No. 23-4331

In the United States Court of Appeals for the Ninth Circuit

C. P., BY AND THROUGH HIS PARENTS, PATRICIA PRITCHARD AND NOLLE PRITCHARD; AND PATRICIA PRITCHARD, *ET AL.*,
PLAINTIFFS-APPELLEES,
V.
BLUE CROSS BLUE SHIELD OF ILLINOIS, *ET AL.*,
DEFENDANT-APPELLANT.

On Appeal from the United States District Court
for the Western District of Washington
No. 3:20-cv-06145-RJB / Hon. Robert J. Bryan

BRIEF OF *AMICUS CURIAE* ETHICS AND PUBLIC POLICY CENTER SUPPORTING APPELLANT AND REVERSAL

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTEREST OF *AMICUS CURIAE* 1

INTRODUCTION AND SUMMARY OF ARGUMENT 2

ARGUMENT 7

I. There is not, and has never been, a national or international medical consensus regarding an authoritative standard of care for gender dysphoria. 7

A. There is no consensus within the medical profession in favor of medicalized gender transitions. 7

B. There is a lack of evidence to support medical gender-transitioning interventions. 13

C. WPATH and Endocrine Society guidelines are not the standard of care. 18

D. The lack of medical consensus is reflected internationally. 25

II. Gender-transitioning interventions can lead to serious harms, especially in minors. 30

III. The WPATH Files and Cass Review underscore the fundamental deficiencies with and uncertainties regarding gender transition medicine. 35

A. WPATH Files 36

B. Cass Review 38

CONCLUSION 41

CERTIFICATE OF COMPLIANCE 42

CERTIFICATE OF SERVICE 43

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INTEREST OF *AMICUS CURIAE*[1]

The Ethics and Public Policy Center ("EPPC") is a nonprofit research institution dedicated to applying the Judeo-Christian moral tradition to critical issues of public policy, law, culture, and politics. EPPC has a strong interest in promoting the Judeo-Christian vision of the human person, protecting religious liberty, and responding to the challenges of gender ideology.

Gender ideology has permeated culture with stunning speed, influencing medicine, business, media, entertainment, government, and education. It has sown confusion and led to unprecedented rates of "transgender" identification and body modification requests. These changes have created an urgent need for clarity, education, and guidance.

To meet this need, EPPC launched the Person & Identity Project, led by Director Mary Rice Hasson.[2] Many EPPC Fellows also write and advocate on issues related to gender ideology.[3]

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[1] No party's counsel authored this brief, no one other than *amicus* and its counsel contributed money for this brief, and all parties have consented to its filing.

[2] EPPC, Person & Identity Project, https://personandidentity.com/.

[3] Relevant publications from EPPC Fellows include:

INTRODUCTION AND SUMMARY OF ARGUMENT

As Defendant-Appellant demonstrates in its opening brief, the Court need not take a position on what Plaintiffs-Appellees call "medically indicated gender-affirming care" in order to find the district court erred in granting summary judgment in Plaintiffs-Appellees' favor.[4]

- Ryan T. Anderson, *When Harry Became Sally* (2018);
- Andrew T. Walker, *God and the Transgender Debate* (2017);
- Carl R. Trueman, *Strange New World: How Thinkers and Activists Redefined Identity and Sparked the Sexual Revolution* (2022);
- Mary Rice Hasson, *Erasing Females in Language and Law*, 11 J. of Christian Legal Thought 44, 46 (Oct. 2011), available at https://eppc.org/publication/erasing-females-in-language-and-law/.
- Rachel N. Morrison, *Gender Identity Policy Under the Biden Administration*, 23 FED. SOC. REV. 85 (2022), available at SSRN: https://ssrn.com/abstract=4104566;
- Theresa Farnan, *Our World Has Lost the Catholic Understanding of Human Anthropology*, Our Sunday Visitor (June 2, 2023), https://www.oursundayvisitor.com/our-world-has-lost-the-catholic-understanding-of-human-anthropology;
- Amicus briefs on gender identity authored by EPPC fellows are available at EPPC, *Amicus Briefs: "Gender Transition" Interventions*, https://eppc.org/amicus-briefs/#16-%E2%80%9Cgender-transition%E2%80%9D-interventions-.

[4] Appellant Br. at 5-6 (Issues presented).

Nonetheless, this case remains an important front in an ongoing battle over whether federal law requires religious employers to participate in so-called "gender transitions" in violation of their conscience and against growing mountains of evidence that these interventions are unnecessary, dangerous, and harmful. As such, it is critical that the Court understand that the representations the Plaintiffs made below, and which remain part of the record in this case, are deeply misleading and in many cases flatly untrue.

Plaintiffs-Appellees told the district court that so-called gender-affirming care is "medically necessary"[5] under well-established "standards of care"[6] "Gender-affirming care is well-established, widely accepted, and evidence-based."[7] "Treatment for gender dysphoria is provided pursuant to well-established guidelines, developed through decades of research and clinical practice."[8] On the flip side, Plaintiffs told the court that Catholic Health Initiative's (CHI) decision to exclude coverage for gender transition procedures "was not based on any objective

[5] 5-ER-1020, 1023, 1026.

[6] *Id*. at 1025, 1028.

[7] *Id*. at 1040.

[8] *Id*. at 1042.

medical or scientific evidence concerning the safety or efficacy of the treatment."[9]

Plaintiffs also made important misrepresentations about medical studies related to gender transitions. They told the district court that "[t]reatment with puberty-delaying medications is reversible,"[10] but that the failure to prescribe puberty blockers "are serious, including irreversible and harmful physical changes and irreparable mental harm."[11]

Amicus offers this brief to show the Court that these claims are demonstrably false.

Part I demonstrates that *there is not, and has never been, a national or international medical consensus regarding an authoritative standard of care for gender dysphoria.* Medical "gender transitioning" interventions in minors (puberty suppression, cross-sex hormones, and surgeries that include amputating primary and secondary sex organs) reflect neither a medical consensus nor the standard of care. Plaintiffs'

[9] *Id*. at 1044.

[10] *Id*. at 1040.

[11] *Id*. at 1042.

claims cannot be reconciled with recent changes in **Sweden**, **Finland**, **Denmark**, **Norway**, **England**, **Australia**, **New Zealand**, **France, Germany**, **The Netherlands**, and **Scotland**, which reflect growing evidence and well-grounded concerns that these medical interventions cause more harm than good.

Part II surveys recent studies showing that *gender-transitioning interventions can lead to serious harms, especially in minors.* Even proponents of puberty blockers have backed off claims that these drugs are "safe and fully reversible." Today, the drugs are known to have negative effects on bone density, social and emotional maturation, and other aspects of neuro-development. Cross-sex hormones likewise affect irreversible changes in children's bodies, including genital or vaginal atrophy, hair loss/gain, voice changes, impaired fertility, and cardiovascular risks, among others. Surgeries to amputate primary and secondary sex organs—performed on children as young as thirteen—are obviously irreversible.

Finally, Part III draws attention to two important developments from the past two months that reflect the evidence amassed in Parts I and II. First, on March 4, 2024, a think tank released the WPATH Files,

which consist of leaked internal discussions between doctors, nurses, and other WPATH members. These unguarded conversations reveal that WPATH members are aware of the serious problems documented in Parts I and II: scientific and ethical deficiencies, doubts that minors are giving informed consent to these procedures, and practitioners' failure to address pre-existing psychological conditions before pushing minors toward "transition." The WPATH Files reveal WPATH as an unethical organization dabbling in pseudoscience, a discredited outfit that should not be trusted to develop standards of care.

Second, on April 9, 2024, British pediatrician Hilary Cass published the 388-page Cass Review, the culmination of a four-year study commissioned by the National Health Service in England into "gender identity services for children and young people." Dr. Cass concluded that "gender medicine . . . is built on shaky foundations." The Report recommends that England abandon the gender-clinic model of care, which has generally granted on-demand provision of gender-reassignment interventions. NHS England promptly welcomed the Cass Review's recommendations and has already expressed a firm commitment to implement the recommended changes.

Based on the evidence collected here and the arguments of parties, *Amicus* urges this Court to reverse the decision below.

ARGUMENT

I. There is not, and has never been, a national or international medical consensus regarding an authoritative standard of care for gender dysphoria.

Contrary to what Plaintiffs told the district court, there is no consensus within the medical profession that supports medical interventions for minors' gender transitions.[12] This lack of consensus is reflected historically, domestically, and internationally.

A. There is no consensus within the medical profession in favor of medicalized gender transitions.

The medical profession has never reached a consensus in favor of medical interventions for minors experiencing identity-related distress. From the very beginning of this movement, serious voices have pushed back, raising ethical concerns, revealing flaws in the studies used to justify medical interventions, and publishing critiques in major medical journals.

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[12] *Amicus* uses the common term "gender transition" to denote efforts to change a child's appearance or body so that it more closely resembles the child's expressed gender identity. A person cannot change his or her sex.

Until recently, "clinicians actively worked with children and their parents to lessen gender dysphoria or adopted a neutral strategy of 'watchful waiting.'"[13] Under this approach, most cases of early onset "gender distress"—61% to 98%—resolved "through the natural course of puberty, if not earlier."[14]

A different approach—medical interventions for the purpose of gender transition in minors—emerged in the Netherlands in the late 1980s and early 1990s.[15] But as the Dutch program grew over the following decades, opposition grew too. By 1999, a "wave of negative publicity" threatened the fledgling program: Dutch gender clinicians were publicly castigated as "Nazis experimenting with children."[16] Leiden University Professor Heleen Dupuis, a progressive ethicist, described the Dutch youth gender program as "reckless" and an "abuse

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[13] Devita Singh et al., *A Follow-Up Study of Boys with Gender Identity Disorder*, Frontiers Psychiatry, Mar. 2022 1, 12-13, https://doi.org/10.3389/fpsyt.2021.632784.

[14] Sarah C.J. Jorgensen, *Transition Regret and Detransition: Meanings and Uncertainties*, 52 Archives Sexual Behav. 2173, 2176 (2023), https://doi.org/10.1007/s10508-023-02626-2.

[15] Alex Bakker, *The Dutch Approach: Fifty Years of Transgender Health Care at the VU Amsterdam Gender Clinic* 120 (2021).

[16] *Id.* at 116.

of medicine."[17] In the early 2000s, prominent Dutch psychiatrists expressed concerns that a child's "wish for sex change" might mask other psychiatric illnesses, including early psychoses.[18]

Dutch clinicians engaged in gender transitions continued to face skepticism and worry over peer "disapproval," "reactions of the correctional medical boards, or litigation."[19] Feeling great "urgency" to prove that medical interventions benefitted minors, psychiatrist Annelou de Vries initiated the first follow-up research on puberty-suppressed adolescents.[20] Her studies in 2011 and 2014 touted positive outcomes[21] and "launched the experimental practice of pediatric gender transition into mainstream medical practices."[22] For nearly a decade, advocates for

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[17] *Id*. at 127.

[18] *Id*. at 13.

[19] Peggy Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1893 (2008), https://doi.org/10.1111/j.1743-6109.2008.00870.x.

[20] Bakker, *supra* n.15, at 158.

[21] *Id*. at 160.

[22] Stephen B. Levine and E. Abbruzzese, *Current Concerns About Gender-Affirming Therapy in Adolescents*, 15 Current Sexual Health Reps. 113, 118 (2023), https://doi.org/10.1007/s11930-023-00358-x.

so-called "gender-affirming care" touted these Dutch studies as evidence that transgender minors benefitted from medical interventions.

The seeming promise of the Dutch approach led Dr. Norman Spack to open the first U.S. pediatric gender clinic at Boston Children's Hospital in 2007. With scant research to guide him, Spack perceived "[s]topping puberty" as "diagnostic": if this drug regimen brought psychological relief, that confirmed that the child was "transgender." [23] Spack quickly moved beyond the Dutch age protocol and began using puberty blockers with children as young as nine.[24]

The 2014 Dutch study noted above made the strongest case for performing medical gender-transitions on minors, claiming positive psychological functioning in fifty-five medically transitioned adolescents.[25] In recent years, however, the methodology and the ethics

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[23] Pagan Kennedy, *Q&A with Norman Spack*, Bos. Globe, Mar. 30, 2008, http://archive.boston.com/bostonglobe/ideas/articles/2008/03/30/qa_with_norman_spack/?page=full.

[24] Beth Schwartzapfel, *How Norman Spack transformed the way we treat transgender children*, Bos. Phoenix, Aug. 10, 2012, https://thephoenix.com/boston/life/142583-how-norman-spack-transformed-the-way-we-treat-tran/.

[25] Annelou L.C. de Vries et al., *Young adult psychological outcome after puberty suppression and gender reassignment*, 134 Pediatrics 696, 702 (2014), https://pubmed.ncbi.nlm.nih.gov/25201798/.

of the Dutch protocol have drawn fierce criticism.[26] A 2021 UK study designed to replicate the reportedly rosy outcomes from the 2014 Dutch study failed to do so, finding instead "no changes in psychological function."[27] A 2023 re-analysis of the UK data reported that while most "participants experience no reliable change in distress across all time points," a substantial portion (15-34%) actually saw their mental health outcomes "reliably deteriorate," an outcome that contradicts the earlier Dutch reports.[28]

> Several veteran researchers recently warned:
>
> [The gender industry] has a penchant for exaggerating what is known about the benefits of [youth medical gender transition], while downplaying the serious health risks and

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[26] Michael Biggs, *The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence*, 49 J Sex Marital Ther 348, 362 (2023), https://doi.org/10.1080/0092623X.2022.2121238 ("Evidence for the benefits of puberty suppression must be acknowledged as slender. . . .").

[27] Polly Carmichael et al., *Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK*, Pub. Libr. Sci. One (Feb. 2021)https://doi.org/10.1371/journal.pone.0243894 (failing to replicate Dutch study).

[28] Compared to the 15-34% who deteriorated, between 9-29% reliably improved. Susan McPherson & David E. P. Freedman, *Psychological Outcomes of 12–15-Year-Olds with Gender Dysphoria Receiving Pubertal Suppression in the UK: Assessing Reliable and Clinically Significant Change*, 50 J. Sex Marital Therapy (2023), https://doi.org/10.1080/0092623X.2023.2281986.

> uncertainties . . . As a result, a false narrative has taken root. It is that "gender-affirming" medical and surgical interventions for youth are as benign as aspirin, as well-studied as penicillin and statins, and as essential to survival as insulin for childhood diabetes—and that the vigorous scientific debate currently underway is merely "science denialism" motivated by ignorance, religious zeal, and transphobia . . . This highly politicized and fallacious narrative, crafted and promoted by clinician-advocates, has failed to withstand scientific scrutiny internationally, with public health authorities in Sweden, Finland, and most recently England doing a U-turn on pediatric gender transitions in the last 24 months. In the U.S., however, medical organizations so far have chosen to use their eminence to shield the practice of pediatric 'gender affirmation' from scrutiny.[29]

Even in the Netherlands, the façade of consensus surrounding the Dutch protocol and medical interventions for minors is collapsing. Dutch legal advocates, ethicists, journalists, and clinicians have expressed growing alarm over the stark evidence of irreversible harm to minors and the vanishingly small evidence that minors benefit from these interventions.[30] A scathing November 2023 critique of the Amsterdam

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[29] E. Abbruzzese, Stephen B. Levine & Julia W. Mason, *The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed*, 49 J. Sex Marital Therapy 673, 673-74 (2023), https://doi.org/10.1080/0092623X.2022.2150346 (internal citations omitted).

[30] Bernard Lane, *In the dark: A major documentary in the Netherlands shakes the foundations of gender medicine*, Gender Clinic News, Oct. 28, 2023, https://www.genderclinicnews.com/p/in-the-dark.

Gender Team's clinical lesson on "gender incongruence" in minors was blunt:

> The first and most fundamental problem is that treatment with puberty blockers and cross-sex hormones (hormones of the opposite biological sex) are still given as regular treatment in the Netherlands, while the scientific basis is very weak.[31]

In short, there has never been a consensus within the medical community on the appropriate standard of care to address gender dysphoria in minors.

B. There is a lack of evidence to support medical gender-transitioning interventions.

Plaintiffs-Appellees' claim that medical guidelines supporting medical gender transitioning interventions for minors are "evidence-based" falls short. Gender specialists admit that "[t]ransgender medicine presents a particular challenge for the development of evidence-based guidelines" because of "limited" data, "lower-quality evidence," retrospective study design, "lack of uniform data collection," and limited

[31] Jilles Smids & Patrik Vankrunkelsven, *Uncertainties surrounding current gender care: Five Problems with the Gender Incongruent Youth Clinical Lesson*, Ned Tijdschr Geneeskd (Nov. 7, 2023) https://www.ntvg.nl/artikelen/onzekerheden-rond-de-huidige-genderzorg?check_logged_in=1 (translation on file with amicus counsel).

research funding.[32] Experts admit the "field of gender-affirming medicine is characterized by a . . . slim (biomedical) evidence base."[33]

In 2020, an "international interdisciplinary team of experts" seeking to assess the "neurodevelopmental effects" of puberty suppression lamented the lack of "larger-scale, longitudinal studies . . . required to understand possible neurodevelopmental impacts of pubertal suppression over time in transgender youth."[34] A year later, Dutch gender clinician Dr. Thomas Steensma conceded, "Little research has been done so far on treatment with puberty blockers and hormones in young people. That is why it is also seen as experimental. . . . This makes

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[32] Madeline B. Deutsch et al., *What's in a Guideline? Developing Collaborative and Sound Research Designs that Substantiate Best Practice Recommendations for Transgender Health Care*, 18 AMA J. Ethics 1098, 1099 (2016), https://journalofethics.ama-assn.org/article/whats-guideline-developing-collaborative-and-sound-research-designs-substantiate-best-practice/2016-11.

[33] Karl Gerritse et al., *Decision-making approaches in transgender healthcare: conceptual analysis and ethical implications*, 24 Med. Health Care Phil. 687 (2021), https://doi.org/10.1007/s11019-021-10023-6.

[34] Diane Chen et al., *Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth*, 5 Transgender Health 246, 249 (2020), https://doi.org/10.1089/trgh.2020.0006.

it so difficult, almost all research comes from ourselves."[35] Lawrence Tabak, the acting director of the National Institutes of Health, told a U.S. Senate Committee in 2022 that "no long-term studies are available evaluating the effects of puberty blockers when used for gender dysphoria."[36] Diane Chen, a leading psychologist with Lurie Children's Hospital gender clinic, admitted that "a lot of the questions around long-term medical health outcomes we won't be able to answer until the youth who started hormones at 13, 14, 15, are in their 50s, 60s, 70s."[37]

Undaunted by either their own lack of knowledge or the scale of possible harm, the gender clinicians continued their experiment on vulnerable youth. Dr. Johanna Olson-Kennedy leads The Trans Youth Research Network, a collaborative, multi-million-dollar research project

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[35] Grace Williams, *Dutch puberty-blocker pioneer: Stop "blindly adopting our research,"* 4thWaveNow (March 16, 2021), https://4thwavenow.com/2021/03/16/dutch-puberty-blocker-pioneer-stop-blindly-adopting-our-research/.

[36] Fla. Agency for Health Care Admin., *Fla. Medicaid: Gen. Accepted Pro. Med. Standards Determination on the Treatment of Gender Dysphoria*, at 14 (June 2022) [hereinafter Florida Medicaid Report], https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf.

[37] Frieda Klotz, *The Fractious Evolution of Pediatric Transgender Medicine*, Undark (Apr. 6, 2022), https://undark.org/2022/04/06/the-evolution-of-pediatric-transgender-medicine/.

involving four major gender clinics. In 2019, Olson-Kennedy claimed the project was needed to address the "consensus gap about the best approach to the care of youth with gender dysphoria," the "lack of consensus among professionals around timing of initiation of medical interventions," and also over "optimal dosing regimens."[38] But in 2023, after five years and nearly $8 million in federal grants, Dr. Olson-Kennedy's grant renewal application continues to describe a "scant evidence-base currently guiding the clinical care of [transgender/gender diverse] youth," and a continued need for "rigorous scientific evidence outlining the longer-term impact and safety of early treatments based on pubertal development stage."[39]

Other applicants for federal grant funding have similarly referenced the lack of evidence to support medical interventions in gender-dysphoric minors. A 2022 funding request admits that "[t]he

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[38] Johanna Olson-Kennedy et al., *Creating the Trans Youth Research Network: A Collaborative Research Endeavor*, 4 Transgender Health 304, 305 (2019), https://liebertpub.com/doi/full/10.1089/trgh.2019.0024.

[39] NIH RePORTER, *The Impact of Early Medical Treatment in Transgender Youth*, NIH Project No. 5R01HD082554-08 (2023 Renewal), https://reporter.nih.gov/search/XpRRv6FfvUGhJqpvQKxCZQ/project-details/10615754 (multi-year, four-center study led by Dr. Johanna Olson-Kennedy received $8,711,908 to date).

overall impacts of [puberty suppression] have not been systematically studied."[40] Another grant application from Stanford researchers sought to study the use of cross-sex hormones "in early pubertal adolescents" because clinicians need a "foundation for understanding the longitudinal impact of treatments that are *already being used* in clinical settings."[41]

A 2023 grant to Boston Children's Hospital, the first U.S. youth gender clinic, notes that "[l]ittle is known about how pubertal blockade, the first step in the medical management of a young transgender adolescent, affects bone health and psychological well-being."[42] In 2024, researcher Sallie Baxendale warned that "there is no evidence to date to

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[40] Eric Nelson et al., *The Impact of Pubertal Suppression on Adolescent Neural and Mental Health Trajectories*, NIH RePORTER (2022), https://reporter.nih.gov/search/Xr4WhUWe906AqRywwpsXVA/project-details/10442698.

[41] David S. Hong et al., *Sex hormone effects on neurodevelopment: Controlled puberty in transgender adolescents*, NIH RePORTER (2018), https://reporter.nih.gov/project-details/9597181 (emphasis added).

[42] NIH RePORTER, *Skeletal Health and Bone Marrow Composition Among Youth*, NIH Project No. 5R01HD101421-04 (2023), https://reporter.nih.gov/search/XpRRv6FfvUGhJqpvQKxCZQ/project-details/10611431.

support the oft cited assertion that the effects of puberty blockers are fully reversible."[43]

Perhaps worse, gender clinicians have shown little interest in studying how puberty suppression effects their young patients' brains:

> Despite the broad and multidisciplinary knowledge base which indicates disruption of GnRH expression is likely to have an impact on cognitive function, and explicit calls in the literature for this to be studied that date back three decades, there have been no human studies to date that have systematically explored the impact of these treatments on neuropsychological function with an adequate baseline and follow-up.[44]

C. WPATH and Endocrine Society guidelines are not the standard of care.

Plaintiffs-Appellees have referred to WPATH's and the Endocrine Society's guidelines as "generally accepted treatment standards."[45] According to the U.S. Institute of Medicine ("IOM"), authoritative standards of care or clinical practice guidelines (CPGs)

> should be based on a systematic review of the existing evidence; be developed by a knowledgeable, multidisciplinary panel of experts and representatives from key affected groups; … be based on an explicit and transparent process that

[43] Sallie Baxendale, *The impact of suppressing puberty on neuropsychological function: A review*, Acta Paediatrica 9 (Jan. 2024), https://doi.org/10.1111/apa.17150.

[44] *Id.*

[45] 5-ER-1028.

> minimizes distortions, biases, and conflicts of interest; … provide ratings of both the quality of evidence and the strength of recommendations; and be reconsidered and revised as appropriate when important new evidence warrants modifications of recommendations.[46]

WPATH's and the Endocrine Society's guidelines fall well short of this standard.

Aside from its title "standards of care" (currently, Standards of Care 8 or "SOC 8"), the WPATH document never claims to represent a legal, ethical, or professional standard of care. Instead, the guidelines repeatedly emphasize their "flexible" and "adaptable" nature.[47] Indeed, the Centers for Medicare & Medicaid Services (CMS) cited the "flexibility" of WPATH's previous version (SOC 7) as a reason why it refused to endorse WPATH guidelines for Medicare coverage determinations.[48] Further, WPATH merely states that its

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[46] IOM Comm. on Standards for Dev. Trustworthy Clinical Prac. Guidelines, *Clinical Practice Guidelines We Can Trust* 5 (Robin Graham et al. eds., 2011). https://www.ncbi.nlm.nih.gov/books/NBK209546/.

[47] E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. Transgender Health S1, S3 (2022), https://doi.org/10.1080/26895269.2022.2100644.

[48] Decision Memo, CMS, *Gender Dysphoria and Gender Reassignment Surgery*, CAG–00446N, Aug. 30, 2016 [hereinafter "CMS Decision Memo"], https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=282.

recommendations are based on "data derived" from systematic evidence reviews "*where available*" (emphasis added); it fills the remaining gaps with "background reviews and expert opinions."[49]

Unlike true evidence-based standards, SOC 8 does not auger the strength of its recommendations based on the quality of the evidence cited in support. Nor does SOC 8 evaluate the available evidence according to "risk of bias, imprecision, inconsistency, indirectness . . . or publication bias," as do reliable substantive evidence reviews that use GRADE methodology.[50]

According to a 2021 first-of-its-kind systematic analysis[51] of international CPGs for "gender minority/trans health" published in the

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[49] E. Coleman et al., *supra* n.47 at S3.

[50] Deutsch et al., *supra* n.32, at 1099. ("[WPATH's SOC] remains largely based on lower-quality evidence (i.e., observational studies) and expert opinion . . . SOC v7 lacks any rating of the quality of the available evidence or strength of the recommendations or description of how expert contributors are selected to participate in the process of developing the guidelines.").

[51] Sara Dahlen et al., *International clinical practice guidelines for gender minority/trans people: systematic review and quality Assessment*, 11 BMJ Open 1 (2021), https://doi.org/10.1136/bmjopen-2021-048943 ("This is the first systematic review using a validated quality appraisal instrument of international CPGs addressing gender minority/trans health.").

British Medical Journal (BMJ), "WPATH SOCv7 *cannot* be considered 'gold standard'" (emphasis added).[52] Though the BMJ review found that none of the twelve international gender medicine guidelines assessed met the rigorous standard for clinical practice guidelines (or standards of care), the WPATH guidelines were singled out for their "incoherence" and subjected to particularly strong criticism.[53]

Like the WPATH "standards," the Endocrine Society guidelines rely on "low" and "very low" quality evidence and include a disclaimer stating that its "guidelines cannot guarantee any specific outcome, *nor do they establish a standard of care*."[54]

In sum, no current guidelines for treating gender dysphoria, much less the guidelines by WPATH and the Endocrine Society, qualify as an authoritative CPG or standard of care. Indeed, clinicians with diverse perspectives on transitioning treatments for minors recognize that no medical consensus exists. For example, in 2015, medical "proponents and

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[52] *Id*. at 8.

[53] *Id*. (referencing the "incoherence" of WPATH SOCv7).

[54] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clinical Endocrinology & Metabolism 3869, 3895 (2017), https://doi.org/10.1210/jc.2017-01658.

opponents of early treatment (pediatric endocrinologists, psychologists, psychiatrists, ethicists) of 17 treatment teams worldwide"[55] convened to discuss ethical concerns surrounding the WPATH and Endocrine Society recommendations that support medical transitioning for minors. They identified seven areas of debate and concluded that "as long as debate remains on these seven themes and only limited long-term data are available, there will be no consensus on treatment."[56] Gordon Guyatt, a renowned expert on GRADE methodology and standards of care, has criticized the U.S. practice of medicalized interventions for minors as "untrustworthy."[57]

A 2020 study from the Mount Sinai Center for Transgender Medicine and Surgery notes that though WPATH guidelines "are often

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[55] Lieke Josephina Jeanne Johanna Vrouenraets et al., *Early Medical Treatment of Children and Adolescents with Gender Dysphoria: An Empirical Ethical Study*, 57 J. Adolescent Health 367 (2015), https://doi.org/10.1016/j.jadohealth.2015.04.004.

[56] *Id.*

[57] Gordon H. Guyatt (@GuyattGH), Twitter (Mar. 29, 2023, 2:00 PM PST), https://twitter.com/GuyattGH/status/1641183448063967233 ("Current American guidelines for managing gender dysphoria in adolescents [are] untrustworthy. Don't acknowledge the very low certainty evidence regarding alternatives and do not make the very guarded weak/conditional recommendations appropriate for such evidence[.]").

considered the standard of care for [transgender] people throughout the world" but characterizes them as a "barrier to care," "impractical," unclear, and detrimental to patient wellbeing.[58] Indeed, Mount Sinai eventually developed its own criteria for transitioning treatments, which diverged significantly from WPATH guidelines: it found that less than one in ten patients were deemed ready for surgery under both WPATH and Mount Sinai assessments.[59]

Several federal circuit courts have recognized that WPATH guidelines do not reflect medical consensus. *See Gibson v. Collier*, 920 F.3d 212, 223 (5th Cir. 2019) ("WPATH Standards of Care do not reflect medical consensus"); *Doe v. Snyder*, 28 F.4th 103, 112 (9th Cir. 2022) ("WPATH's Standards of Care are not universally endorsed"); *Kosilek v. Spencer*, 774 F.3d 63, 88 (1st Cir. 2014) (en banc) ("[p]rudent medical professionals . . . do reasonably differ in their opinions regarding [WPATH's] requirements"); *cf. Keohane v. Fla. Dep't of Corr. Sec'y*, 952

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[58] Max Lichtenstein et al., *The Mount Sinai Patient-Centered Preoperative Criteria Meant to Optimize Outcomes Are Less of a Barrier to Care than WPATH SOC 7 Criteria Before Transgender-Specific Surgery*, 5 Transgender Health 166, 170 (2020), https://doi.org/10.1089/trgh.2019.0066.

[59] *Id.*

F.3d 1257, 1296 (11th Cir. 2020) (criticizing district court for finding WPATH standards "authoritative for treating gender dysphoria in prison" without considering arguments over the merits of WPATH standards); *Edmo v. Corizon, Inc.*, 935 F.3d 757, 787, 788 & n.16 (9th Cir. 2019) (per curiam) (holding WPATH standards are the "established standards" for evaluating the necessity of transitioning surgery and the "undisputed starting point in determining the appropriate treatment for gender dysphoric individuals"), *reh'g en banc denied*, 949 F.3d 489, 497 (9th Cir. 2020) (O'Scannlain, J., joined by seven judges, respecting the denial of rehearing en banc) (rejecting panel's characterization because "WPATH Standards are merely criteria promulgated by a controversial private organization with a declared point of view").

Furthermore, proponents of medical interventions in gender-dysphoric minors routinely overstate the clinical impact of WPATH's guidelines, particularly the recommendation that a mental health provider diagnose a minor's gender dysphoria.[60]

[60] Br. for Family Research Council as Amicus Curiae Supporting Appellants and Reversal at 8-18, *Texas v. Loe*, No. 23-0697 (Tex. Oct. 26, 2023).

D. The lack of medical consensus is reflected internationally.

Plaintiffs-Appellees' claim that medical interventions for gender dysphoria are safe, effective, and medically necessary is also undercut by the international medical community. Over the past few years, many countries that initially embraced gender-transitioning interventions, including for minors, have reversed course.

Sweden's National Board of Health and Welfare concluded in 2022 "that the risks of anti-puberty and sex-confirming hormone treatment for those under 18 currently outweigh the possible benefits."[61] The **Finnish** Health Authority's new guidelines prioritize psychotherapy as the first-line treatment for gender-dysphoric minors.[62] Last year **Denmark** followed suit: based on the evidence reviews in Sweden and Finland, the

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[61] Socialstyrelsen, Support, Investigation and Hormone Treatment for Gender Incongruence in Children and Adolescents (2022); *see also* Lisa Nainggolan, *Hormonal Tx of Youth with Gender Dysphoria Stops in Sweden*, Medscape (May 12, 2021), https://www.medscape.com/viewarticle/950964.

[62] PALKO/COHERE Finland, *Recommendation of the Council for Choices in Health Care in Finland: Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors* (2020), https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf. COHERE works in conjunction with the Ministry of Social Affairs and Health.

rise in adolescents presenting with significant psychiatric issues, and the resulting ethical concerns over the use of medicalized interventions in minors, Denmark changed policy to prioritize the use of psychotherapeutic treatments over medical interventions.[63] A 2023 evidence review in **Norway** found the evidence base for hormonal intervention for gender-dysphoric minors was "insufficient" and such interventions must be considered "experimental."[64]

In the **United Kingdom**, whistleblower complaints exposed the inadequate psychological care for gender-dysphoric minors at the National Health Service's (NHS) gender clinic.[65] A landmark case in 2020 found that minors lacked capacity to consent to transitioning treatments

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[63] *Denmark Joins the List of Countries That Have Sharply Restricted Youth Gender Transitions*, Soc. Evidence-based Gender Med. (Aug. 17, 2023), https://segm.org/Denmark-sharply-restricts-youth-gender-transitions.

[64] *Patient safety for children and adolescents with gender incongruence*, Ukom (Mar. 9, 2023), https://ukom.no/rapporter/pasientsikkerhet-for-barn-og-unge-med-kjonnsinkongruens/sammendrag.

[65] Lauren Lewis, *NHS's only gender service children believes all girls who don't like 'pink ribbons and dollies' must be transgender, whistleblower claims*, Daily Mail (Nov. 22, 2021), https://www.dailymail.co.uk/news/article-10231507/NHSs-gender-service-children-believes-girls-dont-like-pink-transgender.html.

that cause sterility and impair sexual function.[66] In 2021, the UK's National Institute for Health and Care Excellence (NICE) undertook two evidence reviews that found that medical "gender affirming" treatment in minors produced little evidence of benefit and substantial risk of harm.[67] In early 2024, the NHS adopted a new policy under which puberty blockers "are not available as a routine commissioning treatment option for treatment of children and young people who have gender incongruence / gender dysphoria." Instead, the "primary intervention focuses on psychosocial and psychological support."[68]

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[66] Becky McCall, *NHS Makes Child Gender Identity Service Changes After High Court Ruling*, Medscape (Dec. 4, 2020), https://www.medscape.com/viewarticle/941781 (decision later reversed on procedural grounds).

[67] NICE, *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria* (2021), https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_GnRH-analogues_For-upload_Final.pdf); NICE, *Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria* (2021), (https://cass.independent-review.uk/wp-content/uploads/2022/09 /20220726_Evidence-review_Gender-affirming-hormones_For-upload_Final.pdf).

[68] NHS England, *Clinical Policy: Puberty suppressing hormones (PSH) for children and young people who have gender incongruence / gender dysphoria* (March 12, 2024), https://www.england.nhs.uk/wp-content/uploads/2024/03/clinical-commissioning-policy-gender-affirming-hormones-v2.pdf.

Psychotherapists in **Australia** and **New Zealand** have also recommended mental health treatment for gender-dysphoric minors, not over "gender affirmation." They noted the "paucity of quality evidence on the outcomes of those presenting with gender dysphoria" and stressed the importance of assessing the "psychological state and context in which gender dysphoria has arisen" before any treatment decisions are made.[69]

France's National Academy of Medicine has warned medical professionals that the increase in young people seeking transitioning treatments may be due to social contagion and accordingly urged "great medical caution [with] children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause."[70]

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[69] Becky McCall, *Psychiatrists Shift Stance on Gender Dysphoria, Recommend Therapy*, Medscape (Oct. 7, 2021) (summarizing new position statement from the Royal Australian and New Zealand College of Psychiatrists"), https://www.medscape.com/viewarticle/960390.

[70] Press Release, Fr. Nat'l Acad. of Med., *Medicine and Gender Transidentity in Children and Adolescents* (Feb. 25, 2022), https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en.

In early 2024, **Germany** clinicians published their own update of the UK's NICE substantive evidence review and concluded that "[t]he currently available studies on the use of PB [puberty blockers] and CSH [cross-sex hormones] in minors with GD [gender dysphoria] have significant conceptual and methodological flaws."[71] The Researchers noted the "lack of adequate and meaningful long-term studies" and dearth of evidence suggesting any mental health gains from hormonal intervention, leading them to recommend psychotherapy first.[72]

In March 2024, the **Dutch** Parliament ordered the Dutch health ministry to commission new research assessing the outcomes of young people treated under the "Dutch Protocol," a sign of wavering confidence in medicalized transition.[73]

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[71] Florian Zeph et al., *Beyond NICE: Updated Systematic Review on the Current Evidence of Using Puberty Blocking Pharmacological Agents and Cross-Sex-Hormones in Minors with Gender Dysphoria*, J. Child & Adolescent Psychiatry & Psychotherapy, Feb. 2024, https://doi.org/10.1024/1422-4917/a000972 (translation of abstract available at https://pubmed.ncbi.nlm.nih.gov/38410090/).

[72] *Id.*

[73] Gordon Rayner, *How the Dutch experiment with puberty blockers turned toxic*, Telegraph (March 4, 2024), https://www.telegraph.co.uk/news/2024/03/04/dutch-puberty-blockers-nhs-gender-hormone-treatment/

Finally, just a few days ago **Scotland's** Sandyford clinic announced that "[r]eferrals from the Sandyforth Sexual Health Services to Paediatric Endocrinology for the prescription of puberty suppressing hormones have been paused." Instead, the facility said it will be providing adolescents with gender dysphoria "the psychological support that they require."[74]

II. Gender-transitioning interventions can lead to serious harms, especially in minors.

One important reason why medical professionals continue to resist the push to affirm gender-transitioning interventions is because studies keep confirming that such treatments can cause significant harms.[75] Long-term outcomes for individuals who undergo gender-transitioning treatments are not promising. Those who have had genital surgery are nineteen times more likely than the general population to die by suicide[76]

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[74] Sandyford, *Important service update – Young Person's Gender Service*, https://www.sandyford.scot/sexual-health-services/gender-service-at-sandyford/gender-young-people-service/ (last visited April 18, 2024).

[75] Bill Analysis, SB 14, Tex. House Rsch. Org., at 3-4 (May 12, 2023), https://hro.house.texas.gov/pdf/ba88r/sb0014.pdf.

[76] Cecilia Dhejne et al., *Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden*, 6 PLoS One e16885 (2011), https://pubmed.ncbi.nlm.nih.gov/21364939/.

and studies show that transitioning treatments fail to reduce suicide risks and mental health issues in the long-term.[77]

Equally troubling, the number of children diagnosed with gender dysphoria or identifying as "transgender" has risen dramatically over the past decade, becoming "an international phenomenon, observed across North America, Europe, Scandinavia, and elsewhere."[78] Moreover, the typical patient profile has changed markedly. In the past, patients seeking treatment for gender dysphoria were usually either adult males or very young children, mostly male. Today, the typical patient is an adolescent, usually female.[79]

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[77] Roberto D'Angelo et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, 50 Archives Sexual Behav. 7 (2020), https://doi.org/10.1007/s10508-020-01844-2; Chantel M. Wiepjes et al., *Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria Study (1972-2017)*, 141 Acta Psychiatrica Scandinavia 486 (2020), https://doi.org/10.1111/acps.13164; *Correction to Bränström and Pachankis*, 177 Am. J. Psychiatry 734 (2020), https://ajp.psychiatryonline.org/doi/epdf/10.1176/appi.ajp.2020.1778correction (correcting Richard Bränström et al., *Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study*, 177 Am. J. Psychiatry 727 (2020)).

[78] Kenneth J. Zucker, *Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues*, 48 Archives Sexual Behav. 1983 (2019), https://doi.org/10.1007/s10508-019-01518-8.

[79] *Id.*

As noted above, gender dysphoria in children was traditionally addressed through "watchful waiting" or family therapy, which helped the vast majority of children accept their bodies. *The "gender-affirming" approach changed that pattern dramatically*: most children affirmed in their transgender beliefs persist in those beliefs and are likely to pursue transitioning treatments that irreversibly modify their bodies—and lead to regret.[80]

Clinical concerns over gender-transition interventions have escalated.[81] Puberty blockers, originally praised as safe and fully reversible, are known to have negative effects on bone density, social and emotional maturation, and other aspects of neuro-development.[82] They

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[80] Carmichael et al., *supra* n.27, at 12 (98% of adolescents who underwent puberty suppression continued on to cross-sex hormones); *see also* Lisa Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners*, 50 Archives Sexual Behav. 3353 (2021), https://doi.org/10.1007/s10508-021-02163-w.

[81] William Malone et al., *Puberty blockers for gender dysphoria: the science is far from settled*, 5 Lancet Child & Adolescent Health 33 (2021), https://doi.org/10.1016/s2352-4642(21)00235-2.

[82] NICE Evidence Review, *supra* n.67, at 6-8.

generally fail to lessen the child's gender dysphoria and deliver mixed results for mental health.[83] Long term effects remain unknown.[84]

Nearly all children who begin puberty blockers go on to receive cross-sex hormones, with life-altering consequences.[85] Blocking a child's natural puberty prevents maturation of genitals and reproductive organs; subsequently introducing cross-sex hormones renders the child permanently sterile.[86] Gender clinicians also admit that puberty suppression may impair the child's later sexual functioning as an adult.[87] These losses cannot be fully comprehended by a child, making informed consent impossible.

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[83] Carmichael et al., *supra* n.27, at 12-17.

[84] Diane Chen et al., *Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth*, 5 Transgender Health 246 (2020), https://doi.org/10.1089%2Ftrgh.2020.0006.

[85] *Id.*

[86] Stephen B. Levine, *Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria*, 44 J. Sex Marital Therapy 29 (2018), https://doi.org/10.1080/0092623x.2017.1309482.

[87] Abigail Shrier, *Top Trans Doctors Blow the Whistle on "Sloppy" Care*, Real Clear Politics (Oct. 5, 2021), https://www.realclearpolitics.com/2021/10/05/top_trans_doctors_blow_the_whistle_on_sloppy_care_553290.html.

Cross-sex hormones carry numerous health risks and cause significant irreversible changes in adolescents' bodies, including genital or vaginal atrophy, hair loss (or gain), voice changes, and impaired fertility.[88] They increase cardiovascular risks and cause liver and metabolic changes.[89] The flood of opposite sex hormones has variable emotional and psychological effects as well. Females taking testosterone experience an increase in gender dysphoria, which heightens the likelihood they will undergo double mastectomies—as young as thirteen.[90]

Far from an evidence-based standard of care, gender-transitioning treatments for gender dysphoria amount to unethical human

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[88] Int'l Plan. Parenthood Fed., Int'l Med. Advisory Panel, *IMAP Statement on Hormone Therapy for Transgender and Gender Diverse Persons* 9-11 (June 2023), https://web.archive.org/web/20230706105450/https://www.ippf.org/file/14216/download?token=aj1QbfEG.

[89] *Gender-affirming hormone in children and adolescents*, BJM Evidence-Based Medicine Spotlight (Feb. 25, 2019), https://blogs.bmj.com/bmjebmspotlight /2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/.

[90] Johanna Olson-Kennedy et al., *Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts*, 172 JAMA Pediatric 431 (2018), https://doi.org/10.1001/jamapediatrics.2017.5440 (*see* Figure: Age at Chest Surgery in the Post-surgical Cohort).

experimentation—on *children*. One Swedish teen who underwent medical transition, suffered serious bodily harm, and then de-transitioned has described her experience in stark terms: "They're experimenting on young people . . . we're guinea pigs."[91] Or, as psychotherapist Alison Clayton warns, this is "dangerous medicine."[92]

III. The WPATH Files and Cass Review underscore the fundamental deficiencies with and uncertainties regarding gender transition medicine.

Two recent developments—the WPATH Files and the Cass Review—reflect the evidence outlined above and leave no doubt that Plaintiffs are wrong to claim that so-called gender-affirming care is "medically necessary" and "provided pursuant to well-established guidelines."

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[91] *Mission: Investigate: Trans Children* ("Trans Train 4"), (Sveriges Television documentary Nov. 26, 2021) (last available Mar. 26, 2023), https://www.svtplay.se/video/33358590/uppdrag-granskning/mission-investigate-trans-children-avsnitt-1.

[92] Alison Clayton, *The Gender Affirmative Treatment Model for Youth with Gender Dysphoria: A Medical Advance or Dangerous Medicine?*, 51 Archives Sexual Behav. 691 (2022), https://doi.org/10.1007%2Fs10508-021-02232-0.

A. WPATH Files

On March 4, 2024, a U.S. based think tank released the "WPATH Files," a 241-page PDF that discloses and analyzes leaked internal discussions, including emails and videos, between doctors, nurses, and other WPATH members.[93] The Executive Summary describes WPATH "approach to medicine" as "consumer-driven and pseudoscientific" and observes that WPATH "members appear to be engaged in political activism, not science."[94]

The WPATH Files show that

> sex-trait modification procedures on minors and people with mental health disorders, known as "gender-affirming care," are unethical medical experiments. This experiment causes harm without justification, and its victims are some of society's most vulnerable people. Their injuries are painful and life-altering. WPATH-affiliated healthcare providers advocate for the destruction of healthy reproductive systems, the amputation of healthy breasts, and the surgical removal of healthy genitals as the first and only line of treatment for minors and mentally ill people with gender dysphoria, eschewing any attempt to reconcile the patient with his or her birth sex.[95]

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[93] Mia Hughes, *The WPATH Files*, Environmental Progress (March 4, 2024), https://environmentalprogress.org/big-news/wpath-files.

[94] *Id.* at 3.

[95] *Id.*

Members admit in these pages "that children and adolescents cannot comprehend the lifelong consequences of sex-trait modification interventions, and in some cases, due to poor health literacy, neither can their parents."[96] "[G]ender-affirming healthcare providers are knowingly permitting young patients to compromise their sexual function when they do not have the maturity or experience to comprehend the implications of such a decision in the context of a long-term relationship."[97]

> The WPATH Files concludes with this sobering assessment:
>
> > Currently, lawmakers, judges, insurance companies, and public health providers are duped into trusting WPATH's guidelines as a result of the broken chain of trust. These stakeholders are not aware that the political activists within WPATH are promoting a reckless, consumer-driven transition-on-demand approach to extreme body modification, even for minors and the severely mentally ill. It is for this reason that we believe the medical world must reject WPATH's guidelines.
> >
> > Gender dysphoria is a complex psychiatric condition, and there is no easy answer as to the best way to ease the pain of those afflicted. It . . . is possible to state with unequivocal certainty that [WPATH] does not advocate for the best possible care for this vulnerable patient cohort, and the detrimental impact of WPATH's actions over the past two decades has rendered the organization irredeemable. It is now

[96] *Id.*

[97] *Id.* at 23.

> imperative to usher in a new era in gender medicine, one that prioritizes the health and well-being of patients as its foremost objective.[98]

B. Cass Review

A month after the WPATH Files, on April 9, 2024, British pediatrician Hilary Cass published the 388-page "Cass Review," the culmination of a four-year study commissioned by the National Health Service in England into "gender identity services for children and young people."[99]

Dr. Cass concluded that "gender medicine . . . is built on shaky foundations."[100] The report emphasizes that there are "conflicting views about the clinical approach, with expectations at times being far from usual clinical practice."[101]

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[98] *Id*. at 71.

[99] Hilary Cass, *The Cass Review: Independent review of gender identity services for children and young people* (April 2024), https://cass.independent-review.uk/home/publications/final-report/.

[100] Hilary Cass, *Gender medicine for children and young people is built on shaky foundations. Here is how we strengthen services*, BMJ (April 9, 2024), https://www.bmj.com/content/385/bmj.q814.

[101] Cass Review at 20.

Four years ago, when the study began, "the evidence base . . . had already been shown to be weak."[102] The final report took aim the teetering credibility of WPATH's "Standards of Care" and the Endocrine Society's guidelines, concluding that both "lack developmental rigour" and "transparency."[103] But Cass's broader conclusion took aim at the medical profession as a whole:

> This is an area of remarkably weak evidence, and yet results of studies are exaggerated or misrepresented by people on all sides of the debate to support their viewpoint. The reality is that we have no good evidence on the long-term outcomes of interventions to manage gender-related distress.[104]

Within a few days, the Cass Review was widely hailed as a breakthrough. An article in Psychology Today called the review "eye-opening."[105] A New York Times columnist called Dr. Cass a "hero"[106] and the Wall Street Journal's Editorial Board called the Cass Review "a

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[102] *Id*.

[103] *Id*. at 6.

[104] *Id* at 13.

[105] Noam Shpancer, *Does Our Approach to Gender Dysphoria Need an Overhaul?*, Psychology Today (April 15, 2024), https://www.psychologytoday.com/us/blog/insight-therapy/202404/does-our-approach-to-gender-dysphoria-need-an-overhaul.

[106] David Brooks, *The Courage to Follow the Evidence on Transgender Care*, NY Times (April 18, 2024), https://www.nytimes.com/2024/04/18/opinion/transgender-care-cass-report.html.

rebuke to the gender-industrial complex" and praised it for showing "wisdom and humility on treatment of young people, in contrast to the ideological conformity in U.S. medical associations."[107] NHS England, for its part, expressed its gratitude to "Dr. Cass and her team for their comprehensive work" and pledged to "set out a full implementation plan" in response.[108]

[107] Editorial Board, *Helpful Transgender Lessons from Europe*, WSJ (April 10, 2024), https://www.wsj.com/articles/hilary-cass-review-transgender-medicine-national-health-service-u-k-3d0b6e88.

[108] NHS England, *NHS England responds to the publication of the independent review of gender identity services for children and young people* (April 10, 2024), https://www.england.nhs.uk/2024/04/nhs-england-responds-to-the-publication-of-the-independent-review-of-gender-identity-services-for-children-and-young-people/.

CONCLUSION

The Court should reverse the decision below.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this *amicus* brief complies with Fed. R. App. P. 29(a)(5) and Cir. R. 32-3(2) as it contains 6940 words, excluding the portions exempted by Fed. R. App. P. 32(f). The brief's size and typeface comply with Fed. R. App. P. 32(a)(5) and (6).

Dated: April 19, 2024

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CERTIFICATE OF SERVICE

I hereby certify that on this 19th day of April, 2024, I electronically filed the foregoing brief with the Clerk of Court for the United States Court of Appeals for the Ninth Circuit by using the Court's CM/ECF system. I further certify that service was accomplished on all parties via the Court's CM/ECF system.

Dated: April 19, 2024

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