DEBUNKING THE UTAH DEPARTMENT OF HEALTH AND HUMAN SERVICES' DEFENSE OF PEDIATRIC MEDICAL TRANSITION

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SUMMARY

In May 2025, Utah's Department of Health and Human Services released a report aimed at providing evidence-based recommendations to the Utah state legislature regarding the potential lifting of the moratorium on hormonal interventions for minors with gender dysphoria.[1] However, the report misrepresents the literature and makes several key errors, such as failing to synthesize the evidence, a key component of any systematic review. This memo explains why Utah's report is flawed and why its recommendations are unpersuasive and unsupported by the professional standards of evidence-based medicine.

The review, *Gender-Affirming Medical Treatments for Pediatric Patients with Gender Dysphoria*, conducted by the Drug Regimen Review Center at the University of Utah ("Utah Report"), has its origins in legislation signed into law in 2023. As per the *Report to the Utah Legislature Health and Human Services Interim Committee* ("Amendments"), "The law requires the Utah Department of Health and Human Services (DHHS) to conduct a systematic medical evidence review (systematic review) of the use of hormonal agents in the medical treatment of transgender minors under the age of 18 with gender dysphoria."[2]

As outlined in the Utah Report, the purpose of the report is to provide the Utah legislature "evidence to support the UDHHS in its recommendations about gender-affirming care in transgender, nonbinary, or other gender diverse (TGNB) adolescents."[3] The authors attempted to provide such support with three main deliverables: 1) providing a list of pharmacological agents commonly used in "gender-affirming care," including their regulatory status under the FDA for pediatric use, indications for use, and off-label pediatric use; 2) reviewing recent clinical guidelines for gender-affirming treatments in pediatric patients along with the levels of evidence (LEO) to support these recommendations; and 3) compiling systematic reviews and clinical studies addressing the short-term and long-term safety and efficacy of so-called "gender-affirming care."[4] There is also a brief mention of the rates of desistance and regret, which the Utah Report argues is rare.

Despite their lengthy disposition, the Utah Report and the accompanying Amendments fall short on these deliverables, as outlined in this brief memo. The primary findings highlight several critical shortcomings: the review deviates from established standards for systematic reviews, emphasizes the volume of evidence over its quality, relies uncritically on guidelines from self-proclaimed experts, neglects significant life-altering adverse effects, and includes input from advisors, some of whom demonstrate bias in favor of "gender-affirming care" for minors.

1 Society for Evidence Based Gender Medicine (2015, May 30). Notable publications in gender medicine, April-May 2025. **https://segm.org/SEGM-Digest-Issue1-2025#Utah**.
2 Report to the Utah Legislature Health and Human Services Interim Committee. Transgender medical treatments and procedures amendments (S.B. 16, 2023). (May 2025). **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**.
3 LaFleur, J. et al. (2024). Gender-affirming medical treatments for pediatric patients with gender dysphoria. **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**.
4 LaFleur, J. et al. (2024). Gender-affirming medical treatments for pediatric patients with gender dysphoria. **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**.

THE UTAH REPORT IS NOT A SYSTEMATIC REVIEW

Although presented with academic and technical language, and more than 1,000 pages in length, the Utah Report is a broad narrative review that lacks the scrutiny necessary to produce quality research. Unlike true systematic reviews, it does not assess the reliability of studies and whether the research can provide guidance for weighing the risks and benefits of medical intervention for children with gender dysphoria. While it was intended to be a systematic review, it failed to meet basic requirements, including protocol pre-registration with an online platform for registering systematic review protocols in health and social care (such as PROSPERO, for example), which is essential to increasing transparency and minimizing bias.[5]

The Utah Report also failed to include well-established systematic reviews, such as the NICE or York reviews, partly due to the fact the report's literature search went no further than June 5, 2023, though the report was submitted in August 2024, and not made available until recently in May 2025.[6,7] Furthermore, among the seven systematic reviews subjected to data extraction, the risk-of-bias assessment – relying entirely on the evaluations provided by the Utah Report authors – indicates that six of the seven reviews would receive a "critically low" rating in overall confidence in the results, based on the authors' application of AMSTAR-2 (A MeaSurement Tool to Assess systematic Reviews).[8,9] The one remaining review (Chew 2018) would receive a "low" rating based on the author's analysis. Using AMSTAR-2's definition of "critically low," the majority of these reviews should thus "not be relied on to provide an accurate and comprehensive summary of the available studies."[10]

It does behoove one, however, to discuss the Ludvigsson (2023) systematic review, which is one of the seven noted in the Utah Report. The Utah Report particularly scrutinizes and singles out Ludvigsson's review, describing it as an "outlier" based on Ludvigsson, et al's choice to exclude studies with the "highest risk of study-level bias," arguing this is a "violation of best practices for systematic reviewers."[11] However, it is reasonable to exclude studies with a high level of bias as this can undermine the reliability and validity of findings, which can skew the review's conclusions.[12] Unlike the Utah Report, the Ludvigsson review also clearly used the GRADE (Grading of Recommendations Assessment, Development and Evaluation) approach to assess the quality of evidence of specific outcomes.[13] The GRADE framework is widely used to assess systematic reviews on the certainty of evidence and strength of recommendations.[14,15]

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5 Pieper, D., Rombey, T. (2022). Where to prospectively register a systematic review. *Syst Rev 11, 8*. **https://doi.org/10.1186/s13643-021-01877-1**.
6 The Utah report was submitted on August 6, 2024, but was not publicly available until May 2025.
7 Society for Evidence Based Gender Medicine (2015, May 30). Notable publications in gender medicine, April-May 2025. **https://segm.org/SEGM-Digest-Issue1-2025#Utah**.
8 LaFleur, J. et al. (2024). Gender-affirming medical treatments for pediatric patients with gender dysphoria. **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**.
9 Shea, B.J. (2017). AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *BMJ;358:j4008*. **http://dx.doi.org/10.1136/bmj.j4008**.
10 Shea, B.J. (2017). AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *BMJ;358:j4008*. **http://dx.doi.org/10.1136/bmj.j4008**.
11 LaFleur, J. et al. (2024). Gender-affirming medical treatments for pediatric patients with gender dysphoria. **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**.
12 McDonagh, M., Peterson, K. et. al. (2013). Avoiding bias in selecting studies. In: Methods Guide for Effectiveness and Comparative Effectiveness Reviews [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008-. Available from: **https://www.ncbi.nlm.nih.gov/books/NBK126701/**.
13 Ludvigsson, JF, Adolfsson, J. et. al. (2023). A systematic review of hormone treatment for children with gender dysphoria and recommendations for research. *Acta Paediatrica*. **https://doi.org/10.1111/apa.16791**.
14 Guyatt GH, Oxman AD, Schunemann HJ, et al. (2011). GRADE guidelines: a new series of articles in the journal of clinical epidemiology. J Clin Epidemiol.; 64(4): 380-382. **doi:10.1016/j.jclinepi.2010.09.011**.
15 Society for Evidence Based Gender Medicine (2015, May 30). Notable publications in gender medicine, April-May 2025. **https://segm.org/SEGM-Digest-Issue1-2025#Utah**.

The recent report issued by the Department of Health and Human Services (HHS) also applauds the Ludvigsson systematic review for its low risk of bias in the review.[16]

Nevertheless, the Utah Report asserts that puberty blockers and cross-sex hormones are safe and effective amid a sea of weak evidence, data extraction by a single-reviewer rather than at least two, and conclusions based primarily on narrative summaries rather than quantitative synthesis – all despite reaching conflicting findings from well-established systematic reviews available prior to the Utah Report's submission.[17,18]

Another problem with the Utah Report is its heavy reliance on observational studies, which are designed to systematically describe and summarize characteristics, behaviors, or phenomena within a specific population, without manipulating variables or testing hypotheses about cause and effect.[19] Unlike randomized control trials, considered the gold standard in medicine to evaluate the effectiveness of an intervention or treatment, observational studies generally have small sample sizes and lack a control group.

Unfortunately, the evidence cited in the field of pediatric gender medicine consists of observational and descriptive studies with significant quality issues.[20] Challenges presented by these studies include small sample sizes, significant attrition of enrollees, relatively short follow-up periods, selection bias, uncontrolled confounding, and lack of a comparison group. All of this leads to low or very low certainty of evidence in the face of life-altering interventions. The Utah Report fails to recognize these realities.

16 Department of Health and Human Services. (2025, May 1). Treatment for pediatric gender dysphoria: review of evidence and best practices. **https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf**.

17 Taylor, J., Hall R., Heathcote, C. et al. (2024). Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of guideline quality (part 1). *Arch Dis Child;109:s65–s72*. **doi:10.1136/archdischild-2023-326499**.

18 Taylor, J., Hall R., Heathcote, C. et al. (2024). Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of guideline quality (part 2). *Arch Dis Child;109:s73–s82*. **doi:10.1136/archdischild-2023-326500**.

19 Aggarwal, R. & Ranganathan, P. (2019). designs: Part 2 – descriptive studies. *Perspectives in Clinical Research 10(1):p 34-36*. DOI: 10.4103/picr.PICR_154_18.

20 McDeavitt, K., Cohn, J., & Kulatunga-Moruzi, C. (2025). Pediatric gender affirming care is not evidence-based. *Current Sexual Health Reports 17:12*. **https://doi.org/10.1007/s11930-025-00404-w**.

THE CONFLATION OF QUANTITY WITH QUALITY

The Utah Report goes to great lengths to present a voluminous amount of data with little regard for its quality, as if to suggest the mere "weight" of the data makes it clinically meaningful and thus supportive of the affirmative model of pediatric gender medicine. Yet, quantity of papers does not equate to quality of results. As noted above, the glaring uncertainty of the findings of numerous studies should give us pause and cause for concern. When experts highlight the lack of evidence for pediatric gender transition, they are not pointing to the number of studies but to their poor methodological quality and the resulting uncertainty in the findings.[21] The problem lies not in the amount of "evidence," but in its substantial weakness and very low quality.

In fact, the authors conflate the issue of quantity versus quality by citing a recently FDA-approved novel gene therapy treatment for spinal muscular atrophy (SMA) as an example of how "the amount of evidence available for treating pediatric [gender dysphoria] patients with [gender-affirming hormonal therapy] far exceeds the quantity that supported the use of SMA gene therapy upon FDA approval."[22] The comparison is faulty for two reasons. First, the efficacy of Zolgensma (the gene therapy for SMA) is validated by objective metrics such as survival rate and improvements in motor function.[23] Meanwhile, the efficacy of pediatric "gender-affirming care" is assessed through patient self-reports of mental health (i.e. subjective metrics). A youth gender clinic whistleblower reports that patients sometimes provide dishonest answers as to justify or continue treatment.[24] The absence of a link between access to "gender-affirming care" and suicide should also raise substantial skepticism toward the utility of youth mental health self-reports as an outcome measure.[25]

The other reason that the Zolgensma comparison is faulty concerns differences in research methodologies. In clinical research, randomized control trials represent the gold standard for testing treatments. Because the only difference between the treatment and control groups is access to the treatment, differences in outcomes between the groups can be credibly and causally attributed to the treatment. Zolgensma is currently being evaluated by a randomized control trial thanks to promising results of a small number of observational studies that were suggestive of improvement in clinically objective metrics.[26] Meanwhile, the overwhelming proportion of studies assessing "gender-affirming care" combine observational designs with subjective metrics. Notably, the results of the one randomized control trial that evaluated "gender-affirming care" indicated that observed mental health benefits are placebic (i.e. patients are happy to gain access to a treatment that they believe will help them).[27]

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21 Society for Evidence Based Gender Medicine (2015, May 30). Notable publications in gender medicine, April-May 2025. **https://segm.org/SEGM-Digest-Issue1-2025#Utah**.
22 LaFleur, J. et al. (2024). Gender-affirming medical treatments for pediatric patients with gender dysphoria. **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**.
23 Mendell, JR et. a. (2017). Single-dose gene-replacement for spinal muscular atrophy. The New England Journal of Medicine 377(18): 1713-1722. **https://www.nejm.org/doi/pdf/10.1056/NEJMoa1706198**.
24 **https://nypost.com/2025/01/30/opinion/im-a-clinic-whistleblower-trans-kids-ban-will-save-lives/**
25 **https://www.city-journal.org/article/aclu-attorney-confesses-transgender-suicide-claim-is-a-myth**
26 **https://www.novartis.com/clinicaltrials/NCT05089656**
27 **https://www.nationalreview.com/2023/09/the-medical-establishment-doubles-down-on-its-faulty-effort-to-sell-gender-affirming-care/**

GUIDELINES INCLUDED WITHOUT SCRUTINY

Four major guidelines were reviewed in the Utah Report. These included the 2022 guidelines from the World Professional Association for Transgender Health (WPATH), the 2017 guidelines from the Endocrine Society, the 2020 guidelines from European Society for Sexual Medicine (ESSM), and the 2022 guidelines from American College of Obstetricians and Gynecologists (ACOG). Common practice among the medical community is to review such guidelines with scrutiny and discernment. However, the Utah Report takes these guidelines at face value purely because they come from "organizations that are widely regarded as authorities in their given specialty" and state "a risk-of-bias assessment was not conducted on guidelines as part of the current work because [the authors] restricted inclusion to recognized medical authorities who published evidence-based guidelines."[28] Effectively, the Utah Report simply trusts that the guideline authors used a rigorous process without any verification.[29]

Expert opinion – the least reliable evidence – then advances to the forefront, ahead of all other levels of evidence, which is completely contrary to the "evidence pyramid."[30] Additionally, the Utah Report strongly endorses guidelines that WPATH designated as "recommended," despite the fact "formal recommendations were not assigned a specific [level of evidence]."[31] The Endocrine Society guidelines, however, are assigned a level of evidence (LOE) with many recommendations having "low" or "very-low" LOE ratings.

Unfortunately, these guidelines are taken with absolute certainty by the Utah Report's authors with limited critical review. Both the WPATH and Endocrine Society guidelines, for instance, suggest puberty suppression with GnRH analogs is "fully reversible."[32] However, according to the HHS's report, Treatment for Pediatric Gender Dysphoria, these interventions are associated with significant risks, including diminished bone mineral density. The true impact on neurocognitive development (executive function, emotional regulation, and social cognition) is also unknown. If cross-sex hormones are started thereafter (which occurs in many youth given puberty blockers for gender dysphoria), the risk of permanent infertility and impaired adult sexual function is significant.[33] The effects of these interventions are real and cannot be dismissed by blindly and uncritically accepting guidelines as gospel.

The ESSM and ACOG guidelines included in the review are even further removed from the evidence given their basis in consensus and lack of formal evidence grading.

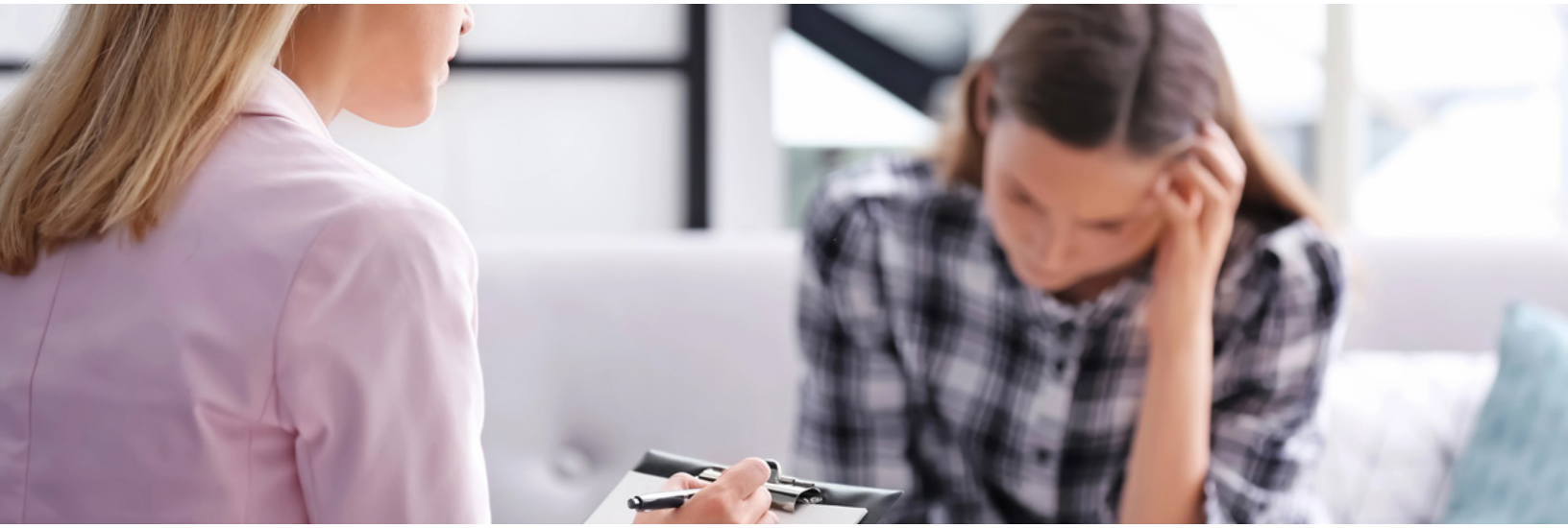
It is striking that these four sets of guidelines were included in the Utah Report even after the University of York's systematic review, published in April 2024, found that all but a couple guidelines were of poor quality and not reliable.[34] The York systematic review notes that "most clinical guidelines for managing

28 LaFleur, J. et al. (2024). Gender-affirming medical treatments for pediatric patients with gender dysphoria. **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**.
29 Ryan, B. [@benryanwriter]. (2025, May 25). The Utah state government commissioned a report on pediatric gender-transition treatment. It comes in at over 1,000 words and concludes that the evidence favorably backs such treatment. But despite the fact that it bills itself as a systematic literature review, it isn't one. [Post]. X. **https://x.com/benryanwriter/status/1926704468336242779?s=12&t=TTipQXhzW0KiZ8gnWbZXTA**.
30 McDeavitt, K., Cohn, J., & Kulatunga-Moruzi, C. (2025). Pediatric gender affirming care is not evidence-based. *Current Sexual Health Reports 17:12*. **https://doi.org/10.1007/s11930-025-00404-w**.
31 LaFleur, J. et al. (2024). Gender-affirming medical treatments for pediatric patients with gender dysphoria. **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**.
32 LaFleur, J. et al. (2024). Gender-affirming medical treatments for pediatric patients with gender dysphoria. **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**.
33 Department of Health and Human Services. (2025, May 1). Treatment for pediatric gender dysphoria: review of evidence and best practices. **https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf**.
34 Ryan, B. [@benryanwriter]. (2025, May 25). The Utah state government commissioned a report on pediatric gender-transition treatment. It comes in at over 1,000 words and concludes that the evidence favorably backs such treatment. But despite the fact that it bills itself as a systematic literature review, it isn't one. [Post]. X. **https://x.com/benryanwriter/status/1926704468336242779?s=12&t=TTipQXhzW0KiZ8gnWbZXTA**.

children/adolescents experiencing gender dysphoria/incongruence lack an independent and evidence-based approach and information about how recommendations were developed."[35] In fact, only the Swedish and Finnish guidelines on caring for these minors were recommended for practice given their scientific rigor.[36]

The Swedish guidelines link the lack of evidence about pediatric medical transition to their recommendation that these interventions should be provided under a research framework and for exceptional cases.[37] The Finnish guidelines also use a much more cautious approach to providing these interventions, which they also describe as experimental.[38] The Swedish and Finnish guidelines rank the highest "for rigour of development due to their evidence-based approach and transparent report" of their methodology. They published a detailed account of the decision-making behind their recommendations and were the only guidelines that included a formal ethics review.[39]

The quality of both the Swedish and Finnish guidelines is not the only thing that sets them apart from the other guidelines analyzed. Not only were they the only two guidelines to adequately follow the principles of evidence-based medicine, they also clearly recommended psychosocial care as the "first line treatment for childhood gender dysphoria/incongruence."[40] Both guidelines also recommend that medical transition, namely the use of puberty blockers and cross-sex hormones, be limited to research only.[41]



35 Taylor, J., Hall R., Heathcote, C. et al. (2024). Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of guideline quality (part 1). *Arch Dis Child;109:s65–s72.* **doi:10.1136/archdischild-2023-326499**.
36 Taylor, J., Hall R., Heathcote, C. et al. (2024). Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of guideline quality (part 1). Arch Dis Child;109:s65–s72. **doi:10.1136/archdischild-2023-326499**.
37 Taylor, J., Hall R., Heathcote, C. et al. (2024). Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of guideline quality (part 1). *Arch Dis Child;109:s65–s72.* **doi:10.1136/archdischild-2023-326499**.
38 Taylor, J., Hall R., Heathcote, C. et al. (2024). Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of guideline quality (part 1). *Arch Dis Child;109:s65–s72.* **doi:10.1136/archdischild-2023-326499**.
39 Taylor, J., Hall R., Heathcote, C. et al. (2024). Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of guideline quality (part 1). *Arch Dis Child;109:s65–s72.* **doi:10.1136/archdischild-2023-326499**.
40 Taylor, J., Hall R., Heathcote, C. et al. (2024). Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of guideline quality (part 2). *Arch Dis Child;109:s73–s82.* **doi:10.1136/archdischild-2023-326500**.
41 Taylor, J., Hall R., Heathcote, C. et al. (2024). Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of guideline quality (part 2). *Arch Dis Child;109:s73–s82.* **doi:10.1136/archdischild-2023-326500**.

KEY ADVERSE EFFECTS OF "GAC" IGNORED

The Utah Report analyzed seven systematic reviews that looked at outcomes related to mental health, psychosocial functioning, body changes, body image, bone health, cardiovascular risk, and cancer. They conclude that gender-affirming hormone therapy (GAHT) is effective in improving mental health and psychosocial outcomes, whereas concerns related to bone health, cardiovascular risk, and cancer are "minimal and manageable."[42] The Utah Report neglects significant adverse effects that are associated with GAHT, including the life-altering effects of infertility/sterility and sexual dysfunction.

While the authors admit in the Amendments that "infertility is a known risk of cross-sex hormone therapy," the authors of the Utah Report felt it was not important enough to be included as an outcome of focus in their report.[43,44] Unlike the Utah Report, the HHS report clearly indicates infertility/sterility and sexual dysfunction as risks of pediatric medical transition.[45] The HHS report notes that suppression of the hypothalamic-pituitary-gonadal (HPG) axis, caused by the administration of puberty blockers, may result in permanent infertility if cross-sex hormones are started shortly afterwards, particularly when gonadal maturation is not completed before normal puberty is interrupted.[46] This level of analysis is not found in the Utah Report and infertility is treated merely as an afterthought. Even the Endocrine Society's guidelines recommend that "all transsexual individuals be informed and counseled regarding options for fertility" before starting medications to suppress puberty or opposite sex hormones.[47]

Sadly, the risk of sexual dysfunction from GAHT is never mentioned in the Utah Report. Puberty blockers and cross-sex hormones all carry the risk of significant harm, including sexual dysfunction. What the Utah Report also fails to mention in its analysis, which was extensively discussed in the HHS report, is the infrequent assessment of sexual dysfunction in pediatric gender studies, despite its importance to long-term well-being.[48] In fact, Dr. Marci Bowers, vaginoplasty surgeon and past president of WPATH, expressed concerns that male patients who began puberty blockers at Tanner Stage 2 and received cross-sex hormones were physiologically anorgasmic, prior to and following vaginoplasty.[49] Despite the heavy focus on mental health, psychosocial function, and body image concerns in the Utah Report, the authors fail to address the concerns of sexual dysfunction and its long-term effect on quality of life.

42 LaFleur, J. et al. (2024). Gender-affirming medical treatments for pediatric patients with gender dysphoria. **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**.
43 Report to the Utah Legislature Health and Human Services Interim Committee. Transgender medical treatments and procedures amendments (S.B. 16, 2023). (May 2025). **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**.
44 Society for Evidence Based Gender Medicine (2015, May 30). Notable publications in gender medicine, April-May 2025. **https://segm.org/SEGM-Digest-Issue1-2025#Utah**.
45 Department of Health and Human Services. (2025, May 1). Treatment for pediatric gender dysphoria: review of evidence and best practices. **https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf**.
46 Department of Health and Human Services. (2025, May 1). Treatment for pediatric gender dysphoria: review of evidence and best practices. **https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf**.
47 Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer WJ 3rd, Spack NP, Tangpricha V, Montori VM. Endocrine Society. (2009). Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab;* 94(9):3132-54. doi: 10.1210/jc.2009-0345.
48 Department of Health and Human Services. (2025, May 1). Treatment for pediatric gender dysphoria: review of evidence and best practices. **https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf**.
49 Grossman, H. (2023, May 3). Influence trans care doctor once warned puberty blockers could cause permanent sexual dysfunction. Fox News. **https://www.foxnews.com/media/infleuntial-trans-care-doctor-once-warned-puberty-blockers-could-cause-permanent-sexual-dysfunction**.

ADVISORS AND POSSIBLE CONFLICTS OF INTEREST

Within the Amendments, "the individuals and entities DHHS is required to consult with" are referred to as "advisors," with nine listed in Appendix A.[50] Among these advisors is **Nikki Mihalopoulos, MD, MPH,** "who is serving as an advisor representing the University of Utah." Dr. Mihalopoulos is Chief of the Division of Adolescent Medicine for the Department of Pediatrics at the University of Utah School of Medicine, and has a special interest in transgender healthcare, which is not disclosed in Appendix A.[51,52] Her publications show support of "gender-affirming care" for minors. In an article published in 2021, co-authored by Dr. Mihalopoulos, she and her colleagues conclude that "pediatric health care providers can play a critical role in building solutions in policy and advocacy…to improve the health of transgender/gender diverse youth. Many government entities, especially at the state and local level, actively resist efforts promoting equal rights."[53] It seems curious that the Amendments does not disclose Dr. Mihalopoulos's clear predisposition for the continuation of "gender-affirming care" practices; nor does it disclose her vociferous political advocacy for the same.

Similarly, **Dr. Brooks Keeshin** is merely listed as one who has served as an "advisor representing the University of Utah." Dr. Keeshin is a Professor of Pediatrics and the Associate Vice Chair of Research in Child Mental Health at the Huntsman Mental Health Institute at the University of Utah. He is also a member of the American Academy of Pediatrics (AAP) Council on Healthy Mental and Emotional Development Executive Committee.[54] The Amendments does not disclose that in the past Dr. Keeshin has written on the topic of "gender-affirming care" for minors, nor does it disclose that in 2024, he wrote a short "Clinical Perspective" highlighting Utah's "potential pathway forward" for "open access to [gender-affirming] care" for adolescents.[55]

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50 Report to the Utah Legislature Health and Human Services Interim Committee. Transgender medical treatments and procedures amendments (S.B. 16, 2023). (May 2025). **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**

51 **https://healthcare.utah.edu/find-a-doctor/nicole-l-mihalopoulos**

52 Report to the Utah Legislature Health and Human Services Interim Committee. Transgender medical treatments and procedures amendments (S.B. 16, 2023). (May 2025). **https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636**.

53 Geist, C., Greenberg, K.B., Luikenaar, R., & Mihalopoulos, N.L. (2021). Pediatric Research and Health Care for Transgender and Gender Diverse Adolescents and Young Adults: Improving (Biopsychosocial) Health Outcomes, *Academic Pediatrics*, Volume 21, Issue 1, Pages 32-42, ISSN 1876-2859, **https://doi.org/10.1016/j.acap.2020.09.010**

54 **https://healthcare.utah.edu/find-a-doctor/brooks-r-keeshin**.

55 Keeshin, B. (2024). 22.3 Policy pathways forward in states with gender-affirming care bans. *Journal of the American Academy of Child & Adolescent Psychiatry, 63(10), S32-S33.* **https://www.jaacap.org/article/S0890-8567(24)00521-5/fulltext**.

CONCLUSION

The Utah Report and its accompanying Amendments seek to persuade legislators to reconsider Utah's ban on so-called "gender-affirming care" by emphasizing its purported benefits and ignoring its risks. However, this extensive report falls short of providing convincing evidence. Its shortcomings include failure to adhere to the fundamental standards of a systematic review, prioritizing the quantity of evidence over its quality, uncritically relying on guidelines from purported experts, overlooking significant life-altering adverse effects, and consulting advisors, some of whom support "gender-affirming care" for minors. Consequently, Utah legislators should not rely on either the Utah Report or its accompanying Amendments as a credible source for evaluating the safety and efficacy of pediatric gender medicine. Utah would be much better served by a thorough review of HHS's report on this subject matter.

Do No Harm