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STATE OF RHODE ISLANDPROVIDENCE, RHODE ISLAND, SC		SUPERIOR COURT
ISABELLE M. AYALA, Plaintiff, vs. AMERICAN ACADEMY OF PEDIATRICS; JASON R. RAFFERTY, MD; MICHELLE FORCIER, MD; MEGHAN GIBSON, MD; GILLIAN A. MORRIS, MD; BRITTANY ALLEN, MD; ILANA SHERER, MD; JILL WAGNER, LCSW, JOHN DOES 1–15; and LIFESPAN PHYSICIAN GROUP, INC., Defendants.	§ §	C.A. No:_____

COMPLAINT

Plaintiff Isabelle M. Ayala hereby alleges as follows:

INTRODUCTION

1. Plaintiff Isabelle M. Ayala (f.k.a. Giovanni Ayala) is an unfortunate victim of a collection of actors who prioritized politics and ideology over children's safety, health, and well-being. Isabelle brings this complaint against Defendants for civil conspiracy, fraud, medical malpractice, and other related causes of action in connection with their collective failure to treat her properly in the name of a so-called "gender-affirmative" model of care, a then-new and experimental model of treating transgender and gender diverse children and adolescents that

Defendants created, promoted, and have continued to advocated for despite (1) immediate criticism that its stated evidence base was misleadingly presented and/or failed to actually support any of its recommendations, conclusions, or proposed treatments, and (2) a growing international skepticism for the evidence base for the recommended interventions and concerns about their harms.

2. Isabelle is but one of an unknown but apparently growing number of children and adolescents who have been unknowing victims of a conspiracy entered into and perpetuated to the present day by certain ideologically captured individuals in positions of power at the American Academy of Pediatrics (the "AAP"), a named Defendant herein, which at the very least failed to exercise any degree of institutional control over those ideological actors whom it had empowered. These individuals saw an opportunity to pioneer new guidance on an emerging field in pediatric medicine—the treatment of the rapidly increasing number of children and adolescents presenting as transgender and gender diverse—that would enshrine as authoritative their ideological beliefs. But finding no evidentiary support for their radical positions, they nonetheless prepared and authored a "policy statement" reviewed, approved, and published by Defendant AAP, proposing an entirely new model of treatment, which not only misrepresented or misleadingly presented its purported evidentiary support but was also rife with outright fraudulent representations. Despite immediate and sustained criticism pointing out the misrepresentations and apparent lack of evidentiary backing in this policy statement, as well as a continually growing body of international research undercutting the policy statement's conclusions and recommendations, Defendants have doubled- and tripled-down on their commitment to the policy statement and its "affirmative model" of treatment, while continuing to promote and profit off it.

3. Since the beginning of the conspiracy, certain of the Defendants, including Defendants Dr. Jason Rafferty and Dr. Michelle Forcier, were testing their radical new approach on patients like Isabelle—which included immediate, no-questions-asked "affirming" of a child's desired gender and quickly placing them on a conveyor belt of life-altering puberty blockers, cross-sex hormones, and/or experimental surgeries.

4. Unfortunately, Isabelle was unaware of the deception the Defendants engaged in to support their practices and reasonably trusted and relied on her medical providers' guidance. Her trust came easily, as early traumatic experiences in her life had left Isabelle in a severely compromised mental state at age fourteen and in need of compassionate, professional medical care. As her mental health issues began manifesting in her belief that she was a boy, Isabelle and her family turned to the group they had identified as "the experts" in this area. These experts included Defendants Dr. Rafferty, Dr. Forcier, and those on their team at Lifespan Physician Group at the Hasbro Children's Hospital, whom she believed would provide the insight and evidence-based medical care Isabelle desperately needed in her time of greatest need. Instead, rather than seeking Isabelle's best interest, they lied to her and her family and coerced them into immediately sending Isabelle down their path of "gender-affirming" medicalization that has forever damaged Isabelle's physical and mental health.

5. Defendants Dr. Rafferty, Dr. Forcier, Dr. Morris, Wagner, and Lifespan Physician Group misled Isabelle into believing that taking testosterone would resolve her mental health issues, particularly her depression and anxiety, and restore her overall health and well-being.

6. Rather than resolving her numerous health issues, Isabelle's depression and anxiety worsened, ultimately leading to an unsuccessful suicide attempt approximately six months after first taking testosterone. Despite this, and her worsening mental health and numerous other red

flags, these Defendants continued to keep Isabelle on cross-sex hormones for the entire duration of the "care" they provided.

7. Isabelle is now twenty years old and longs for what could have been and to have her healthy, female body back. The changes the testosterone have had on her body are a constant reminder that she needed an unbiased medical expert willing to evaluate her mental health and provide her the care she needed, rather than a group of ideologues set on promoting their own agenda and furthering a broader conspiracy at her expense. Isabelle has suffered from vaginal atrophy from the extensive use of testosterone; she deals with excess facial and body hair; she struggles with compromised bone structure; she is unsure whether her fertility has been irreversibly compromised; she still has mental health issues and deals with episodes of anxiety and depression, further compounded by a sense of regret; and she has since contracted an autoimmune disease that only the males in her family have a history of. Isabelle humbly requests that this Court hold Defendants accountable for their wrongful acts. Plaintiff demands judgment against all Defendants including compensatory and punitive damages to the maximum amount allowed. Plaintiff also requests attorney's fees and costs and such other relief as this Court deems meet and just.

PARTIES

8. Isabelle M. Ayala ("Isabelle" or "Plaintiff") is an individual who currently resides in Wellington, Florida.

9. Defendant American Academy of Pediatrics (the "AAP") is a nonprofit corporation organized under the laws of the state of State of Illinois and whose principal place of business is located at 345 Park Boulevard Itasca, Illinois 60143. Plaintiff also designates as Defendants John Does 1-15, as currently unidentified members of the AAP's policy statement review and

approval process, who were aware or should have been aware of the conspiracy and factual allegations detailed below and either perpetuated such conspiracy or failed to act to prevent it (the "Doe Defendants").

10. Defendant Jason R. Rafferty, MD ("Dr. Rafferty") is an individual who is believed to reside in and to have provided medical services to Plaintiff in Providence County, Rhode Island.

11. Defendant Michelle Forcier, MD ("Dr. Forcier") is an individual who is believed to reside in and to have provided medical services to Plaintiff in Providence County, Rhode Island.

12. Defendant Meghan Gibson, MD ("Dr. Gibson") is an individual who is believed to reside in and to have provided medical services to Plaintiff in Providence County, Rhode Island.

13. Defendant Gillian A Morris, MD ("Dr. Morris") is an individual who is believed to reside in and to have provided medical services to Plaintiff in Providence County, Rhode Island.

14. Defendant Brittany Allen, MD ("Dr. Allen") is an individual who is believed to reside in Dane County, Wisconsin.

15. Defendant Ilana Sherer, MD ("Dr. Sherer") is an individual who is believed to reside in Alameda County, California.

16. Defendant Jill Wagner, CSW ("Wagner") is an individual who is believed to reside in and to have provided medical services to Plaintiff in Providence County, Rhode Island.

17. Defendant Lifespan Physician Group, Inc. ("Lifespan") is a non-profit corporation organized under the laws of the State of Rhode Island and whose principal place of business is located at 167 Point Street, Providence, Rhode Island 02903.

JURISDICTIONAL ALLEGATIONS

18. This Court has personal jurisdiction over all Defendants because, at all times relevant to the allegations herein, Defendants committed the alleged torts within the territorial limits of the State of Rhode Island.

19. This Court has subject matter jurisdiction over the allegations herein because, at all times relevant to thereto the conduct and torts committed by the Defendants occurred against a Rhode Island citizen within the territorial limits of the State of Rhode Island.

ALLEGATIONS RELEVANT TO ALL CLAIMS

A. Observing a Growing Number of Children and Adolescents Identifying as Transgender or Gender Diverse at Increasingly Alarming Rates, Certain Defendants Enter Into a Conspiracy to Create a New, Ideologically Driven Model of Treatment

20. From the 20th century through the early 21st, the number of individuals identifying as transgender or gender diverse in the United States was relatively low, with some studies estimating 0.002% of the population to 0.014%. Almost 100% of such individuals were adult males identifying as females. But by 2016, the number of individuals in the United States presenting as transgender had exploded, with one study estimating the percentage to be 0.6%. Not only had the numbers increased alarmingly, but the demographics had dramatically shifted, as the majority were shifting towards minors, and within that number, a majority were young girls. And as those numbers grew, the number of children seeking treatment from their physicians for gender dysphoria skyrocketed. Indeed, as of 2007, there was a single pediatric gender center in the country. By 2016, there were at least 41. To this day, these numbers continue to rise. Recent estimates suggest that 1.4% of adolescents and young adults are identifying as transgender or gender nonconforming; over 70% of such individuals are minor females; and there are believed to be well over 300 pediatric gender clinics in the United States.

21. Instead of asking questions about the underlying reasons for this unprecedented explosion in number and seismic shift in demographics, upon information and belief, a small number of individuals in positions of power within the AAP who were deeply bought certain political and ideological beliefs related to gender identity and gender theory, saw a void of guidance for primary care physicians. Upon information and belief, in 2016 those individuals formed a committee within the AAP—the "LGBT Health & Wellness" (the "Committee")—to seize on an opportunity to lead out on this issue, be the first to offer what they saw as authoritative guidance, and ensure that that guidance aligned with their ideological gender beliefs.

22. Upon information and belief, the Committee quickly set about on a roughly two-year process to create a new "Policy Statement" to be published by the AAP based on those individuals' ideological views and introducing a radical new model for transgender and "gender diverse" children and adolescents, one that would do away with the consensus, scientifically supported approach known as "watchful waiting" (wherein children are not put on life-altering puberty blockers or cross-sex hormones but are instead treated with counseling and psychotherapy as they naturally progress through puberty). Instead, this new, so-called "gender-affirmative care" model would advocate for the immediate, unquestioned embrace of a child's chosen "gender identity," advocate for immediate "social transitioning" of the child to the newly chosen gender identity and would encourage puberty blocking drugs and cross-sex hormones to "affirm" that child's new gender identity.

23. Notably, at least four of the six members of the Committee—including Defendants Dr. Rafferty, Dr. Forcier, Dr. Allen, and Dr. Sherer—worked at pediatric gender clinics that prescribe puberty blockers and cross-sex hormones to patients as young as 10 and 14,

respectively.[1] Naturally, creating a new model of treatment that would promote and encourage the prescription of puberty blockers and cross-sex hormones for gender dysphoric children would stand to benefit those Committee members, and others like them, tremendously.

24. Upon information and belief, not long after they began the work towards drafting this radical new policy, the Committee members and those working with them learned and/or appreciated that their desired, ideologically driven new model of "gender-affirmative" treatment was not supported by medical research or evidence. Upon information and belief, they remained undaunted and continued drafting a policy that maintained their predetermined ideological outcome, regardless of what support they garnered from scientific and medical literature. Instead of supporting the conclusions and recommendations contained in the policy statement with scientific evidence, they fraudulently and misleadingly cited evidence that did not support any of their conclusions and recommendations, and they knowingly misrepresented the known risks and dangers of some of the medical interventions the policy statement promoted.

B. The 2018 "Gender-Affirmative Care" Policy Statement Is Published and Meets Immediate Scrutiny and Pushback for Its Lack of Scientific Basis and Outright Misrepresentations

25. The AAP boasts a robust, extensive draft and review process on its website for any policy statement it issues.[2] It involves the drafting of an "intent" to write a policy, which describes the purpose, research base, list of authors and their areas of expertise, and key topic areas of a proposed policy statement. That "intent" document is submitted to the AAP Board of Directors for consideration and approval. The next phase is the drafting of the policy statement and submission to peer review. This process can take up to two years and includes an evidence

[1] https://www.thefp.com/p/the-hijacking-of-pediatric-medicine.

[2] https://www.aap.org/en/policy/policy-statement-development-process/

review, collaborative writing, and submission to multiple groups of peers for review. Feedback from reviewers is then incorporated into the draft policy statement. Finally, this already thoroughly reviewed draft policy statement is submitted for executive review and approval, which includes senior leadership review and voting by the AAP Board of Directors. If approved, it is published in "Pediatrics," the official peer-reviewed journal of the AAP. The AAP touts that its policy statements are "thoroughly vetted through several rounds of review,"[3] which include peer review of often 30-40 reviewers and three rounds of executive review. This process is supposed to ensure that any policy statement "has been rigorously reviewed and is factual and with a strong scientific basis."[4] Each policy statement is reviewed on a five-year cycle; that is, after 5 years, a policy statement may be reaffirmed, revised, or retired.

26. At some point between January 2016 and October 2018, the Committee chose Defendant Dr. Rafferty—who was then only in his medical residency at the time, not yet an independently practicing physician—to be the lead author for the "gender-affirmative care" policy statement they envisioned.

27. Ultimately, in 2018, the AAP published the policy statement, entitled "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents" (the "Gender Policy Statement") (attached hereto as **Exhibit A**). The Gender Policy Statement was alarming to many in the medical community, as it memorialized and institutionalized the radical personal beliefs and ideologies of its authors and visionaries, as opposed to proposing a treatment model based on cited scientific research and evidence. Indeed, the Gender Policy Statement has been described as "an extraordinary departure from the

[3] *Id.*

[4] *Id.*

international medical consensus" (which was and is watchful waiting).[5] In fact, the work appeared to be so shoddy that one longtime AAP member has believed, "[t]here was clearly no fact-checking" and "[t]he AAP thought trans was the next civil rights crusade and got boondoggled by enthusiastic young doctors."[6]

28. Curiously, despite the robust draft and review process described above, the AAP included an unusual note on the first page of the Gender Policy Statement: "Dr. Rafferty conceptualized the statement, drafted the initial manuscript, reviewed and revised the manuscript, approved the final manuscript, and *agrees to be accountable for all aspects of the work*" (emphasis added). The oddness of this disclaimer has caused at least some to view it as a tacit admission on behalf of the AAP that something is afoul with the Gender Policy Statement.

29. Regardless of this odd disclaimer, Dr. Rafferty has confirmed in an interview that the Gender Policy Statement was a product of the AAP's robust policy statement process. While acknowledging that he "drafted the original draft," he continued that it went out through "multiple rounds of review through various committees in the AAP" and was a product "that has really been vetted."[7] He further claimed that the Gender Policy Statement "becomes the position of the Academy," adding that "it is not my personal position."[8]

30. Despite apparently having undergone a thorough and extensive draft, review, and approval process, the final product was one rife with misrepresentations and outright fraudulent statements regarding (1) the cited science and evidence underpinning the radical new treatment

[5] https://www.thefp.com/p/the-hijacking-of-pediatric-medicine

[6] *Id.*

[7] https://www.youtube.com/watch?v=LVEq45RtMxA

[8] *Id.*

model, and (2) the known dangers and potential side effects of the medical interventions it advocates for.

31. These were immediately noticed by members of the medical community, who expressed their alarm and concern over the radical recommendations and statements contained in the Policy Statement. One doctor in particular, Dr. James Cantor, PhD, CPsych ("Dr. Cantor"), then the Director of Toronto Sexuality Centre in Toronto, Canada, was so alarmed at the statements and conclusions in the Gender Policy Statement that he immediately set about to fact-check its claims and purported evidentiary bases, culminating in a paper he published online in 2018 (less than three months after the Gender Policy Statement was published) (the "Cantor Fact-Check") (attached hereto as **Exhibit B**). The Cantor Fact-Check would then be double-peer reviewed and published in the Journal of Sex and Marital Therapy. The Cantor Fact-Check, which Plaintiff incorporates here in full by reference, thoroughly debunks the cited evidentiary support and exposes many of the fraudulent statements and representations contained in the Gender Policy Statement. Plaintiff notes some of the more significant provisions:

- The Gender Policy Statement "was quite a remarkable document: Although almost all clinics and professional associations in the world use what's called the watchful waiting approach to helping gender diverse (GD) children, the AAP statement rejected that consensus, endorsing only gender affirmation" (emphasis in original).

- "As I read the works on which they based their policy however, I was pretty surprised—rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing watchful waiting" (emphasis in original).

- "The AAP statement was also remarkable in what it left out—namely, the actual outcomes research on GD [gender diverse] children. In total, there have been 11 follow-up studies of GD children, of which AAP cited one (Wallien & Cohen-Kettenis, 2008), doing so without actually mentioning the outcome data it contained. The literature on outcomes was neither reviewed, summarized, nor subjected to meta-analysis to be considered in

the aggregate—It was merely disappeared…As they make clear, every follow-up study of GD children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition." (emphasis in original).

- "Any assertion that [the Gender Policy Statement] is based on evidence is demonstrably false."

- The Gender Policy Statement's claims and criticisms regarding "conversion" or "reparative" treatment models to treat gender diverse children have no evidentiary backing; instead, the Gender Policy Statement misleadingly cites studies regarding conversion therapy for homosexual adults to be supportive of the statement's claims that "conversion" therapy for gender diverse children are "unsuccessful" and "deleterious." As Dr. Cantor writes: "AAP's claims struck me as odd because *there are no studies of conversion therapy for gender identity*. Studies of conversion therapy have been limited to *sexual orientation*, and, moreover, to the sexual orientation of *adults*, not to gender identity and not of children in any case…Neither gender identity, nor even children, received a single mention in" the article AAP cites to support its assertions (emphasis in original).

- Dr. Cantor continues on this point: "[I]n the context of GD children, it simply makes no sense to refer to externally induced 'conversion': The majority of children 'convert' to cisgender or 'desist' from transgender *regardless* of any attempt to change them. 'Conversion' only makes sense with regard to adult sexual orientation because (unlike childhood gender identity), adult homosexuality never or nearly never spontaneously changes to heterosexuality. Although gender identity and sexual orientation may often be analogous and discussed together with regard to social or political values and to civil rights, they are nonetheless distinct—with distinct origins, needs, and responses to medical and mental health care choices. Although AAP emphasized to the reader that 'gender identity is not synonymous with 'sexual orientation'' (Rafferty et al., 2018, p. 3), they went ahead to treat them as such nonetheless" (emphasis in original).

- Dr. Cantor turned to another source (the AACAP) that the AAP cites for its support of "gender affirmation" and observed another instance of flagrant misrepresentation: "Whereas AAP cites AACAP to support gender affirmation as the only alternative for treating GD children, AACAP's actual view was decidedly neutral, noting the lack of evidence: 'Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and

desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed' (AACAP, 2012, p. 969). Moreover, whereas AAP rejected watchful waiting, what AACAP recommended was: 'In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood" (AACAP, 2012, p. 969). So, not only did AAP attribute to AACAP something AACAP never said, but also AAP withheld from readers AACAP's actual view."

- Dr. Cantor continued to remarkably observe that each article cited for the Gender Policy Statement's dismissal of conversion therapy for gender diverse children never mentioned conversion therapy or never mentioned gender identity, and thus could not possibly support the AAP's conclusions. "[Reference 40] never mentions conversion therapy (!)"; "[In Reference 41] [c]onversion therapy is never mentioned"; "How this article supports AAP's claim is a mystery"; "how AAP could cite a 2006 history discussing events of the 1990s and earlier to support a claim about the current consensus in this quickly evolving discussion remains all the more unfathomable" (emphasis in originl).

- On this note, Dr. Cantor concluded his review of this section: "Although AAP (and anyone else) may reject (what they label to be) conversion therapy purely on the basis of political or personal values, there is no evidence to back the AAP's stated claim about the existing science on gender identity at all, never mind gender identity of children."

- Dr. Cantor then examined the citations and support for the AAP's rejection of the watchful waiting approach and found similarly fraudulent results. "AAP also dismissed the watchful waiting approach out of hand, not citing any evidence, but repeatedly calling it 'outdated.' The criticisms AAP provided, however, again defied the existing evidence, with even its own sources repeatedly calling watchful waiting the current standard."

- Looking at the Gender Policy Statement's bizarre assertion that pubertal onset is "arbitrary," Dr. Cantor explains that "AAP gave readers exactly the reverse of what was contained in its own sources."

- Turning to the Gender Policy Statement's support for its alarming critique of watchful waiting, which the statement contends is "outdated" and unsupported by science, Dr. Cantor begins: "[I]t was not clear on what basis AAP could say that watchful waiting withholds support—AAP cited no support for its claim…Also unclear is on what basis AAP could already know exactly which treatments are 'critical' and which are not—Answering that question is the very purpose of this entire endeavor. Indeed, the logic of AAP's claim appears entirely circular: It is only if one were already pre-convinced that gender affirmation is the only acceptable

alternative that would make watchful waiting seem to withhold critical support—What it delays is gender affirmation, the method one has already decided to be critical."

- He continues: "Next was a vague reference alleging concerns and criticisms about early studies. Had AAP indicated what those alleged concerns and flaws were (or which studies they were), then it would be possible to evaluate or address them. Nonetheless, the argument is a red herring: Because all of the later studies showed the same result as did the early studies, any such allegation is necessarily moot."

- "Reference 45 did not support the claim that watchful-waiting is 'outdated' either. Indeed, that source said the very opposite, explicitly referring to watchful waiting as the *current* approach" (emphasis in original).

- Dr. Cantor did note that the authors of one study cited were in fact somewhat critical of watchful waiting, but "they do not come close to the position the AAP policy espouses."

- In summarizing his review of the cited support for the Gender Policy Statement, Dr. Cantor stated: "In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact checking at all. AAP claimed, 'This policy statement is focused specifically on children and youth that identify as [trangender] rather than the larger LGBTQ population'; however, much of that evidence was about sexual orientation, not gender identity. AAP claimed, 'Current available research and expert opinion from clinical and research leaders…will serve as the basis for recommendations"' (pp. 1–2); however, they provided recommendations entirely unsupported and even in direct opposition to that research and opinion."

- Dr. Cantor concluded: "AAP is advocating for something far in excess of mainstream practice and medical consensus. In the presence of compelling evidence, that is just what is called for. The problems with [the Gender Policy Statement], however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide compelling evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence" (emphasis in original).

32. Additional misrepresentations not discussed in Dr. Cantor's article also abound. For example, a particularly egregious misrepresentation, which is repeated multiple times in the

Gender Policy Statement without even a citation (which would explain perhaps why Dr. Cantor did not address it, as there was no state authority to fact check), is the contention that puberty blockers to treat gender diverse children are completely reversible and generally helpful to treat gender diverse youth. And Defendants have stated and continue to state the same fraudulent claim in their private practices as well as their public appearances and in the media. This is an entirely false and extremely dangerous misrepresentation to make and advocate to the public, particularly since the affected audience are children and adolescents (and their families). In truth, puberty blockers are known to impact children's bone density and can lead to early onset osteoporosis and decreased bone density. They can also impact a child's mental illness. In fact, on the package insert for Lupron, one of the most commonly prescribed puberty blockers, it lists "emotional instability" as a side effect and warns to "[m]onitor for development or worsening of psychiatric symptoms during treatment." Lupron has also been associated with and may be the cause of mood disorders, seizures, cognitive impairment, and sterility if the patient proceeds to take cross-sex hormones. Additionally, a leading expert on the subject noted in relation to a recent experimental trial of puberty blockers, "There was no statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. In addition, there is unpublished evidence that after a year on [puberty blockers] children reported greater self-harm, and the girls also experienced more behavioral and emotional problems and expressed greater dissatisfaction with their body—so puberty blockers exacerbated gender dysphoria."

33. Egregious misrepresentations such as this, coupled with the truth exposed in Cantor's Fact-Check, lay bare the brutal reality for Defendants: their ideologically driven new policy/model is wholly unsupported by the evidence it cites in support, and it is replete with outright misrepresentations and lies of both commission and omission.

34. Further, given the AAP's normally robust draft, approval, and review process, and Dr. Rafferty's insistence that that took place with the Gender Policy Statement, there is no conceivable way that these extensive, repeated fraudulent representations and completely incorrect and misleading citations were the product of ignorance. This was not the product of a single, incompetent individual rushing something together. Instead, Defendants contend that dozens of experts reviewed and checked the materials through the course of multiple rounds of review and approval, which leads to the inescapable conclusion that the Gender Policy Statement was knowingly created and published as fraudulent with the obvious intent of misleading the public as to the evidentiary backing for its radical policy and the dangers and risks associated with the treatments it promotes.

C. Defendants Ignored and Continue to Ignore the Scientific and Evidence-Based Criticisms of the Gender Policy Statement, Have Attained a Windfall of Prestige and Profits Because of the Gender Policy Statement, and Continue to Perpetuate the Conspiracy

35. One would expect that after Dr. Cantor's and others' extensive and categorical criticism and refutation of the Gender Policy Statement, the AAP and other Defendants would have responded by either (1) engaging in a revisiting and revising of its policy in light of the exposed misrepresentations and misleading and false statements, or (2) issuing a robust rebuttal and defense of the Gender Policy Statement, bringing truthfully supportive citations, research, and evidence to support its ideologically driven assertions, conclusions, and recommendation. In reality, nothing happened. Defendants, including the AAP, ignored entirely all criticism of the Gender Policy Statement, appearing to take a "if we don't acknowledge it, it does not exist" approach. Indeed, Dr. Cantor has never received a response from the AAP, Dr. Rafferty, or any of the other Defendants, despite trying desperately to engage them. Instead, Defendants, including the AAP, have continued to treat the Gender Policy Statement as *the* authority on how

to treat children presenting as gender diverse. They continue to promote it, uphold it as evidenced-based and authoritative, and enjoy the tremendous reputational and financial benefit that has come with being considered the authorities on this evolving and growing area of medicine.

36. Indeed, the AAP has enjoyed tremendous prestige and holds itself out to be at the forefront as the authority on treating children presenting as gender diverse. Other medical organizations have followed its lead and uphold it and the Gender Policy Statement as the authority on care for transgender and gender diverse children and adolescents. They have no doubt enjoyed significant financial windfall from donations deriving from and fundraising efforts based on the Gender Policy Statement and the newfound expertise it has brought. Certain individual Defendants have similarly become somewhat of celebrities within the gender medical care world and have built large and successful practices based on their sudden perceived authority.

37. Dr. Rafferty, for example, has gone from a little-known resident during his time drafting the Gender Policy Statement to having a highly successful practice in pediatric gender care and considered a leading authority on the subject, all while operating under the imprimatur of the authority he falsely created. He has also published numerous articles on one of the AAP's websites (http://www.healthychildren.org) promoting the "affirmative care model."[9]

38. Dr. Forcier has similarly parlayed her newly bolstered authority status into furthering her own successful private practice as well as paid speaking events. In fact, she was prominently

[9] *See*, *e.g.*, https://www.healthychildren.org/English/ages-stages/gradeschool/Pages/parenting-a-gender-diverse-child-hard-questions-answered.aspx; https://www.healthychildren.org/English/ages-stages/gradeschool/Pages/Gender-Identity-and-Gender-Confusion-In-Children.aspx

featured in one of the most viewed documentaries of all time in 2022 as a leading expert in pediatric gender care and puberty blockers (which she described as "*completely* reversible" and "don't have any permanent effects").[10] Other Defendants have enjoyed similar commercial and reputational benefits.

39. Whether attributable to the significant benefits Defendants have enjoyed in perpetuating the fraudulent Gender Policy Statement and misleading the public about its legitimacy and the dangers of the medical treatments it recommends or some other reason, Defendants have continued to promote and defend it to this day.

40. The AAP in particular has continued to do so despite internal pressure from concerned AAP members to at the very least revisit whether the Gender Policy Statement should be the official position of the AAP.

41. For three consecutive years, concerned AAP members, who became increasingly worried with what they were seeing in their practices with children suffering under the care being promoted by Defendants, brought official resolutions before the AAP challenging the Gender Policy Statement. Each time the AAP used procedural hurdles and even changed certain procedural rules to table and silence those resolutions.

42. Furthermore, over the past almost two years, there have been six systematic reviews of the evidence surrounding "gender-affirming" medical treatments for children and adolescents (i.e., puberty blockers and cross-sex hormones) conducted by research teams across the globe, as advocated for by the Gender Policy Statement, and every single one of them has reached the conclusion that "the evidence for mental-health benefits of hormonal interventions for minors to be of low or very low certainty," whereas, "[b]y contrast, the risks are significant and include

[10] *What is a Woman?*, June 1, 2022, Justin Folk, Digital Astronaut Production.

sterility, lifelong dependence on medication and the anguish of regret."[11] Every systematic review has also contradicted the claims that non-medical intervention for gender diverse youth leads to increased suicides—another claim pushed by the Gender Policy Statement. "There is no reliable evidence to suggest that hormonal transition is an effective suicide-prevention measure."[12]

43. Domestically, more than a dozen states have passed legislation preventing "gender-affirming" medical treatment for minors. [13]

44. In response to the conclusions from these systematic reviews and the development of the state legislation, Defendants have only dug their heels in further, including in particular the AAP. In August 2023, the AAP Board of Directors voted unanimously to reaffirm the Gender Policy Statement (which was due for its five-year vote to be reaffirmed, revised, or retired). In connection with that vote, AAP CEO Mark Del Monte stated, "the board has confidence that the existing evidence is such that the current policy is appropriate" and further stated, defiantly responding to the systematic reviews undercutting the Gender Policy Statement, "They engaged in their process, we're engaging in our process."

45. At every turn, from the conception of the conspiracy in 2016 through the present day, Defendants have continued to misrepresent the evidence and mislead the public as to the dangers of the "gender-affirmative care" model of treatment, which they continue to uphold, publish, and promote to this day.

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[11] https://www.wsj.com/articles/trans-gender-affirming-care-transition-hormone-surgery-evidence-c1961e27

[12] *Id.*

[13] Notably, the AAP has filed *amicus* briefs in several lawsuits supporting challenges to those state laws, and in each of those briefs, the AAP cites the Gender Policy Statement between 7 and 13 times as authority supporting its arguments.

D. Plaintiff Isabelle Ayala and Her Family Become Unknowing Victims of Defendants' Conspiracy

1. Isabelle suffered a deeply traumatic early childhood and struggled with profound mental health issues from a young age.

46. Against this backdrop, Plaintiff Isabelle became an unknowing victim of Defendants' conspiracy when she walked into the Hasbro Children's Hospital to see who she and her family had found as "the experts" on treating gender dysphoria at a time when she was in a deep emotional and mental health crisis.

47. Isabelle has struggled with her mental health from a very early age. In fact, mental health issues run in her family, including anxiety disorder, bipolar disorder, depression, and post-traumatic stress disorder.

48. At or around the age of seven, while living with her parents and half-brother, Isabelle was sexually assaulted.

49. The following year, at the age of eight, Isabelle experienced early-onset puberty, all too often a consequence for sexual assault victims.

50. To say the least, Isabelle felt uncomfortable with the changes to her body elicited by early-onset puberty, but her discomfort was exacerbated by the sexual trauma she endured. Puberty, and the changes that came with it, "just didn't feel right at all" in Isabelle's view. The sexual trauma haunted her and contributed to a profound insecurity that pushed Isabelle to begin looking for help.

51. Around age 11, as her body continued conforming to that of a woman and her apparent body dysmorphia persisted, Isabelle began cutting herself, often doing so multiple times a day. The relief she found in harming herself in this way was fleeting, lasting only minutes. Even so, as a sign of her desperation and the growing severity of her depression and anxiety, she would continue harming herself in this way for many years.

52. It was also around the age of 11 that Isabelle—still in her profound state of desperation and with growing depression and anxiety—engaged substantively in social media interactions for the first time, creating profiles on Instagram, Kik, and Tumblr, among others.

53. These social media interactions introduced Isabelle to the concept of being "trans," an idea that immediately gained traction in her mind since Isabelle's life experiences to that point taught her that to be a woman is to be vulnerable. Within months, to distance herself from the trauma she endured as a young girl, Isabelle began to identify as a boy amongst her group of close friends.

54. The following summer, at the age of 12, Isabelle came out to her mom, explaining to her that she wanted to be a boy. Isabelle recalls that, "it did not go well." Amidst "a lot of crying and screaming," Isabelle's mother explained that Isabelle "would regret it," and that it "could not possibly be true" because Isabelle "did not show signs [of being transgender] when she was really little."

55. The following 12 months were especially turbulent for Isabelle. In her vulnerable mental state, she was convinced—by social media influences and the depth of her pain and despair as a sexual assault victim—that the solution to her mental anguish was to transition from what she viewed as a weak, vulnerable, 13-year-old girl to a strong, confident, independent boy. Her mother, on the other hand, suspected that her daughter had been captured by an ideology that would only end up causing her harm and knew that what she needed was proper counseling, not a purported gender transition.

56. Isabelle's mental health continued to decline, so much so that she began to eat demonstrably less out of a phobia of getting pregnant.

57. Isabelle's determination to pursue the path of medicalization grew to the point that she was ready to do or say whatever she needed to get what she thought would help her.

58. Acting on this self-diagnosis, Isabelle bought a chest binder from a provider on the internet. Without the guidance or direction of a medical practitioner, but only on the advice of the influence she found on the internet, she began to bind her chest to pacify her discomfort with her female figure. She also engaged in "speech exercises" she found online to strain her voice, attempting to force it into a masculine pitch range.

59. Her mother continued to insist that this was the wrong path and would only make things worse. After realizing that she would not be able to talk her daughter out of these thoughts easily, Isabelle's mother encouraged Isabelle to at least wait until she was an adult before allowing anyone to provide her with irreversible medical interventions. Isabelle's father, on the other hand, was content to help Isabelle pursue whatever made her happy in the short term.

60. It was during this tumultuous time that Isabelle's parents separated, compounding Isabelle's grief.

61. Shortly thereafter, Isabelle's mother made it clear to Isabelle and Isabelle's father that if Isabelle's father consented to Isabelle's taking cross-sex hormones, she would "take [him] to court."

62. In late December 2016, when Isabelle was 13 years old, she moved from Florida to Rhode Island with her father and half-brother, leaving behind her mother and her friends.

2. *Isabelle finds Dr. Rafferty and the Hasbro Pediatric Gender Clinic team, who fail to properly evaluate her or share with her all available treatments for her health issues, instead immediately setting about to put her on cross-sex hormones*

63. Upon arriving in Rhode Island and seeking out who they had identified as the experts on gender care in the area, Isabelle's father took her to Hasbro Children's Hospital to visit with their pediatric gender team.

64. At her new patient visit on February 8, 2017, within two weeks of her 14th birthday, the clinician noted Isabelle's family history of anxiety disorder, bipolar disorder, depression, and post-traumatic stress disorder, Isabelle's previously diagnosed ADHD, depression, and anxiety, and her "significant scarring on [her] bilateral upper thighs," evidencing her years of cutting.

65. Isabelle told this clinician that she "ha[d] daily thoughts about wanting to die" and that she had attempted suicide the previous year. Given what was described as the "chronic nature" of her suicidality, however, Isabelle was not admitted on an inpatient basis but rather was sent home with "information on youth pride, specifically the transgender group on Tuesday nights." She was also encouraged to attend her initial appointment with Dr. Horacio Hojman, a child psychiatrist, a week later.

66. She did attend, and at that appointment, on February 15, 2017, the clinicians noted that Isabelle was "transgender" and that the reason for her reported suicidal ideation was that she wanted to "start hormone therapy" but that her mom—who "was not involved"—was "blocking [her] treatment."

67. As it turns out, while Isabelle was experiencing significant mental anguish caused in large part by the sexual assault she endured and had been seeking comfort in cutting for many years at that point, she had not previously attempted suicide after all.

68. On the contrary, her exposure to trans ideologues on social media taught her that in order to progress toward the medical gender transition that she was convinced would help her, she needed to make her situation sound serious. That is, she was coached online that in order to get testosterone, she needed to falsely report a suicide attempt. Isabelle has since learned this is a common tactic "trans elders" and other influencers online give to children who think they need "gender-affirming" cross-sex hormone therapy.

69. Dr. Hojman determined that day that Isabelle's suicidal ideation was serious enough to merit inpatient care, and so she was admitted on that basis that day until she was later discharged on February 22, 2017.

70. It was during this week-long inpatient stay for suicidal ideation that Isabelle first met Defendant Dr. Rafferty.

71. During Isabelle's initial visit with Dr. Rafferty, she—in her deeply compromised mental state—told him that her growing suicidality was related to her level of discomfort with her natal sex and her inability to transition due primarily to her mother's refusal. She was convinced that getting rid of her secondary sex characteristics, dissociating herself from the vulnerable female she was when she was attacked at seven years old, and becoming a boy was the only way to treat her mental health struggles.

72. At this first visit with Dr. Rafferty, Isabelle made the following requests of Dr. Rafferty:

- "[I] would like to start on testosterone 'but my mother said she would not let me until I am an adult and she no longer has any say.'"
- "'I want everything' to transition towards a more masculine expression."
- "I would like to switch bodies with a boy if I could."
- "I would like a penis."

73. At that same meeting, however, Isabelle also shared with Dr. Rafferty a major hesitation regarding her desire to medically transition, namely, "that [she] might want to have a biological child." She further explained, "[g]iving birth really fascinates me and I think it is a beautiful thing," reflecting the fact that even at 14 years old she could sense the unique bond between a mother and a child.

74. Even so, in a matter of minutes and based substantially, if not exclusively, on the endorsements of Isabelle set forth above, Dr. Rafferty concluded that Isabelle "would benefit

[from] and meets criteria to consider hormonal transition," noting only a single "concern," namely "parental (maternal) refusal." Dr. Rafferty formed these conclusions in spite of the fact that Isabelle was at the moment undergoing inpatient mental health evaluation and treatment, and the fact that Isabelle had expressed desire to give birth to a child someday.

75. In sum, after a single visit for less than an hour with Isabelle, and despite having access to all the notes from her prior visits to his clinic listing her profound mental health issues and history of deep trauma, Dr. Rafferty—then still a resident—reached the conclusions that (1) Isabelle would benefit from being put on cross-sex hormones that would radically alter her body, yet somehow cure her underlying depression, anxiety, post-traumatic stress disorder, and other comorbidities, and (2) based on the minutes he had spent with her, she met diagnostic criteria for such radical cross-sex hormone treatment. And the only stated concern Dr. Rafferty acknowledged was that Isabelle's mother—who had just flown up from Florida to be with her daughter when she learned of her inpatient admittance—might refuse to let her take cross-sex hormones.

76. Defendant Dr. Rafferty expounded on this singular concern, by stating that, "[i]f the parents are not willing to engage" in discussions regarding the risks, benefits, and alternatives for all treatment options, "then there would be concern for the ongoing wellbeing of this child based on [her] report during this consultation."

77. Three days later, in a note dated February 22, 2017 (the day Isabelle was discharged from her inpatient hospital stay), Pamela E. Hoffman, MD credited Dr. Rafferty with "identif[ying] that [Isabelle's] issues related to depression were tied to feelings around identity and gender" (ignoring that her depression predated her ever considering that she might be transgender).

78. On March 13, 2017, Isabelle's father took her to an appointment with Defendant Dr. Morris, also a resident at the time at Hasbro Children's Hospital, with Isabelle's mother

participating by speaker phone from her home in Florida. Dr. Rafferty and Defendant Wagner would also join. At the outset of the meeting, Isabelle's mother stated again that, "she and [Isabelle's] father are 'not ready' for [Isabelle] to start hormone[s] and would like to discuss totally reversible interventions first."

79. But after expressing as much, Dr. Rafferty, Defendant Wagner, and/or Dr. Morris made several fraudulent representations, which but for those representations Isabelle's mother would not have consented to her receiving cross-sex hormone treatment. Specifically, these Defendants lied to Isabelle and her parents by telling them that (1) the only treatment for her gender dysphoria and related mental health issues was cross-sex hormonal treatment, and (2) that cross-sex hormonal treatment was the accepted and sole course of action in the medical community and backed by the current body of scientific research. These outright misrepresentations, of course, were entirely consistent with and indeed a byproduct of the fraudulent Gender Policy Statement Dr. Rafferty (and other Defendants) had been working on for the better of a year at this point. In other words, Isabelle was, like untold other patients Dr. Rafferty and the Defendants at Hasbro Children's Hospital were treating, being experimented on as these Defendants tested out the radical new treatment model they were memorializing in the Gender Policy Statement (which they knew lacked any scientific backing). Furthermore, they compound these factual misrepresentations by continuing to pressure and deceive Isabelle's parents by informing them that if they did not consent to cross-sex hormone treatment, Isabelle would kill herself, asking them if they would prefer to have a dead daughter or a living son. Again, this tactic—which Isabelle has learned is commonly employed at pediatric gender clinics pushing for kids to take cross-sex hormone treatments—was consistent with the new treatment model these Defendants were memorializing in the Gender Policy Statement. Ultimately, these tactics worked, as by the end of that meeting, her mother caved to their pressure and coercion and

consented to Isabelle being put on a "low-dose" of testosterone. To be clear, the "consent" Isabelle's mother, father, and Isabelle herself provided was not truly informed consent because of Defendants' lies, misrepresentations, and failures to provide relevant information.

3. Isabelle's testosterone dosage is quickly and repeatedly increased for over a year, despite her consistently increasing anxiety and worsening depression, culminating in an attempted suicide

80. Dr. Rafferty started Isabelle on a "low dose" of depotestosterone cypionate, 20mg/weekly, and states that controlling her depression, restricted eating habits, and cutting will be "essential in optimizing conditions for further gender development." Indeed, rather than giving her testosterone to treat her depression, Rafferty's goal seemed to be to minimize the latter with one drug so that he could advance the former with another.

81. On April 10, 2017, at her first follow-up appointment after being put on testosterone, Isabelle stated that she was "hoping to go up on T," and remarkably, Defendant Morris triples her dose, moving her up to 60mg/weekly. This was less than a month after her initial prescription of a "low dose." Isabelle's mother was not told about the tripling of her dosage (and obviously did not give consent to doing so).

82. On May 15, 2017, Isabelle presented with "profound depression with intermittent suicidal ideation." But because she also "report[ed] initial desirable effect on Testosterone," Rafferty increased her escitalopram, a medication used to treat depression, to address this concern, remarkably stating that Isabelle "continued to do well on testosterone with no adverse effects." Rafferty continued to compartmentalize Isabelle's mental health comorbidities and his gender alteration goals for her.

83. On June 19, 2017, Rafferty declared that Isabelle was "stable with minimal depression and anxiety and no active suicidal ideation," and increased her testosterone dosage to 80mg/weekly.

84. On September 22, 2017, now six months into taking testosterone, Isabelle reported ongoing depression despite the increased dosage of escitalopram.

85. On October 2, 2017, Isabelle was sent home from school for having a panic attack. She visited the Hasbro Children's Clinic that day and saw Defendant Dr. Forcier. She told Dr. Forcier that she "had been increasingly depressed and anxious over the past several months." Dr. Forcier did nothing to slow down Isabelle's testosterone ingestion or the transition process.

86. On October 20, 2017, Isabelle saw Dr. Rafferty, who increased her prescription for escitalopram to treat her worsening depression, noting that there was "still room to go up" further on the dosage if her depressive feelings and thoughts continued.

87. Two weeks later, on November 3, 2017, Isabelle had another appointment with Dr. Rafferty, during which Dr. Rafferty coached Isabelle about "being open with [her] mother (and father) around [her] dysphoria and gradually working up to discussing surgery." Despite her worsening depression, which Rafferty stated months prior needed to be controlled to further her gender development goals (i.e., be recommended for surgery), Rafferty continued to promote medical transition as the solution.

88. On or around November 16, 2017, Isabelle attempted suicide.

89. Isabelle reported the suicide attempt to her therapist on November 30, 2017, and was admitted on an inpatient basis for suicidal ideation from December 1, 2017, to December 15, 2017. During this inpatient stay, she discontinued use of escitalopram and was put on fluoxetine, another antidepressant.

90. In her first appointment with Dr. Rafferty after this inpatient stay on December 29, 2017, he increased her dosage of fluoxetine. He did nothing regarding her extraordinarily high testosterone dosage or attempt to slow down her transition treatment.

91. A month later, Dr. Rafferty's notes on a January 19, 2018, visit with Isabelle include that she has "no history of trauma," a clearly inaccurate statement that indicates that Dr. Rafferty either did not bother to investigate and explore her deeply traumatic past or simply chose to ignore it.

92. Isabelle saw Dr. Rafferty a few more times before she moved back to Florida in June 2018, but not before Rafferty provided her with "plenty of refills" of testosterone on her last visit with him as she was "moving to FL tomorrow." At the time, she was still battling her depression and anxiety. Dr. Rafferty did nothing to ensure that she would continue to receive appropriate treatment (e.g., have her hormone levels monitored by an endocrinologist), nor did he ever follow up with her to ensure she was continuing to receive medical care, a particularly glaring omission given that he had sent her off with an overprescription of testosterone.

93. After returning to Florida, Isabelle continued to take testosterone for roughly another year. Hover, as she distanced from the control and influence of the Defendants at the Hasbro Children's Hospital and Lifespan, she decided to quit taking testosterone "cold-turkey." Off the cross-sex hormones, she gradually grew out of her gender dysphoria and began to become more comfortable with her female body, altered as it was from taking testosterone. She realized she was not a boy and never could have been one. Instead, she realized that her mental health issues and discomfort in her body were likely the result of her traumatic childhood and other mental health comorbidities—a realization any competent physician would have also realized or at least explored—and detransitioned.

94. Not once during her treatment with the Defendants at the Hasbro Children's Hospital did a single one of her providers take a step back to reevaluate whether the testosterone was improving Isabelle's health. Instead, they only ever increased her dosage—despite her mother only ever consenting to a low dosage (and even then doing so without full information required to give true informed consent). As Defendants increased the dosage, not only did Isabelle's mental health spiral out of control—so much so that she attempted suicide—but her body underwent irreversible physical changes and suffered permanent damage. She has experienced significant vaginal atrophy; her voice has been permanently altered; she has to deal with excess facial and body hair and the accompanying stress and mental anguish that brings; she struggles with compromised bone structure; she is unsure whether her fertility has been irreversibly compromised; she has mental health issues and deals with episodes of anxiety and depression, complicated by the regret of feeling like she had made a mistake in choosing to transition (even though she knows that she was actually just a vulnerable young girl who was taken advantage of by people whom she trusted would take care of her); and she has since contracted Hashimotos's disease, an autoimmune disease that only the males in her family have a history of, from taking testosterone.

COUNT I

CIVIL CONSPIRACY

95. Plaintiff repeats and incorporates by reference all of the allegations contained in the complaint.

96. Between 2016 and 2018, certain of Defendants—including the AAP, Dr. Rafferty, Dr. Forcier, Dr. Allen, Dr. Sherer, and the Doe Defendants (the "Conspirator Defendants")—entered into an agreement to commit an unlawful act. Specifically, Conspirator Defendants agreed to

work towards and ultimately knowingly publish, promote, and profit off of—financially and otherwise—the fraudulent and misleading Gender Policy Statement. This unlawful agreement and continued deception of the public in furtherance of such agreement violates the Rhode Island Deceptive Trade Practices Act. R.I. Gen. Laws Ann. § 6-13.1-2. In entering into and carrying out their illegal agreement, which fraudulently and misleadingly misrepresents the evidence cited as supportive of their policy and proposed model for treating transgender and gender diverse children and adolescents and knowingly misrepresents the known risks and dangers of certain recommended medical interventions, Defendants (1) engaged in conduct that creates a likelihood of confusion or misunderstanding, (2) engaged in acts and practices that are unfair and deceptive to consumers in Rhode Island, and (3) used methods, acts, or practices that mislead or deceive members of the public in a material respect.

97. In connection with and in furtherance of their illegal agreement, certain Conspirator Defendants, including Defendants Dr. Rafferty and Dr. Forcier, implemented and tested the new, experimental model contained in the Gender Policy Statement in their private practices and public appearances.

98. In connection with and in furtherance of their illegal agreement, co-conspirators Dr. Rafferty and Dr. Forcier committed the intentional tort of fraud against Plaintiff, as detailed in Count II of this complaint, directly resulting in the damages Plaintiff has suffered.

99. WHEREFORE, Plaintiff demands judgment against the Conspirator Defendants, including compensatory and punitive damages. Plaintiff also requests attorney's fees and costs, and such other relief as this Court deems meet and just.

COUNT II

FRAUD

100. Plaintiff repeats and incorporates by reference all of the allegations contained in the complaint.

101. In February and March 2017, each of Defendants Dr. Rafferty, Dr. Morris, and Wagner (the "Fraud Defendants") provided Isabelle with psychological and/or medical guidance related to evaluating and initially treating her. Isabelle and each of her father and her mother entrusted Isabelle's care to such Defendants, believing that their recommendations would be in line with Isabelle's best interest and would be the product of their respective professional duties to subjugate their own personal, professional, and commercial interests when exercising their judgment in treating Isabelle.

102. With the intent that Isabelle and her parents would rely on such representations and would "consent" to starting a regiment of cross-sex hormones, each of the Fraud Defendants falsely represented that cross-sex hormone therapy was the only treatment option available to Isabelle to effectively treat her gender dysphoria, as well as her anxiety, depression, PTSD, and suicidality. They further knowingly fraudulently represented that cross-sex hormone treatment was the settled medical consensus and was based on sufficient and valid scientific evidence for treating patients such as herself.

103. The Fraud Defendants compounded these fraudulent misrepresentations and coerced Isabelle's mother into giving her "consent" by stating that if Isabelle did not start cross-sex hormone therapy, she would commit suicide.

104. Isabelle, as well as her parents, did rely on these misrepresentations and coercion and provided their consent—although not truly informed consent—to the cross-sex hormone treatment.

105. The cross-sex hormone treatment that Isabelle started that day an continued on caused the significant damage to Plaintiff, including, but not limited to, significant, unnecessary physical, mental, and emotional harm to Isabelle, as described in this complaint, the effects of which Isabelle still deals with today.

106. WHEREFORE, Plaintiff demands judgment against the Fraud Defendants, including compensatory and punitive damages. Plaintiff also requests attorney's fees and costs, and such other relief as this Court deems meet and just.

COUNT III

MEDICAL MALPRACTICE / GROSS NEGLIGENCE

107. Plaintiff repeats and incorporates by reference all of the allegations contained in the complaint.

108. Between December 2016 and July 2018, certain of the Defendants—including Defendants Dr. Rafferty, Dr. Forcier, Dr. Morris, Dr. Gibson, and Wagner (the "Malpractice Defendants")—provided Plaintiff with psychological and/or medical guidance related to her transgender-affirming care and care for her other significant mental health issues. This treatment created a valid doctor/patient relationship between each Defendant and Plaintiff.

109. As Isabelle's treating medical providers, each Malpractice Defendant incurred a duty to apply the applicable standards of care in recommending and prescribing Isabelle's treatments and therapies. Alternatively, in the event of treatments not yet subject to a widely accepted standard of care, Malpractice Defendants incurred a duty to act and exercise judgment in Isabelle's best medical interest and subjugate their own personal, professional, and commercial interests when exercising their professional judgment in treating Isabelle.

Malpractice Defendants' duties encompass the duty to exercise their judgment to bring about an outcome that involves the least amount of medical intervention possible.

110. Each of the Malpractice Defendants breached the duties owed to Isabelle by, including but not limited to, the following:

- Jason Rafferty, MD (Lifespan Physician Group, Inc.): Dr. Rafferty breached his duty to Isabelle by, among other things, failing to properly investigate her history, especially her extensive history of trauma, in connection with initially evaluating her stated reasons for seeking treatment. Rather than considering less invasive treatment options, or even presenting other courses of treatment as options to Isabelle and her parents, Dr. Rafferty accepted Isabelle's self-diagnosis and pressured her and her parents, and especially her mother, toward accepting gender transition treatments as the only viable option for Isabelle. Thereafter, Dr. Rafferty compartmentalized Isabelle's care (because it aligned with his broader professional goal of promoting the conspiracy) by seeking to manage her symptoms of depression, anxiety, and suicidality with increasing and further prescribing numerous additional medications in order to further her cross-sex hormone treatment, one of numerous instances where he put his own professional interest ahead of the best interest of Isabelle. Dr. Rafferty ignored glaring red flags throughout his treatment of Isabelle, including her attempted suicide and declining mental health, the occurrence of which should have caused him to stop or at least question the continued prescription of testosterone. Dr. Rafferty also continued to oversee her treatment, which included repeatedly increasing Isabelle's testosterone, something her mother never consented to.

- Michelle Forcier, MD (Lifespan Physician Group, Inc.): Dr. Forcier breached her duty by, among other things, failing to investigate other underlying causes of anxiety and distress that Isabelle may be experiencing that would explain why her suicidality and depression worsened months after starting cross-sex hormone therapy. She also had access to Isabelle's full medical records and should have done independent evaluation to determine whether Isabelle's mental health issues were related to her gender dysphoria or other sources, such as her extensive history of trauma.

- Meghan Gibson, MD (Lifespan Physician Group, Inc.): Dr. Gibson breached her duty by, among other things, tripling Isabelle's dosage of testosterone on her first follow-up visit after starting cross-sex hormone therapy, less than one month after the initial prescription, yet another example of Defendants' failure to exercise appropriate levels of

professional judgment in treating Isabelle. This high dosage was never consented to by Isabelle's mother.

- Gillian Morris, MD (Lifespan Physician Group, Inc.): Dr. Morris breached her duty by, among other things, coercing Isabelle and her parents into starting on testosterone by misrepresenting that no other treatment options existed treating her symptoms of depression, anxiety, and suicidality. Dr. Morris also had access to Isabelle's full medical records and should have done independent evaluation to determine whether Isabelle's mental health issues were related to her gender dysphoria or other sources, such as her extensive history of trauma.

- Jill Wagner, LCSW (Lifespan Physician Group, Inc.): Jill Wagner breached her duty by, among other things, coercing Isabelle and her parents into starting on testosterone by misrepresenting that no other treatment options would be effective at treating her symptoms of depression, anxiety, and suicidality. Wagner also failed to conduct any independent evaluation of Isabelle before agreeing to put her on cross-sex hormone therapy.

WHEREFORE, Plaintiff demands judgment against Malpractice Defendants including compensatory and punitive damages. Plaintiff also requests attorney's fees and costs, and such other relief as this Court deems meet and just.

COUNT IV

NEGLIGENCE AGAINST LIFESPAN PHYSICIAN GROUP, INC.

111. Plaintiff repeats and incorporates by reference all of the allegations contained in the complaint.

112. Between December 2016 and July 2018, Defendant Lifespan and its agents or employees provided Isabelle with medical care. As such, Isabelle was a patient of Lifespan and Lifespan owed Isabelle a duty to exercise reasonable care in hiring or extending privileges to the doctors it employed or allowed to provide services from its facilities. A health care facility breaches this duty when it hires or extends privileges to a doctor who exposes the patient to an unreasonable risk of harm.

113. During the time of Isabelle's treatments at Lifespan under the care of Dr. Rafferty and the Malpractice Defendants, the Malpractice Defendants had begun developing and employing a novel and untested treatment model that intentionally bypassed the generally accepted standard of care, which includes the standard practice of exploring the root-causes of a patient's gender dysphoria and proposing and ruling out alternative, less invasive therapies. Malpractice Defendants also failed to provide their patients, including Plaintiff, with informed consent. Lifespan was or should have been aware of such practices.

WHEREFORE, Plaintiff demands judgment against Defendant Lifespan including compensatory and punitive damages. Plaintiff also requests attorney's fees and costs, and such other relief as this Court deems meet and just.

COUNT V

LACK OF INFORMED CONSENT

114. Plaintiff repeats and incorporates by reference all of the allegations contained in the complaint.

115. Separate and distinct from their duties owed to Isabelle under the general standard of care, Malpractice Defendants owed a duty to fully address the known risks associated with the invasive "gender-affirming" treatments they pushed and to discuss all viable alternatives to such procedures.

116. Malpractice Defendants each breached this duty to provide and obtain informed consent by failing to address the risks of cross-sex hormone treatment (and indeed actually downplaying/minimizing known risks) and by failing to discuss or even present any other alternative treatments.

117. Because the Malpractice Defendants failed to provide the information necessary for informed consent and failed to discuss the viable, non-invasive alternatives to the "gender-affirming" treatments, Isabelle and her parents were misled into agreeing to take testosterone, which failed to address her underlying issues, and Isabelle now suffers from irreversible changes to her body.

WHEREFORE, Plaintiff demands judgment against Malpractice Defendants including compensatory and punitive damages. Plaintiff also requests attorney's fees and costs, and such other relief as this Court deems meet and just.

COUNT VI

VICARIOUS LIABILITY AGAINST LIFESPAN PHYSICIAN GROUP, INC.

118. Plaintiff repeats and incorporates by reference all of the allegations contained in the complaint.

119. At all times relevant, Malpractice Defendants were agents, principals, employees, or borrowed servants of Defendant Lifespan. Lifespan exercised control and/or supervision over Malpractice Defendants and their ability to practice under the Lifespan name and within its facilities. While in the course and scope of their duties or employment with Lifespan, Malpractice Defendants committed numerous acts of negligence and gross negligence that caused injury to Isabelle. Therefore, Lifespan is vicariously liable for the injuries caused by Malpractice Defendants' negligence and gross negligence under the doctrine of respondeat superior.

120. WHEREFORE, Plaintiff demands judgment against Defendant Lifespan including compensatory and punitive damages. Plaintiff also requests attorney's fees and costs, and such other relief as this Court deems meet and just.

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EXHIBIT A

Gender Policy Statement

[See attached.]

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

Jason Rafferty, MD, MPH, EdM, FAAP, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COMMITTEE ON ADOLESCENCE, SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS

abstract

FREE

As a traditionally underserved population that faces numerous health disparities, youth who identify as transgender and gender diverse (TGD) and their families are increasingly presenting to pediatric providers for education, care, and referrals. The need for more formal training, standardized treatment, and research on safety and medical outcomes often leaves providers feeling ill equipped to support and care for patients that identify as TGD and families. In this policy statement, we review relevant concepts and challenges and provide suggestions for pediatric providers that are focused on promoting the health and positive development of youth that identify as TGD while eliminating discrimination and stigma.

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Dr Rafferty conceptualized the statement, drafted the initial manuscript, reviewed and revised the manuscript, approved the final manuscript as submitted, and agrees to be accountable for all aspects of the work.

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INTRODUCTION

In its dedication to the health of all children, the American Academy of Pediatrics (AAP) strives to improve health care access and eliminate disparities for children and teenagers who identify as lesbian, gay, bisexual, transgender, or questioning (LGBTQ) of their sexual or gender identity.[1,2] Despite some advances in public awareness and legal protections, youth who identify as LGBTQ continue to face disparities that stem from multiple sources, including inequitable laws and policies, societal discrimination, and a lack of access to quality health care, including mental health care. Such challenges are often more intense for youth who do not conform to social expectations and norms regarding gender. Pediatric providers are increasingly encountering such youth and their families, who seek medical advice and interventions, yet they may lack the formal training to care for youth that identify as transgender and gender diverse (TGD) and their families.[3]

This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population, providing brief, relevant background on the basis of current available research

TABLE 1 Relevant Terms and Definitions Related to Gender Care

Term	Definition
Sex	An assignment that is made at birth, usually male or female, typically on the basis of external genital anatomy but sometimes on the basis of internal gonads, chromosomes, or hormone levels
Gender identity	A person's deep internal sense of being female, male, a combination of both, somewhere in between, or neither, resulting from a multifaceted interaction of biological traits, environmental factors, self-understanding, and cultural expectations
Gender expression	The external way a person expresses their gender, such as with clothing, hair, mannerisms, activities, or social roles
Gender perception	The way others interpret a person's gender expression
Gender diverse	A term that is used to describe people with gender behaviors, appearances, or identities that are incongruent with those culturally assigned to their birth sex; gender-diverse individuals may refer to themselves with many different terms, such as transgender, nonbinary, genderqueer,[7] gender fluid, gender creative, gender independent, or noncisgender. "Gender diverse" is used to acknowledge and include the vast diversity of gender identities that exists. It replaces the former term, "gender nonconforming," which has a negative and exclusionary connotation.
Transgender	A subset of gender-diverse youth whose gender identity does not match their assigned sex and generally remains persistent, consistent, and insistent over time; the term "transgender" also encompasses many other labels individuals may use to refer to themselves.
Cisgender	A term that is used to describe a person who identifies and expresses a gender that is consistent with the culturally defined norms of the sex they were assigned at birth
Agender	A term that is used to describe a person who does not identify as having a particular gender
Affirmed gender	When a person's true gender identity, or concern about their gender identity, is communicated to and validated from others as authentic
MTF; affirmed female; trans female	Terms that are used to describe individuals who were assigned male sex at birth but who have a gender identity and/or expression that is asserted to be more feminine
FTM; affirmed male; trans male	Terms that are used to describe individuals who were assigned female sex at birth but who have a gender identity and/or expression that is asserted to be more masculine
Gender dysphoria	A clinical symptom that is characterized by a sense of alienation to some or all of the physical characteristics or social roles of one's assigned gender; also, gender dysphoria is the psychiatric diagnosis in the *DSM-5*, which has focus on the distress that stems from the incongruence between one's expressed or experienced (affirmed) gender and the gender assigned at birth.
Gender identity disorder	A psychiatric diagnosis defined previously in the *DSM-IV* (changed to "gender dysphoria" in the *DSM-5*); the primary criteria include a strong, persistent cross-sex identification and significant distress and social impairment. This diagnosis is no longer appropriate for use and may lead to stigma, but the term may be found in older research.
Sexual orientation	A person's sexual identity in relation to the gender(s) to which they are attracted; sexual orientation and gender identity develop separately.

This list is not intended to be all inclusive. The pronouns "they" and "their" are used intentionally to be inclusive rather than the binary pronouns "he" and "she" and "his" and "her." Adapted from Bonifacio HJ, Rosenthal SM. Gender variance and dysphoria in children and adolescents. *Pediatr Clin North Am*. 2015;62(4):1001–1016. Adapted from Vance SR Jr, Ehrensaft D, Rosenthal SM. Psychological and medical care of gender nonconforming youth. *Pediatrics*. 2014;134(6):1184–1192. DSM-5, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*; FTM, female to male; MTF, male to female.

and expert opinion from clinical and research leaders, which will serve as the basis for recommendations. It is not a comprehensive review of clinical approaches and nuances to pediatric care for children and youth that identify as TGD. Professional understanding of youth that identify as TGD is a rapidly evolving clinical field in which research on appropriate clinical management is limited by insufficient funding.[3,4]

DEFINITIONS

To clarify recommendations and discussions in this policy statement, some definitions are provided. However, brief descriptions of human behavior or identities may not capture nuance in this evolving field. "Sex," or "natal gender," is a label, generally "male" or "female," that is typically assigned at birth on the basis of genetic and anatomic characteristics, such as genital anatomy, chromosomes, and sex hormone levels. Meanwhile, "gender identity" is one's internal sense of who one is, which results from a multifaceted interaction of biological traits, developmental influences, and environmental conditions. It may be male, female, somewhere in between, a combination of both, or neither (ie, not conforming to a binary conceptualization of gender). Self-recognition of gender identity develops over time, much the same way as a child's physical body does. For some people, gender identity can be fluid, shifting in different contexts. "Gender expression" refers to the wide array of ways people display their gender through clothing, hair styles, mannerisms, or social roles. Exploring different ways of expressing gender is common for children and may challenge social expectations. The way others interpret this expression is referred to as "gender perception" (Table 1).[5,6]

These labels may or may not be congruent. The term "cisgender" is used if someone identifies and expresses a gender that is consistent with the culturally defined norms of the sex that was assigned at birth. "Gender diverse" is an umbrella term to describe an ever-evolving array of labels that people may apply when their gender identity, expression, or even perception does not conform

to the norms and stereotypes others expect of their assigned sex. "Transgender" is usually reserved for a subset of such youth whose gender identity does not match their assigned sex and generally remains persistent, consistent, and insistent over time. These terms are not diagnoses; rather, they are personal and often dynamic ways of describing one's own gender experience.

Gender identity is not synonymous with "sexual orientation," which refers to a person's identity in relation to the gender(s) to which they are sexually and romantically attracted. Gender identity and sexual orientation are distinct but interrelated constructs.[8] Therefore, being transgender does not imply a sexual orientation, and people who identify as transgender still identify as straight, gay, bisexual, etc, on the basis of their attractions. (For more information, *The Gender Book*, found at www.thegenderbook.com, is a resource with illustrations that are used to highlight these core terms and concepts.)

EPIDEMIOLOGY

In population-based surveys, questions related to gender identity are rarely asked, which makes it difficult to assess the size and characteristics of the population that is TGD. In the 2014 Behavioral Risk Factor Surveillance System of the Centers for Disease Control and Prevention, only 19 states elected to include optional questions on gender identity. Extrapolation from these data suggests that the US prevalence of adults who identify as transgender or "gender nonconforming" is 0.6% (1.4 million), ranging from 0.3% in North Dakota to 0.8% in Hawaii.[9] On the basis of these data, it has been estimated that 0.7% of youth ages 13 to 17 years (~150 000) identify as transgender.[10] This number is much higher than previous estimates, which were extrapolated from individual states or specialty clinics, and is likely an underestimate given the stigma regarding those who openly identify as transgender and the difficulty in defining "transgender" in a way that is inclusive of all gender-diverse identities.[11]

There have been no large-scale prevalence studies among children and adolescents, and there is no evidence that adult statistics reflect young children or adolescents. In the 2014 Behavioral Risk Factor Surveillance System, those 18 to 24 years of age were more likely than older age groups to identify as transgender (0.7%).[9] Children report being aware of gender incongruence at young ages. Children who later identify as TGD report first having recognized their gender as "different" at an average age of 8.5 years; however, they did not disclose such feelings until an average of 10 years later.[12]

MENTAL HEALTH IMPLICATIONS

Adolescents and adults who identify as transgender have high rates of depression, anxiety, eating disorders, self-harm, and suicide.[13–20] Evidence suggests that an identity of TGD has an increased prevalence among individuals with autism spectrum disorder, but this association is not yet well understood.[21,22] In 1 retrospective cohort study, 56% of youth who identified as transgender reported previous suicidal ideation, and 31% reported a previous suicide attempt, compared with 20% and 11% among matched youth who identified as cisgender, respectively.[13] Some youth who identify as TGD also experience gender dysphoria, which is a specific diagnosis given to those who experience impairment in peer and/or family relationships, school performance, or other aspects of their life as a consequence of the incongruence between their assigned sex and their gender identity.[23]

There is no evidence that risk for mental illness is inherently attributable to one's identity of TGD. Rather, it is believed to be multifactorial, stemming from an internal conflict between one's appearance and identity, limited availability of mental health services, low access to health care providers with expertise in caring for youth who identify as TGD, discrimination, stigma, and social rejection.[24] This was affirmed by the American Psychological Association in 2008[25] (with practice guidelines released in 2015[8]) and the American Psychiatric Association, which made the following statement in 2012:

> *Being transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression.… [Such] discrimination and lack of equal civil rights is damaging to the mental health of transgender and gender variant individuals.*[26]

Youth who identify as TGD often confront stigma and discrimination, which contribute to feelings of rejection and isolation that can adversely affect physical and emotional well-being. For example, many youth believe that they must hide their gender identity and expression to avoid bullying, harassment, or victimization. Youth who identify as TGD experience disproportionately high rates of homelessness, physical violence (at home and in the community), substance abuse, and high-risk sexual behaviors.[5,6,12,27–31] Among the 3 million HIV testing events that were reported in 2015, the highest percentages of new infections were among women who identified as transgender[32] and were also at particular risk for not knowing their HIV status.[30]

GENDER-AFFIRMATIVE CARE

In a gender-affirmative care model (GACM), pediatric providers offer developmentally appropriate care that is oriented toward understanding and appreciating the youth's gender experience. A strong, nonjudgmental partnership with youth and their families can facilitate exploration of complicated emotions and gender-diverse expressions while allowing questions and concerns to be raised in a supportive environment.[5] In a GACM, the following messages are conveyed:

- transgender identities and diverse gender expressions do not constitute a mental disorder;
- variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender do not always reflect emerging gender identities;
- gender identity evolves as an interplay of biology, development, socialization, and culture; and
- if a mental health issue exists, it most often stems from stigma and negative experiences rather than being intrinsic to the child.[27,33]

The GACM is best facilitated through the integration of medical, mental health, and social services, including specific resources and supports for parents and families.[24] Providers work together to destigmatize gender variance, promote the child's self-worth, facilitate access to care, educate families, and advocate for safer community spaces where children are free to develop and explore their gender.[5] A specialized gender-affirmative therapist, when available, may be an asset in helping children and their families build skills for dealing with gender-based stigma, address symptoms of anxiety or depression, and reinforce the child's overall resiliency.[34,35] There is a limited but growing body of evidence that suggests that using an integrated affirmative model results in young people having fewer mental health concerns whether they ultimately identify as transgender.[24,36,37]

In contrast, "conversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. The Substance Abuse and Mental Health Services Administration has concluded that any therapeutic intervention with the goal of changing a youth's gender expression or identity is inappropriate.[33] Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29,39–42] The AAP described reparative approaches as "unfair and deceptive."[43] At the time of this writing,* conversion therapy was banned by executive regulation in New York and by legislative statutes in 9 other states as well as the District of Columbia.[44]

Pediatric providers have an essential role in assessing gender concerns and providing evidence-based information to assist youth and families in medical decision-making. Not doing so can prolong or exacerbate gender dysphoria and contribute to abuse and stigmatization.[35] If a pediatric provider does not feel prepared to address gender concerns when they occur, then referral to a pediatric or mental health provider with more expertise is appropriate. There is little research on communication and efficacy with transfers in care for youth who identify as TGD, particularly from pediatric to adult providers.

DEVELOPMENTAL CONSIDERATIONS

Acknowledging that the capacity for emerging abstract thinking in childhood is important to conceptualize and reflect on identity, gender-affirmation guidelines are being focused on individually tailored interventions on the basis of the physical and cognitive development of youth who identify as TGD.[45] Accordingly, research substantiates that children who are prepubertal and assert an identity of TGD know their gender as clearly and as consistently as their developmentally equivalent peers who identify as cisgender and benefit from the same level of social acceptance.[46] This developmental approach to gender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").[45,47] More robust and current research suggests that, rather than focusing on who a child will become, valuing them for who they are, even at a young age, fosters secure attachment and resilience, not only for the child but also for the whole family.[5,45,48,49]

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@ aap.org.

MEDICAL MANAGEMENT

Pediatric primary care providers are in a unique position to routinely inquire about gender development in children and adolescents as part of recommended well-child visits[50] and to be a reliable source of validation, support, and reassurance. They are often the first provider to be aware that a child may not identify as cisgender or that there may be distress related to a gender-diverse identity. The best way to approach gender with patients is to inquire directly and nonjudgmentally about their experience and feelings before applying any labels.[27,51]

Many medical interventions can be offered to youth who identify as TGD and their families. The decision of whether and when to initiate gender-affirmative treatment is personal and involves careful consideration of risks, benefits, and other factors unique to each patient and family. Many protocols suggest that clinical assessment of youth who identify as TGD is ideally conducted on an ongoing basis in the setting of a collaborative, multidisciplinary approach, which, in addition to the patient and family, may include the pediatric provider, a mental health provider (preferably with expertise in caring for youth who identify as TGD), social and legal supports, and a pediatric endocrinologist or adolescent-medicine gender specialist, if available.[6,28] There is no prescribed path, sequence, or end point. Providers can make every effort to be aware of the influence of their own biases. The medical options also vary depending on pubertal and developmental progression.

Clinical Setting

In the past year, 1 in 4 adults who identified as transgender avoided a necessary doctor's visit because of fear of being mistreated.[31] All clinical office staff have a role in affirming a patient's gender identity. Making flyers available or displaying posters related to LGBTQ health issues, including information for children who identify as TGD and families, reveals inclusivity and awareness. Generally, patients who identify as TGD feel most comfortable when they have access to a gender-neutral restroom. Diversity training that encompasses sensitivity when caring for youth who identify as TGD and their families can be helpful in educating clinical and administrative staff. A patient-asserted name and pronouns are used by staff and are ideally reflected in the electronic medical record without creating duplicate charts.[52,53] The US Centers for Medicare and Medicaid Services and the National Coordinator for Health Information Technology require all electronic health record systems certified under the Meaningful Use incentive program to have the capacity to confidentially collect information on gender identity.[54,55] Explaining and maintaining confidentiality procedures promotes openness and trust, particularly with youth who identify as LGBTQ.[1] Maintaining a safe clinical space can provide at least 1 consistent, protective refuge for patients and families, allowing authentic gender expression and exploration that builds resiliency.

Pubertal Suppression

Gonadotrophin-releasing hormones have been used to delay puberty since the 1980s for central precocious puberty.[56] These reversible treatments can also be used in adolescents who experience gender dysphoria to prevent development of secondary sex characteristics and provide time up until 16 years of age for the individual and the family to explore gender identity, access psychosocial supports, develop coping skills, and further define appropriate treatment goals. If pubertal suppression treatment is suspended, then endogenous puberty will resume.[20,57,58]

Often, pubertal suppression creates an opportunity to reduce distress that may occur with the development of secondary sexual characteristics and allow for gender-affirming care, including mental health support for the adolescent and the family. It reduces the need for later surgery because physical changes that are otherwise irreversible (protrusion of the Adam's apple, male pattern baldness, voice change, breast growth, etc) are prevented. The available data reveal that pubertal suppression in children who identify as TGD generally leads to improved psychological functioning in adolescence and young adulthood.[20,57–59]

Pubertal suppression is not without risks. Delaying puberty beyond one's peers can also be stressful and can lead to lower self-esteem and increased risk taking.[60] Some experts believe that genital underdevelopment may limit some potential reconstructive options.[61] Research on long-term risks, particularly in terms of bone metabolism[62] and fertility,[63] is currently limited and provides varied results.[57,64,65] Families often look to pediatric providers for help in considering whether pubertal suppression is indicated in the context of their child's overall well-being as gender diverse.

Gender Affirmation

As youth who identify as TGD reflect on and evaluate their gender identity, various interventions may be considered to better align their gender expression with their underlying identity. This process of reflection, acceptance, and, for some, intervention is known as "gender affirmation." It was formerly referred to as "transitioning," but many view the process as an affirmation and acceptance of who they have always been rather than a transition

TABLE 2 The Process of Gender Affirmation May Include ≥1 of the Following Components

Component	Definition	General Age Range[a]	Reversibility[a]
Social affirmation	Adopting gender-affirming hairstyles, clothing, name, gender pronouns, and restrooms and other facilities	Any	Reversible
Puberty blockers	Gonadotropin-releasing hormone analogues, such as leuprolide and histrelin	During puberty (Tanner stage 2–5)[b]	Reversible[c]
Cross-sex hormone therapy	Testosterone (for those who were assigned female at birth and are masculinizing); estrogen plus androgen inhibitor (for those who were assigned male at birth and are feminizing)	Early adolescence onward	Partially reversible (skin texture, muscle mass, and fat deposition); irreversible once developed (testosterone: Adam's apple protrusion, voice changes, and male pattern baldness; estrogen: breast development); unknown reversibility (effect on fertility)
Gender-affirming surgeries	"Top" surgery (to create a male-typical chest shape or enhance breasts); "bottom" surgery (surgery on genitals or reproductive organs); facial feminization and other procedures	Typically adults (adolescents on case-by-case basis[d])	Not reversible
Legal affirmation	Changing gender and name recorded on birth certificate, school records, and other documents	Any	Reversible

[a] Note that the provided age range and reversibility is based on the little data that are currently available.
[b] There is limited benefit to starting gonadotropin-releasing hormone after Tanner stage 5 for pubertal suppression. However, when cross-sex hormones are initiated with a gradually increasing schedule, the initial levels are often not high enough to suppress endogenous sex hormone secretion. Therefore, gonadotropin-releasing hormone may be continued in accordance with the Endocrine Society Guidelines.[68]
[c] The effect of sustained puberty suppression on fertility is unknown. Pubertal suppression can be, and often is indicated to be, followed by cross-sex hormone treatment. However, when cross-sex hormones are initiated without endogenous hormones, then fertility may be decreased.[68]
[d] Eligibility criteria for gender-affirmative surgical interventions among adolescents are not clearly defined between established protocols and practice. When applicable, eligibility is usually determined on a case-by-case basis with the adolescent and the family along with input from medical, mental health, and surgical providers.[68–71]

from 1 gender identity to another. Accordingly, some people who have gone through the process prefer to call themselves "affirmed females, males, etc" (or just "females, males, etc"), rather than using the prefix "trans-." Gender affirmation is also used to acknowledge that some individuals who identify as TGD may feel affirmed in their gender without pursuing medical or surgical interventions.[7,66]

Supportive involvement of parents and family is associated with better mental and physical health outcomes.[67] Gender affirmation among adolescents with gender dysphoria often reduces the emphasis on gender in their lives, allowing them to attend to other developmental tasks, such as academic success, relationship building, and future-oriented planning.[64] Most protocols for gender-affirming interventions incorporate World Professional Association of Transgender Health[35] and Endocrine Society[68] recommendations and include ≥1 of the following elements (Table 2):

1. Social Affirmation: This is a reversible intervention in which children and adolescents express partially or completely in their asserted gender identity by adapting hairstyle, clothing, pronouns, name, etc. Children who identify as transgender and socially affirm and are supported in their asserted gender show no increase in depression and only minimal (clinically insignificant) increases in anxiety compared with age-matched averages.[48] Social affirmation can be complicated given the wide range of social interactions children have (eg, extended families, peers, school, community, etc). There is little guidance on the best approach (eg, all at once, gradual, creating new social networks, or affirming within existing networks, etc). Pediatric providers can best support families by anticipating and discussing such complexity proactively, either in their own practice or through enlisting a qualified mental health provider.

2. Legal Affirmation: Elements of a social affirmation, such as a name and gender marker, become official on legal documents, such as birth certificates, passports, identification cards, school documents, etc. The processes for making these changes depend on state laws and may require specific documentation from pediatric providers.

3. Medical Affirmation: This is the process of using cross-sex hormones to allow adolescents who have initiated puberty to develop secondary sex characteristics of the opposite biological sex. Some changes are partially reversible if hormones are stopped, but others become

irreversible once they are fully developed (Table 2).

4. Surgical Affirmation: Surgical approaches may be used to feminize or masculinize features, such as hair distribution, chest, or genitalia, and may include removal of internal organs, such as ovaries or the uterus (affecting fertility). These changes are irreversible. Although current protocols typically reserve surgical interventions for adults,[35,68] they are occasionally pursued during adolescence on a case-by-case basis, considering the necessity and benefit to the adolescent's overall health and often including multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family.[69–71]

For some youth who identify as TGD whose natal gender is female, menstruation, breakthrough bleeding, and dysmenorrhea can lead to significant distress before or during gender affirmation. The American College of Obstetrics and Gynecology suggests that, although limited data are available to outline management, menstruation can be managed without exogenous estrogens by using a progesterone-only pill, a medroxyprogesterone acetate shot, or a progesterone-containing intrauterine or implantable device.[72] If estrogen can be tolerated, oral contraceptives that contain both progesterone and estrogen are more effective at suppressing menses.[73] The Endocrine Society guidelines also suggest that gonadotrophin-releasing hormones can be used for menstrual suppression before the anticipated initiation of testosterone or in combination with testosterone for breakthrough bleeding (enables phenotypic masculinization at a lower dose than if testosterone is used alone).[68] Masculinizing hormones in natal female patients may lead to a cessation of menses, but unplanned pregnancies have been reported, which emphasizes the need for ongoing contraceptive counseling with youth who identify as TGD.[72]

HEALTH DISPARITIES

In addition to societal challenges, youth who identify as TGD face several barriers within the health care system, especially regarding access to care. In 2015, a focus group of youth who identified as transgender in Seattle, Washington, revealed 4 problematic areas related to health care:

1. safety issues, including the lack of safe clinical environments and fear of discrimination by providers;
2. poor access to physical health services, including testing for sexually transmitted infections;
3. inadequate resources to address mental health concerns; and
4. lack of continuity with providers.[74]

This study reveals the obstacles many youth who identify as TGD face in accessing essential services, including the limited supply of appropriately trained medical and psychological providers, fertility options, and insurance coverage denials for gender-related treatments.[74]

Insurance denials for services related to the care of patients who identify as TGD are a significant barrier. Although the Office for Civil Rights of the US Department of Health and Human Services explicitly stated in 2012 that the nondiscrimination provision in the Patient Protection and Affordable Care Act includes people who identify as gender diverse,[75,76] insurance claims for gender affirmation, particularly among youth who identify as TGD, are frequently denied.[54,77] In 1 study, it was found that approximately 25% of individuals who identified as transgender were denied insurance coverage because of being transgender.[31] The burden of covering medical expenses that are not covered by insurance can be financially devastating, and even when expenses are covered, families describe high levels of stress in navigating and submitting claims appropriately.[78] In 2012, a large gender center in Boston, Massachusetts, reported that most young patients who identified as transgender and were deemed appropriate candidates for recommended gender care were unable to obtain it because of such denials, which were based on the premise that gender dysphoria was a mental disorder, not a physical one, and that treatment was not medically or surgically necessary.[24] This practice not only contributes to stigma, prolonged gender dysphoria, and poor mental health outcomes,[77] but it may also lead patients to seek nonmedically supervised treatments that are potentially dangerous.[24] Furthermore, insurance denials can reinforce a socioeconomic divide between those who can finance the high costs of uncovered care and those who cannot.[24,77]

The transgender youth group in Seattle likely reflected the larger TGD population when they described how obstacles adversely affect self-esteem and contribute to the perception that they are undervalued by society and the health care system.[74,77] Professional medical associations, including the AAP, are increasingly calling for equity in health care provisions regardless of gender identity or expression.[1,8,23,72] There is a critical need for investments in research on the prevalence, disparities, biological underpinnings, and standards of care relating to gender-diverse populations. Pediatric providers who work with state government and insurance officials can play an essential role in advocating for

stronger nondiscrimination policies and improved coverage.

There is a lack of quality research on the experience of youth of color who identify as transgender. One theory suggests that the intersection of racism, transphobia, and sexism may result in the extreme marginalization that is experienced among many women of color who identify as transgender,[79] including rejection from their family and dropping out of school at younger ages (often in the setting of rigid religious beliefs regarding gender),[80] increased levels of violence and body objectification,[81] 3 times the risk of poverty compared with the general population,[31] and the highest prevalence of HIV compared with other risk groups (estimated as high as 56.3% in 1 meta-analysis).[30] One model suggests that pervasive stigma and oppression can be associated with psychological distress (anxiety, depression, and suicide) and adoption of risk behaviors by such youth to obtain a sense of validation toward their complex identities.[79]

FAMILY ACCEPTANCE

Research increasingly suggests that familial acceptance or rejection ultimately has little influence on the gender identity of youth; however, it may profoundly affect young people's ability to openly discuss or disclose concerns about their identity. Suppressing such concerns can affect mental health.[82] Families often find it hard to understand and accept their child's gender-diverse traits because of personal beliefs, social pressure, and stigma.[49,83] Legitimate fears may exist for their child's welfare, safety, and acceptance that pediatric providers need to appreciate and address. Families can be encouraged to communicate their concerns and questions. Unacknowledged concerns can contribute to shame and hesitation in regard to offering support and understanding,[84] which is essential for the child's self-esteem, social involvement, and overall health as TGD.[48,85–87] Some caution has been expressed that unquestioning acceptance per se may not best serve questioning youth or their families. Instead, psychological evidence suggests that the most benefit comes when family members and youth are supported and encouraged to engage in reflective perspective taking and validate their own and the other's thoughts and feelings despite divergent views.[49,82]

In this regard, suicide attempt rates among 433 adolescents in Ontario who identified as "trans" were 4% among those with strongly supportive parents and as high as 60% among those whose parents were not supportive.[85] Adolescents who identify as transgender and endorse at least 1 supportive person in their life report significantly less distress than those who only experience rejection. In communities with high levels of support, it was found that nonsupportive families tended to increase their support over time, leading to dramatic improvement in mental health outcomes among their children who identified as transgender.[88]

Pediatric providers can create a safe environment for parents and families to better understand and listen to the needs of their children while receiving reassurance and education.[83] It is often appropriate to assist the child in understanding the parents' concerns as well. Despite expectations by some youth with transgender identity for immediate acceptance after "coming out," family members often proceed through a process of becoming more comfortable and understanding of the youth's gender identity, thoughts, and feelings. One model suggests that the process resembles grieving, wherein the family separates from their expectations for their child to embrace a new reality. This process may proceed through stages of shock, denial, anger, feelings of betrayal, fear, self-discovery, and pride.[89] The amount of time spent in any of these stages and the overall pace varies widely. Many family members also struggle as they are pushed to reflect on their own gender experience and assumptions throughout this process. In some situations, youth who identify as TGD may be at risk for internalizing the difficult emotions that family members may be experiencing. In these cases, individual and group therapy for the family members may be helpful.[49,78]

Family dynamics can be complex, involving disagreement among legal guardians or between guardians and their children, which may affect the ability to obtain consent for any medical management or interventions. Even in states where minors may access care without parental consent for mental health services, contraception, and sexually transmitted infections, parental or guardian consent is required for hormonal and surgical care of patients who identify as TGD.[72,90] Some families may take issue with providers who address gender concerns or offer gender-affirming care. In rare cases, a family may deny access to care that raises concerns about the youth's welfare and safety; in those cases, additional legal or ethical support may be useful to consider. In such rare situations, pediatric providers may want to familiarize themselves with relevant local consent laws and maintain their primary responsibility for the welfare of the child.

SAFE SCHOOLS AND COMMUNITIES

Youth who identify as TGD are becoming more visible because gender-diverse expression is increasingly admissible in the media, on social media, and in schools and communities. Regardless of whether a youth with a gender-diverse

identity ultimately identifies as transgender, challenges exist in nearly every social context, from lack of understanding to outright rejection, isolation, discrimination, and victimization. In the US Transgender Survey of nearly 28 000 respondents, it was found that among those who were out as or perceived to be TGD between kindergarten and eighth grade, 54% were verbally harassed, 24% were physically assaulted, and 13% were sexually assaulted; 17% left school because of maltreatment.[31] Education and advocacy from the medical community on the importance of safe schools for youth who identify as TGD can have a significant effect.

At the time of this writing,* only 18 states and the District of Columbia had laws that prohibited discrimination based on gender expression when it comes to employment, housing, public accommodations, and insurance benefits. Over 200 US cities have such legislation. In addition to basic protections, many youth who identify as TGD also have to navigate legal obstacles when it comes to legally changing their name and/or gender marker.[54] In addition to advocating and working with policy makers to promote equal protections for youth who identify as TGD, pediatric providers can play an important role by developing a familiarity with local laws and organizations that provide social work and legal assistance to youth who identify as TGD and their families.

School environments play a significant role in the social and emotional development of children. Every child has a right to feel safe and respected at school, but for youth who identify as TGD, this can be challenging. Nearly every aspect of school life may present safety concerns and require negotiations regarding their gender expression, including name/pronoun use, use of bathrooms and locker rooms, sports teams, dances and activities, overnight activities, and even peer groups. Conflicts in any of these areas can quickly escalate beyond the school's control to larger debates among the community and even on a national stage.

The formerly known Gay, Lesbian, and Straight Education Network (GLSEN), an advocacy organization for youth who identify as LGBTQ, conducts an annual national survey to measure LGBTQ well-being in US schools. In 2015, students who identified as LGBTQ reported high rates of being discouraged from participation in extracurricular activities. One in 5 students who identified as LGBTQ reported being hindered from forming or participating in a club to support lesbian, gay, bisexual, or transgender students (eg, a gay straight alliance, now often referred to as a genders and sexualities alliance) despite such clubs at schools being associated with decreased reports of negative remarks about sexual orientation or gender expression, increased feelings of safety and connectedness at school, and lower levels of victimization. In addition, >20% of students who identified as LGBTQ reported being blocked from writing about LGBTQ issues in school yearbooks or school newspapers or being prevented or discouraged by coaches and school staff from participating in sports because of their sexual orientation or gender expression.[91]

One strategy to prevent conflict is to proactively support policies and protections that promote inclusion and safety of all students. However, such policies are far from consistent across districts. In 2015, GLSEN found that 43% of children who identified as LGBTQ reported feeling unsafe at school because of their gender expression, but only 6% reported that their school had official policies to support youth who identified as TGD, and only 11% reported that their school's antibullying policies had specific protections for gender expression.[91] Consequently, more than half of the students who identified as transgender in the study were prevented from using the bathroom, names, or pronouns that aligned with their asserted gender at school. A lack of explicit policies that protected youth who identified as TGD was associated with increased reported victimization, with more than half of students who identified as LGBTQ reporting verbal harassment because of their gender expression. Educators and school administrators play an essential role in advocating for and enforcing such policies. GLSEN found that when students recognized actions to reduce gender-based harassment, both students who identified as transgender and cisgender reported a greater connection to staff and feelings of safety.[91] In another study, schools were open to education regarding gender diversity and were willing to implement policies when they were supported by external agencies, such as medical professionals.[92]

Academic content plays an important role in building a safe school environment as well. The 2015 GLSEN survey revealed that when positive representations of people who identified as LGBTQ were included in the curriculum, students who identified as LGBTQ reported less hostile school environments, less victimization and greater feelings of safety, fewer school absences because of feeling unsafe, greater feelings of connectedness to their school

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@ aap.org.

community, and an increased interest in high school graduation and postsecondary education.[91] At the time of this writing,* 8 states had laws that explicitly forbade teachers from even discussing LGBTQ issues.[54]

MEDICAL EDUCATION

One of the most important ways to promote high-quality health care for youth who identify as TGD and their families is increasing the knowledge base and clinical experience of pediatric providers in providing culturally competent care to such populations, as recommended by the recently released guidelines by the Association of American Medical Colleges.[93] This begins with the medical school curriculum in areas such as human development, sexual health, endocrinology, pediatrics, and psychiatry. In a 2009–2010 survey of US medical schools, it was found that the median number of hours dedicated to LGBTQ health was 5, with one-third of US medical schools reporting no LGBTQ curriculum during the clinical years.[94]

During residency training, there is potential for gender diversity to be emphasized in core rotations, especially in pediatrics, psychiatry, family medicine, and obstetrics and gynecology. Awareness could be promoted through the inclusion of topics relevant to caring for children who identify as TGD in the list of core competencies published by the American Board of Pediatrics, certifying examinations, and relevant study materials. Continuing education and maintenance of certification activities can include topics relevant to TGD populations as well.

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@ aap.org.

RECOMMENDATIONS

The AAP works toward all children and adolescents, regardless of gender identity or expression, receiving care to promote optimal physical, mental, and social well-being. Any discrimination based on gender identity or expression, real or perceived, is damaging to the socioemotional health of children, families, and society. In particular, the AAP recommends the following:

1. that youth who identify as TGD have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space;
2. that family-based therapy and support be available to recognize and respond to the emotional and mental health needs of parents, caregivers, and siblings of youth who identify as TGD;
3. that electronic health records, billing systems, patient-centered notification systems, and clinical research be designed to respect the asserted gender identity of each patient while maintaining confidentiality and avoiding duplicate charts;
4. that insurance plans offer coverage for health care that is specific to the needs of youth who identify as TGD, including coverage for medical, psychological, and, when indicated, surgical gender-affirming interventions;
5. that provider education, including medical school, residency, and continuing education, integrate core competencies on the emotional and physical health needs and best practices for the care of youth who identify as TGD and their families;
6. that pediatricians have a role in advocating for, educating, and developing liaison relationships with school districts and other community organizations to promote acceptance and inclusion of all children without fear of harassment, exclusion, or bullying because of gender expression;
7. that pediatricians have a role in advocating for policies and laws that protect youth who identify as TGD from discrimination and violence;
8. that the health care workforce protects diversity by offering equal employment opportunities and workplace protections, regardless of gender identity or expression; and
9. that the medical field and federal government prioritize research that is dedicated to improving the quality of evidence-based care for youth who identify as TGD.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
GACM: gender-affirmative care model
GLSEN: Gay, Lesbian, and Straight Education Network
LGBTQ: lesbian, gay, bisexual, transgender, or questioning
TGD: transgender and gender diverse

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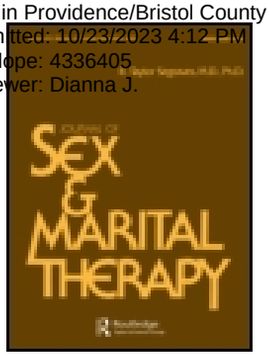
EXHIBIT B

Cantor Fact-Check

[See attached.]



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Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

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ABSTRACT

The American Academy of Pediatrics (AAP) recently published a policy statement: *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents*. Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping gender diverse (GD) children, the AAP statement instead rejected that consensus, endorsing *gender affirmation* as the only acceptable approach. Remarkably, not only did the AAP statement fail to include any of the actual outcomes literature on such cases, but it also misrepresented the contents of its citations, which repeatedly said the very opposite of what AAP attributed to them.

The American Academy of Pediatrics (AAP) recently published a policy statement entitled, *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents* (Rafferty, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, 2018). These are children who manifest discontent with the sex they were born as and desire to live as the other sex (or as some alternative gender role). The policy was quite a remarkable document: Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping transgender and gender diverse (GD) children, the AAP statement rejected that consensus, endorsing only *gender affirmation.* That is, where the consensus is to delay any transitions after the onset of puberty, AAP instead rejected waiting before transition. With AAP taking such a dramatic departure from other professional associations, I was immediately curious about what evidence led them to that conclusion. As I read the works on which they based their policy, however, I was pretty surprised—rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing *watchful waiting*.

The AAP statement was also remarkable in what it left out—namely, the actual outcomes research on GD children. In total, there have been 11 follow-up studies of GD children, of which AAP cited one (Wallien & Cohen-Kettenis, 2008), doing so without actually mentioning the outcome data it contained. The literature on outcomes was neither reviewed, summarized, nor subjected to meta-analysis to be considered in the aggregate—It was merely disappeared. (The list of all existing studies appears in the appendix.) As they make clear, *every* follow-up study of GD children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition. AAP is, of course, free to establish whatever policy it likes on

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whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false, as detailed below.

AAP divided clinical approaches into three types—conversion therapy, watchful waiting, and gender affirmation. It rejected the first two and endorsed *gender affirmation* as the only acceptable alternative. Most readers will likely be familiar already with attempts to use conversion therapy to change sexual orientation. With regard to gender identity, AAP wrote:

> "[C]onversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. … Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29,39–42]

The citations were:

38. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol.* 1994;62(2):221–227.

29. Adelson SL; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *J Am Acad Child Adolesc Psychiatry.* 2012;51(9):957–974.

39. Byne W. Regulations restrict practice of conversion therapy. *LGBT Health.* 2016;3(2):97–99.

40. Cohen-Kettenis PT, Delemarrevan de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. *J Sex Med.* 2008;5(8):1892–1897.

41. Bryant K. Making gender identity disorder of childhood: historical lessons for contemporary debates. *Sex Res Soc Policy.* 2006;3(3):23–39.

42. World Professional Association for Transgender Health. *WPATH De-Psychopathologisation Statement.* Minneapolis, MN: World Professional Association for Transgender Health; 2010.

AAP's claims struck me as odd because *there are no studies of conversion therapy for gender identity.* Studies of conversion therapy have been limited to *sexual orientation,* and, moreover, to the sexual orientation *of adults,* not to gender identity and not of children in any case. The article AAP cited to support their claim (reference number 38) is indeed a classic and well-known review, but it is a review of sexual orientation research *only.* Neither gender identity, nor even children, received a single mention in it. Indeed, the narrower scope of that article should be clear to anyone reading even just its title: "The practice and ethics of *sexual orientation* conversion therapy" [italics added].

AAP continued, saying that conversion approaches for GD children have already been rejected by medical consensus, citing five sources. This claim struck me as just as odd, however—I recalled associations banning conversion therapy for sexual orientation, but not for gender identity, exactly because there is no evidence for generalizing from adult sexual orientation to childhood gender identity. So, I started checking AAP's citations for that, and these sources too pertained only to sexual orientation, not gender identity (specifics below). What AAP's sources *did* repeatedly emphasize was that:

A. Sexual orientation of adults is unaffected by conversion therapy and any other [known] intervention;
B. Gender dysphoria in childhood before puberty desists in the majority of cases, becoming (cis-gendered) homosexuality in adulthood, again regardless of any [known] intervention; and
C. Gender dysphoria in childhood persisting after puberty tends to persist entirely.

That is, in the context of GD children, it simply makes no sense to refer to externally induced "conversion": The majority of children "convert" to cisgender or "desist" from transgender

regardless of any attempt to change them. "Conversion" only makes sense with regard to adult sexual orientation because (unlike childhood gender identity), adult homosexuality never or nearly never spontaneously changes to heterosexuality. Although gender identity and sexual orientation may often be analogous and discussed together with regard to social or political values and to civil rights, they are nonetheless distinct—with distinct origins, needs, and responses to medical and mental health care choices. Although AAP emphasized to the reader that "gender identity is not synonymous with 'sexual orientation'" (Rafferty et al., 2018, p. 3), they went ahead to treat them as such nonetheless.

To return to checking AAP's fidelity to its sources: Reference 29 was a practice guideline from the Committee on Quality Issues of the American Academy of Child and Adolescent Psychiatry (AACAP). Despite AAP applying this source to *gender identity,* AACAP was quite unambiguous regarding their intent to speak to sexual orientation and *only* to sexual orientation*:* "Principle 6. Clinicians should be aware that there is no evidence that *sexual orientation* can be altered through therapy, and that attempts to do so may be harmful. There is no established evidence that change in a predominant, enduring *homosexual* pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter *homosexuality*. Psychiatric efforts to alter *sexual orientation* through 'reparative therapy' *in adults* have found little or no change in *sexual orientation,* while causing significant risk of harm to self-esteem" (AACAP, 2012, p. 967, italics added).

Whereas AAP cites AACAP to support gender affirmation as the only alternative for treating GD children, AACAP's actual view was decidedly neutral, noting the lack of evidence: "Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed" (AACAP, 2012, p. 969). Moreover, whereas AAP rejected watchful waiting, what AACAP recommended was: "In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood" (AACAP, 2012, p. 969). So, not only did AAP attribute to AACAP something AACAP never said, but also AAP withheld from readers AACAP's actual view.

Next, in reference 39, Byne (2016) also addressed only sexual orientation, doing so very clearly: "Reparative therapy is a subset of conversion therapies based on the premise that *same-sex attraction* are reparations for childhood trauma. Thus, practitioners of reparative therapy believe that exploring, isolating, and repairing these childhood emotional wounds will often result in reducing *same-sex attractions*" (Byne, 2016, p. 97). Byne does not say this of gender identity, as the AAP statement misrepresents.

In AAP reference 40, Cohen-Kettenis et al. (2008) did finally pertain to gender identity; however, this article never mentions conversion therapy. (!) Rather, in this study, the authors presented that clinic's lowering of their minimum age for cross-sex hormone treatment from age 18 to 16, which they did on the basis of a series of studies showing the high rates of success with this age group. Although it did strike me as odd that AAP picked as support against conversion therapy an article that did not mention conversion therapy, I could imagine AAP cited the article as an example of what the "mainstream of traditional medical practice" consists of (the logic being that conversion therapy falls outside what an 'ideal' clinic like this one provides). However, what this clinic provides is the very *watchful waiting* approach that AAP rejected. The approach

espoused by Cohen-Kettenis (and the other clinics mentioned in the source—Gent, Boston, Oslo, and now formerly, Toronto) is to make puberty-halting interventions available at age 12 because: "[P]ubertal suppression may give adolescents, together with the attending health professional, more time to explore their gender identity, without the distress of the developing secondary sex characteristics. The precision of the diagnosis may thus be improved" (Cohen-Kettenis et al., 2008, p. 1894).

Reference 41 presented a very interesting history spanning the 1960s–1990s about how feminine boys and tomboyish girls came to be recognized as mostly pre-homosexual, and how that status came to be entered into the DSM at the same time as homosexuality was being *removed* from the DSM. Conversion therapy is never mentioned. Indeed, to the extent that Bryant mentions treatment at all, it is to say that treatment is entirely irrelevant to his analysis: "An important omission from the *DSM* is a discussion of the kinds of treatment that GIDC children should receive. (This omission is a general orientation of the DSM and not unique to GIDC)" (Bryant, 2006, p. 35). How this article supports AAP's claim is a mystery. Moreover, how AAP could cite a 2006 history discussing events of the 1990s and earlier to support a claim about the *current* consensus in this quickly evolving discussion remains all the more unfathomable.

Cited last in this section was a one-paragraph press release from the World Professional Association for Transgender Health. Written during the early stages of the American Psychiatric Association's (APA's) update of the DSM, the statement asserted simply that "The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide." Very reasonable debate can (and should) be had regarding whether gender dysphoria should be removed from the DSM as homosexuality was, and WPATH was well within its purview to assert that it should. Now that the DSM revision process is years completed however, history has seen that APA ultimately retained the diagnostic categories, rejecting WPATH's urging. This makes AAP's logic entirely backwards: That WPATH's request to depathologize gender dysphoria was *rejected* suggests that it is *WPATH's* view—and therefore the AAP policy—which fall "outside the mainstream of traditional medical practice." (!)

AAP based this entire line of reasoning on their belief that conversion therapy is being used "to prevent children and adolescents from identifying as transgender" (Rafferty et al., 2018, p. 4). That claim is left without citation or support. In contrast, what is said by AAP's sources is "delaying affirmation should *not* be construed as conversion therapy or an attempt to change gender identity" in the first place (Byne, 2016, p. 2). Nonetheless, AAP seems to be doing exactly that: simply relabeling any alternative approach as equivalent to conversion therapy.

Although AAP (and anyone else) may reject (what they label to be) conversion therapy purely on the basis of political or personal values, there is no evidence to back the AAP's stated claim about the existing science on gender identity at all, never mind gender identity of children.

AAP also dismissed the watchful waiting approach out of hand, not citing any evidence, but repeatedly calling it "outdated." The criticisms AAP provided, however, again defied the existing evidence, with even its own sources repeatedly calling watchful waiting the current standard. According to AAP:

> [G]ender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").[45,47]

The citations from AAP's reference list are:

45. Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Keo-Meier C. Prepubertal social gender transitions: what we know; what we can learn—a view from a gender affirmative lens. *Int J Transgend.* 2018;19(2):251–268

47. Olson KR. Prepubescent transgender children: what we do and do not know. *J Am Acad Child Adolesc Psychiatry.* 2016;55(3):155–156.e3

I was surprised first by the AAP's claim that watchful waiting's delay to puberty was somehow "arbitrary." The literature, including AAP's sources, repeatedly indicated the pivotal importance of puberty, noting that outcomes strongly diverge at that point. According to AAP reference 29, in "*prepubertal* boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance" (Adelson & AACAP, 2012, p. 963, italics added), whereas "when gender variance with the desire to be the other sex is present *in adolescence,* this desire usually does persist through adulthood" (Adelson & AACAP, 2012, p. 964, italics added). Similarly, according to AAP reference 40, "Symptoms of GID *at prepubertal ages* decrease or even disappear in a considerable percentage of children (estimates range from 80–95%). Therefore, any intervention in childhood would seem premature and inappropriate. However, GID persisting *into early puberty* appears to be highly persistent" (Cohen-Kettenis et al., 2008, p. 1895, italics added). That follow-up studies of prepubertal transition differ from postpubertal transition is the very meaning of non-arbitrary. AAP gave readers exactly the reverse of what was contained in its own sources. If AAP were correct in saying that puberty is an arbitrarily selected age, then AAP will be able to offer another point to wait for with as much empirical backing as puberty has.

Next, it was not clear on what basis AAP could say that watchful waiting withholds support—AAP cited no support for its claim. The people in such programs often receive substantial support during this period. Also unclear is on what basis AAP could already know exactly which treatments are "critical" and which are not—Answering that question is the very purpose of this entire endeavor. Indeed, the logic of AAP's claim appears entirely circular: It is only if one were already pre-convinced that gender affirmation is the only acceptable alternative that would make watchful waiting seem to withhold critical support—What it delays is gender affirmation, the method one has already decided to be critical.

Although AAP's next claim did not have a citation appearing at the end of its sentence, binary notions of gender were mentioned both in references 45 and 47. Specifically, both pointed out that existing outcome studies have been about people transitioning from one sex to the other, rather than from one sex to an in-between status or a combination of masculine/feminine features. Neither reference presented this as a reason to reject the results from the existing studies of complete transition however (which is how AAP cast it). Although it is indeed true that the outcome data have been about complete transition, some future study showing that partial transition shows a different outcome would not invalidate what is known about complete transition. Indeed, data showing that partial transition gives better outcomes than complete transition would, once again, support the watchful waiting approach which AAP rejected.

Next was a vague reference alleging concerns and criticisms about early studies. Had AAP indicated what those alleged concerns and flaws were (or which studies they were), then it would be possible to evaluate or address them. Nonetheless, the argument is a red herring: Because all of the later studies showed the same result as did the early studies, any such allegation is necessarily moot.

Reference 47 was a one-and-a-half page commentary in which the author off-handedly mentions criticisms previously made of three of the eleven outcome studies of GD children, but does not provide any analysis or discussion. The only specific claim was that studies (whether early or late) had limited follow-up periods—the logic being that had outcome researchers lengthened the follow-up period, then people who seemed to have desisted might have returned to the clinic as

cases of "persistence-after-interruption." Although one could debate the merits of that prediction, AAP instead simply withheld from the reader the result from the original researchers having tested that very prediction directly: Steensma and Cohen-Kettenis (2015) conducted another analysis of their cohort, by then ages 19–28 (mean age 25.9 years), and found that 3.3% (5 people of the sample of 150) later returned. That is, in long-term follow-up, the childhood sample showed 66.7% desistence instead of 70.0% desistance.

Reference 45 did not support the claim that watchful-waiting is "outdated" either. Indeed, that source said the very opposite, explicitly referring to watchful waiting as the *current* approach: "Put another way, if clinicians are straying from SOC 7 guidelines for social transitions, not abiding by the watchful waiting model *favored by the standards,* we will have adolescents who have been consistently living in their affirmed gender since age 3, 4, or 5" (Ehrensaft et al., 2018, p. 255). Moreover, Ehrensaft et al. said there are cases in which they too would still use watchful waiting: "When a child's gender identity is unclear, the watchful waiting approach can give the child and their family time to develop a clearer understanding and is not necessarily in contrast to the needs of the child" (p. 259). Ehrensaft et al. are indeed critical of the watchful waiting model (which they feel is applied too conservatively), but they do not come close to the position the AAP policy espouses. Where Ehrensaft summaries the potential benefits and potential risks both to transitioning and not transitioning, the AAP presents an ironically binary narrative.

In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all. AAP claimed, "This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population"; however, much of that evidence was about sexual orientation, not gender identity. AAP claimed, "Current available research and expert opinion from clinical and research leaders … will serve as the basis for recommendations" (pp. 1–2); however, they provided recommendations entirely unsupported and even in direct opposition to that research and opinion.

AAP is advocating for something far in excess of mainstream practice and medical consensus. In the presence of compelling evidence, that is just what is called for. The problems with Rafferty, however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide compelling evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence.

Disclosure statement

No potential conflict of interest was reported by the author.

References

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Steensma, T. D., & Cohen-Kettenis, P. T. (2015). More than two developmental pathways in children with gender dysphoria? *Journal of the American Academy of Child and Adolescent Psychiatry*, *52*, 147–148. doi:10.1016/j.jaac.2014.10.016

Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*, 1413–1423. doi:10.1097/CHI.0b013e31818956b9

Appendix

Count	Group	Study
2/16 4/16 10/16	gay* trans-/crossdress straight*/uncertain	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry, 128,* 1283–1289.
2/16 2/16 12/16	trans- uncertain gay	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. *Comprehensive Psychiatry, 19,* 363–369.
0/9 9/9	trans- gay	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology, 4,* 29–41.
2/45 10/45 33/45	trans-/crossdress uncertain gay	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172,* 90–97.
1/10 2/10 3/10 4/10	trans- gay uncertain straight	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior, 15,* 511–517.
1/44 43/44	trans- cis-	Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.
0/8 8/8	trans- cis-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia, 146,* 565–569.
21/54 33/54	trans- cis-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 1413–1423.
3/25 6/25 16/25	trans- lesbian/bi- straight	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*, 34–45.
17/139 122/139	trans- cis-	Singh, D. (2012). *A follow-up study of boys with gender identity disorder*. Unpublished doctoral dissertation, University of Toronto.
47/127 80/127	trans- cis-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 582–590.

*For brevity, the list uses "gay" for "gay and cis-", "straight" for "straight and cis-", etc.