No. 23-477

In the Supreme Court of the United States

UNITED STATES OF AMERICA, PETITIONER
Petitioner,

v.

JONATHAN THOMAS SKRMETTI, ATTORNEY GENERAL AND REPORTER FOR TENNESSEE, ET AL.,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF THE FLORIDA HOUSE OF REPRESENTATIVES AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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INTEREST OF THE *AMICUS CURIAE*

The Florida House of Representatives ("the Florida House"),[1] along with the Florida Senate, passed a bill during its 2023 legislative session that prohibits certain medical interventions for minors as treatment for gender dysphoria. In recently declaring Florida's law to be unconstitutional, a District Court—much like the District Courts in Tennessee and elsewhere—invoked and relied on the public position of numerous medical associations that purport to endorse medicalized "gender affirming care" for minors ("pediatric GAC") and that tout their position as a "medical consensus." The American Academy of Pediatrics ("the Academy") is among those organizations, having taken a leading advocacy role in the ongoing debate.

Following a series of letters from the Academy and the Florida Chapter of the American Academy of Pediatrics ("FCAAP") to Florida's state health regulators urging the purported benefits of pediatric GAC, the Florida House issued legislative subpoenas to FCAAP in an effort to determine what it actually means when such organizations announce that they endorse certain medical interventions. Specifically,

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[1] No party's counsel authored this brief in whole or in part, and no party, party's counsel, or other person contributed money to fund the preparation or submission of this brief.

The Speaker of the Florida House has authorized the submission of this brief pursuant to Rule 2.6 of the Rules of The Florida House of Representatives, which authorizes the Speaker to "participate in any suit on behalf of the House, [or] a committee or subcommittee of the House . . . when the Speaker determines that such suit is of significant interest to the House."

the Florida House sought to determine whether these organizational endorsements are the result of a robust discussion among its physician membership, whether they are made in a perfunctory manner by a small group of organizational leaders, or whether they may even be the product of a decision made unilaterally by a single organizational leader. The Florida House now seeks to advise the Court of what it learned from the response to its subpoenas.[2] Given that the fate of its own legislation hangs in the balance, the Florida House also submits this brief to highlight the constitutional hazards of excessive deference to the advocacy of "the experts" at the expense of core state legislative authority.

SUMMARY OF THE ARGUMENT

"Every major medical association agrees." Largely influenced by that superficial mantra, federal courts around the country have cast aside legislative judgment, effectively transferred the presumption of good faith from state legislatures to private medical advocacy organizations, and thereby allowed those organizations to dictate how the States may regulate the services their members provide. And they have done so despite repeated recognition by this Court and the Circuit Courts that the asserted views of professional organizations do not determine the scope of constitutional rights. *See*, *e.g.*, *Brown v. Plata*, 563 U.S. 493, 539–40 (2011) (recognizing that "courts must not confuse professional standards with constitutional requirements"); *Otto v. City of Boca Raton*, 981 F.3d 854, 869 (11th Cir. 2020) (The

[2] All FCAAP documents quoted or referenced in this brief are on file with the Florida House.

"institutional positions" of medical professional societies "cannot define the boundaries of constitutional rights. They may hit the right mark—but they may also miss it. Sometimes by a wide margin, too."). The decision-making process apparently employed by the Academy and FCAAP demonstrates why that admonition is both constitutionally and pragmatically sound.

As explained below, medical organizations do not necessarily speak for their membership—not even for a *majority* of their membership—when they declare their institutional positions. But the rhetorical force of the arguments advanced by those who promote pediatric GAC depends on the willingness to make that inferential leap.

It has long been established that regulation of the practice of medicine is fundamentally a matter for the States, and that legislatures are entitled to even *greater* deference when they legislate in areas of "medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). To overcome this daunting obstacle, advocates of pediatric GAC have constructed a narrative in which the science is said to be so well settled that there *is no* uncertainty. *See*, *e.g.*, *Eknes-Tucker v. Governor of Alabama*, 80 F.4th 1205, 1216 (11th Cir. 2023) (discussing expert testimony that the superiority of pediatric GAC is so well settled that it actually "would be unethical" even to conduct randomized controlled trials).

And many have bought into it. As one member of Congress declared during a House committee hearing, pediatric GAC "is supported by every major medical association" collectively "representing over 1.3 million

American doctors. *It's just not up for debate*."[3] Of course, nearly all science is by its very nature "up for debate," and the Court has recognized as much. *See, e.g.*, *Daubert v. Merrell Dow Pharma., Inc.*, 509 U.S. 579, 597 (1993) ("Scientific conclusions are subject to perpetual revision.").[4] Unfortunately, numerous courts have unquestioningly accepted the premise that these medical associations' pronouncements necessarily represent the settled views of their membership—a premise that this Court should question and reject.

Although a comprehensive discussion of the legitimate formation of medical consensus is beyond the scope of this brief, the salient point is that the seemingly widespread institutional support of pediatric GAC should not be taken at face value to support the critical proposition that all—or even *most*—physicians agree with these institutional pronouncements. It is bad enough that courts have subordinated legislative judgment to the decrees of private medical associations. That constitutional

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[3] *The Dangers and Due Process Violations of 'Gender-Affirming Care' for Children: Hearing Before the Subcomm. on the Const. and Limited Govt. of the H. Comm. on the Judiciary*, 118th Cong. 4 (2023) (statement of Rep. Mary Gay Scanlon, Ranking Member, H. Subcomm. on the Const. and Limited Govt.).

[4] Even the WPATH "standards of care" on which pediatric GAC supporters primarily rely describes this as a "rapidly evolving" field. E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. of Transgender Health S1, S3 (2022), https://www.tandfonline.com/doi/full/10.1080/26895269.2022.2100644. *See also id.* at S44 ("Our understanding of gender identity development in adolescence is continuing to evolve.").

harm is exacerbated when those decrees are the product of a black-box approach to decision-making that empowers a mere handful of organizational leaders to dictate public health policy. The problem is compounded further when the purported medical consensus that is invoked to justify this outcome is the product of censorship and intimidation rather than open scientific debate. Finally, undue deference to expert testimony in support of pediatric GAC has effectively loaded the dice against the States and distorted the federal judiciary's proper constitutional role in reviewing the States' regulation of the practice of medicine.

ARGUMENT

State legislative authority to regulate the practice of medicine has long been considered "too well settled to require discussion." *Watson v. Maryland*, 218 U.S. 173, 176 (1910). *See also Gonzales*, 550 U.S. at 157 (recognizing that "it is clear the State has a significant role to play in regulating the medical profession"). Yet pediatric GAC proponents often say derisively that legislatures cannot know better than "the experts" do, and therefore that courts should resolve disagreements in favor of the latter. State regulatory authority would serve little purpose if the Constitution compels this result. After all, regulatory guardrails would not be needed if their proper function was limited to telling practitioners to do whatever they wish. Reasonable legislative judgments in this area are not, and cannot be, subject to an "expert's veto." In the remainder of this brief, the Florida House seeks to demonstrate why.

I. There is no evidence of consensus even within the "major medical associations," let alone within the medical profession at large.

The legitimacy of the purported professional consensus bears on the analysis under either proposed standard of review. Under the appropriate level of equal protection review (rational basis), supporters of pediatric GAC may argue that the States cannot have a rational basis to disagree with a consensus of the entire medical profession—or, relatedly, that rejection of a true consensus can be explained only by discriminatory animus. *Cf. Kadel v. Folwell*, 100 F.4th 122, 176 (4th Cir. 2024) (Richardson, J., dissenting) ("plaintiffs must show that the choice to exclude gender dysphoria from coverage is so irrational that nothing could explain it other than an intent to discriminate against transgender persons"). Similarly, under an erroneous heightened-scrutiny standard, they have argued that legislative judgment cannot survive heightened scrutiny if it conflicts with the purported consensus. *See*, *e.g.*, U.S. Br. 35–41; *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 889–92 (E.D. Ark. 2021) (enjoining similar Arkansas law almost entirely on the basis of the purported medical consensus), *aff'd*, 47 F.4th 661 (8th Cir. 2022). As the following discussion demonstrates, however, institutional pronouncements do not suffice to create a valid consensus.

In 2022, the Academy and FCAAP jointly sent a series of letters and rule comments to the Florida Board of Medicine and to Florida's Agency for Health Care Administration touting the purported benefits of

pediatric GAC. In those letters, they claimed that the Academy represents 67,000 pediatricians, that FCAAP represents 2,600 Florida pediatricians, and that both organizations "endorse and recommend" the use of pediatric GAC. They went on to describe pediatric GAC as the "irrefutable" standard of care as determined by "medical consensus" and "robust scientific consensus."

Around this time, however, an increasing number of physicians and other health professionals publicly expressed concerns suggesting that the purported consensus was not what it seemed. Notably, some of the doctors expressing these concerns were otherwise longtime advocates for GAC.[5] These and similar

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[5] For example, Dr. Laura Edwards-Leeper, a psychologist at what has been described as the first major gender clinic in the U.S. (Boston Children's Hospital), publicly expressed concern about the "irresponsible" treatment being administered to minors with gender dysphoria. Referring to her fellow practitioners, she stated in a *60 Minutes* interview that "everyone is very scared to speak up because we're afraid of not being seen as being 'affirming.'" *60 Minutes: Transgender Healthcare, Geldingadalir, Exhume the Truth* (CBS television broadcast May 23, 2021), https://www.cbsnews.com/news/transgender-health-care-60-minutes-2021-05-23/; Mike Francis, *Professor Edwards-Leeper Tells 60 Minutes of Her Concerns About Rushed Gender Transitions*, PACIFIC UNIVERSITY OREGON (June 10, 2021), https://www.pacificu.edu/about/media/professor-edwards-leeper-tells-60-minutes-her-concerns-about-rushed-gender-transitions. And even Dr. Marci Bowers, a transgender gynecologic surgeon who has performed more than 2,000 "sex-change" operations and served as president of WPATH, has commented regarding the state of open discourse and debate: "There are definitely people who are trying to keep out anyone who doesn't absolutely buy the party line that everything should be affirming and that there's no room for dissent." Abigail Shrier, *Top Trans Doctors Blow the*

statements aroused skepticism whether medical organizations necessarily speak for their physician membership when they take positions on pediatric GAC. Accordingly, in April 2023, the Health and Human Services Committee of the Florida House issued a subpoena to FCAAP to investigate whether its public support of pediatric GAC (as expressed to Florida's state health regulators) was actually supported by its membership and the product of an open and transparent decision-making process.

Rather than share any information, Florida's preeminent pediatrics organization responded by suing the Florida House in federal court and invoking associational freedom. *See Fla. Chapter of Am. Academy of Pediatrics, Inc. v. Fine*, No. 4:23-cv-174-AW-MAF (N.D. Fla. filed May 1, 2023). After the District Court denied its motion for preliminary injunction and subsequent motion for summary judgment, FCAAP provided its documents to the Florida House and confirmed through counsel that it was producing all documents in its possession reflecting its organizational discussion and decision to recommend pediatric GAC.[6]

The trove of documents was surprisingly paltry. As FCAAP explained through its counsel, "the reason [it did] not have any more responsive documents is that the Florida Chapter *has not been involved in the*

Whistle on 'Sloppy' Care, THE FREE PRESS (Oct. 4, 2021), https://www.thefp.com/p/top-trans-doctors-blow-the-whistle.

[6] The Committee sought documents from January 1, 2018 through November 6, 2023, the date the Committee issued a follow-up subpoena to FCAAP.

national organization's policy-making process" and because its ostensible organizational support of pediatric GAC "did not become a matter of discussion in the Florida Chapter until after the date range of the second subpoena"—i.e., until after November 6, 2023. Yet FCAAP told Florida's state health regulators *in 2022* that it "recommended and endorsed" pediatric GAC. If its membership did not participate in that decision, who did?

Before answering that question, it is helpful to consider the development of America's foremost authority on mental health conditions, the American Psychiatric Association's ("APA") Diagnostic and Statistical Manual of Mental Disorders ("DSM"), for what it reveals about how a professional "consensus" may be formed. Dr. James Davies, an Oxford-trained medical anthropologist who studied the development of the DSM by interviewing multiple generations of DSM leadership and combing through the APA's archives, has explained in lectures that the DSM was drafted based on decisions made by very small committees rather than on the basis of intensive research or comprehensive surveys of practitioners and researchers—in his words, a "consensus of an extremely small group of people – nine people."[7] Tellingly, he interviewed Dr. Robert Spitzer, the Chair of the DSM-III task force who is widely regarded as among the most influential psychiatrists

[7] The Weekend University, *Psychiatry & Big Pharma: Exposed - Dr James Davies, PhD*, YOUTUBE (Nov. 24, 2019), https://www.youtube.com/watch?v=-Nd40Uy6tbQ at 37:30.

in American history, and quoted Dr. Spitzer as follows:

> Our [leadership] team was certainly not typical of the psychiatry community, and that was one of the major arguments against DSM-III: *it allowed a small group with a particular viewpoint to take over psychiatry and change it in a fundamental way. . . We took over because we had the power*.[8] [9]

Based on his interviews and research, Dr. Davies drew the following conclusion that just as aptly describes today's purported consensus regarding pediatric GAC:

> What an inspection of the construction of DSM . . . reveals is that the separate disorders into which DSM organized diverse behavioral and mental phenomena were largely the outcome of vote-based judgments, *settled by a small, culturally homogenous subset of mental-health professionals who were socially positioned at a given time to have their judgments ratified by the institutional*

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[8] *Id.* at 38:00 (emphasis added).

[9] Notably, the formal recognition of gender dysphoria and the creation of its diagnostic criteria were themselves the result of this fundamentally flawed process. *Cf. Bostock v. Clayton Cnty.*, 590 U.S. 644, 716 (2020) (Alito, J., dissenting) ("It was not until 1980 that the APA, in DSM–III, recognized two main psychiatric diagnoses related to this condition, 'Gender Identity Disorder of Childhood' and 'Transsexualism' in adolescents and adults.").

> *apparatus* of the American Psychiatric Association. [And] while such judgments may indicate that a group of professionals sharing similar sociocultural beliefs, biases, persuasions, and interests may see some things in the same way at a given point in time, they do not confirm that what they see is either objectively true, universal, or indeed stable in any verifiable sense.[10] [11]

None of this is conspiratorial, or even unusual.[12] Instead, it is consistent with how large organizations typically allocate decision-making power. The documents that FCAAP provided to the Florida House demonstrate the point. They appear to show that FCAAP's organizational promotion of pediatric GAC was engineered by the Academy's headquarters and FCAAP's president, with FCAAP's executive director

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[10] *See* note 7, *supra*, at 49:00 (emphasis added).

[11] The Chair of the DSM-IV Task Force, Dr. Allen Frances, was quoted as saying his Task Force "knew that most decisions" in the DSM-III "were arbitrary" but that the DSM-IV largely incorporated those decisions anyway because its objective was merely to "stabilize" the system that the DSM-III created. *Id.* at 46:20–48:20. With regard to the current version, DSM-5, the APA allegedly has prevented its authors from discussing its creation by securing confidentiality agreements from them, and allegedly has denied access to its archives by "embargoing" the relevant documents for 20 years post-publication. *Id.* at 1:42:00. Small wonder, if true.

[12] Of course, the Court need not make any determinations about the veracity of Dr. Davies' research, although there is little reason to doubt it. Instead, the Court need only consider the obvious possibility that private organizations can and do make decisions in this manner.

playing the role of liaison. For example, the communications surrounding FCAAP's submission of rule comments to Florida's health regulators reveal a process by which an Academy "team" drafted rule comments and coordinated with FCAAP's executive director to have FCAAP's president sign and submit the comments on behalf of 2,600 Florida pediatricians who apparently were never consulted. On what basis can those comments possibly be said to reflect the views of the 2,600 Florida pediatricians who comprise FCAAP's membership?

The content of these communications is equally concerning. Discussing the proposed rule comments to the Florida Board of Medicine, FCAAP's president suggested to its executive director that the comments should note that the inability to conduct ongoing studies would "preempt attaining more data on the effectiveness of care." Notably, she wanted to emphasize in the proposed comments "how important ongoing research is and it should be maintained/allowed as medicine is often evolving." The Academy "team" responded by shooting down this suggestion. As FCAAP's executive director explained to its president, the Academy's team was reluctant "to add an argument that additional studies/research is needed." Why? Partly because it would "lend[] credence to the argument that these bans are needed because there is insufficient evidence to support this type of care."

The communications relating to FCAAP's submission of earlier rule comments to the Florida Board of Medicine at least involved a few more participants—the four other physician members who

served on FCAAP's executive committee. Even then, their roles were passive. Their approval of those rule comments was memorialized in perfunctory "I approve" emails, and the executive committee meeting minutes reflect that all discussion of pediatric GAC proceeded from the premise that it was to be supported.

Indeed, FCAAP produced but one email to its entire membership regarding pediatric GAC—and it was not an invitation for members to authorize or otherwise participate in the formation of an organizational position on the matter. Instead, it was a call to action from FCAAP's president that urged FCAAP's membership to write to the Florida Board of Medicine "in opposition to any proposed policy to limit or prohibit" pediatric GAC. *Any* limit. Disturbingly, the minutes of an executive committee meeting several months later reflect that a committee member "indicated that the Chapter needs to think about how to collect data on the mental health outcomes for these kids and asked if there is an entity that is tracking this data." One would expect FCAAP's decision-makers to know about the mental health outcomes of "kids" receiving pediatric GAC *before* encouraging FCAAP's members to oppose *any* limiting regulations.

Although the views of five organizational leaders are known (or can reasonably be inferred by their acquiescence), the views of the other 2,600 or so members of FCAAP are a mystery. Do 2,000 of those pediatricians agree with the five who used FCAAP's organizational brand to promote pediatric GAC? Perhaps. It is equally plausible that 2,000 of them *disagree*, however. Neither the Florida House nor the

courts have any way of knowing. And given that FCAAP apparently did not poll its membership, here is the more critical point—even *FCAAP* likely does not know how many of its pediatrician members actually agree that pediatric GAC is advisable. It seemingly has no basis to conclude that there is a consensus *even within its own organization*, let alone within the entire medical profession.

The same is true of the Academy itself. FCAAP's acknowledgment through counsel that it (and by extension, its membership) was not involved in the Academy's "policy-making process" demonstrates the point. It stands to reason that if the Academy did not include in its decision-making process the physician membership of the Nation's third-largest state, it did not include the physician membership of its other 58 chapters in the United States either.[13] So where is the evidence of consensus *even within the Academy*?

Although it is certainly true that "a single dissenting expert" does not "automatically defeat[] medical consensus," *Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019), the opacity of the Academy's decision-making process leaves the judiciary in the dark as to whether relatively few of its members disagree with its formal position or relatively few members *agree* with it. The same is true of the other "major medical organizations" that promote pediatric GAC. Thus, courts miss the point when they merely

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[13] *Join Your Chapter*, AMERICAN ACADEMY OF PEDIATRICS, https://www.aap.org/en/community/join-your-chapter/ (last visited Oct. 10, 2024) ("There are 59 chapters in the United States").

acknowledge in passing that there may be a few dissenters.[14]

Some might respond that the pronouncements of these organizations necessarily reflect the views of a majority of their membership because their members would leave or vote for new leadership were it otherwise. But there is little reason to believe that is so. Membership in prominent professional societies provides a variety of benefits, and many members undoubtedly calculate that such benefits warrant continued membership despite their disagreement with certain organizational positions. For example, some attorneys disagree with the American Bar Association's positions on certain matters but choose to maintain membership for a variety of reasons. Indeed, there can be no doubt that some of the ABA's attorney members disagree with the position the ABA advances in the amicus brief it filed in support of Petitioner.[15] But continued membership in an

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[14] *See*, *e.g.*, *Doe v. Ladapo*, No. 4:23cv114-RH-MAF, 2024 WL 2947123, at *35 (N.D. Fla. June 11, 2024), appeal pending, No. 24-11996 (11th Cir. filed June 18, 2024) ("The standards have been unanimously endorsed by reputable medical associations, even though not unanimously endorsed by all the members of the associations.").

[15] The ABA makes sure to note in its amicus brief that "[n]either this brief nor the decision to file it should be interpreted to reflect the views of any *judicial* member of the ABA[,]" and that "[n]o inference should be drawn that any members of the Judicial Division Council participated in the adoption or endorsement of the positions in this brief." Br. for Am. Bar Ass'n as Amicus Curiae Supporting Petitioner, at 1 n.2 (emphasis added). Of course, the ABA presumably intends that its brief *should* be interpreted to reflect the views of its attorney members, and that the Court *should* draw an inference that the ABA's non-judicial

organization does not signal approval of every organizational pronouncement. Nor should it be expected that most busy practitioners are even aware of every position that their professional association adopts.

As it turns out, the Academy announced its official position in a formal policy statement drafted by Dr. Jason Rafferty and titled "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents" ("the Policy Statement").[16] Although the Academy's policy statement process (assuming it is followed) ostensibly provides for some level of collaboration,[17] the Policy Statement identifies the "lead author" as Dr. Rafferty.[18] Remarkably, it appears that the lead

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membership (comprising "the largest voluntary association of attorneys and legal professionals in the world") endorses the advocacy in its brief. The Academy, for its part, plainly intends for this Court to infer that the Academy's membership of 67,000 physicians endorses the views expressed in the Academy's amicus brief.

[16] Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 PEDIATRICS 4 (2018), https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for.

[17] *Policy Statement Development Process*, AMERICAN ACADEMY OF PEDIATRICS, https://www.aap.org/en/policy/policy-statement-development-process/ (last visited Oct. 10, 2024).

[18] The Policy Statement also identifies a single "contributor" and otherwise simply lists the members of three Academy committees (along with their "liaisons" and support staff) without indicating the extent of their involvement. *See* note 16, *supra*.

author tasked with speaking for the Nation's preeminent pediatrics organization on this issue was fresh out of medical school and still *in residency* at the time.[19] [20]

One cannot help but speculate why Academy leadership selected such an inexperienced practitioner for that weighty task,[21] or how his "area

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[19] *See Ayala v. Am. Academy of Pediatrics*, *et al.*, No. PC-2023-05428 (R.I. Super. Ct. filed Oct. 23, 2023). *See also* Benjamin Ryan, *The AAP Files: Complete American Academy of Pediatrics Emails Showing LGBTQ Affinity Group Balking Over Florida Conference, Plus Background on Elusive Top Gender Doc Jason Rafferty*, SUBSTACK, https://benryan.substack.com/p/the-aap-files-complete-american-academy (Sept. 27, 2024) (displaying email from Dr. Rafferty in which he indicates that he was "taking [his] child psych board[]" exam on September 16, 2019—nearly a full year *after* the Academy published his Policy Statement and began touting it as the Academy's authoritative position on pediatric GAC).

[20] The recent elevation of medical residents to the status of "experts" in treating gender dysphoria apparently is not unique to the Academy. The APA, for its part, recently published a textbook titled *Gender-Affirming Psychiatric Care* that is marketed as an authoritative scientific source of best practices. Its lead author is a medical resident. *Gender-Affirming Psychiatric Care*, AMERICAN PSYCHIATRIC ASS'N PUBLISHING, https://www.appi.org/Products/Gender-Related-Issues/Gender-Affirming-Psychiatric-Care (last visited Oct. 10, 2024). To date, the APA has seemingly ignored calls to disclose details about the peer-review process that allowed this publication. *An Open Letter to the American Psychiatric Association Regarding the Publication of* Gender-Affirming Psychiatric Care, FOUNDATION AGAINST INTOLERANCE AND RACISM (January 2024), https://www.fairforall.org/open-letters/open-letter-apa/.

[21] The Policy Statement discloses that Dr. Rafferty "conceptualized the statement, drafted the initial manuscript, reviewed and revised the manuscript, approved the final

of expertise" might have been described in the "intent" document that constitutes the first step in the Academy's formal Policy Statement Development Process.[22] Regardless of the answers, it seems clear enough that far fewer than one percent of the Academy's physician membership of 67,000 had any involvement in the development and approval of its Policy Statement. And if its Florida activities are indicative of its nationwide practices, it appears that to the extent the Academy's leadership interfaced with its membership at all, it was merely with state-chapter leadership and for the purpose of securing cooperation in promoting the message that had been announced from on high.

In practical terms, then, a small task force or even a single person (for example, the president) of an organization such as the Academy may well operate within the bounds of *organizational authority* by declaring that the organization of 67,000 physicians supports a position. But it does not follow that 67,000—or even 10,000—physicians *actually* support that position. No amount of bluster from the Academy about how diligently or rigorously its curated team worked on the Policy Statement can change this. It is entirely possible—and for all the Court knows, it is the actual state of affairs—that far fewer than 50% of these organizations' physician members actually support pediatric GAC.[23] "Words have no meaning if

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manuscript as submitted, and agrees to be accountable for all aspects of the work." *See* note 16, *supra*.

[22] *See* note 17, *supra*.

[23] According to one physician who set up a booth at the Academy's 2023 annual conference "to bring awareness to the problems of

the views of less than 50% . . . can constitute a national consensus." *Roper v. Simmons*, 543 U.S. 551, 609 (2005) (Scalia, J., dissenting).

To be clear, the problem is not that a handful of physicians may have authority under their organization's bylaws to speak for their organization, or to appoint a committee or task force for that purpose. As a general matter, that is no problem at all—an organization is certainly free to designate a small leadership team to make its decisions, or even to designate a single person to make unilateral decisions that bind the organization without input from its membership. The problem arises when the person (or small group) designated to make decisions on the organization's behalf leverages that *organizational* grant of authority to override (with the federal judiciary's assistance) the *constitutional* authority of State legislatures to protect the public health, safety, and welfare.

In light of the foregoing discussion, it is easy to see why the Court should continue to reject the idea that legislative authority "depends on" the views of "the psychiatric community"—views on which the Academy and other "major medical organizations" have relied (however dubiously) in recommending

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gender medicine," "the vast majority of [Academy] members with whom we engaged in discussion either shared our concerns or had no knowledge of gender medicine and wanted to learn more." Leor Sapir, *Is the AAP Placing Its Own Members at Risk?*, CITY JOURNAL (Oct. 31, 2023), https://www.city-journal.org/article/is-the-aap-placing-its-own-members-at-risk. "Unfortunately, those who agreed that something has gone wrong with how we help kids with distress over their bodies said they fear the personal and professional repercussions of voicing their concerns." *Id.*

pediatric GAC. *Jones v. U.S.*, 463 U.S. 354, 364 n.13 (1983). The "lesson" this Court has drawn from the "uncertainty of diagnosis in this field [of psychiatry] and the tentativeness of professional judgment" is "not that government may not act in the face of this uncertainty, but rather that courts should pay *particular deference* to reasonable legislative judgments." *Id.* (emphasis added). That lesson simply cannot be squared with the deference that courts have afforded to "the bureaucratic organizations that present themselves to the world as the voices of official medical opinion." *State v. Loe*, 692 S.W.3d 215, 241 n.5 (Tex. 2024) (Blacklock, J., concurring). The "appeal to authority" fallacy is not a constitutional command.

II. Advocates of pediatric GAC have engineered an illusion of consensus by dissuading the public expression of dissent.

If proponents of pediatric GAC are falsely portraying a medical consensus, it is fair to ask why more dissenting physicians have not spoken out. Some

have, of course—in statehouses,[24] in the media,[25] within their professional organizations,[26] and elsewhere. But they do so at great personal risk[27]—

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[24] *See*, *e.g.*, *Panel Discussion on Gender Dysphoria and Minors: Hearing Before the H. Comm. on Health and Human Services*, 91st House (Fla. 2023), https://www.myfloridahouse.gov/VideoPlayer.aspx?eventID=8453. Dr. Laidlaw, a member of the Endocrine Society, provided a critique of its oft-cited guidelines and explained that "nine out of ten of the persons who created" its guidelines are members of WPATH—"so it's a very biased sample of physicians and others who created this document." *Id.* at 21:45– 32:20. Accordingly, the Court should not be impressed when the government describes the Endocrine Society as "an organization of more than 18,000 endocrinologists." U.S. Br. 3.

[25] *See*, *e.g.*, note 5, *supra*.

[26] For example, some members of the Academy introduced and supported a resolution several years ago for consideration at the Academy's annual leadership forum, seeking a systematic review of the evidence regarding pediatric GAC. According to its co-sponsor, the Academy's "leadership voted it down" and "decried the resolution as transphobic." Julia Mason and Leor Sapir, Opinion, *The American Academy of Pediatrics' Dubious Transgender Science*, WALL ST. J. (Aug. 17, 2022), https://www.wsj.com/articles/the-american-academy-of-pediatrics-dubious-transgender-science-jack-turban-research-social-contagion-gender-dysphoria-puberty-blockers-uk-11660732791.

[27] The highly publicized saga of Dr. Lisa Littman is but one of myriad examples. Dr. Littman, who coined the term "rapid onset gender dysphoria" and dared to describe the recent and widely observed "phenomenon whereby teens and young adults who did not exhibit childhood signs of gender issues appeared to suddenly identify as transgender," reportedly lost her job as a result of the ensuing backlash. Jonathan Kay, *An Interview with Lisa Littman, Who Coined the Term 'Rapid Onset Gender Dysphoria*,' QUILLETTE (Mar. 19, 2019), https://quillette.com/2019/03/19/an-

one that understandably leaves them "very scared to speak up."[28] No legitimate consensus can be formed in such an environment.[29] *See*, *e.g.*, *Daubert*, 509 U.S. at 596 ("open debate is an essential part of both legal and scientific analyses").

The reported examples of institutional censorship, public pressure campaigns, and the resulting self-censorship are far too numerous to catalogue here. A recent testimonial from a pioneer of pediatric GAC is illustrative, though. Dr. Riittakerttu Kaltiala, a psychiatrist who led Finland's national pediatric gender program and published extensively on the topic, is among those who have summoned the courage to speak out. She has explained that she and many physicians in her professional network observed that the seminal "Dutch protocol" that formed the basis for pediatric GAC was entirely inconsistent with their clinical experiences. Among other reasons, she observed that "young people we were treating were not thriving. Instead, their lives were deteriorating."

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interview-with-lisa-littman-who-coined-the-term-rapid-onset-gender-dysphoria/.

[28] *See* note 5, *supra*.

[29] As University of South Florida psychiatrist (and former liaison to the Academy) Dr. Kristopher Kaliebe has explained, there is a "spiral of silence" in which professional associations "look to each other for cues" and take the position that "until they change their stance, we don't want to change ours." Aaron Sibarium, *They Support Sex Changes for Children, with Safeguards. A Top Child Psychiatry Group Won't Let Them Speak at Its Annual Conference*, THE WASHINGTON FREE BEACON (Aug. 11, 2023), https://freebeacon.com/campus/they-support-sex-changes-for-children-with-safeguards-a-top-child-psychiatry-group-wont-let-them-speak-at-its-annual-conference/.

"But no one was saying anything publicly" because "[t]here was a feeling of pressure to provide" pediatric GAC.[30]

Dr. Kaltiala "understood this silence. Anyone, including physicians, researchers, academics, and writers, who raised concerns about the growing power of gender activists, and about the effects of medically transitioning young people, were [sic] subjected to organized campaigns of vilification and threats to their careers." As she explained further, "Medicine, unfortunately, is not immune to dangerous groupthink that results in patient harm."[31] This is not the rhetoric of a partisan ideologue, but the observation of a leading practitioner in the field of pediatric GAC—one whose work is even cited in the amicus brief the Academy, WPATH, and other GAC-supporting "major medical organizations" filed in this case. Moreover, when experienced practitioners such as Dr. Kaltiala seek a professional forum to voice their concerns, they are denied that forum by *the very professional societies* that turn around and claim there is no significant disagreement within the medical profession.[32]

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[30] Riittakerttu Kaltiala, *Gender-Affirming Care Is Dangerous. I Know Because I Helped Pioneer It.*, THE FREE PRESS (Oct. 30, 2023), https://www.thefp.com/p/gender-affirming-care-dangerous-finland-doctor.

[31] *Id.*

[32] *See*, *e.g.*, *id.* (Dr. Kaltiala explaining that she "attempted to address the rising international concerns about pediatric gender transition at this year's annual conference of the American Academy of Child and Adolescent Psychiatry" but her "two proposed panels were rejected by the academy"). The American

This Court has recognized that "[o]ne must not expect uncommon courage even in legislators." *Tenney v. Brandhove*, 341 U.S. 367, 377 (1951). Even less should one expect uncommon courage from physicians who stand to lose their livelihoods should they express opinions disfavored in today's political climate. More to the point, the constitutional authority of the States to regulate the practice of medicine and to protect minors from medical misadventures cannot depend on whether a critical mass of physicians is willing to exhibit such uncommon courage. The fate of such legislation in a courtroom should not depend on it, either.

III. Deference to expert testimony in support of pediatric GAC has effectively loaded the dice against the States.

Expert testimony often incorporates the recommendations of leading professional organizations, and pediatric GAC litigation has been no exception. As demonstrated above, those recommendations do not necessarily reflect anything more than the views of a small number of organizational leaders who currently are socially positioned to leverage their institutional platforms.[33] Accordingly, expert testimony on this issue is inherently problematic to the extent that it

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Academy of Child and Adolescent Psychiatry is among the "major medical organization" amici here. *See also* note 29, *supra* (corroborating Dr. Kaltiala's account).

[33] Even then, it is not fanciful to imagine that some organizational leaders may not actually hold those views but may go along as a matter of political expediency or a misguided desire to be "on the right side of history."

incorporates or parrots those recommendations. But a host of other problems arise when expert witnesses are deputized to decide whether the Constitution requires the States to allow pediatric GAC.

First, as should be expected, physicians who believe pediatric GAC is harmful generally do not engage in it or participate in developing and promoting it. But that is used against the States when they seek to introduce expert testimony from such physicians. After all, the reasoning goes, what would a physician know about pediatric GAC without having administered it or participated in its development? *See*, *e.g.*, *Brandt v. Rutledge*, 677 F. Supp. 3d 877, 914 (E.D. Ark. 2023), appeal pending, No. 23-2681 (8th Cir. argued en banc Apr. 11, 2024) (excluding expert testimony partly because surgeon "never provided gender-affirming surgery"); *Kadel v. Folwell*, 620 F. Supp. 3d 339, 370 (M.D.N.C. 2022) (excluding criticism of WPATH, Endocrine Society, Academy of Pediatrics, and other organizational guidelines and position statements because surgeon expert witness was not among the privileged few selected to be in the room when they were created); *Kadel v. Folwell*, 100 F.4th 122, 198–99 (4th Cir. 2024) (Quattlebaum, J., dissenting) (criticizing the exclusion of proffered expert testimony from a different defense witness on similar grounds).

So the States must also engage experts[34] who *have* administered pediatric GAC and therefore may

[34] Anecdotally, well-credentialed practitioners who oppose pediatric GAC have expressed reluctance to appear as expert witnesses for the reasons explained in Part II, *supra*.

believe it to be appropriate at least sometimes. But this invites the courts to reject the States' defenses on the basis that "even the States' experts agree" with the plaintiffs, at least in part. *See*, *e.g.*, *Brandt*, 677 F. Supp. 3d at 913, 919; *Ladapo*, 2024 WL 2947123, at *7 ("Even the defendants' expert Dr. Levine testified that treatment with GnRH agonists and cross-sex hormones is sometimes appropriate."). Heads, the plaintiffs win; tails, the States lose.

Second, the outsized influence of expert testimony precludes due consideration of the profound harm and regret that many adolescents have experienced (and undoubtedly will experience in the future as they become adults). Some of these "detransitioners" have testified in Congress and in statehouses—including Chloe Cole, who testified in detail before a Congressional committee that her "childhood was ruined" as were those of "thousands of detransitioners" that she "know[s] through [their] networks."[35] Many other detransitioners have spoken out publicly, through social media and otherwise. More than 30 detransitioners were interviewed for the aforementioned 60 Minutes episode.[36] That episode also referenced a large Internet community for detransitioners, now consisting of 55,000 members

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[35] *See* note 3, *supra*, at 14.

[36] *See* note 5, *supra*. Like clockwork, activists promptly denounced this information as "shameful," "harmful," and "dangerous." Valerie Richardson, *'60 Minutes' Hit with Backlash from LGBTQ Advocates for Detransition Report*, THE WASHINGTON TIMES (May 26, 2021), https://www.washingtontimes.com/news/2021/may/26/60-minutes-backlash-lgbt-advocates-detransitioning/.

and containing thousands of posts (many with detailed first-hand accounts and photographs).[37]

Unfortunately, trial courts have credited expert testimony that this phenomenon is virtually non-existent. *See*, *e.g.*, *Brandt*, 677 F. Supp. 3d at 905 (crediting fantastical testimony of plaintiffs' expert who claimed to have treated "thousands of patients with gender dysphoria over 30 years" without *even a single patient* detransitioning due to regret). How are the States to push back at trial? Sure, they can call (and have called) a few witnesses who have detransitioned due to regret, but it is all too easy for a court to write that off as a rare occurrence when faced with the sort of countervailing expert testimony described above. What if those witnesses testify that many of their adolescent friends also have regrets, or if they reference the "detrans" Reddit community or other online communities where detransitioners congregate? Inadmissible hearsay, surely. Must the States recruit hundreds of detransitioners who are willing to share intimate details of their experiences in a federal courtroom? The Equal Protection Clause surely does not place the States in this sort of evidentiary straightjacket when defending their constitutional authority to protect minors from harmful or experimental medical practices.

Occasionally, a topic by its very nature engenders expert testimony that devolves into the farcical no matter how well-credentialed the expert witnesses

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[37] *See* r/detrans, REDDIT, https://www.reddit.com/r/detrans/ (last visited Oct. 10, 2024). Of course, it is not necessary to assume that *all* 55,000 members are themselves detransitioners.

may be. *See Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 56 n.6 (1973) (explaining that "the 'expert witness' practices employed in these [obscenity] cases have often made a m[o]ckery out of the otherwise sound concept of expert testimony"); *Kahm v. U.S.*, 300 F.2d 78, 84 (5th Cir. 1962) ("We think it may fairly be said that no amount of testimony by anthropologists, sociologists, psychologists or psychiatrists could add much to the ability of the jury to apply those tests of obscenity to the materials here present."). The fact that adolescents are prone to social influence and risky behavior that lead to decisions they may later regret is universally known and cannot seriously be questioned—not even by those who qualify as experts under the Federal Rules of Evidence.[38]

Third, expert testimony often includes references to scientific studies,[39] but the courtroom is no place for a comprehensive explication of such studies. *Cf. Chiles v. Salazar*, No. 22-1445, 2024 WL 4157902, at *40 n.5 (10th Cir. Sept. 12, 2024) (Hartz, J., dissenting) (examining the consequences of the

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[38] Even WPATH's "standards of care" acknowledge that adolescence is "often associated with increased risk-taking behaviors" and that the "heightened focus on peer relationships" can be "detrimental." *See* note 4, *supra*, at S44. And even the lead author of the Academy's Policy Statement has described psychiatry as a field "where we cannot objectively see/assess what someone feels, especially in adolescence when feels [sic] change so drastically and so quickly." *See* Benjamin Ryan, *The AAP Files*, note 19, *supra*.

[39] *See*, *e.g.*, *Smith v. Arizona*, 144 S. Ct. 1785, 1801 n.5 (2024) (describing "books and journals, surveys, and economic or scientific studies" as "the mine-run of materials on which most expert witnesses rely in forming opinions").

"laissez faire attitude" with which trial courts may "engage in perfunctory review" of flawed studies "endorsed by professional organizations"—an approach that "has bred dismay by true scientists"). Certainly, the States might demonstrate that studies addressing suicide risk (including the very first study the government cites in its merits brief) do not support the inference that deprivation of pediatric GAC contributes to suicidality, instead suggesting that sexual trauma, bullying, and other factors are responsible.[40] They could remind the courts in that regard that correlation does not equal causation. *Cf.* U.S. Br. 36–37 (emphasizing as "most urgent" the mere *association* between adolescent gender dysphoria and suicidality). Or they could point out that the Academy's purported rejection of the "watchful waiting" approach to adolescent gender dysphoria was premised on its author's inexplicable conflation of that approach and "conversion therapy" for *sexual orientation*.[41] But to what end? Plaintiffs and their experts may cite 100 studies, and the States should not have to spend weeks or months in trial endeavoring to refute them all. The States' constitutional authority to restrict or prohibit

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[40] *See* U.S. Br. 3 n.1 (citing Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students*, 68 Morbidity & Mortality Wkly. Rep. 67, 70 (2019)).

[41] *See* James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. of Sex & Marital Therapy (2019), https://www.ohchr.org/sites/default/files/Documents/Issues/SexualOrientation/IESOGI/Other/Rebekah_Murphy_20191214_JamesCantor-fact-checking_AAP-Policy.pdf.

pediatric GAC cannot turn on how many articles GAC advocates manage to publish in medical journals, or how many studies a plaintiff's expert references on the witness stand.

"Given the nuances of scientific methodology and conflicting views, courts—which can only consider the limited evidence on the record before them—are ill equipped to determine which view of science is the right one." *Roper*, 543 U.S. at 618 (Scalia, J., dissenting). Overruling legislative judgment here would effectively transform the federal judiciary into "the Nation's *ex officio* medical board with powers to approve or disapprove medical and operative practices and standards throughout the United States." *Gonzales*, 550 U.S. at 164 (citation omitted). The Equal Protection Clause does not compel that result—particularly because restrictions on pediatric GAC do not even draw lines on the basis of sex, as the Sixth Circuit has cogently explained. Pet. App. 33a–44a.

In summary, "[l]ike many cases . . ., this case boils down to one fundamental question: Who decides?" *Bostock*, 590 U.S. at 780 (Kavanaugh, J., dissenting). By placing "unfailing trust in professional groups," *Otto v. City of Boca Raton*, 41 F.4th 1271, 1276–77 (11th Cir. 2022) (Grant, J., concurring in denial of rehearing en banc), courts have effectively allowed those groups to make the decision. But those groups are imbued with no constitutional authority—least of all the authority to veto legislative judgment about the regulation of medicine. When a court overrules legislative judgment because "the experts" disagree with it, legislative authority is effectively transferred to them, thereby empowering them and their

organizational leaders—rather than the States' elected leaders—to dictate public health policy.

The answer to the question of "who decides" cannot be a few (or even 100) doctors who happen to hold influential leadership or task force positions within their professional associations at a particular moment in time—particularly when they make their decisions behind closed doors. After all, even the Chair of the DSM-IV Task Force has opined that "[g]uidelines should not be left in the hands of professional associations. . . . *use experts, but don't allow them to call the final shots*."[42] Nor can the answer be the expert witnesses whose persuasiveness depends simply on a federal judge's credibility determinations.

Instead, the Tenth Amendment supplies the answer—it is for the States to decide. *See*, *e.g.*, *Barsky v. Bd. of Regents*, 347 U.S. 442, 449 (1954) ("It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power."). The States may "take sides in a medical debate, even when fundamental liberty interests are at stake and even when leading members of the profession disagree with the conclusions drawn by the legislature." *Stenberg v. Carhart*, 530 U.S. 914, 969–70 (2000) (Kennedy, J., dissenting). Thus, for example, the Constitution does not require the States (or the Court, for that matter)

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[42] Lawrence Rubin, *Allen Frances on the DSM-5, Mental Illness and Humane Treatment*, PSYCHOTHERAPY.NET (2018), https://www.psychotherapy.net/interview/allen-frances-interview#section-where-dsm-5-went-wrong.

to accept the purportedly scientific premise that sex is merely "assigned" at birth, or that the biological process of puberty can ever be "the wrong puberty." Nor must they accept the purportedly scientific conclusions that flow from these premises.

CONCLUSION

If ever there was cause for the Court to demonstrate that it does not operate as "the Nation's *ex officio* medical board," this is it. "[T]he States may regulate based on matters beyond 'what various medical organizations have to say about the *physical* safety of a particular procedure.'" *Stenberg*, 530 U.S. at 967 (Kennedy, J., dissenting) (citation omitted). It is of little constitutional significance that "[e]very major American medical organization . . . agrees," as the government urges. U.S. Br. 6. "The permissibility of [pediatric GAC], and the limitations, upon it, are to be resolved like most important questions in our democracy: by citizens trying to persuade one another and then voting." *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 232 (2022) (quoting *Planned Parenthood of S.E. Penn. v. Casey*, 505 U.S. 833, 979 (Scalia, J., concurring in judgment in part and dissenting in part)). Neither the Nation nor the federal judiciary needs another half-century public health policy battle to play out in its courtrooms. The Court should affirm.

Respectfully submitted,

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