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**By Email and Hand Delivery**

February 9, 2026

April J. Tabor
Secretary
Office of the Secretary
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580
atabor@ftc.gov

**Re: FTC Matter No. P264800**

Dear Madam Secretary:

Pursuant to 16 C.F.R. § 2.10 and § 4.2, enclosed please find American Academy of Pediatrics' Petition to Quash or Limit the United States Federal Trade Commission's Civil Investigative Demand dated January 15, 2026, in the above-referenced matter.

Respectfully submitted,

Laura Kim

Enclosures

cc: Via Email

Office of the Secretary
Jonathan Cohen
Gregory Ashe
Annie Chiang
Jennie Hitchcock
Hans Clausen

Via Hand Delivery

Office of the Secretary

**PUBLIC**

**BEFORE THE UNITED STATES**
**FEDERAL TRADE COMMISSION**

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| In the Matter of | ) | **PUBLIC** |
| Civil Investigative Demand dated January 15, 2026, to American Academy of Pediatrics | ) | File No. P264800 |

## PETITION TO QUASH OR LIMIT CIVIL INVESTIGATIVE DEMAND

Pursuant to 16 C.F.R. § 2.10(a), Petitioner American Academy of Pediatrics requests that the Federal Trade Commission ("FTC" or "Commission") quash the Civil Investigative Demand dated January 15, 2026 (the "CID," attached as Exhibit 1). The CID should be quashed in its entirety because it: (1) exceeds the scope of the Commission's authority to investigate; (2) violates the First Amendment; (3) was not issued pursuant to a Commission Resolution; and (4) is overbroad and unduly burdensome.

## BACKGROUND AND PROCEDURAL HISTORY

The American Academy of Pediatrics ("AAP") is an Illinois-based 501(c)(3) non-profit organization. For nearly 100 years, AAP has been dedicated to improving the health of all children. *See* AAP Articles of Incorporation, attached as Exhibit 2. As part of that mission, AAP has issued clinical guidance, such as its 2018 Policy Statement and 2023 Reaffirmation of that Statement (attached as Exhibit 3), to educate medical professionals about gender-affirming care ("GAC") for youth with gender dysphoria.[1] The medical community recognizes GAC as the appropriate treatment for those youth. As with any medical treatment, the decision to begin GAC

[1] Gender dysphoria is a condition characterized by clinically significant distress or impairment in social, occupational, or other important areas of functioning due to an incongruence between a patient's gender identity and sex assigned at birth.

is an individualized one that should be made in consultation with the patient's family and medical professionals. AAP's guidance materials are offered for free to the public.[2] Importantly, AAP does not offer or advertise GAC or any medical products or services to patients.

On January 20, 2025, the President elevated FTC Commissioner Andrew Ferguson to Chairman.[3] In accepting this role, the Chairman confirmed the agency would be acting "[u]nder the President's leadership."[4] Eight days later, the President signed Executive Order No. 14187 directing various executive branch agencies to "end" the practice of GAC.[5] In March 2025, the Chairman voiced his support for the President's firing of Democratic commissioners, stating that the President "is vested with all of the executive power in our government."[6] In July 2025, the FTC held a workshop entitled, "The Dangers of 'Gender-Affirming Care' For Minors."[7] Chairman Ferguson asserted that the workshop was about "the parents and kids the Biden Administration chose to ignore" and "healing the wounds that proponents of [GAC] may have inflicted on our nation's children and parents, and preventing the potential for future harm."[8]

On January 15, 2026, the FTC issued the CID to AAP. The CID identifies the "Subject of Investigation" as:

> Whether the Organization, or any other Person . . . have made, or assisted others in making, false or unsubstantiated representations or engaged in unfair practices in

[2] *See* Exhibit 3.

[3] *See* Press Release, FTC, Andrew N. Ferguson Takes Over as FTC Chairman (Jan. 22, 2025), https://perma.cc/ZSN6-RNAC.

[4] *See id.*

[5] Exec. Order No. 14187, 90 Fed. Reg. 8771 (Jan. 28, 2025).

[6] Statement of Chairman Andrew N. Ferguson, FTC (Mar. 18, 2025), https://perma.cc/C9G9-WBCT.

[7] FTC, The Dangers of "Gender-Affirming Care" for Minors (July 9, 2025), https://perma.cc/8UEN-AFV8.

[8] Transcript of Chairman Ferguson's Address at the Workshop, FTC (July 9, 2025), https://perma.cc/B6TR-PMUY.

> connection with the marketing and advertising of Pediatric Gender Dysphoria Treatment [("PGDT")] . . . [,] which, according to the Organization, purports to treat gender dysphoric or gender diverse minors, to consumers in violation of Sections 5 and 12 of the FTC Act[.]

The "Organization" is defined as AAP and its subsidiaries, directors, officers, members, employees, agents, consultants, and other persons working for or on behalf of the foregoing. AAP met and conferred with Commission staff on February 2, 2026, and raised the concerns discussed in this petition, as required by 16 C.F.R. § 2.7(k). AAP requested an extension of the Petition to Quash deadline to continue to meet-and-confer about the CID, but staff refused without a commitment from AAP to produce materials by February 16.

## ARGUMENT

The FTC's "[s]ubpoena enforcement power is not limitless." *FTC v. Ken Roberts Co.*, 276 F.3d 583, 586 (D.C. Cir. 2001). Instead, this power is circumscribed by the Fourth Amendment, which permits compulsory process only if the inquiry is within the Commission's authority, the demand is not too indefinite, and the information sought is reasonably relevant to the inquiry. *United States v. Morton Salt Co.*, 338 U.S. 632, 652 (1950). Furthermore, when the materials sought by an administrative subpoena implicate First Amendment protections, the Fourth Amendment's standards must be met with "scrupulous exactitude." *Zurcher v. Stan. Daily*, 436 U.S. 547, 564 (1978).

The CID fails to satisfy these standards. *First*, the CID targets AAP statements and activities that are beyond the FTC's regulatory authority because they are not "in or affecting commerce." The requests for AAP's statements and deliberations about GAC and its policy-development history have no relevance to any lawful inquiry into possible violations of Sections 5 or 12. *Second*, the CID purports to investigate AAP for violating the FTC Act, but AAP clearly falls outside the FTC's authority to enforce against "persons, partnerships, or corporations."

Insofar as the CID targets AAP, it demands information that has no relevance to a possible Section 5 or 12 violation. *Third*, the CID violates the First Amendment by targeting protected scientific, medical, and policy speech, compelling disclosure of AAP's associational materials, and constituting retaliation. *Fourth*, the CID was not issued pursuant to a Commission Resolution. *Finally*, the CID is overbroad and unduly burdensome.

## I. The CID's Scope Exceeds the Commission's Authority to Investigate.

The Commission may issue a CID whenever it has "reason to believe that any person may . . . have any information, relevant to unfair or deceptive acts or practices in or affecting commerce (within the meaning of section 45(a)(1) of this title)." 15 U.S.C. § 57b-1(c)(1). This CID fails to meet that requirement because it seeks information that has no relevance to potential FTC Act violations and is thus plainly outside the scope of the FTC's investigatory authority. *First*, the CID targets non-commercial activities and statements, which the FTC Act does not authorize. *Second,* the CID identifies AAP as a potential FTC Act violator, even though it is not a "person, partnership, or corporation" that *could* violate the FTC Act. *Third*, given these points, there is no legitimate purpose for which the CID could have been issued. In fact, the CID violates AAP's First Amendment rights.

### A. The CID Targets Non-Commercial Activities.

The FTC's authority is limited to acts or practices "in or affecting commerce." *See* 15 U.S.C. § 45(a)(1); *see also In re R.J. Reynolds Tobacco Co.*, 1988 WL 490114, *2 (1988) ("[U]nless the . . . advertisement can be classified as commercial speech, it is not subject to the Commission's jurisdiction."). The CID, however, seeks information about AAP statements and activities that are plainly non-commercial and thus outside the scope of the FTC's jurisdiction.

At its core, commercial speech "propose[s] a commercial transaction." *See Bolger v. Youngs Drug Prods. Corp.*, 463 U.S. 60, 64 (1983). The Commission looks to multiple factors to determine if speech is commercial: (1) the speech's content, including whether it promotes demand for a product/service or refers to the attributes of a product/service, such as type, price, quality, or health effects; (2) the means used to publish the speech, including whether it is paid-for; and (3) the speaker's commercial motivation. *See In re R.J. Reynolds Tobacco Co.*, 1988 WL 490114, *3–*5.

AAP's speech and activities satisfy none of these factors. The targeted speech is clinical guidance reflecting scientific research and evidence-based strategies regarding GAC that AAP publishes to help medical professionals support their patients and their families in making informed, individualized health decisions. The guidance emphasizes that decisions about GAC must be made on a case-by-case basis in consultation with family and a qualified medical professional. It discusses potential health effects associated with GAC for the sole purpose of informing clinical judgment—not to shape consumer preferences or steer treatment choices. AAP does not recommend specific providers, nor does it direct, refer, or encourage patients to seek any particular GAC treatments, therapies, clinics or other services. And AAP does not play any role in pricing, prescribing, or providing GAC treatment to patients. In short, AAP's activities are far removed from any effort to generate commercial demand.

Moreover, AAP provides its GAC guidance, and other guidance on a variety of pediatric health conditions, to the public for free, regardless of membership status. Though some practitioners might receive access to AAP guidance statements in connection with paid conferences, workshops, trainings, or compendia, the guidance statements are—and always have been—free to the public. AAP does not pay to advertise its GAC guidance. AAP is a non-profit

organization focused on improving children's health and has no commercial motive in issuing it. The FTC cannot plausibly claim that AAP issued this GAC guidance to generate membership or sales where the guidance is freely available to the non-member public, accessing the guidance in no way impacts membership eligibility or dues, and AAP's GAC policy statement is one of many sets of clinical guidance AAP issues regarding a variety of pediatric health concerns.

The recent decision in *FTC v. Agora Financial, LLC* confirms that AAP's statements are non-commercial speech that falls outside the FTC's jurisdiction. *See* 447 F. Supp. 3d 350 (D. Md. 2020). In *Agora*, the FTC sued the sellers of a medical publication called "The Doctor's Guide" that provided recommendations on how to manage Type 2 diabetes. *Id.* at 355–56. The FTC conceded that it did not seek to regulate the book—only ads for the book—and the court agreed that the book's content was non-commercial speech that "lies outside of the FTC's jurisdiction." *Id.* at 364; *see also id.* at 366 ("The FTC . . . [is] charged with protecting consumers from false or misleading advertising of products being sold, not from being exposed to novel or unproven medical ideas contained in health-related publications."). AAP's GAC guidance is directly analogous; it is medical and scientific speech contained in a health-related publication. AAP does not sell GAC or advertise its GAC guidance. The FTC thus has no basis to assert jurisdiction over AAP's speech or activities.[9] For this reason, the CID should be quashed.

[9] For the same reasons, AAP's speech cannot be considered "advertisements" under Section 12. *See In re R.J. Reynolds Tobacco Co.*, 1988 WL 490114, *6 (defining Commission's understanding of "advertisement" as "a notice or announcement that is publicly published or broadcast and is paid-for").

B. AAP is a Non-Profit and Not a Person, Partnership, or Corporation.

Section 5 prohibits "persons, partnerships, or corporations" from engaging in unfair or deceptive acts or practices "in or affecting commerce." 15 U.S.C. § 45(a)(1)–(2). Section 4 limits "corporation" to an entity "organized to carry on business for its own profit or that of its members." *Id.* § 44. Because AAP was not organized for that purpose, the CID—by purporting to investigate AAP as a potential FTC Act violator—seeks information not relevant to any lawful enforcement purpose. The CID must therefore be quashed, or at a minimum, substantially narrowed.

The Supreme Court decision *California Dental Association v. FTC* confirms that Section 4's definition of "corporation" reaches a non-profit membership association where its activities "plainly fall within the object of enhancing its members' profit"—which AAP's do not. *See* 526 U.S. 756, 767 (1999) (citation omitted). There, the Court held that a trade association of dentists qualified as a "corporation" because it conferred substantial economic benefits on its members through litigation, marketing, lobbying, and public relations for the benefit of members' interests, and by offering members advantageous insurance arrangements and preferential financing for real estate, equipment, cars, or patients' bills—through its own for-profit subsidiaries. *Id.* at 760, 767. That "congeries of activities" conferred "far more than *de minimis*" economic benefits on its members, bringing it within the FTC's jurisdiction. *Id.* at 766–68.

AAP, by contrast, engages in no such "congeries of activities." While AAP's members have access to discounted insurance rates and third-party vendor services such as meal kits, car rentals, office supply purchases, and website hosting,[10] these benefits are incidental to AAP's mission and thus distinguishable from *California Dental*, where the contributions to individual

[10] *Member Advantage Programs*, AAP (last accessed Feb. 7, 2026), https://perma.cc/X7R7-FZQX.

members' profits were "proximate and apparent." *Id.* at 766–67. Because AAP's ongoing operations confer no more than *de minimis* economic benefits on its members, AAP is not a "corporation" that can violate the FTC Act. *Id.* at 767 ("the FTC Act does not cover all membership organizations of profit-making corporations *without more*") (emphasis added).

Even where membership in an organization incidentally confers more than *de minimis* economic benefits, the FTC still must show the organization was "organized" to profit itself or its members to assert jurisdiction. In *American Medical Association v. FTC*, the Second Circuit concluded the American Medical Association qualified as a "corporation" in part because its organizing documents included an objective to "safeguard the material interests of the medical profession" (i.e., its members), and the record showed lobbying and business advice benefiting its members. 638 F.2d 443, 448 (2d Cir. 1980). By contrast, AAP's Articles of Incorporation reflect the opposite—an objective to "foster and stimulate interest in pediatrics and correlate all aspects of the work for the welfare of children . . . [and] to promote publications and encourage contributions to medical and scientific literature pertaining to pediatrics . . . *none of which objects is for pecuniary profit.*" *See* Exhibit 2 (emphasis added). *Accord FTC v. Grand Canyon Educ., Inc.,* 745 F. Supp. 3d 803, 819–20, 823–24 (D. Ariz. 2024) (emphasizing Section 4's "organized to" language and rejecting an attempt to substitute how an entity "*has been operated*" for the statute's organizing-purpose requirement).

Accordingly, insofar as the CID investigates AAP as the "Organization" that may have violated the FTC Act, it exceeds the Commission's authority and must be quashed or substantially limited.

C. The CID Was Issued for An Improper Purpose.

Supreme Court precedent requires that an investigation have a "legitimate purpose." *United States v. Powell*, 379 U.S. 48, 57–58 (1964). Here, where the CID targets activities that patently fall outside the scope of the FTC's authority to regulate, and where the CID raises constitutional concerns, the CID lacks a legitimate investigative purpose.

## II. The CID Violates AAP's First Amendment Rights.

The First Amendment prohibits the government from "restrict[ing] expression because of its message, its ideas, its subject matter, or its content." *Nat'l Inst. of Fam. & Life Advocs. v. James*, 160 F.4th 360, 373 (2d Cir. 2025) ("*NIFLA*"). Content-based speech regulations are generally subject to strict scrutiny.

The Commission should quash the CID because it abridges AAP's First Amendment rights in three ways: (1) the CID is a content-based restriction that risks chilling medical discourse, which triggers heightened scrutiny and requires narrow tailoring even at the investigative stage; (2) the CID's demands for the identities of AAP's associates and deliberations about the development of GAC guidance violate AAP's right to freely associate; and (3) the CID constitutes retaliation. Even if AAP's speech were deemed commercial and "subject to a less-exacting standard of judicial scrutiny," *id.* at 373–74, the CID does not pass intermediate scrutiny.

A. The CID Will Chill Medical Discourse.

The CID is a content-based restriction on AAP's non-commercial speech. As described in Section I, AAP's statements are non-commercial and thus entitled to the highest level of First Amendment protection. *See id.* at 375 (affirming conclusion that non-profits' statements about abortion pill reversal ("APR") were likely not commercial because non-profits provided free information about APR, did not sell APR, and received no commission, fee, or other renumeration

from referrals made to third-party providers). To conclude otherwise "could potentially subject a sweeping range of non-profits to regulation of their speech . . . [such as] an LGBT rights group in a state with gender-affirming care restrictions that provides free information about out-of-state organizations that will help individuals seeking hormone therapy to obtain it." *Id.* at 376.

Where a CID exceeds constitutional limits or operates as coercive pressure on protected expression, it serves no lawful purpose. *See Media Matters for Am. v. FTC*, 2025 WL 2988966, at *7 (D.C. Cir. Oct. 23, 2025) (citing cases). This CID is content-based on its face, targeting a specific category of speech—AAP's statements and guidance concerning PGDT. Exhibit 1, Subject of Investigation. The FTC's own public framing of GAC demonstrates that the CID is part of an enforcement initiative shaped by predetermined disfavor for AAP's viewpoint, and thus constitutes viewpoint discrimination. *See* Background, *supra.* Government action that singles out speech based on its subject matter and viewpoint is constitutionally suspect, and must be justified and narrowly tailored. *See NRA of Am. v. Vullo*, 602 U.S. 175, 188 (2024) (government officials may not "use the power of [the State] to punish or suppress disfavored expression"). Where, as here, the content burden is imposed through compulsory process that compels disclosure of materials protected by the First Amendment, the Fourth Amendment imposes an additional constraint: the request must avoid sweeping intrusions and precisely identify the information sought "with scrupulous exactitude." *See Zurcher*, 436 U.S. at 564 (citation omitted). The CID satisfies neither the "narrowly tailored" or "scrupulous exactitude" standard. It contains sweeping demands for information protected by the First Amendment, including but not limited to: a catalog of statements about "PGDT," including location, context, purpose, means of communication, and timing of dissemination; materials reflecting AAP's internal deliberative processes; the identities of each person or entity who developed or evaluated substantiation for any Covered Statement;

AAP's financial statements; and "all documents" related to any partnership with certain medical entities or clinicians. *See* Exhibit 1, Specifications A.6–10, A.12–13, B.1–5, B.10–11. The CID is plainly unconstitutionally broad.

The Supreme Court has long recognized that investigations and threatened sanctions can violate the First Amendment when they operate as informal censorship and intimidation. In *Bantam Books, Inc. v. Sullivan*, the Court held unconstitutional a scheme in which a state commission sent notices identifying "objectionable" publications and reminding distributors of possible prosecution because the effect was "clearly to intimidate" and suppress protected expression, even where the commission could not levy formal legal sanctions. 372 U.S. 58, 64 (1963). The same constitutional principle applies here. This CID is targeted at a category of medical speech and a viewpoint that the Commission has already deemed problematic, *see* Background, *supra*, and its requests impose coercive pressure that chills protected discourse.

AAP's scientific and medical information is not commercial speech, but even if it were, these requests would fail to satisfy even intermediate scrutiny. A government restriction on commercial speech is unconstitutional unless it "directly advance[s]" a "substantial" governmental interest, and the means chosen are not "more extensive than is necessary." *Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of New York*, 447 U.S. 557, 564–66 (1980). The CID's broad requests—in particular, the requests calling for "all Communications" with other professional medical organizations and "all Documents" that reflect "Communications with other organizations or institutions, or individuals" regarding AAP's guidance—are significantly more extensive than necessary for the Commission to investigate AAP's statements about GAC.[11]

[11] Even assuming some of AAP's speech were commercial, it is "inextricably intertwined" with protected speech, and entitled to all the same protections. *Riley v. Nat'l Fed'n of the Blind of N.C., Inc.,* 487 U.S. 781, 796 (1988).

The CID thus violates the First Amendment and should be quashed.[12]

B. The CID Infringes on AAP's Right to Free Association.

Next, the CID's demands for the identities of all individuals and entities involved in the development of GAC guidance, as well as deliberations about that guidance, infringe on AAP's First Amendment right to free association. The Supreme Court has stated that, "implicit in the right to engage in activities protected by the First Amendment" is "a corresponding right to associate with others in pursuit of a wide variety of political, social, economic, educational, religious, and cultural ends." *Roberts v. U.S. Jaycees*, 468 U.S. 609, 622 (1984); *see also Boy Scouts of Am. v. Dale*, 530 U.S. 640, 647–48 (2000) (recognizing the right to associate as "crucial" in preventing the majority from imposing views on groups with "perhaps unpopular" ideas). The compelled disclosure of associations and activities can "have a chilling effect on, and therefore infringe, the exercise of fundamental rights." *Perry v. Schwarzenegger*, 591 F.3d 1147, 1160 (9th Cir. 2010). The CID seeks to compel disclosure of precisely that protected information, including (1) the identities of any person or organization involved in the development and issuance of guidance such as the 2018 Policy Statement, 2023 Reaffirmation, and "SOC 8," a publication issued by the World Professional Association for Transgender Health; and (2) communications reflecting discussions around the development of these guidance documents. *See* Exhibit 1, Specifications A.8, A.13, B.4–5. Such requests reach deeply into the deliberative process through which medical guidance is developed and are not narrowly tailored to any legitimate investigative need. Moreover, disclosure would chill AAP's ability to engage in open discussions about GAC and other scientific topics of study and debate, as participants would fear burdensome

[12] The CID's request for "testimony, advocacy, or other information" submitted to legislatures infringes on AAP's right to freely petition the government. Exhibit 1, Specification B.7; *see White v. Lee*, 227 F.3d 1214, 1227 (9th Cir. 2000).

investigations or FTC enforcement. It would likewise deter new members and prompt current members to withdraw, fearing their association with AAP could expose them to FTC scrutiny.

Under *Perry*, once a party makes a prima facie showing that enforcement of a request will result in "(1) harassment, membership withdrawal, or discouragement of new members, or (2) other consequences which objectively suggest an impact on, or 'chilling' of, the members' associational rights," the burden shifts to the government to demonstrate the request is "rationally related to a compelling governmental interest" and the "least restrictive means of obtaining" the information. 591 F.3d at 1160–61 (citation omitted). The Commission cannot satisfy that standard here where it seeks overbroad associational information that is not narrowly tailored to a legitimate investigative need. And because the FTC has no plausible basis to assert jurisdiction here, it has no cognizable interest in the demanded information, let alone a compelling one.

C. The CID Constitutes Retaliation.

The First Amendment prohibits government agencies from wielding investigatory power to retaliate against protected speech. A cognizable retaliation claim exists where: (1) an entity engaged in First Amendment–protected conduct; (2) the government took an adverse action that would deter a person of ordinary firmness from speaking again; and (3) a causal link exists between the protected activity and the adverse action. *Aref v. Lynch*, 833 F.3d 242, 258 (D.C. Cir. 2016). AAP satisfies each element.

First, AAP's publication of medical guidance and policy advocacy constitutes protected speech entitled to robust First Amendment protection. *See NIFLA v. Becerra*, 585 U.S. 755, 756 (2018) (citing *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 566 (2011)) (recognizing the "danger of content-based regulations 'in the fields of medicine and public health'"). The CID targets precisely this form of protected discourse. *See* Exhibit 1, Subject of Investigation.

Second, the CID is an adverse action sufficient to deter a person of ordinary firmness from continuing to speak. *Media Matters for America v. FTC* is directly instructive: there, the FTC's "sweeping and burdensome CID calling for sensitive materials" likely constituted retaliatory action that would reasonably deter continued First Amendment activity. 2025 WL 2378009, at *15–*16 (D.D.C. Aug. 15, 2025). The court emphasized that compulsory process seeking "resource materials" (including internal analyses, methodology, communications, and financial information) posed a serious threat to protected activity and could chill future speech. *Id.* at *16 (citing *Shoen v. Shoen*, 48 F.3d 412, 415–16 (9th Cir. 1995)). This CID similarly demands wide-ranging internal "resource materials," including information regarding AAP's policy-development process, underlying substantiation files, communications with other organizations and individuals, and financial records. Exhibit 1, Specifications A.8–9, A.13, B.1–5, B.10–11. Such demands—issued under threat of enforcement—would deter a person of ordinary firmness from engaging further in protected medical and policy speech by imposing the burden and risk of intrusive discovery.

Third, the CID's focus on GAC and the FTC's public statements evidencing hostility to GAC demonstrate a causal link between AAP's protected activity and the FTC's adverse action. The CID seeks expansive internal materials and communications beyond what would be necessary for any neutral inquiry regarding allegedly deceptive advertising—even assuming AAP's statements constituted advertising. That misalignment alone raises retaliation concerns. Because direct evidence of motive rarely exists, retaliation may be proven through circumstantial evidence, including expressions of hostility toward the protected speech. *See Media Matters*, 2025 WL 2988966, at *8. Here, the FTC's statements about GAC for minors demonstrate that the agency has already identified content it deems acceptable and will cast opposing medical viewpoints as

harmful. For example, an FTC spokesperson described PGDT as "needless mutilation of children" that "no sane person could endorse."[13] *See also* Chairman Ferguson's Address, *supra* note 8. Coupled with the CID's broad scope and intrusive demands, these contemporaneous statements show that the CID was issued to deter and suppress disfavored speech rather than to pursue neutral fact-finding.

Because the CID retaliates against AAP's protected speech, it should be quashed.

## III. The CID Was Not Issued Pursuant to a Commission Resolution.

The FTC Act requires that a valid CID be "signed by a Commissioner acting pursuant to a Commission resolution." 15 U.S.C § 57b-1(i). Here, the FTC failed to satisfy this requirement because the Resolutions do not support the investigation subject matter described in the CID.

First, both Resolutions only authorize investigations into acts or practices "in or affecting commerce" in violation of the FTC Act, which can only be enforced against "persons, partnerships, or corporations." The statements the CID purports to investigate are not "in commerce" and AAP is not a "corporation" subject to the FTC's enforcement jurisdiction. *See* Section I, *supra*.

Second, neither Resolution supports the CID's Subject of Investigation. Specifically, the 2019 Resolution targets the "advertising, marketing, or sale" of health-related products or services, but AAP does not advertise, market, or sell such products or services. Exhibit 1 at 17. The 2021 Resolution similarly targets acts or practices related to goods or services marketed "to children under 18." *Id.* at 18. AAP does not engage in commercial activities or practices that are marketed to children. As explained above, AAP offers scientific and medical information about GAC to medical professionals, not patients. Thus, the Resolutions fail to support the CID.

[13] *See* Jody Godoy, *US FTC workshop criticizing medical care for transgender youth draws staff opposition*, Reuters (July 2, 2025), https://perma.cc/E8SU-MF9L.

## IV. The CID is Overbroad and Unduly Burdensome.

In addition to the fatal defects raised above, the CID's requests must be quashed or substantially limited because they are overbroad and unduly burdensome. *See FTC v. Texaco, Inc*., 555 F.2d 862, 882 (D.C. Cir. 1977) (Commission may not enforce an "unduly burdensome or unreasonably broad" CID where "compliance threatens to unduly disrupt or seriously hinder" normal operations). AAP has only two full-time lawyers, no paralegals, and no dedicated discovery professionals or administrative assistants. AAP has a small team of system administrators who could perform the tasks required by the CID. Much of the requested information related to GAC is not stored in a central repository from which AAP can easily collect responsive information, nor does AAP possess the tools needed to do so without significant burden. AAP's limited staff would have to undertake significant effort just to search for the requested materials related to GAC, let alone collect, review, and produce them. *See* Exhibit 4, Declaration of Robert Katchen. The significant burden imposed by the CID will thus directly disrupt normal operations, and is not proportional to the needs of the investigation.

For example, the time period for the CID is five years, and some requests call for "all Communications" or "all Documents" "regardless of time period." *See* Exhibit 1, Specifications B.4–5. This would require AAP's limited staff to search for documents that are potentially over a decade old. These requests are not proportionate to the FTC's investigative need.

The CID's broad definitions only exacerbate this burden. For example, the definitions of "Document" and "Collaborative Work Environment" capture every possible method of communication that AAP or its employees might use, including chats, texts, social media, as well as any messages sent via any device (including employee-owned devices) as well as any other platform, app, or system to communicate and access information. This definition is incorporated

into nearly every document request, and compounding the burden, most requests use broad language seeking "any" or "all" responsive documents. *See id.*, Specifications B.1–10, B.12.

The CID seeks an overwhelming amount of information that would require an unreasonable diversion of AAP's limited resources. The nature of AAP's speech regarding GAC is plainly non-commercial, the CID raises important constitutional concerns, and thus the CID's overbroad requests are disproportionate to any legitimate investigative need. Accordingly, the requests identified above should be quashed or substantially limited.

## RESERVATION OF RIGHTS

By submitting this Petition to Quash, AAP does not intend to—and does not—waive any rights to make additional arguments against the Commission's investigation of AAP, the CID, or both, including under the U.S. Constitution, the FTC Act, or any other statute or rule.

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## CONCLUSION

The CID should be quashed in its entirety or limited substantially.

DATED: February 9, 2026

Respectfully submitted,

COVINGTON & BURLING LLP

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**PUBLIC**

## CERTIFICATE OF SERVICE

I hereby certify that, on February 9, 2026, the foregoing Petition to Quash or Limit the Civil Investigative Demand was served by hand delivery or email to the following:

By hand delivery:

Office of the Secretary
Federal Trade Commission
9050 Junction Dr.
Annapolis Junction, MD 20701

By email:

Office of the Secretary
600 Pennsylvania Ave. NW
Washington, D.C. 20580
electronicfilings@ftc.gov

Annie Chiang
600 Pennsylvania Ave. NW
Washington, D.C. 20580
achiang@ftc.gov

Secretary April Tabor
600 Pennsylvania Ave. NW
Washington, D.C. 20580
atabor@ftc.gov

Jennie Hitchcock
600 Pennsylvania Ave. NW
Washington, D.C. 20580
jhitchcock@ftc.gov

Jonathan Cohen
600 Pennsylvania Ave. NW
Washington, D.C. 20580
Jcohen2@ftc.gov

Hans Clausen
233 Peachtree Street, NE
Atlanta, Georgia 30303
hclausen@ftc.gov

Gregory Ashe
600 Pennsylvania Ave. NW
Washington, D.C. 20580
gashe@ftc.gov

Laura Kim

# EXHIBIT 1

**PUBLIC**

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of the Secretary

January 15, 2026

Via U.S. Mail
American Academy of Pediatrics
c/o Illinois Corporation Service Company
801 Adlai Stevenson Drive
Springfield, IL 62703

FTC Matter No. P264800

Dear American Academy of Pediatrics:

The Federal Trade Commission ("FTC") has issued the attached Civil Investigative Demand ("CID") asking for information as part of a non-public investigation. Our purpose is to determine whether the Organization or any other Person, as those terms are defined in the enclosed CID Schedule, have made, or assisted others in making, false or unsubstantiated representations or engaged in unfair practices in connection with the marketing and advertising of Pediatric Gender Dysphoria Treatment (as defined in the enclosed CID Schedule), which, according to the Organization, purports to treat gender dysphoric or gender diverse minors, to consumers in violation of Sections 5 and 12 of the FTC Act, 15 U.S.C. §§ 45, 52, and whether FTC action to obtain monetary relief would be in the public interest. Please read the attached documents carefully. Here are a few important points we would like to highlight:

1. Contact **FTC counsel Gregory Ashe (202-326-3719/gashe@ftc.gov)**, as soon as possible to schedule a telephone call to be held within 14 days. During that telephone call, FTC counsel can address any questions or concerns you have regarding this CID, including whether there are changes to how you comply with the CID that would reduce your cost or burden while still giving the FTC the information it needs. Please read the attached documents for more information about that meeting.

2. **You must preserve, and immediately stop any deletion or destruction of, electronic or paper documents** in your possession, custody, or control that are in any way relevant to this investigation, even if those documents are being retained by

a third party or you believe the documents are protected from discovery by privilege or some other reason. You must also disable auto-delete for, or suspend, restrict, or limit use of, any applications or platforms that automatically delete messages or information that may be relevant to this investigation.

3. **The FTC will use information you provide in response to the CID for the purpose of investigating violations of the laws the FTC enforces.** We will not disclose the information under the Freedom of Information Act, 5 U.S.C. § 552. We may disclose the information in response to a valid request from Congress, or to other civil or criminal law enforcement agencies for their official law enforcement purposes. The FTC or other agencies may use and disclose your response in any civil or criminal proceeding, or if required to do so by law. However, we will not publicly disclose your information without giving you prior notice.

4. **Please read the attached documents closely.** They contain important information about how you should provide your response.

Please contact FTC counsel as soon as possible if you have any questions. We appreciate your cooperation.

Very truly yours,

April J. Tabor
Secretary

United States of America
Federal Trade Commission

**PUBLIC**

# *Civil Investigative Demand*

| 1. TO | 1a. MATTER NUMBER |
|---|---|
| American Academy of Pediatrics<br>c/o Illinois Corporation Service Company<br>801 Adlai Stevenson Drive<br>Springfield, IL 62703 | P264800 |

This demand is issued pursuant to Section 20 of the Federal Trade Commission Act, 15 U.S.C. § 57b-1, in the course of an investigation to determine whether there is, has been, or may be a violation of any laws administered by the Federal Trade Commission by conduct, activities or proposed action as described in Item 3.

2. ACTION REQUIRED

☐ You are required to appear and testify.

| LOCATION OF HEARING | YOUR APPEARANCE WILL BE BEFORE |
|---|---|
| | DATE AND TIME OF HEARING OR DEPOSITION |

☒ You are required to produce all documents described in the attached schedule that are in your possession, custody, or control, and to make them available at your address indicated above for inspection and copying or reproduction at the date and time specified below.

☒ You are required to answer the interrogatories or provide the written report described on the attached schedule. Answer each interrogatory or report separately and fully in writing. Submit your answers or report to the Records Custodian named in Item 4 on or before the date specified below.

☐ You are required to produce the tangible things described on the attached schedule. Produce such things to the Records Custodian named in Item 4 on or before the date specified below.

DATE AND TIME THE DOCUMENTS, ANSWERS TO INTERROGATORIES, REPORTS, AND/OR TANGIBLE THINGS MUST BE AVAILABLE

March 16, 2026 by 5:00pm ET

3. SUBJECT OF INVESTIGATION

Whether the Organization or any other Person, as those terms are defined in the enclosed CID Schedule, have made, or assisted others in making, false or unsubstantiated representations or engaged in unfair practices in connection with the marketing and advertising of Pediatric Gender Dysphoria Treatment (as defined in the enclosed CID Schedule) which, according to the Organization, purports to treat gender dysphoric or gender diverse minors, to consumers in violation of Sections 5 and 12 of the FTC Act, 15 U.S.C. §§ 45, 52, and whether FTC action to obtain monetary relief would be in the public interest. See also attached schedule and attached resolutions.

| 4. RECORDS CUSTODIAN/DEPUTY RECORDS CUSTODIAN | 5. COMMISSION COUNSEL |
|---|---|
| Gregory Ashe<br>Federal Trade Commission<br>600 Pennsylvania Ave., NW<br>Washington, DC 20580<br>202-326-3719 | Gregory Ashe<br>Federal Trade Commission<br>600 Pennsylvania Ave., NW<br>Washington, DC 20580<br>202-326-3719 |

| DATE ISSUED | COMMISSIONER'S SIGNATURE |
|---|---|
| 1/15/26 | Alvaro N. Fyr |

## INSTRUCTIONS AND NOTICES

The delivery of this demand to you by any method prescribed by the Commission's Rules of Practice is legal service and may subject you to a penalty imposed by law for failure to comply. The production of documents or the submission of answers and report in response to this demand must be made under a sworn certificate, in the form printed on the second page of this demand, by the person to whom this demand is directed or, if not a natural person, by a person or persons having knowledge of the facts and circumstances of such production or responsible for answering each interrogatory or report question. This demand does not require approval by OMB under the Paperwork Reduction Act of 1980.

## PETITION TO LIMIT OR QUASH

The Commission's Rules of Practice require that any petition to limit or quash this demand be filed within 20 days after service, or, if the return date is less than 20 days after service, prior to the return date. The original and twelve copies of the petition must be filed with the Secretary of the Federal Trade Commission, and one copy should be sent to the Commission Counsel named in Item 5.

## YOUR RIGHTS TO REGULATORY ENFORCEMENT FAIRNESS

The FTC has a longstanding commitment to a fair regulatory enforcement environment. If you are a small business (under Small Business Administration standards), you have a right to contact the Small Business Administration's National Ombudsman at 1-888-REGFAIR (1-888-734-3247) or www.sba.gov/ombudsman regarding the fairness of the compliance and enforcement activities of the agency. You should understand, however, that the National Ombudsman cannot change, stop, or delay a federal agency enforcement action.

The FTC strictly forbids retaliatory acts by its employees, and you will not be penalized for expressing a concern about these activities.

## TRAVEL EXPENSES

Use the enclosed travel voucher to claim compensation to which you are entitled as a witness for the Commission. The completed travel voucher and this demand should be presented to Commission Counsel for payment. If you are permanently or temporarily living somewhere other than the address on this demand and it would require excessive travel for you to appear, you must get prior approval from Commission Counsel.

A copy of the Commission's Rules of Practice is available online at http://bit.ly/FTCSRulesofPractice. Paper copies are available upon request.

**FEDERAL TRADE COMMISSION ("FTC")**
**CIVIL INVESTIGATIVE DEMAND ("CID") SCHEDULE**
**FTC File No. P264800**

**Meet and Confer**: You must contact FTC counsel Gregory Ashe (202-326-3719; gashe@ftc.gov), as soon as possible to schedule a telephonic meeting to be held within fourteen (14) days after You receive this CID. At the meeting, You must discuss with FTC counsel any questions You have regarding this CID or any possible CID modifications that could reduce Your cost, burden, or response time yet still provide the FTC with the information it needs to pursue its investigation. The meeting also will address how to assert any claims of protected status (e.g., privilege, work-product, etc.) and the production of electronically stored information. You must make available at the meeting personnel knowledgeable about Your information or records management systems, Your systems for electronically stored information, custodians likely to have information responsive to this CID, and any other issues relevant to compliance with this CID.

**Document Retention**: You must retain all Documents used in preparing responses to this CID. The FTC may require the submission of additional Documents later during this investigation. **Accordingly, You must preserve, and immediately stop any deletion or destruction of, Documents in Your possession, custody, or control** that are in any way relevant to this investigation, even if those Documents are being retained by a third party or You believe those Documents are protected from discovery. *See* 15 U.S.C. § 50; *see also* 18 U.S.C. §§ 1505, 1519. In addition, You must disable auto-delete for, or suspend, restrict, or limit use of, any messaging applications or Collaborative Work Environments that automatically delete messages or information that may be relevant to this investigation.

**Sharing of Information:** The FTC will use information You provide in response to the CID for the purpose of investigating violations of the laws the FTC enforces. We will not disclose such information under the Freedom of Information Act, 5 U.S.C. § 552. We also will not disclose such information, except as allowed under the FTC Act (15 U.S.C. § 57b-2), the Commission's Rules of Practice (16 C.F.R. §§ 4.10 & 4.11), or if required by a legal obligation. Under the FTC Act, we may provide Your information in response to a request from Congress or a proper request from another law enforcement agency. However, we will not publicly disclose such information without giving You prior notice.

**Manner of Production**: Contact **FTC counsel Gregory Ashe (202-326-3719; gashe@ftc.gov)** by email or telephone at least five days before the return date for instructions on how to produce information responsive to this CID.

**Certification of Compliance**: You or any person with knowledge of the facts and circumstances relating to the responses to this CID must certify that such responses are complete by signing the "Certification of Compliance" attached to this CID.

**Certification of Records of Regularly Conducted Activity**: Attached is a Certification of Records of Regularly Conducted Activity. Please execute and return this Certification with Your response. Completing this certification may reduce the need to subpoena You to testify at future proceedings to establish the admissibility of Documents produced in response to this CID.

**Definitions and Instructions**: Please review carefully the Definitions and Instructions that appear after the Specifications and provide important information regarding compliance with this CID.

## I. SUBJECT OF INVESTIGATION

Whether the Organization or any other Person, as those terms are defined herein, have made, or assisted others in making, false or unsubstantiated representations or engaged in unfair practices in connection with the marketing and advertising of Pediatric Gender Dysphoria Treatment (as defined herein), which, according to the Organization, purports to treat gender dysphoric or gender diverse minors, to consumers in violation of Sections 5 and 12 of the FTC Act, 15 U.S.C. §§ 45, 52, and whether FTC action to obtain monetary relief would be in the public interest. See also attached resolutions.

## II. SPECIFICATIONS

**Applicable Time Period:** Unless otherwise directed, the applicable time period for the requests set forth below is from January 1, 2021**, until the date of full and complete compliance with this CID.**

**A. Interrogatories**. Please describe in detail:

1. All requirements for membership in Your Organization.

2. The extent to which Your Organization's membership includes members organized for profit, or that provide goods and services for profit.

3. All benefits and services You offer or provide to Your members, including but not limited to any (a) discounts or advantageous access to any products and services, such as insurance or financing, (b) legal advocacy or litigation, (c) lobbying services, (d) marketing or lead generation of any type, (e) public relations, and (f) education and training.

4. Each training or certification program offered by You, including but not limited to: (a) the cost of each training or certification program, (b) the requirements (*e.g.*, membership requirements, course titles, hours, testing) for completing the program, (c) the requirements for maintaining the certification, (d) the number of individuals that hold a current certification, and (e) the number of individuals that have completed the training or certification program.

5. Each workshop, townhall or other formal or informal session, and conference You hosted and that relates to PGDT in any way, including but not limited to the cost to attend and education or trainings offered at those workshops, townhalls or other formal or informal sessions, and conferences.

6. Each type of PGDT You advertised, marketed, promoted, addressed, or referred to in any Document You disseminated. Your response should include but not be limited to descriptions of any pamphlets, posters, or other materials concerning PGDT that You disseminated to healthcare professionals, patients, and their families, to whom those materials were disseminated, for what purpose they were disseminated, and the dates when You disseminated the materials.

7. Any Covered Statements You have made, including but not limited to the exact wording, its location and context, the means of communication, and when dissemination occurred.

8. Regardless of time period, the process for developing and issuing the 2018 Policy Statement and 2023 Reaffirmation, including but not limited to every individual or entity that participated in development and issuance, and any funding sources.

9. Any payments, grants, consulting or financial relationships, or partnerships relating to PGDT between You and any (a) pharmaceutical company, (b) medical device manufacturer, and/or (c) clinic, hospital system, or individual clinician.

10. All formal or informal complaints, questions, or inquiries You received related to concerns that the Covered Statements lack substantiation or do not adequately disclose risks associated with PGDTs.

11. All investigations and lawsuits involving You and either the Covered Statements or PGDTs, including any lawsuit in which You are amicus.

12. Your views regarding whether the Covered Statements are substantiated, and the reasoning therefor.

13. Regardless of time period, identify each person, company, agency, or other entity with responsibility for developing, reviewing, or evaluating substantiation, scientific or otherwise, for each Covered Statement, including the qualifications of each such Person, and describe the functions performed by each.

14. Describe Your record retention policies, including the manner and duration of preservation of email.

15. Identify all persons who participated in preparing responses to this CID.

**B. Document Requests**:

1. Regardless of time period, and whether or not You believe a Covered Statement was made in Your advertising or other promotional materials, all Documents (including tests, reports, studies, scientific literature, and written opinions) upon which You have relied to substantiate each Covered Statement.

2. Regardless of time period, all Documents relating to substantiation for the Covered Statements, that question or disprove any of the Covered Statements or their substantiation.

3. Regardless of time period, all Documents relating to any study You sponsored, conducted, or contributed to that involved PGDT.

4. Regardless of time period, all Communications with Professional Medical Organizations related to the 2018 Policy Statement, 2023 Reaffirmation, and SOC 8.

5. Regardless of time period, all Documents reflecting or constituting Communications with other organizations or institutions, or individuals regarding the development and publication of the 2018 Policy Statement, 2023 Reaffirmation, and SOC 8.

6. All materials used in any education, training, or certification program You offer, or used to promote such programs.

7. All testimony, advocacy, or other information provided to any legislature or regulator related to PGDTs.

8. With respect to any workshop, townhall or other formal or informal session, or conference You hosted or organized related in any way to PGDTs: (a) all recordings and transcripts; (b) all Documents distributed to attendees or participants; and (c) Documents required to be signed by any attendee, participant, or speaker.

9. All Documents You disseminated referencing the Covered Statements.

10. All Documents related to payments, grants, consulting or financial relationships, or partnerships between You and any (a) pharmaceutical company, (b) medical device manufacturer, or (c) clinic, hospital system or individual clinician.

11. Your Financial Statements for each year.

12. All Documents referenced in, or relied upon, in answering any Interrogatory.

## III. DEFINITIONS

The following definitions apply to this CID:

**D-1.** "**Collaborative Work Environment**" means any platform, application, product, or system used to communicate, or to create, edit, review, approve, store, organize, share, and access Documents, Communications, and information by and among users, including Microsoft SharePoint sites, cloud storage systems (*e.g.*, Google Drive, OneDrive, Dropbox), eRooms, document management systems (*e.g.*, iManage), intranets, chat (*e.g.*, Slack), web content

management systems (*e.g.*, Drupal), wikis (*e.g.*, Confluence), work tracking software (*e.g.*, Jira), version control systems (*e.g.*, Github), and blogs.

**D-2.** "**Communication**" means the transmittal of information by any means.

**D-3.** **"Covered Statement"** means any representation, whether express or implied, that:

a. PGDTs are safe, including without limitation the representation that a treatment is safe for muscle, bone, or brain development;
b. PGDTs are proven effective, including without limitation the representation that PGDTs are supported by evidence-based science;
c. PGDTs improve mental health;
d. PGDTs reduce the incidence of suicide, including without limitation the representation that PGDTs are life-saving;
e. PGDTs are fully or partly reversible, including without limitation the representation that a treatment is only a pause or otherwise do not cause permanent physical changes; and
f. PGDTs have few side effects.

**D-4.** "**Document**" means the complete original, including all attachments and copies of all hyperlinked materials (other than hyperlinks to publicly accessible websites), all drafts or prior versions, and any non-identical copy, whether different from the original because of notations on the copy, different metadata, or otherwise, of any item covered by 15 U.S.C. § 57b-1(a)(5), 16 C.F.R. § 2.7(a)(2), or Federal Rule of Civil Procedure 34(a)(1)(A), including chats, instant messages, text messages, direct messages, information stored on or sent through social media accounts or messaging or other applications (*e.g.*, Microsoft Teams, Slack), information contained in, hyperlinked to, or sent through Collaborative Work Environments, and information on all devices (including employee-owned devices) used for Organization-related activity.

**D-5.** "**Financial Statements**" means balance sheets, statements of financial position, profit and loss statements, income statements, statements of activities, statement of cash flows, and statements of functional expenses.

**D-6.** "**Organization**," "**You**," or "**Your**" means or refers to the **American Academy of Pediatrics,** its wholly or partially owned subsidiaries, unincorporated divisions, joint ventures, operations under assumed names, and affiliates, and all directors, officers, members, employees, agents, consultants, and other persons working for or on behalf of the foregoing.

**D-7.** "**Pediatric Gender Dysphoria Treatment**" or ("**PGDT**") means any medical intervention which, according to the Organization, purports to treat gender dysphoric or gender diverse minors, including but not limited to pubertal suppression, hormone therapy, and surgery (*e.g.*, subcutaneous mastectomy, vaginoplasty, metoidioplasty, and phalloplasty).

**D-8** **"Person"** means any natural person, an organization or other legal entity, including a corporation, partnership, sole proprietorship, limited liability company, association, cooperative, or any other group or combination acting as an entity.

**D-9. "Policy Statement" or "2018 Policy Statement"** means the American Academy of Pediatrics' statement entitled "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents" published in 2018.

**D-10. "Professional Medical Organizations"** means, including, but not limited to, the Endocrine Society, American College of Obstetrics and Gynecology, American Medical Association (AMA), and its Surgical Groups (American Society of Plastic Surgery, American Academy of Cosmetic Surgery, International Society of Aesthetic Plastic Surgery, American Board of Plastic Surgery, American Association of Plastic Surgery, and the American College of Surgeons), World Professional Association for Transgender Health (WPATH), and United States Professional Association for Transgender Health (USPATH).

**D-11. "Reaffirmation" or "2023 Reaffirmation"** means Your August 2023 reaffirmation of the 2018 Policy Statement.

**D-12. "SOC 8"** means WPATH's 2022 publication entitled "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8."

## IV. INSTRUCTIONS

**I-1. Petitions to Limit or Quash**: You must file any petition to limit or quash this CID with the Secretary of the FTC no later than twenty (20) days after service of the CID, or, if the return date is less than twenty (20) days after service, prior to the return date. Such petition must set forth all assertions of protected status or other factual and legal objections to the CID and comply with the requirements set forth in 16 C.F.R. § 2.10(a)(1) – (2). **The FTC will not consider petitions to quash or limit if You have not previously met and conferred with FTC staff and, absent extraordinary circumstances, will consider only issues raised during the meet and confer process.** 16 C.F.R. § 2.7(k); *see also* § 2.11(b). **If You file a petition to limit or quash, You must still timely respond to all requests that You do not seek to modify or set aside in Your petition.** 15 U.S.C. § 57b-1(f); 16 C.F.R. § 2.10(b).

**I-2. Withholding Requested Material / Privilege Claims**: For specifications requesting production of Documents or answers to written interrogatories, if You withhold from production any material responsive to this CID based on a claim of privilege, work product protection, statutory exemption, or any similar claim, You must assert the claim no later than the return date of this CID, and You must submit a detailed log, in a searchable electronic format, of the items withheld that identifies the basis for withholding the material and meets all the requirements set forth in 16 C.F.R. § 2.11(a) – (c). The information in the log must be of sufficient detail to enable FTC staff to assess the validity of the claim for each Document, including attachments, without disclosing the protected information. If only some portion of any responsive material is privileged, You must submit all non-privileged portions of the material. Otherwise, produce all responsive information and material without redaction. 16 C.F.R. § 2.11(c). The failure to provide information sufficient to support a claim of protected status may result in denial of the claim. 16 C.F.R. § 2.11(a)(1).

**I-3. Modification of Specifications**: The Bureau Director, a Deputy Bureau Director, Associate Director, Regional Director, or Assistant Regional Director must agree in writing to any modifications of this CID. 16 C.F.R. § 2.7(l).

**I-4. Scope of Search**: This CID covers Documents and information in Your possession or under Your actual or constructive custody or control, including Documents and information in the possession, custody, or control of Your attorneys, accountants, directors, officers, employees, service providers, and other agents and consultants, whether or not such Documents or information were received from or disseminated to any person or entity.

**I-5. Identification of Responsive Documents**: For specifications requesting production of Documents, You must identify in writing the Documents that are responsive to the specification. Documents that may be responsive to more than one specification of this CID need not be produced more than once. If any Documents responsive to this CID have been previously supplied to the FTC, You may identify the Documents previously provided and the date of submission.

**I-6. Maintain Document Order**: For specifications requesting production of Documents, You must produce Documents in the order in which they appear in Your files or as electronically stored. If Documents are removed from their original folders, binders, covers, containers, or electronic source, You must specify the folder, binder, cover, container, or electronic media or file paths from which such Documents came.

**I-7. Numbering of Documents**: For specifications requesting production of Documents, You must number all Documents in Your submission with a unique identifier such as a Bates number or a Document ID.

**I-8. Production of Copies**: For specifications requesting production of Documents, unless otherwise stated, You may submit copies in lieu of original Documents if they are true, correct, and complete copies of the originals and You preserve and retain the originals in their same state as of the time You received this CID. Submission of copies constitutes a waiver of any claim as to the authenticity of the copies should the FTC introduce such copies as evidence in any legal proceeding.

**I-9. Production in Color**: For specifications requesting production of Documents, You must produce copies of advertisements in color, and You must produce copies of other materials in color if necessary to interpret them or render them intelligible.

**I-10. Electronically Stored Information**: For specifications requesting production of Documents, see the attached FTC Bureau of Consumer Protection Production Requirements ("Production Requirements"), which detail all requirements for the production of electronically stored information to the FTC. You must discuss issues relating to the production of electronically stored information with FTC staff **prior to** production.

**I-11. Sensitive Personally Identifiable Information ("Sensitive PII") or Sensitive Health Information ("SHI")**: For specifications requesting production of Documents or answers to

written interrogatories, if any responsive materials contain Sensitive PII or SHI, please contact FTC counsel before producing those materials to discuss whether there are steps You can take to minimize the amount of Sensitive PII or SHI You produce, and how to securely transmit such information to the FTC.

Sensitive PII includes an individual's Social Security number; an individual's biometric data; and an individual's name, address, or phone number in combination with one or more of the following: date of birth, driver's license or state identification number (or foreign country equivalent), military identification number, passport number, financial account number, credit card number, or debit card number. Biometric data includes biometric identifiers, such as fingerprints or retina scans, but does not include photographs (with the exception of photographs and corresponding analyses used or maintained in connection with facial recognition software) or voice recordings and signatures (with the exception of those stored in a database and used to verify a person's identity). SHI includes medical records and other individually identifiable health information relating to the past, present, or future physical or mental health or conditions of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

**I-12. Interrogatory Responses**: For specifications requesting answers to written interrogatories: (a) answer each interrogatory and each interrogatory subpart separately, fully, and in writing; and (b) verify that Your answers are true and correct by signing Your answers under the following statement: "I verify under penalty of perjury that the foregoing is true and correct. Executed on (date). (Signature)." The verification must be submitted contemporaneously with Your interrogatory responses.

**I-13. Submission of Documents in Lieu of Interrogatory Answers**: You may answer any written interrogatory by submitting previously existing Documents that contain the information requested in the interrogatory so long as You clearly indicate in each written interrogatory response which Documents contain the responsive information. For any interrogatory that asks You to identify Documents, You may, at Your option, produce the Documents responsive to the interrogatory so long as You clearly indicate the specific interrogatory to which such Documents are responsive.

## CERTIFICATION OF COMPLIANCE
**Pursuant to 28 U.S.C. § 1746**

I, _____, certify the following with respect to the Federal Trade Commission's ("FTC") Civil Investigative Demand directed to American Academy of Pediatrics (the "Organization") (FTC File No. P264800) (the "CID"):

1. The Organization has identified all documents, information, and/or tangible things ("responsive information") in the Organization's possession, custody, or control responsive to the CID and either:

   (a) provided such responsive information to the FTC; or

   (b) for any responsive information not provided, given the FTC written objections setting forth the basis for withholding the responsive information.

2. I verify that the responses to the CID are complete and true and correct to my knowledge.

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

Date: _____

_____
Signature

_____
Printed Name

_____
Title

**CERTIFICATION OF RECORDS OF REGULARLY CONDUCTED ACTIVITY**
**Pursuant to 28 U.S.C. § 1746**

1. I, _____, have personal knowledge of the facts set forth below and am competent to testify as follows:

2. I have authority to certify the authenticity of the records produced by American Academy of Pediatrics (the "Organization") and attached hereto.

3. The documents produced and attached hereto by the Organization are originals or true copies of records of regularly conducted activity that:

   a) Were made at or near the time of the occurrence of the matters set forth by, or from information transmitted by, a person with knowledge of those matters;

   b) Were kept in the course of the regularly conducted activity of the Organization; and

   c) Were made by the regularly conducted activity as a regular practice of the Organization.

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

Date: _____ _____
Signature

**Federal Trade Commission - Bureau of Consumer Protection**

**Production Requirements**

Revised January 2024

In producing information to the FTC, comply with the following requirements, unless the FTC agrees otherwise. If you have questions about these requirements, please contact FTC counsel.

## Production Format

1. **General Format**: Provide load-ready electronic productions with:

    a. A delimited data load file (.DAT) containing a line for every document, unique id number for every document (DocID), metadata fields, and native file links where applicable; and

    b. A document level text file, named for the DocID, containing the text of each produced document.

    Do not produce corresponding image renderings (e.g., TIFF or JPEG) for files in native format unless the FTC requests them. If the FTC requests corresponding image renderings, provide an Opticon image load file (.OPT) containing a line for every image file.

2. **Electronically Stored Information (ESI)**: Documents stored in electronic format in the ordinary course of business must be produced in the following format:

    a. For ESI other than the categories below, submit in native format with all metadata and either document level extracted text or Optical Character Recognition (OCR). Do not produce corresponding image renderings (e.g., TIFF or JPEG) for files in native format unless the FTC requests them. If the FTC requests corresponding image renderings, they should be converted to Group IV, 300 DPI, single-page TIFF (or color JPEG images when necessary to interpret the contents or render them intelligible.)

    b. For Microsoft Excel, Access, or PowerPoint files, submit in native format with extracted text and metadata. Data compilations in Excel spreadsheets or delimited text formats must contain all underlying data, formulas, and algorithms without redaction.

    c. For other spreadsheet, database, presentation, or multimedia formats; messaging applications and platforms (e.g., Microsoft Teams, Slack); or proprietary applications, discuss the production format with FTC counsel.

3. **Hard Copy Documents**: Documents stored in hard copy in the ordinary course of business must be scanned and submitted as either one multi-page pdf per document or as 300 DPI single page TIFFs (or color JPEGs when necessary to interpret the contents or render them intelligible), with corresponding document-level OCR text and logical document determination in an accompanying load file.

4. **Document Identification**: Provide a unique DocID for each hard copy or electronic document, consisting of a prefix and a consistent number of numerals using leading zeros. Do not use a space to separate the prefix from numbers.

5. **Attachments**: Preserve the parent/child relationship by producing attachments as separate documents, numbering them consecutively to the parent email, and including a reference to all attachments.

6. **Metadata Production**: For each document submitted electronically, include the standard metadata fields listed below in a standard delimited data load file. The first line of the data load file shall include the field names. Submit date and time data in separate fields. Use these standard Concordance delimiters in delimited data load files:

| Description | Symbol | ASCII Character |
|---|---|---|
| Field Separator | ¶ | 20 |
| Quote Character | þ | 254 |
| Multi Entry delimiter | ® | 174 |
| <Return> Value in data | ~ | 126 |

7. **De-duplication**: Do not use de-duplication or email threading software without FTC approval.

8. **Password-Protected Files**: Remove passwords prior to production. If password removal is not possible, provide the original and production filenames and the passwords, under separate cover.

**Producing Data to the FTC**

1. Prior to production, scan all data and media for viruses and confirm they are virus-free.

2. For productions smaller than 50 GB, submit data electronically using the FTC's secure file transfer protocol. Contact FTC counsel for instructions. **The FTC cannot accept files via Dropbox, Google Drive, OneDrive, or other third-party file transfer sites**.

3. If you submit data using physical media:

    a. Use only CDs, DVDs, flash drives, or hard drives. Format the media for use with Windows;

    b. Use data encryption to protect any Sensitive Personally Identifiable Information or Sensitive Health Information (as defined in the instructions), and provide passwords in advance of delivery, under separate cover; and

    c. Use a courier service (e.g., Federal Express, UPS) because heightened security measures delay postal delivery.

4. Provide a transmittal letter with each production that includes:

    a. Production volume name (e.g., Volume 1) and date of production;

    b. Numeric DocID range of all documents in the production, and any gaps in the DocID range; and

    c. List of custodians and the DocID range for each custodian.

**Standard Metadata Fields**

| DAT FILE FIELDS | DEFINITIONS | POPULATE FIELD FOR: |
|---|---|---|
| DocID | Unique ID number for each document | All Documents |
| FamilyID | Unique ID for all documents in a family including parent and all child documents | All Documents |
| ParentID | Document ID of the parent document. This field will only be populated on child items | All Documents |
| File Path | Path to produced native file | All Documents |
| TextPath | Path to document level text or OCR file | All Documents |
| Custodian | Name of the record owner/holder | All Documents |
| AllCustodians | Names of all custodians that had copy of this record (populate if data was deduplicated or email threading was used) | All Documents |
| Source | Source of documents: CID, Subpoena, Third Party Data, etc. | All Documents |
| Filename | Original file name | All Documents |
| File Size | Size of documents | All Documents |
| File Extensions | Extension of file type | All Documents |
| MD5 Hash | Unique identifier for electronic data used in de-duplication | All Documents |
| PRODUCTION_VOLUME | Production Volume | All Documents |
| HASREDACTIONS | Redacted document | All Documents |
| Exception Reason | Reason for exception encountered during processing (e.g., empty file, source file, password-protected file, virus) | All Documents |
| PRODBEG | Beginning production bates number | Documents with Produced Images |
| PRODEND | Ending production bates number | Documents with Produced Images |
| PRODBEG_ATTACH | Beginning production family bates number | Documents with Produced Images |
| PRODEND_ATTACH | Ending production family bates number | Documents with Produced Images |
| Page Count | The number of pages the document contains | Documents with Produced Images |
| From | Names retrieved from the FROM field in a message | Emails |
| To | Names retrieved from the TO field in a message; the recipient(s) | Emails |
| CC | Names retrieved from the CC field in a message; the copied recipient(s) | Emails |
| BCC | Names retrieved from the BCC field in a message; the blind copied recipient(s) | Emails |
| EmailSubject | Email subject line | Emails |
| Date Sent | The date an email message was sent | Emails |
| Time Sent | The time an email message was sent | Emails |
| Date Received | The date an email message was received | Emails |
| Time Received | The time an email message was received | Emails |
| Author | File Author | Loose Native Files and Email Attachments |
| Title | File Title | Loose Native Files and Email Attachments |
| Subject | File Subject | Loose Native Files and Email Attachments |
| Date Created | Date a document was created by the file system | Loose Native Files and Email Attachments |
| Time Created | Time a document was created by the file system | Loose Native Files and Email Attachments |
| Date Modified | Last date a document was modified and recorded by the file system | Loose Native Files and Email Attachments |
| Time Modified | Last time a document was modified and recorded by the file system | Loose Native Files and Email Attachments |
| Date Printed | Last date a document was printed and recorded by the file system | Loose Native Files and Email Attachments |
| Time Printed | Last time a document was printed and recorded by the file system | Loose Native Files and Email Attachments |

**UNITED STATES OF AMERICA**
**BEFORE THE FEDERAL TRADE COMMISSION**

**COMMISSIONERS:** Joseph J. Simons, Chairman
Noah Joshua Phillips
Rohit Chopra
Rebecca Kelly Slaughter
Christine S. Wilson

# RESOLUTION DIRECTING USE OF COMPULSORY PROCESS IN A NON-PUBLIC INVESTIGATION OF DIETARY SUPPLEMENTS, FOODS, DRUGS, DEVICES, OR ANY OTHER PRODUCT OR SERVICE INTENDED TO PROVIDE A HEALTH BENEFIT OR TO AFFECT THE STRUCTURE OR FUNCTION OF THE BODY

File No. 002 3191

Nature and Scope of Investigation:

To investigate whether unnamed persons, partnerships, or corporations, or others have engaged or are engaging in deceptive or unfair acts or practices in or affecting commerce in the advertising, marketing, or sale of dietary supplements, foods, drugs, devices, or any other product or service intended to provide a health benefit or to affect the structure or function of the body; have misrepresented or are misrepresenting the safety or efficacy of such products or services; or otherwise have engaged or are engaging in unfair or deceptive acts or practices or in the making of false advertisements, in or affecting commerce, in violation of Sections 5 or 12 of the Federal Trade Commission Act, 15 U.S.C. §§ 45 and 52, as amended. The investigation is also to determine whether Commission action to obtain monetary relief would be in the public interest.

The Federal Trade Commission hereby resolves and directs that any and all compulsory processes available to it be used in connection with this investigation for a period not to exceed ten (10) years from the date of issuance of this resolution. The expiration of this ten-year period shall not limit or terminate the investigation or the legal effect of any compulsory process issued during the ten-year period. The Federal Trade Commission specifically authorizes the filing or continuation of actions to enforce any such compulsory process after the expiration of the ten-year period.

Authority to Conduct Investigation:

Sections 6, 9, 10, and 20 of the Federal Trade Commission Act, 15 U.S.C. §§ 46, 49, 50, and 57b-1, as amended; and FTC Procedures and Rules of Practice, 16 C.F.R. § 1.1 *et seq.*, and supplements thereto.

By direction of the Commission.

APRIL TABOR
Digitally signed by APRIL TABOR
Date: 2019.08.12 12:09:40 -04'00'

April J. Tabor
Acting Secretary

Issued: August 9, 2019

**PUBLIC**

**UNITED STATES OF AMERICA**
**BEFORE THE FEDERAL TRADE COMMISSION**

**COMMISSIONERS:** **Lina M. Khan, Chair**
**Noah Joshua Phillips**
**Rohit Chopra**
**Rebecca Kelly Slaughter**
**Christine S. Wilson**

# RESOLUTION DIRECTING USE OF COMPULSORY PROCESS REGARDING ACTS OR PRACTICES AFFECTING CHILDREN

**File No. 212 3123**

Nature and Scope of Investigation:

To investigate whether any persons, partnerships, corporations, or others have engaged or are engaging in unfair, deceptive, anticompetitive, collusive, coercive, predatory, exploitative, or exclusionary acts or practices, in or affecting commerce, related to goods or services marketed, in whole or in part, to children under 18, in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, as amended or any statutes or rules enforced by the Commission; and to determine the appropriate action or remedy, including whether injunctive and monetary relief would be in the public interest.

The Federal Trade Commission hereby resolves and directs that any and all compulsory processes available to it be used in connection with any inquiry within the nature and scope of this resolution for a period not to exceed ten years. The expiration of this ten-year period shall not limit or terminate the investigation or the legal effect of any compulsory process issued during the ten-year period. The Federal Trade Commission specifically authorizes the filing or continuation of actions to enforce any such compulsory process after the expiration of the ten-year period.

Authority to Conduct Investigation:

Sections 6, 9, 10, and 20 of the Federal Trade Commission Act, 15 U.S.C. §§ 46, 49, 50,and 57b-1, as amended; and FTC Procedures and Rules of Practice, 16 C.F.R. § 1.1 *et seq.*, and supplements thereto.

By direction of the Commission.

April J. Tabor
Secretary

**Issued: September 2, 2021**
**Expires: September 2, 2031**

# EXHIBIT 2

Certificate Number 2105

STATE OF ILLINOIS

OFFICE OF

THE SECRETARY OF STATE

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETING:

WHEREAS, a CERTIFICATE, duly signed and acknowledged, has been filed in the Office of the Secretary of State, on the 10th day of July, A. D. 1930, for the organization of the

AMERICAN ACADEMY OF PEDIATRICS

under and in accordance with the provisions of "AN ACT CONCERNING CORPORATIONS" approved April 18, 1872, and in force July 1, 1872, and all acts amendatory thereof, a copy of which certificate is hereto attached;

NOW THEREFORE, I, WILLIAM J. STRATTON, Secretary of State of the State of Illinois, by virtue of the powers and duties vested in me by law, do hereby certify that the said AMERICAN ACADEMY OF PEDIATRICS is a legally organized Corporation under the laws of this State.

IN TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois. Done at the City of Springfield this 10th day of July, A. D. 1930, and of the Independence of the United States the one hundred and 55th.

( S E A L )

WILLIAM J. STRATTON

SECRETARY OF STATE.

THIS STATEMENT MUST BE FILED IN DUPLICATE

FEE $10

STATE OF ILLINOIS, )
) ss.
Cook County, )

P A I D
JUL 10 1930
I.F. $10.00
F.T.

To WILLIAM J. STRATTON, Secretary of State:

We, the undersigned Isaac A. Abt, C. Anderson Aldrich, Clifford G. Grulee, citizens of the United States, propose to form a corporation under an Act of the General Assembly of the State of Illinois, entitled, "An Act concerning Corporations," approved April 18, 1872, and all acts amendatory thereof; and for the purpose of such organization we hereby state as follows, to-wit:

1. The name of such corporation is AMERICAN ACADEMY OF PEDIATRICS.

2. The object for which it is formed is to foster and stimulate interest in pediatrics and correlate all aspects of work for the welfare of children which properly comes within the scope of pediatrics; to promote and maintain the highest possible standards for pediatric education in medical schools and hospitals, pediatric practice and research; to perpetuate the history and best traditions of pediatrics and ethics; to maintain the dignity and efficiency of pediatric practice in its relationship to public welfare; to promote publications and encourage contributions to medical and scientific literature pertaining to pediatrics; none of which objects is for pecuniary profit.

3. The management of the aforesaid American Academy of Pediatrics shall be vested in a board of seven Directors, to be known as the Executive Board.

4. The following persons are hereby selected as the Directors to control and manage said corporation for the first year of its corporate existence, viz:

| NAME | ADDRESS | | | |
|---|---|---|---|---|
| | NUMBER | STREET | CITY | STATE |
| Isaac A. Abt | 4810 | Kenwood Avenue, | Chicago, | Ill. |
| C. Anderson Aldrich | 1189 | Oakley Avenue, | Winnetka, | Ill. |
| Clifford G. Grulee | 1410 | Asbury Avenue, | Evanston, | Ill. |
| Samuel McC. Hamill | 1822 | Spruce Street, | Philadelphia, | Pa. |
| William P. Lucas | 2449 | Pacific Avenue, | San Francisco, | Cal. |
| John L. Morse | 169 | Park Street, | Newton, | Mass. |
| Lawrence T. Royster | University, | | Va. | |

5. The location is in the city of Chicago in the county of Cook in the State of Illinois, and the postoffice address of its business office is at No. 310 S. Michigan Avenue in the said City of Chicago.

SIGNED,

C. ANDERSON ALDRICH
CLIFFORD G. GRULEE
ISAAC A. ABT.

STATE OF ILLINOIS, )
) ss.
Cook County, )

I, John Stone, a Notary Public in and for the County and State aforesaid, do hereby certify that on this 7th day of July, A. D. 1930, personally appeared before me Isaac A. Abt, C. Anderson Aldrich, and Clifford G. Grulee, to me personally known to be the same persons who executed the foregoing certificate, and severally acknowledged that they had executed the same for the purposes therein set forth.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year above written.

JOHN STONE
Notary Public.

(SEAL)

F I L E D
JUL 10 1930
William J. Stratton
Sec'y of State

State of Illinois)
Cook. Co. ) S.S. No. 10702876

1930-July 11-P.M.-355

and recorded in Book 636, Page 555

Recorder

Clayton Smith

# EXHIBIT 3

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™

**This Policy Statement was reaffirmed August 2023.**

# 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.

*Department of Pediatrics, Hasbro Children's Hospital, Providence, Rhode Island; Thundermist Health Centers, Providence, Rhode Island; and Department of Child Psychiatry, Emma Pendleton Bradley Hospital, East Providence, Rhode Island*

*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.*



**To cite:** Rafferty J, AAP COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, AAP COMMITTEE ON ADOLESCENCE, AAP SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics.* 2018;142(4): e20182162

## 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 of 180 trans youth and matched cisgender peers, 56 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 4

**BEFORE THE UNITED STATES**
**FEDERAL TRADE COMMISSION**

| | | |
|---|---|---|
| In the Matter of | ) | **PUBLIC** |
| Civil Investigative Demand dated January 15, 2026, to American Academy of Pediatrics | ) | File No. P264800 |

**DECLARATION OF ROBERT KATCHEN IN SUPPORT OF PETITION TO QUASH OR LIMIT CIVIL INVESTIGATIVE DEMAND**

I, Robert Katchen, declare the following:

1. I am Senior Vice President of Information Technology at the American Academy of Pediatrics ("AAP"). I have held that position since February 2012.
2. I have reviewed the January 15, 2026 CID ("CID") served on AAP. I have also reviewed the February 5, 2026 letter from FTC staff regarding the January 2026 CID.
3. The CID contains fifteen interrogatories and twelve document requests. The applicable time period is more than five years, and as modified, some of the most burdensome requests seek information and documents from over a decade ago to present. Some requests still seek documents regardless of time period (Request Nos. B.4-5, seeking Communications with Professional Medical Organizations and other organizations).
4. The interrogatories are extremely broad. They seek information on topics including: (1) all information about benefits and services provided to members; (2) training and certification programs; (3) various workshops, townhalls, or other sessions and conferences hosted by AAP related to statements about gender-affirming care; (4) any disseminated materials concerning statements about gender-affirming care; (5) internal processes for developing AAP's policy statement about gender-affirming care; (6) financial information; (7) formal

and informal complaints, including investigations and lawsuits about certain statements; (8) identification of every individual or entity responsible for developing these statements; and (9) record retention policies.

5. The document requests are similarly overinclusive. Among other things, they require production of (1) all documents referenced or relied upon in answering any of the CID interrogatories; (2) all documents relating to substantiation for making statements about gender-affirming care; (3) all communications with professional medical organizations and other institutions or individuals related to those same statements; (4) all materials used for education, training, or certification programs; (5) all testimony or information provided to legislatures or regulators about these statements; (6) all recordings, transcripts, and documents related to any event hosted concerning gender-affirming care; (7) all documents disseminated referencing statements about gender-affirming care; and (8) financial documents.

6. AAP is a 501(c)(3) non-profit organization with limited operational capacity. There are four system administrators who could assist with the task of collecting and reviewing relevant documents. Of the four individuals, two of them would require additional training. These individuals are extremely busy with performing essential information technology, systems maintenance, and cybersecurity and information-security functions to support AAP's mission. AAP also only has two full-time lawyers, no paralegals, and no dedicated discovery professionals or administrative assistants. Because of these limited resources, I expect that compliance with these requests would require significant time and resources from individuals at AAP whose job responsibilities are focused on advancing AAP's mission of improving children's health.

7. The CID calls for documents that are maintained in multiple internal repositories, including network drives and Sharepoint. In addition, the CID requests documents that may be locally stored on individual employee laptops. AAP does not have a dedicated system for collecting electronic communications such as emails and chat messages and lacks efficient search tools beyond Microsoft's native functionality, which would be extremely laborious to use for the volume of documents requested by the CID. In particular, the process of searching individual employee laptops would be extremely laborious as it would require manual, individual searches and assistance from AAP's system administrators, which would divert them from their daily support of AAP staff. Overall, it would require significant time to not only locate where all the relevant materials are stored, but also to manually collect these documents, review them for responsiveness, and prepare them for production.
8. Materials related to publications and education are also stored on several third-party platforms that are only accessible by a few AAP employees, who perform other substantial responsibilities, such as developing educational programming. Responding to these requests would impose a substantial additional burden and require coordination with these service providers, resulting in additional costs for AAP.
9. Staff's proposed production schedule, which requires the first production on February 16 and the next production one month later, fails to account for the burdens associated with all of the CID's requests. I project that complying with these requests will take significantly more time and effort than allowed for by the current schedule.
10. Given the breadth of the interrogatory topics and the volume of documents the CID requests, I predict that complying with these requests would take extraordinary time and effort by AAP

employees even if the production schedule is extended. This will divert attention away from carrying out AAP's mission of promoting the health of children and adolescents.

11. For the reasons above, it is extremely burdensome for AAP to comply with the CID as issued, even with the modification set forth in staff's letter.

I declare that the foregoing is true and correct to the best of my knowledge.

Executed on 2/9, 2026.

Robert Katchen

**PUBLIC**

**BEFORE THE UNITED STATES**
**FEDERAL TRADE COMMISSION**

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| In the Matter of | ) | **PUBLIC** |
| Civil Investigative Demand dated January 15, 2026, to American Academy of Pediatrics | ) | File No. P264800 |

**STATEMENT OF COUNSEL PURSUANT TO 16 C.F.R. § 2.10(a)(2)**

Counsel for petitioners, Covington & Burling LLP ("Covington"), respectfully submits this Statement of Counsel pursuant to 16 C.F.R. § 2.10(a)(2) in support of the Petition to Quash or Limit filed by American Academy of Pediatrics ("AAP") on February 9, 2026.

The CID was served on AAP on January 16, 2026. Covington reached out to FTC staff on January 30, 2026 to schedule a meet-and-confer. Staff agreed to meet on February 2, 2026.

On Monday, February 2, 2026 at 3pm ET, Covington met with staff via videoconference to discuss the CID. Laura Kim and Alexandra Remick attended on behalf of AAP, and Jonathan Cohen, Gregory Ashe, and Annie Chiang attended on behalf of the Commission. During the meeting, Covington raised several concerns with the Commission's authority to issue the CID.

First, Covington asked staff about the genesis of the investigation, and what the Commission's purpose was in conducting it given the highly unusual nature of a CID issued to a non-profit organization focused on non-commercial statements. Staff generally stated he could not share that information, but that a high level, AAP could infer from the CID that there were concerns that representations were being made to "consumers" about the safety and efficacy of "purported treatments for pediatric gender dysphoria."

Second, Covington raised threshold jurisdictional concerns with the CID, noting that AAP is a non-profit organization dedicated to the welfare of children, not the economic interests

of pediatricians, making it not a "person, partnership, or corporation" under the FTC Act. Covington quoted from AAP's Articles of Incorporation, which expressly state this mission. Staff stated that AAP was not "ruled out as a target" of the investigation. Staff did not explain why AAP was an appropriate target for an FTC investigation, and instead justified the CID's scope by asserting the FTC had broad investigatory authority.

Third, Covington asked whether the Commission viewed AAP's medical and scientific guidance material as "commercial" speech that is subject to the Commission's jurisdiction. In particular, Covington explained that the 2018 Policy Statement—a focus of the investigation—is medical guidance provided by physicians and scientists that is free to the public and does not promote the purchase of any product or service. Staff declined to address these questions, stating that the meet-and-confer was not the appropriate venue for such discussion and that it did not "make a difference" whether staff considered the speech to be commercial.

Fourth, Covington also raised First Amendment concerns, asking why the CID would not abridge AAP's constitutional rights, for instance by chilling medical discourse. In response, staff conveyed that the First Amendment had been considered but expressed skepticism that the CID would have a chilling effect, stating that the CID would not have been issued if staff believed it violated the First Amendment. Staff declined to engage in further discussion of AAP's First Amendment concerns by stating that such discussion was not "constructive" during a meet-and-confer.

Fifth, Covington also asked about how the CID aligned with the authorizing resolutions, in particular the resolution on "advertising, marketing, or sale of" health-related products or services and the resolution related to marketing of products and services "to children." Staff stated that the investigation was not limited to AAP and could extend to other entities, and that

whether certain materials were promotional or advertising materials was subject to debate. Staff concluded that there was a "clear basis" for the investigation.

Finally, Covington objected to the breadth and burden of the CID's requests, including the five-year time period and specifications stating, "Regardless of time period." Covington emphasized that the lack of a time limitation creates an unduly burdensome and potentially irrelevant universe of documents. Staff responded that they would consider time limitations for some of these specifications. Covington also stated that some of the definitions, including "Organization" (Definition 6), "Document" (Definition 4), and "Collaborative Work Environment" (Definition 1), in the context of requests that require "any" and "all," impose a significant burden on AAP to produce a vast amount of information across digital platforms used by individuals affiliated with AAP or working on behalf of AAP. Staff clarified that "members" in the definition of "Organization" referred to LLC members, not AAP's individual members. Staff also responded that the rest of these definitions were standard Commission definitions that would not be modified.

Instead of providing meaningful clarifications about the scope of the investigation or resolving AAP's threshold concerns about the CID, staff set forth a proposal under which AAP would receive a 30-day extension to respond to the CID if it agreed to respond to Document Requests 9 and 11 a full month *before* the return date.[1] While reiterating that the threshold jurisdictional concerns had not been properly addressed, Covington requested an extension of the Petition to Quash deadline to enable both parties to share additional information in an attempt to resolve these important issues and to continue meeting and conferring about the CID. Staff

[1] Staff explained that the term "disseminated" as used in RFP 9 referred to documents shared outside of AAP.

stated that the Petition to Quash deadline would not be extended without AAP agreeing to fully respond to two document requests 30 days before the return date indicated on the CID. Staff indicated during the call that they would send a proposal to AAP in writing. Although staff indicated they had been authorized to conduct the meet-and-confer during the partial government shutdown, staff noted that there could be some delay associated with the shutdown.

On the evening of Wednesday, February 4, 2026, Covington reached out to staff via email seeking a status update and restating First Amendment concerns discussed in the first meet-and-confer call, particularly with respect to requests seeking communications for inter-organizational deliberations and identities of individuals involved. Covington stated that when First Amendment concerns are raised, the standards imposed by the Fourth Amendment must be applied even more strictly. Covington also expressed a desire to continue discussing these concerns.

Staff responded with a letter on Thursday, February 5, 2026 at 7:28 PM. The letter set forth the proposal staff had referenced on February 2. Staff confirmed that the Petition to Quash deadline (two business days away) would not be extended unless AAP agreed to respond to two requests 30 days before the CID return date. Staff's letter did not resolve any of the first five concerns Covington raised during the meet-and-confer on February 2 but addressed two points relating to AAP's burden as discussed below.

Staff's letter also purported to summarize the concerns AAP raised on the first meet-and-confer, but omitted several important points. Specifically, staff's letter did not memorialize the first concern Covington raised on the meet-and-confer—specifically, the genesis of the investigation and the Commission's purpose in conducting it. Staff's letter incorrectly claimed that Covington raised "new" issues via email. However, Covington specifically raised the

requirement, set forth in *Morton Salt* and grounded in the Fourth Amendment, that a CID must be within the FTC's authority and the information sought must be relevant to a lawful purpose in the first meet-and-confer call.

As to burden, staff's letter offered to modify the time period for certain requests that previously stated "regardless of time period" to the period from January 1, 2015 to present. However, staff did not agree to modify the time period for Requests 4 and 5, which seek all documents and all communications with professional medical organizations, other organizations, and individuals related to the 2018 Policy Statement, 2023 Reaffirmation, and the "SOC 8." Furthermore, although staff confirmed that the definition of "AAP" does not encompass individual members of AAP, staff did not address concerns about the breadth of the definition of "Document" and the use of words such as "all" or "any" for several requests.

Covington sent a letter responding to staff at 4:46 PM on Friday, February 6. The letter described each of the topics discussed on February 2 and reaffirmed the concerns that Covington had expressed in that meet-and-confer, which remain outstanding. Covington also reiterated that AAP wished to have the opportunity to continue to discuss its concerns with staff, but the Petition to Quash deadline was now only one business day away, and staff had refused to provide any extension unless AAP began responding to the CID a month before the return date. Covington once again requested that staff provide a modest extension of the Petition to Quash deadline to allow the parties to continue to meet and confer in good faith.

FTC staff responded to Covington by email on Saturday, February 7, 2026. The email asserted that AAP had requested an extension of the Petition to Quash deadline in exchange for "nothing at all." Staff reiterated that no extension would be granted absent AAP's agreement to make a document production on February 16, 2026—30 days before the CID return date.

Covington replied to staff via email on Sunday, February 8 and emphasized that AAP had hoped to continue to meet and confer with staff in good faith in exchange for a modest extension of the Petition to Quash deadline. Additional time would have allowed AAP to share more information with staff about its serious concerns with the CID in an attempt to resolve, or at least narrow, the issues contained in the petition.

At this time, the issues identified in the petition remain unresolved.

DATED: February 9, 2026

Respectfully submitted,

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