IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF ARKANSAS

DYLAN BRANDT, et al., Plaintiffs, v. LESLIE RUTLEDGE, et al., Defendants.	Case No.: 4:21-CV-00450-JM-01

DECLARATION OF DEANNA ADKINS, MD
IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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

2. The purpose of this declaration is to provide my expert opinions on: (1) the treatment protocols for transgender adolescents with gender dysphoria including the provision of pubertal suppression treatment and hormone therapy; and (2) the severe risk of harm to these adolescents of withholding or withdrawing this medical treatment where such treatment is medically necessary.

3. I have knowledge of the matters stated in this declaration and have collected and cite to relevant literature concerning the issues that arise in this litigation in the body of this declaration.

4. In preparing this declaration, I reviewed House Bill 1570 (the "Health Care Ban"). I also relied on my scientific education and training, my research experience, my knowledge of the scientific literature in the pertinent fields, and my clinical experience treating adolescents

with gender dysphoria. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field regularly rely upon when forming opinions on these subjects. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

BACKGROUND AND QUALIFICATIONS

5. I received my medical degree from the Medical College of Georgia in 1997. I served as the Fellowship Program Director of Pediatric Endocrinology at Duke University School of Medicine for fourteen years and am currently the Director of the Duke Center for Child and Adolescent Gender Care.

6. I have been licensed to practice medicine in the state of North Carolina since 2001.

7. I have extensive experience working with children with endocrine disorders and I am an expert in the treatment of children with intersex traits, also known as differences or disorders of sex development, and in the treatment of children with gender dysphoria.

8. I am a member of the American Academy of Pediatrics, the North Carolina Pediatric Society, the Pediatric Endocrine Society, and The Endocrine Society. I am also a member of the World Professional Association for Transgender Health ("WPATH"), the leading association of medical and mental health professionals in the treatment of transgender individuals.

9. I am the founder of the Duke Center for Child and Adolescent Gender Care ("Gender Care Clinic"), which opened in 2015. I currently serve as the director of the clinic. The Gender Care Clinic sees patients between age 7 and 22 with gender dysphoria and/or

differences or disorders of sex development. I have been caring for these individuals in my routine practice for many years prior to opening the clinic.

10. I currently treat approximately 400 transgender and intersex young people from North Carolina and across the Southeast at the Gender Care clinic. I have treated approximately 500 transgender and intersex young people in my career.

11. As part of my practice, I stay familiar with the latest medical science and treatment protocols related to differences or disorders of sex development and gender dysphoria.

12. I am regularly called upon by colleagues to assist with the sex assignment of infants who cannot be classified as male or female at birth due to a range of variables in which sex-related characteristics are not completely aligned as male or female.

13. In the past four years, I was deposed and testified at trial as an expert in one case, *Adams v. The School Board of St. Johns Cty., Florida*, No. 17-CV-739 (M.D.Fla. 2017).

14. I am being compensated at an hourly rate of $250 per hour for preparation of expert declarations and reports, and $400 per hour for time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

GENDER IDENTITY AND GENDER DYSPHORIA

15. A person's gender identity refers to a person's inner sense of their gender.

16. Although the precise origin of gender identity is unknown, a person's gender identity is a fundamental aspect of human development and there is a general medical consensus that there is a significant biological component to gender identity.

17. Everyone has a gender identity.

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

19. A transgender person is someone who has a gender identity that differs from the person's sex designated at birth.

20. Many transgender children become aware of their gender identity early in life, as young as two years old. Others may not become fully aware of their gender identity until the onset of puberty or later.[2]

21. A person's gender identity (regardless of whether that identity matches other sex-related characteristics) is fixed, is not subject to voluntary control, cannot be voluntarily changed, and is not undermined or altered by the existence of other sex-related characteristics that do not align with it.[3]

22. According the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders ("DSM V"), "gender dysphoria" is the diagnostic term for the

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

[2] Endocrine Guidelines at 3874-3875.

[3] Endocrine Guidelines at 3874.

condition where clinically significant distress results from the lack of congruence between a person's gender identity and the sex they were designated at birth. In order to be diagnosed with gender dysphoria, the incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

23. Being transgender is not itself a mental disorder or a medical condition to be cured. But gender dysphoria is a serious medical condition that, if left untreated, can result in severe anxiety and depression, self-harm, and suicidality.[4]

24. Before receiving treatment, many individuals with gender dysphoria have high rates of anxiety, depression and suicidal ideation. I have seen in my patients that without appropriate treatment this distress impacts every aspect of life.

25. The only effective treatment to avoid this serious harm is for the person to live in accordance with their gender identity and follow appropriate treatment protocols to affirm gender identity and alleviate distress.

26. When appropriately treated, gender dysphoria is easily managed. I currently treat hundreds of transgender patients. All of my patients have suffered from persistent gender dysphoria, which has been alleviated through clinically appropriate treatment.

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[4] Spack NP, Edwards-Leeper L, Feldmain HA, et al. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. 2012; 129(3):418-425. Olson KR, Durwood L, DeMeules M, McLaughlin KA. Mental health of transgender children who are supported in their identities. *Pediatrics*. 2016; 137:1-8.

TREATMENT PROTOCOLS FOR PATIENTS WITH GENDER DYSPHORIA

27. The Endocrine Society and WPATH have published widely accepted standards of care for treating gender dysphoria.[5] The precise treatment for gender dysphoria depends on each person's individualized need, and the medical standards of care differ depending on whether the treatment is for a pre-pubertal child, an adolescent, or an adult.

28. Treatment for gender dysphoria is aimed at eliminating the clinically significant distress a patient experiences by helping the patient live in alignment with their gender identity. This treatment is sometimes referred to as "gender transition," "transition related care," or "gender affirming care." All of the major medical professional groups in the United States, including the American Academy of Pediatrics, the American Medical Association and the American Academy of Child and Adolescent Psychiatry, agree that this care is safe, effective, and medically necessary treatment for the health and wellbeing of children and adolescents suffering from gender dysphoria.[6]

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[5] Endocrine Guidelines; World Prof'l Ass'n for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (7th Version, 2011), http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=4655 (hereafter, WPATH SOC).

[6] Rafferty J, Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, *Pediatrics* October 2018; 142(4): 2018-2162; Beers, L. American Academy of Pediatrics Speaks Out Against Bills Harming Transgender Youth (March 16, 2021), https://services.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-speaks-out-against-bills-harming-transgender-youth/; American Academy of Child & Adolescent Psychiatry, AACAP Statement Responding to Efforts to ban Evidence-Based Care for Transgender and Gender Diverse Youth (Nov. 8, 2019), https://www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts-to_ban_Evidence-Based_Care_for_Transgender_and_Gender_Diverse.aspx; American Medical Association, State Advocacy Update (March 26, 2021), https://www.ama-assn.org/health-care-advocacy/advocacy-update/march-26-2021-state-advocacy-update

29. The Endocrine Society Clinical Guidelines were developed through rigorous scientific processes that "followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines." The guidelines affirm that patients with gender dysphoria often must be treated with "a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender."[7]

30. Before puberty, treatment does not include any drug or surgical intervention. For this group of patients, treatment is limited to "social transition," which means allowing a transgender child to live and be socially recognized in accordance with their gender identity.[8] This can include allowing children to wear clothing, to cut or grow their hair, to use names and pronouns, and to access restrooms and other sex-separated facilities and activities in line with their gender identity instead of the sex assigned to them at birth. Social transition is a critical part of treatment of patients with gender dysphoria of all ages and it is the only treatment for pre-pubertal children.

31. For many transgender adolescents with gender dysphoria, going through endogenous puberty can cause extreme distress. Puberty delaying treatment allows them to avoid going through their endogenous puberty thereby avoiding the heightened gender dysphoria and permanent physical changes that puberty would cause. This fully reversible treatment also gives a young person time to further understand their gender identity without the distress of

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[7] Endocrine Guidelines at 3869.

[8] Endocrine Guidelines at 3878; WPATH SOC at 15-17.

puberty and before initiating gender-affirming hormone therapy if it becomes medically indicated.

32. Puberty delaying treatment works by pausing endogenous puberty at the stage it has reached when the treatment begins. This has the impact of limiting the influence of a person's endogenous hormones on the body. For example, after the initiation of puberty delaying treatment, a girl who is transgender will experience none of the impacts of testosterone that would be typical if she underwent her full endogenous puberty.

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

- A qualified mental health professional has confirmed that:
  - the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
  - gender dysphoria worsened with the onset of puberty,
  - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
  - has sufficient mental capacity to give informed consent to this (reversible) treatment, and
- The adolescent:
  - has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility, and

  - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

- And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
  - agrees with the indication for GnRH agonist treatment,
  - has confirmed that puberty has started in the adolescent, and
  - has confirmed that there are no medical contraindications to GnRH agonist treatment.

34. For some patients, initiating puberty consistent with gender identity through gender-affirming hormone therapy may also be medically necessary. Around the age of fourteen, depending on the medical needs of the patient, and the patient's mental health and medical history, gender-affirming hormone therapy can be prescribed and the adolescent will go through hormonal puberty consistent with their gender identity on a comparable timeline to their non-transgender peers.

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

- A qualified mental health professional has confirmed:
  - the persistence of gender dysphoria,
  - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are

stable enough to start sex hormone treatment,

- the adolescent has sufficient mental capacity to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,

- And the adolescent:
    - has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
    - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal induction:
    - agrees with the indication for sex hormone treatment,
    - has confirmed that there are no medical contraindications to sex hormone treatment.

36. When treating a transgender adolescent with gender dysphoria, when medically indicated, I prescribe puberty delaying treatment at the Tanner 2 stage of puberty. For people assigned male at birth, Tanner Stage 2 of puberty is typically between ages 9 and 14, and for people assigned female at birth, between ages 8 and 12. Where I first meet a patient after the patient has begun puberty, I assess the patient's individual medical needs. Depending on the patient's needs and the changes that have already been caused by their endogenous puberty, I either initiate pubertal suppression, and wait to initiate gender-affirming hormones until they are

ready; or, initiate puberty consistent with their gender identity with gender affirming hormones. The goal is to minimize the patient's dysphoria and initiate puberty consistent with gender identity within the typical age range. In my extensive clinical experience, I have observed the substantial benefits of providing individualized care to patients through pubertal suppression and gender-affirming hormones. This treatment also substantially minimizes dysphoria later in life and can eliminate the need for surgical treatment in adulthood altogether.

37. For many patients, social transition and hormone therapy are sufficient forms of treatment for gender dysphoria. Others also need one or more forms of surgical treatment to alleviate gender dysphoria. I do not perform surgery, but I refer my older patients for surgery when clinically appropriate.

38. Individuals assigned female at birth may receive chest reconstruction surgery before the age of 18 provided they have been living consistent with their gender identity for a significant period of time. Genital surgery for transgender women and men is not recommended until the person has reached the age of at least 18.

PUBERTY BLOCKERS AND GENDER-AFFIRMING HORMONES ARE SAFE AND EFFECTIVE TREATMENTS FOR TRANSGENDER YOUTH

39. The Endocrine Society's treatment protocols for providing puberty blockers and gender affirming hormone therapy are safe and effective treatments for gender dysphoria.

40. Puberty blockers began to be used in transgender patients in 2004, which is not considered recent in medicine. We also have over thirty years of data on the impact of puberty blockers on children who undergo precocious puberty that we can apply to the transgender population. From the more than thirty years of data that we have, there is no scientific evidence of short or long-term negative effects on patients who receive puberty blockers. And for transgender youth (as compared to those treated for precocious puberty), the treatment is used for

a much shorter period of time, in order to pause puberty before either initiating puberty with cross-sex hormones or resuming endogenous puberty. This medication is also used in adolescents and adults undergoing chemotherapy to preserve fertility and in patients with hormone sensitive cancers, like breast and prostate cancer.

41. In a 2020 study published in *Pediatrics*, the official journal of the American Academy of Pediatrics, researchers concluded that "Treatment with pubertal suppression among those who wanted it was associated with lower odds of lifetime suicidal ideation when compared with those who wanted pubertal suppression but did not receive it. Suicidality is of particular concern for this population because the estimated lifetime prevalence of suicide attempts among transgender people is as high as 40%."[9]

42. As noted above, under the Endocrine Society Clinical Guidelines, once a transgender adolescent establishes further maturity and competence to make decisions about additional treatment, it may then be medically necessary and appropriate to provide gender-affirming hormone therapy to initiate puberty consistent with gender identity. For girls who are transgender this means administering both testosterone suppressing treatment as well as estrogen to initiate hormonal puberty consistent with the patient's female gender identity. For boys who are transgender this means administering testosterone.

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[9] Turban JL, King D, Carswell JM, et al. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. 2020;145(2):e20191725. Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., ... & Gooren, L. J. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine*, *15*(4), 582-590. De Vries, A. L., McGuire, J. K., Steensma, T. D., Wagenaar, E. C., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, *134*(4), 696-704.

43. There is nothing inherently harmful about undergoing hormone treatment to sustain one's health and it is a common practice in many non-transgender patients for reasons unrelated to treatment of gender dysphoria. Many transgender people have been on hormone therapy for decades and we are not seeing evidence of negative health outcomes as a result. Likewise, many non-transgender individuals have to undergo hormone treatment for the majority of their lives, and it is well-managed. This includes patients with various intersex conditions such as Turner syndrome and Klinefelter syndrome, premature ovarian failure, and cancer.

44. In addition to my patients with intersex traits, I regularly treat cisgender patients with the same hormone therapy that is provided to transgender patients. For example, cisgender boys with delayed puberty are often prescribed testosterone if they have not begun puberty by age 14. Without testosterone, for most of these patients, puberty would eventually initiate naturally but testosterone is often prescribed to avoid some of the social stigma that comes from undergoing puberty later than one's peers. Likewise, cisgender girls with hypogonadotropic hypogonadism (delayed puberty due to lack of estrogen caused by a problem with the pituitary gland or hypothalamus) may be treated with estrogen to initiate puberty. I also treat cisgender girls with Polycystic Ovarian Syndrome (PCOS) with hormonal birth control or testosterone suppression to reduce some symptoms of the condition including excess facial hair. Similarly, a cisgender boy and a transgender boy could both seek surgery to remove breast tissue to help align their body or appearance with their gender. In other words, as a pediatric endocrinologist I provide the same types of treatments to people with intersex traits and cisgender people to affirm their gender that is prohibited by the Health Care Ban if provided to transgender people for the same reasons.

45. One argument against treatment for transgender youth that is often raised is that the treatment is automatically sterilizing, but this is not accurate. Many people undergo fertility preservation before any treatment that would compromise fertility. Many more transgender people may be treated with gender affirming surgery that has no impact on fertility such as chest reconstruction. Many transgender individuals conceive children after undergoing hormone therapy.[10] More generally, many medical interventions that are necessary to preserve a person's health and well-being can impact an individual's fertility, but we proceed with the treatment after informed consent. In contrast to care for transgender youth, which can always leave room for fertility preservation, many surgical interventions performed on intersex infants – which this law permits – would permanently impact fertility. In fact, there are often no medical benefits to surgical interventions performed on intersex infants.

46. The legislative findings in the Health Care Ban also claim that "cross-sex hormones" pose serious health risks including an increase in red blood cells, severe liver dysfunction, heart attack, stroke, hypertension, increased risk of breast and uterine cancers, blood clots, gallstones, tumors of the pituitary gland, and elevated levels of triglyclerides in the blood. All of these risks are rare when this treatment is provided and supervised by a clinician. These very same risks are present in the exact same way when hormone therapy is used to treat cisgender individuals. None of these risks are unique to transgender patients. Of the purported risks identified, the only ones I see regularly are increased red blood count, which is not

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[10] Light AD, Obedin-Maliver J, Sevelius JM, Kerns JL. Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstet Gynecol*. 2014;124(6):1120-1127; Maxwell S, Noyes N, Keefe D, Berkeley AS, Goldman KN. Pregnancy Outcomes After Fertility Preservation in Transgender Men. *Obstet Gynecol*. 2017;129(6):1031-1034; Neblett MF 2nd, Hipp HS. Fertility Considerations in Transgender Persons. *Endocrinol Metab Clin North Am*. 2019;48(2):391-402.

considered a risk as the count generally increased with testosterone to within the range that is typical for people assigned male at birth, and high cholesterol. For high cholesterol, that is largely based on family history and is identical in transgender and cisgender patients. All of these side effects are standard for hormonal medical intervention and each is increased substantially when treatment is obtained on the black market and not supervised by appropriate clinical providers.

47. Another argument against treatment for transgender youth is the inaccurate claim in the legislative findings of the Health Care Ban that for those children who "experience distress at identifying with their biological sex, studies consistently demonstrate that the majority come to identify with their biological sex in adolescence or adulthood, thereby rendering most physiological interventions unnecessary." Adolescents with persistent gender dysphoria after reaching Tanner Stage 2 almost always persist in their gender identity in the long-term whether or not they were provided gender affirming care.[11] No medical treatment is provided to transgender youth until they have reached Tanner Stage 2.

48. The goal of treatment for gender dysphoria is not to make someone cisgender or transgender; it is to resolve the distress associated with the disconnect between a person's assigned sex at birth and their gender identity. Denying puberty blockers and gender affirming hormones to a transgender adolescent will not cause the adolescent to "desist" from being transgender. It will only cause the minor to experience distress from lack of treatment.

49. Puberty delaying medication and gender-affirming hormones are only provided after careful evaluation where a patient is experiencing consistent and persistent gender

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[11] Turban JL, DeVries ALC, Zucker K. Gender Incongruence & Gender Dysphoria. In Martin A, Bloch MH, Volkmar FR (Editors): *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook*, Fifth Edition. Philadelphia: Wolters Kluwer 2018.

identification different from their assigned sex and clinically significant distress related to the incongruence. Each stage of the treatment is carefully evaluated and can be changed at any time by carefully tapering a patient off of the treatment. In the case of puberty blocking medication, once stopped, a patient's endogenous puberty begins immediately. With hormone therapy, once stopped, a patient's naturally occurring hormones will continue. This treatment does not make people transgender; it safely and effectively treats patients with gender dysphoria.

50. Treatment for transgender youth and adolescents is safe, effective and essential for the well-being of transgender young people. My patients who receive medically appropriate hormone therapy and who are treated consistent with their gender identity in all aspects of life experience significant improvement in their health. Medical treatment recommended for and provided to transgender adolescents with gender dysphoria can substantially reduce lifelong gender dysphoria and can eliminate the medical need for surgery later in life. Providing gender-affirming medical care can be lifesaving treatment and can improve the short- and long-term health outcomes for transgender youth.

HARMS OF WITHHOLDING OR TERMINATING TREATMENT FOR TRANSGENDER YOUTH WITH GENDER DYSPHORIA

51. Withholding pubertal suppression and hormone therapy from transgender young people when it is medically indicated is extremely harmful. As noted above, administration of pubertal suppression has shown to significantly reduce suicidality in transgender patients. If I was prohibited from treating my patients with this treatment where it is medically indicated, it would result in predictable and significant harms, including the at least partially irreversible changes from endogenous puberty described below.

52. From a medical perspective, it is at least as dangerous to withdraw treatment once it has been initiated as it is to withhold the initiation of treatment. If a clinician is forced to

immediately stop pubertal suppression as a result of a legal prohibition on the care, it will cause patients to immediately resume their endogenous puberty. This could result in extreme distress for patients who have been relying on the suppression to prevent bodily changes that come with their endogenous puberty. For a girl who is transgender, this could mean that she would immediately start experiencing genital growth, body hair growth, deepening of her voice and development of a more pronounced Adam's apple. For a boy who is transgender, this could mean that he would have the initiation of a menstrual cycle and breast growth. These changes can be extremely distressful for a young person who had been experiencing gender dysphoria that was then relieved by the initiation of pubertal suppression.

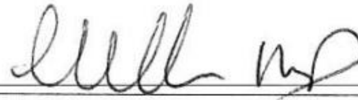
53. Additionally, the effects of undergoing one's endogenous puberty may not be reversible even with subsequent hormone therapy and surgery, thus exacerbating lifelong gender dysphoria in patients who would have this treatment withheld or cut off. Bodily changes from puberty as to stature, hair growth, genital growth, voice and breast development can be impossible or more difficult to counteract.

54. For patients who are currently undergoing treatment with gender-affirming hormones like estrogen or testosterone, abruptly withdrawing care can result in a range of serious physiological and mental health consequences. The body takes about six weeks to ramp up endogenous hormones so if a clinician is forced to abruptly stop treatment, a patient will be without sufficient circulating hormones at all. This can result in depressed mood, hot flashes, and headaches. For patients on spironolactone – a testosterone suppressant – abruptly terminating treatment can cause a patient's blood pressure to spike, increasing a young person's risk of heart attack or stroke. The abrupt withdrawal of treatment also results in predicable and negative mental health consequences including heightened anxiety and depression.

55. If I had to pull my patients off treatment, even for a short time, I would be concerned that some could become so traumatized they would resort to self-harm and potentially even attempt suicide. We barely save some of these young people's lives by getting them on treatment; to take them off mid-treatment could be life threatening.

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

Executed on 6/11/2021



Deanna Adkins, MD