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MONTANA FOURTH JUDICIAL DISTRICT COURT, MISSOULA COUNTY

MOLLY CROSS, et al. Plaintiffs, v. STATE OF MONTANA, et al., Defendants.	Cause No. DV 2023–541 Hon. Jason Marks **DEFENDANTS' BRIEF IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT** [ORAL ARGUMENT REQUESTED]

INTRODUCTION

SB 99 is Montana's response to the alarming trend of giving children puberty blockers, cross-sex hormones, and surgery as experimental treatment for those minors' subjective feelings about his or her sex and gender. Pursuant to the Montana Constitution's Article II, Section 15, the Legislature passed SB 99 with the clear purpose of enhancing minors' protections against the shocking harms of such experimental treatments. Indeed, SB 99 furthers the plain and uncontroversial objective that medical providers should not push treatments on vulnerable children and their families stemming from an ideological rather than evidence-based agenda.

STATEMENT OF UNDISPUTED FACTS[1]

Plaintiffs directly challenge the Montana Legislature's authority to exercise its police power to enhance minors' protections against grievous harms such as sterilization, disfigurement, and lifelong medicalization, to name a few. The scientific evidence on the safety of so-called on "gender-affirming care" ("GAC")—nationally and internationally—continues to trend in support of the conclusion that the treatments at issue result in far more harm than good. At best, the relevant evidence is conflicted and uncertain. Yet Plaintiffs claim that children—who cannot vote, purchase alcohol or tobacco, enter into contracts, join the military, or consent to sexual intercourse—can consent to experimental and irreversible procedures likely to exacerbate preexisting mental and emotional problems, harm them physically, suppress the natural development of their bodies and brains, and causes sterilization.

Consensus on bona-fide health risks. There is consensus in the medical community that GAC presents unique bona fide health risks to minors. The long-awaited 2024 Cass Review Final Report[2] highlights these risks. (Decl. of Geeta Nangia, ¶ 60 (Jan. 15, 2025), **attached as Exhibit A**). It was an "independent review (commissioned by the NHS of England) of gender identity services for children and young people. This review … is the most comprehensive review of gender identity services that has been done to date … [and] included 113,269 children and adolescents from 18 countries." (*Id.*) The findings include, among many others, that: WPATH "has been highly influential in directing international practice, although its guidelines were found by the University of York appraisal process to lack developmental rigour"; "given that the vast majority of young people started on puberty blockers proceed from puberty blockers to masculinizing or feminising

[1] The State incorporates by reference the background section of Defendants' Response in Opposition to Plaintiffs' Motion for Preliminary Injunction, as well as Exhibits A through EE provided with that Response. (Docs. 77-108).
[2] The Final Report is available at: https://cass.independent-review.uk/home/publications/final-report/. For the Preliminary Injunction, Defendants provided the Interim Report. (Doc. 95.)

hormones, there is no evidence that puberty blockers buy time to think, and some concern that they may change the trajectory of psychosexual and gender identity development"; and "[i]t has been suggested that hormone treatment reduces the elevated risk of death by suicide in this population, but the evidence found did not support this conclusion." (*Id.* ¶¶ 64–80).[3] Within a short time, the sale and supply of puberty blockers for treatment of gender dysphoria was restricted in the United Kingdom, followed by the government announcing its intent to ban such practices indefinitely.

The United Kingdom is not alone[4] with this determination:

- Sweden does not offer gender transitioning outside of research settings;
- Finland requires psychotherapy and has sharply restricted eligibility of this kind of treatment;
- Following the Cass Report, Scotland and Wales set the age of puberty blocker access to 18;
- Denmark restricted eligibility for puberty blockers and cross-sex hormones;
- Norway declared gender affirming care as "experimental"; and
- Italy's National Bioethics Committee recently updated its stance that puberty blockers should be provided only in the context of research trials.

And many other countries, including their major medical journals, have initiated internal reviews and are reconsidering access to puberty blockers.

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[3] The author of the report, Hilary Cass, later stated in an interview with NPR, "[W]e have even less research on what the right approach is for those young people. So you can't put all of these young people into the same treatment group and say they're all going to respond in exactly the same way to this kind of approach … [T]here has been a real swing to seeing gender-affirming care as being pretty much synonymous with medical care. And that certainly doesn't have to be the case … [I]t's really worth saying that just giving hormones without supporting people is not helpful." 'The evidence was disappointingly poor': The full interview wit Dr. Hilary Cass, NPR (May 8, 2024), https://www.nprillinois.org/2024-05-08/the-evidence-was-disappointingly-poor-the-full-interview-with-dr-hilary-cass.

[4] *SEGM promotes safe, compassionate, ethical and evidence-informed healthcare for children, adolescents, and young adults with gender dysphoria.,* SEGM (Dec. 30, 2024), https://segm.org/ (referring to country list and citations located about halfway down page).

Contrary to Plaintiffs' unevidenced contentions that puberty blockers are safe and reversible (Doc. 50 at 3), experts continue to raise concerns about puberty blockers. GnRH analogs are puberty blockers—"[t]hey are approved for use in children who have the relatively rare disorder called central precocious puberty." (Doc. 92 at ¶ 125). "There are no controlled trials that prove the safety of GnRH analogs in children with normal puberty." (*Id.* ¶ 128). "Without long-term controlled prospective studies, there is no way to show any additional benefits or harm. What we are left with is retrospective data and proven physiology from the general population as well as registry data from those patients who have received GnRH agonist therapy for hormone-dependent cancers and from GnRH-treated children with precocious puberty." (Decl. Quentin Van Meter, ¶ 17 (Jan. 15, 2025), **attached as Exhibit B**).

Lack of consensus on health benefits.

In July 2024, the High Court of Justice in England dismissed, in its entirety, plaintiffs' application for judicial review of the Secretary of State for Health and Social Care's emergency prohibition that restricted access to puberty blockers being prescribed to gender dysphoric minors. *TransActual CIC v. Sec'y of State for Health and Soc.*, [2024] EWHC 1936 (Admin), ¶¶ 1-2, 6-9, 257. In the Court's Order, it made these findings: "[A]ny benefits of puberty blockers were (save in one "very narrow" respect) unproven or non-existent." *Id.* ¶ 195; *See also id.* ¶¶ 196-199. "Blocking the release of [] sex hormones could have a range of unintended and as yet unidentified consequences," including "rewiring of neural circuits underlying executive function"; "temporarily or permanently disrupted" brain maturation; and "bone density [being] compromised during puberty suppression." *Id.* ¶¶ 200(i)-(v). Moreover, "[a] known side effect of puberty blockers was to reduce psychological functioning." *Id.* ¶ 200. Most importantly, "the evidence did not support the conclusion that gender-affirming treatment reduced suicide risk." *Id.* ¶ 202.

Ultimately, for the many significant concerns, puberty blockers became "only [] offered under a research protocol." *Id.* ¶ 205.

Despite Plaintiffs' claims that "medical interventions beyond puberty blockers and hormone therapy are rare," (Doc. 50 at 5), gender-affirming surgeries tripled in the United States between 2016 and 2019. (Doc. 94). There is insufficient evidence to demonstrate that gender reassignment surgery improves health outcomes. (Doc. 77 at n.59). Additionally, "[n]o methodologically sound studies have provided meaningful evidence that medical transition reduces suicidality in minors." (Doc. 79 at ¶ 146). According to a Swedish study, "[w]hen 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." (Doc. 78 at ¶ 214) (emphasis added). "Among post-operative patients in the Netherlands, long-term suicide rates of six times to eight times that of the general population were observed depending on age group." (Doc. 79 at ¶ 147). Another study in the Netherlands "reported the 'important finding' that 'suicide occurs similarly' before and after medical transition." (Doc. 79 at ¶ 147). In other words, surgical transitioning failed to resolve and may in fact have exacerbated the children's core physical and mental health issues.

What's left are those that were misled and have suffered. A few testified before the first Senate Judiciary Committee hearing on SB 99.[5] (*See*, *e.g.*, 1/27/23 Hearing at approx. 08:34:00 (Jared Evans, a Montana father, assuring this is happening in this state based on his personal experience with his daughter transitioning and becoming estranged from her family following meetings with a school counselor who told her never to speak to her parents about these issues); *id.* at approx. 08:09:30 (detransitioner Walt Heyer); *id.* at approx. 08:14:00

[5] 1/27/23 Hearing video available at https://tinyurl.com/33nr5fs5.

(detransitioner Camille Kiefel); *id.* at approx. 08:16:40 (detransitioner Erin Brewer); *id.* at approx. 09:27:25 (detransitioner Laura Smith, representing thousands who have contacted her about transition regret). Then there are those that felt compelled, despite its social unpopularity, to become involved. (*See*, *e.g.*, Docs. 105-108 (detransitioners Camille Kiefel and Aether Dixon, as well as parents Yaacov Sheinfeld and Jeanne Crowley); detransitioner Luka Hein (Decl. of Luka Hein, (Jan. 15, 2025), **attached as Exhibit C**); as well as detransitioner and Montanan Elle Palmer (Decl. of Elle Palmer, (Jan. 15, 2025), **attached as Exhibit D**). This also includes Jamie Reed—a whistleblower and former believer in this so-called treatment—now exhausting herself trying to stop it. (Doc. 104).

The clearest (and saddest) example of the failure of gender affirming care is the ongoing medical negligence lawsuits, including the one where Plaintiffs' primary expert is the main defendant. Shortly after the New York Times published an exposé[6] accusing Dr. Johanna Olson-Kennedy of hiding a multi-million-dollar taxpayer-funded study from the public, a former patient of Olson-Kennedy sued the doctor over Olson-Kennedy's provided services. The former patient alleged that despite being a "vulnerable girl struggling with complex mental health struggles and suffering from multiple instances of sexual abuse," she was "prescribed a series of life-altering puberty blockers and cross-sex hormones, [and] ultimately, receive[d] a double mastectomy at the age of 14." (*Breen v. Olson-Kennedy*, Case No. 24STCV32096, 2024 Cal. Sup., ¶1, **attached as Exhibit H**). The gender dysphoria diagnosis and medical recommendations occurred "after mere minutes" with Dr. Olson-Kennedy. *Breen* is just one of the growing number[7] of lawsuits against providers of gender affirming care.

[6] Azeen Ghorayshi, *U.S. Study on Puberty Blockers Goes Unpublished Because of Politics, Doctor Says*, The New York Times, (Oct. 23, 2024) ("The leader of the long-running study said that the drugs did not improve mental health in children with gender distress and that the finding might be weaponized by opponents of the care.")
[7] More Complaints can be found here: https://cmppllc.com/?page_id=203.

This suffering is avoidable. Both WPATH and the Endocrine Society agree on this point: not every child who believes he or she is gender dysphoric will continue to believe that as they grow and mature. WPATH's SOC 7 states as much: "Gender dysphoria during childhood does not inevitably continue into adulthood. 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." (Doc. 85 at 11.) According to the Endocrine Society, "the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain [gender dysphoric]/gender incongruent in adolescence." (Doc. 86 at 3879.) Accepting the WPATH and Endocrine Society's—the leading advocacy groups for gender affirming care—statements as true, as well as the ACLU's concession that completed suicide is rare and that there's no evidence that the treatment reduces completed suicide,[8] there is no reason to subject children to unproven, experimental treatments that can destroy their bodies.

Ideological underpinning of Gender-Affirming Care ("GAC").

The consensus that GAC poses bona fide health risks, coupled with the lack of consensus on GAC's health benefits, begs the following question: what is driving the very recent and drastic increase in minors perceiving themselves to be the opposite sex and seeking GAC? The answer is ideology. (Decl. of James Lindsay Ph.D., ¶ 57 (Jan. 15, 2025), **attached as Exhibit G**). Indeed, the phenomenon of so-called "gender transition" via GAC "is based upon an ideological worldview known as critical constructivism as it is applied particularly to sex, gender, and sexuality[.]" (*Id.* ¶ 14.) This is colloquially referred to as "gender ideology." (*Id.*) Gender ideology derives from (Western) Marxist ideology and its specific derivatives as developed in academic literature beginning in the twentieth century. (*Id.*, generally.)

[8] On this point, Chase Strangio, the Deputy Director for Transgender Justice and staff attorney for the ACLU, conceded to Justice Samuel Alito in oral argument for *United States v. Skrmetti* that "there is no evidence in some -- in the studies that this treatment reduces completed suicide. And the reason for that is completed suicide, thankfully and admittedly, is rare[.]" (Transcript at 88:16-20.) Available at: supremecourt.gov/oral_arguments/audio/2024/23-477.

At bottom, gender ideology aims to oppose, disrupt, deconstruct, critique, and dismantle the existing societal sense of normalcy and legitimacy, and it rejects the idea that an objective shared reality exists. (*Id.* ¶¶ 52-53.)

The sudden rise in gender dysphoria in young individuals is worrisome considering this condition was extremely rare just a generation ago. (Doc. 81). In Sweden, for example, "[a] total of 12 people under 25 were diagnosed with gender dysphoria in 2001, by 2023 the figure was 2,248." (Decl. of Sven Roman, ¶ 7 (Jan. 15, 2025), **attached as Exhibit E**). By 2022, "2–9% of U.S. high school students identif[ied] as transgender, while in colleges, 3% of males and 5% of females identif[ied] as gender-diverse." (Doc. 81 at 3). This phenomenon spans the western world. In 2018, the UK reported a "4,400 percent rise over the previous decade in teenage girls seeking gender treatments." (Doc. 77 at n.16). The same was true for Canada, Germany, Finland, and Sweden over the same period. (Doc. 82); (Doc. 77 at n.17). "The increase in the diagnosis of childhood gender dysphoria was moderate until 2007, … and then the increase accelerated to become very high from 2014 onwards, when social media had become ubiquitous among adolescents." (Ex. E, ¶ 8.) Based on 256 reports from parents of adolescent girls who discovered transgender identity in adolescence, almost 65% of those girls had done so after a period of prolonged social media or internet use. (Doc. 84.)

Because most gender dysphoric youths desist, "watchful waiting" is the safest treatment method for affected children. Watchful waiting is not a passive approach—rather, it provides time for the child to "undergo therapy, resolving other issues which may be exacerbating psychological stress or dysphoria." (Doc. 79 at ¶ 244). Watchful waiting is a compassionate, effective, and much less risky approach that entails "a comprehensive assessment, individual and family therapy, and harnessing a support network for the patient." (Doc. 87 at ¶ 164).

In contrast, so-called "gender-affirming care" is a *far* riskier treatment modality. This model represents a branch of medicine which, outside of cosmetic surgery, may be the only one in which *the patient* makes the diagnosis and prescribes the treatment. Gender-affirming care "aim[s] to directly and immediately validate the adolescent's feelings about becoming the opposite gender" and then sets the patient on a likely irreversible path toward puberty blockers, cross-sex hormone therapy, and eventually gender reassignment surgery. (Doc. 87 at ¶ 118). "Social transition serves to convince the child or adolescent that they can be the opposite sex." (Doc. 78 at ¶ 285). Early validation and encouragement of social transitioning sets the child's course toward full gender transitioning. The study finding the highest rate of persistence "included some patients who had made a partial or complete gender social transition prior to puberty and *this variable proved to be a unique predictor of persistence*[.]" (Doc. 89 at 14) (emphasis added). Social transitioning encourages full medical transition, including puberty suppression.

Informed Consent and Medical Ethics. In this context, it is unclear how informed consent could be achieved. "That adolescents find it difficult to contemplate or comprehend what their life will be like as adults and that they do not always consider the longer-term consequences of their actions is perhaps a statement of the obvious." *Bell v. Tavistock*, [2020] EWHC 3274 (Admin), ¶ 141 (*see* Doc. 91).[9] "There does not exist—indeed, there cannot exist—an age-appropriate way to equip a child who has not gone through puberty to make an informed decision about age-inappropriate issues, such as their future sex life, choices of sexual partners, sex-bonded relationships including marriage, and sacrificing ever experiencing orgasm." (Ex. 79 at ¶ 234). This is because, "[w]hen there is perceived reward with one

[9] The *Bell* Court exhaustively laid out eight critical points of data that a "child would have to understand, retain and weigh up in order to have the requisite competence" to make an informed decision. (Doc. 91 at ¶ 138.) "We do not think that the answer to this case is simply to give the child more, and more detailed, information. The issue in our view is that in many cases, however much information the child is given as to long-term consequences, s/he will not be able to weigh the implications of the treatment to a sufficient degree. There is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years." (*Id*. ¶ 144).

pathway, despite long-term risks associated with that pathway, adolescents will generally select it rather than consider that there are alternative pathways with fewer long-term risks. ” (Ex. A, ¶ 10). “With medical gender transition, adolescents are likely to perceive reward (in this case, reduced dysphoria) with the pathway of puberty blockers and cross-sex hormones and hence, they are likely to choose this path rather than considering other paths (such as engaging in exploratory or supportive therapy, socially transitioning, and waiting until adulthood for medical transition).” (*Id*.) A parent cannot make this drastic and consequential decision for a child, and a child is simply incapable of making such a decision. (Doc. 79 at ¶¶ 207, 212, 234); (Doc. 87 J at ¶¶ 61–112, 115–135); (Ex. A, ¶¶ 12–14). “When the adolescent matures to adulthood and can’t reverse consequences (e.g., fertility) of interventions that the parent consented to without the adolescent having had full capacity to appreciate, psychological repercussions are likely to be profound.” (Ex. A, ¶ 13).

“WPATH's revisions of guidelines to eliminate or minimize the doctor's responsibility regarding decision-making with respect to [medicalized gender transition] violate accepted principles of medical ethics.” (Decl. Farr Curlin, ¶ 53 (Jan. 15, 2025), **attached as Exhibit G**). “In its Standards of Care, version 8, WPATH suggests that gaps in evidence demonstrating the safety and efficacy of MGT should not prevent the use of MGT in adolescents ‘given the ethics of self-determination in care.’” (*Id*.) (quoting WPATH SOC 8 at S45.) “The new guidelines also emphasize a ‘right to bodily and mental integrity, autonomy, and self-determination,’ and a putative need for healthcare practitioners to ‘[m]atch the treatment approach to the specific needs of patients, particularly their goals for gender identity and expression.’” (*Id*.) (quoting WPATH SOC 8 at S21.)

“[B]ut the ethical standard for medical decision-making with respect to minors is decidedly not ‘self-determination.’ Rather, as noted in the [American

Academy of Pediatrics] Committee on Bioethics Report, 'Informed Consent in Decision- Making in Pediatric Practice,' the physician acts in a fiduciary relationship with the child, governed by 'the duties to protect and promote health-related interests of the child and adolescent … [, and] these duties may conflict with the parent's or patient's wishes.'" (*Id*. ¶ 54) (quoting AAP Committee on Bioethics Report at e2). "'Historically and legally,' the AAP report continues, 'medical decision-making in children has centered on the best-interest standard, which directs the surrogate to maximize benefits and minimize harms to the minor.'" (*Id*.) (quoting AAP Committee on Bioethics Report at e6). "'A reliance on individual liberties and autonomy in the pediatric patient,' the AAP report notes, 'is not realistic or legally accepted.'" (*Id*.) (quoting AAP Committee on Bioethics Report at e2). Therefore, "[b]y appealing to self-determination to justify [medicalized gender transition] for minors, WPATH and the plaintiffs are putting the onus on children to make clinical decisions that they haven't information, comprehension, or authority to make, and thereby retreating from physicians' ethical obligations to protect children—a class of vulnerable subjects—from interventions that subject children to risks and harms without clear evidence of proportionate medical benefit. (*Id*. ¶ 55). This alone is enough to justify that no controlled studies can ever be justified on an ethical basis. No institutional review board would ever condone such harmful experimentation on human subjects." (Ex. B at ¶ 18); see also 45 C.F.R. § 46.401, et seq.

STANDARD OF REVIEW

Mont. R. Civ. P. 56 provides that summary judgment is proper when there are no issues of material fact and the moving party is entitled to judgment as a matter of law. *Satterlee v. Luberman's Mut. Cas. Co.*, 2009 MT 368, ¶ 9, 353 Mont. 265, 222 P.3d 566. To satisfy this burden, the movant must exclude any real doubt as to the existence of any genuine issue of material fact by making a clear showing as to what the truth is. *Lorang v. Fortis Ins.*, 2008 MT 352, ¶ 37, 345 Mont. 12, 192 P.3d 186.

If the moving party meets its burden of proving a complete absence of genuine issues of material fact, the burden then shifts to the non-moving party to set forth specific facts, not merely denials, speculation, or conclusory statements, to establish that a genuine issue of material fact exists. *Id.* ¶ 39. If no genuine issues of material fact exist, the Court must determine whether the moving party is entitled to judgment as a matter of law. Mont. R. Civ. P. 56(c).

"The constitutionality of a legislative enactment is prima facie presumed, and every intendment in its favor will be presumed, unless its unconstitutionality appears beyond a reasonable doubt." *Powell v. State Comp. Ins. Fund*, 2000 MT 321, ¶ 13, 302 Mont. 518, 15 P.3d 877. "Every possible presumption must be indulged in favor of the constitutionality of a legislative act." *Id.* "We regard that presumed constitutionality as a high burden to overcome." *Planned Parenthood v. State*, 2024 MT 178, ¶ 16, 417 Mont. 457, 554 P.3d 153 (citing *Hernandez v. Bd. of Cnty. Comm'rs*, 2008 MT 251, ¶ 15, 345 Mont. 1, 189 P.3d 638). The party challenging the constitutionality of a statute bears the burden of proof. *Molnar v. Fox*, 2013 MT 132, ¶ 49, 370 Mont. 238, 301 P.3d 824. "[I]f any doubt exists, it must be resolved *in favor of the statute*." *Powell*, ¶ 13 (emphasis added).

ARGUMENT

I. THE UNDISPUTED FACTS SHOW THAT SB 99 CONSTITUTIONALLY ENHANCES MINORS' PROTECTION.

The record shows the undisputed facts: SB 99 prohibits experimental treatments that present real risks that their speculative benefits do not outweigh. The people's representatives in the Legislature enacted SB 99 to "enhance the protection of minors and their families … from any form of pressure to receive harmful, experimental puberty blockers and cross-sex hormones and to undergo irreversible, life-altering surgical procedures prior to attaining the age of majority." Mont. Code Ann. § 50-4-1002. SB 99 does just that—it prohibits medical providers from pushing

and using unvetted, irreversible, and often sterilizing—that is, unacceptably risky—medications and procedures on Montana children.

"The rights of persons under 18 years of age shall include, but not be limited to, all the fundamental rights of this Article *unless specifically precluded by laws which enhance the protection of such persons*." Mont. Const. art. II, § 15 (emphasis added). The Montana Constitution thus "recognizes that the State's interest in protecting children may conflict with their fundamental rights." *In re C.H.*, 210 Mont. 184, 202, 683 P.2d 931 (1984). As the comments provide from the constitutional convention's Bill of Rights Committee, "In such cases where the protection of the special status of minors demands it, *exceptions can be made on clear showing* that such protection is being enhanced." *Id.* at 202–03 (quoting Committee Report, Vol. II, 636 (1971–72) (emphasis added). "[I]f the legislature seeks to carve exceptions to this guarantee, it must not only show a compelling state interest," *In re S.L.M.*, 287 Mont. 23, 35, 951 P.2d 1365 (1997), but also must show that the provision enhances "the *protections* provided minors." *Planned Parenthood*, ¶ 21.

In sum, in Montana, minors and adults alike possess all the fundamental rights found in the Declaration of Rights. Mont. Const. art. 2, § 15. Yet the Constitution also creates an explicit exception allowing the Legislature to enact laws for enhancing minors' protection that specifically preclude minors' fundamental rights. *Id.* Section 15 presents a unique exception to minors' normal exercise of fundamental rights. Rather than being a creature of statute or jurisprudence, Section 15 creates a textual exception to minors' exercise of fundamental rights. To fit this constitutional mandate, the Legislature must clearly show: (1) a compelling state interest; and (2) that the provisions enhance minors' protections. Accordingly, SB 99 is plainly constitutional under this standard.

"[B]oth the medical and legal grounds regarding the subject treatment of minors addressed by SB 99 are moving under our feet." *Cross*, ¶ 69 (Rice, J., dissenting). National and international concerns of the efficacy of these experimental treatments continually grow. *See TransActual CIC*, ¶¶ 194–95 (England High Court of Justice) (relying on the "best and most-up-to-date scientific evidence available" to find that "any benefits of puberty blockers were (save in one 'very narrow' respect) unproven or non-existent."); *Alabama v. United States Sec'y of Educ.*, No. 24-12444, 2024 U.S. App. LEXIS 21358, at 3-4 (11th Cir. Aug. 22, 2024); *L.W. v. Skrmetti*, 83 F.4th 460 (6th Cir. 2023). And while the medical community's serious doubts over the benefits of these treatments continually grow, there is consensus on these experimental treatments' significant risks.

The reality is that courts are ill-suited to sort out the many issues and ancillary concerns of subjective gender identity. *See Glucksberg*, 521 U.S. 702, 720 (1997). Rather, the "vigorous, sometimes frustrating, 'arena of public debate and legislative action'" is the proper forum to contend with these vexing public policy debates. *Skrmetti*, 73 F.4th at 420 (quoting *Glucksberg*, 521 U.S. at 720). This only confirms why the Legislature has "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007).

A. The State has a compelling interest in protecting minors from pressure to receive the experimental treatments.

The State indisputably has "a compelling interest in protecting the physical and psychological well-being of minors." *Sable Communications of Cal. v. FCC*, 492 U.S. 115, 125 (1989). Indeed, elsewhere in civil and criminal contexts the State protects minors in ways it does not afford to adults. GAC's highly dubious benefits—lacking any evidence-based medicine support—coupled with its confirmed risks, require a policy of enhanced protections for minors. No matter how "safe and effective" or "medically necessary" Plaintiffs purport these experimental treatments and procedures to be, nor how often they repeat these invocations, their

rhetorical flourish simply cannot outweigh the vast countervailing evidence. GAC poses unacceptable risks to Montana's children. There is a reason why "progressive" nations, like those of the Scandinavian region and the United Kingdom, have reversed course on these experimental treatments and procedures. The rapidly changing legal, ethical, and medical landscapes demanded the Legislature step in to protect minors' health and safety. SB 99 does just that.

The Legislature has enacted many laws for enhancing minors' protections. And those laws can preclude fundamental rights, such as the right to privacy under the Montana Constitution. Those laws cover various topics and create different age limits for behaviors permissible for adults—for example: waterskiing; using firearms; contracting for insurance; when to get married; mining; and getting a tattoo. [10] All these laws—absent the Montana Constitution's Article II, Section 15 provision—would violate minors' fundamental rights. Yet because these laws enhance minors' protections, they pass constitutional muster. SB 99 is no different.

1. There is no genuine dispute that no medical consensus exists on the benefits of GAC.

a. The State's experts, WPATH, Plaintiffs' experts, and Plaintiffs establish the medical community lacks consensus on the benefits of GAC.

There is no medical consensus on the benefits of GAC for minors experiencing gender dysphoria. Discerning a benefit can be difficult. For example, some might consider a benefit to be achieving the goal of treatment: giving a female minor testosterone to lower her voice. But that is a short-term benefit; once she stops

[10] Mont. Code Ann. § 23-2-529 (generally prohibits minors 12 years old or younger from solely operating a motorboat or vessel for waterskiing); Mont. Code Ann. § 45-8-344 (generally prohibits minors 14 years old or younger from carrying or using in public any firearm); Mont. Code Ann. § 33-15-103 (generally prohibits minors younger than 15 years old to contract for insurance); Mont. Code Ann. § 40-1-202(1) (generally prohibits minors 16 years old or younger from receiving a marriage license); Mont. Code Ann. § 41-2-107(7) (generally prohibits minors of 16 or 17 years old from being a miner); and Mont. Code Ann. § 45-5-623(g) (generally prohibits minors younger than 18 years old from receiving a tattoo without parental consent).

taking testosterone, the female's physiology and natural body function *should* restart. Yet by taking testosterone, the female minor may develop an increased risk of heart attack or stroke; other secondary sex characteristics, like the deepened voice, are irreversible.

"No methodologically sound studies have provided meaningful evidence that medical transition reduced suicidality in minors. Instead, multiple studies show tragically high rates of suicide *after* medical transition, with that rate beginning to spike several years after medical transition." (Doc. 92, ¶¶ 109–16). "Without long-term controlled prospective studies, there is not way to show any additional benefits or harm." (Ex. B, ¶ 17).

Plaintiffs' experts proffers that, absent puberty blockers, gender dysphoric children are at a higher risk of, among other things, suicide. But Plaintiffs present no valid or reliable evidence to show the experimental treatments and procedures actually improve minors' conditions or outcomes. Tellingly on this point, ACLU's counselors directly contradicted Plaintiffs' expert's testimony here while arguing against a similar Tennessee law before the United States Supreme Court. GAC does not actually reduce the suicidality rates among gender dysphoric minors.[11] During the recent oral argument, the ACLU's counsel conceded, "there is no evidence in some—in the studies that this treatment reduces completed suicide. And the reason for that is completed suicide, thankfully and admittedly, is rare[.]"[12] This admission cuts directly against the purported benefits Plaintiffs' expert Olson-Kennedy proffered. This inconsistency is no surprise.

All the evidence taken together paints a picture: it is unclear what the fully realized benefits of the experimental treatments and procedures are, if any. Some medical providers have pulled back certain treatment regimes, such as in Europe,

[11] *See* n. 8, supra.
[12] *Id*.

while others expand. (*See* Doc. 104, ¶ 18). Justice Rice's assessment of the situation is on point in this regard. This highlights then that courts, as United States Supreme Court justices recognized during those oral arguments, are ill-positioned to decide medical and public policy debates. But the evidence speaks for itself: there is no consensus on GAC's benefits.

2. There is no genuine dispute that there is medical consensus on the risks of these procedures.

In stark contrast to GAC's purported benefits, there is significant medical consensus on the serious consequences of these experimental treatments. Some of these consequences include impaired physical development, bone fragility and density issues, loss of sexual function, infertility, impaired brain development, emotional and intellectual consequences, negative psychological consequences, increased risk of strokes and cancers, and a lifetime dependence on these drugs. These are not speculative harms; if medical providers administer puberty blockers, cross-sex hormones, or surgery to minors, those children are all but certain to suffer any number of these harms. The breadth of the risks is matched by the breadth of expertise that agrees on this point.

a. Medical experts agree these experimental procedures present bona fide risk to minors.

Rather than select alternative pathways which present fewer long-term risks, minors "will generally select" pathways which present perceived rewards despite long-term risks. (Ex. A, ¶ 10). Essentially, minors take the path of immediate gratification without regard for later issues. (*Id*.) This is hardly surprising, and who can blame them? They are confused children and worried families receiving advice from trusted medical providers. But that does not absolve the experimental treatments of risk.

Olson-Kennedy's deposition brims with the risks associated with GAC. For example, risks of puberty blockers in Tanner Stage 2 of puberty for females include

menopausal risks like insomnia, short term memory loss, and hot flashes. (Dep. Tr. of Johanna Olson-Kennedy, 85: 13-22, **excerpts attached as Exhibit J)**. Risks of cross-sex hormones for females include clitoral enlargement and pain with sex while risks for males includes blood clots, stroke, and heart attack. (*Id.* at 87: 12-22; 91: 4-16). To preserve a male's fertility before undergoing cross-sex hormone treatment, he would need to do fertility preservation. (*Id.* at 94: 24-25; 95:1-7).

The experts agree that these experimental treatments and procedures present bona fide risk to minors. These are not hypothetical harms; minor patients suffer the consequences of this experimental treatment. (*See* Ex. C, ¶ 20; Ex. D, ¶ 19); (*see also* Doc. 104, ¶ 9).

b. WPATH and the Endocrine Society.

Even WPATH and the Endocrine Society's protocols recognize the vast risks associated with GAC. These potential harms include sterilization; loss of capacity for breast-feeding; lack of orgasm and sexual function; interference with neurodevelopment and cognitive development; harms associated with delayed puberty; reduced bone density; short-term side effects like leg pain, headache, mood swings, and weight gain; and long-term side effects like unfavorable lipid profiles.

"Systemic long-term studies are *urgently needed* to compare individuals with the same intersex conditions who differ in age at surgery or have had no surgery with regard to gender identity, mental health, and general quality of life." WPATH SOC 8 at S102 (emphasis added). Elsewhere, WPATH states

> We recommend health care professionals working with transgender and gender diverse adolescents requesting gender-affirming medical or surgical treatments inform them, prior to the initiation of treatment, of the reproductive effects, including the potential loss of fertility and available options to preserve fertility within the context of the youth's stage of pubertal development.

WPATH SOC 8 at S57. "Many gender-affirming surgeries can have significant effects on erogenous sensation, sexual desire and arousal as well as sexual function

and pleasure." WPATH SOC 8 at S166–67. Attached is the full list of risks from cross-sex hormone treatment. (Appendix C – Gender-Affirming Hormonal Treatments, **attached as Exhibit I**, at S254–55). WPATH conveniently provides a table of risks associated with cross-sex hormones (what WPATH refers to as gender affirming hormone therapy). "Likely increased risks of estrogen-based regimens include venous thromboembolism, intertility, hyperkalemia, and hypertrigyceridemia, and weight gain. Likely increased risks of testosterone-based regimens include polycythemia, infertility, acne, androgenic alopecia, hypertension, sleep apnea, weight gain, decreased HDL cholesterol, and increased LDL cholesterol." *Id.*

WPATH, knowing of this risk, tried to relieve the medical provider's responsibility for experimental treatments and procedures' consequences. (Ex. F, ¶ 53). Indeed, WPATH places in the minors' hands decisions with lifelong implications under the guise of "ethics of self-determination in care." (*Id.*) (quoting WPATH SOC 8 at S45). "[B]ut the ethical standard for medical decision-making with respect to minors is decidedly not 'self-determination.' Rather, as noted in the [American Academy of Pediatrics] Committee on Bioethics Report, 'Informed Consent in Decision- Making in Pediatric Practice,' the physician acts in a fiduciary relationship with the child, governed by 'the duties to protect and promote health-related interests of the child and adolescent … [, and] these duties may conflict with the parent's or patient's wishes.'" (*Id*. ¶ 54) (quoting AAP Committee on Bioethics Report at e2).

WPATH recognizes the risk and tries to avoid accountability. Nevertheless, it accepts and acknowledges that GAC presents significant, lifelong risks to children.

c. FDA does not approve puberty blockers for treatment of gender dysphoria.

When the FDA approves a drug for a certain use, it is saying that drug is safe and effective for that use. If a drug lacks FDA approval for a certain use, that means

the FDA lacks rigorous testing and sufficient evidence to prove the drug is safe for the use (although this could change). GnRH analogs, also known as puberty blockers, are not FDA approved for treating children with gender dysphoria; the evidence has not established that they are safe for that use. *See* (Ex. B, ¶ 17). They are however approved for children with central precocious puberty, which is when puberty occurs before the typical age of 8 in girls and 9 in boys. They may also be used to treat symptoms of girls suffering polycystic ovarian syndrome. "Under a highly reticulated process that requires considerable long-range testing, the FDA determines when new drugs are safe for public use, including use by minors, and when new drugs are safe for certain purposes but not others." *Skrmetti*, 73 F.4th at 417. "It is well within a State's police power to ban off-label uses of certain drugs. At the same time, it is difficult to maintain that the medical community is of one mind about the use of hormone therapy for gender dysphoria when the FDA is not prepared to put its credibility and careful testing protocols behind the use." *Id*.

B. SB 99 enhances minors' protection.

Section 15 also requires showing that the laws enhance minors' protections. *Planned Parenthood*, ¶ 21. As the Bill of Rights Committee explained, "The only exceptions permitted to this are in cases in which rights are infringed by laws designed and operating to enhance the protection for such persons." Committee Report, Vol. II, 635 (1971–72) This means that "[i]n such cases where the protection of the special status of minors demands it, exceptions can be made on clear showing that such protection is being enhanced." *Id.* at 636. Delegate Monroe explained, "[w]hat this section is attempting to do is help young people reach their full potential." 5 Mont. Const. Convention, Verbatim Transcr. 1749 (March 8, 1972).

SB 99 provides minors with the opportunity to reach their full potential without being denied freedoms or autonomy later in life because of their rash decisions as children. It prevents susceptible youth and their families from medical

providers' pressure to receive experimental treatments and procedures which will all but certainly change their physiology and natural bodily functions. Sterility, bone fragility, inability to achieve orgasm, and a host of other harms can befall minors before they ever reach their full potentials. Taking away procreative autonomy before reaching majority, for example, is unacceptable. SB 99 protects minors from this dim future.

Enhancing minors' protection is still however a vague concept. One man's enhancing protections could be another man's unnecessary overreach. The State contends that enhancing protections means just that: providing greater protection because of the special status of minors. But even under a more rigorous metric of enhancing protections SB 99 survives. *Armstrong*, for example, provides a framework where the State can prove SB 99 enhances minors' protection.

1. The State has established that GAC's risks are medically acknowledged and *bona fide*.

To succeed under *Armstrong*, the State need only show there is a "medically-acknowledged, *bona fide* health risk," *Armstrong v. State*, 1999 MT 261, ¶ 59, 296 Mont. 361, 989 P.2d 364. The State's burden does include showing that there is actual harm (although it has) or the degree of the risk, nor must it design a cost-benefit analysis of that risk. *Armstrong* requires a showing that such risk exists, and the State has done so.

The parties' medical experts agree that medical consensus establishes that GAC presents medically acknowledged, bona fide health risks. (*See* Statement of Undisputed Facts, *supra*).

But it is not just the medical evidence that exposes these risks. The ever-growing number of individuals who received GAC are minors and now regret having done so—detransitioners—are perhaps the most direct evidence of GAC's harms. Plaintiffs' efforts to dismiss or ignore the same cannot change this reality.

Elle Palmer is a Montanan and a detransitioner. (Ex. D, ¶ 3). She underwent typical GAC treatment and began developing male secondary sex characteristics like a deeper voice, body hair growth, and growing an Adam's apple. (*Id.* ¶¶ 8–9). She also developed a thin vaginal wall and conditions that made her feel "like an old person." (*Id.* ¶¶ 10–11). She had unfortunately kept her baritone voice through her detransition and is misidentified as a transwoman. (*Id.* ¶¶ 17–19). Ms. Palmer will have to live with regret for the rest of her life for her decisions as a child. Luka Hein, another detransitioner, shares a similar experience with Ms. Palmer. (Ex. C, ¶4). Ms. Hein, on the advice of her psychotherapist, underwent GAC. (*Id.* ¶¶ 7–14). She now regrets her decision as she does not know if she will be able to naturally conceive children. (*Id.* ¶¶ 18–20). Many others face similar realities. (*See*, *e.g.*, Doc. 104, ¶ 5) ("I personally witnessed children experience shocking injuries from puberty blockers and cross-sex hormones … To my knowledge, the [Washington University Pediatric Transgender Center] did not track patients' adverse outcomes post discharge.").

Moreover, the January 27, 2025 Senate Judiciary Committee hearing on SB 99 overflows with live testimony describing the pressure minors and their families face to undergo GAC and the resulting harms. More than forty individuals testified in support of SB 99. Among those proponents were several individuals who specifically testified to the pressures medical providers place on minors to submit themselves to GAC.

If this were not enough, on the rise are medical malpractice claims resulting from the harms patients suffered at the hands of medical professionals who pressed GAC. These active cases that come from across the country and further demonstrate the need to protect minors include *Chloe E. Brockman a/k/a Chloe Cole v. Kaiser Found., et al.*; *Kayla Lovdahl v. Kaiser Found., et al.*; *Hein v. UNMC Physicians, et al.*; *Towe v. United States*; *Miller v. Identity Hormones, LLC, et al.*; *Stewart v. Turco*;

Ayala v. Am. Acad. of Pediatrics, et al.; *Ulery v. Rafferty, et al.*; *Aldaco v. Perry, et al.*; *Mosley v. Emerson, et al.*; *Hineman v. Planned Parenthood Fed'n of Am.*; *Breen v. Olson-Kennedy*, *M.D., et al.* (Plaintiffs' primary medical expert). The volume of litigation highlights the breadth of harm associated with these experimental treatments.

In *Breen*, a female detransitioner is suing Olson-Kennedy for "fast-track[ing] [Breen] onto the conveyor belt of irreversibly damaging puberty blockers (age 12), cross-sex hormones (age 13), and 'gender-affirming' surgery (age 14)." (Ex H, ¶ 3). "After mere minutes," Olson-Kennedy "'affirmed [Breen] as transgender," "diagnosed [her] with gender dysphoria and recommended surgical implantation of puberty blockers." *Id.* ¶ 5. Although Breen eventually desisted, "the damage has been done, and it is profound." *Id.* ¶ 8.

As an ideology-driven phenomenon, the provision of GAC is in effect a cult-like ritual that results in grievous harm to the victim. State's legitimate police power extends to prohibit such practices for protecting its children. *See*, *e.g.*, 18 U.S.C. § 116 (prohibiting "female genital mutilation" on minors and imposing a prison sentence of up to ten years for violations, regardless of whether it "is required as a matter of religion, custom, tradition, ritual, or standard practice.")

Elle Palmer, Ms. Breen, and myriad more have suffered extensive harm at the hands of medical providers who pressured minors into these experimental treatments and procedures. The risk is real, and Plaintiffs cannot ignore it, no matter how damaging it is to their claims herein. The medical experts know it, the medical providers know it. SB 99 enhances minors' protections against such undue pressure and risk and therefore survives constitutional review.

II. EVEN WITHOUT THE MONTANA CONSTITUTION'S ARTICLE II, SECTION 15 EXCEPTION, SB 99 SURVIVES UNDER ANY LEVEL OF SCRUTINY.

Article II, Section 15 explicitly provides that the Legislature may preclude minors' exercise of their fundamental rights so long as doing so enhances minors' protection. SB 99 does just that. Being included in the Declaration of Rights, this grant of power to the Legislature should cause the Court to hesitate to second guess the Legislature's policy decisions. To ignore this part of the Declaration of Rights would seem like a riff on George Orwell's famous quote: all rights in the declaration of rights are fundamental, but some rights are more fundamental than others. George Orwell, *Animal Farm*, Ch. 10 (1945). That the drafters included this specific grant of power to the Legislature in the Declaration of Rights should not be dismissed.

Typically, when a challenged provision affects a fundamental right, strict scrutiny applies. *Snetsinger v. Mont. Univ. Sys.*, 2004 MT 390, ¶ 17, 325 Mont. 148, 104 P.3d 445. But things are not so simple here. Although SB 99 may implicate fundamental rights, the Montana Constitution's Article II, Section 15, constitutionally empowers the Legislature to preclude exercise of minors' rights so long as the provisions, by clear showing, enhance the protection of minors. Strict scrutiny here then is improper because it would demand weighing Section 15 against other Declaration of Rights provisions.

Plaintiffs urge this Court to second guess the Legislature and apply strict scrutiny review to SB 99. This would be improper—courts ought not "depart[] from the normal rule that courts defer to the judgments of legislatures 'in areas fraught with medical and scientific uncertainties.'" *Dobbs v. Jackson Women's Health Org.*,

597 U.S. 215, 274 (2022) (quoting *Marshall v. United States*, 414 U.S. 417, 427 (1974)).[13] Yet despite this, SB 99 survives under any level of scrutiny.

The core of Plaintiffs' argument is that SB 99 prohibits procedures and treatments which help minors. But Plaintiffs' experts' opinions on the benefits of these experimental procedures and treatments do not defeat the fact that all the experts agree that the procedures and treatments SB 99 prohibits present a medically acknowledged, bona fide health risk. For example, Plaintiffs fail to present rebuttal experts to the comprehensive European research proving the risk of these experimental treatments and procedures. Nor can they present rebuttal evidence to the facts that those same progressive countries are abandoning these practices because of the risk associated with the experimental treatments and procedures. Indeed, Plaintiffs fail to present evidence which proves the experimental treatments and procedures actually improve mental health more than less risky alternatives (*e.g.*, "watchful waiting" and psychotherapy). The Cass Report goes so far as to say these treatments reduce neither suicidality nor suicidal ideation in minors.[14] Plaintiffs cannot even defeat the State's argument that GAC for minors presents bona fide risks. Instead, they rely on a faulty cost-benefit analysis, ignoring potential risks in the name of unvetted, under studied experimental treatments and procedures. For example, Plaintiffs cannot proffer a response for how hormone treatments are likely to sterilize children. Instead, they purport—without the science to back them up—that these treatments improve minors' mental health more than less risky alternatives.

[13] *See also Gonzales v. Carhart*, 550 U.S. at 163 (citing *Kansas v. Hendricks*, 521 U.S. 346, 360, n. 3, 117 S. Ct. 2072, 138 L. Ed. 2d 501 (1997); *Jones v. United States*, 463 U.S. 354, 364-365, n. 13, 370, 103 S. Ct. 3043, 77 L. Ed. 2d 694 (1983); *Lambert v. Yellowley*, 272 U.S. 581, 597, 47 S. Ct. 210, 71 L. Ed. 422, 5 Ohio Law Abs. 88 (1926); *Collins v. Texas*, 223 U.S. 288, 297-298, 32 S. Ct. 286, 56 L. Ed. 439 (1912); *Jacobson v. Massachusetts*, 197 U.S. 11, 30-31, 25 S. Ct. 358, 49 L. Ed. 643 (1905)).

[14] *See* n.2, *supra*.

Montana has a compelling interest in protecting minors' health and safety. SB 99 enhances minors' protections by prohibiting experimental treatments and procedures which present medically acknowledged, bona fide health risks. Prohibiting puberty blockers, cross-sex hormones, and surgery for minors was the most narrowly tailored pathway to achieve Montana's interest in enhancing minors' protections against the harms that these treatments present—while simultaneously permitting adult Montanans who are capable of informed consent to accept the risks associated with these experimental treatments. No less-restrictive alternative means exist for Montana to achieve this objective.

Although SB 99 survives under strict scrutiny, the State does not need to meet that level of scrutiny because it is not the proper level of review. The Montana Constitution's Article II, Section 15 controls this case. Putting that provision aside for the sake of argument, the correct level of review is rational basis.

With more facts established and available, the Court can now apply the correct standard of review to SB 99: rational basis. (Doc 131 at 25–27.) For a law to survive "heightened" or "intermediate" scrutiny, it must "serv[e] important governmental objectives," and "the discriminatory means employed [must be] substantially related to the achievement of those objectives." *Nev. Dep't. of Hum. Res. v. Hibbs*, 538 U.S. 721, 724 (2003) (citing *United States v. Virginia*, 518 U.S. at 533). The law will be upheld if it is "substantially related to the achievement of an important governmental objective." *Adarand Constructors v. Pena*, 515 U.S. 200, 220 (1995) (citation and internal quotations omitted). Middle-tier scrutiny does not require the state to show that a law "is narrowly tailored to serve a compelling government interest." (Doc. 131 at 27) (citing *Snetsinger*, ¶ 17), but "the State must demonstrate the law or policy in question is reasonable and the need for the resulting classification outweighs the value of the right to an individual." *Snetsinger*, ¶ 17. Yet "[u]nder strict scrutiny, the government must adopt 'the least restrictive means of achieving a compelling state

interest,' rather than a means substantially related to a sufficiently important interest." *Ams. for Prosperity Found. v. Bonta*, 594 U.S. 595, 607 (2021) (quoting *McCullen v. Coakley*, 573 U.S. 464, 478 (2014)). These are two distinct legal standards, and the Court should not continue to conflate them in addressing the cross motions for summary judgment.

The Court earlier determined the two fundamental rights burdened by SB 99 were equal protection and privacy. As demonstrated below, Plaintiffs are not in a protected class. SB 99 instead classifies based on age[15] and medical treatment or procedure. Rational basis review applies.

Moreover, SB 99, "like other health and welfare laws, is entitled to a strong presumption of validity." *Dobbs*, 597 U.S. at 301; *see also Powder River Cnty. v. State*, 2002 MT 259, ¶¶ 73–74, 312 Mont. 198, 60 P.3d 357. SB 99 "must be sustained if there is a rational basis on which the legislature could have thought it would serve legitimate state interests." *Dobbs*, 597 U.S. at 301. As "[t]he parties agree[,]…the government has a compelling [not merely substantial or legitimate] interest in the physical and psychosocial well-being of minors." (Doc. 131 at 29).

As established above, SB 99 passes any level of scrutiny. (*See also* Doc. 77 at 27–32.)

III. SB 99 DOES NOT VIOLATE EQUAL PROTECTION.

Regardless of sex, minors cannot receive GAC to address the minors' perception of his or her sex. Should the Court reject the State's constitutional interpretation argument, SB 99 would still survive Plaintiffs' equal protection challenge because SB 99 does not discriminate based on sex.

"No person shall be denied the equal protection of the laws." Mont. Const. art. II, § 4. "Equal protection guarantees that persons similarly situated with respect

[15] Classifications based on age are subject to rational basis review. *In re Wood*, 236 Mont. 118, 125, 768 P.2d 1370, 1375 (1989).

to a legitimate government purpose of a law receive like treatment." *A.J.B. v. Mont. Eighteenth Jud. Dist. Ct.*, 2023 MT 7, ¶ 24, 411 Mont. 201, 523 P.3d 519 (citing *Rausch v. State Comp. Ins. Fund*, 2005 MT 140, ¶ 18, 327 Mont. 272, 114 P.3d 192).

Equal protection means the government generally cannot treat similarly situated classes differently. The first step is to "isolate[e] the factor allegedly subject to impermissible discrimination; if two groups are identical in all other respects, they are similarly situated." *Hensley v. Mont. State Fund*, 2020 MT 317, ¶ 19, 402 Mont. 277, 477 P.3d 1065 (citing *Snetsinger*, ¶ 27). Plaintiffs posit, and at the preliminary injunction stage this Court accepted, that the classes are: "(1) minors who identify as transgender in Montana; and (2) all other minors in Montana." (Doc. 131 at 21). Although the State disagrees with this classification,[16] it proceeds with it for the sake of argument.

Even assuming these classes are similarly situated, the law does not discriminate on transgender status. SB 99 prohibits "a person [from] knowingly provid[ing] the [experimental treatment] to a female minor *to address the minor's perception that her gender or sex is not female*." Mont. Code Ann. § 50-4-1004(1)(a) (emphasis added). It also prohibits "a person [from] knowingly provid[ing] the [experimental treatment] to a male *minor to address the minor's perception that his gender or sex is not male*." Mont. Code Ann. § 50-4-1004(1)(b) (emphasis added). These two provisions do not discriminate on transgender status; no minor, male or female, transgender or not, can receive the experimental treatments or procedures *to address the minor's perception* of his or her gender identity. SB 99 never mentions 'transgender' either. Indeed, the statute only pertains to male and female minors. Neither sex—regardless of transgender status (which is different from being diagnosed with gender dysphoria)—can receive puberty blockers, cross-sex

[16] The State preserves its argument that the two classes are not similarly situated because the different psychological conditions and physical disorders here.

hormones, or surgery if that procedure *addresses* "the minor's perception" that his or her gender or sex is not male or female. Mont. Code Ann. §§ 50-4-1004(1)(a); 50-4-1004(1)(b). SB 99 is sex neutral.

Also, the Plaintiffs, and Court at the preliminary injunction stage, embraced the fallacy that the same drugs mean the same treatments. But not so. Plaintiffs seemingly accept with no analysis that what is proper for correcting biological abnormalities is proper for creating biological abnormalities. Or that what is proper for addressing certain medical or physical conditions is proper for addressing the mental health issues of gender dysphoria. They contend, for example, that because both normal and transgender minors use the same puberty blocking drug, prohibiting them for addressing the minor's perception of his or her gender or sex is discrimination. But this is false. Providing these kinds of drugs to a minor suffering central precocious puberty (*i.e.*, correcting an abnormality) is not the same treatment as providing these kinds of drugs to a minor wishing to delay the natural onset of puberty (*i.e.*, creating an abnormality). Indeed, in the latter case, it is the provision of puberty blockers that *causes* the diseased state of hypogonadotropic hypogonadism. Although they may be the same drug, the treatment—and effects—are strikingly different.

But turning to the classification itself, the Court in its prior Order virtually created a new quasi-suspect class foreign to Montana and federal caselaw. This is wrong. Montana law does not recognize transgender status—or even gender—as a suspect class. "As has been already pointed out, neither federal jurisprudence nor this Court's case law recognizes gender … as … [a] 'suspect class' for equal protection purposes." *Snetsinger*, ¶ 81 (Nelson, J., concurring). The Montana Supreme Court even had the chance to clarify this point when the State appealed this

Court's Preliminary Injunction, yet it declined to do so.[17] This Court is not well-positioned to create a new suspect class and should decline to do so here. Neither state nor federal law supports acting differently.

Federal caselaw is as barren of precedent that transgender status engenders equal protection status. To find otherwise requires a strained reading of *Bostock* that ignores the U.S. Supreme Court's subsequent treatment of this issue. *See, e.g.*, *Dep't of Labor v. Louisiana*, 603 U.S. 866, 867 (2024). *Bostock* did not extend Title VII's sex discrimination protections to gender identity. The U.S. Supreme Court, in a per curiam decision upholding a lower court's stay of a federal rule expanding sex discrimination to include gender identity, made certain that "*all Members* of the Court today *accept* that [Several States] *were entitled to preliminary injunctive relief as to* … the central *provision that newly defines sex discrimination to include discrimination on the basis of sexual orientation and gender identity*." *Louisiana*, 603 U.S. at 867 (emphasis added). Bostock holds that it is "illegal for an employer to rely on an employee's sex when deciding to fire that employee. We do not hesitate to recognize today a necessary consequence of that legislative choice: An employer who fires an individual merely for being gay or transgender defies the law." *Bostock*, 590 U.S. 644, 683 (2020). The U.S. Supreme Court could have extended this opinion to include gender identity; but it did not. The U.S. Supreme Court could have extended this reasoning outside the context of Title VII; but it did not. Instead, Plaintiffs desire this Court to read in subjective gender identity where it is (purposefully) absent. *See Bostock*, 590 U.S. at 680–81 ("The place to make new legislation, or address unwanted consequences of old legislation, lies in Congress … As judges we possess no special expertise or authority to declare for ourselves what

[17] In *Cross v. State*, the Montana Supreme Court had the chance to clarify Montana's equal protection law. *See Cross v. State*, 2024 MT 303, 419 Mont. 290. But it did not. Indeed, only two justices, in a concurrence, articulated that "discrimination on the basis of transgender status is sex discrimination, sex discrimination receives strict scrutiny, and that transgender persons comprise a suspect class also triggering strict scrutiny." *Cross*, ¶ 67 (McKinnon, J., concurring). The majority's silence is telling.

self-governing people should consider just or wise. And the same judicial humility that requires us to refrain from adding to statutes requires us to refrain from diminishing them … Whether other policies and practices might or might not qualify as unlawful discrimination or find justifications under other provisions of Title VII are questions for future cases, not these.") (emphasis added). But the U.S. Supreme Court did not extend its holding beyond Title VII to equal protection or to gender identity. And it did not deem transgender status to be a new quasi-suspect class. This Court should follow suit.

In a different federal case, *L.W. v. Skrmetti*, the Sixth Circuit found unpersuasive the argument that Tennessee's ban—similar to SB 99—discriminates based on sex. That court applied rational basis to the law. "The State plainly has authority, in truth a responsibility, to look after the health and safety of its children." *Skrmetti***,** 73 F.4th at 419. On the claimed discrimination, the ban itself applies to "minors of both sexes," "regardless of their biological birth," and "does not prefer one sex to the detriment of the other," like what courts observe in typical sex discrimination suits. *Id*. That the ban touches sex is nothing more than those plaintiffs' desperate effort to get the argument to a higher scrutiny. "The Act mentions the word 'sex,' true. But how could it not? That is the point of the existing hormone treatments—to help a minor transition from one gender to another. That also explains why it bans procedures that administer cross-sex hormones but not those that administer naturally occurring hormones." *Id*.

So the court determined heightened scrutiny did not apply: "The regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a 'mere pretex[t] designed to effect an invidious discrimination against the members of one sex or the other.'" *Id.* (citing *Dobbs*, 597 U.S. 215, 235–37 (2022)) (quoting *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974)). No such pretext has been shown here. If a law restricting a medical

procedure that applies only to women does not trigger heightened scrutiny, as in *Dobbs*, a law equally applicable to all minors, no matter his or her sex, does not require heightened scrutiny either. *See id*.

In another federal case, *Eknes-Tucker v. Governor of the State of Alabama*, the Eleventh Circuit rejected the plaintiffs' arguments that the Alabama law—again, similar to SB 99—discriminates because of sex. "Of course, [the Alabama law] discusses sex insofar as it generally addresses treatment for discordance between biological sex and gender identity, and insofar as it identifies the applicable cross-sex hormone(s) for each sex—estrogen for males and testosterone and other androgens for females." *Eknes-Tucker*, 80 F.4th 1205, 1128 (11th Cir. 2023). The Court reasoned as follows. But Alabama's law did not establish an unequal regime for males and females. *Id*. And the ban references sex because of the medical procedures it regulates. *Id*. Using puberty blockers and cross-sex hormones as a treatment for gender dysphoria "are themselves sex-based." *Id*. Alabama's law regulates the medical interventions. As for cross-sex hormones, males are given estrogen and females are given testosterone "because of the biological difference between males and females." *Id*. Puberty blockers inhibit and suppress the production of testosterone in males and estrogen in females. *Id*. "For that reason, it is difficult to imagine how a state might regulate the use of puberty blockers and cross-sex hormones for the relevant purposes in specific terms *without* referencing sex in some way. Thus, we do not find the direct sex-classification argument to be persuasive." *Id*.

In summary, SB 99 does not violate equal protection. Although SB 99 mentions sex—a necessity given the topic—it does not elevate or diminish one sex over the other. It is indeed sex neutral. SB 99 prohibits certain procedures for certain age groups. Prohibiting procedures or treatment is not sex discrimination. And it also is not sex discrimination for these treatments and procedures to be available for one

sex but not the other; men and women are inherently different as a matter of biological reality and require different medical attention for similar conditions. Because a woman can receive estrogen to correct a biological abnormality does not mean it is sex discrimination to prevent a man from receiving the same treatment to address his subjective feelings about his gender. Those treatments are sex specific.

IV. SB 99 DOES NOT VIOLATE THE RIGHT TO PRIVACY.

Like other fundamental rights, the right to privacy is not boundless—especially for minors because of the Montana Constitution's Article II, Section 15. Yet even in the absence of that constitutional provision, the State's police power here permissibly limits the right to privacy. "Liberty is necessarily subordinate to reasonable restraint and regulation by the state in the exercise of its sovereign prerogative-police power." *Wiser v. State*, 2006 MT 20, ¶ 24, 331 Mont. 28, 129 P.3d 133; *see also Mont. Cannabis Indus. Ass'n v. State*, 2016 MT 44, ¶ 28, 382 Mont. 256, 368 P.3d 1131. SB 99 permissibly precludes minor's right to privacy specifically to enhance their protections. SB 99's treatment and procedure prohibition does not apply to adults. Nor does it constrict alternative treatments for gender dysphoria. But it does protect children from harmful experimental drugs and procedures. And that is plainly within the purview of the State's police power.

"The Montana Constitution guarantees each individual the right to make medical judgments affecting her or his bodily integrity and health, in partnership with a chosen health care provider free from governmental interference." *Planned Parenthood*, ¶ 22. But "[p]ublic safety, public health, morality, peace and quiet, law and order—these are some of the more conspicuous examples of the traditional application of the police power to municipal affairs. Yet they merely illustrate the scope of the power and do not delimit it." *Billings Properties v. Yellowstone Cnty.*, 144 Mont. 25, 31, 394 P.2d 182 (1964).

Fundamental rights, like privacy, are not immune from state regulation. The State references several statutes above which, although they infringe the right to privacy, are nonetheless constitutional exercises of the State's police power. For example, the State exercises its police power to regulate employment to protect the public's health and welfare. *See, e.g.*, *Wiser*, ¶ 24 (quoting *State v. Safeway Stores*, 106 Mont. 182, 203, 76 P.2d 81 (1938)). So "while one does have the fundamental right to pursue employment, one does not have the fundamental right to practice his or her profession free of state regulation promulgated to protect the public's welfare." *Id.* Much ink has been spilled over the extent of the State's police power. Yet courts across generations agree lawful exercise of the government's police power includes passing laws promoting the health, safety, and morals of its citizenry. *See*, *e.g.*, *Lochner v. New York*, 198 U.S. 45, 66 (1905) (Harlan, J., dissenting) (quoting *Holden v. Hardy*, 169 U.S. 366, 391 (1898)) (arguing the government may lawfully exercise its police power "for the purpose of preserving the public health, safety or morals."); *see also Wiser v. State*, ¶ 19; *State v. Skurdal*, 235 Mont. 291, 294, 767 P.2d 304 (1988) ("Montana recognizes that such police power exists even when the regulations are an infringement of individuals rights.") (citing *State v. Rathbone*, 110 Mont. 225, 241, 100 P.2d 86 (1940)).

"The right of choice in making personal health care decisions and in exercising personal autonomy is not without limits. In certain instances, the state may demonstrate a compelling interest in and obligation to legislature or regulate to preserve the safety, health and welfare of a particular class of patients or the general public from a medically acknowledged, *bona fide* health risk." *Armstrong*, ¶ 59. SB 99 achieves the legislature's obligations to enhance minors' protections against the medically recognized risks these experimental treatments and procedures pose.

Giving an otherwise physically healthy male or female minor puberty blockers, cross-sex hormones, or surgery pose numerous medically acknowledged,

bona fide health risks. The Court issued its Preliminary Injunction on the faulty conclusion that because some in the medical community view these experimental treatments and procedures as the acceptable standard of care for gender dysphoria, they do not present a bona fide health risk. (Doc. 131 at 39). But transgenderism is not the same as having gender dysphoria. Medical professionals offer puberty blockers, cross-sex hormones, and surgeries to otherwise physically healthy minors on the weak (and often shifting) foundations of them having certain mental perceptions of himself or herself. At the same time, alternative, safer treatments go unused.

Plaintiffs argued under *Armstrong* "[t]here is no State interest, let alone a compelling interest, in denying transgender Montanans the right to make medical decisions without state compulsion." (Doc. 50 at 35). The Court, in granting the Preliminary Injunction, determined that although both parties presented competing evidence on existence of a bona fide health risk, Plaintiffs "have put forth sufficient evidence" that the experimental treatments do not present a bona fide health risk. (Doc. 131 at 38–39). But this reasoning is backwards.

Armstrong requires a "*medically-acknowledged, bona fide health risk*." *Armstrong*, ¶ 59 (emphasis added). A court is poorly positioned and, according to *Armstrong*, lacks authority to determine what is a medically acknowledged, bona fide health risk. Such a determination must be made by the medical community. And a mountain of evidence clearly and convincingly shows that the medical community agrees these experimental treatments present a medically acknowledged, bona fide health *risk*.

V. SB 99 VIOLATES NO OTHER RIGHTS.

Plaintiffs perfunctorily contend that SB 99 violates Article II, Section 17 (Parental Rights); Article II, Section 3 (Health); Article II, Section 4 (Human

Dignity); and Article II, Section 7 (Speech & Expression). Each of these arguments fail.

A. SB 99 does not violate Parental Rights.

Parents do not have a fundamental right to subject their children to harmful procedures, especially where their efficacy has not been established. Plaintiffs argue that SB 99 violates the fundamental right to parental autonomy. But this misses the mark. Although Mont. Code Ann. § 40-6-701 codifies a parent's general right to subject their child to experimental medical treatments, that statute is not carte blanche for parents to subject their children to harmful experimental treatments or procedures. While Legislature generally has strengthened parents' rights to direct their children's medical care, it also intended to specifically limit those rights here because these treatments present a medically acknowledged, bona fide health risk. *See* Mont. Code Ann. § 1-2-102 (the Legislature's particular intent controls over its general intent). These facts are not mutually exclusive.

Generally, a "state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized." *Parham v. J.R.*, 442 U.S. 584, 603 (1979). Plaintiffs cannot and do not dispute that the State has the constitutional authority to enact and enforce laws that limit a parent's rights when the exercise of those rights would subject a child to medically acknowledged, *bona fide* risk and real, irreversible harm. This falls squarely within the State's well established compelling interest in preventing such injury and is consistent with several other laws allowing the State to exercise this power under comparable circumstances. *See*, *e.g.*, Mont. Code Ann. § 41-3-101(1)(a) (stating Montana's policy to "provide for the protection of children whose health and welfare are or may be adversely affected and further threatened by the conduct of those responsible for the children's care and protection" in the context of its laws protecting children from abuse and neglect); § 45-5-501(1)(b)(iv)

(identifying persons under 16 years old as being among those categorically incapable of providing sexual consent); § 45-5-622 (prohibiting endangering the welfare of children); § 45-5-625 (prohibiting the sexual abuse of children). *See* also *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014) (rejecting First Amendment, Due Process, Right to Parent, Vagueness, and Overbreadth challenges to law prohibiting therapists from engaging in any practices that "seek to change an individual's sexual orientation … including efforts to change behaviors or gender expressions."). Montana is obligated to "safeguard[]" children from "abuses" and provide "opportunities for growth into free and independent well-developed men" and women. *Prince v. Massachusetts*, 321 U.S. 158, 165 (1944). SB 99 achieves this goal. Plaintiffs' claim then fails as a matter of law.

B. SB 99 does not violate the right to seek health.

Plaintiffs cannot establish the existence of any fundamental right to puberty blockers, cross-sex hormones, or "gender affirming" surgery premised on their right to seek health under the Montana Constitution. The Montana Supreme Court has held that, "in pursuing health, an individual does not have a fundamental affirmative right of access to a particular drug. A patient's 'selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health,' and the regulation of that medication or treatment does not implicate a fundamental constitutional right." *Mont. Cannabis Indus. Assn.*, ¶ 24 (citing *Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir. 1980)). "Because the fundamental right to seek one's own health is not implicated," a strict scrutiny analysis is not appropriate in this context. *Id.*

SB 99 does not prohibit all forms of treatment for gender dysphoria. Instead, it blocks those most risky experimental treatments and procedures for a condition based on minors' subjective feelings about his or her sex and gender. Less risky alternatives remain viable options for treatment.

Accordingly, while SB 99 passes strict scrutiny because of the State's compelling interest established above, the Court should apply rational basis scrutiny because Plaintiffs do not have a fundamental right to a particular drug or treatment. The regulations contained in SB 99 are well within the State's police power to enact and clearly further the State's interest in protecting children's health. SB 99 neither implicates nor violates the fundamental right to seek health. Plaintiffs' claim fails on the merits of this claim.

C. SB 99 does not violate the right to dignity.

Plaintiffs blithely compare *Walker v. State*—a postconviction relief petition appeal involving prison living conditions of cells covered in blood, feces, and vomit—to SB 99 and conclude that SB 99 violates the right to dignity. 2003 MT 134, 316 Mont. 103, 68 P.3d 872. Unlike the deplorable prison conditions in *Walker*, this case involves a commonsense use of the state police power to prevent children from being subjected to a course of treatment unsupported by evidence-based medicine. Plaintiffs do not discuss any of the facts of *Walker*, presumably because they lend Plaintiffs no support.

Walker involved an appeal of a denial of a petition for postconviction relief by a defendant convicted of negligent arson and felony forgery. Walker argued that the trial court erred by denying the petition because the Montana State Prison's behavior management plans violated his right to be free from cruel and unusual punishment. The court agreed, holding that the correctional practices permitting prisons, in the name of behavior modification, to disregard the innate dignity of human beings was unconstitutional. *Walker*, ¶ 82. The Montana Supreme Court analyzed the right to dignity in that case within the context of the state's correctional facilities and the state's responsibility for individuals within residential correctional systems. In contrast, this case involves a law placing age restrictions on dangerous treatments and procedures to help protect children. There is no comparison.

Plaintiffs cite no other cases to support their argument that SB 99 somehow violates their right to dignity. SB 99 does not implicate the right to dignity.

D. SB 99 does not violate the right to speech and expression.

SB 99 is a proper regulation within the State's power to regulate medicine and does not violate the right to free speech and expression. In *Planned Parenthood v. Casey*, 505 U.S. 833, 884 (1992), the United States Supreme Court denied a First Amendment challenge to the requirement that physicians inform patients of risks to the fetus:

> All that is left of petitioners' argument is an asserted First Amendment right of a physician not to provide information about the risks of abortion, and childbirth, in a manner mandated by the State. To be sure, the physician's First Amendment rights not to speak are implicated, but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State. We see no constitutional infirmity in the requirement that the physician provide the information mandated by the State.

Id. (internal citations omitted). Such requirements govern conduct—medical treatment—not speech, and they fall within the state's ability to regulate the practice of medicine. *Accord Doe v. Christie*, 33 F. Supp. 3d 518, 525 (N.J. Dist. 2014) (applying *Casey's* logic to a First Amendment challenge to New Jersey's ban on gay conversion therapy).

SB 99 regulates the practice of medicine. Through SB 99's age restrictions on GAC—and physician advocacy of the same—the State has properly exercised its police power by protecting children from likely devastating long-term effects of experimental treatments. Plaintiffs' claim fails. *See also Garcetti v. Ceballos*, 547 U.S. 410 (2006) (there is no First Amendment protection for the speech of government employees while on the job in the scope of their duties); *Rust*, 500 U.S. at 177, 198 (it is permissible to limit speech about abortion in a federally funded program, upholding a Title X regulation imposing a so-called "gag order.").

VII. THE STATE IS ENTITLED TO JUDGMENT AS A MATTER OF LAW.

The Court must presume that SB 99 is constitutional. *Powder River Cnty.*, ¶ 73. The question for the Court is not can it condemn SB 99 as unconstitutional, but can it uphold SB 99 as constitutional. *Satterlee*, ¶ 10. Plaintiffs also bear the burden to prove beyond a reasonable doubt that SB 99 is unconstitutional. *Id.* If any doubt exists, the Court must resolve that doubt for SB 99's constitutionality. *Id.*

The presumption of "constitutionality [i]s a high burden to overcome." *Planned Parenthood*, ¶ 16 (citing *Hernandez*, ¶ 15). Plaintiffs fail to meet their burden. Indeed, Plaintiffs cannot establish beyond a reasonable doubt that SB 99 does anything except fall into the Article II, Section 15 exception. SB 99 is constitutional because it enhances minors' protections under the Montana Constitution. Plaintiffs' semantics and faulty analysis cannot overcome the Montana Constitution's text. This Court must then uphold SB 99 as constitutional and grant the State's Motion for Summary Judgment.

CONCLUSION

The Court should grant summary judgment for the State. Montana has a compelling interest in protecting minors and their families. SB 99, as the State has shown, enhances the minors' protection. And if this Court disagrees with the State's constitutional interpretation, SB 99 nevertheless survives Plaintiffs' constitutional challenges under any level of scrutiny. Ideological demagoguery is not the law. Gender identity is not sex, and equal protection does not cover transgender status. The State permissibly exercised its police power to protect children from risky, experimental treatments and the ideologue medical providers' pressure to take such treatments. This Court is not in the position to opine otherwise. Federal and state law converge here: transgender status is not a protected class. Plainly then, SB 99 does not violate the Montana Constitution. The Court should find accordingly and grant the State's Motion for Summary Judgment.

DATED this 15th day of January, 2025.

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Exhibit A

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MONTANA FOURTH JUDICIAL DISTRICT COURT, MISSOULA COUNTY

MOLLY CROSS, et al. Plaintiffs, v. STATE OF MONTANA, et al., Defendants.	Cause No. DV 2023–541 Hon. Jason Marks **DECLARATION OF GEETA NANGIA, M.D.**

I, Geeta Nangia, M.D., declare as follows:

1. I am a Board-Certified Child and Adolescent Psychiatrist, and Board-Certified Adult Psychiatrist. I obtained my B.A. in Biochemistry and Molecular Biology from Boston University and my M.D. from Boston University School of Medicine. I graduated with the Ruth Hunter Johnson Prize in Psychiatry. My residency and fellowship training, in Psychiatry and Child and Adolescent Psychiatry, respectively, were at The Medical University of South Carolina (MUSC). I completed my fellowship in 2007.

2. I have been active in teaching medical students and residents throughout my career and received the Circle of Excellence in Teaching at MUSC. In recent years, my clinical lectures have focused on child and adolescent development.

3. I have worked in the field of Child and Adolescent Psychiatry as a community psychiatrist in a wide range of settings, providing comprehensive psychiatric services for children and families. I chose to work as a community psychiatrist because I desired to evaluate and treat a wide range of mental health disorders and wanted to see young people in the context of their families and community "systems" (e.g., schools, extracurriculars, local supports). Throughout my career I have worked in rural, urban, and suburban areas, and in outpatient, inpatient, partial, as well as residential care settings. I have been very active in school consultations and advocating on a community level for mental health accommodations for youths in school. I have worked toward providing access to mental health care for youths who are underfunded and lack services due to barriers of access and cost. I have provided psychiatric evaluations, psychotherapy, and medication management for children and adolescents, as well as family therapy. I have been a part of multiple interdisciplinary teams.

4. Much of my career has been spent educating, equipping, and supporting families of children who struggle with depression, anxiety, and other mental health issues by stressing the importance of attachment between parents and children. I believe that an attachment-centered approach to therapy helps children to find their homes as a safe place to connect, where they feel nurtured, supported, and loved. It is connection and secure attachment to safe caregivers that form the foundation for healthy childhood development, allowing a child to successfully progress through the developmental trajectory toward identity consolidation.

5. I continue to provide community mental health care through my private practice and am providing this opinion as a child psychiatrist working in private practice.

6. Given the nature of being a community child psychiatrist, I have the benefit of being involved with children's health care not only in my office, but also with their families, schools, and outside support systems. This provides me with the ability to have a more complete perspective on their development, and the interventions that produce the best outcomes for their overall wellbeing.

7. I have been an expert witness in several other similar cases, as well as in matters regarding abuse and trauma, and interventions for children struggling with mental health disorders.

8. For medicolegal purposes, I have also, throughout my career in mental health, served as a designated examiner for persons during inpatient hospitalizations, and as part of this process, I have performed numerous capacity assessments and presented them to courts.

Conclusions

9. Minors lack decision-making capacity for medical and surgical transition. In my opinion, due to a lack of full neurologic, psychosocial, and cognitive developmental maturation, adolescents are unable to understand, reason through, appreciate, and comprehend the impact of the shortcomings of the present data, the lack of FDA indication for puberty blockers, the long-term risks and consequences of transition, and the low-grade rating of studies that have been used to support medical and surgical transition. Hence, they lack decision-making capacity.

10. When there is perceived reward with one pathway, despite long-term risks associated with that pathway, adolescents will generally select it rather than consider that there are alternative pathways with fewer long-term risks. With medical gender transition, adolescents are likely to perceive reward (in this case, reduced dysphoria) with the pathway of puberty blockers

and cross-sex hormones and hence, they are likely to choose this path rather than considering other paths (such as engaging in exploratory or supportive therapy, socially transitioning, and waiting until adulthood for medical transition). Additionally, as peer and cultural influences are more significant in adolescence, adolescents may make more impulsive decisions to pursue medical transition without considering risks. This also factors into a capacity judgment.

11. The risks associated with puberty blockers and cross-sex hormones are difficult for adolescents to comprehend and appreciate. First, the near certainty of infertility on the transition pathway is likely to not be appreciated until the age during which most individuals consider having children. The debate over impacts on hormonal shifts, bone density, cardiovascular risk, and brain maturation are simply too difficult for minors to grasp. Furthermore, effects of transition on more abstract situations that the adolescent may face decades later, such as effects on intimate relationships, sexual gratification, reproduction, breastfeeding, child rearing, family relationships, and self-concept are even more difficult to fully realize. Adolescents have not fully developed the ability to appreciate the treatment options in this context of "later life", which is part of decision-making capacity. Their deductive reasoning is developing, but not yet complete.

12. Furthermore, while parental consent and adolescent assent is possible for other medical interventions, it is insufficient in the matter of gender transition in minors. First, the risks to the growing adolescent are remarkable, including infertility, irreversible changes to secondary sex characteristics, potential issues with bone density, cardiovascular risks, metabolic function, endocrine function, reproductive capacity, psychological and medical health, and brain maturation. Second, a parent is unable to determine whether their child will realign with his or her natal sex. This presents inherent risk. Third, the present data supporting the benefit of transition in

adolescence is rated "very low quality." There is no reliable long-term data on safety or efficacy of these treatments.

13. For this reason, I believe that parental consent with adolescent assent for medical gender transition is problematic and can result in long-term detriment to the adolescent that later cannot be reversed. Parental consent may be deemed in the short term to be preserving the adolescent's autonomy by prioritizing the adolescent's desire to self-actualize and reduce dysphoria. However, in the long term, there is remarkable intrusion on the growing adolescent's autonomy as an adult. When the adolescent matures to adulthood and can't reverse consequences (e.g., fertility) of interventions that the parent consented to without the adolescent having had full capacity to appreciate, psychological repercussions are likely to be profound.

14. Furthermore, within my own clinical experience, I cannot envision a circumstance with my own patients wherein parental consent and minor assent would be sufficient for medical or surgical gender transition based on the above explanation. The justification of imminent risk to the child's safety or others around the child is not present. Additionally, not only could proceeding to medical or surgical gender transition profoundly affect the child, but also the parent-child relationship, which is of remarkable concern to me as a child psychiatrist.

Clinical Experience with Gender Dysphoria

15. As part of an initial evaluation, I ask individuals how they identify in terms of sexual orientation and gender. When taking a developmental history during an in-person assessment, I ask about an individual's social development, as well as questions pertaining to self-concept (how one views oneself). As part of this, I may delve into questions that deal with gender, in an age-appropriate manner, with the child, adolescent, and/or parent. Questions that I ask pertaining to gender identity include, but are not limited to:

a. How did you feel about your gender early on in your life?

b. Did you feel comfortable with your gender?

c. If not, did you identify with another gender?

d. How did this affect you, and the way that you saw yourself?

e. What types of play did you enjoy the most?

f. Were most of your friends of the same gender or opposite gender?

g. Do you remember feeling discomfort with your body in any fashion?

h. Did you prefer to ever dress as another gender?

i. If you previously felt more comfortable as another gender, or unsure of identifying with your birth sex, how long did this persist?

j. If you now feel comfortable with your natal sex, but previously did not, what led to you feeling comfortable?

16. The reason such questions are important in addressing self-concept — and gender as a part of self-concept — is that, developmentally, an individual's early experiences and view of oneself in the context of a greater environment are important to understanding the individual's presenting clinical issues.

17. Since becoming a physician in 2002, I estimate that I've evaluated and treated 550 children and adolescents (and hundreds of adults) who have met criteria at some point in their lives for a "gender dysphoria" diagnosis. Of 550 adolescent patients, I approximate that 350 of these patients had a history of gender dysphoria, as discovered on evaluation or over the course of patient care. This was ascertained via parent or child retrospective report wherein they had met criteria for the diagnosis. For these children, the gender dysphoria resolved with age maturation alone prior to seeing me. Many of these children were referred to by their parents as having been a

"tomboy" or "tomgirl," and their parents were not concerned. I discuss these terms above. I did not label or pathologize these children during the course of their mental health treatment as having had "gender dysphoria," despite the diagnostic criteria seeming to have been met. But for the purpose of this declaration, I am including them in the discussion of patients I have treated who have had gender dysphoria.

18. I estimate that I've seen close to 100 additional child patients who meet criteria for gender dysphoria on clinical interview during or over the course of treatment with me (as opposed to retrospective report). I have often observed that children's feelings regarding their own gender are a reflection of their perception of gender roles within their family unit and sphere of influence. I have had many female child patients who enjoy climbing trees and playing "boy sports," playing with "boy toys," who have a strong desire to be boys like their brothers, play with only boys on the playground, reject "girly" toys and activities, and want to use the restroom standing up like boys do. These children often are emotional and experience some real distress for significant periods about having been born as girls and wanting to be boys in every imaginable way. I've had male child patients who do the opposite. With all these children, I have told their parents not to become anxious, and not to pathologize or characterize their child based on their observations.

19. In every case that I have observed, children grow out of such "gender dysphoria" and become comfortable with their natal sex. In fact, these children are naturally some of the most confident children I've seen over time. I have always attributed this to their parents being comfortable allowing them to explore and engage in free play without feeling any anxious desire to push them toward the toys and activities that are stereotypical of only one gender. They have not pathologized or seen their child's preferences for play and fun as something to be concerned about. Hence, their children learn confidence to explore the world around them, feel validated and

affirmed by their parents, without any assumptions that their exploration is anything more than a normal part of growing up.

20. My experience has been that periods of gender incongruence and associated distress are normative and transient, with resolution as the child matures. I have provided these parents and children with guidance; support; and, when needed, exploratory therapy.

21. I also estimate that I have seen just over 100 adolescents who have presented with gender dysphoria that has been more abrupt in onset. The majority of these are biological females, and these cases have grown increasingly frequent over recent years.

22. In these cases, adolescents and/or their parents reported at least one of the following issues as also being primary within their life "systems" (e.g., school, family, peer group, community): 1) a feeling of not fitting in with peers, or feeling "different" and not belonging, 2) an experience of gender roles within their own families, or within their peer groups, that has had a marked influence on their own perception of gender and gender identity, 3) a history of trauma, 4) a history of disruption of primary attachment, 5) a history of feeling vulnerable and emotionally unsafe, 6) a history of depression, anxiety, or social anxiety, 7) a history of an autism spectrum disorder, 8) an exposure to information on gender via social media, TV, or the internet, with a subsequent curiosity about gender exploration, 9) a feeling of vulnerability, followed by a search for belonging, or 10) a feeling of a good "fit" among peers who have also felt vulnerable in an LGBTQA group online or in school.

23. Almost all of the adolescent patients had taken steps to access additional information about their gender dysphoria from readily available online sources and social media, and many found friendship within LGBTQA clubs at school or online friends in the LGBTQA community. They described feeling accepted, supported, and affirmed within these social groups.

Some did not identify as the opposite gender, but rather stated they were "gender queer" or "non-binary."

24. For all of these youth, I provided exploratory therapy, supportive therapy, and family therapy, or I worked with a therapist who collaborated with me in treatment, to address these factors within the adolescent's life systems. I also provided medication management where needed for other mental health issues. Their treatment plans included crafting an individualized approach from the above therapies, harnessing community support, and providing guidance to parents in two key areas: 1) How to best be "present" and establish an emotionally safe environment at home, and 2) how to grow in connection and relationship with their child by loving them for who they are. Among these adolescents, the vast majority realigned with their natal sex over the period of treatment. Some stated, over time, that they were questioning their sexual orientation, and not their gender. All responded to these interventions positively such that, over time, regardless of whether they'd realigned with their natal sex or had a future plan to transition, they no longer experienced gender dysphoria and their mental health improved. Those who had continued gender incongruence felt that they wanted to see how they felt over time rather than pursuing options to medically transition as minors. They were appreciative of the support and therapy and found it helpful.

25. I've treated approximately 25 children/adolescents during their social and/or medical transition. I supported them where they were at on their journey, through psychotherapy and medication management, and I respected their decision based on what treatment options had been afforded to them by other doctors.

The Role of Exploratory Therapy for Gender Dysphoria in My Practice

26. Minor patients with gender dysphoria benefit tremendously from therapy that explores their feelings and experiences within their "life systems," past and present. I have found that adolescents with gender dysphoria are generally very open to this. They voice that they feel supported and that they gain clarity in the process. Through therapy, just like most youth with presentations other than gender dysphoria, these patients improve in self-concept and mindfulness, becoming aware of how their experiences have affected them, and what defenses they employ when feeling challenged or stressed. They learn to identify their own values and what matters to them, which makes their choices and decisions clearer.

27. The primary modality of therapy that I have utilized in treating gender dysphoria is psychodynamic therapy, I have also utilized cognitive behavioral therapy, interpersonal therapy, and family therapy. I *do not* endorse conversion therapy and I believe it is detrimental. I have treated one adolescent who underwent conversion therapy as part of a religious school prior to seeing me, and she suffered significant trauma as a result. This patient required specific therapy to help her process that trauma.

28. Psychodynamic therapy engages individuals in "free association." Free association is the idea that whatever is on a patient's mind guides the clinical session. The free association, or whatever the patient brings up, is deemed of importance and is used to spur exploration of the patient's past and how that past may be affecting the patient's present circumstances and feelings.

29. In this context, then, the therapist can help the patient identify how repressed feelings from the past may be influencing the patient's current decision making, relationships, and behaviors. Over time, this leads to natural "uncovering" of coping and defense mechanisms, fears, desires, and values that are rooted in a person's past experiences.

Gender Dysphoria and Informed Consent In Minors

30. The principle of informed consent rests upon the moral and legal premise of patient autonomy. In all populations, informed consent must balance the respect for patient autonomy with the protection of patient vulnerability. (Appelbaum 2007[1]) This is particularly relevant as it applies to minors.

31. The informed consent process requires that certain criteria be met, and these are dependent on development (neurologic, cognitive, psychosocial) and experience. Informed consent involves the following principles: a) decision-making capacity, b) full disclosure of medical options, c) comprehension, and d) voluntary consent. (Grisso 1998[2]) Voluntary consent is one's agreement to the intervention, without coercion or distress.

32. Decision-making capacity includes the ability to understand, reason, appreciate, and comprehend the information presented in a full disclosure of a diagnosis, its prevalence, available treatments, and the treatments' risks and benefits. There are at least two problems with this within the minor population when it comes to gender dysphoria.

33. First, patients must understand, reason through, and appreciate that the prevalence of gender dysphoria has been on the rise in adolescents, and there has been little research as to contributing factors. Additionally, there are a host of other co-occurring issues that need to be weighed in navigating treatment direction. Patients must understand that when these factors and co-occurring issues are brought to conscious awareness in therapy, gender dysphoria is often transient and remits. This is, at minimum, a difficult task for minors to understand.

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[1] Appelbaum, P. S. (2007). Assessment of Patients' Competence to Consent to Treatment. *New England Journal of Medicine*, *357*(18), 1834–1840. https://doi.org/10.1056/NEJMcp074045

[2] Grisso, T., & Appelbaum, P. S. (1998). *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals*. Oxford University Press.

34. Second, when considering treatment options for gender dysphoria, patients must be able to appreciate and weigh their options. The option of exploratory therapy inherently has far less risk than undergoing medical gender transition, but it takes time and considerable emotional investment as it explores the various systems in an adolescent's life. Albeit very fruitful and with minimal risks, it can still be emotionally taxing. Research confirms that adolescents devalue delayed outcomes relative to adults. (Huang 2017[3]) Adolescents are less inclined to plan ahead or anticipate the future consequences of their actions before acting. (Steinberg 2009[4]).

35. Gender affirming care and medical transition may appear to be "quicker" answers to dysphoria and internal discomfort, as they aim to directly and immediately validate the adolescent's feelings about becoming the opposite gender, and they summarily dispense with any need to understand or explore causation. Considering both options, the impulse-prone adolescent is likely to find the latter far more rewarding.

36. In order for the minor to provide informed consent, the adolescent would need to be developmentally capable of appreciating the long-term consequences and risks of each option, and to be able to supersede impulse and desire for reward (to become the opposite gender), and attribute both options equal consideration. This requires complex deductive reasoning, planning, and thinking through future hypothetical life events like the desire to have children and potentially breastfeed. They would have to be able to fully comprehend and appreciate the debate over medical gender transition side effects, risks, benefits, and outcomes, and the issue of data quality.

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[3] Huang, Y., Hu, P., & Li, X. (2017). Undervaluing delayed rewards explains adolescents' impulsivity in inter-temporal choice: An ERP study. *Scientific Reports*, *7*(1), Article 1. https://doi.org/10.1038/srep42631

[4] Steinberg, L., Graham, S., O'Brien, L., Woolard, J., Cauffman, E., & Banich, M. (2009). Age Differences in Future Orientation and Delay Discounting. *Child Development*, *80*(1), 28–44. https://doi.org/10.1111/j.1467-8624.2008.01244.x

The complexity of the debate over the safety and outcome data is remarkable, and essential for the patient to understand as the potential risks involved can affect a minor patient's entire life. This particular task, in my opinion, is insurmountable for a minor patient.

37. These two barriers and necessary prerequisites to minor informed consent — (1) the requirement to understand, reason through, and appreciate that the prevalence of gender dysphoria has been on the rise in adolescents, that there has been little research as to both contributing factors, and the long-term effects of suggested medical interventions; and (2) that there can be a host of other co-occurring issues that need to be weighed in navigating treatment direction — are discussed further below. These details must be adequately and sensitively considered by all persons involved in the informed consent process to accurately ascertain and preserve the range of informed choices and effective options available to the patient.

Minor Gender Dysphoria Prevalence and Informed Consent

38. The heightened prevalence in recent years should cause physicians to identify possible contributing factors and co-occurring issues, and then craft a two-pronged response that addresses these, all prior to recommending medical transition which entails risk. Patients need to be able to understand, reason through, and appreciate these factors and co-occurring issues and have the opportunity to explore them prior to considering transition. The factors I've observed to contribute to the heightened prevalence of gender dysphoria are an increase in "pathologizing" of a normal part of childhood development, shifts in cultural norms having to do with gender exploration in adolescence, the influence of social media, heightened vulnerability in youth, and what some call "social contagion." Some co-occurring issues that I have observed are trauma, depression, anxiety, autism spectrum disorders, influential gender-role experiences, vulnerability and a lack of feeling socially accepted, and the influence of social media. These are identified and

addressed as the patient goes through the therapeutic process and supports for the patient are also harnessed. As part of informed consent, patients should understand and appreciate that when these issues are addressed, frequently gender dysphoria is transient and remits. This understanding and appreciation is an extremely difficult task for adolescents.

Minor Treatment Recommendations and Informed Consent

39. I believe that several issues must be fully considered and appreciated by patients in order for them to be able to provide appropriate informed consent. However, many of the most vital issues cannot be sufficiently appreciated in adolescence. These issues are listed below:

a. The Dutch Studies have been foundational in the formation of the WPATH recommendations but are suspect in terms of their quality and their applicability to the patient population currently presenting in America. "Several recent international systematic reviews of evidence have concluded that the practice of pediatric gender transition rests on low to very low quality evidence—meaning that the benefits reported by the existing studies are unlikely to be true due to profound problems in the study designs." (Abbruzzese 2023[5])

b. Gender dysphoria is the only diagnosis that I am aware of for which an alteration of bodily integrity is being clinically advised for the purpose of affirming identity.

c. There is debate over the quality of data used in studies assessing links between suicide rates and gender dysphoria, including the change in suicide rates post-transition.

[5] Abbruzzese, E., Levine, S. B., & Mason, J. W. (2023). The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies — and research that has followed. *Journal of Sex & Marital Therapy*, *0*(0), 1–27. https://doi.org/10.1080/0092623X.2022.2150346

d. The WPATH recommendations state that only one comprehensive psychological assessment should be required for minors in order to proceed to transition. (Coleman 2022[6]) Patients should understand that such co-occurring health concerns and issues accompanying gender dysphoria take time to identify, and one comprehensive assessment is not sufficient to do so for any practically condition in mental health.

e. The WPATH recommendations state that decision-making capacity has to be determined in each adolescent wanting to undergo gender transition based on each adolescent's development. (Coleman 2022) But WPATH elides the crucial issue: both patients and parents/guardians should understand that it is not well established that adolescents can *ever* meet such requirements for decision-making capacity when they are offered non-emergent treatments that substantially affect bodily integrity and that have potentially life-long irreversible consequences on reproduction and multiple other bodily systems.

f. There is significant debate about whether the majority of children and adolescents with gender dysphoria realign with their birth sex with time and maturation.

g. There is debate as to the lack of studies that evaluate the factors that are leading to the heightened prevalence of gender dysphoria.

[6] Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., De Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., … Arcelus, J. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, *23*(sup1), S1–S259. https://doi.org/10.1080/26895269.2022.2100644

h. Patients and their parents must understand that while gender medicine experts claim minimal risk with puberty blockers, this is highly controversial. They should also understand that almost one hundred percent of those taking puberty blockers go on to receive cross-sex hormones. Hence, even if puberty blockers themselves were of low risk, the trajectory of medical gender transition includes cross-sex hormones, which render a patient infertile.

i. There is additional debate over the long-term side effects and consequences of the medical transition trajectory, including but not limited to potential problems with bone growth, brain maturation, metabolic function, endocrine function, sexual health, psychological function, and reproductive capacity.

j. There is debate as to whether minors can appreciate the potential impact that infertility can have on an individual's psyche should they one day desire to have children.

k. There is insufficient data on detransitioners, and there is literature that states that those who detransition may not access adequate follow up or support.

l. The interplay between gender dysphoria and common co-occurring conditions, and how treating those conditions may affect an individual's gender dysphoria, have not been adequately studied.

m. Alternative approaches to treating gender dysphoria have not been adequately studied.

40. In my experience, the task of understanding, reasoning through, appreciating, and comprehending the above matters is insurmountable for adolescents.

41. Furthermore, I don't believe that parents should be able to provide medical consent with minor assent for medical gender transition. This is because the debate that exists has to do with the safety of treatments that affect the bodily integrity of the minor, and there is debate as to the long-term outcomes of such treatments. Many of these debated outcomes would stand to permanently affect the quality of life of the minor, in multiple arenas such as romantic relationships, marriage, sexual intimacy, childbirth, child rearing, self-concept, social and workplace relationships, potential adversity due to discrimination, and long-term psychological and medical health. In my opinion, for a parent to provide consent to non-emergent treatments that stand to affect the rest of a minor's life in every arena, and to do so without the minor's full ability to appreciate the above debate and potential long-term ramifications, violates the minor's future right to autonomy.

Trauma and Gender Dysphoria

42. Children and adolescents with gender dysphoria who have been through trauma may have an even greater difficulty with appreciating and weighing the various treatment options for gender dysphoria. Trauma affects how children and adolescents process the world around them, how they interact and engage in relationships, how they perceive various events and situations, and how they react and behave. Trauma influences the way individuals perceive their own bodies. Their sense of bodily safety and how they feel about their outward appearance is often significantly affected. The risk in offering medical or surgical transition to adolescents who have gender dysphoria and a history of trauma is that they may find gender transition to be appealing and a "quick fix" to their complex internal emotions and feelings about their bodies. This may stand in contrast to a child or adolescent's perception of trauma-focused therapy modalities that are directed at helping an individual work through, process, and recover from trauma, as these

treatments take an extensive amount of time (months to years) and are emotionally very difficult. While trauma-focused therapies are data-driven and effective and allow an individual to experience healing and then to make more consequential life decisions, the child or adolescent may not give them consideration when perceiving that medical or surgical transition would help them to feel better faster by changing how they feel about their body. It may prove tempting to try and resolve internal woundedness by changing external appearance, but an adolescent is likely to experience regret after transition if the internal woundedness is not first addressed through the therapeutic process.

43. Trauma can be due to a number of different experiences. Trauma arises when there is a "failure of the natural physiologic activation and hormonal secretions to organize an effective response to threat." In early childhood development, the orbitofrontal and limbic structures in the brain mature in response to the caregiver. Dysfunctional associations in this relationship between caregiver and child result in permanent physicochemical and anatomical changes which impact the child's developing personality and behaviors. Children who have been exposed to ongoing stress lose the ability to use their own emotions to guide effective actions. They often cannot recognize their own feelings, and so they are not able to respond appropriately to stressors. The inability to identify emotional states also often affects the child's ability to recognize others' emotions. Due to difficulty in regulating their own internal state, they become very reactive to their environment. They respond with emotion and impulsivity, behaviors that are often an externalization of the chaos and stress they feel inside. (Trauma Recovery Institute[7])

[7] Trauma Recovery Institute. *Trauma Recovery*. The Trauma Recovery Institute. Retrieved May 18, 2023, from https://www.psychosocialsomatic.com/trauma-recovery/

44. Trauma can occur outside the parent-child relationship. Exposure to domestic violence, abuse, neglect, animal abuse, poverty, substance abuse, bullying, disasters, loss of a loved one, or parental illness can cause similar psychological and physiological responses in children. Some forms of trauma, particularly interpersonal trauma and abuse, place children and other survivors at increased risk of future trauma because past experiences of victimization are associated with an increased risk of subsequent victimization. (Jaffe 2019)

45. Trauma impacts every system in the body: gastrointestinal, genitourinary, endocrine, cardiovascular, neurologic, and immune systems. (Heim 2008) With regard to neurodevelopment, functional neuroimaging of children and adolescents exposed to maltreatment has shown executive, attentional, and affective emotional dysregulation. (Mueller 2010[8]).

46. Children do not generally disclose trauma on initial assessment. Disclosure can take months and sometimes years. Children must experience safety within the therapeutic relationship, which takes time and patience to establish. As therapy continues, children will disclose trauma when they feel safe enough to do so and trust the examiner's response.

47. Trauma treatment (psychodynamic therapy and trauma focused cognitive behavioral therapy) focuses on a) education surrounding trauma; b) identification of feelings and emotions; c) understanding safety and practicing mindfulness, relaxation, and the ability to calm the sympathetic nervous system; d) exploration and processing of the trauma and its effects through a trauma narrative in a safe therapeutic setting; e) harnessing family/loved one support and validation; f) clarification where appropriate; g) building a healthy self-concept; h) a

[8] Mueller, S. C., Maheu, F. S., Dozier, M., Peloso, E., Mandell, D., Leibenluft, E., Pine, D. S., & Ernst, M. (2010). Early-life stress is associated with impairment in cognitive control in adolescence: An fMRI study. *Neuropsychologia*, *48*(10), 3037–3044. https://doi.org/10.1016/j.neuropsychologia.2010.06.013

reorientation to the environment through awareness that trauma can impact all arenas of life; and i) continued support. The goal in recovery is for the individual to heal emotionally, to have internal and external ability to self-regulate and respond to stress appropriately, and to be able to engage in relationships in a healthy fashion. This type of treatment takes time, as there must be patient-therapist rapport and adequate trust laid down as a foundation.

48. Due to the effects of trauma on all bodily systems, and its effects on self-concept and body image and appearance, it is critical to realize that it can contribute to gender dysphoria. Explorative (psychodynamic) therapy and Trauma Focused Cognitive Behavioral Therapy is important to help the patient identify, process, and work through trauma in order to ensure that the patient is not experiencing gender incongruence due to the trauma itself. This information is valuable to patients as they navigate and chart their own courses through their unique, individual processes of healing and growth.

49. Research suggests relatively higher levels of reported trauma among children with gender dysphoria and among transgender and gender-nonconforming adults. In one study that considered relational trauma up to age 14 within primary relationships:

> Results showed that 10% of GD participants had not experienced any early adversity, 13% had experienced one form of trauma, 8% had experienced two forms, 13% had experienced three forms and 56% had experienced four or more forms. In the control group, 30% of participants had not experienced any form of trauma, 37% had experienced one form of trauma, 16% had experienced two forms, 9% had experienced three forms and 7% had experienced four or more forms.

(Giovanardi 2018[9]) Another study reported similar findings. (Schnarrs 2019[10])

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[9] Giovanardi, G., Vitelli, R., Maggiora Vergano, C., Fortunato, A., Chianura, L., Lingiardi, V., & Speranza, A. M. (2018). Attachment Patterns and Complex Trauma in a Sample of Adults Diagnosed with Gender Dysphoria. *Frontiers in Psychology*, *9*. https://www.frontiersin.org/articles/10.3389/fpsyg.2018.00060

[10] Schnarrs, P. W., Stone, A. L., Salcido, R., Baldwin, A., Georgiou, C., & Nemeroff, C. B. (2019). Differences in adverse childhood experiences (ACEs) and quality of physical and mental health

50. Timely and compassionate assessment, diagnosis, and trauma-informed treatment is likely to meaningfully improve long-term outcomes for children with gender dysphoria, whether they come to identify with their natal sex or whether they persist in their transgender identity.

51. It has been my clinical experience that when youths with gender dysphoria are treated with psychodynamic therapy, and a history of trauma is identified and subsequently treated, gender dysphoria often remits or resolves. In other cases, youths have gained clarity about how trauma has affected them and can move forward as adults with the ability to make mindful decisions surrounding gender dysphoria treatments. Each of these children deserves the option to achieve this clarity, treatment, education, and support, regardless of which options they ultimately choose.

A Better and More Compassionate Approach is Provision of Therapy Until Adulthood When Consent Can be Provided

52. Gender dysphoria can be a normal part of childhood development, as discussed in the section on my clinical experience above. It should not be labeled or pathologized, as it is most often transient, making a "watch and wait" approach sensible.

53. A compassionate approach to gender dysphoria in adolescents entails: a comprehensive assessment, individual and family therapy, and harnessing a support network for the patient. I have used this approach for years and have found it to be beneficial and far less risky. The child patients I've treated that meet criteria for gender dysphoria realign with their birth sex with maturation (children) and a "watch and wait" approach. Adolescents most often realign with their natal sex with maturation, therapy, and support. Further, my patients who have decided to

between transgender and cisgender sexual minorities. *Journal of Psychiatric Research*, *119*, 1–6. https://doi.org/10.1016/j.jpsychires.2019.09.001

transition as adults have been grateful that they waited and that therapy helped them to be sure of their choice. They have felt positively about their decision-making capacity as adults.

54. This approach takes into consideration that medical and psychological risks are far too great to risk providing unproven treatment to a substantial number of minors who would otherwise realign with their natal sex.

55. Additionally, this compassionate approach adheres to ethical standards in the field of medicine, while medical and surgical transition for minors, individually and in combination, substantially risks violating those standards.

56. As an example, beneficence requires that the physician actively promote the welfare of the patient and protect the patient from harm. Regardless of positive intentions to provide relief for the minor with gender dysphoria, when a physician is seeking to use controversial treatments for a diagnosis 1) that has an increasing prevalence 2) for which contributing factors have not yet been adequately identified 3) for which alternative treatment pathways with less risk may not have not been well studied 4) that may resolve in children without any intervention or respond to very low risk supportive interventions in adolescence and 5) could be intertwined with co-occurring conditions that could be treated with low risk interventions first, there should be concern over whether the physician violates the standards of beneficence and nonmaleficence. That is especially true when the risky treatments 1) have marked effects on a minor's bodily integrity, 2) carry significant long-term risks, 3) are unsupported by reliable long-term data about safety and efficacy, and 4) are recommended based on evidence deemed to be of very low quality by systematic reviews.

57. The physician seeking to recommend medical transition to a minor also risks violating the principle of informed consent, considering the minor patient lacks decision-making capacity.

58. If all of the above issues of debate and controversy have not been fully disclosed to the minor patient, and comprehended, the standard of truth telling is also not met.

59. And, lastly, the standard of distributive justice may be violated if the minor patient has not been meaningfully offered available resources such as exploratory therapy, family therapy, and supportive mental health care that may be offered to others in this same situation, given these are low in risk and likely high in benefit.

The Therapy Approach Is Supported By The Cass Review

60. The 2024 Cass Review is the most comprehensive and objective review of gender identity services that has been done to date, and results broadly reflect my concerns with gender affirming care. Due to the Review, European countries have subsequently changed policies.

61. Largest and most comprehensive study to date: In April of 2024, the Cass Review was released, an independent review (commissioned by the NHS of England) of gender identity services for children and young people. This review was long awaited, as it is the most comprehensive review of gender identity services that has been done to date. It included 113,269 children and adolescents from 18 countries. (Cass 2024[11])

62. Thorough and well informed: The Cass Review was informed by:

a. Evidence (series of systematic reviews, qualitative research, quantitative research, and the Gender Identity Development Services (GIDS) Summary Audit)

[11] Cass, Hillary (2024) The Cass Review. Independent Review of Gender Identity Services for Children and Young People: Final Report. https://cass.independent-review.uk/home/publications/final-report/

b. Professional Input (listening to clinicians and other professionals), focus groups, thematic roundtables, panels and online surveys, clinical expert groups, workshops and discussions with frontline staff, professional bodies, and national organizations and leaders

c. International Sources (guideline appraisal, international survey, and meetings with international clinicians and policy makers)

d. Lived Experience (listening sessions with individuals and parents, focus groups of young people, regular meetings with support and advocacy groups, documented insights into lived experiences, and personal narratives). (Cass 2024)

63. The goal of Cass Review was to help children and youth with gender incongruence receive a high standard of care and thrive: The goal of the review was also to develop a holistic needs assessment framework to help children and youth more broadly with well-being and functioning. It indicated specifically that the central aim of the review was to help young people thrive. Dr. Cass stated that, for most young people, a medical pathway *may not* be the best pathway to achieve this. (Cass 2024)

64. The Review found significant problems with current WPATH guidelines that have guided clinical care to date: The review noted the problems of the WPATH SOC 8 guidelines (which guide most clinicians globally on treating transgender individuals), stating the guidelines lacked developmental rigor.

a. First, it noted a lack of consensus on the purpose of the assessment process that the WPATH called for when dealing with patients clinically. (Cass 2024)

b. Second, it noted a core problem in that WPATH commissioned a systematic review (Baker 2021) for SOC 8 which found that hormone therapy was associated with

increased quality of life, decreased depression, and decreased anxiety. However, it also stated that the same systematic review found that certainty of this conclusion was limited by high risk of bias in study designs, small sample sizes, and confounding with other interventions. Baker's review recommended that future studies should investigate the psychological benefits of hormone therapy among later and more diverse groups of transgender people using study designs that more effectively isolate the effects of hormone treatment. The Cass Review pointed out that the SOC 8 narrative didn't reference its own systematic review by Baker et al., but rather stated that "Despite the slowly growing body of evidence supporting the effectiveness of early medical intervention, the number of studies is still low, and there are few outcome studies that follow youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible." (Coleman 2022) The WPATH narrative account cited studies that were deemed of low quality with short follow up periods and variable outcomes, and a selected account of detransition rates. (Cass 2024)

c. The Cass Review went on to be further critical of WPATH SOC 8 guidelines, stating the SOC 8 concludes "The evolving evidence has shown a clinical benefit for transgender youth who receive their gender affirming treatment in multi-disciplinary clinics (de Vries et al 2014; Kuper et al. 2020, and Tollit et all 2019)." The Cass Review points out that the WPATH statement is problematic in that the De Vries (2014) original study had marked differences to the population being treated currently and had much stricter criteria for treatment. The Kuper et al (2020) study had a one year follow up with very modest change and fell into a group

rated by the University of York as too low a quality to even be included in the body of evidence on cross sex hormones. The Tollit et al (2019) study did not include any results. Furthermore, the SOC 8, goes on to state that the WPATH's own commissioned systematic review by Baker et al is one of several references cited in support of the SOC 8 statements, "There is strong evidence demonstrating the benefits in quality of life and well-being of gender affirming treatments, including endocrine and surgical procedures, properly indicated and performed as outlined by the Standards of Care Version 8" and "Gender-affirming interventions are based on decades of clinical experience and research; therefore, they are not considered experimental, cosmetic, or for the mere convenience of the patient. They are safe and effective at reducing gender incongruence and gender dysphoria." (Coleman 2022) Therein, the Cass Review notes the WPATH SOC 8 effectively overstated the strength of the evidence in making these statements. (Cass 2024)

65. The Review found that causes of gender incongruence and/or dysphoria are complex and include vulnerability and social media as well as possible exposure to pornographic content: The Cass Review stated that there is a complex interplay between biological, psychological, and social factors in gender incongruence and/or dysphoria, and that incongruence or dysphoria may be a result of one of two of these factors, or a series of them that underpin a young person's experience and sense of self. It cites predisposition/vulnerability (adverse childhood experiences, neurodiversity, biological predisposition), puberty (body distress and mental health vulnerability), transgender narrative, cultural lens, social stress (not meeting stereotyped gender expectations, developing sexuality), and online stressors (including social media and virtual contact). (Cass 2024)

66. In treating gender dysphoria, the Review found that there is an absence of quality evidence assessing psychosocial interventions, but psychotherapy has a good evidence base for treatment in other often comorbid conditions: The systematic review of psychosocial interventions found low quality studies, poor reporting of the intervention details, and a wide variation of psychosocial interventions investigated, so that it was not possible to determine how effective different interventions were for young people with gender dysphoria. Despite this, it is known that psychotherapy has a good evidence base for treatment of other often comorbid conditions like depression and anxiety. Furthermore, treatment arms in most studies have not separated outcomes from medication transition and concurrent psychosocial interventions. The Cass Review emphasized the need for proper research on psychosocial interventions (including psychotherapy, and details of which psychotherapeutic intervention is utilized). (Cass 2024)

67. The systematic review of social transition in childhood showed no clear evidence that social transition is positive or negative in terms of mental health outcomes, and relatively weak evidence for any effect in adolescence. However, it did show a remarkably lower rate of desistance in children who socially transitioned, showing social transitioning to be a likely active intervention (where comparably, when social transition was not occurring in childhood, there was a very high desistance rate in children that occurred naturally and over time). (Cass 2024) (Olson 2022[12]) (Steensma 2013[13])

[12] Olson, K., (2022). Gender Identity 5 Years After Social Transition. *Pediatrics,* 150(2), https://doi.org/10.1542/peds.2021-056082

[13] Steensma TD, McGuire JK, Kreukels BP, Beekman AJ, Cohen-Kettenis PT. (2014) Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *J Am Acad Child Adolesc Psychiatry,* 52(6):582-90. https://doi: 10.1016/j.jaac.2013.03.016

68. The systematic review of puberty blockers revealed multiple studies that showed that bone density is compromised during pubertal suppression. No changes in gender dysphoria nor body satisfaction were demonstrated. There was insufficient evidence for effects of puberty suppression on psychological wellbeing, cognitive development, cardio-metabolic risk, and fertility. Further, the review showed that the vast majority of youth who start on puberty blockers proceed to cross sex hormones, and given that, it found there is no evidence to show that puberty blockers provide time for the youth to "think" as some suggest they are supposed to do. (Cass 2024)

69. The systematic review of outcomes of cross sex hormones found that there is a lack of high-quality research assessing the outcomes of hormone interventions in adolescents with gender dysphoria/incongruence, and few studies that undertake long term follow up. It indicated that no conclusions can be drawn about the effect of cross sex hormones on gender dysphoria, body dissatisfaction, and bone and cardiac health. There is no evidence to support the conclusion that hormone treatment reduces the risk of death or suicide in patients with gender incongruence or gender dysphoria. The review goes on to state that sex hormones are responsible for increasing divergence of the male and female brain, and more work is needed to understand the impacts long term of the influence of sex hormones on brain maturation. (Cass 2024)

70. The systematic review showed no reduction of suicide with gender affirming treatments. It emphasized the lack of data to show gender affirming treatments result in any reduction in suicide related deaths. (Cass 2024)

71. The Review found a lack of evidence on gender non-binary individuals. It also emphasized the lack of data on gender nonbinary individuals, the largest group identifying under the 'trans' umbrella. (Cass 2024)

72. The Review described a problem with the informed consent process. The Cass Review discussed the problems of consent due to the duty of information disclosure complicated by many 'unknown unknowns' about the long-term outcomes of medical transition treatments. It states that this creates a remarkable problem for obtaining informed consent. (Cass 2024)

73. The Review found a lack of evidence on those who detransition: The study found that the percentage of people who detransition remains unknown but is potentially growing. The Cass Review website issued a summary statement that says, "Clinicians are unable to determine with any certainty which children and young people will go on to have an enduring trans identity." (Cass 2024)

74. The Review came to advise that puberty blockers be used only under the auspices of research and even then, that they be part of a greater program that evaluates outcomes of psychosocial interventions and cross sex hormones. The Cass Review does not advise medical transition via puberty blockers unless under the auspices of research secondary to the lack of any quality evidence pertaining to any improvement in gender dysphoria and the highly limited evidence or positive mental health outcomes, the issues with bone maturation, the unknown impact of blocking the normal trajectory of development on mental (cognitive and emotional) and social health in addition to physical health, the demonstrated outcome of reduced psychological functioning, puberty blocker impact on future transition surgeries, and the potential for regret. (Cass 2024)

75. The Review advised that cross sex hormones should not be given under the age of 16 outside of research, and that if given at or after 16 years of age, it should only be done with extreme caution and a clear clinical rationale rather than waiting until the individual is 18 years old. The Cass Review does not advise cross sex hormones under 16 years old and advises extreme

caution between 16 years old and adulthood with thorough clinical rationale documented, given the potential risks to brain maturation and the lack of quality clinical evidence on outcomes of cross sex hormone use in adolescents. The Cass Report website summary statement additionally states, "The use of masculinising / feminizing hormones in those under the age of 18 also presents many unknowns, despite their long standing use in the adult transgender population. The lack of long-term follow-up data on those commencing treatment at an earlier age means we have inadequate information about the range of outcomes for this group." (Cass 2024)

76. The Review advises that professional organizations come together and discuss their guidance on clinical management based on the findings of the Cass Review. (Cass 2024)

77. Additionally, the Cass Review addressed brain development in adolescence and problems with decision making in the context of peers and high emotional states. It discussed changes in the limbic area of the brain, which during puberty becomes sensitized, drives emotional volatility, pleasure, and novelty seeking, and makes adolescents more sensitive to social rejection, as well as vulnerable to a range of mental health problems. Furthermore, it discussed the future orientated prefrontal cortex as maturing later into an individual's mid-20's. This part of the brain, per the review, is concerned with executive functions such as complex decision making, rational judgment, inhibition of impulsivity, and planning. By age 15, the review found an adolescent may make decisions in relation to hypotheticals as an adult would, but the adolescent is still at-risk for dangerous behaviors in the real world due to the limbic or "feeling" portion of the brain and prefrontal cortex not being fully developed. It also stated that studies have shown adolescents to be hypersensitive to social isolation, to the extent that going along with peers to avoid social risks, even if it means taking legal and health risks, may be seen as a rational choice to avoid exclusion. (Cass 2024)

78. The Cass Review advised a holistic assessment and explorative therapy in minor patients with gender incongruence and/or gender dysphoria: In making recommendations for the future, the Cass Review indicated that there should be a holistic assessment framework for children and adolescents with gender incongruence and/or gender dysphoria to include developmental history, family dynamics, educational setting and social context, gender development and experiences, sexual development, physical health, safeguarding, and mental health. It also maintained the position that young people with gender dysphoria may have a range of complex psychosocial challenges and/or mental health problems impacting their gender-related distress. The Review states that exploration of these issues is essential to provide diagnosis, clinical support, and appropriate intervention. (Cass 2024)

79. Dr. Cass's summary statements profoundly characterize the problem: In summary, Dr. Cass writes, "We have no good evidence on the long-term outcomes of interventions to manage gender related distress." A summary statement on her website reads, "While a considerable amount of research has been published in this field, systematic evidence reviews demonstrated the poor quality of the published studies, meaning there is not a reliable evidence base upon which to make clinical decisions, or for children and their families to make informed choices." (Cass 2024)

80. Results of the 2024 Cass Review have led to European countries shifting their policies on gender affirming care for minors: As a result of the Cass Review, NHS England stopped the use of puberty blockers for gender incongruence/dysphoria in children. NIHR is establishing a clinical trial to ensure the effects of puberty blockers can be monitored, and they will only be available for treatment of gender incongruence/dysphoria where there is clinical agreement that the individual will be followed under the research umbrella and may benefit. Other countries in

Europe, considering the results of the Cass Review, have since followed with changes to their gender affirming care policies. (Cass 2024)

81. The Cass Review broadly reflects the prominent issues of concern with gender affirming care in minors that I have discussed within this declaration, and it is the most comprehensive review to date of gender affirming care.

82. The Cass Review also broadly supports my position on problems with the consent process as it relates to gender transition in children and adolescents.

83. I declare under penalty of perjury under the laws of the State of Montana that the foregoing is true and correct.

DATED: January 14, 2025

Geeta Nangia, M.D.
Piedmont, South Carolina

Exhibit B

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MONTANA FOURTH JUDICIAL DISTRICT COURT, MISSOULA COUNTY

MOLLY CROSS, et al. Plaintiffs, v. STATE OF MONTANA, et al., Defendants.	Cause No. DV 2023–541 Hon. Jason Marks **DECLARATION OF QUENTIN L. VAN METER, M.D.**

I, Quentin L. Van Meter, M.D., declare as follows:

1. I am a pediatric endocrinologist at my independent practice, Van Meter Pediatric Endocrinology, P.C., in Atlanta, Georgia which I incorporated in 2003.

2. I hold a medical degree from the Medical College of Virginia.

3. I completed a pediatric internship and a pediatric residency at the Naval Regional Medical Center in Oakland through the University of California, San Francisco.

4. I completed a pediatric endocrinology fellowship at The Johns Hopkins Hospital. I am a former adjunct associate professor of Pediatrics at Emory School of Medicine at Emory University and a former Associate Clinical Professor of Pediatrics at Morehouse School of Medicine.

5. Prior to my arrival in Atlanta in 1991, I held clinical faculty positions at UC San Francisco, UC San Diego, Tulane University, and LSU schools of Medicine.

6. I personally knew the scientists at the Scripps Institute in San Diego who identified and sequenced gonadotropin releasing hormone (GnRH) and subsequently created the therapeutic analogs of this molecule which were used to suppress the release of pituitary gonadotropins for the purpose of controlling sex-hormone dependent cancers in adults and in treating precocious puberty in young children.

7. I began treating children with precocious puberty as soon as the long-acting versions of these drugs were FDA-approved. I have extensive clinical experience using Lupron-Depot Pediatric- 1 month, Supprelin-LA implants, Lupron-Depot Pediatric – 3-month, and was involved in the clinical trials of both Triptodur, and Lupron Depot-Pediatric 6-month as a principal investigator. I am currently the principal investigator of a 12-month injectable analog developed for a clinical trial by DebioPharm.

8. In order to understand the consequences of interrupting puberty when it would otherwise occur at an age-appropriate time, it is important to understand endocrine physiology of intrauterine hormone levels in early gestation and also throughout childhood and adolescence.

9. From the moment of fertilization, cell lines develop along either male or female pathways. Germ cells either become the primordial testis or the ovary. The ovary lies dormant, but the testicle begins to secrete testosterone which virilizes (masculinizes) the tissue of the genital

ridge to develop the penis and scrotum by age 12 weeks gestation. The testicle also secretes anti mullerian hormone which causes the Wolffian structures (uterus, fallopian tubes and the vagina) to disappear. This process is driven by the placental gonadotropins from the mother, while the fetal hypothalamus remains dormant, Thus, by 12 weeks of gestation, if all goes well, the developing fetus has either male or female external and internal reproductive structures in place. There are rare genetic defects that can interrupt this development, some resulting in ambiguity of genital appearance at birth, but the infants are either male or female, not a third sex or a spectrum of sex. Sex is binary.

10. In the final weeks of pregnancy, the hypothalamic hormone, gonadotropin hormone releasing hormone (GnRH) begins stimulating the fetal pituitary to secrete the gonadotropins (LH and FSH). This ignites the testicle or ovary to produce testosterone or estrogen, respectively. Typical male newborns have testosterone levels usually found at the beginning of puberty. Female newborns have estrogen-induced mucoid vaginal discharge and can even have brief spotting of blood, and they often have palpable breast budding. Newborn males have breast budding as well, since they will convert some of their testosterone to an estrogen by way of aromatization. Once the infants are born, their hypothalamic secretion of gonadotropin-releasing hormone dissipates, and all remains quiet until the average age of onset of puberty (average 10.5 yr for females and 11.5 yr for males) Undercurrent in the whole body of the male and female is the fact that all cells are programmed to expect the physiologic levels of the sex hormones that are germane to the biologic sex.

11. What is the purpose of puberty? It is to change the non-reproductive male or female into a reproductive male or female, respectively. Puberty is not a disease that must be quelled to avoid these changes, the exception being when it begins in females before their 8th birthday or in

boys before their 9th birthday. Justification to temporarily interrupt this process in cases of precocious puberty is based on two valid concerns: prevention of early menstruation in females which would otherwise create an intolerable social circumstance, and preservation of reasonable final adult height potential in both sexes. Interrupting puberty in the young child has not been shown to alter fertility or bone density when the suppression is stopped to allow puberty to occur at a normal age. Some of these children develop adverse mental health changes that resolve when suppression is interrupted, as it should be.

12. Are there known harms if puberty blockers are used in adolescence? Inherent in the process is the elimination of maturation of the germ cells of the testis or ovary. We can extrapolate from clinical reports of girls with significant delay of puberty or inability to enter puberty due to a hypothalamic defect that bone density is ultimately compromised, resulting in early osteoporosis. What we do not know is whether or not fertility can be restored fully if puberty blockers are used. Clinical trials to discover such data would not be considered ethical if permanent sterility could be a possible outcome. The brain and other vital organs depend on unimpeded progress through puberty to reach their pre-determined sex-based potential.

13. Estrogen and testosterone are both present in the healthy pubertal adolescent. Estrogen is naturally secreted from the ovary in the female. Estrogen in males comes primarily from the aromatization of testosterone to estrone, an estrogen. Testosterone in females is primarily produced in very low levels by the adrenal gland. The inherent ratio in females is high estrogen and low testosterone. In males, it is high testosterone and low estrogen. Outside of these natural healthy ratios, we know from existing pathologic conditions that high testosterone in females is damaging to fertility and puts females at risk for early heart disease and cancers. It also causes virilization (lowering of voice tambor, increased sexual body hair and acne, male-pattern baldness,

broadening of shoulders hands and feet, increased muscle mass and definition) most of which is not reversible, Increased levels of testosterone in females boosts sexual, emotional and physical energy. It is reported to have seriously exacerbated underlying mental health issues. In males, we know from existing pathologic conditions that high estrogen levels are associated with increased risk of cancer and stroke. High levels of estrogen cause enlargement of the male breast which does not resolve when estrogen levels return to normal, requiring mastectomy to remove the residual breast tissue. Elevated estrogen levels cause atrophy of the testicles by shutting down release of the pituitary gonadotropins. There are no studies to show that intentionally raising testosterone in females and estrogen in males to mimic the healthy levels of these hormones of the opposite sex are safe in terms of recovery of fertility.

14. I have used estrogen replacement therapy in females with Turner syndrome, females with primary ovarian failure, and patients with complete androgen insensitivity status-post gonadectomy. I have used progesterone replacement therapy to induce menstrual flow in females with primary amenorrhea. I have used combined estrogen/progesterone therapy to regulate menses in pubertal females. I have used spironolactone to block excessive sexual hair growth in adolescent females. All of these treatments were for an FDA-approved indication.

15. I have used testosterone in males with constitutional delay of puberty, and primary or secondary testicular failure under FDA-approved guidelines.

16. The plaintiffs claim that the use of GnRH agonists is primarily to interrupt natural puberty to allow the gender incongruent adolescent to have a pause during which they can be evaluated to see if the incongruence is persistent over a number of years. Theoretically, this would allow them to make an informed choice about whether they wish to stop the GnRH agonist and

resume natural puberty, or, instead, stay on the drug and begin excessive, non-physiologic doses of opposite-sex hormones to mimic the pubertal changes of the opposite sex.

17. Without long-term controlled prospective studies, there is no way to show any additional benefits or harm. What we are left with is retrospective data and proven physiology from the general population as well as registry data from those patients who have received GnRH agonist therapy for hormone-dependent cancers and from GnRH-treated children with precocious puberty. There are reports of deteriorating mental health in such adults, adolescents, and young children who have received GnRH agonist therapy. A recently published lead article in the *Journal of Endocrinology and Metabolism* stressed the association of early dementia in the absence of the natural pulsatile secretion of native GnRH. There is theoretical concern that male patients whose puberty is interrupted as they begin stage II of puberty will never be able to recover any pre-treatment testicular cell lines useful for fertility preservation and that it is impossible to prove that even in stage III of puberty that all male patients will have gonadal tissue that is mature enough to cryopreserve. This clearly refutes the idea that puberty blockers used in adolescents are safe because their effects are fully reversible.

18. The combination of blocking puberty at its onset and following on with opposite-sex hormones essentially sterilizes the adolescent. This alone is enough to justify that no controlled studies can ever be justified on an ethical basis. No institutional review board would ever condone such harmful experimentation on human subjects. Sterilization would be considered a serious adverse event, and an independent Safety Committee would find grounds to shut the study down.

19. I declare under penalty of perjury under the laws of the State of Montana that the foregoing is true and correct.

Executed this 15th day of January, 2025.

QUENTIN L. VAN METER, M.D.
Atlanta, Georgia

Exhibit C

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MONTANA FOURTH JUDICIAL DISTRICT COURT, MISSOULA COUNTY

MOLLY CROSS, et al. Plaintiffs, v. STATE OF MONTANA, et al., Defendants.	Cause No. DV 2023–541 Hon. Jason Marks **Declaration of Luka Hein**

I, Luka Hein, declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants.

2. Montana's SB 99, codified in §§ 50-4-1001 to 1006, 37-2-307, 53-6-135, MCA. (the "Act") is a necessary, potentially life-saving law that will protect vulnerable minors and their parents from the heartbreaking regret, irreversible

physical changes, and emotional pain that I have experienced after undertaking medical interventions aimed at "transitioning" me from a female to a "male."

3. I am a 22-year-old college student in Nebraska. When I was 14, my family was dealing with the aftermath of my parents' divorce. I had also been sexually preyed upon online such that the police got involved. As a result of these traumatic events, I began to disassociate from my body.

4. My mental health was not doing well either. I had depression, generalized anxiety and ADHD. I began to discover spaces online that twisted my normal pubertal changes and trauma into the conclusion that I was transgender.

5. I went into an intensive outpatient program. I told the therapist I was trans and she immediately affirmed my male identity and told my parents. From that time on, any other mental health issue I might have was pushed to the side.

6. I started seeing a psychotherapist that worked with "gender diverse youth." The therapist did not do a full mental health assessment. She did not do any screening for anything else that may be going on or that would explain the gender dysphoric feelings that suddenly appeared.

7. About a year after I started seeing the psychotherapist, when I was 16 years old, she recommended a double mastectomy. Other than a puberty blocker implant offered to me when I was well past puberty, this was the only other treatment offered because she perceived that my breasts were causing me the greatest distress. My trauma still had not been explored or addressed.

8. My dad supported the treatment. My mom had reservations, but she was bullied into agreeing with it by the medical professionals. Mom was told that I would commit suicide. They used suicide statistics as a scare tactic. Various medical professionals told my mom, "Do you want a dead daughter or live son?" Mom said she felt she had to go along with the surgery, did not really have a choice and would be seen as a hateful bad parent if she did not agree.

9. I had been binding my chest before the mastectomy, so initially not having to wear the binder felt good. Everyone around me was hyping me up about how great I would feel, and how great I looked. Around the 3rd year after surgery the good feelings were wearing off. The loss of my breasts was easier to ignore at that time in light of the other body pains and problems I was having.

10. A few months after the double mastectomy, I started testosterone, which I continued to take for four years.

11. Once I started taking testosterone my voice got lower, I grew more body hair and facial hair, the fat on my body was redistributed, I had painful acne, grew an Adam's apple, my periods stopped, and vocal cords became achy. I experienced vaginal dryness, atrophy and tearing, frequent urinary tract infections, and sexual dysfunction. I was told about some of these things before beginning testosterone, but at age 16 I had no concept of what it would mean to me.

12. I also developed joint pain in my hips, elbows, wrists, and lower back. Every day I experienced some soreness, but on some days I had so much pain I could hardly get out of bed. I developed heart problems. Sometimes it felt like my heart was

racing or skipping beats. At times, all my limbs felt cold like they were losing circulation.

13. Before starting testosterone I was on mental health medication. Initially the testosterone gave me a good feeling, but after being on it a few years I started getting very bad brain fog. My emotions were really blunted. I couldn't cry or feel emotions, except for irritation. The testosterone also affected my short-term memory.

14. By around the third year that I was on testosterone, my mental health declined and by the fourth year it was poor, with lots of brain fog, apathy, and overall feeling awful. By that time, I was done. I was tired of the shots, and not feeling well. I also realized this entire process limits my freedom since I had to have a pharmacy nearby and be close to medical providers that would continue the treatments.

15. I began to wean myself off the testosterone and stopped in September 2022.

16. I felt horrible after stopping the testosterone. I no longer had a high level of testosterone in my system, but my natural estrogen had also shut down. I went into a pseudo menopause with terrible hot flashes, night sweats, body aches, chills, nausea and dizziness. These symptoms were very bad for several months.

17. The spring of 2023 I had to withdraw from college classes because I was hurting so much and my health was so poor. I am still dealing with joint pain, poor vaginal health, sexual dysfunction, and heart issues.

18. At 16 the concept of pregnancy scared me, but when I turned 20 I discovered that I wanted to have children. Now I have to wait and see if I can even

have children or if my body could handle pregnancy. Even if I can, I will never be able to breastfeed.

19. In my teens I was certain I was not female, that I was a male born in the wrong body. I hated the parts of my body that indicated I was female.

20. I was certain I needed these treatments, but I was never presented with any other option. I wished a professional had told me there was nothing wrong with my body, that I was safe, was not broken and that there was another option in psychotherapy. That was what the 15-year-old me needed to hear. Instead, these professionals took the most chaotic, destructive time in my life and affirmed it into reality.

21. These treatments should not be allowed in minors. If these treatments had been illegal when I was experiencing gender dysphoria as a teen, I would have been given other options to consider. Kids should be allowed to grow up without being chained to an experimental medical industry.

22. The European pioneers of these treatments are doing a u-turn. We should be doing the same.

23. I would like to tell the Plaintiffs in this case that you've always been your authentic selves the way you are. You are perfect the way you are – without making physical changes to your body. I know it will be tough, you will have rough emotions. But you are resilient and you will get through this. Even if you feel you need this, you don't know what it will do to you, what it will mean. You are too young to fully comprehend what this will mean for the future.

24. We protect kids from many things and we need to do that here.

25. The medical community needs to stop telling kids they are going to kill themselves. They believe these adults when they tell them that. It is irresponsible and leads to regrettable decisions.

26. Laws such as Montana's SB 99 that do not allow these treatments to be given to minors should be upheld in order to protect children and teens. I urge the Court to uphold this law.

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

Dated: January 14, 2025.

Luka Hein

Exhibit D

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MONTANA FOURTH JUDICIAL DISTRICT COURT, MISSOULA COUNTY

MOLLY CROSS, et al. Plaintiffs, v. STATE OF MONTANA, et al., Defendants.	Cause No. DV 2023–541 Hon. Jason Marks **Declaration of Elle Palmer**

I, Elle Palmer, declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants.

2. Montana's SB 99, codified in §§ 50-4-1001 to 1006, 37-2-307, 53-6-135, MCA. (the "Act") is a necessary law that will protect vulnerable children and teens like me and their parents from the tremendous regret and irreversible physical

changes that I have experienced after receiving medical treatments that promised to "transition" me into a male.

3. I was born and raised in Montana. I struggled through puberty between ages 12 and 15. Older men began sexualizing me online. My father struggled with alcoholism. I was diagnosed with depression and anxiety and prescribed a cocktail of medications but was only getting worse. I began self-harming and felt suicidal. I had three visits to the psychiatric unit at Shodair Children's Hospital in Helena.

4. For years, I had tried to figure out what was wrong with me. I dropped out of school, had no real friends, and spent all day on the internet. Online "friends" introduced me to gender ideology. I joined a transgender forum on Reddit. Something clicked. I found my true identity and a group where I could fit in.

5. Like many others in the trans community, I thought being transgender was the answer to all my mental health problems. When I was 15, I came out as transgender.

6. When I came out to my parents, I was initially met with pushback. I was a healthy 15-year-old girl, but I truly believed that I was born in the wrong body. I believed that I was supposed to be a boy. I told my parents that being a boy was my true identity and the reason I had struggled throughout puberty.

7. After a year of fighting with my parents, at age 16, they agreed to take me to Planned Parenthood. I told my parents that this was what I wanted and that I would live the rest of my life as a man. I often imagined how I would look as an old

man. I saw myself as finally being happy, for the first time since puberty. I could not wait to feel that way.

8. I knew about the side effects of testosterone that the doctor went over with my parents and me: a deeper voice, facial and body hair, potential for balding, and the social changes that would come with this. I smiled and told the doctor I was ready for my first shot of testosterone. Without any kind of psychological evaluation or other history, I began a testosterone regimen.

9. When I was 16, my voice dropped to a baritone range. When I was 17, I started losing hair on my head. By age 19, I had such a major receding hairline, that I worried that I would go bald. The rest of my body changed quickly. I got a lot of body hair. My face got puffy and I grew facial hair. I began growing a brow bone and grew an Adam's apple. I was binding my breasts, and between that and the testosterone my chest became disfigured.

10. My vaginal wall became very thin to the point that it would tear and begin bleeding during sex.

11. Two years into taking testosterone, my bones felt fragile and ached. I felt that I was beginning to develop osteoporosis. I was very weak and felt like an old person. I could not do basic physical things and when I laid on my side, I could actually push my ribs into my body. I developed pain where my ovaries would be and had pain all over – my joints, my bones – from morning till night, such that at times I could not sleep.

12. My voice started to change quickly and dropped, so that I sounded like a male. My throat began to feel different and my voice became easily strained, at times giving out.

13. Within 6 months, my emotions became numb. I could not cry any more. I barely felt any emotions other than anger or occasionally happy, and I lost all other range of emotions. I began to engage in more reckless behaviors. I stopped caring about being in unsafe sexual situations.

14. I had terrible brain fog. I became extremely forgetful and experienced memory loss.

15. The testosterone helped with my depression for a while. However, once I stopped taking testosterone all of my mental health problems came back.

16. At age 18, I applied for admission to the University of Montana. I realized that I didn't feel comfortable in a male dorm room, but I didn't want to make a woman uncomfortable in a female dorm room. I didn't know where I belonged. I felt foreign in both male and female spaces.

17. So, at age 19, I decided to detransition and started weaning off the effects of three years of testosterone. But the effects of testosterone on the female body are extremely powerful. I still have a baritone voice, and that is permanent. I will never sound female again. That is the reality of my life. If I hadn't taken testosterone as a teenager, I would sound like a normal adult woman.

18. I experienced terrible regret. I hated everything about what testosterone had done to me. I hated how my voice sounded. Being mistakenly identified as a

"transwoman" because of my voice and facial features tremendously bothered me – I could not stop thinking about it.

19. Since detransitioning, only some of my breasts have come back and my hairline has returned somewhat, and my body hair has decreased. I still have an Adam's apple and my voice remains deep, changes that will be permanent, things I could not understand at age 16 when I insisted that testosterone would solve my problems and that I would not change my mind.

20. Children are not able to fully understand the life-changing consequences that hormones will have on their bodies and their futures as adults. These hormones will have lifelong effects on their bodies, their minds, their future romantic relationships, and their social interactions. Parents cannot predict how hormonal interventions will affect their children's future or what decisions their children will want to make as adults regarding their fertility and sexual relationships. Therefore, they should not be put in the place of making those decisions or being pressured by their child or a health care provider to make those decisions on behalf of the child.

21. The State of Montana has taken a critical step to protect the future and future decision-making of its most vulnerable citizens. The Act protects minors and their parents from making decisions that will permanently change children's bodies before they are legal adults and capable of understanding the consequences of these medical interventions.

22. I wish that I had been able to get through the rest of my teenage years to think about the ramifications of the decision that I wanted to make and to decide

whether or not I wanted to start medical changes as an 18-year-old instead of a 16-year-old. Instead of growing into an adult woman, I grew into a person with a beard, a receding hairline and that sounds like a man.

23. I do not want any other teenager to go through what I have been through. I have to live with the consequences of testosterone for the rest of my life. SB99 will ensure that other Montana children and teens do not have to endure the pain, regret and life-long health effects that I and other detransitioners have endured.

24. I respectfully ask this court to uphold this critical, life-saving legislation.

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

DATED: January 15, 2025

Elle Palmer
Seattle Washington

Exhibit E

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MONTANA FOURTH JUDICIAL DISTRICT COURT, MISSOULA COUNTY

MOLLY CROSS, et al. Plaintiffs, v. STATE OF MONTANA, et al., Defendants.	Cause No. DV 2023–541 Hon. Jason Marks **DECLARATION OF SVEN ROMÁN, M.D.**

I, Sven Román, M.D., declare as follows:

1. I am a child and adolescent clinical psychiatrist in Sweden, and have been practicing medicine since 2000, with my focus on child and adolescent psychiatry since 2004. As discussed more completely below, I have personally witnessed the rise of a new class of gender dysphoria patients in Sweden, which now dominate the population of these patients in Sweden. I was educated in medicine at Karolinska Institutet (which would be translated to English as Karolinska Institute), which is the most well-known and prestigious international medical training institute in Sweden. Karolinska Children's Hospital, called Astrid Lindgren's Children's Hospital,

has also played a significant role in the ongoing conversation about treatment of minors with gender dysphoria, as it has handled significant numbers of child and adolescent patients with this condition. I have been treating patients with a variety of psychiatric disorders, both in an in-patient and out-patient setting, since 2004. I meet with and treat patients suffering from virtually the entire range of disorders identified in the DSM-5. I have participated in approximately 800 neuropsychiatric investigations and evaluations.

2. In the course of my work, I have met with approximately 40 children who have been diagnosed as suffering from gender dysphoria. In some cases, I have met with these children after active medical intervention has begun (puberty blockers and cross-sex hormones). Surgical intervention for minor children is extremely rare in Sweden, and therefore I have not treated a child after surgical intervention. I have met with other patients with gender dysphoria who have presented to me prior to medical intervention. For the reasons I give below, I have not referred patients to gender clinics for medical intervention because (1) I have consistently believed that there was a lack of evidence to support such medical interventions and (2) because in my experience all such patients I have met with have other psychiatric conditions in addition to their professed gender dysphoria. Treatment of these other conditions has also been shown to resolve gender dysphoria in many such cases. Through my involvement with GENID, discussed below, I have learned that parents report that children often relinquish their gender dysphoria when receiving psychotherapy or other interventions to address psychiatric comorbidities. It is also very common for teenagers to routinely experience mild body dysphoria (dissatisfaction with their physical appearance and physical changes to their body). This can range from increased acne to an adult body with noticeable physical changes, for both sexes increased height growth and growth of pubic hair, for girls such as breast growth and menstruation, for boys including growth of

genitalia, increased muscle mass, masculine body hair including beard growth and darkening of the voice. Some of these teenagers believe they have gender dysphoria, and for them, psychotherapy and the natural process of maturation are often all they need to get rid of both their body dysphoria and their gender dysphoria.

3. I have written on a variety of medical subjects for major Swedish newspapers and have published articles in the medical press in Sweden. Regarding gender dysphoria, several of the articles have been translated into English and have been widely disseminated internationally. I have also written or co-authored two articles on this subject in foreign medical journals, The American Journal of Psychiatry and Dagens Medisin in Norway.

4. Recently, on July 13, 2023, I co-authored an article with 21 doctors and researchers from nine countries in the Wall Street Journal: "Young people's sex change promoted without evidence."

5. I have spoken about childhood gender dysphoria in several recognized Swedish podcasts, on Finnish public service radio, in the French daily newspaper Le Figaro, and on May 21, a documentary was broadcast on the French TV channel M6, with footage of my lecture in the Swedish Parliament on September 16, 2021. Since 2019, I have held five lectures and two hearings to members of the Swedish Parliament by invitation, including two lectures in 2019 and 2021 on the subject of gender dysphoria in children. I have lectured on the development of gender dysphoria among children and young adults in Sweden at an international two-day symposium at the French Senate in Paris on 29 June 2024.

6. My opinions in this declaration are based on my clinical experience, as well as my review of the literature both in Sweden and the rest of the world, though I will focus on the Swedish experience and the resulting systematic review of the Swedish National Health Service. The

systematic review published in April 2023 by Professor Michael Landén and his colleagues conclusively establish that there is insufficient evidence to support hormonal interventions in gender dysphoric youth.

Gender Dysphoria in Sweden

7. The increase of gender dysphoria diagnoses in Sweden is astonishing and is what gave rise, in part, to concerns raised by the Gender Identity Challenge (GENID) association and others. Gender dysphoria was extremely uncommon in the early 2000s. In 2001, a total of 2 children (age group 0-17 years) were diagnosed with gender dysphoria, in 2018 the number was 484, a 242-fold increase.[1] A total of 12 people under 25 were diagnosed with gender dysphoria in 2001, by 2023 the figure was 2,248. It is my understanding that Sweden has the highest rate of gender dysphoria in children (patients per 100,000 population) in the entire world. More recent data from our government shows the trend potentially leveling out for girls after GENID, Dr. Gillberg, and others began raising concerns, though the COVID pandemic and its restrictions may have caused an increase among boys.

8. The increase in the diagnosis of childhood gender dysphoria was moderate until 2007, the year the iPhone was introduced (I touch later on why gender dysphoria, like many psychiatric diagnoses, is often socially contagious), and then the increase accelerated to become very high from 2014 onwards, when social media had become ubiquitous among adolescents.

9. The differences between boys and girls seen above is not unexpected in my experience as a psychiatrist. What is surprising is the significant increase in the number of diagnoses in both sexes.

[1] https://sdb.socialstyrelsen.se/if_paro/val.aspx. Swedish National Board of Health and Welfare

10. Sweden has long been very accepting regarding 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 the legal age for change of gender to age 12. A series of cases of regret and suicide following medical transition were reported in the media. For example, Richard Orange, Teenage transgender row splits Sweden as dysphoria diagnoses soar by 1,500%, The Observer 22 Feb 2020, reported on the suicide of a 32-year-old trans woman.

11. Due to the accumulating data on remorse and suicide, the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) conducted a systematic inventory of the research. On December 20, 2019, SBU published the systematic review "Gender dysphoria in children and adolescents: an inventory of the literature."[2] The survey showed that the scientific support for medical treatment of gender dysphoria in children was non-existent or extremely weak. I quote the conclusions below.

a. We have not found any scientific studies which explain the increase in children and adolescents who seek healthcare because of gender dysphoria.

b. We have not found any studies on changes in prevalence of gender dysphoria over calendar time, nor any studies on factors that can affect the societal acceptance of seeking for gender dysphoria.

c. There are few studies on gender affirming surgery in general in children and adolescents and only single studies on gender affirming genital surgery.

d. Studies on long-term effects of gender affirming treatment in children and adolescents are few, especially for the groups that have appeared during the recent

[2] https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of the-literature/

decade (the new group with, among other things, onset in adolescence, majority of the original gender female and high prevalence of psychiatric comorbidity; my note).

e. The scientific activity in the field seems high. A large part of the identified studies are published during 2018 and 2019.

f. Almost all identified studies are observational, some with controls and some with evaluation before and after gender affirming treatment. No relevant randomized controlled trials in children and adolescents were found.

g. We have not found any compiled national information from Sweden on:

    i. The proportion of those who seek health care for gender dysphoria that get a formal diagnosis.

    ii. The proportion starting endocrine treatment to delay puberty.

    iii. The proportion starting gender affirming hormonal treatment.

    iv. The proportion subjected to different gender affirming surgery.

The Majority of Gender Dysphoria Patients Today

12. Our experiences of gender dysphoria in Sweden are similar to those of the rest of the Western world. The new group with gender dysphoria, which began to seriously increase in numbers in 2014, differs significantly from the group of people with gender dysphoria on which the DSM-5 diagnostic manual is based. DSM-5 was published in 2013 and the preceding work took place the years before that.[3] The criteria are based on mainly men, onset in early childhood or early adulthood, and a gender dysphoria based on social roles or behavior. In the new group, a

[3] American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders. Fifth edition. Arlington, VA. American Psychiatric Publishing.

clear majority are of the female sex, gender dysphoria onsets at puberty, and gender dysphoria is based on gender identity. Since the new group differs so much from the group on which DSM-5 is based, many in the Swedish medical community now strongly question the reliability of the diagnosis.

13. In psychiatry, it is very common for syndromes to be socially transmitted, especially among teenage and young adult females. Those who have similar problems are in contact or socialize and in these subcultures there can be a kind of competition to go the furthest. One example is anorexia, and experience has shown that it is often directly counterproductive to admit these patients to inpatient care, because then these girls and young women are inspired by the other anorexia patients, and they experience a very destructive desire to extremes. Another example of social contagion is self-harm. It emerged as an epidemic in the early 1990s and has since escalated. Even for this group of patients, inpatient care is often counterproductive. It is not uncommon for patients with self-harm to post pictures and videos of self-harm on social media and, while in hospital, to contact like-minded people and ask when they will be admitted to the clinic.

14. My view is that gender dysphoria in children and young adults is largely explained as a social contagion. A slight increase in prevalence started in 2007, when the first smartphone was launched. However, it took a few years before the majority of teenagers had a smartphone, and this coincides quite well with the sharp increase in the diagnosis of gender dysphoria in young people. American journalist Abigail Schrier's book Irreversible Damage: The Transgender Craze Seducing Our Daughters (2020) provides a vivid and detailed account of the social contagion of

gender dysphoria.[4] In the 1990s and even in the 2000s, teenage girls had greater social contact in the non-virtual world, but since the 2010s, many only have social contact via social media on smartphones/computers.

15. The fact that gender dysphoria is socially contagious is also illustrated by the fact that the gender dysphoria diagnosis among children in Sweden decreased in 2019 and 2020, when the public debate was initiated. But when Sweden from spring 2020 to 2021 had restrictions due to the COVID-19 pandemic, including distance learning in upper secondary schools and universities and less incidence of organized sport, many teenagers and young adults became socially isolated and then the trend reversed and the number of gender dysphoria diagnoses for children increasing again.

16. The high comorbidity rate must also be considered. There is a possibility that the majority of patients in the new group have autism or autism-like conditions. About two-thirds of the children with gender dysphoria that I have met have had autism or autism-like conditions. In their teens, people with autism have even more concerns about their body and identity than other adolescents. Other comorbidities in gender dysphoria are anxiety disorder, depression, ADHD, self-harming behavior, emotional instability, eating disorder and mental trauma/PTSD. All of the above conditions are subject to evidence-based treatment. Gender dysphoria completely lacks evidence-based treatment for children, and probably also for adults 18 to 25 years. The Table below, from the Socialstyrelsen report in 2020 shows the high rates of comorbidity in girls diagnosed with gender dysphoria ages 13-17.[5]

[4] Schrier, A. Irreversible Damage: The Transgender Craze Seducing Our Daughters. (2020). Regnery Publishing.
[5] https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/vanligt-med-flera-psykiatriska-diagnoser-hos-personer-med-konsdysfori/

17. The DSM-5 diagnostic manual states that if a patient has multiple psychiatric conditions, the main problem must be defined. In the case of gender dysphoria, an alternative condition is often the main problem. When adequately treating the main problem, other conditions often disappear, which can thus be regarded as secondary to the main problem.

18. It is my experience and the opinion of many psychiatrists in Sweden that psychosocial treatment of gender dysphoria for children and young adults should always be tried first. As discussed below, after concerns began to be raised in 2018, the Swedish national health service and government initiated a comprehensive review that has resulted in essentially a ban on puberty blockers, cross-sex hormones, and surgeries in children. I say "essentially" a ban because there is the possibility of truly exceptional cases and for research. One example would be someone who has already begun these therapies and needed to be given some time to continue until it was appropriate to stop.

19. The Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) published a pre-print on February 22, 2022. Hormone treatment of children and adolescents with gender dysphoria, a systematic review and evaluation of medical aspects. It was published as an accepted and reviewed article in Acta Pædiatrica on April 17, 2023, I recite the conclusions of the study below. [6]

National Health Response to Concerns About Quality of Evidence

20. Sweden's national health care policy regarding trans issues has developed quite similarly to that of the UK. Twenty 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

[6] https://onlinelibrary.wiley.com/doi/10.1111/apa.16791

referrals ensued in 2013–2014. As reported above, Sweden's Board of Health and Welfare ("Socialstyrelsen") reported that, in 2018, the number of diagnoses of gender dysphoria was 15 times higher than 2008 among girls ages 13–17.

21. On December 16, 2022, The National Board of Health and Welfare published the updated national guidelines for the care of children and adolescents with gender dysphoria.

22. They concluded: "Caution in the use of hormonal and surgical treatment. At group level (i.e. for the group of adolescents with gender dysphoria, as a whole), the National Board of Health and Welfare currently assesses that the risks of puberty blockers and gender-affirming treatment are likely to outweigh the expected benefits of these treatments."[7] Like others, the National Board of Health and Welfare says now that hormonal and surgical treatment in minors can only occur in exceptional cases.

23. SBU did its work, Karolinska made its decision, and the government changed its recommendations. Recently, as mentioned, that work was the subject of peer review and published in a premier academic journal. Professor Michael Landén is the last (most important) author. This comprehensive and now peer-reviewed article accurately addresses the state of scientific research and shows conclusively that there is no demonstrated (as of yet) benefit to these therapies. This study is so important that I quote the entire abstract in the following paragraphs.

> **Aim.** The aim of this systematic review was to assess the effects on psychosocial and mental health, cognition, body composition, and metabolic markers of hormone treatment in children with gender dysphoria.
>
> **Methods.** Systematic review essentially follows PRISMA. We searched PubMed, EMBASE and thirteen other databases until 9 November 2021 for English-language studies of hormone therapy in children with gender dysphoria. Of 9,934 potential studies identified with abstracts reviewed, 195 were assessed in full text, and 24 were relevant.

[7] https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf

> **Results.** In 21 studies, adolescents were given gonadotropin-releasing hormone analogues (GnRHa) treatment. In three studies, cross-sex hormone treatment (CSHT) was given without previous GnRHa treatment. No randomized controlled trials were identified. The few longitudinal observational studies were hampered by small numbers and high attrition rates. Hence, the long-term effects of hormone therapy on psychosocial health could not be evaluated. Concerning bone health, GnRHa treatment delays bone maturation and bone mineral density gain, which, however, was found to partially recover during CSHT when studied at age 22 years.
>
> **Conclusion.** Evidence to assess the effects of hormone treatment on the above fields in children with gender dysphoria is insufficient. To improve future research, we present the GENDHOR checklist, a checklist for studies in gender dysphoria.

24. Adolescence is the most transformative time in a person's life. We now know that the brain undergoes a major change. It matures at different rates, and myelination – the formation of a fatty sheath around the projections of each neuron – occurs from back to front. The frontal lobe matures last, at 25-30 years of age.[8] This is where overall thinking and judgment are located. A teenager therefore cannot understand the consequences of an irreversible sex change treatment. In Sweden, the irreversible sterilization procedure is not allowed until the age of 25, and it is my opinion that it is therefore appropriate to have the same age limit for gender reassignment treatment for gender dysphoria.

25. I declare under penalty of perjury under the laws of the State of Montana that the foregoing is true and correct.

DATED: January 15, 2025

Sven Román

Sven Román, M.D.
Enskede, Sweden

[8] https://www.scottishsentencingcouncil.org.uk/media/2044/20200219-ssc-cognitive-maturity-literature-review.pdf

Exhibit F

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MONTANA FOURTH JUDICIAL DISTRICT COURT, MISSOULA COUNTY

MOLLY CROSS, et al. Plaintiffs, v. STATE OF MONTANA, et al., Defendants.	Cause No. DV 2023–541 Hon. Jason Marks **DECLARATION OF FARR A. CURLIN, M.D.**

I, Farr A. Curlin, M.D., declare as follows:

1. I am the Josiah C. Trent Professor of Medical Humanities in the Trent Center for Bioethics, Humanities, and History of Medicine, and Professor in the Department of Medicine, at Duke University. I am also Co-Director of the Theology, Medicine, and Culture Initiative at Duke Divinity School and Senior Fellow in Duke University's Kenan Institute for Ethics. Prior to joining the Duke University faculty in January 2014, I served on the faculty of the University of Chicago.

2. I am licensed to practice medicine and maintain medical licensure in the State of North Carolina. I am an internist with board certification in Internal Medicine, as well as

subspecialty board certification in Hospice and Palliative Medicine. From 2001 to 2013, I practiced general internal medicine, maintaining an outpatient primary care clinic from 2001 to 2008, and attending on the inpatient wards at the University of Chicago Hospitals from 2003 until I moved to Duke University at the end of 2013. Since January 2014, I have served as a palliative medicine consultant and hospice physician at Duke University. Since 2024, I also have served as a staff physician at the Durham Veterans Affairs Medical Center.

3. My work on medical ethics has included peer-reviewed publications, invitations to lecture at universities nationwide and internationally, and being asked to speak as an expert before national advisory bodies. I have received awards in bioethics. My training, research, and experience give me familiarity with professional ethical norms regarding clinical medicine—their content, history, and application to clinical contexts, including the context of medicalized gender transition. I have published an academic book that addresses, and have given invited talks at a major medical school concerning, ethical issues surrounding transgender medicine. I also have been called as an expert witness in other litigations regarding medicalized gender transition.

4. In addition, I completed a two-year postdoctoral fellowship in health services research at the University of Chicago, and I have spent a substantial portion of my time since then conducting and publishing empirical research, including research on physicians' attitudes and practices regarding controversial clinical interventions. This training and experience give me added expertise in interpreting and applying scientific data to clinical contexts.

5. The fact that a particular intervention is medically indicated for one condition in one population does not imply that it is medically or ethically defensible for a different condition in a different population.

6. The plaintiffs' experts have suggested that because the drugs used in medicalized gender affirmation treatments ("MGT") have been used to treat conditions such as precocious puberty and hormone deficiencies, it is unjust to prevent their use in minors with gender dysphoria ("GD"). But the plaintiffs' experts are comparing apples and oranges.

7. Dr. Hodax and Dr. Olson Kennedy themselves note that puberty blockers are used in central precocious puberty to correct for abnormally early puberty, restoring the pattern found in healthy children (Hodax ¶12, Olson-Kennedy ¶68). Similarly, in hypogonadism sex hormones are used to correct for abnormally low production of those hormones, restoring the levels found in healthy children of that sex (Hodax ¶12, Olson-Kennedy ¶69). That is the standard practice of medicine—correcting deficiencies and excesses that impair health, and the Act does not forbid any such practices. But by the plaintiffs' own description, MGT inverts and contradicts this medical standard: rather than correcting hormone levels that are abnormal, it induces hormone levels that are abnormal. As a result, the ethical analysis for MGT is entirely different and opposite.

8. While treatments for precocious puberty and other conditions such as "Turner syndrome and hypogonadism", as well as polycystic ovarian syndrome (Olson-Kennedy ¶69), aim to preserve and restore healthy development of secondary sex characteristics, MGT intentionally blocks healthy development of those characteristics. Similarly, GnRH agonists are sometimes used when patients have cancer to preserve fertility prior to chemotherapy, but in such cases the hormones are used to protect the patient's gonads from the toxic effects of chemotherapy, whereas, by contrast, MGT directly hinders and suppresses healthy gonadal development and function, harming fertility. In precocious puberty and other contexts, the drugs have medicinal effects; in the case of MGT, the drugs have toxic effects. Put differently, outside the context of MGT, these

hormones are used to restore healthy norms, while in MGT they are used to contradict and override healthy norms.

9. These contradictions in the plaintiffs' arguments expose ethical problems with MGT that the plaintiffs do not address. The plaintiffs claim to use "the very same medications" to treat transgender adolescents as they might use to treat "cisgender minors for reasons other than to treat gender dysphoria, such as precocious puberty and hypogonadism." (Amended Complaint at ¶148) The problem is that the hormones are *medications* only when used to treat hormone excesses or deficiencies, and contrary to plaintiffs' claims (Olson-Kennedy ¶67), the risks are not the same across the different conditions.

10. By way of parallel, the hormone erythropoietin, which stimulates the production of red blood cells, can be used as a medication to correct for a deficiency in that hormone, as is seen in many patients with kidney disease. Such uses are consistent with medical ethics so long as the reasonably foreseen adverse side effects are not disproportionate to the reasonably anticipated benefits. But erythropoietin also can be and has been used by professional cyclists to produce abnormally high levels of red blood cells. In the latter case, erythropoietin is used not as a medication but as a technology for "doping". Similarly, the hormone insulin, with regulates glucose metabolism, is used as a medication for those who, because of Type 1 diabetes, do not produce normal levels of insulin. Such use is consistent with medical ethics and is lifesaving. But, like erythropoietin, insulin has been used for doping by athletes to improve stamina, and in this latter case, such use is dangerous and contrary to health. As with such cases of doping, MGT uses hormones not to correct deficiencies but to achieve other desired characteristics that are not found in healthy persons of the same age and sex. In this, MGT contradicts the ordinary patterns and purposes of medicine.

11. Dr. Olson-Kennedy demonstrates another contradiction when she laments that, "Self-treatment can result in higher-than-physiological hormone levels, which can negatively impact mood and increase several health risks, such as blood clots, cardiovascular problems, and liver and kidney dysfunction." (Olson-Kennedy ¶ 70) But that is precisely what MGT does—induce higher-than-physiological hormone levels, which impact mood and increase several health risks. In MGT hormones are used not to maintain hormone levels within the normal range for the patient's gender (there is no "normal" hormone range for gender, which is a social construct) but for the *opposite sex*. In MGT the levels induced are decidedly *abnormal* for a person of the patient's sex.

12. Based on these contradictions, the Plaintiffs allege that the Act unfairly prohibits "the provision of a wide range of medical treatments" to transgender patients that are allowed for cisgender patients (Amended Complaint ¶¶ 65, 170). On the contrary, the Act prohibits MGT for *all* minors, while it does not prohibit the use of hormones for genuine medical purposes (as in treatment of hormone deficiencies) for *any* minor. Similarly, allowing breasts with breast cancer to be removed or allowing a diseased uterus to be removed, but refusing to remove healthy breasts or take out a healthy uterus because an adolescent perceived them to be at odds with their identity, is not discrimination based on transgender status but based on whether the organs are diseased. Nor are the benefits and risks of such treatments remotely equivalent in these two situations. Medically speaking, patients in the former and latter scenario are no more similarly situated than an adolescent who needs an amputation for bone cancer and an adolescent who asks for an amputation to treat distress that is part of body dysmorphic disorder.

13. As such, the Act, paralleling ordinary medical judgment and the ordinary regulation of the medical profession, distinguishes some interventions as not being sufficiently safe and

effective for medical purposes. Bodies that govern medical practice, from the FDA to state medical boards to hospitals, distinguish and forbid interventions for similar reasons.

14. The fact that GD is listed as a disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) does not imply that GD marks a disorder of the body that warrants MGT in minors.

15. Plaintiffs note that GD is "codified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders" (Amended Complaint ¶ 32, *see also* Olson-Kennedy ¶ 29) The DSM, however, is a manual specifically of what it terms "*mental* disorders" created by the American Psychiatric Association; it does not identify or provide diagnostic criteria for medical illnesses.

16. The Plaintiffs have not identified any other mental disorder for which the indicated treatment is to block or damage the development of healthy organs and functions. On the contrary, MGT in minors contradicts ordinary medical standards with respect to disorders of perception. The person suffering GD perceives their objectively healthy secondary sex characteristics as not compatible with their mental self-perception and therefore needing to be suppressed. MGT problematically takes the minor's mental perception as sufficient reason to treat healthy anatomy and physiology as if it were diseased, thereby contradicting medicine's ordinary regard for the healthy body as its standard.

17. Notably, Olson-Kennedy acknowledges that prior to 2013 the DSM called GD "gender identity disorder" (Olson-Kennedy ¶ 29), consistent with the recognition that GD is a symptom of a disordered perception regarding oneself, not a condition of disordered anatomy or physiology. To my knowledge, in no other case do we treat a disordered perception by treating normal physiology and anatomy as diseased. We do not, for example, prescribe hand soap to

children who, because of obsessive compulsive disorder, misperceive their hands as needing to be washed repeatedly. We do not lock children indoors who, because of agoraphobia, fear going outside. We do not encourage fasting in adolescents with anorexia nervosa. We do not amputate the healthy limbs of minors who suffer from body integrity identity disorder (BIID).

18. It is notable also that, while the plaintiffs claim that MGT treats "clinically significant distress caused by the incongruence between a transgender individual's gender identity and their birth assigned sex" (Amended Complaint ¶38), in fact MGT does not focus on distress itself, in contrast to psychoactive medications that aim to relieve anxiety or depression. The plaintiffs do not provide evidence that puberty blockers, testosterone, or estrogen are either medically indicated for or prescribed for treatment of dysphoria or distress in other clinical contexts.

19. Rather, by the plaintiffs' own description, MGT directly suppresses, alters, or removes otherwise healthy secondary sex characteristics to "align [transgender persons'] bodies with their gender identity." (Amended Complaint ¶169). The goal is to *prevent* development of secondary sex characteristics that are normal/healthy for a person of that age and sex (*Id*. at ¶¶ 84, 92, Olson-Kennedy ¶¶37-39). So Olson-Kennedy says that gender affirmation can include "male chest reconstruction, tracheal shave, facial feminization, and vocal cord alteration." She adds that these "would be required to correct the initial "incorrect" puberty," (Olson-Kennedy ¶ 38), but of course the opposite is the case. The secondary sex characteristics generated by the correct puberty, medically speaking, are precisely what are being suppressed, altered, or removed.

20. The patient's healthy secondary sex characteristics may be suppressed, altered, or removed toward an overarching goal of reducing distress, but the plaintiffs have not shown reliable data that MGT accomplishes this aim. Nor have they shown that MGT is consistent with clinical

standards for treating other forms of dysphoria and distress caused by misperception of the healthy body.

21. Indeed, there are at least two cautionary historical precedents where doctors have removed or damaged healthy tissue attempting to treat mental disorders: "normal ovariotomy" and lobotomy.

22. In "one of the great medical scandals of the 19th century", thousands of women had their healthy ovaries removed in efforts to "treat" diverse mental conditions, including masturbation, nymphomania, "pelvic neurosis", and "all cases of lunacy." (Studd[1] at 411, 413, Longo[2] at 244) As with MGT, proponents of normal ovariotomy justified it as a way of preventing death without evidence that it in fact reduced the risk of death. After the death of one young patient who he thought might benefit from ovariotomy, surgeon Robert Battey, who pioneered normal ovariotomy, resolved that "another such case should not perish in my keeping without my reaching out a friendly hand in hope of rescue." (Longo at 246-7)

23. As with MGT, ovariotomy contradicted standard medical practices by removing healthy organs to treat mental conditions. After coining the term "normal ovariotomy", Battey later alleged that for these patients the ovaries were not in fact normal, yet, as with MGT, he could not show scientific evidence to justify his claim. Just as Plaintiffs have alleged that forbidding MGT violates medical and ethical obligations, proponents of normal ovariotomy accused those who opposed it of "'wanting in humanity' and … criminal neglect of their patients." (*Id*. at 244)

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[1] Studd J., (2006). Ovariotomy for menstrual madness and premenstrual syndrome: 19th century history and lessons for current practice, *Gynecological Endocrinology* 22(8): 411-5.
[2] Longo L.D., (1979). The rise and fall of Battey's Operation: A fashion in surgery, *Bulletin of the History of Medicine* 53(2): 244-67

24. At the end of his historical account of normal ovariotomy, Lawrence Longo opined, "the enthusiastic manner in which Battey's operation was received by leading gynecologic surgeons and a large fraction of the profession illustrates the Achilles' heel of medicine: its too frequent and ready espousal of untested procedures or unproved theories." (*Id*. at 267) In my opinion, MGT displays this same Achilles' heel of medicine.

25. The profession of medicine went awry again in the early and middle 20th century, as lobotomies were performed on thousands of patients who suffered from mental illnesses, including schizophrenia, depression, melancholy, and obsessive-compulsive disorder. As with MGT, "The treatment was introduced … despite the fact that little research had been carried out on its effects." (Torkildsen[3] 2022.) As with MGT, in the absence of adequate scientific data, many people "were convinced that lobotomy reduced suffering." As with MGT, "those who promoted the method, were driven by idealism and a strongly held belief that their treatment alleviated suffering," and they "gave overwhelmingly positive reviews of the efficacy of the treatment, while grossly under-communicating its adverse effects."

26. Lobotomy has come to be seen "as one of the greatest mistakes in modern medicine" (*Id*.)—a prominent example of a collective scientific and ethical misstep by the medical profession that harmed many patients. In my opinion, MGT is likely to be judged the same, not least because it treats a disorder of perception as if it were a disorder of the body, harming the healthy body in efforts to reduce mental suffering.

27. If WPATH allowed the SOC 8 development process to be influenced by financial and other non-medical considerations, then WPATH's Standards of Care report is unreliable not

[3] Torkildsen, Ø. (2022). Lessons to be learnt from the history of lobotomy. Tidsskr Nor Legeforen. Available at: https://tidsskriftet.no/en/2022/12/essay/lessons-be-learnt-history-lobotomy

only because it is contradicted by the evidentiary base, but also because it is the product of ethical misconduct.

28. My own review of SOC 8 indicates WPATH has problematically minimized the doctor's responsibility to exercise independent judgment and fiduciary responsibility to guide patient care for minors.

29. In their widely used textbook, *Principles of Biomedical Ethics*, Beauchamp and Childress note:

> A conflict of interest exists when an impartial observer would determine that a professional's judgments, decisions, or actions are at risk of being unduly influenced by his or her personal interests, such as financial interests … The risk is that the professional's personal interests will create temptations, biases, and the like that will lead to a breach of role responsibilities through judgments, decisions, and actions other than those reasonably expected in the role. The reasonable expectation is that clinicians will seek the patient's welfare and respect his or her rights, that researchers will pursue objective and valid results, and so forth. A conflict of interest poses a risk that the professional in question will compromise these expectations and thereby damage patients' interests and rights, distort research, or teach trainees in a biased way. (Beauchamp and Childress[4] at 328)

30. As this explanation makes plain, it is beyond dispute that clinicians who practice (and are paid for) MGT have a conflict of interest in assessing whether MGT is supported by the evidence. It is problematic that this conflict of interest was neither mentioned in the SOC 8 report nor managed by including outside experts and perspectives in the standard-writing process. Insofar as changes in the recommendations were motivated not by dispassionate assessment of the data but by concern to protect clinicians' financial interests or professional reputations, or to further political or litigation agendas, that clearly "damage[s] patients' interests and rights, distort[s] research" and promulgates standards "in a biased way." All of this contradicts professional ethical

[4] Beauchamp, T.L. and Childress, J.S., Principles of Biomedical Ethics, 7th edition (2013). Oxford University Press.

norms and undermines trust in the medical profession. As Beauchamp and Childress also write, "Health care professions specify and enforce obligations for their members, thereby seeking to ensure that persons who enter into relationships with these professionals will find them competent and trustworthy." (Beauchamp and Childress at 7) If WPATH permitted its standard-development process to be dominated by individuals with a direct financial interest in providing the services covered by that document, without disclosing those conflicts of interest, then WPATH is neither competent nor trustworthy regarding its evaluations or advocacy of MGT.

31. The possibility of meaningful informed consent to MGT for minors is doubtful.

32. The Belmont Report[5] states that respect for persons requires that research can only be conducted ethically if the subjects have given *informed consent*. In 1982, soon after the Belmont Report was published, the principle of informed consent was applied to clinical medicine in another landmark government report, *Making Health Care Decisions*. Since then, the principle and practice of informed consent has been uniformly established across the domains both of clinical research and clinical medicine. Beauchamp and Childress write, "Virtually all prominent medical and research codes and institutional rules of ethics now hold that physicians and investigators must obtain the informed consent of patients and subjects prior to a substantial intervention." (*Id*. at 121) The Belmont Report notes "widespread agreement" that informed consent requires the presence of sufficient "information, comprehension and voluntariness." (Belmont Report[6] § C:1.)

[5] The Belmont Report is a respected statement of principles of medical ethics. It was published in 1979 by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, and authorized by the National Research Act of 1974.

[6] U.S. Department of Health, Education, and Welfare (1979, Apr. 18). Belmont Report: ethical principles and guidelines for the protection of human subjects of research, 44 *Fed. Reg.* 76, 21392–97 (Apr. 18, 1979). ("Belmont Report")

In my opinion, minors cannot give duly informed consent to MGT, because it is doubtful that any of these three conditions of informed consent can be met.

33. Doctors do not possess and are not providing information sufficient to enable children or parents to make "informed" decisions.

34. The absence of well-designed and controlled studies makes it impossible to give minors and their parents information sufficient to consider their consent duly informed, and the plaintiffs' experts by their own admission are misinforming patients regarding that fact. "*Caveat emptor*" does not meet the bar required for consent to be duly informed within clinical medicine and clinical research. It is not enough to say "we don't know" without doing the careful, incremental research to generate information needed for a consent to be duly informed.

35. Moreover, by their own admission the plaintiffs' experts do not disclose to minor patients and their parents that the evidence base does not support their claims of benefit from MGT. As such, by their own admission, they are misinforming minors and their parents who are considering MGT, and therefore contradicting the first condition on which informed consent depends.

36. It is also doubtful that minors have the intellectual maturity to sufficiently *comprehend* the decision to undergo MGT and the potentially life-long consequences that decision will bring.

37. It is well recognized that the ability to evaluate and balance risk and reward, to consider long-term as well as short-term implications, and to make prudent and well-considered decisions is not well developed in children and adolescents. WPATH's recently published SOC 8 acknowledges problems with minors' immature capacity for judgment, noting, "adolescence is . . . often associated with increased risk-taking behaviors" (SOC 8 at S44), and "Adolescents often

experience a sense of urgency that stems from hypersensitivity to reward, and their sense of timing has been shown to be different from that of older individuals" (SOC 8 at S44). Beauchamp and Childress likewise note that immaturity hinders adequate understanding. (Beauchamp and Childress 2012 at 131) For this reason among others, with few exceptions minors are *not* considered capable of granting informed consent to medical interventions. (Katz[7] 2016 at e1, e9)

38. Minors seem particularly incapable of comprehending the long-term implications of MGT, insofar as those implications involve relationships and experiences that come only with adulthood. As shown by Defendants' other experts, MGT brings lifetime physical and social implications including risks of impaired brain development, sterilization, and loss of sexual response. These risks cannot be adequately comprehended by children insofar as these risks relate specifically to aspects of human life that go with being an adult and are outside the life experience of children.

39. Moreover, one form of MGT—puberty blockers—*by design* blocks the mental, physical, and emotional maturation of puberty which may be essential for a child to come in time to comprehend decisions of this magnitude. (Cantor ¶ 212, Weiss ¶143) Dr. Cantor notes that "Blocking puberty blocks the awareness of sexuality and sexual orientation that can play an important role in the individual's understanding of gender identity" (Cantor ¶ 233), and "for all children, blocking puberty necessarily blocks the onset of adult sexual interest, sexual arousal, and sexual response which are part of 'the usual process of sexual orientation and gender identity development'" (Cantor ¶ 233, quoting Cass 2022 at 38).

[7] Katz A., Webb S. (2016) AAP Committee on Bioethics: Informed Consent in Decision-Making in Pediatric Practice. *Pediatrics*.138(2):e20161485.

40. In connection with the comprehensive review commissioned by the English National Health Service, Dr. Cass wrote, "We do not fully understand the role of adolescent sex hormones in driving the development of both sexuality and gender identity through the early teen years, so by extension we cannot be sure about the impact of stopping these hormone surges on psychosexual and gender maturation. We therefore have no way of knowing whether, rather than buying time to make a decision, puberty blockers may disrupt that decision-making process." (Cass Review Letter[8] 2022 at 5.)

41. The final Cass report concludes, "given that the vast majority of young people started on puberty blockers proceed from puberty blockers to masculinising/feminising hormones, there is no evidence that puberty blockers buy time to think, and some concern that they may change the trajectory of psychosexual and gender identity development." (Cass[9] 2024 at 32)

42. It is ethically problematic when the treatment in question—puberty blockers—not only cannot be comprehended adequately by minors, but also prevents the otherwise healthy development of their capacity to comprehend such decisions. This is all the more true for younger children, "[g]iven the highly reliable, repeatedly replicated finding that childhood-onset gender dysphoria resolves with puberty for the large majority of children," and that "the evidence indicates that blocking a child's puberty blocks the child's natural maturation that itself would resolve the dysphoria." (Cantor ¶ 157)

43. With respect to adolescents, WPATH's SOC 8 states that "decision-making regarding gender affirming medical treatments that have life-long consequences requires

[8] Cass, H. (2022, February). The Cass Review: Independent review of gender identity services for children and young people Interim report. National Health Service (NHS), UK.
[9] Cass, H. (2024, April). The Cass Review: Independent review of gender identity services for children and young people: Final report. National Health Service (NHS), UK.

thoughtful, future-oriented thinking by the adolescent." (SOC 8 at S63) However, neither WPATH nor any other source referenced by plaintiffs' experts establishes that minors, whether pre-pubertal or adolescent, are *able* to meaningfully comprehend and reasonably evaluate the risks and lifelong implications of MGT. This is particularly problematic given the fact that those who undergo pre-pubertal social transition are more likely to undergo MGT. (Cass 2024 at 31)

44. There is evidence that many minors who are subjected to MGT cannot meet the informed consent requirement of "voluntariness."

45. The opening statement of the Nuremberg Code declares,

> The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved, as to enable him to make an understanding and enlightened decision.

46. As the Nuremberg Code indicates, voluntariness depends on adequate information and comprehension ("*sufficient knowledge and comprehension of the elements of the subject matter involved"*), both of which, as already noted, are doubtful in the case of minors considering MGT. But voluntariness also depends on freedom from controlling influences, both external and internal.

47. With respect to external influences, minors obviously are commonly under the controlling influence of parents, which I will address below. In addition, a number of international experts have indicated concern that the rapid increase in prevalence of GD, especially among adolescent females, reflects undue influence of social pressure. WPATH's recently published SOC 8 itself acknowledges, "For a select subgroup of young people, susceptibility to social influence impacting gender may be an important differential to consider." (SOC 8 at S45)

48. Beauchamp and Childress note that in addition to external controlling influences, "no less important to autonomy are internal influences on the person, such as those caused by mental illness. All of these conditions can limit voluntariness." (Beauchamp and Childress at 105; *see also id*. at 138.) Dr. Cantor documents ample evidence that a high proportion of minors experiencing GD suffer from mental illnesses. (Cantor ¶ 158-161) The plaintiffs' experts acknowledge the same. Moyer notes "high rates of all of these mental health problems" (*Id*. at ¶ 9). Dr. Hodax notes, "Many of the transgender patients that I see come to my clinic struggling with mental health issues, including depression, anxiety, and suicidal ideation from untreated gender dysphoria." And Olson-Kennedy writes that many of her patients "had contemplated or attempted suicide or self-harm (including cutting and burning)" (*Id*. at ¶ 46).

49. Indeed, all of the adolescent plaintiffs in this case were evidently suffering mental illnesses at the time they were approved for MGT, including "severe depression and anxiety" (Brief at 11), "intense and worsening mental health challenges" including "panic attacks on a daily basis", suicidality and suicide attempts, and self-harm (Paul Cross ¶¶ 5-8, Phoebe Cross ¶¶ 8, 19, Brief at 12, Doe ¶¶13, 32).

50. These mental illnesses constitute an internal controlling influence that can prevent genuine voluntariness. As WPATH itself recognizes, "A young person's mental health challenges may impact their conceptualization of their gender development history and gender identity-related needs, the adolescent's capacity to consent, and the ability of the young person to engage in or receive medical treatment," and "The adolescent's mental health concerns . . . may interfere with diagnostic clarity [and] capacity to consent . . .". (SOC 8 at S62) WPATH also recently admitted that "autistic/neurodivergent transgender youth represent a substantial minority subpopulation" of those seeking medical transition. (SOC 8 at S50)

51. Despite the serious obstacle posed by mental health conditions to genuine voluntariness in decision-making by a minor, WPATH's SOC 8 is problematically unclear as to how these conditions will be addressed prerequisite to any MGT. Instead, it refers to an undefined "biopsychosocial assessment" (SOC 8 at S50) and only calls for known mental health concerns to be "addressed" rather than resolved before accepting consent (or assent) as voluntary (SOC 8 at S62). SOC 8 provides no guidance grounded on empirical evidence as to how or when consent/assent given by a minor who suffers from a mental health condition could be determined to be voluntary. Likewise, the plaintiffs do not give any account of how the mental health conditions of the adolescent plaintiffs were adequately addressed prior to beginning MGT, nor how the assent of these children suffering serious mental illnesses can be determined to be voluntary.

52. The fact that MGT is *wanted* by minors and their parents is not sufficient to justify MGT, medically or ethically.

53. WPATH's revisions of guidelines to eliminate or minimize the doctor's responsibility regarding decision-making with respect to MGT violate accepted principles of medical ethics. In its Standards of Care, version 8, WPATH suggests that gaps in evidence demonstrating the safety and efficacy of MGT should not prevent the use of MGT in adolescents "given the ethics of self-determination in care." (SOC 8 at S45) The new guidelines also emphasize a "right to bodily and mental integrity, autonomy, and self-determination,"[10] and a putative need for healthcare practitioners to "[m]atch the treatment approach to the specific needs of patients, particularly their goals for gender identity and expression." (SOC 8 at S21) This language ignores

[10] Among the "General Principles" asserted by WPATH are: "Respect universal human rights including the right to bodily and mental integrity, autonomy and self-determination; freedom from discrimination, and the right to the highest attainable standard of health." (SOC 8 at S21)

the potential conflict with MGT between "bodily integrity" and "self-determination," as well the conflict between the "needs of patients" and "their goals."

54. Much has been made of the importance of autonomy, but the ethical standard for medical decision-making with respect to minors is decidedly not "self-determination." Rather, as noted in the AAP Committee on Bioethics Report, “Informed Consent in Decision- Making in Pediatric Practice” (Katz 2016), the physician acts in a fiduciary relationship with the child, governed by “the duties to protect and promote health-related interests of the child and adolescent … [, and] these duties may conflict with the parent’s or patient’s wishes.” (Katz 2016 at e2) Parents likewise have “an ethically parallel fiduciary obligation” (e2) to promote the child’s best interests, whether or not that corresponds with what the child wants. “Historically and legally,” the AAP report continues, “medical decision-making in children has centered on the best-interest standard, which directs the surrogate to maximize benefits and minimize harms to the minor.” (e6) “A reliance on individual liberties and autonomy in the pediatric patient”, the AAP report notes, “is not realistic or legally accepted.” (e2)

55. By appealing to self-determination to justify MGT for minors, WPATH and the plaintiffs are putting the onus on children to make clinical decisions that they haven't information, comprehension, or authority to make, and thereby retreating from physicians' ethical obligations to protect children—a class of vulnerable subjects—from interventions that subject children to risks and harms without clear evidence of proportionate medical benefit. By definition, excepting a few legally-specified conditions, minors are not capable of making an informed decision regarding their medical care, and so are not capable of making an informed decision regarding MGT.

56. For all these reasons, it is doubtful that minors experiencing GD have sufficient information, comprehension, or voluntariness to make possible informed consent to MGT. If any minors do possess the level of comprehension and voluntariness required by ethical principles for a choice as momentous as undergoing MGT, I am aware of no evidence-based criteria for identifying those specific minors, and plaintiffs' experts cite none.

57. Parental consent cannot satisfy the doctor's ethical obligation to obtain informed, comprehending, voluntary consent.

58. In many medical contexts, medical ethicists speak of obtaining "assent" from minors, while obtaining "consent" from the child's parents. (Katz 2016, e8) This combination of adolescent assent and parental consent, however, cannot cure the problems with informed consent to MGT.

59. Children have long been considered a category of vulnerable subjects and therefore as deserving more protections. (Beauchamp and Childress at 63.)[11] For example, the Declaration of Helsinki requires that where a clinical trial or experiment involves "vulnerable groups and individuals", those patients must "receive specifically considered protection." (Helsinki Declaration[12] ¶ 19.)

60. In the clinical domain, the vulnerability of children is addressed in part by requiring both parents and physicians to act in ways that are reasonably consistent with the child's medical best interest. (Katz 2016 at e2, e12.) That is to say that whereas adults are given greater latitude to

[11] *See also* HHS policy statement, "Vulnerable and Other Populations Requiring Additional Protections," available at https://grants.nih.gov/policy/humansubjects/policies-and-regulations/vulnerable-populations.htm.
[12] World Medical Association (1964). Declaration of Helsinki: Ethical principles for medical research involving human subjects. ("Helsinki Declaration")

refuse even medically indicated and life-saving treatments, children and their parents generally are not.[13]

61. In this light, ethically speaking, the plaintiffs wrongly claim that prohibiting MGT for minors contradicts "the fundamental right of a parent to make decisions regarding the care of their children" (Amended Complaint ¶ 183) On the contrary, as noted above, minors do not have rights to autonomy in healthcare, nor do parents have rights to interventions that are inconsistent with the child's medical best interest. Rather, both parents and medical practitioners are obligated to provide minors interventions that are genuinely medically necessary, and they are obligated to protect minors from interventions that are inconsistent with the child's medical best interest.

62. Here we see another contradiction in both MGT and the plaintiffs' claims. The plaintiffs describe MGT as "medically necessary" more than 30 times in their Complaint. If MGT were medically necessary, then physicians would be ethically obligated to strongly encourage it and perhaps even to require it (as physicians do when they perform other medically necessary interventions, such as blood transfusions for minors who are Jehovah's Witnesses). And yet the plaintiffs allege that adolescent can simply discontinue MGT (Amended Complaint ¶ 49, Moyer ¶ 27, Olson-Kennedy ¶ 39), and their claim that gender suppression is reversible depends on an adolescent discontinuing treatment. The plaintiffs also repeatedly note that MGT is only begun if the adolescent agrees the treatment is right for him or her. Mistretta describes it as "a profoundly personal and informed decision that is based on a person's innermost sense of self and individual needs. It's a decision made in consultation with their family." (¶ 15)

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[13] Beauchamp and Childress note, "Courts have often allowed adult Jehovah's Witnesses, for example, to reject blood transfusions for themselves, while disallowing parental rejections of medically necessary blood transfusions for their children. Parents are also sometimes appropriately charged with child neglect when they fail to seek or permit potentially beneficial medical treatment recommended by physicians." (at 325)

63. This pattern of nondirectiveness by clinicians—offering options, following the adolescent's wishes and deferring to the adolescent's judgment about whether to start or stop MGT—is not consistent with the claim that MGT is *medically necessary*, since medical practitioners are ethically obligated to encourage, and sometimes to require, pediatric patients to undergo any medically necessary intervention. This is not the way physicians approach insulin therapy in a type-1 diabetic, or antibiotics for a serious infection, and the plaintiffs have not explained how they follow a similarly nondirective approach with respect to any other *medically necessary* intervention. In my opinion, this nondirective pattern affirms that MGT cannot reasonably be considered medically necessary, and that even the plaintiffs, despite their assertions, do not treat it as such.

64. The vulnerability of children also implies parents have much more latitude to accept experimental interventions and even interventions that contradict bodily health (e.g. cosmetic procedures, physician-assisted suicide) for themselves than they have latitude to accept such interventions for their children. (Katz 2016 at e5)

65. Because of the vulnerability of children, it is widely accepted that both physicians and the state are obligated to act as fiduciaries of children's best interests with respect to health, and if necessary to act *en loco parentis*. Just as parents are ethically obligated to prioritize the child's good over their own wishes, medical professionals are obligated to prioritize the child's best interest (where that involves the child's health) over the wishes of the parents. Beauchamp and Childress (at 221) describe such "paternalistic" actions as justified by the ethical principle of beneficence—the obligation to do good and promote the health of individuals, while protecting them from harm. The AAP report on informed consent comments:

> This parental responsibility for medical decision-making in caring for their child or young adult is not an absolute right, however, because the state also has a societal

> interest in protecting the child or young adult from harm and can challenge parental authority in situations in which the child or young adult is put at risk (the doctrine of *parens patriae*). Pediatric health care providers have legal and ethical duties to provide a standard of care that meets the pediatric patient's needs and not necessarily what the parents desire or request. (Katz 2016 at e5)

66. By definition minors experiencing GD are vulnerable subjects, and all the more so in light of the already noted high prevalence of mental illness and other comorbidities among this population. As such, minors experiencing GD are owed protection from interventions that contradict their medical best interest—their health. Because MGT disrupts and contradicts bodily health in several ways, it is doubtful that physicians have ethical warrant to offer, or that parents have ethical authority to consent to, MGT in minors.

67. In addition, for the same reasons I have reviewed above, it is not possible to say that parents are receiving information about the implications of MGT sufficient to make any consent they might provide "informed."

68. If persons suffering GD faced imminent bodily harm from their condition, and if there were no other way to respond but to deploy MGT, and if evidence from animal studies and carefully controlled human trials gave reason to anticipate benefits from MGT proportionate to known harms, then an adult could potentially give valid consent to MGT in knowledge of the absence of otherwise necessary information. But none of these conditions in fact have been met, and that makes it doubtful that the principle of informed consent within clinical medicine and clinical research can be met at all with respect to MGT, much less with MGT for minors.

69. The fact that MGT creates a material risk (or even expectation) of sterilization and failure to develop healthy sexual response raises special ethical problems with accepting parental "consent" on behalf of the child. With respect to loss of healthy sexual response, I note that our society strongly disapproves of clitoral mutilation of girls (denying them sexual response in their

future adult lives) despite parental consent. Indeed, such "medical" procedures have been prohibited by law as a felony subject to imprisonment.[14]

70. Sterilization has likewise long been recognized to raise special ethical issues. One systematic review found that a significant percentage of women who consent to sterilization at relatively young ages (under 30, in that study) later deeply regret that decision. (Curtis[15] 2006; *see also* Burgart[16] 2017; Hillis[17] 1999) Given the possibility of regret and deprivation of what is considered a basic human right in other contexts, it is generally accepted that sterilizing procedures should only be performed on a minor when necessary to save his or her life. And even then, "The validity of parental consent to a sterilizing procedure can be challenged when the procedure could be safely postponed until the child can consent [i.e., when the child reaches adulthood], or where less-invasive alternatives are available." (Burgart 2017; Tamar-Mattis[18] 2009)

71. While medical procedures that impose substantial risk of serious harm are ethical in some settings, plaintiffs' experts do not remotely establish that the necessary conditions justifying such procedures exist in the case of GD and MGT, especially for minors.

72. I declare under penalty of perjury under the laws of the State of Montana that the foregoing is true and correct.

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[14]https://travel.state.gov/content/travel/en/us-visas/visa-information-resources/fact-sheet-on-female-genital-mutilation-or-cutting.html#:~:text=Violation%20of%20the%20law%20is,are%20prohibited%20under%20U.S.%20law.

[15] Curtis, K.M., Mohllajee, A.P. et al. (2006). Regret following female sterilization at a young age: A Systematic Review, *Contraception* 73:205.

[16] Burgart, A.M., Strickland, J. et al. (2017). Ethical controversy about hysterectomy for a minor, *Pediatrics* 139:6, e20163992.

[17] Hillis, S.D., Marchbanks, P.A. et al. (1999). Poststerilization regret: findings from the United States Collaborative Review of Sterilization, *Obstetrics. & Gyn*. 93(6):889.

[18] Tamar-Mattis, A. (2009). Exploring gray areas in the law about DSD and sterilization, *Endocrine Today*, 2009 October ed., https://bit.ly/2YdAHNU).

DATED: Januarv 15. 2025

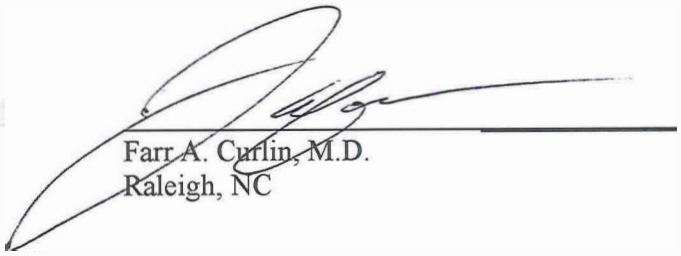

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Exhibit G

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MONTANA FOURTH JUDICIAL DISTRICT COURT, MISSOULA COUNTY

MOLLY CROSS, et al. Plaintiffs, v. STATE OF MONTANA, et al., Defendants.	Cause No. DV 2023–541 Hon. Jason Marks **DECLARATION OF JAMES LINDSAY, PH.D.**

I, James Lindsay, Ph.D., declare as follows:

1. I am over the age of eighteen and submit this expert opinion based upon my personal knowledge and research experience. It reflects the conclusions I have drawn from extensive study of the relevant bodies of academic literature over the last eight years.

2. I hold a Ph.D. in mathematics from the University of Tennessee, awarded in 2010, a Masters of Science degree in mathematics from Tennessee Technological University, awarded in 2003, and a Bachelors of Science degree in physics from Tennessee Technological University, awarded with honors in 2001.

3. Although my Ph.D. is in the field of mathematics (area of specialty: enumerative combinatorics)—and not in gender studies, sociology, social or political philosophy, economics, or history—a Ph.D. (doctorate of philosophy) degree is based upon a demonstrated capacity to do original research in a novel area of study, including basic research tasks like surveying the literature, tracking citations, understanding research-level materials, writing and preparing reports, and so on. Furthermore, such a degree indicates a person's capacity to synthesize unfamiliar academic material and make novel contributions to the field based upon that research.

4. Given my bachelor's of science degree is in physics, I have some background familiarity with the sciences and their basic principles, the scientific methods, and the philosophy of science. In the last case, I augmented my knowledge of that field through independent reading through much of the 2010s.

5. Pertinent to the subject matter in this lawsuit, I began a personal, self-directed study of the relevant bodies of academic literature, including gender studies, sexuality studies, feminist theory, queer theory, critical theory, postmodernism, and critical pedagogy in earnest in 2016. I became aware of these lines of thought perhaps three to four years earlier.

6. In the course of this study, all of which was conducted independently and outside of any university setting, I first wrote and had accepted for publication seven academic papers in these subjects across a wide variety of relevant reputable academic journals as a part of a "white hat" exposé project that came to be known as the Grievance Studies Affair. In addition to the seven accepted papers, four of which were actually published, an additional seven were under peer review and consideration for publication in these and other journals. This project spanned 2017 and 2018 and culminated in that latter year and occupied the vast majority of my professional time and energies during those years.

7. In the capacity of that endeavor, together with two colleagues, I made many novel contributions to the relevant fields of study at the professional research level, even though they were not made in good faith with respect to the fields we sought to probe and expose. This demonstrates unambiguously my capacity to learn the relevant material and reproduce it in such a way that professionals in the fields of study themselves believed they were genuine articles making research contributions to those fields, including feminist theories, gender studies, and sexuality studies.

8. Since 2018, I have devoted the entirety of my professional time and energies to continuing to study the relevant bodies of academic literature and relevant foundational philosophical literature while connecting my findings to observations of these ideas as put into practice. Though they are perhaps modest, it is fair to say that I have made genuine contributions to the understanding of the relevant bodies of literature in good faith from an outsider's perspective.

9. In the course of this work, I have published and/or contributed to six books in the relevant subject areas. I am also often retained as a public speaker on the issue and have delivered my remarks before groups of congresspeople, groups of state legislators and/or other state officials in more than a dozen states, in the European Union Parliament, and at the Oxford Union, in addition to in over one hundred other venues, all by invitation.

10. I have been retained by the Defendants in the above-captioned lawsuit to provide my expert opinions on the ideological nature and philosophical origins and underpinnings of what is sometimes called "gender ideology," which is a shorthand term referring to a critical constructivist ideology of sex, gender, and sexuality, including elements of queer theory and radical feminism, which are at the root of the phenomenon of what is called "gender transition."

11. 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 faithful and accurate reading of the relevant academic literature.

12. My opinions contained in this report are based upon: (1) my reading of the relevant academic literature; (2) my own synthesis of that literature as it spans across several domains of academic pursuit. These domains include feminist theory, postmodernism, structuralism, and poststructualism, sexuality studies, queer theory, critical theory, critical pedagogy, and, in particular, what has been termed "critical constructivism" or "critical constructivist epistemology," which it is my opinion forms the ideological and conceptual basis for the "gender ideology" that underpins the phenomena of what is called gender transition, both social and medical. My objective is to give a satisfactory overview of these ideas and indicate their ideological, if not cult-like, nature and to connect them to the topic of gender transition as is appropriate to this lawsuit.

13. The following expresses my expert opinion regarding "gender ideology" as a critical constructivist ideology of sex, gender, and sexuality, including some of its intellectual history and positions on topics and issues relevant to the present lawsuit, particularly the medical practices prohibited by the Montana statute in question.

14. In my informed and considered opinion, the entire phenomenon of what is called "gender transition" is based upon an ideological worldview known as critical constructivism as it is applied particularly to sex, gender, and sexuality, more colloquially a critical constructivist ideology of sex, gender, and sexuality, or even more colloquially, "gender ideology."

15. Therefore, the ideas at the center of this lawsuit, including "gender," "gender identity," "transgender," "gender dysphoria," and "gender-affirming care" are ideological terms that are not best understood in any medical context.

16. The ideological worldview of critical constructivism in which these terms obtain meaning fails to describe the world as it is and, in fact, is hardly interested in doing so. It is also not only not scientific but is demonstrably openly hostile to science and scientific methodologies except in those cases when it can appropriate science to its cause. It is therefore not a product of any science and is instead derived from agenda-driven activist literature designed to "transform" the world and the people in it as opposed to geared toward understanding it. It is therefore, in my opinion, a completely inadequate and dangerous basis for the practice of medicine, which depends on a scientific understanding of the circumstances of its patients both in diagnosis and in treatment, for the safety, efficacy, and ethical ramifications of the practice.

17. For a similar reason, critical constructivism is not an adequate basis for the practice, application, or adjudication of the law. Just as critical constructivist ideology treats that science that agrees with it as "science" and whatever disagrees with it as "injustice," it treats whatever law that supports it as "justice" and whatever disagrees with it as "injustice."

18. These problems are based on the fact that critical constructivism does not believe in truth or even a shared reality from which we can extract facts. That means this lawsuit is not about adjudicating between various facts and their interpretations. It is about choosing between a worldview in which facts matter and one in which facts do not matter except insofar as they further an ideological cause.

19. In fact, it is further my expert and considered opinion that a critical constructivist worldview is not merely ideological in nature but presents many characteristics indicative of cult-like practices and tendencies. Indeed, it is my opinion that this ideology reproduces in a specific domain (the social phenomena related to sex, gender, and sexuality) some of the oldest cult

practices humanity has ever known and is therefore wholly incompatible with the effective and ethical practice of modern, evidence-based medicine.

20. Understanding these claims and their relevance to this lawsuit requires a great deal of explanation with specific evidence supporting it. The body of my full report provides that. (*See generally* Doc. 149.) This Declaration provides a brief overview that simply states and asserts the main points.

21. Critical constructivism is a worldview, in the words of its creator, (late) critical pedagogue (education theorist) Joe L. Kincheloe, who was working at McGill University in Canada until he died in 2008. It is a constructivist worldview that analyzes the construction of the world using critical theory, thus the name.

22. The critical constructivist worldview, both in theory and in practice, inside and outside of education, is unambiguously a derivative of Marxism that was modified by much twentieth-century theorizing, along with some more recent than that. It retains its essential Marxist ideological core, however, just as unambiguously. As such, and on its own merits, it is ideological in nature and it constructs its view of the world (worldview) in terms of its ideology.

23. Since critical constructivism is derivative of Marxism, and since I have claimed critical constructivism is only interested in truth that agrees with it, it bears noting that Marxism openly holds a view of truth (epistemology) and of ethics that only that which advances a society toward Communism is to be considered true and/or ethical. That is, Marxism and its derivatives subjugate truth, including claims made from within the sciences, to their ideological frameworks and their commitments.

24. Critical constructivism, as stated, has two parts: constructivism and critical theory.

25. Constructivism is a worldview that rejects the idea of an objective, discernible shared reality from which we extract truths. "The world," it insists, is constructed by human beings who live in the world and bring their biases, prejudices, opinions, social and political positioning, and what Marx referred to as their formative "historical conditions" to the interpretive table.

26. That is, constructivism believes that whether some objective reality independent to us exists, we cannot objectively experience, understand, or describe it, even with scientific methods. Constructivism holds that all perceptions and articulations blend subjectivity and objectivity, and the various facts of one's subjectivity determine the reality one lives in.

27. In particular, as a derivative of Marxist thought, constructivist thinking believes that one's "historical conditions," which is to say relationship to prevailing, nearly deterministic systems of power, structure (or construct) what people know, how they know it, and how they express it as "knowledges"—indeed, *who they are*.

28. Generally speaking, constructivism is skeptical of existing political power—or, more accurately, political power it does not hold and wield itself—and biases itself explicitly toward "excluded," "marginalized," and "subjugated" knowledges, including "transgender" experiential knowledge and ideas in gender ideology. Many such "knowledges" are, in fact, ideas that have been discredited by the scientific methods, which constructivism therefore sees as illegitimate.

29. Constructivist thinking regards the scientific methods as just one way of knowing or of validating claims and propositions about reality, one that enjoys unfair prestige, thus power, in our society. For constructivists, science is socially constructed and therefore just as socially constructed—that is, subjective and objective at the same time and also biased to favor existing political power—as any other form of knowing, and because of its relationship to existing power

dynamics it believes are responsible for constructing the world, it is often deemed worse than the "knowledges" it excludes, typically for the sin of falsifying constructivist views.

30. Critical theory, on the other hand, is a derivative of Marxism that evolved through the middle part of the twentieth century, particularly between 1937 (when it was first described formally) and the mid-1970s. It has been described (as evidenced in the body of the report) as deserving to be called "Critical Marxism" to increase the accuracy of what it describes, though there are reasons to believe its creators wanted to hide that fact about it.

31. Critical theory, or Critical Marxism, was designed to address certain failures of classical Marxist theory, particularly that it never took root in Western capitalist democratic republics. Its explicit aim was to advance a new Marxist theory in the West, so much so that it is often considered part of a broader canon of Marxist thought called "Western Marxism." Western Marxism explicitly sought to bring Marxist theory and revolution to the West by attacking its unique cultural institutions and economic structure.

32. Critical theory fuses with constructivism into critical constructivism by amplifying the focus upon the relevance of systemic political, social, and economic power in constructing "worlds" and "knowledges," thus people's understandings of the world.

33. The word "critical" in this capacity does not refer to the methods of critical thinking rooted in skepticism, reason, logic, and empiricism we are familiar with by that name in the "Western" philosophical, scientific, and educational traditions. It instead refers to the critique of power structures in the sense intended by Marx: "the ruthless criticism of all that exists."

34. Critical constructivism is demonstrably disinterested in or hostile to the sciences and even to truth because its object of concern is sociopolitical power. Truth, the sciences, facts, law, and reality—which, recall, it deems a blend of subjective opinion and (Marxist) interpretation

with objective observation—are merely constructions and tools of dominant power used to perpetuate itself, including against incursion by critical constructivist ideology, according to critical constructivism. In a critical constructivist worldview, *everything* is a contrivance of systemic power, and its relevance is only measurable in terms of how it is a contrivance of systemic power. Nothing else is relevant.

35. Critical constructivism as a worldview thus uniquely claims the capacity to declare invalid any proposition, claim, reason, or evidence—or law—that disagrees with its view of the world as an unjust application of political power designed to exclude, marginalize, or subjugate alternative knowledges that might threaten the prestige of the existing allegedly oppressive system and thus undermine its power.

36. In this regard, critical constructivism is not merely a self-serving ideological worldview; it is also an unfalsifiable conspiracy theory about why we accept or believe everything we believe that accuses "dominant power structures" and their accused beneficiaries of contouring knowledge and truth themselves in such a way that serves the political goal of allowing power to maintain itself as the prevailing "status quo."

37. Critical constructivist ideology is therefore the only possible measuring stick for critical constructivist ideology from within critical constructivist ideology, so it is a hermetically sealed worldview derived from Marxist ideology.

38. Further, Critical constructivism is not content to be an idle academic theory. It is a worldview, and it is meant to be practiced. Like all forms of Marxist thought, it must combine theory and practice, which can include activism in all domains as well as education. It must constantly seek to spread, install, and advance the critical constructivist ideology in new institutions and more of the population.

39. Critical constructivism was therefore not just developed in our colleges of education through individuals like Joe Kincheloe. It is also a dominant—if not *the* dominant—educational methodology (or basis therefor) in the United States and Canada today. Critical constructivists themselves report having effectively installed this ideology and its methods in a majority of our colleges of education by at least 1992, to say nothing of news, social, and entertainment media.

40. That is to say, it is overwhelmingly likely that virtually all minors (under 18) in our society who have not been deliberately shielded by their parents from critical constructivist ideologies have been exposed to them, perhaps as a dominant mode of learning and thought, even though they are unlikely to have ever heard the specific term.

41. To note, of course it is possible to adopt and practice an ideology, religion, or worldview in part or in full without knowing anything about it. For example, many mainline Protestant Christians adhere to a theology called "dispensationalism," and any child raised in a household practicing that particular theology could form his beliefs, values, and practices around it whether or not he ever heard the term "dispensationalism" or learned the specific tenets of the theology by that name. In parallel, children exposed to critical constructivism could adopt, believe, and practice it without having ever heard of it or knowing what they learn is part of a broader worldview system called by that term.

42. Critical constructivism can apply to specific topics that are part of the world, since it is a worldview, even beyond education. In particular, as it pertains to this lawsuit, critical constructivism can be applied to "gender" (also sex and sexuality, as we cannot avoid in this case). That is, there are critical constructivist ideologies of gender, sex, and/or sexuality.

43. There are two broad ways to adopt a critical constructivist ideology of gender: with or without the other two aspects (sex and sexuality), though this is slightly more complicated than needs to be discussed in this summary. That is, one can be a critical constructivist of gender who believes sex is an objectively real, essential, immutable category of human biology, or one can be a critical constructivist of gender who also regards sex itself (and sexuality nearly always) as a socially constructed category. The former of these positions is, broadly, "radical feminism." The latter is called "queer theory."

44. All of "gender ideology" as it is named is a critical constructivist ideology of one of these two sorts, and the term much more specifically refers to the queer theory interpretation. Therefore, "gender ideology" is aptly named as an ideology because it is a critical constructivist ideology of gender (*inter alia*).

45. Queer theory is the doctrine of a critical constructivist worldview with cult-like characteristics that primarily targets children and that has little or nothing to do with homosexuality or gay (etc.) identities.

46. Queer theory is explicitly defined by a queer theorist named David Halperin in 1995. A fuller account and history of queer theory is given in Part II of my full report (*see* Doc. 149 at 56—125), but Halperin makes abundantly clear in his definition of "queer" that it doesn't refer to anything essential to a person at all. In fact, he says it "doesn't refer to any natural kind" and that what it is grounded upon need not be "based in any stable reality." He says, "there is nothing in particular to which it refers" and calls it "an identity without an essence," which means it is not rooted in biological facts at all (*pace* Plaintiffs claiming "gender identity" is innate and stable in their First Amended Complaint, Paragraphs 30 and 25, respectively). (Ref: Halperin, *Saint Foucault*, p. 62).

47. Halperin says these characteristics are defining to queer theory explicitly and in direct contrast to what he calls "gay identities," which he insists are grounded in a "positive fact," presumably about a stable, shared reality. He is clear that it can apply to both straight people or gay people: it "is not restricted to lesbians and gay men but is in fact available to anyone who is or who *feels* marginalized because of her or his sexual practices" (p. 62, emphasis added).

48. Because Halperin identifies that "queer identity" is ultimately a matter of *feeling* marginalized based on sexual practices, he recognizes that the determination of a queer identity is *subjective* rather than *objective*.

49. He reinforces this view by definitng "queer" as an oppositional political position that opposes "*whatever* is the normal, the legitimate, the dominant," according to Halperin (p. 62).

50. Therefore, Halperin's definition of "queer" leads us to understand that it is a subjectively determined identity status based upon one's feelings of perceived marginalization and oppositional politics. It is therefore an ideological determination about the self arising from adopting a critical constructivist ideology, namely some aspects of queer theory (or, "gender ideology").

51. That is, queer identities, which is the only way to make sense of a "gender identity" in a meaningful sense (see below, Paragraphs 55–57), are subjectively determined and political, not essential. In other words, they're not identities at all. They're political beliefs based in ideologies derived from (Western) Marxist ideology and its specific derivatives.

52. In the briefest possible summary, queer theory holds that sex, gender, and sexuality are socially constructed and the results of unjust systems of dominant sociopolitical power that always seeks to reinscribe and reassert itself. That power is conveyed through a societal sense (which gender ideology treats as wholly political and ideological) of normalcy and legitimacy,

which critical constructivists believe they have a duty of conscience to oppose, disrupt, deconstruct, critique, and dismantle.

53. "Transgender" identity fits only within this framework. That is, it is an ideological status posing as a personal identity and designed specifically to challenge and destroy any notion of normalcy or legitimacy with respect to beliefs in an intrinsic relationship between sex (objective) and one's sense of being sexed (subjective—aspects of personality, in fact).

54. To make the case that "gender identity" only fits in such a conceptual framework takes considerable effort, and there's an entire section of my full report dedicated to that purpose. It's not so cut and dry as that, though, because as with all issues where critical constructivist ideological interpretations are involved, it always depends on what one means by "gender identity."

55. In brief, the original definition of "gender identity" was given by two UCLA psychiatrists, Robert Stoller and Ralph Greenson, and they used it to mean roughly your conscious sense of being male or female according to some vague set of criteria that largely seem steeped in sex stereotypes, sex roles, and secondary or even tertiary sex characteristics that are likely correlative with the other two categories. It is clear, at least to philosophers of this topic like Alex Byrne, that their choice of the word "gender" in "gender identity" was meant as a direct synonym for "sex," as it is often used. In other words, they were not talking about anything separate from sex except insofar as it is a subjective sense of being sexed.

56. Through a variety of turns through the 1960s and 1970s, eventually, "gender" came to be completely divorced from sex in any respect, taking on a meaning that would best be expressed simply as "sex, or a sense thereof, without meaning sex" or "sex, or a sense thereof, but not sex," both of which are facially absurd. As that evolution was occurring, it was also being

remolded in terms of the critical constructivist worldview. "Gender," as a technical term as pertains to this lawsuit (i.e., not a polite synonym for "sex"), only obtains meaning in a critical constructivist ideology as a result.

57. "Gender identity," including "transgender" status, are therefore ideological, not medical, and not even psychological constructs, as is "gender-affirming care" and the drive to apply it. This must be so because the operative term, "gender," only obtains specific meaning in that context.

58. As a result, I draw the conclusions I began with: "gender-affirming care" is ideological, not medical, in nature and part of a destructive ideology that derives from Marxism. The worldview it is based on is critical constructivist ideology, a Marxist derivative. We have every reason to believe the vast majority of youth, including in Montana, have been exposed to this ideology both in general and in its "gender"-specific forms and could have adopted some of its beliefs and practices regardless of realizing their philosophical origins. Such an ideology is resistant on principle to any law or science that disagrees with it or stands in the way of its activism. It also rejects the idea of an objective shared reality from which we can determine truths that are true for all people in all times and all places. It is therefore a dangerously inadequate basis for science and law, to say nothing of education, and should not be a basis for making decisions about what is objectively best for the vast majority of Montana youth.

59. To further clarify and defend these claims, I refer to the body of my full report (Doc. 149 at 14—166), which explains everything in this Declaration in considerable detail and with strong supporting evidence from the source texts themselves.

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

DATED: January 15, 2025

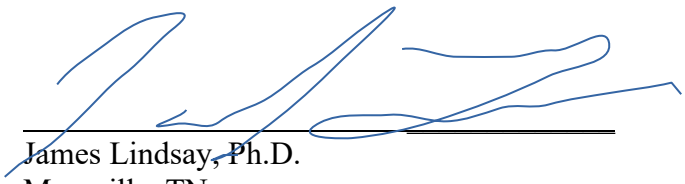

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Exhibit H

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Kaya Clementine Breen

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF LOS ANGELES

KAYA CLEMENTINE BREEN (a/k/a Finn Paul Breen), an individual,

Plaintiff,

v.

JOHANNA OLSON-KENNEDY, M.D., an individual; CHILDREN'S HOSPITAL LOS ANGELES, a California Corporation; CHILDREN'S HOSPITAL LOS ANGELES MEDICAL GROUP, INC., a California Corporation; SCOTT MOSSER, M.D., an individual; SCOTT W. MOSSER, M.D., APMC dba THE GENDER CONFIRMATION CENTER OF SAN FRANCISCO, a California Professional Medical Corporation; UCSF HEALTH COMMUNITY HOSPITALS aka ST. FRANCIS MEMORIAL HOSPITAL, a California Corporation; ST. FRANCIS MEMORIAL HOSPITAL, an entity of

Case No.: 24STCV32096

COMPLAINT FOR:

1. MEDICAL NEGLIGENCE
2. MEDICAL NEGLIGENCE – HOSPITAL/MEDICAL GROUP

JURY TRIAL DEMANDED

unknown form; SUSAN P. LANDON, an individual; and SUSAN P. LANDON, Inc., a California Corporation; and DOE DEFENDANTS 1-20,

Defendants.

Plaintiff Kaya Clementine Breen (a/k/a Finn Paul Breen), an individual ("Plaintiff" or "Clementine"), brings this Complaint against Defendants Johanna Olson-Kennedy, M.D., an individual, Scott Mosser, M.D., an individual, Susan P. Landon., M.A., LMFT, an individual, (collectively, the "Defendant Providers"), Children's Hospital Los Angeles, a California Corporation, Children's Hospital Los Angeles Medical Group, Inc., a California Corporation, Scott W. Mosser, M.D., APMC d/b/a The Gender Confirmation Center of San Francisco, a California Professional Medical Corporation, UCSF Health Community Hospitals a/k/a St. Francis Memorial Hospital, a California Corporation, St. Francis Memorial Hospital, an entity of unknown form, and Susan P. Landon, Inc., a California Corporation (collectively, the "Institutional Defendants") (the Defendant Providers and the Institutional Defendants are collectively referred to as the "Defendants"), alleging as follows:

INTRODUCTION

1. This case is about a team of purported health care providers who collectively decided that a vulnerable girl struggling with complex mental health struggles and suffering from multiple instances of sexual abuse should be prescribed a series of life-altering puberty blockers and cross-sex hormones, ultimately, receive a double mastectomy at the age of 14.

2. Clementine is a female who suffered from a complex, multi-faceted array of mental health symptoms as a child and adolescent. She is also a survivor of multiple instances of sexual abuse as a child and adolescent, something that was never explored, addressed, or discussed by Defendants in the course of their purported treatment. Her presentation of symptoms and concerns included, among other things, anxiety, depression, autism, undiagnosed post-traumatic stress disorder (PTSD), potential bipolarism, as has been suggested by one of her psychiatrists, ongoing confusion regarding her gender, and eventually psychosis (including audio and visual hallucinations), panic

attacks, and paranoia. Her family also has a lengthy history of mental health issues. She needed psychotherapy to evaluate, assess, and treat her complex co-morbid mental health symptoms.

3. Instead, she was fast-tracked onto the conveyor belt of irreversibly damaging puberty blockers (age 12), cross-sex hormones (age 13), and "gender-affirming" surgery (age 14). Around the age of 11 or 12, likely due at least in part to the sexual abuse she experienced as a young child, Clementine began struggling with the thought of developing into a woman and began to believe that life would be easier if she were a boy. She expressed as much to her then-school counselor in some of her sessions discussing her then-declining mental health, who told Clementine that she was transgender and called her parents to tell them the same.

4. Clementine's parents, completely surprised by and unaware of how to handle this supposed diagnosis but wanting to care for their daughter, decided to take Clementine to "the experts," which led them to the Center for Transyouth Health and Development at Children's Hospital in Los Angeles and under the care of Dr. Johanna Olson-Kenedy ("Dr. Olson-Kennedy"), the director of the Center and one of the most prominent advocates for so-called pediatric "gender-affirming care" in the country. Clementine had just turned 12 years old.

5. Dr. Olson-Kennedy and the team at LA Children's immediately and unquestioningly "affirmed" Clementine as transgender, and at her very first visit, after mere minutes, Dr. Olson-Kennedy diagnosed Clementine with gender dysphoria and recommended surgical implantation of puberty blockers. Dr. Olson-Kennedy performed no mental health assessment. She did not ask about things like past trauma, abuse, or mental health struggles or diagnoses. She involved no other providers or health care professionals in this purported gender dysphoria diagnosis and recommendation for puberty blockers. Instead, she simply took a handful of platitudinal statements from a scared, confused, and traumatized barely-12-year-old girl to give a life-altering diagnosis and handed her the prescription pad. In short, it took Dr. Olson-Kennedy and the team at LA Children's a single visit to send Clementine down a life-altering, traumatic, body-disfiguring, and irreversibly damaging path of transgender medicalization.

6. Under Defendants' "care," from the ages of 12 to 19, Clementine had a puberty blocker surgically inserted into her left arm at age 12, was prescribed "gender-affirming" cross-sex

hormones from ages 13 to 19, had a "gender-affirming" double mastectomy at only 14 years old, and was urged to get a "gender-affirming" hysterectomy as a 17-year-old. She did not experience any long-term relief from these gender dysphoria "treatments." Rather, her mental health progressively declined, as she proceeded into depression, anxiety, psychosis, hallucinations, self-harm, and suicidal ideation and even attempted suicide, none of which she had experienced prior to her gender medicalization.

7. Defendants also failed to obtain informed consent, which, for this type of "treatment," is a process requiring an extended period of time and complete assessment of the patient's mental health. It involves extensive discussion of the known and unknown risks of the proposed treatments and ensuring that the patient and parents understand and fully appreciate the long-term consequences and effects, such as the loss of the ability to ever conceive a child or breastfeed one should the patient. It requires discussion of alternative methods of treatment. It should additionally entail discussion of the evidence base, or lack thereof, to support the off-label use of the proposed "treatments." None of the above was discussed or explained in Clementine's case. In fact, the opposite occurred. Defendants obscured and concealed important information and failed to disclose the significant health risks associated with a female taking high doses of harmful male hormone drugs and puberty blockers. Even worse, Defendants made numerous material misrepresentations in order to convince Clementine's parents to agree to puberty blockers, such as assuring them that puberty blockers are "completely reversible," and cross-sex hormones, including asserting that Clementine would commit suicide if she did not begin taking testosterone. Defendants' coercion, concealment, misrepresentations, and manipulation are appalling and represent an egregious breach of the standard of care. This misconduct also constitutes fraud, malice, and oppression.

8. Eventually, through mental health care she began receiving at the end of high school and the natural desistance of gender dysphoria as one progresses into adulthood, Clementine realized that she was not "trans." She was a vulnerable child suffering from untreated PTSD from traumatic events in her childhood. Consequently, she detransitioned and no longer identifies as a male. But the damage has been done, and it is profound. As a result of Defendants' so-called "gender-affirming care," Clementine now has deep physical and emotional wounds, severe regrets, and distrust of the

medical system. She has suffered physically, socially, neurologically, and psychologically. Her voice has permanently deepened. Her female body did not develop, and she has a very masculine body structure. Her fertility is almost certainly destroyed from the combination of years on puberty blockers and testosterone. And even if she could conceive and deliver a child, she would not be able to breastfeed because her healthy breasts were removed when she was only 14. And she has to see the scars from that unnecessary surgery every day. She has experienced vaginal atrophy, and her sex life has been materially impacted. She is also at risk for bone-related problems later in life. In short, her body has been profoundly damaged in ways that can never be repaired. Furthermore, her mental health condition is now also damaged by medical abuse trauma, for which she will likely need long term mental health care as a result.

9. Clementine's providers deliberately, grossly, and recklessly breached the standard of care in this case as discussed above, by among other things, failing to adequately assess and treat Clementine's complex array of mental health symptoms and prior trauma before prescribing irreversible and life-altering medications and performing surgery. Instead, the Defendants coerced Clementine and her parents with the threat of suicide, presentation of false information, and concealment of full information, into an ill-advised experimental course of chemical/surgical imitation sex change treatment that was utterly unsupported by any reliable medical research. This so-called "treatment" of Clementine by her providers represents a despicable, failed medical experiment and a knowing, deliberate, and gross breach of the standard of care that was substantially certain to cause serious harm.

PARTIES

10. At all times relevant herein, Plaintiff, an individual, was a resident of the County of Los Angeles, State of California.

11. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant Johanna Olson-Kennedy, M.D., is a physician duly licensed by the State of California to practice medicine in California. On information and belief, Dr. Olson-Kennedy practices medicine primarily in Los Angeles, California.

12. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged

herein, Defendant Scott Mosser, M.D. ("Dr. Mosser"), is a physician duly licensed by the State of California to practice medicine in California. On information and belief, Dr. Mosser practices primarily in San Francisco, California.

13. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant Susanne P. Landon, M.A., LMFT ("Ms. Landon"), is a therapist duly licensed by the State of California to practice in California. On information and belief, Ms. Landon practices or practiced primarily in Los Angeles, California.

14. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant Children's Hospital Los Angeles Medical Group, Inc. ("LA Children's Medical Group") is, and at all times mentioned in this complaint was, a California corporation with its executive offices located in Los Angeles, California. On information and belief, LA Children's is the medical group through which Dr. Olson-Kennedy provided a course of experimental transgender medical "treatment" to Plaintiff that occurred and caused substantial injury to Plaintiff at least in substantial part in Los Angeles, California and San Francisco, California.

15. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant Children's Hospital Los Angeles ("LA Children's") is, and at all times mentioned in this complaint was, a California corporation with its executive offices located in Los Angeles, California. On information and belief, this hospital is affiliated with LA Children's and Plaintiff may have received care that is at dispute herein through this hospital.

16. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant St. Francis Memorial Hospital ("St. Francis") is, and at all times mentioned in this complaint was, a California corporation operating in and with executive offices located in San Francisco, California. On information and belief, St. Francis is the hospital at which experimental transgender medical treatment was provided by Dr. Mosser to Plaintiff, causing substantial injury to Plaintiff in San Francisco, California and Los Angeles, California.

17. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant UCSF Health Community Hospitals aka St. Francis Memorial Hospital ("UCSF") is, and at all times mentioned in this complaint was, a California Corporation operating in and with

executive offices located in San Francisco, California. On information and belief, UCSF has legally acquired St Francis and is the successor in interest to St. Francis.

18. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant Susan P. Landon, Inc. ("Landon, Inc."), was a California corporation operating in and with executive offices in Los Angeles, California. On information and belief, Landon, Inc. was the entity through which experimental transgender medical treatment was provided by Ms. Landon to Plaintiff, causing substantial injury to Plaintiff in Los Angeles, California and San Francisco, California.

19. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant Scott W. Mosser, M.D., APMC d/b/a The Gender Confirmation Center of San Francisco ("GCC"), was a California professional medical corporation operating in and with executive offices in San Francisco, California. On information and belief, GCC was the entity through which experimental transgender medical treatment was provided by Dr. Mosser to Plaintiff, causing substantial injury to Plaintiff in Los Angeles, California and San Francisco, California.

20. Plaintiff is ignorant of the true names and capacities of defendants sued herein as DOES 1 through 20, inclusive, and therefore sues these defendants by such fictitious names. Plaintiff will amend her Complaint to allege their true names and capacities and causes of action against said fictitiously named defendants when the same have been ascertained. Plaintiff is informed and believes and thereon alleges that each of the defendants designated herein as a "DOE" is responsible in some manner and liable herein to Plaintiff for her injuries.

21. Plaintiff is informed and believes and thereon alleges that at all times herein mentioned all of the DOES were the agents, servants, and employees of their co-defendants and in doing the things hereinafter alleged were acting within the course and scope of their authority as such agents, servants, and employees with the authorization, permission and consent of their co-defendants, except where stated otherwise below. Each of these acts and failures to act is alleged against each Defendant whether acting individually, jointly, or severally. Each of the Defendants or their alter egos agreed and conspired with the others in the commission of these acts or failures to act and fully ratified those acts.

22. At all times mentioned herein, each Defendant was the agent and employee of each and all of the other Defendants and, in performing the acts herein alleged, was acting within the course and scope of such agency and employment. Plaintiffs are informed and believe that all of the wrongful acts alleged herein were authorized and/or ratified by officers, directors, or other managerial agents of Defendants.

23. On September 5, 2024, Clementine sent a notice of intent to sue letter to the Defendants. The statutorily prescribed 90-day hold period for litigation has expired.

JURISDICTION AND VENUE

24. This Court has jurisdiction over this matter, and venue is proper because a substantial portion of the injury and experimental medical treatment upon which this action is based occurred in Los Angeles, State of California, in the city of Los Angeles.

25. The amount in controversy exceeds the jurisdictional minimum of this Court.

GENERAL ALLEGATIONS

26. Clementine is a young woman currently pursuing an acting major at UCLA. As a young child, Clementine was what most would consider a stereotypical young girl. She never expressed feelings of gender confusion or dysphoria. She never felt like or identified as a boy. Quite the contrary, she was always what many would consider a "girly girl." She enjoyed choir, dance, and theatre and loved to collect dolls.

27. However, progressing through childhood and adolescence, she began to suffer from a complex array of mental health issues. These included, among other things: anxiety, depression, presumed autism, and undiagnosed post-traumatic stress disorder (PTSD), as well as potentially bipolarism, as one of her psychiatrists has suggested. Many of these issues may be or are attributable to prolonged sexual abuse she suffered around the ages of 6 and 7, something that was never explored, addressed, or discussed by Defendants in the course of their purported treatment. She also suffered PTSD from growing up around a severely autistic brother, whose autism caused him to act out violently and made him highly volatile, creating a difficult home environment. She had additional unaddressed trauma from a period when she was 10 where both of her grandmothers—both of whom she was very close to and one of whom acted as her caretaker when both parents worked—died within

one month of each other, followed by her dog passing away the day after one of the grandmother's funeral. Her family on both sides had a complex history of mental health issues, including depression, anxiety, autism and developmental disability, suicide attempts, bipolar disorder, and substance abuse.

28. Starting around the age of 11, around the onset of puberty, Clementine began struggling with the thought of developing into a woman, not surprising given the sexual abuse she had suffered. She also began questioning her sexuality.

29. In July 2016 (age 11) she came out as gay. Not long thereafter, in the fall of 2016, Clementine began meeting with a school counselor to discuss issues connected to her deteriorating mental health. In some of those sessions, Clementine expressed that she believed life would be so much easier if she were a boy—a fully understandable feeling given her sexual abuse. Based on those conversations and few statements, the counselor called Clementine's parents and told them she believed Clementine was transgender.

30. Clementine's parents, completely surprised by and unaware of how to handle this supposed diagnosis and wanting to figure out how to best care for their child, decided to take Clementine to "the experts," which led them to the Center for Transyouth Health and Development at Children's Hospital in Los Angeles (the "Center") and under the care of Dr. Johanna Olson-Kenedy. Clementine had just turned 12 years old. To be sure, Dr. Olson-Kennedy is considered one of the most prominent experts and advocates for so-called pediatric "gender-affirming care" in the country. She is the Medical Director of the Center, the nation's largest pediatric gender clinic. She is double board-certified in Pediatrics and Adolescent Medicine and specializes in "the care of transgender youth and gender diverse children." Over the course of her work in this area over the last 18 years, she has treated over 1,200 young people and their families and typically has a panel of 650 patients of varying ages, up to 25 years old. She has been awarded research grants to fund research in pediatric gender medicine. She has lectured extensively across the United States and internationally on the treatment and care of "gender diverse children and transgender adolescents." She is an Associate Professor at the Keck School of Medicine at the University of Southern California. She is an Executive Board Member and President-elect of the U.S. Professional Association for Transgender Health ("USPATH"). And she has been retained as an expert in several cases across the country

challenging states' bans on pediatric gender medicine, in which she has provided expert reports and sworn deposition testimony. Sadly, as Clementine's case demonstrates, she does not practice what she preaches.

31. Clementine first visited LA Children's and Dr. Olson-Kennedy on December 27, 2016. Amongst the first actions that Dr. Olson-Kennedy took was to separate Clementine from her parents. Alone in the room with Dr. Olson-Kennedy, Clementine described her surface-level understanding of gender, stating things like "I mostly have boy friends" and "I like boy things." Based on such statements, Dr. Olson-Kennedy immediately diagnosed Clementine with gender dysphoria and told her that she was "trans," which Dr. Olson-Kennedy described as "all very normal." This all took place within minutes during her very first visit.

32. Dr. Olson-Kennedy performed no mental health assessment. She did not ask about things like past trauma, abuse, or mental health struggles or diagnoses. She involved no other providers or health care professionals in this purported gender dysphoria diagnosis. She did not perform any extensive exploration of psychological, family, or social issues. She did not perform any psychodiagnostics or psychiatric assessments. Instead, she simply took a handful of platitudinal statements from a scared, confused, and traumatized barely-12-year-old girl to give a life-altering diagnosis.

33. Dr. Olson-Kennedy then immediately recommended Clementine be put on puberty blockers so as to prevent her body from going through the "wrong puberty" and prevent the "irreversible" changes of female puberty. Dr. Olson-Kennedy described puberty blockers as "a great option" that would simply "pause puberty" to give Clementine time to figure herself out. Again, she recommended and prescribed life-altering puberty blockers where (1) Clementine did not have a long-lasting or intense pattern of gender nonconformity or gender dysphoria; indeed, her feelings around gender had only recently emerged just a couple of months prior; (2) she had performed no mental health psychodiagnostics, or psychiatric assessment; (3) she failed to address or even discuss potential preexisting mental health comorbidities or psychological or medical issues; and (4) she did not provide anywhere near the information required (or time to consider it) to obtain informed consent, as detailed below.

34. Ultimately, Dr. Olson-Kennedy recommended that Clementine have a puberty blocker surgically implanted in her arm. She ordered the implant that same day.

35. On March 6, 2017, Clementine had a Supprelin LA (histrelin acetate) blocker surgically implanted in her left arm. Histrelin acetate is a drug that has historically been used for two main purposes: treating precocious puberty in children (i.e., children who enter puberty at too early of an age) and treating advanced prostate cancer in adult males. Its use to treat gender dysphoria in children is off-label (i.e., it has not been approved by the FDA for such use).

36. Dr. Olson-Kennedy never discussed nor attempted to treat Clementine with psychotherapy or other less-invasive options to address Clementine's existing comorbidities and past trauma (about which she never asked). She never told Clementine that puberty changes are a struggle for most people, particularly females (and particularly survivors of sexual assault, as Clementine was and is), and that negative emotions tend to increase during puberty, and further that it takes time to settle into these changes to one's evolving body. These are very basic components of psychotherapy for young adolescent girls that should have been evaluated and discussed with Clementine but were not.

37. Dr. Olson-Kennedy pushed Clementine and her parents down this transition path by engaging in intentional, malicious, and false representations and oppressive concealment of important information. This concealment included, among other things, the lack of adequate clinical research supporting this treatment, particularly for 12-year-old girls for treating gender dysphoria; the existence of higher-quality clinical research contra-indicating treatment; the 80-90% desistence rates for childhood gender dysphoria; and the significant possibility of detransition and regret. She misled not just Clementine but also her parents by stating that taking histrelin was akin to pushing pause on puberty and would give Clementine time to explore her gender identity. She described puberty blockers as "completely reversible" to both Clementine and her parents, an outright lie. She failed to list known risks and possible harms of taking puberty blockers, especially for an extended period of time (the FDA recommends replacement of a puberty blocking implant for precocious puberty every 12 months, while one study suggests that a replacement every two years is adequate; Clementine's implant was left in for more than 4 years). She also failed to disclose that of young patients put on

puberty blockers to treat gender dysphoria, almost all of them (some studies showing as many as 95%) are then put on cross-sex hormones, the combination of which has devastating effects on the young female body. Dr. Olson-Kennedy did not state that for girls who are put on puberty blockers and then cross-sex hormones, it is almost a certainty that they will be rendered infertile. She did not discuss with Clementine or make sure that Clementine had the capacity to appreciate the cost of losing the ability to ever conceive a child. Dr. Olson-Kennedy not only misled Clementine and her parents into taking histrelin, but in doing so she also failed to obtain informed consent before putting Clementine on histrelin.

38. Notably, at Clementine's first visit, Dr. Olson-Kennedy ordered a bone density scan to determine her baseline bone density. It is a known risk that puberty blockers in adolescents can have significant detrimental effects on bone density formation. However, according to her records, Dr. Olson-Kennedy never ordered another bone density scan during the entire course of her treatment of Clementine (which alone would be malpractice).

39. At just her third visit to LA Children's with Dr. Olson-Kennedy, on September 9, 2017, Dr. Olson-Kennedy asked Clementine if boys in her class were going through puberty. When Clementine stated that they were, Dr. Olson-Kennedy suggested in order to "keep you on track," Clementine should get started on testosterone. Dr. Olson-Kennedy noted that, despite it only being her third visit and Clementine having only adopted a trans identity less than a year prior, Clementine "would likely benefit from testosterone" and sent her and her parents home with a consent form for testosterone. That consent form has not been produced by LA Children's or Dr. Olson-Kennedy, but upon information and belief, it was highly deficient, failing to properly disclose numerous known risks, discuss alternative treatment options, or disclose the lack of reliable research to support the off-label use of testosterone to treat adolescents for gender dysphoria.

40. Clementine was unsure and expressed doubt about wanting to take testosterone, but Dr. Olson-Kennedy assured her that doing so early on would ensure that later in life, Clementine would be more likely to fully "pass" as a "cis male." Dr. Olson-Kennedy further stated that if Clementine got on cross-sex hormones faster, it "would be easier on your body." Clementine hesitantly agreed.

41. Clementine's parents, on the other hand, were very much against the suggestion that Clementine needed to be put on testosterone, and they expressed as much to Dr. Olson-Kennedy. In order to convince her parents to agree to cross-sex hormone therapy, Dr. Olson-Kennedy again separated Clementine from her parents, this time to address the parents, and lied to them, just as she had done when she convinced them to have Clementine start puberty blockers. Dr. Olson-Kennedy first told them that Clementine was suicidal. This was a lie. At that time, Clementine had never had any thoughts of suicide, and she certainly had never expressed anything along those lines to Dr. Olson-Kennedy. Dr. Olson-Kennedy went even further and lied again by telling them that if they did not agree to cross-sex hormone therapy, Clementine would commit suicide. She bluntly asked them if they would rather have a living son or a dead daughter. In tears, Clementine's parents would "consent" to allowing Dr. Olson-Kennedy and her team inject their confused, suffering child with life-altering testosterone. Upon information and belief, threatening that a child will commit suicide unless undergoing cross-sex medicalization is a common tactic Dr. Olson-Kennedy and others at LA Children's engage in to convince uninformed parents who are averse to puberty blockers, cross-sex hormones, or surgery to treat their gender-confused children.

42. Not only did Dr. Olson-Kennedy obtain the parents' purported consent under fraudulent pretenses, but she also failed to provide the necessary information that they would have needed to consider in order for them or Clementine to provide informed consent—just as she had done when she convinced them to start puberty blockers. This included, among other things, that she failed to meaningfully discuss alternative treatments, failed to go over the all of the known risks and irreversible effects testosterone has on a female body, failed to discuss fertility preservation options given that testosterone following puberty blockers is all but certain to lead to infertility, and failed to discuss the lack of reliable clinical research to support the off-label use of testosterone to treat gender dysphoria.

43. Clementine was started on testosterone injections on January 26, 2018, at 13 years old and just 13 months after her first visit with Dr. Olson Kennedy. She was started at 10 mg shots weekly. She immediately began experiencing significant adverse effects, including bad acne. She requested to be moved to topical testosterone gel. At her request, she was switched to gel, but after labs came

back showing her testosterone levels were "too low" for a boy, she was switched back to injections.

44. By her fifth visit to Dr. Olson-Kennedy, on June 20, 2018, her testosterone prescription had been tripled, up to 30 mg shots weekly. Dr. Olson-Kennedy additionally noted that Clementine would "need [her blocker] implant removed next March in 2019."

45. By her sixth visit, on September 5, 2018, Clementine had had very little breast development (the product of the puberty blocker, which remained implanted in her arm after 16 months). Dr. Olson-Kennedy noted that Clementine had noticeably more body hair, her voice had gone down, and "libido is substantial." She additionally noted that Clementine "has had genital changes including growth of clitoral tissue and dryness" as a result of the blocker and no circulating estradiol.

46. Dr. Olson-Kennedy also recommended that she get a double mastectomy. Just as she had misled and coerced Clementine and her parents to start testosterone, Dr. Olson-Kennedy again misled them by emphasizing the supposed importance of getting such a radical procedure early. She represented that if Clementine got a double mastectomy at an early age, the healing process would be easier, and that if she waited any longer, it would be impossible to do it right. That is, if she wanted a "natural," "cis male-looking chest," they had to do it now. Dr. Olson-Kennedy noted that she would refer for surgery in 4-6 weeks. Clementine was still only 13 years old.

47. Notably, for much of the time that she was seeing Dr. Olson-Kennedy, Clementine was also seeing a therapist, Defendant Susan P. Landon, who was recommended by Dr. Olson-Kennedy.[1] Clementine trusted she would be adequately treated and properly evaluated, but every time she discussed feelings of discomfort with her body or feelings about gender, Ms. Landon simply reduced all of her issues to the notion that all of her problems were perfectly normal for someone who is trans. She also immediately "affirmed" Clementine's transgender identity, never once exploring what might be the reasons she had so suddenly come to identify as transgender or exploring potential other reasons Clementine had felt uncomfortable in her female body as she entered puberty.

[1] Ms. Landon and Dr. Olson-Kennedy are two of three board members—with the third being Dr. Olson-Kennedy's spouse—of Transforming Family, a "support group for families with transgender, non-binary, and gender-expansive children."

Clementine, with the benefit of hindsight, now recognizes that most of her feelings were rooted in her past sexual trauma (i.e., feeling that she hated her body, did not want to grow up, did not want to be an adult woman). But not once, ever, was Clementine asked if she had any history of trauma or physical or sexual abuse (which should be amongst the most basic, first-line questions a therapist asks a girl struggling with her body image of gender identity). Instead, Ms. Landon simply attributed anything and everything to Clementine's purported gender identity.[2]

48. Ms. Landon also cheered on Clementine at every medical step Clementine took. This included encouraging Clementine to get a double mastectomy at age 14. Dr. Olson-Kennedy recommended that Clementine get "gender-affirming top surgery" from Dr. Scott Mosser at St. Francis. The only requirement from Dr. Mosser to perform the surgery on Clementine was getting a letter of recommendation from a primary care physician and a mental health provider that she was a good candidate for a "gender-affirming" double mastectomy at 14 years old. Ms. Landon and Dr. Olson-Kennedy provided those letters, which contained numerous misrepresentations, such as that Clementine had "endorsed a male gender identity since childhood"; had "full understanding that chest reconstruction is a permanent intervention" (even though Clementine could not have and did not appreciate the impact of failing to be able to breastfeed a child and her potential (now actual) deep desire to do so (should she be able to conceive a child, which is highly unlikely)); had "no psychiatric contraindications to Gender Confirmation Surgery"; had "the capacity to give consent and make fully informed decisions about [her] care;" and that her "[d]iagnoses and treatment were conducted in accord with the standards of the World Professional Association for Transgender Health (WPATH)," when none of the diagnoses or treatments prescribed by Dr. Olson-Kennedy met even WPATH's deeply flawed and significantly discredited "standards." Ms. Landon's letter also added that the "surgery will remedy [Clementine's] persistent and unwavering gender dysphoria related to [her]

[2] Notably, Ms. Landon apparently failed to maintain records for Clementine. In response to a request for Clementine's records, Ms. Landon produced merely the original intake paperwork and "Child Identity Questionnaire" originally filled out by Clementine's parents, 2.5 pages of hand-written notes from her first meeting with Clementine's parents, a single bill from August of 2020, and a copy of the letter she wrote in support of Clementine's double mastectomy. She evidently did not maintain and failed to produce a single note from a single session with Clementine.

chest and will bring [her] greater congruency, and add great quality to [her] life." As detailed below, it did anything but.

49. But Dr. Mosser never bothered to discuss the letters with Clementine. Dr. Mosser did not even bother to meet with Clementine before the day of her surgery. Instead, the surgery was scheduled after a perfunctory virtual meeting with someone on Dr. Mosser's staff.

50. Without Dr. Mosser ever meeting with or talking to Clementine, Dr. Mosser's office scheduled the surgery for the morning of May 14, 2019, at St. Francis San Francisco. Clementine and her mother had a brief, 30-minute pre-op meeting with Dr. Mosser the morning before the surgery. There, they were given a packet, which included a "consent form." That form notably stated that "[t]ransgender mastectomy is an elective operation" and that "[t]he best candidates for surgery are those who are mature enough to understand the procedure and have realistic expectations about the results." It additionally was facially deficient, including but not limited to failing to disclose the experimental nature of the procedure, failing to list the known risks, and failing to list all alternative forms of treatment (such as therapy or psychotherapy to treat the gender dysphoria).

51. Clementine and her mother arrived at the hospital around 6:00 AM. Notably, the only "consent form" that Clementine's mother signed with St. Francis was a generic St. Francis "consent" document that merely stated that Clementine's mother would "consent to the procedures that may be performed during the Patient's Hospital stay or provided to the Patient as an outpatient." It was not specific to Clementine's forthcoming double mastectomy. It did not list any particular risks. It did not list possible alternatives to the procedure. In fact, the only mention of risks was a line that "[y]ou understand that diagnosis and treatment may involve risks of injury or even death." And it concluded with several acknowledgment lines, including that "[y]ou have read this form" and "were given the opportunity to ask questions," even though at that point neither Clementine nor her mother had met with any of the doctors involved in the surgery. Clementine's mother signed the document at 6:03 AM. Neither she nor Clementine would meet with Dr. Mosser until 7:00 AM.

52. Although it is unclear from the records, it appears that Dr. Mosser met with Clementine and her mother for no more than 28 minutes before Clementine was taken back for surgery. This brief period of time was enough for Dr. Mosser to sign that he (i) "explained to the

patient, and the patient has demonstrated understanding of the proposed procedure" which he described as "transgender mastectomy," and (ii) explained "the potential risks, expected benefits or effects of the procedure; the recuperation period following the procedure; alternative treatments/modalities as appropriate for the procedure, non-treatment risk and benefits." But Dr. Mosser did not go over any of those. Moreover, Dr. Mosser signed under "History and Physical Examination" that the "History Present Illness" was "gender dysphoria" and that for "Significant Family/Social History" it was "OK to proceed." But Dr. Mosser never diagnosed Clementine, performed any independent evaluation of her fitness for the procedure, and never discussed any of her family/social history, let alone her complex mental health history. Instead, Dr. Mosser simply rubber-stamped Clementine to be wheeled into the operating room without obtaining informed consent from either her or her mother and proceeded to remove her barely-developed healthy breasts. Clementine was discharged early that afternoon.

53. At Clementine's first visit with Dr. Olson-Kennedy post-mastectomy, on August 28, 2019, Dr. Olson-Kennedy noted that Clementine's testosterone prescription had been increased from 30 mg per week to 40 mg per week. She also noted that Clementine "had minimally invasive chest surgery in May of this year with Dr. Mosser." Notably, under "Review of Symptoms," for Psychiatric, she simply noted "Denies anxiety, Denies depression."

54. In reality, between the histrelin, testosterone, and double mastectomy, Clementine's mental health had begun to spiral. For the first time in her life, Clementine began feeling symptoms of depression, intense anger, and thoughts of suicide. She could not focus. For the first time, she began self-harming. After her double mastectomy, she began suffering from symptoms of psychosis. During this time, she grew to hate her body more and more, leading to severe body image issues, which led to obsessively working out and adopting an abnormally low-calorie diet. When she brought up these feelings and struggles with Ms. Landon or Dr. Olson-Kennedy, they were simply dismissed as Clementine's being jealous of "cis men" or not feeling like she fit in because she was trans. All of these symptoms and struggles began after taking testosterone or getting her double mastectomy. And yet not once did Dr. Olson-Kennedy or Ms. Landon question the propriety of continuing to medicalize Clementine. Quite the opposite, they continued to push her further down the path of transition, despite

her obvious decline and growing skepticism over the ensuing years.

55. Desperate to help their spiraling child, Clementine's parents began taking her to see psychiatrists to try to treat her rapidly declining mental state. She first started visiting UCLA Health for such treatment on October 14, 2019, exactly 5 months after her double mastectomy. At that meeting, Clementine discussed how she had begun experiencing auditory and visual hallucinations, describing "seeing bugs and shadows of people on rooftops and hearing voices telling [her] to 'do things.'" She described experiencing "large figures behind me" and hearing voices whispering in her ear, "shouting s@!# in [her] ear," and telling her to "leave and run from the classroom." For the first time, she had reported feeling "thoughts of suicide when [she] 'wants them to stop.'" She also discussed how she began to start having panic attacks. She discussed having thoughts that she "is not real" and was worried she "is only here for others peoples development." Her doctor noted that she appeared to suffer from "trauma and stress related disorder," psychosis, anxiety, and depressive symptoms. The doctor prescribed Sertraline (Zoloft), an antidepressant used to treat depression, obsessive-compulsive disorder (OCD), panic disorder, anxiety, and other mental health issues.

56. At her meeting at UCLA Health the following month, on November 22, 2019, Clementine continued to report "hearing s!@#" in classes, including one episode that led to her feeling such paranoia that she "dissociated and felt like [she] 'woke up' 2 periods later," with friends noting she was "unresponsive." She additionally reported hearing voices telling her "you have to leave" and "he's watching you." She also described a period of not sleeping for 3 days. In response, the doctor increased her Sertraline dosage and started Clementine on a new prescription of hydroxyzine to address her anxiety and insomnia.

57. Clementine returned to UCLA Health on January 7, 2020, and reported that her hallucinations had increased. She relayed that they were "occasionally frightening" and that she had begun seeing hallucinations of "small people" and "spiders." She also relayed that she was now experiencing migraines and continued to have high anxiety. Clementine's Sertraline dosage was further increased to 200 mg. She reported similar struggles regarding hallucinations and sleepless nights at her subsequent appointment on February 19, 2020.

58. Yet at Clementine's next visit to Dr. Olson-Kenned on February 26, 2020, almost none

of these issues were noted. While Dr. Olson-Kennedy passingly noted that Clementine was taking Zoloft for anxiety and "occasionally gets panic attacks," she described Clementine's psychiatric condition as "[a]ppropriate mood and affect, Cooperative, Normal Judgment." And she unquestioningly continued her prescription of 40 mg per week of testosterone. The total time she spent "counseling/coordinating care" for Clementine was 17 minutes, only 4 minutes of which was spent addressing psychological support (as compared to 3 minutes on "safe sex practices"). She did not appear at all to address and made no note regarding Clementine's newly onset suicidality, depression, and deeply disturbing auditory and visual hallucinations.

59. Clementine continued visiting UCLA Health through October 2020, reporting continued anxiety, paranoia, suicidal ideation, "tic-like behavior," and hallucinations, such as seeing "shadows" and hearing voices telling her to "hurt other people" and that "there's someone behind you." She also began engaging in self-harm, including cutting "to feel less numb," "occasionally burn[ing] self with a lighter," and picking at her skin. She additionally reported "dissociative features" and increased panic attacks. She began taking propranolol for tremors and shaking. She was formally diagnosed with PTSD and attenuated psychosis syndrome. She also, sadly, reported being sexually assaulted, again, which caused further trauma and PTSD.

60. That sexual assault took place from December 2018 through March 2019—shortly before her double mastectomy. Notably, Clementine had been discussing her relationship with the perpetrator with Ms. Landon.

61. And yet at Clementine's visits to Dr. Olson-Kennedy during this timeframe (on July 8, 2020, and August 28, 2020), Dr. Olson-Kennedy made only passing notations of panic attacks and anxiety while continuing to describe her "Psychiatric" state as "Appropriate mood and affect, Cooperative, Normal Judgment." Dr. Olson-Kennedy appeared to be more concerned that Clementine was not regularly taking her testosterone shots and was interested in switching to gel, which Dr. Olson-Kennedy prescribed, while noting that Clementine "would probably benefit from an increased dose of testosterone." At no point did Dr. Olson-Kennedy question the propriety of continuing to prescribe (and increasing the dosage of) testosterone during Clementine's spiraling decline.

62. From June 2020 through July 2021, Clementine began seeing a different psychiatrist,

Dr. Robert Holloway at LA Children's. Dr. Holloway's notes similarly reflect Clementine's continual and tragic mental health decline. In visits with Dr. Holloway, Clementine reported "chronic tics including finger snapping, head shaking, hitting [herself] in the head, touching [her] eyes, squinting" and "bit[ing] [her] skin to see if [she] has blood." He similarly noted that she described continuing to hear voices or "see people that aren't there," as well as having hallucinations like "see[ing] bugs all the time and see[ing] blood on [her] face," "see[ing] a corpse lying next to [her] in bed," and "a shadowy black figure that was almost as tall as the ceiling." She heard voices telling her to "kill [herself], kill others, break up with [her] boyfriend, check the doors."[3] She reported feelings of increasing anxiety and obsessive behavior, like changing clothes 5 times per day and "obsessively check[ing] doors, corners, boxes, drains, under [her] bed." She had passive suicidal ideation and reported actually attempting suicide by hanging, and cutting her wrists in response to her hallucinations. She also continued to engage in self-harm and experienced on-and-off insomnia. She was prescribed several new medications with varying degrees of effect. Dr. Holloway noted that she was likely suffering from schizoaffective disorder.

63. But Dr. Olson-Kennedy apparently did not seem concerned. In her December 15, 2020, visit with Clementine, Dr. Olson-Kennedy noted that Clementine was seeing Dr. Holloway and that she was taking Zoloft and Seroquel but noted that "[o]verall [Clementine] tells me [she] is doing well." She noted that Clementine was "[s]truggling still with anxiety but in good mental health." She continued to describe her psychiatric condition as "Appropriate mood and affect, Cooperative, Normal Judgment, Non-suicidal." Dr. Olson-Kennedy concluded that "[i]t is likely that I will increase [her] dose" of testosterone. Again, she ignored almost altogether Clementine's mental health spiral and never questioned the propriety of continuing to prescribe, and even increase the dosage of, testosterone for Clementine.

64. Notably, Dr. Olson-Kennedy did not have Clementine's puberty blocker removed until June 14, 2021—more than four years after it was installed.

65. Eventually, Clementine's and her parents' trust in Dr. Olson-Kennedy began to wane.

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[3] Clementine had been a high-achieving student before the onset of her hallucinations, but she really struggled following the onset of the hallucinations and still struggles to this day.

One of the events that precipitated this was at one of their final visits, when Clementine was 17 Dr. Olson-Kennedy told her that, having been on testosterone for about 5 years, she should get a "gender-affirming" hysterectomy. That prompted Clementine to realize that she likely would want children one day. Dr. Olson-Kennedy, nonetheless, insisted she get a hysterectomy, telling Clementine that having children was probably not possible, due to her having been on histrelin and testosterone for five combined years (something she had not told Clementine years earlier).

66. Shortly before heading to college at UCLA—where she currently studies acting—Clementine saw a Dialectical Behavior Therapist (DBT) specialist. For the first time, she began to realize that many of her mental health struggles were a byproduct of unresolved trauma from being sexually abused, multiple times, over her childhood and adolescence. She began to realize that she may not actually be "trans" but rather had been suffering from PTSD and other issues related to her unresolved trauma. Clementine began to scale back her testosterone dosage/frequency. And when she did so, her mental health issues began to resolve. She began seeing a new therapist, and in early 2024, she stopped taking testosterone altogether.

67. And once she stopped, her mental health issues improved even further. Her psychosis and hallucinations went away. Her depression went away. Her attention problems went away. Her anxiety went away. She began to have a healthy view of her body. In short, she began to heal.

68. Lastly, it is important to note that the relevant facilities and institutions where Clementine received her purported treatment have failed to enact policies and procedures for preventing the grossly negligent, willful and deliberate experimental treatment that occurred in her case. Indeed, the facilities and institutions appear to actively promote, encourage, and advertise the availability of these treatments and procedures on minors. They also present parents and children with a false and manipulative suicide dilemma by asking: "would you rather have dead daughter or a living son?" These acts and omissions, in addition to others, represent additional egregious breaches of the standard of care that are willful and deliberate on the part of the Institutional Defendants with regard to Clementine's treatment. The Institutional Defendants are jointly and severally liable with the providers for the grossly negligent and fraudulent, malicious, and oppressive acts described in this complaint. The Institutional Defendants are also separately and independently liable on the

grounds described in this paragraph and the paragraphs above, pertaining to the failure to provide proper oversight and supervision, failure to maintain proper policies and procedures pertaining to the care that Plaintiff received, and by allowing non-evidenced based medical practices to be performed on minors expressing gender dysphoria symptoms.

69. In addition, from a financial perspective, patients such as Clementine who undergo gender transition medicalization represent a lucrative business opportunity for Defendants. Patients who undergo gender transition typically represent the opportunity for a lifelong revenue stream for certain providers. A patient typically stays on cross-sex hormones for the entirety of her transition treatment. Alternatively, if a patient detransitions after years of taking cross-sex hormones, her body usually has lost the ability to produce her normal hormones, such that the patient will require a prescription for her natural hormones (i.e., a female who has taken testosterone for a prolonged period of time will have to receive a prescription for estrogen after detransitioning). Either way, the patient must continue to rely on prescriptions from her medical providers. Thus, Defendants have a high monetary incentive to send patients who appear to present with some symptoms of gender dysphoria down the path to transition as soon as possible.

70. It appears that the lucrative nature of transition treatment, rather than sound medical evidence and Clementine's wellbeing, represented a substantial factor motivating Defendants' ill-formed advice to start Clementine on the transition path.

71. Clementine now realizes she was never "trans." She has only recently come to realize that the "treatment" provided by Dr. Olson-Kennedy, Dr. Mosser, and Ms. Landon was in reality gross harm. But her body has been irreversibly and profoundly damaged. As noted above, Clementine used to be in choir; she used to love to sing. But her voice is entirely different now, and she no longer sounds like she once did due to years on testosterone. She now has an Adam's apple, which she hates and wants to get surgically removed. But she cannot afford to do so out of pocket, and her insurance will not cover it unless she identifies as transgender again, which would be retraumatizing. She wants to be a mother one day, to give birth to her own children. But due to the years on histrelin and testosterone, she is almost certainly infertile. And because her breasts were taken from her, should she be able to conceive and deliver a child, she will never be able to breastfeed, something that

devastates her to think about. Her body did not develop into the female figure it should have. She has a very masculine body structure, including broadened shoulders and narrower hips. She has significant unwanted body hair. She has facial hair that she has to constantly shave and that she wants to have laser-removed, but she cannot currently afford it. She has experienced vaginal atrophy for which she has taken topical estrogen, and sexual intercourse has been very painful at times. Over the course of her treatment, her labs show that her VLDL cholesterol (considered one of the bad cholesterols) rose from a level of 26 mg/dL at her first visit to a level of 73 mg/dL by her final labs in February 2020. Below 30 is considered healthy; above 30 is considered elevated. Similarly, her final bloodwork in 2020 showed that her total testosterone level was 478 ng/dL. The normal range for testosterone in teenage girls is 7-75 ng/dL. She still does not "pass" as fully female. And because she transitioned so young, most of her friends have only known her as the boy "Finn." Accordingly, she is constantly retraumatized every time she has to "come out" as female to her friends and broader community. She was placed in a boys' dormitory at UCLA. Additionally, although the more severe symptoms of depression and hallucination have subsided, she continues to have mental health issues and still struggles in school, and the medical abuse trauma that she suffered at the hands of the Defendants has likely permanently damaged her mental health condition.

72. But the full extent of Clementine's damages are being investigated and are not fully known at the time of filing this complaint. The allegations herein are intended to be only a partial summary of the relevant facts and medical records and Clementine's medical issues and damages resulting from the gross negligence, coercion, and fraud Defendants committed in this case.

FIRST CAUSE OF ACTION

MEDICAL NEGLIGENCE

(By Plaintiff Against All Defendants)

73. Plaintiff hereby incorporates each and every allegation previously set forth above as though fully set forth herein.

74. During all relevant times, Plaintiff was a patient of Defendants who undertook to supervise, treat, and provide medical care and medical facilities to Plaintiff as described herein. Defendants collaborated to perform a course of experimental chemical and surgical mimicry change

"treatment" on Plaintiff as described in detail above. In summary, Defendants intentionally induced in Plaintiff an endocrine disorder through the administration of puberty blockers, placed Plaintiff on cross-sex testosterone hormones that did profound and irreparable damage to her body, and eventually collaborated to recommend and perform on Plaintiff a mutilating double mastectomy.

75. By virtue of this doctor-patient relationship, Defendants owed Plaintiff a duty to exercise the level of skill, knowledge, and care in the evaluation, diagnosis, and treatment of Plaintiff that other reasonably careful providers in the same respective fields/specialties would use in similar circumstances. Defendants breached the standard of care as described in more detail above by, among other things: (1) failing to properly evaluate, assess, diagnose, discover, and treat Plaintiff's medical and mental health conditions, including, but not limited to, Plaintiffs' medical and mental health co-morbidities and symptoms that presented prior to and concurrent with her gender dysphoria symptoms; (2) failing to recognize and provide or refer Clementine to a provider who could evaluate and treat her on a regular weekly basis over an extended period of time; (3) grossly overemphasizing Plaintiff's gender dysphoria symptoms to the point of excluding and ignoring her co-morbidities, related symptoms, and their relevant treatment options; (4) failing to provide Plaintiff with information necessary to obtain informed consent regarding the treatments, possible alternative options available, and the relevant risks and benefits of the treatments; (5) failing to perform a differential diagnosis; and (6) manipulating Plaintiff and her parents into a false decision making matrix by deliberately obscuring relevant information, by presenting false and misleading information, and by thwarting their rational decision making process through inserting an emotionally supercharged ultimatum of a grossly exaggerated suicide risk when no such risk existed for Clementine.

76. Regarding informed consent, among other things, Defendants obscured and did not disclose the important potential results, risks of, and alternatives to this transition course of "treatment," as discussed and elaborated in detail above. In addition, Defendants intentionally obscured and failed to disclose relevant information regarding the lack of reliable medical research purportedly supporting such treatment, and the existence of higher-quality studies establishing poor mental health outcomes for this treatment. They also affirmatively misrepresented that Plaintiff's

symptoms would never resolve without this chemical/surgical transition and failed to disclose and discuss the high desistence rates. Defendants also failed to discuss and disclose the practical effect of having a mastectomy but not bottom surgery, specifically, having a masculinized chest and feminine reproductive organs, as well the high complication rates for bottom surgery. Defendants also manipulated and derailed Plaintiff and her parents' rational decision-making process, boxing them into a false decision-making matrix by inserting an emotionally supercharged ultimatum of grossly exaggerated suicide risk when no such risk existed for Clementine. Defendants falsely represented that Clementine would commit suicide unless she transitioned. Clementine's parents were also coercively asked if they "would rather have a dead daughter or a living son." Defendants failed to adequately assess, evaluate, and diagnose Plaintiff's widely varied presentation of symptoms and co-morbidities, which fatally undermined and obstructed the possibility of Defendants providing Plaintiff with informed consent. The process of assessing, evaluating, diagnosing, and recommending treatment options, risks, and benefits, could not possibly have met the standard of care in the limited visits that occurred in Plaintiff's case (she was prescribed puberty blockers on her very first visit and recommended testosterone on just her third visit). Defendants did not discuss, evaluate, or inform Clementine as to alternate treatment options, and the related risks and benefits. Defendants failed to disclose to Clementine that the decline in her mental health symptoms was an indicator that she was not responding to "treatment" and that she should not continue with "treatment." These, among other issues, represent a deliberate and gross breach of the standard of care and an egregious failure of informed consent. A reasonable person in Plaintiff's position would not have agreed to the transition treatment if properly and adequately informed of the risks. Plaintiff suffered harm and damage relating to numerous serious risks that should have been disclosed, discussed, and explained to Clementine and her parents but were not disclosed.

77. As a direct and proximate cause of Defendants' breaches of the standard of care, Plaintiff sustained serious and permanent personal injuries, causing her general and special damages to be determined according to proof at trial.

78. The acts and omissions described in this complaint also constituted fraud, oppression, and malice.

79. The harm that Plaintiff experienced in this case as a result of being improperly treated with chemical/surgical interventions would not have occurred unless the Defendants were negligent. The fact that Plaintiff detransitioned after the so-called treatment establishes *res ipsa loquitor* that Plaintiff was not transgender and that Defendants were guilty of medical malpractice in their evaluation, assessment, and treatment of Plaintiff. The fact that Plaintiff's numerous and severe mental health issues resolved once she stopped taking hormones further demonstrates as much. Defendants' diagnoses, evaluation, and "treatment" of Clementine were *de facto* medical malpractice. Proper evaluation, diagnosis, informed consent, and treatment of Plaintiff that met the standard of care would never have started Plaintiff down this harmful path of physical transition that ultimately turned out to be a horrible experiment causing irreversible and serious injuries to Plaintiff.

80. The harm occurred while Plaintiff was under the care and control of Defendants, and Plaintiff's own voluntary actions were not a cause contributing to the events that harmed Plaintiff. Plaintiff was a minor incapable of understanding and evaluating the decisions she was making, yet her providers recklessly treated her as if she could understand the implications of the decisions that she was making as described in greater detail above.

SECOND CAUSE OF ACTION

MEDICAL NEGLIGENCE – INSTITUTIONAL DEFENDANTS

(By Plaintiff Against LA Children's Medical Group, LA Children's, St. Francis, UCSF, and Landon, Inc.)

81. Plaintiff hereby incorporates each and every allegation previously set forth as though fully set forth herein.

82. The Institutional Defendants were a medical provider for Plaintiff and had a duty of reasonable care to Plaintiff. The Institutional Defendants had the obligation to select, maintain, and ensure the competence of the Defendant Providers. The Institutional Defendants also had the obligation to provide procedures, policies, facilities, supplies, and qualified personnel reasonably necessary for the treatment of Clementine. The Institutional Defendants breached these duties by failing to provide the requisite procedures, policies, facilities, supplies, and qualified personnel, and by failing to adequately select, maintain, and ensure the competence of the Defendant Providers.

Among other things, the Institutional Defendants allowed the Defendant Providers to treat Plaintiff with radical, inadequately studied, off-label, and essentially experimental transition "treatment" on Clementine, a minor during the entire course of her "treatment." The Institutional Defendants failed to have adequate policies and procedures in place to prevent the acts, omissions, failures of informed consent, fraudulent concealment, fraudulent misrepresentations, negligent treatment, and other breaches of the standard of care that occurred in regard to Plaintiff as described above. Furthermore, the Institutional Defendants not only have inadequate policies and procedures to prevent such harmful treatment of patients like Clementine, but they actively promote, encourage, and advertise on their websites that their facilities and providers offer proper transgender treatment, including for minors.

83. The Institutional Defendants also failed to employ adequate mental health professionals. This inadequate staffing of mental health providers contributed to preventing Plaintiff from receiving regular psychotherapy evaluation, assessment, and treatment with the same provider, which was necessary in Plaintiff's case to meet the standard of care.

84. Among other acts and omissions, these breaches of the standard of care caused Plaintiff to suffer personal injury and resulting special and general damages according to proof at trial.

85. The acts and omissions described in this complaint also constituted fraud, oppression, and malice. Defendants deliberately conveyed false information and obscured and concealed true information. Defendants failed to inform Plaintiff about the issue of the high likelihood of desistence and the significant risk of regret. Defendants failed to spend sufficient time with Plaintiff over an adequate period of time evaluating her condition and/or failed to inform her of her need for regular psychotherapy and the need for her to seek a therapist who could spend adequate time with her. Defendants did not tell her about the increased risk of suicide for transgender individuals receiving chemical/surgical transition treatment. Defendants did not tell her about the existence of higher-quality evidence demonstrating poor mental health outcomes for this treatment and the existence of only low to very low-quality evidence purportedly supporting this treatment. Defendants did not tell her about all of the extensive health risks. Defendants experienced significant financial gain as the intended result. The Institutional Defendants knowingly authorized and ratified this substandard and

fraudulent treatment of Plaintiff. The Institutional Defendants knowingly failed to employ adequate mental health professionals to treat complex cases like Clementine's. These deficiencies, among other acts and omissions, support a finding of intentional fraud, malice, and oppression.

86. The harm that Plaintiff experienced in this case as a result of being improperly treated with chemical/surgical interventions rather than psychotherapy for her varied presentation of co-morbid symptoms, would not have occurred unless the Defendants were negligent. The fact that Plaintiff detransitioned after the so-called treatment establishes *res ipsa loquitor* that Plaintiff was not transgender and that Defendants were intentional or negligent in their evaluation, assessment, and treatment of Plaintiff. The fact that Plaintiff's numerous and severe mental health issues resolved once she stopped taking hormones further demonstrates as much. Defendants' diagnoses, evaluation, and "treatment" of Clementine were *de facto* incorrect. Proper evaluation, diagnosis, informed consent, and treatment of Plaintiff that met the standard of care would never have started Plaintiff down this harmful path of physical transition that ultimately turned out to be a horrible experiment causing irreversible and serious injuries to Plaintiff.

87. The harm occurred while Plaintiff was under the care and control of Defendants, and Plaintiff's own voluntary actions were not a cause contributing to the events that harmed Plaintiff. Plaintiff was a minor incapable of understanding and evaluating the decisions she was making, yet her providers treated her as if she could understand the implications of the decisions that she was making as described in greater detail above.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for judgment against Defendants according to law and according to proof, for the following:

1. General damages, in an amount according to proof at the time of trial;

2. Special damages for medical and related expenses, in an amount according to proof at the time of trial;

3. Pain and suffering, past and future, and mental anguish, past and future;

4. Pre-judgment interest on damages;

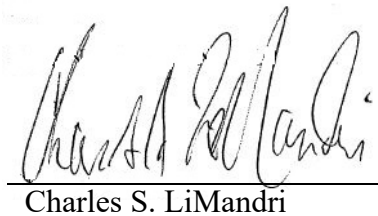
5. Costs of suit; and

6. Such other and further relief as the court deems just and proper.

Respectfully Submitted,

LiMANDRI & JONNA LLP

Campbell Miller Payne, PLLC

Dated: December 5, 2024 By: 

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DEMAND FOR JURY TRIAL

Plaintiff demands a trial by jury on all claims.

Respectfully Submitted,

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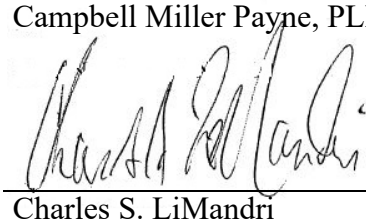
Dated: _December 5, 2024 By: 

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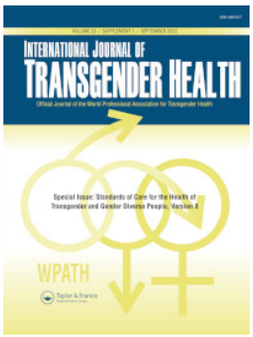
Exhibit I



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Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

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Appendix C GENDER-AFFIRMING HORMONAL TREATMENTS

Table 1. Expected time course of physical changes in response to gender-affirming hormone therapy

Testosterone Based Regimen		
Effect	**Onset**	**Maximum**
Skin Oiliness/acne	1–6 months	1–2 years
Facial/body hair growth	6–12 months	>5 years
Scalp hair loss	6–12 months	>5 years
Increased muscle mass/ strength	6–12 months	2–5 years
Fat redistribution	1–6 months	2–5 years
Cessation of menses	1–6 months	1–2 years
Clitoral enlargement	1–6 months	1–2 years
Vaginal atrophy	1–6 months	1–2 years
Deepening of voice	1–6 months	1–2 years
Estrogen and testosterone-lowering based regimens		
Effect	**Onset**	**Maximum**
Redistribution of body fat	3–6 months	2–5 years
Decrease in muscle mass and strength	3–6 months	1–2 years
Softening of skin/ decreased oiliness	3–6 months	Unknown
Decreased sexual desire	1–3 months	Unknown
Decreased spontaneous erections	1–3 months	3–6 months
Decreased sperm production	Unknown	2 years
Breast growth	3–6 months	2–5 years
Decreased testicular volume	3–6 months	Variable
Decreased terminal hair growth	6–12 months	> 3 years
Increased scalp hair	Variable	Variable
Voice changes	None	

Adapted from Hembree et al., 2017.

Table 2. Risks associated with gender affirming hormone therapy (bolded items are clinically significant) (Updated from SOC-7)

RISK LEVEL	Estrogen-based regimens	Testosterone-based regimens
Likely increased risk	**Venous Thromboembolism** **Infertility** Hyperkalemia[S] Hypertrigyceridemia Weight Gain	**Polycythemia** **Infertility** Acne Androgenic Alopecia Hypertension Sleep Apnea Weight Gain Decreased HDL Cholesterol and increased LDL Cholesterol
Likely increased risk with presence of additional risk factors	Cardiovascular Disease Cerebrovascular Disease Meningioma[C] Polyuria/Dehydration[S] Cholelithiasis	Cardiovascular Disease Hypertriglyceridemia
Possible increased risk	Hypertension Erectile Dysfunction	
Possible increased risk with presence of additional risk factors	Type 2 Diabetes Low Bone Mass/ Osteoporosis Hyperprolactinemia	Type 2 Diabetes Cardiovascular Disease
No increased risk or inconclusive	Breast and Prostate Cancer	Low Bone Mass/ Osteoporosis Breast, Cervical, Ovarian, Uterine Cancer

[C]cyproterone-based regimen
[S]spironolactone-based regimen

Table 3. Gender-Affirming Hormone Regimens In Transgender And Gender Diverse Youth (Adapted from the Endocrine Society Guidelines; Hembree et al., 2017)

Induction of female puberty (estrogen-based regimen) with oral 17ß-estradiol

Initiate at 5µg/kg/d and increase every 6 months by 5 µg/kg/d up to 20 µg/kg/d according to estradiol levels

Adult dose = 2-6 mg/day

In postpubertal TGD adolescents, the dose of 17ß-estradiol can be increased more rapidly:

1 mg/d for 6 months followed by 2 mg/d and up according to estradiol levels

Induction of female puberty (estrogen-based regimen) with transdermal 17ß-estradiol

Initial dose 6.25-12.5 µg/24 h (cutting 24 g patch to ¼ then ½)

Titrate up by every 6 months by 12.5 µg/24 h according to estradiol levels

Adult dose = 50-200 µg/24 hours

For alternatives once at adult dose (Table 4)

Induction of male puberty (testosterone-based regimen) with testosterone esters

25 mg/m^2/2 weeks (or alternatively half this dose weekly)

Increase by 25 mg/m^2/2 weeks every 6 months until adult dose and target testosterone levels are achieved. See alternatives for testosterones (Table 4)

Table 4. Hormone regimens in transgender and gender diverse adults*

Estrogen-based regimen (Transfeminine)	
Estrogen	
Oral or sublingual	
Estradiol	2.0-6.0 mg/day
Transdermal	
Estradiol transdermal patch	0.025-0.2 mg/day
Estradiol gel various	‡ daily to skin
Parenteral	
Estradiol valerate or cypionate	5-30 mg IM every 2 weeks 2-10 IM every week
Anti-Androgens	
Spironolactone	100–300 mg/day
Cyproterone acetate	10 mg/day**
GnRH agonist	3.75–7.50 mg SQ/IM monthly
GnRH agonist depot formulation	11.25/22.5 mg SQ/IM 3/6 monthly
‡ Amount applied varies to formulation and strength	
Testosterone-Based Regimen (Transmasculine)	
Transgender males	
Testosterone	
Parenteral	
Testosterone enanthate/ cypionate	50–100 IM/SQ weekly or 100–200 IM every 2 weeks
Testosterone undecanoate	1000 mg IM every 12 weeks or 750 mg IM every 10 weeks
Transdermal testosterone	
Testosterone gel	50-100 mg/day
Testosterone transdermal patch	2.5–7.5 mg/day

Doses are titrated up or down until sex steroid hormone levels are in the therapeutic range. Hormone regimens do not reflect all formulations that are available in all pharmacies throughout the world. Hormone regimens may have to be adapted to what is available in local pharmacies.

**Kuijpers et al (2021).

Table 5. Hormone monitoring of transgender and gender diverse people receiving gender-affirming hormone therapy (Adapted from the Endocrine Society Guidelines)

Transgender male or trans masculine (including gender diverse/nonbinary) individuals

1. Evaluate patient approximately every 3 months (with dose changes) in the first year and 1 to 2 times per year thereafter to monitor for appropriate physical changes in response to testosterone.
2. Measure serum total testosterone every 3 months (with dose changes) until levels are at goal
   a. For parenteral testosterone, the serum total testosterone should be measured midway between injections. The target level is 400-700 ng/dL. Alternatively, measure peak and trough peaks to ensure levels remain in the range of reference men.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before injection. If the level is < 400 ng/dL, adjust the dosing interval.
   c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 week of daily application (at least 2 hours after application of product).
3. Measure hematocrit or hemoglobin concentrations at baseline and approximately 3 months (with dose changes) for the first year and then one to two times a year.

Transgender Female or trans feminine (including gender diverse/nonbinary) individuals

1. Evaluate patient approximately every 3 months (with dose changes) in the first year and one to two times per year thereafter to monitor for appropriate physical changes in response to estrogen.
   a. Serum testosterone levels should be less than 50 ng/dL.
   b. Serum estradiol should be in the range of 100-200 pg/mL.
2. For individuals receiving spironolactone, serum electrolytes, in particular potassium, and kidney function, in particular creatinine, should be monitored.
3. Follow primary care screening per primary care chapter recommendations

Exhibit J

STATE OF MONTANA FOURTH JUDICIAL DISTRICT COURT

MISSOULA COUNTY

MOLLY CROSS, et al., Plaintiff, v. STATE OF MONTANA, et al., Defendants.	Case No. DV 2023-541

Deposition of JOHANNA OLSON-KENNEDY, taken on behalf of Defendants, at 633 West 5th Street, Suite 5850, Los Angeles, California, commencing at 10:11 a.m. on Monday, October 28, 2024, before Katherine Jones, CSR 10097.

Q And it's my understanding Tanner State 2 can be 8 to 14?
A For people with ovaries, what's considered the typical range, the normal range. The low end is 8 and the highest end is 14.
Q With people with ovaries?
A Yes, people with testes, 9 to 14.
Q Okay. How about Tanner Stage 3?
A It's -- that's why it's a range.
Q Sure.
A So if you start at 9, it's gonna be younger. If you start at 12, it's gonna be older.
Q Okay. Tanner State 2 with a person assigned the sex of female at birth, any other risks that we haven't talked about?
A The issue around somebody who -- we talked about the, like, menopausal type risks, insomnia, potential -- this is a classic example. Short term memory loss, they might have hot flashes. So the further along somebody is in puberty when they start their central blockers, the more likely that they'll have those symptoms.
Q So the biggest risk is the menopausal symptoms.
A But I want to the clarify something,

A Vaginal atrophy can be a risk. I have not seen that a lot in patients on blockers only. I think I've had one patient who that was a risk for them.
Q Okay. And what is vaginal atrophy?
A It's -- the production of estrogen keeps the vaginal wall tissue, sort of -- it supports it in a way that allows it to become both thicker and, also, have more mucus to that mucus membrane. So when you don't have the presence of estrogen, then that's a possibility. That's why we use intervaginal estrogen, if that is a problem for people.
Q How about clitoral enlargement?
A Not from blockers.
Q Okay. That comes with blockers and then cross-sex hormones?
A Or just starting hormones.
Q Okay. How but pain with sex? If they have sex, once they become of age of consent.
A That's usually more of a conversation with people going on hormones.
Q Okay.
A And less so on blockers.
Q Okay. Now, the purpose of the puberty

A The medical risks?
Q Yes.
A No.
Q Okay. So what are the risks of prescribing cross-sex hormones to males assigned at birth?
A So the first thing that we talk about is blood clots. So estrogen -- the delivery of estrogen to both cis gender people and transgender female people is -- makes them more hyper coagulable, which means they can form blood clots easier.
Q Which is a risk of a stroke or a heart attack?
A Correct. That's the first thing that we talk about.
Q Okay.
A We talk about why yes use bioidentical hormones, because the risks of blood clots is lower.
Q What's a bioidentical --
A It's a hormone that is closest to what your body is making already. And they're, also, plant-derived.
Q All right. What is the risk -- if you can quantify it -- of suffering a stroke and/or a heart

important to think about that the risks of somebody taking estrogen -- estradiol bioidentical, are similar to the health risks that cis gender women have. So what I mean by that is, there's not an increase risk compared to other cis gender women, the risk is more than if they didn't take estrogen. And for example, gallstones, women have a higher incidence of gallstones, that's kind of what I'm talking about.

Q Okay.

A I don't think that people would consider many of the side effects risks, I think they're things that they want, so breast development softening of the skin, slowing down of their hair growth, it can have shrinking of their testicular size. The other things that we talked about for people taking blockers, so decreased spontaneous erections, maybe not hard enough to penetrate a partner -- let me think. What am I forgetting? They also have an improvement in their lipid panel. So in general, their cholesterol goes down, their good colesterol goes up bad cholesterol goes down flipping the health profile.

Q Fertility, is that still a risk?

A Fertility -- for somebody who's already

been through the majority of their pubertal process, they would need to discontinue hormones if they wanted to do cryopreservation. But there have been several studies that have looked at recovery of sperm.

Q Okay. So it is a risk, though?

A Yes.

Q Okay. Now, let's go with regard to females assigned at birth, cross-sex hormone risks?

A Okay. So testosterone is the hormone that's used to induce secondary sex characteristics. So similar to what I was talking about, the health risk flips and so the lipid profile resembled cis gender men. So their cholesterol to is gonna go up, their good colesterol is gonna go down, their bad colesterol will go up. There was a study looking at how that translated to cardiovascular events. And in that study, they demonstrated that their risk profile is just slightly lower than cis gender men for cardiovascular events. That's probably the primary thing that we talk about. Similar thing to fertility is that they have all of their fully developed ova in their ovaries. And so if they wanted to harvest or carry a pregnancy, they would have to discontinue testosterone to do that.

CERTIFICATE OF SERVICE

I, Thane P. Johnson, hereby certify that I have served true and accurate copies of the foregoing Answer/Brief - Brief In Support of Motion to the following on 01-15-2025:

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