

Mr. Walker, we lost your audio.

MR. WALKER: Where did I lose connection?

THE COURT: Right after you talked about how I enjoy discretion, because I said I don't enjoy my discretion sometime, and then we lost your ability for your comeback to that response.

MR. WALKER: Well, I didn't hear that, but that was a good come back from you.

Yes. So the Supreme Court has said you enjoy broad discretion is really the point that I was focussed on.

So we would ask the court, at this time,

because the defendants are asserting a plea to the jurisdiction on the question of whether or not there has been ultra vires conduct or not, which would be the exception to sovereign immunity, we would ask the court to table the 202 motion, to delay a hearing on the plea to the jurisdiction, which is, again, from the Supreme Court to grant parties more time, to gather evidence, prepare for a hearing. And we would ask the court to provide us a targeted discovery to respond to that plea so that we may demonstrate to the court, as the defendants are demanding, that there has been a basis to allege ultra vires conduct, such that the plea to the jurisdiction must be denied. So we would ask the court to grant us that discovery. And that discovery request would be a deposition of Dr. Podolsky and a deposition of Dr. Warner, as well as any communication they may have had with any other public officials relating to this ultimate dictate that transgender children are no longer allowed to receive puberty suppression medication at UT Southwestern or Children's.

THE COURT: Before I get a response from the other folks on this. Mr. Walker, there is some difference in the law about the protections of the court has at its finger tips for folks who -- it also affects whether an order is final or not. As to whether the

folks that we are seeking discovery from are potential parties and targets of the eventual lawsuit or not. And I don't know yet if you -- you may not have that answer completely yet, but I need to know if there is a possibility that the folks we are seeking discovery from, at this point, may end up as parties to an ultimate lawsuit if, you know, discovery leads you down that path.

MR. WALKER: I want to answer the court's question. Is the court inquiring, under 202.1, that the two types of depositions, one is to perpetuate testimony in an anticipated suit, or to investigate a potential claim. Is that the distinction the court was looking at there?

THE COURT: No. It's really that I'm looking at the line of cases about the finality of the order and whether it's appealable. I'm trying to make sure that I'm looking big picture at your case, and that we either are in a position that you all can get an answer from the court above me, or whether you may end up in a non-appealable, non-final order if this is discovery sought of folks who are not ultimately expected to be parties if an action is brought.

MR. WALKER: Right. So, the answer is we don't know. That's why we're investigating the claims.

It could be that Dr. Podolsky just woke up one morning and decided he didn't like transgendered children, and so he didn't want them to have care anywhere. That could be what happened. I don't suspect it is, but I don't know. The only thing I know is what Dr. Lopez has told us, she doesn't know either. I don't know if Dr. Podolsky is going to be a party. He very well maybe. I don't know if Dr. Warner's is going to be a party. He maybe. Same thing with UT Southwestern or Children's. I don't know if the sole party might be the governor. If this all needed from the governor, then he maybe the only party. If it's just the attorney general or the attorney general and the governor working together. I don't know. So, until I have the discovery, I can't answer the question in any way about whether I am actively contemplating a claim against specific people. I know we are actively contemplating a claim to save lives. We just need to know who the target's going to be.

THE COURT: So, Mr. Walker, if I understand your position at this point, you are not arguing that they cannot raise a plea to the jurisdiction under these circumstances. You are instead asking the court to address their plea to the jurisdiction by allowing you to have discovery so that then the court can have a full

hearing on that specific plea to the jurisdiction that's been raised?

MR. WALKER: I think so. I would say it a little different. I'm not trying to (inaudible) with the words here, but I can say that they anybody, any citizen has a right to file one. A has a right to file one and the court that has to deal with it. Whether it's meritorious or not, I don't believe it's meritorious, but they have filed one, and they are, candidly, officers of the government. So they have filed one and now the parties and the court must deal with it. And so, because they filed it, we believe we're entitled to discovery under the Supreme Court's guidance, and yet you have broad discretion, broad discretion to allow us to do that.

THE COURT: Okay. Mr. Malouf, did you have something additional on that point before I get a response from the folks who have raised their plea to the jurisdiction?

MR. MALOUF: As the court knows, there's a difference between a challenge to jurisdiction and the challenge to capacity. A challenge to capacity is one ordinarily asserted in the form of a plea in abatement, verified denial of the plaintiff's right, et cetera, et cetera. That affirmative defense is typically addressed

at trial in the form of proof or earlier in a plea in abatement. With a plea to the jurisdiction, the rule seems to be that the burden is upon the plaintiff to demonstrate jurisdiction. So, you know, echoing what Mr. Walker says, I think they certainly have a right to assert a plea to the jurisdiction. I think Mr. Reynolds may have observed at the beginning that the burden is upon us to demonstrate jurisdiction. And in order for us to do so, echoing, again, what Mr. Walker said, I think it's appropriate to permit limited discovery that will enable us to present the court with whatever evidence we can -- thank you, judge.

THE COURT: Thank you.

Okay, Mr. Reynolds, did you want to respond?

MR. REYNOLDS: Yes, Your Honor. Thank you. And I'll try not to repeat what I discussed earlier today.

I would ask the court to go back and review our brief. I think we've set it out at length in the brief, but I do want to just reiterate that based upon what has been plead, and what we have heard today from Dr. Lopez, the actions of Dr. Podolsky and Dr. Warner, there's no evidence that they were outside the scope of their positions with UT Southwestern. As such, they

would be entitled to immunity if there were a subsequent lawsuit. And I believe the case law, we've talked about Combs and other cases, but the plaintiff's have to allege facts that show they could have a valid claim, and I'm paraphrasing, obviously, for the sake of time. We do not believe they have done that, either in their pleadings, or evidence today from Dr. Lopez that would take any claim outside of immunity for Dr. Podolsky and Dr. Warner. And therefore, we believe that the immunity then applies to this proceeding as well as any subsequent lawsuit.

THE COURT: So Mr. Reynolds this is -- I think I posed this question earlier, and I want to make sure I've given you a full chance to answer it.

Let's even assume for a moment that the court -- that I agree with you that the way that this was pleaded, the way the testimony was given, that the two doctors that there does not appear to be any evidence that they were acting outside of their scope. And your argument there is that immunity would apply to them. But even if that is true, how does that shield them from discovery about potential claims about someone else, which is really what I think I'm hearing here, which is they are not looking to bring a claim against those doctors, unless the discovery leads them down a

different path. It is that they're treating them as if they are third parties who have information. And, so, why are those folks -- why should the court protect those folks from discovery, not necessarily from a suit being brought against them, but from the ability for a plaintiff to get discovery from folks who clearly have knowledge of relevant facts.

MR. REYNOLDS: And this maybe a question that Mr. Eldred would be better to answer because I think, again, the ultimate parties would still be governmental entities, be UT Southwestern or AG office. Today we've heard even the governor. So, I think the immunity argument still applies, just further down the road from my clients.

THE COURT: And even if that is true, and ultimately I find that everyone that they want to bring a case against has immunity, how does that prevent us from getting the discovery in order to find out whether they acted within the scope that allows for that immunity to apply? That's where I'm hung up here, which is discovery is exactly that. It's for them to find out whether they have claims or potential claims that you all may have bullet proof defenses against.

MR. REYNOLDS: And I understand the court. We do feel like we're going in circles here. I

understand that. We have all grappled with that, but I keep going back to the Combs case that we talked about earlier. They have to show that there's a claim that they can pursue that would not be barred by sovereign immunity. I think that's the best answer I can give the court, because the claims that we hear they're contemplating would be barred by sovereign immunity.

THE COURT: Thank you, Mr. Reynolds.

Mr. Eldred, did you want to respond?

MR. ELDRED: Yes. I'll be brief.

I agree with what Mr. Eldred has said. Every claim that they've contemplated would be barred by sovereign immunity. And to answer the more recent arguments. No discovery can change that, because they haven't made any allegation that anyone acted outside their scope, or acted illegally. Therefore, you should not allow discovery even to explore jurisdictional question, because to get there, there has to be a question of jurisdictional fact. I haven't heard any. I don't think there are any.

I want to -- this is a picky point. I admit, during the break it was explained to me that I made a mistake earlier. Mr. Walker showed you a list of organizations, and I said that we weren't on the list. Let me try this again.

UT Southwestern does have a 161.001(d) and (c) entity. It's a nonprofit charity. Dr. Lopez does not work for that entity. So that's a Red Herring thing. My point is still the same that that rule that he's cited, and the corporate practice of law does not apply to Dr. Lopez's employer, which is not that kind of entity. I'm sorry I said it wrong before.

THE COURT: Okay.

MR. ELDRED: I know we're probably running out of time. What I keep hearing is they don't know who dictated this policy. We don't know of any law that allowed anybody to depict the policy, other than the people who did dictate the policy, UT Southwestern and Children's Hospitals. So we don't think they've even stated a claim against anybody that wouldn't be barred by immunity. But, you know, the scope of what they're asking for, particularly the document area, goes far beyond that. They've asked for all communications about this and that from various people. And, you know, while we still object to any discovery, make that clear, I'm not waiving anything here. We would ask that it be limited to documents and testimony about who dictated this to you, which I've heard over and over again is what they're looking for. Who dictated to you that you will make these decisions that Dr. Lopez objects to? It

is a broad request. Mr. Walker said it wasn't a broad request, but it is a broad request. Seven categories of documents, and all those documents are UT Southwestern's documents, I think. 6 and 7, as we put in our briefing, isn't even relevant to what they're saying. 1 through 5 ask for communications, but it doesn't ask for just the communications involving the dictations, nor is it limited to time even. So, again, I don't want you to think that I'm agreeing that there should be a discovery, but if you were to order some, we would like you to limit it to just that scope of what they keep talking about. Who dictated this thing to you, as opposed to who maybe talked about gender suppression -- I'm sorry -- gender therapy. I'm sorry, it's been a long day. I maybe using the terminology incorrectly. I'm not trying to do that. I think she called it gender-affirming therapy. Not just who talked to you about it, but who dictated this decision to you about it.

Again, I don't think they need that. It doesn't help their lawsuit. They already know who they want to sue. So I think that's premature even now.

I want to go back to rule 202. Rule 202 is supposed to be to investigate a claim. And from what I'm hearing, they know what the claim is. They might

know the details of every single thing they want to say. That's typical of all lawsuits. There's nothing --

THE COURT: The difference, though, here is that they're not sure who that claim needs to be made against. They may know what they think their claim is, but that's what they have told the court that they're trying to figure out here so that they can correctly identify the right parties because, you know, if your clients are not necessary parties, I'm sure they don't want to be sued for something when really what they're looking for is to find out who the underlying people were who made a decision. And, of course, you would immediately tee up the plea to the jurisdiction if that had happened. So, you know, I hear what you are saying here, and I definitely have some parsing of some case law that I need to do, and your various responses, and the reply, because this immunity issue is sort of the sticky issue here, you know. I can see it from both sides, and there's also certainly conduct that can be outside of what immunity would protect, even if under normal circumstances a party might enjoy such an immunity. So I'm going to have to look at a lot of this more carefully than what we're going to have time for, you know, during this hearing. I'm going to need to stew on it for a little bit.

Was there anything further you wanted to add Mr. Eldred.

MR. ELDRED: I'll finish up. You know, I haven't heard them point to a statute that waives, for instance, the governor's immunity (inaudible) -- the attorney's general's immunity or anyone else's immunity. And I think at a minimum, because of our plea to the jurisdiction, they need to do that to proceed under the Combs case that we've all been citing.

THE COURT: And Mr. Walker, is it fair for the court to -- well here's what I understood from you today which is, if you are focussed on this issue of discriminatory conduct, is it your position that these various immunities for the governor, for the AG's office, for these medical institutions, that those would be outside of any immunity they might enjoy. If, in fact, you can demonstrate that what they did was discriminatory.

MR. WALKER: Yes.

Can you hear me, Your Honor?

THE COURT: I can.

MR. WALKER: Yes, Your Honor. It's hard for me to tell you exactly what's going to be the exception to sovereign immunity. Since there's going to be one, because clearly this whole thing is illegal.

So, whoever is behind it is engaged in acts that are contrary to the law, which is the definition of an ultra vires action. So if it's the governor, the waiver of immunity might be a different thing. It could just very well be that he's exceeded his authority that is set forth in the Texas constitution. You know, I'm old enough to remember when I was in high school they taught us that in Texas when we formed our constitution, we were suppose to have a weak government. When George Bush was running for president they said you came from a state where a lieutenant governor has more authority. You don't do anything. Our governor is suppose to be a very (inaudible) thing. We have divided our executive department in five different offices. The legislative department has the authority over this topic. And if Governor Abbott is dipping his toe in this topic and enforcing things through intimidation, threats, coercion, whatever, he's acting outside his defined authority, as far as separation of powers go, and that is a recognized grounds to sue the governor under an ultra vires action. And so, to tell you exactly which exception to any applies, presumes that I know who violated what. And I can tell you that I think if the governor is involved, it's probably going to be a constitutional limitation. I can tell you that we have

a statutory express waiver of immunity under 106.001 that applies to an officer of the state, or an employee of this state, or an officer or employee of a political subdivision of this state. So there's a whole lot of people who fall into that category. So it's impossible to do what Mr. Eldred just asked me to do, which is tell you precisely what the waiver is here. I can tell you that it's going to be ultra vires, because this action is illegal. Now the question is, who is it that made it, because that will define what their limitation was that prevented them from doing this.

THE COURT: Okay.

Does anyone else have anything we need to address. I did want to try to get us wrapped up here. And at the risk of you all saying, yes. Is there anyone who is requesting leave to provide any further briefing on any specific issues?

I'm going to start with plaintiff's counsel.

MR. WALKER: No, Your Honor. We don't believe we need any additional briefing. We would just, again, request that the court continue any hearing on a plea to the jurisdiction and allow us to have discovery.

MR. REYNOLDS: Your Honor, I don't know if we need additional briefing, but I would like to reserve

the right to do so.

THE COURT: Anyone else have anything else we need to get on the record before we wrap up today?

I like quiet on those questions.

All right. So here is sort of the last thing I need from y'all, and this is probably going to be a little difficult as well which is, I do need some proposed orders. And I know all of these things kind of hinge on, well, if we don't do this, then we're going to need that. So I'm going to ask you to do your best, particularly, to the movant's counsel, because, you know, we do have are we going forward under 202, and can we have discovery under that, or are you continuing the plea and giving us discovery under that, or are you not giving us anything?

So to the best that y'all can, given the -- of issues we've identified today, please do submit proposed orders, do it through the E-file system, circulate them to the other parties so that everyone has them, but that will give me some help in putting together a final order on these issues.

If something else should come up where, you know, there seems to be either an emergent issue, or if somebody wakes up in the middle of the night and says, Oh my God, I forgot to say the most important thing,

then, you know, let the court know through filing, you know, some sort of supplement or additional information. But I really need all of that stuff in the next day or two. I am starting a jury trial in the morning, which means this will be fresh on my mind tonight, and I plan to do a bunch of reading, and some research, and try to get as much as I can this evening. But there are so many hours in the day, and I won't be able to do that while I am in trial. So assuming that tomorrow is a one day trial, and it should be, then I will have some additional time on Wednesday, and my ultimate goal is to get you all some decisions before the end of this week. If our trial goes long, or if something else happens, you all know that we're subject to the whims of juries and how well folks present their cases, but that's at least the expected timeframe from my end.

Is there anything else I can assist with, or anything else that we need to clarify before I excuse everyone today?

Yes, Mr. Walker.

MR. WALKER: I will submit two different orders. One about discovery for the plea to the jurisdiction, one about the 202. My last question, my last request would be we were trying to be hyperbolic. Lives are at stake here, Your Honor. And, so, there are

children being turned away as we speak who need this care. And, so, if there's going to be a bunch of additional briefing, I don't want that to be something that's being done to delay this matter. We need to get as soon as possible.

THE COURT: Let me be clear on that. My expectation is to get you all a decision before the end of this week regardless of whether someone else wants to provide additional briefing. If there is anything else, like I said, if you wake up in the middle of the night and there was something that you're thinking I needed to tell her about that one case, y'all need to get it to me, like, tomorrow. And then, obviously, after I make a ruling, I'm sure there maybe some things, other things y'all may want to talk about. But I need to get y'all rulings so that to the extent that either side needs the court of appeals to address those, that you all can move as quickly as possible, because I know, for all sides, having this resolved, or decided, is, you know, what the goal is.

Okay. Then having not seen anyone else waive their hands frantically, I'm going to thank you all for your time today for your extremely interesting and well researched arguments here, and for also the filings that I can go back to, and wish you all a good

day. Please be safe out there, and I will see y'all on another day.

(End of proceedings)

REPORTER'S CERTIFICATE

THE STATE OF TEXAS)
COUNTY OF DALLAS)

I, Robin N. Washington, Official Court Reporter in and for the County Court at Law No. 2 in Dallas County, State of Texas, do hereby certify that the above and foregoing contains a true and correct transcription of all portions of evidence and other proceedings requested in writing by counsel for the parties to be included in this volume of the Reporter's Record, in the above-styled and numbered cause, all of which occurred in open court or in chambers and were reported by me.

I further certify that this Reporter's Record of the proceedings truly and correctly reflects the exhibits, if any, admitted by the respective parties.

I further certify that the total cost for the preparation of this Reporter's Record is $450.00 and was paid/will be paid by DEFENDANTS/STEED DUNNILL REYNOLDS BAILEY STEPHENSON LLP.

WITNESS MY OFFICIAL HAND this the 25th day of April, 2022.

/S/ Robin N. Washington
Robin N. Washington, Texas CSR 8281
Expiration Date: 01/31/2023
Official Court Reporter
County Court at Law No. 2
Dallas County, Texas
Robin.Washington@dallascounty.org

VERIFICATION OF DAVID M. WALSH IV

STATE OF TEXAS	§
	§
COUNTY OF DALLAS	§

BEFORE ME, the undersigned notary, on this day personally appeared David M. Walsh IV, the affiant, whose identity is known to me. After I administered an oath, affiant testified as follows:

1. "My name is DAVID M. WALSH IV. I am over the age of 21 years, of sound mind, and capable of making this Affidavit. The facts stated in this affidavit are within my personal knowledge based on my personal experience with them, and they are true and correct. I am an attorney licensed to practice in the State of Texas and am a partner with the firm KERSHAW ANDERSON, PLLC.
2. The only item (Item 18) in the Supplemental Mandamus Record is the hearing transcript from the April 11, 2022 hearing on the Rule 202 Petition at issue in this mandamus proceeding. I received a copy of that transcript directly from the court reporter, who transcribed the hearing. The copy of that transcript that is contained in the Supplemental Mandamus Record is a true and correct copy of what was provided by the court reporter.
3. I am one of the custodians of record for the law firm KERSHAW ANDERSON, PLLC and am familiar with the manner in which its records are created and maintained by virtue of my duties and responsibilities. The transcript in the Supplemental Mandamus Record is the original record or an exact duplicate of the original record. This transcript was received by KERSHAW ANDERSON, PLLC in the course of its representation of Dr. John Warner and Dr. Daniel Podolsky and was received at or near the time of each act, event, condition, opinion, or diagnosis set forth in the record. The transcript was received or created so that KERSHAW ANDERSON, PLLC could rely on the information within them. The transcript was provided to KERSHAW ANDERSON, PLLC by persons with knowledge of such matters set forth, and it is the

regular practice of KERSHAW ANDERSON, PLLC to receive and rely on the accuracy of these types of documents in the regular course of its business. Since its receipt, the transcript was kept in the course of regularly conducted business activity, and it is the regular practice of KERSHAW ANDERSON, PLLC to keep this type of record in the course of regular conducted business activity. It is the regular practice of KERSHAW ANDERSON, PLLC to receive, create, accurately keep, and rely on these types of records in its business activities."

Further, Affiant sayeth not.

DAVID M. WALSH IV

SWORN TO AND SUBSCRIBED BEFORE ME, by DAVID M. WALSH IV, on this 27 day of April, 2022.

Notary Public in and for the State of Texas

ANGIE FISHER
Notary Public, State of Texas
Comm. Expires 08-23-2023
Notary ID 11640138

Respectfully submitted,

/s/ David M. Walsh IV

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Certificate of Service

I certify that on April 28, 2022, I served a complete copy of this Supplemental Mandamus Record on all counsel of record through the e-filing system.

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/s/ David M. Walsh IV

David M. Walsh IV

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Associated Case Party: DanielK.Podolsky

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Associated Case Party: Children's Medical Center Dallas

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No. 05-22-00375-CV

In the Fifth Court of Appeals
at Dallas, Texas

In re Daniel K. Podolsky, M.D. and John J. Warner, M.D.
Relators,

Hon. Melissa Bellan,
Respondent

Ximena Lopez, M.D.,
Real Party in Interest

University of Texas Southwestern Medical Center and Children's Medical Center,
Other Interested Parties.

Original Proceeding from County Court at Law No. 2, Dallas County, Texas, Trial Court No. CC-22-01316-B, Hon. Melissa Bellan, Presiding

RELATORS' EMERGENCY MOTION FOR TEMPORARY RELIEF BY 12 PM, WEDNESDAY, APRIL 27, 2022

TO THE HONORABLE FIFTH COURT OF APPEALS:

Relators Daniel K. Podolsky, M.D. and John Warner, M.D. seek temporary relief from the trial court's April 14, 2022 order to proceed with Rule 202 pre-suit depositions before the trial court confirmed that it had subject matter jurisdiction to order the depositions. Further, these depositions are proceeding despite the burden of the depositions outweighing their benefit. Relators seek temporary relief from the

ordered depositions. The trial court ordered the depositions to occur within 14 days of April 14, or no later than April 28, 2022. In compliance with the trial court's order to meet and confer, Relators proposed the depositions occur at 12 pm, April 27, 2022 and 11:30 am, April 28, 2022. Yet, to date, the depositions have not been noticed. Relators fear that this mandamus proceeding and this motion will prompt the issuance of deposition notices. Regardless, Relators need emergency temporary relief from the trial court's order.

Ximena Lopez, M.D. filed the underlying Rule 202 petition and requested depositions purportedly seeking discovery about who decided to change certain services offered to new pediatric patients with gender dysphoria provided by faculty at the University of Texas Southwestern Medical Center at Children's Medical Center clinics. She alleged that this pre-suit discovery would help her to determine if she should pursue claims against Relators, UT Southwestern, or other government officials for changing the services offered at Children's Medical Center clinics. MR.14 and 322. Dr. Lopez served her Rule 202 petition on UT Southwestern, Children's Medical Center, and Relators, all potentially adverse parties. MR.14-15. Relators responded with a plea to the

jurisdiction and objections to Dr. Lopez's proposed discovery. MR. 214-230.

The trial court heard the Rule 202 petition, took the matter under advisement, and welcomed additional briefing. *See* MR.335. In addition to submitting additional briefing, Relators submitted affidavits identifying themselves as the sole decision makers at UT Southwestern for changing the services offered to pediatric patients for treatment of gender dysphoria, as explained in the Joint Statement made by UT Southwestern and Children's Health. MR.301-304.

Despite this evidence and other available information in the public record, the trial court granted the Rule 202 petition and ordered the depositions of Relators to occur remotely with 14 days of the order, or by April 28, 2022. MR.322-324. The trial court specified that it did not "explicitly or implicitly" rule on the jurisdictional pleas. MR.323. Thus, the trial court did not confirm that it had jurisdiction before ordering the depositions to proceed.

Relators have obligations to UT Southwestern that require time and attention, and by proceeding with the depositions in this case, Dr. Lopez has shifted the burden of discovery not only to Relators but also to

the public. Dr. Podolsky is the President of UT Southwestern Medical Center. MR.301. Dr. Warner is the Executive Vice President for Health System Affairs at UT Southwestern Medical Center and has recently become the Chief Executive Officer of the UT Southwestern Health System. MR.303. It is undisputed that Relators are governmental actors who run a large medical institution; taking them away from running this governmental institution harms them and the public.

Further, Relators should not be required to take time away from running a governmental institution because they have been ordered to sit for pre-suit depositions without a determination of whether the ordering trial court has jurisdiction to do so. As governmental actors, Relators are immune to the underlying claims being investigated without a waiver of immunity. The trial court never decided the immunity question and thus never confirmed it had subject-matter jurisdiction. Relators will have no adequate remedy by appeal and will lose the benefits of immunity if the depositions proceed. A trial court has no discretion to order a Rule 202 deposition before determining if it has jurisdiction. *In re City of Dallas*, 501 S.W.3d 71, 74 (Tex. 2016). After a party challenges jurisdiction, the court must determine whether the

alleged facts demonstrate subject-matter jurisdiction, looking to the facts alleged, construed in favor of the pleader, as well as any evidence from the parties. *Texas Dep't of Parks & Wildlife v. Miranda*, 133 S.W.3d 217, 226-227 (Tex. 2004). In this case, the trial court declined to determine its jurisdiction over the underlying claims at issue. Relators need a stay of the depositions or they will forever lose their right to a determination of their immunity before the depositions. And if Relators retain immunity, then they cannot be compelled to be deposed under Rule 202.

Despite Relators raising sovereign immunity in their plea to the jurisdiction, the trial court neither "explicitly [n]or implicitly" ruled on whether there was jurisdiction to order pre-suit depositions on Dr. Lopez's claims. MR.323. While Dr. Lopez attempted to circumvent this immunity by alleging *ultra vires* acts by State officials, Relators' jurisdictional plea raised the immunity question, thereby raising a potential problem with subject-matter jurisdiction. *Miranda*, 133 S.W.3d at 225-227. Because a determination as to whether the trial court has jurisdiction has yet to be made, Relators request a stay of these depositions.

In the mandamus petition filed contemporaneously with this pleading, Relators address the trial court's rulings from April 14, 2022. The Court's order imposes a burden and expense on Relators that cannot be undone without temporary relief. Depositions will occur by April 28, 2022, and Relators will have lost their immunity-based right to be free from Rule 202 depositions. And the benefit of the Rule 202 depositions did not outweigh the burden imposed because Dr. Lopez now knows who to sue and what to sue for. Without a stay, they will lose their right to appellate review of the trial court's benefit-burden analysis.

Texas courts frequently stay Rule 202 depositions while analyzing interlocutory appeals and mandamuses over the propriety of the trial court's order compelling a Rule 202 deposition. *E.g.*, *In re Johnston*, No. 06-10-00095-CV, 2010 WL 3930603, 2010 Tex. App. Lexis 8165 *1 and *13 (Tex. App.—Texarkana 2010) (factually reciting a stay being entered and then lifting stay when mandamus relief was denied); *In re Bed Bath Beyond, Inc.*, No. 02-07-00316-CV, 2007 WL 4292304, 2007 Tex. App. Lexis 9605 *2-*3 (Tex. App.—Fort Worth 2007) (noting the appellate stay pending resolution of the mandamus); *In re Campos*, No. 02-07-00197-CV, 2007 WL 2013057, 2007 Tex. App. Lexis 5485 *4 (Tex. App.—Fort

Worth 2007) (discussing the grant of an emergency stay during the pendency of the mandamus proceeding); *In re Hewlett Packard*, 212 S.W.3d 356, 360 (Tex. App.—Austin 2006) (reciting the grant of an emergency stay of the depositions pending resolution of the mandamus).

"An appellate court may grant 'any just relief pending the court's action on' a mandamus petition, including a stay of all underlying proceedings in the trial court." *In re Bates*, 429 S.W.3d 47, 53 (Tex. App.—Houston [1st Dist.] 2014, orig. proceeding) (quoting TEX. R. APP. P. 52.10(a)-(b)). Thus, this Court is authorized to stay the depositions in this matter. Relators do not ask for a stay of all proceedings, but they do ask that this Court stay their depositions so that it can resolve whether the trial court should have ruled that Relators are immune from the underlying claims. If the Relators are immune, they have no adequate remedy by appeal because they will have been deposed without temporary relief. Further, without a stay, Relators will not have the benefit of the Supreme Court's requirement that courts "strictly limit and carefully supervise pre-suit discovery," which should include appellate review. *In re Wolfe*, 341 S.W.3d 932, 933 (Tex. 2011). And "[t]here are practical and due process problems with demanding discovery from

someone before telling them what the issues are." *In re Jorden*, 249 S.W.3d 416, 423 (Tex. 2008). A stay preserves the status quo, prevents this proceeding from becoming moot, and protects this Court's jurisdiction to consider and decide this matter.

Undersigned counsel acted diligently in preparing this mandamus proceeding. The mandamus petition and this motion were filed at the soonest opportunity these items could be completed.

Relators have notified or made a diligent effort to notify all parties of this mandamus proceeding and this request for emergency temporary relief by expedited means that this motion for temporary relief has been or will be filed. See TEX. R. APP. P. 52.10(a). Specifically, Relators emailed and spoke with counsel for Dr. Lopez about this request for emergency temporary relief and, despite good faith efforts to resolve the issue presented in this request for temporary relief, Dr. Lopez is opposed to the requested temporary relief.

As discussed in the opening paragraph of this motion, the trial court ordered the depositions to occur by April 28, 2022. Within the timeframe provided in the trial court's order, Relators offered deposition dates, noon on April 27, 2022 and 11:30 am on April 28, 2022. But so far, Dr. Lopez

has not noticed those depositions. Relators will update the Court with additional about the depositions as it becomes available.

Relators Daniel K. Podolsky, M.D. and John J. Warner, M.D., therefore, pray that this Court grant this motion for emergency temporary relief and issue an order staying Relators' depositions. Relators pray for such other relief to which they may be entitled.

Respectfully submitted,

/s/ David M. Walsh IV

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Daniel K. Podolsky, M.D. and
John J. Warner, M.D.

Certificate of Conference

I certify that, on April 20, 2022, I conferred with Brent Walker, one of the lawyers for Ximena Lopez, M.D., by email and telephone where we discussed the issues raised by the mandamus petition as well as this motion for temporary relief. Despite our best efforts, we were not able to reach resolution of this request for temporary relief. I have also conferred with counsel for the other interested parties, Children's Medical Center Dallas and UT Southwestern, and they were not opposed to the requested temporary relief.

/s/ David M. Walsh IV

_____

David M. Walsh IV

Certificate of Service

I certify that on April 25, 2022, I served a complete copy of this Emergency Motion for Temporary Relief on all counsel of record through the e-filing system.

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Associated Case Party: Children's Medical Center Dallas

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Order entered April 25, 2022

In The
Court of Appeals
Fifth District of Texas at Dallas

No. 05-22-00375-CV

IN RE DANIEL K. PODOLSKY, M.D. AND JOHN J WARNER, M.D., Relators

Original Proceeding from the County Court at Law No. 2
Dallas County, Texas
Trial Court Cause No. CC-22-01316-B

ORDER
Before Justices Myers, Nowell, and Goldstein

Before the Court is relator's April 22, 2022 petition for writ of mandamus and emergency motion for temporary relief. We **GRANT** relators' motion, and we **STAY** the trial court's April 14, 2022 order to proceed with Rule 202 pre-suit depositions. The stay shall remain in effect pending resolution of this original proceeding.

We request that real party in interest and respondent file a response, if any, to the petition for writ of mandamus by **May 16, 2022**.

/s/ BONNIE LEE GOLDSTEIN
JUSTICE

FILED
5/11/2022 9:25 AM
JOHN F. WARREN
COUNTY CLERK
DALLAS COUNTY

CAUSE NO. CC-22-02427-B

Notice of Related Case under DALLAS COUNTY LOCAL RULE 1.08

This Matter is so related to **Cause No. CC-22-01316-B**, *In re Ximena Lopez, M.D.*, pending in Dallas County Court at Law No. 2, that the assignment or transfer of this matter to County Court at Law No. 2 would facilitate orderly and efficient disposition of this litigation under DALLAS COUNTY LOCAL RULE 1.06.

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.*	IN THE COUNTY COURT AT LAW NO. ____ DALLAS COUNTY, TEXAS

VERIFIED APPLICATION FOR TEMPORARY RESTRAINING ORDER, TEMPORARY INJUNCTION, AND PLAINTIFF'S ORIGINAL PETITION FOR PERMANENT INJUNCTIVE AND DECLARATORY RELIEF

For the last 2500 years, dating back to the time of Hippocrates, it has been a core tenet of medicine that physicians should take an oath upon being licensed reflecting their commitment to practicing medicine ethically above all else. Although commonly thought of in the now-outdated terms of *Primum non nocere*—"first, do no harm"—medical ethics are now viewed as an affirmative obligation of acting in a patient's best interest. Indeed, this tradition survives today and is more formalized, such as in the American Medical Association's Rule 1.1.1 of its Code of Medical Ethics:

> The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to **alleviate suffering**. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

Or in the words of the famous medical bioethicist Dr. Edmund Pellegrino: "In the real world of clinical medicine, there are no absolute moral principles except the injunction to **act in the patient's best interest**."

Dr. Ximena Lopez is a licensed, practicing physician with full privileges to practice pediatric endocrinology at Children's Medical Center at Dallas ("CMC"). She wants to practice ethically and in her patient's best interest to alleviate suffering by utilizing her independent medical judgment. But CMC is preventing that through illegal means and for prohibited and shameful political reasons.

This lawsuit seeks to stop the illegal infringement on Dr. Lopez's medical judgment and scope of her privileges by seeking injunctive and declaratory relief against CMC and anyone acting in concert or participation with it.

But this lawsuit is about much more than Dr. Lopez's clinical independence. This lawsuit is about re-centering the practice of medical care on what should be its sole focus: the patient's best interest and alleviating suffering. For inexplicable and shameful reasons, CMC has sought to interfere with Dr. Lopez's clinical judgment because of political considerations and in direct opposition to the best interest of patients. In so doing, CMC has engaged in unlawful discrimination against patients in need of medical care purely because of a gender identity.

It is Dr. Lopez's moral obligation to "advocate for her patient's welfare." CMC should have that same moral obligation, but CMC has discarded its commitment to patients and chosen to act unlawfully. To remedy that disgraceful failure by CMC and to advocate for her patients' welfare, Dr. Lopez brings this suit.

I.
Factual Background Supporting Plaintiff's Request for Injunctive Relief and Petition

A. Dr. Lopez, the Highly Credentialed Physician.

Dr. Lopez is a highly respected, trained, and decorated pediatric endocrinologist who teaches medical students and treats patients at Defendant CMC Medical Center in Dallas, Texas.

Born in El Paso, Texas, Dr. Lopez attended medical school at Universidad La Salle Medical School in Mexico City. Knowing that she wanted to help provide medical care for children, Dr. Lopez chose to do her residency in pediatrics at the University of Illinois at Chicago. Following her residency, Dr. Lopez pursued her Fellowship training in Pediatric Endocrinology at Harvard Medical School and Massachusetts General Hospital in Boston, Massachusetts. She then spent three years as a Clinical Research Fellow in Endocrinology at the Joslin Diabetes Center at Harvard Medical School.

In 2010, Dr. Lopez was hired by UTSW as an Assistant Professor in Pediatrics to teach medical students and as a Pediatric Endocrinology attending physician to care for patients at UTSW

and CMC. Dr. Lopez went through the credentialing process at CMC and was granted full privileges to provide pediatric endocrinology services. In 2018, Dr. Lopez became an Associate Professor of Pediatrics at UTSW and continued to provide clinical care to patients at CMC consistent with her clinical privileges granted to her at CMC.

In 2022, the Pediatric Endocrine Society also recognized Dr. Lopez's excellence in the field by selecting her as the recipient of the Pediatric Endocrine Society Clinician Award. This award is only given when a physician, like Dr. Lopez, is widely acknowledged by his or her peers as possessing exemplary clinical acumen, knowledge, and expertise. Throughout her career, Dr. Lopez has been engaged in academic endeavors, including obtaining research grants from the National Institutes of Health, serving as a principal investigator in clinical trials, providing lectures nationally and internationally, and publishing numerous peer reviewed articles, book chapters, and abstracts.

This is Dr. Lopez on paper; her *curriculum vitae*. But what defines Dr. Lopez–what makes her so important to her patients and this community–is what she does with that medical training and knowledge and how she exercises that qualified independent medical judgment. With compassion and care, Dr. Lopez has become a respected leader in an important medical field and, for her patients, a life-saving hero.

B. Dr. Lopez, the Life-Saving Hero.

In 2006, during her fellowship training in Boston, Dr. Lopez was exposed to a group of marginalized and discriminated-against patients who needed medical care: transgender patients and their families. Dr. Lopez was introduced to Dr. Norman Spack, a pediatric endocrinologist at Boston Children's Hospital, where he co-founded the hospital's Gender Management Service (GeMS) clinic in February 2007. GeMS was the first major program in the U.S. to focus on gender-diverse and transgender adolescents. Dr. Lopez learned of the difficulties for Dr. Spack and GeMS's patients, and how through the multi-disciplinary approach used at GeMS, patients' lives were transformed for the better. A 2017 feature in *D Magazine* about Dr. Lopez and her life-changing work shared how Dr. Lopez carried that experience with her and ultimately helped create the Gender Education and Care, Interdisciplinary Support ("GENECIS") program at CMC as the first program in the Southwest to provide gender-affirming care to gender-diverse and transgender adolescents:

Health & Medicine

Faces of Change

At Children's Health, home to the Southwest's only pediatric transgender treatment clinic, kids find their true selves.

By Peter Simek | October 1, 2017 | 9:00 am

View Gallery

Dr. Ximena Lopez began her career researching Type 2 diabetes, but a fellowship assisting at the country's first pediatric transgender treatment clinic, in Boston, changed everything. Six years later, she founded the GENECIS program at Children's Health in Dallas.

Jill Broussard and Elizabeth Lavin

"Dr. Ximena Lopez didn't expect her life to be transformed by a fellowship at Massachusetts General Hospital. This was in 2007. The pediatric endocrinologist had begun her career researching Type 2 diabetes, but she found herself in Boston assisting at the country's first pediatric transgender treatment clinic. The stigma around the treatment of transgender children was still strong, despite the pressing need and life-or-death stakes. A recent study found that 30 percent of transgender youth report at least one suicide attempt, and 42 percent report a history of self-injury, such as cutting. One kid in Boston still stands out for Lopez.

'The patient's mother found that no one was willing to treat this child,' she says. 'For me, that was a revealing experience. I knew nothing about it. And this patient told us his story. He was a perfectly normal kid, and he got all the medical support to be himself.'

After she moved to Children's in Dallas and joined the faculty of UT Southwestern Medical Center, in 2012, she founded the GENECIS program, the first treatment clinic in the Southwest for children with gender dysphoria."[1]

[1] Peter Simek, "Faces of Change", D MAGAZINE (October 1, 2017) (available online at: https://www.dmagazine.com/publications/d-magazine/2017/october/pediatric-transgender-treatment-clinic-genecis-childrens-health/)

The *D Magazine* article discusses the families and lives that Dr. Lopez has transformed with her compassionate care and how these families often tell Dr. Lopez:

> "***You are my hero.***
>
> ***You are saving my kid's life.***
>
> ***We don't know what we would do without you.***"[2]

The importance of this work in saving children's lives is no overstatement.

As recently as September 21, 2021–less than 6 months ago–Defendant CMC publicly defended the life and death importance of the care provided by Dr. Lopez and others at CMC's GENECIS program. In the last few years, some fringe political protestors have tried to stop the provision of gender affirming services, apparently under the baseless and offensive delusion that if gender affirming services are not provided, children will not experience any gender identity issues. CMC pushed back against protestors that targeted CMC and publicly noted how the care provided by Dr. Lopez and others at the GENECIS program helps combat the high suicide rate among children with gender dsyphoria:

> "With a suicide attempt rate of up to 41% for children and adolescents with gender dysphoria, there is a need for comprehensive care for these youth," Dallas Children's Medical Center told *Dallas Express* in an email interview. "Given the significant suffering and extraordinarily high suicide rate in these children, offering a comprehensive, multidisciplinary approach is needed to help treat this medical problem."[3]

The care provided by Dr. Lopez and the GENECIS program has a life-saving impact by utilizing gender-affirming care that is the "gold standard" of care for patients with gender dysphoria.

C. The GENECIS Model and Understanding the Gender-Affirming Care.

The GENECIS program at CMC was the first of its kind in the Southwest. Nowhere else in Texas or in surrounding states could patients get the treatment they received at the GENECIS program. Patients from all over the Southwest came to the GENECIS program at CMC.

Dr. Lopez and the GENECIS program follow a gender-affirming care model that is the recommended standard of care of the World Professional Association of Transgender Health ("WPATH"), as well as The Endocrine Society, the world's oldest and largest organization of

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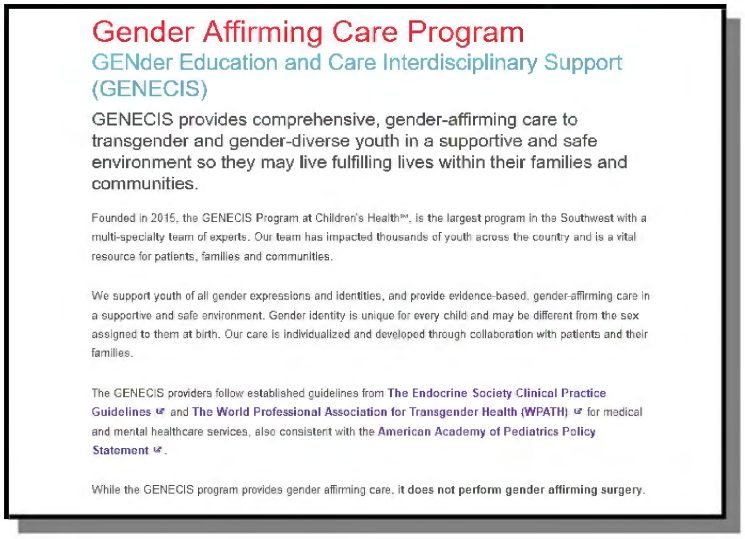
[2] *Id.*

[3] Edgar James, "Dallas Children's Medical Center Responds to Allegations of Wrongdoing", THE DALLAS EXPRESS (available online https://dallasexpress.com/dallas-childrens-medical-center-responds-to-allegations-of-wrongdoing/)

scientists devoted to hormone research. WPATH publishes specific standards of care establishing the procedures for gender-affirming care,[4] and The Endocrine Society publishes similar Clinical Practice Guidelines.[5] Together, these are recognized globally as "best practices" in the treatment of gender dsyphoric/gender-incongruent persons. These best practices are universally medically-accepted and are appropriately relied upon by Dr. Lopez in exercising her independent medical judgment on how to treat her patients. CMC's website as of last year advertised to the world that this treatment was important, necessary, and followed the standards of WPATH and The Endocrine Society:



Gender Affirming Care Program

GENder Education and Care Interdisciplinary Support (GENECIS)

GENECIS provides comprehensive, gender-affirming care to transgender and gender-diverse youth in a supportive and safe environment so they may live fulfilling lives within their families and communities.

Founded in 2015, the GENECIS Program at Children's Health™, is the largest program in the Southwest with a multi-specialty team of experts. Our team has impacted thousands of youth across the country and is a vital resource for patients, families and communities.

We support youth of all gender expressions and identities, and provide evidence-based, gender-affirming care in a supportive and safe environment. Gender identity is unique for every child and may be different from the sex assigned to them at birth. Our care is individualized and developed through collaboration with patients and their families.

The GENECIS providers follow established guidelines from The Endocrine Society Clinical Practice Guidelines and The World Professional Association for Transgender Health (WPATH) for medical and mental healthcare services, also consistent with the American Academy of Pediatrics Policy Statement.

While the GENECIS program provides gender affirming care, it does not perform gender affirming surgery.

It is important to understand what gender-affirming care is and what it is not.

The gender-affirming model of care affirms diversity in gender identity and assists individuals in defining, exploring, and actualizing their gender identity, allowing for exploration without judgments or assumptions. This does not mean that all youth need to undergo medical intervention; indeed, this is often not the case. Gender-affirming care is highly individualized and focuses on the needs of each individual by including psychoeducation about gender and sexuality (appropriate to

[4] *See* Exhibit F, THE WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People" 7th Version, (available online at: https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf).

[5] *See* Exhibit G, Hembree, Wylie C, et al., " Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," J. CLIN. ENDOCRINOL METAB., November 2017, 102(11):3869–3903.

age and developmental level), parental and family support, social interventions, and gender-affirming medical interventions.

Social interventions, which are considered reversible (meaning that if gender identity shifts in the future, these decisions can be adapted), are often attempted in a step-wise manner. For example, children may first begin to use a new name or pronouns in the home, and if this feels positive and eases distress, they may start to do so in other environments, such as school. Social transition may also involve the use of different clothing or engagement in new activities, such as transferring to a new camp or sports league, that are more congruent with the child's gender identity. Social interventions have been found to lower the rates of depression and anxiety in gender-incongruent children.

Pubertal suppression, also considered fully reversible, allows for a "pause" on puberty and for further development of gender identity. This pubertal suppression, as practiced at the GENECIS program and by Dr. Lopez, utilizes gonadotropin-releasing hormone ("GnRH") agonists that block sex hormones, like testosterone and estrogen. ***Importantly***, GnRH puberty suppression is a medical treatment that has been used safely since the 1970s to deal with a variety of medical issues, such as "precocious" puberty—that is, early onset puberty. In precocious puberty, it is important to pause puberty because it can adversely impact the physical growth of the child, the child's self-esteem, and cause conditions such as depression because of the social impact. GnRH puberty suppression is well known to be safe and reversible. There is no creation of risk by utilizing it in gender-affirming care, and, as such, it is part of WPATH and The Endocrine Society's standards of care. In gender-affirming care, delaying puberty to promote physical development that is consistent with a child's gender identity is associated with better mental health outcomes, improved functioning, and life satisfaction.

Once adolescence is reached, hormone therapy can be considered. Hormone therapy involves administering estrogen or testosterone to match a patient's hormone levels to their gender identity. Similar to pubertal suppression, hormone therapy can make gender dysphoria less severe, reduce psychological and emotional distress, improve psychological and social functioning, and improve quality of life. For example, if testosterone hormone therapy is started before the changes of female puberty begin, female secondary sex characteristics, such as the development of breasts, can be avoided. Also like pubertal suppression, hormone therapy is considered safe and effective. Hormone therapy, as practiced by Dr. Lopez and the GENECIS program, is typically begun at the age of 16,

and whether and when to start such treatment involves a thorough process of discussion and consultation between the patient, the patient's family, and the patient's care provider, such as Dr. Lopez.

The use of pubertal suppression and hormone therapy both involve medical treatments that fall within the specialty of pediatric endocrinology and **will be referred to in this Petition as "Gender-Affirming Endocrinology Care."**

Importantly, as practiced by Dr. Lopez and the GENECIS program, what "gender-affirming" care of children is ***NOT*** is surgical "sex change". As Dr. Lopez and the GENECIS program only see children and adolescents, surgery is not indicated as part of the standard of care. If someone does wish to surgically transition later in life, that is handled elsewhere. Dr. Lopez and the GENECIS program instead help children go through the difficulty of youth and puberty in the most affirming and compassionate way by using safe, reversible methods that give children the space to resolve their identity in their time.

D. Dr. Lopez has Clinical Privileges at CMC to provide Pediatric Endocrinology Services which includes Gender-Affirming Endocrinology Care.

From the time that Dr. Lopez began working at CMC, she has enjoyed full privileges to practice "pediatric endocrinology" which includes the privileges to diagnose and treat "illnesses, injuries or disorders of the endocrine system." Those privileges were granted to her after she applied for privileges with the medical staff at CMC. The medical staff recommended that she be granted privileges, and the Medical Executive Committee granted those privileges which were approved by the CMC Board. ***At no point in time has the medical staff or MEC at CMC ever formally removed or limited Dr. Lopez's privileges or taken any formal action against the scope of Dr. Lopez's clinical privileges.*** As such, Dr. Lopez retains full privileges to provide pediatric endocrinology care at CMC today.

Those privileges raise the question of what is included under the umbrella of "pediatric endocrinology" and the treatment of "illnesses, injuries or disorders of the endocrine system." One place to look would be the "Bible" for endocrinologists: Williams Textbook of Endocrinology, 14th Edition. The "Bible" contains different chapters that are an "authoritative discussion of the management of clinical endocrinopathies." That is, authoritative information about disorders of the endocrine system–what Dr. Lopez has privileges to treat. Chapter 21 of *Williams* is dedicated to disorders of endocrine system that relate to transgender endocrinology treatments. In that Chapter,

the treatment for pediatric and adult transgender individuals focuses almost exclusively on "Gender-Affirming Endocrinology Care": puberty suppression and hormone therapy. Thus, according to the "Bible", Gender-Affirming Endocrinology Care is the recognized treatment for the disorders of the endocrine system experienced by transgender individuals. Under *Williams*, clearly Gender-Affirming Endocrinology Care would fall under Dr. Lopez's privileges.

One could also consult The Endocrine Society, the world's oldest and largest organization of endocrinologists devoted to hormone research. As noted above, The Endocrine Society promulgates standards of care in providing endocrinology treatment to transgender patients that compromises Gender-Affirming Endocrinology Care.

Or, perhaps most specifically in this case, one could consult CMC itself. Utilizing the Internet Archive's Wayback Machine, one can see what CMC represented to the public was included in their Pediatric Endocrinology department.[6] On CMC's page dedicated to its Pediatric Endocrinology program, CMC represents to the public what pediatric endocrinology services are provided.

Under "Conditions We Treat" within pediatric endocrinology, CMC identifies the pediatric endocrinology "condition" of "Pediatric and Adolescent Gender Dsyphoria." When the link is clicked through to learn more about the "condition" of "Pediatric and Adolescent Gender Dsyphoria" it describes the treatment for that "condition" as Gender-Affirming Endocrinology Care and notes that the established guidelines used for treatment of this "condition" are The Endocrine Society and WPATH guidelines described above.[7]

Under the "Programs" of pediatric endocrinology, CMC lists "Gender Affirming Care," which when clicked through discusses Gender-Affirming Endocrinology Care and the GENECIS prorgam.

Under the "Treatments and Services" provided by pediatric endocrinologists at CMC, it lists only 8, including "Feminizing Hormone Therapy", "Masculinizing Hormone Therapy", and

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[6] Exhibit A, "Pediatric Endocrinology", available through the Internet Archive's Wayback Machine at: https://web.archive.org/web/20200819072651/https://www.childrens.com/specialties-services/specialty-centers-and-programs/endocrinology

[7] Exhibit B, "Pediatric and Adolescent Gender Dsyphoria", available via the Internet Archive's Wayback Machine at:

"Puberty Suppression Therapy"—the very therapies defined as Gender-Affirming Endocrinology Care in this pleading.

Thus, it is inarguable that Dr. Lopez's privileges to practice "pediatric endocrinology" at CMC and to treat "illnesses, injuries or disorders of the endocrine system" would include Gender-Affirming Endocrinology Care. And those privileges have never been formally restricted or taken from her.

E. CMC Previously Publicly Doubled Down on Its Commitment to Transgender Children and Adolescents.

In 2016, CMC initiated a "diversity initiative" that culminated in 2019 with the publication of a report entitled, "Looking Inward. Taking Action. Diversity and Inclusion at Children's Health."[8] In that report, the CEO of CMC wrote of CMC's commitment to diversity and inclusion, including the concept of "health equity" which it defines as a "fair and just opportunity for all patients to reach their highest level of health." In that report, CMC publicly proclaims its "strong commitment" that no one "should face discrimination or receive inequitable care because of their sexual orientation or gender identity."

[8] *See* Exhibit C, Looking Inward. Taking Action. Diversity and Inclusion at Children's Health.

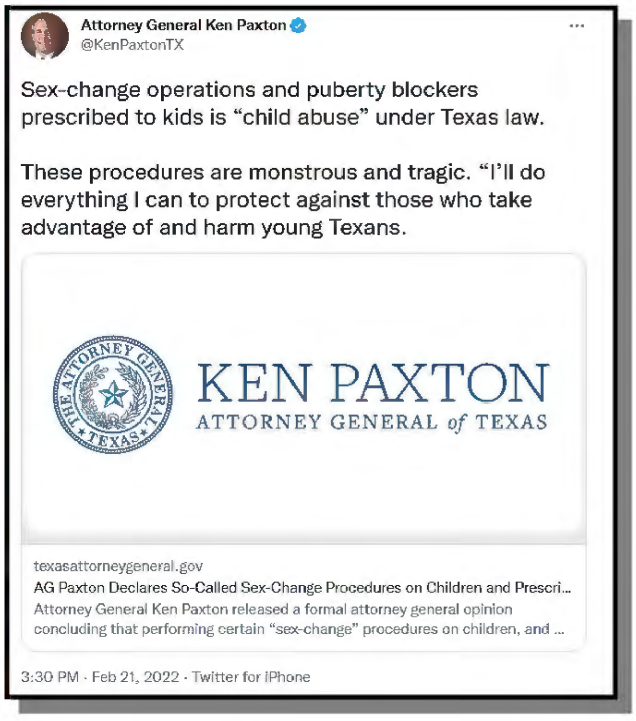
This claim is consistent with CMC's claim in its published "Patient's Rights" that patients should receive care "without regard to race, color, national origin, sex, religion, gender identity, sexual orientation, disability, or cultural, economic or educational background."

Simply stated, Dr. Lopez and the GENECIS program were a well-regarded academic and clinical feather in the cap of CMC, and CMC publicly promoted its commitment to gender-affirming care. Then something changed, and the issue of providing care to children struggling with gender dysphoria and gender identity issues became a political hot-button issue.

E. Gender-Affirming Endocrinology Care Becomes a Political Wedge Issue.

Since 2017, certain members of the Texas Legislature have targeted transgender Texans. The 2017 legislative session caused immense strife over what was called "the Bathroom Bill", which ultimately failed. In 2021, the Texas Legislature considered a bill which would explicitly classify some gender-affirming care as child abuse. That bill failed as well.

Infirmed by the conceit of flaccid convictions, Governor Greg Abbott and Attorney General Ken Paxton publicly vowed to not give up. On February 21, 2022, Attorney General Ken Paxton released Opinion No. KP-0401 which addressed "Whether certain medical procedures performed on children constituted child abuse." Included in that letter was Attorney General Paxton's conclusion that puberty suppression medication *could* constitute child abuse. That same day Attorney General Paxton tweeted:



The following day, on February 22, 2022, Governor Abbott sent a letter to the Commissioner of the Texas Department of Family and Protective Services ("DFPS") demanding that DFPS investigate the parents of children receiving puberty-blocking drugs and insisting that medical providers need to report such parents who seek such medication to DFPS for child abuse.

It is clear from Governor Abbott that this issue is a political one, not a medical one. His top political strategist Dave Carney told reporters "Running on the controversial transgender rule is a '75% to 80% winner' for Abbott."[9] As a result of these political machinations, patients needing the care provided by Dr. Lopez and the GENECIS program have unfortunately become victims of the partisan political demagoguery practiced by Governor Abbott and Attorney General Paxton.

While Governor Abbott and Attorney General Paxton were pursuing such tactics publicly, behind closed doors Governor Abbott was trying to exert influence privately to shut down transgender care at CMC's GENECIS program. In a recently published *New York Times* article, Dr. John Warner of UT Southwestern is quoted as saying on a recorded phone call, "We received a reach [sic] from the Governor also requesting information about the clinic... And with that came an expectation that something different would occur." This representation is consistent with what Dr. Lopez was directly told: either the Governor or the Governor's office has exerted political pressure to close the GENECIS program and to stop clinicians from providing Gender-Affirming Endocrinology Care at CMC.

F. CMC Unlawfully Bans Gender-Affirming Endocrinology Care for New Patients.

Without making any formal statement and without–based on information and belief–undertaking any formal corporate action, CMC decided that physicians like Dr. Lopez cannot provide Gender-Affirming Endocrinology Care. Dr. Lopez was informed, informally, that Gender-Affirming Endocrinology Care could continue to be provided to existing patients, but it could not be provided to any new transgender patients who seek the care from Dr. Lopez.

Recently, on March 28, 2022, CMC issued a joint statement with UT Southwestern in which CMC publicly claimed that CMC took action by "suspend[ing] initiating this treatment for new patients."[10] This was the first public acknowledgment that CMC made such an action. The

[9] Alison Durkee, "Texas Gov. Abbott's Campaign Calls Transgender 'Child Abuse' Rule A Political 'Winner'", Forbes, March 2, 2022.

[10] *See* Exhibit E, Joint Statement of CMC and UT Southwestern, March 28, 2022.

statement does not make clear what office within CMC "suspended" treatment or even what "suspending" such treatment means. Regardless, Dr. Lopez has been informed she cannot provide such treatment because of CMC's dictate.

This dictate by CMC seeking to prohibit Dr. Lopez from providing Gender-Affirming Endocrinology Care **is referred to in this Petition hereafter as the "Unlawful Prohibition."**

Plaintiff calls this dictate an "Unlawful Prohibition" because the dictate does in fact violate multiple laws:

1. The Unlawful Prohibition limits the independent medical judgment of Dr. Lopez as she is not allowed to decide what care her patients or prospective patients need. Under Texas law, corporations such as CMC are prohibited from practicing medicine and are, therefore, likewise prohibited from controlling the medical decision-making of a physician. This is called the prohibition against the corporate practice of medicine. CMC, by attempting to control Dr. Lopez's medical decision-making without regard to the needs of a patient, is engaged in the unlawful corporate practice of medicine.

2. As Dr. Lopez has privileges granted by the medical staff and MEC at CMC, Dr. Lopez's privileges cannot be restricted or taken from her without following the By-laws of CMC and without giving Dr. Lopez due process rights. No formal action has been taken against Dr. Lopez's privileges to provide pediatric endocrinology services. On the contrary, she is entitled to provide those services to existing patients. So there cannot be any limitation on her privileges in that regard. Furthermore, she can provide puberty suppression treatment to patients for reasons other than the gender identity of a patient, so it cannot be that her privileges to provide such treatment has been limited. In the absence of formal action, CMC otherwise cannot restrain her exercise of her clinical privileges.

3. By depriving patients of access to medical care because of their gender identity, CMC is engaged in unlawful discrimination of patients. Discrimination because of gender identity is discrimination because of sex, and discrimination because of sex is illegal under the law.[11] Therefore CMC is violating anti-discrimination laws by implementing the Unlawful Prohibition. Perniciously, CMC is requiring physicians like Dr. Lopez to violate anti-discrimination laws (and their own medical ethics[12]) by trying to force them to discriminate as well.

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[11] *See, e.g., Bostock v. Clayton Cty., Georgia*, 140 S. Ct. 1731 (2020); *Tarrant County Coll. Dist. v. Sims*, 621 S.W.3d 323 (Tex. App.—Dallas 2021, no pet.).

[12] *See* Exhibit D, CMC's Code of Ethical Conduct.

There can be no doubt but that CMC has undertaken a course of conduct that is illegal, and as such, the Court must restrain the Unlawful Prohibition and declare it illegal and unenforceable.

It is for these reasons that Plaintiff brings this suit seeking declaratory and injunctive relief.

II.
ORIGINAL PETITION

A. Discovery Control Plan.

1. Plaintiff intends that discovery be conducted under Level III of TEXAS RULE OF CIVIL PROCEDURE 190.3.

B. Parties.

2. At all relevant times, Plaintiff has been a resident of Texas.

3. Defendant Children's Medical Center of Dallas ("CMC") is Texas nonprofit corporation with a registered principal office in Dallas County located at 1935 Medical District Drive, Dallas, Texas, 75235. CMC can be served with process through its registered agent as follows:

CT Corporation System
1999 Bryan St., Ste. 900
Dallas, TX 75201-3136

C. Jurisdiction and Venue.

4. Venue is proper in Dallas County under TEXAS CIVIL PRACTICES & REMEDIES CODE § 15.002(a)(1) because Dallas County is the county in which all or a substantial portion of the claims arose.

5. This Court has jurisdiction because the amount in controversy exceeds the minimum jurisdictional amounts of the Court.

D. Causes of Action.

6. Plaintiff incorporates the foregoing paragraphs in support of these Counts.

i. Count One: Declaratory Judgment Regarding Illegal Control over Dr. Lopez's Independent Clinical Judgment

7. Under the Declaratory Judgment Act, Dr. Lopez seeks a declaration that CMC's action in prohibiting Dr. Lopez from exercising her unconstrained clinical privileges granted to her by the Medical Staff at CMC and the Medical Executive Committee at CMC is an unlawful restriction on her independent medical judgment and an illegal restraint of trade.

8. Dr. Lopez also seeks a declaration that CMC's dictate in the Unlawful Prohibition is unlawful under the laws banning the corporate practice of medicine.

9. Pursuant to TEXAS CIVIL PRACTICE AND REMEDIES CODE § 37.009, Dr. Lopez requests that the Court award Dr. Lopez her costs and attorneys' fees upon prevailing on this count.

ii. Count Two: Declaratory Judgment on Discrimination

10. Under the Declaratory Judgment Act, Dr. Lopez seeks a declaration that CMC's Unlawful Prohibition is discrimination based on gender identity and because of sex and violates anti-discrimination law.

11. Dr. Lopez further seeks a declaration that CMC's order requiring Dr. Lopez to withhold treatment—that she is otherwise authorized to provide pursuant to th exercise of her independent medical judgment—from certain patients because of their gender identity is an order by CMC that requires Dr. Lopez to engage in unlawful discrimination.

12. Pursuant to TEXAS CIVIL PRACTICE AND REMEDIES CODE § 37.009, Dr. Lopez requests that the Court award Dr. Lopez her costs and attorneys' fees upon prevailing on this count.

iii. Count Three: Request for Permanent Injunction

13. CMC's Unlawful Prohibition constitutes the violation of multiples laws, including laws prohibiting discrimination against individuals because of their gender identity, laws preventing hospitals like CMC from interfering with, controlling, or otherwise directing any physician's professional judgment, and laws preventing hospitals like CMC from limiting a physician's clinical privileges without due process.

14. Dr. Lopez therefore requests that she be granted a permanent injunction that permanently enjoins CMC and anyone in active concert or participation with CMC from doing or attempting to do any of the following:

1. Enforcing CMC's Unlawful Prohibition;

2. Discriminating against patients seeking Gender-Affirming Endocrinology Care by denying Gender-Affirming Endocrinology Care for new patients at CMC;

3. Interfering with, controlling, or otherwise directing any physician's professional judgment with respect to the provision of Gender-Affirming Endocrinology Care at CMC; and

4. Imposing any limitation on Dr. Lopez's exercise of her clinical privileges to provide pediatric endocrinology care, including, but not limited, to prohibiting her from

providing Gender-Affirming Endocrinology Care, in the absence of any formal due process under CMC's by-laws by the appropriate parties to restrict Dr. Lopez's clinical privileges.

III.
Application for Temporary Restraining Order and Temporary Injunction

A. The Court should order injunctive relief to preserve the status quo until the Declaratory Judgment Action is decided.

15. A court has the discretion to grant injunctive relief to preserve the status quo until such time as the Court can determine the matter on the merits. In the injunction context, the status quo is "the last, actual, peaceable, non-contested status that preceded the pending controversy."[13] The Court should look at the evidence of parties' historical practices and operation before the dispute arose.[14] To recover the status quo, the Court can enter prohibitory or mandatory injunctive relief.[15]

16. As the Dallas Court of Appeals recently noted in affirming injunctive relief against Governor Abbott for his unlawful exercise of authority, "continuation of illegal conduct cannot be justified as preservation of the status quo. When the court determines the law is being violated, the court has a duty to restrain that violation."[16]

17. Here, the "last, actual, peaceable time" before the instant controversy was prior to CMC's purported Unlawful Prohibition of Gender-Affirming Endocrinology Care for new patients. The "historical practices and operation" before this Unlawful Prohibition is demonstrated on CMC's own website that shows Gender-Affirming Endocrinology Care was not just allowed, ***it was publicly***

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[13] *In re Newton*, 146 S.W.3d 648, 651 (Tex.2004).

[14] *Intercontinental Terminals Co., LLC v. Vopak N. Am., Inc.*, 354 S.W.3d 887, 892 (Tex. App.–Houston [1st Dist.] 2011, no pet.); *see also Lifeguard Benefit Servs., Inc. v. Direct Med. Network Solutions, Inc.*, 308 S.W.3d 102, 114 (Tex. App.-Fort Worth 2010, no pet.) (noting that, if one party takes action that alters relationship between parties, status quo is relationship that existed before action); *Pharaoh Oil & Gas, Inc. v. Ranchero Esperanza, Ltd.*, 343 S.W.3d 875, 882 (Tex. App.-El Paso 2011, no pet.) (concluding that status quo was circumstances that existed between parties from 1992 to 2004, when dispute arose).

[15] *RP&R, Inc. v. Territo*, 32 S.W.3d 396, 400 (Tex. App.–Houston [14th Dist.] 2000), no pet.)(noting "but it sometimes happens that the status quo is a condition not of rest, but of action, and the condition of rest is exactly what will inflict the irreparable injury on complainant. In such a case, courts of equity issue mandatory writs before the case is heard on the merits.")

[16] *Abbott v. Jenkins*, No. 05-21-00733-CV, 2021 WL 5445813, at *15 (Tex. App.—Dallas Nov. 22, 2021).

promoted by CMC.[17] Further Dr. Lopez was permitted to utilize her clinical privileges and her independent medical judgment to provide Gender-Affirming Endocrinology Care as she deemed appropriate and consistent with the established standard of care in the field.

18. Furthermore, the clinicians at CMC were not required to engage in unlawful discrimination, and patients seeking such care were not subject to unlawful discrimination prior to CMC's Unlawful Prohibition. The Austin Court of Appeals recently held in a similar case, *Abbott v. Doe*, dealing with the Governor's attempt to require state agencies to investigate families and doctors facilitating Gender-Affirming Endocrinology Care, that the status quo was the situation before the attempt to ban Gender-Affirming Endocrinology Care by fiat:

> The State Parties argue that the order "radically alters" the status quo by prohibiting the Department from carrying out its legal obligations to investigate allegations of child abuse and neglect. In particular, the order obligates the Department to cease an investigation of the Does and to not undertake further investigations that meet certain criteria. Because the validity of and effect of the Governor's letter and the Attorney General's opinion is contested by the parties, the order returns the parties to the status quo before the issuance of both documents."[18]

This same analysis regarding the Governor's unilateral dictate applies to the validity of CMC's Unlawful Prohibition, which altered the status quo.[19]

19. Finally, because the Court must restrain conduct "when the court determines the law is being violated", the Court should restrain the Unlawful Prohibition which is plainly unlawful discrimination because of sex and illegally attempts to interfere with clinicians' independent medical judgment in violation of the law and without due process.

20. Thus, to return the matter to the status quo, the Court should enjoin CMC and anyone in active concert or participation with CMC from doing or attempting to do any of the following:

1. Enforcing CMC's Unlawful Prohibition;

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[17] *See supra* Sections I.B.–I.C., p. 5-11.

[18] *Greg Abbott in his Off. Capacity as Governor of the State of Texas; Jaime Masters in her Off. Capacity of Comm'r of the Dep't of Fam. & Protective Services; & the Texas Dep't of Fam. & Protective Servs. v. Jane Doe, individually & as parent & next friend of Mary Doe, a minor; John Doe, individually & as parent & next friend of Mary Doe, a minor; & Dr. Megan Mooney*, No. 03-22-00107-CV, 2022 WL 710093, at *3 (Tex. App.–Austin Mar. 9, 2022).

[19] As reflected in the related case, it is an open question whether CMC's Unlawful Prohibition was directed by the Governor as part of his political war on transgender children that was restrained in *Doe v. Abbott*.

2. Discriminating against patients seeking Gender-Affirming Endocrinology Care by denying Gender-Affirming Endocrinology Care for new patients at CMC;

3. Interfering with, controlling, or otherwise directing any physician's professional judgment with respect to the provision of Gender-Affirming Endocrinology Care at CMC; and

4. Imposing any limitation on Dr. Lopez's exercise of her clinical privileges to provide pediatric endocrinology care, including but not limited to prohibiting her from providing Gender-Affirming Endocrinology Care, in the absence of any formal due process under CMC's by-laws by the appropriate parties to restrict Dr. Lopez's clinical privileges.

21. By enjoining this conduct by CMC and anyone in active concert or participation with CMC, the Court will return the situation to the status quo until such time as the Court may resolve the Declaratory Judgment Action.

B. Dr. Lopez has plead for permanent relief and has a probable right to relief on her Declaratory Judgment Action.

22. A party seeking injunctive relief must plead some form of permanent relief and the request for declaratory relief satisfies that requirement. The Dallas Court of Appeals described the requisite showing necessary to carry the burden of showing a probable right to relief:

> An applicant for injunctive relief must show it has a probable right to relief it seeks on final hearing. The applicant must prove that it is likely to succeed on the merits of its lawsuit but does not have to prove she will ultimately prevail. To establish a probable right to the relief sought, an applicant is required to allege a cause of action and offer evidence that tends to support the right to recover on the merits. An applicant is not required to show he will prevail at the final trial because the ultimate merits of the case are not before the trial court.[20]

23. As set forth more fully above, Dr. Lopez can demonstrate a probable right to relief on the merits as the Unlawful Probition violates multiples laws, including laws prohibiting discrimination against individuals because of their gender identity, laws preventing hospitals like CMC from interfering with, controlling, or otherwise directing any physician's professional judgment, and laws preventing hospitals like CMC from limiting a physician's clinical privileges without due process.

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[20] *Dallas Anesthesiology Associates, P.A. v. Texas Anesthesia Grp., P.A.*, 190 S.W.3d 891, 896-97 (Tex. App.–Dallas 2006, no pet.) (internal citations omitted).

CMC has grossly violated all of these laws, and Dr. Lopez's request for Declaratory Judgment seeks such a declaration. Thus, Dr. Lopez meets the standard for a probable right of relief because she has "allege[d] a cause of action and offer[ed] evidence that tends to support the right to recover on the merits" which is the extent of her burden.

C. Dr. Lopez has demonstrated a probable irreparable injury if an injunction does not issue.

24. At the outset, it must be noted that because Dr. Lopez alleges violations of the law, there is no burden to demonstrate an irreparable injury as the Court cannot allow illegal conduct to continue.[21]

25. Nevertheless, in this instance the failure to issue injunctive relief will result in probable irreparable injury. The unlawful limitations on Dr. Lopez's medical judgment and unlawful limitations on her clinical privileges have already occurred and will likely to continue to occur. These limitations act as a restraint on trade and deprive Dr. Lopez of her rights as a practicing clinical physician with privileges at CMC to provide pediatric endocrinology. Further, Dr. Lopez faces civil liability from having to illegally discriminate because of gender identity as a result of the Unlawful Prohibition by rejecting care sought by new patients, as more than 100 patients have contacted CMC and sought such care only to be turned away since the Unlawful Prohibition. These injuries are irreparable and there is no adequate remedy at law because nothing a court can do at a later date can undo the deprivation of Dr. Lopez's rights and exposure to liability enforced on Dr. Lopez by CMC.

26. More importantly, by allowing CMC to unlawfully discriminate against children and families seeking Gender-Affirming Endocrinology Care—patients that Dr. Lopez wants to care for and believes to be part of her ethical duty to care for—there is a statistical certainty that one or more children turned away will at least attempt suicide and a probability that at least one will succeed. There can be no greater irreparable injury than the loss of a child's life that otherwise did not have to occur.

D. Request for a Temporary Restraining Order.

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[21] *Abbott v. Jenkins*, No. 05-21-00733-CV, 2021 WL 5445813, at *15 (Tex. App.—Dallas Nov. 22, 2021); *Green v. Unauthorized Practice of Law Comm.*, 883 S.W.2d 293, 296 (Tex. App.–Dallas 1994, no writ)(holding "Where the facts conclusively show that a party is violating the substantive law, the trial court should enjoin the violation, and in such case, there is no discretion to be exercised."); *San Miguel v. City of Windcrest*, 40 S.W.3d 104, 108 (Tex. App.–San Antonio 2000, no pet.)(holding, "Similarly, an act that violates a statute or city ordinance may be enjoined without a showing that the legal remedy is inadequate.").

27. Dr. Lopez requests that the Court issue a temporary restraining order for a period of no less than 14 days that specifically enjoins CMC and anyone in active concert or participation with CMC from doing or attempting to do any of the following:

1. Enforcing CMC's Unlawful Prohibition;

2. Discriminating against patients seeking Gender-Affirming Endocrinology Care by denying Gender-Affirming Endocrinology Care for new patients at CMC;

3. Interfering with, controlling, or otherwise directing any physician's professional judgment with respect to the provision of Gender-Affirming Endocrinology Care at CMC; and

4. Imposing any limitation on Dr. Lopez's exercise of her clinical privileges to provide pediatric endocrinology care, including, but not limited to, prohibiting her from providing Gender-Affirming Endocrinology Care, in the absence of any formal due process under CMC's by-laws by the appropriate parties to restrict Dr. Lopez's clinical privileges.

28. Consistent with TEXAS RULE OF CIVIL PROCEDURE 683, the injunction should restrain CMC, its "officers, agents, servants, employees, and attorneys, and those in active concert or participation with them."

29. Dr. Lopez is willing to post a reasonable bond, but submits that any such bond should be *de minimis* as no harm will befall CMC by allowing for the provision of Gender-Affirming Endocrinology Care to new patients. It would be unthinkable for CMC to suggest otherwise given that it has promoted such care in the past and continues to provide it to existing patients.

E. Request for Temporary Injunction.

30. Following the granting of a Temporary Restraining Order, Dr. Lopez respectfully requests that the Court set an evidentiary hearing within 14 days, unless extended by the parties or Court, so that Dr. Lopez can present evidence in support of a temporary injunction.

31. At that injunction hearing, Dr. Lopez requests that the Court enjoin, until such time as the Declaratory Judgment Action may be disposed of by summary judgment or trial, CMC and anyone in active concert or participation with CMC from doing or attempting to do any of the following:

1. Enforcing CMC's Unlawful Prohibition;

2. Discriminating against patients seeking Gender-Affirming Endocrinology Care by denying Gender-Affirming Endocrinology Care for new patients at CMC;

3. Interfering with, controlling, or otherwise directing any physician's professional judgment with respect to the provision of Gender-Affirming Endocrinology Care at CMC; and

4. Imposing any limitation on Dr. Lopez's exercise of her clinical privileges to provide pediatric endocrinology care, including, but not limited to, prohibiting her from providing Gender-Affirming Endocrinology Care, in the absence of any formal due process under CMC's by-laws by the appropriate parties to restrict Dr. Lopez's clinical privileges.

32. Dr. Lopez is willing to carry forward any bond posted in support of the temporary restraining order to support any temporary injunctive relief. Alternatively, Dr. Lopez is willing to post a separate reasonable bond to support the temporary injunction, but submits that any such bond should be *de minimis* as no harm will befall CMC by allowing for the provision of Gender-Affirming Endocrinology Care to new patients. It would be unthinkable for CMC to suggest otherwise given that it has promoted such care in the past and continues to provide it to existing patients.

F. Request for Expedited Discovery

33. Dr. Lopez requests that the Court order expedited discovery under TEXAS RULE OF CIVIL PROCEDURE 191.1 to allow for limited, targeted discovery necessary to prepare for the temporary injunction hearing. As one Court has noted in approving expedited discovery in interim between a TRO and a temporary injunction hearing:

> Parties frequently seek, and trial courts order, expedited discovery in the course of proceedings pertaining to temporary restraining orders. *See, e.g., In re Tex. Health Res.*, No. 05–15–00813–CV, 2015 WL 5029272, at *2 (Tex.App.–Dallas Aug. 26, 2015, orig. proceeding) ("The trial court ordered that the discovery take place before the expiration of the temporary restraining order."); *In re MetroPCS Commc'ns, Inc.*, 391 S.W.3d 329, 332 (Tex.App.–Dallas 2013, orig. proceeding) ("On November 5, 2012, Golovoy filed a 'Motion for a Temporary Restraining Order and an Order Compelling Expedited Discovery.' "); *see also In re Meyer*, No. 14–14–00833–CV, 2014 WL 5465621, at *1 (Tex.App.–Houston [14th Dist.] Oct. 24, 2014, orig. proceeding) (mem. op. per curiam) ("On October 14, 2014, Gulfstream filed an original petition, application for temporary restraining order, application for temporary injunction, and motion for expedited discovery against relators in the trial court."); *Miga v. Jensen*, No. 02–11–00074–CV, 2012 WL 745329, at *2 (Tex.App.–Fort Worth Mar. 8, 2012, no pet.) (mem. op.)... [W]e note that the trial court has discretion to schedule discovery and may shorten or lengthen the time for making a response for good cause. *In re Colonial Pipeline Co.*, 968 S.W.2d 938, 943 (Tex.1998) (orig.proceeding); *In re Exmark Mfg. Co., Inc.*, 299 S.W.3d 519, 532–33

(Tex.App.–Corpus Christi 2009, orig. proceeding); see, e.g., TEX. R. CIV. P. 190.5, 191.1.[22]

So that Dr. Lopez may prepare for the temporary injunction hearing and efficiently present relevant evidence to the Court, Dr. Lopez requests that the Court exercise its discretion to authorize expedited discovery.

34. The expedited discovery that Dr. Lopez requests is that CMC be required to produce to Plaintiff, within 10 days of the issuance of a Temporary Restraining Order, the following categories of information:

1. Dr. Lopez's privileges file.
2. CMC's by-laws and medical staff rules and regulations in effect in 2021.
3. Documentation reflecting any formal corporate action by CMC or any Board of CMC:
    a. against the privileges of Dr. Lopez;
    b. to restrict the provision of Gender-Affirming Endocrine Care at CMC.
4. CMC's written policies and procedures in effect in June of 2021 related to
    a. Gender-Affirming Endocrine Care;
    b. the GENECIS program;
    c. anti-discrimination; and
    d. patients' rights.
5. Any contract or agreement in effect in June 2021 between CMC and UT Southwestern that would apply or relate to either Dr. Lopez's provision of care at CMC or the GENECIS program.
6. All written communication, including email and text messages, from January 2021 to the present sent between executives at CMC and either UT Southwestern or the Executive Branch of the State of Texas related to the GENECIS program or Gender-Affirming Endocrine Care.
7. Any written notice to physicians at CMC regarding any limitation on providing Gender-Affirming Endocrine Care.

[22] *In re Nat'l Lloyds Ins. Co.*, No. 13-15-00390-CV, 2015 WL 6759153, at *5 (Tex. App.–Corpus Christi Nov. 3, 2015).

IV.
Prayer

35. Plaintiff Ximena Lopez respectfully prays that Defendant be cited to appear and answer herein, and that upon final determination of these causes of action, she receive a judgment against CMC awarding her as follows:

a. Temporary restraining order, temporary injunction, and permanent injunctions as requested above;

b. Expedited discovery as requested above;

c. Declaratory Judgment that:

i. CMC's Unlawful Prohibition violates laws prohibiting the corporate practice of medicine and limitations on physician's exercise of independent judgment in the exercise of their clinical privileges; and

ii. CMC's Unlawful Prohibition is illegal discrimination;

d. Her reasonable attorneys' fees under Texas Civil Practice & Remedies Code § 37.009;

e. Her costs of Court;

f. All such other and further relief at law and in equity to which Dr. Lopez may show herself to be justly entitled.

Respectfully submitted,

/s/ Charla G. Aldous

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ATTORNEYS FOR PETITIONER XIMENA LOPEZ, M.D.

VERIFICATION OF XIMENA LOPEZ, M.D.

STATE OF TEXAS §
§
COUNTY OF DALLAS §

BEFORE ME, the undersigned authority, appeared XIMENA LOPEZ, M.D., and upon her oath, testified as follows:

1. "My name is XIMENA LOPEZ, M.D. I am over the age of eighteen (18) years and fully competent to testify to the matters contained in this Verification. The assertions of factual matters contained in this Verification–as distinct from legal argument and conclusions–are true and correct, and within my personal knowledge.

XIMENA LOPEZ, M.D.

SWORN TO AND SUBSCRIBED BEFORE ME, by XIMENA LOPEZ, M.D. on this 10TH day of May, 2022.

ELLEN C. LESSEM
Notary Public, State of Texas
Comm. Expires 07-25-2025
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Notary Public in and for the State of Texas

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Pediatric and Adolescent Gender Dysphoria

Pheochromocytoma

Pituitary Lesions

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Type 2 Diabetes

Cystic Fibrosis Diabetes

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Our Programs

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- General endocrinology – This program covers multiple diseases with hormone imbalances that impact growth and development.
- **Diabetes** – This program offers care for **type 1** and **type 2 diabetes**, including daily maintenance and education.
- **Gender Education and Care Interdisciplinary Support (GENECIS)** – This program provides access to gender-affirming care and support for psychological and social-emotional needs. GENECIS also provides education/training for providers, educators and community partners, and research to improve health and development.
- **Center for Obesity and its Consequences in Health (COACH)** – This is the only comprehensive program for childhood obesity in North Texas. It focuses on reversing obesity and its effects on overall health.

Patient care is truly individualized

A child's disease doesn't define them, but still, many children and families can feel lost during the treatment process. We realize that no two children are the same, and that each child is impacted differently. This patient-focused philosophy is backed by our history of putting children first for over 100 years.

At Children's Health, you and your family will receive personalized education and training tools to help manage your child's condition. You will have the opportunity to attend disease- or treatment-specific classes, for topics such as growth hormones and diabetes, that explain the disease or treatment, possible side effects, and medication administration and management.

Providing answers for childhood hormone imbalances

The endocrinology department studies, diagnoses and provides treatment plans to address hormone disorders. Our team is comprised of specialists with a wide range of expertise. We know hormone-related diseases have medical and social impacts. We'll be with you and your child every step of the way, answering your questions and empowering your child to take charge of their care.

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- **Diabetes Education Classes**
- **Diabetes Sick-Day Bag**
- **Diabetic Sick-Day Guidelines**

- **Endocrinology Industry Updates**
- **Hydrocortisone Injection Video - Spanish**
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Pediatric Endocrinologist

Soumya Adhikari, MD
Pediatric Endocrinologist

Abha Choudhary, MD
Pediatric Endocrinologist

Huay-Lin Lo, MD
Pediatric Endocrinologist

Ximena Lopez, MD
Pediatric Endocrinologist

Ming Yang, MD
Pediatric Endocrinologist

JA

Joaquin Adame, APRN, PNP-PC
Pediatric Nurse Practitioner - Endocrinology

Ayanna Butler-Cephas, MD
Pediatric Endocrinologist

Bryan Dickson, MD
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Ernesto Fernandez, MD
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Olga Gupta, MD
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Melissa Ham, MD
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Pediatric Endocrinologist

Sudha Mootha, MD
Pediatric Endocrinologist

Nivedita Patni, MD
Pediatric Endocrinologist

Amanda Shaw, MD
Pediatric Endocrinologist

Ryan Stewart, MD
Pediatric Endocrinologist

Grace Tannin, MD
Pediatric Endocrinologist

EG

Emily Guthrie, APRN, PNP-PC
Nurse Practitioner - Endocrinology

Laura Kuper, PhD
Pediatric Psychologist

Jimmy Penn, APRN, FNP
Nurse Practitioner - Endocrinology

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Nurse Practitioner - Endocrinology

Preethy Varghese, APRN, PNP-PC
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Pediatric and Adolescent Gender Dysphoria

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What is Pediatric and Adolescent Gender Dysphoria?

Often, individuals with gender dysphoria are referred to as transgender. This is a broader term that refers to individuals who self-report or describe having a gender identity (male, female, non-binary are examples) that is different than their sex assigned at birth (typically male, female, sometimes intersex).

Not all transgender individuals experience gender dysphoria.

How is Pediatric and Adolescent Gender Dysphoria treated?

The GENECIS program uses a gender affirmative model of care. Individualized treatment plans are developed for each patient through collaboration with patients, their parents/guardians, and GENECIS Program providers.

Established guidelines for providers of medical and mental healthcare services including:

- **The Endocrine Society: Practice Guidelines**
- **World Professional Association for Transgender Health (WPATH)**

The GENECIS program includes providers in the following specialties:

- **Endocrinology**
- **Gynecology**
- **Pastoral care**
- Clinical Ethics
- **Adolescent Medicine**
- **Social Work**
- **Psychiatry and Psychology**

- Mental health services including:
  - Yearly assessment visits (all patients)
  - Consultation visits to provide short-term, solutions-focused therapeutic support
  - Outpatient counseling
  - Psychiatric assessment and medication management
  - Referrals to higher levels of care

Treatment Options

- **Feminizing Hormone Therapy**
- Menstruation Suppression
- **Puberty Suppression Therapy**
- Reproductive and sexual health services
- Referrals to additional medical specialties, including:
  - Fertility preservation
  - Voice therapy

Pediatric and Adolescent Gender Dysphoria Doctors and Providers

May Lau, MD
Pediatrician - Adolescent Medicine

M. Brett Cooper, MD
Pediatrician

Jason Jarin, MD
Pediatric Gynecologist

Ximena Lopez, MD
Pediatric Endocrinologist

Laura Kuper, PhD
Pediatric Psychologist

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International Patient Services
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CHNA Report
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Media Toolkit

Newsroom (/web/20200902022506/https://www.childrens.com/footer/media-toolkit/newsroom)

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Shop Children's Health (https://web.archive.org/web/20200902022506/https://shopchildrenshealth.merch

Contact Us (/web/20200902022506/https://www.childrens.com/footer/contact)

Sitemap (/web/20200902022506/https://www.childrens.com/footer/sitemap)

Accessibility (https://web.archive.org/web/20200902022506/https://www.childrens.com/footer/a

children'shealth®

LOOKING INWARD. TAKING ACTION.

DIVERSITY AND INCLUSION
AT CHILDREN'S HEALTH℠

IMPACT REPORT 2019 - 2020

CONTENTS

OUR HEALTH EQUITY, DIVERSITY, AND INCLUSION JOURNEY

2016

Formed Cultural Competency Steering Committee

Created Diversity and Inclusion Role

Recruited Diversity and Inclusion Ambassadors

2017

Formed Sr. Leader Diversity and Inclusion Advisory Council (DIAC)

Created Diversity and Inclusion Guiding Principles

Established Employee Workgroups

Initiated Race, Ethnicity, and Language (REaL) Data Transformation

Started Social Determinants of Health (SDOH) Screening

2018

Implemented Diversity and Inclusion Workshops and Cultural Competency Training

Created Health Equity and Inclusion Leader Role

Created Workforce Development Plan

2019

Conducted Cultural Climate Audit

Integrated Inclusive Leader Accountabilities with MODEL Leadership

Integrated Inclusive Practices with Talent Acquisition

Launched PCT Apprenticeship Program

"We are humbled by and proud of the progress and initiatives presented in this report. We remain driven by the same continuous pursuit of improvement that has helped us build our extraordinary organization."

Chris Durovich
President and Chief Executive Officer

SIGNALING OUR COMMITMENT TO DIVERSITY AND INCLUSION.

Children's Health has a storied history of providing compassionate, innovative, high-quality care to the children of North Texas and beyond. And for more than 100 years, that success has been driven by our extraordinary team members – individuals with the dynamic backgrounds, perspectives, and experiences necessary to fully realize an ambitious mission: to make life better for children.

Today, our work to strengthen and protect this rich culture of diversity and inclusion is more important than ever. For the past decade, we have been thoughtfully expanding our footprint and resources to ensure that more children have access to health care no matter their race, gender, income, or language. We recognize that the culture and environment we cultivate within Children's Health, the different voices around the table, as well as the consideration of every person and every experience, empowers us to better care for, advocate for, and represent the nearly 300,000 unique patients we have the privilege of serving every year.

We are humbled by and proud of the progress and initiatives presented in this report. We remain driven by the same continuous pursuit of improvement that has helped us build our extraordinary organization. This report marks a key first step to measuring our impact, and more importantly, signals a continued commitment to diversity and inclusion for another century.

We are stronger because of our diversity and believe that innovation only thrives when we are intentional about mobilizing a multitude of backgrounds, perspectives, and ideas around the common pursuit of making life better for children. That's something we can all celebrate.

Chris Durovich
President and Chief Executive Officer

Kim Besse
Executive Vice President and
Chief Human Resources Officer

"We all have a role to play in ensuring that everyone who walks through our doors is treated with dignity and respect."

Tina Bowers
Executive Director and
Chief Diversity and Inclusion Officer

DIVERSITY AND INCLUSION – BECOMING INTENTIONAL

It was the great minister and social rights activist Dr. Martin Luther King, Jr. who once said: "We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly." I am reminded of these insightful words when I think about what Children's Health has accomplished in over a century of service for children.

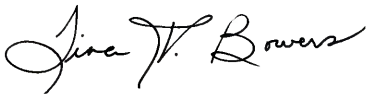
When I joined Children's Health, I realized that diversity and inclusion (D&I) represents yet another opportunity where Children's Health can demonstrate leadership.

It's been gratifying to get to know the people contributing to a culture of diversity and inclusion at Children's Health today. I have met with team members and leaders, across multiple locations, to talk honestly about diversity, inclusion, and belonging. I am grateful for these eye-opening conversations.

Then, for the first time, we integrated a number of inclusion-focused questions into the employee engagement survey. The report you're reading now is based on the feedback shared in focus groups and the employee engagement survey. This impact report will provide a benchmark for improvement in key areas moving forward.

I would like to thank each and every one of the brave team members who safely shared their feedback so openly and honestly with me.

All of us have a role to play in ensuring that everyone who walks through our doors is treated with dignity and respect at Children's Health.



Tina Bowers
Executive Director and Chief Diversity and Inclusion Officer

GUIDING PRINCIPLES FOR DIVERSITY, INCLUSION, AND CULTURAL COMPETENCE

"It's important that we all have a shared understanding of the Guiding Principles. But, even more important? We need to live up to these ideals, every day."

Kim Besse
Executive Vice President and
Chief Human Resources Officer

ESTABLISHING OUR COURSE

GUIDING PRINCIPLES

In 2016, Children's Health underscored its commitment to diversity and inclusion by introducing D&I initiatives into the overarching organizational strategy.

The senior leadership team also acknowledged that in the pursuit of diversity, inclusion, and cultural competence, we needed to be guided by bedrock principles. Aligned with the Children's Health core values, the principles inform how we interact with each other and with the communities we serve.

Care

Aligns with the value of selfless service. We will listen to, invite, and respect the beliefs, identities, and experiences of our colleagues and patients to deliver culturally effective care.

Community

Aligns with the value of passionate advocacy. We embrace diverse populations in the community through meaningful partnerships and initiatives.

Collaboration and Inclusion

Aligns with the value of commitment to excellence. We equip and develop our team members to support an inclusive environment in which all have the opportunity to contribute.

Careers

Aligns with the value of unwavering integrity. We recruit and build talented, diverse teams that reflect the backgrounds, traditions, and experiences of the communities we serve.

HEALTH EQUITY

"Health Equity is not about giving everyone the same thing to be healthy. It's about working to ensure everyone has an opportunity to be as healthy as possible. We must meet our patients and their families where they are to make that happen."

Dr. Stormee Williams
Vice President and Medical Director,
Network Development and Innovation at Children's Health

DELIVERING CARE TO DIVERSE POPULATIONS

HEALTH EQUITY

An eye toward Health Equity means transforming the care we deliver with a goal of closing gaps in care, as well as disparities in outcomes. This results in a fair and just opportunity for all patients to reach their highest level of health. Health Equity also challenges us to make our approach to care culturally effective and linguistically appropriate, eliminating unconscious bias and improving cultural competence.

Children's Health has worked diligently for the past several years to lay a solid foundation for Health Equity work. Among our priorities: standardizing the ways in which we collect self-reported race, ethnicity, and language (REaL) data to help us prospectively deliver care that is culturally effective and linguistically appropriate, implementing a screening tool to assess a patient's social determinants of health which helps to improve care coordination and tailor a plan of care, and introducing a Disparities Portfolio to better understand what health and health care disparities exist in patients of diverse backgrounds.

Taken together, these Health Equity efforts all enhance the quality of care we provide by placing the patient, their unique health care needs, experiences, and background top of mind.

ACTING ON INCLUSION, IN WAYS BIG AND SMALL

PATIENT EXPERIENCE

Children's Health has taken great strides to create an inclusive culture, one where all patients and their families feel welcomed, valued, and heard when it comes to care. This is especially important as Children's Health expands to serve more and more children of different races, ethnicities, faiths, and backgrounds.

Here are just a few examples of steps that Children's Health has taken to make the patient experience more inclusive:

Language and Interpreter Services

Cultural diversity – and with it, linguistic diversity – continues to grow in the communities we serve. Our Language Interpreter Services has team members on staff, and provides other modalities such as phone and video remote interpreters, to assist patients and families whose primary language is not English. Facilitating linguistically appropriate and empathetic communication goes a long way to make families feel welcomed and respected.

Pastoral and Spiritual Care

Naturally, when a child faces medical challenges, family and friends may turn to their faith for comfort. At Children's Health, we respect that, and we want those patients and loved ones to feel supported. Our Pastoral and Spiritual Care Services team provides for patients and families of all religions and faith traditions.

Family Advisor Network (FAN)

Feedback is important – it allows us to make our patient experience more inclusive. One crucial source of feedback is our Family Advisor Network, or FAN, which helps ensure that current and former patients and families feel heard. This collaborative network provides unique perspectives and experiences, allowing us to improve care and overall experiences.

PROGRAM HIGHLIGHT: TELEHEALTH

Telehealth looks to broaden the access of Children's Health quality care, experts, and specialists beyond the walls of our hospital to diverse populations.

As part of our Telehealth efforts, we are creating partnerships with schools, community physicians, and hospitals across the state so that more children can get the care that they need. Telemedicine and virtual health have allowed us to take into consideration the needs of the families we care for by adding a layer of convenience while they access care.

Take School-Based Telehealth as an example. Through this program, we connect hundreds of school nurses and their students with providers from Children's Health in order to care for sick children while they are in school. These schools are located in diverse communities – urban and rural, and spanning socioeconomic status – but the care experience the patient receives is the same.

Likewise, our Remote Patient Monitoring (RPM) program helps children with complex medical needs to reduce the number of trips they have to make to the hospital for follow-up visits. For a family that has to travel hundreds of miles to reach our specialists, this type of access can by life-altering.

"We live and work in a country that grows more diverse with each passing year. Keeping D&I top of mind helps us serve our patients better."

- Stormee Williams, M.D.
Vice President and Medical Director,
Network Development and Innovation at Children's Health

D&I ADVISORY COUNCIL AND EMPLOYEE WORKGROUPS

DIVERSITY AND INCLUSION IN ACTION

PROGRAMS AND INITIATIVES

The greatest asset at Children's Health is our strong and diverse team.

When people can bring their full selves to work each day, we create real change in our industry and provide the best care for families in our community. It takes all of us working together to realize the full potential of all of our team members. It's in this spirit that Children's Health is ensuring D&I initiatives are woven into the organizational strategy. It stands to reason: To provide the best care possible for our diverse patient constituencies, we need to get intentional about not just diversity, but also inclusion, among our own workforce.

To accomplish this across a large health system with many departments and locations, Children's Health established a D&I Advisory Council (DIAC) in 2017. This council includes Executives and Senior Vice Presidents, each of whom is committed to advancing diversity and inclusion within their specific job functions. The DIAC provides oversight and governance of D&I programs and initiatives. By removing barriers and roadblocks, DIAC promotes a diverse and inclusive workplace, serving to highlight Children's Health as a leader in this critical endeavor.

DIVERSITY AND INCLUSION IN ACTION

PROGRAMS AND INITIATIVES *(CONT'D)*

In the four years since the formation of the DIAC, Children's Health has fostered a number of collaborative workgroups, all committed to advancing D&I and creating an inclusive workplace. Each of these workgroups helps to ensure a better workplace for all:

HEALTH EQUITY, DIVERSITY, AND INCLUSION COMMISSION (HEDIC)

PRIDE

WOMEN EMPOWERING WOMEN

VETERANS EMPLOYEE WORKGROUP

These groups include Children's Health employees who volunteer their time. Each employee workgroup is sponsored by an Executive or Senior Vice President and include committees or task forces focused on specific issues.

Any Children's Health team member who wants to champion diversity and inclusion can join one of our employee workgroups. All are welcome to contribute to these change-making teams.

SPOTLIGHT ON HEDIC

HEALTH EQUITY, DIVERSITY, AND INCLUSION COMMISSION

The Health Equity, Diversity, and Inclusion Commission (HEDIC) seeks to promote an environment in which our patients and their families, providers, and team members can heal, thrive, and achieve their greatest potential.

Today, over 100 members serve on this commission and are influencing culture and change across Children's Health by supporting D&I and health equity projects.

In addition to supporting the first D&I Impact Report, the committee has undertaken a number of important activities to promote culturally effective and equitable care, within a diverse and inclusive environment. Those efforts include:

- An ongoing review of Children's Health Policies & Practices to ensure our policies and language are inclusive and non-biased.
- Refreshing our internal web page devoted to D&I as well as our Children's Health career site.
- Completion of the National Diversity Council (NDC) Index, a measurement of organizational commitment to diversity and inclusion among companies.
- Developing a cohort of diverse speakers for panels and forums to articulate our commitment to diversity and inclusion.

"All of us on the Health Equity, Diversity, and Inclusion Commission aspire to make Children's Health work for everyone."

- Victoria Brown

Director of Research Administration at Children's Health and Chairwoman of Health Equity, Diversity, and Inclusion Commission

IN FOCUS: PRIDE

SUPPORTING THE LGBTQ COMMUNITY

At Children's Health, we have long supported the LGBTQ community through our community engagement and patient-centered care and services. We strongly believe that no one in the LGBTQ and allied community should face discrimination or receive inequitable care because of their sexual orientation or gender identity.

Our PRIDE employee workgroup has helped to foster an inclusive, safe, and welcoming environment for those who identify as LGBTQ. PRIDE seeks ways to advocate for our LGBTQ patients, team members, community, and allies. Since its formation, PRIDE has made significant progress in key areas:

- Completion and submission of the Human Rights Campaign Foundation HEI Survey.
- Fostering relationships with LGBTQ-focused community organizations, both locally and nationally.
- Advancing LGBTQ-focused policies within the Children's Health organization, and supporting LGBTQ team members.
- Serving as a conduit for LGBTQ issues related to the employee or patient experience.

IN FOCUS: PRIDE

SUPPORTING THE LGBTQ COMMUNITY *(CONT'D)*

The Human Rights Campaign Foundation has recognized our commitment to LGBTQ equity and inclusion through its annual Healthcare Equality Index (HEI). HEI is the national LGBTQ benchmarking tool that evaluates policies and practices for health care facilities. In 2019, we earned a "Top Performer" HEI designation, scoring an 85 out of a possible 100.

But there is still room for improvement. The HEI benchmarking metric pointed to two opportunities in particular: promoting our LGBTQ-inclusive employee benefits and policies, and providing trans-inclusive benefits to employees.

Children's Health is proud to participate in these local LGBTQ-affiliated events:

- TEEN Pride Festival
- DIFFA/Dallas
- Black Tie Dinner
- The Teddy Bear Party

HUMAN RIGHTS CAMPAIGN FOUNDATION

In 2019, we earned a "Top Performer" HEI designation, scoring 85 out of a possible 100.

PROGRAM HIGHLIGHT: GENECIS

GENECIS stands for GENder Education and Care, Interdisciplinary Support. This Children's Health program is one of the largest of its kind in the Southwest, impacting hundreds of youth nationwide.

GENECIS supports youth of all gender expressions and identities, providing evidence-based, gender-affirming care in a supportive and safe environment. GENECIS recognizes that gender identity is unique for every child, and may be different from their sex assigned at birth. As a result, care is individualized, in collaboration with patients and their families.

GENECIS also provides a safe space for our employees, so team members can thrive in the workplace. The program's impact can be felt systemwide, helping Children's Health implement LGBTQ-inclusive practices and care.

For example, the GENECIS team has implemented the use of preferred name and pronouns markers in electronic medical records, developed an online course on gender competency for Children's Health employees, and has provided training modules for school staff and health providers within the community.

"The GENECIS team champions diversity and inclusion in the workplace. GENECIS upholds a universal view of our humanity and embraces the benefits that diverse ideas and perspectives bring to our society."

- Dr. Ximena Lopez

Associate Professor at UT Southwestern Medical Center, and Medical Director for the GENECIS Program at Children's Health

WOMEN LEADERS IN THE PAST, PRESENT, AND FUTURE

A HOSPITAL FOUNDED BY WOMEN - STILL WORKING TO SUPPORT WOMEN.

It's fitting that a hospital founded by women continues to look to women for care, guidance, and leadership. Today, Children's Health has a female-majority workforce. Women make up 79 percent of our entire organization and 67 percent of our leadership team. In the boardroom, women represent 49 percent of the board seats across our five governing boards. Maintaining those percentages, and seeking to add underrepresented minority women to executive leadership roles, remains an opportunity for growth.

WOMEN LEADERS IN THE PAST, PRESENT, AND FUTURE

A HOSPITAL FOUNDED BY WOMEN - STILL WORKING TO SUPPORT WOMEN. *(CONT'D)*

Our Women Empowering Women employee workgroup is focusing on creating a positive, engaging, and supportive network for diverse females aspiring to leadership roles. The group is committed to diversity and inclusion, seeking to promote advancement and proportionate representation of women at all levels in the organization, as well as work-life balance.

Women Empowering Women spans different areas across Children's Health. This workgroup has identified leadership opportunities in areas including:

- Partnering with employee workgroups to expand the footprint and ability to network with diverse groups.
- Encouraging members to take on leadership roles through committees, volunteer projects, and career advancement programs.
- Building a support network of leaders through events.

"Women started Children's Health, and women will continue to play a vital leadership role as we embark on our second century."

- Chelsea Reynolds
Clinical Manager at Children's Health and Women Empowering Women Chairwoman

SALUTING THOSE WHO SERVE

SUPPORTING VETERANS AT CHILDREN'S HEALTH

We value the hard work and the extraordinary sacrifice made by the men and women who have served, or are actively serving in our military. We also know that making the transition from active duty to civilian life can be challenging. Children's Health is committed to hiring military veterans and helping them make a successful transition to a fulfilling career impacting children's lives in North Texas.

Our newest employee workgroup, Veterans Employee Workgroup, celebrates and supports our military and veteran team members and families.

Veterans Employee Workgroup supports those in uniform and those who have served through recruitment outreach, and by building relationships with military and veteran service organizations. Among our current Veterans Employee Workgroup partnerships:

- Department of Labor
- Texas Veterans Commission
- VettedHeroes™

WORKFORCE DEMOGRAPHICS

WHO WE ARE

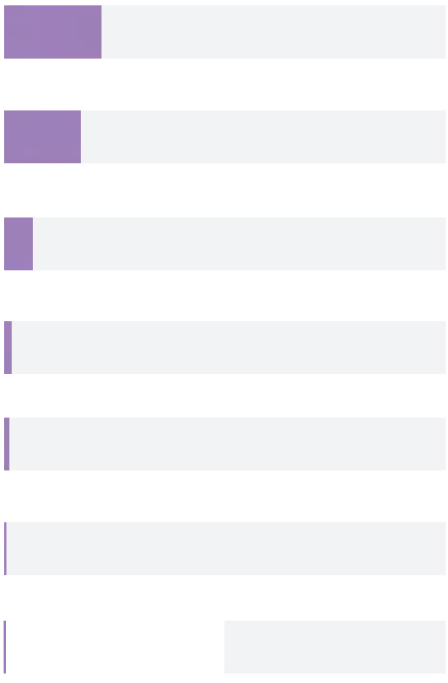
OUR WORKFORCE DEMOGRAPHICS

As part of our commitment to transparency at Children's Health, we're taking a hard look at the demographics among our entire workforce, and across our leadership ranks. This will serve as a benchmark pinpointing where we are today, so that we can measure progress moving forward. Reviewing these numbers will also help us to gain a better understanding of the different backgrounds, communities, and cultures that make up our workforce.

Let's begin by taking a look at the demographics across the entire organization. Overall, women make up 79 percent and men make up 21 percent of our workforce. Our workforce's largest racial demographic group is White, at 51 percent. Of the remaining 49 percent, 22 percent are Hispanic or Latino, 17 percent are Black or African American, 8 percent are Asian, and 1.4 percent self-identify as two or more races.

79.09%
FEMALE

20.91%
MALE



51.01%
WHITE

21.75%
HISPANIC OR LATINO

17.46%
BLACK OR AFRICAN AMERICAN

7.68%
ASIAN

1.39%
TWO OR MORE RACES

0.57%
AMERICAN INDIAN/ALASKA NATIVE

0.14%
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

Notes on Data: The workforce demographic data represent all employees, including leaders, at Children's Health. The data reflect totals as of August 2019.

LOOKING AT LEADERSHIP

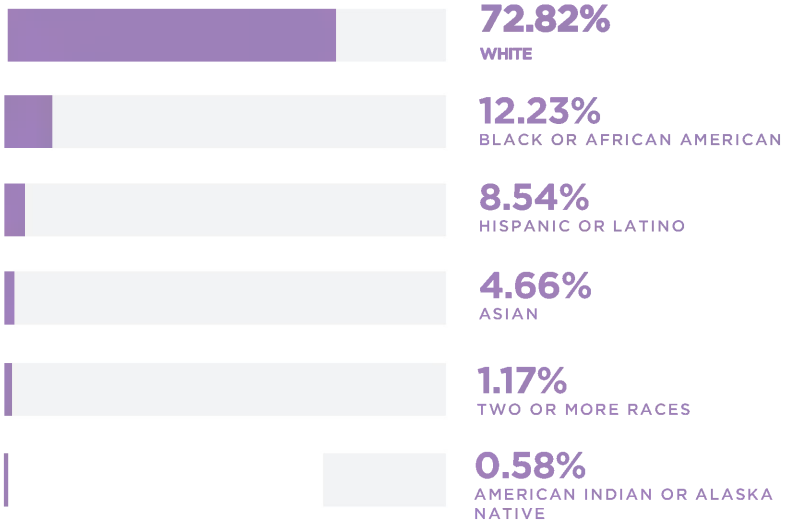
EXPLORING DIVERSITY WITHIN MANAGEMENT

As we look at the numbers of our workforce, we see that there are opportunities to increase diversity at the leadership level. Improving minority representation in leadership roles would bring diverse perspectives and viewpoints to bear on decision-making, and would mean that the leadership at Children's Health would more accurately reflect the patients and families we serve.

Today, women make up 67 percent and men make up 33 percent of our leadership. The largest racial demographic group is White, at 73 percent. Of the remaining 27 percent, 12 percent are Black or African American, 9 percent are Hispanic or Latino, 5 percent are Asian, 1 percent identify as two or more races, and less than 1 percent are American Indian or Alaska Native.

66.60%
FEMALE

33.40%
MALE



Notes on Data: Leadership includes job roles of Managers, Directors, and Executives. The data reflect totals as of August 2019.

A Closer Look

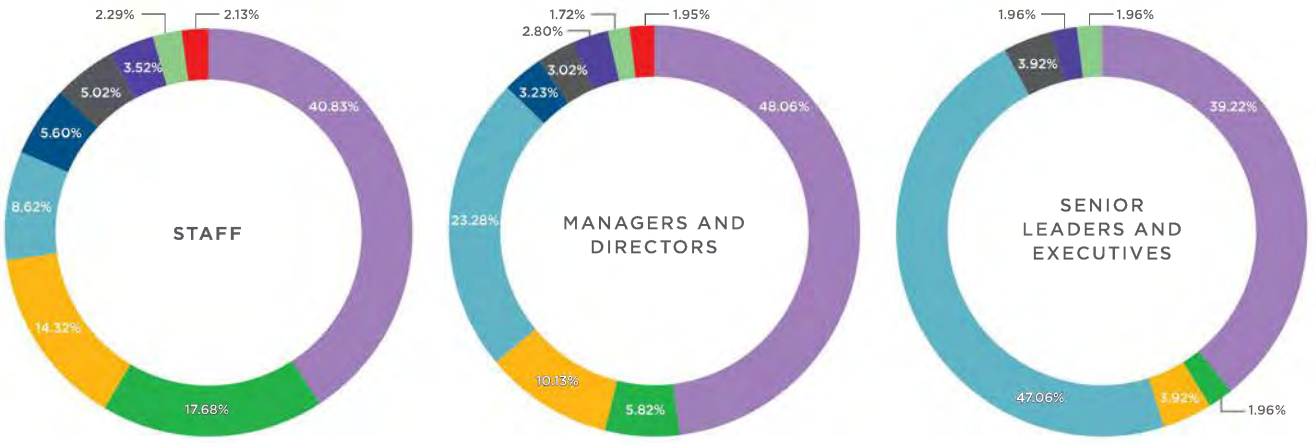
HOW REPRESENTATION INTERSECTS AT KEY LEVELS

In order for us to be truly impactful in our work across D&I, it's important that we take an intersectional look at our workforce. With this approach, we examine the intersection of gender and race/ethnicity to understand the interconnected and overlapping nature of these categorizations, allowing us to recognize the impact of bias and inequity a person may face when they represent the intersection of both race and gender (e.g., African American + Female or Hispanic + Male).

As we look at the data below, there is a clear opportunity to improve underrepresented minorities among our leadership team. When the focus is tightened to Senior Leaders and Executives specifically, minority groups are largely underrepresented.

INTERSECTIONALITY

- FEMALE WHITE
- FEMALE HISPANIC OR LATINO
- FEMALE BLACK OR AFRICAN AMERICAN
- FEMALE ASIAN
- MALE WHITE
- MALE HISPANIC OR LATINO
- MALE BLACK OR AFRICAN AMERICAN
- MALE ASIAN
- OTHER



Notes on Data: Staff represents individual contributor job roles. Managers and Directors represent job roles of Manager, Director, and Senior Director. Senior Leaders and Executives represent job roles of Vice President, Senior Vice President, and Executive Vice President. The data reflect totals as of August 2019.

D&I CULTURAL ASSESSMENT

ASSESSING THE IMPACT

OUR FIRST MILESTONE

After building on a strong foundation for diversity and inclusion, this year we paused to assess the cultural impact of our work. This can help to inform how we move forward, as we continue our D&I journey.

To get a true picture of the organizational culture and climate related to D&I, we took a multi-methods approach to collecting data from our staff and leaders — in part because our culture can be viewed, and measured, in many different ways. Our assessment included the collection of both quantitative (Gallup survey) and qualitative (focus groups) data.

In addition, we reviewed a representative subset of HR policies and organizational practices to gain insight into how the organization has conceptualized and supported diversity and inclusion. We found that there is an opportunity to rethink or eliminate some legacy practices.

ASSESSING THE IMPACT

OUR FIRST MILESTONE

(CONT'D)

Inclusion-focused questions were introduced in the 2019 Experience, Inclusion, and Engagement survey, providing a benchmark to measure progress. The questions asked employees to rate, on a scale of 1-5, how strongly they agree with an inclusion-focused statement. To evaluate these results, we focused on the "top-box" answer (employees who selected 5). As we worked together to improve the culture of inclusion and ensure all team members have an optimal experience, we saw significant progress in our 2020 engagement survey results.

Based on the data collected, here are the results from a year-over-year comparison.

INCLUSION INDEX MEASURES

Strongly Agree	2019	2020
If I raised a concern about ethics and integrity, I am confident my employer would do what is right.	45%	51%
My workplace is committed to building the strengths of each team member.	34%	43%
At work, I am treated with respect.	49%	54%
Everyone at this organization is treated fairly regardless of ethnic background, race, gender, age, disability, or other differences not related to job performance.	52%	59%

Notes on Data: The 2019 Experience, Inclusion, and Engagement survey was sent to the entire organization and 5,866 people responded to the culture of inclusion questions.

THE BIG PICTURE

CULTURE OF INCLUSION – QUANTITATIVE RESULTS *(CONT'D)*

The quantitative results point to two main areas where we can strengthen inclusion in our daily practices.

TWO MAIN AREAS TO STRENGTHEN

VALUING STRENGTHS OF TEAM MEMBERS

When leaders recognize and intentionally welcome the diverse strengths of team members, they will see a more engaged workforce, leading ultimately to higher levels of performance and retention.

DEMONSTRATING RESPECT AND FAIRNESS FOR ALL

Building trust and transparency through active listening and acknowledging different perspectives demonstrates our commitment to fairness to all. People must feel like their voices are being heard and that next steps are taking place, as warranted.

> **"Recognizing and appreciating each other's strengths, emphasizing fairness, and demonstrating respect for diverse perspectives will strengthen our workplace."**

- Tina Bowers

Executive Director and Chief Diversity and Inclusion Officer

INDIVIDUAL VOICES

CULTURE OF INCLUSION – QUALITATIVE RESULTS

The D&I Survey's quantitative results provided a numerical baseline for assessment and improvement. But we also wanted to hear directly from team members, in their own words, to understand how they feel at work.

We spent several months talking with team members across various roles, genders, ages, ethnicities, and locations. We heard honest, candid feedback about diversity and inclusion. We are grateful so many took the time to tell us how we can improve.

Partnered together with Children's Health Research and the University of Texas Health Science Center School of Public Health, we collected and analyzed the qualitative data gathered. We found several areas of strength – and several opportunities to make our workplace better for everyone.

As we resolve to make progress on D&I issues, our key areas of focus include:

HEALTH EQUITY

Overall, many feel that Children's Health has proven to be equitable in providing quality, culturally effective care to patients of various backgrounds.

Progress can be seen in initiatives such as REaL data, which helps to standardize how we collect race, ethnicity, and language data, and social determinants of health (SDOH), which uses a health screening tool to capture discrete, pertinent patient data that can be easily incorporated into care plans.

AWARENESS AND TRAINING

Both leaders and staff members expressed a need for more training on diversity and inclusion.

To address this, we will expand the Diversity, Inclusion, and Cultural Competence workshops (launched in 2018) to all frontline staff and their leaders – adding to the team members who have attended one or both workshops already. We will partner with organizations to develop a full suite of blended learning modules on topics such as unconscious bias and creating an inclusive workplace.

INDIVIDUAL VOICES

CULTURE OF INCLUSION – QUALITATIVE RESULTS

(CONT'D)

VOICES BEING HEARD

Team members want to feel safe when voicing issues, concerns, and opinions. We heard some team members say that they often find it difficult to be open and honest in their communication with leaders. These respondents do not feel that their voices are being heard or valued, especially when a language barrier hampers communication.

In response to these concerns, we are exploring several rapid access solutions that expand the service capability for our Human Resources consultants. For example, we will be partnering with an independent, web-based platform providing a confidential means of reporting potential problems. This partnership will offer all of us professional guidance on issues of bias, harassment, and potential discrimination.

D&I PROGRAMS AND OUTREACH

Team members recognize improvements in D&I through programs, initiatives, and recruitment efforts. Many expressed a desire to become more engaged and would like to see greater promotion of D&I employee workgroups, events, and activities.

Planned programs in this area include forums hosted by our employee workgroups, such as World Day of Diversity and Millennials at Children's Health, held last year. Similar forums are planned for each quarter in 2020.

SUPPORT OF LGBTQ COMMUNITY

According to the qualitative responses, Children's Health has done a tremendous job in supporting and celebrating the LGBTQ community at large.

INDIVIDUAL VOICES

CULTURE OF INCLUSION – QUALITATIVE RESULTS

(CONT'D)

CAREER MOBILITY

Team members expressed concerns regarding career mobility and advancement when it comes to minority talent. Improving opportunities for advancement, along with ensuring a fair and unbiased recruitment process, would be welcomed by many.

In response to such concerns, we are conducting a comprehensive review of our talent acquisition and management practices. We will seek to identify areas of potential bias and inequity. We will also look to integrate inclusive practices that reduce bias, such as:

- Revising job descriptions to eliminate adjectives closely associated with a specific gender.
- Blinding key identifiers on candidate résumés to ensure a focus on talent and qualifications, not demographics.
- Requiring structured interviews, conducted by a diverse panel of interviewers, using a standardized set of questions to minimize bias in candidate evaluation.

LEADERSHIP REPRESENTATION

We heard from many of our staff members that they would like to see more diversity in senior leadership positions. Such diversity would more broadly reflect our workforce, as well as the communities we serve.

To address these concerns, we will be working with senior leadership to develop tangible and achievable goals, with an eye toward increasing diversity at the Director role and above. We will work with our external partners to create a diverse pipeline of candidates as we increase our internal pool through focused leadership development. These goals will be aligned with complementary business strategies – including engagement, experience, talent management, and leadership competency.

WE HEAR YOU

QUOTES FROM INTERNAL FOCUS GROUP RESPONDENTS

"We have standardization and best practices in place to ensure that every patient receives quality care, regardless of age, religion, or race."

"I think the upper management value the opinions of people who have been here longer, not always the new employees."

"The organization is diverse. But, in certain areas, there's no diversity. The same people keep hiring people that are similar to them."

TAKING ACTION, TOGETHER

TAKING ACTION, TOGETHER

KEY PRIORITIES

In this first D&I impact report for Children's Health, we are committed to sharing the data fully, including highlighting areas for improvement. It's our hope that this transparency will build trust, across readers and respondents, fostering a sense of mutual accountability moving forward.

We are committed to make real change and progress towards D&I in the following areas:

INCREASE REPRESENTATION OF UNDERREPRESENTED MINORITIES IN LEADERSHIP

OUR AIM:

Recruit, retain, develop, and advance more underrepresented minority talent into senior leadership roles.

FOSTER AN INCLUSIVE WORKPLACE

OUR GOALS:

Execute comprehensive strategies that create shared ownership for advancing equity and inclusion for the purpose of transforming care delivery.

This approach includes aligning programs and initiatives, optimizing and leveraging resources, and influencing policies and practices.

IMPROVE INCLUSION COMPETENCY ACROSS ALL LEVELS

STEPS TO TAKE:

Better equip leaders with the skills and competencies for managing diverse teams and create more awareness around mitigating biases and microaggressions.

We will begin with a comprehensive training plan across the organization that will include expert workshops, online training around topics impacting the LGBTQ community, and expanded education on unconscious bias.

TAKING ACTION, TOGETHER

KEY PRIORITIES *(CONT'D)*

ESTABLISH KEY METRICS

WHAT THAT MEANS:

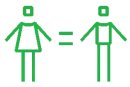
Establish a regular review process of aggregate and business function data in order to consistently and accurately pinpoint gaps and develop solutions.

As part of that work, we will be creating a Metrics Advisory Workgroup comprised of a multidisciplinary team responsible for strategic initiatives to help inform and ensure alignment with D&I metrics.

INCREASE ACCOUNTABILITY

MOVING FORWARD:

Strengthen commitment and ownership for diversity and inclusion at all levels, so that team members hold themselves and each other accountable for building and maintaining an inclusive culture.



BUILD SUSTAINABILITY

THE FINAL STEP:

Build strong policies, practices, and systems that continue the transformation to ensure equitable care and maintain a balance of diverse representation at all levels, and sustain a culture of inclusion for decades to come.

CONCLUSION AND SINCERE THANKS

OPTIMISM FOR THE FUTURE

BECOMING INTENTIONAL ABOUT DIVERSITY AND INCLUSION

Like many other organizations in the country, Children's Health is on a journey to build and maintain a diverse workforce and create an inclusive workplace.

From the D&I Advisory Council to the many employee workgroups, it's clear that more team members than ever are focusing on D&I issues and working to move Children's Health forward.

Everyone who works here should feel proud of their backgrounds and individuality. We should all be proud to embrace our cultural differences in the workplace. And proud that by doing so, we are improving care for children.

SINCERE THANKS

IN APPRECIATION OF A COLLABORATIVE EFFORT

This report represents the work of a collaborative team. We thank the thousands of Children's Health team members who participated in the quantitative or qualitative phases of the D&I assessment. We thank Children's Health senior leadership, for providing the resources for this report and for fostering a culture of openness and self-improvement.

And certainly, we thank those who played a direct role in this 2019 D&I Impact Report, including:

University of Texas Health Science Center School of Public Health
Ashley Ofori, MPH
Joshua Yudkin, MPH, MA

Children's Health
Jesus Vazquez-Alvarez, MBA
Molly Beyer, MS, MPH, CPH
Chelsea Reynolds, BSN, RN, CPN
Victoria Brown, Ph.D., MBA, CHRC
Ira Kirkley, SPHR
Dr. Stormee Williams, MD, FAAP
Dr. Ximena Lopez, MD
Kim Besse, CCP, SPHR
Pio del Castillo, MBA
Rose Gomez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CODE OF ETHICAL CONDUCT

children's health®

Contents

Dear Colleagues,

As you know, Children's Health has a strong commitment to achieving our mission to make life better for children while in full compliance of all applicable laws, regulations and guidelines. Every team member, medical/dental staff member, vendor, contractor and volunteer associated with our system is expected to conduct themselves in a responsible, ethical and legal manner at all times.

Our Code of Ethical Conduct, available here in printed version and on ChildNet 2.0, is designed to help team members navigate and understand the complex rules we're required to follow in the highly regulated health care industry. It outlines standards of ethical conduct that align with our values to follow at all times as you serve patients, their families and other organizational stakeholders. Put simply, being part of the Children's Health team means agreeing to live and work under these critical values.

It's important to remember that you have a responsibility to report actions that are not in compliance with the Children's Health Code of Ethical Conduct. The Code provides details on reporting compliance issues, including hotline numbers, and describes a four-step process for making a report in accordance with our values — selfless service, passionate advocacy, commitment to excellence and unwavering integrity.

Please take time to read the Code carefully so that you understand our organization's expectations for ethical behavior. It's one of many resources available to team members as we strive to do the right thing in all that we do to protect Children's Health, our team members, our patients and their families. To that end, we want to address any questions or concerns you have. Please discuss any questions or concerns with your supervisor, a Human Resources representative or a staff member or the Compliance Officer.

The Board of Directors and Senior Leadership Team join me in pledging to uphold the Code of Ethical Conduct, support our Compliance Program here at Children's Health, and continue to foster an environment of integrity and transparency. Thank you for your commitment to making Children's Health a place where every team member feels heard and respected, and an organization we are proud to call ours.

Sincerely,

Christopher J. Durovich
President and Chief Executive Officer
Children's Health

An Introduction to the Code

Children's Health System of Texas ("Children's Health") is committed to serving our patients, medical/dental staff, applicable third parties, employees and the community in an ethical, and responsible manner, as well as a manner consistent with the Children's Health Code of Ethical Conduct.

Furthermore, Children's Health is committed to providing all services in full compliance with all applicable laws, regulations and guidelines, as well as our own policies and procedures. We are particularly sensitive to those requirements applicable to federal and state health care programs and the submission of accurate claims for services.

The Code of Ethical Conduct ("the Code"), as well as statutes, regulations, guidelines, policies and procedures at Children's Health, must apply to and be observed by all Staff (defined as employees, contract labor, medical/dental staff, members of the Board of Directors, anyone participating in training and anyone else engaged in our work environment or acting on behalf of Children's Health). No one, regardless of position, will be allowed to compromise adherence to the Code, statutes, regulations, business standards, policies or procedures.

Failure to comply with the Code, statutes, regulations, guidance, policies and procedures can result in serious damage to our standing in the community, regulatory action against the Staff and disciplinary action up to and including immediate termination or revocation of clinical privileges.

If there are any questions about the Code or any policies or practices at Children's Health, you should raise the questions with a supervisor, Department Director or the Compliance Office.

The Code of Ethical Conduct adopted by Children's Health is intended to help us meet our ethical and compliance goals in a highly regulated business environment. The Code is designed to provide general guidance, and does not replace the policies and procedures of the hospital. If there is no specific policy, the Code standard becomes the policy. If a policy and a standard of conduct conflict, the standard becomes the policy. In seeking additional guidance and direction regarding the Code, Staff are encouraged to refer to the hospital's pertinent Policies and Procedures.

In addition, the Code supports the values Children's Health stands for: selfless service, passionate advocacy, commitment to excellence and unwavering integrity.

The Code is a "living document," which will be updated periodically in response to changing conditions. Thus, Children's Health reserves the right to modify or terminate any or all of these provisions at any time.

Compliance at Children's Health is made up of the following elements:

- **Standards and Procedures** – This Code of Ethical Conduct, in addition to Children's Health policies and procedures, was created to ensure that all Staff are in compliance with federal, state and local laws, rules and regulations.
- **Program Oversight** – Children's Health has appointed a Chief Compliance Officer to oversee the strategic direction, implementation and operation of the Compliance Program. The Chief Compliance Officer reports to the Audit Committee of Children's Health System of Texas. In addition, Children's Health has established a Compliance Committee, which is a standing hospital committee to assist in the implementation and oversight of the Compliance Program.
- **Staff Training and Education** – Children's Health will provide periodic training to all Staff on various compliance issues.
- **Communication** – Children's Health has set up a comprehensive four-step communication and reporting process.
- **Enforcement and Discipline** – All Children's Health Staff are required to adhere to the Compliance Program, which includes all policies and procedures and the Code of Ethical Conduct. If any Staff violates any of these items, they may be disciplined up to and including termination or revocation of clinical privileges.
- **Monitoring and Auditing** – Children's Health has established a program to continuously monitor and audit compliance with federal, state and local laws, rules and regulations, and to report any audit results as necessary to senior leadership.
- **Response and Prevention** – All reports or concerns of suspected non-compliance will be investigated to determine whether a material violation of law or the requirements of the Compliance Program has occurred, and if so, steps will be taken to correct the problem.

If Children's Health finds credible evidence of alleged misconduct, and after a reasonable inquiry there is reason to believe that the alleged misconduct may violate criminal, civil or administrative law, Children's Health will immediately conduct an investigation to validate the concern and determine what further action may be required, including reporting the matter to the appropriate government authority.

THE CHILDREN'S WAY

SELFLESS SERVICE
Serving others with an enthusiastic spirit

- Transcends the ordinary and exceeds expectations
- Engages with all in a respectful, non-judgmental manner
- Treats others with kindness, humility and dedication
- Recognizes and celebrates the contributions of others

PASSIONATE ADVOCACY
Standing as champions for children

- Acts courageously on behalf of children
- Educates the community about the needs of children
- Understands and honors different perspectives and expectations

COMMITMENT TO EXCELLENCE
Driving innovation and quality care to maximize outcomes

- Collaborates to achieve exceptional quality, safety and continuous improvement
- Innovates to transform possibilities into realities
- Advances knowledge, applies evidence-based best practices and takes ownership of professional development
- Continuously seeks opportunities to be better stewards of the organization's resources

UNWAVERING INTEGRITY
Creating an environment of trust through honesty, transparency and authenticity

- Do the right thing even when no one is looking and regardless of the personal impact
- Willingly shares information with others
- Speaks up with ideas and concerns
- Holds oneself and others accountable for decisions behaviors, actions and results

SELFLESS SERVICE
Serving others with an enthusiastic spirit

General Guidelines

We will exercise good faith and fair dealings in all transactions that involve our responsibilities to Children's Health.

We will, as long as we have a relationship with Children's Health, conduct business to the best of our ability for the benefit and interests of Children's Health.

We will report any actual or perceived conflicts of interest to those who can properly assess the conflict and determine how to proceed.

We will not use our position with Children's Health for personal gain.

We will maintain unbiased relationships with actual and potential vendors and contractors.

We will complete a Conflict of Interest form annually to report all outside employment in which we are involved.

We will not use Children's Health resources, patient information or equipment to conduct outside employment. We will not engage in outside employment while on Children's Health time.

Family Members, Friends or Business Associates

We will avoid situations where the Staff or a related party (e.g., family member, friend or business associate) receives a benefit from any decision or action taken by the Staff member.

Financial Interests

We will report any direct or indirect financial interest (except minor interest in publicly traded securities) in any business that supplies Children's Health with a substantial number of goods or services or where sales to Children's Health constitute a substantial part of the supplying company's business.

We will not use information that comes to us in the course of our work for personal investment or gain, nor will we provide that type of information to members of our family or others.

We, as Staff or agents of Children's Health, will not contribute financial or other support to political candidates, organizations or parties as part of our official duties or solicit such activity in the workplace.

This limitation does not preclude any agent or Staff member from exercising their personal political support outside of Children's Health. Children's Health policies prohibit solicitations of any kind on our premises.

PASSIONATE ADVOCACY

Standing as champions for children

Privacy

We will honor the privacy of patients and not reveal or discuss patient-related information except with health care personnel involved in their care, payers and others authorized by the parent or his/her authorized representative to review patient information.

Confidentiality of Information

We will maintain the confidentiality of quality improvement, peer review and health care services review information in accordance with laws and regulations.

We will protect confidential corporate information and not use or reveal such information except in the proper performance of duties.

Protection of Assets

We will maintain inventory (as appropriate/required) and keep all supplies secure.

We will adequately safeguard, use and care for all property and equipment entrusted to us including mobile devices such as cellphones, laptops and pagers.

We will report the loss or theft of all property or equipment entrusted to us in a timely manner to our supervisor. We will dispose of all surplus or obsolete property and equipment according to established policies and procedures.

Security of Information

We will maintain all medical and business records in accordance with laws and our record retention policies.

We will not alter or falsify information on any record or document.

We will release patient records in accordance with the hospital's policies.

We will prohibit the making of unauthorized copies of computer software or the use of personal software on computer equipment belonging to Children's Health.

We will not knowingly communicate or transfer any information or documents to any unauthorized persons.

We will not use computers, email, facsimile machines or any other technology to communicate information to unauthorized people. Further, the use of technology to send offensive, discriminatory or harassing messages is prohibited.

We will use computers, the email system, the Internet, the Children's Health intranet and other technology only for work-related purposes.

We understand all information sent, received or stored in the email system is the property of Children's Health.

Research

We will conduct all research activities to the highest ethical standards and in compliance with all applicable federal, state and local laws and regulations. This includes the fair and honest presentation and analysis of data, the proper acknowledgment of all contributors, and compliance with all federal and state laws or regulations, as well as all Children's Health policies related to the protection of all human subjects and/or animals.

COMMITMENT TO EXCELLENCE

Driving innovation and quality care to maximize outcomes

Duties and Responsibilities

We have a duty at every level of the organization to maintain our integrity, ethics and the quality of our job performance.

We have a duty and responsibility to promptly address any deficiency or error by reporting it to a supervisor, department director, Compliance Department, Chief Compliance Officer or Children's Compliance Hotline who can assess the problem, take appropriate action (through the event reporting or grievance process) and follow the problem to resolution.

We have a duty and responsibility to employ, grant medical/dental staff privileges to or contract with only fully licensed and properly credentialed providers with the expertise and experience to care for our patients.

Patient Rights

We will affirm and uphold the rights of our patients and their parents, guardians or authorized representatives. This includes Children's Health obligations under the Emergency Medical Treatment and Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay.

Care Delivery

We will encourage all Staff and applicable third parties to continually evaluate existing methods of delivering services in order to discover more effective ways of serving our patients.

We will periodically assess and evaluate the goals and objectives established for medical care and related services provided in order to deliver services according to current standards of practice and the most current knowledge in the field.

We will require that admissions, transfers and discharges are medically appropriate and in accordance with all legal requirements.

Health and Safety

We shall comply with all safety and health requirements whether established by management, federal, state or local laws or our accrediting organizations.

We will promptly report any accidents involving injury to a Staff member, applicable third party or visitor through the event reporting process.

We will take all reasonable precautions and follow all safety rules and regulations to maintain a safe environment for our patients, Staff, applicable third parties and visitors.

We will strive to provide an environment that is free from violence. Unauthorized weapons of any kind are strictly prohibited.

We are responsible for inspecting the work area under our control for potential health and safety risks, eliminating or reporting such risks to the safety officer (or designee), being familiar with health and safety procedures, and training ourselves in health and safety.

The manufacture, sale, possession, distribution or use or misuse of drugs or alcohol at work will not be permitted.

Reporting to work while under the influence of drugs or alcohol will not be tolerated. We will safely store, secure and count all drugs and pharmaceuticals and medical supplies. Missing or diverted drugs will be promptly reported through the event reporting process.

Hazardous Materials & Waste

We will follow all laws and regulations regarding the disposal of medical waste and hazardous material.

We will promptly handle all spills or accidents involving medical waste or hazardous materials and take action immediately to help prevent further harm/damage.

We will provide training in safe work practices to eliminate hazards and correct unsafe behavior to protect the health and safety of Staff and others.

Environmental Laws

We will comply with all applicable environmental laws.

General

We will treat everyone with fairness, dignity and respect.

We will strive to provide an environment for all individuals free from harassment and intimidation. We will not tolerate verbal or physical harassment, including sexual harassment.

We will continually strive to build confidence and professionalism in every individual.

We will work to maintain open lines of communication so that the views of each individual may be considered and their opinions given proper respect.

We will show respect and consideration for one another, regardless of status or position.

We shall maintain personal information confidentially.

We shall apply the Code of Conduct and policies and procedures equally to all, regardless of their position at Children's Health.

We will encourage each individual to continuously evaluate existing methods of delivering services in order to discover more effective ways of allocating resources for patient care and support services.

When caring for patients, we will maintain professional boundaries, treat all families equally and show all families care and respect.

We will require that all Staff and applicable third parties who are providers of patient services are properly licensed and trained prior to providing services.

We will provide reasonable training opportunities to assist the Staff in building and maintaining professional skills.

We will require that our Staff are hired, trained, promoted and compensated on the basis of personal competence and potential for advancement without regard for race, color, sex, national origin, age or disability, as well as any other classifications as required by law.

We shall review and evaluate each Staff member's performance periodically in an objective, consistent and uniform manner.

UNWAVERING INTEGRITY

Creating an environment of trust through honesty, transparency and authenticity

In Accordance with the Law

When any possible violation of law, regulation or policy has occurred, we will promptly report it in accordance with the "Four-Step Communication and Reporting Process."

All compliance issues or reported concerns will be acted upon in a fair and truthful manner. Any retaliation or other negative action against a Staff member who in good faith reports a suspected violation will not be tolerated.

- We will require that all Staff and applicable third parties provide internal and outside auditors with any and all information required for the performance of their responsibilities.
- We will bill payers and patients according to all applicable laws, regulations and policies.
- We shall not hire or contract with individuals who have been sanctioned by the OIG or barred from federal or state procurement programs.
- We will require that all drugs and other controlled substances used in treatment are maintained, dispensed and transported in compliance with all applicable laws and regulations. We will comply with all requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA).
- We will adhere at all times to Children's Health policies regarding the acceptance of gifts and/or courtesies. We will not provide kickbacks, bribes, rebates or anything else of value in order to influence the referrals of patients or business transactions.
- We will comply with all anti-corruption laws that apply to Children's Health operations, including the Foreign Corrupt Practices Act (FCPA). When dealing with Foreign Officials, you are prohibited from giving, offering or authorizing the provision of anything of value to, a Foreign Official, in order to obtain or retain business.

Agreements

We will require that all agreements with individuals or organizations that may be potential referral sources are in writing, approved by appropriate management and reviewed by the Legal Department.

Confidentiality

We will maintain complete and accurate patient medical records and keep all such information confidential.

We will comply at all times with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Children's Health policies addressing the HIPAA regulations related to the privacy and security of patient protected health information.

We will require that confidential patient information is accessible only by health care personnel involved in the patient's care and others authorized to review patient information.

Marketing

We will represent Children's Health fairly and honestly, emphasizing the scope of our services, our capabilities, values and outcomes achieved from our clinical and research activities. We will not engage in any deceptive marketing practices.

Ethics

We will strive to provide patient care and enter into any business dealings in an ethical manner, not only in conjunction with this Code, but also with any and all professional organizations' Codes of Ethical Conduct, as appropriate.

Responsibilities of Our Financial Officers

Financial officers are responsible for certifying the accuracy of financial statements that bear their signatures. By their signature, they attest to the following:

- They have reviewed the report.
- Based upon the officer's knowledge, the report does not contain any untrue statement of a material fact, nor does the report omit material facts necessary to ensure the report is not misleading.
- Based upon the officer's knowledge, the report fairly represents financial statements and other financial information presented the report.

Our financial officers are responsible for establishing, maintaining, testing and reporting on the effectiveness of internal controls within their assigned areas.

Our financial officers are responsible for disclosing to auditors and the Board significant deficiencies in internal controls and fraud involving management or Staff with significant internal control responsibilities.

Billing

We will charge and bill only for services that are actually provided and documented in the patient's medical records.

We will not knowingly submit for payment or reimbursement a claim we know to be false, fraudulent or fictitious.

We will conduct general collection/credit procedures according to the Fair Debt Collection Practices Act.

We will respond to all questions and complaints related to a patient's bill in a direct and honest manner. We require reporting of any suspected charging or billing irregularity to the Compliance Office.

We will regularly review our records and promptly refund any over payments. We will not routinely waive insurance co-payments or deductibles.

Coding

We will assign diagnostic and procedural codes that accurately reflect the services that were provided. Upcoding, unbundling or any other means of artificially enhancing reimbursement is unlawful and strictly prohibited. We shall periodically review coding practices and policies, including software edits, to facilitate compliance with all applicable federal, state and private payer health care program requirements.

Claims and Record Keeping

We will require that all claims for services submitted to any insurance program or payer, Medicare, Medicaid or other federally funded health care programs are accurate and correctly identify the services ordered and performed.

We will maintain all records in a secure location for the period of time required by law. The premature destruction or alteration of any document in response to, or in anticipation of, a request for those documents by any government agency or court is strictly prohibited.

Cost Reports

We will comply with all laws and regulations related to government cost reports. All questions or issues related to cost reports will be promptly reported to the Chief Financial Officer or the Compliance Officer.

Reporting Compliance Issues

Four-Step Communication and Reporting Process

If you have a question or concern about an activity being unethical, illegal or wrong, use the following process to answer questions and report concerns. Throughout this process, your identity will be kept confidential as much as possible

1. Talk to the department supervisor. He or she is most familiar with the laws, regulations and policies that relate to departmental activities.
2. If you are not comfortable contacting the department supervisor, or if you don't receive an adequate response from him/her, talk to the department supervisor's manager or the department director. You may also choose to speak with someone from Human Resources.
3. If you have followed either step 1 or step 2 and still have questions, contact the Compliance Office at **214-456-1070**.
4. If for any reason you feel you cannot follow the above steps, or don't want to give your name, call the Children's Health Compliance Hotline at **1-866-769-0998**. The Children's Health Compliance Office will review and address all reports to the Hotline.

Quality of Care Concerns

In addition to the four-step communication and reporting process, any individual who provides care, treatment and services is free to raise concerns to The Joint Commission and/or Texas Department of Health and Human Services when Children's Health has not adequately prevented or corrected problems that can have or have had a serious adverse impact on patients, without fear of disciplinary or punitive action. You are encouraged to report and escalate as necessary any concerns about safety or quality of care provided by the hospitals, within Children's Health. The Joint Commission's direct phone number is **800-994-6610**.

Compliance Hotline 1-866-769-0998

We recognize that there are times when questions or problems cannot be addressed through the normal communication and reporting process. When this happens, you should use the Compliance Hotline. We have hired an outside company to take Hotline calls, so callers who do not wish to give their names can remain anonymous. The operators of the Hotline are trained to assist you in reporting concerns.

The Children's Health Compliance Hotline may be reached 24 hours a day, seven days a week at **1-866-769-0998**.

Calls to the Hotline will not be traced or recorded. You will remain anonymous, unless you choose to identify yourself. If you do give your name, your identity will be protected to the extent allowed by law.

All calls made to the Hotline will be reviewed by the Compliance Office and will be responded to fairly and in a timely manner. All claims will be carefully investigated before any action is taken. The rights of all Staff, including anyone who is the subject of a Hotline call, will be respected and protected to the extent allowed by law. Actions taken will not be made public.

Helpful Numbers to Know

Compliance Hotline
1-866-769-0998

Privacy Office
1-214-456-4444

Chief Compliance Officer, Vice President Accreditation and Regulatory Affairs
214-456-2020

Senior Director, Compliance
214-456-1070

Human Resources On-Call Consultant
214-717-9648

The Joint Commission
800-994-6610

Non-Retaliation Policy

No disciplinary action or retaliation will be taken against you when you report a perceived issue, problem or concern or violation "in good faith." The "in good faith" requirement means a person actually believes or perceives to be true the information reported. We value and respect the dignity of the individual, therefore, you have the right to be treated fairly and with respect — and Children's Health will require that you are treated that way.

Acknowledgment

I have received and I will read the Code of Ethical Conduct from Children's Health System of Texas. I understand that the Code of Ethical Conduct applies to my employment/affiliation and that following all laws, regulations, policies and the Code of Ethical Conduct is a condition of my employment and/or affiliation with Children's Health System of Texas. I will seek advice from my supervisor, a Human Resources representative, the Compliance Office, or I will call the Compliance Hotline with any compliance questions or issues.

My signature reflects that I have received a copy of the Code of Ethical Conduct. I realize that it is my responsibility to read and comply with procedures and policies set forth in the Code of Ethical Conduct.

I understand this document is available online on the Children's Health Compliance page on ChildNet 2.0

Signature _____

Printed Name _____ Employee # _____

Position _____ Division/Department _____

Date _____

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Joint statement from Children's Health and UT Southwestern

March 28, 2022

Media Cor

News Team
214-648-3404 (tel:+1
404)
Email (mailto:news@
estern.edu)

DALLAS – March 28, 2022 – As public debate over hormone therapy for gender dysphoria for minors continues, and after hearing concerns from some members of our campus, we are writing to clarify the actions taken by UT Southwestern and Children's Health to preserve overall gender-affirming care for youths and also to address misunderstanding of those decisions by some.

Last November, with legal challenges to hormone therapy as a component of care for minors treated for gender dysphoria gaining momentum in Texas and elsewhere, UT Southwestern and Children's Health suspended initiating this treatment for new patients, believing that a failure to act would put the entire program in jeopardy. As we emphasized at that time, the care of existing patients would be unchanged and new patients would still have continued access to the broader array of gender-affirming care we provide, particularly the psychiatric care considered foundational to gender transition and other front-line services necessary for evaluation of potential gender dysphoria.

In taking these actions, Children's Health and UT Southwestern weighed the momentum of opposition to hormone therapy for gender dysphoria for minors – and efforts to curtail it – against the unquestioned need for our other gender-affirming care efforts and decided to focus on these important services. Though we discontinued enrollment of new patients into puberty suppression therapy for the indication of gender dysphoria, families and patients seeking hormone therapy for gender dysphoria have access to outside practitioners not affiliated with a public institution that is ultimately accountable to the state and which, inevitably, must consider conflicting public viewpoints.

Although GENECIS served as a coordinating brand for our pediatric transgender services, contrary to what has been reported, it was never a standalone clinic. After legislative hearings last year brought additional scrutiny of our care, the GENECIS brand became a lightning rod for the controversy over hormone therapy for gender dysphoria, and we made the joint decision to remove the branding so we could care for our patients in a more protective environment. In contrast to how this has been characterized by some, no clinic has been closed, and we continue to accept new patients referred for potential gender dysphoria.

In light of the heightened focus on our gender-affirming care services, however, we concluded that without some modifications in our provision of these treatments, we risked the possibility of having to shut down our program entirely and catalyzing action that would lead to their ban statewide – similar to prohibitions that have already occurred in two other states (with comparable legislation pending in many more). Indeed, a bill to that effect was filed in last year's regular session of the Texas Legislature.

To be clear: UT Southwestern physicians are currently providing gender-affirming care to both youths and adults. Our clinics for youths experiencing or needing evaluation for gender dysphoria were never closed and have been actively accepting new patients. We continue to provide evaluations for gender dysphoria in youths, continue to

provide psychiatric care for gender transition, and continue the coordination of these services.

Whatever the result of ongoing legal battles and future legislative action, it is evident the debate over the appropriate age of consent for hormone treatments, calls for additional medical reviews and study, and uncertainty about the role of public institutions in providing this care will continue for some time. While these discussions play out, we remain firm in our commitment to provide care for patients of all ages, beliefs, backgrounds, and identities. That remains our focus today and always.

Joint statement from Children's Health and UT Southwestern

Related Stories

Try physical therapy before your knee surgery

(/newsroom/articles/year-2022/try-physical-therapy-before-your-knee-surgery.html)

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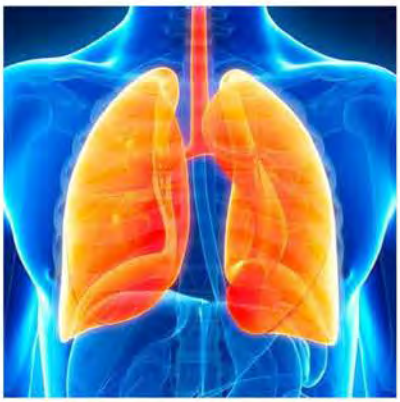

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Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health

7th Version

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7th Version[1] | www.wpath.org

1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

Table of Contents

Purpose and Use of the Standards of Care

The World Professional Association for Transgender Health (WPATH)[1] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[2] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the *SOC*.

The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

1 Formerly the Harry Benjamin International Gender Dysphoria Association

2 *Standards of Care (SOC), Version 7* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

II

Global Applicability of the Standards of Care

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens, or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender nonconforming people in these settings are forced to be hidden, and therefore may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world – even in areas with limited resources and training opportunities – can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culturally and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.

III

The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV
Epidemiologic Considerations

Formal epidemiologic studies on the incidence[3] and prevalence[4] of transsexualism specifically or transgender and gender nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one's gender identity – is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European

3 **incidence**—the number of new cases arising in a given period (e.g., a year)
4 **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974), the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1968 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (for example, Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically-supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.

V

Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1-1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender nonconforming individuals has come of age – many of whom have benefitted from different therapeutic approaches – they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a "transition," because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that is comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatments options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- Offline and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[5] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

5 Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.

4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

2. Gender dysphoria emerged or worsened with the onset of puberty;

3. Any co-existing 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;

4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, monitoring, and risks for puberty suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

VII
Mental Health

Transsexual, transgender, and gender nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the *SOC* focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); or psychotherapy unrelated to gender concerns or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

Tasks Related to Assessment and Referral

1. Assess gender dysphoria

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in person or online contact with other transsexual, transgender, or gender nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses.

Mental health professionals with the competencies described above (hereafter called "a qualified mental health professional") are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider's health care team.

2. Provide information regarding options for gender identity and expression and possible medical interventions

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

3. Assess, diagnose, and discuss treatment options for co-existing mental health concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat co-existing mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. The presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these co-existing mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

4. If applicable, assess eligibility, prepare, and refer for hormone therapy

The *SOC* provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost the client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant co-existing mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

5. If applicable, assess eligibility, prepare, and refer for surgery

The *SOC* also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are considering surgery to be both psychologically prepared (for example, has made a fully informed

decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The *SOC* do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated with a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

- Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and other Health Professionals

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

Tasks Related to Psychotherapy

1. Psychotherapy is not an absolute requirement for hormone therapy and surgery

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy – although highly recommended – is not a requirement.

The *SOC* do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all

phases of exploration of gender identity, gender expression, and possible transition – not just prior to any possible medical interventions. Third, clients differ in their abilities to attain similar goals in a specified time period.

2. Goals of psychotherapy for adults with gender concerns

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

3. Psychotherapy for transsexual, transgender, and gender nonconforming clients, including counseling and support for changes in gender role

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill prepared to accommodate and respect transgender, transsexual, and gender nonconforming people. Psychotherapy can also aid in alleviating any co-existing mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging – often more so than the physical aspects. Because changing

gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender nonconforming people will present for care without ever having been related to or accepted in the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fear about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

4. Family therapy or support for family members

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise to work with family members, or to sources of peer support (e.g., online or offline support networks of partners or families).

5. Follow-up care throughout life

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

6. Etherapy, online counseling, or distance counseling

Online or etherapy has been shown to be particularly useful for people who have difficulty accessing competent psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, etherapy may be a useful modality for psychotherapy with transsexual, transgender, and gender nonconforming people. Etherapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005) but not all; the international situation is even less defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of etherapy is available, caution in its use is advised.

Mental health professionals engaging in etherapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to etherapy has been published (Fraser, 2009b).

Other Tasks of the Mental Health Professional

1. Educate and advocate on behalf of clients within their community (schools, workplaces, other organizations) and assist clients with making changes in identity documents

Transsexual, transgender, and gender nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006) (Currah & Minter, 2000). This role may involve consultation with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.

2. Provide information and referral for peer support

For some transsexual, transgender, and gender nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

Culture and its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the *SOC* have grown out of a Western tradition and may need to be adapted depending on the cultural context.

Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with or inexperienced in working with transsexual, transgender, and gender nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.

Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

VIII
Hormone Therapy

Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria (Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009).

Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

Criteria for Hormone Therapy

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the *SOC*. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *Standards of Care* outlined in section VI);
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the *SOC*, the presence of co-existing mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.

Informed Consent

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (see also Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

Relationship between the Standards of Care and Informed Consent Model Protocols

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The *SOC* are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the *SOC*). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of co-existing mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and decreased percentage of body fat compared to muscle mass.

- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fact compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months[C]	variable
Increased muscle mass/strength	6-12 months	2-5 years[D]
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

[A] Adapted with permission from Hembree et al. (2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Highly dependent on age and inheritance; may be minimal.
[D] Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/ strength	3-6 months	1-2 years[C]
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years[D]
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

[A] Adapted with permission from Hembree et al. (2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Significantly dependent on amount of exercise.
[D] Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy – with the possible exception of voice deepening in FtM persons – can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, co-morbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaberi, 2006; Ettner, Monstrey, & Eyler, 2007).

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	Venous thromboembolic disease[A] Gallstones Elevated liver enzymes Weight gain **Hypertriglyceridemia**	Polycythemia Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	**Hypertension** Hyperprolactinemia or prolactinom[A]	Elevated liver enzymes **Hyperlipidemia**
Possible increased risk with presence of additional risk factors[B]	**Type 2 diabetes**[A]	**Destabilization of certain psychiatric disorders**[C] **Cardiovascular disease** **Hypertension** **Type 2 diabetes**
No increased risk or inconclusive	**Breast cancer**	Loss of bone density **Breast cancer** **Cervical cancer** **Ovarian cancer** **Uterine cancer**

[A] Risk is greater with oral estrogen administration than with transdermal estrogen administration.
[B] Additional risk factors include age.
[C] Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of co-morbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.

2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).

3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.

4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.

5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.

6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.

1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1-6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the *SOC* (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

2. Hormone therapy following gonad removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and co-morbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

3. Hormone maintenance prior to gonad removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens,* below).

4. Initiating hormonal feminization/masculinization

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

Preventive care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

Risk assessment and modification for feminizing hormone therapy (MtF)

There are no absolute contraindications to feminizing therapy *per se*, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Risk assessment and modification for masculinizing hormone therapy (FtM)

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Co-morbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Cattrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (Physicians' Desk Reference, 2011), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Clinical Monitoring during Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with co-morbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

Efficacy and risk monitoring during feminizing hormone therapy (MtF)

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range, and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Efficacy and risk monitoring during masculinizing hormone therapy (FtM)

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of pressure, weight, pulse, and skin; and heart and lung exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or econonomic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

Regimens for feminizing hormone therapy (MtF)

Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular those resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen reducing medications ("anti-androgens")

A combination of estrogen and "anti-androgens" is the most commonly studied regimen for feminization. Androgen reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.

- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).

- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.

- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer III et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer III et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

Regimens for masculinizing hormone therapy (FtM)

Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecenoate, available outside the United States, results in lower serum testosterone levels than non-oral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2-4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecenoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

Bioidentical and compounded hormones

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

IX
Reproductive Health

Many transgender, transsexual, and gender nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals – including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons – should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing the production of mature

gametes (Payer, Meyer III, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignances that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to make eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.

X

Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients.

2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the *SOC*; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication – style, voice, choice of language, etc. – is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissinger, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice and communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and non-verbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice and

communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI
Surgery_

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage

& Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the *SOC*. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve "ideal" results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversibile, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the male-to-female (MtF) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);
2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;
3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the female-to-male (FtM) patient, surgical procedures may include the following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;
2. Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The *SOC* do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

Criteria for breast/chest surgery (one referral)

Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and ovariectomy in FtM patients and for orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled.
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
6. 12 continuous months of living in a gender role that is congruent with their gender identity;

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be

conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruysse, 2009).

Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dysphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called "chest reconstruction") is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or "male chest contouring" procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, ovariectomy (salpingo-oophorectomy), vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and

unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled "purely aesthetic," these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

XII

Postoperative Care and Follow-up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long

distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

XIII

Lifelong Preventive and Primary Care

Transsexual, transgender, and gender nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such

as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions

of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hiltebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the Standards of Care to People Living in Institutional Environments

The *SOC* in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the *SOC* can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess

and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have co-existing mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A "freeze frame" approach is not considered appropriate care in most situations (Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV

Applicability of the Standards of Care to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPES1/ESPE2 Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to *DSD* during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the "disorder" label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term *DSD* in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Rationale for Addition to the SOC

Previously, individuals with a DSD who also met the *DSM-IV-TR's* behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a "Gender Identity Disorder - Not Otherwise Specified." They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization – which explicitly differentiates between gender dysphoric individuals with and without a DSD – is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the *SOC*.

Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals – during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered – the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.

Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam – both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, in press). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010). However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, in press). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, in press).

Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the *SOC*. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).

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APPENDIX A
GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the *SOC* are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite* – and, some would argue, the more recent term *transgender* – have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Bioidentical hormones: Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

Bioidentical compounded hormone therapy (BCHT): Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

Crossdressing (transvestism): Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

Disorders of sex development (DSD): Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

Female-to-Male (FtM): Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Gender dysphoria: Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Gender identity: A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

Gender identity disorder: Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender nonconforming: Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression: Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

Genderqueer: Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

Male-to-Female (MtF): Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Natural hormones: Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

Sex: Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte,

2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Sex reassignment surgery (gender affirmation surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized.

Transphobia, internalized: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through femininizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

APPENDIX B
OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

Risks of Feminizing Hormone Therapy (MtF)

Likely increased risk:

Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal route of estradiol administration, which is recommended for patients at higher risk of VTE.

Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

Possible increased risk:

Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

Other side effects of feminizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

Risks of anti-androgen medications:

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the *SOC*. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

Risks of Masculinizing Hormone Therapy (FtM)

Likely increased risk:

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

Possible increased risk:

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing, may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall.

- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

Other side effects of masculinizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.
- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

APPENDIX C
SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the *SOC*, the criteria put forth in the *SOC* for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

Criteria for Feminizing/Masculinizing Hormone Therapy (one referral or chart documentation of psychosocial assessment)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well-controlled.

Criteria for Breast/Chest Surgery (one referral)

Mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

Hysterectomy and ovariectomy in FtM patients and orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or phalloplasty in FtM patients and vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);

6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

APPENDIX D
EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who underwent sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer III, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment was not recorded. Study participants who were taking testosterone had typically being doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p<.001$). (A similar analysis was not done for genital surgery). In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 2000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990). Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E
DEVELOPMENT PROCESS FOR THE STANDARDS OF CARE, VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial *SOC* "work group" was established in 2006. Members were invited to examine specific sections of *SOC, Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the *SOC* as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International Journal of Transgenderism (IJT)*. Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1-4) in 2009, making them available for discussion and debate.

After these articles were published, a *Standards of Care* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of *SOC, Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision – both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion – and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of *SOC, Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized it was circulated among the broader *SOC* Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revision. Two additional drafts were created and posted on the Google website for consideration by the broader *SOC* Revision Committee and the International Advisory Group. Upon completion of these three iteratations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

The plans are to disseminate this version of the *SOC* and invite feedback for further revisions. The WPATH Board of Directors decides the timing of any revision of the *SOC*.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;
2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;
3. Working meeting of the Writing Group;
4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7* Revision Committee, and WPATH Board of Directors;
5. Costs of printing and distributing *Standards of Care, Version 7* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

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Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

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*Cosponsoring Associations: American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.

Objective: To update the "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," published by the Endocrine Society in 2009.

Participants: The participants include an Endocrine Society–appointed task force of nine experts, a methodologist, and a medical writer.

Evidence: This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation approach to describe the strength of recommendations and the quality of evidence. The task force commissioned two systematic reviews and used the best available evidence from other published systematic reviews and individual studies.

Consensus Process: Group meetings, conference calls, and e-mail communications enabled consensus. Endocrine Society committees, members and cosponsoring organizations reviewed and commented on preliminary drafts of the guidelines.

Conclusion: Gender affirmation is multidisciplinary treatment in which endocrinologists play an important role. Gender-dysphoric/gender-incongruent persons seek and/or are referred to endocrinologists to develop the physical characteristics of the affirmed gender. They require a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender. Hormone treatment is not recommended for prepubertal gender-dysphoric/gender-incongruent persons. Those clinicians who recommend gender-affirming endocrine treatments—appropriately trained diagnosing clinicians (required), a mental health provider for adolescents (required) and mental health

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Abbreviations: BMD, bone mineral density; DSD, disorder/difference of sex development; DSM, Diagnostic and Statistical Manual of Mental Disorders; GD, gender dysphoria; GnRH, gonadotropin-releasing hormone; ICD, International Statistical Classification of Diseases and Related Health Problems; MHP, mental health professional; VTE, venous thromboembolism.

professional for adults (recommended)—should be knowledgeable about the diagnostic criteria and criteria for gender-affirming treatment, have sufficient training and experience in assessing psychopathology, and be willing to participate in the ongoing care throughout the endocrine transition. We recommend treating gender-dysphoric/gender-incongruent adolescents who have entered puberty at Tanner Stage G2/B2 by suppression with gonadotropin-releasing hormone agonists. Clinicians may add gender-affirming hormones after a multidisciplinary team has confirmed the persistence of gender dysphoria/gender incongruence and sufficient mental capacity to give informed consent to this partially irreversible treatment. Most adolescents have this capacity by age 16 years old. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to age 16 years, although there is minimal published experience treating prior to 13.5 to 14 years of age. For the care of peripubertal youths and older adolescents, we recommend that an expert multidisciplinary team comprised of medical professionals and mental health professionals manage this treatment. The treating physician must confirm the criteria for treatment used by the referring mental health practitioner and collaborate with them in decisions about gender-affirming surgery in older adolescents. For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient. We suggest maintaining physiologic levels of gender-appropriate hormones and monitoring for known risks and complications. When high doses of sex steroids are required to suppress endogenous sex steroids and/or in advanced age, clinicians may consider surgically removing natal gonads along with reducing sex steroid treatment. Clinicians should monitor both transgender males (female to male) and transgender females (male to female) for reproductive organ cancer risk when surgical removal is incomplete. Additionally, clinicians should persistently monitor adverse effects of sex steroids. For gender-affirming surgeries in adults, the treating physician must collaborate with and confirm the criteria for treatment used by the referring physician. Clinicians should avoid harming individuals (via hormone treatment) who have conditions other than gender dysphoria/gender incongruence and who may not benefit from the physical changes associated with this treatment. ***(J Clin Endocrinol Metab* 102: 3869–3903, 2017)**

Summary of Recommendations

1.0 Evaluation of youth and adults

1.1. We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or the ICD for diagnostic purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

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1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕◯◯)

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕◯)

2.0 Treatment of adolescents

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕◯◯)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 |⊕⊕◯◯)

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕◯◯)

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 |⊕⊕◯◯).

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕◯◯◯)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 |⊕⊕◯◯)

3.0 Hormonal therapy for transgender adults

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕◯)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment. (1 |⊕⊕⊕◯)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕◯◯)

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕◯◯◯)

4.0 Adverse outcome prevention and long-term care

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕◯◯)

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 |⊕⊕◯◯)

4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕◯◯)

4.4. We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕◯◯)

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for non-transgender females. (2 |⊕⊕◯◯)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕◯◯◯)

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

5.0 Surgery for sex reassignment and gender confirmation

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕◯◯)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕◯◯◯)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕◯◯).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕◯◯◯)

Changes Since the Previous Guideline

Both the current guideline and the one published in 2009 contain similar sections. Listed here are the sections contained in the current guideline and the corresponding number of recommendations: Introduction, Evaluation of Youth and Adults (5), Treatment of Adolescents (6), Hormonal Therapy for Transgender Adults (4), Adverse Outcomes Prevention and Long-term Care (7), and Surgery for Sex Reassignment and Gender Confirmation (6). The current introduction updates the diagnostic classification of "gender dysphoria/gender incongruence." It also reviews the development of "gender identity" and summarizes its natural development. The section on clinical evaluation of both youth and adults, defines in detail the professional qualifications required of those who diagnose and treat both adolescents and adults. We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional. We recommend against puberty blocking followed by gender-affirming hormone treatment of prepubertal children. Clinicians should inform pubertal children, adolescents, and adults seeking gender-confirming treatment of their options for fertility preservation. Prior to treatment, clinicians should evaluate the presence of medical conditions that may be worsened by hormone depletion and/or treatment. A multidisciplinary team, preferably composed of medical and mental health professionals, should monitor treatments. Clinicians evaluating transgender adults for endocrine treatment should confirm the diagnosis of persistent gender dysphoria/gender incongruence. Physicians should educate transgender persons regarding the time course of steroid-induced physical changes. Treatment should include periodic monitoring of hormone levels and metabolic parameters, as well as assessments of bone density and the impact upon prostate, gonads, and uterus. We also make recommendations for transgender persons who plan genital gender-affirming surgery.

Method of Development of Evidence-Based Clinical Practice Guidelines

The Clinical Guidelines Subcommittee (CGS) of the Endocrine Society deemed the diagnosis and treatment of individuals with GD/gender incongruence a priority area for revision and appointed a task force to formulate evidence-based recommendations. The task force followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines (1). A detailed description of the grading scheme has been published elsewhere (2). The task force used the best available research evidence to develop the recommendations. The task force also used consistent language and graphical descriptions of both the strength of a recommendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕◯◯◯ denotes very low–quality evidence; ⊕⊕◯◯, low quality; ⊕⊕⊕◯, moderate quality; and ⊕⊕⊕⊕, high quality. The task force has confidence that persons who receive care according to the strong recommendations will derive, on average, more benefit than harm. Weak recommendations require more careful consideration of the person's circumstances, values, and preferences to determine the best course of action. Linked to each recommendation is a description of the evidence and the

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values that the task force considered in making the recommendation. In some instances, there are remarks in which the task force offers technical suggestions for testing conditions, dosing, and monitoring. These technical comments reflect the best available evidence applied to a typical person being treated. Often this evidence comes from the unsystematic observations of the task force and their preferences; therefore, one should consider these remarks as suggestions.

In this guideline, the task force made several statements to emphasize the importance of shared decision-making, general preventive care measures, and basic principles of the treatment of transgender persons. They labeled these "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.

The Endocrine Society maintains a rigorous conflict-of-interest review process for developing clinical practice guidelines. All task force members must declare any potential conflicts of interest by completing a conflict-of-interest form. The CGS reviews all conflicts of interest before the Society's Council approves the members to participate on the task force and periodically during the development of the guideline. All others participating in the guideline's development must also disclose any conflicts of interest in the matter under study, and most of these participants must be without any conflicts of interest. The CGS and the task force have reviewed all disclosures for this guideline and resolved or managed all identified conflicts of interest.

Conflicts of interest are defined as remuneration in any amount from commercial interests; grants; research support; consulting fees; salary; ownership interests [*e.g.*, stocks and stock options (excluding diversified mutual funds)]; honoraria and other payments for participation in speakers' bureaus, advisory boards, or boards of directors; and all other financial benefits. Completed forms are available through the Endocrine Society office.

The Endocrine Society provided the funding for this guideline; the task force received no funding or remuneration from commercial or other entities.

Commissioned Systematic Review

The task force commissioned two systematic reviews to support this guideline. The first one aimed to summarize the available evidence on the effect of sex steroid use in transgender individuals on lipids and cardiovascular outcomes. The review identified 29 eligible studies at moderate risk of bias. In transgender males (female to male), sex steroid therapy was associated with a statistically significant increase in serum triglycerides and low-density lipoprotein cholesterol levels. High-density lipoprotein cholesterol levels decreased significantly across all follow-up time periods. In transgender females (male to female), serum triglycerides were significantly higher without any changes in other parameters. Few myocardial infarction, stroke, venous thromboembolism (VTE), and death events were reported. These events were more frequent in transgender females. However, the quality of the evidence was low. The second review summarized the available evidence regarding the effect of sex steroids on bone health in transgender individuals and identified 13 studies. In transgender males, there was no statistically significant difference in the lumbar spine, femoral neck, or total hip BMD at 12 and 24 months compared with baseline values before initiating masculinizing hormone therapy. In transgender females, there was a statistically significant increase in lumbar spine BMD at 12 months and 24 months compared with baseline values before initiation of feminizing hormone therapy. There was minimal information on fracture rates. The quality of evidence was also low.

Introduction

Throughout recorded history (in the absence of an endocrine disorder) some men and women have experienced confusion and anguish resulting from rigid, forced conformity to sexual dimorphism. In modern history, there have been numerous ongoing biological, psychological, cultural, political, and sociological debates over various aspects of gender variance. The 20th century marked the emergence of a social awakening for men and women with the belief that they are "trapped" in the wrong body (3). Magnus Hirschfeld and Harry Benjamin, among others, pioneered the medical responses to those who sought relief from and a resolution to their profound discomfort. Although the term transsexual became widely known after Benjamin wrote "The Transsexual Phenomenon" (4), it was Hirschfeld who coined the term "transsexual" in 1923 to describe people who want to live a life that corresponds with their experienced gender vs their designated gender (5). Magnus Hirschfeld (6) and others (4, 7) have described other types of trans phenomena besides transsexualism. These early researchers proposed that the gender identity of these people was located somewhere along a unidimensional continuum. This continuum ranged from all male through "something in between" to all female. Yet such a classification does not take into account that people may have gender identities outside this continuum. For instance, some experience themselves as having both a male and female gender identity, whereas others completely renounce any gender classification (8, 9). There are also reports of individuals experiencing a continuous and rapid involuntary alternation between a male and female identity (10) or men who do not experience themselves as men but do not want to live as women (11, 12). In some countries, (*e.g.*, Nepal, Bangladesh, and Australia), these nonmale or nonfemale genders are officially recognized (13). Specific treatment protocols, however, have not yet been developed for these groups.

Instead of the term transsexualism, the current classification system of the American Psychiatric Association uses the term gender dysphoria in its diagnosis of persons who are not satisfied with their designated gender (14). The current version of the World Health Organization's ICD-10 still uses the term transsexualism when diagnosing adolescents and adults. However, for the ICD-11, the World Health Organization has proposed using the term "gender incongruence" (15).

Treating persons with GD/gender incongruence (15) was previously limited to relatively ineffective elixirs or creams. However, more effective endocrinology-based treatments became possible with the availability of testosterone in 1935 and diethylstilbestrol in 1938. Reports of individuals with GD/gender incongruence who were treated with hormones and gender-affirming surgery appeared in the press during the second half of the 20th century. The Harry Benjamin International Gender Dysphoria Association was founded in September 1979 and is now called the World Professional Association for Transgender Health (WPATH). WPATH published its first Standards of Care in 1979. These standards have since been regularly updated, providing guidance for treating persons with GD/gender incongruence (16).

Prior to 1975, few peer-reviewed articles were published concerning endocrine treatment of transgender persons. Since then, more than two thousand articles about various aspects of transgender care have appeared.

It is the purpose of this guideline to make detailed recommendations and suggestions, based on existing medical literature and clinical experience, that will enable treating physicians to maximize benefit and minimize risk when caring for individuals diagnosed with GD/gender incongruence.

In the future, we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols. Specifically, endocrine treatment protocols for GD/gender incongruence should include the careful assessment of the following: (1) the effects of prolonged delay of puberty in adolescents on bone health, gonadal function, and the brain (including effects on cognitive, emotional, social, and sexual development); (2) the effects of treatment in adults on sex hormone levels; (3) the requirement for and the effects of progestins and other agents used to suppress endogenous sex steroids during treatment; and (4) the risks and benefits of gender-affirming hormone treatment in older transgender people.

To successfully establish and enact these protocols, a commitment of mental health and endocrine investigators is required to collaborate in long-term, large-scale studies across countries that use the same diagnostic and inclusion criteria, medications, assay methods, and response assessment tools (*e.g.*, the European Network for the Investigation of Gender Incongruence) (17, 18).

Terminology and its use vary and continue to evolve. Table 1 contains the definitions of terms as they are used throughout this guideline.

Biological Determinants of Gender Identity Development

One's self-awareness as male or female changes gradually during infant life and childhood. This process of cognitive and affective learning evolves with interactions with parents, peers, and environment. A fairly accurate timetable exists outlining the steps in this process (19). Normative psychological literature, however, does not address if and when gender identity becomes crystallized and what factors contribute to the development of a gender identity that is not congruent with the gender of rearing. Results of studies from a variety of biomedical disciplines—genetic, endocrine, and neuroanatomic—support the concept that gender identity and/or gender expression (20) likely reflect a complex interplay of biological, environmental, and cultural factors (21, 22).

With respect to endocrine considerations, studies have failed to find differences in circulating levels of sex steroids between transgender and nontransgender individuals (23). However, studies in individuals with a disorder/difference of sex development (DSD) have informed our understanding of the role that hormones may play in gender identity outcome, even though most persons with GD/gender incongruence do not have a DSD. For example, although most 46,XX adult individuals with virilizing congenital adrenal hyperplasia caused by mutations in *CYP21A2* reported a female gender identity, the prevalence of GD/gender incongruence was much greater in this group than in the general population without a DSD. This supports the concept that there is a role for prenatal/postnatal androgens in gender development (24–26), although some studies indicate that prenatal androgens are more likely to affect gender behavior and sexual orientation rather than gender identity *per se* (27, 28).

Researchers have made similar observations regarding the potential role of androgens in the development of gender identity in other individuals with DSD. For example, a review of two groups of 46,XY persons, each with androgen synthesis deficiencies and female raised, reported transgender male (female-to-male) gender role changes in 56% to 63% and 39% to 64% of patients, respectively (29). Also, in 46,XY female-raised individuals with cloacal

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Table 1. Definitions of Terms Used in This 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.
Cisgender: This means not transgender. An alternative way to describe individuals who are not transgender is "non-transgender people."
Gender-affirming (hormone) treatment: See "gender reassignment"
Gender dysphoria: This is the distress and unease experienced if gender identity and designated gender are not completely congruent (see Table 2). In 2013, the American Psychiatric Association released the fifth edition of the DSM-5, which replaced "gender identity disorder" with "gender dysphoria" and changed the criteria for diagnosis.
Gender expression: This refers to external manifestations of gender, expressed through one's name, pronouns, clothing, haircut, behavior, voice, or body characteristics. Typically, transgender people seek to make their gender expression align with their gender identity, rather than their designated gender.
Gender identity/experienced gender: This refers to one's internal, deeply held sense of gender. For transgender people, their gender identity does not match their sex designated at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices. Unlike gender expression (see below), gender identity is not visible to others.
Gender identity disorder: This is the term used for GD/gender incongruence in previous versions of DSM (see "gender dysphoria"). The ICD-10 still uses the term for diagnosing child diagnoses, but the upcoming ICD-11 has proposed using "gender incongruence of childhood."
Gender incongruence: This is an umbrella term used when the gender identity and/or gender expression differs from what is typically associated with the designated gender. Gender incongruence is also the proposed name of the gender identity–related diagnoses in ICD-11. Not all individuals with gender incongruence have gender dysphoria or seek treatment.
Gender variance: See "gender incongruence"
Gender reassignment: This refers to the treatment procedure for those who want to adapt their bodies to the experienced gender by means of hormones and/or surgery. This is also called gender-confirming or gender-affirming treatment.
Gender-reassignment surgery (gender-confirming/gender-affirming surgery): These terms refer only to the surgical part of gender-confirming/gender-affirming treatment.
Gender role: This refers to behaviors, attitudes, and personality traits that a society (in a given culture and historical period) designates as masculine or feminine and/or that society associates with or considers typical of the social role of men or women.
Sex designated at birth: This refers to sex assigned at birth, usually based on genital anatomy.
Sex: This refers to attributes that characterize biological maleness or femaleness. The best known attributes include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics.
Sexual orientation: This term describes an individual's enduring physical and emotional attraction to another person. Gender identity and sexual orientation are not the same. Irrespective of their gender identity, transgender people may be attracted to women (gynephilic), attracted to men (androphilic), bisexual, asexual, or queer.
Transgender: This is an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment.
Transgender male (also: trans man, female-to-male, transgender male): This refers to individuals assigned female at birth but who identify and live as men.
Transgender woman (also: trans woman, male-to female, transgender female): This refers to individuals assigned male at birth but who identify and live as women.
Transition: This refers to the process during which transgender persons change their physical, social, and/or legal characteristics consistent with the affirmed gender identity. Prepubertal children may choose to transition socially.
Transsexual: This is an older term that originated in the medical and psychological communities to refer to individuals who have permanently transitioned through medical interventions or desired to do so.

exstrophy and penile agenesis, the occurrence of transgender male changes was significantly more prevalent than in the general population (30, 31). However, the fact that a high percentage of individuals with the same conditions did not change gender suggests that cultural factors may play a role as well.

With respect to genetics and gender identity, several studies have suggested heritability of GD/gender incongruence (32, 33). In particular, a study by Heylens *et al.* (33) demonstrated a 39.1% concordance rate for gender identity disorder (based on the DSM-IV criteria) in 23 monozygotic twin pairs but no concordance in 21 same-sex dizygotic or seven opposite-sex twin pairs. Although numerous investigators have sought to identify specific genes associated with GD/gender incongruence, such studies have been inconsistent and without strong statistical significance (34–38).

Studies focusing on brain structure suggest that the brain phenotypes of people with GD/gender incongruence differ in various ways from control males and females, but that there is not a complete sex reversal in brain structures (39).

In summary, although there is much that is still unknown with respect to gender identity and its expression, compelling studies support the concept that biologic factors, in addition to environmental factors, contribute to this fundamental aspect of human development.

Natural History of Children With GD/Gender Incongruence

With current knowledge, we cannot predict the psychosexual outcome for any specific child. Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence (20, 40). In adolescence, a significant number of these desisters identify as homosexual or bisexual. It may be that children who only showed some gender nonconforming characteristics have been included in the follow-up studies, because the DSM-IV text revision criteria for a diagnosis were rather broad. However, the persistence of GD/gender incongruence into adolescence is more likely if it had been extreme in childhood (41, 42). With the newer, stricter criteria of the DSM-5 (Table 2), persistence rates may well be different in future studies.

1.0 Evaluation of Youth and Adults

Gender-affirming treatment is a multidisciplinary effort. After evaluation, education, and diagnosis, treatment may include mental health care, hormone therapy, and/or surgical therapy. Together with an MHP, hormone-prescribing clinicians should examine the psychosocial impact of the potential changes on people's lives, including mental health, friends, family, jobs, and their role in society. Transgender individuals should be encouraged to experience living in the new gender role and assess whether this improves their quality of life. Although the focus of this guideline is gender-affirming hormone therapy, collaboration with appropriate professionals responsible for each aspect of treatment maximizes a successful outcome.

Diagnostic assessment and mental health care

GD/gender incongruence may be accompanied with psychological or psychiatric problems (43–51). It is therefore necessary that clinicians who prescribe hormones and are involved in diagnosis and psychosocial assessment meet the following criteria: (1) are competent in using the DSM and/or the ICD for diagnostic purposes, (2) are able to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) are trained in diagnosing psychiatric conditions, (4) undertake or refer for appropriate treatment, (5) are able to do a psychosocial assessment of the patient's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) regularly attend relevant professional meetings.

Because of the psychological vulnerability of many individuals with GD/gender incongruence, it is important that mental health care is available before, during, and sometimes also after transitioning. For children and adolescents, an MHP who has training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis, because assessing GD/gender incongruence in children and adolescents is often extremely complex.

During assessment, the clinician obtains information from the individual seeking gender-affirming treatment. In the case

Table 2. DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults

A. A marked incongruence between one's experienced/expressed gender and natal gender of at least 6 mo in duration, as manifested by at least two of the following:
1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender (or some alternative gender different from one's designated gender)
5. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender)
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
1. The condition exists with a disorder of sex development.
2. The condition is posttransitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (*e.g.*, penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

Reference: American Psychiatric Association (14).

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of adolescents, the clinician also obtains information from the parents or guardians regarding various aspects of the child's general and psychosexual development and current functioning. On the basis of this information, the clinician:

- decides whether the individual fulfills criteria for treatment (see Tables 2 and 3) for GD/gender incongruence (DSM-5) or transsexualism (DSM-5 and/or ICD-10);
- informs the individual about the possibilities and limitations of various kinds of treatment (hormonal/surgical and nonhormonal), and if medical treatment is desired, provides correct information to prevent unrealistically high expectations;
- assesses whether medical interventions may result in unfavorable psychological and social outcomes.

In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues. Literature on postoperative regret suggests that besides poor quality of surgery, severe psychiatric comorbidity and lack of support may interfere with positive outcomes (52–56).

For adolescents, the diagnostic procedure usually includes a complete psychodiagnostic assessment (57) and an assessment of the decision-making capability of the youth. An evaluation to assess the family's ability to endure stress, give support, and deal with the complexities of the adolescent's situation should be part of the diagnostic phase (58).

Social transitioning

A change in gender expression and role (which may involve living part time or full time in another gender role that is consistent with one's gender identity) may test the person's resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports. It assists both the individual and the clinician in their judgments about how to proceed (16). During social transitioning, the person's feelings about the social transformation (including coping with the responses of others) is a major focus of the counseling. The optimal timing for social transitioning may differ between individuals. Sometimes people wait until they start gender-affirming hormone treatment to make social transitioning easier, but individuals increasingly start social transitioning long before they receive medically supervised, gender-affirming hormone treatment.

Criteria

Adolescents and adults seeking gender-affirming hormone treatment and surgery should satisfy certain criteria before proceeding (16). Criteria for gender-affirming hormone therapy for adults are in Table 4, and criteria for gender-affirming hormone therapy for adolescents are in Table 5. Follow-up studies in adults meeting these criteria indicate a high satisfaction rate with treatment (59). However, the quality of evidence is usually low. A few follow-up studies on adolescents who fulfilled these criteria also indicated good treatment results (60–63).

Recommendations for Those Involved in the Gender-Affirming Hormone Treatment of Individuals With GD/Gender Incongruence

1.1. We advise that only trained MHPs who meet the following criteria should diagnose GD/gender incongruence in adults: (1) competence in using the DSM and/or the ICD for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or ICD for diagnostic

Table 3. ICD-10 Criteria for Transsexualism

Transsexualism (F64.0) has three criteria:
1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatments.
2. The transsexual identity has been present persistently for at least 2 y.
3. The disorder is not a symptom of another mental disorder or a genetic, DSD, or chromosomal abnormality.

Table 4. Criteria for Gender-Affirming Hormone Therapy for Adults

1. Persistent, well-documented gender dysphoria/gender incongruence
2. The capacity to make a fully informed decision and to consent for treatment
3. The age of majority in a given country (if younger, follow the criteria for adolescents)
4. Mental health concerns, if present, must be reasonably well controlled

Reproduced from World Professional Association for Transgender Health (16).

purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

Evidence

Individuals with gender identity issues may have psychological or psychiatric problems (43–48, 50, 51, 64, 65). It is therefore necessary that clinicians making the diagnosis are able to make a distinction between GD/gender incongruence and conditions that have similar features. Examples of conditions with similar features are body dysmorphic disorder, body identity integrity disorder (a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow wrong or inappropriate) (66), or certain forms of eunuchism (in which a person is preoccupied with or engages in castration and/or penectomy for

Table 5. Criteria for Gender-Affirming Hormone Therapy for Adolescents

Adolescents are eligible for GnRH agonist treatment if:

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

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),
- has confirmed that there are no medical contraindications to GnRH agonist treatment.

Adolescents are eligible for subsequent sex hormone treatment if:

1. A qualified MHP 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.

Reproduced from World Professional Association for Transgender Health (16).

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reasons that are not gender identity related) (11). Clinicians should also be able to diagnose psychiatric conditions accurately and ensure that these conditions are treated appropriately, particularly when the conditions may complicate treatment, affect the outcome of gender-affirming treatment, or be affected by hormone use.

Values and preferences

The task force placed a very high value on avoiding harm from hormone treatment in individuals who have conditions other than GD/gender incongruence and who may not benefit from the physical changes associated with this treatment and placed a low value on any potential benefit these persons believe they may derive from hormone treatment. This justifies the good practice statement.

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕◯◯)

Evidence

In most children diagnosed with GD/gender incongruence, it did not persist into adolescence. The percentages differed among studies, probably dependent on which version of the DSM clinicians used, the patient's age, the recruitment criteria, and perhaps cultural factors. However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence (20). If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty (40). Social transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.

This recommendation, however, does not imply that children should be discouraged from showing gender-variant behaviors or should be punished for exhibiting such behaviors. In individual cases, an early complete social transition may result in a more favorable outcome, but there are currently no criteria to identify the GD/gender-incongruent children to whom this applies. At the present time, clinical experience suggests that persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty.

Values and preferences

The task force placed a high value on avoiding harm with gender-affirming hormone therapy in prepubertal children with GD/gender incongruence. This justifies the strong recommendation in the face of low-quality evidence.

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕◯)

Remarks

Persons considering hormone use for gender affirmation need adequate information about this treatment in general and about fertility effects of hormone treatment in particular to make an informed and balanced decision (67, 68). Because young adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormonal interventions, consent and protocol education should include parents, the referring MHP(s), and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding the future fertility of adolescents or adults beginning gender-affirming treatment.

Treating early pubertal youth with GnRH analogs will temporarily impair spermatogenesis and oocyte maturation. Given that an increasing number of transgender youth want to preserve fertility potential, delaying or temporarily discontinuing GnRH analogs to promote gamete maturation is an option. This option is often not preferred, because mature sperm production is associated with later stages of puberty and with the significant development of secondary sex characteristics.

For those designated male at birth with GD/gender incongruence and who are in early puberty, sperm production and the development of the reproductive tract are insufficient for the cryopreservation of sperm. However, prolonged pubertal suppression using GnRH analogs is reversible and clinicians should inform these individuals that sperm production can be initiated following prolonged gonadotropin suppression. This can be accomplished by spontaneous gonadotropin recovery after

cessation of GnRH analogs or by gonadotropin treatment and will probably be associated with physical manifestations of testosterone production, as stated above. Note that there are no data in this population concerning the time required for sufficient spermatogenesis to collect enough sperm for later fertility. In males treated for precocious puberty, spermarche was reported 0.7 to 3 years after cessation of GnRH analogs (69). In adult men with gonadotropin deficiency, sperm are noted in seminal fluid by 6 to 12 months of gonadotropin treatment. However, sperm numbers when partners of these patients conceive are far below the "normal range" (70, 71).

In girls, no studies have reported long-term, adverse effects of pubertal suppression on ovarian function after treatment cessation (72, 73). Clinicians should inform adolescents that no data are available regarding either time to spontaneous ovulation after cessation of GnRH analogs or the response to ovulation induction following prolonged gonadotropin suppression.

In males with GD/gender incongruence, when medical treatment is started in a later phase of puberty or in adulthood, spermatogenesis is sufficient for cryopreservation and storage of sperm. *In vitro* spermatogenesis is currently under investigation. Restoration of spermatogenesis after prolonged estrogen treatment has not been studied.

In females with GD/gender incongruence, the effect of prolonged treatment with exogenous testosterone on ovarian function is uncertain. There have been reports of an increased incidence of polycystic ovaries in transgender males, both prior to and as a result of androgen treatment (74–77), although these reports were not confirmed by others (78). Pregnancy has been reported in transgender males who have had prolonged androgen treatment and have discontinued testosterone but have not had genital surgery (79, 80). A reproductive endocrine gynecologist can counsel patients before gender-affirming hormone treatment or surgery regarding potential fertility options (81). Techniques for cryopreservation of oocytes, embryos, and ovarian tissue continue to improve, and oocyte maturation of immature tissue is being studied (82).

2.0 Treatment of Adolescents

During the past decade, clinicians have progressively acknowledged the suffering of young adolescents with GD/gender incongruence. In some forms of GD/gender incongruence, psychological interventions may be useful and sufficient. However, for many adolescents with GD/gender incongruence, the pubertal physical changes are unbearable. As early medical intervention may prevent psychological harm, various clinics have decided to start treating young adolescents with GD/gender incongruence with puberty-suppressing medication (a GnRH analog). As compared with starting gender-affirming treatment long after the first phases of puberty, a benefit of pubertal suppression at early puberty may be a better psychological and physical outcome.

In girls, the first physical sign of puberty is the budding of the breasts followed by an increase in breast and fat tissue. Breast development is also associated with the pubertal growth spurt, and menarche occurs ~2 years later. In boys, the first physical change is testicular growth. A testicular volume ≥4 mL is seen as consistent with the initiation of physical puberty. At the beginning of puberty, estradiol and testosterone levels are still low and are best measured in the early morning with an ultrasensitive assay. From a testicular volume of 10 mL, daytime testosterone levels increase, leading to virilization (83). Note that pubic hair and/or axillary hair/odor may not reflect the onset of gonadarche; instead, it may reflect adrenarche alone.

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment (Table 5), and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 ⊕⊕◯◯)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty (Tanner stages G2/B2). (2 ⊕⊕◯◯)

Evidence

Pubertal suppression can expand the diagnostic phase by a long period, giving the subject more time to explore options and to live in the experienced gender before making a decision to proceed with gender-affirming sex hormone treatments and/or surgery, some of which is irreversible (84, 85). Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains (86).

Another reason to start blocking pubertal hormones early in puberty is that the physical outcome is improved compared with initiating physical transition after puberty has been completed (60, 62). Looking like a man or woman when living as the opposite sex creates difficult

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barriers with enormous life-long disadvantages. We therefore advise starting suppression in early puberty to prevent the irreversible development of undesirable secondary sex characteristics. However, adolescents with GD/gender incongruence should experience the first changes of their endogenous spontaneous puberty, because their emotional reaction to these first physical changes has diagnostic value in establishing the persistence of GD/gender incongruence (85). Thus, Tanner stage 2 is the optimal time to start pubertal suppression. However, pubertal suppression treatment in early puberty will limit the growth of the penis and scrotum, which will have a potential effect on future surgical treatments (87).

Clinicians can also use pubertal suppression in adolescents in later pubertal stages to stop menses in transgender males and prevent facial hair growth in transgender females. However, in contrast to the effects in early pubertal adolescents, physical sex characteristics (such as more advanced breast development in transgender boys and lowering of the voice and outgrowth of the jaw and brow in transgender girls) are not reversible.

Values and preferences

These recommendations place a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm from early pubertal suppression.

Remarks

Table 6 lists the Tanner stages of breast and male genital development. Careful documentation of hallmarks of pubertal development will ensure precise timing when initiating pubertal suppression once puberty has started. Clinicians can use pubertal LH and sex steroid levels to confirm that puberty has progressed sufficiently before starting pubertal suppression (88). Reference ranges for sex steroids by Tanner stage may vary depending on the assay used. Ultrasensitive sex steroid and gonadotropin assays will help clinicians document early pubertal changes.

Irreversible and, for GD/gender-incongruent adolescents, undesirable sex characteristics in female puberty are breasts, female body habitus, and, in some cases, relative short stature. In male puberty, they are a prominent Adam's apple; low voice; male bone configuration, such as a large jaw, big feet and hands, and tall stature; and male hair pattern on the face and extremities.

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕○○)

Evidence

Clinicians can suppress pubertal development and gonadal function most effectively via gonadotropin suppression using GnRH analogs. GnRH analogs are long-acting agonists that suppress gonadotropins by GnRH receptor desensitization after an initial increase of gonadotropins during ~10 days after the first and (to a lesser degree) the second injection (89). Antagonists immediately suppress pituitary gonadotropin secretion (90, 91). Long-acting GnRH analogs are the currently preferred treatment option. Clinicians may consider long-acting GnRH antagonists when evidence on their safety and efficacy in adolescents becomes available.

During GnRH analog treatment, slight development of secondary sex characteristics may regress, and in a later phase of pubertal development, it will stop. In girls, breast tissue will become atrophic, and menses will stop. In boys, virilization will stop, and testicular volume may decrease (92).

An advantage of using GnRH analogs is the reversibility of the intervention. If, after extensive exploration of his/her transition wish, the individual no longer desires transition, they can discontinue pubertal suppression. In subjects with

Table 6. Tanner Stages of Breast Development and Male External Genitalia

The description of Tanner stages for breast development:
1. Prepubertal
2. Breast and papilla elevated as small mound; areolar diameter increased
3. Breast and areola enlarged, no contour separation
4. Areola and papilla form secondary mound
5. Mature; nipple projects, areola part of general breast contour

For penis and testes:
1. Prepubertal, testicular volume <4 mL
2. Slight enlargement of penis; enlarged scrotum, pink, texture altered, testes 4–6 mL
3. Penis longer, testes larger (8–12 mL)
4. Penis and glans larger, including increase in breadth; testes larger (12–15 mL), scrotum dark
5. Penis adult size; testicular volume > 15 ml

Adapted from Lawrence (56).

precocious puberty, spontaneous pubertal development has been shown to resume after patients discontinue taking GnRH analogs (93).

Recommendations 2.1 to 2.3 are supported by a prospective follow-up study from The Netherlands. This report assessed mental health outcomes in 55 transgender adolescents/young adults (22 transgender females and 33 transgender males) at three time points: (1) before the start of GnRH agonist (average age of 14.8 years at start of treatment), (2) at initiation of gender-affirming hormones (average age of 16.7 years at start of treatment), and (3) 1 year after "gender-reassignment surgery" (average age of 20.7 years) (63). Despite a decrease in depression and an improvement in general mental health functioning, GD/gender incongruence persisted through pubertal suppression, as previously reported (86). However, following sex hormone treatment and gender-reassignment surgery, GD/gender incongruence was resolved and psychological functioning steadily improved (63). Furthermore, well-being was similar to or better than that reported by age-matched young adults from the general population, and none of the study participants regretted treatment. This study represents the first long-term follow-up of individuals managed according to currently existing clinical practice guidelines for transgender youth, and it underscores the benefit of the multidisciplinary approach pioneered in The Netherlands; however, further studies are needed.

Side effects

The primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization (which can theoretically be reversed with sex hormone treatment), compromised fertility if the person subsequently is treated with sex hormones, and unknown effects on brain development. Few data are available on the effect of GnRH analogs on BMD in adolescents with GD/gender incongruence. Initial data in GD/gender-incongruent subjects demonstrated no change of absolute areal BMD during 2 years of GnRH analog therapy but a decrease in BMD z scores (85). A recent study also suggested suboptimal bone mineral accrual during GnRH analog treatment. The study reported a decrease in areal BMD z scores and of bone mineral apparent density z scores (which takes the size of the bone into account) in 19 transgender males treated with GnRH analogs from a mean age of 15.0 years (standard deviation = 2.0 years) for a median duration of 1.5 years (0.3 to 5.2 years) and in 15 transgender females treated from 14.9 (±1.9) years for 1.3 years (0.5 to 3.8 years), although not all changes were statistically significant (94). There was incomplete catch-up at age 22 years after sex hormone treatment from age 16.6 (±1.4) years for a median duration of 5.8 years (3.0 to 8.0 years) in transgender females and from age 16.4 (±2.3) years for 5.4 years (2.8 to 7.8 years) in transgender males. Little is known about more prolonged use of GnRH analogs. Researchers reported normal BMD z scores at age 35 years in one individual who used GnRH analogs from age 13.7 years until age 18.6 years before initiating sex hormone treatment (65).

Additional data are available from individuals with late puberty or GnRH analog treatment of other indications. Some studies reported that men with constitutionally delayed puberty have decreased BMD in adulthood (95). However, other studies reported that these men have normal BMD (96, 97). Treating adults with GnRH analogs results in a decrease of BMD (98). In children with central precocious puberty, treatment with GnRH analogs has been found to result in a decrease of BMD during treatment by some (99) but not others (100). Studies have reported normal BMD after discontinuing therapy (69, 72, 73, 101, 102). In adolescents treated with growth hormone who are small for gestational age and have normal pubertal timing, 2-year GnRH analog treatments did not adversely affect BMD (103). Calcium supplementation may be beneficial in optimizing bone health in GnRH analog–treated individuals (104). There are no studies of vitamin D supplementation in this context, but clinicians should offer supplements to vitamin D–deficient adolescents. Physical activity, especially during growth, is important for bone mass in healthy individuals (103) and is therefore likely to be beneficial for bone health in GnRH analog–treated subjects.

GnRH analogs did not induce a change in body mass index standard deviation score in GD/gender-incongruent adolescents (94) but caused an increase in fat mass and decrease in lean body mass percentage (92). Studies in girls treated for precocious puberty also reported a stable body mass index standard deviation score during treatment (72) and body mass index and body composition comparable to controls after treatment (73).

Arterial hypertension has been reported as an adverse effect in a few girls treated with GnRH analogs for precocious/early puberty (105, 106). Blood pressure monitoring before and during treatment is recommended.

Individuals may also experience hot flashes, fatigue, and mood alterations as a consequence of pubertal suppression. There is no consensus on treatment of these side effects in this context.

It is recommended that any use of pubertal blockers (and subsequent use of sex hormones, as detailed below) include a discussion about implications for fertility (see recommendation 1.3). Transgender adolescents may

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want to preserve fertility, which may be otherwise compromised if puberty is suppressed at an early stage and the individual completes phenotypic transition with the use of sex hormones.

Limited data are available regarding the effects of GnRH analogs on brain development. A single cross-sectional study demonstrated no compromise of executive function (107), but animal data suggest there may be an effect of GnRH analogs on cognitive function (108).

Values and preferences

Our recommendation of GnRH analogs places a higher value on the superior efficacy, safety, and reversibility of the pubertal hormone suppression achieved (as compared with the alternatives) and a relatively lower value on limiting the cost of therapy. Of the available alternatives, depot and oral progestin preparations are effective. Experience with this treatment dates back prior to the emergence of GnRH analogs for treating precocious puberty in papers from the 1960s and early 1970s (109–112). These compounds are usually safe, but some side effects have been reported (113–115). Only two recent studies involved transgender youth (116, 117). One of these studies described the use of oral lynestrenol monotherapy followed by the addition of testosterone treatment in transgender boys who were at Tanner stage B4 or further at the start of treatment (117). They found lynestrenol safe, but gonadotropins were not fully suppressed. The study reported metrorrhagia in approximately half of the individuals, mainly in the first 6 months. Acne, headache, hot flashes, and fatigue were other frequent side effects. Another progestin that has been studied in the United States is medroxyprogesterone. This agent is not as effective as GnRH analogs in lowering endogenous sex hormones either and may be associated with other side effects (116). Progestin preparations may be an acceptable treatment for persons without access to GnRH analogs or with a needle phobia. If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see adult section).

Remarks

Measurements of gonadotropin and sex steroid levels give precise information about gonadal axis suppression, although there is insufficient evidence for any specific short-term monitoring scheme in children treated with GnRH analogs (88). If the gonadal axis is not completely suppressed—as evidenced by (for example) menses, erections, or progressive hair growth—the interval of GnRH analog treatment can be shortened or the dose increased. During treatment, adolescents should be monitored for negative effects of delaying puberty, including a halted growth spurt and impaired bone mineral accretion. Table 7 illustrates a suggested clinical protocol.

Anthropometric measurements and X-rays of the left hand to monitor bone age are informative for evaluating growth. To assess BMD, clinicians can perform dual-energy X-ray absorptiometry scans.

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule (see Table 8) after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years (Table 5). (1 ⊕⊕◯◯)

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 ⊕◯◯◯)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment (Table 9). (2 ⊕⊕◯◯)

Table 7. Baseline and Follow-Up Protocol During Suppression of Puberty

Every 3–6 mo
Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo
Laboratory: LH, FSH, E2/T, 25OH vitamin D
Every 1–2 y
Bone density using DXA
Bone age on X-ray of the left hand (if clinically indicated)

Adapted from Hembree *et al.* (118).

Abbreviations: DXA, dual-energy X-ray absorptiometry; E2, estradiol; FSH, follicle stimulating hormone; LH, luteinizing hormone; T, testosterone;

Table 8. Protocol Induction of Puberty

Induction of female puberty with oral 17β-estradiol, increasing the dose every 6 mo:
- 5 μg/kg/d
- 10 μg/kg/d
- 15 μg/kg/d
- 20 μg/kg/d
- Adult dose = 2–6 mg/d
- *In postpubertal transgender female adolescents, the dose of 17β-estradiol can be increased more rapidly:*
  - 1 mg/d for 6 mo
  - 2 mg/d

Induction of female puberty with transdermal 17β-estradiol, increasing the dose every 6 mo (new patch is placed every 3.5 d):
- 6.25–12.5 μg/24 h (cut 25-μg patch into quarters, then halves)
- 25 μg/24 h
- 37.5 μg/24 h
- Adult dose = 50–200 μg/24 h
- *For alternatives once at adult dose, see Table 11.*
- *Adjust maintenance dose to mimic physiological estradiol levels (see Table 15).*

Induction of male puberty with testosterone esters increasing the dose every 6 mo (IM or SC):
- 25 mg/m^2/2 wk (or alternatively, half this dose weekly, or double the dose every 4 wk)
- 50 mg/m^2/2 wk
- 75 mg/m^2/2 wk
- 100 mg/m^2/2 wk
- Adult dose = 100–200 mg every 2 wk
- *In postpubertal transgender male adolescents the dose of testosterone esters can be increased more rapidly:*
  - 75 mg/2 wk for 6 mo
  - 125 mg/2 wk
- *For alternatives once at adult dose, see Table 11.*
- *Adjust maintenance dose to mimic physiological testosterone levels (see Table 14).*

Adapted from Hembree *et al.* (118).

Abbreviations: IM, intramuscularly; SC, subcutaneously.

Evidence

Adolescents develop competence in decision making at their own pace. Ideally, the supervising medical professionals should individually assess this competence, although no objective tools to make such an assessment are currently available.

Many adolescents have achieved a reasonable level of competence by age 15 to 16 years (119), and in many countries 16-year-olds are legally competent with regard to medical decision making (120). However, others believe that although some capacities are generally achieved before age 16 years, other abilities (such as good risk assessment) do not develop until well after 18 years (121). They suggest that health care procedures should be divided along a matrix of relative risk, so that younger adolescents can be allowed to decide about low-risk procedures, such as most diagnostic tests and common therapies, but not about high-risk procedures, such as most surgical procedures (121).

Currently available data from transgender adolescents support treatment with sex hormones starting at age 16 years (63, 122). However, some patients may incur potential risks by waiting until age 16 years. These include the potential risk to bone health if puberty is suppressed

Table 9. Baseline and Follow-up Protocol During Induction of Puberty

Every 3–6 mo
- •Anthropometry: height, weight, sitting height, blood pressure, Tanner stages

Every 6–12 mo
- •In transgender males: hemoglobin/hematocrit, lipids, testosterone, 25OH vitamin D
- •In transgender females: prolactin, estradiol, 25OH vitamin D

Every 1–2 y
- •BMD using DXA
- •Bone age on X-ray of the left hand (if clinically indicated)

BMD should be monitored into adulthood (until the age of 25–30 y or until peak bone mass has been reached).
For recommendations on monitoring once pubertal induction has been completed, see Tables 14 and 15.

Adapted from Hembree *et al.* (118).

Abbreviation: DXA, dual-energy X-ray absorptiometry.

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for 6 to 7 years before initiating sex hormones (*e.g.*, if someone reached Tanner stage 2 at age 9-10 years old). Additionally, there may be concerns about inappropriate height and potential harm to mental health (emotional and social isolation) if initiation of secondary sex characteristics must wait until the person has reached 16 years of age. However, only minimal data supporting earlier use of gender-affirming hormones in transgender adolescents currently exist (63). Clearly, long-term studies are needed to determine the optimal age of sex hormone treatment in GD/gender-incongruent adolescents.

The MHP who has followed the adolescent during GnRH analog treatment plays an essential role in assessing whether the adolescent is eligible to start sex hormone therapy and capable of consenting to this treatment (Table 5). Support of the family/environment is essential. Prior to the start of sex hormones, clinicians should discuss the implications for fertility (see recommendation 1.5). Throughout pubertal induction, an MHP and a pediatric endocrinologist (or other clinician competent in the evaluation and induction of pubertal development) should monitor the adolescent. In addition to monitoring therapy, it is also important to pay attention to general adolescent health issues, including healthy life style choices, such as not smoking, contraception, and appropriate vaccinations (*e.g.*, human papillomavirus).

For the induction of puberty, clinicians can use a similar dose scheme for hypogonadal adolescents with GD/gender incongruence as they use in other individuals with hypogonadism, carefully monitoring for desired and undesired effects (Table 8). In transgender female adolescents, transdermal 17β-estradiol may be an alternative for oral 17β-estradiol. It is increasingly used for pubertal induction in hypogonadal females. However, the absence of low-dose estrogen patches may be a problem. As a result, individuals may need to cut patches to size themselves to achieve appropriate dosing (123). In transgender male adolescents, clinicians can give testosterone injections intramuscularly or subcutaneously (124, 125).

When puberty is initiated with a gradually increasing schedule of sex steroid doses, the initial levels will not be high enough to suppress endogenous sex steroid secretion. Gonadotropin secretion and endogenous production of testosterone may resume and interfere with the effectiveness of estrogen treatment, in transgender female adolescents (126, 127). Therefore, continuation of GnRH analog treatment is advised until gonadectomy. Given that GD/gender-incongruent adolescents may opt not to have gonadectomy, long-term studies are necessary to examine the potential risks of prolonged GnRH analog treatment. Alternatively, in transgender male adolescents, GnRH analog treatment can be discontinued once an adult dose of testosterone has been reached and the individual is well virilized. If uterine bleeding occurs, a progestin can be added. However, the combined use of a GnRH analog (for ovarian suppression) and testosterone may enable phenotypic transition with a lower dose of testosterone in comparison with testosterone alone. If there is a wish or need to discontinue GnRH analog treatment in transgender female adolescents, they may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see section 3.0 "Hormonal Therapy for Transgender Adults").

Values and preferences

The recommendation to initiate pubertal induction only when the individual has sufficient mental capacity (roughly age 16 years) to give informed consent for this partly irreversible treatment places a higher value on the ability of the adolescent to fully understand and oversee the partially irreversible consequences of sex hormone treatment and to give informed consent. It places a lower value on the possible negative effects of delayed puberty. We may not currently have the means to weigh adequately the potential benefits of waiting until around age 16 years to initiate sex hormones vs the potential risks/harm to BMD and the sense of social isolation from having the timing of puberty be so out of sync with peers (128).

Remarks

Before starting sex hormone treatment, effects on fertility and options for fertility preservation should be discussed. Adult height may be a concern in transgender adolescents. In a transgender female adolescent, clinicians may consider higher doses of estrogen or a more rapid tempo of dose escalation during pubertal induction. There are no established treatments yet to augment adult height in a transgender male adolescent with open epiphyses during pubertal induction. It is not uncommon for transgender adolescents to present for clinical services after having completed or nearly completed puberty. In such cases, induction of puberty with sex hormones can be done more rapidly (see Table 8). Additionally, an adult dose of testosterone in transgender male adolescents may suffice to suppress the gonadal axis without the need to use a separate agent. At the appropriate time, the multidisciplinary team should adequately prepare the adolescent for transition to adult care.

3.0 Hormonal Therapy for Transgender Adults

The two major goals of hormonal therapy are (1) to reduce endogenous sex hormone levels, and thus reduce

the secondary sex characteristics of the individual's designated gender, and (2) to replace endogenous sex hormone levels consistent with the individual's gender identity by using the principles of hormone replacement treatment of hypogonadal patients. The timing of these two goals and the age at which to begin treatment with the sex hormones of the chosen gender is codetermined in collaboration with both the person pursuing transition and the health care providers. The treatment team should include a medical provider knowledgeable in transgender hormone therapy, an MHP knowledgeable in GD/gender incongruence and the mental health concerns of transition, and a primary care provider able to provide care appropriate for transgender individuals. The physical changes induced by this sex hormone transition are usually accompanied by an improvement in mental well-being (129, 130).

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕◯)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment (Table 10). (1 |⊕⊕⊕◯)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕◯◯)

Evidence

It is the responsibility of the treating clinician to confirm that the person fulfills criteria for treatment. The treating clinician should become familiar with the terms and criteria presented in Tables 1–5 and take a thorough history from the patient in collaboration with the other members of the treatment team. The treating clinician must ensure that the desire for transition is appropriate; the consequences, risks, and benefits of treatment are well understood; and the desire for transition persists. They also need to discuss fertility preservation options (see recommendation 1.3) (67, 68).

Transgender males

Clinical studies have demonstrated the efficacy of several different androgen preparations to induce masculinization in transgender males (Appendix A) (113, 114, 131–134). Regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism (135). Clinicians can use either parenteral or transdermal preparations to achieve testosterone values in the normal male range (this is dependent on the specific assay, but is typically 320 to 1000 ng/dL) (Table 11) (136). Sustained supraphysiologic levels of testosterone increase the risk of adverse reactions (see section 4.0 "Adverse Outcome Prevention and Long-Term Care") and should be avoided.

Similar to androgen therapy in hypogonadal men, testosterone treatment in transgender males results in increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire (137).

Table 10. Medical Risks Associated With Sex Hormone Therapy

Transgender female: estrogen
Very high risk of adverse outcomes:
•Thromboembolic disease
Moderate risk of adverse outcomes:
•Macroprolactinoma
•Breast cancer
•Coronary artery disease
•Cerebrovascular disease
•Cholelithiasis
•Hypertriglyceridemia
Transgender male: testosterone
Very high risk of adverse outcomes:
•Erythrocytosis (hematocrit > 50%)
Moderate risk of adverse outcomes:
•Severe liver dysfunction (transaminases > threefold upper limit of normal)
•Coronary artery disease
•Cerebrovascular disease
•Hypertension
•Breast or uterine cancer

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Table 11. Hormone Regimens in Transgender Persons

Transgender females[a]	
Estrogen	
Oral	
Estradiol	2.0–6.0 mg/d
Transdermal	
Estradiol transdermal patch (New patch placed every 3–5 d)	0.025–0.2 mg/d
Parenteral	
Estradiol valerate or cypionate	5–30 mg IM every 2 wk 2–10 mg IM every week
Anti-androgens	
Spironolactone	100–300 mg/d
Cyproterone acetate[b]	25–50 mg/d
GnRH agonist	3.75 mg SQ (SC) monthly 11.25 mg SQ (SC) 3-monthly
Transgender males	
Testosterone	
Parenteral testosterone	
Testosterone enanthate or cypionate	100–200 mg SQ (IM) every 2 wk or SQ (SC) 50% per week
Testosterone undecanoate[c]	1000 mg every 12 wk
Transdermal testosterone	
Testosterone gel 1.6%[d]	50–100 mg/d
Testosterone transdermal patch	2.5–7.5 mg/d

Abbreviations: IM, intramuscularly; SQ, sequentially; SC, subcutaneously.

[a]Estrogens used with or without antiandrogens or GnRH agonist.

[b]Not available in the United States.

[c]One thousand milligrams initially followed by an injection at 6 wk then at 12-wk intervals.

[d]Avoid cutaneous transfer to other individuals.

In transgender males, testosterone will result in clitoromegaly, temporary or permanent decreased fertility, deepening of the voice, cessation of menses (usually), and a significant increase in body hair, particularly on the face, chest, and abdomen. Cessation of menses may occur within a few months with testosterone treatment alone, although high doses of testosterone may be required. If uterine bleeding continues, clinicians may consider the addition of a progestational agent or endometrial ablation (138). Clinicians may also administer GnRH analogs or depot medroxyprogesterone to stop menses prior to testosterone treatment.

Transgender females

The hormone regimen for transgender females is more complex than the transgender male regimen (Appendix B). Treatment with physiologic doses of estrogen alone is insufficient to suppress testosterone levels into the normal range for females (139). Most published clinical studies report the need for adjunctive therapy to achieve testosterone levels in the female range (21, 113, 114, 132–134, 139, 140).

Multiple adjunctive medications are available, such as progestins with antiandrogen activity and GnRH agonists (141). Spironolactone works by directly blocking androgens during their interaction with the androgen receptor (114, 133, 142). It may also have estrogenic activity (143). Cyproterone acetate, a progestational compound with antiandrogenic properties (113, 132, 144), is widely used in Europe. 5α-Reductase inhibitors do not reduce testosterone levels and have adverse effects (145).

Dittrich *et al.* (141) reported that monthly doses of the GnRH agonist goserelin acetate in combination with estrogen were effective in reducing testosterone levels with a low incidence of adverse reactions in 60 transgender females. Leuprolide and transdermal estrogen were as effective as cyproterone and transdermal estrogen in a comparative retrospective study (146).

Patients can take estrogen as oral conjugated estrogens, oral 17β-estradiol, or transdermal 17β-estradiol. Among estrogen options, the increased risk of thromboembolic events associated with estrogens in general seems most concerning with ethinyl estradiol specifically (134, 140, 141), which is why we specifically suggest that it not be used in any transgender treatment plan. Data distinguishing among other estrogen options are less well established although there is some thought that oral routes of administration are more thrombogenic due to the "first pass effect" than are transdermal and parenteral routes, and that the risk of thromboembolic events is dose-dependent. Injectable estrogen and sublingual

estrogen may benefit from avoiding the first pass effect, but they can result in more rapid peaks with greater overall periodicity and thus are more difficult to monitor (147, 148). However, there are no data demonstrating that increased periodicity is harmful otherwise.

Clinicians can use serum estradiol levels to monitor oral, transdermal, and intramuscular estradiol. Blood tests cannot monitor conjugated estrogens or synthetic estrogen use. Clinicians should measure serum estradiol and serum testosterone and maintain them at the level for premenopausal females (100 to 200 pg/mL and <50 ng/dL, respectively). The transdermal preparations and injectable estradiol cypionate or valerate preparations may confer an advantage in older transgender females who may be at higher risk for thromboembolic disease (149).

Values

Our recommendation to maintain levels of gender-affirming hormones in the normal adult range places a high value on the avoidance of the long-term complications of pharmacologic doses. Those patients receiving endocrine treatment who have relative contraindications to hormones should have an in-depth discussion with their physician to balance the risks and benefits of therapy.

Remarks

Clinicians should inform all endocrine-treated individuals of all risks and benefits of gender-affirming hormones prior to initiating therapy. Clinicians should strongly encourage tobacco use cessation in transgender females to avoid increased risk of VTE and cardiovascular complications. We strongly discourage the unsupervised use of hormone therapy (150).

Not all individuals with GD/gender incongruence seek treatment as described (*e.g.*, male-to-eunuchs and individuals seeking partial transition). Tailoring current protocols to the individual may be done within the context of accepted safety guidelines using a multidisciplinary approach including mental health. No evidence-based protocols are available for these groups (151). We need prospective studies to better understand treatment options for these persons.

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕○○○)

Evidence

Transgender males

Physical changes that are expected to occur during the first 1 to 6 months of testosterone therapy include cessation of menses, increased sexual desire, increased facial and body hair, increased oiliness of skin, increased muscle, and redistribution of fat mass. Changes that occur within the first year of testosterone therapy include deepening of the voice (152, 153), clitoromegaly, and male pattern hair loss (in some cases) (114, 144, 154, 155) (Table 12).

Transgender females

Physical changes that may occur in transgender females in the first 3 to 12 months of estrogen and antiandrogen therapy include decreased sexual desire, decreased spontaneous erections, decreased facial and body hair (usually mild), decreased oiliness of skin, increased breast tissue growth, and redistribution of fat mass (114, 139, 149, 154, 155, 161) (Table 13). Breast development is generally maximal at 2 years after initiating hormones (114, 139, 149, 155). Over a long period of time, the prostate gland and testicles will undergo atrophy.

Although the time course of breast development in transgender females has been studied (150), precise information about other changes induced by sex hormones is lacking (141). There is a great deal of variability among individuals, as evidenced during pubertal development. We all know that a major concern for transgender females is breast development. If we work with estrogens, the result will be often not what the transgender female expects.

Alternatively, there are transgender females who report an anecdotal improved breast development, mood, or sexual desire with the use of progestogens. However, there have been no well-designed studies of the role of progestogens in feminizing hormone regimens, so the question is still open.

Our knowledge concerning the natural history and effects of different cross-sex hormone therapies on breast

Table 12. Masculinizing Effects in Transgender Males

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	—[a]
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	—[b]
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157), Wierckx *et al.* (158).

[a] Prevention and treatment as recommended for biological men.

[b] Menorrhagia requires diagnosis and treatment by a gynecologist.

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Table 13. Feminizing Effects in Transgender Females

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y[a]
Scalp hair	Variable	—[b]
Voice changes	None	—[c]

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157).

[a]Complete removal of male sexual hair requires electrolysis or laser treatment or both.

[b]Familial scalp hair loss may occur if estrogens are stopped.

[c]Treatment by speech pathologists for voice training is most effective.

development in transgender females is extremely sparse and based on the low quality of evidence. Current evidence does not indicate that progestogens enhance breast development in transgender females, nor does evidence prove the absence of such an effect. This prevents us from drawing any firm conclusion at this moment and demonstrates the need for further research to clarify these important clinical questions (162).

Values and preferences

Transgender persons have very high expectations regarding the physical changes of hormone treatment and are aware that body changes can be enhanced by surgical procedures (*e.g.*, breast, face, and body habitus). Clear expectations for the extent and timing of sex hormone–induced changes may prevent the potential harm and expense of unnecessary procedures.

4.0 Adverse Outcome Prevention and Long-Term Care

Hormone therapy for transgender males and females confers many of the same risks associated with sex hormone replacement therapy in nontransgender persons. The risks arise from and are worsened by inadvertent or intentional use of supraphysiologic doses of sex hormones, as well as use of inadequate doses of sex hormones to maintain normal physiology (131, 139).

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 ⊕⊕○○)

Evidence

Pretreatment screening and appropriate regular medical monitoring are recommended for both transgender males and females during the endocrine transition and periodically thereafter (26, 155). Clinicians should monitor weight and blood pressure, conduct physical exams, and assess routine health questions, such as tobacco use, symptoms of depression, and risk of adverse events such as deep vein thrombosis/pulmonary embolism and other adverse effects of sex steroids.

Transgender males

Table 14 contains a standard monitoring plan for transgender males on testosterone therapy (154, 159). Key issues include maintaining testosterone levels in the physiologic normal male range and avoiding adverse events resulting from excess testosterone therapy, particularly erythrocytosis, sleep apnea, hypertension, excessive weight gain, salt retention, lipid changes, and excessive or cystic acne (135).

Because oral 17-alkylated testosterone is not recommended, serious hepatic toxicity is not anticipated with parenteral or transdermal testosterone use (163, 164). Past concerns regarding liver toxicity with testosterone have been alleviated with subsequent reports that indicate the risk of serious liver disease is minimal (144, 165, 166).

Transgender females

Table 15 contains a standard monitoring plan for transgender females on estrogens, gonadotropin suppression, or antiandrogens (160). Key issues include avoiding supraphysiologic doses or blood levels of estrogen that may lead to increased risk for thromboembolic disease, liver dysfunction, and hypertension. Clinicians should monitor serum estradiol levels using laboratories participating in external quality control, as measurements of estradiol in blood can be very challenging (167).

VTE may be a serious complication. A study reported a 20-fold increase in venous thromboembolic disease in a large cohort of Dutch transgender subjects (161). This increase may have been associated with the use of the synthetic estrogen, ethinyl estradiol (149). The incidence decreased when clinicians stopped administering ethinyl estradiol (161). Thus, the use of synthetic estrogens and conjugated estrogens is undesirable because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease. In a German gender clinic, deep vein thrombosis occurred in 1 of 60 of transgender females treated with a GnRH analog and oral

Table 14. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Male

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 3 mo until levels are in the normal physiologic male range:[a]
   a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. The target level is 400–700 ng/dL to 400 ng/dL. Alternatively, measure peak and trough levels to ensure levels remain in the normal male range.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. If the level is <400 ng/dL, adjust dosing interval.
   c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 wk of daily application (at least 2 h after application).
3. Measure hematocrit or hemoglobin at baseline and every 3 mo for the first year and then one to two times a year. Monitor weight, blood pressure, and lipids at regular intervals.
4. Screening for osteoporosis should be conducted in those who stop testosterone treatment, are not compliant with hormone therapy, or who develop risks for bone loss.
5. If cervical tissue is present, monitoring as recommended by the American College of Obstetricians and Gynecologists.
6. Ovariectomy can be considered after completion of hormone transition.
7. Conduct sub- and periareolar annual breast examinations if mastectomy performed. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

[a]Adapted from Lapauw *et al.* (154) and Ott *et al.* (159).

estradiol (141). The patient who developed a deep vein thrombosis was found to have a homozygous C677 T mutation in the methylenetetrahydrofolate reductase gene. In an Austrian gender clinic, administering gender-affirming hormones to 162 transgender females and 89 transgender males was not associated with VTE, despite an 8.0% and 5.6% incidence of thrombophilia (159). A more recent multinational study reported only 10 cases of VTE from a cohort of 1073 subjects (168). Thrombophilia screening of transgender persons initiating hormone treatment should be restricted to those with a personal or family history of VTE (159). Monitoring D-dimer levels during treatment is not recommended (169).

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 l⊕⊕◯◯)

Evidence

Estrogen therapy can increase the growth of pituitary lactrotroph cells. There have been several reports of prolactinomas occurring after long-term, high-dose estrogen therapy (170–173). Up to 20% of transgender females treated with estrogens may have elevations in prolactin levels associated with enlargement of the pituitary gland (156). In most cases, the serum prolactin levels will return to the normal range with a reduction or discontinuation of the estrogen therapy or discontinuation of cyproterone acetate (157, 174, 175).

The onset and time course of hyperprolactinemia during estrogen treatment are not known. Clinicians should measure prolactin levels at baseline and then at least annually during the transition period and every 2 years thereafter. Given that only a few case studies reported prolactinomas, and prolactinomas were not reported in large cohorts of estrogen-treated persons, the risk is likely to be very low. Because the major presenting findings of microprolactinomas (hypogonadism and sometimes gynecomastia) are not apparent in transgender females, clinicians may perform radiologic examinations of the pituitary in those patients whose prolactin levels persistently increase despite stable or reduced estrogen levels. Some transgender individuals receive psychotropic medications that can increase prolactin levels (174).

Table 15. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Female

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 mo.
   a. Serum testosterone levels should be <50 ng/dL.
   b. Serum estradiol should not exceed the peak physiologic range: 100–200 pg/mL.
3. For individuals on spironolactone, serum electrolytes, particularly potassium, should be monitored every 3 mo in the first year and annually thereafter.
4. Routine cancer screening is recommended, as in nontransgender individuals (all tissues present).
5. Consider BMD testing at baseline (160). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not compliant with hormone therapy.

This table presents strong recommendations and does not include lower level recommendations.

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4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕○○)

Evidence

Transgender males

Administering testosterone to transgender males results in a more atherogenic lipid profile with lowered high-density lipoprotein cholesterol and higher triglyceride and low-density lipoprotein cholesterol values (176–179). Studies of the effect of testosterone on insulin sensitivity have mixed results (178, 180). A randomized, open-label uncontrolled safety study of transgender males treated with testosterone undecanoate demonstrated no insulin resistance after 1 year (181, 182). Numerous studies have demonstrated the effects of sex hormone treatment on the cardiovascular system (160, 179, 183, 184). Long-term studies from The Netherlands found no increased risk for cardiovascular mortality (161). Likewise, a meta-analysis of 19 randomized trials in nontransgender males on testosterone replacement showed no increased incidence of cardiovascular events (185). A systematic review of the literature found that data were insufficient (due to very low–quality evidence) to allow a meaningful assessment of patient-important outcomes, such as death, stroke, myocardial infarction, or VTE in transgender males (176). Future research is needed to ascertain the potential harm of hormonal therapies (176). Clinicians should manage cardiovascular risk factors as they emerge according to established guidelines (186).

Transgender females

A prospective study of transgender females found favorable changes in lipid parameters with increased high-density lipoprotein and decreased low-density lipoprotein concentrations (178). However, increased weight, blood pressure, and markers of insulin resistance attenuated these favorable lipid changes. In a meta-analysis, only serum triglycerides were higher at ≥24 months without changes in other parameters (187). The largest cohort of transgender females (mean age 41 years, followed for a mean of 10 years) showed no increase in cardiovascular mortality despite a 32% rate of tobacco use (161).

Thus, there is limited evidence to determine whether estrogen is protective or detrimental on lipid and glucose metabolism in transgender females (176). With aging, there is usually an increase of body weight. Therefore, as with nontransgender individuals, clinicians should monitor and manage glucose and lipid metabolism and blood pressure regularly according to established guidelines (186).

4.4. We recommend that clinicians obtain BMD measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕○○)

Evidence

Transgender males

Baseline bone mineral measurements in transgender males are generally in the expected range for their pretreatment gender (188). However, adequate dosing of testosterone is important to maintain bone mass in transgender males (189, 190). In one study (190), serum LH levels were inversely related to BMD, suggesting that low levels of sex hormones were associated with bone loss. Thus, LH levels in the normal range may serve as an indicator of the adequacy of sex steroid administration to preserve bone mass. The protective effect of testosterone may be mediated by peripheral conversion to estradiol, both systemically and locally in the bone.

Transgender females

A baseline study of BMD reported T scores less than −2.5 in 16% of transgender females (191). In aging males, studies suggest that serum estradiol more positively correlates with BMD than does testosterone (192, 193) and is more important for peak bone mass (194). Estrogen preserves BMD in transgender females who continue on estrogen and antiandrogen therapies (188, 190, 191, 195, 196).

Fracture data in transgender males and females are not available. Transgender persons who have undergone gonadectomy may choose not to continue consistent sex steroid treatment after hormonal and surgical sex reassignment, thereby becoming at risk for bone loss. There have been no studies to determine whether clinicians should use the sex assigned at birth or affirmed gender for assessing osteoporosis (*e.g.*, when using the FRAX tool). Although some researchers use the sex assigned at birth (with the assumption that bone mass has usually peaked for transgender people who initiate hormones in early adulthood), this should be assessed on a case-by-case basis until there are more data available. This assumption will be further complicated by the increasing prevalence of transgender people who undergo hormonal transition at a pubertal age or soon after puberty. Sex for comparison within risk assessment tools may be based on the age at which hormones were initiated and the length of exposure to hormones. In some cases, it may be

reasonable to assess risk using both the male and female calculators and using an intermediate value. Because all subjects underwent normal pubertal development, with known effects on bone size, reference values for birth sex were used for all participants (154).

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for those designated female at birth. (2 ⊕⊕◯◯)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 ⊕◯◯◯)

Evidence

Studies have reported a few cases of breast cancer in transgender females (197–200). A Dutch study of 1800 transgender females followed for a mean of 15 years (range of 1 30 years) found one case of breast cancer. The Women's Health Initiative study reported that females taking conjugated equine estrogen without progesterone for 7 years did not have an increased risk of breast cancer as compared with females taking placebo (137).

In transgender males, a large retrospective study conducted at the U.S. Veterans Affairs medical health system identified seven breast cancers (194). The authors reported that this was not above the expected rate of breast cancers in cisgender females in this cohort. Furthermore, they did report one breast cancer that developed in a transgender male patient after mastectomy, supporting the fact that breast cancer can occur even after mastectomy. Indeed, there have been case reports of breast cancer developing in subareolar tissue in transgender males, which occurred after mastectomy (201, 202).

Women with primary hypogonadism (Turner syndrome) treated with estrogen replacement exhibited a significantly decreased incidence of breast cancer as compared with national standardized incidence ratios (203, 204). These studies suggest that estrogen therapy does not increase the risk of breast cancer in the short term (<20 to 30 years). We need long-term studies to determine the actual risk, as well as the role of screening mammograms. Regular examinations and gynecologic advice should determine monitoring for breast cancer.

Prostate cancer is very rare before the age of 40, especially with androgen deprivation therapy (205). Childhood or pubertal castration results in regression of the prostate and adult castration reverses benign prostate hypertrophy (206). Although van Kesteren *et al.* (207) reported that estrogen therapy does not induce hypertrophy or premalignant changes in the prostates of transgender females, studies have reported cases of benign prostatic hyperplasia in transgender females treated with estrogens for 20 to 25 years (208, 209). Studies have also reported a few cases of prostate carcinoma in transgender females (210–214).

Transgender females may feel uncomfortable scheduling regular prostate examinations. Gynecologists are not trained to screen for prostate cancer or to monitor prostate growth. Thus, it may be reasonable for transgender females who transitioned after age 20 years to have annual screening digital rectal examinations after age 50 years and prostate-specific antigen tests consistent with U.S. Preventive Services Task Force Guidelines (215).

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

Evidence

Although aromatization of testosterone to estradiol in transgender males has been suggested as a risk factor for endometrial cancer (216), no cases have been reported. When transgender males undergo hysterectomy, the uterus is small and there is endometrial atrophy (217, 218). Studies have reported cases of ovarian cancer (219, 220). Although there is limited evidence for increased risk of reproductive tract cancers in transgender males, health care providers should determine the medical necessity of a laparoscopic total hysterectomy as part of a gender-affirming surgery to prevent reproductive tract cancer (221).

Values

Given the discomfort that transgender males experience accessing gynecologic care, our recommendation for the medical necessity of total hysterectomy and oophorectomy places a high value on eliminating the risks of female reproductive tract disease and cancer and a lower value on avoiding the risks of these surgical procedures (related to the surgery and to the potential undesirable health consequences of oophorectomy) and their associated costs.

Remarks

The sexual orientation and type of sexual practices will determine the need and types of gynecologic care required following transition. Additionally, in certain countries, the approval required to change the sex in a birth certificate for transgender males may be dependent on having a complete hysterectomy. Clinicians should help patients research nonmedical administrative criteria and

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provide counseling. If individuals decide not to undergo hysterectomy, screening for cervical cancer is the same as all other females.

5.0 Surgery for Sex Reassignment and Gender Confirmation

For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role. The type of surgery falls into two main categories: (1) those that directly affect fertility and (2) those that do not. Those that change fertility (previously called sex reassignment surgery) include genital surgery to remove the penis and gonads in the male and removal of the uterus and gonads in the female. The surgeries that effect fertility are often governed by the legal system of the state or country in which they are performed. Other gender-conforming surgeries that do not directly affect fertility are not so tightly governed.

Gender-affirming surgical techniques have improved markedly during the past 10 years. Reconstructive genital surgery that preserves neurologic sensation is now the standard. The satisfaction rate with surgical reassignment of sex is now very high (187). Additionally, the mental health of the individual seems to be improved by participating in a treatment program that defines a pathway of gender-affirming treatment that includes hormones and surgery (130, 144) (Table 16).

Surgery that affects fertility is irreversible. The World Professional Association for Transgender Health Standards of Care (222) emphasizes that the "threshold of 18 should not be seen as an indication in itself for active intervention." If the social transition has not been satisfactory, if the person is not satisfied with or is ambivalent about the effects of sex hormone treatment, or if the person is ambivalent about surgery then the individual should not be referred for surgery (223, 224).

Gender-affirming genital surgeries for transgender females that affect fertility include gonadectomy, penectomy, and creation of a neovagina (225, 226). Surgeons often invert the skin of the penis to form the wall of the vagina, and several literatures reviews have reported on outcomes (227). Sometimes there is inadequate tissue to form a full neovagina, so clinicians have revisited using intestine and found it to be successful (87, 228, 229). Some newer vaginoplasty techniques may involve autologuous oral epithelial cells (230, 231).

The scrotum becomes the labia majora. Surgeons use reconstructive surgery to fashion the clitoris and its hood, preserving the neurovascular bundle at the tip of the penis as the neurosensory supply to the clitoris. Some surgeons are also creating a sensate pedicled-spot adding a G spot to the neovagina to increase sensation (232). Most recently, plastic surgeons have developed techniques to fashion labia minora. To further complete the feminization, uterine transplants have been proposed and even attempted (233).

Neovaginal prolapse, rectovaginal fistula, delayed healing, vaginal stenosis, and other complications do sometimes occur (234, 235). Clinicians should strongly remind the transgender person to use their dilators to maintain the depth and width of the vagina throughout the postoperative period. Genital sexual responsivity and other aspects of sexual function are usually preserved following genital gender-affirming surgery (236, 237).

Ancillary surgeries for more feminine or masculine appearance are not within the scope of this guideline. Voice therapy by a speech language pathologist is available to transform speech patterns to the affirmed gender (148). Spontaneous voice deepening occurs during testosterone treatment of transgender males (152, 238). No studies have compared the effectiveness of speech therapy, laryngeal surgery, or combined treatment.

Breast surgery is a good example of gender-confirming surgery that does not affect fertility. In all females, breast size exhibits a very broad spectrum. For transgender females to make the best informed decision, clinicians should delay breast augmentation surgery until the patient has completed at least 2 years of estrogen therapy, because the breasts continue to grow during that time (141, 155).

Another major procedure is the removal of facial and masculine-appearing body hair using either electrolysis or

Table 16. Criteria for Gender-Affirming Surgery, Which Affects Fertility

1. Persistent, well-documented gender dysphoria
2. Legal age of majority in the given country
3. Having continuously and responsibly used gender-affirming hormones for 12 mo (if there is no medical contraindication to receiving such therapy)
4. Successful continuous full-time living in the new gender role for 12 mo
5. If significant medical or mental health concerns are present, they must be well controlled
6. Demonstrable knowledge of all practical aspects of surgery (*e.g.*, cost, required lengths of hospitalizations, likely complications, postsurgical rehabilitation)

laser treatments. Other feminizing surgeries, such as that to feminize the face, are now becoming more popular (239–241).

In transgender males, clinicians usually delay gender-affirming genital surgeries until after a few years of androgen therapy. Those surgeries that affect fertility in this group include oophorectomy, vaginectomy, and complete hysterectomy. Surgeons can safely perform them vaginally with laparoscopy. These are sometimes done in conjunction with the creation of a neopenis. The cosmetic appearance of a neopenis is now very good, but the surgery is multistage and very expensive (242, 243). Radial forearm flap seems to be the most satisfactory procedure (228, 244). Other flaps also exist (245). Surgeons can make neopenile erections possible by reinervation of the flap and subsequent contraction of the muscle, leading to stiffening of the neopenis (246, 247), but results are inconsistent (248). Surgeons can also stiffen the penis by imbedding some mechanical device (*e.g.*, a rod or some inflatable apparatus) (249, 250). Because of these limitations, the creation of a neopenis has often been less than satisfactory. Recently, penis transplants are being proposed (233).

In fact, most transgender males do not have any external genital surgery because of the lack of access, high cost, and significant potential complications. Some choose a metaoidioplasty that brings forward the clitoris, thereby allowing them to void in a standing position without wetting themselves (251, 252). Surgeons can create the scrotum from the labia majora with good cosmetic effect and can implant testicular prostheses (253).

The most important masculinizing surgery for the transgender male is mastectomy, and it does not affect fertility. Breast size only partially regresses with androgen therapy (155). In adults, discussions about mastectomy usually take place after androgen therapy has started. Because some transgender male adolescents present after significant breast development has occurred, they may also consider mastectomy 2 years after they begin androgen therapy and before age 18 years. Clinicians should individualize treatment based on the physical and mental health status of the individual. There are now newer approaches to mastectomy with better outcomes (254, 255). These often involve chest contouring (256). Mastectomy is often necessary for living comfortably in the new gender (256).

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕◯◯)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕◯◯◯)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕◯◯).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕◯◯◯)

Evidence

Owing to the lack of controlled studies, incomplete follow-up, and lack of valid assessment measures, evaluating various surgical approaches and techniques is difficult. However, one systematic review including a large numbers of studies reported satisfactory cosmetic and functional results for vaginoplasty/neovagina construction (257). For transgender males, the outcomes are less certain. However, the problems are now better understood (258). Several postoperative studies report significant long-term psychological and psychiatric pathology (259–261). One study showed satisfaction with breasts, genitals, and femininity increased significantly and showed the importance of surgical treatment as a key therapeutic option for transgender females (262). Another analysis demonstrated that, despite the young average age at death following surgery and the relatively larger number of individuals with somatic morbidity, the study does not allow for determination of

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causal relationships between, for example, specific types of hormonal or surgical treatment received and somatic morbidity and mortality (263). Reversal surgery in regretful male-to-female transsexuals after sexual reassignment surgery represents a complex, multistage procedure with satisfactory outcomes. Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for sexual reassignment surgery. We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment.

When a transgender individual decides to have gender-affirming surgery, both the hormone prescribing clinician and the MHP must certify that the patient satisfies criteria for gender-affirming surgery (Table 16).

There is some concern that estrogen therapy may cause an increased risk for venous thrombosis during or following surgery (176). For this reason, the surgeon and the hormone-prescribing clinician should collaborate in making a decision about the use of hormones before and following surgery. One study suggests that preoperative factors (such as compliance) are less important for patient satisfaction than are the physical postoperative results (56). However, other studies and clinical experience dictate that individuals who do not follow medical instructions and do not work with their physicians toward a common goal do not achieve treatment goals (264) and experience higher rates of postoperative infections and other complications (265, 266). It is also important that the person requesting surgery feels comfortable with the anatomical changes that have occurred during hormone therapy. Dissatisfaction with social and physical outcomes during the hormone transition may be a contraindication to surgery (223).

An endocrinologist or experienced medical provider should monitor transgender individuals after surgery. Those who undergo gonadectomy will require hormone replacement therapy, surveillance, or both to prevent adverse effects of chronic hormone deficiency.

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CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.*	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

CERTIFICATE OF COMPLIANCE WITH DALLAS COUNTY LOCAL RULE 2.02 IN ADVANCE OF PRESENTATION OF PLAINTIFF'S VERIFIED APPLICATION FOR TEMPORARY RESTRAINING ORDER

I hereby certify, pursuant to DALLAS COUNTY LOCAL RULE 2.02(a), that the undersigned notified counsel for Defendant Children's Medical Center at Dallas and presented counsel with a copy of the application and proposed order at least 2 hours before the application and proposed order are to be presented to the Court for a decision.

Specifically, the Application for Temporary Restraining Order and for Expedited Discovery was filed at 9:25 a.m. this morning and accepted through the e-filing system and assigned a cause and court at 11:03 a.m. Immediately upon being assigned a court, the undersigned called lead counsel for Defendant Children's Medical Center at Dallas in the related case, Ms. Yvonne Puig of NORTON ROSE FULBRIGHT, at approximately 11:05 a.m. The undersigned was unable to connect with Ms. Puig but left a voicemail indicating that we would be heading to court at 1:15 p.m. today. The undersigned then called Ms. Daphne Calderon of NORTON ROSE FULBRIGHT and got her voicemail as well, leaving a similar message.

At 11:15 a.m., the undersigned sent the attached email to Ms. Puig and Ms. Calederon reaffirming the substance of the voicemails and providing them both a copy of the Application and the Proposed Order and notifying that we would be going to the courthouse at 1:15 p.m. to attempt to have this matter heard. As such, Plaintiff has complied with Local Rule 2.02.

Certified on May 11, 2022.

/s/ Brent R. Walker
BRENT R. WALKER
State Bar No. 24047053

From: Brent Walker
Sent: Wednesday, May 11, 2022 11:15 AM
To: Calderon, Daphne; Puig, Yvonne K.
Cc: Diaz, Maria; Charla Aldous; Sha'Huni Robinson; Firm @ Aldous \ Walker
Subject: NOTICE OF TRO APPLICATION AGAINST CHILDRENS BEING SOUGHT TODAY
Attachments: +Dr. Lopez's TRO and Petition + Exhibits (file-marked).pdf; +Lopez TRO and Order Granting Expedited Discovery.pdf

Importance: High

Yvonne and Daphne,

Following up on our phone calls to you, attached is a courtesy copy of an Application for Temporary Restraining Order and Expedited Discovery filed this morning on behalf of our client, Dr. Ximena Lopez, against your client, Children's Medical Center at Dallas.

This email services as notice under the Rules that **at 1:15 p.m. today**, our office will be at the **Dallas County Court at Law No. 2** to have this matter heard by Judge Bellan or, if she is not available, any other judge that is. Also attached is the proposed Temporary Restraining Order we will ask the Court to enter today.

Should your client agree with the relief requested before 1:00 p.m., please let us know. Otherwise, we will proceed with seeking this relief.

Thank you,
Brent

Brent R Walker
ATTORNEY AT LAW

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Sha'Huni Robinson on behalf of Charla Aldous
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Envelope ID: 64398785
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REPORTER'S RECORD
VOLUME 1 OF 1
COURT CAUSE NO. CC-22-02427-B
COURT OF APPEALS NO. 05-22-00588-CV

XIMENA LOPEZ, M.D., Plaintiff,	)	IN THE COUNTY COURT
VS.	)	AT LAW NO. 2
CHILDREN'S MEDICAL CENTER AT DALLAS Defendants.	)	DALLAS COUNTY, TEXAS

TRO HEARING

On the 11th day of May, 2022, the following proceedings came on to be heard in the above-entitled and numbered cause before the Honorable Judge Melissa Bellan, Judge presiding, held via Court Call in Dallas County, Texas;

Proceedings reported by machine shorthand.

COPY

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I N D E X

VOLUME 1 of 1
(TRO HEARING)

P R O C E E D I N G S

(April 11, 2022)

(Proceedings held via videoconference)

THE COURT: Let's get on the record in *Cause Number CC-22-02427-B; Ximena Lopez, M.D., versus Children's Medical Center at Dallas*.

Let me get appearances for the Plaintiffs, please?

MS. ALDOUS: Charla Aldous for Dr. Lopez.

MR. WALKER: Brent Walker for Dr. Lopez.

MR. MALOUF: Steve Malouf for Dr. Lopez.

THE COURT: Thank you.

And who do I have on behalf of Children's today?

MS. PUIG: Thank you. Thank you, Your Honor. I'll introduce the team. Yvonne Puig, Daphne Calderon, Eric Hoffman, and Chase Sippel. Thank you.

THE COURT: Okay. We had some technical issues before we got on. If we continue to have any, just get your audio reconnected, and then we will proceed. Just a few housekeeping matters. This matter is being streamed for any member of the public who would like to see it. However, I will remind everyone, both on the call and viewing, that there is no audio or video recording of court proceedings without prior permission

of the Court, and I did not get any such requests. So, while we are happy to have you listen, and you can take notes if you want, you just can't use any recording device to do so.

This is a separate cause number from the 202 Petition that we had talked about a few weeks ago now. And, as you all know, I have been in an afternoon docket. So while I have all of your documents, I have not had a chance to read them, which I like to know what's going on and I try to help you guys short circuit if I know what we have here, but you're going to have to walk me through a little bit more detail today.

Who is taking the lead for the Plaintiffs today?

MS. ALDOUS: Your Honor, with the Court's permission, I'd like to do a brief just introduction, and then Mr. Walker is going to go into more of the technical meat of the matter, if that would be okay with the Court?

THE COURT: Okay. Give me a brief summary, and then we'll launch into the meat.

MS. ALDOUS: The first thing I want to say, Your Honor, is Dr. Lopez did not want to have to take this action. You heard this in our 202 Petition. She did not want to have to sue her employer, UT

Southwestern. She did not want to have to sue Children's Medical Center, where she renders care to her patients. She is at the end of her rope, and feels she has absolutely no choice. The reason we filed this Temporary Restraining Order, Judge, is, quite literally, children's lives are at stake. There are over a hundred children who want to see the group that was formally known as Genecis. There are children that are in crisis. There are families in crisis. And, yet, the care that they could have received has been stopped. We want to know who stopped it. And hopefully, at some point, we'll find out who. And when we do, I can promise you, we'll sue them. But right now, we are simply trying to get relief so that Dr. Lopez can treat her patients; and I want to tell you, to make it clear, what she needs, Judge.

She has been told by UT Southwestern and Children's that the patients that she is currently seeing and was seeing before the halt was put to her care, from an endocrinology standpoint. And from an endocrinology standpoint, her care is puberty suppression and hormone therapy. She was initially told that she had to stop that form of treatment to all of her patients. After much pushback, they finally said, okay, here's what we will allow you to do. The patients

that are currently receiving this hormone therapy, you may continue to allow to give that treatment to your patients, but the patients that are already in the process that have gender dysphoria, if you, in your clinical judgment, believe it's time to start this hormone therapy with these patients, you can't do it. And furthermore, any new patients that come to the UT Southwestern providers that have gender dysphoria, they can go through the counselling process. They can receive psychiatric counselling. They can get all the other care, up to they need this hormone therapy or puberty suppression. And at that point, these new patients cannot receive this type of care.

Judge, I don't know how much more discriminatory you can get. They are basically saying if you have precocious puberty patients, you can give them this care. If you have patients that have already been receiving it, you can give them this care. But for this other group, they may need it, their life may depend on it, but nuh-uh, you can't do it. All we want, Judge, is to return to the status quo so that this doctor can treat her patients in a way all of the (inaudible) states is within the standard of care. This is politicians interfering with patient care. It's wrong, and it needs to be stopped. And I want to say

this, Judge. There are patients who were on the list to see Dr. Lopez who had attempted suicide many times. Their families finally felt like they found hope, but she can't give these kids the care that they need, and that is wrong. We don't take this lightly. We don't want to be here. We wanted them to give us the answers in the 202 Petition so we could sue whoever started this process and stop it. They are not letting us. The AG's Office has intervened. They filed plea to the jurisdiction. They're delaying, delaying, delaying, because they don't want the truth to come out as to why these decisions were made, number one; and number two, they obviously don't care about these children who are in distress. And, yes, I'm emotional about it, Judge, because this is an emotional issue for me. The statistics show that over 40 percent of these children are suicidal. They will attempt suicide or they will kill themselves. Every day that goes by that these kids that are -- over a hundred -- that want to see Dr. Lopez are being denied the care that they should receive. Some of them are thinking about moving to another state just simply so these families, so their children can get this care. And these are children who are already in crisis.

And with that, that's all I have to say,

Judge. I want you to know that we did not do this lightly, but time is of the essence. We need to get these kids the care they need.

THE COURT: Thank you, Ms. Aldous.

MR. WALKER: Your Honor --

THE COURT: Hang on, Mr. Walker. I want to clarify something, because what I heard in Ms. Aldous' opening is a little different than what I understood at our last hearing. I just want to make sure it's not a mistake on my end. As I understood it in our prior discussions, there were, essentially, for lack of a better term, three boxes that these kids fall into. There are the ones who are currently undergoing treatment, they can continue treatment. There are new patients that need the same treatment, but for different reasons, who can be treated; and then we have new patients who come in for body dysphoria, that those are the ones who cannot be given this hormone-suppressant treatment. Is that right?

MS. ALDOUS: It's a little bit different than that, Judge; and let me go through it, because it was confusing for me.

THE COURT: Because the thing that -- and let me let you know where I need you to focus on, because what I heard that was different this time is

that kids who were already in the Genecis Program but had not started hormone suppressants, also cannot be given those at this time. That's where I was confused.

So tell me what our boxes --

MS. ALDOUS: It looks like Mr. Walker wants to jump in, but I will tell you the truth is, no. The patients that were already in the Genecis Program but had not yet started on this hormone-therapy treatment cannot get it. She has been told you will not start this treatment on any patients, whether they're brand-new patients to the clinic -- or nonexistent clinic -- or if they're already in the system. Because what happens is they have to go through a lot of counselling. It's a step-by-step process, but when these kids reach a certain age, if they meet all the scientific criteria, it's time to start them. She has patients right now who need to be started on this therapy, and she cannot give it to them.

THE COURT: Okay. So instead of three boxes, we have four boxes.

MS. ALDOUS: We do.

THE COURT: We have patients at the program who have already started getting treatment. They can continue with this treatment. Patients who are already in the program, but had not yet started the hormone

treatment, cannot be given that. New patients who come in for a need, other than body dysphoria, can be given the treatment. New patients who come in for body dysphoria, cannot be given the treatment. Have I got it?

MS. ALDOUS: That's exactly right.

THE COURT: So there are four boxes, not three. That's what -- I thought I heard that difference today.

All right, Mr. Walker?

Hang on, we've lost Ms. Calderon. Let me wait for her to get reconnected before you start, Mr. Walker, okay?

MR. WALKER: Certainly, Your Honor.

THE COURT: And I should have un-muted everybody's line from my end, but if you are not a current speaker, when we get back rolling, I'm going to ask you to mute your phone lines yourselves on your end, just so we don't get any background noise.

Ms. Calderon, I think I have you by phone now, correct?

MS. CALDERON: Yes, Your Honor.

THE COURT: I have two boxes for Ms. Puig, but as long as we've got her, that's all that matters.

I'm not exactly sure where we dropped you,

Ms. Calderon. I just had clarified with them that there are actually four boxes of potential patients, and Mr. Walker was going to start, but I asked him to wait until we got you reconnected.

MS. CALDERON: I appreciate that, Your Honor.

THE COURT: Sure thing. And I've also asked that if everyone could, if you're not the current speaker, mute your lines from your own end just so we don't get any background noise, that will help for clear audio for my court reporter.

Okay, Mr. Walker?

MR. WALKER: Thank you, Your Honor.

Dr. Lopez is a pediatric endocrinologist. As a pediatric endocrinologist, she provides a number of types of treatment to a host of patients. Only a subset of the patients she sees, as a pediatric endocrinologist, are those with gender-identity issues. And some of those patients with gender-identity issues have been diagnosed with gender dysphoria. Among the treatments she can provide as a pediatric endocrinologist, and has historically been able to provide as a pediatric endocrinologist, is that of pubertal suppression or hormone therapy. Now, there are people -- there are patients and children who do not

have gender identity issues or gender dysphoria that she is authorized, still till this day, to provide this type of care to, but she has been told -- and probably the best evidence as to the extent of what she's been told is in Exhibit E to our petition, which is a statement from Children's Health that they have decided to, quote on quote, suspend this type of treatment for any new patients. Now, there's a problem with that. The problem with that is Dr. Lopez was provided back in 2012 with privileges at Children's Medical Center to provide pediatric endocrinology care. And those privileges that she was provided have never been restricted, have never been suspended, have never been revoked. The medical staff, not the people in the C-suits, the medical staff at Children's Medical Center are the ones who granted or recommended those privileges for Dr. Lopez in a group called a Medical Executive Committee, the MEC, approved those privileges, and she was granted those privileges, and has been continuously since 2012. Now, the way the law works is when you're a physician you have privileges. Those cannot be restricted, suspended, or removed, unless and until there's some form of a due-process hearing, and there's a whole host of law that surrounds that process. None of that's occurred. So, she currently, as she exists today, has the right to

provide anything within the realm of pediatric endocrinology, and she has the right to do so, under the law, within her independent medical judgment. And no corporation, like Children's Medical Center, can come in and tell her how to exercise her independent medical judgment. And no corporation, or hospital in this instance, like Children's Medical Center, can restrict, restrain, or remove for privileges unless they go through a process, and that hasn't been done. So the real question here is, is what is pediatric endocrinology? The thing that she has privileges for? And we noted in our petition that one can look in the textbook on endocrinology, and it has an entire chapter on types of treatments to provide the patients who have gender-identity issues, which includes pubertal suppression and hormone therapy. But probably the best evidence as to what exactly Children's Medical Center meant when it told Dr. Lopez that she had the right to provide pediatric endocrinology care is what is on the website of Children's Medical Center that they published to the public. And that's Exhibit A to our petition. And on that Exhibit A, there's a list of approximately -- I'm going to just ballpark, 40 different types of, quote, conditions we treat in Exhibit A. And what is on that list? One is pediatric and adolescent gender

dysphoria. That is a representation by Children's Medical Center that conditions pediatric endocrinologists treat includes gender dysphoric patients. So that's within the realm of those privileges of pediatric endocrinology. Children's went on to list their programs, which includes Gender-Affirming Care Program, which we talked a lot about at the 202. And then the next section in Exhibit A, page 3 of Exhibit A, at the box, talks about treatment --

THE COURT: Mr. Walker, before you go further there, I'm looking at your Exhibit A. I can see that it came from the Wayback Machine. When was this on their website, because clearly I'm guessing it's not currently there, or I would not be looking at the Wayback Machine?

MR. WALKER: That's correct, Your Honor. It has been scrubbed. That's what I was going to get to. This has all been scrubbed off of their website, which is what my next point I was going to get to was the status quo. This evidence -- this evidence will be at -- on the top of Exhibit A, page one, Your Honor. It has the actual URL, and it indicates that this was 2020, August 19th of 2020. So this is their website August 19th of 2020. And at the bottom of page three of

Exhibit A, it notes -- it indicates the types of treatments and services that are provided under the category of pediatric endocrinology, and those would include feminizing hormone therapy, masculinizing hormone therapy, and puberty-suppression therapy. So, this is what's in the privileges and authority that Dr. Lopez had to both treat as a condition, and the types of treatment she had within her rights to provide to her patients within those privileges. And that's never been restrained, restricted, or taken away from her by any formal action of a medical staff or the medical executive to her. She never received notice of any such thing. It never happened. So she has these rights to provide this, unless and until they do something different.

Now, we're here on a TRO asking to return the status quo. And this document reflects this status quo. And then, frankly, the admissions of Children's Medical Center, in their statement that they made publically requests that that is, quote, and that is, we used to provide this therapy, and now we no longer are.

There's an open question, candidly. There's an open question of who made this decision to, quote on quote, suspend initiating this treatment for new patients. Where did that come from? Was it the CEO

of Children's? Did he just unilaterally say it? Well, unfortunately, that's not how hospitals work. Hospitals are authorized by the joint commission that governs all hospitals, by CMS, which regulates the type of procedures and things that people can provide at a hospital. And hospitals have to go through all kinds of regulatory red tape in order to provide services, and to remove services. And if they're talking about limiting the privileges of a doctor, there's a process that they go through, and that has not been gone through at all.

And, so, we are asking the Court to grant a temporary restraining order, until a temporary injunction that can be heard, that allows Dr. Lopez to continue to exercise her medical judgment independently, and not allow a corporation, like Children's Medical Center, to violate the law by engaging in the corporate practice of medicine in trying to tell her how she's supposed to exercise that judgment. It is against the law for a corporation like Children's Medical Center to do that. And we also believe they should be restrained from trying to limit her privileges, unless and until they go through the process prescribed by law and prescribed by their own bylaws, to properly remedy her privileges, which has never been done. There would be a whole host of different rights and lawsuits that arise

from that.

So that's one bucket is that the actions taken by Children's when they publicly proclaimed, we are no longer providing these services for new patients, violated the law in those two regards. It's the unauthorized legal corporate practice and medicine by the institution, and it violates her clinical independent judgment in the absence of any sort of restriction under privileges. So, it's against the law.

The second reason why we're asking for a temporary restraining order is that, as Ms. Aldous noted, this is explicitly discriminatory. Discriminates patients, based on their gender identity which, under -- as we talked about last time -- the U.S. Supreme Court and Texas Court, including the Dallas Court of Appeals has said that discrimination, based on gender identity, is discrimination because of such, which is against the law. And a facility, such as Children's Medical Center, by virtue of their licensure with the Center for Medicare Services, cannot discriminate the provision of medical care. It's against the law. So their discrimination is illegal.

Moreover, by engaging in this legal discrimination, they are requiring physicians, such as Dr. Lopez, to engage in illegal discrimination

themselves. When Dr. Lopez tells a patient who comes to her and says, you know, doctor, I need to see you. And Dr. Lopez, you know, works up the patient, does the physical history, finds out what it is the patient needs. And the patient says, you know, I have a gender identity issue, or I'm not exactly sure how they will tell her. But once they utter those words to her, once she becomes aware of that fact, she has to tell that person, I cannot provide you treatment that I am authorized to, under the law, because of your characteristic. That's discrimination, making Dr. Lopez discriminate.

So, as the institution who has granted her privileges, we are asking for a temporary restraining order until we can have an injunction hearing to restrain them from interfering with that medical judgment. And, ultimately, as the Court will see in our petition, we're going to be asking for permanent relief in the form of declaratory judgment action and a permanent injunction. And we believe we will have a probable right of relief on those claims, because we will be able to demonstrate that this is an interference, an illegal interference on her judgment, an illegal corporate practice of medicine, and illegal discrimination.

Now when a Court is brought -- when it's brought to a Court's attention that someone is engaged in illegal activity, under a Temporary Restraining Order Law, the Plaintiff has no further burden. The Court must, under the Dallas Court of Appeals precedent, the Court must restrain any conduct that's illegal. That actually came up in *Abbott versus Jenkins*, a case that our office litigated against the Governor with respect to mask mandates. But there's a whole host of law, beyond that, that says, plainly, that when conduct itself is illegal, then the Court must restrain, without any further inquiry, because the Court cannot allow illegal activity to occur.

That being said, we believe we do meet the standards of general temporary restraining order rights by being able to show this Court that we think we will probably recover on the merits, and that there are irreparable injuries if the Court does not grant this temporary restraining order. So, what are those irreparable injuries? Well, for one, Dr. Lopez is exposed to liability by having to discriminate. For two, there are patients to whom Dr. Lopez has an ethical duty, as a physician, to treat; who may, themselves, because of the treatment she does not give them, may then themselves go and try to do something, as Ms.

Aldous said, as horrific as committing suicide. And there is a authority in this state. There are cases that have been brought in this state, and there are cases that have been successful in this state where a patient goes to a doctor, is turned away from a doctor and kills themselves, and someone sues that doctor. So Dr. Lopez is being exposed to liability that a Court, in an appellate remedy, cannot fix. So there is an irreparable injury facing Dr. Lopez; and, of course, it is undoubtedly true that there's an irreparable injury facing the patients who have been turned away. Those patients, as the statistics show and as Children's Medical Center itself has publicly said, shows that 41 percent of patients with gender dysphoria who do not receive proper care will attempt suicide. And if just one of those patients succeeds, that is an irreparable injury and a stain on our city.

And I would ask the Court if you -- on page five of our petition, the Court can see for themselves that it is Children's Medical Center who publicly said last year, "With a suicide attempt rate of up to 41 percent for children and adolescents with gender dysphoria, there is a need for comprehensive care for these youth." That is a statement by Children's Medical Center about the need for this. And given the

significant suffering and extraordinarily high suicide rate in these children, offering this approach is needed to help treat this medical problem. What better evidence of an irreparable injury than Children's own words. Children's Medical Center has, up until this decision that we have discussed before with this Court, had publicly proclaimed the value of this treatment, has authorized this treatment, has granted physicians privileges to provide this treatment. And they decided, with just a swipe of a pen, that it wasn't going to happen anymore. And, unfortunately for them, that's not the way the law works. They have no authority to swipe their pen in that regard. There's a process they must follow. They haven't followed it. So, we would ask the Court to grant a temporary restraining order that prohibits them from trying to enforce this unlawful dictate until an injunction can be heard, and preventing them from discriminating, and preventing them from interfering with Dr. Lopez's clinical privileges.

The only other point I would ask at this point, Your Honor, is if the Court grants a temporary restraining order, we obviously will post whatever bond is necessary. We don't believe one is necessary, because what's the harm that's going to occur? That patients will get treatment and their lives will be

saved? That Children's is going to claim that there's a financial impact during this interim period if they are restrained from actually having to do their job and taking care of these kids? I don't believe that argument is going to be heard. So, I don't think a bond is necessary, but we'll post whatever the Court says.

But one thing we ask for, in addition for a TRO, is request for an expedited discovery. And we have cited to the Court the law, under Rule 191.1, and host of cases which recognize that, in the context of temporary restraining orders and temporary injunctions, a trial court, such as yourself, enjoy broad discretion to alter the usual discovery process and order information to be provided that we can then use at the temporary injunction hearing, which has to occur in 14 days. So, we believe that there are certain things that would be very beneficial to this Court's own inquiry at the Temporary Injunction Hearing. And, so, what we ask for is seven categories of documents. First, Dr. Lopez's privilege file, because it will demonstrate the privileges that she had in order to demonstrate that no action has been taken against those privileges. The second thing is we ask for the bylaws and medical staff's rules and regulations in effect in 2021, because those will demonstrate to the Court the

process, by law, seeing Children's Medical Center had to follow before they tried to limit those privileges. Literally outlined in there. And you'll see that none of that actually occurred.

The third thing we ask for was any formal corporate action by the CNC or the Board against the privileges of Dr. Lopez with restrict care. Because I think what that will show is that the decision making to do this was done at a corporate level. And that is -- that decision, at that point in time, would be the illegal corporate practice and medicine, because it would be a corporation deciding how medical judgment should be exercised.

The fourth thing we asked for was whatever written policies and procedures they had, in fact last year, before they made this policy change, because we believe it will show, within those policies, the appropriateness of the care that Dr. Lopez is seeking to provide, and the policies appalled of Children's to not discriminate, based on gender identity, which they now are doing, and the rights patients have to not be discriminated against.

The fifth thing we asked for was contracts or agreements between Children's and UT Southwestern. There's some sort of relationship between these two

entities. The extent to which, I'm not entirely sure, I know, but there's some sort of relationship. And what we are inquiring that for is if a decision -- if Children's Medical Center makes -- takes the position that this was dictated to us by UT Southwestern, well, I'd like to see the contract that authorizes that type of decision.

The sixth thing is written communication about this topic, because we, frankly, want to show the Court that this was not made in the usual process of going to the joint commission and withdrawing service lines, or going through the process of limine and privileges, but rather was a dictate handed down to them that they just rubber stamped and imposed.

And the seventh thing that we asked for was any written notice regarding any limitation of providing gender-affirming care because, to our knowledge, none such notice exists. So if it exists, we'd like to see it. But I think what the Court is going to find is that this decision, which is highly regulated, was simply done by a statement to the press by Children's Medical Center saying, we're not doing this anymore. I think when the Court sees that, you'll support our notion that, ultimately, will prevail at trial; and, therefore, it will be relevant to our injunctive request at the

temporary injunction stage.

So with that, Your Honor, unless the Court has any further questions, I think I covered what I intended to cover.

THE COURT: Mr. Walker, I do have maybe just one -- probably a line of questions. I always have more than one. But you sort of outlined this to me with what I see as two different main arguments as to why we need to get here. There is the discriminatory piece. And I understand your argument there. That's why I wanted to make sure I understood what the four boxes were so I can make a determination as to whether I think that falls under the protection or sex that we have in the Constitution. But this second argument about how there has to be some sort of administrative procedure to change someone's privileges or their practice areas with the hospital. Now, I know that part of what you're asking for in this discovery goes to those corporate bylaws, or rules and regulations. But if there's something outside of those bylaws and regulations that tells me that that has to exist. Is there something that codifies the fact that there has to be some sort of process for either giving or taking privileges away?

MR. WALKER: Yes, Your Honor, and I haven't tried to itemize that for the Court, but there is both

federal and state law that deals with the very regulated issue of clinical privileges of physicians. There's federal law. There's the HIQA Statute and a host of other things that talk about, you know, if you're going to be granting privileges, here's immunity. Under Texas law, the Texas Occupation Code -- I believe it's Section 162, I believe -- but there's an entire process about physicians are the only ones allowed to make medical decisions, and a hospital, ordinarily, is not allowed to employ physicians, but they are allowed to bring in independent contractors to provide medical care. Now, when they bring in independent contractors, there's an obligation upon hospitals to credential those physicians. And that's regulated in the Texas Occupations Code. There's also a mountain of case law about this whole process, *KPH versus Romero* is a Supreme Court case, I think from 2005, I'm going to guess, that covers this topic. But there's -- the credentialing of physicians is a regulated matter that is done by the medical staff. That is the other independent physician at a facility. And the idea here is, we don't want corporations deciding who practices in the facility in trying to limit their judgment. So other physicians and the medical staff, which is an independent entity separate and apart from the corporation, decided in the

first instance when privileges are applied for whether that physician should be on the staff. That is then referred to -- referred to a Medical Executive Committee. The Medical Executive Committee is something that is prescribed by the joint commission on accreditation of the Hospital Associations. It's something that is necessary to insulate facilities from being considered employers of these doctors. And the Medical Executive Committee, which is going to be in the bylaws of Children's itself, will be the entity that has to approve those privileges. That is, again, so that the corporation itself can't do it, because under Texas law, we have a strong prohibition against the corporate practice of medicine. And I could go on for hours about this topic, but this is a -- I don't think you're going to hear any pushback from the other side. This is a highly regulated area, and they can't just dispense with things. When they do attempt to dispense it -- dispense with it and terminate a physician, there's case law out there that you can sue the hospital for violation of due process rights, because physicians enjoy due process rights, under HIQA and under state law, to have a process in place to have their privileges challenged, instead of just allowing a facility to unilaterally dispose of them. And, so, the point being that when a

physician has privileges. This is not an issue of privileges. Children's can't stand before you and tell you, well, she doesn't have the privileges to provide this care. Well, she clearly does. If she has the privileges, the next question becomes, well, how can you tell her what she can and can't do? And that is where we come in where you're interfering with the independent medical judgment of a licensed physician in the State of Texas. And under the Texas Medical Practice Act, only physicians are allowed to exert medical judgment, and corporations cannot. And, so, a corporation like Children's Medical Center can't say, you know what, you're not allowed to diagnose patients with colds, or, you know, think of your absurd hypothetical. Corporations do not have medical licenses. And so, under the Medical Practice Act, only physicians can make decisions based on medical judgment.

THE COURT: Mr. Walker, then is that -- I'm sorry to interrupt you. And is that also, essentially, the framework for the argument about, if this is indeed found to be a discriminatory practice because it is only the doctor who has to say to the patient, I have to refuse to treat you, or I cannot treat you. Does that then put the doctor in the position of being the one who is having to effectively discriminate, if this is found

to be a discriminatory decision?

MR. WALKER: Absolutely, Your Honor. To make this point very, very plain, in the easiest way possible. Dr. Lopez receives -- a patient comes to her and says, Dr. Lopez, I was born with an XY chromosome. I am now 13 years old, and I do not want to go through -- or 11, I guess, probably 11 is a better age. I'm 11 years old. I do not want to go through puberty at this stage. Dr. Lopez, as a pediatric endocrinologist has within her rights, as far as credentialing, and within the standards of care in the industry, to prescribe pubertal suppression. But if that person says, well, I have gender-identity issues, she has to discriminate and say, I can't. The other side of that coin makes it even clearer. If a patient presents to her presenting as a female and was born a female and presents as a female, she can provide pubertal suppression. If a patient presents to her looking like a female but was born as a male, she has to deny pubertal suppression because of their sex. And that is illegal discrimination, and she is being forced to do that. And, so, that type of trying to enforce someone else to engage in illegal conduct, we believe, has to be restrained as well, because a corporation cannot enforce people to engage in illegal activity, nor can they do it

themselves.

THE COURT: Okay. Who is taking the lead on behalf of Children's today?

All right, Ms. Puig, I think you've muted from your end. So you may need to -- let me try un-muting you from this end, then.

MR. MALOUF: Your Honor, your video feed has frozen.

THE COURT: Okay. Hang on one second.

Do we at least have audio from me? I just want to make sure, even if my video freezes?

MR. MALOUF: Yes, Your Honor.

THE COURT: Okay. I'm on that courthouse wifi, so no hope that it will stay safe.

Okay, Ms. Puig?

MS. PUIG: Thank you, Your Honor.

May it please the court and counsel. I want to state at the outset that I am in an unusual procedural posture. And, so, I am appearing in a very limited purpose to respond to this TRO in that we have not been served. And, so, we have not been served, and we do not, by this appearance, agree to accept service. So, I wanted to say that at the outset. As well, Your Honor, I want to state, so that while the arguments have been heartfelt, and I respect everybody on this phone

call and have practiced decades with and against them. I've got to level set the most important statement made, because it will be the common denominator of all that follows in my comments. The suggestion that Dr. Lopez cannot treat current patients is incorrect. Had I had the ability and the time to bring a live witness, I would have done so to contest it. I am going to ask the Court, prior to any rulings on the TRO, that I have a full and fair opportunity for post-hearing briefing, and to submit an affidavit that will state that all children being treated by Dr. Lopez when this occurred were, in effect, grandfathered, and are currently and able to get the medications needed.

THE COURT: Ms. Puig, hang on. Let me make sure I -- I'm the one who asked to divide out those boxes. So let me make sure. I don't think we have any dispute that children who were in this program and were already receiving hormone-suppressant therapy could continue to be treated. I think we all agree on that. I think the place where you may be disagreeing is children who were in the Genecis Program but had not yet started hormone suppressant therapy. The Plaintiffs have told me that Dr. Lopez has been instructed that she cannot start those patients. They could have been existing patients of Genecis, but if they had not

previously started, they could not start after this decision. Is that where we're having a disagreement?

MS. PUIG: Yes, it's completely false.

THE COURT: Okay. So your position is, is that if they were already in the Genecis Program but had not started hormone suppressant, that Dr. Lopez could start them on hormone suppressant therapy today?

MS. PUIG: That is correct.

THE COURT: Okay. Now Ms. Puig, for some reason, you keep getting new boxes, and I think it's because your video is resetting. So let me get you un-muted here, okay?

You should be able --

MS. PUIG: Thank you, Your Honor. So with that level set to frame what arguments come next, I'd like to start by telling the Court that the Plaintiffs are trying to accomplish, by TRO, that which they could not accomplish in the Rule 202 Petition for pre-suit depositions.

THE COURT: Well, I mean, they accomplished it. Y'all mandamused it, and you asked for a stay. So they accomplished it, it's just that now it's at the Court of Appeals with a stay.

MS. PUIG: That is correct. And they went to extremes not to join UT Southwestern or the

physicians because they knew that if they did, they would, in effect, be getting a second bite at the apple. And this Court should deny them a second bite at the apple for an end run to try to get around UT Southwestern and the doctors. They are well aware. In our last hearing, they talked about wanting to get to the bottom of it, wanting to understand who instructed these institutions, what persons, what individuals? There are no mysteries. There is no new matter before this Court that would justify a TRO, much less a TRO hearing. They were served with the affidavit of Dr. John Warner, and Dr. Podolsky. They are a matter of record, and I'm asking the Court today to take judicial notice of them. In those affidavits --

THE COURT: That's a whole different filing number. So that's not filed in this case.

MS. PUIG: I will file them in this case, Your Honor, if the Court doesn't take judicial notice of the filing in the original cause number. There are no surprises. They state, under oath at paragraph four, the decisions were made jointly with Children's Health and UT Southwestern, and Ms. Aldous repeated that at the beginning of her opening statement.

THE COURT: Right. Ms. Puig, you understand, though, that the issue here today was not

what was in the 202 which is, we want to know who told them to do this and we might sue these folks. This, as I understand it -- and, again, I did not have a chance to read the entirety of the petition -- is her saying -- is Dr. Lopez saying, Children's Medical Center has done something that is in violation of the privileges I had been granted to treat my patients in the way that I see fit, and Children's Medical Center can't make medical decisions for patients? So I do view these as two different issues. I understand where there is overlap, but this is not the same question that was before this Court in the 202.

MS. PUIG: I understand, Your Honor.

They have the burden, and any allegation or suggestion that there was illegal activity or conduct magically transformed their duties, under Rule 683, is incorrect, and I want to go over the three necessary elements.

Number one, that there be a cause of action against the Defendant. There is no cause of action here against the Defendant to allege that there's a cause of action, because she cannot treat a whole group of patients. There is no physician-patient relationship that is being violated or interfered with. There is no cause of action upon which they can seek relief.

Number two, they have to establish a probable right to the relief sought. They haven't come anywhere close to establishing a right to a class of persons or a cohort of patients that have never been seen, never been evaluated, and no treatment has been undertaken.

As to the second element, the probable rights. Applicant has to seek to enjoin the party that needs to be restrained. So here, UT Southwestern, Podolsky and Warner aren't even parties. So, how can they enjoin people who aren't parties, and they went to such extremes today to advise your court's clerk to make sure they didn't get a Court Call notice.

THE COURT: What? Hang on, Ms. Puig. I don't know where you're getting that, because I'm looking at this request. Everything in here is about restraining Children's. There's nothing about restraining UT Southwestern or either of those doctors.

MS. PUIG: Your Honor, our point is that the rule specifically says, and I'll read it: "That any order is binding on the parties to the action and those persons in active concert for participation with them who receive actual notice of the order by personal service, or otherwise."

They chose not to have them here because

it's a thinly vail attempt to have the Court enter this TRO, and then serve that order on UT Southwestern and Dr. Podolsky and Warner to have it report to bind them. That is why they excluded them from this hearing, in our view.

THE COURT: Unless they fall under a officer, agent, servant, employee, attorney, and then, I mean, we do have this entity -- individuals or entities in active concert or participation with them. That means that you all are telling me that y'all did make this as a joint decision from somewhere, if you're telling me --

MS. PUIG: We did, Your Honor, and it's matter of record. We did, Your Honor. It's a matter of record in the affidavits in the other cause number.

THE COURT: Okay. Keep going, Ms. Puig.

MS. PUIG: Thank you. Thank you, Your Honor.

The issue now of corporate practice of medicine, privileges, all of it are red herring, and designed to confuse the Court or cloud the judgment of this Court.

THE COURT: That's not --

MS. PUIG: You heard about --

THE COURT: Well, that isn't happening.

Even if --

MS. PUIG: I understand, Your Honor.

THE COURT: -- even if you are able to demonstrate to this Court -- I want to get to the meat of this. If you are able to demonstrate to this Court that I'm going to, for lack of a better term, call it Box 2, that they were incorrect about that being patients who were already in the program who had not started the care, that those patients could not start care. Even if they are incorrect about that, that still leaves me with the kids who can be treated for any other reason with these same types of therapies, except for the body dysphoria. So how is it that that is not a discriminatory practice, Ms. Puig? That's the answer I need.

MS. PUIG: Your Honor, I'm happy to give it. And that is that a hospital, under the Texas Hospital Licensing Standards, can state the programs that they will offer. The Texas Hospital Licensing Standards specifically states that they are the arbiter of the care to be rendered within the four walls. Privileges are privileges. It's not a contract. And the hospital can and did, in effect, closed a unit. They no longer provide a service line. There's a lot of Texas case law to support that. It's not

discriminatory. They chose to close a service line or a product line. And this idea that there was no notice to Dr. Lopez. She talked about sitting in a room --

THE COURT: No --

MS. PUIG: With representatives of UT Southwestern.

THE COURT: No. Hang on. Let's be clear. Their claim was that there was no written notice to her. They haven't changed their position that there was the phone call and the meeting that was called an hour before, that I heard about before.

MS. PUIG: Your Honor, the hospital can close a unit, stop a service line, and it is nondiscriminatory, and it is not illegal, and it is not the corporate practice of medicine. So --

THE COURT: That may have --

MS. PUIG: Mr. Walker's argument --

THE COURT: But Ms. Puig, they may have closed a unit, but they have not discontinued a service line. They still provide these types of care, as long as you aren't asking for them for gender dysphoria. That is the disconnect for me, because it is very clear to this Court that they are telling Dr. Lopez, you can still treat precocious puberty. I think one of the other things Dr. Lopez told us about was that children

with cancer, that they might want to prevent puberty because the hormone changes can affect both the cancer growth and how the treatment works. So, if a child comes in with cancer and they say, okay, we're going to do this delay to puberty while we're treating this cancer. They told Dr. Lopez, that's okay, Dr. Lopez. You can give this therapy for that reason, but you can't give this therapy if it's because of gender dysphoria.

MS. PUIG: Your Honor, I will move on in this way. There is nothing new here. Why would a TRO be needed today, in May 2022, when the decision, and by her own testimony before you in the original hearing, she was told November 2021. This is not right for a TRO. Maybe a TI hearing, but not a TRO. A TRO attempts to establish the status quo. The status quo in this, in November 2021, there's no status quo to restore here today.

THE COURT: Mr. Walker, that is a fair point and one that has been bothering me because, you know, I know that I'm probably going to hear about how we tried to go through these other channels, and we did this and we did that. But, I mean, you have not presented this as an emergency, even though we talked about the reasons for the children, that there maybe issues there. But, you know, this is almost six months

from when this change has been made. So, why is it that we're getting to this point now, and why is that appropriate for a TRO, when you're basically asking me to put back into place a status quo from six months ago?

MR. WALKER: Certainly, Your Honor. The answer to the question is, is that there's nothing within the law about status quos, or temporary restraining orders, or injunctions themselves that says, well, if you could have filed your harm a day earlier, a week earlier, a month earlier, then you're out of luck. You have to suffer through the harm now. I mean, that's not what the law is. The law is, if there is harm, and we have demonstrated to the Court there is, and if we meet the elements of injunctive relief, which we have, then we are entitled to it. But to be specific as to why now. I think the thing that we can look at is that the decision to do this, while it's been percolating through the system, has been sort of a touch and go, well, we might have to do this back and forth dance that over the months that Dr. Lopez has been told that, and it was not. And so, this particular hearing on the 202, and the joint statement issued on March 28th -- so six weeks ago, which is attached as Exhibit E -- that is the first time they ever officially said this is the policy at Children's Medical Center. And, so, it's not

the case that all though this has been, quote on quote, in the cards, or it's been discussed for some period of time. It wasn't until this point in time in trying to avoid the 202 proceeding that we had this joint statement that was issued that says, Children's made this decision themselves. And that becomes immediately problematic because, contrary to what Ms. Puig said, we actually have alleged a cause of action, a request for permit relief, both in the form of a request for permanent injunction, and the declaratory judgment. And declaratory judgment can sustain a TRO and a temporary injunction. So, contrary to what she told you, a petition explicitly lays it out. And in that petition, what we're alleging is not that Podolsky's done something wrong, or that Warner's done something wrong, or that Governor Abbott has done something wrong. We have alleged something very specific, and that is that the institution that provides her privileges is not UT Southwestern. UT Southwestern can grant privileges in their hospitals, but not at Children's. The bylaws will show this. The privileges at Children's are granted by Children's medical staff. And if she's being limited, and if she's being forced to discriminate by Children's, which the statement on March 28, 2022 makes clear for the very first time, that Children's has a hand in this.

Then, at that point in time, Your Honor, there is a right for this Court to declare such conduct illegal, under the corporate practice and medicine; illegal on the restriction on her independent medical judgment, and illegal discrimination. That's what a declaratory judgment exists for, for a Court to be able to declare rights, and declare when things are not allowed.

THE COURT: And those are the causes of action that you have pleaded. Ms. Puig had addressed the Court earlier as to whether there were actually any causes of action pleaded against this Defendant. But that is your position that it's the declaratory judgment. I think you have two different dec actions. One regarding the discriminatory, the alleged discriminatory act. And then what was it, your other dec action?

MR. WALKER: The other one has to do with the corporate interference with her decision making, which is illegal under two different ways.

THE COURT: Okay.

MR. WALKER: So those would be the declaratory judgment. And then, separate and apart from the declaratory judgment action, there is the capacity to have the sole cause of action be a request for permanent injunction, which we've also sought, as well.

Because, for the same reason that the temporary injunction and temporary restraining order would exist, or you can just have a request for a permanent injunction, which we sought.

Now, lives are at risk right now, according to these statements by Children's themselves. And so the notion from Ms. Puig that there's no harm, is beyond absurd, and it's offensive, frankly.

THE COURT: Well, Mr. Malouf, you had your hand up, then let me come back to Ms. Puig.

MR. MALOUF: Your Honor, this will be 42 seconds. You made the observation that, in fact, Children's provides this therapy for children who are experiencing precocious puberty, and they do that because that's the standard of care. And I don't remember Mr. Walker referring the Court to the Children's website. Seven years ago on Children's website, and I can share screen if the Court --

THE COURT: No, it's not -- let's not make that attempt. It will probably kick somebody out.

MR. MALOUF: Seven years ago, the Children's website stated, quote, prescribing puberty blockers is standard of care -- their words -- that grants time to gender-dysphoric adolescents as they contemplate their long-term gender identity.

Seven years ago. Seven years ago. So, with regards to whether or not Children's is directing Dr. Lopez to violate this standard of care, that says it all. And if you look at Children's statement in March, "We're going to continue to provide gender-dysphoric care to pediatric patients."

What they don't tell you is that, but we're going to require that our physicians violate the standard of care that we, ourselves, recognized seven years ago, because we're not going to let our doctors give you the puberty blockers, again, that we recognized seven years ago as the standard of care. And I would submit, as long as Children's elects to provide gender dysphoric care, it does not have the legal, or certainly the moral right, to instruct its physicians that its physicians may not, or are prohibited from complying with the standard of care that has been the standard of care for over a decade and is recognized at Children's seven years ago. That's all I have to say.

THE COURT: Let me come back to Ms. Puig. I cut her off midstream to get clarification, and then we went down a rabbit hole.

Hang on, Ms. Puig. I think we may have -- you should be un-muted.

MS. PUIG: Your Honor, thank you. I was

still in the middle of my argument when those questions were directed to counsel, and I understand it.

The third prong, again, they have failed on the third and an essential prong, under Rule 683. And that is, an imminent and irreparable harm in the interim, if the Court doesn't grant a TRO. As amply demonstrated by Mr. Walker's argument, which was quite contradictory. It's imminent. It's immediate. We need to do it immediately, but we don't need to put up a bond, because we're just going to have them do what they're suppose to. You know, forget that it is unprecedented to interfere with the operations of a hospital in closing a department. And, so, this argument that, well, you know, doesn't matter much, but it really does matter, and it really did matter six months ago, and it really does matter today. The argument, with all respect, on the Wayback Machine, and something that was said seven years ago, 20 years ago, whenever it was said, is nearly laughable. Everybody on this call knows that there was an AG opinion and a governor's order that were entered, and people in the State of Texas were required to comply with it.

THE COURT: Woe, woe, woe. Hold on. No, no, no, that AG opinion is not legally binding. So, no, they weren't --

MS. PUIG: That's right. It is --

THE COURT: They weren't required. Ms. Puig, hang on. I want to make sure we're real clear here. They weren't required to comply with it. They have chosen, it seems, to do so because they fear that there maybe some risks that they should be complying with it. And again, I do want to check though, again, because you just made the comment about that it would be, essentially, way outside the scope for this Court to order them to reopen a program within their hospital. I don't see that within the request that they have asked for. They have asked for them not to limit, or restrict, or prohibit gender-affirming endocrinology care. They have asked for them to be restrained, during the pendency of the order, from discriminating against patients seeking gender-affirmative care. They have asked for them to not interfere, control, or otherwise direct a physician's professional judgment, and they have asked to -- for them to be restrained from imposing any limitation on the exercise of her clinical privileges, and provide pediatric endocrinology. I don't see anything that says we need to reopen the Genecis wing.

MS. PUIG: Your Honor, they're asking that we treat patients, for whom there's no physician-

patient relationship. Dr. Lopez is well aware that -- that patients, who are not currently in the system, are not grandfathered. We can't do that. The patients that are currently there and grandfathered, are getting treatment. So they're not being discriminated against, and the request for all of the discovery is a request that, clearly, they wouldn't have gotten under their Rule 202. And you know, as stated, Your Honor, we would like a full and fair opportunity to brief all of this.

THE COURT: This is a TRO hearing. I mean, this is a TRO hearing. This is what we do. You get two hours notice. We come down, we argue about it, and I make a decision that either something goes into effect for 14 days, until a TI hearing, or I decide that they haven't met their burden. But, I mean, I understand the desire to want to fight out the full thing today, but that's not what we're here for. You know, obviously, I hear you about, you know, some of the things that they're asking for in the discovery requests do go to the Genecis Program. But as I'm reading the actual items of what they want restrained, I don't see anything that says we've got to reopen the Genecis wing. And you just said a moment ago that it's asking for relief related to parties where there is no patient-doctor care. But, again, I have that box of kids who can come

in and say, I have gender dysphoria, and I'm pretty sure the statement that Children's put out -- I'll have to go back and look at it again. It says, we will continue to provide them care. And my understanding of that is that that is the social and psychological portion of that care. So there is care and a patient-doctor relationship. It's just that we can't give them a certain kind of care.

MS. PUIG: That's right, Your Honor. And I'm going to also state, and again, I would have provided it with a live person or an affidavit, but I'll ask the Court to consider it as a statement from an officer of the Court, and that is that the people who call to ask to be considered, when they're told, yes, we will see you, but we can't give you the suppression therapy. They don't want an appointment. They don't come back. So.

THE COURT: Well that's kind of what Dr. Lopez will argue was the problem is that they don't --

MS. PUIG: We understand.

THE COURT: They don't have somewhere else to go.

MS. PUIG: We have the right to do it. They do have choices.

THE COURT: And that is what the -- I think what Mr. Walker's argument is trying to focus on here is that the hospital doesn't have the right to do that. He's making the argument that only the doctor can decide what type of treatment to give, and you may have an argument that's counter to that. But that is how I have heard the argument from Mr. Walker which is, the hospital does not have any right to tell a doctor that you can give this type of treatment, but you can't give this type of treatment, if in your medical opinion the second type of treatment that we're telling you not to give is what is most appropriate for that patient. I mean, it would be like -- this is an outlandish example just to illustrate it. It would be like if a hospital said, well, if somebody comes in with appendicitis, you can give them acupuncture, but you can't take out their appendix. And a doctor is saying, that sucker has to come out of there. You can't tell me I can't remove it from that patient. That's the same type of argument the Plaintiffs are making here which is, yes, I can still give them referrals to the social and psychological portions of the program, but what the doctor believes to be the necessary treatment, and what Mr. Malouf told the Court Children's stated was the standard of care for this type of issue, being body dysphoria, is the hormone

suppressant therapy. And the hospital has come in and said, you can't treat your patients that way.

Do we have a dispute about that portion, Ms. Puig, because I want to make sure that I'm hearing from your side what they -- what the hospital says they did or didn't do?

MS. PUIG: Yes, your Honor. A hospital can definitely say, we do not offer these services anymore, and the physician is free to refer the patient elsewhere for those services.

THE COURT: But isn't that the key --

MS. PUIG: The patient isn't --

THE COURT: I'm sorry, Ms. Puig.

MS. PUIG: That is the key.

THE COURT: The key is the hospital is providing that type of care, just not to these patients. They're providing hormone-therapy care to precocious puberty. They're providing the gender -- the hormone-suppressant therapy to kids with cancer, but if they come in because they have gender dysphoria, they're told, I can't give you the same type of care. That is the key for me. And that's what I need to understand if Children's agrees with that position or not, which is, yes, we can give this care for certain things, but not for this thing.

MS. PUIG: Your Honor, all I can answer is, we have the absolute right not to offer certain services.

THE COURT: But -- and I don't disagree with you, but you are offering those services. You're just not offering them to all patients.

MS. PUIG: I think we're arguing the same thing, Your Honor. We offer numerous types of treatments in different context, and we can decide whether to provide the treatment in one context and not the other, and it's not illegal.

THE COURT: Is that a medical decision?

MS. PUIG: It's a decision as the operator of a hospital charged by the Texas Hospital Licensing standards to state what services will be offered. We don't practice medicine --

THE COURT: Ms. Puig, let me ask that question again. Is it not a medical decision to determine whether a certain type of treatment can be given for some issues and not for others?

MS. PUIG: I think I'm saying the same thing, Your Honor.

THE COURT: I think you are in a box right now, and we've -- I don't know if there's a way out of it, because it is very clear to this Court that that is

exactly what Children's has said. It has said, and they put a statement out. It says, We will give kids who have this issue -- being body dysphoria -- psychological and social services treatment. We will no longer give them hormone-suppressant therapy or other endocrinology -- I can't say that word right now -- therapy. However, if you come in because you have precocious puberty, or because you are undergoing cancer treatment, we will give you the same type of therapy that we're telling you you can't get if it's because of body dysphoria.

Do we agree that that is what the position is?

MS. PUIG: Your Honor, I don't think so. I think to your cancer question or the cancer question posed by Mr. Walker. We are a pediatric hospital. We provide cancer care to children, not to adults. How is that not a product line or service distinction? Are we discriminating against adults with cancer?

THE COURT: That is not the same thing, Ms. Puig, and I -- I know you are making the best of what you have here, but it is very difficult for this Court not to see that exact issue in this way, because part of the argument I heard was, we're not telling a doctor how they should or shouldn't treat a patient. We're not

telling a doctor what they can and can't do for a patient, or what they can and can't provide, but we absolutely are. We're telling a doctor that if a patient needs this therapy for one reason, you cannot treat them, even if you, Dr. Lopez, think that that is the best course of medical treatment for a patient.

Ms. Puig, I think you are still connected, but I need to double check. You might have ended up muted again.

Ms. Puig, are you un-muted at this point? Ms. Puig?

MS. PUIG: Yes. Can you restate it? Thank you.

THE COURT: I'll try to remember what I was saying there. It is very clear to this Court that Children's has taken the position that a child can be treated with this type of therapy for one reason, but cannot be given this same treatment for the reason of body dysphoria, even if their doctor thinks that is in the best medical interest of that patient.

MS. PUIG: My response, at a high level, is the physician has the opportunity to practice the privileges given within the facility. They're privileges, not a right. Those privileges are exercised in the context of what services a hospital provides. If

a hospital chooses not to provide it anymore, then that physician is free to go elsewhere or refer patients elsewhere. It's fundamental.

THE COURT: But we don't have an issue here where the hospital has said, we are not providing this type of treatment at all. And, obviously, we all know the hot-button issue with abortion care right now. The hospital is not saying the equivalent of, we are not going to provide abortions at this facility. I have no question that a hospital can make that decision. There has been cases about. You know, hospitals that have religious founders. They can make the decision not to provide that type of care. But what they can't do is say, we provide abortions if you are over 25, but we won't provide them to you if you're under 25; or we will provide them to you if you are white, but we won't provide them to you if you are black, which is probably a better instance, because that is actually a protected class. That is what Mr. Walker is arguing to me is the equivalency here which is, we will provide this hormone-therapy care to you if you aren't asking for it because of gender dysphoria. So it is not, in my mind -- it's not that they have discontinued a type of treatment. They have said, we're going to continue this type of treatment, but we are discontinuing it as to

certain people who need it. And you may very well have the argument that that is not a protected class. They've obviously also made the argument that -- that goes to sex. Therefore, it falls under a protected class, which is how they get to discrimination. But there is no doubt in my mind that that is a difference in the type of care that a doctor is being told they can give to one patient than they can give to another patient. So, again, you may have the argument that even if that is true, that is not discriminatory. It doesn't fit these categories. But I don't think there's any question that Dr. Lopez has been told, you can give this exact type of therapy to a kid for precocious puberty. You can't give this type of therapy to a kid that has come in for gender dysphoria. And it's not that we stopped treating gender dysphoria all together. We're still treating it. We'll treat it with social and psychological services, but we won't treat it with the hormone therapy. That is how I understand these boxes to be.

So Ms. Puig, how do I reconcile those things? And as I said, part of that maybe your argument that even if that's true, judge, that's not discrimination. So where does Children's fall on that?

MS. PUIG: Your Honor, I'm back -- I'm

almost back to the beginning. I'm back to the cause of action. In the (inaudible) case, the Supreme Court said that they rely on it to say, we're discriminating. It doesn't extend to a hospital's decision regarding types of treatment provided in the four walls. It goes back to, they don't have a cause of action. They don't meet the three prongs of a TRO, flat out.

THE COURT: So they --

MS. PUIG: I don't have the opportunity to --

THE COURT: Hang on. If they pleaded it -- they've pleaded three different causes of action. So let's address those then, directly. So they have pleaded that they can get a declaratory judgment, regarding an illegal control over Dr. Lopez's independent clinical judgment. Whether you believe that they can meet that and eventually prevail, my first question is, is that a cause of action against the hospital? Can it be one? Not whether they have succeeded in showing me that they're going to win on it, but just whether a declaratory judgment is a cause of action?

MS. PUIG: Well, obviously, you know, under the Texas Rules of Civil Procedure, a request for a declaratory judgment is a cause of action, but they

haven't established it. They didn't come before this Court through a dec action, either. Look at the way they -- how they pled this matter. It's artful pleading, and it's designed to get around UT Southwestern and the doctors. It's designed to try to effectuate a result that they are (inaudible) by all the other procedural matters that have been brought. It has to be an underlying cause of action. Does this declare -- here's the dec action. What's the underlying cause of action to support a dec action?

THE COURT: But that is the cause of action. That's what I was trying to address with you. That is its own cause of action. Whether you are going to argue to me that they can't succeed on it, and they have to show me that there's a substantial likelihood. I hear you on that. That is the standard for a TRO, but I don't -- there is not a requirement that there be some underlying cause of action for a dec action. That also doesn't mean that they could win a dec action on this particular issue. Then they have a second declaratory judgment related to the discrimination issue. And that is, you know, what we talked about earlier, as I see it, as -- they've told me today there are four categories of potential patients. Existing patients who had started treatment already, existing patients who had not started

treatment, and then new patients who can receive that hormone-therapy treatment for some reason, and then the other set of patients who are new patients who want it for gender dysphoria and cannot be given that. I understand from your position is that that second box, you think they're incorrect about that a -- that a patient who was already within the program and needs to start the hormone-therapy treatment, you're telling the Court that they can begin that if they were an existing patient in this program?

MS. PUIG: Yes, Your Honor.

THE COURT: But even if we remove that box and we go back to the original three, there is an argument to be made. And, obviously, you're going to have a counter argument for me, that the new patients -- new patients who come in for precocious puberty, they can get this hormone-suppressant therapy. New patients that come for gender dysphoria cannot get this same type of treatment, even though it's offered in the hospital for other reasons. Do you want to respond to me as to why, even if those facts are 100 percent accurate on those new patient boxes, why that is not discriminatory, which would then lead me to, is there a substantial likelihood of prevailing on this count?

MS. PUIG: Your Honor, I'm -- I'm not sure

about your boxes. I understand the restatement of the boxes at the very beginning. I understand what Ms. Aldous and Mr. Walker have said about the boxes. I stand on my argument that grandfathered children get it. The children who do not get it, the hospital has the right to deny a service for a service line or a product line, and, you know, I stand on my argument.

THE COURT: I hear you. And I'm not talking about the grandfathered patients. I only want to talk about the new patients for a second. Because I think that is where -- because assuming that there is a discrepancy between your understanding of what can happen with existing patients, and their understanding of what can be done with existing patients. Taking those existing patients out of our equation for a moment. Their argument, in part, is that for a new patient that comes in for precocious puberty, they can be given this hormone therapy. For a new patient that comes for gender dysphoria, they cannot be given hormone therapy. Do we agree on that part?

MS. PUIG: I understand your restatement. I am, myself, unclear as to one of your boxes.

THE COURT: Okay. So you don't -- do you agree that Dr. Lopez can give or prescribe hormone therapy for reasons, other than gender dysphoria, for

new patients at Children's Medical Center?

MS. PUIG: That is my understanding, but I don't know it for a fact.

THE COURT: Okay. And that's fair.

And do you also agree, without necessarily knowing it for a fact; but is it your understanding that a new patient who comes in and says I want hormone therapy treatment for my gender dysphoria, that Dr. Lopez cannot provide that treatment for gender dysphoria for new patients?

MS. PUIG: I do not know that for a fact.

THE COURT: Again, I know you don't know that for a fact. Is that your understanding?

MS. PUIG: Yes.

THE COURT: Okay. So just those two boxes. That's all we're talking about. It's our understanding of new patients, one with precocious puberty, one with gender dysphoria. The argument that they have made to me in count two is that that is a discriminatory act that Dr. Lopez is being forced to tell her patients that I can't treat you because it is related to gender identity, which comes back to an issue of sex, which is a protected class. You may very well have an argument to me that that is not protected under these circumstances, but that is how the Plaintiffs have

presented it as their cause of action. So, I fully understand your argument that they may not be able to succeed, or there may not be a likelihood of success, as is required under the TRO. So let's address that. How could --

MS. PUIG: Your Honor, even -- let's assume that it is protected. Let's assume that.

THE COURT: Okay.

MS. PUIG: How does Dr. Lopez have standing to sue on their behalf? How is the doctor the representative of that cohort. It's impossible.

THE COURT: And I agree with you, but I don't think that's how it's pleaded, but I may need to come to Mr. Walker about that. Because as I'm reading their petition, their position is, is that the hospital has changed the policy in such a way that it is causing Dr. Lopez to have to discriminate, and that that is the issue that she's asking for a declaratory judgment on, that they cannot put her in a position where she -- I mean, she's the one who's going to get tagged, because she's the one who is denying care.

So Mr. Walker, do you want to further clarify that, or do I have it figured out?

MR. WALKER: Your Honor, you do. I think the problem is, is that Ms. Puig doesn't know what is

actually happening at Children's at the present moment. If you look at Exhibit E, which is attached to our position, which is the statement from Children's Medical Center. It says that they are still bringing in new patients who have gender dysphoria. So this patient comes to UT Southwestern, and those patients need to see a host of doctors, as this Court has ably noted before, and they can receive patients for Children's -- there's a whole panoply of other services we provide, but the Court's generally right that those other services fall in the neighborhood of psychological and social services. And if a patient comes to or Dr. Lopez and says, I want to get this type of treatment. She has to refuse those patients. So they haven't discontinued gender-dysphoria treatment. They haven't discontinued the provision of this type of treatment, as this Court has noted. It's just a very small subset of people. Now Dr. Lopez is not filing this lawsuit merely as like a class representative for all these other patients. All though the Court is within its right to consider those other patients. Dr. Lopez is filing a lawsuit because her medical judgment, the thing she has a property interest in, is being restricted by Children's Medical Center. Dr. Lopez is filing this suit because she is impacted by the illegal conduct of Children's

Medical Center when they engage in the corporate practice of medicine, because she is the one is being interfered with. Dr. Lopez is filing this claim because Children's Medical Center is enforcing discrimination that subjects her to potential liability. So, the Court should, and I think, can consider the fact that there are other victims to this conduct, because it goes to whole host of things, not the least of which showing how egregious this conduct is. But at the end of the day, the petition is what it is. And it says, very clearly, what we're suing for. And it's been repeatedly misrepresented to you what we are, in fact, suing for.

I think the Court, at this point, has everything Ms. Puig is going to say about it. But at the end of the day, we still have this issue before the Court that the conduct we have alleged, and the Court is not suppose to go to the merits of whether we are going to ultimately prove it or not. Have we alleged something that if we are -- if what we're saying is true, and the only evidence you have before the Court that it is, could that support a judgment? And the answer is, yes. And the -- I think the thing that this Court should really turn on is a case that we have cited on page 18 of our motion, Dallas Anesthesiology Associates, PA versus Texas Anesthesiology Group, PA,

2006 Dallas Court of Appeals case.

THE COURT: What's the cite?

MR. WALKER: 190 -- 891. It talks about that we don't have to prevail on the merits. I realize that that's not the one I meant to cite you to. I apologize. Let me put my glasses on. I was going to put my glasses on because the issue is -- here it is. Abbott versus Jenkins. My case. Our firm's case.

In that citation -- in that case, they cited the long line of cases in Texas law, which is that when a court determines the law as being violated, that there's a duty to restrain that violation, irrespective, irrespective of whether or not the party can show a probable right to relief, and irrespective of whether or not the party can show an irreparable injury. When the conduct's illegal, the inquiry ends. And the conduct here, we alleges, is illegal. Now, again, we believe we meet the standards and we've tried to show the Court the way we meet those standards, but if you look at 21, it's Abbott versus Jenkins; Green versus Unauthorized Practice of Law Committee, and San Miguel versus City of Windcrest. Those three cases all stand for the same provision which is that, when the conduct's illegal, there's nothing else to argue about. And there's nothing else to argue about here, Your Honor. This

conduct's illegal. The Court has heard that Children's Medical Center believes that it's totally cool to discriminate, and it's totally appropriate for them to limit the medical judgment. That's not allowed, period, end of story.

THE COURT: Ms. Puig, let me let you --

MS. PUIG: Your Honor, if I might respond.

First of all, counsel mischaracterizes our comments. No one is saying it's cool to do anything. There's very serious issues involved in this matter. And I come back to, if a TRO is to establish or restore the status quo? The status quo was November 2021. It's not today. Second, to raise violation of corporate practice of medicine. Again, a red herring. Dr. Lopez doesn't have a contract with Children's. Privileges are not a contract. Texas law is well established that privileges do not constitute a contract. There's no theory on earth where Dr. Lopez could prevail on a violation of corporate practice of medicine. So it's not a cause of action that either supports the TRO today, or would support a dec action. We believe they are not entitled to discovery, that which they couldn't have under 202. And for all those reasons, Your Honor, we ask that the TRO be, in all things, denied. I understand that a TRO doesn't necessarily give me the

opportunity to submit an affidavit that would clarify some of the issues raised today about continuing care and treatment. That being said, I ask the Court to deny the TRO for all the reasons stated.

THE COURT: Thank you, Ms. Puig.

Mr. Walker, one of the things you just kind of ran through the analysis of, well, if it's illegal, you don't have to get to these other things, but some of the things you're asking me to find in this order, particularly at the top of page (inaudible) is that there is imminent and irreparable harm to Plaintiffs, being Dr. Lopez, if a temporary restraining order is not issued as requested. So I'm not sure if I've heard today what the imminent and irreparable harm to Dr. Lopez will be if the Court fails to issue such a restraining order?

MR. WALKER: Sure, Your Honor. And I apologize if I wasn't clear on that point.

The injury to Dr. Lopez is threefold. First, if it requires her to discriminate, that is it requires her to violate the law. So that is an injury to her, because it exposes her to potential culpability for doing so. The second is that Dr. Lopez is subjected to liability, because she has to turn away patients that could be of this care. As I mentioned earlier, as

Children's own words that we have cited in this brief show, on page five of this brief, that up to 41 percent of children will commit suicide if they don't receive this care, and she has to be the one who says, I'm not giving it to you. So there is authority for the notion that a doctor who turns away a patient and they subsequently injure themselves, that doctor can be liable for violating the standard of care. And by the way, as Mr. Malouf said, the Court can look on page six of our brief where it's cut and pasted on there. Children's Medical Center statement that is standard of care. We have attached, as Exhibit F and G of our petition, this standard of care that Children's says is the standard of care. Now, Dr. Lopez is having to violate that standard of care and turn away patients. And if one of those patients is one of the 41 percent who try to commit suicide and kill themselves, there is a claim to be made against Dr. Lopez. So she is being exposed to that liability that a subsequent appeal will not be able to remedy. And the third thing, and we -- simply the thing that we began our motion with, which is that Dr. Lopez is a physician who has ethical duties to patients, including to alleviate their suffering to act in their best interests. She's authorized by the State of Texas to provide that care. She's credentialed by

Children's to provide that care. And Children's is forcing her to violate those oaths by refusing to provide care to her patients. Those are all harms, and they're not compensable harms. They don't have a dollar value that can be assigned to it. They're not reparable. If she has to do this and destroy children's lives because of something Children's said. And Court of Appeals can't come back later and say, okay, you can do it now, so we'll just forget all those other patients that were turned away, and all the bad things they had the do, or happened to them. That's not -- that's not nothing that can be repaired on appeal. So we believe that is irreparable injury for Dr. Lopez. And again, as I mentioned earlier, the Court can consider the third party beneficiaries of the care that Dr. Lopez would be providing, pursuant to those privileges. That is the patients themselves. And there is certainly a harm those patients. And so, we would ask the Court to find that there is irreparable injury to Plaintiff. And I'm not asking you to find that there's a specific individual named John Smith out there who is not getting the care, but I think the Court can consider that fact. That there are patients out there who are not getting that care. We submitted evidence to the Court by virtue of the authorization and by the statements themselves of

Children's Medical Center that patients will be turned away. And those patients will likely -- at least 41 percent of them will try to commit suicide.

MS. PUIG: Your Honor, if I may reply. Mr. Walker refers to a body of Texas case law that Dr. Lopez can be sued if she turns away patients. I've never heard of it.

THE COURT: I heard that -- hang on. I heard that differently. I heard it was that if a doctor refuses care and the patient commits suicide, that they could somehow be held liable. Mr. Walker, what was your position? Is it just refusing care of any point, or was it --

MR. WALKER: So if a doctor -- a physician -- so again, by the statement of Children's Medical Center themselves, these people will become patients of a hospital. Because the hospital has not discontinued the service line, they are still providing care for gender dysphoric patients. And Dr. Lopez, as a physician who consults with those patients, will have to violate the standard of care and not provide standard of care treatment to them. I know Your Honor did -- has done a lot of medical malpractice cases, and that's where Ms. Puig has spent most of her career I know, as well. We all know on this call right now that if a

physician violates the standard of care, and a patient is harmed because of that violation of standard of care, there is a cause of action against that physician. Psychiatric hospitals get sued for this all the time. That's like all the cases in psychiatric hospitals fall under this thing when patients self-harm, as a result of the standard of care. Now, Children's has stipulated what the standard of care is. We have patients of the facility and patients who Dr. Lopez has consulted with by these psychiatrist who say, hey, I've got this gender dysphoric patient. There's an issue with their hormones. Will you consult with us? And Dr. Lopez walks in the room and says, yeah, but I can't do this anymore. Dr. Lopez is being forced to violate the standard of care, exposing herself to liability if harm happens, as a result of that violation of standard care. That is, in fact, the definition of medical malpractice. Harm that occurs as a result of the violation of the standard of care.

MS. PUIG: This is not a medical malpractice case, number one. Number two, I'd like you to give me a citation to any case that says, if Dr. Lopez doesn't take a category of people as patients, that she has liability? It doesn't exist.

THE COURT: Again, that's not what

Mr. Walker just argued. What Mr. Walker argued was that a doctor, if there is a known standard of care, and their position, whether correct or not; is that Children's own website up until November of last year, says that the standard of care for these patients includes this type of therapy. So if a doctor then refuses to provide that type of care that is within the standard of care, and a patient self-harms, that that doctor can be sued. Whether someone is successful or not, that maybe different. And I do know -- I don't know if he has a cite handy. I do know there is a line of cases, and it is usually regarding psychiatric facilities when a patient is released, and a family argues that they never should have been released. They should have been given this type of care or that type of care, and there's an instance where someone harms themselves or someone else, that that can come back to the doctor. But I did not hear that they are arguing that there is a medical-malpractice claim here. It is an issue of what the potential risks to Dr. Lopez are, which is, as she is the doctor who is refusing to provide care, that they have argued is the required standard of care, that she has violated both that issue, and that she could potentially be the target of a claim for discrimination from a patient, because she is the

one having to communicate the fact that he will not provide them with the hormone-therapy care. That -- that is how I have understood their position.

So Ms. Puig, let me give you a final chance to add anything additional that you want the Court to consider, and then if there is anyone else on behalf of Children's who has anything to add, and then I will swing back to the Plaintiffs to ensure I haven't missed anything, and then we will conclude for today.

Ms. Puig, are there any further points from you that you want the Court to be sure is at the top of my list to consider this evening?

MS. PUIG: Yes, Your Honor. Just the fact that the status quo ended in November. Secondly, this line of cases assumes that they were, in fact, patients, and that a patient-physician relationship existed, which cannot exist with a set of people that have never been accepted for care and treatment. So, I'd ask that you consider that. And I would ask that the Court disregard the argument of illegality, as there's been no showing of illegality that would, any way, trump the requirement of Texas Rules of Civil Procedure 683, or magically transform this into illegal conduct.

So for all those reasons, Your Honor, and I thank you and counsel for your extraordinary patience

with the technical issues. I know it's late in the day. I would ask that you deny it. I have orders, as well, denying. I'd like the opportunity to send those to your clerk, Mr. Fitzgerald, if needed, but I have them ready to go, as well as Mr. Walker and Ms. Aldous. Thank you.

THE COURT: Yes. If you would, please e-mail any proposed orders to Mr. Fitzgerald, because if we file them tonight, they won't process them until the morning, and I don't know how long that will take, and I'm hoping to get you all a response ASAP, and I'm planning to make a ruling tonight, but obviously it won't get put in the system until tomorrow.

Ms. Puig, one thing we did not address, in the event that I think that Plaintiffs have succeeded in one or more areas for a TRO, do you have a position regarding bond? Because I lost your video for a second. It muted you again. So let me un-mute you.

MS. PUIG: Your Honor, nothing about the facts and circumstances here would justify not imposing some type of bond. And to argue that one is not needed, but, yet, at the same time, there's irreparable imminent harm, and people will kill themselves. You can't have it both ways. So I'd ask the Court to consider it.

THE COURT: But the bond is here to protect Children's Medical, if I restrain them. And the way

that I understand the situation is, as I said before, I'm not hearing a request for it, nor do I think I have the power to ask Children's to reopen a wing of the hospital or an entire program. What they're asking for, as I see it, is Dr. Lopez's ability to provide the same treatment that she's already providing to other Children's patients to more people. So is there a monetary cost to Children's of doing that? You know, for instance, if we had to buy a thousand more flu shots, there maybe some value to that. Is there something that addresses that issue, regarding therapy that they are providing, just expanding it to additional patients?

MS. PUIG: Your Honor, honestly, I don't have an amount in mind, and I don't know the answer. I will tell you, without necessarily revealing client confidences but talking with my team, to implement some of the elements of this order will be very difficult to implement as written. Whether there is a monetary cost assigned to it, I don't know it. Again, I didn't have the opportunity to visit with my clients, because of this short notice. So, I will leave it with the Court's discretion, as always.

THE COURT: Okay. Thank you, Ms. Puig.

Was there anyone else from the Children's

side who wanted to be heard before we conclude today? I think you all should have the ability to -- let me make sure that I don't have you muted on my end.

Mr. Hoffman, was there anything you wanted to add?

MR. HOFFMAN: No, Your Honor. Thank you.

THE COURT: Ms. Calderon, was there anything that you wanted to add?

MS. CALDERON: No, Your Honor. Thank you.

THE COURT: All right. Thank you.

And then let me open up for Mr. Sippel. It looks like you are un-muted. Was there anything you wanted to add Mr. Sippel?

MR. SIPPEL: No, Your Honor, but thank you for the opportunity.

THE COURT: All right. Thank you.

Mr. Walker, Ms. Aldous, Mr. Malouf, is there anything from the Plaintiffs?

THE COURT: Shaking heads --

MS. ALDOUS: No, Your Honor, nothing else from us.

MR. MALOUF: No, Your Honor.

THE COURT: Okay. Please do forward those orders.

Ms. Puig, do you have the e-mail address

for Mr. Fitzgerald?

MS. PUIG: Yes, we do have it, and we'll get it right over right away with copies to counsel.

THE COURT: I need to read the pleading, and I need to read some of these cases, but I will have a decision for you all in the morning. I don't know if that will be 8:00 a.m. or 10:00 a.m., because I have a couple of hearings and a meeting at 9:00. My endeavor is to get it done first before that meeting, but it maybe after.

MS. PUIG: Well, thank you, Your Honor. And I want to say, on behalf of all of us, we appreciate the Courts willingness to entertain this today on behalf of everyone because your background knowledge of it is invaluable, and had the Plaintiffs been forced to go to a different court, there would have been a big learning curve. So we're very appreciative of your willingness to work us in.

THE COURT: I'm amazed that y'all landed on this court on the first try. You had a one in five chance, and then it would have been the related case motion, but I was worried because I was, like, that Court is the one who has to issue the order to send it to me, and I knew there could be a delay there. So y'all managed to leapfrog over that issue by somehow

getting the right lottery ball and landing in the one and five chance.

So, all right. Thank you-all. Excellent arguments, as always. There is clearly a very important issue to everyone. The Court takes it very seriously, and I want to make sure that I make the decision that I believe is the correct one, and also the one that gives you-all the most guidance of what your clients need to do next, or what your next steps maybe.

Thank you all. You all are excused.

(End of proceedings).

REPORTER'S CERTIFICATE

THE STATE OF TEXAS)
COUNTY OF DALLAS)

I, Robin N. Washington, Official Court Reporter in and for the County Court at Law No. 2 in Dallas County, State of Texas, do hereby certify that the above and foregoing contains a true and correct transcription of all portions of evidence and other proceedings requested in writing by counsel for the parties to be included in this volume of the Reporter's Record, in the above-styled and numbered cause, all of which occurred in open court or in chambers and were reported by me.

I further certify that this Reporter's Record of the proceedings truly and correctly reflects the exhibits, if any, admitted by the respective parties.

I further certify that the total cost for the preparation of this Reporter's Record is $260 and was paid/will be paid by THE ATTORNEY GENERAL OFFICE OF TEXAS.

WITNESS MY OFFICIAL HAND this the 19th day of May, 2022.

/S/ Robin N. Washington
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Expiration Date: 01/31/2023
Official Court Reporter
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CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff,* v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.*	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

TEMPORARY RESTRAINING ORDER AND ORDER GRANTING EXPEDITED DISCOVERY

On May 11, 2022, the Court heard Plaintiff Ximena Lopez, M.D.'s Application for Temporary Restraining Order. After reviewing the pleading, evidence, and the arguments of counsel, the Court makes the following findings and GRANTS the Application as follows:

1. The Court has jurisdiction to hear the Application and issue appropriate injunctive relief pursuant to it.

2. Plaintiff has substantially complied with Local Rule 2.02.

3. Pursuant to TEXAS RULE OF CIVIL PROCEDURE 683, the Court has the authority and discretion to enjoin Children's Medical Center at Dallas and its officers, agents, servants, employees, attorneys, as well as any individuals and entities in active concert or participation with them (together "CMC"). MP
* who receive actual notice of the order by personal service or otherwise.

4. The Court finds that Plaintiff has carried her burden at this stage by proving temporary injunctive relief is appropriate for the following reason(s):
Plaintiff demonstrated a probable right to relief on her claims that:

   a. CMC is violating the law by interfering with, controlling, or otherwise directing any physician's professional judgment, in violation of the prohibition against the corporate practice of medicine, and by attempting to restrict Dr. Lopez's exercise of her clinical privileges without taking any formal action to limit her clinical privileges or provide her due process rights.

   b. CMC is violating the law by discriminating against patients on the basis of the patient's gender identity and directing Plaintiff to violate the law by discriminating against patients on the basis of a patient's gender identity.

c. There is an imminent and irreparable harm to Plaintiff if a temporary restraining order is not issued as requested.

5. The Court finds the *status quo* to be preserved during the pendency of this temporary restraining order—that is, the last, actual, peaceable time before the instant controversy as reflected in the historical practices and operations at CMC—was the situation prior to CMC's restriction on providing gender-affirming endocrinology care to new patients at CMC. The *status quo* to be maintained therefore permits providers at CMC to provider gender-affirming endocrinology care to both new and existing patients.

6. Based on these findings, and to maintain the status quo, the Court grants the Application for Temporary Restraining Order and orders injunctive relief as follows:

a. Children's Medical Center at Dallas and its officers, agents, servants, employees, attorneys, as well as any individuals and entities in active concert or participation with them who recieve actual notice of the order by personal service or otherwise are restrained during the pendency of this Order from enforcing any policy or limitation that restricts or prohibits gender-affirming endocrinology care, including specifically pubertal suppression or hormone therapy, to new or established patients due the patient's gender identity or gender dysphoria;

b. Children's Medical Center at Dallas and its officers, agents, servants, employees, attorneys, as well as any individuals and entities in active concert or participation with them who recieve actual notice of the order by personal service or otherwise are restrained during the pendency of this Order from discriminating against patients seeking gender-affirming endocrinology care by restricting or prohibiting care because of the patient's gender identity;

c. Children's Medical Center at Dallas and its officers, agents, servants, employees, attorneys, as well as any individuals and entities in active concert or participation with them who recieve actual notice of the order by personal service or otherwise are restrained from interfering with, controlling, or otherwise directing any physician's professional judgment with respect to the provision of gender-affirming endocrinology care at CMC; and

d. Children's Medical Center at Dallas and its officers, agents, servants, employees, attorneys, as well as any individuals and entities in active concert or participation with them who recieve personal notice of the order by personal service or otherwise are restrained from imposing any limitation on Dr. Lopez's exercise of her clinical privileges to provide pediatric endocrinology care, including, but not limited to, prohibiting her from providing gender-affirming endocrinology care, in the absence of any formal due process under CMC's by-laws by the appropriate parties to restrict Dr. Lopez's clinical privileges.

The temporary restraining order expires without further action from the parties at midnight on 5/26/2022

The Court further finds that there is good cause to permit expedited discovery by Plaintiff in advance of the temporary injunction hearing and therefore orders that Defendant Children's Medical Center at Dallas shall produce to Plaintiff, within 10 days of the date of this Temporary Restraining Order, the following categories of documents:

1. Dr. Lopez's privileges file.

2. CMC's by-laws and medical staff rules and regulations in effect in 2021.

3. Documentation reflecting any formal corporate action by CMC or any Board of CMC:
   a. against the privileges of Dr. Lopez;
   b. to restrict the provision of gender-affirming endocrine care at CMC.

4. CMC's written policies and procedures in effect in June of 2021 related to
   a. gender-affirming endocrine care;
   b. the GENECIS program;
   c. anti-discrimination; and
   d. patients' rights.

5. Any contract or agreement in effect in 2021 between CMC and UT Southwestern that would apply or relate to either Dr. Lopez's provision of care at CMC or the GENECIS program.

6. All written communication, including email and text messages, from January 2021 to the present sent between executives at CMC and either UT Southwestern or the Executive Branch of the State of Texas related to GENECIS program or gender-affirming endocrine care. except those that are covered by a recognized legal privilege.

7. Any written notice to physicians at CMC regarding any limitation on providing gender-affirming endocrine care.

In support of this Temporary Restraining Order, the Court finds that a bond in the amount of $ 100.00 must be paid by the Plaintiff to secure the order.

The hearing on Plaintiff's request for a Temporary Injunction shall take place before this Court on 5/26 2022 at 1:30 am/(pm)

It is so Ordered.

Signed May 12, 2022 at 11:58 am

Melissa Bellan

HON. MELISSA BELLAN,
Presiding Judge of County Court at Law No. 2
Dallas County, Texas

CAUSE NO. CC-22-01316-B

IN RE XIMENA LOPEZ, M.D., *Petitioner*,	IN THE COUNTY COURT OF LAW NO. 2 DALLAS COUNTY, TEXAS

NOTICE OF NONSUIT WITHOUT PREJUDICE OF XIMENA LOPEZ, M.D.'S VERIFIED PETITION TO TAKE DEPOSITION BEFORE SUIT PURSUANT TO TEXAS RULE OF CIVIL PROCEDURE 202

Pursuant to TEXAS RULE OF CIVIL PROCEDURE 162, Petitioner Ximena Lopez, M.D. files this Notice of Nonsuit Without Prejudice as to her Verified Petition to Take Deposition Before Suit Pursuant to TEXAS RULE OF CIVIL PROCEDURE 202. Under Texas law, the notice of nonsuit is effective immediately without the necessity of a hearing or a Court order. *See, e.g., Epps v. Fowler*, 351 S.W.3d 862, 868 (Tex. 2011). Additionally, nonsuit of this matter is timely given no trial on the merits has occurred and no claims have been adjudicated. *See, e.g. In re Baxter*, No. 05-16-01174-CV, 2016 WL 6099547 (Tex. App.–Dallas, 2016). This dismissal takes effect immediately upon filing.

Respectfully submitted,

/s/ Charla G. Aldous

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* * *

Certificate of Service

I certify that this document is being served on all counsel of record via electronic mail on May 16, 2022.

/s/ Charla G. Aldous
Charla G. Aldous

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NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*,	**IN THE COUNTY COURT AT LAW**
v.	**NO. 2**
CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant*.	**DALLAS COUNTY, TEXAS**

THE STATE OF TEXAS' ORIGINAL PETITION IN INTERVENTION

Pursuant to Texas Rule of Civil Procedure 60, the State of Texas files this Petition in Intervention in accordance with his constitutional, statutory, and common law powers to defend the laws of Texas. The State of Texas intervenes to prevent irreparable harm to the children of the State, and to protect its interest in the uniform, consistent application of the laws of the State of Texas.

BACKGROUND

On May 11, 2022, Plaintiff, Ximena Lopez, M.D., filed an Application for Temporary Restraining Order, Temporary Injunction, and Original Petition for Permanent Injunctive and Declaratory Relief. Plaintiff contends that Defendant Children's Medical Center (CMC) is engaging in the corporate practice of medicine and unlawfully discriminating on the basis of gender identity and sex by prohibiting her from providing hormone treatment to *new* pediatric patients treated for gender dysphoria.

On May 12, 2022, this Court entered a Temporary Restraining Order against Defendant and scheduled a Temporary Injunction Hearing for May 26, 2022.

Argument

I. Standard for Intervention

"Any party may intervene by filing a pleading, subject to being stricken out by the court for sufficient cause on the motion of any party." Tex. R. Civ. P. 60. An intervenor is not required to secure a court's permission to intervene in a cause of action or establish standing. *Guar. Fed. Sav. Bank v. Horseshoe Operating Co.*, 793 S.W.2d 652, 657 (Tex. 1990). An intervenor need only show a "justiciable interest in a pending suit to intervene in the suit as a matter of right." *In re Union Carbide Corp.*, 273 S.W.3d 152, 154 (Tex. 2008). "A party has a justiciable interest in a lawsuit, and thus a right to intervene, when his interests will be affected by the litigation." *Jabri v. Alsayyed*, 145 S.W.3d 660, 672 (Tex. App.—Houston [14th Dist.] 2004, no pet.) (citing *Law Offices of Windle Turley P.C. v. Ghiasinejad*, 109 S.W.3d 68, 71 (Tex. App.—Fort Worth 2003, no pet.)). "The interest asserted by the intervenor may be legal or equitable." *Guar. Fed. Sav. Bank*, 793 S.W.2d at 657 (citation omitted).

II. Intervention is Necessary to Protect the Interests of the State in the Welfare of Children.

The State of Texas has a solemn responsibility to defend the constitutional rights of the People of Texas. And "[i]n matters of litigation," specifically, "the Attorney General is the officer authorized by law to protect the interests of the State . . . ." *Bullock v. Tex. Skating Ass'n*, 583 S.W.2d 888, 894 (Tex. Civ. App. 1979). Here, there are two reasons as to why the State of Texas, through the Texas Attorney General's Office, must intervene to protect its interests.

First, in line with this general authorization to protect the interests of the State, the State is also specifically tasked with protecting the interests of minors. "'*Parens patriae*,' literally 'parent of the country,' refers traditionally to the role of the state as sovereign and guardian of persons

under legal disability." *Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 600 n.8 (1982) (quoting Black's Law Dictionary 1003 (5th ed. 1979)). Under this sovereign authority, as to minors, "[t]he state thus act[s] upon the assumption that its parentage supersedes all authority conferred by birth on the natural parents, [and] takes upon itself the power and right to dispose of the custody of children as it shall judge best for their welfare." *In re Barry*, 42 F. 113, 118 (S.D.N.Y. 1844), *approved by and attached as appendix to Ex parte Burrus*, 136 U.S. 586, 594–95 & n.1 (1890) (referring to *parens patriae* as a "common-law function" of the state).

As explained by the United States Supreme Court in *Schall v. Martin*, there are only two possible decision makers when contemplating the welfare of children, i.e., their natural parents and the state as *parens patriae*:

> Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae.* In this respect, the [child]'s liberty interest may, in appropriate circumstances, be subordinated to the State's "*parens patriae* interest in preserving and promoting the welfare of the child."

467 U.S. 253, 265 (1984) (citations omitted) (quoting *Santosky v. Kramer*, 455 U.S. 745, 766 (1982)); *Ex parte McIntyre*, 558 S.W.3d 295, 300 n.3 (Tex. App.—Fort Worth 2018, pet. ref'd) (per curiam) (quoting *Schall*). And as observed by Justice Scalia in *Reno v. Flores*, " '[Children], unlike adults, are always in some form of custody' and where the custody of the parent or legal guardian fails, the government may (indeed, we have said *must*) either exercise custody itself or appoint someone else to do so." 507 U.S. 292, 302 (1993) (citation omitted) (quoting *Schall*, 467 U.S. at 265).

Plaintiffs' petition seeks a decision by this Court that the provision of prescription medication to a child is simply a matter of medical judgment that should be left entirely to a treating

physician. This decision will have to be made despite the fact that certain forms of the medication in question are controlled substances[1], which could constitute child abuse under Texas law if provided to a minor.[2] The decision will also have to be made by ignoring the significant and, oftentimes, irreparable alterations that will occur to the children in this State while they are in the midst of their most critical developmental period.[3] And the decision will have to be made even in the face of numerous studies that such treatment may have other long-term harmful and detrimental impacts on the child, including infertility.[4] In order to protect its interest, as *parens patriae*, in the welfare of children subject to this life-altering decision in the hands of a doctor, the State surely has a right to intervene in this matter.

Second, the UDJA provides that when "declaratory relief is sought, all persons who have or claim any interest that would be affected by the declaration must be made parties." TEX. CIV. PRAC. & REM. CODE § 37.006(b). Here, Plaintiffs seek declaratory relief in order to obtain a permanent injunction that limits CMC from imposing standards upon their physicians that they disfavor. The State of Texas establishes and regulates the hospitals in this state, both private and

[1] For example, testosterone, which is a Schedule III controlled substance. Tex. Admin. Code 481.002(5) ("Controlled substance" means a substance, including a drug, an adulterant, and a dilutant, listed in Schedules I through V or Penalty Group 1, 1-A, 1-B, 2, 2-A, 3, or 4).

[2] Tex. Admin. Code 707.455 ("Physical abuse is a subset of the statutory definitions of abuse that appear in Texas Family Code §261.001(1) and includes the following acts or omissions by a person: (4) Causing, expressly permitting, or encouraging a child to use a controlled substance as defined by Chapter 481, Health and Safety Code").

[3] *Standards of Care for the Health of Transsexual, Transgender and Gender-Nonconforming People*, WPATH, available at: https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf at p. 11 ("formal epidemiologic studies on gender dysphoria—in children, adolescents, and adults—are lacking"); *id.* at 18 (providing that some of the medications Plaintiffs advocate for are "partially reversible." "These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone)."); *id.* at 18-19 (stating studies on the approach of puberty-suppressing hormones have only included children over 12); *id.* at 40 (showing risks associated with hormone treatment, including potentially fatal risks);

[4] *See, e.g.,* Asscheman, Henk, *A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones*, European Journal of Endocrinology, available at: https://pubmed.ncbi.nlm.nih.gov/21266549/; *see also* WPATH *Standards of Care* at p. 50 ("feminizing/masculinizing hormone therapy limits fertility")

public, as well as conducts the licensure and regulation of all state physicians. 25 Tex. Admin. Code § 133.1, *et. seq.* (hospitals); Tex. Occ. Code Ann. § 155.001, *et. seq.* (physicians). It has a well-established interest not only in regulating the hospitals' and physicians' provision of treatment to its patients but also in ensuring hospitals are able to direct their own physicians in the proper care of patients without judicial intervention. Thus, because the relief sought in this case could potentially undermine the State's interest in the uniform application of its laws, the State of Texas must be made a party to this case under § 37.006(b). *See Alfred L. Snapp & Son, Inc. v. Puerto Rico, ex rel., Barez*, 458 U.S. 592, 601 (1982) ("the power to create and enforce a legal code" is one "easily identified" example of sovereign interest.).

III. Intervention is Timely.

The State of Texas' petition is timely filed. Litigation in this matter has only just begun. Further, there is no pre-judgment deadline for intervention. *Tex. Mut. Ins. Co. v. Ledbetter*, 251 S.W.3d 31, 36 (Tex. 2008) (citing Tex. R. Civ. P. 60; *Citizens State Bank of Sealy v. Caney Invs.*, 746 S.W.2d 477, 478 (Tex. 1988). Texas courts recognize an "expansive" intervention doctrine in which a plea in intervention may be untimely only if it is "filed after judgment," though even post-judgment interventions are permissible in some circumstances. *State of Texas v. Naylor*, 466 S.W.3d 783, 788 (Tex. 2015) (quoting *First Alief Bank v. White*, 682 S.W.2d 251, 252 (Tex. 1984)); *Tex. Mut. Ins. Co.*, 251 S.W.3d at 36 (citing *In re Lumbermens Mut. Cas. Co.*, 184 S.W.3d 718, 725–26 (Tex. 2006)). Because there is no final judgment in this case, the State of Texas' intervention is timely.

Conclusion

For the foregoing reasons, the State of Texas respectfully requests that the Court permit it to appear and be heard in this cause of action as Intervenor and for such other and further relief, at law or in equity, to which Intervenor is justly entitled.

Respectfully Submitted.

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CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.*	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF XIMENA LOPEZ, M.D.'S SPECIAL EXCEPTIONS, AND, IN THE ALTERNATIVE, MOTION TO STRIKE PETITION IN INTERVENTION

Nonsense on stilts. There is really no more apt description of the Attorney General's Petition in Intervention. There is no legal, equitable, or even rational basis for the AG's Intervention in this private matter. Indeed, probably the only explicable reason for the filing is that the AG is headed for a runoff in his primary race next week.

This issue between Dr. Lopez and Children's ought not be political. There are clearly defined laws at issue, and it is those laws—not the AG's personal views—that will be determinative in this matter. If the AG wants to pound his chest about his personal beliefs on this matter, he is free to do so on Twitter. But, he cannot abuse the civil justice system for his own personal ends. The AG has no business being in this case. If the AG truly believes he does, then he needs to follow the law and plead a ***valid*** legal basis for intervention instead of relying on rejected arguments and case cites from 1844.

THE PETITION IS FATALLY DEFECTIVE IN ITS ENTIRETY

The State's Petition in Intervention is fatally defective. The Court must require the State to replead around these defects, and if the State is unable to do so, to strike the Intervention. The Petition is defective for the following reasons:

1. The State fails to plead a legal, justiciable interest in *this* matter. **What is the interest implicated?**

This case, and the relief sought in it, is about what a private hospital (Children's) can and cannot legally dictate to a private physician (Dr. Lopez) in the exercise of that physician's medical

judgment. What is the "State's" legal interest in this issue? The AG claims a legal interest in protecting children that only arises after a court's finding that abuse is occurring. That interest is contingent and remote and therefore is not an interest that supports an Intervention.[1]

The State claims it has an interest in controlling hospitals and the practice of medicine. That is a rather curious claim given that, in the Rule 202 proceeding in which Dr. Lopez sought discovery as to the involvement of Governor or AG in shutting the GENECIS clinic, AG Paxton said that:

> Nobody—not even the Governor or Legislators—can "dictate" to UT Southwestern how to provide or not provide particular care outside of duly enacted state law." Dr. Lopez does not (because she cannot) show that anyone can "dictate" such decisions to UT Southwestern.[2]

If the Governor or Legislature cannot dictate how UTSW–a state agency–provides care, what possible legal basis would it have to do that for a private hospital like Children's?

Every declaratory judgment or judicial action involves the interpretation of a law. It cannot be that the State has an interest in every such determination. That is why the interest has to be justiciable, meaning that the State of Texas could have brought this case itself or defeated this case itself.[3] The State fails to show how it could have brought this case itself or defeated any aspect of the relief sought by itself.

2. The State fails to plead the basis for claiming it is the State of Texas's interest at issue. **On behalf of whose interest is the AG acting?**

The only department or agency of the state that even has a legal right to dictate the provision of medical services is the Legislature, under the Texas Constitution, and the Texas Medical Board, which was created by the Legislature and delegated authority through the Texas Medical Practice Act. The Texas Medical Board has not issued any agency rules that are in jeopardy by the relief requested in this matter. Nor has the Legislature passed any statute that needs defending in this action.

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[1] *See Smith v. City of Garland*, 523 S.W.3d 234, 241 (Tex. App.–Dallas 2017) (noting "An intervenor's interest must be greater than a merely contingent or remote interest." and citing *Mendez v. Brewer*, 626 S.W.2d 498, 500 (Tex. 1982)).

[2] See UTSW's Plea to the Jurisdiction and Response to 202 Application filed in Cause No. CC-22-01316-B.

[3] *Guaranty Fed. Sav. Bank v. Horseshoe Oper. Co.*, 793 S.W.2d 652, 657 (Tex. 1990).

On the contrary, during the last regular session, the Texas Legislature considered, but did not pass, proposed legislation that would have changed Texas law to include treatment for gender dysphoria under the definition of child abuse. Specifically, Senate Bill 1646 ("SB 1646") would have amended Section 261.001 of the TEXAS FAMILY CODE to add certain treatments to the definition of "child abuse." The bill would have amended this provision of the law to include within the definition of "child abuse": "administering or supplying, or consenting to or assisting in the administration or supply of, a puberty suppression prescription drug or cross-sex hormone to a child, other than an intersex child, for the purpose of gender transitioning or gender reassignment; or performing or consenting to the performance of surgery or another medical procedure on a child other than an intersex child, for the purpose of gender transitioning or gender reassignment."13 SB 1646 did not pass. The Legislature considered additional bills that would have prohibited medical treatment for gender dysphoria in minors, including House Bill 68 and House Bill 1339. None of these bills were passed by the duly elected members of the Legislature.[4]

The Texas Legislature determines the public policy of the State of Texas through the statutes it passes.[5] It is not within the Governor or the Attorney General's authority to say what the public policy is for the State or that the State has an interest in an issue that is not set forth in the law. When the Legislature considers but declines to pass a statute, Courts must give effect to the Legislature's decision to *not* make the proposed statute the policy or law of the State.[6] Thus, this Court must give effect to the Legislature's decision to **not** make it the public policy of this state that gender-affirming care is child abuse.

As it explicitly is not the public policy of the State that gender-affirming is child abuse, by what right does the AG now come before this Court and claim it is acting in the State's interest? While the AG speaks publicly like he is a roving warrior to advance his political agenda, that's not

[4] On July 19, 2021, after the above-referenced legislation failed to pass, Governor Abbott explained on a public radio show that he had a "solution" to what he called the "problem" of medical treatment for minors with gender dysphoria.

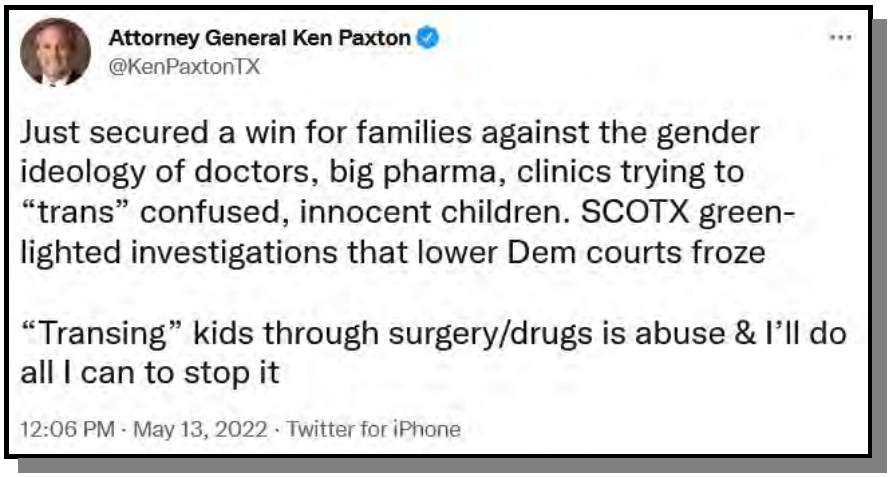
[5] *Fairfield Ins. Co. v. Stephens Martin Paving, LP*, 246 S.W.3d 653, 665 (Tex. 2008).

[6] *See, e.g., City of Round Rock v. Rodriguez*, 399 S.W.3d 130, 139 (Tex. 2013) (noting that the Court "we must give effect to the statute's silence on this issue and the Legislature's decision not to confer representation rights akin to Weingarten rights on Texas public-sector employees.").

what the legal authority of an Attorney General entails.[7] The AG's only right is to defend and enforce duly enacted state laws, but the AG never describes what state law is at risk in this case.

Just five days ago, the AG's similar claims about its claimed interest in investigating child abuse were resoundingly rejected by the Texas Supreme Court when the Court said that the AG has no role and no statutory authority to decide whether the provision of gender affirming care is or is not abuse. Yet, here the AG claims to act on behalf of the State in defining the medical care at issue as abusive.

Five days ago. Presumably the AG's office is aware of that opinion, given that the AG completely misrepresented the Supreme Court's opinion publicly:



How can the AG's office use as a basis for Intervention a legal right the Texas Supreme Court just said he did not have? The AG must plead the alleged source of the alleged State's interest.

3. The State does not show why it must be allowed to intervene to protect its interest. **Why does the State need to be a party?**

To intervene, the State is required to show that intervention is essential to protect the intervenor's interest.[8] As this Court is aware, the State is already litigating the issue of whether

[7] TEXAS CONST. Art. 4, Sec. 22 "ATTORNEY GENERAL. The Attorney General shall represent the State in all suits and pleas in the Supreme Court of the State in which the State may be a party, and shall especially inquire into the charter rights of all private corporations, and from time to time, in the name of the State, take such action in the courts as may be proper and necessary to prevent any private corporation from exercising any power or demanding or collecting any species of taxes, tolls, freight or wharfage not authorized by law. He shall, whenever sufficient cause exists, seek a judicial forfeiture of such charters, unless otherwise expressly directed by law, and give legal advice in writing to the Governor and other executive officers, when requested by them, and perform such other duties as may be required by law."

[8] *Guaranty Fed.*, 793 S.W.2d at 657 (intervention is improper if it is not essential to protect the intervenor's interest).

gender-affirming care should be investigated as child abuse in a different proceeding. So why does the State need to excessively multiply the issues by litigating that topic in this Court?[9] There is nothing about the declaratory judgment or injunction in this case that will prejudice the rights of the State in that different proceeding.

This action includes an application for injunctive relief against Children's Medical Center at Dallas, enjoining Children's from:

1. enforcing Children's policy that prohibits Plaintiff from providing endocrinological care for the treatment of gender dysphoria;

2. discriminating against gender dysphoric patients seeking endocrinological care for the treatment of gender dysphoria in accordance with the medical standard of care;

3. interfering with, controlling, or otherwise directing any physician's professional judgment with respect to the provision of endocrinological care for the treatment of gender dysphoria; and

4. imposing any limitation on Dr. Lopez's exercise of her clinical privileges to provide pediatric endocrinology care, including, but not limited, to prohibiting her from providing endocrinological care for the treatment of gender dysphoria, in the absence of any formal due process under Children's Medical Staff Bylaw by-laws by the appropriate parties to restrict Dr. Lopez's clinical privileges.

The Court granted a temporary restraining order granting this requested relief, and set the preliminary injunction hearing for May 26, 2022.

The State has intervened, but Plaintiff seeks no relief against the State, and the State seeks no relief, asserts no claims for relief, and has no "interest that would be affected by the declaration" sought by Plaintiff. TEX. CIV. PRAC. & REM. CODE § 37.006(a) (Texas Declaratory Judgment Act). Indeed, because the State was not a defendant in this action, a declaratory judgment against Children's could not, as a matter of law, "prejudice the rights of [the State]" because a declaratory judgment only impacts the rights of the parties to the proceeding. *Id.* The State attempts to circumvent the legal infirmity of its intervention in a most unusual way.

The Petition in Intervention falls prey to the fallacy of *circulus in probandō* (circular reasoning). It goes something like this: (1) the law says that because the State is not a party, a

[9] *Id.* (intervention is improper if it will complicate the case by excessive multiplication of the issues).

declaratory judgment is not binding on the State, (2) but the State wants to argue that it has an interest in the action because it will be bound by a declaratory judgment, (3) so the State will intervene so that it can argue that it would be bound by a declaratory judgment since it is a party, and (4) the State can then argue that a declaratory judgment affects the interest the State.

In a fatuous effort to manufacture a right to intervene, the State simply alleges that "where the custody of the parent or legal guardian fails, the government may (indeed, we have said must) either exercise custody itself or appoint someone else to do so." But this (incorrect) assertion states no claim for relief, and the Prayer for Relief does not inform a determination of exactly what this Court will do that will impact the State's claim that it must act when a parent fails in custody of their child.

The State vaguely, but incorrectly, asserts that:

> Plaintiffs' (sic) petition seeks a decision by this Court that the provision of prescription medication to a child is simply a matter of medical judgment that should be left entirely to a treating physician. This decision will have to be made despite the fact that certain forms of the medication in question are controlled substances, which could constitute child abuse under Texas law if provided to a minor.

It is certainly correct that the Texas Department of Family and Protective Services ("DFPS") is statutorily empowered to investigate allegations of child abuse in Texas. But Plaintiff seeks no relief against either the State or DFPS that would interfere with that investigatory function.

So what does the State need to protect by intervening? Legally, nothing. Rather, it appears that the sole basis for the Intervention is that the AG wants to offer his opinion on whether this care is appropriate, in which case the AG should have filed an amicus brief, not an Intervention.

The AG's Petition in Intervention is fatally defective on these points, and as such, Plaintiff files the following special exceptions demanding that the State of Texas replead. If the Court grants these exceptions, and the State is forced to replead but cannot cure the defects, the Court should strike the Intervention.

Special Exceptions to Specific Paragraphs

While the Petition in Intervention is fatally defective in what it *does not* contain, it is also defective in what it does contain.

A. Special Exception to Page 4-5.

Pursuant to Tex. R. Civ. P. 91, Plaintiff objects and specially excepts to page 4-5 of the Petition in Intervention on the grounds that the following allegation fails to provide Plaintiff with fair notice of the specific interest of the State that "would be affected by the declaration" sought by Plaintiff:

> [T]he UDJA provides that when "declaratory relief is sought, all persons who have or claim any interest that would be affected by the declaration must be made parties." TEX. CIV. PRAC. & REM. CODE § 37.006(b). Here, Plaintiffs seek declaratory relief in order to obtain a permanent injunction that limits CMC from imposing standards upon their physicians that they disfavor. The State of Texas establishes and regulates the hospitals in this state, both private and public, as well as conducts the licensure and regulation of all state physicians. 25 TEX. ADMIN. CODE § 133.1, et. seq. (hospitals); TEX. OCC. CODE ANN. § 155.001, et. seq. (physicians). It has a well-established interest not only in regulating the hospitals' and physicians' provision of treatment to its patients but also in ensuring hospitals are able to direct their own physicians in the proper care of patients without judicial intervention. Thus, because the relief sought in this case could potentially undermine the State's interest in the uniform application of its laws, the State of Texas must be made a party to this case under § 37.006(b).

This allegation is deficient for several reasons.

First, the State fails to cite which "laws," the enforcement of which "could potentially [be] undermine[d]" if the Court grants relief sought by the Plaintiff and therefore deprives Plaintiff and this Court from fair notice of the basis of the Plea.

Second, the State fails to specify what specific relief requested "could potentially undermine the State's interest in the uniform application of its laws" and how that it could undermined. Further, it fails to specify why this concern is anything more than a remote or contingent concern—or really anything other than just a makeweight hypothetical—such that it is a sufficient justiciable interest justifying an intervention.

Third, it asserts that the State has an interest in "ensuring hospitals are able to direct their own physicians in the proper care of patients without judicial intervention," but it fails to cite any authority for the proposition that a hospital in Texas, or anywhere else, has the authority to demand that a physician withhold treatment within the medical standard of care from one group of patients while providing it to others. It is also unclear, as the AG fails to cite any authority, as to why it is the public policy of the state that any hospital or any physician—or, for that matter, any person or

company—is allowed to act "without judicial intervention."[10] Such a frivolous claim is contrary to the entire notion of a rule of law and our justice system.

Fourth, it asserts that the State "conducts the licensure and regulation of all state physicians," but fails to connect this to any issue in this case—it cites no law, statute, regulation, and/or Texas Medical Board Rule implicated by the relief sought by Plaintiff.

Fifth, Plaintiff specially excepts because this paragraph does not provide the information or cure the fatal defects noted above that are missing from the entire Petition.

B. Special Exception to Page 3-4.

Plaintiff also objects and specially excepts to pages 3-4 Petition in Intervention on the grounds that the following allegation fails to provide Plaintiff with fair notice of the specific affirmative relief the State seeks:

> Plaintiffs'(sic) petition seeks a decision by this Court that the provision of prescription medication to a child is simply a matter of medical judgment that should be left entirely to a treating physician. This decision will have to be made despite the fact that certain forms of the medication in question are controlled substances, (footnote omitted) which could constitute child abuse under Texas law if provided to a minor. (Footnote omitted). The decision will also have to be made by ignoring the significant and, oftentimes, irreparable alterations that will occur to the children in this State while they are in the midst of their most critical developmental period. (Footnote omitted). And the decision will have to be made even in the face of numerous studies that such treatment may have other long-term harmful and detrimental impacts on the child, including infertility. (Footnote omitted). In order to protect its interest, as parens patriae, in the welfare of children subject to this life-altering decision in the hands of a doctor, the State surely has a right to intervene in this matter.

This allegation is also deficient for several reasons.

First, the State opens with the flaccid, panic-stricken statement that "Plaintiffs' (sic) petition seeks a decision by this Court that the provision of prescription medication to a child is simply a matter of medical judgment that should be left entirely to a treating physician." That is, of course, wrong. Plaintiff makes no such allegation and seeks no such decision. As such, this allegation fails to apprise Plaintiff and this Court of what aspect of the relief requested justifies this claim. The

[10] It bears noting that in other contexts, the Attorney General has explicitly advocated that judicial intervention be used to regulate hospitals and the practice of medicine. Dr. Lopez would ask the Court to take judicial notice of the Attorney General's public statements and voluminous briefing on the "Bounty Hunter" lawsuits allowing individuals to sue doctors for providing abortions.

State then proceeds to argue the medical merits by asserting a number of (medically rejected) bases for denying care within the standard of care. The allegations do not, however, (1) include a cite to any law, statute, regulation, and/or Texas Medical Board Rule implicated by the relief sought, (2) articulate any threat to the enforcement authority of the State presented by the relief sought, (3) cite any authority for the proposition that the State has the absolute right to intervene in the physician/patient relationship (including the parents of minors), as opposed to a legally insufficient contingent or remote right, (4) state that the State has any present, ripe absolute right to supervene and, against the parents' wishes, dictate the care that will or will not be provided by Dr. Lopez, (5) or cite to any authority for the proposition that the State has the right to criminalize the treatment of a gender dysphoric child simply because the child is gender dysphoric. Without such clarity, Plaintiff and the Court cannot evaluate and respond to such allegations which are too general and legally spurious.

Second, the State alleges that "[i]n order to protect its interest, as parens patriae, in the welfare of children subject to this life-altering decision in the hands of a doctor, the State surely has a right to intervene in this matter." Counsel have located no authority for the proposition that the State may seek absolute or general relief as parens patriae for every decision involving medical treatment of or procedures on children. On the contrary, the authority makes clear that the State may only intervene in response to a specific threat, to the life or limb of a specific child, created by a parent's refusal to consent to life or limb saving medical treatment.[11] Even then, relief as parens patriae is only available by court order, and only after the State has alleged and proven its case against a specific parent.[12] In other words, in its capacity as parens patriae, the State appears to want the Court to deny the relief requested without the State itself seeking the court order legally necessary for the State to supervene the constitutional authority of a parent to consent to or withhold medical treatment for his/her child. Such a step would have to happen first, and as such, it makes this interest too remote or contingent to justify an intervention.

Third, the State's allegation ignores well-settled black letter law that a district court, and not the State, has exclusive jurisdiction to "to supervene the decisional authority of parents," and "interfere with the rights and duties of parents to consent to, withhold, or withdraw medical

[11] *See, generally, TL v. Cook Children's Medical Center*, 607 S.W.3d 9, 44 (Tex. App.–Fort Worth 2020, pet. denied).

[12] *Id*.

treatment from their child is the state through its police powers."[13] If the State seeks to invoke its right as parens patriae, it may only do so in the district court in response to a specific threat to a child, not a generalized concern.

C. Special Exception to Page 3.

Plaintiff also objects and specially excepts to page 3 of the Petition in Intervention in which the AG argues:

> Under this sovereign authority, as to minors, "[t]he state thus act[s] upon the assumption that its parentage supersedes all authority conferred by birth on the natural parents, [and] takes upon itself the power and right to dispose of the custody of children as it shall judge best for their welfare." In re Barry, 42 F. 113, 118 (S.D.N.Y. 1844), approved by and attached as appendix to Ex parte Burrus, 136 U.S. 586, 594–95 & n.1 (1890) (referring to parens patriae as a "common-law function" of the state).

Plaintiff specially excepts for the reason that such a claim is vague in general and appears to imply that the State has greater authority than parents in making medical decisions for their children as a general rule. If that is not what the State is claiming, then the statement is vague, ambiguous and misleading and deprives Plaintiff of the ability to know what the State is claiming. If that is what the State is claiming, it is defective for a number of reasons.

First, in citing to this 1844 opinion of a New York judge that predated the 14th Amendment of the Constitution and its guarantee of rights, it is unclear how that applies given the mountain of authority from the United States Supreme Court that has explicitly rejected such a notion. "[T]he interest of parents in the care, custody, and control of their children—is perhaps the oldest of the fundamental liberty interests recognized by [the Supreme] Court."[14] Though this right is not absolute, "the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder."[15] This parental liberty interest generally encompasses the "fundamental right to direct the medical care of their children."[16] Until a showing is made otherwise"parents are presumed to be acting in

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[13] *Cook Children's*, 607 S.W.3d at 44.

[14] *Troxel v. Granville*, 530 U.S. 57, 65 (2000).

[15] *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944)

[16] *Kanuszewski v. Michigan Dep't of Health & Human Servs.*, 927 F.3d 396, 419 (6th Cir. 2019); see also *Parham v. J.R.*, 442 U.S. 584, 602 (1979). (parent's right to raise their child includes the ability "to recognize symptoms of illness and to seek

the child's best interest," and the existence of medical risks in a procedure are inadequate to question that presumption and to give the State any say in medical decision-making:

> Simply...because [the medical procedure] involves risks does not automatically transfer the power to make that decision from the parents to some agency or officer of the state. The same characterizations can be made for a tonsillectomy, appendectomy, or other medical procedure. Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments...Neither state officials nor federal courts are equipped to review such parental decisions.[17]

On this exact topic of gender-affirming care, a Federal District Judge recently rejected arguments in excepted-to paragraph and enjoined an Alabama law that attempted to prohibit the provision of gender-affirming care as unconstitutional:

> The Court finds that the Parent Plaintiffs have a fundamental right to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary. So long as a parent adequately cares for his or her children, "there will normally be no reason for the State to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children." *Troxel*, 530 U.S. at 68-69, 120 S.Ct. 2054.[18]

Or, as the Supreme Court of Texas said five days ago in rejecting the arguments of the AG while recognizing that the DFPS is vested with authority to investigate credible allegations of abuse: "DFPS's preliminary authority to investigate allegations does not entail the ultimate authority to interfere with parents' decisions about their children, ***decisions which enjoy some measure of constitutional protection whether the government agrees with them or not***."[19] The AG fails to apprise this Court as to how its claimed general interest survives in the face of law that rejects that very notion.

Second, Plaintiff specially excepts to this portion of the Petition because claiming that the State has a greater authority than authority granted to parents by birth to care for their children is

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and follow medical advice")

[17] *Parham v. J. R.*, 442 U.S. 584, 603 (1979).

[18] *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 892 (E.D. Ark. 2021)

[19] *In re Abbott*, No. 22-0229, 2022 WL 1510326, at *3 (Tex. May 13, 2022).

simply nothing short of fascism. Or, as the United States Supreme Court said over four decades ago, "The statist notion that governmental power should supersede parental authority in all cases because some parents abuse and neglect children is repugnant to American tradition."[20]

The paragraph should be struck from a pleading because it is antithetical to the Rule of Law and mountains of authority, and the attorneys arguing it should be ashamed, if not sanctioned.

Relief Requested

Plaintiff respectfully requests the Court order the State to replead and:

1. State with specificity what valid, legal interest of the State is implicated by the relief sought in this matter;

2. State with specificity upon whose legal interest is the AG purporting to act given that the public policy, as defined by the Texas Legislature, was to not categorize gender-affirming care as abuse;

3. State with specificity why the State needs to be a party in this matter given the issues it raises are being litigated in another forum and including it in this case would needlessly complicate the issues here;

4. State with specificity the precise "laws," the enforcement of which "could potentially [be] undermine[d]" if the Court grants relief sought by the Plaintiff;

5. State with specificity each claim for relief which, if granted by the Court, "could potentially undermine the State's interest in the uniform application of its laws";

6. Cite the law, statute, regulation, and/or Texas Medical Board Rule permitting the State, or any hospital regulated by the State, to require a physician to deprive a child of treatment for gender dysphoria within the medical standard of care, solely because the child is being treated for gender dysphoria, while providing that treatment to other children;

7. Cite the law, statute, regulation, and/or Texas Medical Board Rule pursuant to which the State "conducts the licensure and regulation of all state physicians" which you contend is implicated in any regard by the relief sought by the Plaintiff;

8. Cite every law, statute, regulation, and/or Texas Medical Board Rule that vests in the State the right to criminalize treatment of a gender dysphoric child within the medical standard of care simply because the child is gender dysphoric;
9. Cite every law, statute, regulation, and/or Texas Medical Board Rule upon which the State relies in asserting that it may seek "to protect its interest, as parens patriae,"

[20] *Parham v. J. R.*, 442 U.S. 584, 603 (1979).

except in response to a specific threat, to the life or limb of a specific child, created by a parent's refusal to consent to life or limb saving medical treatment;

10. Cite every law, statute, regulation, and/or Texas Medical Board Rule upon which the State relies in asserting that it may seek "to protect its interest, as parens patriae," without affirmatively seeking a court order; and

11. State with specificity whether it is the position of the Attorney General of the State of Texas that the State of Texas has a general and greater right to make medical decisions for children than natural parents do in the absence of any specific finding of abuse.

Given the impending temporary injunction hearing, Plaintiff requests that the State be ordered to replead within 24 hours, and if they are not able to replead sufficiently, that the Court strike the intervention as it fails to meet the standard for a petition in intervention.

Plaintiff further prays for any such further relief, in law or equity, appropriate or to which Plaintiff has a right.

Respectfully submitted,

/s/ Charla G. Aldous

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* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on May 18, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

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Associated Case Party: CHILDREN'S MEDICAL CENTER AT DALLAS

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DISMISS and Opinion Filed May 20, 2022

In The
Court of Appeals
Fifth District of Texas at Dallas

No. 05-22-00375-CV

IN RE DANIEL K. PODOLSKY, M.D. AND JOHN J WARNER, M.D., Relators

Original Proceeding from the County Court at Law No. 2
Dallas County, Texas
Trial Court Cause No. CC-22-01316-B

MEMORANDUM OPINION

Before Justices Myers, Nowell, and Goldstein
Opinion by Justice Goldstein

Before the Court is relators' May 17, 2022 unopposed motion to dismiss their petition for writ of mandamus. In the motion, relators inform the Court that this original proceeding is moot.

We grant relators' motion and dismiss this original proceeding. We also lift the stay issued by this Court's April 25, 2022 order.

/Bonnie Lee Goldstein/
BONNIE LEE GOLDSTEIN
JUSTICE

220375F.P05

Order entered May 20, 2022

In The
Court of Appeals
Fifth District of Texas at Dallas

No. 05-22-00375-CV

IN RE DANIEL K. PODOLSKY, M.D. AND JOHN J WARNER, M.D., Relators

Original Proceeding from the County Court at Law No. 2
Dallas County, Texas
Trial Court Cause No. CC-22-01316-B

ORDER

Before Justices Myers, Nowell, and Goldstein

Based on the Court's opinion of this date, we **DISMISS** this original proceeding and **LIFT** the stay issued by our order of April 25, 2022.

/s/ BONNIE LEE GOLDSTEIN
JUSTICE

CAUSE NO. 22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant*, and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF XIMENA LOPEZ, M.D.'S
ANSWER TO THE STATE OF TEXAS'S PETITION IN INTERVENTION
AND COUNTERCLAIMS

Ximena Lopez, M.D. responds to the State of Texas's Petition in Intervention and asserts the following.

I.
GENERAL DENIAL UNDER TEXAS RULE OF CIVIL PROCEDURE 92

It is not entirely clear from the State of Texas's Petition in Intervention as to the purpose of it. There is no relief requested against any party. Nevertheless, Dr. Lopez asserts a General Denial under TEXAS RULE OF CIVIL PROCEDURE 92 and generally denies all the allegations in the Petition for Intervention which, by Rule, places every allegation in the Petition at issue in this case and joins the State and all of the allegations from the Petition before the Court and within the Court's jurisdiction.

II.
SPECIFIC DENIAL AND
MOTION TO SHOW AUTHORITY AGAINST THE ATTORNEY GENERAL

Pleading further, Dr. Lopez objects to and specifically denies that Attorney General Ken Paxton has the authority to prosecute this Petition in Intervention in the name of the State of Texas.

The Attorney General of Texas's authority is both given and circumscribed by the Texas Constitution and the statutes of this State. Under those, the Attorney General has the authority to:

1. represent the State in all suits and pleas in the Supreme Court of the State in which the State may be a party (TEX. CONST. Art. 4, § 22)

2. give legal advice in writing to the Governor and other executive officers, when requested by them (*Id.*);

3. perform such other duties as may be required by the law (*Id.*);

4. prosecute and defend all actions in which the State is interested before the supreme court and courts of appeals (TEX. GOV'T CODE § 402.021);

5. defend the laws of the State of Texas when a party challenges the constitutionality of a statute (TEX. GOV'T CODE § 402.010);

6. defend a state district attorney in an action in a federal court under certain circumstances (TEX. GOV'T CODE § 402.024);

7. defend a local entity in any court if requested and the subject matter involves an immigration detainer (TEX. GOV'T CODE § 402.0241);

8. assist district or county attorneys in criminal cases if requested (TEX. GOV'T CODE § 402.0241);

9. issue opinions (TEX. GOV'T CODE § 402, Subchapter C);

10. defend state agencies, elected and appointed officials (in their official capacity) and state employees (in their official capacity) in civil litigation; and

11. various other administrative duties unrelated to civil litigation.

None of these issues which define the authority of the Texas Attorney General are implicated here or would authorize him to act on behalf of the State in this matter. The original suit was not against the State, an agency of the state, an elected or appointed official in their official capacity, or a state employee in their official capacity. The original suit did not challenge the constitutionality of any statute. This court is not a court of appeals, Supreme Court, or federal court. It is a civil case and not a criminal case. There has been no request, that is publicly known, from a party authorized to make such a request on behalf of the State that sought the Attorney General to intervene on behalf of the State.

The Attorney General has limited authority, and he is not empowered by the Constitution or any statute to intervene in private matters on his own whim, especially this matter. Indeed, the Texas Supreme Court specifically told the Attorney General less than a week prior to filing this pleading on behalf of Texas that he has no legal authority to claim that the medical treatment of gender dysphoria is felony abuse under Texas law, as the Attorney General attempted to do in authoring an "Opinion letter" making that claim. *In re Abbott*, No. 22-0229, 2022 WL 1510326, at *3 (Tex. May 13, 2022). As the Supreme Court noted, the basis for such a claim must be derived from a statute and there is no statute saying that such care is illegal child abuse—indeed, the Texas Legislature specifically decided to not make such a law. *See* Tex. S.B. 1646, 87th Leg., R.S. (2021). The only official to say that it is child abuse is AG Paxton himself in his opinion letter, and the Supreme Court made clear he did not have the authority to criminalize the conduct he attempted to criminalize: "The pertinent question for now is whether AG Opinions create or change legal obligations, as opposed to explaining them. They do not." *Id.* at fn. 2. The Texas Supreme Court went to lengths to explain that only the Texas Department of Family and Protective Services—***not the Attorney General or Governor***—is statutorily authorized to investigate allegations of abuse—and only then after a Texas court authorizes it to act upon a credible showing of abuse. As such, the Supreme Court's opinion rejects the authority of the Attorney General to involve himself in this issue:

> Nor does the Attorney General have any formal legal authority to direct the investigatory decisions of DFPS. In sum, we are directed to no source of law obligating DFPS to base its investigatory decisions on the Governor's letter or the Attorney General's Opinion. The Governor and the Attorney General were certainly well within their rights to state their legal and policy views on this topic, but DFPS was not compelled by law to follow them.

Id. Just as the Attorney General cannot push DFPS to accept the Attorney General's viewpoints, nor can the Attorney General *sua sponte* decide to press such a viewpoint in the name of the State of Texas in litigation and try to enforce it upon this Court or these parties.

Under TEXAS RULE OF CIVIL PROCEDURE 12, the Court should cite Attorney General Paxton and require him to appear for a hearing to show his authority to prosecute this Petition for Intervention in the name of the State of Texas, failing which the Court should refuse to permit the Attorney General or his office to appear in this matter.

III.
Facts Relevant to the Counterclaim

This lawsuit is about the care provided by a licensed physician, Dr. Lopez, who is credentialed to provide pediatric endocrinology services at Children's Medical Center at Dallas. Dr. Lopez provided such services for years at Children's pursuant to internationally published standards of care adopted by Children's. The care was provided to patients and parents with their full knowledge and consent. There is no allegation of violations of standards of care or that Dr. Lopez did anything improper. Rather, Children's made a decision to restrict Dr. Lopez's privileges and exercise of clinical judgment following threats received by members of the Executive Department of the State of Texas. But this lawsuit was a lawsuit between two private parties who had a legally-defined relationship.

The Attorney General, who is in the middle of a contentious primary battle for re-election, has repeatedly claimed publicly that he intends to fight against this kind of medical care. There is ample evidence that the Attorney General is politically motivated on this topic. In fact, the Supreme Court recently rebuked the Attorney General for trying to involve himself in this issue as it was outside his authority. The Supreme Court noted:

> On February 18, 2022, the Attorney General issued Opinion No. KP-0401, which concludes that certain "'sex change' procedures and treatments . . . when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code." Relying on this opinion, the Governor sent a letter to the Commissioner of the Department of Family and Protective Services(DFPS) expressing his view that "a number of so-called 'sex change' procedures constitute child abuse under existing Texas law." The letter closes with the instruction that "DFPS and all other state agencies must follow the law as explained in OAG Opinion No. KP-0401." DFPS then issued the following statement to the media: "In accordance with Governor Abbott's directive today to Commissioner Masters, we will follow Texas law as explained in Attorney General opinion KP-0401."

In re Abbott, at *1.The Supreme Court's rebuke makes clear that the Attorney General had no authority to issue his opinion, and his opinion is not consistent with the laws of the State of Texas. The intermediate Court of Appeals noted that the Attorney General and the Governor threatened criminal investigations for anyone seeking or providing such care.

Undeterred by the rebuke from the Supreme Court, the Attorney General publicly proclaimed that he would keep fighting to stop this important medical care. Without any law being at issue, and despite this case being between private parties, the Attorney General has voluntarily interjected the State of Texas into this matter. The gravamen of the claim made by the Attorney

General is that the State of Texas needs to intervene to "protect children". This tracks the Attorney General's opinion by implicitly arguing that the care at issue in this case is abusive. The implicit label of "abuse" undergirds everything alleged in the Petition for Intervention.

However, the Attorney General was wrong when he claimed in his formal Opinion that this care is abuse—as the Supreme Court told him—and the only entity that could make it so, the Legislature, has specifically decided not to make it abuse. *Id.* Thus, the allegations made in this case are wrong, as *In re Abbott* makes plain. The Attorney General knew that the arguments he made in this proceeding had been rejected by the Supreme Court less than a week before he filed this Intervention.

IV.
Counterclaim Against the State of Texas And Request for Sanctions Against Attorney General

A. Parties.

1. Plaintiff and Counter-Plaintiff Dr. Ximena Lopez has previously appeared in this matter and is represented by the undersigned counsel.

2. Defendant Children's Medical Center at Dallas has previously appeared in this matter and is represented by counsel.

3. Intervenor The State of Texas has voluntarily appeared in this matter, waiving its sovereign immunity. The State of Texas, on paper, is represented by the Texas Attorney General. As set forth more fully in the specific denials above, it remains to be seen if the Attorney General has authority to be prosecuting this matter in the name of the State.

B. Declaratory Judgment under Texas Civil Practice and Remedies Code § 37.004(a).

4. Plaintiff and Counter-Plaintiff Dr. Lopez incorporates the above paragraphs by reference.

5. Pursuant to the Declaratory Judgment Act, Dr. Lopez seeks a declaration that the provision of pediatric endocrinology services to patients suffering from gender dysphoria, including pubertal suppression and hormone therapy, is not child abuse on its face when the care is provided by a licensed provider, indicated under the applicable standards of care, and is consented to by the patient and their parent or legal guardian.

6. Pursuant to the Declaratory Judgment Act, Dr. Lopez seeks a declaration that the provision of pediatric endocrinology services to patients suffering from gender dysphoria, including pubertal suppression and hormone therapy, is not against any Texas state law and is not illegal when

the care is provided by a licensed provider, indicated under the applicable standards of care, and is consented to by the patient and their parent or legal guardian.

7. Pursuant to the DECLARATORY JUDGMENT ACT, Dr. Lopez seeks a declaration that the public policy of the State of Texas with regard to the provision of pediatric endocrinology services to patients suffering from gender dysphoria, including pubertal suppression and hormone therapy, is not dictated by the Governor of the State of Texas or the Attorney General of the State of Texas.

8. Pursuant to TEXAS CIVIL PRACTICE AND REMEDIES CODE § 37.009, Dr. Lopez requests that the Court award her costs and attorneys' fees.

C. Plea for Sanctions against Attorney General Ken Paxton.

9. Plaintiff and Counter-Plaintiff Dr. Lopez incorporates the above paragraphs by reference.

10. The pleading filed by Attorney General Ken Paxton was unauthorized by the law of this State and outside the authority the Attorney General has by constitution and by statute. What's more, the Texas Supreme Court made that exact point on this exact topic less than a week before the Attorney General filed this matter. As such, the Attorney General was well aware of the existing law that this issue between two private parties was outside the scope of his authority, and he had no legal authority to pursue this matter. As such, the Petition in Intervention was groundless and brought in bad faith, brought for the purpose of harassment against the medical providers providing care in this case as well as harassment of their patients and prospective patients, and claims regarding the care at issue were false when made. Each of these grounds independently and collectively warrant sanctions against the Attorney General. *See* TEX. R. CIV. P. 13.

11. Further, the Attorney General's groundless pleading was brought for an improper purpose, including harassment as set forth above, to illegally intimidate, coerce, and threaten the medical providers providing care in this case as well as harassment of their patients and prospective patients, and for the personal political interests of the Attorney General himself. Each of these grounds independently and collectively warrant sanctions against the Attorney General. *See* TEX. CIV. PRAC. & REM. CODE § 10.004.

12. Finally, as the Petition in Intervention was brought by the State of Texas by the Attorney General and is frivolous, Dr. Lopez is entitled under TEXAS CIVIL PRACTICE & REMEDIES CODE § 105.002 to be awarded as a sanction–in addition to all other costs allowed by law or rule—a total amount not to exceed $1 million for fees, expenses, and attorney's fees upon the dismissal of the Petition in Intervention or a judgment in Dr. Lopez's favor.

13. Sanctions should be awarded against the attorney and not the party as there is no reason to believe the State of Texas approved, requested, or was even aware that the Attorney General intended to engage in such sanctionable conduct, and the Attorney General is personally responsible for the sanctionable Petition.

V.
Prayer

14. In addition to the relief sought in her petition, Counter-Plaintiff Dr. Lopez respectfully prays as follows:

a. That the Court cite Attorney General Paxton and require him to appear for a hearing to show his authority to prosecute this Petition for Intervention in the name of the State of Texas, failing which the Court should refuse to permit the Attorney General or his office to appear in this matter;

b. That the Court render a Declaratory Judgment that:

i. the provision of pediatric endocrinology services to patients suffering from gender dysphoria, including pubertal suppression and hormone therapy, is not child abuse on its face when the care is provided by a licensed provider, indicated under the applicable standards of care, and is consented to by the patient and their parent or legal guardian,

ii. the provision of pediatric endocrinology services to patients suffering from gender dysphoria, including pubertal suppression and hormone therapy, is not against any Texas state law and is not illegal when the care is provided by a licensed provider, indicated under the applicable standards of care, and is consented to by the patient and their parent or legal guardian, and

iii. the public policy of the State of Texas with regard to the provision of pediatric endocrinology services to patients suffering from gender dysphoria, including pubertal suppression and hormone therapy, is not dictated by the Governor of the State of Texas or the Attorney General of the State of Texas;

c. That the Court award to Dr. Lopez her reasonable attorneys' fees and costs under Texas Civil Practice & Remedies Code § 37.009;

d. That the Court order sanctions against Attorney General Ken Paxton pursuant to Texas Rule of Civil Procedure 13, Texas Civil Practice & Remedies Code § 10.004, and Texas Civil Practice & Remedies Code § 105.002;

e. That Dr. Lopez be awarded her costs of Court;

f. For all such other and further relief at law and in equity to which Dr. Lopez may show herself justly entitled.

Respectfully submitted,

/s/ Charla G. Aldous

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* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on May 23, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

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Associated Case Party: CHILDREN'S MEDICAL CENTER AT DALLAS

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CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff,* v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.*	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

ORDER GRANTING AGREED TEMPORARY INJUNCTION

Based on the agreement of the Parties and the pleadings in this case and the evidence before the Court, the Court GRANTS Ximena Lopez M.D.'s Application for Temporary Injunction and makes the following findings and orders:

1. The Court has jurisdiction to hear the Application and issue appropriate injunctive relief pursuant to it.

2. Pursuant to TEXAS RULE OF CIVIL PROCEDURE 683, the Court has the authority and discretion to enjoin Children's Medical Center at Dallas and its officers, agents, servants, employees, attorneys, as well as any individuals and entities in active concert or participation with them who receive actual notice of the Order by personal service or otherwise (together "CMC").

3. The Court finds that Plaintiff has carried her burden at this stage by proving temporary injunctive relief is appropriate and that Plaintiff has demonstrated a probable right to relief on her claims. In support of that, the Court finds that, unless the injunction issues as set forth below, Dr. Lopez will suffer imminent and irreparable harm through being precluded from exercising her independent medical judgment as a licensed physician with privileges at CMC to provide pediatric endocrinology and by being prevented from providing a level of care to her patients that jeopardizes her licensure or impacts her reputation or business. Each of these bases for probable imminent and irreparable harm independently supports the issuance of the requested temporary injunction.

4. The Court finds the *status quo* to be preserved during the pendency of this temporary injunction—that is, the last, actual, peaceable time before the instant controversy as reflected in the historical practices and operations at CMC—was the situation prior to any restriction on providing gender-affirming endocrinology care to new patients

at CMC. The *status quo* to be maintained therefore permits providers at CMC to provide gender-affirming endocrinology care to both new and existing patients.

5. IT IS THEREFORE ORDERED that the Clerk of this Court issue a Writ of Injunction, operative until final judgment in this matter, restraining Children's Medical Center at Dallas and its officers, agents, servants, employees, attorneys, as well as any individuals and entities in active concert or participation with them who receive actual notice of the Order by personal service or otherwise as follows:

   a. Children's Medical Center at Dallas and its officers, agents, servants, employees, attorneys, as well as any individuals and entities in active concert or participation with them who receive actual notice of the Order by personal service or otherwise are restrained during the pendency of this Order from enforcing any policy or limitation that restricts or prohibits gender-affirming endocrinology care, including specifically pubertal suppression or hormone therapy, to new or established patients due the patient's gender identity or gender dysphoria;

   b. Children's Medical Center at Dallas and its officers, agents, servants, employees, attorneys, as well as any individuals and entities in active concert or participation with them who receive actual notice of the Order by personal service or otherwise are restrained during the pendency of this Order from discriminating against patients seeking gender-affirming endocrinology care by restricting or prohibiting care because of the patient's gender identity;

   c. Children's Medical Center at Dallas and its officers, agents, servants, employees, attorneys, as well as any individuals and entities in active concert or participation with them who receive actual notice of the Order by personal service or otherwise are restrained from interfering with, controlling, or otherwise directing any physician's professional judgment with respect to the provision of gender-affirming endocrinology care at CMC; and

   d. Children's Medical Center at Dallas and its officers, agents, servants, employees, attorneys, as well as any individuals and entities in active concert or participation with them who receive actual notice of the Order by personal service or otherwise are restrained from imposing any limitation on Dr. Lopez's exercise of her clinical privileges to provide pediatric endocrinology care, including, but not limited to, prohibiting her from providing gender-affirming endocrinology care, in the absence of any formal due process under CMC's by-laws by the appropriate parties to restrict Dr. Lopez's clinical privileges.

6. IT IS FURTHER ORDERED that the discovery previously identified and ordered produced within 10 days of May 12, 2022 (due May 23, 2022), is due within sixty (60) days of the date of this Order, the scope of which will be subject to good faith negotiations by counsel.

7. IT IS FURTHER ORDERED that, in lieu of requiring Dr. Lopez to execute and file a new bond for issuance of the Temporary Injunction, the $100.00 cash deposit filed by Dr. Lopez and accepted by the Dallas County Clerk on May 12, 2022 in connection with the Temporary Restraining Order signed in this lawsuit is hereby deemed extended in conformity with the law to the period during which the Temporary Injunction is in effect.

IT IS FURTHER ORDERED that trial on the merits is set for Apr. 18 2023 at 9, a.m., which is a trial date more than ten (10) months from the date of the original filing of this proceeding.

It is so Ordered.

Signed: May 23, 2022

HON. MELISSA BELLAN,
Presiding Judge of County Court at Law No. 2
Dallas County, Texas

Agreed to on behalf of Dr. Lopez by:

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COUNSEL FOR CHILDREN'S MEDICAL CENTER OF DALLAS

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff,* v. CHILDREN'S MEDICAL CENTER OF DALLAS, *Defendant.*	§ § § § § § § § § § §	IN COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

DEFENDANT CHILDREN'S MEDICAL CENTER OF DALLAS' SPECIAL EXCEPTIONS, PLEA TO THE JURISDICTION, AND ORIGINAL ANSWER TO PLAINTIFF'S VERIFIED APPLICATION FOR TEMPORARY RESTRAINING ORDER, TEMPORARY INJUNCTION, AND ORIGINAL PETITION FOR PERMANENT INJUNCTIVE AND DECLARATORY RELIEF

Defendant Children's Medical Center of Dallas[1] ("Children's") files the following Special Exceptions, Plea to the Jurisdiction, and Original Answer to Plaintiff's Verified Application for Temporary Restraining Order, Temporary Injunction, and Original Petition for Permanent Injunctive and Declaratory Relief ("the Petition"). In support, Children's shows the following:

I.
SPECIAL EXCEPTIONS[2]

1. The purpose of special exceptions is to compel clarification of pleadings when the pleadings are not clear or sufficiently specific or fail to plead a cause of action. *See, e.g.*, *Baylor Univ. v. Sonnichsen*, 221 S.W.3d 632, 635 (Tex. 2007) (per curiam); *see also Horizon/CMS Healthcare Corp. v. Auld*, 34 S.W.3d 887, 897 (Tex. 2000) ("An opposing party should use special exceptions to identify defects in a pleading so that they may be cured, if possible, by amendment.").

[1] As shown below, Plaintiff incorrectly named Children's as "Children's Medical Center at Dallas" instead of "Children's Medical Center of Dallas."

[2] In the event this Court concludes that the argument in Children's plea to the jurisdiction is more properly asserted as part of Children's special exceptions, Children's – out of an abundance of caution – expressly incorporates that argument by reference herein.

2. Children's specially excepts to the Petition in its entirety because Plaintiff has failed to sue Defendant in its correct name. Plaintiff has misnamed Defendant as "Children's Medical Center at Dallas." Defendant's correct name is "Children's Medical Center of Dallas."

3. Children's specially excepts to the Petition in its entirety because Plaintiff failed to comply with Texas Civil Practice & Remedies Code § 30.014(a), which requires the identification of certain information regarding Plaintiff's driver's license number and social security number. *See* TEX. CIV. PRAC. & REM. CODE § 30.014(a)(1)-(2) ("In a civil action … filed in a … county court …, each party or the party's attorney must include in its initial pleading: (1) the last three numbers of the party's driver's license number, if the party has been issued a driver's license; and (2) the last three numbers of the party's social security number, if the party has been issued a social security number."). The Petition fails to disclose the required information above.

4. Children's specially excepts to the Petition in its entirety because Plaintiff has failed to identify a statute, case law, or other legal authority granting Plaintiff a private cause of action to sue Children's in state court in connection with any of her claims against Children's. For example, Plaintiff fails to cite any Texas law granting her a private cause of action to sue Children's in state court for: (1) allegedly forcing Plaintiff to discriminate against new patients with gender dysphoria by ceasing endocrinology care for such patients (as opposed to a direct discrimination claim brought by such patients against Children's or a discrimination claim based on a patient's medical condition or whether a patient is new or not); (2) allegedly violating the prohibition against the corporate practice of medicine; (3) allegedly restricting her staff privileges at Children's without formal due process; and (4) allegedly engaging in an illegal restraint of trade. For example, discrimination is a statutory-based claim and does not arise under the common law. Yet Plaintiff fails to cite to a single state or federal statute to support her argument that Children's engaged in

discrimination. The Petition and allegations violate Rule 45 of the Texas Rules of Civil Procedure because they are stated in general terms and do not "consist of . . . statement[s] in plain concise language" that give Children's fair notice of Plaintiff's allegations against it. *See* TEX. R. CIV. P. 45. Children's respectfully requests that the Court strike Plaintiff's causes of action in their entirety or, in the alternative, direct Plaintiff to amend the Petition to specifically plead the statutory or common law bases on which Plaintiff relies to assert her claims.

5. As to Plaintiff's claim for unlawful restraint of trade, to the extent Plaintiff is asserting a claim for unlawful restraint of trade under Section 15.05(a) of the Texas Free Enterprise and Antitrust Act of 1983 – which states that "[e]very contract, combination, or conspiracy in restraint of trade or commerce is unlawful" (TEX. BUS. & COM. CODE § 15.05(a)) – Plaintiff has failed to plead the required elements of such claim, including: (1) what "the alleged contract, combination, or conspiracy" to restrain trade was and between whom; (2) how any such restraint was unreasonable; (3) how any such restraint had an adverse effect on competition in the relevant market; and (4) what the relevant market is for the specific therapy at issue in this case. *See, e.g.*, *In re Mem'l Hermann Hosp. Sys.*, 464 S.W.3d 686, 709-10 (Tex. 2015) (orig. proceeding) ("'In order to successfully allege injury to competition, a . . . claimant may not merely recite the bare legal conclusion that competition has been restrained unreasonably.' At a minimum, the claimant must 'sketch the outline of the antitrust violation with allegations of supporting factual detail.'"); *id*. at 709 ("Claims of improper restraint of trade require a plaintiff to 'plead . . . a reduction of competition in the market in general and not mere injury to their own positions as competitors in the market.'"); *Marlin v. Roberson*, 307 S.W.3d 418, 427 (Tex. App.–San Antonio 2009, no pet.) (requiring pleading and showing that "the alleged contract, combination, or conspiracy is unreasonable and has an adverse effect on competition in the relevant market."). The Petition and

allegations violate Rule 45 of the Texas Rules of Civil Procedure because they are stated in general terms and do not "consist of . . . statement[s] in plain concise language" that give Children's fair notice of Plaintiff's allegations against it. *See* TEX. R. CIV. P. 45. Children's respectfully requests that the Court strike Plaintiff's claim for unlawful restraint of trade in its entirety or, in the alternative, direct Plaintiff to amend the Petition to specifically plead the required elements of her claim.

II.
GENERAL DENIAL

6. Children's generally denies each and every allegation contained in Plaintiff's Petition and demands strict proof thereof.

III.
PLEA TO THE JURISDICTION[3]

7. The issue of whether a trial court has subject-matter jurisdiction over a claim is a question of law that can be challenged by a plea to the jurisdiction. *See, e.g.*, *Suarez v. City of Tex. City*, 465 S.W.3d 623, 632 (Tex. 2015). If the evidence creates a fact question regarding subject-matter jurisdiction, then the plea to the jurisdiction must be denied pending resolution of the fact issue by the fact finder. *See, e.g.*, *id.* at 633. If, however, the evidence is undisputed or fails to raise a question of fact, then the plea to the jurisdiction must be granted as a matter of law. *Id*.

8. To the extent Plaintiff attempts to assert a discrimination claim against Children's on behalf of patients or any other individuals, Plaintiff lacks standing to do so. It is black-letter Texas law that "the standing inquiry begins with the ***plaintiff's*** alleged injury" and that "the plaintiff must be personally injured – he must plead facts demonstrating that he, himself (rather

[3] In the event this Court concludes that any of the arguments in Children's special exceptions are more properly asserted as part of Children's plea to the jurisdiction, Children's – out of an abundance of caution – expressly incorporates those arguments by reference herein.

than a third party or the public at large), suffered the injury." *See, e.g.*, *Heckman v. Williamson County*, 369 S.W.3d 137, 155-56 (Tex. 2012) (emphasis added). Plaintiff has failed to plead or prove any legal, contractual, or factual bases to provide her with standing to prosecute a discrimination claim in state court on behalf of new patients with gender dysphoria.

IV.
AFFIRMATIVE DEFENSES AND OTHER DEFENSES[4]

9. The Petition fails, in whole or in part, to state a claim upon which relief may be granted.

10. Plaintiff's claims are barred, in whole or in part, under the doctrines of laches and waiver.

11. Plaintiff's claims are barred, in whole or in part, because Children's actions were based on reasonable factors, made in good faith and for good cause, were essential and necessary to the operation of Children's business, and were at all times motivated and required by legitimate, non-discriminatory business considerations.

12. At all times, Children's acted in good faith and had reasonable grounds to believe its actions did not violate any Texas statutes or administrative regulations.

13. Plaintiff's claims are barred, in whole or in part, because Children's is legally entitled to determine the type(s) of care provided at its facilities under Texas law.

14. Children's affirmatively pleads that it has in place anti-discrimination policies, which include complaint and grievance procedures to prevent and/or correct any alleged discrimination or other unlawful conduct. Plaintiff unreasonably failed to take advantage of these procedures.

[4] Children's pleads the defenses below in the event the Court concludes that those defenses are affirmative defenses. Children's does not concede that it bears the burden of proving the defenses below.

15. Plaintiff's claims are barred, in whole or in part, under the doctrine of exhaustion of administrative remedies.

16. To the extent Plaintiff has suffered irreparable harm as described in the Petition, any harm was caused by the acts or omissions of entities or persons over which Children's had no control.

17. None of the actions taken by Children's entitle Plaintiff to due process rights or other procedural rights of review under the Children's Medical Staff Bylaws.

18. Permanent injunctive relief should be denied because Plaintiff cannot show a cause of action against Children's, the existence of imminent harm, or the existence of irreparable injury. The application is procedurally defective and must be denied.

19. Permanent injunctive relief should be denied because it will alter, rather than preserve, the status quo.

20. Children's reserves the right to amend or supplement this Original Answer with additional defenses as they become known through the course of discovery.

V.
JURY DEMAND

21. Children's demands a trial by jury of this case.

VI.
CONCLUSION AND PRAYER

Children's respectfully requests that the Court: (1) grant Children's plea to the jurisdiction and dismiss with prejudice Plaintiff's claims for lack of subject-matter jurisdiction; or, in the alternative, (2) grant Children's special exceptions and order Plaintiff to replead the matters above and strike the pleadings not cured. Children's further respectfully requests that the Court enter a take-nothing judgment on all of Plaintiff's claims against Children's, award Children's its costs, and grant Children's any and all other relief to which it may be entitled.

Respectfully submitted,

NORTON ROSE FULBRIGHT US LLP

By *__/s/ Yvonne K. Puig__*

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Counsel for Defendant Children's Medical Center of Dallas

CERTIFICATE OF SERVICE

The undersigned counsel hereby certifies that a copy of Defendant's Special Exceptions, Plea to the Jurisdiction, and Original Answer to Plaintiff's Verified Application for Temporary Restraining Order, Temporary Injunction, and Original Petition for Permanent Injunctive and Declaratory Relief was served in compliance with Texas Rules of Civil Procedure 21 and 21a by electronic filing on June 3, 2022, upon the following:

Ms. Charla G. Aldous
Mr. Brent R. Walker
Mr. Caleb Miller
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Counsel for Plaintiff

Mr. Stephen F. Malouf
Mr. Jonathan Nockels
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4305 West Lovers Lane
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Counsel for Plaintiff

Ms. Courtney Corbello
Mr. Johnathan Stone
General Litigation Division
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P.O. Box 12548
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Counsel for Intervenor

/s/ Yvonne K. Puig
Yvonne K. Puig

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Maria Diaz on behalf of Yvonne Puig
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CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant*, AND THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

NOTICE OF HEARING ON PLAINTIFF XIMENA LOPEZ, M.D.'S SPECIAL EXCEPTIONS, AND, IN THE ALTERNATIVE, MOTION TO STRIKE PETITION IN INTERVENTION

TO: ALL COUNSEL OF RECORD

Please allow this notice to confirm that a hearing regarding Ximena Lopez M.D.'s *Special Exceptions, And, in the Alternative, Motion to Strike Petition in Intervention* has been set for **Friday June 17, 2022 at 10:30am via CourtCall**. By service of this notice, all counsel are advised they will need to schedule their own appearances through CourtCall 24 hours prior to the hearing**.** To register an account and schedule your appearance, visit www.courtcall.com or dial (888) 882-6878.

Respectfully submitted,

/s/ Charla G. Aldous

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Attorneys for Plaintiff Ximena Lopez, M.D.

* * *

Certificate of Service

I certify that this document is being served on all counsel of record via electronic mail on June 3, 2022.

/s/ Charla G. Aldous
Charla G. Aldous

FILED
6/6/2022 1:35 PM
JOHN F. WARREN
COUNTY CLERK
DALLAS COUNTY

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S NOTICE OF INTENTION TO REQUEST PRODUCTION OF DOCUMENTS FROM NON-PARTY THE REPUBLICAN PARTY OF TEXAS

TO: THE REPUBLICAN PARTY OF TEXAS, an unincorporated association, by and through its Chief Operating Officer, Brandon Moore, P.O. Box 2206, Austin, Texas 78768, bmoore@texasgop.org, and all parties by and through their attorney(s) of records.

PLEASE TAKE NOTICE THAT, under TEXAS RULES OF CIVIL PROCEDURE 205, Plaintiff Ximena Lopez, M.D. intends to subpoena from The Republican Party of Texas the documents indicated in the attached Exhibit A, to be produced on or before June 24, 2022 to offices of counsel for Plaintiff at Aldous\Walker LLP, 4311 Oak Lawn Ave., Suite 150, Dallas, Texas 75219 or via electronic mail to ealdous@aldouslaw.com. The Republican Party of Texas will be served with a subpoena ten days from the date of service of this notice.

Respectfully submitted,

/s/ Charla G. Aldous
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ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 6, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S FIRST REQUESTS FOR PRODUCTION TO THE REPUBLICAN PARTY OF TEXAS

TO: THE REPUBLICAN PARTY OF TEXAS, an unincorporated association, by and through its Chief Operating Officer, Brandon Moore, P.O. Box 2206, Austin, Texas 78768, bmoore@texasgop.org.

Plaintiff Ximena Lopez, M.D. hereby serves the following First Requests for Production on The Republican Party of Texas pursuant to TEXAS RULE OF CIVIL PROCEDURE 205.

DEFINITIONS AND INSTRUCTIONS

A. Definitions

1. "**You**," "**your**," and/or "**The Republican Party of Texas**" refers to the Republican Party of Texas, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Republican Party of Texas regardless of whether authorized by it to do so.

2. "**Children's Medical Center at Dallas**" refers to Children's Medical Center at Dallas, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Children's Medical Center of Dallas regardless of whether authorized by it to do so.

3. "**Save Texas Kids**" refers to Save Texas Kids, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Save Texas Kids regardless of whether authorized by it to do so.

4. "**Ms. Cato"** refers to Natalie Cato and any of Ms. Cato's past and present employees, agents, and representatives, and also includes agents, employees, or entities who act or acted on behalf of Ms. Cato or who are subject to Ms. Cato's control.

5. "**UTSW**" refers to UT Southwestern, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of UTSW regardless of whether authorized by it to do so.

6. "**Person**" or "**persons**" means all individuals, associations, partnerships, corporations, and any other type of entity or institution whether formed for business purposes or for any other purpose.

7. "**GENECIS program**" means the GENder Education and Care Interdisciplinary Support program at Children's Medical Center of Dallas or UT Southwestern Medical Center.

8. **"Gender dysphoria"** has the meaning provided by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

9. **"Gender-affirming endocrine care"** means the use of hormone therapy and/or puberty suppressors as part of the treatment of gender dysphoria.

10. "**Communication**" or "**communications**" mean the transmission, sending and/or receipt of information of any kind by or through any means including, but not limited to, speech writings, language (machine, foreign or otherwise), computer electronics of any kind (e.g. e-mail), videotape, photographs, graphs, symbols, signs, floppy disks, CD-ROM discs, telecommunication, cell phone, telephone, teletype, facsimile, telegram, microfilm, microfiche, photographic film of all type and other media of any kind. The term "communication" also

includes, without limitation, all records, inquiries, discussions, conversations, explanations, negotiations, agreements, understandings, meetings, notices, requests, responses, demands, complaints, publicity or trade releases and statements of any kind.

11. "**Document**" or "**documents**" mean any original or copy, including each non-identical copy, whether non-identical because of alteration, attachments, blanks, comments, notes, deletions, underlying or otherwise, of any written record, graphic material, or other tangible evidence or thing, however, described or titled, whether a letter, memorandum, report, affidavit, personal and/or handwritten note, tape recording, video, film, telegram, fax, transcript, purchase order, catalogue, brochure, diary, calendar, inter-office or intra-office communication, statement, investigative report, announcement, deposition, answers to questions, pleading, judgment, newspaper article, photograph, motion picture and any carbon or photographic copies of any such material. As used herein, the term "document" is also intended to include electronically stored information, including electronically generated and stored data files, computer files, e-mails, archived voicemail, and data storage devices such as floppy discs, and hard discs. The term "document" is further intended to include any computer records reflecting earlier drafts, revisions, addenda, memorandums and the like with regard to any responsive document.

12. "**Any**" refers to any and all documents, persons, or entities inclusively, not the option of responding as to some but not to others.

B. Electronic or Magnetic Data

Pursuant to Rule 196.4, Plaintiff hereby requests production of all electronic or magnetic data that is responsive to the requests contained herein. Such electronic or magnetic data is to be produced in the form in which it is kept, and is to include all meta-data associated with each file. If you cannot retrieve the data or information requested or produce it in the form requested, you must state an objection complying with Texas Rule of Civil Procedure 196. You have an obligation to preserve all electronic communications including but not limited to: digital or analog electronic files in electronic format, regardless of whether hard copies of the information exist; all computer servers, stand-alone personal computers, hard drives, laptops, PDAs, and other electronic processing devices; all potentially relevant internal and external emails that were sent or received, and the email must be preserved in electronic format, regardless of whether hard copies of the information exist; all records of internet and web-browser generated files in electronic format, regardless of whether hard copies of the information exist, including internet and web-browser-generated history files, caches, and "cookies"; files stored on backup media; and all hard copy or electronic logs documenting computer use.

Requests for Production

Request for Production 1: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to every communication occurring or dated between (1) The Republican Party of Texas (including its agents, employees, or representatives) and (2) Children's Medical Center at Dallas, UTSW, Ms. Cato, Save Texas Kids, or the Executive Branch of the State of Texas (including their agents, employees, and representatives) and related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

Response:

Request for Production 2: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to every phone call between (1) The Republican Party of Texas (including its agents, employees, and representatives) and (2) any member of the Texas Legislature (including such legislator's agents, employees, and representatives) or the Executive Branch of the State of Texas (including any agent, employee, and representative of the Executive Branch) and related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

Response:

Request for Production 3: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to communications, including video recordings, emails, or text messages, that discuss, reference, or allude to any protests or picketing at the home or place of business of any agent of UTSW, employee of UTSW or, board member of UTSW related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

Response:

Request for Production 4: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to communications, including video recordings, emails or text messages, that discuss, reference, or allude to any protests or picketing at the home or place of business of any agent of Children's Medical Center at Dallas, employee of Children's Medical Center at Dallas or, board member of Children's Medical Center at Dallas related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

RESPONSE:

REQUEST FOR PRODUCTION 5: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to every communication between (1) any agent or employee of The Republican Party and (2) any agent, employee, or representative of Save Texas Kids or Ms. Cato and related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

RESPONSE:

REQUEST FOR PRODUCTION 6: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to focus groups or surveys related to or including information related to related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

RESPONSE:

Respectfully submitted,

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ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 6, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Sha'Huni Robinson on behalf of Charla Aldous
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Associated Case Party: THE STATE OF TEXAS

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6/6/2022 1:35 PM
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CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S NOTICE OF INTENTION TO REQUEST PRODUCTION OF DOCUMENTS FROM NON-PARTY NATALIE CATO

TO: NATALIE CATO, 327 W. College St., #204, Nacogdoches, Texas 75965, and all parties by and through their attorney(s) of records.

PLEASE TAKE NOTICE THAT, under TEXAS RULES OF CIVIL PROCEDURE 205, Plaintiff Ximena Lopez, M.D. intends to subpoena from Natalie Cato the documents indicated in Exhibit A, to be produced on or before June 24, 2022 to offices of counsel for Plaintiff at Aldous\Walker LLP, 4311 Oak Lawn Ave., Suite 150, Dallas, Texas 75219 or via electronic mail to ealdous@aldouslaw.com. Natalie Cato will be served with a subpoena ten days from the date of service of this notice.

Respectfully submitted,

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ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 6, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

EXHIBIT A

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S FIRST REQUESTS FOR PRODUCTION TO NATALIE CATO

TO: NATALIE CATO, 327 W. College St., #204, Nacogdoches, Texas 75965.

Plaintiff Ximena Lopez, M.D. hereby serves the following First Requests for Production on Natalie Cato pursuant to TEXAS RULE OF CIVIL PROCEDURE 205.

DEFINITIONS AND INSTRUCTIONS

A. Definitions

1. "**You**," "**your**," and/or "**Ms. Cato**" refers to Natalie Cato and any of Ms. Cato's past and present employees, agents, and representatives, and also includes agents, employees, or entities who act or acted on behalf of Ms. Cato or who are subject to Ms. Cato's control.

2. "**Children's Medical Center at Dallas**" refers to Children's Medical Center at Dallas, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Children's Medical Center of Dallas regardless of whether authorized by it to do so.

3. "**UTSW**" refers to UT Southwestern, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of UTSW regardless of whether authorized by it to do so.

4. "**Save Texas Kids**" refers to Save Texas Kids, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Save Texas Kids regardless of whether authorized by it to do so.

5. "**Republican Party of Texas**" refers to the Republican Party of Texas, an unincorporated association, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Republican Party of Texas regardless of whether authorized by it to do so.

6. "**Person**" or "**persons**" means all individuals, associations, partnerships, corporations, and any other type of entity or institution whether formed for business purposes or for any other purpose.

7. "**GENECIS program**" means the GENder Education and Care Interdisciplinary Support program at Children's Medical Center of Dallas or UT Southwestern Medical Center.

8. "**Gender dysphoria**" has the meaning provided by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

9. "**Gender-affirming endocrine care**" means the use of hormone therapy and/or puberty suppressors as part of the treatment of gender dysphoria.

10. "**Communication**" or "**communications**" mean the transmission, sending and/or receipt of information of any kind by or through any means including, but not limited to, speech writings, language (machine, foreign or otherwise), computer electronics of any kind (e.g. e-mail), videotape, photographs, graphs, symbols, signs, floppy disks, CD-ROM discs, telecommunication, cell phone, telephone, teletype, facsimile, telegram, microfilm, microfiche, photographic film of all type and other media of any kind. The term

"communication" also includes, without limitation, all records, inquiries, discussions, conversations, explanations, negotiations, agreements, understandings, meetings, notices, requests, responses, demands, complaints, publicity or trade releases and statements of any kind.

11. "**Document**" or "**documents**" mean any original or copy, including each non-identical copy, whether non-identical because of alteration, attachments, blanks, comments, notes, deletions, underlying or otherwise, of any written record, graphic material, or other tangible evidence or thing, however, described or titled, whether a letter, memorandum, report, affidavit, personal and/or handwritten note, tape recording, video, film, telegram, fax, transcript, purchase order, catalogue, brochure, diary, calendar, inter-office or intra-office communication, statement, investigative report, announcement, deposition, answers to questions, pleading, judgment, newspaper article, photograph, motion picture and any carbon or photographic copies of any such material. As used herein, the term "document" is also intended to include electronically stored information, including electronically generated and stored data files, computer files, e-mails, archived voicemail, and data storage devices such as floppy discs, and hard discs. The term "document" is further intended to include any computer records reflecting earlier drafts, revisions, addenda, memorandums and the like with regard to any responsive document.

12. "**Any**" refers to any and all documents, persons, or entities inclusively, not the option of responding as to some but not to others.

B. Electronic or Magnetic Data

Pursuant to Rule 196.4, Plaintiff hereby requests production of all electronic or magnetic data that is responsive to the requests contained herein. Such electronic or magnetic data is to be produced in the form in which it is kept, and is to include all meta-data associated with each file. If you cannot retrieve the data or information requested or produce it in the form requested, you must state an objection complying with Texas Rule of Civil Procedure 196. You have an obligation to preserve all electronic communications including but not limited to: digital or analog electronic files in electronic format, regardless of whether hard copies of the information exist; all computer servers, stand-alone personal computers, hard drives, laptops, PDAs, and other electronic processing devices; all potentially relevant internal and external emails that were sent or received, and the email must be preserved in electronic format, regardless of whether hard copies of the information exist; all records of internet and web-browser generated files in electronic format, regardless of whether hard copies of the information exist, including internet and web-browser-generated history files, caches, and "cookies"; files stored on backup media; and all hard copy or electronic logs documenting computer use.

Requests for Production

Request for Production 1: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to every communication occurring or dated from January 1, 2021 to the present between (1) Natalie Cato and (2) Children's Medical Center at Dallas, UTSW, the Republican Party of Texas, or the Executive Branch of the State of Texas and related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or the treatment of gender dysphoria.

Response:

Request for Production 2: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to every phone call between (1) Natalie Cato and (2) any member of the Texas Legislature (including such legislator's agent, employee, or representative) or the Executive Branch of the State of Texas (including any agent, employee, or representative of the Executive Branch) and related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or the treatment of gender dysphoria.

Response:

Request for Production 3: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to communications, including video recordings, emails, or text messages, that discuss, reference, or allude to any protests or picketing at the home or place of business of any agent of UTSW, employee of UTSW or, board member of UTSW related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or the treatment of gender dysphoria.

Response:

Request for Production 4: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to communications, including video recordings, emails, or text messages, that discuss, reference, or allude to any protests or picketing at the home or place of business of any agent of Children's Medical Center at Dallas, employee of Children's Medical Center at Dallas or, board member of Children's Medical Center at Dallas related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or the treatment of gender dysphoria.

Response:

REQUEST FOR PRODUCTION 5: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to focus groups or surveys related to or including information related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or the treatment of gender dysphoria.

RESPONSE:

Respectfully submitted,

/s/ Charla G. Aldous
CHARLA G. ALDOUS
State Bar No. 20545235
caldous@aldouslaw.com
BRENT R. WALKER
State Bar No. 24047053
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MALOUF & NOCKELS LLP
4305 W. Lovers Ln.
Dallas, Texas 75209
Ph: (214) 969-7373
Fax: (214) 969-7648

ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 6, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Sha'Huni Robinson on behalf of Charla Aldous
Bar No. 20545235
srobinson@aldouslaw.com
Envelope ID: 65157464
Status as of 6/6/2022 3:12 PM CST

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
Elizabeth Davila		edavila@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Brent Walker		bwalker@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Charla Aldous		caldous@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Ellen Lessem		elessem@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Eric Hoffman		eric.hoffman@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT
Stephen Malouf	12888100	maloufs@smalouf.com	6/6/2022 1:35:41 PM	SENT
Maria Diaz		maria.diaz@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT
Caleb Miller		cmiller@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Eleanor Aldous		ealdous@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Sha'Huni Robinson		srobinson@aldouslaw.com	6/6/2022 1:35:41 PM	SENT

Associated Case Party: CHILDREN'S MEDICAL CENTER AT DALLAS

Name	BarNumber	Email	TimestampSubmitted	Status
Daphne Marie Andritsos	793266	daphne.calderon@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT
Yvonne K. Puig	16385400	yvonne.puig@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT

Associated Case Party: THE STATE OF TEXAS

Name	BarNumber	Email	TimestampSubmitted	Status
Rosalinda Luna		Rosalinda.Luna@oag.texas.gov	6/6/2022 1:35:41 PM	SENT
Thomas Ray		thomas.ray@oag.texas.gov	6/6/2022 1:35:41 PM	SENT
Johnathan Stone	24071779	Johnathan.Stone@oag.texas.gov	6/6/2022 1:35:41 PM	SENT
Courtney Corbello		courtney.corbello@oag.texas.gov	6/6/2022 1:35:41 PM	SENT

FILED
6/6/2022 1:35 PM
JOHN F. WARREN
COUNTY CLERK
DALLAS COUNTY

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S NOTICE OF INTENTION TO REQUEST PRODUCTION OF DOCUMENTS FROM NON-PARTY SAVE TEXAS KIDS

TO: SAVE TEXAS KIDS, by and through its President, Natalie Cato, 327 W. College St., #204, Nacogdoches, Texas 75965, and all parties by and through their attorney(s) of records.

PLEASE TAKE NOTICE THAT, under TEXAS RULES OF CIVIL PROCEDURE 205, Plaintiff Ximena Lopez, M.D. intends to subpoena from Save Texas Kids the documents indicated in Exhibit A, to be produced on or before June 24, 2022 to offices of counsel for Plaintiff at Aldous\Walker LLP, 4311 Oak Lawn Ave., Suite 150, Dallas, Texas 75219 or via electronic mail to ealdous@aldouslaw.com. Save Texas Kids will be served with a subpoena ten days from the date of service of this notice.

Respectfully submitted,

/s/ Charla G. Aldous
CHARLA G. ALDOUS
State Bar No. 20545235
caldous@aldouslaw.com
BRENT R. WALKER
State Bar No. 24047053
bwalker@aldouslaw.com
CALEB MILLER
State Bar No. 24098104
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4305 W. Lovers Ln.
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Ph: (214) 969-7373
Fax: (214) 969-7648

ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 6, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S FIRST REQUESTS FOR PRODUCTION TO SAVE TEXAS KIDS

TO: SAVE TEXAS KIDS, by and through its President Natalie Cato, 327 W. College St., #204, Nacogdoches, Texas 75965.

Plaintiff Ximena Lopez, M.D. hereby serves the following First Requests for Production on Save Texas Kids pursuant to TEXAS RULE OF CIVIL PROCEDURE 205.

Definitions and Instructions

A. Definitions

1. "**You**," "**your**," and/or "**Save Texas Kids**" refers to Save Texas Kids, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Save Texas Kids regardless of whether authorized by it to do so.

2. "**Ms. Cato"** refers to Natalie Cato and any of Ms. Cato's past and present employees, agents, and representatives, and also includes agents, employees, or entities who act or acted on behalf of Ms. Cato or who are subject to Ms. Cato's control.

3. "**Children's Medical Center at Dallas**" refers to Children's Medical Center at Dallas, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Children's Medical Center of Dallas regardless of whether authorized by it to do so.

4. "**UTSW**" refers to UT Southwestern, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of UTSW regardless of whether authorized by it to do so.

5. "**Republican Party of Texas**" refers to the Republican Party of Texas, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Republican Party of Texas regardless of whether authorized by it to do so.

6. "**Person**" or "**persons**" means all individuals, associations, partnerships, corporations, and any other type of entity or institution whether formed for business purposes or for any other purpose.

7. "**GENECIS program**" means the GENder Education and Care Interdisciplinary Support program at Children's Medical Center of Dallas or UT Southwestern Medical Center.

8. "**Gender dysphoria**" has the meaning provided by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

9. "**Gender-affirming endocrine care**" means the use of hormone therapy and/or puberty suppressors as part of the treatment of gender dysphoria.

10. "**Communication**" or "**communications**" mean the transmission, sending and/or receipt of information of any kind by or through any means including, but not limited to, speech writings, language (machine, foreign or otherwise), computer electronics of any kind (e.g. e-mail), videotape, photographs, graphs, symbols, signs, floppy disks, CD-ROM discs, telecommunication, cell phone, telephone, teletype, facsimile, telegram, microfilm, microfiche,

photographic film of all type and other media of any kind. The term "communication" also includes, without limitation, all records, inquiries, discussions, conversations, explanations, negotiations, agreements, understandings, meetings, notices, requests, responses, demands, complaints, publicity or trade releases and statements of any kind.

11. "**Document**" or "**documents**" mean any original or copy, including each non-identical copy, whether non-identical because of alteration, attachments, blanks, comments, notes, deletions, underlying or otherwise, of any written record, graphic material, or other tangible evidence or thing, however, described or titled, whether a letter, memorandum, report, affidavit, personal and/or handwritten note, tape recording, video, film, telegram, fax, transcript, purchase order, catalogue, brochure, diary, calendar, inter-office or intra-office communication, statement, investigative report, announcement, deposition, answers to questions, pleading, judgment, newspaper article, photograph, motion picture and any carbon or photographic copies of any such material. As used herein, the term "document" is also intended to include electronically stored information, including electronically generated and stored data files, computer files, e-mails, archived voicemail, and data storage devices such as floppy discs, and hard discs. The term "document" is further intended to include any computer records reflecting earlier drafts, revisions, addenda, memorandums and the like with regard to any responsive document.

12. "**Any**" refers to any and all documents, persons, or entities inclusively, not the option of responding as to some but not to others.

B. Electronic or Magnetic Data

Pursuant to Rule 196.4, Plaintiff hereby requests production of all electronic or magnetic data that is responsive to the requests contained herein. Such electronic or magnetic data is to be produced in the form in which it is kept, and is to include all meta-data associated with each file. If you cannot retrieve the data or information requested or produce it in the form requested, you must state an objection complying with Texas Rule of Civil Procedure 196. You have an obligation to preserve all electronic communications including but not limited to: digital or analog electronic files in electronic format, regardless of whether hard copies of the information exist; all computer servers, stand-alone personal computers, hard drives, laptops, PDAs, and other electronic processing devices; all potentially relevant internal and external emails that were sent or received, and the email must be preserved in electronic format, regardless of whether hard copies of the information exist; all records of internet and web-browser generated files in electronic format, regardless of whether hard copies of the information exist, including internet and web-browser-generated history files, caches, and "cookies"; files stored on backup media; and all hard copy or electronic logs documenting computer use.

Requests for Production

Request for Production 1: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to every communication occurring or dated from January 1, 2021 to the present between (1) any employee, agent, or representative of Save Texas Kids and (2) Children's Medical Center at Dallas, UTSW, the Republican Party of Texas, or the Executive Branch of the State of Texas and related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

Response:

Request for Production 2: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to every phone call between (1) any employee or agent of Save Texas Kids and (2) any member of the Texas Legislature, including such legislator's agent or employee, or the Executive Branch of the State of Texas, including any agents or employees of the Executive Branch, related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

Response:

Request for Production 3: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to communications, including video recordings, emails or text messages, that discuss, reference, or allude to any protests or picketing at the home or place of business of any agent of UTSW, employee of UTSW or, board member of UTSW related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

Response:

Request for Production 4: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to communications, including video recordings, emails or text messages, that discuss, reference, or allude to any protests or picketing at the home or place of business of any agent of Children's Medical Center at Dallas, employee of Children's Medical Center at Dallas or, board member of Children's Medical Center at Dallas related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

RESPONSE:

REQUEST FOR PRODUCTION 5: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to focus groups or surveys related to or including information related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

RESPONSE:

Respectfully submitted,

/s/ Charla G. Aldous
CHARLA G. ALDOUS
State Bar No. 20545235
caldous@aldouslaw.com
BRENT R. WALKER
State Bar No. 24047053
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ALDOUS\WALKER LLP
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JONATHAN NOCKELS
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jnockels@smalouf.com

MALOUF & NOCKELS LLP
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Dallas, Texas 75209
Ph: (214) 969-7373
Fax: (214) 969-7648

ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 6, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Sha'Huni Robinson on behalf of Charla Aldous
Bar No. 20545235
srobinson@aldouslaw.com
Envelope ID: 65157464
Status as of 6/6/2022 3:12 PM CST

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
Elizabeth Davila		edavila@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Brent Walker		bwalker@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Charla Aldous		caldous@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Ellen Lessem		elessem@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Eric Hoffman		eric.hoffman@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT
Stephen Malouf	12888100	maloufs@smalouf.com	6/6/2022 1:35:41 PM	SENT
Maria Diaz		maria.diaz@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT
Caleb Miller		cmiller@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Eleanor Aldous		ealdous@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Sha'Huni Robinson		srobinson@aldouslaw.com	6/6/2022 1:35:41 PM	SENT

Associated Case Party: CHILDREN'S MEDICAL CENTER AT DALLAS

Name	BarNumber	Email	TimestampSubmitted	Status
Daphne Marie Andritsos	793266	daphne.calderon@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT
Yvonne K. Puig	16385400	yvonne.puig@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT

Associated Case Party: THE STATE OF TEXAS

Name	BarNumber	Email	TimestampSubmitted	Status
Rosalinda Luna		Rosalinda.Luna@oag.texas.gov	6/6/2022 1:35:41 PM	SENT
Thomas Ray		thomas.ray@oag.texas.gov	6/6/2022 1:35:41 PM	SENT
Johnathan Stone	24071779	Johnathan.Stone@oag.texas.gov	6/6/2022 1:35:41 PM	SENT
Courtney Corbello		courtney.corbello@oag.texas.gov	6/6/2022 1:35:41 PM	SENT

FILED
6/6/2022 1:35 PM
JOHN F. WARREN
COUNTY CLERK
DALLAS COUNTY

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S NOTICE OF INTENTION TO REQUEST PRODUCTION OF DOCUMENTS FROM NON-PARTY TEXAS HOSPITAL ASSOCIATION

TO: TEXAS HOSPITAL ASSOCIATION, by and through its registered agent, Walter T. Shaw, 1108 Lavaca Street, Suite 700, Austin, Texas 78701, and all parties by and through their attorney(s) of records.

PLEASE TAKE NOTICE THAT, under TEXAS RULES OF CIVIL PROCEDURE 205, Plaintiff Ximena Lopez, M.D. intends to subpoena from the Texas Hospital Association the documents indicated in Exhibit A, to be produced on or before June 24, 2022 to offices of counsel for Plaintiff at Aldous\Walker LLP, 4311 Oak Lawn Ave., Suite 150, Dallas, Texas 75219 or via electronic mail to ealdous@aldouslaw.com. The Texas Hospital Association will be served with a subpoena ten days from the date of service of this notice.

Respectfully submitted,

/s/ Charla G. Aldous
CHARLA G. ALDOUS
State Bar No. 20545235
caldous@aldouslaw.com
BRENT R. WALKER
State Bar No. 24047053
bwalker@aldouslaw.com
CALEB MILLER
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cmiller@aldouslaw.com

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maloufs@smalouf.com
JONATHAN NOCKELS
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jnockels@smalouf.com

MALOUF & NOCKELS LLP
4305 W. Lovers Ln.
Dallas, Texas 75209
Ph: (214) 969-7373
Fax: (214) 969-7648

ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 6, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S FIRST REQUESTS FOR PRODUCTION TO TEXAS HOSPITAL ASSOCIATION

TO: TEXAS HOSPITAL ASSOCIATION, by and through its registered agent, Walter T. Shaw, 1108 Lavaca Street, Suite 700, Austin, Texas 78701.

Plaintiff Ximena Lopez, M.D. hereby serves the following First Requests for Production on the Texas Hospital Association pursuant to TEXAS RULE OF CIVIL PROCEDURE 205.

DEFINITIONS AND INSTRUCTIONS

A. Definitions

1. "**You**," "**your**," and/or "**Texas Hospital Association**" refers to Texas Hospital Association, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Texas Hospital Association regardless of whether authorized by it to do so.

2. "**Children's Medical Center at Dallas**" refers to Children's Medical Center at Dallas, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Children's Medical Center of Dallas regardless of whether authorized by it to do so.

3. "**UTSW**" refers to UT Southwestern, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of UTSW regardless of whether authorized by it to do so.

4. "**Person**" or "**persons**" means all individuals, associations, partnerships, corporations, and any other type of entity or institution whether formed for business purposes or for any other purpose.

5. "**GENECIS program**" means the GENder Education and Care Interdisciplinary Support program at Children's Medical Center of Dallas or UT Southwestern Medical Center.

6. "**Gender dysphoria**" has the meaning provided by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

7. "**Gender-affirming endocrine care**" means the use of hormone therapy and/or puberty suppressors as part of the treatment of gender dysphoria.

8. "**Communication**" or "**communications**" mean the transmission, sending and/or receipt of information of any kind by or through any means including, but not limited to, speech writings, language (machine, foreign or otherwise), computer electronics of any kind (e.g. e-mail), videotape, photographs, graphs, symbols, signs, floppy disks, CD-ROM discs, telecommunication, cell phone, telephone, teletype, facsimile, telegram, microfilm, microfiche, photographic film of all type and other media of any kind. The term "communication" also includes, without limitation, all records, inquiries, discussions, conversations, explanations, negotiations, agreements, understandings, meetings, notices, requests, responses, demands, complaints, publicity or trade releases and statements of any kind.

9. "**Document**" or "**documents**" mean any original or copy, including each non-identical copy, whether non-identical because of alteration, attachments, blanks, comments, notes, deletions, underlying or otherwise, of any written record, graphic material, or other tangible

evidence or thing, however, described or titled, whether a letter, memorandum, report, affidavit, personal and/or handwritten note, tape recording, video, film, telegram, fax, transcript, purchase order, catalogue, brochure, diary, calendar, inter-office or intra-office communication, statement, investigative report, announcement, deposition, answers to questions, pleading, judgment, newspaper article, photograph, motion picture and any carbon or photographic copies of any such material. As used herein, the term "document" is also intended to include electronically stored information, including electronically generated and stored data files, computer files, e-mails, archived voicemail, and data storage devices such as floppy discs, and hard discs. The term "document" is further intended to include any computer records reflecting earlier drafts, revisions, addenda, memorandums and the like with regard to any responsive document.

10. "**Any**" refers to any and all documents, persons, or entities inclusively, not the option of responding as to some but not to others.

B. Electronic or Magnetic Data

Pursuant to Rule 196.4, Plaintiff hereby requests production of all electronic or magnetic data that is responsive to the requests contained herein. Such electronic or magnetic data is to be produced in the form in which it is kept, and is to include all meta-data associated with each file. If you cannot retrieve the data or information requested or produce it in the form requested, you must state an objection complying with Texas Rule of Civil Procedure 196. You have an obligation to preserve all electronic communications including but not limited to: digital or analog electronic files in electronic format, regardless of whether hard copies of the information exist; all computer servers, stand-alone personal computers, hard drives, laptops, PDAs, and other electronic processing devices; all potentially relevant internal and external emails that were sent or received, and the email must be preserved in electronic format, regardless of whether hard copies of the information exist; all records of internet and web-browser generated files in electronic format, regardless of whether hard copies of the information exist, including internet and web-browser-generated history files, caches, and "cookies"; files stored on backup media; and all hard copy or electronic logs documenting computer use.

Requests for Production

Request for Production 1: Any policy statements issued, authored, or endorsed by Texas Hospital Association between January 1, 2015, and the present related to the GENECIS program, gender-affirming endocrine care, or the treatment of gender dysphoria.

Response:

Request for Production 2: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to every communication between (1) any employee, agent, or representative of Texas Hospital Association and (2) Children's Medical Center at Dallas, UTSW, or the Executive Branch of the State of Texas and related to the GENECIS program, gender-affirming endocrine care, or the treatment of gender dysphoria.

Response:

Request for Production 3: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to every phone call between (1) any employee or agent of Texas Hospital Association and (2) any member of the Texas Legislature (including such legislator's agents, employees, and representatives) or the Executive Branch of the State of Texas (including agents, employees, or representatives of the Executive Branch) and related to the GENECIS program, gender-affirming endocrine care, or the treatment of gender dysphoria.

Response:

Respectfully submitted,

/s/ Charla G. Aldous
CHARLA G. ALDOUS
State Bar No. 20545235
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MALOUF & NOCKELS LLP
4305 W. Lovers Ln.
Dallas, Texas 75209
Ph: (214) 969-7373
Fax: (214) 969-7648

ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 6, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Sha'Huni Robinson on behalf of Charla Aldous
Bar No. 20545235
srobinson@aldouslaw.com
Envelope ID: 65157464
Status as of 6/6/2022 3:12 PM CST

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
Elizabeth Davila		edavila@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Brent Walker		bwalker@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Charla Aldous		caldous@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Ellen Lessem		elessem@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Eric Hoffman		eric.hoffman@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT
Stephen Malouf	12888100	maloufs@smalouf.com	6/6/2022 1:35:41 PM	SENT
Maria Diaz		maria.diaz@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT
Caleb Miller		cmiller@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Eleanor Aldous		ealdous@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Sha'Huni Robinson		srobinson@aldouslaw.com	6/6/2022 1:35:41 PM	SENT

Associated Case Party: CHILDREN'S MEDICAL CENTER AT DALLAS

Name	BarNumber	Email	TimestampSubmitted	Status
Daphne Marie Andritsos	793266	daphne.calderon@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT
Yvonne K. Puig	16385400	yvonne.puig@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT

Associated Case Party: THE STATE OF TEXAS

Name	BarNumber	Email	TimestampSubmitted	Status
Rosalinda Luna		Rosalinda.Luna@oag.texas.gov	6/6/2022 1:35:41 PM	SENT
Thomas Ray		thomas.ray@oag.texas.gov	6/6/2022 1:35:41 PM	SENT
Johnathan Stone	24071779	Johnathan.Stone@oag.texas.gov	6/6/2022 1:35:41 PM	SENT
Courtney Corbello		courtney.corbello@oag.texas.gov	6/6/2022 1:35:41 PM	SENT

FILED
6/6/2022 1:35 PM
JOHN F. WARREN
COUNTY CLERK
DALLAS COUNTY

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S NOTICE OF INTENTION TO REQUEST PRODUCTION OF DOCUMENTS FROM NON-PARTY TEXAS MEDICAL ASSOCIATION

TO: TEXAS MEDICAL ASSOCIATION, by and through its registered agent, Michael J. Darrouzet, 401 W 15th Street, Austin, Texas 78701, and all parties by and through their attorney(s) of records.

PLEASE TAKE NOTICE THAT, under TEXAS RULES OF CIVIL PROCEDURE 205, Plaintiff Ximena Lopez, M.D. intends to subpoena from the Texas Medical Association the documents indicated in Exhibit A, to be produced on or before June 24, 2022 to offices of counsel for Plaintiff at Aldous\Walker LLP, 4311 Oak Lawn Ave., Suite 150, Dallas, Texas 75219 or via electronic mail to ealdous@aldouslaw.com. The Texas Medical Association will be served with a subpoena ten days from the date of service of this notice.

Respectfully submitted,

/s/ Charla G. Aldous
CHARLA G. ALDOUS
State Bar No. 20545235
caldous@aldouslaw.com
BRENT R. WALKER
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MALOUF & NOCKELS LLP
4305 W. Lovers Ln.
Dallas, Texas 75209
Ph: (214) 969-7373
Fax: (214) 969-7648

ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 6, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S FIRST REQUESTS FOR PRODUCTION TO TEXAS MEDICAL ASSOCIATION

TO: TEXAS MEDICAL ASSOCIATION, by and through its registered agent, Michael J. Darrouzet, 401 W 15th Street, Austin, Texas 78701.

Plaintiff Ximena Lopez, M.D. hereby serves the following First Requests for Production on the Texas Medical Association pursuant to TEXAS RULE OF CIVIL PROCEDURE 205.

Definitions and Instructions

A. Definitions

1. "**You**," "**your**," and/or "**Texas Medical Association**" refers to Texas Medical Association, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Texas Medical Association regardless of whether authorized by it to do so.

2. "**Children's Medical Center at Dallas**" refers to Children's Medical Center at Dallas, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Children's Medical Center of Dallas regardless of whether authorized by it to do so.

3. "**UTSW**" refers to UT Southwestern, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of UTSW regardless of whether authorized by it to do so.

4. "**Person**" or "**persons**" means all individuals, associations, partnerships, corporations, and any other type of entity or institution whether formed for business purposes or for any other purpose.

5. "**GENECIS program**" means the GENder Education and Care Interdisciplinary Support program at Children's Medical Center of Dallas or UT Southwestern Medical Center.

6. "**Gender dysphoria**" has the meaning provided by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

7. "**Gender-affirming endocrine care**" means the use of hormone therapy and/or puberty suppressors as part of the treatment of gender dysphoria.

8. "**Communication**" or "**communications**" mean the transmission, sending and/or receipt of information of any kind by or through any means including, but not limited to, speech writings, language (machine, foreign or otherwise), computer electronics of any kind (e.g. e-mail), videotape, photographs, graphs, symbols, signs, floppy disks, CD-ROM discs, telecommunication, cell phone, telephone, teletype, facsimile, telegram, microfilm, microfiche, photographic film of all type and other media of any kind. The term "communication" also includes, without limitation, all records, inquiries, discussions, conversations, explanations, negotiations, agreements, understandings, meetings, notices, requests, responses, demands, complaints, publicity or trade releases and statements of any kind.

9. "**Document**" or "**documents**" mean any original or copy, including each non-identical copy, whether non-identical because of alteration, attachments, blanks, comments, notes, deletions, underlying or otherwise, of any written record, graphic material, or other tangible

evidence or thing, however, described or titled, whether a letter, memorandum, report, affidavit, personal and/or handwritten note, tape recording, video, film, telegram, fax, transcript, purchase order, catalogue, brochure, diary, calendar, inter-office or intra-office communication, statement, investigative report, announcement, deposition, answers to questions, pleading, judgment, newspaper article, photograph, motion picture and any carbon or photographic copies of any such material. As used herein, the term "document" is also intended to include electronically stored information, including electronically generated and stored data files, computer files, e-mails, archived voicemail, and data storage devices such as floppy discs, and hard discs. The term "document" is further intended to include any computer records reflecting earlier drafts, revisions, addenda, memorandums and the like with regard to any responsive document.

10. "**Any**" refers to any and all documents, persons, or entities inclusively, not the option of responding as to some but not to others.

B. Electronic or Magnetic Data

Pursuant to Rule 196.4, Plaintiff hereby requests production of all electronic or magnetic data that is responsive to the requests contained herein. Such electronic or magnetic data is to be produced in the form in which it is kept, and is to include all meta-data associated with each file. If you cannot retrieve the data or information requested or produce it in the form requested, you must state an objection complying with Texas Rule of Civil Procedure 196. You have an obligation to preserve all electronic communications including but not limited to: digital or analog electronic files in electronic format, regardless of whether hard copies of the information exist; all computer servers, stand-alone personal computers, hard drives, laptops, PDAs, and other electronic processing devices; all potentially relevant internal and external emails that were sent or received, and the email must be preserved in electronic format, regardless of whether hard copies of the information exist; all records of internet and web-browser generated files in electronic format, regardless of whether hard copies of the information exist, including internet and web-browser-generated history files, caches, and "cookies"; files stored on backup media; and all hard copy or electronic logs documenting computer use.

Requests for Production

Request for Production 1: Every policy statement issued, authored, or endorsed by Texas Medical Association between January 1, 2015, and the present, related to the GENECIS program, gender-affirming endocrine care, or the treatment of gender dysphoria.

Response:

Request for Production 2: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to any communication between (1) any agent, employee, or representative of the Texas Medical Association and (2) Children's Medical Center at Dallas, UTSW, or the Executive Branch of the State of Texas (and their agents, employees, or representatives) related to the GENECIS program, gender-affirming endocrine care, or the treatment of gender dysphoria.

Response:

Request for Production 3: All documents dated between January 1, 2015 and the present regarding, discussing, or pertaining in any way to every phone call between (1) any agent, employee, or representative of the Texas Medical Association and (2) any member of the Texas Legislature (including such legislator's agent, employee, or representative) or the Executive Branch of the State of Texas (including any agent, employee, or representative the Executive Branch), and related to the GENECIS program, gender-affirming endocrine care, or the treatment of gender dysphoria.

Response:

Respectfully submitted,

/s/ Charla G. Aldous
CHARLA G. ALDOUS
State Bar No. 20545235
caldous@aldouslaw.com
BRENT R. WALKER
State Bar No. 24047053
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4305 W. Lovers Ln.
Dallas, Texas 75209
Ph: (214) 969-7373
Fax: (214) 969-7648

ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 6, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Sha'Huni Robinson on behalf of Charla Aldous
Bar No. 20545235
srobinson@aldouslaw.com
Envelope ID: 65157464
Status as of 6/6/2022 3:12 PM CST

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
Elizabeth Davila		edavila@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Brent Walker		bwalker@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Charla Aldous		caldous@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Ellen Lessem		elessem@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Eric Hoffman		eric.hoffman@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT
Stephen Malouf	12888100	maloufs@smalouf.com	6/6/2022 1:35:41 PM	SENT
Maria Diaz		maria.diaz@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT
Caleb Miller		cmiller@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Eleanor Aldous		ealdous@aldouslaw.com	6/6/2022 1:35:41 PM	SENT
Sha'Huni Robinson		srobinson@aldouslaw.com	6/6/2022 1:35:41 PM	SENT

Associated Case Party: CHILDREN'S MEDICAL CENTER AT DALLAS

Name	BarNumber	Email	TimestampSubmitted	Status
Daphne Marie Andritsos	793266	daphne.calderon@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT
Yvonne K. Puig	16385400	yvonne.puig@nortonrosefulbright.com	6/6/2022 1:35:41 PM	SENT

Associated Case Party: THE STATE OF TEXAS

Name	BarNumber	Email	TimestampSubmitted	Status
Rosalinda Luna		Rosalinda.Luna@oag.texas.gov	6/6/2022 1:35:41 PM	SENT
Thomas Ray		thomas.ray@oag.texas.gov	6/6/2022 1:35:41 PM	SENT
Johnathan Stone	24071779	Johnathan.Stone@oag.texas.gov	6/6/2022 1:35:41 PM	SENT
Courtney Corbello		courtney.corbello@oag.texas.gov	6/6/2022 1:35:41 PM	SENT

FILED
6/6/2022 1:35 PM
JOHN F. WARREN
COUNTY CLERK
DALLAS COUNTY

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S NOTICE OF INTENTION TO REQUEST PRODUCTION OF DOCUMENTS FROM UT SOUTHWESTERN MEDICAL CENTER

TO: UT SOUTHWESTERN MEDICAL CENTER, by and through its Vice President for Legal Affairs, Erin M. Sine, 5323 Harry Hines Blvd, Dallas, TX 75239-9008, erin.sine@utsouthwestern.edu, and all parties by and through their attorney(s) of records.

PLEASE TAKE NOTICE THAT, under TEXAS RULES OF CIVIL PROCEDURE 205, Plaintiff Ximena Lopez, M.D. intends to subpoena from UT Southwestern Medical Center the documents indicated in Exhibit A, to be produced on or before June 24, 2022 to offices of counsel for Plaintiff at Aldous\Walker LLP, 4311 Oak Lawn Ave., Suite 150, Dallas, Texas 75219 or via electronic mail to ealdous@aldouslaw.com. UT Southwestern Medical Center will be served with a subpoena ten days from the date of service of this notice.

Respectfully submitted,

/s/ Charla G. Aldous
CHARLA G. ALDOUS
State Bar No. 20545235
caldous@aldouslaw.com
BRENT R. WALKER
State Bar No. 24047053
bwalker@aldouslaw.com
CALEB MILLER
State Bar No. 24098104
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Ph: (214) 969-7373
Fax: (214) 969-7648

ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 6, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor*.	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S FIRST REQUESTS FOR PRODUCTION TO UT SOUTHWESTERN MEDICAL CENTER

TO: UT SOUTHWESTERN MEDICAL CENTER, by and through its Vice President for Legal Affairs, Erin M. Sine, 5323 Harry Hines Blvd, Dallas, TX 75239-9008, erin.sine@utsouthwestern.edu.

Plaintiff Ximena Lopez, M.D. hereby serves the following First Requests for Production on UT Southwestern Medical Center ("UTSW") pursuant to TEXAS RULE OF CIVIL PROCEDURE 205.

Definitions and Instructions

A. Definitions

1. "**You**," "**your**," and/or "**UTSW**" refers to UT Southwestern Medical Center, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of UTSW regardless of whether authorized by it to do so.

2. "**Children's Medical Center at Dallas**" refers to Children's Medical Center at Dallas, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Children's Medical Center of Dallas regardless of whether authorized by it to do so.

3. "**Save Texas Kids**" refers to Save Texas Kids, its employees, representatives, agents, and all natural persons or business or legal entities acting or purporting to act for or on behalf of Save Texas Kids regardless of whether authorized by it to do so.

4. "**Person**" or "**persons**" means all individuals, associations, partnerships, corporations, and any other type of entity or institution whether formed for business purposes or for any other purpose.

5. "**GENECIS program**" means the GENder Education and Care Interdisciplinary Support program at Children's Medical Center of Dallas or UT Southwestern Medical Center.

6. "**Gender dysphoria**" has the meaning provided by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

7. "**Gender-affirming endocrine care**" means the use of hormone therapy and/or puberty suppressors as part of the treatment of gender dysphoria.

8. "**Communication**" or "**communications**" mean the transmission, sending and/or receipt of information of any kind by or through any means including, but not limited to, speech writings, language (machine, foreign or otherwise), computer electronics of any kind (e.g. e-mail), videotape, photographs, graphs, symbols, signs, floppy disks, CD-ROM discs, telecommunication, cell phone, telephone, teletype, facsimile, telegram, microfilm, microfiche, photographic film of all type and other media of any kind. The term "communication" also includes, without limitation, all records, inquiries, discussions, conversations, explanations, negotiations, agreements, understandings, meetings, notices, requests, responses, demands, complaints, publicity or trade releases and statements of any kind.

9. "**Document**" or "**documents**" mean any original or copy, including each non-identical copy, whether non-identical because of alteration, attachments, blanks, comments, notes, deletions, underlying or otherwise, of any written record, graphic material, or other tangible evidence or thing, however, described or titled, whether a letter, memorandum, report, affidavit, personal and/or handwritten note, tape recording, video, film, telegram, fax, transcript, purchase order, catalogue, brochure, diary, calendar, inter-office or intra-office communication, statement, investigative report, announcement, deposition, answers to questions, pleading, judgment, newspaper article, photograph, motion picture and any carbon or photographic copies of any such material. As used herein, the term "document" is also intended to include electronically stored information, including electronically generated and stored data files, computer files, e-mails, archived voicemail, and data storage devices such as floppy discs, and hard discs. The term "document" is further intended to include any computer records reflecting earlier drafts, revisions, addenda, memorandums and the like with regard to any responsive document.

10. "**Any**" refers to any and all documents, persons, or entities inclusively, not the option of responding as to some but not to others.

B. Electronic or Magnetic Data

Pursuant to Rule 196.4, Plaintiff hereby requests production of all electronic or magnetic data that is responsive to the requests contained herein. Such electronic or magnetic data is to be produced in the form in which it is kept, and is to include all meta-data associated with each file. If you cannot retrieve the data or information requested or produce it in the form requested, you must state an objection complying with Texas Rule of Civil Procedure 196. You have an obligation to preserve all electronic communications including but not limited to: digital or analog electronic files in electronic format, regardless of whether hard copies of the information exist; all computer servers, stand-alone personal computers, hard drives, laptops, PDAs, and other electronic processing devices; all potentially relevant internal and external emails that were sent or received, and the email must be preserved in electronic format, regardless of whether hard copies of the information exist; all records of internet and web-browser generated files in electronic format, regardless of whether hard copies of the information exist, including internet and web-browser-generated history files, caches, and "cookies"; files stored on backup media; and all hard copy or electronic logs documenting computer use.

Requests for Production

Request for Production 1: UTSW's by-laws and medical staff rules and regulations in effect in 2021.

Response:

Request for Production 2: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to UTSW's policies and procedures in effect in June 2021 related to:

a. gender-affirming endocrine care;
b. treatment for gender dysphoria;
c. the GENECIS program;
d. anti-discrimination; and
e. patients' rights.

Response:

Request for Production 3: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to any contract or agreement in effect at any time between Children's Medical Center at Dallas and UTSW that would apply or relate to Dr. Ximena Lopez's provision of care at Children's Medical Center at Dallas, the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

Response:

Request for Production 4: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to every communication occurring between (1) any agent, employee, or representative of UTSW and (2) any agent, employee, or representative of Children's Medical Center at Dallas or any agent, employee, or representative of the Executive Branch of the State of Texas and related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

Response:

REQUEST FOR PRODUCTION 5: All documents regarding, discussing, or pertaining in any way to notice to physicians at UTSW regarding any limitation on providing gender-affirming endocrine care.

RESPONSE:

REQUEST FOR PRODUCTION 6: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to every phone call between (1) any agent, employee, or representative of UTSW and (2) any member or agent, employee, or representative of a member of the Texas Legislature or any agent, employee, or representative of the Executive Branch of the State of Texas and related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

RESPONSE:

REQUEST FOR PRODUCTION 7: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to communications, including video recordings, emails, or text messages, that discuss, reference, or allude to any protests or picketing at the home or place of business of any agent of UTSW, employee of UTSW or, board member of UTSW related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

RESPONSE:

REQUEST FOR PRODUCTION 8: All documents dated between January 1, 2015, and the present regarding, discussing, or pertaining in any way to any communication between any agent, employee, or representative of UTSW and any agent, employee, or representative of Save Texas Kids and related to the GENECIS program, Dr. Ximena Lopez, gender-affirming endocrine care, or treatment for gender dysphoria.

RESPONSE:

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 6, 2022.

/s/ Charla G. Aldous
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No. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff,*	§	IN COUNTY COURT AT LAW No. 2
v.	§	
CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant,*	§	
and	§	
THE STATE OF TEXAS, *Intervenor.*	§	DALLAS COUNTY, TEXAS

INTERVENOR'S NOTICE OF APPEAL

Intervenor the State of Texas hereby files this Notice of Appeal.

1. On May 17, 2022, Intervenor filed a Petition in Intervention formally intervening in this matter pursuant to Tex. R. Civ. P. 60.

2. The rules governing pleadings apply equally to parties and intervenors. *See* Tex. R. Civ. P. 61.

3. On May 23, 2022, Intervenor was surprised to receive an Order Granting Agreed Temporary Injunction signed by this Court.

4. This so-called "agreed temporary injunction" purports to enjoin not only Defendant Children's Medical Center at Dallas, but also "any individuals and entities in active concert or participation with them who receive actual notice of the Order by personal services or otherwise[.]"

5. Intervenor is affected by the Order Granting Agreed Temporary Injunction.

6. Intervenor was not consulted, nor did it agree, to the "agreed temporary injunction."

7. The Texas Civil Practice and Remedies Code entitles Intervenor to take an interlocutory appeal from the Order Granting Agreed Temporary Injunction. Tex. Civ. Prac. & Rem. Code § 51.014(a)(4) ("A person may appeal from an interlocutory order of a district court . . . that . . . grants or refuses a temporary injunction. . . .").

8. Intervenor the State of Texas appeals the Order Granting Temporary Injunction.

9. This appeal is taken to the Fifth Court of Appeals in Dallas, Texas, and is an accelerated appeal pursuant to Tex. R. App. P. 28.1.

10. Intervenor is not required to post bond. *See* Tex. Civ. Prac. & Rem. Code §§ 6.001 and 104.006.

Respectfully Submitted.

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No. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff,*	§	IN COUNTY COURT AT LAW No. 2
v.	§	
CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant,*	§	
and	§	
THE STATE OF TEXAS, *Intervenor.*	§	DALLAS COUNTY, TEXAS

THE STATE OF TEXAS' PLEA TO THE JURISDICTION

Intervenor the State of Texas files this Plea to the Jurisdiction. This Court does not have jurisdiction to adjudicate the claims in either Plaintiff's Original Petition or Plaintiff's counterclaims brought against the State and this suit should be dismissed in its entirety.

FACTS

On May 11, 2022, Plaintiff, Ximena Lopez, M.D., filed an Application for Temporary Restraining Order, Temporary Injunction, and Original Petition for Permanent Injunctive and Declaratory Relief. Plaintiff contends that Defendant Children's Medical Center (CMC) is engaging in the corporate practice of medicine and unlawfully discriminating on the basis of gender identity and sex by prohibiting her from providing hormone treatment to *new* pediatric patients treated for gender dysphoria.

On May 12, 2022, this Court entered a Temporary Restraining Order against Defendant CMC. The State thereafter intervened in this suit on May 17, 2022. Following this intervention, Plaintiff moved to strike the petition in intervention arguing that it was "frivolous", and the State

had no reasonable basis to intervene as the case in no way impacted state law. Stunningly, only 5 days later, Plaintiff filed an answer to the intervention *and counterclaims* against the State asking this Court to declare her rights under State law. That same day, on May 23, 2022, the Court also issued a Temporary Injunction, which was agreed to by Plaintiff and CMC, but not by the State despite having already intervened in this suit.

This frivolous suit has languished long enough and must be dismissed. The State asks this Court to find that it lacks jurisdiction to hear any of Plaintiff's claims against both the State as and CMC, and to dismiss Plaintiff's case in its entirety.

ARGUMENT

I. Standard of Review

A plea to the jurisdiction challenges the court's authority to determine the subject matter of the controversy. *Bland Indep. Sch. Dist. v. Blue*, 34 S.W.3d 547, 553–54 (Tex. 2000). Subject-matter jurisdiction is "never presumed and cannot be waived." *Tex. Ass'n of Bus. v. Tex. Air Control Bd.*, 852 S.W.2d 440, 443–44 (Tex. 1993). "When a plea to the jurisdiction challenges the pleadings, [the district court] determine[s] if the pleader has alleged facts that affirmatively demonstrate the court's jurisdiction to hear the cause." *Tex. Dep't of Parks & Wildlife v. Miranda*, 133 S.W.3d 217, 226 (Tex. 2004). "If the pleadings affirmatively negate the existence of jurisdiction, then a plea to the jurisdiction may be granted without allowing the plaintiffs an opportunity to amend." *Id.* at 227.

When reviewing a plea to the jurisdiction, a court should limit itself to the jurisdictional issue and avoid considering the merits of the claims. *Bland*, 34 S.W.3d at 552. The plaintiff bears the burden of alleging facts affirmatively showing that the trial court has subject-matter

jurisdiction. *Tex. Ass'n of Bus.*, 852 S.W.2d at 446; *Tex. Dep't of Crim. Just. v. Miller*, 48 S.W.3d 201, 203 (Tex. App.—Houston [1st Dist.] 1999), *rev'd on other grounds*, 51 S.W.3d 583, 589 (Tex. 2001)). "If the pleadings affirmatively negate the existence of jurisdiction, then a plea to the jurisdiction may be granted without allowing the plaintiffs an opportunity to amend." *Miranda*, 133 S.W.3d at 227.

II. This Court Lacks Jurisdiction Over Plaintiff's Counterclaims Against the State.

The State is sovereignly immune from Plaintiff's UDJA counterclaims made against it. Sovereign immunity generally deprives the trial court of jurisdiction over a lawsuit in which the plaintiff has sued the State or a state agency unless the Legislature has waived immunity. *Texas Parks & Wildlife Dep't v. Sawyer Trust*, 354 S.W.3d 384, 388 (Tex. 2011). In determining whether the Legislature has waived immunity from suit, "a statute shall not be construed as a waiver of sovereign immunity unless the waiver is effected by clear and unambiguous language." Tex. Gov't Code § 311.034.

The UDJA is not a general waiver of sovereign immunity but does provide a narrow waiver of immunity for claims challenging the validity of ordinances or statutes. *See* Tex. Civ. Prac. & Rem. Code § 37.006(b); *see also Patel v. Texas Dep't of Licensing & Regulation*, 469 S.W.3d 69, 76 (Tex. 2015); *Sawyer Trust*, 354 S.W.3d at 388; *City of El Paso v. Heinrich*, 284 S.W.3d 366, 373 n.6 (Tex. 2009). However, the UDJA does "not waive the state's sovereign immunity when the plaintiff seeks a declaration of his or her rights under a statute or other law." *Texas Dep't of Transp. v. Sefzik*, 355 S.W.3d 618, 621 (Tex. 2011) (per curiam) (citing *Heinrich*, 284 S.W.3d at 372–73); *Abbott v. G.G.E*, 463 S.W.3d 633, 653 n.14 (Tex. App.–Austin 2015, pet. denied).

Plaintiff brings her counterclaims against the State solely under the UDJA. Pursuant to the UDJA, Plaintiff demands the Court declare her rights regarding the provision of pubertal suppression and hormone therapy to children with gender dysphoria. Specifically, she asks the Court to rule that these actions "[are] not child abuse on [their] face" and "not against any Texas state law and [are] not illegal." Plaintiff's Answer at p.5. Plaintiff also claims to be entitled to a general declaration that the "public policy of the State of Texas" regarding giving children pubertal blockers and hormones to alter their mental and physical state "is not dictated by the Governor of the State of Texas or the Attorney General of the State of Texas." *Id*. at p.6. In sum, Plaintiff seeks a declaration of not only her rights under state law but of the rights of all "licensed provider[s]" who provide these medications as well as any "parent or legal guardian" who consents to it. *Id.* The UDJA does not waive sovereign immunity when the plaintiff seeks a declaration of her rights; consequently, this Court must dismiss these claims. *See Sefzik*, 355 S.W.3d at 621.

The State's intervention in this matter does not waive sovereign immunity. "When a government agency joins the lawsuit but does not seek 'its own affirmative claims for monetary relief,' it does not waive immunity." *Tex. Dep't of Ins. v. Green*, No. 01-15-00321-CV, 2016 WL 2745063, at *5 (Tex. App.—Houston [1st Dist.] May 10, 2016, pet. denied) (quoting *City of Dallas v. Jill Herz, P.C.*, 363 S.W.3d 896, 900–01 (Tex.App.–Dallas 2012, no pet.) (holding that City's intervention did not waive immunity because City did not assert affirmative claims for monetary relief); *see also In re K.G.S.*, No. 14–12–00673–CV, 2014 WL 801127, at *6 (Tex.App.–Houston [14th Dist.] Feb. 27, 2014, no pet.) (mem.op.) (holding that agency's intervention in suit did not waive sovereign immunity because agency did not request monetary relief). The State has brought

no affirmative claims and does not seek money damages in this matter. See State's First Amended Petition in Intervention. Instead, the State seeks only to defend against the claims Plaintiff brings that would implicate the enforcement of state law. *Id.* Under well-established law, this does not invoke a clear and unequivocal waiver of sovereign immunity. In the absence of a waiver of sovereign of immunity, this Court lacks jurisdiction and should dismiss Plaintiff's counterclaims.

III. This Court Lacks Jurisdiction Over Plaintiff's Claim Against CMC for Terminating Certain Clinical Privileges Because it is Not Subject to Judicial Review.

Plaintiff's Count One claim is based on a theory that she should be provided "unrestrained" clinical privileges and any attempt by CMC to alter those privileges is unlawful. This Court does not have jurisdiction to decide what clinical privileges CMC can or cannot decide to provide physicians that work in its hospital. The decision of a governing board of a private hospital with regard to clinical privileges is not subject to judicial review. *Armintor v. Community Hosp. of Brazosport,* 659 S.W.2d 86, 88–89 (Tex.App.—Houston [14th Dist.] 1983, no writ); *Tigua Gen. Hosp. v. Feuerberg,* 645 S.W.2d 575, 578 (Tex.App.—El Paso 1982, writ dism'd w.o.j.); *Hodges v. Arlington Neuropsychiatric Ctr., Inc.,* 628 S.W.2d 536, 538 (Tex.App.—Fort Worth 1982, writ ref'd n.r.e.); *Charter Medical Corp. v. Miller,* 605 S.W.2d 943, 951 (Tex.Civ.App.—Dallas 1980, writ ref'd n.r.e.). *See also Grossling v. Ford Memorial Hosp.*, 614 F.Supp. 1051, 1058 (E.D.Tex.1985). In other words, case after case has dictated that "a physician in this State has **no cause of action against a private hospital** for the termination of staff privileges, even when the action of the hospital was arbitrary and capricious or where common law rights to procedural or substantive due process were violated." *Dallas Cnty. Med. Soc'y v. Ubinas Brache*, 68 S.W.3d 31, 42 (Tex. App.—Dallas 2001, pet. denied).

Federal courts have held consistent with those that bind this Court. In *Grossling v. Ford Mem'l Hosp.*, for example, the Eastern District made clear that the exclusion of a physician's privileges from a private hospital "is solely within the discretion of the hospital's management, and **courts may not interfere**." 614 F. Supp. 1051, 1058 (E.D. Tex. 1985) (citing *Charter Medical Corp. v. Miller,* 605 S.W.2d 943 (Tex.Civ.App.—Dallas 1980, writ ref'd n.r.e.) (emphasis added); *Weary v. Baylor University Hospital,* 360 S.W.2d 895 (Tex.Civ.App.—Waco 1962, writ ref'd n.r.e.)). It also noted that "[t]his rule does not provide an exception for cases . . . where the hospital's management did not strictly follow its own self-imposed procedures, especially since Texas courts have held that procedural due process is not required in these cases." *Id.* (citing *Charter Medical,* 605 S.W.2d at 951).

In Count One of her Petition, Plaintiff brings a claim under the UDJA on the basis that she is not being given "unconstrained clinical privileges" by CMC. Pet. at 14. She alleges this constitutes "illegal control" of her independent medical judgment. *Id.* She also makes this same claim as part of the basis for her request for injunctive relief going even further by claiming such a practice violates due process. *Id.* at 15. Because these claims are precisely those that numerous courts have ruled are outside the judiciary's purview to review, this Court lacks subject matter jurisdiction and must dismiss. *GuideOne Ins. Co. v. Cupps*, 207 S.W.3d 900, 904 (Tex. App.—Fort Worth 2006, pet. denied) (holding that, where a plaintiff brings a claim that is not subject to judicial review, "the trial court lacks subject matter jurisdiction and must dismiss the claims.").

IV. Plaintiff Lacks Standing to Bring Count Two on Behalf of Third-Party Unnamed Patients.

Subject matter jurisdiction is essential to the authority of a court to decide a case. *Tex. Ass'n of Bus. v. Tex. Air Control Bd.*, 852 S.W.2d 440, 443 (Tex. 1993). "Standing is implicit in the concept of subject matter jurisdiction." *Id.* "Because standing is a constitutional prerequisite to maintaining a suit under both federal and Texas law," courts are required "to look to the more extensive jurisprudential experience of the federal courts on this subject for any guidance it may yield." *Id.* at 444.[1] Under Texas law, as under federal law, standing has three elements: (1) a concrete and particularized, actual or imminent injury to the plaintiff; (2) the plaintiff's alleged injury is "fairly traceable" to the defendant's conduct; and (3) whether plaintiff's alleged injury is "likely to be redressed by the requested relief[.]" *Heckman v. Williamson County*, 369 S.W.3d 137, 155 (Tex. 2012). The threshold question of standing must be considered before any other matter. *Id.* at 151.

Plaintiff's Count Two of her Original Petition alleges "CMC's Unlawful Prohibition is discrimination based on gender identity and because of sex and violates antidiscrimination law." Pet. at p.15. But Plaintiff does not contend *she* is being discriminated against on the basis of sex or gender identity; she claims her *patients* are. *See id*. This does not confer standing. "For standing, a plaintiff must be **personally** aggrieved." *DaimlerChrysler Corp. v. Inman,* 252 S.W.3d 299, 304–05 (Tex. 2008) (emphasis added). While Plaintiff may believe herself above having to comply with this clear requirement of standing, such is not a basis for this Court to overlook it. Thus, because

[1] Texas courts may "look to federal standing jurisprudence for guidance" unless specifically contradicted by state law. *Pike v. Tex. EMC Mgmt., LLC*, 610 S.W.3d 763, 776 (Tex. 2020).

Plaintiff cannot bring a claim of discrimination under the laws of Texas against CMC on behalf of her patients, this Court lacks jurisdiction over Count Two.

CONCLUSION

For the foregoing reasons, the State of Texas respectfully requests that the Court grant its plea in the jurisdiction and dismiss Plaintiff's suit in its entirety.

Respectfully submitted.

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NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*,	IN THE COUNTY COURT AT LAW
v.	NO. 2
CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant*.	DALLAS COUNTY, TEXAS

THE STATE OF TEXAS' RESPONSE TO PLAINTIFF'S SPECIAL EXCEPTIONS AND MOTION TO STRIKE

Plaintiff moved to specially except or strike the State of Texas's Petition in Intervention (Plaintiff's Motion) on May 18, 2022. On June 3, 2022, Plaintiff noticed a hearing on her motion, which is currently set for June 17, 2022.

The State of Texas responds in opposition to Plaintiff's Motion. On the same day of this filing, the State of Texas has also filed an Amended Petition in Intervention as permitted under Texas Rule of Civil Procedure 63. As dictated by Texas Rule of Civil Procedure 65, "[u]nless the substituted instrument shall be set aside on exceptions, the instrument for which it is substituted shall no longer be regarded as a part of the pleading in the record of the cause." Tex. R. Civ. P. 65. The State's Original Petition in Intervention has not been set aside on exceptions, therefore, its Amended Petition supersedes the Original Petition. *See, e.g., Lee v. GST Transp. Sys., LP*, 334 S.W.3d 16, 19 (Tex. App.—Dallas 2008, pet. denied) ("an amended pleading supersedes and supplants earlier pleadings[.]"). This Court should, therefore, deny Plaintiff's Motion as moot because it seeks an order from this Court regarding a pleading that is no longer a part of the State's pleading in the record.

Additionally, the State of Texas has filed a plea to the jurisdiction concurrent with its Amended Petition. This plea challenges this Court's jurisdiction to hear the entirety of Plaintiff's claims, including her counterclaims brought against the State of Texas. Defendant Children's Medical Center (CMC) has also filed a plea to the jurisdiction.

The jurisdictional arguments raised in these pleas are threshold issues that must be addressed prior to a ruling on Plaintiff's Motion or any other motion that comes before the Court. The Texas Supreme Court has counseled that "a court **must not act** without determining that it has subject-matter jurisdiction to do so." *Bland Indep. Sch. Dist. v. Blue*, 34 S.W.3d 547, 554 (Tex. 2000) (emphasis added); *see also Abbott v. Anti-Defamation League Austin, Sw., & Texoma Regions*, 610 S.W.3d 911, 917 (Tex. 2020) (quoting *BP Am. Prod. Co. v. Laddex, Ltd.*, 513 S.W.3d 476, 479 (Tex. 2017)) (Stating that "'[b]ecause lack of standing deprives the court of subject-matter jurisdiction,' courts "would normally 'address the issue first[.]'"). Thus, assuming *arguendo* that Plaintiff's Motion is not moot as a result of the Amended Petition in Intervention, this Court must first address the State's and CMC's pleas prior to a hearing or ruling on Plaintiff's Motion.

CONCLUSION

For the foregoing reasons, the State of Texas respectfully requests that this Court deny Plaintiff's Motion as moot. In the alternative, the State of Texas requests that this Court continue the June 17th hearing on Plaintiff's Motion until after the State and CMC's pleas have been briefed, heard and ruled on.

Respectfully Submitted.

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CERTIFICATE OF SERVICE

I, **COURTNEY CORBELLO**, Assistant Attorney General of Texas, hereby certify that a true and correct copy of the foregoing document has been served electronically through the electronic-filing manager in compliance with TRCP 21a on June 14, 2022 to:

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No. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff,*	§	IN COUNTY COURT AT LAW No. 2
v.	§	
CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant,*	§	
and	§	
THE STATE OF TEXAS, *Intervenor.*	§	DALLAS COUNTY, TEXAS

THE STATE OF TEXAS' FIRST AMENDED PETITION IN INTERVENTION

Intervenor the State of Texas, by and through the Attorney General's Office, files this, its First Amended Petition in Intervention, which replaces its previously filed Petition and moots any motions or responses to that Petition. Tex. R. Civ. P. 65. The State seeks only to ensure its interests in the uniform application of its laws and to guard the safety of its children that Plaintiff is treating.

BACKGROUND

On May 11, 2022, Plaintiff, Ximena Lopez, M.D., filed an Application for Temporary Restraining Order, Temporary Injunction, and Original Petition for Permanent Injunctive and Declaratory Relief. Plaintiff contends that Defendant Children's Medical Center (CMC) is engaging in the corporate practice of medicine and unlawfully discriminating on the basis of gender identity and sex by prohibiting her from providing hormone treatment to *new* pediatric patients treated for gender dysphoria. She seeks declaratory relief under the Uniform Declaratory Judgment Act ("UDJA") as well as a permanent injunction.

On May 12, 2022, this Court entered a Temporary Restraining Order against Defendant and scheduled a Temporary Injunction Hearing for May 26, 2022.

On May 23, 2022, this Court signed an Order Granting Agreed Temporary Injunction ("Agreed Order") enjoining CMC and "any individuals and entities in active concert or participation with them who receive actual notice of the Order by personal services or otherwise" from, *inter alia*, "enforcing any policy or limitation that restricts or prohibits gender-affirming endocrinology care, including specifically pubertal suppression or hormone therapy, to new or established patients due the patient's gender identity or gender dysphoria." The State was not consulted, nor did it agree, to the Agreed Order.

On June 13, 2022, the State appealed the Agreed Order.

PETITION FOR INTERVENTION

I. Standard for Intervention

An intervenor is not required to secure a court's permission to intervene in a cause of action or establish standing. *Guar. Fed. Sav. Bank v. Horseshoe Operating Co.*, 793 S.W.2d 652, 657 (Tex. 1990). An intervenor need only show a "justiciable interest in a pending suit to intervene in the suit as a matter of right." *In re Union Carbide Corp.*, 273 S.W.3d 152, 154 (Tex. 2008). "A party has a justiciable interest in a lawsuit, and thus a right to intervene, when his interests will be affected by the litigation." *Jabri v. Alsayyed*, 145 S.W.3d 660, 672 (Tex. App.—Houston [14th Dist.] 2004, no pet.) (citing *Law Offices of Windle Turley P.C. v. Ghiasinejad*, 109 S.W.3d 68, 71 (Tex. App.—Fort Worth 2003, no pet.)).

Intervention is proper so long as (1) the intervenor would be able to defeat "some part" of the recovery "if the action had been brought against him"; (2) intervention "will not complicate

the case by an excessive multiplication of the issues;" and (3) intervention "is almost essential to effectively protect the intervenor's interest." *Guar. Fed. Sav. Bank v. Horseshoe Operating Co.*, 793 S.W.2d 652, 657 (Tex. 1990) (citing *Inter-Continental Corp. v. Moody,* 411 S.W.2d 578, 589 (Tex.Civ.App.—Houston [1st Dist.] 1966, writ ref'd n.r.e.). "The interest asserted by the intervenor may be legal or equitable." *Id*. at 657 (citation omitted).

II. Intervention is Essential to Protect the Interests of the State in the Uniform Enforcement of its Laws and the Welfare of Children.

The State of Texas has a solemn responsibility to defend the rights of the people of Texas. This responsibility, "[i]n matters of litigation," is exercised by "the Attorney General [as] the officer authorized by law to protect the interests of the State . . . ." *Bullock v. Tex. Skating Ass'n*, 583 S.W.2d 888, 894 (Tex. Civ. App. 1979); *see also State v. Naylor*, 466 S.W.3d 783, 799–800 (Tex. 2015) (Willet, J dissenting) ("In my view, the State's chief legal officer—sworn to "preserve, protect, and defend" Texas law—should in fact be permitted to preserve, protect, and defend it."). And those sovereign interests entitle the State to intervene in suits, like this one, brought under the UDJA because the UDJA requires that "all persons who have or claim any interest that would be affected by the declaration must be made parties." Tex. Civ. Prac. & Rem. Code § 37.006(b) (emphasis added).

Intervention is essential in this case because the State has well-recognized sovereign interests in the uniform application of its laws and the welfare of children in this State, both of which would be affected by the declaratory relief sought in this suit. Further, the State would have been able to defeat Plaintiff's requested relief against those interests as an original party. Finally, the defense of those interests will not complicate the case because they are already being litigated

by virtue of Plaintiff's Petition. Given that, as further explained below, the State satisfies all of the *Guaranty* requirements, intervention is essential.

A. Plaintiff's Claims Threaten the State's Interest in the Uniform Regulation and Enforcement of its Laws.

As Plaintiff admits, "this lawsuit is about much more than Dr. Lopez's clinical independence." Pet. at 2**.** Plaintiff seeks broad declaratory relief that would require this Court to interpret and enforce numerous state laws in a manner inconsistent with the State's current uniform enforcement of them. As the Fifth Circuit has put it, "[t]he state *qua* state has an important sovereign interest" in ensuring that its own statutory schemes are "properly enforced." *Sierra Club v. City of San Antonio*, 115 F.3d 311, 315 (5th Cir. 1997). For this reason, the State's interests are implicated in this suit. *Alfred L. Snapp & Son, Inc. v. Puerto Rico, ex rel., Barez*, 458 U.S. 592, 601 (1982) ("the power to create and enforce a legal code" is one "easily identified" example of sovereign interest).

There can be no meritorious disagreement that the State of Texas has such a sovereign interest or that, because of this interest, the State is entitled to zealously advocate for its laws that are under direct or indirect attack. After all, "[i]f the chief legal officer of Texas, sworn to 'preserve, protect, and defend' the Constitution and laws of Texas, is convinced that a court is being urged, albeit quietly, to strike something down, State law deserves the State's lawyer." *State v. Naylor*, 466 S.W.3d 783, 807 (Tex. 2015) (Willet, J. dissenting).

Here, Plaintiff asks this Court to make specific findings about her alleged employer's decision to discontinue treatment of prepubescent gender dysphoria with hormone medication for new patients. This Court necessarily, if tacitly, will be required to weigh in on the application of laws concerning child welfare, the regulation of private hospitals and liability for discriminatory

practices. Because these laws are impacted by the relief sought in this case, the State's interests are clear and intervention is essential.

1. State Law will be Impacted by a Declaration that Gender Dysphoria Treatment is Solely a Matter of Plaintiff's Independent Medical Judgment.

Plaintiff's claims rest on the theory that the provision of specific medications which alter a child's natural physical development and may cause severe, long-term risks to their health[1] is not a service provided by a hospital, but rather, a treatment provided by a physician. An order that giving hormone medications to gender dysphoric prepubescent children is *always* a reasonable treatment solely within the discretion of the treating physician defies Texas' child welfare laws.

First, such an order would effectively abrogate to the Court medical-decision-making power over the State's minors, who are legally incapacitated from consenting to this treatment. Tex. Civ. Prac. & Rem. Code § 129.001. This directly contrasts state law that grants the authority to make medical decisions on behalf of a child to the child's parents and the State, when acting *parens patriae*. Tex. Fam. Code § 151.001; *see generally T.L. v. Cook Children's Med. Ctr.*, 607 S.W.3d 9, 42 (Tex. App.—Fort Worth 2020), cert. denied, 141 S. Ct. 1069 (2021) ("Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae*."). As the State has an obvious sovereign interest in the uniform application of

[1] See *Standards of Care for the Health of Transsexual, Transgender and Gender-Nonconforming People*, WPATH, available at: https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf at p. 11 ("formal epidemiologic studies on gender dysphoria—in children, adolescents, and adults—are lacking"); *id.* at 18 (providing that some of the medications Plaintiffs advocate for are "partially reversible." "These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone)."); *id.* at 18-19 (stating studies on the approach of puberty-suppressing hormones have only included children over 12); *id.* at 40 (showing risks associated with hormone treatment, including potentially fatal risks).

Texas' law regarding consent to the medical treatment of a minor, intervention is necessary to protect this interest. See Pet. Ex. F at 26 ("Adolescents may be eligible to begin feminizing/masculinizing hormonal therapy, *preferably with parental consent*.") (emphasis added).

Second, the court order that Plaintiff desires could have the effect of nullifying some of Texas' child abuse statutes. Family Code Chapter 261 provides for the reporting and investigation of abuse or neglect of a child. *See* Tex. Fam. Code §§ 261.001–.505; *see also* Tex. Penal Code § 22.04 (providing for the offense of injury to a child). Section 261.001 defines abuse through a broad and nonexclusive list of acts and omissions. Tex. Fam. Code § 261.001(1). Subsection 261.001(1)(A) identifies "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." Subsection 261.001(1)(B) provides that "causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning" is abuse. Subsection 261.001(1)(C) includes as abuse a "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child." And Subsection 261.001(1)(D) includes "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child."

Plaintiff's own Petition belies any contention that her case does not require the Court to make a blanket determination that is *never* child abuse, regardless of the individual circumstances, for Plaintiff to provide hormone-altering medications to prepubescent children. Plaintiff gives four pages of her Petition to arguing against the Attorney General's Opinion regarding the provision of hormone medication to children; she affirmatively contends that stunting children's physical

development and creating risks to their long-term health is inarguably medically reasonable whenever Plaintiff decides it is so. Pet. 5-8. Any argument by Plaintiff that she does not intend to obtain a decision invalidating or interpreting Texas' child abuse laws is nonsensical. And it becomes more so by following Plaintiff's desired relief to its logical conclusion. If this Court rules in favor of Plaintiff and declares that providing children hormone medications to interrupt their natural physical development is *always* a matter solely involving Plaintiff's medical judgment and *never* child abuse, irrespective of the case-by-case circumstances, that necessarily operates as an order that the child abuse statutes, although still concurrently applied to everyone else, are inapplicable to Plaintiff. Thus, Plaintiff's claims implicate the State's sovereign interest not only in a proper interpretation of its legal code but also in the *uniform* application of that legal code. This alone entitles the State to intervene and defend those interests.

2. State Law Will be Impacted by a Declaration that a Private Hospital is Unable to Determine What Treatments It Provides.

Plaintiff demands a declaration that CMC violated the law by discontinuing certain services for the treatment of gender dysphoria in children. Pet. at 14-15. She also wants CMC to be permanently enjoined from "[i]mposing *any* limitation on Dr. Lopez's exercise of her clinical privileges to provide pediatric endocrinology" in whatever form of service she deems fit. *Id.* at 15. An order to this effect would upend Texas' regulatory structure for private hospitals.

Plaintiff argues that physicians, and no one else, should determine what services and treatments a hospital must provide to patients. This extreme position ignores all other considerations that a hospital may take into account when deciding which services to provide, including, *inter alia*, the hospital-patient relationship; federal and state regulations; insurance company requirements; the cost-benefit of the services; community, institutional, and patient

concerns; and the sustainability and profitability of the services. "A hospital is not a mere hostery providing room and board and a place for physicians to practice their craft. . . ." *Tex. Health Huguley, Inc. v. Jones*, 637 S.W.3d 202, 213 (Tex. App.—Fort Worth 2021, no pet.) (quoting *Tenet Health Ltd. v. Zamora*, 13 S.W.3d 464, 471 (Tex. App.—Corpus Christi–Edinburg 2000, pet. dism'd w.o.j.)). Hospitals can choose to discontinue patient care for any reason that isn't unlawful. For example, some hospitals do not provide contraception due to sincerely held religious beliefs and affiliations, while others may close entire units due to staffing shortages or a lack of profitability.

Texas law gives hospitals the duty and responsibility of determining what services they will provide. It does so through statute, requiring private hospitals licensed in this state to establish a "governing body" that is "formally organized in accordance with a written constitution and bylaws which clearly set forth the organizational structure and responsibilities." 25 Tex. Admin. Code § 133.41(f)(2). The governing body is required to "ensure that the medical staff has current bylaws, rules, and regulations which are implemented and enforced." *Id.* at 113.41(f)(4)(A). Acting on behalf of the hospital, the governing body thus "determine[s] the scope of services to be provided at their facilities, mindful of the best interest of the facilities and, one presumes, the needs of the patient population they serve." *In re Children's Med. Ctr. of Dallas*, No. 05-22-00459-CV, 2022 WL 1566139, at *4 (Tex. App.—Dallas May 18, 2022, no pet. h.) (Schenck J. dissenting).

In other words, Texas law is structured to specifically entrust a hospital, not the physicians who are permitted to practice there, with the authority "to determine what services will be available at their facilities" and to "exercise[] its judgment in how and to whom it chooses to grant hospital privileges." *Huguley*637 S.W.3d at 212. In turn, this structure is what informs the extent

of private hospitals' civil and criminal liabilities to Texas citizens. Tex. Health & Safety Code § 241.101; *In re Children's Med. Ctr. of Dallas*, 2022 WL 1566139, at *4 (Schenck J. dissenting).

In *Huguley*, the Second Court of Appeals held that the "judiciary is called upon to serve in black robes, not white coats. And it must be vigilant to stay in its lane and remember its role. Even if we disagree with a hospital's decision, we cannot interfere with its lawful exercise of discretion without a valid legal basis." *Huguley,* 637 S.W.3d at 214. The wife of Jones, a patient in a medically induced coma and on a ventilator due to COVID-19 at Texas Health Huguley, obtained a prescription from a physician without privileges at the hospital to treat Jones with Ivermectin. *Id.* at 208. Huguley refused to comply with the prescription. *Id.* Jones' wife sought and obtained a temporary restraining order directing Huguley to provide Ivermectin. *Id.* At the temporary injunction hearing, the judge ordered the Ivermectin-prescribing physician to apply for temporary emergency privileges to Huguley, ordered Huguley to grant the physician privileges, and ordered Huguley to provide Jones with the prescribed Ivermectin treatment. *Id.* at 211. The Second Court of Appeals dissolved the injunction after finding that the trial court lacked the authority to issue it. *Id.* at 215-16. The Second Court of Appeals concluded that "the law does not allow this court, the trial court, or any other court to substitute our nonmedical judgment for the professional medical judgment of health care providers—whether we agree with their decisions, have serious doubts about them, or disagree with them entirely." *Id.* at 223-24.

Plaintiff's demanded relief necessarily dismantles this structure by asking the court to issue a blanket order forcing CMC to give hormone therapy services to prepubescent children, who are new patients. If this Court were to conclude that private hospitals can be deprived of their statutorily-imposed control over their own policies and services whenever an employee demands

something different, that holding will have wide-reaching effects on the State. First, the State clearly has an interest in the medical care its citizens are provided by hospitals in this State. *Snapp*, 458 U.S. at 602 (holding that a state has quasi-sovereign interests in the "well-being of its populace."). It demonstrates that interest by imposing distinct regulatory requirements on hospitals and on physicians. So, if "[h]ospitals exist to determine what services will be available at their facilities[,]" but an order from this Court permits *doctors* to make this determination instead, the State will be left with a nonuniform application of its laws, which would undoubtedly affect the medical care provided to its citizens. *In re Children's Med. Ctr. of Dallas*, 2022 WL 1566139, at *4 (Schenck J. dissenting).

Second, the State has in interest in being able to enforce its statutory requirements upon hospitals and physicians. Currently, that "enforcement is statutorily placed in the hands of the State and its agencies" such that liabilities may be "redressed *solely* through actions by the attorney general, the Texas Department of Health, or the commissioner of health." *Stephan v. Baylor Med. Ctr. at Garland*, 20 S.W.3d 880, 886 (Tex. App.—Dallas 2000, no pet.) (emphasis added) (citing *Cole v. Huntsville Mem'l Hosp.,* 920 S.W.2d 364, 372–73 (Tex. App.-Houston [1st Dist.] 1996, writ denied; and Tex. Health & Safety Code §§ 241.051–.059). There is no private "right of action in favor of physicians against hospitals that fail to comply [with Texas laws]." *Contra* Pet. at 14-16. Granting Plaintiff relief would deprive the State of its exclusive enforcement authority specifically set out by its Legislature; that sovereign interest permits it to intervene in this case. *Sierra Club*, 115 F.3d at 315 (holding that "[t]he state *qua* state has an important sovereign interest" in ensuring that its own statutory schemes are "properly enforced.").

This is especially true here, where the relief requested isn't specific to an individual patient, but instead to an entire patient population without regard to their individual needs or circumstances. Plaintiff is asking this court to compel medical treatment for hundreds, or perhaps even *thousands*, of patients without the benefit of reviewing a single medical record, medical history, psychological evaluation, or any of the other essential information that could allow an independent medical expert to evaluate, on a case-by-case basis, whether hormone treatment meets the applicable standard of care. *See* e.g., Wylie C. Hembree, et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. of Clin. Endo. & Metab., 3132–3154, at 1.2 (Sept. 2009), https://doi.org/10.1210/jc.2009-0345 (recommending against hormone treatment in prepubertal children with gender identity disorder because 75-80% of prepubertal children with the diagnosis do not turn out to be transexual in adolescence); see also, Marc. D. Feldman & Gregory P. Yates, DYING TO BE ILL: TRUE STORIES OF MEDICAL DECEPTION, 106-08 (Routledge; 1st ed. 2018) (discussing factitious transsexualism by proxy where parents "are so enamored of the attention that comes with having an ostensibly transsexual child that they engage in an associated variant of medical child abuse to try to make others perceive the child as gender dysphoric–and themselves as deeply understanding and wholly supportive parents.").

3. State Law Will be Affected by a Declaration Contrary to Texas' Discrimination Laws.

In Count Two of her Petition, Plaintiff seeks a "declaratory judgment on discrimination." Pet. at 15. Specifically, she seeks a declaration that CMC's decision to discontinue treatment of prepubescent gender dysphoria with hormone therapy "is discrimination based on gender identity." *Id.* She also demands this Court declare that CMC's decision is an order requiring

Plaintiff to engage in gender discrimination because she is unable to provide medical treatment that *she* claims she is "authorized to provide pursuant to the exercise of her independent medical judgment." *Id.*

A declaration that CMC is discriminating against *Plaintiff's patients*, not herself, and is "requiring her to engage in unlawful discrimination" would be a severe and significant deviation from how Texas' discrimination laws are enforced. The State does not grant physicians any statutory authority to bring discrimination suits on behalf of their patients. State law does not provide an individual physician with a private cause of action under the UDJA for "discrimination" on the basis that a hospital is "forcing" the physician to comply with its policies. *Stephan*, 20 S.W.3d at 886. For the Court to read Texas' anti-discrimination laws to permit such an action would, therefore, result in a nonuniform application of those laws. *See Snapp*, 458 U.S. at 601 (stating that "the power to create and enforce a legal code" is one "easily identified" example of sovereign interest.). This creates a sovereign interest the State is entitled to defend.

B. The State's *Parens patriae* Interest in the Welfare of Children Requires Intervention.

The State is also a proper intervenor as protecting its quasi-sovereign interest in the welfare of its citizens, in particular, children. *Snapp*, 458 U.S. at 607 ("[A] State has a quasi-sovereign interest in the health and well-being—both physical and economic—of its residents in general."). "A state has a *parens patriae* interest in preserving and promoting the welfare of its children." *Alvarez v. Tex. Dep't of Protective & Regulatory Services*, No. 03-02-00008-CV, 2002 WL 31599225, at *1 (Tex. App.—Austin Nov. 21, 2002, no pet.).

Plaintiff's Petition seeks a decision by this Court that the provision of hormone medication to a child in order to interrupt their natural physical and mental development is simply a matter of

medical judgment that should be left entirely to a treating physician. Her Petition demands this Court to accepts such claims as "GnRH puberty suppression is well known to be safe and reversible" and "hormone therapy is considered safe and effective." Pet. at 7. And it discusses, in detail, the recent events in this State in which the provision of these medications she touts as "safe and effective" have been recognized by an Attorney General's Opinion as constituting child abuse, at least in some cases. Pet. at 11-12. Plaintiff's misrepresentation of medical science aside (*see supra,* n. 1), these assertions make it clear that the proper care and treatment of children with gender dysphoria, as well as the application of state law regarding child abuse, are at issue in Plaintiff's claims. Because this is so, the State's *parens patriae* interest is implicated and intervention is essential to defend that interest.

Parens patriae is a proper basis for intervention because it is not an interest that is limited to certain types of cases or present only under specific circumstances.[2] The Supreme Court has stated there are no "definitive limits on the proportion of the population of the State that must be adversely affected by the challenged behavior" in order to support a *parens patriae* action. *Snapp*, 458 U.S. at 607. And there is similarly no limit on the subject matter, such as only the medical decision-making for an individual child as Plaintiff has suggested. See Plaintiff's Special Exceptions and Alternative Motion to Strike at 9. Instead, the *parens patriae* interest has been invoked in a multitude of contexts ranging from guardianship disputes over a minor, *see In re KC Greenhouse*

[2] Plaintiff's prior suggestion that *parens patriae* only exists when there is "a specific threat, to the life or limb of a specific child, created by a parent's refusal to consent to life or limb saving medical treatment" is readily disproven. Motion to Strike at p. 9. First, the singular case she uses to support such a broad claim makes no such assertion. *T.L. v. Cook Children's Med. Ctr.*, 607 S.W.3d 9, 26 (Tex. App.—Fort Worth 2020), cert. denied, 141 S. Ct. 1069 (2021). Second, as demonstrated in both the direct quotation from *Alvarez*, *supra*, as well as the cases discussed, *infra*, that position is simply baseless; the interest is implicated both in cases involving specific children and cases involving children generally. *See also Ginsberg v. New York*, 390 U.S. 629, 640 (1968) ("The State also has an independent interest in the well-being of its youth.").

Patio Apartments, LP, 445 S.W.3d 168, 174 (Tex. App.—Houston [1st Dist.] 2012, no pet.), to providing medical care to children, s*ee, e.g., O.G. v. Baum,* 790 S.W.2d 839, 840–41 (Tex.App.-Houston [1st Dist.] 1990, orig. proceeding), to the establishment of state agencies to ensure the State's interests are actively defended, *see Alvarez*, 2002 WL 31599225, at *1. It has also been "invoked in other states to authorize government suits against makers and sellers of tobacco, lead paint, and guns." *Farmers Group, Inc. v. Lubin*, 222 S.W.3d 417, 424 (Tex. 2007) (citing cases). Thus, the State's *parens patriae* interest is well-recognized as a *general* "authority and duty to guard the wellbeing of children." *Id*; *see also Ginsberg v. New York*, 390 U.S. 629, 640 (1968) ("The State . . . has an independent interest in the *well-being of its youth*.").

And the *parens patriae* interest is not implicated only when there is no third party with a simultaneous interest in the welfare of a child or children. "[T]he state, acting as *parens patriae*, . . . guard[s] the well-being of minors, *even where* doing so requires limiting the freedom and authority of parents over their children." *HCA, Inc. v. Miller ex rel. Miller*, 36 S.W.3d 187, 192 (Tex. App.—Houston [14th Dist.] 2000), aff'd, 118 S.W.3d 758 (Tex. 2003). In other words, the State is not suggesting, as Plaintiff has previously appeared to misunderstand it, that the State's interests in children's welfare is any more than a parent's, generally, or supersedes any parent's interest in this particular case. As the case law demonstrates, the presence of another party's interest in the welfare of children or a particular child does not nullify the State's concurrent interest. *See, supra*; *see also In re Nelson*, 149 N.H. 545, 548, 825 A.2d 501, 503 (2003) ("The State does have a competing interest in the welfare of children within its jurisdiction[.]"). And, more importantly, it does not serve as a reason to deny the State its entitlement to intervene in a matter such as this where the welfare of children is indisputably at issue. *Cf. Mass. v. EPA*, 549 U.S. 497, 520 & n.17

(2007) (noting States are entitled to "special solicitude in [Article III standing] analysis" because of their *parens patriae* status). The "protection of the child is paramount" and, Plaintiff's misunderstanding of *parens patriae* notwithstanding, there is no basis to deny the State intervention to provide that protection in this case. *In Interest of J.W.T.*, 872 S.W.2d 189, 195 (Tex. 1994).

C. Intervention is Warranted on Equitable Grounds.

The State should be a party to this proceeding on equitable grounds. Plaintiff's Petition repeatedly refers to the State, including the Governor and Attorney General. Plaintiff's Petition alleges, in so many words, that CMC is acting as a cat's paw for the State, who directed it to stop providing the prepubescent hormone therapy for gender dysphoria, the very treatment for which she now seeks declaratory and injunctive relief. See Pet. at 12 ("either the Governor or the Governor's office has exerted political pressure to close the GENECIS program and to stop clinicians from providing [sex-change] care at CMC."). Plaintiff made the State an appropriate intervening party when she alleged that it is behind CMC's actions giving rise to this suit– regardless of whether these allegations have any merit.

Finally, to the extent there can be any doubt, Plaintiff has brought a declaratory judgment counterclaim against the State as an intervenor asking this court to find that prepubescent hormone therapy for gender dysphoria is *never* against Texas state law when provided by a licensed physician and asking for an award of attorneys' fees. Plaintiff has also filed a motion for sanctions against undersigned counsels for seeking to intervene. Although these filings are incongruous (simultaneously filing a counterclaim and seeking sanctions for intervening), their filing opened the door to the State intervening to defend itself.

III. Intervention is Necessary Because Defendant Has Different Interest that May Not Alight with the State's.

CMC is a private litigant that cannot be expected to defend fully the interests of the State, and it should not be asked to do so. This fact has already created adverse consequences for the State. On May 23, 2022, this Court signed an Agreed Order that imposes the very restrictions implicating the State's interests described above. *See, supra*, Sections I-II. The Agreed Order states that CMC agrees with Plaintiff that providing hormone medications to minors is entirely within the "independent medical judgment [of] a licensed physician." Agreed Order at 1. The Agreed Order also states that it violates Texas' discrimination laws to not provide a minor child with hormone treatments that may stunt their pubertal development and inhibit their fertility. In other words, CMC agreed, at the temporary injunction stage, that Plaintiff is likely to succeed on her claims and that this Court has jurisdiction over the claims. Finally, the Agreed Order upends the statutory structure that existing Texas law imposes on the relationship between private hospitals and physician. The Agreed Order bestows dictatorial powers on Plaintiff to perform any action that relates to the treatment of gender dysphoria without regard to CMC.

The State's laws and interests are implicated in this matter, as described above. CMC and the State may have different interests. CMC signed the Agreed Order, whereas, the State has appealed the Agreed Order. CMC's failure to appeal the temporary injunction against it would itself show a divergence from the State's interests. So much more so where the injunction is entered by agreement. CMC cannot be relied on to defend the State's laws and interest–nor should it. The State should defend its own interests and laws. Consequently, the State's intervention is essential.

IV. Intervention is Timely.

The State of Texas' intervention is timely filed. Litigation in this matter has only just begun. Further, there is no pre-judgment deadline for intervention. *Tex. Mut. Ins. Co. v. Ledbetter*, 251 S.W.3d 31, 36 (Tex. 2008) (citing Tex. R. Civ. P. 60; *Citizens State Bank of Sealy v. Caney Invs.*, 746 S.W.2d 477, 478 (Tex. 1988). Texas courts recognize an "expansive" intervention doctrine in which a plea in intervention may be untimely only if it is "filed after judgment." *State of Texas v. Naylor*, 466 S.W.3d 783, 788 (Tex. 2015) (quoting *First Alief Bank v. White*, 682 S.W.2d 251, 252 (Tex. 1984)); *Tex. Mut. Ins. Co.*, 251 S.W.3d at 36 (citing *In re Lumbermens Mut. Cas. Co.*, 184 S.W.3d 718, 725–26 (Tex. 2006)). Because there is no final judgment in this case, the State of Texas' intervention is timely.

CONCLUSION AND PRAYER FOR RELIEF

For the foregoing reasons, the State of Texas respectfully requests that the Court permit it to appear and be heard in this cause of action as Intervenor. The State of Texas further requests that the Court vacate the temporary injunction and dismiss all of Plaintiff's claims against all parties in their entirety, as more fully explained in the State's concurrently filed plea to the jurisdiction, and for such other and further relief, at law or in equity, to which Intervenor is justly entitled.

Respectfully submitted.

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CERTIFICATE OF SERVICE

I, **Johnathan Stone**, Assistant Attorney General of Texas, hereby certify that a true and correct copy of the foregoing document has been served electronically through the electronic-filing manager in compliance with TRCP 21a on June 14, 2022, to:

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Cause No. 22-02427-B

Ximena Lopez, M.D., **Plaintiff,** **v.** **Children's Medical Center at Dallas,** **Defendant,** **and** **The State of Texas,** **Intervenor.**	**In the County Court At Law No. 2** **Dallas County, Texas**

Plaintiff Ximena Lopez, M.D.'s Amended Special Exceptions, and, in the Alternative, Motion to Strike Petition in Intervention

Comes now Ximena Lopez. M.D., Plaintiff, and files the *Plaintiff Ximena Lopez, M.D.'s Amended Special Exceptions, and, in the Alternative, Motion to Strike Petition in Intervention* ("Amended Special Exceptions") and would respectfully show the Court as follows:

I.
BACKGROUND

1. Evil convictions are not transmuted into something sublime by the embrace of those in power – this only makes them more dangerous. And so it is here.

2. Ximena Lopez, M.D. ("Dr. Lopez") is a pediatric endocrinologist and member of the Medical Staff of Children's Medical Center at Dallas ("CMC").

3. On May 11, 2022, Dr. Lopez filed her *Verified Application for Temporary Restraining Order, Temporary Injunction, and Plaintiff's Original Petition for Permanent Injunctive and Declaratory Relief* ("Plaintiff's Original Petition") seeking declaratory relief against CMC and an injunction enjoining CMC and "those individuals and entities in **active concert or participation** with" CMC from implementing or enforcing a policy prohibiting Dr.

Lopez from providing endocrine care to gender dysphoric children and adolescents. Plaintiff's Original Petition at ¶¶ 7-8; 10-11; 14.

4. On May 12, 2022, the Court granted a temporary restraining order in favor of Dr. Lopez.

5. On May 17, 2022, the State of Texas ("State") filed it's the *State of Texas' Petition in Intervention* ("Petition in Intervention") "to prevent irreparable harm to the children of the State, and to protect its interest in the uniform, consistent application of the laws of the State of Texas." Petition in Intervention at 1. The Petition in Intervention is devoid of any request for affirmative relief. Indeed, the Petition in Intervention does not contain a Prayer for Relief and concludes by simply stating "the State of Texas respectfully requests that the Court permit it to appear and be heard in this cause of action as Intervenor and for such other and further relief, at law or in equity, to which Intervenor is justly entitled."

6. On May 18, 2022, Plaintiff filed her *Plaintiff Ximena Lopez, M.D.'s Special Exceptions, and, in the Alternative, Motion to Strike Petition in Intervention*. ("Special Exceptions"). The Special Exceptions are set for hearing on June 17, 2022.

7. On June 14, 2022, the State filed its *The State of Texas' First Amended Petition in Intervention* ("Amended Petition in Intervention"). Also on June 14, 2022, the State filed its *The State of Texas' Response to Plaintiff's Special Exceptions and Motion to Strike* ("State's Response") requesting that the Court deny the Special Exceptions on the grounds that the Amended Petition in Intervention "mooted" the Special Exceptions to the State's Original Petition in Intervention. State's Response at 1. The State does not, however, aver in its Response that the Amended Petition in Intervention cured the defects in the Original Petition in

Intervention – it did not. Indeed, the Amended Petition in Intervention amplifies and underscores the infirmities in the Original Petition in Intervention. Accordingly, Plaintiff submits these Amended Special Exceptions to the Amended Petition in Intervention.

II.
THE PETITION IS FATALLY DEFECTIVE IN ITS ENTIRETY

8. The Amended Petition in Intervention is fatally defective. The Court must require the State to replead around these defects, and if the State is unable to do so, strike the intervention. The Amended Petition in Intervention is defective for the following reasons:

A. The State fails to plead a legal, justiciable interest in *this* matter. What is the interest implicated?

9. This case, and the relief sought in it, is about what a private hospital can and cannot legally dictate to a private physician in the exercise of that physician's medical judgment. What is the "State's" legal interest in this issue? The State claims a legal interest in protecting children that only arises after a court's finding that abuse is occurring. That interest is contingent and remote and therefore is not an interest that supports an intervention.[1]

10. The State claims it has an interest in controlling hospitals and the practice of medicine. That is a rather curious claim given that, in the Rule 202 proceeding in which Dr. Lopez sought discovery as to the involvement of the Governor and Attorney General in shutting the GENECIS clinic, counsel for the State argued:

> Nobody—not even the Governor or Legislators—can "dictate" to UT Southwestern how to provide or not provide particular care outside of duly

[1] *See Smith v. City of Garland*, 523 S.W.3d 234, 241 (Tex. App.–Dallas 2017) (noting "An intervenor's interest must be greater than a merely contingent or remote interest." and citing *Mendez v. Brewer*, 626 S.W.2d 498, 500 (Tex. 1982)).

enacted state law." Dr. Lopez does not (because she cannot) show that anyone can "dictate" such decisions to UT Southwestern.[2]

11. If the Governor and Legislature cannot dictate how UTSW–a state agency–provides care, what possible legal basis would they have to do that for a private hospital like CMC?

12. Every declaratory judgment or judicial action involves the interpretation of a law. It cannot be that the "State" has an interest in every such determination. That is why the interest has to be justiciable, meaning that the "State" could have brought this case itself or defeated this case itself.[3] The State fails to show how it could have brought this case itself or defeated any aspect of the relief sought by itself.

B. The State fails to plead the basis for claiming it is the State of Texas's interest at issue. On behalf of whose interest is the AG acting?

13. The only department or agency of the state that even has a legal right to dictate the provision of medical services is the Legislature under the Texas Constitution and the Texas Medical Board, which was created by the Legislature and delegated authority through the Texas Medical Practice Act. The Texas Medical Board has not issued any agency rules that are in jeopardy by the relief requested in this matter. Indeed, to the contrary, the Texas Medical Board expressly prohibits a physician from failing to provide medical care within the standard of care. Nor has the Legislature passed any statute that needs defending in this action.

14. On the contrary, during the last regular session, the Texas Legislature considered, but did not pass, proposed legislation that would have changed Texas law to include treatment

[2] *See* UTSW's *Plea to the Jurisdiction and Response to 202 Application* filed in Cause No. CC-22-01316-B.
[3] *Guaranty Fed. Sav. Bank v. Horseshoe Oper. Co.*, 793 S.W.2d 652, 657 (Tex. 1990).

for gender dysphoria under the definition of child abuse. Specifically, Senate Bill 1646 ("SB 1646") would have amended Section 261.001 of the Texas Family Code to add certain treatments to the definition of "child abuse." The bill would have amended this provision of the law to include within the definition of "child abuse": "administering or supplying, or consenting to or assisting in the administration or supply of, a puberty suppression prescription drug or cross-sex hormone to a child, other than an intersex child, for the purpose of gender transitioning or gender reassignment; or performing or consenting to the performance of surgery or another medical procedure on a child other than an intersex child, for the purpose of gender transitioning or gender reassignment." SB 1646 did not pass. The Legislature considered additional bills that would have prohibited medical treatment for gender dysphoria in minors, including House Bill 68 and House Bill 1339. None of these bills were passed by the duly-elected members of the Legislature.[4]

15. The Texas Legislature determines what is the public policy of the State of Texas through the laws it passes.[5] It is not within the Governor or the Attorney General's authority to say what the public policy is for the State or that the State has an interest in an issue that is not set forth in the law. When the Legislature considers but declines to pass a statute, courts must give effect to the Legislature's decision to *not* make the proposed statute the policy or law of the State.[6] Thus, this Court must give effect to the Legislature's decision to **not** make it the public

[4] On July 19, 2021, after the above-referenced legislation failed to pass, Governor Abbott explained on a public radio show that he had a "solution" to what he called the "problem" of medical treatment for minors with gender dysphoria.

[5] *Fairfield Ins. Co. v. Stephens Martin Paving, LP*, 246 S.W.3d 653, 665 (Tex. 2008).

[6] *See, e.g., City of Round Rock v. Rodriguez*, 399 S.W.3d 130, 139 (Tex. 2013) (noting that the Court "must give effect to the statute's silence on this issue and the Legislature's decision not to confer representation rights akin to Weingarten rights on Texas public-sector employees.").

policy of this state that gender-affirming care is child abuse.

16. As it is not the law of the State that all endocrine care for gender dysphoric children is child abuse, by what right does the State now come before this Court asserting that it is – and make no mistake about it – that's precisely what the State is arguing. While the Attorney General speaks publicly like he is a roving warrior to advance his political agenda, that's not what the legal authority of an Attorney General entails.[7] The Attorney General's only right is to defend and enforce duly enacted state laws, but the Attorney General never identifies the state law he seeks to enforce, or how the relief sought by Plaintiff is a violation of any such law – except by implication as to the law that the Legislature **did not pass**.

17. The Original Petition in Intervention and the Amended Petition in Intervention suffer from an intentionally self-inflicted infirmity – they identify the intervening party as simply "The State of Texas," without identifying the specific state actor or agency on whose behalf the Attorney General purports to act, or whose authority is threatened by the relief requested herein. It cannot be the Legislature – it failed to pass the above-referenced legislation, nor can it be the Governor or the Attorney General. As recently noted by the Texas Supreme Court:

> [T]he Legislature has granted to DFPS, not to the Governor or the Attorney General, the statutory responsibility to "make a prompt and thorough investigation of a report of child abuse or neglect." TEX. FAM. CODE § 261.301(a). And, when deciding whether and how to exercise that authority,

[7] Texas Const. Art. 4, Sec. 22 "ATTORNEY GENERAL. The Attorney General shall represent the State in all suits and pleas in the Supreme Court of the State in which the State may be a party, and shall especially inquire into the charter rights of all private corporations, and from time to time, in the name of the State, take such action in the courts as may be proper and necessary to prevent any private corporation from exercising any power or demanding or collecting any species of taxes, tolls, freight or wharfage not authorized by law. He shall, whenever sufficient cause exists, seek a judicial forfeiture of such charters, unless otherwise expressly directed by law, and give legal advice in writing to the Governor and other executive officers, when requested by them, and perform such other duties as may be required by law."

> DFPS—not the Governor or the Attorney General—naturally must assess whether a report it receives is actually "a report of child abuse or neglect." Id. Of course, the Legislature, by statute, may constrain DFPS's discretion in this regard (subject to constitutional limitations), but neither the Governor nor the Attorney General has statutory authority to directly control DFPS's investigatory decisions. They have every right to express their views on DFPS's decisions and to seek, within the law, to influence those decisions—but DFPS alone bears legal responsibility for its decisions.

In re Greg Abbott, No. 22-0229, (Tex. May 13, 2022) (original proceeding).

18. The relief sought by Plaintiff does not implicate any interest of the State. Even if it did, however, the Attorney General may only assert a justiciable interest on behalf of the specific actor or agency whose legal authority extends to those matters so implicated or in the enforcement of a law duly passed by the Legislature – because there is no law to be enforced, the Attorney General has not identified the state actor or agency whose authority is threatened. But that has not stopped the Attorney General.

C. The State does not show why it must be allowed to intervene to protect its interest. Why does the State need to be a party?

19. To intervene, the State is required to show that intervention is essential to protect the intervenor's interest.[8] As this Court is aware, the State is already litigating the issue of whether gender-affirming care should be investigated as child abuse in a different proceeding. So why does the State need to excessively multiply the issues by litigating that topic in this Court?[9] There is nothing about the declaratory judgment or injunction in this case that will prejudice the rights of the State in that different proceeding.

[8] *Guaranty Fed.*, 793 S.W.2d at 657 (intervention is improper if it is not essential to protect the intervenor's interest).
[9] *Id*. (intervention is improper if it will complicate the case by excessive multiplication of the issues).

20. **Counts 1 and 2 in the Original Petition**: Count 1 seeks a declaratory judgment (against CMC only), that CMC's actions in "prohibiting Dr. Lopez from exercising her unconstrained clinical privileges granted to her by the Medical Staff at CMC and the Medical Executive Committee at CMC is an unlawful restriction on her independent medical judgment and an illegal restraint of trade" and that CMC's conduct in prohibiting Dr. Lopez from providing endocrine care to gender dysphoric youth is unlawful under the laws banning the corporate practice of medicine." Original Petition at ¶ 7-8.

21. Count 2 seeks a declaratory judgment (against CMC only), that CMC's conduct in prohibiting Dr. Lopez from providing endocrine care to gender dysphoric youth is "discrimination based on gender identity and because of sex and violates antidiscrimination law" and that "CMC's order requiring Dr. Lopez to withhold treatment—that she is otherwise authorized to provide pursuant to the exercise of her independent medical judgment—from certain patients because of their gender identity is an order by CMC that requires Dr. Lopez to engage in unlawful discrimination." Original Petition at ¶ 10-11.

22. The State has intervened, but Plaintiff seeks no declaratory relief against the State, and the State seeks no relief, asserts no claims for relief, and has no "interest that would be affected by the declaration[s]" sought by Plaintiff. Tex. Civ. Prac. & Rem. Code § 37.006(a) (Texas Declaratory Judgment Act). Indeed, because the State was not a defendant in this action, a declaratory judgment against CMC would not and could not, as a matter of law, have "prejudice[d] the rights of [the State]" because a declaratory judgment only impacts the rights of the parties to the proceeding. *Id*. The State attempts to circumvent the legal infirmity of its intervention in a most unusual way.

23. The Original Petition in Intervention and Amended Petition in Intervention fall prey to the fallacy of *circulus in probandō* (circular reasoning). It goes something like this: (1) the law says that because the State is not a party, a declaratory judgment is not binding on the State, (2) but the State wants to argue that it has an interest in the action so that it can become a party, (3) so that the State can claim that its interest will be affected and it will be bound by a declaratory judgment, (4) so the State will intervene so that it can argue that it would be bound by a declaratory judgment since it is a party, and (5) the State can then argue that a declaratory judgment affects the interest the State.

24. In a fatuous effort to manufacture a right to intervene, the State simply alleges that "where the custody of the parent or legal guardian fails, the government may (indeed, we have said must) either exercise custody itself or appoint someone else to do so." But this (incorrect) assertion states no claim for relief, and the Prayer for Relief does not inform a determination of exactly what this Court will do that will impact the State's claim that it must act when a parent fails in custody of their child. Indeed, as noted above, the "Prayer" in the Amended Petition in Intervention does not seek affirmative relief, it simply requests the Court grant the relief requested by the State in the State's June 14, 2022, *The State of Texas's Plea to the Jurisdiction* ("Plea to the Jurisdiction"). But if the State is not properly before the Court because the State does not have the right to intervene, the Plea to the Jurisdiction is nothing more than the musings of one infirmed by pernicious convictions.

25. **Count 3**: Count 3 seeks an injunction that "permanently enjoins CMC and anyone in active concert or participation with CMC from doing or attempting to do any of the following:

a. Enforcing CMC's Unlawful Prohibition;

b. Discriminating against patients seeking Gender-Affirming Endocrinology Care by denying Gender-Affirming Endocrinology Care for new patients at CMC;

c. Interfering with, controlling, or otherwise directing any physician's professional judgment with respect to the provision of Gender-Affirming Endocrinology Care at CMC; and

d. Imposing any limitation on Dr. Lopez's exercise of her clinical privileges to provide pediatric endocrinology care, including, but not limited, to prohibiting her from providing Gender-Affirming Endocrinology Care, in the absence of any formal due process under CMC's by-laws by the appropriate parties to restrict Dr. Lopez's clinical privileges.

Original Petition at ¶¶ 13-14.

26. The State does not aver or concede that it is "in active concert or participation with CMC" in engaging in any of the enjoined conduct, **nor would it dare to do so**. Instead, the State dips its ham-fisted toe into the sea of this case by cobbling together a litany of buzz words, e.g., "*parens patriae*," "abuse or neglect of a child," "mental or emotional injury to a child," etc., but never jumps into the water, or demonstrates the courage (or logic) to make a full-throated argument grounded in law. The reason for this is clear when one considers the acts actually enjoined.

27. The Temporary Injunction enjoins enforcement of "any policy or limitation that restricts or prohibits gender-affirming endocrinology care, including specifically pubertal suppression or hormone therapy, to new or established patients due the patient's gender identity or gender dysphoria." The State's interest is implicated only if the State avers or concedes that it has undertaken to enforce a "policy or limitation" at CMC. The Court will recall, however, that

at the 202 Petition hearing, the State expressly disavowed any right to force CMC to do anything, must less undertake enforcement of any policies:

> **BY MR. ELDRED ASSISTANT ATTORNEY GENERAL:** Now, I'm trying to keep things in the right box, but they know that UT Southwestern and Children's Hospital have decided to make these decisions. We argue that's -- from the rule 202 perspective, there's no reason to have a rule 202 deposition to find out whether they made those decisions. They did make those decisions. Everyone knows they made those decisions. So, whether or not they're allowed to make those decisions is one thing. We say they can. And the reason they can – because they can, we have immunity. But whether they can or can't, it gets them to the next issue about whether there should be a 202 deposition to find out whether they were the ones who did it. Well, they already know who did it. So, that's not -- so is there an ultra vires claim against other parties? I've heard the governor mentioned. I've heard the attorney general mentioned. In the pleadings, I've heard legislatures. They have not stated an ultra vires claim against any of those people because none of those people have authority to dictate these decisions to UT Southwestern and to Children's hospital.
>
> ***
>
> [The 202 Petition] [] doesn't state a claim that is not barred by immunity. The governor is allowed to have opinions. The hospitals, not just state hospitals, but all hospitals, are allowed to consider outside opinions. You, yourself, are allowed to consider outside opinions, but you're the one who makes the decisions, at the end of the day, if you succumb to pressure, or if the hospital succumbs to pressure. It doesn't mean it didn't make the decision. The hospital made the decision. And this goes back to why they need a 202 deposition. They know who made the decision.[10]

In other words, according to the State, the Court (1) had no jurisdiction to grant the 202 Petition in that case because the State had no role in CMC's decision-making, but (2) should not strike the State's intervention in this case because the State is in "active concert or participation" with CMC in the conduct that is the subject of the declaratory relief sought and the actions enjoined.

[10] Exhibit 1, 202 Petition Hearing 65:11-66:7; 72:15-25.

28. So, what does the State need to protect by intervening? Legally, nothing. Rather, it appears that the sole basis for the Intervention is that the Attorney General wants to pander to his base and offer his opinion on whether this care is appropriate, in which case the Attorney General should have filed an amicus brief, not an Intervention.

29. The State's Amended Petition in Intervention is fatally defective on these points and for this reason, Plaintiff files the following special exceptions seeking an order of the Court that the State replead as requested herein. If the Court grants these exceptions, and the State is forced to replead but cannot cure the defects, Plaintiff moves the Court strike the intervention.

III.
SPECIAL EXCEPTIONS TO THE AMENDED PETITION IN INTERVENTION

A. Introduction

30. The Amended Petition in Intervention does not itself seek affirmative relief. Rather, it "requests that the Court permit [the State] [] to appear and be heard in this cause of action as Intervenor" and "further requests that the Court vacate the temporary injunction and dismiss all of Plaintiff's claims against all parties in their entirety, as more fully explained in the State's concurrently filed plea to the jurisdiction, and for such other and further relief, at law or in equity, to which Intervenor is justly entitled." Amended Petition in Intervention at 17 (emphasis added). More importantly, the Amended Petition in Intervention does not provide any clarity on the threshold issue: what specific interest of the State "will be affected by the litigation" between Dr. Lopez and CMC.[11] For this reason, Plaintiff objects and specially excepts as follows to the contents of the Amended Petition in Intervention:

[11] *Jabri v. Alsayyed*, 145 S.W.3d 660, 672 (Tex. App.—Houston [14th Dist.] 2004, no pet.).

B. Special Exceptions

31. **Special Exception No. 1**: Plaintiff objects and specially excepts to the averment in the Amended Petition in Intervention that "[t]he State seeks only to ensure its interests in the uniform application of its laws and to guard the safety of its children that Plaintiff is treating" on the grounds that it does not give the Plaintiff fair notice of the identity of the state actor or agency on whose behalf the State intervenes.

32. **Special Exception No. 2**: Plaintiff objects and specially excepts to the averment in the Amended Petition in Intervention that "Intervention is essential in this case because the State has well-recognized sovereign interests in the uniform application of its laws and the welfare of children in this State, both of which would be affected by the declaratory relief sought in this suit" on the grounds that this averment does not provide Plaintiff with fair notice of how the relief sought against CMC threatens "the uniform application of [State's] laws and the welfare of children in this State." Amended Petition in Intervention at 3. Accordingly, Plaintiff moves the Court order the State to (1) replead and identify the enjoined act(s) in which the State is in active concert and participation with CMC and (2) state specifically how the following relief, if granted, interferes with the State's "sovereign interests in the uniform application of its laws and the welfare of children in this State:"

> a. a declaratory judgment (against CMC only), that CMC's actions in "prohibiting Dr. Lopez from exercising her unconstrained clinical privileges granted to her by the Medical Staff at CMC and the Medical Executive Committee at CMC is an unlawful restriction on her independent medical judgment and an illegal restraint of trade" and that CMC's conduct in prohibiting Dr. Lopez from providing endocrine care to gender dysphoric youth is unlawful under the laws banning the corporate practice of medicine." Original Petition at ¶ 7-8.

b. a declaratory judgment (against CMC only), that CMC's conduct in prohibiting Dr. Lopez from providing endocrine care to gender dysphoric youth is "discrimination based on gender identity and because of sex and violates antidiscrimination law" and that "CMC's order requiring Dr. Lopez to withhold treatment—that she is otherwise authorized to provide pursuant to the exercise of her independent medical judgment—from certain patients because of their gender identity is an order by CMC that requires Dr. Lopez to engage in unlawful discrimination." Original Petition at ¶ 10-11: and

c. an injunction that "permanently enjoins CMC and anyone in active concert or participation with CMC from doing or attempting to do any of the following:

1. Enforcing CMC's Unlawful Prohibition [as defined in the Original Petition];

2. Discriminating against patients seeking Gender Affirming Endocrinology Care by denying Gender-Affirming Endocrinology Care for new patients at CMC;

3. Interfering with, controlling, or otherwise directing any physician's professional judgment with respect to the provision of Gender-Affirming Endocrinology Care at CMC; and

4. Imposing any limitation on Dr. Lopez's exercise of her clinical privileges to provide pediatric endocrinology care, including, but not limited, to prohibiting her from providing Gender-Affirming Endocrinology Care, in the absence of any formal due process under CMC's by-laws by the appropriate parties to restrict Dr. Lopez's clinical privileges."

Original Petition at ¶¶ 13-14.

33. Plaintiff also moves the Court order the State to replead and identify specifically:

a. every policy(ies) or limitation(s) promulgated by the State that restrict(s) or prohibit(s), in every case, gender-

affirming endocrinology care consisting of pubertal suppression or hormone therapy for the treatment of gender dysphoria;

b. every act of the State discriminating against patients seeking gender-affirming endocrinology care by restricting or prohibiting care because of the patient's gender identity;

c. every act of the State that interferes with, controls, or directs any physician's professional judgment with respect to the provision of gender-affirming endocrinology care at CMC;

d. on whose behalf the State is purporting to intervene given that the public policy, as defined by the Texas Legislature, was to not categorize gender-affirming care as abuse;

e. the precise "laws," the enforcement of which "could potentially [be] undermine[d]" if the Court grants relief sought by the Plaintiff and how such laws could be undermined;

f. every law, statute, regulation, and/or Texas Medical Board Rule permitting the State, or any hospital regulated by the State, to require a physician to deprive every child diagnosed with gender dysphoria of endocrine treatment within the medical standard of care consisting of puberty blockers or cross-sex hormones;

g. every law, statute, regulation, and/or Texas Medical Board Rule pursuant to which the State conducts the licensure and regulation of all state physicians which the State contends is implicated in any regard by the relief sought by the Plaintiff; and

h. every law, statute, regulation, and/or Texas Medical Board Rule that vests in the State the right to criminalize treatment of a gender dysphoric child within the medical standard of care simply because the child is gender dysphoric.

34. **Deadline for Compliance with the Court's Order**: In the event or to the extent that the Court grants Plaintiff's Special Exceptions, Plaintiff requests that the Court order that the

State replead to cure the defect in the Amended Petition in Intervention on or before 4:00 p.m. on Tuesday, June 21, 2022. If the State fails to replead or informs the Court it will not do so, Plaintiff requests that the Court dismiss the State's intervention on Tuesday, June 21, 2022.[12] If the State attempts to replead, Plaintiff requests that the Court hold another hearing early next week on the sufficiency of the amendment.

35. As the Court has the right to set deadlines in a manner that will result in the expeditious resolution of disputes in order to manage its docket, appellate courts "will not interfere with the trial court's discretion to manage its docket without a clear showing of abuse."[13] Plaintiff requests that the Court exercise the broad discretion to dispose of this matter quickly given the State of Texas's attempts to appeal the agreed temporary injunction order. As this Court knows given the evidence before the Court, the issue of receiving care is a matter of life or death for some of these kids. The State's intervention throws into doubt for these kids the ability to rely on the Agreed Temporary Injunction. Furthermore, Plaintiff needs to file a Motion to Dismiss the State's improvident appeal in an expeditious manner before the Court of Appeals and this Court wastes valuable time and resources going through the motions of preparing the record and transmitting it for what is clearly a frivolous appeal. If the State is unable to plead a justiciable interest, that will inform the Motion to Dismiss before the Court of Appeals.

[12] *See Ford v. Performance Aircraft Servs., Inc*., 178 S.W.3d 330, 336 (Tex. App.—Fort Worth 2005, pet. denied) (noting "If the pleader fails or refuses to amend the pleading, the trial court may dismiss the case.").
[13] *See In re City of Dallas*, 445 S.W.3d 456, 463 (Tex. App.—Dallas 2014, no pet.) (citing *Clanton v. Clark*, 639 S.W.2d 929, 931 (Tex.1982)).

V.
PRAYER

WHEREFORE, premises considered, Plaintiff respectfully moves the Court (1) order the State to replead as requested herein and (2) strike the State's intervention in the event the State fails to replead to cure the defects in the Amended Petition in Intervention as set forth herein.

Plaintiff further prays for any such further relief, in law or equity, appropriate or to which Plaintiff has a right.

Respectfully submitted,

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/s/ Charla G. Aldous
Charla G. Aldous

REPORTER'S RECORD
VOLUME 1 OF 1
COURT CAUSE NO. CC-22-01316-B

EX PARTE	)	IN THE COUNTY COURT
	)	
	)	
	)	
VS.	)	AT LAW NO. 2
	)	
	)	
XIMENA LOPEZ, M.D.,	)	
	)	
Petitioner.	)	DALLAS COUNTY, TEXAS
	)	
	)	

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202 PETITION HEARING

On the 11th day of April, 2022, the following proceedings came on to be heard in the above-entitled and numbered cause before the Honorable Judge Melissa Bellan, Judge presiding, held via Court Call in Dallas County, Texas;

Proceedings reported by machine shorthand.

organization, is not a 161.001(b) organization, which applies to nonprofit. Government is not a nonprofit. So that -- once -- and the administrative code that he'd been arguing about does not apply to 161.001(c). And the reason I start with that is because this gets into how can you get around sovereign immunity in a ultra vires claim? The way to get around sovereign immunity ultra vires claim is you have to actually state an ultra vires claim. You have to put out facts that show that what happened might have been ultra vires. They have not done that. Now, I'm trying to keep things in the right box, but they know that UT Southwestern and Children's Hospital have decided to make these decisions. We argue that's -- from the rule 202 perspective, there's no reason to have a rule 202 deposition to find out whether they made those decisions. They did make those decisions. Everyone knows they made those decisions. So whether or not they're allowed to make those decisions is one thing. We say they can. And the reason they can -- because they can, we have immunity. But whether they can or can't, it gets them to the next issue about whether there should be a 202 deposition to find out whether they were the ones who did it. Well, they already know who did it. So, that's not -- so is there an ultra

virus claim against other parties? I've heard the governor mentioned. I've heard the attorney general mentioned. In the pleadings, I've heard legislatures. They have not stated an ultra vires claim against any of those people because none of those people have authority to dictate these decisions to UT Southwestern and to Children's hospital. If the governor did pressure them or conspired with them, as Mr. Malouf put, that's not the ultra vires action. The governor is allowed to have opinions about these things. The governor is allowed to pressure people. So they have to state some sort of theory that shows the governor might have committed something ultra vires, or somebody might have committed something ultra vires. If you look at the request for documents, they even want documents from advocacy groups. Well, I don't think they're saying advocacy groups can dictate things -- can dictate treatment that's (inaudible) by UT Southwestern and Children's Hospital.

So, Your Honor, it is -- there is a confusing ball of immunity, ultra vires, and 202 standards all kind of blur together. At a minimum, you look at everything together, Dr. Lopez needs to state facts that show that she might have a claim that is not barred by sovereign immunity. She's not done so.

minute that this change in policy, as to medicine, the practice of medicine by Dr. Lopez was initiated by anything other than politics. We believe there maybe a claim that Dr. Lopez has against those people responsible for. And to make the argument that, you know, Dr. Podolsky or Dr. Warner made the decision, no one believes that. Certainly they implemented the decision. But by their own pleadings, by their own pleadings, they concede that the decision was politically motivated or made for political expediency.

So, with all due respect, Your Honor, we just want to take a couple of depositions.

THE COURT: Okay. Let me come back to Mr. Eldred.

MR. ELDRED: It doesn't state a claim that is not barred by immunity. The governor is allowed to have opinions. The hospitals, not just state hospitals, but all hospitals, are allowed to consider outside opinions. You, yourself, are allowed to consider outside opinions, but you're the one who makes the decisions, at the end of the day, if you succumb to pressure, or if the hospital succumbs to pressure. It doesn't mean it didn't make the decision. The hospital made the decision. And this goes back to why they need a 202 deposition. They know who made the decision.

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Cause No. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.*	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S NOTICE OF INTENTION TO OBTAIN ORAL AND VIDEOTAPED IN-PERSON DEPOSITION OF KELLY NEIDERT

TO: KELLY NEIDERT, 435 Cleve Cole Rd, Denison, TX 75021, and all parties by and through their attorney(s) of records.

PLEASE TAKE NOTICE THAT, under TEXAS RULES OF CIVIL PROCEDURE 205, Plaintiff Ximena Lopez, M.D. intends to subpoena Kelly Neidert for oral videotaped deposition testimony to occur at the Law Offices of Malouf & Nockels LLP, 12720 Hillcrest Rd., Suite 1045, Dallas, TX 75230 on June 30, 2022 at 2:00 p.m. Kelly Neidert is simultaneously being served with a subpoena with this notice.

I.
APPLICABLE RULES

The deposition is being taken under the Texas Rules of Civil Procedure and Texas Rules of Evidence for all purposes allowed by such Rules.

II.
COURT REPORTER

The deposition will be stenographically recorded by a certified shorthand reporter from the firm of Corona Court Reporting, P.O. Box 191528, Dallas, TX 75219, phone:(214) 528-7912, or a like qualified individual.

III.

Non-Stenographic Recordation

Pursuant to Texas Rule of Civil Procedure 199.1(c), Plaintiff hereby gives notice of her intention that, in addition to stenographic recordation, the deposition will be videotaped.

Plaintiff's intent to videotape the deposition is subject to change, so if any other party wishes to videotape the deposition such party should make its own independent arrangements and give the proper notice of such intention.

The videotape recording will be made by Sideris Litigation Support, 4553 Hawkhurst Dr., Plano, TX 75204, (214) 215-3684, or a like qualified individual.

The original of the videotape will remain in the above operator's possession, subject to inspection by any parties, at the above address upon reasonable notice. In the event that any party desires a copy of the videotape(s), it will be delivered to an independent videotape transfer company for copying, at requestor's expense.

Respectfully submitted,

/s/ Charla G. Aldous

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ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 22, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

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Cause No. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.*	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S NOTICE OF INTENTION TO OBTAIN ORAL VIDEOTAPED IN-PERSON DEPOSITION OF NATALIE CATO

TO: NATALIE CATO, 1023 Kingston Dr., Mansfield, TX 76063-2661, and all parties by and through their attorney(s) of records.

PLEASE TAKE NOTICE THAT, under TEXAS RULES OF CIVIL PROCEDURE 205, Plaintiff Ximena Lopez, M.D. intends to subpoena Natalie Cato for oral videotaped deposition testimony to occur at the Law Offices of Malouf & Nockels LLP, 12720 Hillcrest Rd., Suite 1045, Dallas, TX 75230 on June 30, 2022 at 10:00 a.m. Natalie Cato is simultaneously being served with a subpoena with this notice.

I.
APPLICABLE RULES

The deposition is being taken under the Texas Rules of Civil Procedure and Texas Rules of Evidence for all purposes allowed by such Rules.

II.
COURT REPORTER

The deposition will be stenographically recorded by a certified shorthand reporter from the firm of Corona Court Reporting, P.O. Box 191528, Dallas, TX 75219, phone:(214) 528-7912, or a like qualified individual.

III.

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Pursuant to Texas Rule of Civil Procedure 199.1(c), Plaintiff hereby gives notice of her intention that, in addition to stenographic recordation, the deposition will be videotaped.

Plaintiff's intent to videotape the deposition is subject to change, so if any other party wishes to videotape the deposition such party should make its own independent arrangements and give the proper notice of such intention.

The videotape recording will be made by Sideris Litigation Support, 4553 Hawkhurst Dr., Plano, TX 75204, (214) 215-3684, or a like qualified individual.

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Respectfully submitted,

/s/ Charla G. Aldous

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ATTORNEYS FOR PLAINTIFF XIMENA LOPEZ, M.D.

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on June 22, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

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Sha'Huni Robinson on behalf of Charla Aldous
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Associated Case Party: CHILDREN'S MEDICAL CENTER AT DALLAS

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Associated Case Party: THE STATE OF TEXAS

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CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff,* v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.* and THE STATE OF TEXAS, *Intervenor.*	IN THE COUNTY COURT AT LAW NO. 2 DALLAS COUNTY, TEXAS

ORDER GRANTING PLAINTIFF XIMENA LOPEZ, M.D.'S MOTION TO STRIKE STATE'S PETITION IN INTERVENTION

On June 17, 2022, the Court heard Plaintiff Ximena Lopez, M.D.'s Original and Amended *Special Exceptions, and, in the Alternative, Motion to Strike Petition in Intervention* (together "Plaintiff's Motion"). After considering the motions, the responses, the arguments of counsel, the evidentiary record before the Court as set forth in the temporary restraining order hearing, and for the reasons stated on the record, the Court GRANTS Plaintiff's Motion, and finds the following:

1. The State declined the Court's invitation to replead and chose to stand on its Amended Petition in Intervention.

2. The Court finds that the Amended Petition in Intervention suffers from the same defects as the Original Petition and, therefore, there is no prejudice to a party for the Court to consider Plaintiff's Motion.

3. The Court finds the State has failed carry its burden to plead and show that it has a justiciable interest in this lawsuit that is more than contingent or remote, and therefore the State does not meet the test for intervention.

4. The Court finds that the Attorney General's office failed to establish its authority or standing to intervene in this matter in the name of the State as there are no state actors at issue and the issues in this case do not challenge the constitutionality of any law or otherwise jeopardize the State's uniform application of its laws.

5. The Court finds that the State has failed to meet its burden to show any state interest implicated by the issues in this matter that would give rise to standing or a justiciable interest of the State to intervene, and therefore the intervention is not essential and would complicate this case by an excessive multiplication of the issues. The State elected to not cure or otherwise would be unable to cure the failure to show any state interest at issue in this case based on the record before this Court.

6. The Court finds that the State has failed to meet its burden to show any state law implicated by the issues in this matter that would give rise to standing or a justiciable interest of the State to intervene, and therefore the intervention is not essential and would complicate this case by an excessive multiplication of the issues. The State elected to not cure or otherwise would be unable to cure the failure to show any state law at issue in this case based on the record before this Court.

7. The Court further finds that, as Plaintiff non-suited her counterclaims against the State, the State has no justiciable interest in this matter as a counter-defendant.

For any of these foregoing reasons, singularly or collectively, it is therefore ORDERED that the Court exercises its broad discretion and GRANTS Plaintiff's Motion to Strike the State's Petition in Intervention.

It is further ORDERED that the State's Petition in Intervention be Stricken and that the State be removed from the court's docket and service list as an intervening party in this case.

It is so Ordered.

Signed: July 7, 2022

HON. MELISSA BELLAN,
Presiding Judge of County Court at Law No. 2
Dallas County, Texas

AGREED AS TO FORM ONLY:

/s/ Brent R. Walker
BRENT R. WALKER
Counsel for Plaintiff Ximena Lopez, M.D.

/s/ Courtney Corbello
COURTNEY CORBELLO
Counsel for Intervenor The State of Texas

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiffs,* v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendants.*	IN THE COUNTY COURT OF LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S NOTICE OF INTENTION TO OBTAIN ORAL VIDEOTAPED IN-PERSON DEPOSITION OF JOHN J. WARNER, MD

To: JOHN J. WARNER, MD, by and through his attorney of record, TIM REYNOLDS of STEED LAW FIRM at 1717 Main Street, Suite 2950, Dallas, Texas 75201.

Plaintiffs' counsel intends to take the oral videotaped in-person deposition of JOHN J. WARNER, MD beginning at **10:00 a.m.** Central Time on **Monday, October 24, 2022** at the offices of STEED LAW FIRM at 1717 Main Street, Suite 2950, Dallas, Texas 75201, or a mutually agreed upon location. You are invited to attend and examine the witness.

I.
APPLICABLE RULES

The deposition is being taken under the Texas Rules of Civil Procedure and Texas Rules of Evidence for all purposes allowed by such Rules.

II.
COURT REPORTER

The deposition will be stenographically recorded by a certified shorthand reporter from the firm of Corona Court Reporting, P.O. Box 191528, Dallas, TX 75219, (214) 528-7912, or a like qualified individual.

III.

Non-Stenographic Recordation

Pursuant to Texas Rule of Civil Procedure 199.1(c), Plaintiffs hereby give notice of their intention that, in addition to stenographic recordation, the deposition will be videotaped.

Plaintiffs' intent to videotape the deposition is subject to change, so if any other party wishes to videotape the deposition such party should make its own independent arrangements and give the proper notice of such intention.

The videotape recording will be made by Sideris Litigation Support, 4553 Hawkhurst Dr., Plano, TX 75204, (214) 215-3684, or a like qualified individual.

The original of the videotape will remain in the above operator's possession, subject to inspection by any parties, at the above address upon reasonable notice. In the event that any party desires a copy of the videotape(s), it will be delivered to an independent videotape transfer company for copying, at requestor's expense.

Respectfully submitted,

/s/ Charla G. Aldous

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Attorneys for Plaintiffs

* * *

Certificate of Service

I certify that this document is being served on all counsel of record via electronic mail on July 12, 2022.

/s/ Charla G. Aldous
Charla G. Aldous

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiffs,* v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendants.*	IN THE COUNTY COURT OF LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S NOTICE OF INTENTION TO OBTAIN ORAL VIDEOTAPED IN-PERSON DEPOSITION OF DANIEL K. PODOLSKY, MD

To: DANIEL K. PODOLSKY, MD, by and through his attorney of record, TIM REYNOLDS of STEED LAW FIRM at 1717 Main Street, Suite 2950, Dallas, Texas 75201.

Plaintiffs' counsel intends to take the oral videotaped in-person deposition of DANIEL K. PODOLSKY, MD beginning at **10:00 a.m.** Central Time on **Wednesday, October 12, 2022** at the offices of STEED LAW FIRM at 1717 Main Street, Suite 2950, Dallas, Texas 75201, or a mutually agreed upon location. You are invited to attend and examine the witness.

I.
APPLICABLE RULES

The deposition is being taken under the Texas Rules of Civil Procedure and Texas Rules of Evidence for all purposes allowed by such Rules.

II.
COURT REPORTER

The deposition will be stenographically recorded by a certified shorthand reporter from the firm of Corona Court Reporting, P.O. Box 191528, Dallas, TX 75219, (214) 528-7912, or a like qualified individual.

III.

Non-Stenographic Recordation

Pursuant to Texas Rule of Civil Procedure 199.1(c), Plaintiffs hereby give notice of their intention that, in addition to stenographic recordation, the deposition will be videotaped.

Plaintiffs' intent to videotape the deposition is subject to change, so if any other party wishes to videotape the deposition such party should make its own independent arrangements and give the proper notice of such intention.

The videotape recording will be made by Sideris Litigation Support, 4553 Hawkhurst Dr., Plano, TX 75204, (214) 215-3684, or a like qualified individual.

The original of the videotape will remain in the above operator's possession, subject to inspection by any parties, at the above address upon reasonable notice. In the event that any party desires a copy of the videotape(s), it will be delivered to an independent videotape transfer company for copying, at requestor's expense.

Respectfully submitted,

/s/ Charla G. Aldous

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Attorneys for Plaintiffs

* * *

Certificate of Service

I certify that this document is being served on all counsel of record via electronic mail on July 12, 2022.

/s/ Charla G. Aldous
Charla G. Aldous

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiffs,* v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendants.*	IN THE COUNTY COURT OF LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S NOTICE OF INTENTION TO OBTAIN ORAL VIDEOTAPED IN-PERSON DEPOSITION OF STEPHEN SKAPEK, MD

To: STEPHEN SKAPEK, MD, by and through his attorney of record, TIM REYNOLDS of STEED LAW FIRM at 1717 Main Street, Suite 2950, Dallas, Texas 75201.

Plaintiffs' counsel intends to take the oral videotaped in-person deposition of STEPHEN SKAPEK, MD beginning at **10:00 a.m.** Central Time on **Thursday, October 20, 2022** at the offices of STEED LAW FIRM at 1717 Main Street, Suite 2950, Dallas, Texas 75201, or a mutually agreed upon location. You are invited to attend and examine the witness.

I.
APPLICABLE RULES

The deposition is being taken under the Texas Rules of Civil Procedure and Texas Rules of Evidence for all purposes allowed by such Rules.

II.
COURT REPORTER

The deposition will be stenographically recorded by a certified shorthand reporter from the firm of Corona Court Reporting, P.O. Box 191528, Dallas, TX 75219, (214) 528-7912, or a like qualified individual.

III.

Non-Stenographic Recordation

Pursuant to Texas Rule of Civil Procedure 199.1(c), Plaintiffs hereby give notice of their intention that, in addition to stenographic recordation, the deposition will be videotaped.

Plaintiffs' intent to videotape the deposition is subject to change, so if any other party wishes to videotape the deposition such party should make its own independent arrangements and give the proper notice of such intention.

The videotape recording will be made by Sideris Litigation Support, 4553 Hawkhurst Dr., Plano, TX 75204, (214) 215-3684, or a like qualified individual.

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Respectfully submitted,

/s/ Charla G. Aldous

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Attorneys for Plaintiffs

* * *

Certificate of Service

I certify that this document is being served on all counsel of record via electronic mail on July 12, 2022.

/s/ Charla G. Aldous
Charla G. Aldous

CAUSE NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiffs,* v. CHILDREN'S MEDICAL CENTER AT DALLAS, *Defendant.*	IN THE COUNTY COURT OF LAW NO. 2 DALLAS COUNTY, TEXAS

PLAINTIFF'S FIRST AMENDED NOTICE OF INTENTION TO OBTAIN ORAL VIDEOTAPED IN-PERSON DEPOSITION OF DAI H. CHUNG, MD

To: DAI H. CHUNG, MD, by and through his attorney of record, TIM REYNOLDS of STEED LAW FIRM at 1717 Main Street, Suite 2950, Dallas, Texas 75201.

Plaintiffs' counsel intends to take the oral videotaped in-person deposition of DAI H. CHUNG, MD beginning at **10:00 a.m.** Central Time on **Thursday, October 27, 2022** at the UT Southwestern campus, details to be determined. You are invited to attend and examine the witness.

I.
APPLICABLE RULES

The deposition is being taken under the Texas Rules of Civil Procedure and Texas Rules of Evidence for all purposes allowed by such Rules.

II.
COURT REPORTER

The deposition will be stenographically recorded by a certified shorthand reporter from the firm of Corona Court Reporting, P.O. Box 191528, Dallas, TX 75219, (214) 528-7912, or a like qualified individual.

III.

Non-Stenographic Recordation

Pursuant to Texas Rule of Civil Procedure 199.1(c), Plaintiffs hereby give notice of their intention that, in addition to stenographic recordation, the deposition will be videotaped.

Plaintiffs' intent to videotape the deposition is subject to change, so if any other party wishes to videotape the deposition such party should make its own independent arrangements and give the proper notice of such intention.

The videotape recording will be made by Sideris Litigation Support, 4553 Hawkhurst Dr., Plano, TX 75204, (214) 215-3684, or a like qualified individual.

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Respectfully submitted,

/s/ Charla G. Aldous

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ATTORNEYS FOR PLAINTIFFS

* * *

CERTIFICATE OF SERVICE

I certify that this document is being served on all counsel of record via electronic mail on July 14, 2022.

/s/ Charla G. Aldous
CHARLA G. ALDOUS

NO. CC-22-02427-B

XIMENA LOPEZ, M.D., *Plaintiff*, **v.** **CHILDREN'S MEDICAL CENTER AT DALLAS,** *Defendant*.	**IN THE COUNTY COURT AT LAW** **NO. 2** **DALLAS COUNTY, TEXAS**

INTERVENOR'S NOTICE OF ACCELERATED INTERLOCUTORY APPEAL

Intervenor the State of Texas hereby files this Notice of Appeal.

The State of Texas filed its Petition in Intervention pursuant to Texas Rule of Civil Procedure 60 in this case on May 17, 2022.

On May 23, 2022, Plaintiff filed her Answer to the State of Texas's Petition in Intervention and Counterclaims. Plaintiff's counterclaims against the State include a motion for the Attorney General to show authority to intervene in this lawsuit, relief pursuant to the Declaratory Judgment Act (Texas Civil Practices and Remedies Code § 37.004(a)) seeking three declarations from the Court, and attorneys' fees and court costs against the State. In addition, Plaintiff sued for sanctions against Attorney General Ken Paxton, alleging the State's intervention was "groundless and brought in bad faith".

As a result of Plaintiff's Original Complaint and Plaintiff's Answer and Counterclaims, the State filed its Plea to the Jurisdiction on June 14, 2022, arguing that this Court lacks jurisdiction over the Plaintiff's claims and counterclaims because the State had not waived its immunity from suit when it intervened in this suit, decisions by the governing boards of private hospitals relating to clinical privileges are not subject to judicial review, and Plaintiff lacks standing to bring claims on behalf of unidentified third-party patients.

On June 17, 2022, at a hearing on Plaintiff's Motion to Strike State's Petition in Intervention, the State asked the trial court to first consider the issue of whether it had jurisdiction before considering the motion to strike. The trial court refused, thereby implicitly denying the motion. See *Abbott v. Jenkins*, No. 05-21-00733-CV, 2021 WL 5445813, at *5 (Tex. App.—Dallas Nov. 22, 2021, pet. filed).

On July 7, 2022, the Court issued an Order striking the State's intervention in this suit.

Defendants are entitled to an interlocutory appeal pursuant to Civil Practice and Remedies Code section 51.014(a)(8), which allows for an immediate appeal from an order that grants or denies a plea to the jurisdiction by a governmental unit. Defendants appeal to the Fifth Court of Appeals. This is an accelerated appeal as provided by Texas Rule of Appellate Procedure 28.1. This is not a parental termination or child protection case, as defined in Rule 28.4.

Pursuant to Texas Civil Practice and Remedies Code § 51.014(b), all further proceedings in this court are stayed pending resolution of the State's appeal. Pursuant to section 6.001, as governmental officers/entities, Defendant is not required to file a supersedeas bond for court costs. Defendant's appeal is therefore perfected upon the filing of the notice of appeal.

Respectfully submitted.

Ken Paxton
Attorney General of Texas

Brent Webster
First Assistant Attorney General

Grant Dorfman
Deputy First Assistant Attorney General

Shawn Cowles
Deputy Attorney General for Civil Litigation

Christopher Hilton
Chief, General Litigation Division

/s/ Courtney Corbello
Courtney Corbello
Attorney-in-Charge
Assistant Attorney General
Texas State Bar No. 24097533
Courtney.Corbello@oag.texas.gov

/s/ Johnathan Stone
Johnathan Stone
Assistant Attorney General
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General Litigation Division
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Attorneys for Intervenor

CERTIFICATE OF SERVICE

I, **Johnathan Stone**, Assistant Attorney General of Texas, hereby certify that a true and correct copy of the foregoing document has been served electronically through the electronic-filing manager in compliance with TRCP 21a and Tex. R. App. P. 9.5(e) on July 13, 2022, to:

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Counsel for Defendant

/s/ Johnathan Stone
Johnathan Stone
Assistant Attorney General

Automated Certificate of eService

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Associated Case Party: CHILDREN'S MEDICAL CENTER AT DALLAS

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Associated Case Party: THE STATE OF TEXAS

Name
Johnathan Stone

Automated Certificate of eService

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thomas.ray@oag.texas.gov
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Associated Case Party: THE STATE OF TEXAS

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Associated Case Party: Kelly Neidert

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The New York Times https://www.nytimes.com/2021/05/11/well/family/what-are-puberty-blockers.html

What Are Puberty Blockers?

Recent conservative legislation has targeted a class of drugs used to treat transgender adolescents. But what do these drugs actually do?

By Lena Wilson
May 11, 2021

When Sebastian Liafsha came out as transgender in middle school, his mother, Heather, jumped into research mode.

Ms. Liafsha, a registered nurse in Lexington, S.C., put together a three-inch-thick binder packed with printouts of various laws, medical guidelines, pharmaceutical records and more. It was there that she would record the dates and details of Sebastian's puberty blocker injections every three months for two and a half years, starting at age 14.

As a child who had never truly understood himself to be a girl, female puberty felt like an obstacle on Mr. Liafsha's journey to manhood.

For Mr. Liafsha, now 19, puberty blockers not only paused the development of unwanted secondary sexual characteristics like breasts and a menstrual cycle, they gave him and his family time to continue his social transition (the process of presenting and living as the desired gender) and prepare for any future medical interventions.

"Before he started his transition, there were just a few months where puberty hit him, and he was off the wall," Ms. Liafsha recalled. "He became really depressed."

Puberty blockers helped to increase Sebastian's confidence and happiness as an adolescent, which Ms. Liafsha likes to illustrate by pointing to her son's life in the theater. In middle school, she said, he had always hidden in the ensemble, but by 10th grade — after two years on puberty blockers — he had flourished into a leading man.

Lately, puberty blockers have become a subject of debate in state legislatures, as lawmakers across the country introduce bills to limit health care options for transgender youth. Legislators in Arkansas already passed such a law, although Gov. Asa Hutchinson vetoed it last month. Arkansas conservatives argued that "the risks of gender transition procedures far outweigh any benefit at this stage of clinical study on these procedures." But medical experts say that's not the case.

Among the significant benefits of puberty blockers are a reduction in suicidal tendencies, which are often high in transgender adolescents, and a reduced need for expensive gender-affirming operations as adults. But while puberty blockers are commonly referred to as "fully reversible," more research is needed to fully understand the impact they may have on certain patients' fertility. There is also little known about the drugs' lasting effects on brain development and bone mineral density.

Transgender youth have been the focus of new laws in states including Mississippi and Idaho, and pending in many others, designed to restrict their participation in sports — but this debate is largely separate from the discussion of puberty blockers.

Because the use of puberty blockers in transgender kids is still relatively new, the information is developing.

Here is a roundup of what experts know so far.

What are puberty blockers?

Puberty blockers are medications that suppress puberty by halting the production of estrogen or testosterone. They can stop transgender kids from experiencing the effects of puberty that may not align with their gender identities. Medically, the class of medications are called gonadotropin-releasing hormone agonists, or GnRH agonists. They are approved by the Food and Drug Administration to treat precocious puberty — puberty occurring at an unusually early age — so when they are prescribed to treat transgender youth, it's considered an off-label use.

"Off-label," the American Academy of Pediatrics noted in a 2014 statement, "does not imply an improper, illegal, contraindicated or investigational use" — it merely refers to the process of F.D.A. approval.

Ms. Liafsha recorded details about Sebastian's puberty blockers in her binder, including date and time of injection, site of injection on the body, dosage and type of needle used. Leslie Ryann McKellar for The New York Times

The medications may be given as shots in a doctor's office every one, three or six months, or as an implant which lasts for about a year. Dr. Jessica Kremen, a pediatric endocrinologist for Boston Children's Hospital's Gender Multispecialty Service, noted that patients and families may prefer the convenience of the implants or six-month shots.

"It depends a lot on what is obtainable through a patient's insurance," Dr. Kremen said. Insurance companies are reluctant to cover off-label drug treatments, and implants can run up to approximately $45,000 per implant out of pocket, while shots cost can cost thousands of dollars per dose.

"That often determines which form we ended up using," Dr. Kremen said. "But they all work well, as long as you administer them on time."

How do they work?

Typically, in puberty, gonadotropin-releasing hormone helps to produce follicle-stimulating hormone (FSH) and luteinizing hormone (L.H.). In people assigned female at birth, these hormones prompt the ovaries to make estrogen, which promotes processes like breast growth and menstruation. In people assigned male at birth, they prompt the testes to make testosterone, which promotes processes like facial hair growth and a deepening of the voice.

Puberty blockers disrupt the production of FSH and L.H., therefore blocking the production of estrogen or testosterone. As a result, transgender adolescents do not continue to develop unwanted secondary sexual characteristics — transgender boys do not develop breasts and transgender girls do not develop facial hair, for example.

Puberty blockers do not stop an early stage in sexual maturation called adrenarche, which can cause acne, the growth of underarm and pubic hair and body odor.

Who can get puberty blockers?

Although parents might think they should start puberty blockers very young, so that a child never has to experience any physical changes associated with the unwanted gender, experts say it's better to wait at least until the early stages of puberty have started. Dr. Stephen Rosenthal, medical director of the child and adolescent gender center for U.C.S.F. Benioff Children's Hospitals, was a co-author of the Endocrine Society's 2017 guidelines for transgender health care. He recommended starting puberty blockers when breast budding or the enlargement of the testes has begun, at the earliest.

That's because Dr. Rosenthal does not recommend puberty blockers for prolonged use outside of the normal window of puberty. They restrict the functioning of the gonads, which may lead to adverse health effects. The longer blockers are used past the typical start of puberty — generally age 14, at the latest — the greater the possible risk.

When blockers are initiated in the early stages of puberty, Dr. Rosenthal typically suggests that his patients stop using them by age 14. At that point, patients, with their families and their doctors, can determine whether to introduce hormones that help them develop according to their gender identity or resume puberty in the gender assigned at birth.

Dr. Rosenthal further recommended that before starting blockers, children be evaluated by a mental health professional and determined to have gender dysphoria. He said families should also undergo a thorough process of informed consent, during which they are educated about the potential effects of blocking puberty — including adverse ones.

The World Professional Association for Transgender Health's guidelines for medical care suggest that "before any physical interventions are considered for adolescents, extensive exploration of psychological, family and social issues should be undertaken." Professionals emphasized mental health care as an integral part of the process.

What are the benefits?

Treatment with puberty blockers may improve the mental health of transgender adolescents, who are at high risk for suicide. A 2020 study found lower odds of lifetime suicidal ideation in transgender adults who wanted to take puberty blockers and were able to access this treatment. Another recent study showed similarly positive effects: transgender

adolescents receiving puberty blockers had less “emotional and behavioral problems” than transgender adolescents recently referred to care, and also reported rates of self-harm and suicidality similar to those of their non-transgender peers. A 2020 study of 50 transgender adolescents indicated that puberty blockers and gender-affirming hormone treatments, or both, could positively impact quality of life and decrease depression and suicidal ideation. A 2014 study found that 55 young transgender adults who used puberty blockers, took gender-affirming hormones and had gender confirmation surgeries were able to “resolve” their gender dysphoria and showed overall well-being “in many respects comparable to peers.”

When Mr. Liafsha was an adolescent, puberty blockers helped to increase his confidence. After years in his school’s ensemble theater casts, he became a leading man. Leslie Ryann McKellar for The New York Times

Because puberty blockers halt the development of secondary sexual characteristics, transgender adolescents who take them before gender-affirming hormones may also be able to avoid future gender-affirming procedures. For instance, transgender men who don’t develop breasts wouldn’t have reason to have mastectomies, while transgender women who don’t develop masculine facial features might no longer choose to have facial feminization surgery.

What are the risks?

Puberty blockers are largely considered safe for short-term use in transgender adolescents, with known side effects including hot flashes, fatigue and mood swings. But doctors do not yet know how the drugs could affect factors like bone mineral density, brain development and fertility in transgender patients.

The Endocrine Society recommends lab work be done regularly to measure height and weight, bone health and hormone and vitamin levels while adolescents are taking puberty blockers.

A handful of studies have underscored low bone mineral density as a potential issue, though a 2020 study posited that low bone mineral density may instead be a pre-existing condition in transgender youth. Treatment with gender-affirming hormones may theoretically reverse this effect, according to Endocrine Society guidelines.

The impact of puberty blockers on brain development is similarly hazy. The Endocrine Society guidelines point to two studies: A small one published in 2015 showed that the drugs did not seem to impact executive functioning (cognitive processes including self-control and working memory), while a 2017 study of rams treated with GnRH agonists suggested chronic use could harm long-term spatial memory. (Of course, rams are not humans.)

The effects of puberty blockers are often referred to as “fully reversible,” including in both the Endocrine Society and WPATH guidelines, because of evidence showing that girls treated for precocious puberty were still able to undergo normal puberty and have children later in life.

While much of the data gleaned from precocious puberty treatments are applicable to transgender patients, Dr. Kremen said, “you’re asking a different question for precocious puberty than you are for a transgender child” when it comes to fertility. Halting puberty at its onset and then later starting gender-affirming hormones — a typical course for some transgender adolescents — may affect the ability to have children, she said. The Endocrine Society advises clinicians to counsel patients on “options for fertility preservation prior to initiating puberty suppression in adolescents.”

It is also worth noting that Lupron, one of the drugs widely used as a puberty blocker, has been reported to have long-term adverse effects in women who used it to treat precocious puberty. Women have reported issues including depression, bone thinning and chronic pain.

Puberty blockers may also impact future gender-affirming surgeries for transgender women. A recent study showed that transgender women who began puberty blockers at the start of puberty were 84 times more likely to require abdominal surgery if they wanted to pursue gender-affirming surgery. Because tissue from the penis and testes is used to construct a neovagina, and puberty blockers prevent the growth of those organs, material from the colon or omentum may need to be used.

An in-depth conversation detailing puberty blocker treatment and all its potential effects is an essential part of any transgender adolescent’s care. Specialists are eager for more

research, but for now, they say the apparent benefits outweigh the hypothetical risks.

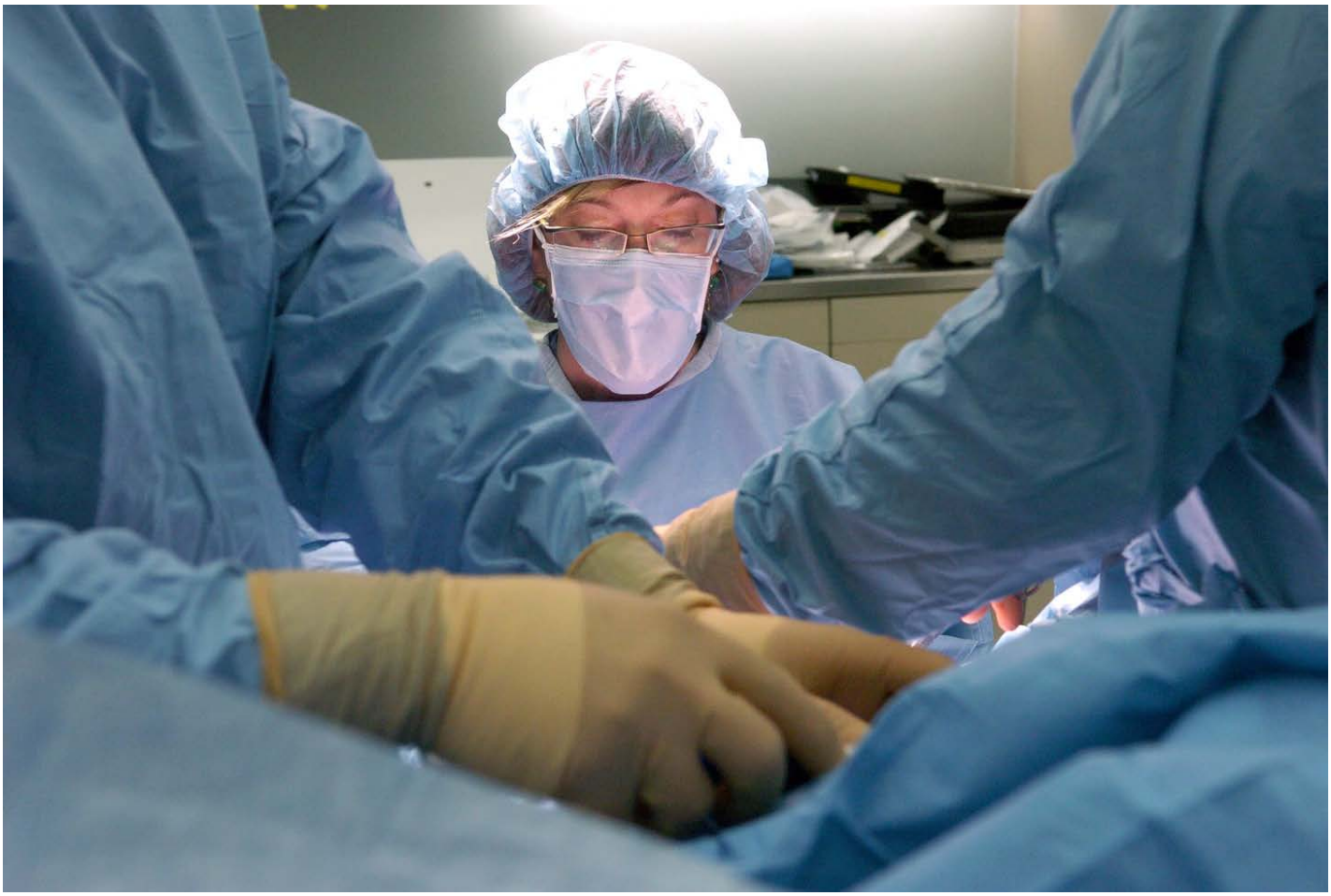
“Medications are rarely without side effects,” Dr. Kremen said. “That is usually not enough of a reason to allow a child, who is telling you that they’re extremely distressed by the pubertal changes that they’re seeing, to continue going through puberty.”

“Knowing what we do know, these medications have enormous benefits for the population that we care for,” she added.

Top Trans Doctors Blow the Whistle on ‘Sloppy’ Care

In exclusive interviews, two prominent providers sound off on puberty blockers, 'affirmative' care, the inhibition of sexual pleasure, and the suppression of dissent in their field.

Abigail Shrier
Oct 4, 2021



Dr. Marci Bowers performs gender reassignment surgery in Trinada’ss Mount San Rafael Hospital. (Glenn Asakawa/The Denver Post via Getty Images)

For nearly a decade, the vanguard of the transgender-rights movement — doctors, activists, celebrities and transgender influencers — has defined the boundaries of the new orthodoxy surrounding transgender medical care: What’s true, what’s false, which questions can and cannot be asked.

They said it was perfectly safe to give children as young as nine puberty blockers and insisted that the effects of those blockers were "fully reversible." They said that it was the job of medical professionals to help minors to transition. They said it was not their job to question the wisdom of transitioning, and that anyone who did — including parents — was probably transphobic. They said that any worries about a social contagion among teen girls was nonsense. And they never said anything about the distinct possibility that blocking puberty, coupled with cross-sex hormones, could inhibit a normal sex life.

Their allies in the media and Hollywood reported stories and created content that reaffirmed this orthodoxy. Anyone who dared disagree or depart from any of its core tenets, including young women who publicly detransitioned, were inevitably smeared as hateful and accused of harming children.

But that new orthodoxy has gone too far, according to two of the most prominent providers in the field of transgender medicine: Dr. Marci Bowers, a world-renowned vaginoplasty specialist who operated on reality-television star Jazz Jennings; and Erica Anderson, a clinical psychologist at the University of California San Francisco's Child and Adolescent Gender Clinic.

In the course of their careers, both have seen thousands of patients. Both are board members of the World Professional Association for Transgender Health (WPATH), the organization that sets the standards worldwide for transgender medical care. And both are transgender women.

Earlier this month, Anderson told me she submitted a co-authored op-ed to The New York Times warning that many transgender healthcare providers were treating kids recklessly. The Times passed, explaining it was "outside our coverage priorities right now."

Over the past few weeks, I have spoken at length to both women about the current direction of their field and where they feel it has gone wrong. On some issues, including their stance on puberty blockers, they raised concerns that appear to question the current health guidelines set by WPATH — which Bowers is slated to lead starting in 2022.

WPATH, for instance, recommends that for many gender dysphoric and gender non-conforming kids, hormonal puberty suppression begin at the early stages of puberty. WPATH has also insisted since 2012 that puberty blockers are "fully reversible interventions."

When I asked Anderson if she believes that psychological effects of puberty blockers are reversible, she said: "I'm not sure." When asked whether children in the early stages of

puberty should be put on blockers, Bowers said: "I'm not a fan."

When I asked Bowers if she still thought puberty blockers were a good idea, from a surgical perspective, she said: "This is typical of medicine. We zig and then we zag, and I think maybe we zigged a little too far to the left in some cases." She added "I think there was naivete on the part of pediatric endocrinologists who were proponents of early [puberty] blockade thinking that just this magic can happen, that surgeons can do anything."

I asked Bowers whether she believed WPATH had been welcoming to a wide variety of doctors' viewpoints — including those concerned about risks, skeptical of puberty blockers, and maybe even critical of some of the surgical procedures?

"There are definitely people who are trying to keep out anyone who doesn't absolutely buy the party line that everything should be affirming, and that there's no room for dissent," Bowers said. "I think that's a mistake."

Bowers is not only among the most respected gender surgeons in the world but easily one of the most prolific: she has built or repaired more than 2,000 vaginas, the procedure known as vaginoplasty. She rose to celebrity status appearing on the hit reality-television show "I Am Jazz," which catalogues and choreographs the life of Jazz Jennings, arguably the country's most famous transgender teen.

In January 2019, Jeanette Jennings threw her famous daughter a "Farewell to Penis" party. Over a million viewers looked in on guests feasting on meatballs and miniature wieners in the Jennings' Mediterranean-style Florida home. Family and friends cheered as Jazz sliced into a penis-shaped cake. The rather complicated upcoming procedure came to seem as little more than a Sweet Sixteen.

By that point, Jazz was already Time magazine's top 25 most influential teen, the co-author of a bestselling children's book and the inspiration for a plastic doll. She had served as youth ambassador to the Human Rights Campaign, and she had about one million Instagram followers. Hers was no longer just a personal story but an advertisement for a lifestyle and an industry.

On the day of the procedure — dutifully recorded for Instagram — Jazz's sister, Ari, teasingly wiggled a sausage in front of the camera. As Jazz was about to be wheeled into the operating room, she snapped her fingers and said, "Let's do this!"

The vaginoplasty she underwent is what surgeons call a "penile inversion," in which surgeons use the tissue from the penis and testicles to create a vaginal cavity and clitoris. With grown men, a penile inversion was eminently doable. With Jazz, it was much more difficult.

Like thousands of adolescents in America treated for gender dysphoria (severe discomfort in one's biological sex), Jazz had been put on puberty blockers. In Jazz's case, they began at age 11. So at age 17, Jazz's penis was the size and sexual maturity of an 11-year-old's. As Bowers explained to Jazz and her family ahead of the surgery, Jazz didn't have enough penile and scrotal skin to work with. So Bowers took a swatch of Jazz's stomach lining to complement the available tissue.

At first, Jazz's surgery seemed to have gone fine, but soon after she said experienced "crazy pain." She was rushed back to the hospital, where Dr. Jess Ting was waiting. "As I was getting her on the bed, I heard something go pop," Ting said in an episode of "I Am Jazz." Jazz's new vagina — or neovagina, as surgeons say — had split apart.

Gender dysphoria, which Jazz had suffered from since age two, is very real, and by all accounts, excruciating. For the nearly 100-year diagnostic history of gender dysphoria, it overwhelmingly afflicted boys and men, and it began in early childhood (ages two to four). According to the DSM-V, the latest edition of the historical rate of incidence was .01 percent of males (roughly one in 10,000).

For decades, psychologists treated it with "watchful waiting" — that is, a method of psychotherapy that seeks to understand the source of a child's gender dysphoria, lessen its intensity, and ultimately help a child grow more comfortable in her own body.

Since nearly seven in 10 children initially diagnosed with gender dysphoria eventually outgrew it — many go on to be lesbian or gay adults — the conventional wisdom held that, with a little patience, most kids would come to accept their bodies. The underlying assumption was children didn't always know best.

But in the last decade, watchful waiting has been supplanted by "affirmative care," which assumes children *do* know what's best. Affirmative care proponents urge doctors to corroborate their patients' belief that they are trapped in the wrong body. The family is pressured to help the child transition to a new gender identity — sometimes having been told by doctors or activists that, if they don't, their child may eventually commit suicide. From there, pressures build on parents to begin concrete medical steps to help children on their path to transitioning to the "right" body. That includes puberty blockers as a preliminary step. Typically, cross-sex hormones follow and then, if desired, gender surgery.

The widespread use of puberty blockers can be traced to the Netherlands. In the mid-1990s, Peggy Cohen-Kettenis, a psychologist in Amsterdam who had studied young people with gender dysphoria, helped raise awareness about the potential benefits of blockers — formerly used in the chemical castration of violent rapists. Pharmaceutical companies were happy to fund studies on the application of blockers in children, and, gradually, what's called the Dutch Protocol was born. The thinking behind the protocol was: Why make a child who has suffered with gender dysphoria since preschool endure puberty, with all its discomforts and embarrassments, if that child were likely to transition as a young adult? Researchers believed blockers' effects were reversible — just in case the child did not ultimately transition.

Cohen-Kettenis later grew doubtful about that initial assessment. "It is not clear yet how pubertal suppression will influence brain development," she wrote in the European Journal of Endocrinology in 2006. Puberty is not merely a biochemical development; it is also "a psycho-social event that occurs in concert with one's peers," Doctor William Malone, an endocrinologist and member of the Society for Evidence Based Gender Medicine, told me. Hormones do not merely stimulate sex organs during puberty; they also shower the brain.

But at the very moment when Dutch researchers were beginning to raise concerns about puberty blockers, American health providers discovered it. In 2007, the Dutch Protocol arrived at Boston Children's Hospital, one of the preeminent children's hospitals in the nation. It would soon become the leading course of treatment for all transgender-identified children and adolescents in the United States. One of them was Jazz Jennings.

In 2012, a surgeon implanted a puberty blocker called Supprelin in Jazz's upper arm to delay the onset of facial hair and the deepening of her voice, among other things. Without these

conventional masculine features, it would be easier, down the road, for doctors to make her look more feminine — more like the budding young woman she felt she was deep inside.

At the time, doctors knew less than they do now about the effects of puberty blockers. "When you enter a field like this where there's not a lot of published data, not a lot of studies, the field is in its infancy, you see people sometimes selling protocols like puberty blockers in a dogmatic fashion, like, 'This is just what we do,'" Bowers told me.

Once an adolescent has halted normal puberty and adopted an opposite-sex name, Bowers said: "You're going to go socially to school as a girl, and you've made this commitment. How do you back out of that?"

Another problem created by puberty blockade — experts prefer "blockade" to "blockage" — was lack of tissue, which Dutch researchers noted back in 2008. At that time, Cohen-Kettenis and other researchers noted that, in natal males, early blockade might lead to "non-normal pubertal phallic growth," meaning that "the genital tissue available for vaginoplasty might be less than optimal."

But that hair-raising warning seems to have been lost in the trip across the Atlantic.

Many American gender surgeons augment the tissue for constructing neovaginas with borrowed stomach lining and even a swatch of bowel. Bowers draws the line at the colon. "I never use the colon," she said. "It's the last resort. You can get colon cancer. If it's used sexually, you can get this chronic colitis that has to be treated over time. And it's just in the discharge and the nasty appearance and it doesn't smell like vagina."

The problem for kids whose puberty has been blocked early isn't just a lack of tissue but of sexual development. Puberty not only stimulates growth of sex organs. It also endows them with erotic potential. "If you've never had an orgasm pre-surgery, and then your puberty's blocked, it's very difficult to achieve that afterwards," Bowers said. "I consider that a big problem, actually. It's kind of an overlooked problem that in our 'informed consent' of children undergoing puberty blockers, we've in some respects overlooked that a little bit."

Nor is this a problem that can be corrected surgically. Bowers can build a labia, a vaginal canal and a clitoris, and the results look impressive. But, she said, if the kids are "orgasmically naive" because of puberty blockade, "the clitoris down there might as well be a fingertip and brings them no particular joy and, therefore, they're not able to be responsive as a lover. And so how does that affect their long-term happiness?"

Few, if any, other doctors acknowledge as much. The Mayo Clinic, for instance, does not note that permanent sexual dysfunction may be among puberty blockers' risks. St. Louis Children's Hospital doesn't mention it, either. Oregon Health & Science University Children's Hospital and University of California at San Francisco don't. Nor was there any mention of sexual dysfunction in a recent New York Times story, "What Are Puberty Blockers?"

Jack Turban, the chief fellow in child and adolescent psychiatry at Stanford University School of Medicine, wrote, in 2018: "The only significant side effect is that the adolescent may fall behind on bone density."

But lack of bone density is often just the start of the problem. Patients who take puberty blockers almost invariably wind up taking cross-sex hormones — and this combination tends to leave patients infertile and, as Bowers made clear, sexually dysfunctional.

On an episode of "I Am Jazz," Jazz revealed that she had never experienced an orgasm and may never be able to. But she remains optimistic. "I know that once I fall in love and I really admire another individual that I'm going to want to have sex with them," Jazz said at 16, in an episode that aired in July of 2017.

In the year after her operation, Jazz would require three more surgeries, and then defer Harvard College for a year to deal with her depression. In 2021, she opened up about a binge-eating disorder that caused her to gain nearly 100 pounds in under two years.

Jazz has insisted she has "no regrets" about her transition. (I reached out to Jazz for an interview and never heard back). But subjecting patients to a course of serious interventions that cannot be scrutinized — even by experts — without one risking being tarred as anti-trans seems unlikely to be in anyone's best interest.

Bowers told me she now finds early puberty blockade inadvisable. "I'm not a fan of blockade at Tanner Two anymore, I really am not," she told me, using the clinical name of the moment when the first visible signs of puberty manifest. "The idea all sounded good in the very beginning," she said. "Believe me, we're doing some magnificent surgeries on these kids, and they're so determined, and I'm so proud of so many of them and their parents. They've been great. But honestly, I can't sit here and tell you that they have better — or even as good — results. They're not as functional. I worry about their reproductive rights later. I worry about their sexual health later and ability to find intimacy."

Bowers knows what the loss of fertility and sexual intimacy might entail: She has three children, all born before she transitioned, and she spent a decade tending to victims of female genital mutilation. "Those women, a lot of them experience broken relationships because they cannot respond sexually," she said. "And my fear about these young children who never experience orgasm prior to undergoing surgery are going to reach adulthood and try to find intimacy and realize they don't know how to respond sexually."

In 2007, the year the U.S. began implementing the Dutch Protocol, the U.S. had one pediatric gender clinic, and it overwhelmingly served patients like Jazz: natal males who expressed discomfort in their bodies in the earliest stages of childhood. (At age 2, Jazz reportedly asked Jeanette when the good fairy would turn him into a girl. Jazz's own social transition did not appear to proceed from peer influence and predated social media.)

Today, the U.S. has hundreds of gender clinics. Most patients are not natal males, like Jazz, but teenage girls. I wrote a book about these girls, "Irreversible Damage," which was based on interviews with them and their families. Peer influence and exposure to trans influencers on social media play an outsized role in their desire to escape womanhood. Unlike the patients of the Dutch Protocol, who were screened for other mental health comorbidities, these young women almost always suffer from severe anxiety and depression or other significant mental health problems — and those problems are often overlooked or ignored.

When public health researcher and former Brown University Professor Lisa Littman dubbed this phenomenon "rapid onset gender dysphoria" in 2018, the university apologized for her paper and ultimately pushed her out. Activists called the hypothesis of a social contagion among teen girls a "poisonous lie used to discredit trans people."

But Littman's research about the sudden spike in teen girl trans-identification has become increasingly difficult to deny: A recent survey by the American College Health Association showed that, in 2008, one in 2,000 female undergraduates identified as transgender. By 2021, that figure had jumped to one in 20.

While both Anderson and Bowers pointed out that "ROGD" has yet to be accepted as a diagnosis, Anderson said: "At our clinic at UCSF, for two years now running, we're running two to one natal females to natal males." Two to one.

"As for this ROGD thing," Bowers said, "I think there probably are people who are influenced. There is a little bit of 'Yeah, that's so cool. Yeah, I kind of want to do that too.'"

Anderson agreed that we're likely to see more regret among this teenage-girl population. "It is my considered opinion that due to some of the — let's see, how to say it? what word to choose? — due to some of the, I'll call it just 'sloppy,' sloppy healthcare work, that we're going to have more young adults who will regret having gone through this process. And that is going to earn me a lot of criticism from some colleagues, but given what I see — and I'm sorry, but it's my actual experience as a psychologist treating gender variant youth — I'm worried that decisions will be made that will later be regretted by those making them."

What, exactly, was sloppy about the healthcare work? "Rushing people through the medicalization, as you and others have cautioned, and failure — *abject* failure — to evaluate the mental health of someone historically in current time, and to prepare them for making such a life-changing decision," Anderson said.

I asked Bowers about the rise of detransitioners, young women who have come to regret transitioning. Many said they were given a course of testosterone on their first visit to a clinic like Planned Parenthood. "When you have a female-assigned person and she's feeling dysphoric, or somebody decides that she's dysphoric and says your eating disorders are not really eating disorders, this is actually gender dysphoria, and then they see you for one visit, and then they recommend testosterone — red flag!" Bowers said. "Wake up here."

Abigail Shrier is the author of "Irreversible Damage," which the Economist named one of the best books of 2020. Read more of her work at her newsletter, The Truth Fairy.

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A guest post by

Abigail Shrier

Writer, Author: IRREVERSIBLE DAMAGE: The Transgender Craze Seducing Our Daughters (2020). Named to "Best Books" lists by the Economist, Times of London
philosophicalinvestigations@protonmail.com

224 Comments

Steven N. Oct 4, 2021

At 2 years old, Jazz did not experience gender dysphoria, Jazz's parents did.

♡ 218 Reply Collapse

13 replies

ThinkPieceOfPie Oct 4, 2021

They're not creating a vagina by inverting a penis, anymore than a surgeon is creating a younger person by performing a facelift. At best it's a facsimile, at worst it's a disaster--the necessity for follow up surgeries is very high, from 40-60%, with as noted, limited function. Of course, a child doesn't understand what is at risk when they are 2, or 4 or 11. As Abigail has written elsewhere, some of these adolescent girls having breast amputated & taking testosterone haven't had a first kiss.

♡ 188 Reply Collapse

4 replies

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The mental health establishment is failing trans kids

Gender-exploratory therapy is a key step. Why aren't therapists providing it?

Perspective by Laura Edwards-Leeper and Erica Anderson

November 24, 2021 at 5:54 p.m. EST

CORRECTION

A previous version of this essay said that a quarter of study subjects who reversed their gender transitions did not report this change to their doctors. In fact, three-quarters did not share the information.

At 13, Patricia told her parents she was a transgender boy. She had never experienced any gender dysphoria — distress at a disconnect between gender identity and the sex assigned at birth — she said. But a year earlier, she'd been sexually assaulted by an older girl. Soon after this trauma, she met another older girl who used they/them pronouns and introduced her to drugs, violent pornography and the notion of dissociation from her body. Her lingering psychic wounds, coinciding with a raft of new and unsettling ideas, plunged her into depression and anxiety. Patricia's parents took her to a therapist so she could talk through her shifting identity and acute mood swings.

The job of a mental health provider here should have been clear: Perform an assessment, ask how long she'd experienced dysphoria and investigate how mental health issues and any other changes in her life might be contributing to it. Instead, on first meeting, the therapist simply affirmed her new identity, a step that can lead to hormonal and eventually surgical treatments. Was Patricia ready for these next steps — or, her parents wondered, was this a normal bout of teenage confusion stemming from a recent trauma? The therapist instructed them to "support" their child's trans self-diagnosis and to socially transition her. If they didn't, Patricia might end her own life: 41 percent of unsupported children commit suicide, they were told. Would Patricia's parents rather have a dead child or a trans child?

They sought another therapist, one who was more curious and less certain, one who listened closely. After a year of exploring who she was, Patricia no longer felt she was a boy. She decided to stop binding her breasts and wearing boys' clothes.

We are both psychologists who have dedicated our careers to serving transgender patients with ethical, evidence-based treatment. But we see a surge of gender dysphoria cases like Patricia's — cases that are handled poorly. One of us was the founding psychologist in 2007 of the first pediatric gender clinic in the United States; the other is a transgender woman. We've held recent leadership positions in the World Professional Association for Transgender Health (WPATH), which writes the standards of care for transgender people worldwide. Together, across decades of doing this work, we've helped hundreds of people transition their genders. This is an era of ugly moral panic about bathrooms, woke indoctrination and identity politics in general. In response, we enthusiastically support the appropriate gender-affirming medical care for trans youth, and we are disgusted by the legislation trying to ban it.

But the number of adolescents requesting medical care is skyrocketing: Now 1.8 percent of people under 18 identify as transgender, double the figure from five years earlier, according to the Trevor Project. A flood of referrals to mental health providers and gender medical clinics, combined with a political climate that sees the treatment of each individual patient as a litmus test of social tolerance, is spurring many providers into sloppy, dangerous care. Often from a place of genuine concern, they are hastily dispensing medicine or recommending medical doctors prescribe it — without following the strict guidelines that govern this treatment. Canada, too, is following our lead: A study of 10 pediatric gender clinics there found that half do not require psychological assessment before initiating puberty blockers or hormones.

The standards of care recommend mental health support and comprehensive assessment for all dysphoric youth before starting medical interventions. The process, done conscientiously, can take a few months (when a young person's gender has been persistent and there are no simultaneous mental health issues) or up to several years in complicated cases. But few are trained to do it properly, and some clinicians don't even believe in it, contending without evidence that treating dysphoria medically will resolve other mental health issues. Providers and their behavior haven't been closely studied, but we find evidence every single day, from our peers across the country and concerned parents who reach out, that the field has moved from a more nuanced, individualized and developmentally appropriate assessment process to one where every problem looks like a medical one that can be solved quickly with medication or, ultimately, surgery. As a result, we may be harming some of the young people we strive to support — people who may not be prepared for the gender transitions they are being rushed into.

American opinions about transgender youth have shifted dramatically in the past 15 years. The pendulum has swung from a vile fear and skepticism around ever treating adolescents medically to what must be described, in some quarters, as an overcorrection. Now the treatment pushed by activists, recommended by some providers and taught in many training workshops is to affirm without question. "We don't actually have data on whether psychological assessments lower regret rates," Johanna Olson-Kennedy, a pediatrician at Children's Hospital in Los Angeles who is skeptical of therapy requirements and gives hormones to children as young as 12 (despite a lack of science supporting this practice, as

well), told the Atlantic. “I don’t send someone to a therapist when I’m going to start them on insulin.” This perspective writes off questions about behavioral and mental health, seeing them as a delaying tactic or a dodge, a way of depriving desperate people of the urgent care they clearly need.

But comprehensive assessment and gender-exploratory therapy is the most critical part of the transition process. It helps a young person peel back the layers of their developing adolescent identity and examine the factors that contribute to their dysphoria. In this stage, patients reflect on the duration of the dysphoria they feel; the continuum of gender; the intersection with sexual orientation; what medical interventions might realistically entail; social media, Internet and peer influences; how other factors (e.g., autism, trauma, eating disorders/body image concerns, self-esteem, depression, anxiety) may help drive dysphoria, rather than assuming that they are always a result of dysphoria; family dynamics and social/peer relationships; and school/academic challenges. The messages that teens get from TikTok and other sources may not be very productive for understanding this constellation of issues.

There are several reasons the process can move too quickly and hurtle toward medical treatment. For one, the stigma around mental health in general, along with the trauma caused to transgender adults by the health-care field in the past (yes, including conversion therapy), has made our peers extremely skeptical of becoming “gatekeepers” — experts who deny the needed help because they supposedly know best. Slowing down the process and encouraging deeper, thoughtful exploration is considered, many tell us, unnecessary and unaffirming. Providers may also be afraid of being cast as transphobic bigots by their local colleagues and referral sources if they engage in gender exploring therapy with patients, as some have equated this with conversion therapy. We’ve personally experienced this backlash at professional conferences.

All this means only that the purpose of assessment is improperly understood. The approach WPATH recommends is collaborative and aims to provide a developmentally appropriate process that involves the parents and takes the complexities of adolescence into consideration. (The constituency of agitated parents who feel excluded is also growing rapidly. These are not conservative evangelicals who don’t believe trans people exist or deserve treatment. They’re usually progressive, educated, loving people who all say, *If our kid is really trans, we’ll fully support them. We just want to be as sure as possible, and we can’t find a provider who will actually engage in gender exploring therapy. Instead, doctors and psychologists and social workers are ready to start hormones after one short visit.*)

Another reason that teens can receive substandard mental health care is that gender clinics are disastrously overwhelmed. Most have a single social worker who completes a brief “intake,” relying instead on other mental health clinicians in the community to assess patients and offer their conclusions. Frequently, those community clinicians, just like the parents, assume that a more comprehensive assessment will occur in the gender specialty clinic. But in our experience, and based on what our colleagues share, this is rarely the case. Most clinics appear to assume that a referral means a mental health provider in the community has diagnosed gender dysphoria and thereby given the green light for medical intervention.

When working in gender clinics, we’ve also both received letters from therapists who had “assessed” patients they were referring to us. An astonishing number of these were nothing but

a paragraph that stated the youth identified as trans, had dysphoria and wanted hormones, so that course was recommended. There are nearly 200,000 members of the American Psychological Association and the American Psychiatric Association. Add to that the clinical social workers, marriage counselors and family therapists. The overwhelming majority of those well-intentioned professionals receive limited or no training in the assessment of gender-diverse youth. (We receive requests frequently from people eager for more comprehensive, nuanced trainings, which we both deliver.) In simple terms, the demand for competent care has outstripped the supply of competent providers.

In professional circles, we hear from pediatric endocrinologists and others who prescribe hormones for trans youth. Many openly discuss how they use the adult informed-consent model of care with their teen patients, which almost always means no mental health involvement and sometimes no parent input, either. “If you are trans, I believe you,” says A.J. Eckert, the medical director of Anchor Health Initiative in Connecticut. Eckert is wary of psychologists who follow the guidelines by completing a comprehensive assessment before recommending medical intervention for youths. “Gender-affirming medicine,” Eckert holds, means that “you are best equipped to make decisions about your own body,” full stop. These providers do not always realize they’ve confessed to ignoring the standards of care. (Contacted by The Post for comment on this essay, Eckert said that “no medical or surgical interventions are provided to anyone who has not started puberty” but added that, as Anchor Health sees it, “Therapy is not a requirement in this approach because being trans is not a pathology.”)

Some providers may move quickly because they believe that an adolescent's clarity around their gender identity is no different than that of transgender adults, whose care is now typically based on simple informed consent. Some assume that a person with gender dysphoria who declares they are transgender is transgender and needs medical interventions immediately. Yet we know this is not always true. In a recent study of 100 detransitioners, for instance, 38 percent reported that they believed their original dysphoria had been caused by “something specific, such as trauma, abuse, or a mental health condition.” Fifty-five percent said they “did not receive an adequate evaluation from a doctor or mental health professional before starting transition.”

A handful of studies supposedly showing the suicide risk of gender minority youth who are not supported are also not entirely conclusive. The term “support,” for instance, is defined differently across studies, and it is never defined as “starting medical interventions.” Supporting trans youth may include using the correct name/pronouns or allowing the young person to present in a way that aligns with their affirmed gender (e.g., clothing, hairstyle). These studies also show correlations between teen-transition hurdles and suicidality, but not causal relationships. Suicide is a horrifying outcome for too many gender-diverse youth, but its specter should not be used to push forward unrelated medical treatment without professional care or attention for each patient.

Longer-term longitudinal studies are needed to better understand the role of medical interventions on lifetime psychological health, particularly with the newer subset of adolescents presenting with no childhood dysphoria and significant mental health concerns. Research is needed to help determine whether quick medical treatment or a more cautious approach is best in these cases. Based on our experience with patients, we suspect that there will be variability

based on age, when gender identity questions first emerged and other factors — which is why an individualized approach with careful assessment is so critical.

Trans youth, more than most patients in the health-care system, require an interdisciplinary approach: Their doctors rely on mental health colleagues for direction, and it is crucial that those therapists take the reins. Without proper assessment, many youths are being rushed toward the medical model, and we don't know if they will be liberated or restrained by it. National figures do not yet exist, but the rising number of detransitioners that clinicians report seeing (they are forming support groups online) indicates that this approach can backfire. This is not the most common outcome of a transition process, but it is hardly unheard of, either. These are typically youth who experienced gender dysphoria and other complex mental health issues, rushed to medicalize their bodies and regretted it later. Only a quarter of them told their doctors they had reversed their transitions, making this population especially hard to track.

Many trans activists want to silence detransitioners or deny their existence, because those cases do add fuel to the conservative agenda that is pushing to deny medical treatment to all transgender young people. (Those conservative views are unacceptable, and medically unsound.) Instead, we should be learning from them and returning to the empirically supported careful assessment model recommended by WPATH. And none of this means that we shouldn't be listening to the views of gender-diverse teens; it only means that we should listen in the fullest and most probing way possible.

The pressure by activist medical and mental health providers, along with some national LGBT organizations to silence the voices of detransitioners and sabotage the discussion around what is occurring in the field is unconscionable. Not only is it harmful to detransitioned young people — to be made to feel as if their lived experiences are not valid, the very idea that the gender-transition treatment is meant to remedy — but it will undoubtedly raise questions regarding the objectivity of our field and our commitment to help trans people. The fact that some people detransition does not mean that transgender people should not receive the services they need.

The energy currently spent fighting this political battle would be much better directed toward improving care for all gender-diverse young people. They deserve nothing less.

NEWS

Doctor at heart of fight over trans youth care says she is racing against time

A temporary order allowing her to provide gender-affirming care is set to expire next week

Dr. Ximena Lopez, a pediatric endocrinologist at Children's Health and UT Southwestern Medical Center, on Thursday, May 19, 2022 outside her lawyer's office in Dallas. Lopez headed the Genecis program, which provided treatment to transgender youth, before UT Southwestern and Children's Health halted certain treatments provided by the program. (Jeffrey McWhorter / Special Contributor)

By Marin Wolf and Lauren McGaughy
6:27 PM on May 19, 2022

In the first 24 hours after a court order allowed Dr. Ximena Lopez to temporarily resume gender-affirming medical care at Children's Medical Center Dallas, her office received 50 phone calls from new patients scrambling to get an appointment.

"We have hope. Maybe the tide is turning. Maybe we can preserve this care," Lopez, who once headed up Genecis as its lead endocrinologist, told *The Dallas Morning News* on Thursday.

The biggest challenge is time.

Related: Texas AG Paxton wants to intervene in battle over care for trans youth at Dallas hospital

In the exam room, her team of medical professionals is trying to fit in as many new patients as possible before the court's two-week temporary restraining order against Children's ends May 26. In the courtroom, Lopez's legal team is seeking a temporary injunction so she can continue seeing new patients.

In total, they've received 60 appointment requests and have scheduled around 20.

Even if they were able to fit every new patient into a slot, there's no promise that those patients would be able to start or continue the treatments that were halted, including puberty blockers or hormone therapy, in the future. Lopez hates not being able to give them answers.

The future of transgender health care access in Texas will be dete

against Children's, she is seeking to depose UT Southwestern's top officials to learn who directed the changes to t Genecis program.

The state has asked the court to allow it to intervene in case against Children's and is also fighting a lawsuit over a directive to require child abuse investigations into families with transgender youth receiving certain medical treatments.

Genecis through the years

In November, UT Southwestern and Children's removed all Genecis branding from the internet and began to refer new underage patients who were seeking puberty suppressants and hormone therapy for the treatment of gender dysphoria to outside providers.

Transgender patients previously enrolled in Genecis still can access these treatments, UT Southwestern said, as can youth seeking hormones for other medical reasons like early puberty. The hospitals continue to provide mental health care to new child and adolescent patients experiencing gender dysphoria, which is the feeling of discomfort or distress that can occur in people who identify as a gender that is different from the gender or sex assigned at birth.

Lopez isn't the only staff member at Children's and UT Southwestern to oppose the changes.

About 850 doctors, medical students and other employees of the institutions signed a petition decrying the decision to cut certain care to new patients, and dozens held a protest on UT Southwestern's campus on the International Transgender Day of Visibility on March 31.

Protestors gather at the University of Texas Southwestern Medical Center following the shuttering of the Genecis program on Thursday, March 31, 2022, in Dallas. The protest fell on Transgender Day of Visibility and was organized by The Resource Center. (Juan Figueroa / Staff Photographer)

Lopez is by far the most visible as the provider taking the hospitals to court. She said the treatments for transgender youth can save lives.

Age appropriate and individualized medical treatments for transgender youth, including the ones Paxton has called abuse, are supported by the state and nation's largest physicians groups, including the American and Texas Medical Associations. These groups have opposed the state's abuse investigations and other efforts to block or alter gender-affirming care for minors.

The Genecis program abided by a strict standard of care that involved psychologists, social workers and doctors working together with parents and the children themselves to determine the best course of treatment, she said.

"[Parents] realize that if their child is not living as their true self, they're just miserable," Lopez said. "It gives me hope to see these parents so loving and willing to do anything for their kids."

A doctor in the courtroom

The legal battles she is waging offer a sort of shield, she explained, making her feel comfortable enough to speak publicly about her former program. Before taking her employer to court, Lopez said she worried about losing her job if she spoke out.

That fear is in stark contrast to her experience in the early years of Genecis.

Opened seven years ago, the program was lauded by Children's and UT Southwestern as the first and largest of its kind in the southwest. Lopez recalled doing "maybe 40 interviews" about the care she and her team provided

Texans. The bill didn't become law, hastened to its death with the mark the escalation of the battle over transgender rights in Texas.

In response, the hospitals shifted from publicly celebrating the Genecis program to quietly continuing care so patients and doctors weren't targeted by anti-trans groups, Lopez said. It was a move she found reasonable at the time.

"I wanted to do whatever was necessary to protect the care of the patients," she said. "And if that meant not being out in the public, well, that's OK."

There was a real safety concern, Lopez said. The program's staff received threats, she remembered, and a panic button was installed so police could be quickly reached in the event of an emergency.

Still, care continued unabated. Lopez said Genecis treated more than 1,000 patients in the program's seven years. When the Genecis brand was discontinued in November, she was outraged.

Children's Health's flagship hospital is about 3 miles north of downtown Dallas. (Children's Health)

Children's declined to comment on Lopez's remarks.

In February, just ahead of a competitive GOP primary election, Al

calling certain gender-affirming medical treatments akin to child abuse. Gov. Greg Abbott then directed Child Protective Services to investigate any allegations of youth undergoing such treatments, leading to a separate lawsu which briefly paused the inquiries.

The Texas Supreme Court ruled last week that Abbott and Paxton had no authority to order these investigations, but CPS indicated Thursday that they would resume.

Amid the firestorm of opinions and arguments over transgender rights in Texas, Lopez said she's focused on restoring comprehensive care for new patients.

None of the new patients they've seen so far have started puberty suppressants or hormone therapy. Lopez said the process to begin treatments like these takes a minimum of three to four visits, and they are not going to rush these important medical decisions.

She's emotionally exhausted — but not as tired as the families she's met this week. Despite the past several months, Lopez is cautiously optimistic. Still, she has to be realistic with her new patients.

"It's all very fluid, so I have to be honest and say that I'm not sure," Lopez said. "It's heartbreaking because they've been waiting for this moment. They're so excited."

Related: Texas to resume abuse investigations into families with trans children

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The New York Times Magazine | https://www.nytimes.com/2022/06/15/magazine/gender-therapy.html

The Battle Over Gender Therapy

More teenagers than ever are seeking transitions, but the medical community that treats them is deeply divided about why — and what to do to help them.

By Emily Bazelon

Published June 15, 2022 Updated June 24, 2022

Scott Leibowitz is a pioneer in the field of transgender health care. He has directed or worked at three gender clinics on the East Coast and the Midwest, where he provides gender-affirming care, the approach the medical community has largely adopted for embracing children and teenagers who come out as transgender. He also helps shape policy on L.G.B.T. issues for the American Academy of Child and Adolescent Psychiatry. As a child and adolescent psychiatrist who is gay, he found it felt natural to work under the L.G.B.T. "umbrella," as he put it, aware of the overlap as well as the differences between gay and trans identity.

It was for all these reasons that Leibowitz was selected, in 2017, to be a leader of a working group of seven clinicians and researchers drafting a chapter on adolescents for a new version of guidelines called the Standards of Care to be issued by the World Professional Association for Transgender Health (WPATH). The guidelines are meant to set a gold standard for the field of transgender health care, and this would be the first update since 2012. What Leibowitz and his co-authors didn't foresee, when they began, was that their work would be engulfed by two intersecting forces: a significant rise in the number of teenagers openly identifying as transgender and seeking gender care, and a right-wing backlash in the United States against allowing them to medically transition, including state-by-state efforts to ban it.

During the last decade, the field of transgender care for youth has greatly shifted. A decade ago, there were a handful of pediatric gender clinics in the United States and a dozen or so more in other countries. The few doctors and therapists who worked in them knew one another, and the big debate was whether kids in preschool or elementary school should be allowed to live fully as the gender they identified as when they strongly and consistently asserted their wishes.

Now there are more than 60 comprehensive gender clinics in the United States, along with countless therapists and doctors in private practice who are also seeing young patients with gender-identity issues. The number of young people who identify as transgender nationally is about 300,000, according to a new report by the Williams Institute, a research center at U.C.L.A.'s law school, which is much higher than previous estimates. In countries that collect national data, like the Netherlands and Britain, the number of 13-to-17-year-olds seeking treatment for gender-identity issues has also increased, from dozens to hundreds or thousands a year.

Just as striking, the *types* of cases have changed. Many of the current group of teenagers haven't told their families, from a young age, that they feel they are a different gender, though they often say they internalized such feelings for years. The average age when a young person first comes to a clinic tends to be around 14 or 15, according to some clinicians I talked to. Cases of teenagers coming out as trans aren't new. But their prevalence is. In addition, the current caseload is around two-thirds youths who were "assigned female at birth," in the current parlance of the field, and identify as trans boys — or as nonbinary, in a smaller but growing number of cases. In the past, by contrast, most patients at gender clinics were trans girls who were "assigned male at birth."

As they worked on a draft of the adolescent chapter of the Standards of Care, the big debate among clinicians was how they should respond to the thousands of teenagers who are arriving at their doors. Some are asking about medication that suppresses puberty or about hormone-replacement treatments. Leibowitz and his co-authors thought that the timing of the rise in trans-identified teenagers, as well as research from Britain and Australia, suggested that the increased visibility of trans people in entertainment and the media had played a major — and positive — role in reducing stigma and helping many kids express themselves in ways they would have previously kept buried. At the same time, the authors acknowledged that they weren't sure that visibility was the *only* factor at play.

As they wrote in their December draft chapter, part of the rise in trans identification among teenagers could be a result of what they called "social influence," absorbed online or peer to peer. The draft mentioned the very small group of people who detransition (stop identifying as transgender), saying that some of them "have described how social influence was relevant in their experience of their gender during adolescence." In adolescence, peers and culture often affect how kids see themselves and who they want to be. Their sense of self can consolidate, or they can try on a way of being that doesn't prove right in the long run as the brain further develops the capacity for thinking long-term. To make matters more complicated, as a group, the young people coming to gender clinics have high rates of autism, depression, anxiety and eating or attention-deficit disorders. Many of them are also transgender, but these other issues can complicate determining a clear course of treatment.

Without stating them outright, the draft raises tricky questions: Could some of the teenagers coming out as trans today be different from the adults who transitioned in previous generations? For them the benefits are well established and the rate of regret is very low. How many young people, especially those struggling with serious mental-health issues, might be trying to shed aspects of themselves they dislike?

Leibowitz and his colleagues knew these were delicate issues. They were deeply troubled when right-wing politicians grasped the unsettled nature of these matters — which barely registered for most Americans 10 years ago — and turned them into political dynamite. In 2019, right-wing groups, the Heritage Foundation and Family Policy Alliance, which fought for many years against same-sex marriage, held a meeting on "Protecting Children From Sexualization" that covered "controversial medical treatments to treat gender dysphoria," which is defined as a form of distress and is also a psychiatric diagnosis. Model legislation followed. Organizations like Family Policy Alliance helped state legislators draft a ban on gender-related medical treatment for anyone under age 18. Arkansas passed the first such ban in April 2021, and over the next months, similar bills were introduced in 18 other Republican-led state legislatures.

WPATH is a 3,300-member international organization, mostly made up of health care professionals. It came into existence in 1979, the year it issued its first Standards of Care. These standards influence the positions taken by major medical groups, including the American Academy of Pediatrics and the American Psychological Association, and the coverage offered by health insurers and national health services around the world. Trans and nonbinary practitioners are helping to write and oversee the new guidelines, called the SOC8 because it's the eighth edition.

Over the eight months I reported on this story, I talked to more than 60 clinicians, researchers, activists and historians, as well as more than two dozen young people and about the same number of parents. WPATH gave me exclusive access to the final SOC8 (which is divided into 18 chapters, most of which address treatment for transgender adults) and lifted some of the confidentiality agreements the authors signed. Now the final version of the new Standards of Care is scheduled to come out this summer — in the midst of a raging political battle.

When I started talking to Leibowitz last December, he was watching the political attacks unfold with growing alarm. In his own state, Ohio, there was a bill afoot to ban the care he himself provides to trans young people and sees as essential to their well-being. His group's job for the SOC8 was to be "as rigorous and scientific as possible," he said, about how to translate the evidence about gender care into clinical practice. But they were acutely aware that any unknowns that the working group acknowledged — any uncertainties in the research — could be read as undermining the field's credibility and feed the right-wing effort to outlaw gender-related care.

Scott Leibowitz, a child and adolescent psychiatrist, helped lead the working group writing a chapter on adolescents for the Standards of Care, a set of guidelines from the World Professional Association for Transgender Health (WPATH).
Maddie McGarvey for The New York Times

The group was stocked with experts, including Leibowitz's co-leader for the adolescent chapter, the Dutch child psychiatrist Annelou de Vries, who for 19 years has worked at what was the first transgender pediatric clinic in the world, and the clinical psychologist Ren Massey, who is a former president of the Georgia Psychological Association and is transgender. When WPATH released the draft of the SOC8 for public comment, Leibowitz and his co-authors braced for the inevitable conservative attack. For teenagers who have parental consent, the draft adolescent chapter lowered to 14 (from 16 in the previous guidelines) the recommended minimum age for hormone treatments, which can

permanently alter, in a matter of months, voice depth and facial and body hair growth and, later, other features like breast development. It set a minimum recommended age of 15, for breast removal or augmentation, also called top surgery. (The previous standards didn't set a minimum age.)

Opponents of gender-related care did, indeed, denounce all of this. But Leibowitz and his co-authors also faced fury from providers and activists within the transgender world. This response hit them harder, as criticism from your colleagues and allies often does. It arose from two of the conditions the draft chapter established in order for young people to start taking puberty suppressants and hormones. First, the draft said, preteens and teenagers should provide evidence of "several years" of persistently identifying as, or behaving typically like, another gender, to distinguish kids with a long history from those whose stated identification is recent. And second, they should undergo a comprehensive diagnostic assessment, for the purpose of understanding the psychological and social context of their gender identity and how it might intersect with other mental-health conditions.

Assessments for children and adolescents have long been integral to the Standards of Care. But this time, the guard rails were anathema to some members of a community that has often been failed by health care providers. "The adolescent chapter is the worst," Colt St. Amand, a family-medicine physician at the Mayo Clinic and a clinical psychologist, posted on the Facebook page of International Transgender Health, which has thousands of members and functions as a bulletin board for the field. (St. Amand is on the working group for another chapter in the SOC8 on hormone treatments.) In a publicly streamed discussion on YouTube on Dec. 5, activists and experts criticized the adolescent chapter, with the emotion born of decades of discrimination and barriers to care. "This statement sucks," Kelley Winters, a moderator of International Transgender Health who is an interdisciplinary scholar and community advocate in the field, said of the assessment. "This is talking about singling out trans kids, and specifically with a mental-health provider, not medical staff, to interrogate, to go down this comprehensive inquisition of their gender." The requirement for evidence of several years of gender incongruity before medical treatment is "harmful and destructive and abusive and unethical and immoral," said Antonia D'orsay, another moderator of the group who is a sociologist and psychologist. In January, in a public comment to WPATH, International Transgender Health blasted the adolescent chapter for "harmful assertion of psychogatekeeping" that "undermines patient autonomy."

And just like that, after four years of painstaking work, Leibowitz, de Vries and the rest of their group were being called out as traitors by peers and the community they sought to care for. "We understood the enormity of the need for these standards from the beginning," Leibowitz told me. "I'm not sure we recognized the enormity of the controversy. It's a result of the fact that our world, the world of gender care, has exploded."

In the 1950s and '60s, a small cadre of doctors in Europe and the United States started to talk about how to evaluate adults who wanted to medically transition. Harry Benjamin, the endocrinologist for whom WPATH was originally named, embraced the idea that the people he agreed to treat (mostly trans women) were "born in the wrong body." Fearing lawsuits from dissatisfied patients, the doctors were quick to exclude patients for reasons of mental stability. And, arbitrarily, they only included those who they believed would go on to pass as the gender they identified with, as Beans Velocci, a historian at the University of Pennsylvania, wrote in an article last year in TSQ: Transgender Studies Quarterly. Some doctors made trans adults promise to live as heterosexuals after they transitioned.

The small group of clinicians who wrote the first Standards of Care were all cisgender. After WPATH was created in 1979, transgender advocates increasingly gained influence in the organization, but many transgender people viewed subsequent versions of the standards as imposing paternalistic and demeaning barriers to treatment. For some genital surgery, the standards required adults to live for a year as the gender they identified with and to provide referrals from two mental-health professionals. The SOC8 is the first version to dispense with these requirements, adopting a model of "shared decision-making" between adult patient and surgeon.

The leap toward medical transition for young people occurred in the Netherlands in the 1980s. Peggy Cohen-Kettenis, a Dutch clinical psychologist specializing in children, began receiving referrals of teenagers who were experiencing gender dysphoria (then called gender identity disorder). But therapy wasn't the primary answer, Cohen-Kettenis, who is retired, told me over the phone this spring. "We can sit and talk forever, but they really needed medical treatment." As their bodies developed in ways they didn't want, "they only did worse because of that." She decided to help a few of her patients start hormone treatments at 16 rather than waiting until 18, the practice in the Netherlands and elsewhere at the time. She monitored them weekly, then monthly. "To my surprise, the first couple were doing much better than when they first came," she said. "That encouraged me to continue."

Cohen-Kettenis helped establish a treatment protocol that proved revolutionary. Patient Zero, known as F.G., was referred around 1987 to Henriette A. Delemarre-van de Waal, a pediatric endocrinologist who went on to found the gender clinic in Amsterdam with Cohen-Kettenis. At 13, F.G. was in despair about going through female puberty, and Delemarre-van de Waal put him on puberty suppressants, with Cohen-Kettenis later monitoring him. The medication would pause development of secondary sex characteristics, sparing F.G. the experience of feeling that his body was betraying him, buying time and making it easier for him to go through male puberty later, if he then decided to take testosterone. Transgender adults, whom Cohen-Kettenis also treated, sometimes said they wished they could have transitioned earlier in life, when they might have attained the masculine or feminine ideal they envisioned. "Of course, I wanted that," F.G. said of puberty suppressants, in an interview in "The Dutch Approach," a 2020 book about the Amsterdam clinic by the historian Alex Bakker. "Later I realized that I had been the first, the guinea pig. But I didn't care."

Over the next decade, Cohen-Kettenis and Delemarre-van de Waal designed an assessment for young people who seemed like candidates for medical treatment. In questionnaires and sessions with families, Cohen-Kettenis explored the reasons for a young person's gender dysphoria, considering whether it might be better addressed by therapy or medication or both. The policy was to delay treatment for those with issues like attention-deficit and eating disorders or who lacked stable, supportive families, in order to eliminate factors that might interfere with the treatment. "We did a lot of other work before letting them start, which created a lot of frustration for them," Cohen-Kettenis said. "Maybe we were too selective in the early stages." In retrospect, she says, she thinks young people who might have benefited were excluded.

The stringent screenings seemed critical, however, given the opposition they faced. Other doctors, in the Netherlands and outside it, publicly accused them of recklessness. At a low moment, at a medical conference in the late 1990s, she said, they were likened to Nazis experimenting on children.

Cohen-Kettenis stressed that she and her growing team at the Amsterdam clinic were not channeling children toward a particular outcome. The Dutch advised what they called “watchful waiting.” Throughout his childhood, with his parents’ support, F.G. lived as a boy, with short hair and a gender-neutral nickname. But Cohen-Kettenis counseled parents to “keep the door open, as much as possible, for children to be able to change back.” Among the adolescents who came to the clinic beginning at the age of puberty, 41 percent went on puberty suppressants, and more than 70 percent received hormone treatments and went on to surgery.

The Amsterdam clinic attracted international interest. Norman Spack, an endocrinologist at Boston Children’s Hospital who began treating transgender adults in the 1980s, and Laura Edwards-Leeper, then a child psychologist there, visited Amsterdam in 2007 for a gathering of clinicians from countries including Canada, Britain, Norway and Belgium. Spack and Edwards-Leeper went back to Boston, where they and another doctor were opening the first dedicated gender clinic for kids in the United States that provided medical treatment based on the fundamentals of the Dutch approach — a comprehensive assessment before patients could begin puberty suppressants or hormone treatments and close consultation between a clinic’s mental-health professionals and medical doctors.

Scott Leibowitz joined the Boston clinic as a psychiatrist in training a year later. In the early days, families traveled long distances for appointments. The waiting list grew. Edwards-Leeper and Spack eventually shortened the period a child had to be in therapy before the clinic did its own assessment, from a year to between three and six months. “If a child was on the cusp of puberty, and anxious about how their body was about to change, we tried to squeeze them in faster, which I still think is really important,” Edwards-Leeper says.

Tori (a nickname), who is 13 and lives outside Atlanta: “With gender, it has been more and more, wanting more things to happen. And luckily I have parents who are willing to let me describe myself and be whoever I want.” Anne Vetter for The New York Times

In 2011, de Vries and her colleagues published the first of two landmark studies about medical interventions in adolescence. Among the first 70 patients who received puberty suppressants at the Amsterdam clinic after their initial assessment at the mean age of about 13½, the researchers found “a significant decrease in behavioral and emotional problems over time.” A second study published in the journal Pediatrics in 2014, of about 55 of those who went from puberty suppressants to hormone treatments at the mean age of about 16½, showed that five years after starting hormone treatments and at least one year after surgery, they had the same or better levels of well-being as a control group of cisgender adults their age. None of the 55 regretted their treatment. (The 15 of the original 70 who were not included in the follow-up study did not take part mainly because of the timing of their surgery.)

For the first time, a long-term, peer-reviewed study showed positive outcomes after medical treatment in adolescent patients who’d gone through Cohen-Kettenis and Delemarre-van de Waal’s protocol. They had all been through a version of the type of assessment the December draft of the SOC8 adolescent chapter would recommend years later. They had experienced gender dysphoria since childhood (according to their families), lived in supportive environments and had no interfering mental-health

conditions. As is often the case in medicine, the question for those drafting the SOC8 would be how to apply the findings of a particular cohort to the growing numbers of teenagers lining up at clinics in a host of countries.

In the United States and Canada, meanwhile, two dueling approaches to therapy for young children, before they reached puberty, were vying for supremacy. At what is now called the Child and Adolescent Gender Center at the University of California, San Francisco, Diane Ehrensaft, a developmental and clinical psychologist, was counseling families to take what she and others called a "gender affirming" approach, which included a social transition: adopting a new name and pronouns for a child who expressed such a preference, along with letting kids dress and play as they pleased.

For years, Ehrensaft's intellectual foil was Ken Zucker, a psychologist and prominent researcher who directed a gender clinic in Toronto. Between 1975 and 2009, Zucker's research showed that most young children who came to his clinic stopped identifying as another gender as they got older. Many of them would go on to come out as gay or lesbian or bisexual, suggesting previous discomfort with their sexuality, or lack of acceptance, for them or their families. Based on this research, in some cases Zucker advised parents to box up the dolls or princess dresses, so a child who was being raised as a boy (a majority then) wouldn't have those things to play with.

In 2012, the last version of WPATH's Standards of Care, with Cohen-Kettenis and Zucker among the authors, cited his work 15 times and called social transition in early childhood "controversial." The American Psychological Association said in 2015 guidelines that there was no consensus about a best practice for children before puberty, describing both accepting children's "expressed gender identity" (citing de Vries and Cohen-Kettenis, Ehrensaft, Edwards-Leeper and Spack, among others) and, alternatively, encouraging them to "align with their assigned gender roles" (citing Zucker, among others).

At the end of 2015, the Canadian medical center that ran Zucker's clinic in Toronto shut it down because of complaints from activists about his method. (Zucker sued the center for defamation and later received an apology and a settlement of $450,000.) In February 2017, protesters interrupted and picketed a panel featuring Zucker at the inaugural conference of USPATH (the U.S. affiliate of WPATH) in Los Angeles. That evening, at a meeting with the conference leaders, a group of advocates led by transgender women of color read aloud a statement in which they said the "entire institution of WPATH" was "violently exclusionary" because it "remains grounded in 'cis-normativity and trans exclusion.'" The group asked for cancellation of Zucker's appearance on a second upcoming panel. Jamison Green, a trans rights activist and former president of WPATH, said the board agreed to the demand. "We are very, very sorry," he said.

After that controversy, other providers were on notice that Zucker's methods were no longer acceptable. His approach was likened to conversion therapy, which treats being gay or trans as a mental illness to be cured, and which many states and localities have made illegal.

The Amsterdam clinic shifted, too. Some Dutch families socially transitioned kids on their own, which de Vries and her colleagues accepted; they began counseling other families about social transition too. Though the Amsterdam researchers' previous results, like Zucker's, showed that most kids who came to the clinic in elementary school later realigned with the genders of their birth, and often came out as

gay, lesbian or bisexual, de Vries and her colleagues now see those findings as a product of their time, when the children whom parents brought to the clinic included many boys with an interest in wearing feminine clothing and playing with dolls that didn't turn out to be gender dysphoria. Today many Dutch parents are more accepting of this behavior, and the Amsterdam clinicians think that as a result, most of the children who come to the clinic are asserting a strong and persistent gender preference. It's more likely that such children will stay the course of being transgender, research shows. One long-term study, published in 2021, of 148 kids in the United States who socially transitioned with their families' support between the ages of 8 and 14, found that five years later their psychological well-being was on par with their siblings and a control group of cisgender peers.

There is a separate chapter in the SOC8 that focuses on young children and that recommends that health care professionals and parents support social transition when it originates with the child while also recognizing that for some kids, gender is fluid. An outstanding question, asked by gay commentators like the author Andrew Sullivan, is whether some kids who socially transition today, and remain trans, would have grown up to be gay or lesbian in previous generations. "I know there are worries that effeminate males can be assumed to be female or masculine girls can be assumed to be male," says Amy Tishelman, the lead author of the SOC8 chapter on children and a child psychologist who is the former director of clinical research at the gender clinic at Boston Children's Hospital. "That's not what we're advocating. Support for trans people should not be a way of limiting what a girl or a boy or a woman or a man or a person can be."

Marci Bowers, a gynecologic and reconstructive surgeon, is slated to be the next president of WPATH.
Ryan Young for The New York Times

A few months before the release of the December draft of the SOC8, WPATH had a preview of the firestorm to come. In October 2021, the journalist Abigail Shrier published a post called "Top Trans Doctors Blow the Whistle on 'Sloppy' Care" on the Substack of Bari Weiss, a former opinion editor and writer for The New York Times." The word "sloppy" was a quote from Erica Anderson, a clinical psychologist who was a past president of USPATH and who worked at the U.C.S.F. gender center for years before leaving in October (for unrelated reasons). She told Shrier she expected more regret among young people because some providers were rushing them toward medication without sufficient mental-health evaluations.

Shrier also quoted Marci Bowers, a gynecologic and reconstructive surgeon who is slated to be the next president of WPATH, who voiced a separate concern about blocking puberty too early. Though there is no published data on this question, over hundreds of surgeries, Bowers has found that trans girls who don't go through male puberty may find it difficult to have an orgasm after they have genital surgery as adults. They also could have less penile tissue with which to create a vagina, which can lead to more complications from surgery, according to Bowers. These concerns apply in a small percentage of cases in the United States, as most teenagers come to gender clinics at 14 or older, after puberty. But for the younger kids, Bowers advocated delaying puberty suppressants to a later stage of development.

Anderson and Bowers are transgender women, which brought more attention to their critique and to their decision to talk to Shrier, who is the author of a 2020 book, "Irreversible Damage: The Transgender Craze Seducing Our Daughters," which many trans people and their allies abhor. Many trans health providers were furious. "I was like, Whoa, what is this? And then I texted Erica," says Maddie Deutsch, the president of USPATH and a professor at U.C.S.F. as well as the medical director of the Gender Affirming Health Program there, who is also transgender. "We were all broadsided." She worries about the political fallout. "States like Texas and Florida are looking to these articles to fan the flames."

About a week after Shrier's post appeared, USPATH and WPATH issued a statement opposing "the use of the lay press" for scientific debate about gender-related medical treatment. Anderson disagreed with the directive. "Some of our colleagues would have us shut up," she told me in the fall. "No. It's not OK to ignore the problems." In late November, she and the child psychologist Laura Edwards-Leeper published an opinion essay in The Washington Post. They said they were "disgusted" by the proposed state bans on gender-related medical treatment for minors, but they warned that some providers in the United States were "hastily dispensing medicine" and skipping comprehensive assessments.

'Young people are quite capable of understanding themselves, but not all of them will.'

The following week, news broke in Texas that the only gender clinic for adolescents that provides hormone therapy in the Dallas region, Genecis, was being disbanded, a result of political pressure from Gov. Greg Abbott. "We have wolves at the door," says Ehrensaft, who worked with Anderson at U.C.S.F. and is an author on the SOC8 chapter on children with Edwards-Leeper. "Conversations among us get aired as controversy and confusion. You end up eating your own instead of making the wolves go away." Others were scathing about placing blame. "Every time a law passes blocking trans youth from getting care, I hope it's called an Edwards-Leeper law," Andrew Cronyn, a pediatrician and a former adviser on policy about L.G.B.T. health for the American Academy of Pediatrics, wrote on a professional email list with more than 500 recipients. "And I hope that every time one of the youth who is blocked from affirmative care dies, she gets sent a copy of the obituary." He subsequently apologized and the post was removed at his request.

When I spoke to Bowers in December, she distanced herself from Anderson and Edwards-Leeper. “The most important thing is access to care,” she said. “And that is a much bigger problem than the issue of how the medical community and transition is failing people.” But she remained intent on drawing attention to her concerns about the early suppression of puberty. “Sexual satisfaction is a huge thing,” she said. “You’ve got to talk about it.”

Partly in response to Bowers’s concerns, the December draft of the SOC8 adolescent chapter suggested that health care providers discuss “future unknowns related to sexual health” when families consider puberty suppressants. The Amsterdam clinic often waits to prescribe suppressants until later in puberty.

In the United States, waiting would be a major shift for the relatively small group of younger kids at gender clinics. For them, families weigh the relief the medications can provide against the health implications. Taking puberty suppressants (or hormones) for gender affirmation is “off-label,” meaning this specific use of the medications is not approved by the Food and Drug Administration. Off-label prescriptions are common and don’t imply anything improper, but there may be less research about the drug’s effects. If young people continue on to hormone treatments, puberty suppressants “probably” compromise fertility, especially for trans girls, Stephen M. Rosenthal, a pediatric endocrinologist at the gender center at U.C.S.F. who is on the group for the SOC8 chapter on hormone treatments, explained in a review last year for Nature Reviews Endocrinology. The medication can also prevent bone density from increasing as it typically would, and while levels returned to normal in trans boys who went on to hormone therapy, they remained low in trans girls who did the same, according to a 2020 study from the Amsterdam clinic. Little is known about the impact on brain development. “The relative paucity of outcomes data raises notable concerns,” Rosenthal wrote in his review. But he has no hesitation about prescribing puberty suppressants to kids who are deemed ready for them at his clinic. “The observed benefits greatly outweigh the potential adverse effects,” he said.

As winter approached, criticism of Anderson and Edwards-Leeper by their peers mounted as right-wing attacks on medical care for minors grew louder. In early November, the board of USPATH privately censured Anderson, who served as a board member. In December, the board imposed a 30-day moratorium on speaking to the press for all board members. That month, Anderson resigned.

In February, Governor Abbott ordered child-abuse investigations of parents and providers in Texas who give gender-related medical treatments to kids, generating national headlines and causing fear and anguish for families. In March, Arizona became the second state to ban gender medical care for minors. (The law, which applies to surgery, not medications, is scheduled to go into effect in 2023.)

The next month, four doctoral students in psychology asked to drop Edwards-Leeper from their dissertation committees at Pacific University, where she is an emeritus professor. And yet in the same week, she presented on the SOC8 adolescent chapter at the annual pediatric conference of the American Psychology Association, where the moderator of one of her panels praised her for her bravery in voicing her concerns about her field. The roller coaster of reaction, at the same time kids were losing access to care altogether in red states, shook Edwards-Leeper and her co-authors of the SOC8 chapters on adolescents and children. They didn't want to be blamed for the right-wing backlash — neither by activists nor their own peers.

Watching the waves of conflict break, Leibowitz worried. He respected Bowers, Anderson and Edwards-Leeper for raising difficult issues but could see their views being mischaracterized to justify banning gender-related care. For people who don't know much about the issues, "banning the care probably sounds more enticing than the idea that kids are dictating what treatment they should get," he says. "Our guidelines are the voice from the middle."

Kat (a nickname), who is 18 and lives in the Midwest: “When I was younger, I tried to wear girls’ clothes, but it hurt. I still can’t quite explain why. But I don’t focus on gender that much now. It’s just one aspect of myself.” Anne Vetter for The New York Times

One morning over the phone, Leibowitz explained to me the elements of the mental-health assessments he saw as essential. His starting point, when a child presents as transgender, is obtaining a complete diagnostic profile. This means understanding the relationship between gender dysphoria and any other conditions (like depression or an eating disorder) or another factor that might be causing discomfort (like trauma or feeling confined by gender stereotypes) before coming up with a treatment plan. “It’s about understanding how the issues that might make someone experience gender dysphoria are connected,” he said.

As Leibowitz and his co-authors discussed revisions over video calls and email, colleagues who were critical of the draft chapter were also working together. Colt St. Amand, the psychologist and physician who disparaged the adolescent chapter on the Facebook page of International Transgender Health, brought together a collective of 16 mental-health professionals who are either transgender (as he is) or nonbinary, or have a close family member who is, to talk about how the assessment guidelines in the adolescent chapter fit with their lived experience and professional knowledge.

St. Amand thinks the purpose of an assessment is not to determine the basis of a kid’s gender identity. “That just reeks of some old kind of conversion-therapy-type things,” he told me over the phone in April. “I think what we’ve seen historically in trans care is an overfocus on assessing identity.” He continued: “People are who they say they are, and they may develop and change, and all are normal and OK. So I am less concerned with certainty around identity, and more concerned with hearing the person’s embodiment goals. Do you want to have a deep voice? Do you want to have breasts? You know, what do you want for your body?”

The draft of the adolescent chapter suggests that “extended assessments” may be useful for young people who are autistic or have some characteristics of autism without a full diagnosis. “One of the key accommodations for autistic youth is providing more time and structure to support the young person’s self-advocacy and communication capacity,” said John Strang, the specialist on the intersection of autism and gender identity on the SOC8 adolescent and child chapters and a neuropsychologist at Children’s National Hospital in Washington, D.C. But St. Amand calls a standard of extended assessments a “gross generalization” and “discriminatory.”

The priority for the collective St. Amand organized, which is working on a series of articles and training materials, is to ensure that transgender and nonbinary youth get the care they need rather than to shield teenagers from taking medication with effects they might later decide they didn’t want. St. Amand’s focus is on a young person’s response after beginning puberty suppression or hormone therapy. “If that is the right thing for them, then the response over time will tell me,” he says. “Once we start those interventions, we are checking in with the patient to see how they’re doing.” If the drugs don’t suit them, in his view, they can simply stop.

Colt St. Amand, a family-medicine physician at the Mayo Clinic and a clinical psychologist, is in the working group for a chapter on hormone treatments in WPATH’s new Standards of Care.
Ben Innes for The New York Times

Other providers, however, see an ethical dilemma stemming from the principle of justice — which promotes access to care for trans youth — and the principle of doing no harm. “I wouldn’t recommend just initiating testosterone straight away,” says Nathaniel Sharon, a child psychiatrist in New Mexico who has helped shape mental-health policy that affects transgender young people for the American Academy of Child & Adolescent Psychiatry. “Their voice gets permanently low. They’re hairy. Their clitoris is enlarged. And what do you do now? I just find that inappropriate and unsafe.”

The differences among gender-affirming providers over assessments and medical intervention don’t break down along cisgender-transgender lines. Some transgender practitioners, like Sharon and Ren Massey, a psychologist on the SOC8 adolescent chapter, support the chapter’s approach to assessments. “We need to understand that the reality is that adolescents go through a lot of developmental changes and have a lot of internal and external influences on their development,” Massey says. And some transgender activists also support a cautious approach. “It is life changing,” Jamison Green, the former president of WPATH, says of transitioning. “It is all encompassing. If it’s right for you, then it’s really important. It’s very easy to get interested in a new idea, get excited and not think it through all the way. Young people are quite capable of understanding themselves, but not all of them will. That’s why I think prudence is useful.”

Leibowitz had a related concern. For young people who have yearned for puberty suppressants or hormone treatments, reversing course can be difficult, he says. “Some people, once they make the decision, they’re not going to go against it, because they feel internal pressure to continue. They might be susceptible to feeling ashamed.”

Research is just beginning about why young people halt medical treatment and what it means for them. Some continue to identify as trans or nonbinary, like Nova West, a 27-year-old filmmaker I spoke to, who was happy with top surgery and the way testosterone lowered their voice and helped them build muscle — and then stopped the treatment because they didn’t want to go bald (which sometimes happens) and felt they’d reached their “optimal gender expression.”

Others decide they want to fully detransition and return to their cis identities. Grace Lidinsky-Smith, who is 28, has written about her regret over taking testosterone and having her breasts removed in her early 20s. She told me that she wished she’d had the kind of comprehensive assessment the last

Standards of Care endorsed for adults. “That would have been really good for me,” she said.

St. Amand and the collective argue that as no study has directly compared different types of assessment, there’s no evidence that the Amsterdam clinic’s approach is better. They point to research from clinics in the United States, which shows small-to-moderate improvements in depression and anxiety and large improvements in body-related dysphoria for young patients six months or a year after beginning medication. One of those studies is by the clinical child psychologist Laura Kuper, based on a sample of young patients, some of who went through a streamlined assessment process that Kuper helped design at the Genecis program in Dallas. “In medicine in general, if you find a new treatment and it seems overwhelmingly helpful, you start to roll it out before you have a 10-year follow up,” says Kuper, who helped start the collective with St. Amand and is one of the authors of a SOC8 chapter on nonbinary individuals. “You continually reflect on new research and clinical findings as you go.”

It’s not yet known how well improvement in the short term predicts how teenagers today will feel as older adults about the changes they made to their bodies. In their draft chapter, Leibowitz, de Vries, Massey and their co-authors note that to date, only the Amsterdam clinic, with its comprehensive assessments, has results showing strong psychological benefits later in life for people who medically transitioned in their teens. Today, the Amsterdam clinic usually requires at least six monthly sessions (following a longer period on a waiting list) to begin medical treatment. “We’ve always said, Do it in a careful way,” de Vries says.

Most of the young people today who come to clinics for treatment are affluent and white, live in progressive metropolitan areas and have health insurance. For them, gender-related care has become more accessible since 2016, when the Obama administration included gender identity in a rule against denying health care benefits on the basis of sex. If a provider deems the care medically necessary, it’s possible to get insurance coverage for puberty suppressants, which can be injected or implanted under the skin, and hormone treatments, which can be taken orally, injected or applied as a gel or a patch. Each can cost thousands of dollars a year.

But in other parts of the country, there is often no gender clinic and sometimes no therapist or doctor to help transgender kids — who often still face bullying and harassment — navigate the process of coming out. “I have a patient in rural Mississippi who tried to find mental-health support, but it was traumatic,” says Izzy Lowell, a family-practice doctor and the founder of QueerMed, which treats patients mostly via telemedicine (without in-person visits) in about a dozen states covering the Southeast. In effect, states like Arkansas are banning care where it is already rare.

‘I say to parents, “I have no idea if your child is trans or not — they need an open field to explore.” ’

Finding care can also be harder for low-income or religious families and families of color. Lizette Trujillo, a mother in Arizona, told me that when she realized her son was trans several years ago, she found a parent support group on Facebook where her family was one of only two that were Hispanic. When she became the group's facilitator, she worked to get the word out in her community. But some parents are reluctant to join because of their religious backgrounds, and the wave of bills to ban gender-related medical treatment is generally increasing families' fears. "It's terrifying," Trujillo said. "It was the first time my son was actually afraid. 'Could this happen here? Will you make sure I'm safe?' He's 14."

Among those who had access to care, many parents and kids told me they were deeply grateful for a relatively smooth path to medical transition. Tori (a nickname) told her parents she didn't want a boy's body at the beginning of seventh grade. Her pediatrician in Atlanta referred her to QueerMed, Lowell's practice. "We asked all our questions," says Tori's father, who belongs to the local chapter of TransParent USA, a national support group. "What if she changes her mind? What can you and can't you come back from? There was no question on the table they didn't have a research-based answer for. You see your kid light up at the answers, and you say, 'OK, this is the right thing to do.'" Tori says she just wishes her transition could go faster.

Other parents, however, were bewildered by a landscape in which there are no labels for distinguishing one type of therapeutic care from another. In recent years, the Endocrine Society, the American Psychological Association, the American Psychiatric Association and the American Academy of Pediatrics have endorsed gender-affirming care as the only acceptable approach. But the major medical groups tended to speak in broadly supportive terms without specifying how providers should actually do it.

It's not clear how common comprehensive assessments are among gender-affirming providers in the United States. "The American Psychiatric Association doesn't really have an official position on the best way to treat the kids," says Jack Drescher, a clinical professor of psychiatry at Columbia University who helped write the group's position statements.

One mother in New England told me about talking to a therapist when her 6-year-old, Charlie (a nickname), became tearful about using the girls' bathroom and urgently asked for a buzz cut. Without meeting Charlie, the therapist told the mother during a single session that her child was a trans boy. Feeling overwhelmed, the mother took Charlie to another therapist, Julie Mencher. "I say to parents, 'I have no idea if your child is trans or not,'" Mencher told me. "They need an open field to explore." Charlie, who is now 12, told me that he figured out over the next year or so that he was sure of his male identity. His parents could see it solidifying and supported his wish to go on puberty suppressants. "The first therapist was right," his mother says. "But we needed a process we could trust."

Charlie (a nickname), who is 12 and lives in New England: “Here’s something I really remember: My older brother introducing me as ‘Hey, this is my brother’ for the first time. I was so happy. We were at camp. I think I was around 7.” Anne Vetter for The New York Times

I also talked to parents who were surprised when their teenagers came out as trans. Some wanted to be both supportive and cautious. Four years ago, when she was 12, Catherine (her middle name) left a note under her mother's pillow saying she was a trans boy. She followed a script from YouTube videos she'd watched of other teenagers coming out. Catherine's mother says she looked for a therapist who "would be open to whatever came," and found Jennifer Butzen, a licensed counselor in the Atlanta area. Butzen estimates that about two-thirds of her young clients with gender-identity issues eventually choose to go on hormones, while the other one-third either are nonbinary, nonconforming or trans but decide not to have medical interventions or are cisgender.

Butzen told me about the influence of the types of YouTube videos Catherine watched. She calls them "butterfly videos" because of their curated, beautiful portrayal of self-transformation. For some kids, the videos are a valuable resource — a bridge to the self they desire that they can't easily find in real life. But others, Butzen finds, are on a less coherent search for belonging. "Being trans comes with goals — this is what to do," Butzen says. "It comes with a support network and a cause to fight for." Online, where the stakes start relatively low, teenagers in progressive communities can trade in a cisgender, heterosexual, white identity — the epitome of privilege and oppression — to join a community with a clear claim to being marginalized and deserving of protection.

When Catherine started seeing Butzen, the pair talked about sexuality as well as gender identity and did exercises, using a whiteboard, about male and female stereotypes, which Butzen wants her clients to know they can challenge whatever their gender. Butzen also explained the physical and social changes that come with medical transition. "Everything became more real, and it got a little scary," Catherine says. "But I was in this forward movement, like, 'I have to do this.'"

But one day on the way to her appointment with Butzen, Catherine started crying and told her mother she'd been lying to herself. In retrospect, she thinks the YouTube videos gave her a way to relieve discomfort she felt about being attracted to girls, which wasn't accepted at her Catholic school. Later, Catherine came out as bisexual. If her parents had said no to the idea that she was trans, she says, "I would have revolted against them." But when they gave her room to explore, "I internalized what I wanted to do."

Other teenagers talked about the way misogyny affected their thinking. One 18-year-old, Kat (a nickname), started using a boy's name and pronouns four years ago and asked to take puberty suppressants, as a friend was doing in her Midwestern college town. Her mother said no to medication. She worried about the health effects and the role of peer influence; she also told me she wanted to make sure her child understood there was no right or wrong way to be a girl. "I didn't get it as well as other people did, what being a girl even meant," Kat told me, looking back. "And my mental health wasn't great. I was cutting around that time." At about 17, she went back to her girl's name and pronouns. "I still have weird, internalized misogyny in my brain I'm trying to get over," she says. "I don't even get where it's coming from."

In other families, a teenager's decision to come out was a source of prolonged conflict. F., now 18 and living in Maryland, started identifying as a trans boy and binding his breasts in seventh grade. His mother told me that when she found out, she told F. she didn't believe anyone was born in the wrong body. Later, she went to a protest at a gender clinic in Washington, D.C., which upset F. His group of friends, which included other trans and queer kids, became "a really big part in me being able to be

myself," he says. These days, F., who has not medically transitioned, identifies as nonbinary. "I'm kind of coming to terms with my body," he says. "Who's to say my body is female? I'm not a girl and it's my body. Don't put your labels on me."

To parents who doubt the authenticity of a child's assertion or oppose medical treatments their kids strongly want, the smooth road to gender care looks like a dangerously slippery slope. Such parents have increasingly found each other online, in Facebook groups and on websites. Last fall, an international group called Genspect started holding web-based seminars that are critical of social and medical transition and, a spokeswoman said, gained thousands of members.

Some Genspect parents told me the rise in trans-identified teenagers was the result of a "gender cult" — a mass craze. (In February, an anonymous parent on a Substack newsletter affiliated with Genspect wrote a post called "It's Strategy People!" about how the group gets its perspective into the media by making sure not to talk about their kids as "mentally ill" or "deluded.") Other parents said they were not conservative and generally supported L.G.B.T. rights but not medical transition for their own children or usually for anyone under the age of 18. Several parents argued that though 18 is the legal age to vote, buy a gun and consent to medical treatment, in this single area of medicine — gender-related treatment — the age of consent should be 25, when brain development is largely complete. (At 18, these parents are aware, teenagers can go to Planned Parenthood, one of the largest providers of gender-affirming hormones in the country, and receive hormones after a roughly half-hour consultation and giving consent.)

Several Genspect parents told me their teenagers came out as trans after struggling for years with serious mental-health issues. One mother in Northern California said her child had previously been hospitalized for a suicide attempt and started identifying as trans while spending many hours online. The mother said yes to puberty suppressants at the recommendation of a local gender clinic, but her child became more volatile, she said. Around 15, her child wanted to progress to hormone treatment, which the gender clinic supported, according to emails I reviewed. When the mother refused, she became the object of her child's fury. "What if I'm wrong?" she asked. "Knowing my kid sees me as the barrier to happiness — that's the worst part. I feel like a monster."

Laura Kuper, a clinical child psychologist, is one of the authors of a chapter in the Standards of Care on nonbinary individuals.
Misty Keasler for The New York Times

As the United States battled over whether gender-related care should be banned or made more accessible, a few European countries that had some liberal practices concerning young people seeking medication imposed new limits recently. In February, the national health board in Sweden limited access to puberty suppressants and hormones before the age of 18 to "exceptional cases" and in research settings. The shift followed a Swedish public-television documentary that claimed doctors tried to hide spinal damage in a young patient whose bone density wasn't adequately monitored. Finland has similarly restricted access. One month after Sweden's decision, the National Academy of Medicine in France called for "great medical caution" regarding treatment for young people, citing health risks (including for bone density and fertility) and noting the unexplained rise in trans-identified teenagers.

In March, I visited the Amsterdam clinic to talk to de Vries about its trailblazing program and what she made of the responses of other European countries. We talked in her office, near a waiting room with a foosball table and artsy photos of an androgynous masked dancer. As a child, de Vries told me she resisted stereotypical gender roles. "Why were the boys asked to help the teacher carry heavy loads and the girls had to bring coffee and tea?" she said. "You could make me quite angry by asking me as a kid to do those things, as a girl."

Working in her clinic now, de Vries is concerned about the waiting list, which she called "devastating." Young people often wait two years or more for an appointment in the Netherlands. One of them, a theater student named Yaël who is now 22, told me that the delay felt endless. "My friends started growing beards, and people were looking at me like they were the guys and I was a girl or their little brother," he said. "It was just very frustrating and depressing." He remembered the day he started hormones at 16. "Someone came to the door to deliver a package, and when I signed for it, he said, 'Have a good day, ma'am.' For the first time, it didn't bother me. I thought, I know in a couple of months you won't say that." He added, "I can't imagine a life without being able to transition."

De Vries said she was disappointed by the developments in Scandinavia and France. But she thought the retreat in those countries signaled a different kind of conservatism, about how to practice medicine in light of scientific uncertainty, from the bans in the red American states, fueled by anti-trans vitriol. The shift from European health authorities also suggested that scientists and physicians who don't have the clinical experience of seeing young people receive gender treatments felt more constrained by the limitations of the research.

England's National Health Service, too, asked for an independent review of the country's gender-identity services (following a whistle-blower's report in 2018 that the nation's only pediatric clinic was fast-tracking young people into medical treatment and a lawsuit by a former patient — who later detransitioned — over the care she received there). Hilary Cass, a prominent pediatrician, is leading that effort. In a preliminary report in February that doesn't make a final recommendation, she said the "lack of available high-level evidence" about puberty suppressants and hormone therapy for young people was "too inconclusive to form the basis of a policy position" on whether to continue the treatments. She also described a "mismatch" between the ethical responsibilities of clinicians to meet certain standards before a treatment and the distress some young people feel about a detailed

assessment because they want "rapid access to physical interventions." Like the SOC8 adolescent chapter, Cass suggested that the Dutch approach to assessment is the one best supported by the research.

New findings continue to support that approach. In April, de Vries presented data at a pediatric conference, still unpublished, about more than 80 patients from the clinic's early cohort who were now between the ages of 25 and 50. (The response rate was about 50 percent.) According to the answers they provided, the trans men were doing just as well, in terms of mental health, as the general population. The trans women were slightly below the norm. No one in the group had reversed their hormonal treatments or surgeries. There is no published research on the physical effects in middle or old age of having transitioned in adolescence; the Amsterdam clinic is now collecting data on this question.

'In our society right now, something is either all good or all bad. Either there should be a vending machine for gender hormones or people who prescribe them to kids should be put in jail.'

In a video chat this spring, I talked to F.G., the first patient to take puberty suppressants for gender affirmation 35 years ago, when he was 13. He's a veterinarian, and when we spoke, he wore a yellow track jacket and had a short brush cut and a patch of beard under his lip. He told me that when he was a child, he wanted simply to *be* a boy. But of course that was impossible. Taking medication to stop puberty, he said, saved his life. He waited until he was 18 for hormone treatment. It would be unusual now to have such a prolonged stint on puberty suppressants. F.G. says he never wanted to have children, though he's not sure if that's because he didn't know if he could. For years, he stayed away from romantic and sexual relationships, but that changed in his 30s, and these days he has a serious girlfriend.

F.G. has watched the rise in numbers of transgender young people with a mix of joy and trepidation. He thinks kids who want the medical treatment he received should go through a significant assessment process. "It makes me sound a bit of a hypocrite, because I needed that to be who I am," he said. And yet the time on the suppressants, to test the strength of his own desires, was essential to his peace of mind. "I really, really thought about it," he said, "and I've never been so sure of anything in my whole entire life."

In March, the Biden administration's Department of Health and Human Services put out a statement unequivocally supporting gender care for minors, "when medically appropriate and necessary," as a matter of federal civil rights law. But the backlash was gaining momentum. The bill to ban trans medical treatment that Leibowitz had been worrying about was moving through the Ohio House; in April, Alabama passed a similar bill. On Fox News, Tucker Carlson called treatment for young people

"chemical castration." And the Florida Department of Health issued guidelines that opposed social or medical transition for kids of any age. Conservatives usually champion parental authority, but in families with trans kids, they were lining up to take it away.

Judges blocked the statewide bans, but in some cases, preteens and teenagers were losing access to a course of medication they'd already begun because pharmacies refused to fill prescriptions and doctors or hospitals preemptively stopped treatment, fearing liability or political opposition. In Texas, Ximena Lopez, a pediatric endocrinologist who worked at Genecis, the Dallas program that was forced to disband in November, sued to continue to see patients, and Leibowitz prepared to testify in support of her case. (Lopez has continued to see her previous patients and is temporarily accepting new ones under a one-year injunction.)

Leibowitz was frustrated by a political dilemma. To defend against the bans, some gender-affirming providers were oversimplifying aspects of the treatments. They said minors never or almost never had surgery at all, even though top surgery is important to some trans teenagers to relieve their dysphoria and is rising. (In the Kaiser Permanente health care system in Northern California, the incidence rose from a handful of operations in 2013 to nearly 50 in 2019, according to a study published in Annals of Plastic Surgery in May. Only two of the 200-plus teenagers in the study said they regretted the surgery at least one year later.)

To make the urgent case that medical interventions are necessary, some providers started emphasizing the risk of suicide among trans kids. The rate of suicide attempts among them in the previous year is terribly high — nearly 35 percent in a 2017 survey of high school students by the Centers for Disease Control and Prevention compared with single digits for the cisgender population. A 2020 study of trans patients of all ages, over more than four decades, at the Amsterdam clinic, found that deaths by suicide, which are fortunately rare, though still higher than for the general Dutch population, seem to "occur during every stage of transitioning."

In the overheated political moment, however, parents were getting the terrifying message that if they didn't quickly agree to puberty suppressants or hormone treatments, their children would be at severe risk. Many parents told me they'd heard the mantra: "It's better to have a live son than a dead daughter."

In individual cases, teenagers often say that being able to medically transition is lifesaving. Jack Turban, a fellow in psychiatry at Stanford Medical School, has become a major voice in the media and on Twitter among gender-affirming providers including on the question of medications and suicide risk. He leads a research team that worked with data from a 2015 survey of transgender adults in the United States. The survey asked respondents if they remembered taking puberty suppressants or hormone treatments before age 18. Using those adult recollections, Turban's team published articles in 2020 and 2022 finding an association between taking puberty suppressants and hormone treatments and having lower odds of suicidal thoughts in adulthood. But the studies didn't find the same link between taking the medications in adolescence and actually planning or attempting suicide. (Through a Stanford spokeswoman, Turban said he didn't have time to talk to me.)

Another 2022 study based on a different survey, by researchers from the Trevor Project (which provides crisis support to L.G.B.T.Q. young people), did show a 40 percent lower incidence in recent depression and in past-year suicide attempts for transgender and nonbinary 13-to-17-year-olds who said they had hormone treatments. There was no such finding for 18-to-24-year-olds.

The survey-based studies received prominent media coverage. But this research doesn't prove that young people who get puberty suppressants or hormones are at lower risk *because* of the medications, points out Christine Yu Moutier, a psychiatrist and the chief medical officer for the American Foundation for Suicide Prevention. The adults who remembered getting the treatments as teenagers could have had other advantages — "socioeconomic factors, having health insurance, having supportive families" — that better accounted for why their rates of suicidal thoughts or attempts were lower, Moutier says. And they could have received the medications they wanted in part because their mental health was evaluated as stable beforehand.

One of the clearest and most consistent findings about L.G.B.T. young people is that support from their families is essential for protecting them from a host of poor outcomes, from depression and suicide attempts to homelessness. The Family Acceptance Project, a research and intervention program for families of L.G.B.T. children, tells parents that refusing to use a child's chosen names and pronouns is a form of rejection. But the project stops short of saying that parents who delay or refuse to consent to medication, despite their children's wishes, are rejecting them or putting them at risk.

In the heat of a battle like the one raging over gender-related medical care for minors, insisting on precision about scientific evidence can seem nitpicky. But Leibowitz thinks gaining the trust of families necessitates acknowledging complexity. "It's irresponsible to reinforce very scary statistics to families in an attempt to gain consent for treatment," Leibowitz says. "This strategy doesn't build the type of love and acceptance that a child needs, which is truly at the heart of preventing suicidal behavior."

Maddie Deutsch, the president of USPATH, worries that the loud voices on all sides are the extreme ones. "In our society right now, something is either all good or all bad," she says. "Either there should be a vending machine for gender hormones or people who prescribe them to kids should be put in jail."

At a hearing called by the Ohio Assembly in May, supporters testified in favor of a ban on gender-related medical treatment, called the "Save Adolescents From Experimentation Act," while opponents rallied outside the hearing-room window. One conservative activist singled out Leibowitz for attack, based on statements he has made about gender-affirming care and supporting transgender young people and their families. It felt surreal to him to hear his remarks turned into fodder for testimony about how parents were being "coerced" into agreeing to medical intervention. It was a reminder, if he needed one, that for all the care and moderation he tried to take, he would always be perceived as dangerous by the right.

The 62-page final version of the adolescent chapter, which WPATH sent me the first week of June, is scheduled to be released this summer. It will include a key change in the top-line recommendations of the SOC8, in response to advocates like International Transgender Health. In place of the December draft's recommendation of evidence of *several* years of gender incongruence before a preteen or teenager begins any medical intervention, the final chapter set a vaguer timeline: gender incongruence that is "marked and sustained over time." Below their recommendations, Leibowitz, de Vries and their

committee did note that several years of experience is important for teenagers who want hormones and surgery but said that for puberty suppressants, several years was “not always practical or necessary.” In the end, the chapter sided with the trans advocates who didn’t want kids to have to wait through potentially painful years of physical development.

Leibowitz, de Vries and their co-authors held their ground on assessments. The final version of their chapter said that because of the limited long-term research, treatment without a comprehensive diagnostic assessment “has no empirical support and therefore carries the risk that the decision to start gender-affirming medical interventions may not be in the long-term best interest of the young person at that time.”

“Sometimes I feel that the field is so polarized that I worry whether the guidelines will be followed — how much authority will they have?” de Vries said of the upcoming publication of the chapter. “But I think a sensible reader will read a very nuanced, thoughtful approach that will help those who really need it.”

In the run-up to the release of the final SOC8, Leibowitz couldn’t imagine a more nerve-racking moment to make the guidelines public. In early June, the administration of Gov. Ron DeSantis of Florida asked the state’s health department essentially to ban gender-related medical care for minors — and in addition, to lay the groundwork to take that care away from trans *adults* with a report that justified ending Medicaid coverage for them.

Leibowitz said he hoped the SOC8 would improve the quality of care. He knew it wouldn’t settle the larger debates about how well teenagers know themselves and how parents and professionals should respond to them. “It’s convenient to say there’s not enough evidence if you *don’t* believe in the treatment — and that there’s enough evidence, if you *do* believe,” Leibowitz said. The clinical experience he had, seeing kids every day, was uppermost. “Evidence matters, yes, but common sense matters, too.”

Emily Bazelon is a staff writer for the magazine and the Truman Capote fellow for creative writing and law at Yale Law School. Her 2019 book, “Charged,” won the Los Angeles Times Book Prize in the current-interest category. **Anne Vetter** is a photographer and writer in California and Massachusetts. Their work is focused on the fluidity of identity, as well as Jewishness, whiteness and wealth.

Every trans child treated on NHS in past decade will have medical records scrutinised to see how many regret nsitioning

searchers to study data on around 9,000 children given counselling or drugs
alth Secretary wants to know if treatment improves lives or leads to regret
iders say he thinks the current system is 'failing children' by rushing drugs

By CONNOR BOYD DEPUTY HEALTH EDITOR FOR MAILONLINE
PUBLISHED: 10:20 EDT, 30 June 2022 | **UPDATED:** 11:34 EDT, 30 June 2022

Every child treated for gender dysphoria in the last decade will have their medical records scrutinised to see if **NHS** care is causing more harm than good.

Sajid Javid will today start to change the law to allow researchers to study data on around 9,000 adolescents given counselling or drugs for the condition.

The Health Secretary wants to know whether the treatment improves trans children's lives or leads to further problems or regret.

Currently, the data is protected by medical confidentiality laws that mean people are given a new NHS number when they legally change their gender.

Mr Javid has expressed concern that some vulnerable youngsters are being wrongly prescribed powerful puberty blockers. Insiders claim he thinks the current system is 'failing children' and has likened the uneasiness to speak out to officials' fear of investigating Asian grooming gangs.

It follows several lawsuits against NHS gender clinics by patients who feel they were not challenged more by medics when they changed genders.

Keira Bell, 25, (pictured outside the Royal Courts of Justice in 2020) launched a lawsuit against Tavistock - the NHS' only child gender clinic - which she said rushed her into taking drugs

Every child treated for gender dysphoria in the last decade will have their medical records scrutinised to see if NHS care is causing more harm than good. Sajid Javid will today start to change the law to allow researchers to study data on around 9,000 adolescents given counselling or drugs for the disorder

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Clinics in London, Leeds and Bristol, run by the Tavistock & Portman NHS Foundation Trust, are England's only specialist services for trans children.

It has been accused of being too willing to prescribe life-altering treatments and drugs that can permanently warp patients' hormones.

Legislation to change the Gender Recognition Act 2004 will be introduced today and is expected to take a month to become law.

It will allow the records of everyone who had therapy between 2009 and 2020 to be studied as part of a larger review of NHS gender dysphoria treatment.

The review is being led by paediatrician Dr Hilary Cass.

It will also look at the reasons behind an increase in referrals in recent years and why the increase has disproportionately been among girls.

Number of trans people receiving NHS treatment rises 75% in five years

The number of adults in the UK being treated for gender dysphoria on the **NHS** has risen 75 per cent in five years, MailOnline can reveal.

Latest figures for 2021 show more than 11,000 patients received care for the condition that causes sufferers to feel they were born the wrong gender.

This is 74 per cent more compared to the 6,371 patients being treated in 2016.

A Government source said: 'It is crucial that the relevant data is made available to Dr Cass as part of her independent review.

'It will build a world-leading clinical evidence base, better inform the planning of these services and improve our understanding of whether the treatment being provided is working.

'Ultimately that will benefit everyone, particularly children who may be questioning their gender identity.'

The Times reports that Mr Javid is concerned the NHS is offering drugs to children with gender dysphoria too liberally.

Doctors in the UK can prescribe children with puberty blockers after going through several rounds of counselling.

They can be given hormone therapies, which cause the development of female or male characteristics, once they turn

e has been a dramatic rise in
ren receiving treatment for gender
noria in Britain.

Just 138 children were referred for treatment in 2010/11, compared to 2,383 in 2020/21, a 17-fold increase.

Keira Bell, a 25-year-old who was given puberty blockers by Tavistock at 16, launched a lawsuit against Tavistock, which she said rushed her into taking the drugs.

A gender dysphoria diagnosis is the first step to getting prescribed cross-sex hormone therapies that help trans people develop the characteristics of their preferred gender.

MailOnline complied the data on gender dysphoria based on Freedom of Information (FOI) requests sent to 12 NHS gender clinics in the UK.

Of these, 11 provided data on their patient numbers stretching back to 2016, or to when they first opened.

Only four of the services were able to provide the number of patients prescribed oestrogen as part of their treatment, meaning the total is likely higher.

Overall there were 11,085 gender dysphoria patients being treated in 2021/22, compared to 6,371 in 2016/17.

Of the 2021 patients 1,592 were prescribed oestrogen.

In December 2020, the High Court ruled that children under 16 lacked capacity to give informed consent to the treatment following Ms Bell's case.

But the decision was overturned a year later.

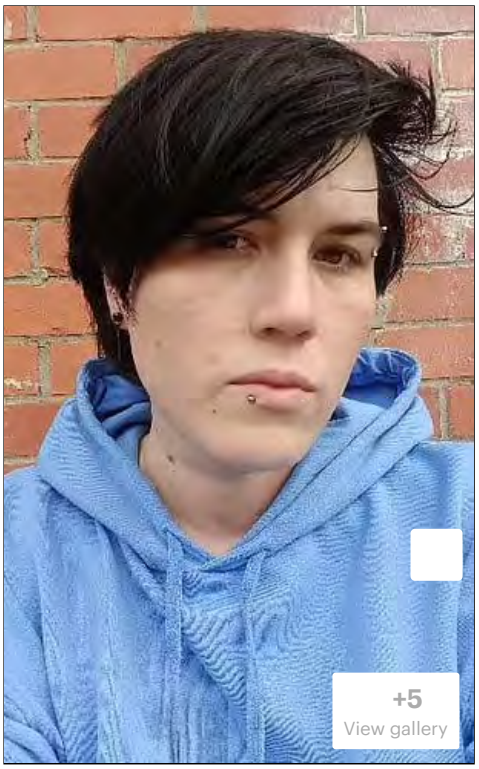
It comes after a British man who had his genitals removed during gender reassignment surgery revealed he is suing the NHS over the operation.

Ritchie Herron, 35, claims doctors did not warn him of the drastic outcome of the body-altering surgery which has left him infertile, incontinent and feeling like a 'sexual eunuch'.

It is thought to be the first medical negligence case over NHS transgender care in this country. The NHS trust involved has not been named.

'My first thought as I came round was Oh God! What have I done?': Man suing the NHS over trans surgery he bitterly regrets has bravely waived anonymity to share his ordeal

For Ritchie Herron, a bright and articulate civil servant from Newcastle, life over the past four years has become almost unbearable. It takes him ten minutes to empty his bladder, a process as painful as it is slow. Any sex drive is long gone. In fact, he says, his crotch is numb, 'shell-shocked' from the damage done to him under the apparent care of the **NHS**.



Pictured: Ritchie Herron says he was fast-tracked by the NHS into life-changing surgery

'Numb' rather sums up Ritchie's whole demeanour as he struggles to process what has happened to him. Today he reveals – in an exclusive interview – that he is the man preparing legal action against the NHS over an operation that removed his genitals.

ie's case emerged last week when osted about his experience on **er** under a pseudonym, TullipR. His testimony, which was picked up by aily Mail, was as shocking as it was ing for the NHS '**gender** clinics' that help people change sex.

Battling mental health issues – and after decades of suppressing his homosexuality – Ritchie, 35, had thought the answer was to become a woman. But instead, he says, he was fast-tracked into making 'the biggest mistake of his life' and left infertile, incontinent and with ongoing pain.

Not only had the NHS clinic failed to take into account his spiralling mental health crisis, he claims, but it had also failed to properly counsel him about the risks.

Ritchie has decided to waive his anonymity to tell the story of his ordeal in full, detail the physical and mental scars he has been left with – and warn there are more like him ready to take legal action over the surgery they bitterly regret.

His account raises serious questions about the safeguards in place at NHS gender clinics, which have seen a 1,700 per cent rise in referrals over the past ten years, accounted for mainly by children and young adults.

The speed at which Ritchie – who had been living as a woman called Abby – was diagnosed and subsequently referred for irreversible surgery is disturbing in itself.

In fact, he says, he had repeatedly turned down the procedure and had voiced deep misgivings to the clinic's staff about having it.

His case, he believes, could spark a wave of further claims.

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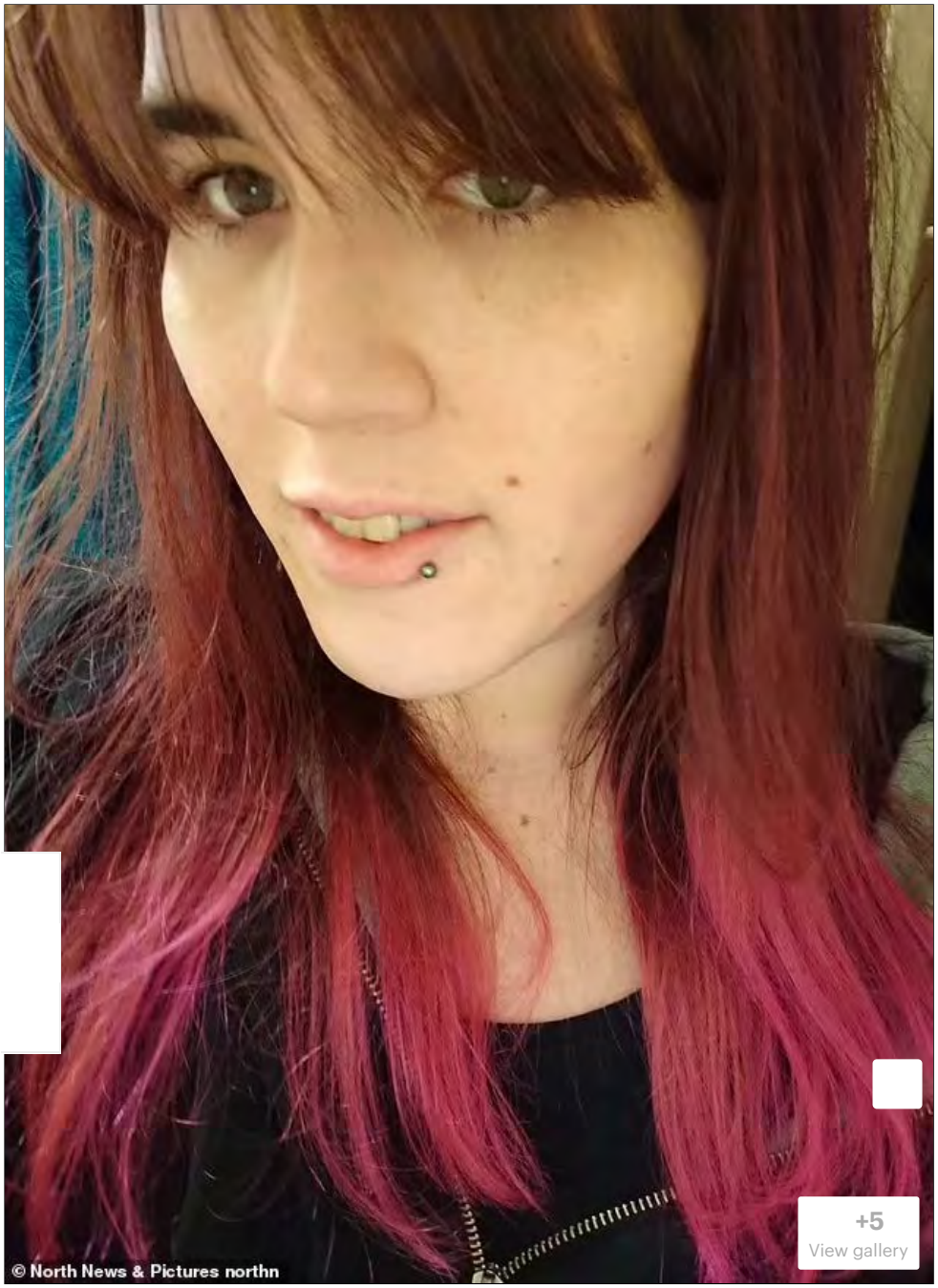

Pictured: Ritchie dressed in female clothes and went by 'Abby' before his surgery

'This is an avalanche waiting to happen,' he tells The Mail on Sunday. 'Transition is now being sold to people on a mass scale. It's like PPI, but more sinister.

'In a few years, I'm sure we'll have law firms asking people if they transitioned and would like to claim compensation.'

According to Ritchie, not one professional explored whether mental health issues may have led him to believe he was trans.

Today, he is one of a growing number of 'de-transitioners', living once again as a man and grieving his 'mistake'. Much of his confusion was around accepting he was gay, he now acknowledges.

Ritchie says he buried his sexuality, which left him with depression, anxiety and obsessive-compulsive disorder, using repetitive behaviours to mask his unhappiness.

Then, in his 20s, he stumbled across the idea of gender dysphoria in an internet chatroom. Older men on the forum convinced the vulnerable young man he 'must be trans'.

At that time for Ritchie, it felt like a lightbulb moment. After a series of breakdowns, in 2012 he decided to seek professional help.

He was referred to a psychologist, who did not dissuade him of the notion he had gender dysphoria, and then to the Northern Region Gender Dysphoria Service, run by Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust.

Pictured: Ritchie Herron as a young boy

The waiting list for appointments was long but, consumed with the idea, Ritchie took out a payday loan to pay for an appointment at a private gender clinic in March 2014.

According to Ritchie, he was diagnosed with 'transsexualism' after just two 30-minute appointments.

A psychiatrist recommended he take medication to block his testosterone production – the first step towards gender reassignment.

The only attempt to put the brakes on came from a close family member, who came to the appointment at the clinic with him. Ritchie says: 'She told the doctor I was on a high dose of antidepressants and had lots of complex issues, and yet they were referring me for gender treatment.'

So why did Ritchie go along with it? 'I was 26,' he says, 'but I was very vulnerable.'

He began living full-time under the name Abby, dressing in female clothes. The testosterone-suppressing drugs meant he began developing breasts. By March 2015, he was attending appointments at the NHS gender clinic in Newcastle.

'The first question you get asked there is, "Do you want genital surgery?" ' he says. 'I wasn't sure. But I'd heard you could get therapy if you were on the waiting list for surgery, so I said yes.'

The clinic – which will not comment on Ritchie's specific case – told the MoS it does not provide mental health services to patients.

Less than six months later, in July 2015, Ritchie received a referral for vaginoplasty surgery. Ritchie says he told the psychiatrist he was unsure and turned it down, but continued to receive therapy.

In 2017, he was given another referral for surgery, to be performed at the Nuffield Health hospital in Brighton but paid for by the NHS. Ritchie refused it again – but says he was told that if he did not accept the referral he would be discharged from the service.

This sent him into a 'tailspin', he recalls. He believed it meant his therapy would also be withdrawn, which had been a 'lifeline'. He had recently admitted he felt suicidal.

By 7am on May 23, 2018, Ritchie was wheeled into the operating theatre. 'I didn't want to see the surgeon,' he says. 'I was very much in the mindset of "I'm here now, there's no stopping it even if I wanted to." '

The irreversible operation involves removing the penis and testicles, and reforming the area to resemble female genitals.

For eight days he lay in a blur of painkillers. His first thought as he recovered his lucidity was: 'Oh God, what have I done?'

Ritchie is now planning a legal case against Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust. His barrister, Peter Harthan, says patients like Ritchie faced 'a lifetime of medical care and consequences' and 'cannot be put back together again'.

He adds: 'My concern is clinicians failed to identify red flags and change direction. Proper consideration needs to be given to issues such as OCD, internalised homophobia, depression, drug use, sexual abuse and childhood trauma as potential reasons for patients rejecting their sexed body.'

In a statement, the Trust said it could not comment on an individual, but it added: 'Care plans are collaborative and tailored to each patient's needs and goals, and treatment decisions are made following a thorough assessment in line with national recommendations.'

Ritchie says: 'I'm proof the whole system has to become far more robust. How many more people are there out there like me?'

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Lewis Hamilton arrives at Silverstone ahead of the British Grand Prix... hours after ex F1 boss Bernie Ecclestone backed Nelson Piquet in N-word racism row

'I drink more than I'm supposed to': Louis Theroux reveals his wife Nancy Strang warned him he was drinking 'quite a lot' during lockdown

Holly Candy is head-to-toe in Chanel as she sports a £12,000 outfit while leading the star arrivals alongside husband Nick on Wimbledon day four

A box office dream team! Co-star pals George Clooney and Julia Roberts have netted more than $962 MILLION with their joint projects since 2001

Golden girl of British tennis! How coach's daughter Katie Boulter, 25, has gone from career-threatening injury to dazzling at Wimbledon

'My emotions have been everywhere right now': Molly-Mae Hague admits she's not happy with her body after putting on half a stone

Drama queen! Letizia of Spain leads the glamour as she joins Brigitte Macron and NATO leaders' partners on visit to a Madrid theatre

Eve and Jess Gale send temperatures soaring in swimsuits after revealing Love Island producers banned them from wearing racy bikinis

Hat's embarrassing! Princess Anne steps in to pick up brother Charles' cap as they stood in for their mother the Queen at the Order of the Thistle service

Love Island SPOILER: Davide vows to give Ekin-Su a second chance as the reunited pair enjoy an intimate date after shock recoupling

Claire Foy was at 'significant risk' from obsessed stalker, 39, who bombarded star's publicist with emails about her being raped and repeatedly rang her doorbell, court hears

'That's some schoolgirl s*': Love Island fans brand Paige 'b***chy' as she turns away Danica from joining in on the girls' chat**

Kevin Spacey is seen for the first time since he appeared in court accused of sexually assaulting three men - as he films a docu-drama in Croatia

'My future will be a lot brighter': Kelly Holmes says she is 'processing' after coming out as gay but feels more 'positive' now... after she was hailed as an 'inspiration'

Love Island 2022: Gemma Owen leaves viewers aghast after flashing her breasts at semi-naked Luca Bish as he lathers himself up in the shower

Amanda Holden, 51, turns heads in a retro-style floral co-ord after saying she 'still wants to get wolf whistled at by builders in her 70s'

Emma Raducanu's OUTRAGEOUS reaction to getting blasted out of Wimbledon by a nobody proves she's fine with losing, writes MIKE COLMAN

Love Island's Georgia Steel shows off her sensational figure in a barely-there black bikini on holiday in Dubai

Lilly Becker goes makeup free as she gets beauty treatment in Wimbledon after her estranged husband Boris was jailed for bankruptcy fraud

Harry Maguire's wife Fern Hawkins shows off her svelte figure in a bikini as she joins her shirtless husband on their Honeymoon in Positano

Juliette Lewis debuts very big flame red hair with a sexy black ensemble as she is seen for the first time on set of Chippendales miniseries

'Do I leave it or flush it?' Martin Kemp recalls the embarrassing moment he accidentally went to the toilet in a stranger's hotel room as they slept

What spitting scandal? Tennis bad boy Nick Kyrgios' girlfriend shares a video of him as they cuddled on the sofa to watch Andy Murray's match

'Island girl': Liberty Poole shows off her sensational figure in busty white bikini on holiday in Spain

Model Stella Tennant's friends and family gather for a Service of Thanksgiving near her Scottish home - 18 months after she took her own life

Joe Wicks takes his exercise class to the stage as fitness fanatic trains a crowd in Hyde Park with the aim of beating world record for a mass workout

Denise Van Outen goes public with property developer Jimmy Barba at the Grand Prix Ball after dumping fiancé Eddie Boxshall

'One year home with my family sure looks good on me': Bill Cosby brags about his home life a week after court found him guilty of sexually assault

- Emma Louise Connolly looks radiant as she enjoys first date night with MIC's Oliver Proudlock since welcoming baby daughter Bonnie
- Paul McCartney, 80, goes incognito with a face mask and umbrella as he steps out after his triumphant set at Glastonbury
- 'Is it legal for a 19-year-old to be doing this to men?': Love Island fans left uneasy after Gemma's striptease and suggest show will face complaints
- Cat Deeley shows off her long legs in a statement blue mini dress in behind the scenes snaps from her latest episode of So You Think You Can Dance
- Buckingham Palace faces questions over Meghan 'bullying' probe as it 'revises' its HR policies in wake of inquiry but keeps its findings a SECRET
- Camila Cabello flashes her cleavage in a daring crop top as she poses up a storm for raunchy Instagram snaps
- Ashley Roberts looks typically fashion forward in red tartan dress with daringly high slit as she leaves work at Heart FM
- Meghan Markle is 'rubbing shoulders with the right people and making the right noises' if she wants to pursue a career in Washington, royal expert says
- Sharon Gaffka displays her incredible figure in colourful lingerie as she blasts Love Island for their lack of LGBTQ representation
- 'First a clairvoyant and now a magician': Eagle-eyed Love Island fans spot editing FAIL as Dami appears on screen in two places at once

Nice day for a WAG wedding! Spanish footballer Dani Carvajal is joined by his Real Madrid teammates as he ties the knot with model Daphne Cañizares

Leo DiCaprio's girlfriend Camila Morrone stuns in white thong bikini as she hits beach in Malibu... after Twitter mocked actor, 47, on her 25th birthday

Tom Hiddleston and fiancée Zawe Ashton expecting first child together as actress debuts baby bump at premiere of movie Mr. Malcolm's List

'We had to go against people obstructing us': Sugababes claim they were 'sabotaged' by music industry figures who didn't want them to succeed after reforming

Singer Chanel Haynes says she was fired from Tina Turner musical on West End after being given 'once in a lifetime opportunity' to perform with the Rolling Stones

Friends co-creator Marta Kauffman apologises for lack of

black leads in the hit sitcom and apologises with a $4m donation to her alma mater

'I had to cancel on the President': Paris Hilton reveals she snubbed Joe Biden to attend the wedding of 'angel' friend Britney Spears

Freida Pinto looks effortlessly elegant in an ab-flashing embellished bralette and beaded trousers at the VIP reception of her film Mr. Malcolm's List

Cardi B nails off-duty glam in a blue ensemble as she leaves a New York City recording studio... hours after declaring she wants a tummy tuck

Stranger Things will show 'a lot of Vecna in the last two episodes' after big identity reveal in volume 1 finale

'I feel like s**t': Machine Gun Kelly says he smashed a champagne flute on his head as he was trying to 'clink' the glass for a toast

Pop superstar Kylie Minogue reveals the moment she realised she finally had 'made it' - as she reflects on her early years

Love Island's Amy Hart suffers health scare as she reveals she has a stomach parasite and toxic metal in her system

Shirtless Damian Hurley sets pulses racing as he shows off his gym-honed physique in a smouldering snap

Ray Liotta's daughter Karsen hits the red carpet with his fiancé Jacy Nittolo at premiere of Black Bird - the last show he filmed before he died

Larsa Pippen shows off her sizzling figure as she slips into racy black bodysuit dress for early 48th birthday bash at PrettyLittleThing event in Florida

Spider-Man star Laura Harrier flaunts her incredible figure in a patterned bikini as she enjoys a sun soaked getaway

Pregnant Zawe Ashton dresses her baby bump in a floral mini for Mr. Malcom's List afterparty after revealing she's expecting her first child with Tom Hiddleston

'Please stick to kissing under the bedsheets': Love Island viewers left disgusted and say they will 'vomit' after Luca sucks on Gemma Owen's toes

'It's a reinvention of Bond': Barbara Broccoli says filming is 'at least two years away' and insists they won't rush into casting Daniel Craig's successor

Pregnant Leona Lewis shows off her bump in a sports bra and leggings as she heads out on a hike with her husband Dennis Jauch

Brooke Kinsella gives birth! Actress welcomes a boy and names him Ben in tribute to late brother after going into labour on anniversary of his death

Ozark's Julia Garner sports kooky yellow glasses as she steps out in a shirt dress after a dinner date with friends at Craig's

Amber Heard's legal troubles continue after losing defamation trial against Johnny Depp as she is investigated for allegations of PERJURY in Australia

Naomi Watts reveals her CRAZY nails after visiting a beauty salon with her friends in London

Cindy Crawford opts for laid back look in navy top and matching

skinny jeans as she steps out for a stroll in Malibu

John Boyega admits realizing he has 'big head' after seeing Madame Tussauds wax figure of himself

Jordana Brewster gives a glimpse at her cupping therapy marks as she heads out for breakfast with her sons Rowan and Julian

Now even the Queen is feeling the pinch: The Royal Family is back on duty... but palace income has taken an £14m hit after Covid pandemic

Scout Willis shows off her lithe legs in denim hot pants and a chic linen shirt as she runs errands
Stylish

- Kanye West threatens to SUE a small Melbourne burger joint - forcing the mega-fan owner to totally rebrand his business
- Alabama Barker gives thanks for 'prayers and love' after her father Travis Barker is 'hospitalised for pancreatitis': 'I appreciate you'
- Prince Charles had 'emotional' first meeting with granddaughter Lilibet and a reunion with Archie during Harry and Meghan's visit to the UK for the Jubilee
- Jesy Nelson displays her killer curves in a cleavage boosting red bikini as former Little Mix star kicks back while recording her debut solo album
- Kylie Minogue and Riley Keough glam up in black Louis Vuitton ensembles for designer's jewellery dinner in Morocco
- Meghan 'bullying' inquiry buried: Findings of Palace probe into claims duchess drove out two 'traumatised' assistants will NEVER be made public
- Love Island fans BAFFLED as Danica recouples with Jay despite him telling her he fancies Antigoni... as viewers root for her to make it to Casa Amor
- Andy Murray and Emma Raducanu crash out of Wimbledon... but defiant teenager Emma shrugs off loss and says: 'Why is there any pressure?'
- 'Let's get it straight, they left me!' Eamonn Holmes accuses ITV of 'lying' over his exit from This Morning as he admits he STILL doesn't know why he was axed
- Tessa Thompson rocks a casual look as she hugs male pal after he helped load up her luggage following stay at NYC hotel

- Jennifer Lopez 'refused to perform on a British TV show unless her dressing room was redecorated in all-white', claims Dannii Minogue
- Real Housewives Of Beverly Hills: Diana Jenkins declares herself 'new villain' on Bravo show during intense argument with Sutton Stracke
- Elizabeth Olsen steps out with a unique print dress arriving at The Tonight Show... where she teased her uncertain future with Marvel Studios
- 'What an incredible lady': Kelsey Parker says late husband Tom will be 'waiting with a glass of something special' for Dame Deborah James
- Ben Affleck gets to work in the director's chair with Matt Damon and Viola Davis on their untitled Nike/Michael Jordan project
- Kirsten Dunst looks groovy in tie-dye Rodarte T-shirt as she runs errands in Los Angeles
- Madonna's daughter Lourdes Leon puts on a bootylicious display as she shows off Kali Uchis' jean collection OBSESIÓN in sensual advert
- Freida Pinto looks pretty in yellow pleated gown with cascading sleeves at the NYC premiere of her movie Mr. Malcolm's List
- Travis Barker, 46, was 'hospitalized for pancreatitis' that was 'triggered by colonoscopy' as he remains under medical care in LA
- Love Island 2022: Islanders are stunned as Ekin-Su makes shock decision to recouple with Davide, while Danica chooses Turkish actress's ex Jay

Dakota Johnson reveals director Alfred Hitchcock once sent her mother Melanie Griffith a doll of her grandmother Tippi Hedren... in a coffin: 'Hitchcock was a tyrant'

First look at Chris Hemsworth's eight-year-old son playing a young Thor in the trailer for Love and Thunder: 'He really wanted to be in it'

Justin Bieber rocks silver sunglasses as he steps out several weeks after revealing battle with facial paralysis

'Financially independent' Prince Harry paid for Easter visit to England with Meghan
Received no assistance from his family

'You taught your victims that love is enslavement and violence': Brooklyn judge sentences R&B star R Kelly, 55, to 30 years in prison

Khloe Kardashian shows off her svelte physique in NUDE outfit as she attends sister Kim's SKKN launch with Kimora Lee Simmons and daughter Ming

Adele cuts a glamorous figure in black gown as she makes rare appearance with boyfriend Rich Paul at NBA star Kevin Love's wedding in NYC

LOVE ISLAND 2022 DAY 24 RECAP: Danica's shock decision to recouple with Jay ruffles feathers while Ekin-Su reunites with Davide Sanclimenti

Selena Gomez looks every bit the makeup mogul in spliced blazer dress and heels at the launch of Rare Beauty's Kind Words lip collection

EDEN CONFIDENTIAL: SOS to find saviour for Winston Churchill funeral boat
Forty years after the state funeral of the iconic Prime Minister

That's hot! Paris Hilton struts her stuff in a velour tracksuit despite sweltering LA heat ahead of Jimmy Kimmel Live! interview... before slipping into sexy black number

Katie Holmes flashes cute smile while out and about in New York City in long floral print dress

Whistle away, boys! Amanda Holden says she LIKES receiving compliments from builders... even if it's considered sexist
Enjoys the attention

Alan Shearer's busty daughter Hollie showcases her incredible figure in a green bikini as she soaks up the sun during Greek getaway

Warner Bros defends JK Rowling's saying studio is PROUD of working with 'world's best storytellers' and PR was 'wrong' to say she was 'not relevant'

Uma Thurman's daughter Maya Hawke says she 'wouldn't exist' if her mother hadn't had an abortion in her late teens
Opening up

Russell Crowe to star in upcoming supernatural horror movie based on the true story of a real-life exorcist

Cardi B declares she wants a tummy tuck nine months after giving birth to her son Wave: 'I just don't like this extra little skin'
Not happy

Joel Dommett's wife Hannah Cooper gives a glimpse at her midriff in white crop top as they attend the Gay Times with Apple Music's pre-Pride party

Naomie Harris stuns in a sophisticated fuchsia evening gown as she makes a glamorous entrance at the 12th annual Grand Prix Ball amid dating rumours

TOWIE's Amber Turner flashes a glimpse of her toned midriff in a stylish peach co-ord as she joins co-star's Chloe Meadows and Courtney Green for a night out

Ryan Gosling returns to cowboy Ken look filming Barbie... as wife Eva Mendes reveals she asked him to bring his costume underwear home for her to wear!

Lindsay Lohan pays tribute to Mean Girls and pokes fun of her name pronunciation in new All Birds shoe commercial
Lighthearted

Now Hailey Bieber has a Barbie moment! Justin Bieber's wife gets dolled up in bubblegum pink minidress as she becomes latest celeb to embrace the toy icon

Ricky Martin's former manager Rebecca Drucker says he 'completely and maliciously refused to pay' her in $3 million lawsuit

'I didn't realize how thin I was': Kristin Cavallari says she's 'happy' to have put on weight after being 'shocked' at how skinny she looked in old snaps

Today's headlines | Most Read


From 'chestfeeding' to 'human milk' and 'birthing PARENTS': How NHS language is going woke - with women...


NHS ambulance of the future? British-manufactured, electric-powered and with X-rays ON BOARD, experts claim...


Scientists want to create a poo BANK: Future faecal transplants have 'better potential' than umbilical cord...

Britain should offer abortions to American women for FREE in wake of Roe v Wade ruling, doctors say


Grandmother, 90, with leukaemia was left in A&E corridor for 30 HOURS after splitting her head open in...


Every trans child treated on NHS in past decade will have medical records scrutinised to see how many regret...


Return of the mask! Covid's resurgence sparks NHS hospitals to bring back guidance urging patients to wear...


End of the family GP? A quarter of doctc nurse posts could be vacant by 2030, re warns


DAILY MAIL COMMENT: GP system is dire need of intensive care


Family doctors 'don't know enough' abou menopause... so women are turning to each other for help, study...


Seeing the same GP is good for your health... but only HALF of patients are able to do so: Country's top...


Day by day, the secret powers of a woman's cycle: The best time to diet, when to bag a bargain, and the...


Getting enough sleep is now officially a marker of good health: List of eight life-prolonging steps now...


NHS staff are told to change bedsheets only if it's essential amid hospitals laundry shortage


Why Serena Williams REALLY had black stickers on her face: Tennis ace is using muscle-healing tape...

MORE HEADLINES

MORE DON'T MISS

Robin Williams' daughter Zelda to direct zom-com Lisa Frankenstein starring Cole Sprouse and Kathryn Newton
New project

Jaime Winstone enjoys a boozy night out with Daisy Lowe at Grey Goose event after announcing her

engagement to James Suckling

Jennifer Lawrence maintains a healthy lifestyle as she steps out for spot of exercise in LA
Ventured out for a walk on Wednesday morning

Russell Crowe, 57, is 'set to sell his Wolloomooloo pad' featuring 11 bedrooms and its own 35-metre marina berth for a whopping $40million

Kevin Love marries Kate Bock! Swimsuit model stuns in a lace gown as she ties the knot with the NBA star in a Great Gatsby-inspired wedding

Machine Gun Kelly hides behind shades after horrifying Megan Fox by smashing champagne flute on his head and performing covered in blood

Halsey responds to fans who left her outdoor concert in Arizona after the singer gave a passionate speech on abortion rights

Christine Quinn opts for casual chic look in tan suit and crop top while out and about in New York

TikTok star Ophelia Nichols' son was dealing marijuana when he was shot dead: Mom said she never thought he'd do anything to 'get into trouble'

How you can grant Dame Deborah's last wish: Mail's Gut Health Guru, who knew the 'Bowelbabe', urges readers to honour her legacy

EXCLUSIVE **Megan Barton Hanson and on/off beau James Lock reignite their romance as they hold hands during trip to the Costa del Sol**

Royals step in for the Queen: Prince Charles, Sophie Wessex and Princess Anne host Holyroodhouse garden party - but Her Majesty stays away

Izabel Goulart flashes her washboard abs in a cropped shirt and shorts as she strolls hand-in-hand with fiancé Kevin Trapp during Greek getaway

Jessika Power reveals the ONE thing you get for free on Married At First Sight Australia - as she admits she had to 'buy a whole new wardrobe' for the show

Mira Sorvino looks sharp in a black jacket and lace dress while out in New York... after teasing a Romy and Michele's High School Reunion sequel

Erika Jayne must turn in $750K diamond earrings her estranged husband Tom Girardi bought with stolen money following court ruling

'God pulled me out of Hollywood': Spy Kids star Alexa PenaVega reveals she quit life of fame in LA and moved to rural Hawaii with her ex pop-star husband

Amber Le Bon cuts an elegant figure in a glittering blush pink plunging gown as she attends the Pronovias bridal store launch in London

Elizabeth Olsen reveals she and husband Robbie Arnett had a secret wedding BEFORE they eloped during pandemic: 'I just never talked about it'

Stephen King reveals the only movie he has ever walked out of was Michael Bay's 2007 action epic Transformers
Disappointed

Who's The Boss? sequel series starring Tony Danza and Alyssa Milano now in development at Amazon Freevee
.

Howard Stern reveals Bradley Cooper as his running mate... just one day after announcing he's running for President in 2024
Surprise

Chelsea player Ross Barkley shows off his ripped physique as he joins stunning bikini-clad girlfriend Katherine Pilkington on a relaxing beach break in Sardinia

Real Housewives Of Dubai star Caroline Stanbury, 46, dons pink swimsuit as she kisses Sergio Carrallo, 27, in Mykonos... just days after getting ROBBED

She means business! Lara Worthington shows off her slender figure in a three-piece pinstripe suit at MaxMara fashion show in Portugal

Lady Victoria Hervey catches the eye in revealing black tuxedo jumpsuit with cut out sides as she attends the 12th annual Grand Prix Ball

Abbie Quinnen looks sensational in red evening gown as she puts on a loving display with beau AJ Pritchard at The 12th annual Grand Prix Ball

Junior Andre has terrifying run-in with ferocious dog on set of music video for his track Slide, with pop star losing his shoe as he desperately flees

Rachel Riley nails summer chic in a tangerine floral dress as she leaves the Countdown studio in Manchester
Finishing work

Cameron Diaz's big comeback! 'Retired' star announces her surprise return to acting in new Netflix film starring Jamie Foxx and Tom Brady

Lewis Hamilton could be BANNED from British Grand Prix as row over nose stud reaches boiling point... with driver not backing down

Heartbreak for Emma Raducanu as she limps out of Wimbledon in the second round after being beaten inside an hour and a half

Pretty in pink! Kim Murray stuns in a fuchsia shirt and stylish sunglasses as she cheers on her husband Andy at Wimbledon
Lookjng good

EXCLUSIVE **Flying solo! Calista Flockhart is seen touching down in LA in pilot hubby Harrison Ford's $18.8million private jet**

EXCLUSIVE **Get a room! Ryan Seacrest, 47, and his influencer girlfriend Aubrey Paige, 24, pack on the PDA as they share a kiss in Ibiza**

Lionel Messi flaunts his muscular frame as he cosies up to his wife Antonela Roccuzzo during Ibiza getaway with Cesc Fabregas and Luis Suarez

Kristen Stewart rocks a dark brunette mullet for latest dramatic role in romantic thriller Love Lies Bleeding... as she films in Albuquerque
Quiet on set

Molly-Mae Hague puts on a busty display in a crop top and skin-tight leggings as she steps out in Manchester
The Love Islander pounded the pavement

Nicole Scherzinger swaps her bathrobe for a fringed white dress and dances with Thom Evans in Switzerland as star enjoys her TENTH holiday this year

Tobey Maguire celebrates his 47th birthday with pals Leonardo DiCaprio and Kevin Connelly at star studded Hollywood pool party

'I caught up on all of the topless antics!' Stacey Solomon reunites with Joe Swash and gets an update on her fiancé's antics during boozy stag do

Jeremy Clarkson's ex Phillipa Sage says he would 'lose his

patience' with co-stars James May and Richard Hammond as she details her 'bizarre job'

Bumping along nicely! Pregnant Michelle Williams wears striped maternity shirt-dress out in NYC as she counts down to the birth of third child

Sofia Richie looks chic in long black coat for beachside dinner with her fiancé Elliot Grainge
Cut a seriously stylish figure

Date night! Ashton Kutcher and Mila Kunis leave their kids at home for romantic dinner at Italian restaurant
Enjoyed a night away from the children

Reese Witherspoon is her own best advert as she strikes pin-up pose in swimsuit from her brand
fired up her Instagram page this Wednesday

Megan Fox and Machine Gun Kelly clarify marriage rumors... as pop punk rapper insists actress 'never felt like my girlfriend'

'Americans made it clear in 1776 they don't want British Royals making decisions for them': Republicans slam Meghan Markle for wading into politics

Rebel Wilson soaks in the hot tub of her £2,000 a night Turkish cave hotel during her romantic getaway with girlfriend Ramona Agruma

EXCLUSIVE **Out-en with the old! Denise Van Outen has moved on from love rat ex Eddie Boxshall and 'is happily dating a property developer'**

Tamara Francesconi shows off her sensational figure in a very skimpy chainmail set before flashing her abs in a crop top for a

sizzling new shoot

Christine McGuinness takes a break from her overseas girls' holiday to announce she will front a second documentary on the 'secret life of autism'

REVEALED: 'Ray Donovan' and 'ER' actress Mary Mara died of asphyxiation due to drowning in St. Lawrence river, New York police confirm

Billie Eilish must answer which famous person she has kissed or eat gross foods in fun 'spill the tea' game with James Corden
Unpleasant

Summer House shake up! Andrea Denver, Luke Gulbranson and Alex Wach CUT from cast ahead of reality show's seventh season
Big changes

Travis Barker's daughter Alabama, 16, dances around in new TikTok before quickly deleting it... after asking for 'prayers' as her dad remains in hospital

Kevin Bacon and wife Kyra Sedgwick try the Footloose viral dance as the actor jokes: 'I don't remember this being part of the choreography'

Machine Gun Kelly is covered in blood as he leaves his party after smashing a champagne flute on his head during gig where he shouted 'I don't give a s**t'

'I'm in a good place!' Chris Hughes breaks his silence after shock split from his golfer girlfriend Annabel Dimmock - just a year after they started dating

'Looking back at this person, I see fear': Michelle Heaton shares heartbreaking photos of bloated stomach and puffy face as she marks 14 months of sobriety

'If pregnancy is God's will then so is your limp d**k': Furious Bette Midler takes aim at men and calls for a ban on Viagra after Scotus overturned Roe V. Wade

'Please say a prayer': Travis Barker's daughter shares photo of Blink-182 drummer in hospital as he's treated for a mystery illness in Los Angeles

One Tree Hill's Hilarie Burton, 39, condemns Roe v. Wade reversal as she reveals how getting a termination after a miscarriage helped her 'uterus to heal'

Rebel Wilson and girlfriend Ramona Agruma strike a pose atop a mountain in 'magical cappadocia' while on holiday in Turkey

Julia Roberts' romcom return! America's sweetheart reunites with George Clooney for a FOURTH time as they play warring exes in Ticket to Paradise

Saoirse Ronan tries to solve a 50s murder mystery in London's West End while Ruth Wilson stars as an elusive suspect in See How They Run trailer

Boris Becker's girlfriend Lillian de Carvalho Monteiro and his son watch Novak Djokovic... two months after fallen tennis star was jailed

Gisele Bündchen nails summer chic as she and husband Tom Brady step out in Portofino with their two children Vivian Lake, 9, and Benjamin, 12

'It still fits!' Abbey Clancy tries on her wedding dress and shares loved-up snap as she marks 11 year anniversary with husband Peter Crouch

Prince Charles admires a portrait of Prince Philip during a visit to Royal College of Surgeons of Edinburgh after following in his father's footsteps

Copy of £165,000 Snow White and the Seven Dwarfs artwork commissioned as a christening gift for Princess Charlotte goes up for auction

Blooming lovely! Queen Maxima of the Netherlands is elegant in a floral dress as she joins King Willem-Alexander in Graz during visit to Austria

R Kelly victim slams him in court for 'using fame and power to groom' children for his 'own sexual gratification' ahead of his sentencing

Gigi Hadid pulls her long blonde locks into messy bun for a casual outing after faking shaved head for edgy catwalk look

'20 years later...': Avril Lavigne recreates album cover for her hit 2002 debut record Let Go for TikTok
The performer stood in the middle of city street.

Britney Spears 'loves' new $11.8M mansion with husband Sam Asghari... as it was important to own home without approval after conservatorship

Prince Charles 'will never again handle large donations' to his charities after he was presented with €3m in bags from former Qatari prime minister

Miranda Lambert talks about 'heartbreak' and 'hard' journey to happiness after finding love with Brendan McLoughlin following Blake Shelton divorce

Stranger Things propels Kate Bush to the top of the Australian charts with her song Running Up That Hill 37 years after it was released

Hugh Grant to lead cast of Greek gods in upcoming Netflix mythological thriller Zeus, with series set to go into production this summer

Georgia Toffolo is the picture of sophistication in lacy corset as she joins a leggy Rose Ayling-Ellis at day three of Wimbledon

Shaughna Phillips reveals she had to 'milk' her calves after having liposuction for lipoedema and says her ex-boyfriend told her to 'sort her legs out'

EXCLUSIVE ITV bosses 'desperate' to sign up Gemma Owen's mum Louise Bonsall for Real Housewives of Cheshire

Love Island SPOILER: 'I'd love to prove to you how much you mean!' Jacques grovels to Paige after saying Gemma's dance gave him 'sex flashbacks'

Amy Jackson puts on a smitten display with new boyfriend Ed Westwick as pair make public event debut at day three of Wimbledon

Nelson Piquet APOLOGISES for using N-word to 'anyone that was affected, including Lewis' but will be banned from Formula 1 as Lewis Hamilton is spotted for first time

Jason Derulo and baby mama Jena Fumes fuel reconciliation rumours as they take son Jason King for lunch together at Nobu in Malibu

JoJo Siwa CONFIRMS she has rekindled relationship with girlfriend Kylie Prew... and reveals they are 'setting new boundaries'

A royal Glastonbury! Duchess of Kent's granddaughters Lady Amelia and Lady Marina Windsor share wild snaps partying at festival

Bachelorette stars Trista and Ryan Sutter open up about his debilitating Lyme disease battle: 'For so long I was only thinking about how to survive'

Neighbours' Ian Smith, 83, who played Harold

Bishop, says Australian government should have saved axed soap: 'It could be a working school for actors'

Lorraine and Susanna Reid become emotional as they pay tribute to 'remarkable' cancer campaigner and friend - as Holly Willoughby praises her 'legacy'

'I've had 'Porky Posh', I've had 'Skeletal Posh': Victoria Beckham slams Chris Evans for forcing her to weigh herself live on '90s hit TFI Friday

Love Island hit with 75 Ofcom complaints as fans accuse the boys of 'bullying' Ekin-Su after Jacques called her a 'f***g headache' following explosive row with Jay**

Love Island hits 100MILLION streams! Eighth series becomes the most watched yet - after contestants set pulses racing in X-rated striptease

Love Island SPOILER: 'What do I do?!' Ekin-Su, Danica and Antigoni are ALL unsure which boy they want as the latest recoupling looms

Travis Barker, 46, hospitalised with mystery illness as wife Kourtney Kardashian stays by his side - hours after he tweeted: 'God save me'

Eva Longoria wows in chic white trouser suit as she attends the Taormina Film Festival 2022 in Italy

'We'll be going to DC together soon': Meghan Markle hints at presidential ambitions and urges voters to 'take action' over Roe v Wade abortion ruling

Sophie Countess of Wessex dons smart trouser suit as she gets

stuck into activities such as planting and painting during a centre supporting people with disabilities

Katie Price's daughter Princess, 15, stuns fans as she bears strong resemblance to her mother while wearing heavy makeup in beauty snap

Bikini-clad Katie Price showcases her assets before wrapping her legs around Hannah Elizabeth for OnlyFans shoot - after star was reported to police again

Jenny Powell, 54, puts her gym-honed figure on full display in a halterneck bikini during her Ibiza getaway

R&B star R Kelly is due in court today to be sentenced for up to 25 years over sex-trafficking conviction as his lawyers argue for just ten years

Cristiano Ronaldo's partner Georgina Rodriguez cuts a sporty figure in blue leggings and a grey vest as she steps out for a stroll with her kids in Madrid

Jaime Winstone is engaged! Actress reveals her boyfriend James Suckling got down on one knee in 'perfect proposal' at Glastonbury

Looking ace! Carole Middleton sports £150 jumpsuit from Boden as she and husband Michael step out on third day of Wimbledon
Smart

'Why post this drivel?': Jeremy Vine is blasted online for performing Craig David song on TikTok as he continues to present his TV show from home while still battling Covid

'Bully-boy actions from a BBC staff pitchfork mob': Piers Morgan

says Michael Vaughan is a victim of 'cancel culture at its worst'

Tracee Ellis Ross dazzles in a vibrant orange midi dress as she washes her hair in front of guests at the UK launch of Pattern Beauty in London

Prince Andrew breaks cover amid calls for him and other Epstein associates to become FBI's 'next target' after his friend Ghislaine Maxwell was jailed for 20 years

Vogue Williams shows off her long legs in high waisted leather shorts as she steps out with a friend

Meghan Markle says men need to be 'more vocal' in wake of Roe v Wade decision and describes Prince Harry's reaction to the news as 'guttural'

Malin Andersson confidently shows off her post-baby figure in busty black bikini and magenta swimsuit... five months after giving birth

Rosie Huntington-Whiteley shares a look at her chic neutral summer wardrobe as she posts series of selfies

Little Mix star Leigh-Anne Pinnock's record label launch an investigation as her solo music is leaked online

'She was an inspiration whose legacy will live on': Prince William and Kate pay tribute to 'unfalteringly brave' Dame Deborah James after her death aged 40

Caitlyn Jenner sparks fierce debate on GMB over swimming governing body's ban on transgender female

athletes as she claims they have 'too much of an advantage'

Mark Wahlberg gifts a pair of trainers from his own brand to a fan during promotional tour in Paris

Selling Sunset's Tina Louise, 41, flaunts her sensational bikini body while holidaying on the French Riviera

Newlywed Sam Fox puts on a loved-up display with wife Linda Olsen as they share a kiss while enjoying al fresco lunch

Jacqueline Jossa confidently shows off her curves in a range of colourful bikinis as she models her new In The Style swimwear collection

Amanda Holden brings some summer style in a frilly pink shirt and bold maxi skirt while Ashley Roberts is chic in a white suit as they leave Heart FM

'If it's good enough for Kendall Jenner!' Ulrika Jonsson, 54, poses NAKED in eye-popping snap as she recreates reality's star shock nude post

Ashley Graham is unrecognisable as she transforms into a punk rocker with a bright orange wig, bleached brows, facial piercings and prosthetic HORNS

Why Serena Williams REALLY had black stickers on her face: Tennis ace is using muscle-healing tape popularised by Cristiano Ronaldo and Tiger Woods

She's a Barbie girl! Khloe Kardashian is a living doll in a tight pink latex dress as she showcases her birthday transformation in new TikTok video

Avril Lavigne wows in bustier top and leather trousers as she attends MGK after-party with fiancé Mod Sun

Damon Hill calls on Formula One to stop merely 'nodding in the direction of political correctness' and take FIRM action against Nelson Piquet

Chanel Iman displays her model frame in a chic bikini as she cosies up to her shirtless beau Davon Godchaux during luxe Mykonos getaway

Dame Deb's incredible final month: After being given days to live, she raised £6m, met royalty, went to Ascot and launched a bestselling book and fashion range

'It was way overdue for us': Britney Spears' husband Sam Asghari calls married life 'a fairytale' three weeks on from their lavish wedding

Landon Barker and new girlfriend Charlie D'Amelio leave MGK's afterparty together - following his father Travis' mystery hospital dash

Outkast's Big Boi 'divorced from wife Sherlita Patton' after 20 years of marriage 'and said there is no reasonable hope of reconciliation'

Jack Black wears a 'not fake news' T-shirt and garish patterned shorts as he makes rare appearance in sunny LA

Alex Rodriguez, 46, and leggy girlfriend Kathryne Padgett, 25, hold hands as they leave Machine Gun Kelly's afterparty

Baby, I'm your man: Wham! star Andrew Ridgeley's new love is super-rich divorcee 'with the longest legs in Belgravia'
Has found love again

- Kim Kardashian shows off VERY tiny waist in skintight faux leather pants and busty halter top in LA... after sister Khloe's boozy 38th birthday lunch
- Megan Fox struts her stuff in an ab-baring fuchsia top for stroll through NYC... before holding hands with fiance Machine Gun Kelly after his concert
- 'The country is no longer a democracy': Wanda Sykes lays into Scotus judges who 'lied' and dismisses Americans in 'states in the middle'
- 'Would anyone in the world not like to kiss her?': Cara Delevingne talks locking lips with Selena Gomez for Only Murders In The Building
- Heidi Klum makes a wild fashion statement in leopard print as she steps out hand-in-hand with her husband Tom Kaulitz
- 'Want some blackout sunglasses?' Michael Owen reacts to daughter Gemma's raunchiest Love Island moment yet in WILD striptease challenge
- The devastated family Dame Deborah has left behind: Husband who was her 'rock', her 'unsung hero' father and the mother who 'relentlessly nursed' her
- Paddy McGuinness moans he is being a 'skivvy' for his children while his wife Christine is on a girls' trip - and enlists TV chef Chris Baber to cook for him
- Pregnant Ashley Greene displays her baby bump in form-fitting workout gear as she hits the gym with husband Paul Khoury
- 'We formed a new band!' Rita Ora poses for 'spicy' snap with Hollywood superstar Robert DeNiro and Emma Bunton at star-studded hotel party

'It was the longest most fun party!' Celebrity Juice is ending after 14 years on air as Leigh Francis confirms two farewell specials

Love Island 2022: Exes Gemma and Jacques' hearts race most for EACH OTHER in striptease... with rugby ace admitting he had sex flashbacks

Katherine Ryan and husband Bobby Kootstra enjoy a date night at Nobu event - after revealing she kept her pregnancy a secret from TV bosses

Chris Hemsworth confirms his twin sons Tristan and Sasha, eight, and daughter India Rose, 10, will be appearing in Thor: Love and Thunder

Louisa Lytton lands in Italy as she prepares to FINALLY marry fiancé Ben Bhanvra this weekend - after being forced to postpone their wedding three times

Kevin De Bruyne's wife Michele Lacroix puts on a leggy display in emerald green mini dress as the couple attend friend's wedding in California

'Our family is growing': Hollyoaks stars Emmett J. Scanlan and Claire Cooper reveal they are expecting their second child together

Casey Batchelor puts on busty display in plunging black swimsuit as she enjoys a girls' holiday in Ibiza

'I am very prone to it... sharing stage fright is electrifying:' Dame Judi Dench admits she fell in love with Hamlet co-star John Neville

Deborah saved our lives: Cancer survivors praise the campaigner for raising awareness - as one says, 'I realised if she could get cancer so could I'

'You got the power tonight': Love Island's Ekin-Su holds all the cards as she decides between Davide, Jay and Charlie in latest recoupling

Eva Longoria cuts a glamorous figure in white blouse and matching skirt as she attends Tell It Like A Woman Gala in Sicily

Dolph Lundgren, 64, and fiancée Emma Krokdal, 25, enjoy an al fresco lunch date after revealing plans to get married 'next year'

'I'll have a bit more free time': James Corden hints at return of Gavin and Stacey and says he will trust Ruth Jones' 'judgement'

Ashlee Simpson and husband Evan Ross look effortlessly stylish as they party into the early hours at London hotspot

For you Debs! Bowelbabe fund rockets by tens of thousands of pounds in the hours after family revealed Dame Deborah James had died aged 40

Just call him PC Nesbitt! As actor James plays a detective for the EIGHTH time in Suspect, how the star has built a career playing coppers

Lauren Conrad reveals she received 'lifesaving reproductive care' for an ectopic pregnancy six years ago as she speaks out on Roe v. Wade reversal

Something kinda woah! Cheryl stuns in a plunging black top as rarely seen star reunites with Nicola Roberts at Fantastically Great Women Who Changed The World press night

Paris Hilton looks lovely in floral summer dress at Dreamscape by Hilton Estates Group event in LA

Dame Deborah James dies aged 40: BBC presenter passes away peacefully surrounded by her family - after raising £6.7m during cancer battle

Ewan McGregor and Mary Elizabeth Winstead look pensive as they leave NYC hotel - after actor said divorce from Eve Mavrakis 'was a bomb going off'

Where are the Queer As Folk cast now? As a US remake arrives on British screens, FEMAIL reveals how the series was a springboard for successful careers

Watch What Happens Live: Jill Zarin and Brandi Glanville BOTH reveal having abortions as teenagers after Supreme Court decision overturned Roe v. Wade

Margot Robbie SLAPS a handsy character while rollerblading with Ryan Gosling in Venice Beach on the set of Barbie

Sofia Vergara and husband Joe Manganiello pose with their dog Bubbles at LA premiere of his AMC+ series Moonhaven

With a splash of lipstick and that smile, Dame Deborah James achieved more in a few short weeks than most do in a lifetime, writes BETH HALE

'My heart is broken': Dame Deborah James's mother Heather posts devastating tribute to daughter who has died of bowel cancer aged 40
Devastated

Scott Disick dines out with pal in Miami... as ex Kourtney Kardashian rushes to hospital with husband Travis Barker for medical emergency

Tiger Woods' former mistress Rachel Uchitel is 'working on a tell-all memoir' that will detail her affair with the golfer - despite his attorneys already SUING her

Addison Rae sizzles in a navy blue slip dress as

she heads out on smoothie run in LA... after taking on Paris Fashion Week

'Not the finger in the mouth!' Love Island's Ekin-Su causes viewers to cringe over 'disgusting' act during X-rated striptease challenge

'A truly special person who saved lives and did so much to help others': Friends and colleagues pay tribute to Dame Deborah James as she passes away peacefully

Back to top

Home | U.K. | News | Sports | U.S. Showbiz | Australia | Femail | Health | Science | Money | Video | Travel | Shop | DailyMailTV

Sitemap | Archive | Video Archive | Topics Index | Mobile Apps | Screensaver | RSS | Text-based site | Reader Prints | Our Papers | Top of page
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Trans kids' treatment can start younger, new guidelines say

A leading transgender health association has lowered its recommended minimum age for gender transition treatment in teens, including starting sex hormones at age 14 and some surgeries at 15

By Lindsey Tanner Ap Medical Writer
June 15, 2022, 8:22 AM

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A leading transgender health association has lowered its recommended minimum age for starting gender transition treatment, including sex hormones and surgeries.

The World Professional Association for Transgender Health said hormones could be started at age 14, two years earlier than the group's previous advice, and some surgeries done at age 15 or 17, a year or so earlier than previous guidance. The group acknowledged potential risks but said it is unethical and harmful to withhold early treatment.

The association provided The Associated Press with an advance copy of its update ahead of publication in a medical journal, expected later this year. The international group promotes evidence-based standards of care and includes more than 3,000 doctors, social scientists and others involved in transgender health issues.

The update is based on expert opinion and a review of scientific evidence on the benefits and harms of transgender medical treatment in teens whose gender identity doesn't match the sex they were assigned at birth, the group said. Such evidence is limited but has grown in the last decade, the group said, with studies suggesting the treatments can improve psychological well-being and reduce suicidal behavior.

Starting treatment earlier allows transgender teens to experience physical puberty changes around the same time as other teens, said Dr. Eli Coleman, chair of the group's standards of care and director of the University of Minnesota Medical School's human sexuality program.

But he stressed that age is just one factor to be weighed. Emotional maturity, parents' consent, longstanding gender discomfort and a

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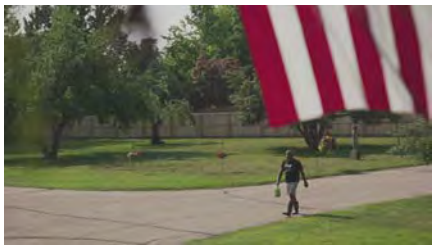

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"Certainly there are adolescents that do not have the emotional or cognitive maturity to make an informed decision," he said. "That is why we recommend a careful multidisciplinary assessment."

The updated guidelines include recommendations for treatment in adults, but the teen guidance is bound to get more attention. It comes amid a surge in kids referred to clinics offering transgender medical treatment, along with new efforts to prevent or restrict the treatment.

Many experts say more kids are seeking such treatment because gender-questioning children are more aware of their medical options and facing less stigma.

Critics, including some from within the transgender treatment community, say some clinics are too quick to offer irreversible treatment to kids who would otherwise outgrow their gender-questioning.

Psychologist Erica Anderson resigned her post as a board member of the World Professional Association for Transgender Health last year after voicing concerns about "sloppy" treatment given to kids without adequate counseling.

She is still a group member and supports the updated guidelines, which emphasize comprehensive assessments before treatment. But she says dozens of families have told her that doesn't always happen.

"They tell me horror stories. They tell me, 'Our child had 20 minutes with the doctor'" before being offered hormones, she said. "The parents leave with their hair on fire.''

Estimates on the number of transgender youth and adults worldwide vary, partly because of different definitions. The association's new guidelines say data from mostly Western countries suggest a range of between a fraction of a percent in adults to up to 8% in kids.

Anderson said she's heard recent estimates suggesting the rate in kids is as high as 1 in 5 — which she strongly disputes. That number likely reflects gender-questioning kids who aren't good candidates for lifelong medical treatment or permanent physical changes, she said.

Still, Anderson said she condemns politicians who want to punish parents for allowing their kids to receive transgender treatment and those who say treatment should be banned for those under age 18.

"That's just absolutely cruel,'' she said.

Dr. Marci Bowers, the transgender health group's president-elect, also has raised concerns about hasty treatment, but she

gatekeepers ... and subjected to scrutiny that is not applied to another medical diagnosis.''

Gabe Poulos, 22, had breast removal surgery at age 16 and has been on sex hormones for seven years. The Asheville, North Carolina, resident struggled miserably with gender discomfort before his treatment.

Poulos said he's glad he was able to get treatment at a young age.

"Transitioning under the roof with your parents so they can go through it with you, that's really beneficial,'' he said. "I'm so much happier now.''

In South Carolina, where a proposed law would ban transgender treatments for kids under age 18, Eli Bundy has been waiting to get breast removal surgery since age 15. Now 18, Bundy just graduated from high school and is planning to have surgery before college.

Bundy, who identifies as nonbinary, supports easing limits on transgender medical care for kids.

"Those decisions are best made by patients and patient families and medical professionals,'' they said. "It definitely makes sense for there to be fewer restrictions, because then kids and physicians can figure it out together.''

Dr. Julia Mason, an Oregon pediatrician who has raised concerns about the increasing numbers of youngsters who are getting transgender treatment, said too many in the field are jumping the gun. She argues there isn't strong evidence in favor of transgender medical treatment for kids.

"In medicine ... the treatment has to be proven safe and effective before we can start recommending it,'' Mason said.

Experts say the most rigorous research — studies comparing treated kids with outcomes in untreated kids — would be unethical and psychologically harmful to the untreated group.

The new guidelines include starting medication called puberty blockers in the early stages of puberty, which for girls is around ages 8 to 13 and typically two years later for boys. That's no change from the group's previous guidance. The drugs delay puberty and give kids time to decide about additional treatment; their effects end when the medication is stopped.

The blockers can weaken bones, and starting them too young in children assigned males at birth might impair sexual function in adulthood, although long-term evidence is lacking.

—Sex hormones — estrogen or testosterone — starting at age 14. This is often lifelong treatment. Long-term risks may include infertility and weight gain, along with strokes in trans women and high blood pressure in trans men, the guidelines say.

—Breast removal for trans boys at age 15. Previous guidance suggested this could be done at least a year after hormones, around age 17, although a specific minimum ag wasn't listed.

—Most genital surgeries starting at age 17, including womb and testicle removal, a year earlier than previous guidance.

The Endocrine Society, another group that offers guidance on transgender treatment, generally recommends starting a year or two later, although it recently moved to start updating its own guidelines. The American Academy of Pediatrics and the American Medical Association support allowing kids to seek transgender medical treatment, but they don't offer age-specific guidance.

Dr. Joel Frader, a Northwestern University a pediatrician and medical ethicist who advises a gender treatment program at Chicago's Lurie Children's Hospital, said guidelines should rely on psychological readiness, not age.

Frader said brain science shows that kids are able to make logical decisions by around age 14, but they're prone to risk-taking and they take into account long-term consequences of their actions only when they're much older.

Coleen Williams, a psychologist at Boston Children's Hospital's Gender Multispecialty Service, said treatment decisions there are collaborative and individualized.

"Medical intervention in any realm is not a one-size-fits-all option," Williams said.

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NO. D-1-GN-22-002569

PFLAG, INC., ET AL., *Plaintiffs*, v. GREG ABBOTT, ET AL., *Defendants*.	IN THE DISTRICT COURT OF TRAVIS COUNTY, TEXAS 459th JUDICIAL DISTRICT

EXPERT REPORT OF DR. JAMES CANTOR

TABLE OF CONTENTS

I. Background & Credentials

1. I am a neuroscientist and sex researcher, with an internationally recognized record studying the development of human sexuality and atypical sexualities. I am the author of over 50 peer-reviewed articles in my field, spanning the development of sexual orientation, gender identity, hypersexuality, and atypical sexualities collectively referred to as *paraphilias*. I am the author of the past three editions of the gender identity and atypical sexualities chapter of the *Oxford Textbook of Psychopathology*. These works are now routinely cited in the field and are included in numerous other textbooks of sex research. These publications span the biological and non-biological development of human sexuality, the classification of sexual interest patterns, the assessment and treatment of atypical sexualities, and the application of statistics and research methodology in sex research.

2. Over my academic career, my posts have included Senior Scientist and Psychologist at the Centre for Addiction and Mental Health (CAMH), Head of Research for CAMH's Sexual Behaviour Clinic, Associate Professor of Psychiatry on the University of Toronto Faculty of Medicine, and Editor-in-Chief of the peer reviewed journal, *Sexual Abuse*. That journal is one of the top-impact, peer-reviewed journals in sexual behavior science and is the official journal of the Association for the Treatment of Sexual Abusers. In that appointment, I was charged to be the final arbiter for impartially deciding which contributions from other scientists in my field merited publication. I believe that appointment indicates not only my extensive experience evaluating scientific claims and methods, but also the faith put in me by the other scientists in my field. I have also served on the Editorial Boards of the *Journal of Sex Research*, the *Archives of Sexual Behavior*, and *Journal of Sexual Aggression*. I am currently the Director of the Toronto Sexuality Centre in Canada. Thus, although I cannot speak for other scientists, I regularly interact with and

am routinely exposed to the views and opinions of most of the scientists active in our field today, within the United States and throughout the world.

3. For my education and training, I received my Bachelor of Science degree from Rensselaer Polytechnic Institute, where I studied mathematics, physics, and computer science. I received my Master of Arts degree in psychology from Boston University, where I studied neuropsychology. I earned my Doctoral degree in psychology from McGill University, which included successfully defending my doctoral dissertation studying the effects of psychiatric medication and neurochemical changes on sexual behavior, and included a clinical internship assessing and treating people with a wide range of sexual and gender identity issues.

4. I began providing clinical services to people with gender dysphoria in 1998. I trained under Dr. Ray Blanchard of CAMH and have participated in the assessment and treatment of over one hundred individuals at various stages of considering and enacting both transition and detransition, including its legal, social, and medical (both cross-hormonal and surgical) aspects. My clinical experience includes the assessment and treatment of several thousand individuals experiencing other atypical sexuality issues. I am regularly called upon to provide objective assessment of the science of human sexuality by the courts (prosecution and defense), professional media, and mental health care providers.

5. I have served as an expert witness in 17 cases in the past four years. In these cases I have provided courts with the research and scientific background regarding the full range of human sexual interest patterns, including the sexual orientation, gender identity, and paraphilias, including the forensic aspects they sometimes involve, and how to distinguish these features, which is not obvious and often confused by non-experts. These cases listed on my *curriculum vitae*, attached here as Appendix 1. They include Frye hearings, custody hearings, trials, and a range of pre-trial

hearings.

6. A substantial proportion of the existing research on gender dysphoria comes from two clinics, one in Canada and one in the Netherlands. The CAMH gender clinic (previously, Clarke Institute of Psychiatry) was in operation for several decades, and its research was directed by Dr. Kenneth Zucker. I was employed by CAMH between 1998 and 2018. Although I was a member of the hospital's adult forensic program, I remained in regular contact with members of the CAMH child psychiatry program (of which Dr. Zucker was a member), and we collaborated on multiple research projects.

7. For my work in this case, I am being compensated at the hourly rate of $400 per hour. My compensation does not change based on the conclusions and opinions that I provide here or later in this case or on the outcome of this lawsuit.

II. Executive Summary

- The scientific research literature has long and consistently demonstrated that there is more than one distinct phenomenon that can lead to gender dysphoria. These types show distinct epidemiological and demographic patterns, unique psychological and behavioral profiles, and differing responses to treatment options. Much misunderstanding follows from mis-attributing information across these types.
- For adults with gender dysphoria, studies show that those who are otherwise mentally healthy and undergo thorough (1–2 year) assessments supervised by clinics engaged in gate-keeping roles typically adjust well to life as the opposite sex.
- For pre-pubescent children with gender dysphoria, there have been exactly 11 cohort studies reporting on outcomes. All 11 reported the majority of children to cease to feel dysphoric by puberty, reporting being gay or lesbian instead.
- For pubescent and adolescent age minors using puberty blockers or cross-sex hormones, there have been (also) 11 cohort studies: In four, mental health failed to improve and even deteriorated on several variables. In five, some mental health variables improved, but because psychotherapy and medical interventions were provided together, it cannot be known which treatment caused what changes. The two remaining studies employed methods that did permit psychotherapy effects to be distinguished from medical effects, and neither found medical intervention to be superior to psychotherapy-only. These studies are often misrepresented as support for medicalization by overlooking the concurrent psychotherapy.

- Psychological research importantly distinguishes completed suicide—which occurs primarily among biological males and involves the intent to die—from suicidal ideation, gestures, and attempts—which occur primarily among biological females and represent psychological distress and cries for help. The evidence is minimally consistent with transphobia being the predominant cause of suicidality. The evidence is very strongly consistent with the hypothesis that other mental health issues, such as Borderline Personality Disorder (BPD), cause suicidality and unstable identities, including gender identity confusion.
- The international consensus of public health care agencies is that there is insufficient evidence to support medicalized transition of minors. Although initially supportive, Sweden, Finland, France, and the United Kingdom have issued increasingly restrictive statements and policies, now prioritizing psychotherapy as the treatment of choice, including an outright ban on medical transition of minors in Sweden.
- For reference, the following table summarizes the age recommendations for the transition of minors within the Dutch Protocol, the Endocrine Society guideline, and the current and the expected upcoming version of the WPATH standards of care:

Procedure	Dutch Protocol (2012)	Endocrine Society (2017)	WPATH v7 (2011)	WPATH v8 (expected 2022)
Social Transition	Post-puberty	Neutral	No recommendation	No recommendation
Puberty Blockers	12	As soon as puberty begins	As soon as puberty begins	As soon as puberty begins
Cross-sex Hormones	16	16, unless "compelling reasons"	Age of majority, "in many countries, 16"	14
Mastectomy	18	No recommendation	1 year after cross-sex hormones	15
Breast Augmentation	18	Not mentioned	Not mentioned	16
Vaginoplasty, Metoidioplasty, Orchidectomy	18	18	Age of majority	17
Phalloplasty	18	Not mentioned	Age of majority	18

III. Fact-Check of Plaintiff Expert Declaration

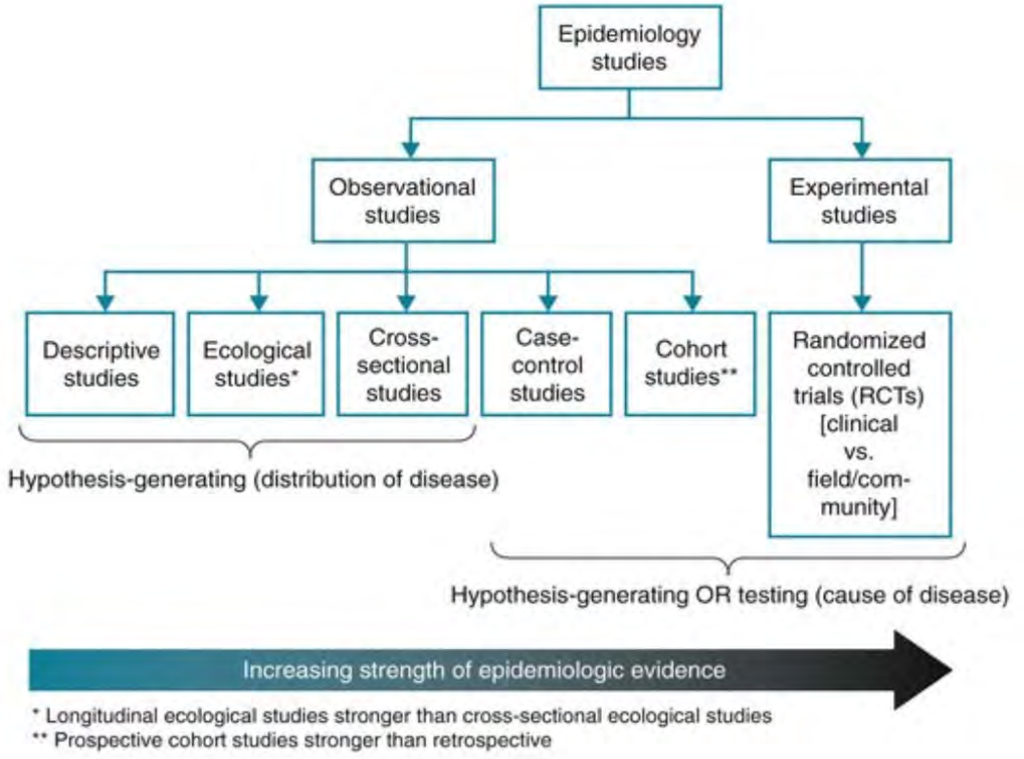
8. In clinical science, there are two kinds of expertise: A physician's expertise regards

applying general principles to the care of an individual patient and the unique features of that case. A scientist's expertise goes the other way around, accumulating information about many individual cases and identifying the generalizable principles that may be applied to all cases. Thus, different types of decision may require different kinds of expert, such that questions about how the general rules might apply to an individual patient's specific situation might be better posed to a physician's expertise, whereas questions about establishing the general rules might be better posed to a scientist's.

9. I have compared the claims in Dr. Brady's declaration with the contents of the peer-reviewed research literature and according to the scientific principles and statistical methods of clinical science and sex research. As detailed in the following, Dr. Brady shared only a small and misrepresentative selection of the relevant research, which, when described in full, supports the very opposite conclusions. The methods Dr. Brady applied in developing her opinions violated multiple basic scientific principles for identifying reliable scientific evidence and interpreting research statistics.

10. In the assessment of the science of this field, prospective *cohort studies* represent high quality research, whereas *descriptive* and *cross-sectional studies* are of very low quality:

Figure 1: Study designs and increasing strength of evidence



Source: Basicmedical Key. Retrieved from https://basicmedicalkey.com/common-research-designs-and-issues-in-epidemiology/

The Brady report excluded most of the high quality, cohort studies, but repeatedly cited inferior cross-sectional survey studies.

11. There have been a total of eleven cohort studies of pre-pubescent children, of which, Dr. Brady cited *none*. In direct contrast with the plaintiffs' claims of "immutability" (Plaintiff petition, para 48), all eleven studies came to the same conclusion: The majority of gender dysphoric children cease to feel dysphoric by puberty. There have also been eleven cohort studies of pubescent/adolescent children treated with puberty-blocking medication or cross-sex hormones. Of these, Dr. Brady cited six,[1] and neglected five.[2] In short, rather than provide a comprehensive

[1] I.e., de Vries, *et al.* (2011, 2014); van der Miesen, *et al.* (2020); Tordoff, *et al.* (2022); Allen, *et al.* (2019); and Achille, *et al.* (2020)

[2] Kuper, *et al.* (2020); Carmichael, *et al.* (2021); Hisle-Gorman, *et al.* (2021); Kaltiala, *et al.* (2020); Costa, *et al.* (2015)

or unbiased summary of the existing science, Dr. Brady's report included only those studies which suggested patient improvement and excluded the studies showing failures of improvement and instances of deterioration. Selective citation such as this represents a gross violation of the basic principles of unbiased scientific analysis.

12. Moreover, of the six cohort studies cited, Dr. Brady also left out a pivotal aspect: The youth in these studies were all receiving psychotherapy at the same time as medical services. In research science, this is called a *confound:* It is not possible for Dr. Brady, or anyone else, to know which of these two co-occurring treatments produced which outcomes. Moreover, one of the six studies, Achille, *et al.* (2020), employed a research design that permitted comparison of medical versus psychotherapeutic methods, and it found medical interventions not to provide any significant improvement above psychotherapy. Importantly, because medical options entail greater risks than psychotherapy, the bar (i.e., the risk:benefit ratio) for medical intervention is higher than for psychotherapy.

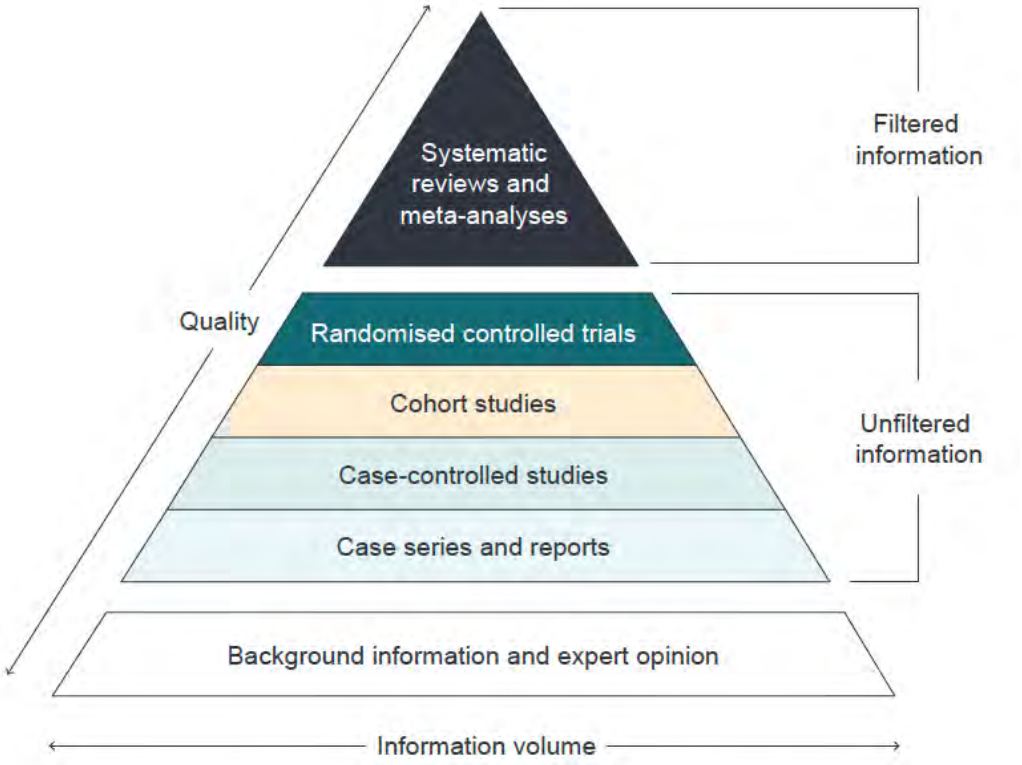
13. The much lower quality descriptive and cross-sectional survey studies included James, *et al.*, (2016);[3] Turban, *et al.* (2020); and Turban, *et al.* (2022). It is straight-forward and inexpensive for interested individuals—professional researchers, political advocates, and marketing companies alike—to assemble a set of questions and post them online for anyone willing to respond to them. Such surveys represent the very earliest step of research projects and can help generate ideas for subsequent research that requires greater resources and time to complete. Unlike surveys of "convenience samples," cohort studies consider a specific, identifiable group, such as attendees of a clinic or people with a distinct genetic feature, and

[3] Dr. Brady's declaration did not provide the complete citation, which is:
James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

systematically follow up with them to observe and record changes over time (i.e., prospectively). Prospective cohort studies can answer questions issues that surveys cannot, and even a single cohort study can "outweigh" any number of survey studies. Because Internet surveys can be conducted within a few weeks or months, many such studies can be published quickly; however, a 10-year follow-up study of a cohort of gender dysphoric youth requires waiting those 10 years. Research on the present issue has largely been limited to surveys until only recently, with eight of the existing 11 studies published in 2019 or later.

14. Dr. Brady repeatedly relied also her personal recollections of providing medical services to this population, providing what science refers to as anecdotal evidence. Although reporting ongoing experience with such patients, Dr. Brady has never published and did not report engaging in any scientific, statistical, or other systematic analysis that would rule out potential biases to yield generalizable knowledge. In clinical science, expert opinion (in the clinical sense rather than the legal sense) represents only the lowest form of scientific evidence:

Figure 2: Pyramid of standards of evidence



Source: OpenMD. Retrieved from https://openmd.com/guide/levels-of-evidence

15. The advantages of accumulated personal experience is its low cost and potential utility when there do not exist systematic studies of the unique combination of variables represented by some cases. The disadvantages are that it is the most subject to human biases, such as recall bias and confirmation bias, as well as to sampling biases including both self-selection biases (who decides to come into the clinic in the first place) and any variables which led to dropping out of the clinic, leaving clinicians no capacity for determining why.

16. If there did not already exist multiple studies systematically studying cohorts of minors undergoing puberty-blocking or cross-sex hormone treatment, then expert opinion relying on anecdotal evidence might represent the only option available. That is not the current situation, however: Rather than engage in the scientifically valid research method of accepting higher order evidence over lower order evidence (expert opinion), the Brady report retained only the lowest.

17. I have also compared the claims in Dr. Antommaria's declaration with the contents of the peer-reviewed research literature and according to the scientific principles and statistical methods of clinical science and sex research.[4] The Antommaria declaration similarly failed to provide the relevant findings from the research literature. Of the 11 cohort studies of prepubescent children, his report included *none.* Of the 11 cohort studies of adolescent children, his report included *one.* Moreover, of the 24 references that Dr. Antommaria did cite, only 11 were peer-reviewed, and of those, only four pertained to gender dysphoria at all. Instead, Dr. Antommaria repeatedly deferred to the Endocrine Society guideline (cited as Hembree, *et al.*, 2017) as the source of his scientific claims.

18. Drs. Brady and Antommaria both egregiously misrepresent the Endocrine Society guideline, insinuating to the reader that the guideline indicates there being a strong scientific basis for the medical transition of minors, when it actually says the reverse:

> The Endocrine Society, for example, developed its clinical practice guideline for the endocrine treatment of gender-dysphoric/gender-incongruent persons using the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group. The Society both grades the quality of the evidence and the strength of its recommendations. It recommends that "adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development (2.1).
> (Antommaria declaration, para 22)

> The protocols and policies set forth by the Endocrine Society Guidelines and the WPATH Standards of Care are endorsed and cited as authoritative by the major professional medical and mental health associations in the United States.
> (Brady declaration, para 43)

[4] Dr. Antommaria has not yet provided a declaration in this case, however, she did provide a declaration in the case of *Jane Doe, et al., v. Abbott*, D-1-GN-22-977, which is a case from earlier this year with the same claims against the same Defendants.

Although Drs. Brady and Antommaria both inform the reader that the Endocrine Society *assessed* these recommendation using the GRADE system, they both withheld the actual *results* of that assessment. The guideline used this rating system:

> [S]trong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕OOO denotes very low-quality evidence; ⊕⊕OO, low quality; ⊕⊕⊕O, moderate quality; and ⊕⊕⊕⊕, high quality.[5]

The section pertaining to adolescents was:

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕○○)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 |⊕⊕○○)

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕○○)

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 |⊕⊕○○).

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕○○○)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 |⊕⊕○○)

Hembree, *et al.* (2017), at 3871, column 1.

[5] Hembree, *et al.*, 2017, at 3872.

Where Drs. Brady and Antommaria cite the Endocrine Society guideline to insinuate strong science, the GRADE assessment yielded exactly the reverse: In every category, without exception, the research quality was rated as "low" or "very low" (i.e., rated ⊕OOO or ⊕⊕OO).

19. Dr. Brady similarly misrepresented the scientific strength represented by the WPATH Standards of Care document. Although referring to the WPATH Standards with many subjective adjectives, such as "widely adopted" (para 41), "authoritative" (para 43), and "extensively researched" (para 102), Dr. Brady's report did not indicate that the WPATH standards have also undergone objective evaluation with a standardized approach, called the Appraisal of Guidelines for Research and Evaluation ("AGREE II"), as part of an appraisal of all published Clinical Practice Guidelines (CPGs) regarding sex and gender minority healthcare.[6] Utilizing community stakeholders to set domain priorities for the evaluation, the assessment concluded that the guidelines regarding HIV and its prevention were of high quality, but that "[T]ransition-related CPGs tended to lack methodological rigour and rely on patchier, lower-quality primary research."[7] The WPATH guidelines received *unanimous* ratings of "Do not recommend."[8]

20. Importantly, despite the repeated citation of WPATH and Endocrine Society as the scientific sources, most of the cohort studies of adolescent did not yet exist when those documents were produced. The WPATH standards were released in 2011, and Endocrine Society guideline, in 2017, whereas 8 of the 11 cohort studies were not published until 2019. That is, the WPATH and Endocrine Society documents were developed almost exclusively from Internet surveys and the necessarily inconclusive interpretations of the correlations in them. Now that cohort studies have become available, it is known that the survey results did not show what they were purported

6 Dahlen, *et al.*, 2021.
7 Dahlen, *et al.*, 2021, at 6.
8 Dahlen, *et al.*, 2021, at 7.

to show: It is *not* the case that youth receiving medical interventions improve in mental health, but that the youth with better mental health are permitted to undergo medical interventions. That is, medication use correlates with mental health, but it does *not cause* mental health—Rather, medication use *reflects* mental health. By relying on the WPATH and Endocrine Society documents, Drs. Brady and Antommaria exclude consideration of 8/11's of the most relevant research. They present no counter-argument to any of the content of this evidence. They neglect it entirely.

21. The reports from Dr. Brady and Dr. Antommaria (and thereby plaintiff's counsel) repeatedly violated another fundamental scientific principle, often known to the public as "*Correlation doesn't imply causation*." None of the plaintiffs' documents cites any research studies employing the scientific methodologies necessary to draw causal conclusions: Indeed, no such studies exist. It is simply not scientifically possible for Drs. Brady or Antommaria (or anyone else) to know which factors are causing which outcomes, yet both repeatedly assume causal relationships in the entire absence of scientific evidence of causality. Examples include:

- "can *cause* extreme distress" (Plaintiff petition, para 61)
- "can *cause* extreme distress" (Brady declaration, para 54)
- "given that gender dysphoria can *cause…"* (Brady declaration, para 38)
- *"effective"* (Antommaria declaration, para 28)
- "the diagnosis *resulting* from the incongruity" (Brady declaration, para 32)
- "distress that *results* from the incongruity" (Brady declaration, para 33)
- "Medical treatment…*can* substantially *reduce*" (Plaintiff petition, para 70)
- "administration of puberty suppression has shown *to* significantly *reduce* suicidality" (Brady declaration, para 96)
- "Pubertal suppression has been shown *beneficial* in psychological functioning and *decreasing* suicidal ideation" (Brady declaration, para 56)
- "my clinical experience confirms that these treatments are highly *beneficial*" (Brady declaration, para 80)
- "These therapies are greatly *beneficial"* (Brady declaration, para 75)
- *exacerbating* lifelong gender dysphoria" (Brady declaration, para 97)
- "withholding pubertal suppression and hormone therapy…is extremely *harmful"* (Brady declaration, para 96)

- "Preventing gender affirming care…*will worsen* their gender dysphoria and health outcomes" (Brady declaration, para 95)
- "*prevent* severe harm including possible death from suicide" (Brady declaration, para 42)
- "these *risks* do *decline* when transgender individuals are supported" (Brady declaration, para 38).
- "*Can save* many lives given that reports of suicidality in trans youth…" (Brady declaration, para 56).
- "Withholding these therapies *can lead to* worsened mental health outcomes and suicide" (Brady declaration, para 67)
- *"life saving"* (Plaintiff petition, para 46)
- *"lifesaving"* (Antommaria declaration, para 36)
- *"life-saving"* (Brady declaration, para 75)
- *"essential"* (Plaintiff petition, para 46)
- *"urgent"* (Antommaria declaration, para 28)
- "assessed to have a medical *need"* (Brady declaration, para 48)
- "medically *necessary"* and "medical *necessity"* (Plaintiff petition, para's 1, 16, 17, 28, 64, 68; Antommaria declaration, e.g., para's 6, 7, 19, 20, 21, 27, 32)

22. Despite such repeatedly confident language, it is not scientifically possible to know which way causality runs. One cannot support any such causal claims on the basis of the existing, entirely correlational, science. When a survey shows a correlation between medication and mental health, it is possible that the medications caused improvement in the mental health variables, and it is possible that only those patients with superior mental health were permitted to receive hormonal treatments in the first place. (Both situations can also be true at the same time, with each factor making partial contributions.) Neither Dr. Brady nor Dr. Antommaria provided evidence to support one interpretation over the other, instead failing to mention any others at all. Moreover, there now exists a generation of more advanced studies, those employing cohort designs, which contradict the first interpretation and instead support the second. These are summarized in their own section to follow.

23. Of the many terms in the plaintiff documents that erroneously claim causality, the most directly relevant is their repeated use of "medically necessary." Whereas the other misused terms convey inaccuracies about the known science, the term "medically necessary" has special technical

meanings in many legal and other contexts, especially regarding insurance coverage, which do not necessarily match the lay public's understanding and everyday use of the term. The plaintiffs' documents obscure which of these meanings applies when.

24. Scientifically, "*necessary*" is a causal statement, and there do not exist any studies using a research design capable of yielding causal conclusions. There only exist observational correlations, and such correlations are scientifically incapable of supporting the claim that medical transition is necessary, medically or otherwise.

25. Dr. Antommaria provided a definition of 'medically necessary' from HealthCare.gov: "[H]ealth care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms *and that meet accepted standards of medicine"* (para 21, italics added). Antommaria asserted flat out that "Gender affirming healthcare is medically necessary" (Antommaria declaration, paragraph 21), but cited no evidence to indicate meeting those standards. As noted already, the only evidence offered in the Antommaria declaration was the Endocrine Society guideline which explicitly and consistently rated the evidence as low and very low quality, never mind meeting the standards required for establishing necessity or any other causal claim.

26. The declaration defines gender identity as an inner sense. The phrase is increasingly popular, but neither "inner sense" nor any similar phrase is scientifically valid. In science, a valid construct must be both objectively measurable and falsifiable. The concept of an "inner sense" is neither. If claims of one's inner sense represented scientifically meaningful evidence, then science would have evidence of people's past life experiences. To base decisions on subjective and unfalsifiable accounts is to fail to provide evidence-based medicine. Gender identity is unlike emotions, which are associated with physiological changes such as heartrate and brain activity. Gender identity is unlike sexual orientation, which is associated with objectively ascertained

evidence, including brain anatomy. Gender Dysphoria is unlike disorders of sexual development (DSD's, also called "intersex conditions"), again in that DSDs are objectively verifiable with physical measures, whereas gender identity is not. DSDs include, for example, genetic disorders which prevent a person's body from responding to testosterone, a disease called Androgen Insensitivity Syndrome.[9] Still more unlike gender identity, the physical nature of such disorders allows many of them to be detected before birth, whereas gender identity has no such feature.

27. Dr. Brady (and plaintiff's counsel) repeatedly belittled the risks posed by medicalized transition procedures by comparing them to treatments for physical medical disorders, relying on Dr. Brady's experience with disorders of sexual development (DSD's) to inform her treatment of gender dysphoria:

- "Effects are not unique to the use of these hormones in transgender individuals" (Brady declaration, para 78)
- "Venous thromboembolism risk is not unique to treating gender dysphoria" (Brady declaration, para 81)
- "Other side effects noted, again, are not unique to transgender individuals placed on these therapies" (Brady declaration, para 82)
- "Treatment for gender dysphoria is in no way the riskiest or potentially harmful" (Brady declaration, para 88)
- "treatments use to treat gender dysphoria are also used to treat other conditions in minors with comparable side effects and risks" (Plaintiff petition, para 73).
- "Many forms of medical treatment carry comparable risks and side effects. Treatment for gender dysphoria is not uniquely risky" (Plaintiff petition, para 75).

28. That comparison avoids the central point: For DSD's and other physical disorders there exists objective evidence of the disorder. There exist medical tests capable of objectively confirming the presence of DSD's with extreme accuracy, and medical decision-making can be made on the basis of very high levels of confidence.[10] No such objective verification exists with regard to gender dysphoria, however. Diagnoses rely entirely on subjective reports and whether

[9] E.g., Vilain, 2006.
[10] Audi, *et al.*, 2018; Witchel, 2018.

the clinician believes the self-report of the child. Whereas DSD's can be treated when confirmed with physical evidence, treatment of GD is proceeding *in spite of* all available physical evidence.

29. In these comparisons, Dr. Brady again provides only one side of the relevant question. *Psychotherapy also represents healthcare* and poses *zero* attendant physical risk. The relevant comparison is not medical intervention versus nothing, but medical intervention versus psychotherapy. As demonstrated by the cohort studies research cited herein (including those cited by Dr. Brady) psychotherapy is as consistently associated as medical intervention with mental health improvement among these youth. All surgery entails risk. The side-effects associated with of puberty blockers and cross-sex hormones include loss of bone density, decrease in some memory functions, and increases in blot clots, stroke, and heart attack.[11]

30. Dr. Brady claimed gender identity "cannot be voluntarily changed" (Brady declaration, para 27). In actual clinical practice, that is rarely the relevant issue. The far more typical situation is youth who are *mistaken* about their gender identity. These youth are misinterpreting their experiences to indicate they are transgender, or they are exaggerating their descriptions of their experiences in service of attention-seeking or other psychological needs. The claim is not merely lacking any science to support it; the claim itself defies scientific thinking. In science, it is not possible to know that gender identity cannot be changed: We can know only that we lack evidence of such a procedure. In the scientific method, it remains eternally possible for evidence of such a treatment to emerge, and unlike sexual orientation's long history with conversion therapy, there have not been systematic attempts to change gender identity.

31. Whereas Dr. Brady's expert report referred to *voluntary* change in gender identity (allowing for the possibility of spontaneous changes), the plaintiffs' petition instead referred to

[11] Lee, *et al.,* 2020; Getahun, *et al.,* 2018.

gender identity as entirely "*immutable*," (Plantiff petition, para 48), that is, not allowing for any change at all. No evidence or citation accompanied this stronger claim. It is not at all apparent upon what basis such a statement could be made: It has been the unanimous conclusion of every follow-up study of gender dysphoric children ever conducted, not only that gender identity does change, but also that it changes in the large majority of cases, as documented in its own section of the present report. Such claims also deny the consistent reports of youth de-transitioning[12] and even re-transitioning.[13]

32. Dr. Brady refers to gender identity as "*innate*" (Brady declaration, para 29), having a "strong biological basis" (Brady declaration, para 27). Such claims misrepresent the research literature. Although brain imaging is capable of distinguishing sex and sexual orientation on the basis of neuroanatomical differences, gender identity has repeatedly failed to demonstrate any such analogous features.[14] Rather, the consensus of the scientists (including me) is that childhood onset gender dysphoria is neuroanatomically related to homosexuality, whereas adult-onset gender dysphoria represents an entirely distinct phenomenon that seems similar only superficially.[15] I myself originally published these observations in the research literature, which have been confirmed: As noted by Guillamon, *et al.* (2016), "Following this line of thought, Cantor (2011, 2012, but also see Italiano, 2012) has recently suggested that Blanchard's predictions have been fulfilled in two independent structural neuroimaging studies….*Cantor seems to be right*".[16] To the extent that any neuroanatomical differences have been reported, they have been attributable to sexual orientation rather than gender identity.

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12 Littman, 2021; Vandenbusshe, 2021.
13 Turban, *et al.*, 2021.
14 Baldinger-Melich, *et al.*, 2020; Skorska, *et al.*, 2021.
15 Mueller, *et al.*, 2021
16 *c.f.*, Cantor, 2011; Cantor, 2012; Guillamon, *et al.*, p. 1634, italics added; Italiano, 2012.

33. There is no basis by which the petition and supporting documents to claim there is a "medical consensus" (Plaintiff petition, para 16) or "established best practices" (Plaintiff petition, para 121), to follow guidelines that are "well-established" (Plaintiff petition, para 47) "widely accepted" (Plaintiff petition, para 57). Dr. Brady and Dr. Antommaria are in error to assert there exists a consensus where there does not. Indeed, that there exists enormous controversy and disagreement among experts is itself the topic of major media coverage, including the New York Times' *The Battle Over Gender Therapy: More teenagers than ever are seeking transitions, but the medical community that treats them is deeply divided about why—and what to do to help them.*[17] As detailed within its own section of the present report, the full scientific literature on the outcomes of medical transition of minors has been evaluated by the health care departments of several national governments, including Sweden[18] and the U.K.,[19] with each finding the research to be of very low quality, receiving the lowest quality ratings available. No matter one's views on these issues, they cannot be resolved when their very existence is denied.

34. The plaintiffs' documents repeatedly refer to a national medical consensus on the treatment of gender dysphoric minors. This, however, fails to convey that the international consensus of public health care systems around the world is the opposite, and it is the U.S. which stands as an international outlier. The specific developments in Australia, the United Kingdom, France, Sweden, and Finland are summarized in their own section to follow.

35. In sum, the Brady and Antommaria reports provided only a cherry-picked selection of the science, to which they failed to apply scientific methods of data interpretation. Their multiple instance sharing only decontextualized quotes grossly misrepresented the documents they cited.

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17 Bazelon, 2022.
18 Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019.
19 U.K. National Health Service (NHS), 2021.

Their conclusions contradict what the existing research evidence and scientific method reveal.

IV. Science of Gender Dysphoria and Transsexuality

A. Introduction

36. One of the most widespread public misunderstandings about transsexualism and people with gender dysphoria is that all cases of gender dysphoria represent the same phenomenon; however, the clinical science has long and consistently demonstrated that gender dysphoric children (cases of *early-onset* gender dysphoria) do not represent the same phenomenon as adult gender dysphoria (cases of *late-onset* gender dysphoria),[20] merely attending clinics at younger ages. That is, gender dysphoric children are not simply younger versions of gender dysphoric adults. They differ in every known regard, from sexual interest patterns, to responses to treatments. A third presentation has recently become increasingly observed among people presenting to gender clinics: These cases appear to have an onset in adolescence in the absence of any childhood history of gender dysphoria. Such cases have been called adolescent-onset or "rapid-onset" gender dysphoria (ROGD). Very many public misunderstandings and expert misstatements come from misattributing evidence or personal experience from one of these types to another.

B. Adult-Onset Gender Dysphoria

37. People with adult-onset gender dysphoria typically attend clinics requesting transition services in mid-adulthood, usually in their 30s or 40s. Such individuals are nearly exclusively biological males.[21] They typically report being sexually attracted to women and rarely showed gender atypical (effeminate) behavior or interests in childhood (or adulthood). Some individuals express being sexually attracted to both men and women, and some profess asexuality, but very

[20] Blanchard, 1985.
[21] Blanchard, 1990, 1991.

few indicate having a primary sexual interest only in men.[22] Cases of adult-onset gender dysphoria are typically associated with a sexual interest pattern involving themselves in female form (medically, a paraphilia called autogynephilia).[23]

1. Outcome Studies of Transition in Adult-Onset Gender Dysphoria

38. Clinical research facilities studying gender dysphoria have repeatedly reported low rates of regret (less than 3%) among adult-onset patients who underwent complete transition (*i.e.*, social, plus hormonal, plus surgical transition). This has been widely reported by clinics in Canada,[24] Sweden,[25] and the Netherlands.[26]

39. Importantly, each of the Canadian, Swedish, and Dutch clinics for adults with gender dysphoria all performed "gate-keeping" procedures, disqualifying from medical services people with mental health or other contraindications. One would not expect the same results to emerge in the absence of such gate-keeping or when gate-keepers apply only minimal standards or cursory assessment.

40. An important caution applies to interpreting these results: The side-effect of removing these people from the samples of transitioners is that if a researcher compared the average mental health of individuals coming into the clinic with the average mental health of individuals going through medical transition, then the post-transition group would appear to show a substantial improvement, even though transition had *no effect at all*: The removal of people with poorer mental health created the statistical illusion of improvement among the remaining people.

2. Mental Health Issues in Adult-Onset Gender Dysphoria

41. The research evidence on mental health issues in gender dysphoria indicates it to be

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22 Blanchard, 1988.
23 Blanchard 1989a, 1989b, 1991.
24 Blanchard, *et al.*, 1989.
25 Dhejneberg, *et al.*, 2014.
26 Wiepjes, *et al.*, 2018.

different between adult-onset versus adolescent-onset versus prepubescent-onset types. The co-occurrence of mental illness with gender dysphoria in adults is widely recognized and widely documented.[27] A research team in 2016 published a comprehensive and systematic review of all studies examining rates of mental health issues in transgender adults.[28] There were 38 studies in total. The review indicated that many studies were methodologically weak, but nonetheless demonstrated (1) that rates of mental health issues among people are highly elevated both before *and after* transition, (2) but that rates were less elevated among those who completed transition. Analyses were not conducted in a way so as to compare the elevation in mental health issues observed among people newly attending clinics to improvement after transition. Also, several studies showed more than 40% of patients to become "lost to follow-up." With attrition rates that high, it is unclear to what extent the information from the remaining participants would accurately reflect the whole population. The very high rate of "lost to follow-up" leaves open the possibility of considerably more negative results overall.

42. The long-standing and consistent finding that gender dysphoric adults continue to show high rates of mental health issues after transition indicates a critical point: To the extent that gender dysphoric children resemble adults, we should not expect mental health to improve as a result of transition—that is, transition does not appear to be what causes mental health improvement. Rather, mental health issues should be resolved before any transition, as has been noted in multiple standards of care documents, as detailed in their own section of this report.

C. Childhood-Onset (Pre-pubertal) Gender Dysphoria

1. Cohort Studies Show Most Children Desist by Puberty

43. Prepubescent children (and their parents) have been approaching mental health

[27] *See, e.g.*, Hepp, *et al*., 2005.
[28] Dhejne, *et al*., 2016.

professionals for help with their unhappiness with their sex and belief they would be happier living as the other for many decades. The large majority of childhood onset cases of gender dysphoria occur in biological males, with clinics reporting 2–6 biological male children to each female.[29]

44. In total, there have been 11 outcomes studies of these children, listed in Appendix 2. In sum, despite coming from a variety of countries, conducted by a variety of labs, using a variety of methods, all spanning four decades, every study without exception has come to the identical conclusion: Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty—ranging from 61–88% desistance across the large, prospective studies. Such cases are often referred to as "desisters," whereas children who continue to feel gender dysphoric are often called "persisters."

45. Notably, in most cases, these children were receiving professional psychosocial support across the study period aimed, not at affirming cross-gender identification, but at resolving stressors and issues potentially interfering with desistance. While beneficial to these children and their families, the inclusion of therapy in the study protocol represents a complication for the interpretation of the results: It is not possible to know to what extent the outcomes were influenced by the psychosocial support or would have emerged regardless. In science, this is referred to as a confound.[30]

46. While the absolute number of those who present as prepubescent children with gender dysphoria and "persist" through adolescence is very small in relation to the total population, persistence in some subjects was observed in each of these studies. Thus, a clinician cannot take either outcome for granted.

47. It is because of this long-established and unanimous research finding of desistance

[29] Cohen-Kettenis, *et al*., 2003; Steensma, *et al.,* 2018; Wood, *et al.*, 2013.
[30] Skelly *et al.,* 2012.

being probable but not inevitable, that the "watchful waiting" method became the standard approach for assisting gender dysphoric children. The balance of potential risks to potential benefits is very different for groups likely to desist versus groups unlikely to desist: If a child is very likely to persist, then taking on the risks of medical transition might be more worthwhile than if that child is very likely to desist in transgender feelings.

48. The consistent observation of high rates of desistance among pre-pubertal children who present with gender dysphoria demonstrates a pivotally important—yet often overlooked—feature: because gender dysphoria so often desists on its own, clinical researchers cannot assume that therapeutic intervention cannot facilitate or speed desistance for at least some patients. That is, gender identity is not the same as sexual orientation, and it cannot be assumed that gender identity is as unchangeable as is sexual orientation. Such is an empirical question, and there has not yet been any such study.

49. It is also important to note that research has not yet identified any reliable procedure for discerning which children who present with gender dysphoria will persist, as against the majority who will desist, absent transition and "affirmation." Such a method would be valuable, as the more accurately that potential persisters can be distinguished from desisters, the better the risks and benefits of options can be weighted. Such "risk prediction" and "test construction" are standard components of applied statistics in the behavioral sciences. Multiple research teams have reported that, on average, groups of persisters are somewhat more gender non-conforming than desisters, but not so different as to usefully predict the course of a particular child.[31]

50. In contrast, one research team (the aforementioned Olson group) claimed the opposite, asserting that they developed a method of distinguishing persisters from desisters, using a single

[31] Singh, *et al.* (2021); Steensma *et al.*, 2013.

composite score representing a combination of children's "peer preference, toy preference, clothing preference, gender similarity, and gender identity."[32] They reported a statistical association (mathematically equivalent to a correlation) between that composite score and the probability of persistence. As they indicated, "Our model predicted that a child with a gender-nonconformity score of .50 would have roughly a .30 probability . . . of socially transitioning. By contrast, a child with gender-nonconformity score of .75 would have roughly a .48 probability."[33] Although the Olson team declared that "social transitions may be predictable from gender identification and preferences,"[34] their actual results suggest the opposite: The gender-nonconforming group who went on to transition (socially) had a mean composite score of .73 (which is less than .75), and the gender-nonconforming group who did not transition had a mean composite score of .61, also less than .75.[35] Both of those are lower than the value of .75, so both of those would be more likely than not to desist, rather than to proceed to transition. That is, Olson's model does not distinguish likely from unlikely to transition; rather, it distinguishes unlikely from even less likely to transition.

51. Although it remains possible for some future discovery to yield a method to identify with sufficient accuracy which gender dysphoric children will persist, there does not exist such a method at the present time. Moreover, in the absence of long-term follow-up, it cannot be known what proportions come to regret having transitioned and then *de*transition. Because only a minority of gender dysphoric children persist in feeling gender dysphoric in the first place, "transition-on-demand" increases the probability of unnecessary transition and unnecessary medical risks.

52. It was this state of the science—that the majority of prepubescent children will desist

[32] Rae, *et al*., 2019, at 671.
[33] Rae, *et al.*, 2019, at 673.
[34] Rae, *et al.*, 2019, at 669.
[35] Rae, *et al*., 2019, Supplemental Material at 6, Table S1, bottom line.

in their feelings of gender dysphoria and that we lack an accurate method of identifying which children will persist—that led to the development of a clinical approach, The Dutch Protocol,[36] including its "Watchful Waiting" period. Internationally, the Dutch Protocol remains the most empirically supported protocol for the treatment of children with gender dysphoria.

2. Cohort Studies of Puberty-Blockers and Cross-Sex Hormones

53. Very many strong claims have appeared in the media and on social media asserting that transition results in improved mental health or, contradictorily, in decreased mental health. In the highly politicized context of gender and transgender research, many outlets have cited only the findings which appear to support one side, cherry-picking from the complete set of research reports. It total, there have been 11 prospective outcomes studies following up gender dysphoric children undergoing medically induced suppression of puberty or cross-sex hormone treatment. Four studies failed to find evidence of improvement in mental health functioning at all, and some groups deteriorated on some variables.[37] Five studies successfully identified evidence of improvement, but because patients received psychotherapy along with medical services, which of those treatments caused the improvement is unknowable.[38] In the remaining two studies, both psychotherapy and medical interventions were provided, but the studies were designed in such a way as to allow the effects of psychotherapy to be separated from the effects of the puberty-blocking medications.[39] As detailed in the following, neither identified benefits of medication over psychotherapy alone.

a) Four found no mental health improvement

54. Carmichael, *et al.* (2021) recently released its findings from the Tavistock and Portman

[36] Delemarre-van de Waal & Cohen-Kettenis (2006).
[37] Carmichael, *et al.*, 2021; Hisle-Gorman, *et al*., 2021; Kaltiala, *et al.*, 2020; Kuper, *et al.*, 2020.
[38] Allen, *et al.*, 2019; de Vries, *et al.*, 2011, 2014; Tordoff, *et al.*, 2022; van der Miesen, *et al.*, 2020.
[39] Achille, *et al.*, 2020; Costa, *et al.*, 2015.

clinic in the U.K.[40] Study participants were ages 12–15 (Tanner stage 3 for natal males, Tanner stage 2 for natal females) and were repeatedly tested before beginning puberty-blocking medications and then every six months thereafter. Cases exhibiting serious mental illnesses (*e.g.*, psychosis, bipolar disorder, anorexia nervosa, severe body-dysmorphic disorder unrelated to gender dysphoria) were excluded. Relative to the time point before beginning puberty suppression, there were *no* significant changes in any psychological measure, from either the patients' or their parents' perspective.

55. In Kuper, *et al.* (2020), a multidisciplinary team from Dallas published a prospective follow-up study which included 25 youths as they began puberty suppression.[41] (The other 123 study participants were undergoing cross-sex hormone treatment.) Interventions were administered according to practice guidelines from the Endocrine Society.[42] Their analyses found *no statistically significant changes* in the group undergoing puberty suppression on any of the nine measures of wellbeing measured, spanning tests of body satisfaction, depressive symptoms, or anxiety symptoms.[43] Notably, whereas the Dutch Protocol includes age 12 as a minimum for puberty suppression treatment, this team provided such treatment beginning at age 9.8 years (full range: 9.8–14.9 years).[44]

56. Hisle-Gorman, *et al.* (2021) analyzed military families' healthcare data to compare 963 transgender and gender-diverse youth before versus after hormonal treatment, with their non-gender dysphoric siblings as controls. The study participants included youth undergoing puberty-blocking as well as those undergoing cross-sex hormone treatment, but these subgroups did not

[40] Carmichael, *et al*., 2021.
[41] Kuper, *et al*., 2020, at 5.
[42] Kuper, *et al*., 2020, at 3, referring to Hembree, *et al*., 2017.
[43] Kuper, *et al*., 2020, at Table 2.
[44] Kuper, *et al*., 2020, at 4.

differ from each other. Study participants had a mean age of 18 years when beginning the study, but their initial clinical contacts and diagnoses occurred at a mean age of 10 years. According to the study, "mental health care visits overall did not significantly change following gender-affirming pharmaceutical care,"[45] yet, "psychotropic medication use *increased,"*[46] indicating *deteriorating* mental health.

57. Kaltiala et al. (2020) similarly reported that after cross-sex hormone treatment, "Those who had psychiatric treatment needs or problems in school, peer relationships and managing everyday matters outside of home continued to have problems during real-life."[47] They concluded, "Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development."[48]

b) Five confounded psychotherapy with medical treatment

58. The initial enthusiasm for medical blocking of puberty followed largely from early reports from the Dutch clinical research team suggesting at least some mental health improvement.[49] It was when subsequent research studies failed to replicate those successes that it became apparent that the successes were due, not to the medical interventions, but to the psychotherapy that accompanied such interventions in most clinics, including the Dutch clinic.

59. The Dutch clinical research team followed up a cohort of youth at their clinic undergoing puberty suppression[50] and later cross-hormone treatment and surgical sex

45 Hisle-Gorman, et al., 2021, at 1448.
46 Hisle-Gorman, et al., 2021, at 1448, emphasis added.
47 Kaltiala et al., 2020, at 213.
48 Kaltiala et al., 2020, at 213.
49 de Vries, *et al.,* 2011; de Vries, *et al.,* 2014
50 de Vries, *et al*., 2011.

reassignment.[51] The youth improved on several variables upon follow-up as compared to pre-suppression measurement, including depressive symptoms and general functioning. No changes were detected in feelings of anxiety or anger or in gender dysphoria as a result of puberty suppression; however, natal females using puberty suppression suffered *increased* body dissatisfaction both with their secondary sex characteristics and with nonsexual characteristics.[52]

60. As the report authors noted, while it is possible that the improvement on some variables was due to the puberty-blockers, it is also possible that the improvement was due to the mental health support, and it is possible that the improvement occurred only on its own with natural maturation. So any conclusion that puberty blockers improved the mental health of the treated children is not justified by the data. Because this study did not include a control group (another group of adolescents matching the first group, but *not* receiving medical or social support), these possibilities cannot be distinguished from each other. The authors of the study were explicit in noting this themselves: "All these factors may have contributed to the psychological well-being of these gender dysphoric adolescents."[53]

61. In a 2020 update, the Dutch clinic reported continuing to find improvement in transgender adolescents' psychological functioning, reaching age-typical levels, "after the start of specialized transgender care involving puberty suppression."[54] Unfortunately, because the transgender care method of that clinic involves both psychosocial support and puberty suppression, it again cannot be known which of those (or their combination) is driving the improvement. Also, the authors indicate that the changing demographic and other features among gender dysphoric youth might have caused the treated group to differ from the control group in unknown ways. As

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51 de Vries, *et al.*, 2014.
52 Biggs, 2020.
53 de Vries, *et al*. 2011, at 2281.
54 van der Miesen, *et al*., 2020, at 699.

the study authors noted again, "The present study can, therefore, not provide evidence about the direct benefits of puberty suppression over time and long-term mental health outcomes."[55]

62. Allen, *et al.* (2019) reported on a sample of 47 youth, ages 13–20, undergoing cross-sex hormone treatment. They reported observing increases in measures of well-being and decreases in measures of suicidality; however, as the authors also noted, "whether a patient is actively receiving psychotherapy" may have been a confounding variable.[56]

63. Tordoff, *et al.* (2022) reported on a sample of youth, ages 13–20 years, treated with either puberty blockers or cross-sex hormones. There were improvements in mental health functioning; however, 62.5% of the sample was again receiving mental health therapy.[57]

c) Two showed no advantage of medical intervention

64. Costa, *et al.* (2015) reported on preliminary outcomes from the Tavistock and Portman NHS Foundation Trust clinic in the UK. They compared the psychological functioning of one group of youth receiving psychological support with a second group receiving both psychological support as well as puberty blocking medication. Both groups improved in psychological functioning over the course of the study, but no statistically significant differences between the groups was detected at any point.[58] This clinical team subsequently released its final report, finding that neither group actually experienced significant improvement,[59] making moot any discussion of the source any improvement.

65. Achille, *et al.* (2020) at Stony Brook Children's Hospital in New York treated a sample of 95 youth with gender dysphoria, providing follow-up data on 50 of them. (The report did not

55 van der Miesen, *et al*., 2020, at 703.
56 Allen, *et al.*, 2019.
57 Tordoff, et al., 2022, Table 1.
58 Costa, *et al*., 2015, at 2212 Table 2.
59 Carmichael, et al., 2021.

indicate how these 50 were selected from the 95.) As well as receiving puberty blocking medications, "Most subjects were followed by mental health professionals. Those that were not were encouraged to see a mental health professional."[60] The puberty blockers themselves "were introduced in accordance with the Endocrine Society and the WPATH guidelines."[61] Upon follow-up, some incremental improvements were noted; however, after statistically adjusting for psychiatric medication and engagement in counselling, "*most predictors did not reach statistical significance*."[62] That is, puberty blockers did not improve mental health any more than did mental health care on its own.

d) Conclusions

66. The authors of the original Dutch studies were careful not to overstate the implications of their results, "We *cautiously* conclude that puberty suppression *may be* a valuable *element* in clinical management of adolescent gender dysphoria."[63] Nonetheless, many other clinics and clinicians intrepidly proceeded on the basis of only the perceived positives, broadened the range of people beyond those represented in the research findings, and removed the protections applied in the procedures that led to those outcomes. Many clinics and individual clinicians have reduced the minimum age for transition to 10 instead of 12. While the Dutch Protocol involves interdisciplinary teams of clinicians, many clinics now rely on a single assessor, in some cases one without adequate professional training in childhood and adolescent mental health. Comprehensive, longitudinal assessments (*e.g.*, 1 to 2 *years*[64]) became approvals after one or two assessment sessions. Validated, objective measures of youths' psychological functioning were replaced with

60 Achille, *et al*., 2020, at 2.
61 Achille, *et al*., 2020, at 2.
62 Achille, *et al*., 2020, at 3 (italics added).
63 de Vries, *et al*. 2011, at 2282, italics added.
64 de Vries, *et al*., 2011.

clinicians' subjective (and first) opinions, often reflecting only the clients' own self-report. Systematic recordings of outcomes, so as to allow for detection and correction of clinical deficiencies, were eliminated.

67. Notably, Dr. Thomas Steensma, central researcher of the Dutch clinic, has decried other clinics for "blindly adopting our research" despite the indications that those results may not actually apply: "We don't know whether studies we have done in the past are still applicable to today. Many more children are registering, and also a different type."[65] Steensma opined that "every doctor or psychologist who is involved in transgender care should feel the obligation to do a good pre- and post-test." But few if any are doing so.

3. Social transition may increase persistence/decrease desistance

68. In addition to these, another study followed-up children, ages 3–12 (average of 8), who had already made a complete, binary (rather than intermediate) social transition, including a change of pronouns.[66] (Olson et al., in press). The study did not employ DSM-5 diagnoses, as "Many parents in this study did not believe that such diagnoses were either ethical or useful and some children did not experience the required distress criterion."[67] Rather, children were classified according to their pronoun preference. In contrast with the studies of non-transitioned children, only few (7.3%) in the Olson sample desisted (7.3%, which Olson et al. called "retransitioned").[68] Although the Olson team did not discuss it, their finding matches the Zucker hypothesis that social transition itself represents an active intervention, such that social transition causes the persistence (or, conversely, that social transition prevents desistance, such as by withholding from the child

[65] Tetelepta, 2021.
[66] Olson, *et al.,* in press.
[67] Olson, *et al.,* in press.
[68] Olson, *et al.,* in press.

opportunities to develop confidence as members of their biological sex).[69]

4. Mental Health Issues in Childhood-Onset Gender Dysphoria

69. As shown by the outcomes studies, there is little evidence that transition improves the mental well-being of children. As shown repeatedly by clinical guidelines from multiple professional associations, mental health issues are expected or required to be resolved *before* undergoing transition. The reasoning behind these conclusions is that children may be expressing gender dysphoria, not because they are experiencing what gender dysphoric adults report, but because they mistake what their experiences indicate or to what they might lead. For example, a child experiencing depression from social isolation might develop the hope—and the unrealistic expectation—that transition will help them fit in, this time as and with the other sex.

70. If a child undergoes transition, discovering only then that their mental health or social situations will not in fact change, the medical risks and side-effects (such as sterilization) will have been borne for no reason. If, however, a child resolves the mental health issues first, with the gender dysphoria resolving with it (which the research literature shows to be the case in the large majority), then the child need not undergo transition at all, but retains the opportunity to do so later.

71. Elevated rates of multiple mental health issues among gender dysphoric children are reported throughout the research literature. A formal analysis of children (ages 4–11) undergoing assessment at the Dutch child gender clinic showed 52% fulfilled criteria for a formal DSM diagnosis.[70] A comparison of the children attending the Canadian versus Dutch child gender dysphoria clinic showed only few differences between them, but a large proportion in both groups were diagnosable with clinically significant mental health issues. Results of standard assessment

[69] Singh, *et al.,* 2021; Zucker, 2018, 2020.
[70] Wallien, *et al*., 2007.

instruments (Child Behavior Check List, or CBCL) demonstrated that the average score was in the clinical rather than healthy range, among children in both clinics.[71] When expressed as percentages, among 6–11-year-olds, 61.7% of the Canadian and 62.1% of the Dutch sample were in the clinical range.

72. A systematic, comprehensive review of all studies of Autism Spectrum Disorders (ASDs) and Attention-Deficit Hyperactivity Disorder (ADHD) among children diagnosed with gender dysphoria was recently conducted. It was able to identify a total of 22 studies examining the prevalence of ASD or ADHD I youth with gender dysphoria. Studies reviewing medical records of children and adolescents referred to gender clinics showed 5–26% to have been diagnosed with ASD.[72] Moreover, those authors gave specific caution on the "considerable overlap between symptoms of ASD and symptoms of gender variance, exemplified by the subthreshold group which may display symptoms which could be interpreted as either ASD or gender variance. Overlap between symptoms of ASD and symptoms of GD may well confound results."[73] The rate of ADHD among children with GD was 8.3–11%. Conversely, in data from children (ages 6–18) with Autism Spectrum Disorders (ASDs) show they are more than seven times more likely to have parent-reported "gender variance."[74]

D. Adolescent-Onset Gender Dysphoria

1. Features of Adolescent-Onset Gender Dysphoria

73. In the social media age, a third profile has recently begun to present clinically or socially, characteristically distinct from the two previously identified profiles.[75] Unlike adult-onset

[71] Cohen-Kettenis, *et al*., 2003, at 46.
[72] Thrower, *et al*., 2020.
[73] Thrower, *et al*., 2020, at 703.
[74] Janssen, *et al*., 2016.
[75] Kaltiala-Heino, *et al*., 2015; Littman, 2018.

or childhood-onset gender dysphoria, this group is predominately biologically female. This group typically presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is that feature which led to the term Rapid Onset Gender Dysphoria (ROGD).[76] The majority of cases appear to occur within clusters of peers and in association with increased social media use[77] and especially among people with autism or other neurodevelopmental or mental health issues.[78]

74. It cannot be easily determined whether the self-reported gender dysphoria is a result of other underlying issues or if those mental health issues are the result of the stresses of being a sexual minority, as some writers are quick to assume.[79] (The science of the *Minority Stress Hypothesis* appears in its own section.) Importantly, and unlike other presentations of gender dysphoria, people with rapid-onset gender dysphoria often (47.2%) experienced *declines* rather than improvements in mental health when they publicly acknowledged their gender status.[80] Although long-term outcomes have not yet been reported, these distinctions demonstrate that one cannot apply findings from the other types of gender dysphoria to this type. That is, in the absence of evidence, researchers cannot assume that the pattern found in childhood-onset or adult-onset gender dysphoria also applies to adolescent-onset gender dysphoria. The multiple differences already observed between these groups argue against predicting that features present in one type would generalize to be present in all types of gender dysphoria.

2. Social Transition and Puberty Blockers with Adolescent Onset

75. There do not yet exist prospective outcomes studies either for social transition or for

[76] Littman, 2018.
[77] Littman, 2018.
[78] Kaltiala-Heino, *et al.*, 2015; Littman, 2018; Warrier, *et al.*, 2020.
[79] Boivin, *et al.*, 2020.
[80] Biggs, 2020; Littman, 2018.

medical interventions for people whose gender dysphoria began in adolescence. That is, instead of taking a sample of individuals and following them forward over time (thus permitting researchers to account for people dropping out of the study, people misremembering the order of events, etc.), all studies have thus far been *retrospective.* It is not possible for such studies to identify what factors caused what outcomes. No study has yet been organized in such a way as to allow for an analysis of the adolescent-onset group, as distinct from childhood-onset or adult-onset cases. Many of the newer clinics (not the original clinics which systematically tracked and reported on their cases' results) fail to distinguish between people who had childhood-onset gender dysphoria and have aged into adolescence versus people whose onset was not until adolescence. (Analogously, there are reports failing to distinguish people who had adolescent-onset gender dysphoria and aged into adulthood from adult-onset gender dysphoria.) Studies selecting groups according to their current age instead of their ages of onset produces confounded results, representing unclear mixes according to how many of each type of case wound up in the final sample.

3. Mental Illness in Adolescent-Onset Gender Dysphoria

76. In 2019, a Special Section appeared in the *Archives of Sexual Behavior* titled, "Clinical Approaches to Adolescents with Gender Dysphoria." It included this brief yet thorough summary of rates of mental health issues among adolescents expressing gender dysphoria, by Dr. Aron Janssen of the Department of Child and Adolescent Psychiatry of New York University:[81] The literature varies in the range of percentages of adolescents with co-occurring disorders. The range for depressive symptoms ranges was 6–42%,[82] with suicide attempts ranging 10 to 45%.[83] Self-injurious thoughts and behaviors range 14–39%.[84] Anxiety disorders and disruptive behavior

[81] Janssen, *et al*., 2019.
[82] Holt, *et al*., 2016; Skagerberg, *et al*., 2013; Wallien, *et al*., 2007.
[83] Reisner, *et al.*, 2015.
[84] Holt, *et al*., 2016; Skagerberg, *et al*., 2013.

difficulties including Attention Deficit/Hyperactivity Disorder are also prevalent.[85] Gender dysphoria also overlaps with Autism Spectrum Disorder.[86]

77. Of particular concern in the context of adolescent onset gender dysphoria is Borderline Personality Disorder (BPD; diagnostic criteria to follow). It is increasingly hypothesized that very many cases appearing to be adolescent-onset gender dysphoria actually represent cases of BPD.[87] That is, some people may be misinterpreting their experiencing of the broader "identity disturbance" of symptom Criterion 3 to represent a gender identity issue specifically. Like adolescent-onset gender dysphoria, BPD begins to manifest in adolescence, is three times more common in biological females than males, and occurs in 2–3% of the population, rather than 1-in-5,000 people. (Thus, if even only a portion of people with BPD experienced an identity disturbance that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria.)

78. DSM-5-TR Diagnostic Criteria for Borderline Personality Disorder:

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
>
> 1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
> 2. A pattern of unstable and intense interpersonal relationship characterized by alternating between extremes of idealization and devaluation.
> 3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
> 4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
> 5. *Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behavior.*
> 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

[85] de Vries, *et al*., 2011; Mustanski, *et al*., 2010; Wallien, *et al*., 2007.
[86] de Vries, *et al*., 2010; Jacobs, *et al*., 2014; Janssen, *et al*., 2016; May, *et al*., 2016; Strang, *et al*., 2014, 2016.
[87] *E.g.*, Anzani, *et al.*, 2020; Zucker, 2019.

7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(Italics added.)

79. Mistaking cases of BPD for cases of Gender Dysphoria may prevent such youth from receiving the correct mental health services for their condition, and a primary cause for concern is symptom Criterion 5: Recurrent suicidality. (The research on suicide and suicidality are detailed in their own section herein.) Regarding the provision of mental health care, the distinction between these conditions is crucial: A person with BPD going undiagnosed will not receive the appropriate treatments (the currently most effective of which is Dialectical Behavior Therapy). A person with a cross-gender identity would be expected to feel relief from medical transition, but someone with BPD would not: The problem was not about *gender* identity, but about having an *unstable* identity. Moreover, after a failure of medical transition to provide relief, one would predict for these people increased levels of hopelessness and increased risk of suicidality.

80. Regarding research, there have now been several attempts to document rates of suicidality among gender dysphoric adolescents. The scientific concern presented by BPD is that it poses a potential confound: Samples of gender dysphoric adolescents could appear to have elevated rates of suicidality, not because of the gender dysphoria (or transphobia in society), but because of the number of people with BPD in the sample.

E. Suicide and Suicidality

81. Social media increasingly circulate demands for transition accompanied by hyperbolic warnings of suicide should there be delay or obstacle. Claims accompany admissions that "I'd rather have a trans daughter than a dead son," and such threats are treated as the justification for referring to affirming gender transitions as 'life-saving' or 'medically necessary'. Such claims

convey only grossly misleading misrepresentations of the research literature, however, deploying terms for their shock value rather than accuracy, and exploiting common public misperceptions about suicide. Indeed, suicide prevention research and public health campaigns repeatedly warn against circulating such exaggerations, due to the risk of copy-cat behavior they encourage.[88]

82. Despite that the media treat them as near synonyms, suicide and suicidality are distinct phenomena. They represent different behaviors with different motivations, with different mental health issues, and with different clinical needs. *Suicide* refers to completed suicides and the sincere intent to die. It is substantially associated with impulsivity, using more lethal means, and being a biological male.[89] *Suicidality* refers to parasuicidal behaviors, including suicidal ideation, threats, and gestures. These typically represent cries for help rather than an intent to die and are more common among biological females. Suicidal threats can indicate any of many problems or represent emotional blackmail, as typified by "If you leave me, I will kill myself." Professing suicidality is also used for attention-seeking or for the support or sympathy it evokes from others, denoting distress much more frequently than an intent to die.

83. Notwithstanding public misconceptions about the frequency of suicide and related behaviors, the highest rates of suicide are among middle-aged and elderly men in high income countries.[90] Biological males are at three times greater risk of death by suicide than are biological females, whereas suicidal ideation, plans, and attempts are three times more common among biological females.[91] In contrast with completed suicides, the frequency of suicidal ideation, plans, and attempts is highest during adolescence and young adulthood, with reported ideation rates

88 Gould & Lake, 2013.
89 Freeman, *et al.*, 2017.
90 Turecki & Brent, 2016
91 Klonsky et al., 2016; Turecki & Brent, 2016

spanning 12.1–33%.[92] Relative to other countries, Americans report elevated rates of each of suicidal ideation (15.6%), plans (5.4%), and attempts (5.0%).[93] Suicide attempts occur up to 30 times more frequently than completed suicides.[94] The rate of completed suicides in the U.S. population is 14.5 per 100,000 people.[95] The widely discrepant numbers representing completed suicides versus transient suicidal ideation has left those statistics open to substantial abuse in the media and social media. Despite public media guidelines urging "Avoid dramatic headlines and strong terms such as 'suicide epidemic'," [96] that is exactly what mainstream outlets have done.[97]

84. There is substantial research associating sexual orientation with suicidality, but much less so with completed suicide.[98] More specifically, there is some evidence suggesting gay adult men are more likely to die by suicide than are heterosexual men, but there is less evidence of an analogous pattern among lesbian women. Regarding suicidality, surveys of self-identified LGB Americans repeatedly report rates of suicidal ideation and suicide attempts 2–7 times higher than their heterosexual counterparts. Because of this association of suicidality with sexual orientation, one must apply caution in interpreting findings allegedly about gender identity: Because of the overlap between people who self-identify as non-heterosexual and as non-cis-gendered, correlations detected between suicidality and gender dysphoria may instead reflect (be confounded by) homosexuality. Indeed, other authors have made explicit their surprise that so many studies, purportedly of gender identity, entirely omitted measurement or consideration of sexual orientation, creating the situation where features that seem to be associated with gender identity

92 Borges et a., 2010; Nock et al., 2008
93 Klonsky, et al., 2016.
94 Bachman, 2018.
95 World Health Organization, 2022.
96 Samaritans, 2020.
97 E.g., MSNBC, 2015, *Trans youth and suicide: An epidemic.*
98 Haas, *et al.*, 2011.

instead reflect the sexual orientation of the members of the sample.[99]

85. Among post-transition transsexuals, completed suicide rates are elevated, but are nonetheless rare.[100] Regarding suicidality, there have been three recent, systematic reviews of the research literature.[101] All three included specific methods to minimize any potential effects of cherry-picking findings from within the research literature. Compiling the results of 108 articles reported from 64 research projects, Adams and Vincent (2019) found an overall average rate of 46.55% for suicidal ideation (ranging 18.18%–95.5%) and an overall average rate of 27.19% for suicidal attempts (ranging 8.57%–52.4%). These findings confirmed those reported by McNeil, *et al.* (2017), whose review of 30 articles revealed a range of 37%–83% for suicidal ideation and 9.8%–43% for suicidal attempts. Thus, on the one hand, these ranges are greater than those reported for the mainstream population—They instead approximate the rates reported among sexual orientation minorities. On the other hand, with measures so lacking in reliability that they produce every result from 'rare' to 'almost everyone', it is unclear which, if any of them, represents a valid conclusion.

86. McNeil *et al.* (2017) observed also the research to reveal rates of suicidal ideation and suicidal attempts to be related—not to transition status—but to the social support received: The studies reviewed showed support to decrease suicidality, but transition not to. Indeed, in some situations, social support was associated with *increased* suicide attempts, suggesting the reported suicidality may represent attempts to evoke more support.[102]

87. Marshall et al. (2016) identified and examined 31 studies, again finding rates of suicidal ideation and suicide attempts to be elevated, particularly among biological females, indicating that

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99 McNeil, *et al.* (2017)
100 Wiepjes, *et al.,* 2020.
101 Adams & Vincent, 2019; Marshall, *et al.,* 2016; McNeil, *et al.* (2017).
102 Bauer, *et al.,* 2015; Canetto, et al., 2021.

suicidality patterns correspond to biological sex rather than self-identified gender.[103]

88. Despite that mental health issues, including suicidality, are repeatedly required by clinical standards of care to be resolved before transition, threats of suicide are instead oftentimes used as the very justification for labelling transition a 'medical necessity'. However plausible it might seem that failing to affirm transition causes suicidality, the epidemiological evidence indicates that hypothesis to be incorrect: Suicide rates remains elevated even after complete transition, as shown by a comprehensive review of 17 studies of suicidality in gender dysphoria.[104]

89. The scientific study of suicide is inextricably linked to that of mental illness, and Borderline Personality Disorder is repeatedly documented to be greatly elevated among sexual minorities.[105]

F. Conversion Therapy

90. Activists and social media increasingly, but erroneously, apply the term "conversion therapy" moving farther and farther from what the research has reported. "Conversion therapy" (or "reparative therapy" and other names) was the attempt to change a person's sexual orientation; however, with the public more frequently accustomed to "LGB" being expanded to "LGBTQ+", the claims relevant only to sexual orientation are being misapplied to gender identity. The research has repeatedly demonstrated that once one explicitly acknowledges being gay or lesbian, one is only very rarely mistaken. That is entirely unlike gender identity, wherein the great majority of children who declare cross-gender identity cease to do so by puberty, as already shown unanimously by all follow-up studies. As the field grows increasingly polarized, any therapy failing to provide affirmation-on-demand is mislabeled "conversion therapy."[106] Indeed, even

[103] Marshall, et al., 2016.
[104] McNeil, *et al.*, 2017.
[105] Reuter, *et al.*, 2016; Rodriguez-Seiljas, *et al.*, 2021; Zanarni, *et al.*, 2021.
[106] D'Angelo, *et al.*, 2021.

actions of non-therapists, unrelated to any therapy, have been (mis-)labelled conversion therapy, including the prohibition of biological males competing on female teams.[107]

G. Affirmation-on-Demand vs Gate-Keeping

91. Colloquially, affirmation refers broadly to any actions that treat the person as belonging to a new gender. In different contexts, that could apply to social actions (use of a new name and pronouns), legal actions (changes to birth certificates), or medical actions (hormonal and surgical interventions). That is, social transition, legal transition, and medical transition (and subparts thereof) need not, and rarely do, occur at the same time. In practice, there are cases in which a child has socially only partially transitioned, such as presenting as one gender at home and another at school or presenting as one gender with one custodial parent and another gender with the other parent.

92. Referring to "affirmation" as a treatment approach is ambiguous: Although often used in public discourse to take advantage of the positive connotations of the term, it obfuscates what exactly is being affirmed. This often leads to confusion, such as quoting a study of the benefits and risks of social affirmation in a discussion of medical affirmation, where the appearance of the isolated word "affirmation" refers to entirely different actions.

93. It is also an error to divide treatment approaches into affirmative versus non-affirmative. As noted already, the widely adopted Dutch Approach (and the guidelines of the multiple professional associations based on it) cannot be said to be either: It is a staged set of interventions, wherein social transition (and puberty blocking) may not begin until age 12 and cross-sex hormonal and other medical interventions, later.

94. Formal clinical approaches to helping children expressing gender dysphoria employ a

[107] Turban, 2021, March 16.

gate-keeper model, with decision trees to help clinicians decide when and if the potential benefits of affirmation of the new gender would outweigh the potential risks of doing so. Because the gate-keepers and decision-trees generally include the possibility of affirmation in at least some cases, it is misleading to refer to any one approach as "the affirmation approach." The most extreme decision-tree would be accurately called affirmation-*on-demand*, involving little or no opportunity for children to explore at all whether the distress they feel is due to some other, less obvious, factor, whereas more moderate gate-keeping would endorse transition only in select situations, when the likelihood of regretting transition is minimized.

95. Many outcomes studies have been published examining the results of gate-keeper models, but no such studies have been published regarding affirmation-on-demand with children. Although there have been claims that affirmation-on-demand causes mental health or other improvement, these have been the result only of "retrospective" rather than "prospective" studies. That is, such studies did not take a sample of children and follow them up over time, to see how many dropped out altogether, how many transitioned successfully, and how many transitioned and regretted it or detransitioned. Rather, such studies took a sample of successfully transitioned adults and asked them retrospective questions about their past. In such studies, it is not possible to know how many other people dropped out or regretted transition, and it is not possible to infer causality from any of the correlations detected, despite authors implying and inferring causality.

H. Assessing the "Minority Stress Hypothesis"

96. The elevated levels of mental health problems among lesbian, gay, and bisexual populations is a well-documented phenomenon, and the idea that it is caused by living within a socially hostile environment is called the *Minority Stress Hypothesis*.[108] The association is not

[108] Meyer, 2003.

entirely straight-forward, however. For example, although lesbian, gay, and bisexual populations are more vulnerable to suicide ideation overall, the evidence specifically on adult lesbian and bisexual women is unclear. Meyer did not include transgender populations in originating the hypothesis, and it remains a legitimate question to what extent and in what ways it might apply to gender identity.

97. Minority stress is associated, in large part, with being a visible minority. There is little evidence that transgender populations show the patterns suggested by the hypothesis. For example, the minority stress hypothesis would predict differences according to how visibly a person is discernable as a member of the minority, which often changes greatly upon transition. Biological males who are very effeminate stand out throughout childhood, but in some cases can successfully blend in as adult females; whereas the adult-onset transitioners blend in very much as heterosexual cis-gendered males during their youth and begin visibly to stand out in adulthood, only for the first time.

98. Also suggesting minority stress cannot be the full story is that the mental health symptoms associated with minority stress do not entirely correspond with those associated with gender dysphoria. The primary symptoms associated with minority stress are depressive symptoms, substance use, and suicidal ideation.[109] The symptoms associated with gender dysphoria indeed include depressive symptoms and suicidal ideation, but also include anxiety symptoms, Autism Spectrum Disorders, and personality disorders.

99. A primary criterion for readiness for transition used by the clinics demonstrating successful transition is the absence or resolution of other mental health concerns, such as suicidality. In the popular media, however, indications of mental health concerns are instead often

[109] Meyer, 2003.

dismissed as an expectable result caused by Sexual Minority Stress (SMS). It is generally implied that such symptoms will resolve upon transition and integration into an affirming environment.

V. Clinical Guidelines

100. Several sets of recommendations have been offered regarding the clinical treatment of people with gender dysphoria. The best scientifically validated among them is the Dutch Protocol. Many clinics, however, instead employ Endocrine Society or WPATH guidelines, which leave nearly all decisions to the discretion of the physician rather than to establish any boundaries at all. These sets of guidelines are summarized in table form on the Executive Summary at the beginning of the present report. There do not exist any research studies supporting or justifying the lowering of standards from the Dutch Protocol to the Endocrine Society/WPATH levels. Although the cohort studies with the guidelines cannot distinguish benefits of psychotherapy from medical intervention, the studies showing improvement were those using the Dutch Protocol. None of the studies employing Endocrine Society/WPATH methods suggested substantial improvement.

A. The Dutch Protocol (aka Dutch Approach)

101. The purpose of the protocol was to compromise the conflicting needs among: clients' initial wishes upon assessment, the long-established and repeated observation that those wishes will change in the majority of (but not in all) childhood cases, and that cosmetic aspects of medical transition are perceived to be better when they occur earlier rather than later.

102. The Dutch Protocol was developed over many years by the Netherlands' child gender identity clinic, incorporating the accumulating findings from their own research as well as those reported by other clinics working with gender dysphoric children. They summarized and explicated the approach in their peer-reviewed report, *Clinical management of gender dysphoria*

in children and adolescents: The Dutch Approach.[110] The components of the Dutch Approach are:

- no social transition at all considered before age 12 (watchful waiting period),
- no puberty blockers considered before age 12,
- cross-sex hormones considered only after age 16, and
- resolution of mental health issues before any transition.

103. For youth under age 12, "the general recommendation is watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty."[111]

104. The age cut-offs of the Dutch Approach were not based on any research demonstrating their superiority over other potential age cut-off's. Rather, they were chosen to correspond to the ages of consent to medical procedures under Dutch law. Nevertheless, whatever the original rationale, the data from this clinic simply contain no information about the safety or efficacy of employing these measures at younger ages.

105. The authors of the Dutch Approach repeatedly and consistently emphasize the need for extensive mental health assessment, including clinical interviews, formal psychological testing with validated psychometric instruments, and multiple sessions with the child and the child's parents.

106. Within the Dutch approach, there is no social transition before age twelve. That is, social affirmation of the new gender may not begin until age 12—as desistance is less likely to occur past that age. "Watchful Waiting" refers to a child's developmental period up to that age. Watchful waiting does not mean do nothing but passively observe the child. Rather, such children and families typically present with substantial distress involving both gender and non-gender issues, and it is during the watchful waiting period that a child (and other family members as appropriate) would undergo therapy, resolving other issues which may be exacerbating

[110] de Vries & Cohen-Kettenis, 2012
[111] de Vries & Cohen-Kettenis, 2012, at 301.

psychological stress or dysphoria. As noted by the Dutch clinic, "[T]he adolescents in this study received extensive family or other social support . . . [and they] were all regularly seen by one of the clinic's psychologists or psychiatrists."[112] One is actively treating the person, while carefully "watching" the dysphoria.

B. World Professional Association for Transgender Health (WPATH)

107. The WPATH Standards (version seven) acknowledge the high rates of desistance among prepubescent children:

> [I]n follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6–23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12–27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).[113]

That is, "In most children, gender dysphoria will disappear before, or early in, puberty."[114]

108. Although WPATH does not refer to puberty blocking medications as "experimental," the document indicates the non-routine, or at least inconsistent availability of the treatment:

> Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., [2012]).[115]

109. WPATH neither endorses nor proscribes social transitions before puberty, instead recognizing the diversity among families' decisions:

> Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health

[112] de Vries, *et al*., 2011, at 2280-2281.
[113] Coleman, *et al*., 2012, at 172.
[114] Coleman, *et al*., 2012, at 173.
[115] Coleman, *et al*., 2012, at 173.

> professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood.[116]

It does caution, however, "Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria."[117]

110. An eighth version of the WPATH Standards of Care have been circulated for public comment[118] and is expected to be released in 2022. No cohort studies nor any validation studies have been conducted to assess its contents. Regarding transition among adolescents, version eight recommendations these age and developmental cut-off's:

> F. The adolescent has reached Tanner 2 stage of puberty for pubertal suppression.
>
> G. The adolescent is the following age for each treatment:
>
> - 14 years and above for hormone treatment (estrogens or androgens), unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.
> - 15 years and above for chest masculinization; unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.
> - 16 years and above for breast augmentation, facial surgery (including rhinoplasty, tracheal shave, and genioplasty) as part of gender affirming treatment; unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.
> - 17 and above for metoidioplasty, orchidectomy, vaginoplasty, and hysterectomy and fronto-orbital remodeling as part of gender affirming treatment unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.
> - 18 years or above for phalloplasty, unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.[119]

111. Version eight cites most of the cohort studies of adolescent minors undergoing medical transition. It does not, however, compile, assess, or systematically review their results to identify any patterns across them. Rather, Version eight concludes only that the "design makes interpreting

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116 Coleman, *et al*., 2012, at 176.
117 Coleman, *et al*., 2012, at 176 (quoting Drummond, *et al*., 2008; Wallien & Cohen-Kettenis, 2008).
118 Coleman *et al.*, 2021.
119 Coleman, *et al.*, 2021, at 60.

outcomes more challenging".[120] The document notes "the data consistently demonstrate improved or stable psychological functioning, body image, and/or treatment satisfaction"[121] and repeatedly emphasizes the inclusion of mental health treatment, but never acknowledges the confound that psychotherapy poses to the demonstrated improvements.

C. Endocrine Society (ES)

112. The 150,000-member Endocrine Society appointed a nine-member task force, plus a methodologist and a medical writer, who commissioned two systematic reviews of the research literature and, in 2017, published an update of their 2009 recommendations, based on the best available evidence identified. The guideline was co-sponsored by the American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Paediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society (PES), and the World Professional Association for Transgender Health (WPATH).

113. The document acknowledged the frequency of desistance among gender dysphoric children:

> Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence. . . . In adolescence, a significant number of these desisters identify as homosexual or bisexual.[122]

114. The statement similarly acknowledges inability to predict desistance or persistence, "With current knowledge, we cannot predict the psychosexual outcome for any specific child."[123]

115. Although outside their area of professional expertise, mental health issues were also addressed by the Endocrine Society, repeating the need to handle such issues before engaging in

[120] Coleman, *et al.*, 2021, at 56.
[121] Coleman, et al., 2021, at 56.
[122] Hembree, *et al*., 2017, at 3876.
[123] Hembree, *et al*., 2017, at 3876.

transition, "In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues."[124] This ordering—to address mental health issues before embarking on transition—avoids relying on the unproven belief that transition will solve such issues.

116. The Endocrine Society did not endorse any affirmation-only approach. The guidelines were neutral with regard to social transitions before puberty, instead advising that such decisions be made only under clinical supervision: "We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional."[125]

117. The Endocrine Society guidelines make explicit that, after gathering information from adolescent clients seeking medical interventions and their parents, the clinician "provides correct information to prevent unrealistically high expectations [and] assesses whether medical interventions may result in unfavorable psychological and social outcomes."[126]

D. American Academy of Pediatrics (AAP)

118. The policy of the American Academy of Pediatrics (AAP) is unique among the major medical associations in being the only one to endorse an affirmation-on-demand policy, including social transition before puberty without any watchful waiting period. Although changes in recommendations can obviously be appropriate in response to new research evidence, the AAP provided none. Rather, the research studies AAP cited in support of its policy simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy

[124] Hembree, *et al*., 2017, at 3877.
[125] Hembree, *et al*., 2017, at 3872.
[126] Hembree, *et al*., 2017, at 3877.

instead outright contradicted that policy, repeatedly endorsing watchful waiting.[127] Moreover, of all the outcomes research published, the AAP policy cited *one*, and that without mentioning the outcome data it contained.[128].

119. Immediately following the publication of the AAP policy, I conducted a point-by-point fact-check of the claims it asserted and the references it cited in support. I submitted that to the *Journal of Sex & Marital Therapy*, a well-known research journal of my field, where it underwent blind peer review and was published. I append that article as part of this report. *See* Appendix 3. A great deal of published attention ensued; however, the AAP has yet to respond to the errors I demonstrated its policy contained. Writing for *The Economist* about the use of puberty blockers, Helen Joyce asked AAP directly, "Has the AAP responded to Dr Cantor? If not, have you any response now?" The AAP Media Relations Manager, Lisa Black, responded: "We do not have anyone available for comment."

VI. International Health Care Consensus

120. As detailed in the following, Westernized countries other than the U.S. have followed a remarkably similar pattern of policy development: The health care systems of these countries responded to the demands of transgender advocates by facilitating transition-on-demand, which was followed by the identification of the failure of those efforts to improve the mental health of an exponentially increasing number of youth, and, currently, by the reversal of initial policy, now endorsing psychotherapy as the treatment of choice, with medical interventions representing a method of last resort, if permitted at all. These range from medical advisories to outright bans on the medical transition of minors.

[127] Cantor, 2020.
[128] Cantor, 2020, at 1.

A. United Kingdom

121. The National Health Service (NHS) of the United Kingdom centralizes gender counselling and transitioning services in a single clinic, the Gender Identity Development Service (GIDS) of the Tavistock and Portman NHS Foundation Trust. Between 2008 and 2018, the number of referrals to the clinic had increased by a factor of 40, leading to a government inquiry into the causes[129]. The GIDS was repeatedly accused of over-diagnosing and permitting transition in cases despite indicators against patient transition, including by 35 members of the GIDS staff, who resigned by 2019[130].

122. The NHS appointed Dr. Hilary Cass, former President of the Royal College of Paediatrics and Child Health, to conduct an independent review[131]. That review included a systematic consolidation of all the research evidence, following established procedures for preventing the "cherry-picking" or selective citation favouring or down-playing any one conclusion[132]. The review's results were unambiguous: "The critical outcomes for decision making are the impact on gender dysphoria, mental health and quality of life. The quality of evidence for these outcomes was assessed as very low"[133], again using established procedures for assessing clinical research evidence (called GRADE). The review also assessed as "very low" the quality of evidence regarding "body image, psychosocial impact, engagement with health care services, impact on extent of an satisfaction with surgery and stopping treatment"[134]. The report concluded that of the existing research, "The studies included in this evidence review are all small, uncontrolled observational studies, which are subject to bias and confounding….They suggest

[129] Marsh, 2020; Rayner, 2018.
[130] BBC, 2021; Donnelly, 2019.
[131] National Health Service, 2020, Sept. 22.
[132] U.K. National Health Service (NHS), 2021.
[133] U.K. National Health Service (NHS), 2021, at 4.
[134] U.K. National Health Service (NHS), 2021, at 5.

little change with GnRH analogues [puberty blockers] from baseline to follow-up"[135].

B. Finland

123. In Finland, the assessments of mental health and preparedness of minors for transition services are centralized by law into two research clinics, Helsinki University Central Hospital and Tampere University Hospital. The eligibility of minors began in 2011. In 2019, Finnish researchers published an analysis of the outcomes of adolescents diagnosed with transsexualism and receiving cross-sex hormone treatment[136]. That study showed that despite the purpose of medical transition to improve mental health: "Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development"[137]. The patients who were functioning well after transition were those who were already functioning well before transition, and those who were functioning poorly, continued to function poorly after transition.

124. Consistent with the evidence, Finland's health care service (Council for Choices in Health Care in Finland—COHERE) thus ended the surgical transition of minors, ruling in 2020 that "Surgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors" (COHERE, 2020). The review of the research concluded that "[N]o conclusions can be drawn on the stability of gender identity during the period of disorder caused by a psychiatric illness with symptoms that hamper development." COHERE also greatly restricted access to puberty-blocking and other hormonal treatments, indicating they "may be considered if the need for it continues *after* the other psychiatric symptoms have ceased and adolescent

135 U.K. National Health Service (NHS), 2021, at 13.
136 Kaltiala et al., 2020.
137 Kaltiala et al., 2020, at 213.

development is progressing normally"[138]. The council was explicit in noting the lack of research needed for decision-making, "There is also a need for more information on the *disadvantages* of procedures and on people who regret them"[139].

C. Sweden

125. Sweden's national health care policy regarding trans issues has developed quite similarly to that of the UK. Already in place 20 years ago, Swedish health care policy permitted otherwise eligible minors to receive puberty-blockers beginning at age 14 and cross-sex hormones at age 16.) At that time, only small numbers of minors sought medical transition services. An explosion of referrals ensued in 2013–2014. Sweden's Board of Health and Welfare reported that, in 2018, the number of diagnoses of gender dysphoria was 15 times higher than 2008 among girls ages 13–17.

126. Sweden has long been very accepting with regard to sexual and gender diversity. In 2018, a law was proposed to lower the age of eligibility for surgical care from age 18 to 15, remove the requirement for parental consent, and lower legal change of gender to age 12. A series of cases of regret and suicide were reported in the Swedish media, leading to questions of mental health professionals failing to consider. In 2019, the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) therefore conducted its own comprehensive review of the research[140]. Like the UK, the Swedish investigation employed methods to ensure the encapsulation of the all the relevant evidence[141].

127. The SBU report came to the same conclusions as the UK commission. From 2022 forward, the Swedish National Board or Health and Welfare therefore "recommends restraint when

[138] Council for Choices in Health Care in Finland, 2020; italics added.
[139] Council for Choices in Health Care in Finland, 2020; italics added.
[140] Orange, 2020, Feb 22.
[141] Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019.

it comes to hormone treatment…Based on the results that have emerged, the National Board of Health and Welfare's overall conclusion is that the risks of anti-puberty and sex-confirming hormone treatment for those under 18 currently outweigh the possible benefits for the group as a whole"[142]. Neither puberty blockers nor cross-sex hormones would be provided under age 16, and patients ages 16–18 would receive such treatments only within research settings (clinical trials monitored by the appropriate Swedish research ethics board).

D. France

128. In 2022, the Académie Nationale de Médecine of France issued a strongly worded statement, citing the Swedish ban on hormone treatments. "[A] great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause…such as impact on growth, bone fragility, risk of sterility, emotional and intellectual consequences and, for girls, symptoms reminiscent of menopause"[143]. For hormones, the Académie concluded "the greatest reserve is required in their use," and for surgical treatments, "[T]heir irreversible nature must be emphasized." The Académie did not outright ban medical interventions, but warned "the risk of over-diagnosis is real, as shown by the increasing number of transgender young adults wishing to "detransition". Rather than medical interventions, it advised health care providers "to extend as much as possible the psychological support phase." The Académie reviewed and emphasized the evidence indicating the very large and very sudden increase in youth requesting medical transition. It attributed the change, not to society now being more accepting of sexual diversity, but to social media, "underlining the addictive character of excessive consultation of social networks which is both harmful to the psychological development

[142] Swedish National Board of Health and Welfare, 2022.
[143] Académie Nationale de Médecine, 2022, Feb. 25.

of young people and responsible, for a very important part, of the growing sense of gender incongruence."

E. Australia

129. In Australia, from 2004 to 2017, court approval was required before starting hormone treatment. The end of that policy was followed by a jump to the opposite extreme: The subsequent Australian standards of care were explicit in indicating "decision making should be driven by the child or adolescent wherever possible; this applies to options regarding not only medical intervention but also social transition",[144] emphasizing that "Social transition should be led by the child."[145] Notably, these guidelines were based, not on the research literature, but on expert consensus.[146] In 2019, however, the Royal Australian and New Zealand College of Psychiatrists withdrew its support for those guidelines, issuing a position statement prioritizing psychotherapy. In an interview with Medscape, the president of the National Association of Practising Psychiatrists in Australia said that exploration of a patients reasons for identifying as transgender is essential, and "There may be other reasons for doing it and we need to look for those, identify them and treat them. This needs to be done before initiating hormones and changing the whole physical nature of the child."[147]

VII. U.S. Professional Associations

130. In stark contrast with the consensus of the international health bodies endorsing evidence-based medicine, some U.S. medical associations instead continue to endorse medical intervention for children. The value of such endorsement should not be either over or under-estimated. The general public typically infers from such support that it followed from the

144 Telfer, *et al.*, 2018, at 133.
145 Telfer, *et al.*, 2018, at 134.
146 Telfer, *et al.*, 2018, at 132.
147 *Medscape*, 2021, Oct. 7.

association having conducted a scholarly review of the scientific evidence, ideally using standardized research methods to isolate biases and prevent cherry-picking that favors any specific results. Yet, whereas European public health services have engaged in exactly these comprehensive and transparent methods,[148] the American professional associations have not.

131. With the broad exception of the AAP, the professional associations' statements repeatedly noted instead that:

- Desistance of gender dysphoria occurs in the majority of prepubescent children.
- Mental health issues need to be assessed as potentially contributing factors and need to be addressed before transition.
- Puberty-blocking medication is an experimental, not a routine, treatment.
- Social transition is not generally recommended until after puberty.

Although some other associations have published broad statements of moral support for sexual minorities and against discrimination, they did not include any specific standards or guidelines regarding medical- or transition-related care.

A. Pediatric Endocrine Society and Endocrine Society (ES/PES)

132. In 2020, the 1500-member Pediatric Endocrine Society partnered with the Endocrine Society to create and endorse a brief, two-page position statement.[149] Although strongly worded, the document provided no specific guidelines, instead deferring to the Endocrine Society guidelines.[150]

133. It is not clear to what extent this endorsement is meaningful, however. According to the PES, the Endocrine Society "recommendations include evidence that treatment of gender dysphoria/gender incongruence is medically necessary and should be covered by insurance."[151] However, the Endocrine Society makes neither statement. Although the two-page PES document

148 U.K. National Health Service (NHS), 2021.
149 PES, online; Pediatric Endocrine Society & Endocrine Society, Dec. 2020.
150 Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1; Hembree, *et al*., 2017.
151 Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1.

mentioned insurance coverage four times, the only mention of health insurance by the Endocrine Society was: "If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action."[152] Despite the PES asserting it as "medically necessary," the Endocrine Society stopped short of that. Its only use of that phrase was instead limiting: "We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being."[153]

B. American Academy of Child & Adolescent Psychiatry (AACAP)

134. The 2012 statement of the American Academy of Child & Adolescent Psychiatry (AACAP) is not an affirmation-only policy. It notes:

135. Just as family rejection is associated with problems such as depression, suicidality, and substance abuse in gay youth, the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects. . . . In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent.[154]

136. The AACAP's language repeats the description of the use of puberty blockers only as an exception: "For situations in which deferral of sex reassignment decisions until adulthood is *not clinically feasible*, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using

[152] Hembree, *et al*. 2017, at 3883.
[153] Hembree, *et al*., 2017 at 3872, 3894.
[154] Adelson & AACAP, 2012, at 969.

gonadotropin-releasing hormone analogues."[155]

137. The AACAP statement acknowledges the long-term outcomes literature for gender dysphoric children: "In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood,"[156] adding that "[c]linicians should be aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality."[157]

138. The policy similarly includes a provision for resolving mental health issues: "Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and *treatment of associated mental health problems*."[158] The document also includes minority stress issues and the need to deal with mental health aspects of minority status (*e.g.*, bullying).[159]

139. Rather than endorse social transition for prepubertal children, the AACAP indicates: "There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential risks and benefits of doing so."[160]

C. American College of Obstetricians & Gynecologists (ACOG)

140. The American College of Obstetricians & Gynecologists (ACOG) published a "Committee Opinion" expressing recommendations in 2017. The statement indicates it was

[155] Adelson & AACAP, 2012, at 969 (italics added).
[156] Adelson & AACAP, 2012, at 963.
[157] Adelson & AACAP, 2012, at 968.
[158] Adelson & AACAP, 2012, at 970 (italics added).
[159] Adelson & AACAP, 2012, at 969.
[160] Adelson & AACAP, 2012, at 969.

developed by the ACOG's Committee on Adolescent Health Care, but does not indicate participation based on professional expertise or a systematic method of objectively assessing the existing research. It includes the disclaimer: "This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed."[161]

141. Prepubertal children do not typically have clinical contact with gynecologists, and the ACOG recommendations include that the client additionally have a primary health care provider.[162]

142. The ACOG statement cites the statements made by other medical associations—European Society for Pediatric Endocrinology (ESPE),, PES, and the Endocrine Society—and by WPATH.[163] It does not cite any professional association of *mental* health care providers, however. The ACOG recommendations repeat the previously mentioned eligibility/readiness criteria of having no mental illness that would hamper diagnosis and no medical contraindications to treatment. It notes: "*Before* any treatment is undertaken, the patient must display eligibility and readiness (Table 1), meaning that the adolescent has been evaluated by a mental health professional, has no contraindications to therapy, and displays an understanding of the risks involved."[164]

143. The "Eligibility and Readiness Criteria" also include, "Diagnosis established for gender dysphoria, transgender, transsexualism."[165] This standard, requiring a formal diagnosis, forestalls affirmation-on-demand because self-declared self-identification is not sufficient for

[161] ACOG, 2017, at 1.
[162] ACOG, 2017, at 1.
[163] ACOG, 2017, at 1, 3.
[164] ACOG, 2017, at 1, 3 (citing the Endocrine Society guidelines) (italics added).
[165] ACOG, 2017, at 3 Table 1.

DSM diagnosis.

144. ACOG's remaining recommendations pertain only to post-transition, medically oriented concerns. Pre-pubertal social transition is not mentioned in the document, and the outcomes studies of gender dysphoric (prepubescent) children are not cited.

D. American College of Physicians (ACP)

145. The American College of Physicians published a position paper broadly expressing support for the treatment of LGBT patients and their families, including nondiscrimination, antiharassment, and defining "family" by emotional rather than biological or legal relationships in visitation policies, and the inclusion of transgender health care services in public and private health benefit plans.[166]

146. ACP did not provide guidelines or standards for child or adult gender transitions. The policy paper opposed attempting "reparative therapy;" however, the paper confabulated sexual orientation with gender identity in doing so. That is, on the one hand, ACP explicitly recognized that "[s]exual orientation and gender identity are inherently different."[167] It based this statement on the fact that "the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change *sexual orientation*."[168] The APA's document, entitled "Report of the American Psychological Task Force on appropriate therapeutic responses to *sexual orientation*" does not include or reference research on gender identity.[169] Despite citing no research about transgenderism, the ACP nonetheless included in its statement: "Available research does not support the use of reparative therapy as an effective method in the treatment of LGB*T*

[166] Daniel & Butkus, 2015a, 2015b.
[167] Daniel & Butkus, 2015b, at 2.
[168] Daniel & Butkus, 2015b, at 8 (italics added).
[169] APA, 2009 (italics added).

persons."[170] That is, the inclusion of "T" with "LGB" is based on something other than the existing evidence.

147. There is another statement,[171] which was funded by ACP and published in the Annals of Internal Medicine under its "*In the Clinic*" feature, noting that "'In the Clinic' does not necessarily represent official ACP clinical policy."[172] The document discusses medical transition procedures for adults rather than for children, except to note that "[n]o medical intervention is indicated for prepubescent youth,"[173] that a "mental health provider can assist the child and family with identifying an appropriate time for a social transition,"[174] and that the "child should be assessed and managed for coexisting mood disorders during this period because risk for suicide is higher than in their cisgender peers."[175]

E. The ESPE-LWPES GnRH Analogs Consensus Conference Group

148. Included in the interest of completeness, there was also a collaborative report in 2009, between the European Society for Pediatric Endocrinology (ESPE) and the Lawson Wilkins Pediatric Endocrine Society (LWPES).[176] Thirty experts were convened, evenly divided between North American and European labs and evenly divided male/female, who comprehensively rated the research literature on gonadotropin-release hormone analogs in children.

149. The effort concluded that "[u]se of gonadotropin-releasing hormone analogs for conditions other than central precocious puberty requires additional investigation and cannot be suggested routinely."[177] However, gender dysphoria was not explicitly mentioned as one of those

170 Daniel & Butkus, 2015b, at 8 (italics added).
171 Safer & Tangpricha, 2019.
172 Safer & Tangpricha, 2019, at ITC1.
173 Safer & Tangpricha, 2019, at ITC9.
174 Safer & Tangpricha, 2019, at ITC9.
175 Safer & Tangpricha, 2019, at ITC9.
176 Carel et al., 2009.
177 Carel et al. 2009, at 752.

other conditions. Such additional investigations have still not appeared in the research literature, and the need for them continues to be expressed by these same professional bodies.

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APPENDICES

Appendix 1

Curriculum Vita

Appendix 2

The Outcomes Studies of Childhood-Onset Gender Dysphoria

Appendix 3

Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy, 46,* 307–313. doi: 10.1080/0092623X.2019.1698481

Appendix 4

WPATH Standards of Care For The Health Of Transsexual, Transgender, And Gender-Nonconforming People (Version 7), Chapter 6 (Adolescents)

Appendix 5

WPATH Standards of Care (Version 8),

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EDUCATION

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Doctor of Philosophy Sep., 1993–Jun., 2000
Psychology • McGill University • Montréal, Canada

Master of Arts Sep., 1990–Jan., 1992
Psychology • Boston University • Boston, MA

Bachelor of Science Sep. 1984–Aug., 1988
Interdisciplinary Science • Rensselaer Polytechnic Institute • Troy, NY
Concentrations: Computer science, mathematics, physics

EMPLOYMENT HISTORY

Director Feb., 2017–Present
Toronto Sexuality Centre • Toronto, Canada

Senior Scientist (Inaugural Member) Aug., 2012–May, 2018
Campbell Family Mental Health Research Institute
Centre for Addiction and Mental Health • Toronto, Canada

Senior Scientist Jan., 2012–May, 2018
Complex Mental Illness Program
Centre for Addiction and Mental Health • Toronto, Canada

Head of Research Nov., 2010–Apr. 2014
Sexual Behaviours Clinic
Centre for Addiction and Mental Health • Toronto, Canada

Research Section Head Dec., 2009–Sep. 2012
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Psychologist May, 2004–Dec., 2011
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Clinical Psychology Intern Sep., 1998–Aug., 1999
Centre for Addiction and Mental Health • Toronto, Canada

Teaching Assistant Sep., 1993–May, 1998
Department of Psychology
McGill University • Montréal, Canada

Pre-Doctoral Practicum Sep., 1993–Jun., 1997
Sex and Couples Therapy Unit
Royal Victoria Hospital • Montréal, Canada

Pre-Doctoral Practicum May, 1994–Dec., 1994
Department of Psychiatry
Queen Elizabeth Hospital • Montréal, Canada

ACADEMIC APPOINTMENTS

Associate Professor Jul., 2010–May, 2019
Department of Psychiatry
University of Toronto Faculty of Medicine • Toronto, Canada

Adjunct Faculty Aug. 2013–Jun., 2018
Graduate Program in Psychology
York University • Toronto, Canada

Associate Faculty (Hon) Oct., 2017–Dec., 2017
School of Behavioural, Cognitive & Social Science
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Assistant Professor Jun., 2005–Jun., 2010
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Clinical Psychology Residency Program
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PUBLICATIONS

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64. Pilkington, N. W., & Cantor, J. M. (1996). Perceptions of heterosexual bias in professional psychology programs: A survey of graduate students. *Professional Psychology: Research and Practice*, *27*, 604–612.

PUBLICATIONS

LETTERS AND COMMENTARIES

1. Cantor, J. M. (2015). Research methods, statistical analysis, and the phallometric test for hebephilia: Response to Fedoroff [Editorial Commentary]. *Journal of Sexual Medicine, 12,* 2499–2500. doi: 10.1111/jsm.13040
2. Cantor, J. M. (2015). In his own words: Response to Moser [Editorial Commentary]. *Journal of Sexual Medicine, 12,* 2502–2503. doi: 10.1111/jsm.13075
3. Cantor, J. M. (2015). Purported changes in pedophilia as statistical artefacts: Comment on Müller et al. (2014). *Archives of Sexual Behavior, 44,* 253–254. doi: 10.1007/s10508-014-0343-x
4. McPhail, I. V., & Cantor, J. M. (2015). Pedophilia, height, and the magnitude of the association: A research note. *Deviant Behavior, 36,* 288–292. doi: 10.1080/01639625.2014.935644
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6. Cantor, J. M. (2012). Reply to Italiano's (2012) comment on Cantor (2011) [Letter to the Editor]. *Archives of Sexual Behavior, 41,* 1081–1082. doi: 10.1007/s10508-012-0011-y
7. Cantor, J. M. (2012). The errors of Karen Franklin's *Pretextuality* [Commentary]. *International Journal of Forensic Mental Health, 11,* 59–62. doi: 10.1080/14999013.2012.672945
8. Cantor, J. M., & Blanchard, R. (2012). White matter volumes in pedophiles, hebephiles, and teleiophiles [Letter to the Editor]. *Archives of Sexual Behavior, 41, 749–752.* doi: 10.1007/s10508-012-9954-2
9. Cantor, J. M. (2011). New MRI studies support the Blanchard typology of male-to-female transsexualism [Letter to the Editor]. *Archives of Sexual Behavior, 40*, 863–864. doi: 10.1007/s10508-011-9805-6
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11. Cantor, J. M. (2003, Summer). Review of the book *The Man Who Would Be Queen* by J. Michael Bailey. *Newsletter of Division 44 of the American Psychological Association, 19*(2), 6.
12. Cantor, J. M. (2003, Spring). What are the hot topics in LGBT research in psychology? *Newsletter of Division 44 of the American Psychological Association, 19*(1), 21–24.
13. Cantor, J. M. (2002, Fall). Male homosexuality, science, and pedophilia. *Newsletter of Division 44 of the American Psychological Association, 18*(3), 5–8.
14. Cantor, J. M. (2000). Review of the book *Sexual Addiction: An Integrated Approach. Journal of Sex and Marital Therapy, 26*, 107–109.

EDITORIALS

1. Cantor, J. M. (2012). Editorial. *Sexual Abuse: A Journal of Research and Treatment, 24*.

2. Cantor, J. M. (2011). Editorial note. *Sexual Abuse: A Journal of Research and Treatment, 23,* 414.
3. Barbaree, H. E., & Cantor, J. M. (2010). Performance indicates for *Sexual Abuse: A Journal of Research and Treatment* (SAJRT) [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 22,* 371–373.
4. Barbaree, H. E., & Cantor, J. M. (2009). *Sexual Abuse: A Journal of Research and Treatment* performance indicators for 2007 [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 21,* 3–5.
5. Zucker, K. J., & Cantor, J. M. (2009). Cruising: Impact factor data [Editorial]. *Archives of Sexual Research, 38,* 878–882.
6. Barbaree, H. E., & Cantor, J. M. (2008). Performance indicators for *Sexual Abuse: A Journal of Research and Treatment* [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 20,* 3–4.
7. Zucker, K. J., & Cantor, J. M. (2008). The *Archives* in the era of online first ahead of print[Editorial]. *Archives of Sexual Behavior, 37,* 512–516.
8. Zucker, K. J., & Cantor, J. M. (2006). The impact factor: The *Archives* breaks from the pack [Editorial]. *Archives of Sexual Behavior, 35,* 7–9.
9. Zucker, K. J., & Cantor, J. M. (2005). The impact factor: "Goin' up" [Editorial]. *Archives of Sexual Behavior, 34,* 7–9.
10. Zucker, K., & Cantor, J. M. (2003). The numbers game: The impact factor and all that jazz [Editorial]. *Archives of Sexual Behavior, 32,* 3–5.

FUNDING HISTORY

Principal Investigators:	Doug VanderLaan, Meng-Chuan Lai
Co-Investigators:	James M. Cantor, Megha Mallar Chakravarty, Nancy Lobaugh, M. Palmert, M. Skorska
Title:	*Brain function and connectomics following sex hormone treatment in adolescents experience gender dysphoria*
Agency:	Canadian Institutes of Health Research (CIHR), Behavioural Sciences-B-2
Funds:	$650,250 / 5 years (July, 2018)

Principal Investigator:	Michael C. Seto
Co-Investigators:	Martin Lalumière , James M. Cantor
Title:	*Are connectivity differences unique to pedophilia?*
Agency:	University Medical Research Fund, Royal Ottawa Hospital
Funds:	$50,000 / 1 year (January, 2018)

Principal Investigator:	Lori Brotto
Co-Investigators:	Anthony Bogaert, James M. Cantor, Gerulf Rieger
Title:	*Investigations into the neural underpinnings and biological correlates of asexuality*
Agency:	Natural Sciences and Engineering Research Council (NSERC), Discovery Grants Program
Funds:	$195,000 / 5 years (April, 2017)

Principal Investigator:	Doug VanderLaan
Co-Investigators:	Jerald Bain, James M. Cantor, Megha Mallar Chakravarty, Sofia Chavez, Nancy Lobaugh, and Kenneth J. Zucker
Title:	*Effects of sex hormone treatment on brain development: A magnetic resonance imaging study of adolescents with gender dysphoria*
Agency:	Canadian Institutes of Health Research (CIHR), Transitional Open Grant Program
Funds:	$952,955 / 5 years (September, 2015)

Principal Investigator:	James M. Cantor
Co-Investigators:	Howard E. Barbaree, Ray Blanchard, Robert Dickey, Todd A. Girard, Phillip E. Klassen, and David J. Mikulis
Title:	*Neuroanatomic features specific to pedophilia*
Agency:	Canadian Institutes of Health Research (CIHR)
Funds:	$1,071,920 / 5 years (October, 2008)

Principal Investigator:	James M. Cantor
Title:	*A preliminary study of fMRI as a diagnostic test of pedophilia*
Agency:	Dean of Medicine New Faculty Grant Competition, Univ. of Toronto
Funds:	$10,000 (July, 2008)

Principal Investigator:	James M. Cantor
Co-Investigator:	Ray Blanchard
Title:	*Morphological and neuropsychological correlates of pedophilia*
Agency:	Canadian Institutes of Health Research (CIHR)
Funds:	$196,902 / 3 years (April, 2006)

KEYNOTE AND INVITED ADDRESSES

1. Cantor, J. M. (2021, September 28). *No topic too tough for this expert panel: A year in review.* Plenary Session for the 40th Annual Research and Treatment Conference, Association for the Treatment of Sexual Abusers.
2. Cantor, J. M. (2019, May 1). *Introduction and Q&A for 'I, Pedophile.'* StopSO 2nd Annual Conference, London, UK.
3. Cantor, J. M. (2018, August 29). *Neurobiology of pedophilia or paraphilia? Towards a 'Grand Unified Theory' of sexual interests.* Keynote address to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
4. Cantor, J. M. (2018, August 29). *Pedophilia and the brain: Three questions asked and answered.* Preconference training presented to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
5. Cantor, J. M. (2018, April 13). *The responses to* I, Pedophile *from We, the people.* Keynote address to the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
6. Cantor, J. M. (2018, April 11). *Studying atypical sexualities: From vanilla to* I, Pedophile. Full day workshop at the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
7. Cantor, J. M. (2018, January 20). *How much sex is enough for a happy life?* Invited lecture to the University of Toronto Division of Urology Men's Health Summit, Toronto, Canada.
8. Cantor, J. M. (2017, November 2). Pedophilia as a phenomenon of the brain: Update of evidence and the public response. Invited presentation to the 7th annual SBC education event, Centre for Addiction and Mental Health, Toronto, Canada.
9. Cantor, J. M. (2017, June 9). Pedophilia being in the brain: The evidence and the public's reaction. Invited presentation to *SEXposium at the ROM: The science of love and sex,* Toronto, Canada.
10. Cantor, J. M., & Campea, M. (2017, April 20). *"I, Pedophile" showing and discussion.* Invited presentation to the 42nd annual meeting of the Society for Sex Therapy and Research, Montréal, Canada.
11. Cantor, J. M. (2017, March 1). *Functional and structural neuroimaging of pedophilia: Consistencies across methods and modalities.* Invited lecture to the Brain Imaging Centre, Royal Ottawa Hospital, Ottawa, Canada.
12. Cantor, J. M. (2017, January 26). *Pedophilia being in the brain: The evidence and the public reaction.* Inaugural keynote address to the University of Toronto Sexuality Interest Network, Toronto, Ontario, Canada.
13. Cantor, J. M. (2016, October 14). *Discussion of CBC's "I, Pedophile."* Office of the Children's Lawyer Educational Session, Toronto, Ontario, Canada.
14. Cantor, J. M. (2016, September 15). *Evaluating the risk to reoffend: What we know and what we don't.* Invited lecture to the Association of Ontario Judges, Ontario Court of Justice Annual Family Law Program, Blue Mountains, Ontario, Canada. [Private link only: https://vimeo.com/239131108/3387c80652]
15. Cantor, J. M. (2016, April 8). *Pedophilia and the brain: Conclusions from the second generation of research.* Invited lecture at the 10th annual Risk and Recovery Forensic Conference, Hamilton, Ontario.

16. Cantor, J. M. (2016, April 7). *Hypersexuality without the hyperbole.* Keynote address to the 10th annual Risk and Recovery Forensic Conference, Hamilton, Ontario.
17. Cantor, J. M. (2015, November). *No one asks to be sexually attracted to children: Living in Daniel's World.* Grand Rounds, Centre for Addiction and Mental Health. Toronto, Canada.
18. Cantor, J. M. (2015, August). *Hypersexuality: Getting past whether "it" is or "it" isn't.* Invited address at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
19. Cantor, J. M. (2015, July). *A unified theory of typical and atypical sexual interest in men: Paraphilia, hypersexuality, asexuality, and vanilla as outcomes of a single, dual opponent process.* Invited presentation to the 2015 Puzzles of Sexual Orientation conference, Lethbridge, AL, Canada.
20. Cantor, J. M. (2015, June). *Hypersexuality.* Keynote Address to the Ontario Problem Gambling Provincial Forum. Toronto, Canada.
21. Cantor, J. M. (2015, May). *Assessment of pedophilia: Past, present, future.* Keynote Address to the International Symposium on Neural Mechanisms Underlying Pedophilia and Child Sexual Abuse (NeMUP). Berlin, Germany.
22. Cantor, J. M. (2015, March). *Prevention of sexual abuse by tackling the biggest stigma of them all: Making sex therapy available to pedophiles.* Keynote address to the 40th annual meeting of the Society for Sex Therapy and Research, Boston, MA.
23. Cantor, J. M. (2015, March. *Pedophilia: Predisposition or perversion?* Panel discussion at Columbia University School of Journalism. New York, NY.
24. Cantor, J. M. (2015, February). *Hypersexuality.* Research Day Grand Rounds presentation to Ontario Shores Centre for Mental Health Sciences, Whitby, Ontario, Canada.
25. Cantor, J. M. (2015, January). *Brain research and pedophilia: What it means for assessment, research, and policy.* Keynote address to the inaugural meeting of the Netherlands Association for the Treatment of Sexual Abusers, Utrecht, Netherlands.
26. Cantor, J. M. (2014, December). *Understanding pedophilia and the brain: Implications for safety and society.* Keynote address for The Jewish Community Confronts Violence and Abuse: Crisis Centre for Religious Women, Jerusalem, Israel.
27. Cantor, J. M. (2014, October). *Understanding pedophilia & the brain.* Invited full-day workshop for the Sex Offender Assessment Board of Pennsylvania, Harrisburg, PA.
28. Cantor, J. M. (2014, September). *Understanding neuroimaging of pedophilia: Current status and implications.* Invited lecture presented to the Mental Health and Addition Rounds, St. Joseph's Healthcare, Hamilton, Ontario, Canada.
29. Cantor, J. M. (2014, June). *An evening with Dr. James Cantor.* Invited lecture presented to the Ontario Medical Association, District 11 Doctors' Lounge Program, Toronto, Ontario, Canada.
30. Cantor, J. M. (2014, April). *Pedophilia and the brain.* Invited lecture presented to the University of Toronto Medical Students lunchtime lecture. Toronto, Ontario, Canada.
31. Cantor, J. M. (2014, February). *Pedophilia and the brain: Recap and update.* Workshop presented at the 2014 annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Cle Elum, WA.
32. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, February). *Functional connectivity in pedophilia.* Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario, Canada.

33. Cantor, J. M. (2013, November). *Understanding pedophilia and the brain: The basics, the current status, and their implications.* Invited lecture to the Forensic Psychology Research Centre, Carleton University, Ottawa, Canada.
34. Cantor, J. M. (2013, November). *Mistaking puberty, mistaking hebephilia.* Keynote address presented to the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
35. Cantor, J. M. (2013, October). *Understanding pedophilia and the brain: A recap and update.* Invited workshop presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
36. Cantor, J. M. (2013, October). *Compulsive-hyper-sex-addiction: I don't care what we all it, what can we* do*?* Invited address presented to the Board of Examiners of Sex Therapists and Counselors of Ontario, Toronto, Ontario, Canada.
37. Cantor, J. M. (2013, September). *Neuroimaging of pedophilia: Current status and implications.* McGill University Health Centre, Department of Psychiatry Grand Rounds presentation, Montréal, Québec, Canada.
38. Cantor, J. M. (2013, April). *Understanding pedophilia and the brain.* Invited workshop presented at the 2013 meeting of the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, MN.
39. Cantor, J. M. (2013, April). *The neurobiology of pedophilia and its implications for assessment, treatment, and public policy.* Invited lecture at the 38th annual meeting of the Society for Sex Therapy and Research, Baltimore, MD.
40. Cantor, J. M. (2013, April). *Sex offenders: Relating research to policy.* Invited roundtable presentation at the annual meeting of the Academy of Criminal Justice Sciences, Dallas, TX.
41. Cantor, J. M. (2013, March). *Pedophilia and brain research: From the basics to the state-of-the-art.* Invited workshop presented to the annual meeting of the Forensic Mental Health Association of California, Monterey, CA.
42. Cantor, J. M. (2013, January). *Pedophilia and child molestation.* Invited lecture presented to the Canadian Border Services Agency, Toronto, Ontario, Canada.
43. Cantor, J. M. (2012, November). *Understanding pedophilia and sexual offenders against children: Neuroimaging and its implications for public safety.* Invited guest lecture to University of New Mexico School of Medicine Health Sciences Center, Albuquerque, NM.
44. Cantor, J. M. (2012, November). *Pedophilia and brain research.* Invited guest lecture to the annual meeting of the Circles of Support and Accountability, Toronto, Ontario, Canada.
45. Cantor, J. M. (2012, January). *Current findings on pedophilia brain research.* Invited workshop at the San Diego International Conference on Child and Family Maltreatment, San Diego, CA.
46. Cantor, J. M. (2012, January). *Pedophilia and the risk to re-offend.* Invited lecture to the Ontario Court of Justice Judicial Development Institute, Toronto, Ontario, Canada.
47. Cantor, J. M. (2011, November). *Pedophilia and the brain: What it means for assessment, treatment, and policy.* Plenary Lecture presented at the Association for the Treatment of Sexual Abusers, Toronto, Ontario, Canada.
48. Cantor, J. M. (2011, July). *Towards understanding contradictory findings in the neuroimaging of pedophilic men.* Keynote address to 7th annual conference on Research in Forensic Psychiatry, Regensberg, Germany.

49. Cantor, J. M. (2011, March). *Understanding sexual offending and the brain: Brain basics to the state of the art.* Workshop presented at the winter conference of the Oregon Association for the Treatment of Sexual Abusers, Oregon City, OR.
50. Cantor, J. M. (2010, October). *Manuscript publishing for students.* Workshop presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
51. Cantor, J. M. (2010, August). *Is sexual orientation a paraphilia?* Invited lecture at the International Behavioral Development Symposium, Lethbridge, Alberta, Canada.
52. Cantor, J. M. (2010, March). *Understanding sexual offending and the brain: From the basics to the state of the art.* Workshop presented at the annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Blaine, WA.
53. Cantor, J. M. (2009, January). *Brain structure and function of pedophilia men.* Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario.
54. Cantor, J. M. (2008, April). *Is pedophilia caused by brain dysfunction?* Invited address to the University-wide Science Day Lecture Series, SUNY Oswego, Oswego, NY.
55. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, September). *MRIs of pedophilic men.* Invited presentation at the 25th annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
56. Cantor, J. M., Blanchard, R., & Christensen, B. K. (2003, March). *Findings in and implications of neuropsychology and epidemiology of pedophilia.* Invited lecture at the 28th annual meeting of the Society for Sex Therapy and Research, Miami.
57. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, July). *Neuropsychological functioning in pedophiles.* Invited lecture presented at the 27th annual meeting of the International Academy of Sex Research, Bromont, Canada.
58. Cantor, J. M., Blanchard, R., Christensen, B., Klassen, P., & Dickey, R. (2001, February). *First glance at IQ, memory functioning and handedness in sex offenders.* Lecture presented at the Forensic Lecture Series, Centre for Addiction and Mental Health, Toronto, Ontario, Canada.
59. Cantor, J. M. (1999, November). *Reversal of SSRI-induced male sexual dysfunction: Suggestions from an animal model.* Grand Rounds presentation at the Allan Memorial Institute, Royal Victoria Hospital, Montréal, Canada.

PAPER PRESENTATIONS AND SYMPOSIA

1. Cantor, J. M. (2020, April). "I'd rather have a trans kid than a dead kid": Critical assessment of reported rates of suicidality in trans kids. *Paper presented at the annual meeting of the Society for the Sex Therapy and Research.* Online in lieu of in person meeting.
2. Stephens, S., Lalumière, M., Seto, M. C., & Cantor, J. M. (2017, October). *The relationship between sexual responsiveness and sexual exclusivity in phallometric profiles.* Paper presented at the annual meeting of the Canadian Sex Research Forum, Fredericton, New Brunswick, Canada.
3. Stephens, S., Cantor, J. M., & Seto, M. C. (2017, March). *Can the SSPI-2 detect hebephilic sexual interest?* Paper presented at the annual meeting of the American-Psychology Law Society Annual Meeting, Seattle, WA.
4. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Victim choice polymorphism and recidivism.* Symposium Presentation. Paper presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
5. McPhail, I. V., Hermann, C. A., Fernane, S. Fernandez, Y., Cantor, J. M., & Nunes, K. L. (2014, October). *Sexual deviance in sexual offenders against children: A meta-analytic review of phallometric research.* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
6. Stephens, S., Seto, M. C., Cantor, J. M., & Goodwill, A. M. (2014, October). *Is hebephilic sexual interest a criminogenic need?: A large scale recidivism study.* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
7. Stephens, S., Seto, M. C., Cantor, J. M., & Lalumière, M. (2014, October). *Development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI–2).* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, September). *Pedophilia and the brain: White matter differences detected with DTI.* Paper presented at the 13th annual meeting of the International Association for the Treatment of Sexual Abusers, Porto, Portugal.
9. Stephens, S., Seto, M., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2014, March). *The role of hebephilic sexual interests in sexual victim choice.* Paper presented at the annual meeting of the American Psychology and Law Society, New Orleans, LA.
10. McPhail, I. V., Fernane, S. A., Hermann, C. A., Fernandez, Y. M., Nunes, K. L., & Cantor, J. M. (2013, November). *Sexual deviance and sexual recidivism in sexual offenders against children: A meta-analysis.* Paper presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
11. Cantor, J. M. (2013, September). *Pedophilia and the brain: Current MRI research and its implications.* Paper presented at the 21st annual World Congress for Sexual Health, Porto Alegre, Brazil. [Featured among Best Abstracts, top 10 of 500.]
12. Cantor, J. M. (Chair). (2012, March). *Innovations in sex research.* Symposium conducted at the 37th annual meeting of the Society for Sex Therapy and Research, Chicago.
13. Cantor, J. M., & Blanchard, R. (2011, August). fMRI versus phallometry in the diagnosis of pedophilia and hebephilia. In J. M. Cantor (Chair), *Neuroimaging of men's object*

preferences. Symposium presented at the 37th annual meeting of the International Academy of Sex Research, Los Angeles, USA.

14. Cantor, J. M. (Chair). (2011, August). *Neuroimaging of men's object preferences.* Symposium conducted at the 37th annual meeting of the International Academy of Sex Research, Los Angeles.
15. Cantor, J. M. (2010, October). A meta-analysis of neuroimaging studies of male sexual arousal. In S. Stolerú (Chair), *Brain processing of sexual stimuli in pedophilia: An application of functional neuroimaging.* Symposium presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
16. Chivers, M. L., Seto, M. C., Cantor, J. C., Grimbos, T., & Roy, C. (April, 2010). *Psychophysiological assessment of sexual activity preferences in women.* Paper presented at the 35th annual meeting of the Society for Sex Therapy and Research, Boston, USA.
17. Cantor, J. M., Girard, T. A., & Lovett-Barron, M. (2008, November). *The brain regions that respond to erotica: Sexual neuroscience for dummies.* Paper presented at the 51st annual meeting of the Society for the Scientific Study of Sexuality, San Juan, Puerto Rico.
18. Barbaree, H., Langton, C., Blanchard, R., & Cantor, J. M. (2007, October). *The role of age-at-release in the evaluation of recidivism risk of sexual offenders.* Paper presented at the 26th annual meetingof the Association for the Treatment of Sexual Abusers, San Diego.
19. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, July). *Pedophilia and brain morphology.* Abstract and paper presented at the 32nd annual meeting of the International Academy of Sex Research, Amsterdam, Netherlands.
20. Seto, M. C., Cantor, J. M., & Blanchard, R. (2006, March). *Child pornography offending is a diagnostic indicator of pedophilia*. Paper presented at the 2006 annual meeting of the American Psychology-Law Society Conference, St. Petersburg, Florida.
21. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove, S. M., & Ellis, L. (2005, August). *Interaction of fraternal birth order and handedness in the development of male homosexuality.* Abstract and paper presented at the International Behavioral Development Symposium, Minot, North Dakota.
22. Cantor, J. M., & Blanchard, R. (2005, July). *Quantitative reanalysis of aggregate data on IQ in sexual offenders.* Abstract and poster presented at the 31st annual meeting of the International Academy of Sex Research, Ottawa, Canada.
23. Cantor, J. M. (2003, August). *Sex reassignment on demand: The clinician's dilemma.* Paper presented at the 111th annual meeting of the American Psychological Association, Toronto, Canada.
24. Cantor, J. M. (2003, June). *Meta-analysis of VIQ–PIQ differences in male sex offenders.* Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
25. Cantor, J. M. (2002, August). *Gender role in autogynephilic transsexuals: The more things change…* Paper presented at the 110th annual meeting of the American Psychological Association, Chicago.

26. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, June). *IQ, memory functioning, and handedness in male sex offenders.* Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
27. Cantor, J. M. (1998, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 106th annual meeting of the American Psychological Association.
28. Cantor, J. M. (1997, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 105th annual meeting of the American Psychological Association.
29. Cantor, J. M. (1997, August). *Convention orientation for lesbian, gay, and bisexual students*. Paper presented at the 105th annual meeting of the American Psychological Association.
30. Cantor, J. M. (1996, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 104th annual meeting of the American Psychological Association.
31. Cantor, J. M. (1996, August). *Symposium: Question of inclusion: Lesbian and gay psychologists and accreditation*. Paper presented at the 104th annual meeting of the American Psychological Association, Toronto.
32. Cantor, J. M. (1996, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 104th annual meeting of the American Psychological Association.
33. Cantor, J. M. (1995, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 103rd annual meeting of the American Psychological Association.
34. Cantor, J. M. (1995, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 103rd annual meeting of the American Psychological Association.
35. Cantor, J. M. (1994, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 102nd annual meeting of the American Psychological Association.
36. Cantor, J. M. (1994, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 102nd annual meeting of the American Psychological Association.
37. Cantor, J. M., & Pilkington, N. W. (1992, August). *Homophobia in psychology programs: A survey of graduate students.* Paper presented at the Centennial Convention of the American Psychological Association, Washington, DC. (ERIC Document Reproduction Service No. ED 351 618)
38. Cantor, J. M. (1991, August). *Being gay and being a graduate student: Double the memberships, four times the problems*. Paper presented at the 99th annual meeting of the American Psychological Association, San Francisco.

POSTER PRESENTATIONS

1. Klein, L., Stephens, S., Goodwill, A. M., Cantor, J. M., & Seto, M. C. (2015, October). *The psychological propensities of risk in undetected sexual offenders.* Poster presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
2. Pullman, L. E., Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Why are incest offenders less likely to recidivate?* Poster presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
3. Seto, M. C., Stephens, S. M., Cantor, J. M., Lalumiere, M. L., Sandler, J. C., & Freeman, N. A. (2015, August). *The development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI-2).* Poster presentation at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
4. Soh, D. W., & Cantor, J. M. (2015, August). *A peek inside a furry convention.* Poster presentation at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
5. VanderLaan, D. P., Lobaugh, N. J., Chakravarty, M. M., Patel, R., Chavez, S. Stojanovski, S. O., Takagi, A., Hughes, S. K., Wasserman, L., Bain, J., Cantor, J. M., & Zucker, K. J. (2015, August). *The neurohormonal hypothesis of gender dysphoria: Preliminary evidence of cortical surface area differences in adolescent natal females.* Poster presentation at the 31st annual meeting of the International Academy of Sex Research. Toronto, Canada.
6. Cantor, J. M., Lafaille, S. J., Moayedi, M., Mikulis, D. M., & Girard, T. A. (2015, June). *Diffusion tensor imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses.* Harvey Stancer Research Day, Toronto, Ontario Canada.
7. Newman, J. E., Stephens, S., Seto, M. C., & Cantor, J. M. (2014, October). *The validity of the Static-99 in sexual offenders with low intellectual abilities.* Poster presentation at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Lykins, A. D., Walton, M. T., & Cantor, J. M. (2014, June). *An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior.* Poster presentation at the 30th annual meeting of the International Academy of Sex Research, Dubrovnik, Croatia.
9. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, November). *The utility of phallometry in the assessment of hebephilia.* Poster presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
10. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, October). *The role of hebephilic sexual interests in sexual victim choice.* Poster presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
11. Fazio, R. L., & Cantor, J. M. (2013, October). *Analysis of the Fazio Laterality Inventory (FLI) in a population with established atypical handedness.* Poster presented at the 33rd annual meeting of the National Academy of Neuropsychology, San Diego.
12. Lafaille, S., Hannah, J., Soh, D., Kucyi, A., Girard, T. A., Mikulis, D. M., & Cantor, J. M. (2013, August). *Investigating resting state networks in pedohebephiles.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.

13. McPhail, I. V., Lykins, A. D., Robinson, J. J., LeBlanc, S., & Cantor, J. M. (2013, August). *Effects of prescription medication on volumetric phallometry output.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.
14. Murray, M. E., Dyshniku, F., Fazio, R. L., & Cantor, J. M. (2013, August). *Minor physical anomalies as a window into the prenatal origins of pedophilia.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.
15. Sutton, K. S., Stephens, S., Dyshniku, F., Tulloch, T., & Cantor, J. M. (2013, August). *Pilot group treatment for "procrasturbation."* Poster presented at 39th annual meeting of the International Academy of Sex Research, Chicago.
16. Sutton, K. S., Pytyck, J., Stratton, N., Sylva, D., Kolla, N., & Cantor, J. M. (2013, August). *Client characteristics by type of hypersexuality referral: A quantitative chart review.* Poster presented at the 39th annual meeting of the International Academy of Sex Research, Chicago.
17. Fazio, R. L., & Cantor, J. M. (2013, June). *A replication and extension of the psychometric properties of the Digit Vigilance Test.* Poster presented at the 11th annual meeting of the American Academy of Clinical Neuropsychology, Chicago.
18. Lafaille, S., Moayedi, M., Mikulis, D. M., Girard, T. A., Kuban, M., Blak, T., & Cantor, J. M. (2012, July). *Diffusion Tensor Imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses.* Poster presented at the 38th annual meeting of the International Academy of Sex Research, Lisbon, Portugal.
19. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010, July). *Sexual arousal to female children in gynephilic men.* Poster presented at the 38th annual meeting of the International Academy of Sex Research, Prague, Czech Republic.
20. Cantor, J. M., Girard, T. A., Lovett-Barron, M., & Blak, T. (2008, July). *Brain regions responding to visual sexual stimuli: Meta-analysis of PET and fMRI studies.* Abstract and poster presented at the 34th annual meeting of the International Academy of Sex Research, Leuven, Belgium.
21. Lykins, A. D., Blanchard, R., Cantor, J. M., Blak, T., & Kuban, M. E. (2008, July). *Diagnosing sexual attraction to children: Considerations for DSM-V.* Poster presented at the 34th annual meeting of the International Academy of Sex Research, Leuven, Belgium.
22. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, October). *Physical height in pedophilia and hebephilia.* Poster presented at the 26th annual meeting of the Association for the Treatment of Sexual Abusers, San Diego.
23. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, August). *Physical height in pedophilia and hebephilia.* Abstract and poster presented at the 33rd annual meeting of the International Academy of Sex Research, Vancouver, Canada.
24. Puts, D. A., Blanchard, R., Cardenas, R., Cantor, J., Jordan, C. L., & Breedlove, S. M. (2007, August). *Earlier puberty predicts superior performance on male-biased visuospatial tasks in men but not women.* Abstract and poster presented at the 33rd annual meeting of the International Academy of Sex Research, Vancouver, Canada.
25. Seto, M. C., Cantor, J. M., & Blanchard, R. (2005, November). *Possession of child pornography is a diagnostic indicator of pedophilia.* Poster presented at the 24th annual meeting of the Association for the Treatment of Sexual Abusers, New Orleans.

26. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove. S. M., & Ellis, L. (2005, July). *Interaction of fraternal birth order and handedness in the development of male homosexuality.* Abstract and poster presented at the 31st annual meeting of the International Academy of Sex Research, Ottawa, Canada.
27. Cantor, J. M., & Blanchard, R. (2003, July). *The reported VIQ–PIQ differences in male sex offenders are artifactual?* Abstract and poster presented at the 29th annual meeting of the International Academy of Sex Research, Bloomington, Indiana.
28. Christensen, B. K., Cantor, J. M., Millikin, C., & Blanchard, R. (2002, February). *Factor analysis of two brief memory tests: Preliminary evidence for modality-specific measurement.* Poster presented at the 30th annual meeting of the International Neuropsychological Society, Toronto, Ontario, Canada.
29. Cantor, J. M., Blanchard, R., Paterson, A., Bogaert, A. (2000, June). *How many gay men owe their sexual orientation to fraternal birth order?* Abstract and poster presented at the International Behavioral Development Symposium, Minot, North Dakota.
30. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, November). *Fluoxetine inhibition of male rat sexual behavior: Reversal by oxytocin*. Poster presented at the 26th annual meeting of the Society for Neurosciences, Washington, DC.
31. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, June). *An animal model of fluoxetine-induced sexual dysfunction: Dose dependence and time course*. Poster presented at the 28th annual Conference on Reproductive Behavior, Montréal, Canada.
32. Cantor, J. M., O'Connor, M. G., Kaplan, B., & Cermak, L. S. (1993, June). *Transient events test of retrograde memory: Performance of amnestic and unimpaired populations*. Poster presented at the 2nd annual science symposium of the Massachusetts Neuropsychological Society, Cambridge, MA.

EDITORIAL AND PEER-REVIEWING ACTIVITIES

Editor-in-Chief

Sexual Abuse: A Journal of Research and Treatment Jan., 2010–Dec., 2014

Editorial Board Memberships

Journal of Sexual Aggression Jan., 2010–Dec., 2021
Journal of Sex Research, The Jan., 2008–Aug., 2020
Sexual Abuse: A Journal of Research and Treatment Jan., 2006–Dec., 2019
Archives of Sexual Behavior Jan., 2004–Present
The Clinical Psychologist Jan., 2004–Dec., 2005

Ad hoc Journal Reviewer Activity

American Journal of Psychiatry
Annual Review of Sex Research
Archives of General Psychiatry
Assessment
Biological Psychiatry
BMC Psychiatry
Brain Structure and Function
British Journal of Psychiatry
British Medical Journal
Canadian Journal of Behavioural Science
Canadian Journal of Psychiatry
Cerebral Cortex
Clinical Case Studies
Comprehensive Psychiatry
Developmental Psychology
European Psychologist
Frontiers in Human Neuroscience
Human Brain Mapping
International Journal of Epidemiology
International Journal of Impotence Research
International Journal of Sexual Health
International Journal of Transgenderism
Journal of Abnormal Psychology
Journal of Clinical Psychology
Journal of Consulting and Clinical Psychology
Journal of Forensic Psychology Practice
Journal for the Scientific Study of Religion
Journal of Sexual Aggression
Journal of Sexual Medicine
Journal of Psychiatric Research
Nature Neuroscience
Neurobiology Reviews
Neuroscience & Biobehavioral Reviews
Neuroscience Letters
Proceedings of the Royal Society B (Biological Sciences)
Psychological Assessment
Psychological Medicine
Psychological Science
Psychology of Men & Masculinity
Sex Roles
Sexual and Marital Therapy
Sexual and Relationship Therapy
Sexuality & Culture
Sexuality Research and Social Policy
The Clinical Psychologist
Traumatology
World Journal of Biological Psychiatry

GRANT REVIEW PANELS

2017–2021 Member, College of Reviewers, *Canadian Institutes of Health Research,* Canada.

2017 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2017 Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2016 Reviewer. National Science Center [*Narodowe Centrum Nauki*], Poland.

2016 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2015 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2015 Reviewer. *Czech Science Foundation,* Czech Republic.

2015 Reviewer, "Off the beaten track" grant scheme. *Volkswagen Foundation,* Germany.

2015 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada

2015 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2014 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2014 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada.

2014 Panel Member, Dean's Fund—Clinical Science Panel. *University of Toronto Faculty of Medicine*, Canada.

2014 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2013 Panel Member, Grant Miller Cancer Research Grant Panel. *University of Toronto Faculty of Medicine*, Canada.

2013 Panel Member, Dean of Medicine Fund New Faculty Grant Clinical Science Panel. *University of Toronto Faculty of Medicine,* Canada.

2012 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence (2nd round). *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2012 External Reviewer, University of Ottawa Medical Research Fund. *University of Ottawa Department of Psychiatry*, Canada.

2012 External Reviewer, Behavioural Sciences—B. *Canadian Institutes of Health Research*, Canada.

2011 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

TEACHING AND TRAINING

PostDoctoral Research Supervision
Law & Mental Health Program, Centre for Addiction and Mental Health, Toronto, Canada

Dr. Katherine S. Sutton	Sept., 2012–Dec., 2013
Dr. Rachel Fazio	Sept., 2012–Aug., 2013
Dr. Amy Lykins	Sept., 2008–Nov., 2009

Doctoral Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Michael Walton • University of New England, Australia	Sept., 2017–Aug., 2018
Debra Soh • York University	May, 2013–Aug, 2017
Skye Stephens • Ryerson University	April, 2012–June, 2016

Masters Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Nicole Cormier • Ryerson University	June, 2012–present
Debra Soh • Ryerson University	May, 2009–April, 2010

Undergraduate Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Kylie Reale • Ryerson University	Spring, 2014
Jarrett Hannah • University of Rochester	Summer, 2013
Michael Humeniuk • University of Toronto	Summer, 2012

Clinical Supervision (Doctoral Internship)
Clinical Internship Program, Centre for Addiction and Mental Health, Toronto, Canada

Katherine S. Sutton • Queen's University	2011–2012
David Sylva • Northwestern University	2011–2012
Jordan Rullo • University of Utah	2010–2011
Lea Thaler • University of Nevada, Las Vegas	2010–2011
Carolin Klein • University of British Columbia	2009–2010
Bobby R. Walling • University of Manitoba	2009–2010

TEACHING AND TRAINING

Clinical Supervision (Doctoral- and Masters- level practica)
Centre for Addiction and Mental Health, Toronto, Canada

Tyler Tulloch • Ryerson University	2013–2014
Natalie Stratton • Ryerson University	Summer, 2013
Fiona Dyshniku • University of Windsor	Summer, 2013
Mackenzie Becker • McMaster University	Summer, 2013
Skye Stephens • Ryerson University	2012–2013
Vivian Nyantakyi • Capella University	2010–2011
Cailey Hartwick • University of Guelph	Fall, 2010
Tricia Teeft • Humber College	Summer, 2010
Allison Reeves • Ontario Institute for Studies in Education/Univ. of Toronto	2009–2010
Helen Bailey • Ryerson University	Summer, 2009
Edna Aryee • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Iryna Ivanova • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Jennifer Robinson • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Zoë Laksman • Adler School of Professional Psychology	2005–2006
Diana Mandelew • Adler School of Professional Psychology	2005–2006
Susan Wnuk • York University	2004–2005
Hiten Lad • Adler School of Professional Psychology	2004–2005
Natasha Williams • Adler School of Professional Psychology	2003–2004
Lisa Couperthwaite • Ontario Institute for Studies in Education/Univ. of Toronto	2003–2004
Lori Gray, née Robichaud • University of Windsor	Summer, 2003
Sandra Belfry • Ontario Institute for Studies in Education/Univ. of Toronto	2002–2003
Althea Monteiro • York University	Summer, 2002
Samantha Dworsky • York University	2001–2002
Kerry Collins • University of Windsor	Summer, 2001
Jennifer Fogarty • Waterloo University	2000–2001
Emily Cripps • Waterloo University	Summer, 2000
Lee Beckstead • University of Utah	2000

PROFESSIONAL SOCIETY ACTIVITIES

OFFICES HELD

2018–2019	Local Host. Society for Sex Therapy and Research.
2015	Member, International Scientific Committee, World Association for Sexual Health.
2015	Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers
2012–2013	Chair, Student Research Awards Committee, Society for Sex Therapy & Research
2012–2013	Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers
2011–2012	Chair, Student Research Awards Committee, Society for Sex Therapy & Research
2010–2011	Scientific Program Committee, International Academy of Sex Research
2002–2004	Membership Committee • APA Division 12 (Clinical Psychology)
2002–2003	Chair, Committee on Science Issues, APA Division 44
2002	Observer, Grant Review Committee • Canadian Institutes of Health Research Behavioural Sciences (B)
2001–2009	Reviewer • APA Division 44 Convention Program Committee
2001, 2002	Reviewer • APA Malyon-Smith Scholarship Committee
2000–2005	Task Force on Transgender Issues, APA Division 44
1998–1999	Consultant, APA Board of Directors Working Group on Psychology Marketplace
1997	Student Representative • APA Board of Professional Affairs' Institute on TeleHealth
1997–1998	Founder and Chair • APA/APAGS Task Force on New Psychologists' Concerns
1997–1999	Student Representative • APA/CAPP Sub-Committee for a National Strategy for Prescription Privileges
1997–1999	Liaison • APA Committee for the Advancement of Professional Practice
1997–1998	Liaison • APA Board of Professional Affairs
1993–1997	Founder and Chair • APA/APAGS Committee on LGB Concerns

PROFESSIONAL SOCIETY ACTIVITIES

MEMBERSHIPS

2017–2021 Member • *Canadian Sex Research Forum*

2009–Present Member • *Society for Sex Therapy and Research*

2006–Present Member (elected) • *International Academy of Sex Research*

2006–Present Research and Clinical Member • *Association for the Treatment of Sex Abusers*

2003–2006 Associate Member (elected) • *International Academy of Sex Research*

2002 Founding Member • CPA Section on Sexual Orientation and Gender Identity

2001–2013 Member • *Canadian Psychological Association* (CPA)

2000–2015 Member • *American Association for the Advancement of Science*

2000–2015 Member • *American Psychological Association* (APA)

APA Division 12 (Clinical Psychology)

APA Division 44 (Society for the Psychological Study of LGB Issues)

2000–2020 Member • *Society for the Scientific Study of Sexuality*

1995–2000 Student Member • *Society for the Scientific Study of Sexuality*

1993–2000 Student Affiliate • *American Psychological Association*

1990–1999 Member, American Psychological Association of Graduate Students (APAGS)

CLINICAL LICENSURE/REGISTRATION

Certificate of Registration, Number 3793
College of Psychologists of Ontario, Ontario, Canada

AWARDS AND HONORS

2017 Elected Fellow, Association for the Treatment of Sexual Abusers

2011 Howard E. Barbaree Award for Excellence in Research
Centre for Addiction and Mental Health, Law and Mental Health Program

2004 fMRI Visiting Fellowship Program at Massachusetts General Hospital
American Psychological Association Advanced Training Institute and NIH

1999–2001 CAMH Post-Doctoral Research Fellowship
Centre for Addiction and Mental Health Foundation and Ontario Ministry of Health

1998 Award for Distinguished Contribution by a Student
American Psychological Association, Division 44

1995 Dissertation Research Grant
Society for the Scientific Study of Sexuality

1994–1996 McGill University Doctoral Scholarship

1994 Award for Outstanding Contribution to Undergraduate Teaching
"TA of the Year Award," from the McGill Psychology Undergraduate Student Association

MAJOR MEDIA

(Complete list available upon request.)

Feature-length Documentaries

Vice Canada Reports. *Age of Consent.* 14 Jan 2017.
Canadian Broadcasting Company. *I, Pedophile.* Firsthand documentaries. 10 Mar 2016.

Appearances and Interviews

11 Mar 2020. Ibbitson, John. It is crucial that Parliament gets the conversion-therapy ban right. *The Globe & Mail.*
25 Jan 2020. Ook de hulpvaardige buurman kan verzamelaar van kinderporno zin. *De Morgen.*
3 Nov 2019. Village of the damned. *60 Minutes Australia.*
1 Nov 2019. HÅKON F. HØYDAL. Norsk nettovergriper: – Jeg hater meg selv: Nordmannen laster ned overgrepsmateriale fra nettet – og oppfordrer politiet til å gi amnesti for slike som ham.
10 Oct 2019. Smith, T. Growing efforts are looking at how—or if—#MeToo offenders can be reformed. *National Public Radio.*
29 Sep 2019. Carey, B. Preying on Children: The Emerging Psychology of Pedophiles. *New York Times.*
29 Apr 2019. Mathieu, Isabelle. La poupée qui a troublé les Terre-Neuviens. *La Tribune.*
21 Mar 2019. Pope Francis wants psychological testing to prevent problem priests. But can it really do that? *The Washington Post.*
12 Dec 2018. Child sex dolls: Illegal in Canada, and dozens seized at the border. Ontario Today with Rita Celli. *CBC.*
12 Dec 2018. Celli, R. & Harris, K. Dozens of child sex dolls seized by Canadian border agents. *CBC News.*
27 Apr 2018. Rogers, Brook A. The online 'incel' culture is real–and dangerous. *New York Post.*
25 Apr 2018. Yang, J. Number cited in cryptic Facebook post matches Alek Minassian's military ID: Source. *Toronto Star.*
24 Ap 2018 Understanding 'incel'. *CTV News.*
27 Nov 2017. Carey, B. Therapy for Sexual Misconduct? It's Mostly Unproven. *New York Times.*
14 Nov 2017. Tremonti, A. M. The Current. *CBC.*
9 Nov2017. Christensen, J. Why men use masturbation to harass women. *CNN.* http://www.cnn.com/2017/11/09/health/masturbation-sexual-harassment/index.html
7 Nov 2017. Nazaryan, A. Why is the alt-right obsessed with pedophilia? *Newsweek.*
15 Oct 2017. Ouatik, B. Déscouvre. Pédophilie et science. *CBC Radio Canada.*
12 Oct 2017. Ouatik, B. Peut-on guérir la pédophilie? *CBC Radio Canada.*
11 Sep 2017. Burns, C. The young paedophiles who say they don't abuse children. *BBC News.*
18 Aug 2017. Interview. *National Post Radio.* Sirius XM Canada.
16 Aug 2017. Blackwell, Tom. Man says he was cured of pedophilia at Ottawa clinic: 'It's like a weight that's been lifted': But skeptics worry about the impact of sending pedophiles into the world convinced their curse has been vanquished. *National Post.*
26 Apr 2017. Zalkind, S. Prep schools hid sex abuse just like the catholic church. *VICE.*
24 Apr 2017. Sastre, P. Pédophilie: une panique morale jamais n'abolira un crime. *Slate France.*
12 Feb 2017. Payette, G. Child sex doll trial opens Pandora's box of questions. *CBC News.*
26 Nov 2016. Det morke uvettet ["The unknown darkness]". *Fedrelandsvennen.*
13 July 2016. Paedophilia: Shedding light on the dark field. *The Economist.*

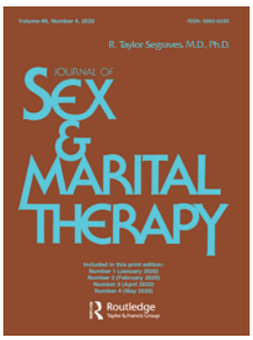
1 Jul 2016. Debusschere, B. Niet iedereen die kinderporno kijkt, is een pedofiel: De mythes rond pedofilie ontkracht. *De Morgen.*
12 Apr 2016. O'Connor, R. Terence Martin: The Tasmanian MP whose medication 'turned him into a paedophile'. *The Independent.*
8 Mar 2016. Bielski, Z. 'The most viscerally hated group on earth': Documentary explores how intervention can stop pedophiles. *The Globe and Mail.*
1 Mar 2016. Elmhirst, S. What should we do about paedophiles? *The Guardian.*
24 Feb 2016. The man whose brain tumour 'turned him into a paedophile'. *The Independent.*
24 Nov 2015. Byron, T. The truth about child sex abuse. *BBC Two.*
20 Aug 2015. The Jared Fogle case: Why we understand so little about abuse. *Washington Post.*
19 Aug 2015. Blackwell, T. Treat sex offenders for impotence—to keep them out of trouble, Canadian psychiatrist says. *National Post.*
2 Aug 2015. Menendez, J. BBC News Hour. *BBC World Service.*
13 Jul 2015. The nature of pedophilia. *BBC Radio 4.*
9 Jul 2015. The sex-offender test: How a computerized assessment can help determine the fate of men who've been accused of sexually abusing children. *The Atlantic.*
10 Apr 2015. NWT failed to prevent sex offender from abusing stepdaughter again. *CBC News.*
10 Feb 2015. Savage, D. "The ethical sadist." In Savage Love. *The Stranger.*
31 Jan 2015. Begrip voor/van pedofilie [Understanding pedophilia]. *de Volkskrant.*
9 Dec 2014. Carey, B. When a rapist's weapon is a pill. *New York Times*.
1 Dec 2014. Singal, J. Can virtual reality help pedophiles? *New York Magazine.*
17 Nov2014. Say pedófile, busco aydua. *El Pais.*
4 Sep 2014. Born that way? *Ideas, with Paul Kennedy.* CBC Radio One.
27 Aug 2014. Interrogating the statistics for the prevalence of paedophilia. BBC.
25 Jul 2014. Stephenson, W. The prevalence of paedophilia. *BBC World Service.*
21 Jul 2014. Hildebrandt, A. Virtuous Pedophiles group gives support therapy cannot. *CBC.*
26 Jan 2014. Paedophilia a result of faulty wiring, scientists suggest. *Daily Mail.*
22 Dec 2013. Kane, L. Is pedophilia a sexual orientation? *Toronto Star.*
21 Jul 2013. Miller, L. The turn-on switch: Fetish theory, post-Freud. *New York Magazine.*
1 Jul 2013. Morin, H. Pédophilie: la difficile quête d'une origine biologique. *Le Monde.*
2 Jun 2013. Malcolm, L. The psychology of paedophilia. *Australian National Radio.*
1 Mar 2013. Kay, J. The mobbing of Tom Flanagan is unwarranted and cruel. *National Post.*
6 Feb 2013. Boy Scouts board delays vote on lifting ban on gays. *L.A. Times.*
31 Aug 2012. CNN Newsroom interview with Ashleigh Banfield. *CNN.*
24 Jun 2012. CNN Newsroom interview with Don Lemon. *CNN.*

LEGAL TESTIMONY, PAST 4 YEARS

1.	2022	A.M. v Indiana Public Schools	Southern District, IN
2.	2022	Ricard v Kansas	Geery County, KS
3.	2022	Eknes-Tucker v Alabama	Montgomery County, AL
4.	2022	Hersom & Doe v WVa Health & Human Services	Southern District, WVa
5.	2022	BPJ v West Virginia Board of Education	Southern District, WVa
6.	2021	Cox v Indiana Child Services	Child Services, IN
7.	2021	Josephson v University of Kentucky	Western District, KY
8.	2021	Cross et al. v Loudoun School Board	Loudoun, VA
9.	2021	Re Commitment of Michael Hughes (Frye Hearing)	Cook County, IL
10.	2019	US vs Peter Bright	Southern District, NY
11.	2019	Spiegel-Savoie vs Savoie-Sexten (Custody Hearing)	Boston, MA
12.	2019	Re Commitment of Steven Casper (Frye Hearing)	Kendall County, IL
13.	2019	Re Commitment of Inger (Frye Hearing)	Poughkeepsie, NY

Prospective Outcomes Studies of Gender Dysphoric Children

2/16 4/16 10/16	gay trans-/crossdress straight/uncertain	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry, 128,* 1283–1289.
2/16 2/16 12/16	trans- uncertain gay	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. *Comprehensive Psychiatry, 19, 363–369.*
0/9 9/9	trans- gay	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology, 4,* 29–41.
2/45 10/45 33/45	trans-/crossdress uncertain gay	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172,* 90–97.
1/10 2/10 3/10 4/10	trans- gay uncertain straight	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior, 15,*511–517.
1/44 43/44	trans- cis-	Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.
0/8 8/8	trans- cis-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia, 146,* 565–569.
21/54 33/54	trans- cis-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 1413–1423.
3/25 6/25 16/25	trans- lesbian/bi- straight	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*, 34–45.
47/127 80/127	trans- cis-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 582–590.
17/139 122/139	trans- cis-	Singh, D., Bradley, S. J., and Zucker, K. J. (2021) A follow-up study of boys with gender identity disorder. Frontiers in Psychiatry, 12, 632784. doi: 10.3389/fpsyt.2021.632784



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Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

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ABSTRACT

The American Academy of Pediatrics (AAP) recently published a policy statement: *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents*. Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping gender diverse (GD) children, the AAP statement instead rejected that consensus, endorsing *gender affirmation* as the only acceptable approach. Remarkably, not only did the AAP statement fail to include any of the actual outcomes literature on such cases, but it also misrepresented the contents of its citations, which repeatedly said the very opposite of what AAP attributed to them.

The American Academy of Pediatrics (AAP) recently published a policy statement entitled, *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents* (Rafferty, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, 2018). These are children who manifest discontent with the sex they were born as and desire to live as the other sex (or as some alternative gender role). The policy was quite a remarkable document: Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping transgender and gender diverse (GD) children, the AAP statement rejected that consensus, endorsing only *gender affirmation.* That is, where the consensus is to delay any transitions after the onset of puberty, AAP instead rejected waiting before transition. With AAP taking such a dramatic departure from other professional associations, I was immediately curious about what evidence led them to that conclusion. As I read the works on which they based their policy, however, I was pretty surprised—rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing *watchful waiting*.

The AAP statement was also remarkable in what it left out—namely, the actual outcomes research on GD children. In total, there have been 11 follow-up studies of GD children, of which AAP cited one (Wallien & Cohen-Kettenis, 2008), doing so without actually mentioning the outcome data it contained. The literature on outcomes was neither reviewed, summarized, nor subjected to meta-analysis to be considered in the aggregate—It was merely disappeared. (The list of all existing studies appears in the appendix.) As they make clear, *every* follow-up study of GD children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition. AAP is, of course, free to establish whatever policy it likes on

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whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false, as detailed below.

AAP divided clinical approaches into three types—conversion therapy, watchful waiting, and gender affirmation. It rejected the first two and endorsed *gender affirmation* as the only acceptable alternative. Most readers will likely be familiar already with attempts to use conversion therapy to change sexual orientation. With regard to gender identity, AAP wrote:

> "[C]onversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. … Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29,39–42]

The citations were:

38. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol.* 1994;62(2):221–227.

29. Adelson SL; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *J Am Acad Child Adolesc Psychiatry.* 2012;51(9):957–974.

39. Byne W. Regulations restrict practice of conversion therapy. *LGBT Health.* 2016;3(2):97–99.

40. Cohen-Kettenis PT, Delemarrevan de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. *J Sex Med.* 2008;5(8):1892–1897.

41. Bryant K. Making gender identity disorder of childhood: historical lessons for contemporary debates. *Sex Res Soc Policy.* 2006;3(3):23–39.

42. World Professional Association for Transgender Health. *WPATH De-Psychopathologisation Statement.* Minneapolis, MN: World Professional Association for Transgender Health; 2010.

AAP's claims struck me as odd because *there are no studies of conversion therapy for gender identity.* Studies of conversion therapy have been limited to *sexual orientation,* and, moreover, to the sexual orientation *of adults,* not to gender identity and not of children in any case. The article AAP cited to support their claim (reference number 38) is indeed a classic and well-known review, but it is a review of sexual orientation research *only.* Neither gender identity, nor even children, received a single mention in it. Indeed, the narrower scope of that article should be clear to anyone reading even just its title: "The practice and ethics of *sexual orientation* conversion therapy" [italics added].

AAP continued, saying that conversion approaches for GD children have already been rejected by medical consensus, citing five sources. This claim struck me as just as odd, however—I recalled associations banning conversion therapy for sexual orientation, but not for gender identity, exactly because there is no evidence for generalizing from adult sexual orientation to childhood gender identity. So, I started checking AAP's citations for that, and these sources too pertained only to sexual orientation, not gender identity (specifics below). What AAP's sources *did* repeatedly emphasize was that:

A. Sexual orientation of adults is unaffected by conversion therapy and any other [known] intervention;
B. Gender dysphoria in childhood before puberty desists in the majority of cases, becoming (cis-gendered) homosexuality in adulthood, again regardless of any [known] intervention; and
C. Gender dysphoria in childhood persisting after puberty tends to persist entirely.

That is, in the context of GD children, it simply makes no sense to refer to externally induced "conversion": The majority of children "convert" to cisgender or "desist" from transgender

regardless of any attempt to change them. "Conversion" only makes sense with regard to adult sexual orientation because (unlike childhood gender identity), adult homosexuality never or nearly never spontaneously changes to heterosexuality. Although gender identity and sexual orientation may often be analogous and discussed together with regard to social or political values and to civil rights, they are nonetheless distinct—with distinct origins, needs, and responses to medical and mental health care choices. Although AAP emphasized to the reader that "gender identity is not synonymous with 'sexual orientation'" (Rafferty et al., 2018, p. 3), they went ahead to treat them as such nonetheless.

To return to checking AAP's fidelity to its sources: Reference 29 was a practice guideline from the Committee on Quality Issues of the American Academy of Child and Adolescent Psychiatry (AACAP). Despite AAP applying this source to *gender identity,* AACAP was quite unambiguous regarding their intent to speak to sexual orientation and *only* to sexual orientation*:* "Principle 6. Clinicians should be aware that there is no evidence that *sexual orientation* can be altered through therapy, and that attempts to do so may be harmful. There is no established evidence that change in a predominant, enduring *homosexual* pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter *homosexuality*. Psychiatric efforts to alter *sexual orientation* through 'reparative therapy' *in adults* have found little or no change in *sexual orientation,* while causing significant risk of harm to self-esteem" (AACAP, 2012, p. 967, italics added).

Whereas AAP cites AACAP to support gender affirmation as the only alternative for treating GD children, AACAP's actual view was decidedly neutral, noting the lack of evidence: "Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed" (AACAP, 2012, p. 969). Moreover, whereas AAP rejected watchful waiting, what AACAP recommended was: "In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood" (AACAP, 2012, p. 969). So, not only did AAP attribute to AACAP something AACAP never said, but also AAP withheld from readers AACAP's actual view.

Next, in reference 39, Byne (2016) also addressed only sexual orientation, doing so very clearly: "Reparative therapy is a subset of conversion therapies based on the premise that *same-sex attraction* are reparations for childhood trauma. Thus, practitioners of reparative therapy believe that exploring, isolating, and repairing these childhood emotional wounds will often result in reducing *same-sex attractions*" (Byne, 2016, p. 97). Byne does not say this of gender identity, as the AAP statement misrepresents.

In AAP reference 40, Cohen-Kettenis et al. (2008) did finally pertain to gender identity; however, this article never mentions conversion therapy. (!) Rather, in this study, the authors presented that clinic's lowering of their minimum age for cross-sex hormone treatment from age 18 to 16, which they did on the basis of a series of studies showing the high rates of success with this age group. Although it did strike me as odd that AAP picked as support against conversion therapy an article that did not mention conversion therapy, I could imagine AAP cited the article as an example of what the "mainstream of traditional medical practice" consists of (the logic being that conversion therapy falls outside what an 'ideal' clinic like this one provides). However, what this clinic provides is the very *watchful waiting* approach that AAP rejected. The approach

espoused by Cohen-Kettenis (and the other clinics mentioned in the source—Gent, Boston, Oslo, and now formerly, Toronto) is to make puberty-halting interventions available at age 12 because: "[P]ubertal suppression may give adolescents, together with the attending health professional, more time to explore their gender identity, without the distress of the developing secondary sex characteristics. The precision of the diagnosis may thus be improved" (Cohen-Kettenis et al., 2008, p. 1894).

Reference 41 presented a very interesting history spanning the 1960s–1990s about how feminine boys and tomboyish girls came to be recognized as mostly pre-homosexual, and how that status came to be entered into the DSM at the same time as homosexuality was being *removed* from the DSM. Conversion therapy is never mentioned. Indeed, to the extent that Bryant mentions treatment at all, it is to say that treatment is entirely irrelevant to his analysis: "An important omission from the *DSM* is a discussion of the kinds of treatment that GIDC children should receive. (This omission is a general orientation of the DSM and not unique to GIDC)" (Bryant, 2006, p. 35). How this article supports AAP's claim is a mystery. Moreover, how AAP could cite a 2006 history discussing events of the 1990s and earlier to support a claim about the *current* consensus in this quickly evolving discussion remains all the more unfathomable.

Cited last in this section was a one-paragraph press release from the World Professional Association for Transgender Health. Written during the early stages of the American Psychiatric Association's (APA's) update of the DSM, the statement asserted simply that "The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide." Very reasonable debate can (and should) be had regarding whether gender dysphoria should be removed from the DSM as homosexuality was, and WPATH was well within its purview to assert that it should. Now that the DSM revision process is years completed however, history has seen that APA ultimately retained the diagnostic categories, rejecting WPATH's urging. This makes AAP's logic entirely backwards: That WPATH's request to depathologize gender dysphoria was *rejected* suggests that it is *WPATH's* view—and therefore the AAP policy—which fall "outside the mainstream of traditional medical practice." (!)

AAP based this entire line of reasoning on their belief that conversion therapy is being used "to prevent children and adolescents from identifying as transgender" (Rafferty et al., 2018, p. 4). That claim is left without citation or support. In contrast, what is said by AAP's sources is "delaying affirmation should *not* be construed as conversion therapy or an attempt to change gender identity" in the first place (Byne, 2016, p. 2). Nonetheless, AAP seems to be doing exactly that: simply relabeling any alternative approach as equivalent to conversion therapy.

Although AAP (and anyone else) may reject (what they label to be) conversion therapy purely on the basis of political or personal values, there is no evidence to back the AAP's stated claim about the existing science on gender identity at all, never mind gender identity of children.

AAP also dismissed the watchful waiting approach out of hand, not citing any evidence, but repeatedly calling it "outdated." The criticisms AAP provided, however, again defied the existing evidence, with even its own sources repeatedly calling watchful waiting the current standard. According to AAP:

> [G]ender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").[45,47]

The citations from AAP's reference list are:

45. Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Keo-Meier C. Prepubertal social gender transitions: what we know; what we can learn—a view from a gender affirmative lens. *Int J Transgend.* 2018;19(2):251–268

47. Olson KR. Prepubescent transgender children: what we do and do not know. *J Am Acad Child Adolesc Psychiatry.* 2016;55(3):155–156.e3

I was surprised first by the AAP's claim that watchful waiting's delay to puberty was somehow "arbitrary." The literature, including AAP's sources, repeatedly indicated the pivotal importance of puberty, noting that outcomes strongly diverge at that point. According to AAP reference 29, in "*prepubertal* boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance" (Adelson & AACAP, 2012, p. 963, italics added), whereas "when gender variance with the desire to be the other sex is present *in adolescence,* this desire usually does persist through adulthood" (Adelson & AACAP, 2012, p. 964, italics added). Similarly, according to AAP reference 40, "Symptoms of GID *at prepubertal ages* decrease or even disappear in a considerable percentage of children (estimates range from 80–95%). Therefore, any intervention in childhood would seem premature and inappropriate. However, GID persisting *into early puberty* appears to be highly persistent" (Cohen-Kettenis et al., 2008, p. 1895, italics added). That follow-up studies of prepubertal transition differ from postpubertal transition is the very meaning of non-arbitrary. AAP gave readers exactly the reverse of what was contained in its own sources. If AAP were correct in saying that puberty is an arbitrarily selected age, then AAP will be able to offer another point to wait for with as much empirical backing as puberty has.

Next, it was not clear on what basis AAP could say that watchful waiting withholds support—AAP cited no support for its claim. The people in such programs often receive substantial support during this period. Also unclear is on what basis AAP could already know exactly which treatments are "critical" and which are not—Answering that question is the very purpose of this entire endeavor. Indeed, the logic of AAP's claim appears entirely circular: It is only if one were already pre-convinced that gender affirmation is the only acceptable alternative that would make watchful waiting seem to withhold critical support—What it delays is gender affirmation, the method one has already decided to be critical.

Although AAP's next claim did not have a citation appearing at the end of its sentence, binary notions of gender were mentioned both in references 45 and 47. Specifically, both pointed out that existing outcome studies have been about people transitioning from one sex to the other, rather than from one sex to an in-between status or a combination of masculine/feminine features. Neither reference presented this as a reason to reject the results from the existing studies of complete transition however (which is how AAP cast it). Although it is indeed true that the outcome data have been about complete transition, some future study showing that partial transition shows a different outcome would not invalidate what is known about complete transition. Indeed, data showing that partial transition gives better outcomes than complete transition would, once again, support the watchful waiting approach which AAP rejected.

Next was a vague reference alleging concerns and criticisms about early studies. Had AAP indicated what those alleged concerns and flaws were (or which studies they were), then it would be possible to evaluate or address them. Nonetheless, the argument is a red herring: Because all of the later studies showed the same result as did the early studies, any such allegation is necessarily moot.

Reference 47 was a one-and-a-half page commentary in which the author off-handedly mentions criticisms previously made of three of the eleven outcome studies of GD children, but does not provide any analysis or discussion. The only specific claim was that studies (whether early or late) had limited follow-up periods—the logic being that had outcome researchers lengthened the follow-up period, then people who seemed to have desisted might have returned to the clinic as

cases of "persistence-after-interruption." Although one could debate the merits of that prediction, AAP instead simply withheld from the reader the result from the original researchers having tested that very prediction directly: Steensma and Cohen-Kettenis (2015) conducted another analysis of their cohort, by then ages 19–28 (mean age 25.9 years), and found that 3.3% (5 people of the sample of 150) later returned. That is, in long-term follow-up, the childhood sample showed 66.7% desistence instead of 70.0% desistance.

Reference 45 did not support the claim that watchful-waiting is "outdated" either. Indeed, that source said the very opposite, explicitly referring to watchful waiting as the *current* approach: "Put another way, if clinicians are straying from SOC 7 guidelines for social transitions, not abiding by the watchful waiting model *favored by the standards,* we will have adolescents who have been consistently living in their affirmed gender since age 3, 4, or 5" (Ehrensaft et al., 2018, p. 255). Moreover, Ehrensaft et al. said there are cases in which they too would still use watchful waiting: "When a child's gender identity is unclear, the watchful waiting approach can give the child and their family time to develop a clearer understanding and is not necessarily in contrast to the needs of the child" (p. 259). Ehrensaft et al. are indeed critical of the watchful waiting model (which they feel is applied too conservatively), but they do not come close to the position the AAP policy espouses. Where Ehrensaft summaries the potential benefits and potential risks both to transitioning and not transitioning, the AAP presents an ironically binary narrative.

In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all. AAP claimed, "This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population"; however, much of that evidence was about sexual orientation, not gender identity. AAP claimed, "Current available research and expert opinion from clinical and research leaders … will serve as the basis for recommendations" (pp. 1–2); however, they provided recommendations entirely unsupported and even in direct opposition to that research and opinion.

AAP is advocating for something far in excess of mainstream practice and medical consensus. In the presence of compelling evidence, that is just what is called for. The problems with Rafferty, however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide compelling evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence.

Disclosure statement

No potential conflict of interest was reported by the author.

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Rafferty, J., AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*, *142*(4), e20182162 doi:10.1542/peds.2018-2162

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Appendix

Count	Group	Study
2/16 4/16 10/16	gay* trans-/crossdress straight*/uncertain	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry, 128,* 1283–1289.
2/16 2/16 12/16	trans- uncertain gay	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. *Comprehensive Psychiatry, 19,* 363–369.
0/9 9/9	trans- gay	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology, 4,* 29–41.
2/45 10/45 33/45	trans-/crossdress uncertain gay	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172,* 90–97.
1/10 2/10 3/10 4/10	trans- gay uncertain straight	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior, 15,* 511–517.
1/44 43/44	trans- cis-	Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.
0/8 8/8	trans- cis-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia, 146,* 565–569.
21/54 33/54	trans- cis-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 1413–1423.
3/25 6/25 16/25	trans- lesbian/bi- straight	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*, 34–45.
17/139 122/139	trans- cis-	Singh, D. (2012). *A follow-up study of boys with gender identity disorder*. Unpublished doctoral dissertation, University of Toronto.
47/127 80/127	trans- cis-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 582–590.

*For brevity, the list uses "gay" for "gay and cis-", "straight" for "straight and cis-", etc.

VI

Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[5] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

5 Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.

4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

2. Gender dysphoria emerged or worsened with the onset of puberty;

3. Any co-existing 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;

4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, monitoring, and risks for puberty suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

Statement 12G:

The adolescent is the following age for each treatment:

> ***14 years and above for hormone treatment (estrogens or androgens), unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.***
> ***15 years and above for chest masculinization; unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.***
> ***16 years and above for breast augmentation, facial surgery (including rhinoplasty, tracheal shave, and genioplasty) as part of gender affirming treatment; unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.***
> ***17 and above for metoidioplasty , orchidectomy, vaginoplasty, and hysterectomy and fronto-orbital remodeling as part of gender affirming treatment unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.***
> ***18 years or above for phalloplasty, unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.***

The ages outlined above provide general guidance on the age at which gender affirming interventions may be considered. Age criteria should be considered in addition to other criteria outlined for gender affirming interventions in youth as outlined in statements 12 A-F. Individual needs, decision making capacity for the specific treatment being considered, and developmental stage (rather than age) are most relevant when determining timing of treatment decisions for individuals. Age has a strong correlation, though not perfect, with cognitive and psychosocial development and may be a useful objective marker in determining potential timing of interventions (Ferguson, Brunsdon, & Bradford, 2021). Higher (i.e., more advanced) ages are provided for treatments with greater irreversibility and/or complexity. This approach allows for continued cognitive/emotional maturation that may be required for the adolescent to fully consider and consent to increasingly complex treatments (See 12C).

Recommendations above are based on available evidence; expert consensus; and ethical considerations including, respect for the emerging autonomy of adolescents and minimizing harm in the setting of a limited evidence base. Historically, there has been hesitancy in the transgender healthcare setting to offer gender affirming treatments with potential irreversible effects to minors. The age criteria set forth in these guidelines are intended to facilitate youth's access to gender affirming treatments, and are younger than ages stipulated in previous guidelines (Coleman et al., 2012; Hembree et al., 2017). Importantly, for each gender affirming intervention being considered youth must communicate consent/assent and be able to demonstrate an understanding and appreciation of potential benefits and risks specific to the intervention (See statement 12C).

NO. D-1-GN-22-002569

PFLAG, INC., ET AL., *Plaintiffs,*	**IN THE DISTRICT COURT OF**
v.	**TRAVIS COUNTY, TEXAS**
GREG ABBOTT, ET AL., *Defendants.*	**459th JUDICIAL DISTRICT**

Expert Declaration and Report of Michael K. Laidlaw, MD

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

1. I am over the age of eighteen and submit this expert declaration based on my personal knowledge and experience.

2. I am a board-certified endocrinologist. I received my medical degree from the University of Southern California in 2001. I completed my residency in internal medicine at Los Angeles County/University of Southern California Medical Center in 2004. I also completed a fellowship in endocrinology, diabetes and metabolism at Los Angeles County/University of Southern California Medical Center in 2006.

3. The information provided regarding my professional background are detailed in my curriculum vitae. A true and correct copy of my curriculum vitae is attached as Exhibit A.

4. In my clinical practice as an endocrinologist, I evaluate and treat patients with hormonal and/or gland disorders. Hormone and gland disorders can cause or be associated with psychiatric symptoms, such as depression, anxiety, and other psychiatric symptoms. Therefore, I frequently assess and treat patients demonstrating psychiatric symptoms and determine whether their psychiatric symptoms are being caused by a hormonal issue, gland issue, or something else.

5. I have been retained by Defendants in the above-captioned lawsuit to provide an expert opinion on the standards of care for treating minors diagnosed with gender dysphoria, including considerations of various proposed treatments.

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

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

8. My opinions contained in this report are based on: (1) my clinical experience as an endocrinologist; (2) my clinical experience evaluating individuals who have or have had gender incongruence; (3) my knowledge of research and studies regarding the treatment of gender dysphoria, including for minors; and (4) my review of the various declarations submitted by Plaintiffs in the present lawsuit, PFLAG, Inc. et al. v. GREG ABBOT et al., CAUSE NO. D-1-GN-22-000977, in the District Court of Travis County, Texas, 353rd Judicial District.

9. I was provided with and reviewed the following case-specific materials:
(1) PLAINTIFFS' ORIGINAL PETITION, APPLICATION FOR TEMPORARY RESTRAINING ORDER, TEMPORARY AND PERMANENT INJUNCTION, AND REQUEST FOR DECLARATORY RELIEF; (2) THE EXPERT DECLARATION OF ARMAND H. MATHENY ANTOMMARIA, MD, PhD, FAAP, HEC-C; (3) THE EXPERT DECLARATION OF DR. CASSANDRA C. BRADY, MD; (4) Attorney General Ken Paxton's Opinion No. KP-0401, dated February 18, 2022; (5) Governor Greg Abbott's Letter Directive to Texas Department of Family and Protection Services ("DFPS") Commissioner Jaime Masters, dated February 22, 2022.

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

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

I. Background

A. Endocrine Disorders

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

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

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

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

An endocrinologist can recognize thyroid hormone excess in part by signs and symptoms, but can also confirm the diagnosis with laboratory testing that shows the thyroid hormones to be out of balance. Once this is determined and the degree of excess is known, then treatments can be given to bring these levels back into balance to benefit the patient's health and to prevent other disease effects caused by excess hormone.

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

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

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

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

B. Gender Dysphoria is a Psychological Diagnosis

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

Likewise what is termed gender identity is a psychological concept. It has no correlate in the human body. In the letter to the editor I wrote with my colleagues, discussed above, we wrote in our critique of the Endocrine Society Guidelines that "There are no laboratory, imaging, or other objective tests to diagnose a 'true transgender' child" (Laidlaw et al., 2019).

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

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

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

C. Gender Dysphoria and Desistance

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

For example, in the UK, "The number of referrals to GIDS [Gender Identity Development Service] has increased very significantly in recent years. In 2009, 97 children and young people were referred. In 2018 that number was 2519" (Bell v Tavistock Judgment, 2020). There is evidence that this increase may be in part due to social contagion and fueled by social media/internet use (Littman, 2018).

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

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

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

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

D. Biological Sex in Contrast to Gender Identity

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

Biological sex is the objective physical condition of having organs and body parts which correspond to a binary sex. There are only two physical sexes, male and female. The male is identified as having organs and tissues such as the penis, testicles and scrotum. The

female sex is identified by having organs and tissues such as the labia, vagina, uterus, and ovaries. Biological sex is easily identified by physical observation such that adults and even young children can identify the biological sex of a newborn baby.

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

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

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

E. Human Sexual Development

1. Embryologic development

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

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

The sex binary of the human embryo is further developed between roughly weeks 8 to 12 of human development. There are two primitive structures present within the developing embryo called the Wolffian duct and Mullerian ducts (Larsen et al., 2003). The Wolffian ducts develop into substructures of the genitalia including the vas deferens and epididymis which belong exclusively to the male sex. For the female, the Mullerian ducts go on to form the uterus, fallopian tubes, cervix and upper one third of the vagina which belong exclusively to the female sex (Id.)

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

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

2. Pubertal Development

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

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

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

For the female, pubertal development includes changes such as breast development, widening of the pelvis, and menstruation. The female will also begin the process of ovulation which is a part of the menstrual cycle and involves the release of an egg or eggs from the ovary. Once the eggs are released in a manner in which they can become fertilized by human sperm then the female is termed fertile. The inability to release ovum that can be fertilized is infertility (Kuohong and Hornstein, 2021).

3. Tanner stages of development

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

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

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

4. Biological Sex Cannot Be Changed

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

Furthermore, as noted earlier, several of the sex specific structures (such as the epidymis of the male or uterus of the female) are produced early in embryological development from around weeks 8 to 12. The primitive ducts which lead to these organs of the opposite sex are obliterated. There is no known way to resuscitate these ducts and continue development of opposite sex structures.

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

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

F. Iatrogenic Harms

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

G. Gender Affirmative Therapy

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

third option, which is the focus of that which follows, is referred to as gender affirmative therapy.

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

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

1. Social transition

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

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

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

Therefore, it would be quite frightening for a boy who believes he is a girl to be turning into a man with all of the adult features that accompany manhood. Vice versa, the girl who

has become convinced that she is a boy will be frightened by the physical changes brought on by womanhood.

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

2. Medications which Block Pubertal Development

a. Background

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

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

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

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

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

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

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

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

b. GnRH Agonist Medication Effects Vary by Use Case

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

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

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

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

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

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

c. Adverse Health Consequences of Blocking Normal Puberty

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

Dr. Brady states that "[f]ertility preservation is offered to all transgender patients prior to the initiation of gender affirming hormones" (Brady declaration, p. 21). Although procedures to preserve fertility are available, studies show that less than 5% of adolescents receiving GAT even attempt fertility preservation (FP) (Nahata, 2017). Moreover, "ovarian tissue cryopreservation is still considered experimental in most centers and testicular tissue cryopreservation remains entirely experimental. These experimental forms of FP would be the only options in children [with puberty] blocked prior to spermarche and menarche and are high in cost and limited to specialized centers. Even with FP there is no guarantee of having a child" (Laidlaw, Cretella, et al., 2019).

Naturally, these children are at a developmental age where they are not thinking about adult related concepts such as having children as they are children themselves. This is only

natural and to be expected. The medical problem imposed on them is that if they remain blocked in an early pubertal stage then even the addition of opposite sex hormones will not allow for the development of fertility. In fact, high dose opposite sex hormones may permanently damage the immature sex organs leading to sterilization. Certainly the removal of the gonads, which will be discussed later, will ensure sterilization.

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

The impairment of sexual function was evident in the TLC reality show "I am Jazz". In the show Jazz who was identified male at birth has been given puberty blockers at an early pubertal stage. In an episode where Jazz visits a surgeon and has a discussion about sexual function, Jazz states: “I haven’t experienced any sexual sensation.” Regarding orgasm, Jazz says: “I don’t know, I haven’t experienced it”[1] (TLC, accessed 2022).

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

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

Another consideration is maturation of the human brain. Much of what happens is actually unknown. However, “sex hormones including estrogen, progesterone, and testosterone can influence the development and maturation of the adolescent brain” (Arain, 2013).

[1] Jazz's age is somewhere in the mid-teens during this episode.

Therefore there are unknown, but likely negative consequences to blocking normal puberty with respect to brain development.

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

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

d. The Effect of Puberty Blockers on Desistance

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

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

e. Infertility as a result of Puberty Blockers in GAT

Dr. Antommaria states that "[p]uberty blockers do not, by themselves, impair fertility. Children with central precocious puberty are routinely treated with puberty blockers and have normal fertility in adulthood" (Antommaria declaration, p. 10). These statements fail to recognize the very different effects of PB medication in early childhood versus during adolescence.

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

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

3. Opposite Sex Hormones

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

a. Testosterone

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

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

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

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

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

With respect to the cardiovascular system of men using ordinary doses, “Long-term clinical safety trials have not been conducted to assess the cardiovascular outcomes of testosterone replacement therapy in men” (Actavis Pharma, 2018). No clinical safety trials have been performed for women or adolescent girls to my knowledge.

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

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

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

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

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

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

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

Recommendations from the Endocrine Society's clinical guidelines related to GAT are to ultimately raise female levels of testosterone to 320 to 1000 ng/dL[2] which is on the same

[2] In the Endocrine Society's Guidelines there is no grading of evidence for the rationale of using such high supraphysiologic doses of opposite sex hormones for the female or male. There seems to be an underlying assumption that because the person believes to be the opposite sex then they acquire the sex specific laboratory ranges of the opposite sex. "The root cause of this flaw in thinking about diagnostic ranges was exemplified in a response letter by Rosenthal et al claiming that gender identity determines the ideal physiologic range of cross-sex hormone levels (5).

order as dangerous endocrine tumors for women as described above (Hembree, 2017). A simple calculation shows this level for the adult may be anywhere from 6 to 100 times higher than native female testosterone levels. In doing so they are creating a hormone imbalance known as hyperandrogenism. These extraordinarily high levels of testosterone are associated with multiple risks to the physical and mental health of the patient.

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

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

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

According to research regarding testosterone abuse, high doses of testosterone have been shown to predispose individuals towards mood disorders, psychosis, and psychiatric disorders. The "most prominent psychiatric features associated with AAS [anabolic androgenic steroids, i.e. testosterone] abuse are manic-like presentations defined by irritability, aggressiveness, euphoria, grandiose beliefs, hyperactivity, and reckless or

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Thus, a psychological construct, the ‘gender identity’, is imagined to affect physical reality and change a person’s sex-specific laboratory reference ranges. This is clearly not the case, otherwise there would be no serious complications of high-dose androgen treatment in transgender males" (Laidlaw et al., 2021). Dr. Brady makes the same error in using the wrong reference ranges for his patients: “Many times, the lipid profiles, hematologic profiles, and findings are equivalent to that of the gender these individuals identify as opposed to that of their sex they were born. I note this often when the medical record and lab utilize laboratory data ranges for the sex assigned as opposed to the gender identity and do not align with the true physiologic milieu of the patient. I take this into consideration for all my patients” (Brady declaration, p. 22).

dangerous behavior. Other psychiatric presentations include the development of acute psychoses, exacerbation of tics and depression, and the development of acute confusional/delirious states" (Hall, 2005). Moreover, "[s]tudies... of medium steroid use (between 300 and 1000 mg/week of any AAS) and high use (more than 1000 mg/week of any AAS) have demonstrated that 23% of subjects using these doses of steroids met the DSM-III-R criteria for a major mood syndrome (mania, hypomania, and major depression) and that 3.4% — 12% developed psychotic symptoms" (Hall, 2005).

c. Estrogen

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

d. Opposite Sex Hormones - Supraphysiologic Estrogen for Males

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

The doses of estrogen given to males for GAT are high and may vary from two to eight or more times higher than normal adult male levels. This produces the endocrine condition called hyperestrogenemia. Long-term consequences include increased risk of myocardial infarction and death due to cardiovascular disease (Irwig, 2018). Also "[t]here is strong evidence that estrogen therapy for trans women increases their risk for venous thromboembolism[3] over 5 fold" (Irwig, 2018).

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

[3] Venous thromboembolism is a blood clot that develops in a deep vein and "can cause serious illness, disability, and in some cases, death" (CDC, 2022).

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

4. Surgeries

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

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

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

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

Though modern surgical techniques and procedures are astounding, there are very noteworthy limitations. Importantly, surgery cannot de novo create new organs. If a person's kidneys fail, the surgeon has no scientific method for creating a new set of kidneys that can be implanted or grown within the patient. This conceptual background is helpful when considering various gender affirming surgeries.

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

a. Mastectomy

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

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

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

b. GAT Surgeries on the Male

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

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

c. GAT Surgeries of the Female Pelvis and Genitalia

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

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

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

Complications may include urinary stricture, problems with blood supply to the transplanted roll of tissue, large scarring to the forearm or thigh, infections including peritonitis, and possible injury to the sensory nerve of the clitoris (Mayo Clinic, Masculinizing Surgery, 2022).

H. Life Threatening Physical Medical Conditions Versus Suicidal Ideation

Any child or adolescent who has suicidal ideation or has attempted suicide should receive immediate, appropriate psychiatric care. Psychologists and psychiatrists are trained in the recognition and treatment of suicidal ideation and prevention of suicide. A child or adolescent with gender dysphoria who also has suicidal ideation should not be treated any differently. They require compassionate care and a full psychological evaluation of comorbidities such as depression, anxiety, and self-harming behaviors.

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

physical condition. In contrast, the danger to the self with suicidal ideation relates to a condition of the mind.

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

I. Informed Consent

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

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

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

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

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

J. The WPATH and The Endocrine Society

Dr. Cassandra Brady is a member of the advocacy group WPATH (Brady declaration, p. 2). Dr. Antommaria refers to the WPATH's Standard of Care 7 document to support the contention that "[t]he potential benefits of such treatment, including gender-affirming medical care, may be sufficient to outweigh the risks" (Antommaria declaration, p. 10).

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

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

In the Endocrine Society's guidelines, the quality of evidence for the treatment of adolescents is rated "very low-quality evidence" and "low quality evidence". "The quality of evidence for [puberty blocking agents] is noted to be low. In fact, all of the evidence in the guidelines with regard to treating children/adolescents by [gender affirmative therapy] is low to very low because of the absence of proper studies" (Laidlaw et al., 2019).

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

Endocrinologists W. Malone and P. Hruz and colleagues have written critically of the Endocrine Society's (ES) guidelines: "Unlike standards of care, which should be

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

K. The Lack of Evidence of Effectiveness of GAT

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

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

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

2. The Branstrom and Panchankis Retraction

Other published studies of GAT have been shown to have serious errors. For example, a major correction was issued by the American Journal of Psychiatry. The authors and editors of a 2020 study, titled "Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study" (Bränström study, 2020) retracted their original primary conclusion. Letters to the editor by twelve authors including myself led to a reanalysis of the data and a corrected conclusion stating that in fact the data showed no improvement in mental health for transgender identified individuals after surgical treatment nor was there improvement with opposite sex hormones ("Correction", 2020; Van Mol et al., 2020).

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

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

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

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

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

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

presented in the article do not support the conclusion that such surgery is beneficial to mental health in individuals with gender dysphoria" (Wold, 2020).

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

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

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

4. Mastectomy Surgery for Minors

Any serious look at long-term effects at surgical treatment would follow subjects out at least ten years. For example, an article was published recently examining patients who had mild calcium disorders due to a gland called the parathyroid. They compared a group of patients who had surgical removal of the parathyroid to a control group who had not. They examined data ten years after surgery was completed and concluded that parathyroid surgery in this group "did not appear to reduce morbidity or mortality" in that patient group (Pretorius, 2022).

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

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

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

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

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

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

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

3. Centers for Medicare and Medicaid Services

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

4. Nations and States Question and Reverse Course on GAT

Also noteworthy is that other nations are questioning and reversing course regarding gender affirmative therapy. For example in the *Bell v. Tavistock* Judgment in the UK, regarding puberty blockers in GAT, they concluded that "there is real uncertainty over the

short and long-term consequences of the treatment with very limited evidence as to its efficacy, or indeed quite what it is seeking to achieve. This means it is, in our view, properly described as experimental treatment" (*Bell v. Tavistock* Judgment, 2020).

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

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

In 2020, Finland recognized that "[r]esearch data on the treatment of dysphoria due to gender identity conflicts in minors is limited," and recommended prioritizing psychotherapy for gender dysphoria and mental health comorbidities over medical gender affirmation (Council for Choices in Healthcare in Finland, 2020). Additionally, "[s]urgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors".

In 2021, Sweden's largest adolescent gender clinic announced that it would no longer prescribe puberty blockers or cross-sex hormones to youth under 18 years outside clinical trials (SEGM, 2021). "In December 2019, the SBU (Swedish Agency for Health Technology Assessment and Assessment of Social Services) published an overview of the knowledge base which showed a lack of evidence for both the long-term consequences of the treatments, and the reasons for the large influx of patients in recent years. These

treatments are potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis. This makes it challenging to assess the risk / benefit for the individual patient, and even more challenging for the minors or their guardians to be in a position of an informed stance regarding these treatments" (Gauffen and Norgren, 2021).

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

In April of 2022, the Florida Secretary of the Agency for Health Care Administration requested that Florida Medicaid program review "whether treatments are consistent with widely accepted professional medical standards".

On June 2, 2022, the report was completed and concluded: "Following a review of available literature, clinical guidelines, and coverage by other insurers and nations, Florida Medicaid has determined that the research supporting sex reassignment treatment is insufficient to demonstrate efficacy and safety. In addition, numerous studies, including the reports provided by the clinical and technical experts listed above, identify poor methods and the certainty of irreversible physical changes. Considering the weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures when compared to the stronger research demonstrating the permanent effects they cause, these treatments do not conform to GAPMS and are experimental and investigational" (Florida Medicaid, 2022)

L. Assessment of the patient with gender dysphoria

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

1. Patients should be evaluated to determine if they will follow the natural pattern of desistance which 50 to 98% of pediatric age children will follow[4].
2. Patients, parents and guardians should be made aware of other options for treatment of gender dysphoria including active psychosocial treatment or watching and waiting with support in order to help with natural desistance.
3. The patient should be provided an assessment by a qualified psychologist or psychiatrist who does not follow the WPATH GAT model. If underlying psychological conditions are diagnosed then these should be adequately evaluated and treated before proceeding to hormones and surgery.
4. If a medicalized approach with hormones such as testosterone or medications to stop menstruation is being considered then a clear description of the risks and benefits needs to be conveyed to the minor and the parent or guardian. It needs to be verified that they fully understand these risks.
5. If surgical procedures such as mastectomy, hysterectomy, ovariectomy, orchiectomy, or vaginoplasty are being considered then clear descriptions of the risks and benefits need to be conveyed to the minor and the parent or guardian.

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

II. Conclusion

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

Children and adolescents are of such immature minds that they are likely to believe that it is possible. In fact they may come to believe that their inherent, biologically necessary puberty is "terrifying" or needs to be stopped. Social transition serves to convince the child

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

or adolescent that they can be the opposite sex. Puberty blockers sustain this state of mind by retaining a childlike state with respect to the genitalia and body habitus. High dose opposite sex hormones then cause medical conditions such as hirsutism and irreversible damage to the vocal cords in females and gynecomastia in males. These conditions serve to convince the young person that they are going through puberty of the opposite sex when in fact they are not developing sexually and are infertile.

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

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

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Date: ___07/03/2022____ _____

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Statement from a University of Texas Southwestern Medical Center spokesperson:

UT Southwestern physicians provide a wide variety of clinical services for both adult and pediatric populations including those who identify as members of the LGBTQ+ community. Care for transgender adult patients, including hormone therapy and some surgical procedures, is provided principally through clinics and hospitals operated by UT Southwestern.

UT Southwestern physicians provide pediatric care at Children's Health facilities through our affiliation agreement. This includes care for transgender pediatric patients and specifically for those families seeking care for potential gender dysphoria.

While the latter had been nominally provided over several years under the aegis of an entity designated GENECIS at Children's Health, effective November 18, 2021, the constellation of services comprising pediatric endocrinology, psychiatry, and adolescent and young adult care started being managed through each specialty department. Since that time, this care is coordinated through these departmentally based pediatric clinics much as our longstanding practice for our adult patients.

Clinic phone and email services to contact the clinics were consistently available during this transition, which communicated to patients and clinic personnel. The phone number formerly dedicated to GENECIS is still active, and now is answered by the Children's Health endocrinology clinic. Patients and their families communicate with their care teams through My Chart.

GENECIS was never a stand-alone clinic and was not "closed" as has been misreported in the media. The decision to remove the *GENECIS program* branding was made to provide a more private experience for patients and families. For existing patients, there has been no change in the care provided. New patients continue to be accepted for evaluation and treatment and they too receive gender affirming care which were previously provided under the "brand" GENESIS including what is commonly recognized as the cornerstone of that care – appropriate psychological and counseling care – with one exception.

Those new patients and their families seeking puberty blockers and hormone replacement therapy after diagnosis of gender dysphoria are now referred to an outside practice for this treatment. Current patients who had already been begun on these treatments continue to receive them as before.

Hormone therapy continues to be provided to pediatric patients for diagnosis including precocious puberty as approved by the FDA.

The hormone therapy typically used for suppression of puberty for the diagnosis of gender dysphoria is not currently approved by the FDA for this purpose and is not offered to new pediatric patients for this diagnosis.

The decision to cease offering puberty blockers and hormone therapy to new pediatric patients was based on a variety of factors, including growing concern in the medical community about

our limited understanding of the long-term effects – both psychological and physical – on children who receive this treatment. We considered that there have not been controlled trials that have clearly delineated the effectiveness and safety of these treatments. According to the scientific journal *Transgender Health*, as of 2021: No medications carry an FDA indication for use in youth with gender dysphoria. Media attention and political and scientific controversy, as well as UT Southwestern's status as a state agency, were considered in the months leading up to these joint decisions.

Clinic operational decisions are not routinely run by an ethics board and this is in no way different than changes in operations or services of other clinical areas.

UT Southwestern and Children's Health do not provide gender affirming surgery for pediatric patients.

A required course (Endocrinology, Energy Homeostasis and Reproductive Health) in each medical student's first 18 months includes lectures on Gender Identity and Healthcare Topics for LGBTQ+ Patients.

An elective clinical rotation was paused in December 2021 by faculty without review or approval by senior institutional leaders. In fact, fewer than 2% of our students have chosen to take this elective in the last several years. As a result the leadership responsible for the student curriculum wanted to ensure that all of our students are exposed to the needs of LGBTQ+ patients. Therefore additional lectures on related topics are being incorporated into the required course so that all medical students have access and opportunity to learn about adolescent and young adult transgender care rather than only the small percentage that elected the 2-week elective course.

As an institution of higher education authorized and organized under Texas law, UT Southwestern is a state agency and does not take positions on political issues, and complies with all applicable federal and state laws and regulations. UT Southwestern and Children's Health remain committed to providing care for and a welcoming environment for everyone, regardless of their race, gender, sexual orientation, socioeconomic status, or condition, and to ensuring our patients receive the care they need. The safety and privacy of our patients is our top priority.

UT Southwestern leadership has not been contacted by Governor Abbott regarding these clinical services. Inquiries regarding actions by the Governor's Office should be directed to the Governor's Office.

CHILDREN'S MEDICAL CENTER OF DALLAS

MEDICAL/DENTAL STAFF BYLAWS

children's health
Children's Medical Center Dallas

CHILDREN'S MEDICAL CENTER OF DALLAS
MEDICAL/DENTAL STAFF BYLAWS

ARTICLE I. PURPOSES AND ORGANIZED HEALTH CARE ARRANGEMENT

The purpose of the organized Medical/Dental Staff is to bring the physicians/dentists who practice at Children's Medical Center of Dallas (hereby referred to as "Children's Dallas" – see further definition below), together into a cohesive body to promote quality patient care and patient safety and to uphold the mission of Children's Dallas. To this end, among other activities and subject to the authority of the Board, the self-governing, organized Medical/Dental Staff shall be responsible for reviewing initial applications and reappointment information for Medical/Dental Staff membership and/or clinical privileges; evaluating and assisting in improving the quality and safety of patient care administered by the staff; providing education; offering medical counsel to the Governing Board President, the Hospital Administrator, the JPE Chief Medical Officer, and the Board; and enforcing the Medical/Dental Staff Bylaws (hereby referred to as "Bylaws"), the Rules and Regulations, and all policies and procedures of the Medical/Dental Staff.

Children's Dallas along with each member of the Medical/Dental Staff, and other health care providers granted clinical privileges, shall be considered members of, and shall participate in, the hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the federal privacy and security regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") for the protection of individually identifiable health information. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one healthcare provider. An OHCA allows the hospital to share protected health information with the Medical/Dental Staff and other health care providers granted clinical privileges and their offices for purposes of treatment, payment and practice operations. The patient will receive one Notice of Privacy Practices during the hospital's registration or admissions process, which shall include information about the OHCA with the Medical/Dental Staff and other health care providers granted clinical privileges. Each Medical/Dental Staff member agrees to comply with the hospital's policies as adopted regarding the use and disclosure of individually identifiable health information and protected health information, as those terms are defined by HIPAA or as any similar terms are defined by more stringent state law.

DEFINITIONS

1. "Administrator of Children's Medical Center of Dallas" (Hospital Administrator) is defined as the individual appointed by the Board to act on its behalf in the overall day-to-day management of Children's Dallas.

2. "Advanced Practice Professional" (APP) is defined as an individual licensed, certified, registered, or otherwise authorized in the State of Texas, who is not a member of the Medical/Dental Staff, who has advanced training as an Advanced Practice Registered Nurse, Physician Assistant, Certified Registered Nurse Anesthetist, or a Certified Anesthesiologist Assistant. APPs are trained in some aspect of the evaluation or treatment of human illness to perform specified services to patients at Children's Dallas under the responsibility of a Medical/Dental Staff member as outlined in the Medical/Dental Staff policies and procedures.

3. "Allied Health Professional" (AHP) is defined as an individual licensed, certified, registered, or otherwise qualified in the State of Texas, who is not a member of the Medical/Dental Staff, and not an APP, who is granted permission to perform specified patient care related services at Children's Dallas under the responsibility and supervision of a Medical/Dental Staff member as outlined in the Medical/Dental Staff policies and procedures.

4. "Anesthesiologist-in-Chief" is defined as the individual who is a full time faculty member at UT Southwestern and appointed by the Board upon recommendation by the JPE Chief Medical Officer, President of UT Southwestern, and by the President of the Children's Medical Center of Dallas Operating Division. This individual shall be responsible for system oversight of the quality of clinical operations and the integration of clinical and academic activities within the Anesthesiology Division and shall report to the JPE Chief Medical Officer.

5. "Board" (Board) is defined as the oversight board of the Children's Medical Center of Dallas Operating Division that serves as the governing body of Children's Medical Center of Dallas, including for the purposes of the requirements, standards, laws and regulations promulgated by The Joint Commission, the Centers for Medicare and Medicaid Services and the Texas Health and Human Services Commission, as applicable, and in that capacity has the responsibility for and the authority over, the operation of Children's Medical Center of Dallas, including, but not limited to, the hospital's organization and management.

6. "Chair of the Dental Department" is defined as the chair of the Department of Pediatric Dentistry at Texas A&M University School of Dentistry.

7. "Chief Medical Officer at Children's Medical Center of Dallas" (Chief Medical Officer Dallas) is the individual who has been appointed by the JPE Chief Medical Officer to provide oversight of clinical operations at Children's Medical Center of Dallas.

8. "Children's Health System of Texas" (CHST or system) is defined as the not for profit corporation that is the corporate parent of Children's Health Clinical Operations.

9. "Children's Medical Center of Dallas" (Children's Dallas) is defined as all inpatient and outpatient facilities, services, programs or other centers of care providing health care services pursuant to the State of Texas hospital license and Medicare provider number, or Medicaid provider number held by Children's Dallas or licensed as Children's End Stage Renal Disease Facility, or Children's Health Specialty Center Dallas.

10. "Children's Medical Center of Dallas Operating Division" (Operating Division or Governing Board) is an organized operating division of Children's Health Clinical Operations, a Texas non-profit corporation, which Operating Division includes Children's Medical Center of Dallas and facilities designated by the Children's Health Clinical Operation's Board of Directors as Operating Division facilities. Operating Division provides oversight of and serves as the governing board for Children's Medical Center of Dallas.

11. "Department Chair" is defined as the chair of an academic department at UT Southwestern, except Dental as stated above.

12. "Division" is defined as a major clinical service area of the Medical/Dental Staff, grouping members in accordance with their specialty or major practice interest.

13. "Ex-Officio" is defined as a member of a body by virtue of an office or position held and, unless otherwise provided, means without voting rights.

14. "Fellow" is defined as a physician who is receiving additional training and/or experience in a medical specialty following completion of a primary residency. A "Dental Fellow" is defined as a dentist who is receiving additional training and/or experience in a dental specialty.

15. "JPE Chief Medical Officer" is the individual who has been appointed by the joint pediatric enterprise, of which Children's Dallas is a part, to provide overall system level oversight of medical operations and clinical care.

16. "Medical/Dental Staff" is defined as University of Texas Southwestern Medical School (UT Southwestern) faculty members, community physicians, and dentists from the community and from Texas A&M University School of Dentistry who support the mission of Children's Dallas and who have been granted membership by the Board.

17. "Medical/Dental Staff Division Director" (Division Director) is defined as the individual appointed by the Board upon recommendation by the JPE Chief Medical Officer, President of UT Southwestern, the President of the Children's Medical Center of Dallas Operating Division, and the appropriate Pediatrician-in-Chief, Surgeon-in-Chief, or Anesthesiologist-in-Chief, and in consultation with the appropriate UT Southwestern Department Chair. This individual shall have specific, identified roles and responsibilities developed by the Pediatrician-in-Chief, Surgeon-in-Chief, or Anesthesiologist-in-Chief under which the Division falls and shall report directly to the appropriate Pediatrician-in-Chief, Surgeon-in-Chief, or Anesthesiologist-in-Chief.

18. "Medical/Dental Staff Year" is defined as January 1 through December 31 of each year.

19. "Medical Director" or "Surgical Director" is defined as an individual who shall oversee specific programs or clinical areas within his/her Division.

20. "Medical Executive Committee" (MEC) is defined as the administrative and executive body of the Medical/Dental Staff.

21. "Member" is defined as a physician/dentist appointed by the Board of Children's Dallas to any category of the Medical/Dental Staff in accordance with these Bylaws.

22. "Pediatrician-in-Chief" is defined as the individual who is a full-time faculty member at UT Southwestern and appointed by the Board upon recommendation by the JPE Chief Medical Officer, President of UT Southwestern, and by the President of the Children's Medical Center of Dallas Operating Division. This individual shall be responsible for oversight of the quality of clinical operations and the integration of clinical and academic activities within the medical Divisions and shall report to the JPE Chief Medical Officer.

23. "President of the Children's Medical Center of Dallas Operating Division" (Governing Board President) is defined as the individual appointed by the Board having general executive charge, management and control of the properties and operations of the Children's Medical Center of Dallas Operating Division in the ordinary course of business, with all such powers with respect to such properties and operations as may be reasonably incident to such responsibilities. The Medical/Dental Staff may rely upon all actions of the Governing Board President as being the actions of the Board taken pursuant to a proper delegation of authority from the Board.

24. "President of the Medical/Dental Staff" is defined as the principal elected Officer of the Medical/Dental Staff.

25. "Psychologist" is defined as an individual licensed by the Texas State Board of Examiners of Psychologists for the independent practice of psychology, and who is not a member of the Medical/Dental Staff.

26. "Resident" is defined as a medical or dental school graduate who is receiving additional training and/or experience in a medical or dental specialty or subspecialty training program.

27. "Surgeon-in-Chief" is defined as the individual who is a full-time faculty member at UT Southwestern and appointed by the Board upon recommendation by the JPE Chief Medical Officer, President of UT Southwestern, and by the President of the Children's Medical Center of Dallas Operating Division. This individual shall be responsible for system oversight of the quality of clinical operations and the integration of clinical and academic activities within the surgical Divisions and shall report to the JPE Chief Medical Officer.

28. "UT Southwestern" is defined as the University of Texas Southwestern Medical School.

29. "Vice President, Medical Staff Affairs" is defined as the administrative position that oversees medical staff administrative functions, specifically but not limited to credentialing, privileging, and continuing medical education.

ARTICLE II. MEDICAL/DENTAL STAFF MEMBERSHIP

Section A. Medical/Dental Staff Appointment

Appointment to the Medical/Dental Staff at Children's Dallas is a privilege which may be granted to competent physicians, dentists and podiatrists who continuously meet the qualifications, standards, and requirements set forth in the Bylaws, the Rules and Regulations, and associated policies and procedures of the Medical/Dental Staff of Children's Dallas, and who are necessary for Children's Dallas to attain its mission.

Section B. Qualifications for Membership and/or Clinical Privileges

1. Only physicians with Doctor of Medicine or Doctor of Osteopathy degrees or equivalent (e.g. M.B.B.S. degree), dentists with Doctor of Dental Medicine or Doctor of Dental Surgery degrees or equivalent (e.g. B.D.S degree), or podiatrists with a Doctor of Podiatric Medicine degree, and holding a license or permit to practice in the State of Texas, are qualified for membership on the Medical/Dental Staff of Children's Dallas.

   These practitioners must be able to document:

   a. appropriate background, training, experience, and demonstrated current competence for requested privileges;

   b. good character and judgment;

   c. physical and mental capabilities;

   d. adherence to the ethics of their profession; and

   e. the ability to work with other Medical/Dental Staff members and the Board to promote Children's Dallas mission.

2. No physician/dentist is entitled to membership on the Medical/Dental Staff, nor entitled to exercise clinical privileges at Children's Dallas, merely by virtue of licensure to practice in this or any other state, membership in any professional organization, or privileges at any other hospital.

3. Documentation of experience and training including completion of an accredited residency and fellowship (if applicable) is required.

4. Board certification[1] in the physician's/dentist's applicable specialty or subspecialty area is required. Accepted Boards include American Board of Medical Specialties, American Osteopathic Association, Royal College of Physicians and Surgeons in Canada and the United Kingdom, and the Australian Medical Council. Any Medical/Dental Staff applicant boarded by another country's certifying body (other than those listed above) would need to submit documentation to deem the certification equivalent to the ABMS requirements and the request shall be reviewed on a case by case basis by the Credentials Committee.

   a. All **new applicants** to Children's Dallas Medical/Dental Staff who have **completed their post-graduate training within the past two (2) years** shall be required to obtain board certification within six (6) years of completing their most recent training (i.e., residency or fellowship). The respective director of the applicant's most recent training program will designate the completion date of training.

   b. All **new applicants**[2] to Children's Dallas Medical/Dental Staff **who completed their post-graduate training more than two (2) years prior** to their application for medical/dental staff membership must be board eligible through the applicable certifying board and shall be required to obtain board certification within four (4) years of their initial appointment to the Medical/Dental Staff and granting of clinical privileges.

   c. **Current members** of the Medical/Dental Staff who complete additional post-graduate training and/or **qualify for and request new privileges in a separate sub-specialty area** must be board eligible through the applicable certifying board and shall be required to obtain board certification within four (4) years of their initial approval of the new clinical privileges.

   d. Current members of the Medical/Dental Staff who fail to maintain their applicable board certification or applicable sub-board certification shall be allotted two (2) years from date of expiration to renew their board certification. Failure to renew within the two (2) year period will result in non-renewal of Medical/Dental Staff membership and clinical privileges. Staff whose membership and/or clinical privileges are not renewed, or allowed to expire, due to failure to maintain board certification will not be eligible to reapply until such time that certification is obtained.

   e. Exceptions to the above (Section B. 4, a – d) must be requested by the appropriate Division Director in consultation with the appropriate Pediatrician-in-Chief, Surgeon-in-Chief, or Anesthesiologist-in-Chief the Credentials Committee, and (for UT Southwestern

[1] Required of all new applicants to the Medical/Dental Staff effective in October, 2000. Exempted from this requirement are those non-board-certified physicians/dentists on the Medical/Dental Staff who had been on the Medical/Dental Staff for ten (10) or more years as of the date the requirement became effective (October, 2000).

[2] Required of all new applicants to the Medical/Dental Staff effective October 7, 2008. Members who were appointed prior to this date are required to obtain certification within six (6) years of completing their post graduate training as reflected in the Bylaws at the time of their initial appointment.

practitioners only) the relevant UT Southwestern Department Chair. The request for an exception must then be approved by the Medical Executive Committee and the Board.

f. The board certification requirement may be waived for physicians who have been experts in their specialty field for a significant number of years and/or hold national or international prominence[3], or serve a specific need of patients at Children's Dallas. These physicians must be considered distinguished practitioners in their specialty and will be admitted only upon the approval of the Credentials Committee, MEC, and the Board.

g. The board certification requirement may be waived for Dental Specialists[4] specifically determined by the Division Director of Dentistry to serve a specific need for patients at Children's Dallas, and with the approval of the Credentials Committee, MEC, and the Board.

5. A clinical faculty appointment at UT Southwestern is desirable but not required for Medical Staff membership. A clinical faculty appointment at Texas A&M University School of Dentistry is desirable but not required for Dental Staff membership. A faculty appointment is necessary in order to admit patients to teaching services and participate in teaching or supervision of medical students, dental students, Residents and Fellows.

6. Current documentation of professional liability insurance coverage, in the amounts as recommended by the MEC and approved by the Board $200,000 per occurrence/$600,000 aggregate, is required for physicians/dentists granted clinical privileges. Involvement in any professional liability action including final judgments and claims settled must be reported at initial appointment, at each reappointment, or as specified on the application for medical/dental staff membership.

Section C. Nondiscrimination

Children's Dallas shall not discriminate in granting staff appointment and/or clinical privileges on the basis of age, gender, race, sexual orientation, creed, physical disability, color, nationality, religion or any other basis prohibited by law.

Section D. Conditions and Duration of Appointment and Granting of Clinical Privileges

1. All appointments to the Medical/Dental Staff of Children's Dallas shall be made upon nomination by the appropriate Division Director, and with the recommendation of the

[3] The Credentials Committee, in collaboration with the appropriate Division Director, shall make the determination regarding whether the information submitted is sufficient to deem the individual an expert in his/her field or if the individual serves a specific need of patients at Children's.

[4] The American Dental Association recognizes the following 8 Dental Specialties: Oral/Maxillofacial Surgery, Pediatric Dentistry, Periodontics, Endodontics, Oral Pathology, Orthodontics, Prosthodontics and Public Health Dentistry.

Credentials Committee, MEC, and with final approval and appointment by the Board after the credentialing process has been completed as outlined in the Medical/Dental Staff policies.

2. Appointments to the Medical/Dental Staff and clinical privileges shall not exceed two (2) years. The MEC may recommend membership and/or clinical privileges for a period of less than two (2) years as deemed appropriate by the MEC and as approved by the Board.

    a. Membership and Clinical Privileges are not exclusively interconnected and may be granted independent of one another as further outlined in the Medical/Dental Staff credentialing policies.
    b. All members or providers granted clinical privileges must continuously meet the competency and activity requirements as established through the Medical/Dental Staff credentialing policies and procedures and otherwise exhibit a continuous interest and involvement in the welfare and clinical affairs of Children's Dallas as noted in Article III.
    c. Providers shall request only those privileges that he or she intends to utilize at Children's Dallas during the appointment period. Providers who fail to exercise their clinical privileges at Children's Dallas during the reappointment cycle will no longer be deemed eligible for continuous granting of said privileges (with the exception of approved consult services as outlined in the Medical/Dental Staff credentialing policies). Should this occur, the provider shall have the following options as further defined in the Medical/Dental Staff credentialing policies:
        - Modify his or her request to more appropriately reflect the clinical privileges that he or she exercises at Children's Dallas (i.e. refer and follow);
        - Withdraw his or her request to maintain clinical privileges and request to maintain Medical/Dental Staff membership only (if membership criteria was met at the time of reappointment);
        - If the provider intends to increase his or her utilization over the next six (6) months, the Division Director and Credentials Committee have the option to recommend a focused practice professional evaluation as outlined in the Focused Practice Professional Evaluation Policy.

3. The processes for: credentialing, membership appointment, focused and ongoing practice evaluations, granting, termination or reduction of clinical privileges, for both Medical/Dental Staff Members and Advanced Practice Professionals, are outlined in the Medical/Dental Staff policies and procedures. All requests for Medical/Dental Staff membership and/or requests for clinical privileges shall be processed according to said policies and shall not be effective until formal approval by the Board is obtained. The basic steps include:

    a. Completion of all required applications, attestations, acknowledgements and other required paperwork by the applicant;

    b. Verification of current clinical competency as applicable;

c. Verification of all reported relevant information as applicable and as outlined in the Medical/Dental Staff policies;

d. Review and evaluation of the data by the appropriate Medical/Dental Staff leaders and Medical/Dental Staff committees; and

e. Final action by the Board.

4. Clinical privileges may be granted without Medical/Dental Staff membership upon verification of current clinical competency and verification of all credentialing requirements outlined in the Medical/Dental Staff policies and procedures. Membership may also be granted without clinical privileges as outlined in the Medical/Dental Staff policies and procedures.

5. Temporary privileges may be granted under two (2) circumstances, each of which have different criteria for granting privileges: (a) to fulfill an important patient care, treatment, and service need; or (b) to initial or current staff members requesting new clinical privileges. Temporary privileges in either circumstance may be granted for a limited period of time, not to exceed 120 days. The criteria for requesting and granting of temporary privileges are outlined in the Medical/Dental Staff policies and procedures. Upon confirmation that the applicant meets the criteria for temporary privileges, the credentialing process and approval process is completed in accordance with the temporary privilege policy.

    a. When temporary privileges are granted to meet an important patient care need, the required credentialing process includes, but is not limited to, verification of the following: current licensure, current competency for privileges requested, and current professional liability insurance that meets or exceeds the minimum criteria outlined in the Medical/Dental Staff privileging policy.

    b. Temporary privileges may also be granted while awaiting review and approval from the MEC and/or Board upon verification of the following: current licensure, current clinical competency for the privileges requested, relevant training or experience, current professional liability insurance that meets or exceeds the minimum criteria outlined in the Medical/Dental Staff privileging policy, a query of the National Practitioner Data Bank, and other criteria as outlined in the Medical/Dental Staff credentialing policies.

    c. Temporary privileges are recommended by the President of the Medical/Dental Staff or his/her designee which may include the appropriate Division Director, Chair of the Credentials Committee, or the President-Elect of the Medical/Dental Staff.

    d. Temporary Privileges are granted by the Governing Board President or the Hospital Administrator.

e. The Governing Board President, after consultation with the Medical/Dental Staff President and appropriate Division Director, may terminate any or all of a Medical/Dental Staff member's temporary clinical privileges. Temporary clinical privileges shall automatically terminate on issuance of an adverse recommendation or action. They shall be automatically terminated on issuance of an unfavorable recommendation by the Credentials Committee or automatically modified to conform to a recommendation by the Credentials Committee that the Medical/Dental Staff member be granted clinical privileges which are different from the temporary clinical privileges. In the event of termination, the Medical/Dental Staff member's patients then in the hospital shall be assigned temporarily to another Medical/Dental Staff member by the Division Director until a permanent assignment can be made in conjunction with the patient, or if appropriate, with the patient's legal guardian(s).

f. The granting of temporary clinical privileges is a courtesy of the hospital. A Medical/Dental Staff member is not entitled to any procedural rights afforded by these Bylaws or otherwise as a result of granting temporary clinical privileges, a failure to grant temporary privileges or because of any termination or suspension of temporary clinical privileges.

6. If the Hospital's Emergency Medical Plan has been activated, any Member or other health care provider with Clinical Privileges, to the degree permitted by his/her license, shall be permitted to and be assisted by hospital personnel in doing everything possible to save the life of a patient or to save the patient from serious harm. Additionally, temporary disaster privileges may be granted to non-staff practitioners and other health care providers who are not members of the Medical/Dental Staff by the Governing Board President, Hospital Administrator, JPE Chief Medical Officer, Vice President, Medical Staff Affairs, Medical/Dental Staff President, or their designees, as provided in Hospital policy.

   a. The process for granting temporary disaster privileges shall include the basic steps of photo identification and direct observation, mentoring, and clinical record review of volunteer staff in accordance with legal and accreditation requirements.

   b. Once the immediate situation has passed and such determination has been made consistent with the Hospital's Emergency Medical Plan, all temporary disaster privileges shall automatically terminate immediately. Any person identified in the Emergency Medical Plan or Hospital policy with the authority to grant temporary disaster privileges shall also have the authority to terminate such privileges. Such authority may be exercised in the sole discretion of the Hospital and will not give rise to any procedural rights of review under these Bylaws or otherwise.

7. In an emergency, any Medical/Dental Staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or

to prevent serious harm—regardless of his or her medical staff status or clinical privileges—provided that the care, treatment, and services provided are within the scope of the individual's license. The care of the patient shall be turned over to a physician with appropriate clinical privileges as soon as the emergency is under control.

Section E. Staff Dues or Application Fees

1. Annual Medical/Dental Staff dues or application fees shall be governed by the most recent action recommended by the MEC.

2. Honorary members of the Medical/Dental Staff shall not be required to pay dues.

Section F. Responsibilities of Membership

Each Medical/Dental Staff member shall:

1. Direct the care of his/her patient(s) in a manner consistent with generally accepted standards of care and with the Bylaws, the Rules and Regulations, and the policies and procedures of Children's Dallas.

2. Supervise the work of any Residents, Fellows, APPs or AHPs under his/her supervision, as applicable.

3. Assist Children's Dallas in fulfilling its responsibilities for providing emergency and charitable care.

4. Assist other physicians/dentists in caring for their patients when consulted.

5. Conduct himself/herself in an ethical and professional manner.

6. Treat employees, patients, visitors, and other physicians/dentists in a dignified and courteous manner.

7. Maintain compliance with the Bylaws, the Rules and Regulations, and the policies and procedures of the Medical/Dental Staff and Children's Dallas.

8. Cooperate with the committees of the Medical/Dental Staff and Children's Dallas, as appropriate.

Section G. Leave of Absence

Members of the Medical/Dental Staff may be granted a leave of absence as set forth in the policies and procedures of the Medical/Dental Staff.

Section H. History & Physical Examinations

1. A history and physical examination must be completed and documented by a physician member of the Medical/Dental Staff with clinical privileges, or by a licensed individual approved for such privilege based on demonstrated competence. A history and physical must be completed and documented in the medical record of all inpatients within twenty-four (24) hours of admission, and for all elective surgical procedures and ambulatory (same-day) surgery patients at the time of admission and prior to the patient leaving the pre-procedural area, unless an emergency situation exists. Elective inpatient or outpatient surgery shall be canceled or delayed until a history and physical examination is completed and documented in the medical record. A complete Pre-Anesthetic Summary and /or Sedation Assessment shall be considered the history and physical for outpatient non-invasive procedures.

   When the history and physical examination is recorded by a resident, intern, or other approved practitioner, the supervising physician/dentist shall review such history and physical, make a separate entry, and countersign or authenticate it, according to Children's Dallas policy, to indicate his/her approval and agreement with the contents.

   A new history and physical must be completed if the original history and physical was performed and completed greater than thirty (30) days prior to admission, registration or a procedure. If the original history and physical was performed and completed within the past thirty (30) days (prior to admission, registration or a procedure), there must be evidence of an updated examination of the patient, including any changes in the patient's condition. This is called an interval note.

   The Medical/Dental Staff Rules and Regulations as well as the health information management policies and procedures outline specific requirements related to the content and other requirements for completion of histories and physicals.

Section I. Telemedicine Clinical Privileges

1. General. Practitioners who wish to provide telemedicine services in prescribing, rendering a diagnosis or otherwise providing clinical treatment to a Hospital patient shall be required to apply for and, except as provided below, be granted Clinical Privileges for these services as provided in these Bylaws and as required by Texas law.

2. Reliance on Distant Site Credentialing. The Board, following consultation with the MEC, may authorize a written agreement with a distant site hospital or other entity, which agreement allows reliance on the credentialing and privileging decisions of that distant site; provided that, the process meets the applicable requirements of The Joint Commission and the Medicare Conditions of Participation and the criteria in these Bylaws for the applicable Telemedicine Clinical Privileges.

3. Scope of Telemedicine Services. Only those clinical services that are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards, shall be recommended to the Board by the MEC as appropriate for Telemedicine Clinical Privileges. This limited scope shall be documented in writing in Hospital policy. Consideration of appropriate utilization of telemedicine equipment by the Telemedicine Practitioner shall be encompassed in the Clinical Privileges delineation which is reviewed by the appropriate Division Director and the recommendation is sent to the Credentials Committee, MEC and the Board for final approval.

ARTICLE III. CATEGORIES OF THE MEDICAL/DENTAL STAFF

Each member of the Medical/Dental Staff shall be assigned by the Board to one of the following categories of Medical/Dental Staff: Associate, Active, Honorary or Emeritus.

Section A. The Associate Staff Category of the Medical/Dental Staff

The Associate Staff category of the Medical/Dental Staff shall include all initially credentialed members of the Medical/Dental Staff and all current members of the Medical/Dental Staff who do not meet the eligibility requirements for the Active or Honorary Staff Category as outlined in the membership criteria policy.

1. **Qualifications:** Appointees to the Associate Staff **must**:

   a. Have met the general qualifications for Medical/Dental Staff membership set forth under Article II., Section B.

   b. Meet the activity requirements as applicable for Associate Staff membership, established through the Medical/Dental Staff membership policy, on an annual basis and otherwise exhibit a continuous interest and involvement in the welfare and clinical affairs of Children's Dallas.

2. **Prerogatives:** Appointees to the Associate Staff **may**:

   a. Exercise clinical privileges granted without limitation, except as otherwise provided in the Medical/Dental Staff Rules and Regulations or by specific clinical privilege restriction.

   b. Sit on any committee to which he or she is appointed or elected as a non-voting member.

   c. Request to advance to Active Staff category at any time after completion of their initial twelve (12) month appointment as an Associate Staff member, if they can demonstrate that they have met the activity requirements at Children's Dallas required for Active Staff within the past twelve (12) months.

3. **Responsibilities:** Appointees to the Associate Staff **shall**:

   a. Comply with all responsibilities of membership as noted under Article II., Section F, as well as all Rules and Regulations, Medical/Dental Staff and Children's Dallas policies and procedures, and the code of conduct at Children's Dallas.

   b. Refer and/or treat patients at Children's Dallas and otherwise exhibit a continuous interest and involvement in the welfare and clinical affairs of Children's.

   c. Actively participate in recognized functions of staff appointment.

   d. Meet educational program requirements of the Medical/Dental Staff.

   e. Participate in the coverage of clinical services, including that of the Emergency Division and other specialty programs, as scheduled and/or as required by the Division Director, as approved by the MEC.

Section B. The Active Staff Category of the Medical/Dental Staff

The Active Staff category of the Medical/Dental Staff shall include credentialed members of the Medical/Dental Staff who have served on the Associate Staff for a minimum of one year[5] and have demonstrated the required level of involvement in the clinical affairs of Children's Dallas for Active Medical/Dental Staff membership as outlined in the Medical/Dental Staff membership policy.

1. **Qualifications**: Appointees to the Active Staff **must**:

   a. Have met the general qualifications for Medical/Dental Staff membership set forth under Article II., Section B., OR

   b. Be appointed through the appropriate process as defined in the Bylaws or Medical/Dental Staff policies as the JPE Chief Medical Officer, Chief Medical Officer Dallas, Pediatrician-in-Chief, Surgeon-in-Chief, Anesthesiologist-in-Chief, Vice President, Medical Staff Affairs, Division Director, Committee Chair, Training Program Director or a Medical or Surgical Director, **OR**

   c. Meet the activity requirements for Active membership established through the Medical/Dental Staff membership policy and otherwise have exhibited a continuous interest and required level of involvement in the welfare and clinical affairs of Children's Dallas.

[5] One year Associate Staff appointment is waived for members appointed to a Medical/Dental Staff leadership role.

2. **Prerogatives**: Appointees to the Active Staff **may**:

   a. Exercise the clinical privileges granted without limitation, except as otherwise provided in the Medical/Dental Staff Rules and Regulations, or by specific clinical privilege restriction.

   b. Hold office, sit on, or be chair of any committee to which he or she is appointed or elected, unless otherwise specified in these Bylaws.

   c. Vote at meetings of committees to which he or she is appointed and on amendments to the Bylaws, Rules and Regulations, and policies and procedures as applicable.

   d. Make nominations for Representatives-at-Large to the MEC and participate in the election of Officers.

3. **Responsibilities**: Appointees to the Active Staff **shall**:

   a. Comply with all responsibilities of membership as set forth under Article II., Section F as well as all Rules and Regulations, policies and procedures, and the code of conduct at Children's Dallas.

   b. Contribute to the organizational and administrative affairs of the Medical/Dental Staff.

   c. Actively participate in recognized functions of staff appointment including but not limited to quality and performance monitoring activities.

   d. Attend meetings of committee(s) to which he or she is appointed, according to his or her respective attendance requirements.

   e. Meet educational program requirements of the Medical/Dental Staff.

   f. Participate in the coverage of clinical services, including that of the Emergency Division and other specialty programs, as scheduled and/or as required by the Division Director, as approved by the MEC.

Section C. The Honorary Staff Category of the Medical/Dental Staff

The Honorary Staff category shall be restricted to those individuals whom the Medical/Dental Staff wishes to honor. Honorary Staff shall not be eligible to admit patients, vote or exercise clinical privileges at Children's Dallas. They may, however, attend Medical/Dental Staff meetings. They shall not be appointed or reappointed in the same manner as Active and Associate Staff members of the Medical/Dental Staff, nor shall they be required to hold professional liability insurance coverage.

Section D. Emeritus Staff Category for the Medical/Dental Staff

The Emeritus Staff category shall be restricted to the Medical/Dental Staff Members who have made outstanding contributions to the field of medicine, the community or the Hospital whom the Medical/Dental Staff wish to honor. Emeritus Staff shall not be eligible to admit patients, vote or exercise clinical privileges at Children's Dallas. They may, however, attend Medical/Dental Staff meetings, teach, attend conferences and be privy to patient data for education purposes. They shall not be appointed or reappointed in the same manner as Active and Associate Staff members of the Medical/Dental Staff, nor shall they be required to hold professional liability insurance coverage or licensure.

Section E. Waiver from Call Coverage

Criteria: A member of the Medical/Dental Staff who meets at least one of the following criteria may request a waiver from any further emergency services call coverage obligation: (a) is at least 60 years of age; or (b) who has been a member of the Medical/Dental Staff for at least 25 consecutive years; or (c) another need/circumstance that is deemed an appropriate reason by the Division Director. The waiver request shall be submitted to the appropriate Division Director for review and approval. The MEC and Board shall be notified when a waiver is approved by a Division Director. The waiver may only be considered if the Hospital's emergency services coverage needs are being adequately met by other members of the Medical/Dental Staff from that Division.

ARTICLE IV. OFFICERS AND REPRESENTATIVES-AT-LARGE OF THE MEDICAL/DENTAL STAFF

Section A. Officers of the Medical/Dental Staff and Representatives-at-Large to the MEC

1. The Officers of the Medical/Dental Staff shall be:

    a. President

    b. President-Elect

    c. Immediate Past President

2. The Representatives-at-Large of the Medical/Dental Staff to the MEC shall be:

    a. Three (3) Medical Representatives-at-Large;

        i. Two (2) Medical Representative positions will be open for election to ALL medical Divisions;
        ii. A third position will be open for election for medical Divisions that have not been represented on the MEC in the past five (5) years.

b. Three (3) Surgical Representatives-at-Large;

i. Two (2) Surgical Representative positions will be open for election to ALL surgical Divisions;
ii. A third position will be open for election for surgical Divisions that have not been represented on the MEC in the past five (5) years.

Section B. Qualifications of Officers and Representatives-at-Large

1. Officers of the Medical/Dental Staff and Representatives-at-Large to the MEC must be members in good standing of the Active Staff and remain in good standing on the Active Staff during their term in office; be actively involved in patient care at Children's Dallas; have no major or egregious adverse recommendations concerning medical staff appointment or clinical privileges at Children's Dallas pending or recorded within the past five (5) years; have demonstrated an ability to work well with others; and be in compliance with the professional conduct policies of Children's Dallas. The Nominating Committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

2. Officers may not simultaneously hold Medical/Dental Staff office (i.e., President, President-Elect, or equivalent) on the medical or dental staff of a hospital other than Children's Dallas.

3. Officers may not simultaneously hold an administrative leadership position at Children's Dallas or any Children's Dallas affiliate.

Section C. Nomination of Officers and Representatives-at-Large

1. A Nominating Committee shall be appointed yearly by the MEC and shall be chaired by the President of the Medical/Dental Staff. Other members of the Committee shall include the President-Elect, Immediate Past President, and two (2) other voting members of MEC whose specialty is not already represented on the Committee who shall be appointed by the Chair of the committee.

2. The candidates for President-Elect will be nominated by the voting members of MEC and Representatives-at-Large will be nominated by members of the Active Medical/Dental Staff.

3. The Nominating Committee will review the Divisions represented on the MEC during the past five (5) years to determine eligibility for the third Representative-at-Large positions as referenced above in Article IV, Section A.2.

4. Nominations for Officers and Representatives-at-Large may also be made by a petition signed by at least ten percent (10%) of the members of the Active Medical/Dental Staff during the fourteen (14) day nomination period.

5. The Nominating Committee will finalize the draft ballot to be presented for review and final approval by the MEC. Criteria used by the Nominating Committee include but are not limited to the following: number of nominations received, percentage of practice at Children's Dallas, professionalism and collegiality with team members, diversity of specialties, gender, ethnicity and race, and proven engagement and commitment to Children's Dallas.

6. Every effort will be made to secure at least two candidates for each position. All candidates who have accepted the nominations shall be placed on a ballot.

Section D. Election of Officers and Representatives-at-Large

1. Only Active members of the Medical/Dental Staff shall be eligible to vote.

2. The ballot will be distributed to all Active members of the Medical/Dental Staff and they shall have fourteen (14) calendar dates to vote.

3. The candidate for each office receiving the most votes cast shall be elected, subject to approval and confirmation by the Board.

4. If the results of the election should end in a tie for any position, a runoff election will be initiated. The runoff ballot will be distributed to all Active Staff and they shall have fourteen (14) calendar days to vote. The candidate receiving the most votes cast shall be elected, subject to approval and confirmation by the Board. If the runoff election should end in a tie, the voting members of the MEC will conduct a vote to decide the winner of the election.

Section E. Terms of Office

1. All Officers and Representatives-at-Large shall take office on the first day of the calendar year.

2. The term of the President of the Medical/Dental Staff shall be three (3) years: one (1) year as President-Elect, one (1) year as President, and one (1) year as Immediate Past President.

3. Presidency shall include membership on the MEC in all three (3) capacities, i.e., for three (3) years.

4. The Representatives-at-Large shall serve terms of two (2) years. The terms of the three (3) Representatives-at-Large from Medical and Surgical Divisions shall be staggered.

5. Each elected Medical/Dental Officer may, in each year of the Officer's term, receive an annual stipend established and approved by the Board. Such stipend, if any, and associated documentation shall be made in accordance with Medical/Dental Staff policies and procedures and applicable law.

Section F. Vacancies in Office

1. If there is a vacancy in the office of the President, the Immediate Past President shall serve the remainder of the term and the subsequent term to which he or she was elected.

2. If there is a vacancy in the office of the Immediate Past President, the President shall serve the remainder of the term and the subsequent term to which he/she was elected.

3. Vacancies in other offices (President-Elect, Medical Representative-at-Large or Surgical Representative-at-Large) shall be filled by a specially called election of the Medical/Dental Staff.

Section G. Duties of Officers

1. Duties of all Officers:

It is expected that all elected Officers serve as a role model for all staff and his/her behavior represents Children's Dallas and the care provided by Children's Dallas in a positive light at all times; this includes, but is not limited to:

i. Behave in a professional and ethical manner
ii. Maintain a positive relationship with staff, patients and families
iii. Represent Children's Dallas in a positive manner
iv. Adhere to Medical/Dental Staff Bylaws and Rules and Regulations
v. Comply with all hospital policies and procedures and the Code of Ethical Conduct
vi. Be a role model to all staff and lead by example

2. The duties of the President of the Medical/Dental Staff shall include but not be limited to:

a. Act in coordination and cooperation with all Medical Staff leaders and administrative leaders at Children's Dallas on an as needed basis on issues that impact the practice of the Medical/Dental Staff at Children's Dallas;

b. Participate in the quality and credentialing processes of the Medical/Dental Staff;

c. Serve as a voting member on the Peer Review Committee, Medical Advisory Committee, Credentials Committee, Medical Executive Committee, Bylaws Committee and any other committees as deemed appropriate by the MEC;

d. Chair the Medical Executive Committee;

e. Chair the Medical Advisory Committee;

f. Chair the annual Nominating Committee;

g. Chair the Bylaws Committee;

h. Lead and/or participate in ad hoc panels appointed to investigate physician practice concerns upon request;

i. Lead all investigations related to allegations of potentially impaired practitioners;

j. Represent the views, policies, needs, and grievances of the Medical/Dental Staff to the President and to the Board of Children's Dallas, in cooperation with the Administrator, the JPE Chief Medical Officer, and Vice President, Medical Staff Affairs; Attend Board meetings as an ex-officio, non-voting member;

k. Be a spokesperson for the Medical/Dental Staff in its external, professional, and public relations upon request.

3. The duties of the President-Elect of the Medical/Dental Staff shall include but not be limited to:

a. Perform duties to assist the President of the Medical/Dental Staff upon request;

b. Act in coordination and cooperation with all medical staff leaders and administrative leaders at Children's Dallas on an as needed basis on issues that impact the practice of the Medical/Dental Staff at Children's Dallas;

c. Participate in the quality and credentialing processes of the Medical/Dental Staff;

d. Serve as a voting member of the Peer Review Committee, Medical Advisory Committee, Credentials Committee, the Medical Executive Committee, Bylaws Committee, and other committees deemed appropriate by the MEC;

e. Participate in ad hoc panels appointed to investigate physician practice concerns upon request;

f. Assume the Presidency of the Medical/Dental Staff at the end of the Medical/Dental Staff year.

4. The duties of the Immediate Past President of the Medical/Dental Staff shall include but not be limited to:

a. Assume all duties of the President of the Medical/Dental Staff in his/her absence upon request or should the position be vacated.

b. Act in coordination and cooperation with all Medical Staff leaders and administrative leaders at Children's Dallas on an as needed basis on issues that impact the practice of the Medical/Dental Staff at Children's Dallas;

c. Participate in the quality and credentialing processes of the Medical/Dental Staff;

d. Serve as the chair of the Medical/Dental Staff Credentials Committee and Peer Review Committee;

e. Serve as a voting member of the Peer Review Committee, Medical Advisory Committee, Medical Executive Committee, Bylaws Committee, and other committees deemed appropriate by the MEC;

f. Lead and/or participate in ad hoc panels appointed to investigate physician practice concerns upon request.

5. The duties of Representatives-at-Large of the MEC shall include but not be limited to:

a. Serve as a voting member of the MEC.

b. Participate in other Medical/Dental Staff committees and activities as recommended by the MEC.

Section H. Removal of an Officer or Representative-at-Large

1. The Board may remove any Officer or Representative-at-Large, if he or she meets one or more of the criteria outlined below for removal, but only after a consultation with representatives of the MEC. The affected individual will not participate in this consultation.

2. The Medical/Dental Staff may remove any Officer or Representative-at-Large by petition of twenty-five percent (25%) of the Active Medical/Dental Staff and a subsequent two-thirds (2/3) vote by ballot of the Active Medical/Dental Staff, if he or she meets one or more of the criteria outlined below for removal.

3. Each of the following conditions, in itself, may constitute grounds for removal of an Officer or Representative-at-Large from office by the MEC or if requested through one of the above processes:

a. Revocation of professional license by the authorizing state agency;

b. Suspension or resignation from the Medical/Dental Staff;

c. Failure to maintain professional liability insurance;

d. Failure to adhere to professional ethics;

e. Failure to comply with or support enforcement of the policies and procedures of Children's Dallas and with the Bylaws, the Rules and Regulations, and the policies and procedures of the Medical/Dental Staff;

f. Failure to perform the required duties of the office; or

g. Failure to maintain Active Staff status.

This is not an all-inclusive list and other actions by an Officer or Representative-at-Large such as those involving moral turpitude may give rise to removal from office. Removal of an Officer or Representative-at-Large shall not be grounds for a hearing or appeal as set forth in Article XI.

ARTICLE V. ORGANIZATION OF MEDICAL/DENTAL STAFF GOVERNANCE

Section A. Medical Divisions and Surgical Divisions

The Medical/Dental Staff shall be organized into Medical Divisions and Surgical Divisions. The Medical Divisions will be directed by the Pediatrician-in-Chief while the Surgical Divisions will be directed by the Surgeon-in-Chief. The Pediatrician, Surgeon, and Anesthesiologist-in-Chiefs shall be appointed annually by the Board upon recommendation by the JPE Chief Medical Officer, with the concurrence of the President of UT Southwestern, and the President of the Children's Medical Center of Dallas Operating Division.

The Pediatrician-in-Chief shall be responsible for the oversight of the quality of clinical operations and the integration of clinical and academic activities within the medical disciplines. The Surgeon-in-Chief and Anesthesiologist-in-Chief shall be responsible for the system oversight of the quality of clinical operations and the integration of clinical and academic activities within the respective surgical or anesthesia disciplines. All three positions shall report to the JPE Chief Medical Officer.

Section B. Clinical Divisions

The Medical and Surgical Divisions of the Medical/Dental Staff shall be further organized into Clinical Divisions categorized by specialty or sub-specialty.

The Medical Divisions of the Medical/Dental Staff are: Allergy and Immunology, Cardiology, Critical Care, Dermatology, Developmental and Behavioral Pediatrics, Emergency Medicine, Endocrinology, Gastroenterology, Genetics and Metabolism, Hematology/Oncology, Hospital Medicine, Infectious Disease, Neonatal-Perinatal Medicine, Nephrology, Neurology, Pathology, Physical Medicine and Rehabilitation, Psychiatry, Pulmonology, Radiology, and Rheumatology

The Surgical Divisions of the Medical/Dental Staff are: Cardiovascular and Thoracic Surgery, Dentistry, Gynecology, Maternal-Fetal Medicine, Neurosurgery, Ophthalmology, Oral Surgery, Orthopaedic Surgery, Otolaryngology, Pediatric Surgery, Plastic and Craniofacial Surgery, and Urology.

Each Clinical Division shall have a Division Director who shall be appointed initially by the Board upon recommendation by the JPE Chief Medical Officer, with the concurrence of the President of UT Southwestern, the President of the Children's Medical Center of Dallas Operating Division, the corresponding Pediatrician-in-Chief, Surgeon-in-Chief or Anesthesiologist-in-Chief, and the respective Department Chair. After the initial appointment, the Division Director will be appointed annually thereafter by the Board. The Division Directors shall have overall responsibility for the supervision and satisfactory discharge of functions and identified roles and responsibilities which are summarized within these Bylaws and he/she shall report directly to the applicable Pediatrician-in-Chief, Surgeon-in-Chief, or Anesthesiologist-in-Chief.

Section C. Medical and Surgical Directors

The Division Directors may submit a request to appoint Medical or Surgical Directors to oversee specific programs or clinical areas within their division.

Section D. Changes to Clinical Divisions

1. Medical/Dental Staff Clinical Divisions may be established or re-organized by the MEC with approval by the Board.

2. Further, in the interests of efficiency, department management, quality of patient care, education, and/or in the interest of financial stewardship, the Board may in its sole discretion determine that certain physician/dentist services shall be provided on an exclusive basis in accordance with written agreements between Children's Dallas and qualified practitioners. An individual whose application, reapplication, or request for extension of privileges is declined or not granted due to such exclusive agreement is not entitled to the hearing and appeal procedures as outlined in Article XI.

Section E. Meetings and Activities

1. Division Directors may require attendance at Divisional Morbidity and Mortality conferences. Attendance requirements must be approved by the MEC. Specially called meetings must be preceded by prior written notification of at least fourteen (14) calendar days for all of those expected to attend.

2. Divisions, among other activities, shall perform the following:

    a. Discussion and development of policies and procedures;

b. Development of recommendations for consideration by the Pediatrician-in-Chief, Surgeon-in-Chief, Anesthesiologist-in-Chief, or the MEC;

c. Participation in the development of criteria for clinical privileges;

d. Discussion of a specific issue at the special request of the Pediatrician-in-Chief, Surgeon-in-Chief, Anesthesiologist-in-Chief, or the MEC; and

e. Monitoring and reporting of quality improvement activities.

Section F. Qualifications and Tenure of Division Directors

1. Each Director shall be a member of the Active Medical/Dental Staff, willing and able to discharge the functions of his/her office.

2. Each Director shall be appointed by the Board for a one (1) year term.

3. Any Director may be removed by the Board following the Board's consultation with the JPE Chief Medical Officer and the MEC. The removal of a Division Director from office shall not be grounds for a hearing and appeal as outlined in Article XI.

4. If in the event the JPE Chief Medical Officer, Chief Medical Officer Dallas, Vice President, Medical Staff Affairs, Pediatrician-in-Chief, Surgeon-in-Chief, Anesthesiologist-in-Chief or a Division Director is out of town or otherwise unavailable, he/she may assign the administrative responsibilities (e.g., recommending privileges, establishing call schedules, reviewing incident or quality reports, etc.) to a qualified designee.

Section G. Division Director Roles and Responsibilities

1. Each Division Director shall be responsible for the following:

   a. All clinically related activities of the Division;

   b. All administratively related activities of the Division, unless otherwise provided for by Children's Dallas;

   c. The continuing supervision of the professional performance of all individuals in the Division who have delineated clinical privileges;

   d. The recommendation to the Medical/Dental Staff of the criteria for clinical privileges that are relevant to the care provided in the Division;

e. The recommendation of clinical privileges for each Medical/Dental Staff member of the Division;

f. The assessment and recommendation to Children's Dallas administration of off-site sources for necessary patient care, treatment, and services not provided by the Division or the organization;

g. The integration of the Division into the primary functions of Children's Dallas;

h. The coordination and integration of interdepartmental and intradepartmental services;

i. The development and implementation of policies and procedures to guide and support the provision of care, treatment, and services;

j. The recommendation of a sufficient number of qualified and competent persons to provide care, treatment, and services;

k. The determination of the qualifications and competence of Division personnel who are not licensed independent physicians/dentists but who provide patient care, treatment and services;

l. The continuous assessment and improvement of the quality and safety of care, treatment and services provided, including peer review and the analysis of aggregate data and performance improvement data, at all times including at each member's reappointment.

m. The maintenance of quality control programs, as appropriate;

n. The orientation and continuing education of all physicians/dentists in the Division; and

o. Recommendations for space and other resources needed by the Division.

2. Division Directors are responsible for quality and/or peer review matters in their Division and will see that such matters are conducted in accordance with and completed within the time frame outlined in the associated Medical/Dental Staff Policies. This includes, but is not limited to, divisional M&M case reviews, individual practice evaluations, ongoing professional practice evaluations, focused professional practice evaluations and any incident reports or educational needs brought to their attention.

3. Division Directors are responsible for distributing communication to members within their Division regarding policy revisions that may impact divisional or individual practice. This includes, but is not limited to, regulatory readiness education and communication to provide that all staff are educated on regulatory requirements in which they must comply while providing services at Children's Dallas.

4. Division Directors will represent members and/or concerns within their Division at Medical/Dental Staff leadership meetings and partner with the appropriate administrative leaders to resolve any conflicts which may arise.

Section H. Assignment to Clinical Divisions

Each credentialed Medical/Dental Staff member shall be assigned to a Clinical Division by the Board upon the recommendation of the MEC.

ARTICLE VI. COMMITTEES OF THE MEDICAL/DENTAL STAFF

Section A. Medical Executive Committee (MEC)

Central to the operation of the Medical/Dental Staff shall be a MEC whose composition and duties, set forth below, shall be designed to facilitate communication between all levels of governance of Children's Dallas, including the Board, UT Southwestern, the Clinical Divisions, and the members of the Medical/Dental Staff.

1. **Composition:**

   a. The President of the Medical/Dental Staff shall be the Chair of the MEC.

   b. The voting members of the MEC shall include:

   - JPE Chief Medical Officer
   - Chair, Department of Pediatrics at UT Southwestern
   - President of the Medical/Dental Staff, the President-Elect of the Medical/Dental Staff, and the Immediate Past President of the Medical/Dental Staff
   - Pediatrician-in-Chief, Surgeon-in-Chief and Anesthesiologist-in-Chief
   - Division Directors from Radiology, Dentistry, and Pathology and Laboratory Medicine
   - Three (3) Representatives-at-Large from the Medical Services and three (3) Representatives-at-Large from the Surgical Services

   Should any individual hold more than one (1) of these positions simultaneously, that individual shall be entitled to one (1) vote.

   c. Ex-officio, non-voting members of the committee shall include:

   - Chief Medical Officer Dallas
   - Hospital Administrator
   - Medical Director, Graduate Medical Education
   - Vice President of Quality and Safety

- System Chief Nursing Executive
- Vice President, Medical Staff Affairs
- Medical Director, Infection Prevention and Control
- Medical Director, Research
- Chief Medical Information Officer
- Associate General Counsel

d. In the event there is a need for an executive session of the MEC, the following ex-officio, non-voting members will be permitted to attend in addition to the voting members listed above:
    - Chief Medical Officer Dallas
    - Hospital Administrator
    - Vice President, Medical Staff Affairs
    - Associate General Counsel

e. A voting member's removal from the MEC will occur if he or she is removed by virtue of his or her position as outlined in Article IV and V above. Non-voting members can be removed based on vacating their existing position within the organization or by two-thirds (2/3) vote of the MEC with the approval of the Board.

2. **Duties:** The duties of the MEC shall include:

a. To represent and act on behalf of the Medical/Dental Staff between meetings of the organized Medical Staff. This authority is delegated to the MEC by approval of these Bylaws by the Active Staff and can be removed via the processes for Bylaws revisions as outlined in Article IX.

b. To be accountable on behalf of the Medical/Dental Staff to the Board for the medical, surgical, and dental care of patients at Children's Dallas and to make suggestions to the Board on matters of hospital management and planning;

c. To act as a liaison between the Medical/Dental Staff and the Governing Board President and Hospital Administrator and to recommend action to the Governing Board President and Hospital Administrator on medical administrative matters;

d. To recommend to the Board a set of Bylaws, a set of Medical/Dental Staff Rules and Regulations, and a set of policies and procedures as outlined in Article IX of these Bylaws; to maintain compliance of the Medical/Dental Staff with these documents; and to periodically review and propose revision or amendment of the documents as it deems necessary or upon request by an individual member or committee of the Medical/Dental Staff;

e. To recommend to the Board a Corrective Action and Due Process Procedure as outlined in Article XI of these Bylaws and to participate in the processes;

f. To implement and coordinate the activities and general policies of the Medical/Dental Staff, as set forth in these Medical/Dental Staff Bylaws, Rules and Regulations, and associated policies and procedures.

g. To designate committees to conduct the business of the Medical/Dental Staff and to receive and act upon committee reports;

h. To recommend to the Board a mechanism for reviewing the credentials of applicants for Medical/Dental Staff membership and for delineating individual clinical privileges and to periodically review and propose revisions to this process as necessary;

i. To review the report of the Credentials Committee on all applicants and to make recommendations to the Board for staff membership, including staff category, divisional assignment, and delineation of clinical privileges;

j. To approve the required levels of division membership criteria set by the Division Directors to maintain Active or Associate Staff appointment (e.g., call requirements, M&M attendance requirements, etc.);

k. To take all reasonable steps to maintain and enforce professionally ethical conduct and competent clinical performance by all members of the Medical/Dental Staff, participants in graduate or post graduate medical education training programs, advanced practice professionals, and allied health professionals;

l. To recommend to the Board a mechanism by which Medical/Dental Staff membership and/or clinical privileges may be terminated;

m. To provide consultation to the Board concerning removal of Officers or Representatives-at-Large of the Medical/Dental Staff, Pediatrician-in-Chief, Surgeon-in-Chief, Anesthesiologist-in-Chief or Division Directors;

n. To review and approve Division policies and procedures as necessary and to provide a liaison between the Division Directors and the members of the Medical/Dental Staff;

o. To review and approve the requirements set by Division Directors for coverage of clinical services;

p. To provide a designee who will meet upon request with any practitioner on the Medical/Dental Staff regarding an impending issue of importance not included in Article XI. Corrective Action and Due Process, and to resolve conflicts related to this issue;

q. To provide recommendations to the Medical/Dental Staff concerning membership dues or application fees;

r. To schedule special meetings of the Medical/Dental Staff when presented with a valid petition from members of the Active Medical/Dental Staff that requires a discussion and/or a vote by the Medical/Dental Staff;

s. To establish a mechanism to organize, conduct, evaluate and revise the performance-improvement activities of the Medical/Dental Staff; and to ensure the participation of the Medical/Dental Staff in the performance-improvement activities of the greater hospital organization;

t. To coordinate activities related to the accreditation program of Children's Dallas and to keep the Medical/Dental Staff informed of the requirements of the program and the accreditation status of Children's Dallas;

u. To conduct such other functions as are necessary for the effective operation of the Medical/Dental Staff; and

v. To report on the activities of the MEC and its subsidiary bodies and representatives at each meeting of the Medical/Dental Staff.

3. **Meetings:**

a. **Frequency** – The MEC shall meet as often as necessary to fulfill its responsibility, but not less than quarterly. It shall maintain a permanent record of its proceedings and actions. Special meetings of the MEC may be called at any time by the President of the Medical/Dental Staff.

b. **Quorum** – The quorum requirement for the MEC shall be fifty percent (50%) of the voting members of the Committee. The quorum requirement also applies to business conducted electronically in between regularly scheduled meetings as outlined further in the Medical/Dental Staff Committee Policy.

c. **Attendance Requirements** – Members of the MEC shall be required to attend at least seventy-five percent (75%) of the meetings in each calendar year.

Section B. Medical/Dental Staff Committee Functions

Committees of the Medical/Dental Staff (as defined in Medical/Dental Staff Policy #3.13) shall exist as needed to perform these functions:

1. Monitor, evaluate, and develop clinical policies to improve patient care and safety in: special care areas, such as intensive care or cardiac care units; patient care support services, such as

respiratory therapy, physical medicine, and anesthesia; and emergency, outpatient, and other ambulatory care services;

2. Conduct or coordinate activities related to the quality, safety, appropriateness, and improvement of patient care, including invasive procedures, blood usage, drug utilization, medical records, and other reviews;

3. Conduct or coordinate utilization review activities;

4. Conduct or coordinate credentialing investigations for staff membership and the granting of privileges;

5. Provide continuing education responsive to quality assessment/improvement activities, current medical and scientific developments, and other perceived needs;

6. Direct Medical/Dental Staff organization activities, including reviewing and proposing revisions to the Bylaws, the Rules and Regulations, the associated policies and procedures of the Medical/Dental Staff;

7. Nominate candidates for Officers and Representatives-at-Large;

8. Coordinate the care provided by members of the Medical/Dental Staff with the care provided by the nursing services and with the activities of other patient care and administrative services;

9. Conduct and/or coordinate all peer review activities;

10. Review and regulate the adequacy and appropriateness of Medical/Dental Staff documentation; and

11. Engage in other functions reasonably requested by the MEC and the Board.

Section C. Medical Peer Review

1. Authorization: Each committee (whether Medical/Dental Staff, Division, standing, special, subcommittee, or joint) and each Division, as well as the Medical/Dental Staff when meeting as a whole, shall be established and operate as a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined by state and federal law, and is authorized by the Board through these Bylaws to engage in medical peer review. Specific policies and procedures for the accomplishment of its charge may be developed and established by a committee or Division, subject to the approval of the Medical Executive Committee and the Board.

2. Privilege and Confidentiality: All records and proceedings of the Medical/Dental Staff, the Divisions, and all Medical/Dental Staff and Children's Dallas committees, including, without

limitation, any minutes of meetings, disclosures, discussion, statements, actions or recommendations in the course of Medical Peer Review, shall be privileged and confidential, subject to disclosure only in accordance with these Bylaws and the policies of Children's Dallas unless otherwise required by state or federal law, and shall be privileged to the fullest extent permitted by state and federal law.

ARTICLE VII. MEDICAL/DENTAL STAFF MEETINGS

Section A. Special Meetings

1. The President of the Medical/Dental Staff may call a special meeting of the Medical/Dental Staff at any time.

2. The President of the Medical/Dental Staff shall call a special meeting within twenty (20) calendar days after receipt of a written request for such a meeting signed by not less than twenty-five percent (25%) of the Active Medical/Dental Staff or upon resolution by the MEC. Such request or resolution shall state the purpose of the meeting. The President of the Medical/Dental Staff shall designate the time and place of any special meeting.

3. Written or printed notice stating the time, place, and purposes of any special meeting of the Medical/Dental Staff shall be conspicuously posted and shall be sent to each member of the Medical/Dental Staff at least seven (7) calendar days before the date of such meeting. The attendance of a member of the Medical/Dental Staff at a meeting shall constitute a waiver of notice of such meeting for that member. No business shall be transacted at any special meeting except that stated in the notice of such meeting.

4. The Chair of any Medical/Dental Staff committee or the Division Director of any Clinical Division may call a special meeting or may arrange for a special meeting to be called at the request of the Pediatrician in Chief, Surgeon-in-Chief, Anesthesiologist-in-Chief, or the President of the Medical/Dental Staff.

5. A special executive meeting of the voting members of the Medical Executive Committee may be called by or at the request of the Chair of the Medical Executive Committee. Such request shall be sent two (2) days in advance and shall state the purpose of the meeting and state the time and place of the meeting.

Section B. Notice of Meetings

Committees or Divisions may, by resolution, hold regular meetings without further notice. Written notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the committee or Division not less than three (3) calendar days before the time of such meeting by the person or persons calling

the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting for that member.

Section C. Quorum and Attendance Requirements

1. The quorum requirement for Medical/Dental Staff committee meetings shall be those present and voting (minimum of three (3) voting members), except as otherwise specified in these Bylaws. Members appointed to a Medical/Dental Staff committee shall be required to attend at least 75% of the committee meetings. Any member who is unable to meet this requirement must obtain advanced approval from the chair for any further absences. If the regularly scheduled meeting is canceled, and business items are reviewed and voted upon electronically, a voting member's review, response and vote on these items shall count as present and voting for that month's meeting.

2. This quorum requirement for committee business conducted electronically shall be 50% of the voting members. Requirements for conducting committee business electronically are further outlined in the Medical/Dental Staff Committee Policy.

3. Members of the Medical/Dental Staff are encouraged to attend general Medical/Dental Staff meetings; however, attendance is not a requirement. If they are not in attendance, members of the Medical/Dental Staff may be required to acknowledge receipt of the information that shall be distributed to members after the meeting.

Section D. Rules of Order

The rules of the latest edition of "ROBERT'S RULES OF ORDER" shall prevail at all meetings of the Medical/Dental Staff and all Medical/Dental Staff committees, unless waived. Notwithstanding the foregoing, the chair of any meeting may vote.

Section E. Rights of Ex-Officio Members

Persons serving as ex-officio members of a committee shall have all rights and privileges of regular members, except that they shall not vote or be counted in determining the existence of a quorum, except as otherwise specified in these Bylaws, the Rules and Regulations and/or associated policies and procedures of the Medical/Dental Staff.

Section F. Minutes

Minutes of each regular or special meeting of a committee or Clinical Division shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. All Division and committee minutes are privileged and confidential.

ARTICLE VIII. MEDICAL/DENTAL STAFF MEMBER RIGHTS

Section A. Right to Meet with the MEC

Each physician/dentist on the Medical/Dental Staff shall have the right to meet with the MEC or its designee regarding an impending issue of importance that cannot be resolved at the appropriate Division level. In this circumstance, the physician/dentist may, upon presentation of a written request, meet with the MEC or its designee (as appointed at the discretion of the Chair) to review the issue and to refer the issue to the MEC for resolution. This section does not pertain to issues involving disciplinary action, denial of a request for appointment or clinical privileges, or any other matter relating to individual "credentialing or privileging" actions. Article XI, Corrective Action and Due Process provides recourse in such matters.

Section B. Right to Initiate a Recall Election of a Medical/Dental Staff Officer or Representative-at-Large

Any physician/dentist on the Active Medical/Dental Staff shall have the right to initiate, by petition, a recall election of a Medical/Dental Staff Officer or Representative-at-Large. Upon presentation to the Chair of the Medical Executive Committee of a valid petition signed by at least twenty-five percent (25%) of the members of the Active Medical/Dental Staff, the MEC shall schedule a special Medical/Dental Staff meeting for purposes of discussing the issue and holding a recall election.

Section C. Right to Initiate the Scheduling of a Meeting of the Medical/Dental Staff

Any physician/dentist on the Active Medical/Dental Staff shall have the right to initiate, by petition, the scheduling of a meeting of the Medical/Dental Staff. Upon presentation to the MEC of a valid petition signed by at least twenty-five percent (25%) of the members of the Active Medical/Dental Staff, the MEC shall schedule a meeting of the Medical/Dental Staff for the specific purpose addressed by the petition. No business other than that in the petition may be transacted.

Section D. Right to Due Process

Any physician/dentist on or applying for membership on the Active or Associate Staff categories of the Medical/Dental Staff shall have the right to a hearing, appeal, and mediation as outlined in Article XI of these Bylaws.

ARTICLE IX. REVIEW, REVISION, ADOPTION, AND AMENDMENT OF THE MEDICAL/DENTAL STAFF BYLAWS, RULES AND REGULATIONS AND ASSOCIATED POLICIES

Section A. Medical/Dental Staff Responsibility

1. The Medical/Dental Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board, the Bylaws and any amendments thereto. The Bylaws and any amendments thereto shall become effective when approved by the Board. The Medical/Dental Staff must exercise this responsibility regarding Bylaws by direct vote of its Active Staff members. Neither the Medical/Dental Staff nor the Board may unilaterally amend these Bylaws.

2. The Medical/Dental Staff may exercise its responsibility to formulate, review at least biennially, and recommend to the Board the Rules and Regulations any associated policies and procedures, and any amendments thereto, through the MEC. The MEC will exercise this responsibility in good faith and in a reasonable, responsible, and timely manner.

Section B. Methods of Adoption and Amendment

1. Technical Amendments:

Amendments that are strictly limited to correcting typographical or inadvertent errors or updating references in the Medical/Dental Staff Bylaws, such as titles of positions or names of policies, that do not involve a substantive change may be made by Medical Affairs, with the approval of the Medical/Dental Staff President, without the necessity of compliance with the procedures in this Article.

2. Substantive Amendments:

a. **Medical/Dental Staff Bylaws:** Proposed amendments to the Medical/Dental Staff Bylaws may be originated by the MEC or by a petition signed by twenty-five percent (25%) of the voting members of the Medical/Dental Staff.
   - When amendments to the Bylaws are proposed by the MEC, the proposed amendments will be distributed to the voting members of the organized Medical/Dental Staff for review and vote (via the process outlined below) before final vote by the MEC and subsequent submission to the Board for final approval.
   - When amendments to the Bylaws are proposed via a petition signed by twenty-five percent (25%) of the voting members of the Medical/Dental Staff, there will be communication of the proposed amendment to the MEC before the proposed amendments are distributed and voted upon by the voting members of the Medical/Dental Staff.

b. **Rules and Regulations:** Proposed amendments to the Medical/Dental Staff Rules and Regulations may be originated by the MEC or by a petition signed by twenty-five percent (25%) of the voting members of the Medical/Dental Staff.
   - When amendments to the Rules and Regulations are proposed by the MEC, the proposed amendments will be communicated to the Medical/Dental Staff before they are voted upon by the MEC. If there are no concerns or conflicts expressed by the voting members of the Medical/Dental Staff within fourteen (14) calendar days following the communication, the proposed amendments will be presented to the Board for final approval. If there are conflicts or concerns expressed regarding the proposed amendments by the voting members of the Medical/Dental Staff during this period, the conflict resolution process outlined in Article IX. – Section C of these Bylaws will be carried out.
   - In cases of a documented need for an urgent amendment to the Rules and Regulations necessary to comply with law or regulation, the amendment process outlined in Section 3 below shall be applied.
   - When amendments to these Rules and Regulations are proposed by twenty-five percent (25%) of the voting members of the Medical/Dental Staff, they will be communicated to the MEC before they are presented to the Board for final approval. The MEC shall review the proposed amendments at their next regularly scheduled meeting and consider the proposal. If there are conflicts or concerns expressed by the MEC regarding the amendments proposed by the Medical/Dental Staff, the conflict resolution process outlined in Article IX. – Section C of these Bylaws will be carried out.

c. **Medical/Dental Staff Policies and Procedures:** As referenced in Article IX – Section A, the voting members of the organized Medical/Dental Staff have delegated to the MEC the authority to establish, amend and enforce the policies and procedures of the Medical/Dental Staff that may contain the associated details governed by the Bylaws.
   - Policies and procedures, with the exception of those dealing with Medical Peer Review, shall be effective on approval by the Medical/Dental Staff or the MEC in accordance with the procedures described above. Medical Peer Review policies shall require approval by the Board and not be effective until approved.

d. Any proposed amendments to these Bylaws, Rules and Regulations that are submitted to the voting members of the Medical/Dental Staff shall be distributed in writing, and voting members shall have fourteen (14) calendar days to respond. Greater than 50% affirmative vote received from at least 20% of the voting members of the Medical/Dental Staff is required before a proposal can be presented to the Board for final approval.

e. Acceptance of the amendment by the voting members of the Medical/Dental Staff shall constitute a recommendation of the amendment to the Board. The amendment shall become effective when approved by the Board and all proposed amendments to the

Bylaws, Rules and Regulations and associated policies and procedures shall be communicated to all members of the Medical/Dental Staff.

3. Urgent Amendments

a. In the event that the hospital becomes aware of the need to amend the Rules and Regulations in order to comply with law or regulation, as delegated by the voting members to do so, the MEC shall have the authority to provisionally adopt, and the Board may provisionally approve the urgent amendment without prior communication to the Medical/Dental Staff.

b. In such case, the MEC shall immediately notify the Medical/Dental Staff of such amendment.

c. The voting members of the Medical/Dental Staff shall have a minimum of fourteen (14) days to retrospectively review and comment on the provisional amendment.

d. If there is no conflict between the voting members of the Medical/Dental Staff and the MEC, the provisional amendment will remain in effect. If there is conflict regarding the provisional amendment, the process for resolving conflict as outlined in Article IX. – Section C will be applied.

Section C. Conflict Management

A conflict management process will be initiated to address any disagreement or conflict between the Medical/Dental Staff and the MEC relating to the Medical/Dental Staff governing documents or functions, including, but not limited to, a proposal to adopt or amend the Medical/Dental Staff Bylaws, Rules and Regulations, and/or policies, or a proposal to remove some authority delegated to the Medical Executive Committee by the Medical/Dental Staff under these Bylaws (by amending the Bylaws) using the mechanisms noted below:

1. A member of the Medical/Dental Staff that is eligible to vote may express concerns regarding a bylaw, rule or policy established by the MEC or the authority delegated to the MEC through the following process:

   a. The Medical/Dental Staff member will submit in writing the concerns including any recommended changes to the bylaws, rule, policy or delegated authority to the MEC to the President of the Medical/Dental Staff.

   b. The MEC shall review and discuss the concerns at the next regularly scheduled MEC meeting to determine if any changes will be made to the bylaw, rule, policy or delegated authority. The MEC has the option to appoint an ad hoc committee if needed to review the inquiry and recommend options to address the concerns to the MEC.

c. The MEC, or an appointed ad-hoc committee may request an interview with the Medical/Dental Staff member submitting the concerns to gain additional information, clarity and/or understanding. The MEC, or the appointed ad-hoc committee, may request the Medical/Dental Staff member to submit additional information for consideration in the review of the concerns.

d. The President of the Medical/Dental Staff will send written notice to the Medical/Dental Staff member of any proposed revisions to address the expressed concerns, and to define a timeframe for the Medical/Dental Staff member to review and to respond to the proposed revisions to the MEC. At its next regularly scheduled MEC meeting, the MEC will review the response received from the Medical/Dental Staff member regarding the proposed revisions.

e. If the MEC takes final action on proposed revisions in response to the concerns regarding a bylaw, rule or policy established by the MEC or the authority delegated to the MEC, the communication and adoption process as outlined above in Article IX. Section B, will be followed.

This process will not apply to Individual Medical Peer Review decisions regarding individual Practitioners, including but not limited to those pertaining to appointment, reappointment, Clinical Privileges, or Corrective Action.

2. If twenty-five percent (25%) of the voting members of the Medical/Dental Staff recommend directly to the Board an amendment to the Bylaws, Rules and Regulations, or associated policies and procedures or a change to the authority delegated to the MEC that is different from what has been recommended by the MEC, the following conflict resolution process shall be followed:

a. The MEC shall have the option of appointing an ad hoc committee to review the differing recommendations of the MEC and the voting members of the Medical/Dental Staff and recommend language or change to the authority delegated to the MEC that is agreeable to both the voting members of the Medical/Dental Staff and the MEC.

b. Whether or not the MEC adopts modified language, the voting members of the Medical/Dental Staff shall still have the opportunity to recommend alternative language directly to the Board.

c. If the Board receives differing recommended proposals from the MEC and the voting members of the Medical/Dental Staff, the Board will have the option of appointing a task force of the Board and/or using external resources to study the basis of the differing recommendations and to recommend appropriate Board action.

d. The Board has the final authority to resolve the differences between the Medical/Dental Staff and the MEC.

ARTICLE X. JOINT CONFERENCE

If the Board does not accept a recommendation submitted to it by the MEC, the MEC is entitled to a joint conference between the Officers of the Board and the Officers of the Medical/Dental Staff to mediate and resolve the issue. Upon a request submitted by JPE Chief Medical Officer and the President of the Medical/Dental Staff, the Governing Board President or the Hospital Administrator as his or her designee shall schedule this joint conference within two (2) weeks. If after a joint conference the issue cannot be resolved, the Board shall make the final determination.

ARTICLE XI. CONFIDENTIALITY AND MEDICAL PEER REVIEW, IMMUNITY AND CONFLICT OF INTEREST

1. Confidentiality and Medical Peer Review.

   a. Authorization. Each committee (whether Medical/Dental Staff, Division, standing, special, subcommittee, or joint) and each Division, as well as the Medical/Dental Staff when meeting as a whole, shall be established and operate as a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined by state and federal law, and is authorized by the Board through these bylaws to engage in medical peer review. Specific policies and procedures for the accomplishment of its charge may be developed and established by a committee or Division, subject to the approval of the MEC and the Board.

   b. Privilege and Confidentiality. All records and proceedings of the Medical/Dental Staff, the MEC, the Division, and any committees (whether standing, special, ad hoc, subcommittees, joint committees, or task forces, including a Hearing Committee or Appellate Review Panel under XII) thereof, and the Board, including but not limited to any minutes of meetings, disclosures, discussion, statements, actions, or recommendations in the course of medical peer review, shall be privileged and confidential. They shall be subject to disclosure only in accordance with written Hospital policies, unless otherwise required by Texas and/or federal law and shall be privileged to the fullest extent permitted by Texas and federal law.

   c. Obligation to Maintain Confidentiality. All Medical/Dental Staff Members and other providers holding Clinical Privileges, as well as those applying for such status, and all other individuals participating in, providing information to, or attending meetings of a medical peer review committee are required to maintain the records and proceedings related to any medical peer review activities as confidential, subject to disclosure only in accordance with Hospital policies, unless otherwise required by Texas and/or federal law.

   d. Waiver. Waiver of the privilege of confidentiality as to the records and proceedings of those listed in this Article shall require the written consent of the chair of the committee, Division, or Medical/Dental Staff President and the Governing Board President or authorized designee.

e. Minutes. Minutes of all meetings of those listed in this Article, except for the Board, shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be approved by the presiding chair of the meeting and forwarded to the MEC.

f. Maintenance and Access. All minutes subject to this Article will be maintained by the Hospital as records and proceedings of a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined under Texas and/or federal law, in a confidential manner to provide maximum protection under the law. They are the property of the Hospital and, except for Board minutes, are maintained by Medical Affairs.

i. They will be available for inspection by the MEC, the Governing Board President, the Board, and any employees and agents of the Hospital whose authorized functions necessitate access.

ii. A Division Director, and committee members, may also inspect the records and proceedings of their committee, which were generated during their division as members, as long as the member is currently a Member of the Medical/Dental Staff.

iii. Access is also permitted pursuant to Hospital policy and as required by Texas and/or federal law, accreditation requirements, or third-party contract of the Hospital.

iv. Access of a Practitioner to records and proceedings shall be only as required by law, written Policy, or as approved by the Governing Board President or authorized designee.

2. Immunity from Liability.

a. Immunity. The Medical/Dental Staff and its Members, the Board, the Hospital, and any committees, representatives, agents, employees, or members thereof, and third parties as defined below, will have immunity to the fullest extent permitted by Texas and/or federal law and shall include any immunity for any permissive and mandatory reporting provided for by Texas and/or federal law.

b. Third Parties. The reference above to third parties shall mean all individuals and entities, including without limitation their representatives, Medical/Dental Staff, directors, Officers, and employees, who provide information, whether orally or in writing, to the Hospital and/or the Medical/Dental Staff, concerning any matter that might directly or indirectly affect a Member, Practitioner or provider's exercise of Clinical Privileges or Medical/Dental Staff membership, or relating to the Member, Practitioner or provider's qualifications for appointment or reappointment to the Medical/Dental Staff or practice at the Hospital.

c. Authorization and Release of Liability. All applicants for appointment to the Medical/Dental Staff, reappointment, and/or Clinical Privileges shall execute a release of

liability consistent with the immunity and release of liability provisions in these Bylaws and an authorization for the Hospital, the Medical/Dental Staff, and third parties to disclose confidential information as necessary for Medical Peer Review in the course of application and at all times thereafter. The effectiveness of the immunity provisions of these Bylaws, however, is not contingent on execution of these authorizations and releases. The immunity provisions in these Bylaws and any releases of liability shall be in addition to and not in limitation of any immunity afforded by Texas and/or federal law.

3. Mandatory Reporting and Investigation.

Duty. The Governing Board President or authorized designee, in consultation with the Medical/Dental Staff President, shall be responsible to comply with any mandatory reporting requirements of the Hospital under Texas and/or federal law pertaining to Medical/Dental Staff membership and/or Clinical Privileges, and under Articles II and XIII of the Bylaws. Nothing in this section or the other provisions of the Bylaws shall prevent an individual Member or member of the Board from making any other report to Texas and/or federal agencies as permitted or required by law.

4. Conflict of Interest.

a. Disclosure. Whenever a Practitioner is participating in Medical Peer Review and/or performing a function for the Medical/Dental Staff, the MEC or a Division, or a committee thereof, or the Hospital, and the Practitioner's personal or professional interests could be reasonably interpreted as being in conflict with the interests of the Medical/Dental Staff, MEC, Division, or other committee, Hospital, or individual under review, the Practitioner shall disclose those interests and the potential for conflict to the appropriate decision makers prior to such participation. The Division Director or applicable committee chair may require the Practitioner to refrain from any participation in decisions that may be affected by or affect the Practitioner's interests.

b. Individual Peer Review. A Practitioner shall not be eligible to participate in, or be present during, any meeting, discussion, or deliberation of the MEC, a Division, or committee or task force of which he is a member regarding his Clinical Privileges or Medical/Dental Staff membership or any other Medical Peer Review activity involving the Practitioner, except to the extent specifically provided for in these Bylaws, Rules and Regulations, or Policy, or when invited by the Division Director or applicable committee chair.

c. Involvement of Family or Business Partners. Any family members or business partners of a Practitioner shall not be eligible to participate in, or be present during, any meeting, discussion, or deliberation of the MEC, a Division, or committee or task force regarding the Practitioner's Clinical Privileges or Medical/Dental Staff membership or any other medical peer review activity involving the Practitioner. "Family member" shall mean a Practitioner's: (i) parents or stepparents, including spouses of the same, (ii) ancestors, (iii) spouse, (iv) child or stepchild, grandchild, or great grandchildren, (v) siblings, whether related

by whole or half blood, or (vi) the spouse of an individual described in clause (iv) or clause (v), and shall include adoptive relationships of the above.

d. Hospital. These provisions shall be in addition to any requirements of the Hospital's conflict of interest policies.

ARTICLE XII. PROFESSIONAL PRACTICE EVALUATION AND CORRECTIVE ACTION

Section A. Professional Practice Evaluation

1. Professional practice evaluation, as a part of Peer Review, specifically to include but not be limited to medical peer review and professional review activity, is conducted on an ongoing basis in accordance with written Medical/Dental Staff policy, with primary responsibility for implementation of Children's Medical Center of Dallas quality and patient safety program and plan pertinent to the Medical/Dental Staff and others with clinical privileges placed on the MEC, Division Directors , and appropriate Medical/Dental Staff Committees. In addition to ongoing professional practice evaluation (OPPE), verification of competence for initially granted clinical privileges and reported concerns regarding the professional competence or conduct of a Practitioner are evaluated through focused professional practice evaluation (FPPE) in accordance written Medical/Dental Staff policy.

2. Focused professional practice evaluation and performance monitoring programs for an individual Practitioner with existing clinical privileges are intended to be implemented on a voluntary and collegial basis to the fullest extent possible. If necessary changes cannot be implemented on a voluntary and collegial basis, matters may be referred for corrective action as set forth below.

3. Information generated pursuant to the ongoing and focused professional practice evaluation processes is also used in the reappointment process.

Section B. Corrective Action

1. Grounds – Initiation: Whenever a Practitioner's action or failure to act: (i) is in violation of accepted standards of professional practice, (ii) is disruptive or unprofessional, (iii) is in violation of these Bylaws, the Rules and Regulations, or policies of the Medical/Dental Staff or the Hospital, or (iv) is in any manner disruptive to the Hospital or to the care of patients, any Member of the Medical/Dental Staff, the Governing Board President or authorized designee, or the chairman of the Board may request corrective action. All requests for corrective action shall be in writing, submitted to the MEC and shall specify the conduct constituting the basis for the request.

2. Investigation:

a. Within thirty (30) calendar days of receipt of a request for corrective action, the MEC shall determine whether to: (i) initiate a corrective action investigation, (ii) refer the request for handling in another manner, or (iii) dismiss the request. If the MEC decides to conduct a corrective action investigation, it shall be so noted in the MEC minutes. The MEC may conduct the investigation itself or through an ad hoc committee or subcommittee of the MEC, or delegate this responsibility to an appropriate standing committee, as it deems necessary ("Investigating Committee").

b. The investigation may include interviews with the requester, the affected Practitioner, or other persons. Such review may include, at the Investigating Committee's discretion, a review of pertinent medical records, policies and procedures, Peer Review records, clinical literature and practice guidelines, or any other documents. If it deems necessary, the Investigating Committee may, subject to the approval of the Hospital Administrator or authorized designee, utilize individuals not employed by or on the Medical/Dental Staff to assist in the investigation including, but not limited to, an external consultant. The Investigating Committee may also require the Practitioner under review to undergo a physical and/or mental examination, to the extent permitted by law, and may require access to the results of such exams to assist in its deliberation.

c. During an investigation, the Practitioner under review shall be granted the opportunity to meet with the Investigating Committee. The Investigating Committee shall determine the date(s), frequency, and duration of any such meeting(s).

d. If the request for corrective action is the result of a review of essentially the same acts or omissions by a standing committee, which review afforded the Practitioner an opportunity to meet with the committee and address the issues, the MEC may decide that the results of the review may be used as the investigation under this section and that no further investigation is required.

e. Neither the investigation nor any other activities of the Investigating Committee, including any meeting(s) with the affected Practitioner or any other person, in acting upon a request for corrective action, shall constitute a hearing and none of the procedural rights of review in this Article shall apply.

f. If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation in a prompt manner and shall forward a written report of its findings, conclusions, and recommendations to the MEC as soon as possible.

g. The Practitioner under review shall be notified, in writing by hand delivery or certified mail, return receipt requested by the MEC, that an investigation for purposes of possible corrective action has been initiated within five (5) business days of such action, and shall be given an opportunity to provide information in a manner and upon such terms as the Investigating Committee deems appropriate. The Practitioner shall not have the right to be represented by legal counsel before the Investigating Committee nor to compel the Medical/Dental Staff to engage external consultation.

h. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, and permitted under these Bylaws, including suspension, termination of the investigative process, or other action.

3. Time for Taking Action – Notice: Within thirty (30) calendar days of completion of the investigation, or within such reasonable additional time as the MEC deems necessary, the MEC shall take action upon the request for Corrective Action. Within five (5) business days after taking such action, the MEC shall give written notice to the affected Practitioner stating the actions the MEC has taken or recommended.

4. Possible Actions: The action of the MEC on a request for corrective action may be to reject the request, recommend a voluntary performance monitoring plan or other collegial intervention, or recommend any of the following corrective actions:

   a. A letter of warning or reprimand;

   b. Additional education or training;

   c. Probation;

   d. Proctoring, including observation, use of a physician first assistant, co-admitting requirements, or consultation;

   e. Reduction, suspension, or revocation of clinical privileges;

   f. Termination, modification or affirmation of an already imposed summary suspension or restriction of clinical privileges;

   g. Suspension or revocation of the Practitioner's Medical/Dental Staff membership; or

   h. Other corrective actions deemed appropriate by the MEC.

5. If the action of the MEC is an Adverse Action, all further procedures shall be as set forth in Article XIII, Procedural Rights of Review. In no event shall a Practitioner be entitled to the procedural rights of review in Article XIII unless the action taken by the MEC is an action defined as a ground for mediation or hearing under Article XIII. Any MEC recommendation or action that does not give the Practitioner procedural rights of review under Article XIII may be implemented by the MEC and shall be effective as of the date and time determined by the MEC. The MEC's recommendation or action will be forwarded to the Board for review at its next regularly scheduled meeting.

   a. If the Board affirms the action or recommendation of the MEC, it shall be the final decision and the Chair of the MEC shall provide the Practitioner with notice of the final decision, including a statement of the basis for the decision, within twenty (20) business days of the

decision. The notice shall be in writing and sent by hand delivery or certified mail, return receipt requested.

b. If the Board modifies or reverses the MEC's recommendation or action which results in an Adverse Action, the Practitioner shall be entitled to the procedural rights of review under Article XIII, and any further procedures shall be as set forth in Article XIII.

6. The affected Practitioner may submit a written response to any action taken by the MEC in addition to any procedural rights to which the Practitioner may be entitled under Article XIII, which response shall be maintained in the Practitioner's file.

7. Notice to the Governing Board President: The chairperson of the MEC shall immediately notify the Governing Board President in writing of each request for corrective action and shall keep him fully informed of all actions in connection with each request.

Section C. Summary Suspension or Restriction

1. Grounds – Authority. All or any portion of a Practitioner's clinical privileges may be summarily suspended or restricted if failure to take such an action may result in an imminent danger to the health and/or safety of any individual. Each of the following persons have the authority to summarily suspend or restrict a Practitioner's clinical privileges:

   a. Chief Medical Officer Dallas

   b. Medical/Dental Staff President

   c. Hospital Administrator

2. Summary action pursuant to this Section shall be reported immediately to the MEC and shall be temporary and effective only until further action is taken by the MEC. The individual imposing the summary action shall promptly give oral notice of action taken, including the reason for the action, to the affected Practitioner, and each of the other individuals listed under Article XII. The Chair of the MEC shall promptly give the Practitioner written notice of the summary action, with a statement of the reason for the action.

3. The MEC, before taking further action, shall conduct such investigation as it deems necessary or delegate this responsibility to an appropriate standing or ad hoc committee, which may include an interview with the suspending party. The affected Practitioner shall be afforded an opportunity to meet with the MEC or committee conducting the investigation. Such investigation may include chart reviews, if applicable, and interviews with other reports from other persons or relevant Divisions or committees. Neither the investigation nor any other activities of the MEC in taking its further action shall constitute a hearing, nor shall the procedural rights of review provided in Article XIII and process with respect to hearings, appeals and mediation apply.

4. The MEC must review the summary action and the results of any investigation within ten (10) business days of imposition of the summary action and recommend modification, continuance, or termination of the terms of the summary action. If, as a result of such investigation, the MEC does not recommend the termination of the summary action and the action is an Adverse Action under Article XII, the Practitioner shall be entitled to the procedural rights of review in accordance with Article XIII and all further procedures shall be as set forth in Article XIII. Additionally, the terms of the summary action as sustained or as modified by the MEC shall remain in effect pending a final decision thereon by the Board. For purposes of mandatory reporting under the federal Health Care Quality Improvement Act, a summary action, although taken in the course of Peer Review, is considered a "professional review action" when affirmed by the MEC.

5. Immediately upon the imposition of a summary action, the Chair of the MEC or the appropriate Division Director shall have authority to assist the Practitioner's patients in the hospital at the time of the summary action to secure alternative medical coverage.

Section D. Temporary Suspension or Restriction

1. The same individuals who are authorized to impose a summary action under Section C above may impose a temporary suspension or restriction of a Practitioner's clinical privileges for a period not to exceed fourteen (14) calendar days, during which an investigation is being conducted to determine the need for corrective action.

2. Temporary action pursuant to this Section shall be reported immediately to the MEC and shall be temporary and effective only until further action is taken by the MEC or expiration of the fourteen (14) calendar days, whichever occurs first. The individual imposing the temporary action shall promptly give oral notice of the action taken to the affected Practitioner, and each of the other individuals authorized to take the action. The Chair of the MEC shall give the Practitioner written notice of the temporary action, with a statement of the reason for the action, within twenty-four (24) hours of imposition by hand delivery or certified mail, return receipt requested.

3. Temporary action under this Section is taken in the course of Peer Review but is not considered corrective action and does not entitle the Practitioner to any procedural rights of review under Article XIII, the Bylaws or otherwise.

Section E. Voluntary Agreement

A Practitioner may voluntarily agree not to exercise any or all of his clinical privileges at Children's Medical Center of Dallas, or to a condition on those privileges, for a specified or unlimited period of time pending a review, an investigation, or the exercise of procedural rights of review under Article XIII. While taken in the course of Peer Review, a voluntary agreement shall not constitute a surrender of clinical privileges or corrective action. The agreement shall be in writing and shall allow the Practitioner to terminate the agreement on written prior notice to the Governing Board President under the terms set out in the agreement.

Section F. Automatic Action

1. No Hearing. Automatic Action imposed under this Section, while taken in the course of medical peer review and professional review activity, is not considered corrective action and does not entitle the Practitioner to the procedural rights of review under Article XIII.

2. Grounds. Appointment to the Medical/Dental Staff and/or all clinical privileges shall be automatically suspended, terminated or relinquished, as outlined specifically within each section below, upon the occurrence of any of the following events:
   a. Licensure. Upon receipt by Children's Medical Center of Dallas of notice that a Practitioner's license to practice in Texas is revoked, not renewed, restricted, suspended, or voluntarily relinquished to the licensing agency, the Practitioner's Staff membership and clinical privileges at Children's Medical Center of Dallas shall automatically terminate. If a Practitioner's license to practice in Texas is made subject to probationary terms by the licensing agency, the Practitioner's Staff membership and clinical privileges shall automatically become subject to the terms of probation.

   b. Drugs/Medication. An automatic suspension of a Practitioner's privileges to prescribe, administer, or obtain controlled substances and/or other medications at or through Children's Medical Center of Dallas shall be immediately imposed upon receipt by Children's Medical Center of Dallas of notice that such Practitioner's right or license to prescribe or obtain controlled substances or medications has been suspended, revoked, or otherwise restricted by the applicable governmental agency. Such automatic suspension shall include only those controlled substances or medications suspended or revoked by the governmental agency and shall be effective until the governmental agency reinstates the Practitioner's right or license in question. If a Practitioner's right or license to prescribe or obtain controlled substances or medications is subject to an order of probation, the Practitioner's privileges to prescribe or obtain controlled substances or other medications at or through Children's Medical Center of Dallas shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation. A Practitioner shall not be permitted to prescribe medications under Children's Medical Center of Dallas DEA number.

   c. Loss of Professional Liability Insurance. If a Practitioner fails to maintain professional liability insurance coverage in an amount not less than $200,000 per occurrence and $600,000 in aggregate as required by the Board or fails to provide evidence of such coverage, the Practitioner's Staff membership and clinical privileges, shall be automatically suspended and shall remain so until the Practitioner provides evidence to the Medical Staff Office that he/she has secured the required professional liability coverage, to include coverage for any period of lapse in coverage. Failure to provide such evidence within ninety (90) calendar days after the date the automatic suspension became effective shall be deemed a voluntary relinquishment of Medical/Dental Staff membership and clinical privileges.

d. Immunizations. A Practitioner who fails to submit the required immunization documentation within the timeframe set forth in the Medical/Dental Staff credentialing policies shall have his/her clinical privileges automatically suspended. With the exception of seasonal influenza vaccinations, failure to submit the required immunization documentation within ninety (90) calendar days after the date the automatic suspension became effective shall be deemed a voluntary relinquishment of Medical/Dental Staff membership and clinical privileges.

e. Medical Records. A Practitioner who is delinquent in completing medical records shall have his/her clinical privileges automatically suspended, until the deficiency is cured. Such suspension shall be in accordance with the Rules and Regulations of the Medical/Dental Staff. Failure to complete delinquent records within ninety (90) calendar days after the date the automatic suspension became effective shall be deemed a voluntary relinquishment of Medical/Dental Staff membership and clinical privileges.

f. Required Education Documentation. When an educational training requirement is implemented as a requirement for all Medical/Dental Staff members or all members in a certain specialty or subspecialty, Practitioners who fail to comply after the expiration of the time specified in the written notice shall have their clinical privileges automatically suspended on expiration of the time-period. Failure to provide documentation of compliance with the requirement within ninety (90) calendar days after the date the automatic suspension became effective shall be deemed a voluntary relinquishment of Medical/Dental Staff membership and clinical privileges.

g. Omission, Misstatement or Misrepresentation on Application. Failure to provide accurate and complete information on an application or documentation supporting an application for Medical/Dental Staff membership and/or clinical privileges, resulting in a material omission, misstatement or misrepresentation the Practitioner, including but not limited to credentialing documentation, or other hospital related communications, will result in the Practitioner's Medical/Dental Staff membership and clinical privileges being automatically terminated or, if the application is pending, automatic withdrawal from further processing.

3. The imposition of automatic action does not preclude the imposition of corrective action on the same or similar grounds.

ARTICLE XIII. PROCEDURAL RIGHTS OF REVIEW

Section A. General

A Practitioner is entitled to the procedural rights of review as set out in this Article whenever the MEC takes Corrective Action or the Board takes Corrective Action following a recommendation by the MEC that was not Corrective Action.

Section B. Adverse Action Defined and Notice to Practitioner

1. Adverse Action. Only the following actions or recommendations, when taken by the MEC, or by the Board following a recommendation by the MEC that was not an Adverse Action, constitute an Adverse Action and entitle a Practitioner to the procedural rights of review in this Article:

    a. Denial of Medical/Dental Staff appointment or reappointment;

    b. Revocation or termination of Medical/Dental Staff appointment;

    c. Denial of requested Clinical Privileges;

    d. Revocation or termination of Clinical Privileges;

    e. Requirement and assignment of a proctor or supervisor based on an assessment of the Practitioner's professional competence or conduct in which the proctor's or supervisor's approval is required for the Practitioner to exercise clinical privileges;

    f. Suspension of Medical/Dental Staff appointment or clinical privileges, other than a temporary action pursuant to Article XII;

    g. Requirement to have a concurring consultation prior to exercising clinical privileges; or

    h. Requirement to obtain education, training, or counseling prior to exercising clinical privileges.

    i. Any other restriction or limitation of Clinical Privileges based on competence or professional conduct if such action, when final, would be reportable to the National Practitioner Data Bank.

2. Not Grounds for Procedural Rights of Review. The following are not considered an Adverse Action, nor any other actions or recommendations so specified in these Bylaws, and do not entitle the Practitioner to the procedural rights of review set forth in these Bylaws:

    a. Issuance of a letter of guidance, warning, or reprimand, placement under a FPPE, or probation;

    b. Resignation of Staff membership or clinical privileges;

    c. Determination that an application will not be processed due to a misrepresentation, misstatement or omission; or

    d. A determination by the Board that certain professional services shall be provided on an exclusive basis in accordance with written agreements between Children's Medical Center

of Dallas and qualified practitioners, limiting the availability of clinical privileges in those areas.

e. A voluntary performance monitoring plan or placement on probation that is not accompanied by any limitation or restriction on the Practitioner's Clinical Privileges;

f. Imposition of proctoring, monitoring or any other performance monitoring requirements in the course of FPPE on an initial grant of Clinical Privileges;

g. Any limitation or restriction of Clinical Privileges imposed equally on all Practitioners with the same or similar Clinical Privileges;

h. Imposition of conditions, monitoring or a consultation requirement that the Practitioner must comply with, but that does not require any approval or concurrence prior to the Practitioner's exercise of Clinical Privileges;

i. Imposition of a requirement to verify required health status through requested assessment or testing, or for treatment or counseling that may be satisfied while the Practitioner continues to exercise Clinical Privileges;

j. Retrospective chart review, conducting a review or Investigation into any matter, or a requirement to appear for a special meeting under the provisions of these Bylaws;

k. Any automatic action under Article XII, automatic relinquishment of Clinical Privileges, or automatic resignation from the Medical/Dental Staff provided for in these Bylaws;

l. Imposition of a temporary action under Article XII;

m. Imposition of a summary Corrective Action except as provided in Article XII;

n. Denial of a request for leave of absence or for an extension of a leave of absence;

o. A voluntary surrender or relinquishment of Clinical Privileges by the Practitioner, including voluntary acceptance of a limitation on Clinical Privileges, while under an Investigation or to avoid such an Investigation or a professional review action;

p. Failure to process an application for Medical/Dental Staff appointment and/or Clinical Privileges due to a determination (i) that the application is not a Complete Application, or (ii) that the Practitioner is not eligible due to a failure to meet minimum or threshold criteria or requirements, a lack of need or resources, closure of a specialty, or because of an exclusive professional services arrangement;

q. Denial of a requested change in Staff category or reassignment of Staff category at the time of reappointment due to failure to meet threshold eligibility requirements as provided in Article II;

r. Failure to grant, termination or limitation of temporary Clinical Privileges;

s. Removal or limitation of emergency services call coverage obligations; and

t. Denial of appointment or reappointment to the Affiliate or Honorary Staff.

3. Notice of Recommendation. When an Adverse Action is taken or recommended by the MEC, or by the Board following a recommendation or action by the MEC which was not an Adverse Action, the Practitioner shall be entitled to request a hearing and the other procedural rights of review in this Article prior to a final decision of the Board. The affected Practitioner shall be given Special Notice by the Governing Board President within five (5) business days of issuance of the Adverse Action. This notice shall contain:

   a. A statement of the nature of and reasons for the Adverse Action, including a statement of the alleged acts or omissions and subject matter forming the basis of the action with a list, if applicable, of specific patient records;

   b. A notice that the Practitioner has the right to request a hearing on the Adverse Action within thirty (30) calendar days of receipt of such notice;

   c. Notice that failure to request a hearing within the time frame and in the manner required shall result in a waiver of the right to a hearing and any other procedural rights of review under these Bylaws or otherwise; and

   d. A copy of this Article and a summary of the Practitioner's rights during the hearing.

Section C. Request for Hearing and Waiver

1. The request for a hearing shall be made in writing, by hand delivery or certified mail, return receipt requested, to the Governing Board President within thirty (30) calendar days of the Practitioner's receipt of notice of the Adverse Action.

2. In the event the Practitioner does not request a hearing within the timeframe and in the manner required by this Article, the Practitioner shall be deemed to have waived the right to such hearing and any other procedural rights of review under these Bylaws and otherwise, and to have accepted the Adverse Action. Such Adverse Action, if taken by the MEC, shall become effective immediately pending a final decision by the Board. The Governing Board President shall provide the Practitioner with Special Notice of the Board's final decision within twenty (20) calendar days of the final decision.

3. Notice of Hearing and Statement of Reasons. If a hearing is properly requested, the Governing Board President shall schedule the hearing and shall give Special Notice to the Practitioner who requested the hearing. The notice shall include:

   a. The time, place, and date of the hearing;

b. A proposed list of witnesses who will give testimony or evidence in support of the Adverse Action at the hearing, to include the witnesses' titles/positions and a brief summary of the nature of the expected testimony);

c. The names of the Hearing Panel members and chair;

d. A list of patient records and/or information supporting the Adverse Action (this list of supporting patient record numbers and other supporting information may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the Adverse Action, and the Practitioner has sufficient time to study this additional information and rebut it); and

e. Notice to the Practitioner of the obligation to provide a list of witnesses and exchange hearing documents as provided below.

f. The hearing shall begin as soon as practicable, but no sooner than thirty (30) calendar days after the notice of hearing to the Practitioner unless an earlier hearing date has been specifically agreed to in writing by the parties. Once commenced, the hearing must be completed within sixty (60) calendar days, unless rescheduled upon written agreement of the parties or upon a showing of good cause, as determined by the Presiding Officer/Hearing Panel chair of the hearing.

4. Witness List. At least fifteen (15) calendar days before the hearing, the Practitioner requesting the hearing shall provide a written list of the witnesses that the Practitioner intends to present, as well as the titles/positions of the witnesses and a brief summary of the nature of the anticipated testimony.

5. Supplementation of Witness List. The witness list of either party may, in the discretion of the Presiding Officer/Hearing Panel chair, be supplemented or amended at any time prior to or during the course of the hearing, provided that written notice of the change is given to the other party and the other party is afforded time to prepare for the additional witness. The Presiding Officer/Hearing Panel chair shall have the authority to limit the number of witnesses.

6. The MEC or Board, whichever issued the Adverse Action, shall appoint one or more individuals to represent it at the hearing. The Governing Board President may appoint legal counsel to accompany that individual or individuals in the hearing, which may be legal counsel for the Hospital.

Section D. Hearing Panel and Presiding Officer

1. Hearing Panel

a. When a hearing is requested, the Governing Board President, after considering the recommendations of the Medical/Dental Staff President (and that of the chair of the Board, if the hearing is occasioned by a Board determination), shall appoint a Hearing Panel that

shall be composed of not less than three (3) members, one of whom shall be designated as the chair. No individual appointed to the Hearing Panel shall have actively participated in the consideration of the matter involved at any previous level. Individuals who are not on the Medical/Dental Staff may be members of the Hearing Panel. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. The Governing Board President shall provide the affected Practitioner with written notice of the identity and specialty of the Hearing Panel members at least thirty (30) calendar days prior to the date of the hearing.

b. The Hearing Panel shall not include any individual who is in direct economic competition with the affected Practitioner or any individual who is professionally associated with or related to the affected Practitioner.

c. Any objection to any member of the Hearing Panel shall be made in writing within ten (10) calendar days of issuance of notice of same. Such written objection shall be delivered to the Governing Board President who shall resolve the objection in his/her sole discretion, unless delegated to the Presiding Officer appointed under Section 2 below.

2. Presiding Officer

a. The Governing Board President may appoint an attorney as Presiding Officer. Such Presiding Officer will not act as a prosecuting Officer or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and is a legal advisor to it, but shall not be entitled to vote on its recommendations. The Governing Board President shall provide the Practitioner with Special Notice of the identity of the Presiding Officer at least twenty (20) calendar days prior to the date of the hearing. Any objection to the Presiding Officer shall be made in writing within ten (10) calendar days of issuance of notice of same. Such written objection shall be delivered to the Governing Board President who shall resolve the objection in his/her sole discretion.

b. If no Presiding Officer has been appointed, the chair of the Hearing Panel shall serve as the Presiding Officer but shall be allowed to vote.

c. The Presiding Officer shall:

i. Require that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

ii. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive or that causes undue delay;

iii. Maintain decorum throughout the hearing;

iv. Determine the order of procedure throughout the hearing;

v. Have the authority and discretion, in accordance with this policy, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence prior to the hearing and during the hearing, unless otherwise provided in this Article;

vi. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the Practitioner requesting the hearing is considered by the Hearing Panel in formulating its recommendations; and

vii. Conduct prehearing conferences and argument by counsel on procedural points outside the presence of the Hearing Panel to the extent practical unless the Panel wishes to be present.

Section E. Pre-Hearing and Hearing Procedure

1. Provision of Relevant Information: There is no right to formal "discovery" in connection with the hearing except as specifically provided herein. The Practitioner requesting the hearing shall be entitled, upon specific, written request, to the following at least thirty (30) calendar days prior to the hearing, subject to a stipulation signed by the Practitioner and counsel if applicable that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

   a. Copies of, or reasonable access to, all patient medical records or other documents referred to in the notice of statement of reasons under Sections A and B above, at his or her expense; and

   b. Reports of experts relied upon by the MEC or Board in issuing the Adverse Action.

   c. No information regarding other Practitioners shall be requested, provided or considered, nor is the Practitioner entitled to access minutes of Medical/Dental Staff committees, Services or other medical peer review committees unless those minutes will be presented in the hearing.

2. Evidence unrelated to the reasons for the recommendations or to the Practitioner's qualifications for appointment or the relevant clinical privileges shall be excluded.

3. If either party will be represented by an attorney or other individual in the hearing, the party must notify the other party in writing of the name of such attorney or other individual at least ten (10) calendar days prior to the date of the hearing.

4. At least fourteen (14) calendar days prior to the hearing, each party shall provide the other party with a list of and copies of all proposed exhibits unless previously provided. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing at least seven (7) calendar days prior to the hearing and shall be ruled on by the Presiding Officer. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause for not raising the objection within the required time frame.

5. If any expert is to be presented as a witness by either party, when the expert is identified as a witness as provided above in Section D above, the other party must be provided with the following:

   a. a copy of the expert's curriculum vitae;

   b. a written report from the expert setting forth the substance of the expert's testimony, opinions, and grounds for the opinions;

   c. a copy of any literature or references relied upon by the expert in reaching the opinions; and

   d. a copy of all documents or other information provided by the party to the expert for review or a list of those documents and information if previously provided to the other party.

   No expert witness may be called by a party, nor testimony, opinions, or documents submitted for consideration in the hearing, unless disclosed in accordance with this section or the Presiding Officer determines that the failure to disclose was unavoidable.

6. There shall be no contact by the Practitioner with Hospital employees concerning the subject matter of the hearing, unless arranged with Hospital counsel.

7. Failure to Appear. Failure, without good cause, of the Practitioner to appear and proceed at such a hearing shall be deemed a waiver by the Practitioner of his/her right to a hearing and to any other procedural right of review under these Bylaws or otherwise, and voluntary acceptance of the Adverse Action, which shall then be forwarded to the Board for final decision as provided in Section C above.

8. Record of Hearing. The Governing Board President shall arrange for a court reporter to create a record of the hearing. The cost of such reporter shall be borne by Children's Medical Center of Dallas, but copies of the transcript shall be provided by the court reporter to the Practitioner requesting the hearing at the Practitioner's expense. The Presiding Officer may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of Texas.

Section F. Rights of Both Parties

1. At a hearing, both parties shall have the following rights, subject to reasonable limits determined by the Presiding Officer and any limitations in this Article:

   a. To call, examine and cross-examine witnesses;

   b. To present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law;

   c. To have a record made of the proceedings, copies of which may be obtained on payment of any reasonable preparation costs;

   d. To representation by an attorney or other person, who may call, examine, and cross-examine witnesses and present the case;

   e. To submit a written statement at the close of the hearing; and

   f. To receive the written recommendation of the Hearing Panel, including a statement of the basis for the recommendation, as well as to receive the written final decision of the Board, including a statement of the basis for the decision.

2. Testimony of Practitioner. The Practitioner requesting the hearing who does not testify on his or her own behalf may be called and cross-examined by the MEC or Board. The Hearing Panel and the Presiding Officer may question any parties and witnesses, request that additional witnesses be called, or request the presentation of additional documentary evidence.

3. Admissibility of Evidence. The hearing shall not be conducted according to rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

4. Official Notice. The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice. The Hearing Panel may also require submission of written statements on any relevant matter, including objections.

5. Postponements and Extensions. Postponements and extensions of time beyond any time limit set forth in this Article may be requested by either party but shall be permitted only by the Presiding Officer or the Governing Board President on a showing of good cause.

6. Persons to be Present. Attendance at the hearing shall be restricted to the Hearing Panel, Presiding Officer, court reporter, parties, attorneys, and witnesses when testifying. Administrative personnel may be present as requested by the Governing Board President or the Medical/Dental Staff President. All attendees must agree to maintain the confidentiality of the proceedings consistent with the requirements applicable to records and proceedings of medical peer review committees.

7. Order of Presentation. The MEC or Board, whichever issued the Adverse Action prompting the hearing, shall first present evidence in support of the Adverse Action. Thereafter, the Practitioner who requested the hearing may present evidence. Opening statements and closing arguments are permitted.

8. Burden of Proof. Consistent with the requirement for the Practitioner to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, re-appointment, and clinical privileges, the Practitioner who requested the hearing has the burden of proving by clear and convincing evidence that: (i) he/she meets the standards for appointment/re-appointment or for the granting of clinical privileges requested or the Medical/Dental Staff category requested, and (ii) the Adverse Action that prompted the hearing was arbitrary or capricious or there is not substantial evidence to support the Adverse Action.

9. Adjournment and Conclusion. The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the Hearing Panel. Upon conclusion of the presentation of evidence by the parties, including submission of any written statements, and questions by the Hearing Panel, the hearing shall be closed.

10. Deliberations and Recommendation of the Hearing Panel. Within twenty (20) calendar days after closing the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person (except the Presiding Officer) and shall render a recommendation set out in a written report, which shall contain a concise statement of the reasons for the recommendation. On completion of its report, the hearing is considered adjourned. The Hearing Panel may deliberate prior to issuance of the court reporter's transcript of the hearing.

11. Disposition of the Hearing Panel Report. The Presiding Officer shall deliver its report to the Governing Board President who shall forward it to the MEC or Board, whichever issued the Adverse Action, and by Special Notice to the Practitioner. The MEC or Board, as applicable, shall review the Hearing Panel's report within twenty (20) days and determine whether to affirm, modify or reverse the original Adverse Action. The MEC or Board shall issue a written report of its decision with a statement of the basis for its decision.

    a. If the reconsidered decision is still an Adverse Action, the Practitioner shall be notified of his or her right to an appeal by the Governing Board President. The notice of right to

appeal shall be sent by Special Notice within ten (10) calendar days, and all further procedures shall be as set forth in Section G. below.

b. If the reconsidered decision is not an Adverse Action, it shall be forwarded to the Board for a final decision; provided that, if the Board's decision is an Adverse Action, the Practitioner shall be notified of his or her right to an appeal by the Governing Board President before the decision is final. The notice of the right to appeal shall be sent by Special Notice within ten (10) calendar days, and all further procedures shall be as set forth in Section G below.

Section G. Appeal to the Board

1. Time for Appeal. Within twenty (20) calendar days after the Practitioner's receipt of the notice of the right to appeal under Section F above, the Practitioner may request appellate review of the recommendation. The request for appellate review, including a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review, shall be in writing, and shall be delivered to the Governing Board President either by hand delivery or by certified mail, return receipt requested. If such appellate review is not requested within the required time frame and in the manner required, the Practitioner shall be deemed to have accepted the Adverse Action, which shall be forwarded to the Board for final action.

2. Grounds for Appeal. The grounds for appeal shall be limited to whether:

   a. There was substantial failure to comply with the procedures set forth in these Bylaws;

   b. The recommendation of the Hearing Panel was made arbitrarily or capriciously; or

   c. The recommendation of the Hearing Panel was not supported by credible evidence, based upon the hearing record.

3. Time, Place and Notice. When an appeal is requested as set forth in the preceding sections, the Chair of the Board shall schedule and arrange for an appellate review as soon as arrangements can reasonably be made. The Chair of the Board may take into account the schedules of all individuals involved but in no event shall the appellate review be scheduled later than forty-five (45) calendar days from the receipt of the Practitioner's request unless the Chair of the Board extends the time for good cause. The Practitioner shall be given at least thirty (30) calendar days prior notice of the time, place and date of the appellate review.

4. Nature of Appellate Review

   a. The Chair of the Board shall appoint a Review Panel composed of not less than three (3) members of the Board to conduct the appellate review.

   b. In its sole discretion, the Review Panel may accept additional oral or written evidence subject to the same right of cross-examination or confrontation provided at the Hearing

Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it was not available at the time of the hearing.

c. The Practitioner shall be required to present a written statement in support of his or her position on appeal at least fifteen (15) calendar days prior to the appeal which statement must set out the specific grounds and support for the appeal with reference to the three (3) grounds in Section F above. The Review Panel shall provide a copy of the statement to the MEC or Board, which may submit a written response at least five (5) calendar days prior to the appeal. A copy of the response, if any, shall be provided to the Practitioner as well as the Review Panel.

d. In its sole discretion, the Review Panel may allow each party or its attorney or other representative to appear personally and make a time-limited thirty (30) minute argument. If oral arguments are permitted, the parties shall answer any questions presented by the Review Panel. The Review Panel shall issue written findings on the grounds for appeal in Section F above to the Board within twenty (20) calendar days of completion of the appeal.

5. Final Decision of the Board. Within thirty (30) calendar days after receipt of the Review Panel's written findings or upon expiration of the timeframe allowed for the affected Practitioner to appeal and the Practitioner's failure to exercise the right to appeal, the Board shall render a final decision in writing, including the results of the appeal, if any, and the specific reasons for its final decision. The final decision shall be delivered to the chairpersons of the Credentials Committee and the MEC, and by Special Notice to the affected Practitioner within twenty (20) calendar days of the decision. The Board may affirm, modify, or reverse the Adverse Action, or in its discretion, refer the matter for further review and recommendation based upon the Board's ultimate legal responsibility for granting appointment and clinical privileges.

6. Further Review. Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal (or waiver of the right to appeal) shall be effective immediately and shall not be subject to further review. However, if the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. Such further review process and the report back to the Board shall in no event exceed thirty (30) calendar days in duration, except as the Board may otherwise stipulate.

7. Right to One Hearing and Appeal Only. No Practitioner shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of procedural rights of review under this Article.

8. Re-application to the Medical/Dental Staff. In the event that the Board issues a final Adverse Action to deny Medical/Dental Staff appointment or re-appointment or clinical privileges, or to revoke or terminate Medical/Dental Staff appointment or clinical privileges, the affected Practitioner is not eligible to reapply within five (5) years for Medical/Dental Staff appointment or those clinical privileges, unless the Board provides otherwise.

Section H. Initiation and Notice of Mediation

1. Right to Mediation. A Practitioner may require Children's Medical Center of Dallas to participate in mediation under Chapter 154 of the Texas Civil Practice and Remedies Code, if:

   a. The Credentialing Committee has failed to take action on a completed application or re-application for Medical/Dental Staff membership or clinical privileges within the time frame required by law; or

   b. The Practitioner is subject to an Adverse Action as defined in Section B; provided that, the request for mediation must be made prior to, at the same time as or in lieu of the request for hearing.

2. Request for Mediation. When a Practitioner is entitled to request mediation as provided above, the Practitioner shall have fifteen (15) calendar days following the date the application became complete or the date of the issuance of notice of an Adverse Action within which to request mediation. The request shall be made in writing to the Governing Board President by hand delivery or certified mail, return receipt requested. If the Practitioner does not request mediation within the time frame or in the manner required by this section, the Practitioner shall be deemed to have waived his/her right to require mediation. Waiver of the right to mediation does not constitute a waiver of the Practitioner's right to the procedural rights of review under this Article in the case of an Adverse Action.

3. Scheduling Mediation. Within fifteen (15) calendar days of filing a timely written request for mediation, the Practitioner must propose in writing to the Governing Board President the names of three (3) acceptable mediators, who meet the qualifications set forth in Section 154.052 of the Texas Civil Practice and Remedies Code and who have experience in hospital-medical/dental staff privileges disputes. Within five (5) calendar days thereafter, the Governing Board President shall select one of the mediators proposed by the Practitioner or object in writing. If the Governing Board President objects in writing to all three (3) mediators proposed by the Practitioner within five (5) calendar days, the Governing Board President and the Practitioner each will propose a mediator who meets the above requirements. The two (2) mediators shall then select a third mediator who meets the above requirements and who will conduct the mediation. The mediation shall take place within thirty (30) calendar days of the selection of a mediator, unless the Governing Board President and the Practitioner agree in writing to waive that deadline.

4. The standards and duties of the mediator are those set forth in Section 154.053 of the Texas Civil Practice and Remedies Code.

5. The cost of mediation shall be borne equally by Children's Medical Center of Dallas and the Practitioner.

6. The Practitioner is entitled to only one (1) mediation on any single matter which may be the subject of mediation and the mediation shall be limited to one full day of mediation.

A request for mediation suspends the time periods for a requested hearing. If mediation does not resolve the Adverse Action to the satisfaction of all parties, the timelines for the requested hearing shall resume.

ADOPTED BY THE BOARD OF DIRECTORS OF THE OPERATING DIVISION ON AFTER RECEIPT OF A RECOMMENDATION FROM THE MEC.

children's health
Children's Medical Center
Dallas

RULES

AND

REGULATIONS

OF THE

MEDICAL / DENTAL STAFF

children's health
Children's Medical Center
Dallas

TABLE OF CONTENTS

SECTION 1. Admission, Transfer and Discharge of Patients

1.1. A patient may be admitted to Children's Medical Center of Dallas ("Children's Dallas" as defined in the Medical/Dental Staff Bylaws) only by a member of the Medical/Dental Staff having admitting privileges. A member of the Medical/Dental Staff may, in the course of caring for a patient, request that the patient be admitted to a different medical or surgical service. In that case, the referring Medical/Dental Staff member is responsible for conducting an appropriate hand-off of care.

1.2. Except in an emergency situation, no patient shall be admitted to Children's Dallas without a provisional diagnosis or valid reason for admission being stated. In the case of an emergency, this information shall be recorded in the medical record as soon as possible after admission.

1.3. In situations where there is a transfer of attending responsibilities between two providers, the accepting provider is responsible for confirming the attending designation within the electronic medical record has been changed.

1.4. If an unforeseen inpatient emergency arises and the patient's physician/dentist cannot be contacted, the appropriate Division Director shall be contacted, and the appropriate chain of command shall be followed.

1.5. Children's Dallas is a setting for the education of Residents, Fellows and medical students. While patients at Children's Dallas may be evaluated and treated by Residents, Fellows or medical students, the attending physician/dentist is responsible for the supervision of medical/dental care provided to the patient. Residents, Fellows and medical students must comply with the policies established by Children's Dallas and University of Texas Southwestern Medical Center ("UT Southwestern").

1.6. Except as otherwise provided in Children's Dallas policies, no patient shall be transferred within Children's Dallas without the approval of the attending physician/dentist, with the exception of a critically ill or infectious patient who requires immediate relocation to protect him/her self or others. In case of an emergency, the attending physician shall be notified as soon as he or she can be reached.

1.7. When a patient is being transferred to another hospital or other health care facility, the attending physician shall follow Children's Dallas transfer

policy and procedures and all applicable state and federal laws governing patient transfers.

1.8. If the patient is considered to be a source of danger to him/her self or others, the admitting physician shall be responsible for providing such information as may be necessary to protect the patient from self-harm and harm to other patients, staff or visitors as defined by hospital policy.

1.9. Any patient who is evaluated in the Emergency Department (ED) or is being admitted to or is already an inpatient at Children's Dallas, and who is known or suspected to be suicidal, has taken a chemical/drug overdose, or is otherwise suspected to exhibit intentional self-harm behavior, shall have a mental health assessment. The assessment may be performed by a mental health clinician (LCSW, LPC, LMFT, PhD, MD or DO) who will provide the findings of that assessment to the ED attending or the patient's treating physician. The attending will determine if additional psychiatric consultation is needed. If this assessment is refused by the patient, parent or other authorized party, the medical record shall indicate that the assessment was recommended, offered, and refused. A referral shall be made by the physician to Child Protective Services, if appropriate and necessary suicide prevention precautions shall be taken according to Children's Dallas policy and procedure.

1.10. The patient shall be discharged only on the written order of the attending physician, Resident, Fellow or an authorized Advanced Practice Professional ("APP") defined as an advanced practice registered nurse ("APRN"), physician assistant ("PA"), certified registered nurse anesthetist ("CRNA") or certified anesthesiologist assistant ("CAA") authorized by the attending physician. If a patient leaves Children's Dallas against medical advice ("AMA"), the patient, parent or other authorized party shall be requested to sign an AMA release. If a release cannot be obtained, document the refusal and leaving AMA in the patient's medical record along with any reason given, and witnessed by an employee. A patient leaving Children's Dallas AMA without signing the appropriate document(s) shall be considered to be officially discharged AMA.

1.11. The attending physician, Resident, Fellow, or APP authorized by the attending physician shall discharge the patient as soon as medically appropriate. Pre-Discharge orders shall include, but not limited to, medications, patient teaching requirements, and follow-up appointments.

1.12. Physicians/dentists shall abide by admitting/discharge requirements that have been delineated in other sections of these Rules and Regulations or applicable Policies and Procedures.

1.13. Admitting physicians/dentists shall:

1.13.1. Refer elective cases to the Admitting Office for advance arrangements;

1.13.2. Complete reports required to secure payment of insurance or compensation claims by Children's Dallas;

1.13.3. Record information required for Children's Dallas billing; and

1.13.4. Adhere to Children's Dallas admitting policies and procedures.

SECTION 2. Medical Records

2.1. General Medical Record Practices

2.1.1. The attending physician/dentist is responsible for the preparation of an accurate, timely, complete and legible medical record for each patient. The medical record shall be sufficiently detailed and organized to enable another physician/dentist to assume the care of the patient at any time and to enable the retrieval of pertinent information required for quality assurance/improvement and utilization review activities. The medical record shall contain sufficient information to: identify the patient; support the diagnosis/condition; justify the care, treatment, and service; document the course and results of care, treatment, and service; and promote continuity of care among providers.

2.1.1.1. The contents for inpatient admission records shall include but not be limited to: identification data; a history and physical; a plan of care; patient orders; all required consent forms; special reports such as laboratory (clinical laboratory/pathology), radiology, and electrocardiography; treatment; progress notes; operative or procedure reports; consultations; condition on discharge; discharge summary; final diagnosis; and, if performed, an autopsy report. As appropriate, an anesthesia record and any patient, parent, or other authorized party's instructions/education shall be documented in the medical record.

2.1.1.2. The contents for an outpatient record shall include, but not be limited to identification data; appropriate consent forms; appropriate reports; provisional diagnoses; documentation of the medical or surgical treatment; any patient/family instructions/education; a continuity of care list by the third visit (if

applicable to the area); condition on discharge or transfer; and a note summarizing the case.

2.1.2. The use of scribes for the purposes of medical transcription into the medical record shall be limited to those scribes who are approved and authorized through an appropriate contractual relationship.

2.1.2.1. The attending medical/dental staff member is ultimately responsible for all medical record documentation entered by the scribe. Scribes act under the direct supervision of an attending medical/dental staff member; they may not act independently. A scribe may document the previously determined medical/dental staff member's dictation and/or activities.

2.1.2.2. A scribe is not permitted to accept, transcribe into the medical record or implement orders, including verbal orders.

2.1.2.3. All entries into the record by a scribe shall include the following:

- Name and title of scribe, date, time and signature of scribe
- Name of attending physician or APP on whose behalf the scribe is entering documentation

2.1.2.4. The attending medical/dental staff member must authenticate all documentation entered into the record by a scribe by making a separate entry to confirm his or her agreement with the contents of the entry (date, time and attending signature required).

- Authentication must take place before the physician and scribe leave the patient care area and prior to the patient being admitted, transferred to the operating room or other treatment area within the hospital or transferred to an outside health care facility for further evaluation. Authentication for patients being discharged must be completed according to the process defined in Section 2.6.1.
- Authentication by the attending cannot be delegated

2.1.3. Written authorization from the patient, parent or other authorized party is required for release of medical information to persons not otherwise authorized to receive this information.

2.1.4. The medical record, including but not limited to imaging files, pathology slides and test results, is the property of Children's Dallas and shall not be removed from Children's Dallas premises without a release from the Health

Information Management Department, except as outlined in Section 6.24. Unauthorized removal of medical records from Children's Dallas by any person is grounds for suspension of the person for a period to be determined by the Medical Executive Committee of the Medical/Dental Staff.

2.1.5. In case of readmission of a patient, all previous records shall be available for the use of the attending physician or dentist. This shall apply whether the patient is attended by the same physician/dentist or by other physicians/dentists.

2.1.6. Subject to applicable laws, access to all medical records of all patients shall be afforded to members of the Medical/Dental Staff for research, consistent with preserving the confidentiality of personal information concerning the individual patients. All research projects must be approved by the Institutional Review Board ("IRB") before the medical records can be studied.

2.1.7. Medical records shall not be permanently filed until completed by the attending medical/dental staff member or ordered to be filed by the Health Electronic Record/Health Information Management Committee of the Medical/Dental Staff. An incomplete record will not ordinarily be filed if the attending physician/dentist is still a member of the Medical/Dental Staff or holds clinical privileges at Children's Dallas. No physician or dentist shall be permitted or requested, for any reason, to complete a medical record on a patient unfamiliar to him/her, regardless of the status of the physician/dentist who is responsible for completing the record. Any physician/dentist whose privileges are suspended or relinquished per the Medical/Dental Staff Bylaws and/or the Medical/Dental Staff Rules and Regulations for delinquent records or who resigns from the Medical/Dental Staff without adequately completing all medical records will not be reinstated or allowed to reapply for Medical/Dental Staff membership until such records are satisfactorily completed.

2.1.8. Physicians or dentists who are going to be on a leave of absence or vacation must arrange in advance for an extension from the Health Information Management Department regarding completion of medical records, if necessary.

2.1.9. An addendum/correction shall be documented to correct erroneous entries in electronic documentation. For any paper record, if an error is made on an entry in the medical record, a single line shall be drawn through the word(s) and "error" or "void" written near it. The error is not to be obliterated, whited out, or erased. The approved practitioner initials shall be noted above the erroneous entry. The correct entry shall then be written in with

the date and time, then signed or authenticated, according to Children's Dallas policy, by the approved practitioner.

2.1.10. All medical record entries shall be dated, timed, identified by author's name, credentials indicated and signed or authenticated electronically, with stamped or legibly printed name, according to Children's Dallas policy. The attending physician must countersign all histories and physical examinations, operative reports, discharge summaries, consultations, anesthesia records, radiology reports, pathology reports, and autopsy reports written by Residents and Fellows or APPs practicing in an inpatient setting. See section 3.8 for additional countersignature requirements.

2.1.11. Any document filed in a patient's medical record shall be the original, a faxed copy, or a photocopy legible in its entirety.

2.1.12. Only black or blue ink shall be used for documenting in any medical record.

2.1.13. Any use of handheld mobile devices, smart phones and/or tablets must use Children's Dallas' approved applications and tools when accessing protected health information.

2.2. History and Physical

A. Minimum History and Physical Requirements:

2.2.1. A physician member of the Medical/Dental Staff shall be responsible for the medical care and treatment of each patient at Children's Dallas. All patients shall have a history and physical examination completed and documented in the medical record by a physician member of the Medical/Dental Staff with clinical privileges or licensed individual approved for such privileges based on demonstrated clinical competence.

2.2.2. A complete history and physical shall consist of the following: chief complaint; history of present illness; medications; allergies; relevant past medical, surgical, family, and social history; review of systems; pertinent diagnostic results; assessment and plan of care.

2.2.3. The extent of the physical examination performed is dependent on clinical judgment and the nature of the presenting problem. At a minimum it shall contain, vital signs, cardiovascular, pulmonary/respiratory, and relevant physical examination of areas of the body relevant to the chief complaint. These requirements relate only to the inpatient setting. Outpatient notes should have physical exam findings appropriate to the patient need.

B. Time Frame for Completion of History and Physical:

2.2.4. All inpatients shall have a complete history and physical documented in the medical record within twenty-four (24) hours of admission.

2.2.5. For all elective surgical procedures and ambulatory (same-day) surgery patients, the history and physical shall be documented at the time of admission and prior to the patient leaving the pre-procedural area, unless an emergency situation exists.

2.2.6. Elective inpatient or outpatient surgery shall be canceled or delayed until a complete history and physical examination is completed and documented in the medical record.

2.2.7. A complete Pre-Anesthetic Summary and/or Sedation Assessment can be considered the history and physical for outpatient, non-invasive procedures.

2.2.8. A new history and physical must be completed if the original history and physical was performed and completed greater than thirty (30) days prior to admission, registration, or a procedure. If the original history and physical was performed and completed within the past thirty (30) days (prior to admission, registration or a procedure), there must be evidence of an updated examination of the patient, including any changes in the patient's condition – this is called an interval note.

C. History and Physical Countersignature and Pre-Procedural Requirements:

2.2.9. When a history and physical examination is recorded in the medical record by a Resident, Fellow, or an authorized APP, for any elective procedure requiring more than local anesthesia, the supervising physician/dentist shall complete the following prior to the patient leaving the pre-procedural area:

- review the history and physical
- make a separate entry to indicate his/her approval and agreement with the contents, or document any revisions that he/she may have
- countersign or authenticate the history and physical
- ensure informed consent has been obtained in accordance to Children's Dallas Informed Consent Policy and sign the consent form.

2.2.10. Inpatient history and physicals recorded in the medical record by a Resident, Fellow or an authorized APP must be countersigned by the attending physician within twenty-four (24) hours of admission.

2.2.11. For APPs practicing in an ambulatory clinic setting or the emergency department, the history and physical, procedural reports and consultations do not require an attending countersignature.

2.3. Progress Notes

2.3.1. Progress notes shall be entered by the attending physician/dentist at least daily on all patients, except as stated below in Section 2.3.1.1. When a progress note is entered by an APP or resident/fellow, the attending physician/dentist may enter an attestation to the note. The attestation entered by the attending shall qualify as the progress note.

2.3.1.1. Progress notes for all patients of the outpatient psychiatry program shall be documented by the attending physician at least weekly and shall clearly document any change in the treatment plan or condition of the patient.

2.3.2. Pertinent progress notes shall be recorded at the time of observation to provide for continuity of care and transferability. They should provide a chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment. The patient's clinical problems should be clearly identified and correlated with specific orders as well as test, procedure, and treatment results.

2.4. Operative Reports

2.4.1. An operative report shall be dictated or documented upon completion of the operative or high-risk procedures before the patient is transferred to the next level of care. The operative report shall contain the name(s) of the primary surgeon(s) who performed the procedure and his or her assistant(s), pre-operative diagnosis, indications for the procedure, name of the procedure performed, a full description of the procedure, findings of the procedure, any intra-operative complications, estimated blood loss, any specimen(s) removed, and the post-operative diagnosis. The operative report must be signed or authenticated by the surgeon and filed in the medical record as soon as possible after the surgery.

2.4.2. When a full operative report cannot be entered immediately into the patient's record after the operation or procedure, a brief operative note shall be entered in the medical record before the patient is transferred to the next level of care. The brief operative note shall contain the name(s) of the primary surgeon(s) and his or her assistant(s), pre-operative diagnosis, name of the procedure performed, findings of the procedure, estimated blood loss, any specimens removed, and postoperative diagnosis. If a brief

operative note is written, the full operative report shall be written or dictated within twenty-four (24) hours.

2.5. Discharge Summary

2.5.1. A discharge summary shall be documented or dictated on all medical records of patients hospitalized more than forty-eight (48) hours. A final progress note shall suffice for all admissions less than forty-eight (48) hours. In all instances, the content of the medical record must be sufficient to justify the diagnosis, warrant the treatment and end result, and address any pertinent instructions to the patient, parent, or other authorized party. A complete summary is required on all deaths. All summaries shall be signed or authenticated, according to Children's Dallas policy, by the attending physician or dentist.

2.5.2. The discharge summary shall concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition and disposition of the patient at discharge, information provided to the patient, family, or other authorized party, and provisions for follow-up care. The condition of the patient on discharge shall be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague terminology such as "improved", "satisfactory", "good", etc.

2.5.3. When an autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record within two (2) working days. The final autopsy report should be made part of the medical record no later than sixty (60) working days after the autopsy, barring requirements for offsite or complex testing.

2.6. Attending Dentist Medical Records

2.6.1 Specifically for dental procedures/surgeries, the dentogram shall be completed by the attending dentist on the day of the case and included in the patient's medical record as soon as possible after the procedure/surgery. At a minimum, the dentogram shall contain, when applicable, the name and signature of the primary attending dentist, date/time of the procedure/surgery, teeth present, occlusion, soft tissue examination, notation of radiographs taken in the private office and/or intraoperative radiographs, and the completed treatment.

2.6.2 Attending dentists shall be responsible for documenting a history and physical examination relative to the dental problem. Any medical problem present on admission, or arising during the hospitalization of a dental patient, that

is considered outside the scope of a dentist's privileges, shall become the responsibility of an attending physician member of the Medical/Dental Staff upon acceptance after consultation with the attending dentist.

2.6.3 Dental imaging taken within the hospital shall remain the property of Children's Dallas and shall be included in the patient's medical record. A copy of the pre-operative images taken in a dentist's private office in preparation for a dental procedure/surgery at Children's Dallas shall be provided by the dentist and included as part of the patient's medical record.

2.7. Incomplete/Delinquent Medical Records

2.7.1. The patient's inpatient, emergency room, and day surgery medical record, as appropriate to the service delivery, shall be completed at the time of discharge, including progress notes, final diagnosis, discharge instructions/summary, and appropriate signatures. Outpatient records shall be completed contemporaneously with the patient's visit.

2.7.1.1. Incomplete records are defined as those records that are lacking any appropriate signatures and/or reports.

2.7.1.2. Delinquent records are those records deemed to be incomplete within seven (7) calendar days after discharge.

2.7.2. Delinquent operative reports are defined as those reports not dictated or documented by midnight the day following the surgery/procedure.

2.8. Automatic Suspension and Relinquishment of Privileges

2.8.1. The privileges of attending physicians, dentists, or APPs shall be suspended if medical records become delinquent as defined in section 2.6. for greater than fourteen (14) calendar days.

2.8.2. Additionally, the Medical Executive Committee of the Medical/Dental Staff shall be notified promptly if any physician or dentist has had his/her elective privileges suspended because of delinquent medical records five (5) times in a rolling twelve (12) month period.* In such cases, the Medical Executive Committee of the Medical/Dental Staff shall consider recommending to the Board that the attending physician's or dentist's privileges be revoked. Failure to complete the delinquent records within three (3) calendar months after the date the automatic suspension became effective shall be deemed a voluntary resignation from the Medical/Dental Staff and all privileges are

deemed to have been voluntarily relinquished as outlined in Article XI of the Medical/Dental Staff Bylaws.

*One suspension period shall not exceed four (4) consecutive weeks. If a physician or dentist remains on the suspension list for more than four (4) consecutive weeks, the suspension period shall renew and count as an additional suspension period.

2.9. Organ and Tissue Donation

The medical records of the donor and recipient shall fulfill the requirements of any surgical inpatient medical record when an organ is obtained from a live donor.

2.9.1 When an organ is removed from a cadaver for transplantation, a report that includes a description of the technique used to remove and prepare or preserve the donated organ shall be documented in the medical record. This report shall be made part of the recipient's medical record.

2.9.2 When a donor organ is obtained from a brain-dead patient, the medical record of the donor shall include the date and time of the determination of brain death, documentation by and identification of the physician who determined the brain death, the method of transfer of the organ or tissue, and the treatment provided to the brain-dead donor, as well as an operative report.

2.9.3 Informed consents for the removal and/or transplantation of donor organs or tissues must be filed in the donor's medical record.

SECTION 3. Orders

3.1. All patient orders shall be entered in the medical record by an attending medical/dental staff member, resident, APP, or another provider who is providing care to the patient, and who, in accordance with Children's Dallas policy; law and regulation; and Medical/Dental Staff Bylaws and Rules and Regulations, is authorized to write orders.

3.2. A verbal order shall be considered to be "in writing" if dictated to a duly authorized individual and signed, dated, and timed or authenticated, according to Children's Dallas policy, by the attending, Resident, Fellow, or APP. The attending, Resident, Fellow, APP, or another provider who is providing care to patient, and who, in accordance with Children's Dallas policy; law and regulation; and Medical/Dental Staff Bylaws and Rules and Regulations, is authorized to write orders, must sign the verbal order within

ninety-six (96) hours. The signature must be dated and timed. Verbal orders should be limited to: situations in which a delay in treatment poses a risk to the patient; or there is a need to clarify a written order; or to optimize care along the continuum. All verbal orders must be "read back" to the provider for accuracy.

3.2.1. The authorized individual shall: 1) record the order; 2) make note of the name of the ordering physician/dentist, or APP; 3) record the date and time of the order; and 4) sign the order. Verbal medication orders may be received only by licensed nurses (RN or LVN/LPN), registered pharmacists, and, when approved by the Medical/Dental Staff for limited use in their respective specialties, by licensed/registered/certified respiratory therapists, and cardiopulmonary technologists functioning within their scope of licensure/competence. Verbal orders for specific therapy shall be received only by licensed nurses (RN or LVN/LPN) and, when approved by the Medical/Dental Staff, by licensed/registered/certified laboratory technologists, cardiopulmonary technologists, physical therapists, speech therapists, audiologists, occupational therapists, and respiratory therapists, when functioning within their scope of licensure/competence. Verbal orders shall be received only from members of the medical/dental staff with clinical privileges and/or APPs, Residents and Fellows functioning within their scope of practice (outside of the ICU).

3.3. Any standing medical order, standing delegation order, or medical protocol needs to be co-signed within ninety-six (96) hours by the Attending Physician, Resident, Fellow, APP, or another provider who is responsible for the patient's care and who is authorized to write orders in accordance with Children's Dallas policy, applicable laws and regulations, and the Medical/Dental Staff Bylaws and Rules and Regulations. The signature must be dated and timed. A copy of the standing delegation order or medical protocol shall be included in the patient's medical record.

3.4. Physician/dentist and APP orders shall be documented in the electronic medical record. Orders documented on paper shall be written clearly, legibly, and completely. Orders that are illegible or improperly written shall not be carried out until rewritten properly or understood by the nurse, technologist, therapist, dietitian, etc. The use of "renew", "repeat", or "continue" orders is not acceptable. Orders must be specific. Only approved hospital abbreviations may be used in the documented orders.

3.5. "DO NOT RESUSCITATE" and "LIMITED RESUSCITATION (PARTIAL CODE) orders must be entered by the attending physician (as outlined in the Children's Dallas policy on withholding/withdrawing of resuscitative services or life-sustaining treatment) in the medical record. The attending physician must verify in the medical record that the patient, parent, or other authorized party has 1) been fully apprised of the patient's condition; 2) consented to the "DO NOT RESUSCITATE" or the "LIMITED RESUSCITATION (PARTIAL CODE)" order, and 3) been notified of the issuance of the order.

3.5.1 For inpatients, orders are valid for the duration of the current admission, unless revoked. If the patient is discharged and readmitted, a new order must be entered in the medical record.

3.6. All orders, including DNR and Limited Resuscitation Orders, shall be canceled at the time the patient undergoes surgery unless otherwise directed by the attending surgeon and anesthesiologist.

3.7. Orders shall be re-documented for patients transferred to a lesser or higher level of care, e.g., from a special care unit to a medical-surgical nursing unit or vice versa, or from outpatient to inpatient status.

3.8. Residents, Fellows, and APPs may document orders (except as specified in Section 3.8) in the medical record.

3.9. Orders for oncologic chemotherapy, when documented for treatment of patients with a malignancy, require two signatures prior to administration of medication, one of which must be an attending physician. An Oncology Fellow, or APP can be the secondary signature. Residents may not document orders for oncologic chemotherapy.

SECTION 4. Medication Management

4.1. All medications administered to patients shall have been approved by the Food and Drug Administration. Specific approval for pediatric use is not required. The only exceptions are those medications administered under a protocol for investigational or experimental medication use that has been approved by the Institutional Review Board ("IRB"). When certain organic or inorganic substances (such as vitamins, metals, minerals, nutrients, etc.) are used in an unconventional manner, and specifically are not defined as a medication, administration of these substances shall also be in accordance with an established protocol that has been approved by the Medical/Dental Staff through its designated mechanism.

4.2. Investigational or experimental medications shall be used only under the direct supervision of the principal investigator who shall be a physician/dentist member of the Medical/Dental Staff with clinical privileges and who shall be responsible for securing the necessary consents.

4.3. Access to basic information concerning the medication including dosage, strengths available, actions and uses, side effects, symptoms/signs of toxicity, and personal safety, if applicable and known, shall be provided to all individuals preparing or administering investigational medications.

4.4. The pharmacy shall store all investigational medications used at Children's Dallas and be responsible for labeling and dispensing in accordance with the physician/dentist investigator's written orders.

4.5. Medication administration by parents is only performed as part of a teaching program for home use.

4.6. It is the policy of Children's Dallas that only medication dispensed through Children's Dallas pharmacy may be used at Children's Dallas. Under special circumstances, the hospital pharmacist may identify the need for medications from other sources that are required for the care of the patient. In such cases, the attending physician/dentist, Resident, Fellow, or APP must clearly specify the use of each of these medications in documented orders in the medical record. These medications will be procured, stored and dispensed by the pharmacy.

4.7. For each medication, the administration times or the interval between doses must be clearly stated in the order.

4.8. The use of "prn" and "on call" in a medication order must be qualified by dosage, indication, and dosing interval.

4.9. All standing orders for medications shall be initially evaluated and, if approved, shall be reevaluated at least annually thereafter by the Pharmacy & Therapeutics Committee.

4.10. The pharmacy may substitute generic equivalent medications unless specifically noted otherwise on the order form. Non-formulary medications must be obtained through the approval processes.

4.11. Medication samples may only be distributed by the pharmacy in accordance with the Medication Management Policies.

4.12. Physicians/dentists shall abide by medication requirements that have been delineated in other sections of these Rules and Regulations and applicable Medical/Dental Staff and Children's Dallas policies because of their relevance to the subject matter in those sections.

4.13. When, in the opinion of a member of the nursing staff or the pharmacy, a medication dosage ordered represents a potential hazard to the patient (e.g., excessive dose, incompatibility problem, contraindicated for patient's condition), and the prescribing provider disagrees, the Division Director to which the prescribing provider is assigned, the Chair of the Pharmacy & Therapeutics Committee, or the Vice President, Medical Staff Affairs shall be consulted by the nursing staff member or pharmacist.

4.14. All orders for medications in the following categories shall automatically expire as follows:

4.14.1. Vancomycin empiric therapy expires forty-eight (48) hours from the initial order

4.14.2. Orders for all other medications, including controlled and non-controlled substances, expire in thirty (30) calendar days.

4.15. Pharmacists may modify the duration of an order to assure appropriate length of therapy with respect to safety, patient needs or hospital policy. Pharmacists should modify any critical medication order that is due to expire during the night to continue until the prescriber can be notified and a new order entered if the medication should be continued.

4.16. There shall be a documented diagnosis, condition, or indication in the medical record for each medication ordered.

4.17. Adverse medication reactions shall be reported by clinicians, including Medical/Dental staff members, to the pharmacy.

4.18. The Pharmacy and Therapeutics Committee of the Medical/Dental Staff is delegated the responsibility of restricting the use of a specific medication or class of medications and expectations for use, either entirely or for use only in stated conditions or for use only on consent of a specified expert. The Medical Executive Committee has a right to review the recommended restriction of medications as developed by the Pharmacy and Therapeutics Committee on an ongoing basis.

SECTION 5. Consultation

5.1. A consultation is defined as an evaluation of a patient provided at the request of an attending physician/dentist, Resident, Fellow, or APP to either recommend care for a specific patient's condition or to determine whether to accept responsibility for ongoing management of the patient's care. Any consultation request, whether in-person or by telephone, that seeks medical advice about a **specific patient** is considered a consultation and therefore must be documented in the medical record in the timeframe as described below in Section 5.5.

5.1.1. The following reports and/or forums are excluded from the definition of a consult and do not need to be documented as a consultation: preliminary readings from radiology or pathology, pathology reports, radiology reports, test interpretation reports, tumor board and other patient care conferences where recommendations are communicated, and/or factual information about treatment (i.e. antibiotic choice or medication information) that is not related to a specific patient.

5.2 The attending physician/dentist, Resident, Fellow, or APP is responsible for requesting consultation when indicated, calling the appropriate on call consultant, and placing an order for the consult in the medical record. The requesting attending physician/dentist, Resident, Fellow, or APP shall supply the consultant with all relevant information regarding the patient and communicate the relative urgency and desired timeframe for completion of the consultation. The consultant shall communicate any anticipated delays in completion of the consultation. The primary responsibility for the patient shall remain with the requesting physician/dentist, unless notice of transfer of care is documented in the medical record.

5.3. Once the consultation is completed, the consultant and the requesting attending physician/dentist, Resident, Fellow, or APP shall discuss the final recommendation. Attending physician/dentist to attending physician/dentist verbal communication is preferred. A consult is considered complete when advice about a specific patient is given by phone or when the patient has been examined by the consultant and a recommendation has been communicated to the requesting attending physician/dentist, Resident, Fellow or APP. This is when the documentation timeframe requirement as defined below in Section 5.5 will begin.

5.4. Consultation reports shall show evidence that the consultant has provided sufficient documentation to address the request from the requesting attending physician/dentist, Resident, Fellow, or APP. A limited statement such as "I concur" generally would not constitute an adequate consultation report. Except in emergency situations, as verified in the medical record, a

consultation relative to an operative or potentially hazardous procedure shall be recorded prior to the surgery or procedure being performed.

5.5. It is highly recommended that a brief note containing the consultant's recommendation(s) be placed in the medical record as soon as possible but not later than twenty-four (24) hours of completing the consultation. If further documentation is needed that is not contained in the brief note, the consulting service shall enter a consultation note within 48 hours of completing the consultation as defined above in Section 5.3.

5.6. Consult requests from the Emergency Department (ED)

When a consult is needed in the ED, the requesting ED attending physician, Resident, Fellow or APP must clarify if the phone call is for general advice or for advice on a **specific patient**. If the request meets the definition for a consult as defined above in Section 5.1, a consult order must be entered by the requesting ED attending physician/Resident, Fellow or APP. The requesting ED attending physician/Resident, Fellow or APP shall supply the consultant with all relevant information regarding the patient and communicate (i.) if the patient needs to be seen in person or if the consultant's recommendations can be provided by telephone, and (ii.) the relative urgency and desired timeframe for completion of the consult.

5.6.1. The consultant shall communicate the anticipated timeframe for completion of the consultation. Disagreements regarding relative urgency, desired timeframe, and the need for an in-person consultation shall be resolved by attending to attending physician discussion. If the disagreement cannot be resolved, then the ED attending physician who has seen and evaluated the patient shall make the final determination.

5.6.2. The primary responsibility for the patient shall remain with the requesting ED attending physician, Resident, Fellow or APP unless notice of transfer of care is documented in the medical record. The consultant (or Resident/Fellow/APP designee) shall communicate the recommendations verbally to the requesting ED attending physician, Resident, Fellow or APP. Attending to attending physician communication is preferred.

5.6.3. A brief consult note shall be placed by the consultant (or Resident/Fellow/APP designee) in the medical record as soon as possible or within **12 hours** of completion of the consult defined above in Section 5.3.

5.6.4. If the ED attending physician requests the consultant to see the patient in person with a potential emergency medical condition, the consultant will appear within a reasonable time (which is expected not to exceed thirty (30) minutes), unless there are circumstances beyond the physician's control (such as, currently operating on another patient, is responding to call coverage at

another hospital, or is delayed due to extreme weather condition, personal illness, or transportation failures).

SECTION 6. General Requirements

6.1. Written authorization of the patient, parent, or other legally authorized representative is required for release of medical information to individual's not otherwise authorized by law to receive this information.

6.2. General consent for treatment covers evaluation and routine medical, nursing, and other patient care, treatment and procedures that do not require informed consent (i.e. procedures and treatment that do not have risks, hazards, or alternative treatments that a reasonable person would want to know prior to giving consent). General consent must be obtained from a patient or the patient's legal representative before medical services/care can be provided at Children's Dallas or as otherwise outlined in the Children's Dallas Disclosure and Informed Consent Policy (hospital policy). General consent is valid and remains in effect during the patient's hospital admission for inpatients and for one year from the date of signature for outpatients.

6.3. In addition to general consent obtained by Children's Dallas at the time of the patient's admission, in accordance with the process outlined in the hospital policy, informed consent is required for procedures and treatment that have benefits, risks, side effects and alternative treatments that a reasonable person would want to know prior to giving consent. Informed consent shall be obtained and signed by the physician/dentist performing the procedure or treatment ("Responsible Physician/Dentist") or by a qualified designee (i.e. associate physician, resident, fellow or APP) who has the clinical knowledge and/or expertise for the procedure or treatment being performed to adequately provide information for informed consent and who has been designated by the Responsible Physician/Dentist to provide such information. The "Responsible Physician/Dentist" has the full responsibility for the procedure or treatment being provided to the patient. The Responsible Physician/Dentist of record is responsible for verifying that informed consent has been properly obtained.

6.4. Exceptions to obtaining consent may be made for emergency conditions, life-threatening situations, or suspicion of abuse, as outlined in hospital policy. The attending physician/dentist, who is ultimately responsible for the care of the patient, shall be responsible for determining, and subsequently documenting, whether the patient has what reasonably appears to be an emergency, life-threatening injury or illness; care shall not be delayed if the attending physician/dentist deems emergent care is needed

and there is either insufficient time to obtain consent and/or the patient's parent or legal representative is not present and cannot be contacted immediately.

6.5. Telephone consent may be obtained when the patient's parent or legal representative is not available in person to provide written consent; however, the parent or legal representative shall sign the consent form as soon as possible. Documentation of telephone consent into the medical record shall be made in accordance with hospital policy.

6.6. If consent covers a series of like procedures that may be performed over a period of days, the consent form shall indicate the number of procedures and time frame for which the consent is in effect.

6.7. If a patient's condition changes or the risks associated with the procedure change a new consent form must be executed.

6.8. If a written consent was obtained greater than sixty (60) calendar days prior to the scheduled procedure or treatment, the Responsible Physician/Dentist must:

- Obtain a new written consent; or
- If the patient's parent or legal representative is the same individual who previously signed the consent form and there are no changes to the patient's condition noted in the updated history and physical, re-sign and re-date the consent form and have the parent/legal representative re-sign and re-date the consent form after review and discussion and have the re-signed/re-dated signatures witnessed.

6.9. Informed consent must be obtained for research as required by the Institutional Review Board ("IRB") and Children's Dallas policy for informed consent for research.

6.10. Each patient shall be assigned an attending physician/dentist. A patient or the patient's parent/legally authorized representative may request a change of the assigned attending physician or dentist. Such a request will be honored to the extent possible, after consideration of the patient's medical care needs. When such a change occurs, all previous orders for treatment shall be canceled and new orders will be required.

6.10.1. The attending physician/dentist can delegate to an APP, under the supervision of an attending physician/dentist.

6.10.2. The patient shall have the right to request to be seen by the attending physician/dentist instead of, or in addition to, the APP.

6.11. When necessary and in the absence of the regular attending physician/ dentist any member of the Medical/Dental Staff with clinical privileges may be requested by the Division Director to attend a colleague's patient. The requested Medical/Dental Staff member shall be expected to show the same consideration he or she would wish to have shown to one of his or her patients under similar circumstances.

6.12. All physicians/dentists, APRNs and PAs shall participate in patient discharge planning in accordance with the utilization review plan or other written requirements.

6.13. Clinical laboratory tests shall be done by Children's Dallas or in an outside (reference) laboratory recommended by the Division Director of Pathology or designee and approved by the Medical Executive Committee. The Division Director of Pathology or designee shall take reasonable steps to assure itself that any outside laboratory sources, from which test reports are used as the official Children's Dallas medical record report are in compliance with applicable state, federal and Joint Commission requirements.

6.14. The Radiology Division shall provide authenticated reports for all radiologic examinations performed under the radiologist's supervision at Children's Dallas and, when requested, for review of CT and MRI examinations performed outside of Children's Dallas and its affiliates. Otherwise, the attending physician/dentist or authorized licensed practitioner may record his/her own interpretation in the history or progress note section of the medical record (to include dental images, non-radiologist fluoroscopy, and speech studies). When special cardiovascular radiologic procedures can be properly interpreted only with the findings and observations of the authorized physician/dentist (e.g., cardiologist) performing the procedure, this individual shall be responsible, based on approved privileges to do so, for rendering the official report for the medical record.

6.15. When surgical procedures or medical therapy are to be performed based on tissue examined at another institution or laboratory, the admitting attending physician/ dentist shall be responsible for furnishing a copy of the pathology report from the outside institution or laboratory for the patient's medical record. When possible, the diagnostic slides from the referring institution or laboratory shall be reviewed by a Children's Dallas staff pathologist, and a report shall be issued for the patient's medical record.

6.16. The ordering of any baseline admission testing (e.g., laboratory, imaging, electrocardiography, etc.) shall be the responsibility of the attending physician/dentist (or authorized designee) on an individual-patient basis. For surgical cases, this shall be done, as indicated, in conjunction with the anesthesia division.

6.17. Physicians/dentists, APRNs or PAs requesting diagnostic examinations by a pathologist or radiologist shall provide, in the written request, all relevant information available, so as to assist in the determination of an accurate diagnosis/impression.

6.18. Human materials removed at surgery (e.g., surgical specimens) or autopsy (excluding teeth and those specimens exempt from pathological examination as defined below in Section 2.1.5.1) shall be disposed of in a manner commensurate with the Texas Administrative Code for Disposition of Special Waste. Specimens removed during the procedure shall be sent to the Pathologist who shall make necessary examinations to arrive at diagnosis. The Pathologist's written report of this examination and conclusions shall be included in the patient's medical record. Specimens (other than teeth and certain non-human foreign bodies, such as coins or jewelry) shall not be returned to the patient or patient's family expect in specific circumstances as authorized by law and Children's Dallas policy and approved by the legal department.

6.18.1. The following specimens will be exempt from microscopic and macroscopic examination (at the surgeon's or proceduralist's discretion) and will be properly disposed in a biohazardous waste bag:

- Extraocular muscles from strabismus repairs
- Foreign bodies
- Foreskins if grossly normal
- Nail Plates (fingernails and toenails that are grossly normal)
- Teeth
- Tonsils
- Adenoids
- Bone and cartilage from reconstructive procedures and osteotomies
- Prosthetic devices and hardware
- Orthodontic appliances
- Surgical hardware
- Skin and skin scars from cosmetic procedures
- Omentium from Dialysis placement
- Hyperplastic gingival tissue for which there is a clear etiology
- Gingival tissue removed for gingival plastic procedures

- Calculi
- Polydactylous digits

6.19. In the event of a patient death at Children's Dallas, the deceased shall be pronounced dead by a physician. The body shall not be released until a record of the patient's death is completed and placed in the medical record of the deceased.

6.20. It shall be the responsibility of the attending physician, coordinated as needed with other members of the Medical Staff/Fellows/Residents, to inform every family of the option for an autopsy, and to attempt to secure an autopsy in all cases including, but not limited to, cases of unusual death and those of educational interest. It is also the responsibility of the attending physician to report cases of medical legal interest to the appropriate authorities. If an autopsy is obtained, it is the responsibility of the attending physician to communicate the results of the autopsy and the implications of the findings with the child's family. Autopsies shall be performed following appropriate written consent and in accordance with state law. All autopsies shall be performed by a Children's Dallas pathologist, unless by law the autopsy comes under the jurisdiction of the Medical Examiner/Coroner, or the family requests otherwise.

6.20.1. The attending physician will be notified (via paging system or phone call) of any autopsies prior to the start of the autopsy; however, the autopsy will not be delayed if the attending physician is unavailable.

6.21. All physicians/dentists and APPs shall foster a strong culture of safety by participating in quality, safety, and performance improvement initiatives upon request as defined by the code of conduct.

6.22. Transfusion of blood and blood components shall be done in accordance with hospital and laboratory policies and procedures, in accordance with recommendations of Children's Dallas Tissue and Transfusion Utilization Committee.

6.23. Copies pathology slides are the property of Children's Dallas and may be lent to other hospitals, physicians/dentists/APPs, or research institutions for valid reasons and upon approval of a Children's Dallas pathologist.

6.24. All physicians/dentists and APPs shall be responsible for knowing their obligations in the event of a disaster or other emergency situation (i.e., fire,

tornado, bomb threat, etc.) and shall report accordingly. They shall participate in emergency management/fire prevention drills as required.

6.25. Oxygen and respiratory therapy shall be administered in accordance with the attending physician's, dentist's, or APP's order or in accordance with established policy and protocol approved by the Medical/Dental Staff through its designated mechanism. In cases where the duration of treatment is not specified or is stated indefinitely, the treatment shall be discontinued as per policies of the Respiratory Care Department unless new orders are documented; however, prior to discontinuing the treatment, the nurse or therapist shall notify the attending physician, dentist, or APP and confirm that the treatment should be discontinued.

6.26. All respiratory therapy orders for critical care patients must be reviewed and documented daily. All oxygen and respiratory therapy orders on non-critical care patients shall be reviewed at least every seventy-two (72) hours.

6.27. Designated qualified members of the Medical/Dental Staff present at Children's Dallas shall respond to cardiopulmonary resuscitation codes in accordance with Children's Dallas policy.

6.28. Any member of the Medical/Dental Staff who has reason to find fault with an employee of Children's Dallas, shall report the deficiency to the relevant supervisor or department director immediately and if needed, follow the appropriate escalation path. In no case shall the Medical/Dental Staff member take it upon him or herself to discipline an employee. In cases where the patient may suffer harm if action is not taken immediately, the physician/dentist may require that the employee relinquish care of his or her patient(s) until the matter is investigated.

6.29. The Infection Prevention and Control Committee, through its chairperson or members, has the authority to institute any appropriate control measures or studies when it is reasonably believed that a danger to patients, visitors, or personnel exists. This authority includes placing a patient under isolation precautions even though the attending physician/dentist/APP may not believe such precautions are necessary.

6.30. All inpatients shall be visited by their attending physician/dentist within twenty-four (24) hours of admission and once every calendar day thereafter; this visit shall be documented by entering a note that day in the medical record (see section 2.3). If this requirement cannot be fulfilled, the attending physician/dentist shall arrange for another qualified member of the Medical/Dental Staff with clinical privileges to attend the patient, and

the nursing staff shall be notified of the name of the physician/dentist who shall be responsible in the interim.

6.31. Patients in need of behavioral restraint/seclusion shall be restrained/secluded for the protection of self or others in compliance with applicable laws. When use of behavioral restraints/seclusion is indicated, justification for such use and a time-limited order by the physician noting both start and end times shall be present. The time-limited order should be no longer than four (4) hours for patients eighteen years of age and older, two (2) hours for patients aged nine (9) to eighteen (18) years, and one (1) hour for patients under the age of nine (9) years. The time-limited order must be signed and an assessment of the patient made by a licensed physician within one (1) hour of the application of behavioral restraint/seclusion. Other requirements of Children's Dallas restraint/seclusion policy and procedure shall also be met.

6.32. When a life-threatening situation develops requiring the administration of blood or blood products for survival, even if the patient, parent or other authorized party objects due to religious reasons or other reasons, the attending physician, with the assistance of Children's Dallas, shall attempt to obtain the necessary legal means to administer blood or blood products to sustain life.

6.33. When any professional person of the care team has any reason to doubt or question the care provided to a patient or believes that consultation is needed and has not been obtained or requested, he or she may call this to the attention of his/her supervisor. The supervisor shall follow Children's Dallas escalation policy. This concern may be brought to the attention of the JPE Chief Medical Officer or the Division Director to which the physician/dentist is assigned. When circumstances justify action, the Division Director or the JPE Chief Medical Officer may request a consultation.

6.34. Physician, dentist, and APP performance should comply with performance measurement initiatives, national patient safety goals and other national and institutional practice standards.

SECTION 7. Emergency Services

7.1. A medical screening examination ("MSE") may be performed by a qualified physician, APRN, or PA.

7.2. The emergency medical record shall be made a part of the patient's permanent medical record.

7.3. Each emergency medical record shall be signed by the physician/dentist/APP in attendance who is responsible for its accuracy.

7.4. There shall be a triage system to identify patients requiring emergent/urgent care.

7.5. The disposition of each patient shall be a physician responsibility. This responsibility can be delegated to an APP through established collaborative practice agreements.

7.6. The established list of procedures permitted to be performed in the Emergency Department shall not be exceeded except in a bona fide emergency.

7.7. Procedures requiring general anesthesia shall not be performed in the Emergency Department but must be performed in the surgical suite.

7.8. In an emergency case, as soon as it appears that a patient requires admission to an inpatient unit, the physician/dentist or designee shall contact the Bed Control Coordinator to ascertain whether there is an available bed.

7.9. When a patient requiring admission on an emergency basis does not have a primary care physician, the patient shall be admitted to the appropriate medical or surgical service.

7.10. When a patient requiring admission on an emergency basis has a primary care physician, the primary care physician shall be notified regarding both the patient's admission and the service to which the patient was admitted. If the primary care physician is a physician on the Medical/Dental Staff at Children's Dallas with clinical privileges, the patient should be admitted to the primary care physician's service, unless admission to another medical staff service is requested by the primary care physician.

7.11. At least one Emergency Services attending must be present in the Emergency Department at all times.

7.12. Patients, parents, or other authorized parties, on leaving the Emergency Department following evaluation and/or treatment, shall be given written follow-up instructions, which shall have been signed by the patient, parent, or other authorized party, stating that the patient, parent, or other authorized party has received and understands the instructions provided by the attending physician/dentist or Emergency Department registered nurse. Any language barrier shall be compensated for through the use of an

interpreter, by instructions written in the patient's, parents, or other authorized party's language, or by another acceptable system, and this shall be noted on the instruction sheet.

7.13. The emergency medical record for each patient treated shall include: the time of the patient's arrival; the means of arrival and by whom transported; any available details of the emergency care rendered to the patient prior to arrival at Children's Dallas; whether (and, if relevant, when and for what) the patient visited any Emergency Department previously; acknowledgment of any ordered test results; and the conclusions at termination of treatment (including final disposition, condition on discharge, and any instructions given to the patient on discharge for follow-up care).

7.14. Specialist coverage shall be provided by Medical/Dental Staff members with appropriate clinical privileges in accordance with an established roster or on-call system as required by Children's Dallas. When a transportable patient requires Medical/Dental Staff consultation/treatment not available at Children's Dallas, the patient shall be transferred to an appropriate facility as soon as possible after being stabilized for transfer, subject to compliance with the hospital's transfer policy, and subject to having first obtained acceptance by that facility through a physician and the administrator or designee of that facility.

SECTION 8. Obtaining Organs and Tissues for Transplantation

8.1. Consent for the removal of organs and/or tissues for the purpose of transplantation shall be obtained from the patient, parent, or other authorized party by a representative of Southwest Transplant Alliance Organ and/or Tissue Donation for Transplantation Tissue and Organ Donor at UTSW using their appropriate consent form.

8.2. The diagnosis of the death of the patient shall be made by the patient's attending physician using the criteria he or she deems appropriate in his/her clinical judgment according to Children's Dallas policies. The patient's physician may delegate this responsibility to another physician provided he or she is a member of the current Medical Staff and is not a member of the transplantation team.

8.3. In all instances where brain death is thought to precede the cessation of cardiopulmonary function, the patient shall be evaluated by two (2) attending physicians to determine if the brain death criteria have been met. Compliance with these criteria shall be necessary in order for the patient to be considered for organ and/or tissue donation via brain death.

8.4. In instances where cessation of cardiopulmonary function will be utilized to pronounce patient death, prior to organ and tissue donation, hospital policies will be followed for the donation of the patient's organ and/or tissue following cardiac death. All organ and/or tissue donation criteria will be met and the documentation for the organ and/or tissue procurement will be done in accordance with the current applicable policies.

8.5. All organ and/or tissue procurement documentation and criteria must be done so under the requirements established and outlined in the current Brain Death policy and Organ and Tissue Donation After Cardiac Death policy.

8.6. Physicians involved with the procurement of organs and/or tissues for transplantation shall not be involved with the decision to discontinue life support systems or the declaration of death.

8.7. If an autopsy is also requested, discussion of the planned organ and/or tissue procurement by the transplantation team with the attending pathologist should occur prior to procuring any organs and/or tissues, so that the autopsy is not compromised.

SECTION 9. Surgical Care

For purposes of Section 9, "responsible physician/dentist" shall have the same meaning as defined above in subsection 6.3.

9.1. Each physician/dentist/APP working in the Operating Room must abide by the policies of the Operating Room.

9.2. All requirements in the "Medical Records" section of these rules and regulations shall apply in the care of surgical patients, particularly with reference to the history and physical examination, recording of preoperative diagnosis, completion of operative reports, and all sedation/anesthesia-related requirements. The requirements for informed consent also apply.

9.3. The responsible physician/dentist/APP shall be present at Children's Dallas before the patient is brought into the operating room.

9.4. The responsible physician/dentist/APP shall be within the hospital and ready to begin surgery/procedure prior to that patient being brought to the operating room/procedure room. The responsible physician/dentist/APP must be present within thirty (30) minutes after arrival of the patient into the operating room/procedure room.

9.5. The responsible physician/dentist must be present in the operating room for all key portions of the procedure (excluding auditory brainstem response

(ABR), peripherally inserted central catheter (PICC) line placement and cast application).

9.6. All patients receiving general, epidural, spinal anesthesia, or sedation by Anesthesiology shall go to a Post Anesthesia Care Unit ("PACU"), directly to a critical care unit, or other designated recovery area. Patients receiving only local anesthesia may be returned to their room or may go to the PACU or other designated recovery area at the request of the responsible Physician/Dentist/APP.

9.7. All patients must have a discharge order prior to transfer from the PACU or other area of the hospital where anesthesia is being administered ("procedure room"). In the case of patients who have not received care from the Anesthesiology Division, the discharge order must be from the attending physician/dentist responsible for the procedure/sedation, which preceded PACU or other designated recovery area. (Also refer to sections Anesthesia - 10.9 and Sedation - 11.4).

9.8. Any day surgery patient (outpatient) who has received anesthesia (other than local or topical anesthesia), and has remained in the Phase II recovery area of the PACU or other designated recovery area for two (2) hours or longer after leaving the Phase I recovery area of the PACU or other designated recovery area shall be evaluated by both an anesthesia care team member (attending anesthesiologist, Fellow, APRN, PA, CAA or CRNA) and a member of the operative/procedural care team at the time of discharge. Disposition of the patient at this point is the responsibility of, and must be a joint decision between, the attending surgeon/proceduralist and attending anesthesiologist.

9.9. Day surgical procedures are limited to those surgical procedures approved as such by the Medical/Dental Staff and Administration.

9.10. Day surgery shall be included in surgical case evaluations performed by the divisions and, as indicated, by the Surgery Department.

9.11. Physicians/dentists/APPs performing surgical procedures shall report all complications to the respective Division Director.

9.12. Operation scheduling is done through the operating room and according to a block scheduling system.

9.13. Patients shall be transported from the operating room or procedure room to the PACU or other designated recovery area by an attending anesthesiologist, Fellow, Resident, CAA, CRNA or physician prescribing sedation.

9.14. All responsible physicians/dentists/APPs shall abide by the Operating Room policy regarding confirmation of the identity of the patient; the proposed procedure; the site, side and level to be operated upon; and that the pre-operative anesthesia fasting guideline("NPO" nils per os) status has been maintained.

9.15. All responsible physicians/dentists/APPs with operating room privileges must cooperate with the current operating room protocol for needle, sponge, and instrument counts.

SECTION 10. Anesthesia

10.1. An anesthesiologist must complete or co-sign the pre-anesthesia evaluation within 48 hours prior to surgery or a procedure, and the evaluation must include at a minimum: contemplated choice of anesthesia for the procedure; drug history; review of the patient's physical status (using the classification of the American Society of Anesthesiologists); history of allergies; previous anesthetic experiences; and an anesthetic risk evaluation.

10.2. The anesthesiologist or anesthesia care team ("ACT") member shall record in the medical record evidence of a pre-anesthesia check of the anesthesia machine and monitoring equipment. The anesthesiologist shall also document his or her assessment of the patient immediately prior to the induction of anesthesia. The anesthesiologist or ACT member shall also record all pertinent events occurring during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood and blood components.

10.3. The responsible anesthesiologist or ACT member, (Fellow, Resident, CRNA, or CAA), shall be in constant attendance during the entire procedure. Following the procedure, the anesthesiologist, Resident, Fellow, CRNA or CAA shall be available as long as required by the patient's condition and until the responsibility for proper patient care has been assumed by another qualified physician.

10.4. An attending anesthesiologist must be physically present during induction, emergence and all critical portions of the case and immediately available from the time preoperative medication is administered until the patient is suitable for discharge from the PACU or other designated recovery area, or the patient's care has been transferred to another suitably qualified physician. An attending anesthesiologist who is working with another Anesthesia Care Team member (CRNA, CAA, Fellow, Resident) is

providing anesthetic care by medical direction. A Medically Directing Anesthesiologist is considered "immediately available" if he/she is located within the same area as the Anesthesia Care Team Member, and not occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed. The Medically Directing Anesthesiologist is in physical proximity that allows him/her to re-establish direct contact with the patient to meet medical needs and any urgent or emergent clinical problems. These responsibilities may also be met through coordination among attending Anesthesiologists working together at Children's Dallas. There will be an identifiable Medically Directing Anesthesiologist at all times in the anesthetic care of each patient.

10.5. The anesthesiologist shall review all pertinent laboratory work.

10.6. An emergency call system shall be maintained by the Division of Anesthesiology to allow for adequate coverage for the services of an anesthesiologist.

10.7. Safety policies and procedures regarding the administration of anesthesia, maintenance of machines, techniques and methods of delivery, and safety hazards shall be developed and periodically reviewed by the Division of Anesthesiology. Members of the Medical/Dental Staff and all hospital employees shall comply with these safety policies and procedures.

10.8. The Anesthesiologist in Chief or his/her designee is responsible for medical direction of the PACU and any designated recovery area.

10.9. All patients must have a discharge order prior to the transfer from the PACU or other designated recovery area, and a post-anesthesia evaluation note completed within forty-eight (48) hours; for outpatients, this note will be completed prior to discharge. The 48-hour timeframe begins at the point the patient is moved into the designated recovery area. When a patient has received care from the Anesthesiology Division, the discharge order may come from an attending anesthesiologist, Fellow, CAA or CRNA. Refer to Section 9.7 above for discharge order requirements for a patient not receiving care from the Anesthesiology Division.

10.10. Disposition of a patient from the Operating Room or Procedure Room is the responsibility of and must be a joint decision between the responsible physician/dentist/APP and the anesthesiologist.

SECTION 11. Sedation

11.1. A pre-sedation evaluation of the patient must be documented in the medical record prior to any procedure in which moderate/deep sedation/analgesia is to be administered. This evaluation shall include reference to the choice of sedation, the patient's allergies and any previous medication, drug history, other anesthesia/sedation experiences, any potential anesthetic/sedation problems, and the anticipated location for post-sedation recovery. The patient's physical status shall be categorized using the classification of the American Society of Anesthesiologists.

11.2. The individual administering moderate sedation must be capable of managing inadvertent deep sedation, which means that he or she must be competent in managing a compromised airway including provision of adequate oxygenation and ventilation. The sedation credentialed licensed independent practitioner shall re-assess the patient immediately prior to induction of moderate sedation.

11.3. The physician/dentist administering deep sedation must be capable of managing inadvertent general anesthesia; which means that he or she must be competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation. The physician/dentist shall re-assess the patient immediately prior to induction of deep sedation.

11.4. There shall be documentation in the medical record that the discharge of any patient from the PACU or other designated recovery area has met the criteria as outlined in section 9.7 above.

11.5. Medical record information from a post-sedation recovery area (regardless of type or location) shall include the patient's level of consciousness on entering and leaving the area, the vital signs, pain intensity and quality, medications administered, and, when such are in use, the status of infusions, surgical dressings, tubes, catheters, and drains.

SECTION 12. Ambulatory Services

12.1. The Medical/Dental Staff shall provide medical/dental diagnosis and treatment in the ambulatory patient care areas. This responsibility can be delegated to an APP through an established collaborative practice agreement. This shall be in accordance with Children's Dallas basic plan for delivery of such services, including the delineation of clinical privileges for all attending physicians and dentists who render ambulatory patient care.

Residents and Fellows may provide care to patients under the direct supervision of an attending physician or dentist.

12.2. An appropriate medical record shall be maintained for every patient receiving ambulatory care and shall be incorporated into the patient's permanent medical record. The record of ambulatory care must include the following:

12.2.1. Adequate patient demographic data;

12.2.2. Pertinent medical and surgical history;

12.2.3. Description of significant clinical, laboratory, and imaging findings;

12.2.4. Diagnosis;

12.2.5. Treatment provided;

12.2.6. Condition of the patient on discharge or transfer;

12.2.7. Any instruction given to the patient and/or family relating to necessary follow-up care; and

12.2.8. Reconciliation of medication, including known allergic and other adverse drug reactions, known long-term medications prescribed for or used by the patient including over-the-counter and herbal treatments.

SECTION 13. Psychiatric Unit

13.1. Overall clinical direction of the psychiatric unit and day-treatment program shall be provided by designated qualified child and adolescent psychiatrist.

13.2. A patient may be admitted to the psychiatric unit only upon the verbal or written order of the medical director of the unit or her/his designee.

13.3. The psychiatric unit shall not accept patients with acute medical problems, unless, in the opinion of the admitting physician, the psychiatric disorders are overriding, and the medical problem has been stabilized and can be safely handled within the psychiatric setting.

13.4. Admissions to the psychiatric unit shall be voluntary.

13.5. Each patient admitted to the unit shall be seen by the attending physician or a designee with appropriate Medical/Dental Staff privileges, preferably at the time of admission but in no case later than twenty-four (24)) hours after admission. A medical history and physical examination shall be completed by a physician with Medical/Dental Staff privileges, APP within twenty-four (24) hours of admission of a patient to the unit. A psychiatric history, mental status examination, differential diagnosis, and proposed treatment plan shall be written by a psychiatrist with Medical/Dental Staff privileges within twenty-four (24) hours after admission of a patient to the psychiatric unit.

13.6. When multidisciplinary treatment plans are used for the care of psychiatric patients, there shall be written policies and procedures relating to their use, including appropriate physician involvement.

SECTION 14. Critical Care Units

14.1. Patients may be referred for admission to the critical care units by any member of the Medical/Dental Staff with clinical privileges on a priority basis. For any patient admitted to the critical care unit, consultation with the Intensive Care Unit intensivist shall be required upon the patient's admission.

14.2. Beds in the critical care units shall be reserved for the care of critically ill patients who have the potential to recover from their acute critical illness by active intervention in an intensive care unit.

14.3. The attending physician is responsible for the care of the patient while in Pediatric Intensive Care Unit ("PICU") and also for the patient's discharge from the unit.

14.4. Approved criteria for admission to the critical care units shall be found in the policy "Admission/Discharge Criteria for Critical Care Units".

14.5. During times when the critical care units are full, the Medical Director of the Critical Care Units shall review each patient's condition on a daily basis and shall have the authority to transfer a patient from the critical care unit to a general nursing unit if such transfer is medically indicated after notification of the patient's attending physician.

SECTION 15. Resident's Scope of Practice

15.1. Residents must meet the qualifications for Resident eligibility outlined in the "Essentials of Accredited Residencies in Graduate Medical Education" in the American Medical Associate's Graduate Medical Education Directory. Dental Residents must meet the qualifications for advanced education students as outlined in the Commission on Dental Accreditation Standards for advanced specialty education programs for their respective specialty.

15.2. The position of Resident shall involve a combination of supervised, progressively more complex, and independent patient evaluation and management function and formal educational activities. The competence of the Resident shall be evaluated on a regular basis by the Program Director.

15.3. The Resident shall provide care commensurate with his/her level of advancement and competence under the general supervision of appropriately privileged attending teaching physicians/dentists. This includes:

15.3.1. Participation in safe, effective and compassionate patient care;

15.3.2. Development of an understanding of ethical, socioeconomic and medical/legal issues that affect graduate medical/dental education;

15.3.3. Utilization, when appropriate, of institutional clinical practice guidelines;

15.3.4. Participation in the educational activities of the training program and, as appropriate, responsibility for teaching and supervising other Residents and students;

15.3.5. Participation in institutional orientation and education programs;

15.3.6. Participation in institutional committees and councils to which the Resident is appointed or invited;

15.3.7. Performance of these duties in accordance with the established practices, procedures, and policies of Children's Dallas, and those of its programs, clinical divisions, and other institutions to which the Resident is assigned, including, among other duties, state licensure requirements for physicians/dentists in training, as applicable;

15.3.8. Compliance with the guidelines of care as defined by the Resident's individual training program; and

15.3.9. Compliance with Children's Dallas policies and procedures, Rules and Regulations, contracts, and institutional agreements.

SECTION 16. Faculty Permit Physicians Scope of Practice

16.1. Physicians who hold faculty permits must meet the qualifications for Active or Associate Staff category membership of the Medical/Dental staff. They may exercise the Active or Associate Staff Category prerogatives outlined in the Medical/Dental Staff Bylaws except as limited by this Section.

16.2. The practice of medicine by faculty permit physicians and their duties and responsibilities shall be limited to the teaching confines of UT Southwestern as required by the Texas Medical Board. They may participate in the clinical, patient care, and teaching activities of UT Southwestern at Children's Dallas.

16.3. Faculty permit physicians may write orders for or prescribe controlled substances for patients of Children's Dallas as allowed under the hospital's controlled substance registration.

SECTION 17. Adoption, Review, and Amendments of the Rules and Regulations

17.1. The Medical/Dental Staff, through its designee, shall periodically review the Rules and Regulations, and the results of this review shall be presented to the Medical Executive Committee. Any revisions based on this review shall be made in accordance with the process outlined in the Medical/Dental Staff Bylaws.

17.2. Rules and Regulations may be adopted, repealed, or amended by a majority vote of the Medical Executive Committee and the Board, in accordance with the process outlined in the Medical/Dental Staff Bylaws.

17.3. Neither the Medical/Dental Staff nor the Board of Directors may unilaterally amend these Rules and Regulations of the Medical/Dental Staff.

ADOPTED BY THE BOARD OF DIRECTORS ON SEPTEMBER 15, 2021 AFTER RECEIPT OF A RECOMMENDATION FROM THE MEDICAL EXECUTIVE COMMITTEE.

Dallas Lawyers Pledge Free Defense of Local Hospitals, Health Care Providers, and Texas Parents in Criminal Cases Involving Gender-Affirming Care

NEWS PROVIDED BY
Aldous\Walker LLP →
May 20, 2022, 16:02 ET

Aldous\Walker, Stephen Malouf ready to provide $1 million in legal services

DALLAS, May 20, 2022 /PRNewswire/ -- Lawyers in Dallas are pledging up to $1 million in free legal services for certain institutions, doctors and parents if the state charges them with a crime for providing or receiving gender-affirming care involving transgender youth.

The offer applies to the following:

- Children's Medical Center at Dallas
- University of Texas Southwestern Medical School
- Officers, employees and doctors at those institutions, as well as any parents seeking care there.

Attorneys Charla Aldous of Aldous\Walker and Stephen Malouf of Malouf & Nockels say they are responding to repeated threats of criminal prosecution made by Texas Gov. Greg Abbott and Attorney General Ken Paxton.

In February, the attorney general issued an opinion that providing gender-affirming care to youth may constitute child abuse, and the state used the opinion as a basis to open investigations of families that allowed transgender children to receive puberty blockers and hormone therapy.

The attorney general's opinion has since been discredited by scientists and doctors familiar with this type of medical care. And last week, the Supreme Court of Texas ruled Gov. Abbott and AG Paxton had no authority to direct the Texas Department of Family and Protective Services to start such investigations. But the court also lifted a stay on the investigations, which are now going forward.

"We are hearing that the state is threatening doctors, hospitals and families with criminal prosecution for simply doing their jobs or caring for their child," says Ms. Aldous. "Steve and I want those parents and doctors to know that if it happens, we will step in and defend them free of charge. Parents who need this care for their children should have a right to it, and the state should not stand in the way. Period."

Ms. Aldous and her law partner Brent Walker, along with Mr. Malouf, already are providing pro bono representation for Dr. Ximena Lopez, the founder of Dallas' GENECIS clinic which, prior to its shutdown last year, was the largest provider of gender-affirming care in the southwest. Aldous, Walker, and Malouf have not received any financial support or funds related to their representation from any person or interest group and have made clear that they are pursuing this matter solely to help children in need.

Last week, the attorneys succeeded in securing a temporary restraining order allowing Dr. Lopez and others to continue such care. A hearing on a temporary injunction is scheduled for May 26.

The Aldous\Walker LLP law firm represents clients in civil litigation and specializes in high-profile, high-stakes cases. Learn more about the firm at http://www.aldouslaw.com.

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SOURCE Aldous\Walker LLP

AAP News™

Risk of pseudotumor cerebri added to labeling for gonadotropin-releasing hormone agonists

July 1, 2022

from the Food and Drug Administration

Article type: FDA Update

Topics: Endocrinology, Hematology/Oncology, Nephrology, Therapeutics, Urology

The Food and Drug Administration (FDA) has added a warning about the risk of pseudotumor cerebri (idiopathic intracranial hypertension) to the labeling for gonadotropin-releasing hormone (GnRH) agonists that are approved for the treatment of central precocious puberty in pediatric patients. These products include Lupron Depot-Ped (leuprolide acetate), Fensolvi (leuprolide acetate), Synarel (nafarelin), Supprelin LA (histrelin) and Triptodur (triptorelin).

The new warning includes recommendations to monitor patients taking GnRH agonists for signs and symptoms of pseudotumor cerebri, including headache, papilledema, blurred or loss of vision, diplopia, pain behind the eye or pain with eye movement, tinnitus, dizziness and nausea.

The FDA assessed the potential risk of pseudotumor cerebri with use of GnRH agonists in pediatric patients by reviewing post-marketing safety data submitted by the GnRH agonist manufacturers, searching the FDA Adverse Event Reporting System and conducting a literature search.

Six cases were identified that supported a plausible association between GnRH agonist use and pseudotumor cerebri. All six cases were reported in birth-assigned females ages 5 to 12 years. Five were undergoing treatment for central precocious puberty and one for transgender care. The onset of pseudotumor cerebri symptoms ranged from three to 240 days after GnRH agonist initiation.

Symptoms included visual disturbances (n=5), headache or vomiting (n=5), papilledema (n=3), blood pressure increase (n=1) and abducens neuropathy (n=1). Treatments included lumbar puncture (n=3), acetazolamide therapy (n=5) and ventricular peritoneal shunting (n=1).

At the time of the FDA's review, symptoms had resolved in three patients, were resolving in one patient, had not resolved in one patient, and one patient's status was unknown. GnRH agonist therapy was discontinued in three patients; the status of continued therapy was unknown for the remaining three patients.

The incidence rate of pseudotumor cerebri associated with GnRH agonist use in pediatric patients could not be reliably established due to the small number of cases and data limitations.

The FDA's Office of Pediatric Therapeutics (OPT), Division of Pediatrics and Maternal Health (DPMH) and Division of General Endocrinology (DGE) contributed to this article. OPT resides in the Office of Clinical Policy and Programs in the Office of the Commissioner. DPMH resides in the Office of Rare Diseases, Pediatrics, Urologic and Reproductive Medicine. DGE resides within the Office of Cardiology, Hematology, Endocrinology and Nephrology. Both DPMH and DGE reside within the Office of New Drugs in the Center for Drug Evaluation and Research.

Resource

Information for health care professionals on reporting adverse events to the FDA

VERIFICATION

THE STATE OF TEXAS §
§
COUNTY OF TRAVIS §

Before me, the undersigned notary, on this day personally appeared Courtney Corbello, the affiant, a person whose identity is known to me. After I administered the oath to affiant, she testified as follows:

1. "My name is Courtney Corbello. I am over 18 years of age, of sound mind, and can make this affidavit. The facts in this affidavit are within my personal knowledge and are true and correct."

2. "I am an Assistant Attorney General in the Office of the Attorney General of Texas. I represent the State of Texas, the relator in this original proceeding. The Mandamus Record (MR) attached hereto contains true and correct copies of pleadings, exhibits, orders, and other documents material to relator's claims for relief."

Courtney Corbello

Subscribed and sworn to me this the 3rd day of August 2022.

Notary Public in and for the State of Texas

My commission expires:

TAMERA MARTINEZ
Notary Public-State of Texas
Notary ID #12505100-3
Commission Exp. AUG. 16, 2023

Notary without Bond

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Thomas Ray on behalf of Johnathan Stone
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