No. 23-477

In the Supreme Court of the United States

UNITED STATES OF AMERICA,
Petitioner,

v.

JONATHAN 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 FOR FAMILY RESEARCH COUNCIL AS *AMICUS CURIAE* IN SUPPORT OF STATE RESPONDENTS

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INTEREST OF *AMICUS CURIAE*

Family Research Council is a nonprofit research and educational organization. It respects the dignity of every human life, which entails protection of the vulnerable. It thus has a significant interest in this case, which challenges Tennessee's efforts to protect children from unproven, sterilizing interventions.*

SUMMARY OF THE ARGUMENT

The American Academy of Pediatrics, World Professional Association for Transgender Health, Endocrine Society, American Medical Association, and other medical interest groups (collectively, "AAP") file an *amicus* brief in most cases challenging the public's efforts to protect children from sterilizing sex-modification interventions. But the original version of that brief looked much different. It asserted that "[a] robust body of scientific evidence supports the efficacy of" gender transition medical interventions for "young people."[1] AAP repeatedly touted a "robust consensus" and a "robust body of empirical evidence."[2]

But AAP's claim of robust evidence has always been false. How do we know? Because after the Family Research Council filed a brief in that early case showing that nearly everyone—except ideologically-captured American medical interest groups—

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* Under Rule 37.6, no counsel for a party authored this brief in whole or in part, and no person other than *amicus curiae*, its members, or its counsel made a monetary contribution to it.

[1] Brief for AAP et al. 12, *Brandt* v. *Griffin*, No. 4:21-cv-00450, Doc. 30 (E.D. Ark. June 24, 2021) ("*Brandt* Brief").

[2] *Id.* at 3, 13; see *id.* at 4, 8, 9, 20.

recognizes the lack of reliable long-term evidence about sterilizing interventions in minors,[3] AAP quietly deleted *every claim* about a "robust body of empirical evidence" from its brief. Then AAP refused repeated invitations to explain its about-face, instead retreating to meaningless and still-incorrect claims that "evidence indicates the effectiveness of treating gender dysphoria according to the Guidelines." Br. 17 (capitalization omitted). AAP's "indicatory" evidence is a handful of slipshod studies that failed to control for relevant variables or to reach statistically or clinically significant results. No systematic review supports AAP's position.

The medical groups' reliance on low-quality studies to claim a "robust" scientific "consensus" exposes them for what they are, at least on this issue: policy advocates rather than honest brokers of medical evidence. The one common ground in the literature is that, as the World Health Organization concluded, "the evidence base for children and adolescents is limited and variable regarding the longer-term outcomes of gender affirming care for children and adolescents."[4] WPATH's Standards of Care, which nonetheless approve genital surgeries for children, say that because "the number of studies" about adolescent treatment "is still low," "a systematic review regarding outcomes of treatment in adolescents is not possible," and "the long-term effects of gender-affirming

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[3] Brief for Family Research Council, *Brandt* v. *Rutledge*, 47 F.4th 661 (CA8 Nov. 23, 2021).

[4] World Health Org., *WHO Development* 3 (2024), https://perma.cc/HR4L-B4GD.

treatments initiated in adolescence are not fully known."[5]

Even this misstates the scientific process: systematic reviews *are* possible. Just ask many European countries, where health authorities have repeatedly determined that childhood transitioning interventions flunk systematic reviews *because* of the lack of evidence. The United Kingdom's lead reviewer summarized: "I can't think of another area of paediatric care where we give young people a potentially irreversible treatment and have no idea what happens to them in adulthood."[6]

AAP continues to withhold this information from courts, suggesting no evidentiary doubt about giving sterilizing cross-sex hormones to an 11-year-old. AAP projects to the courts a united front of the "medical community" as agreeing on "widely accepted," "established" science. Br. 4, 8. Putting aside that the "medical community" in most of the world disagrees, a peek behind the curtain shows a much uglier reality.

WPATH hastily issued a major "correction" ditching minimum surgery ages days after releasing its vaunted standards—years in the making—because the U.S. government and AAP told it to.[7] For its part, AAP just reaffirmed its position statement—written

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[5] Coleman, *Standards of Care, Version 8*, 23 Int'l J. of Transgender Health S1, S46, S65 (2022) ("SOC-8").
[6] Abbasi, *"Medication is Binary,"* 385 BMJ q794, at *1 (2024).
[7] Ex. 186, at 11, 57, *Boe* v. *Marshall*, No. 22-cv-184, Doc. 700-15 (M.D. Ala. Oct. 9, 2024), https://perma.cc/9TB3-2TFP; see Defendants' Motion for Summary Judgment 19–21, *Boe*, Doc. 619 (June 26, 2024), https://perma.cc/YZ6X-9AJU ("*Boe* Mot.").

by one doctor still in training—even as it belatedly commissioned a systematic review for the first time. No wonder then, after AAP demanded changes from WPATH but *still* refused to endorse its new standards, WPATH leaders lashed out: "the AAP is so thin on scientific evidence," and the "guidelines that they mentioned so many times have a very weak methodology, written by few friends who think the same."[8] The AMA also refused to endorse WPATH's standards, leading WPATH's president to charge that it is run by "white cisgender heterosexual hillbillies from nowhere."[9] Yet here and across the country, courts are told by the experts that the debate is over.

As these repeated episodes show, there is no reason to trust AAP and the other groups on this politicized issue. If the medical groups tell lies about "robust," "widely accepted," "evidence-based" treatments in court, they will push physicians to tell the same lies to children and families who could face a lifetime of devastation. The reason to wait for medical interventions—and the reason Tennessee's law passes any level of scrutiny—is that the consequences of "gender-affirming care" for a minor are drastic. Gender dysphoria in most children does not persist into adulthood. But children who take puberty blockers then cross-sex hormones—the near-universal transitioning pathway—are expected to become sterile and potentially suffer many other negative

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[8] *Boe* Mot., *supra* note 7, at 12 & n.52; Ex. 187, at 100, 107, *Boe*, Doc. 700-16, https://perma.cc/2D9G-FHFM.
[9] *Boe* Mot., *supra* note 7, at 12 & n.53.

repercussions.[10] Even WPATH's president admitted elsewhere "that 'really about zero' biological males who block puberty at the typical Tanner 2 Stage of puberty (around 11 years old) will go on to ever achieve an orgasm."[11] As for benefits, there are no long-term outcome studies of children put on WPATH's or the Endocrine Society's present protocols—*none*.

Amicus has pointed out these flaws in the medical interest groups' analysis in case after case. AAP's response? Filing the same brief. The groups have no answer but a regurgitation of their ideological positions. Those self-interested positions should not be substituted for the default rule that the People may govern themselves when it comes to protecting health and welfare. The Court should affirm.

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[10] Levine, *Reconsidering Informed Consent*, 48 J. Sex & Marital Therapy 706, 711, 713 (2022), https://perma.cc/6AMV-4XG4.

[11] Larson, *Duke Health emerges as Southern hub for youth gender transition*, Carolina J. (Aug. 31, 2022), https://perma.cc/8KVP-GCY8.

ARGUMENT

The cornerstone of the United States' case is that "[e]very major American medical organization," "including the American Academy of Pediatrics and the American Medical Association, agrees that puberty blockers and hormone therapy 'are appropriate and medically necessary'" in children. U.S. Br. 6, 35. Less than a year ago, the United States even claimed that "overwhelming evidence" supports those interventions—again relying on the purported "position" of "every major American medical organization." Pet. 7.

But "[t]he law need not give [physicians] unfettered choice in the course of their medical practice." *Gonzales* v. *Carhart*, 550 U.S. 124, 163 (2007). No business likes to be regulated. And medical advocacy groups like AAP, WPATH, and the Endocrine Society have financial incentives and ideological commitments at play. No honest broker of science could have claimed a "robust body of empirical evidence" about these experimental treatments. Systematic reviews repeatedly find a *lack* of robust evidence. The groups' reliance instead on badly-designed studies confirms that they are oriented toward policy—not science.

I. The United States' favored medical groups are driven by ideology.

In most areas of the law, courts properly recognize that interest groups with ideological or financial stakes may push a self-interested legal view. Cf. The Federalist No. 10 (Madison). These groups can advocate for their positions, but courts are "not

required to exhibit a naiveté from which ordinary citizens are free." *Dep't of Commerce* v. *New York*, 588 U.S. 752, 785 (2019). Yet some courts treat (certain) medical groups differently, letting them drive constitutional interpretation despite ideological and self-interested motivations. The United States convinced the district court here to take that route. App. 198a–99a.

But historically, medical interest groups are hardly paragons of truth or virtue. Not long ago, "[e]ugenics captivated the country's scientific and academic elite." Gorsuch & Nitze, *Over Ruled: The Human Toll of Too Much Law* 55 (2024). "Relying on 'hard data' and 'science,'" *id.* at 56–57, "[t]he most important elite advocating eugenic sterilization was the medical establishment": "every article on the subject of eugenic sterilization published in a medical journal between 1899 and 1912 endorsed the practice."[12]

Other examples abound: racist medical experimentation, lobotomies, opioids, thalidomide, and smoking. See generally Makary, *Blind Spots: When Medicine Gets It Wrong, and What It Means for Our Health* (2024). The American Medical Association's "systematic, long-term wrongdoing" has led courts to "doubt[] the AMA's genuineness regarding its concern for scientific method in patient care." *Wilk* v. *AMA*, 895 F.2d 352, 363, 366 (CA7 1990).

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[12] Cohen, *Imbeciles* 66 (2016).

Skepticism is even more appropriate here. The interest groups repeatedly claim that their "treatment protocols" are "evidence-based." Br. 8. They are not.

A. WPATH

WPATH's vaunted Standards of Care—which changed in 2022 and then again a few days later—"reflect not consensus, but merely one side in a sharply contested medical debate." *Gibson* v. *Collier*, 920 F.3d 212, 221 (CA5 2019). According to Dr. Stephen Levine, who helped author an earlier version of WPATH's guidelines, "[s]kepticism and strong alternative views are not well tolerated" and have been "greeted with antipathy from [WPATH's] large numbers of nonprofessional adults." *Kosilek* v. *Spencer*, 774 F.3d 63, 78 (CA1 2014) (alteration omitted).

The latest, 8th edition of its standards (SOC-8) admit that they are based on not just "the published literature" "but also" "consensus-based expert opinion."[13] This "consensus" is cover for ideology. For instance, SOC-8 initially retained age requirements for surgically transitioning minors.[14] This displeased WPATH's activists—and the U.S. government and AAP.

Just nine days after WPATH published SOC-8—years in the making—it issued a "correction" eliminating minimum ages for transition surgeries.[15]

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[13] SOC-8, *supra* note 5, at S8.

[14] Davis, *Kid Gender Guidelines Not Driven by Science*, N.Y. Post (Sept. 29, 2022), https://perma.cc/8MDU-VF9Y.

[15] *Correction*, 23 Int'l J. of Transgender Health S259 (2022), https://perma.cc/2UJ4-V73E.

"[L]imited research" on adolescent issues is a "challenge[]," an author admitted, but the "[un]correct[ed]" SOC-8 would "make it more likely that practitioners would be sued" for malpractice.[16] Plus, according to WPATH's president, to "propose" surgeries at defined "younger age[s]" would require "a better political climate."[17] Contra Br. 8, 15 (WPATH's Standards are "evidence-based").

And those were just the *public* explanations. The fuller story, from private communications, has now been revealed. WPATH retracted the ages—without running that change through its purportedly "rigorous process" (Br. 5)—because Admiral Rachel Levine at the U.S. Department of Health and Human Services told it to for political reasons, and because AAP threatened to oppose the standards if it didn't.[18]

A few years ago, WPATH's brief assured that "genital surgeries on youth under 18 are not recommended and are not performed in [the state]."[19] Even this claim was highly questionable—in a two-year partial analysis of insurance claims, Reuters found hundreds of child surgeries[20]—and now

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[16] Videorecording of Dr. Tishelman's WPATH Presentation, Twitter (Sep. 19, 2022), https://perma.cc/H88Z-CW7X (video: https://perma.cc/S9W4-4563).

[17] Ghorayshi, *More Trans Teens Are Choosing 'Top Surgery,'* N.Y. Times (Sept. 26, 2022), https://tinyurl.com/4347f5np.

[18] See sources cited *supra* note 7 and *infra* note 55; Ex. 186, *supra* note 7, at 28–33.

[19] *Brandt* Brief, *supra* note 1, at 12 n.44.

[20] See Resput & Terhune, *Putting Numbers on the Rise in*

WPATH deflects with the disingenuous statement that its brief "does not discuss surgeries that are typically available to transgender adults." Br. 3 n.3; see also U.S. Br. 8 n.5.

Of course not. That's because childhood transitioning surgeries *should* be "typically available" under SOC-8—and WPATH *knows* surgeries have been happening for years. Presented with a Yale "Integrity Project" critique of state laws like Tennessee's and asked to endorse it—including its claim that standards "set the age of majority as the threshold for considering surgery on genitals"[21]—WPATH initially balked. According to its leaders, though that might be "correct from an academic point of view, from a clinical point of view gender affirming surgeries (genital and otherwise) are currently taking place for [transgender] people under the age of 18 years" "in the US."[22] But "[a]fter consultation with those involved in" litigation against state laws, WPATH accepted simply "quoting the standards of care" as "most helpful."[23]

A few months later, WPATH's new standards largely abandoned even the veneer of age minimums for surgery. And politics, ideology, and malpractice fear are not the only explanations for WPATH's child

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Children Seeking Gender Care, Reuters (Oct. 6, 2022), https://www.reuters.com/investigates/special-report/usa-transyouth-data/.

[21] McNamara, *Biased Science* 8 (Apr. 28, 2022), https://perma.cc/FT6Z-F6CQ.

[22] Ex. 184, at 50, *Boe*, Doc. 700-13, https://perma.cc/A249-8MDK.

[23] *Id.* at 49.

genital surgery backtracking. As a doctor in Vanderbilt's transition clinic bragged, the hospital started the clinic after being convinced that it would be a "big money maker": hormone interventions "bring[] in several thousand dollars," while "top" surgeries "bring in" $40,000, and "female to male bottom surgeries are *huge* money makers" ($100,000) because they are so "labor-intensive" and "require a lot of follow-up."[24] Why bother with the difficult work of addressing underlying mental health issues through psychosocial support—which many countries mandate but WPATH's brief ignores—when profitable genital surgeries on vulnerable children without threat of lawsuits await?

Indeed, one surgeon profiled by the *New York Times* "has built a thriving top surgery specialty" by advertising to children on social media.[25] Dr. Sidhbh Gallagher's social media "feeds often fill with photos tagged #NipRevealFriday" of patients "whose bandages were just removed."[26] Gallagher regularly provides surgeries to minors as young as 13.[27] She professed ignorance about one patient who detransitioned sixteen months after surgery and said: "I lost something about myself that I could have loved."[28]

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[24] White, *Follow the Money*, Washington Examiner (Sept. 20, 2022), https://perma.cc/8PE8-X8U9 (video).
[25] *More Trans Teens*, *supra* note 17.
[26] *Ibid.*
[27] *Ibid.*
[28] *Ibid.*

WPATH claims that its standards "were developed through a robust and transparent process" with "scientific rigor." Br. 15 (capitalization omitted). This is a bold claim for an organization that yanked from the internet even evidence of SOC-8's surgery age correction.[29] If SOC-8's formulation was—all evidence to the contrary—"robust and transparent," surely WPATH would provide details. Yet when Alabama subpoenaed documents about SOC-8's creation, WPATH (unsuccessfully) argued that it was an "advocacy organization[]" shielded from public disclosure.[30]

When those documents emerged, they exposed WPATH's "robust" guidelines creation for what it was. WPATH here claims its guidelines "went through rigorous review" with "119 authors" and "feedback from experts." Br. 16. Well. After telling the U.S. government it "could not remove" the minimum surgery ages—because those ages had gone through "endless discussions by experts to reach [a] consensus"—WPATH caved and removed the ages, without running that major change through its trumpeted expert review.[31]

Privately, WPATH's authors said the change "make[s] a joke of our methodology," and WPATH's president was "disappoint[ed] that politics always

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[29] See *Statement of Removal*, 23 Int'l J. of Transgender Health S259 (2022), https://tinyurl.com/2wv6mxhf.
[30] Joint Motion to Quash 3, *Boe*, Doc. 208 (Dec. 27, 2022).
[31] Ex. 186, *supra* note 7, at 17, 26, 57; *Boe* Mot., *supra* note 7, at 21 & n.113.

trumps common sense and what is best for patients."[32] Publicly, WPATH began telling courts what it still says here: that its guidelines "went through rigorous review." Br. 16. Compare Br. of Clinical Practice Guideline Experts 11, 36 (WPATH "followed" a "rigorous" "Delphi process to approve the recommendation statements"), with Ex. 186, *supra* note 7, at 32 (WPATH author explaining that if the ages were changed, "we can never say that the adolescent chapter passed Delphi").

At the same time, WPATH authors admitted that the ages themselves never "ha[d] any scientific backup," but it justified them anyway as "consensus based."[33] That was the broad justification for *most* of the adolescent standards—"consensus," not "evidence."

Unlike AAP (as discussed next), WPATH bothered to commission systematic evidence reviews, but those reviews "found little to no evidence about children and adolescents."[34] WPATH, along with "the social justice lawyers [it] spoke with," recognized the problem: "evidence-based review reveals little or no evidence and puts us in an untenable position in terms of affecting policy or winning lawsuits."[35] WPATH's solution was to publish its "consensus"-based standards but *not* most of its evidence review.[36]

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[32] Ex. 187, *supra* note 8, at 100–01, 338.
[33] *Id.* at 100.
[34] Ex. 173, at 22–25, *Boe*, Doc. 560-23, https://perma.cc/ES5V-H62U.
[35] Ex. 174, at 2, *Boe*, Doc. 560-24, https://perma.cc/K7GV-VF6V.
[36] *Boe* Mot., *supra* note 7, at 16–18.

Last, WPATH's guidelines are not true standards of care. Contra U.S. Br. 3–4 ("accepted standard of care," "widely followed"). No physician must adhere to them. One survey found that 55% of WPATH surgeons did *not* follow its (since-abandoned) age recommendations for gender surgeries.[37] As for cross-sex hormones, WPATH assures courts that "[h]ormone therapy is only prescribed when a qualified mental health professional has confirmed the persistence of the patient's gender dysphoria, the patient's mental capacity," "and that any coexisting problems have been addressed," and another clinician agrees. Br. 14. An unsuspecting reader might think that describes the real world. It does not.

The *Los Angeles Times* recently told the story of an OB-GYN physician at the West Alabama Women's Center, whose abortion business practically disappeared after *Dobbs*. "A key prong of its" search for new revenue sources became transitioning minors.[38] The OB-GYN—who admitted that "this area of medicine is pretty new to me"—said that she "does not believe adolescents seeking hormones require mental health evaluations": "'No, I don't need a psychologist or psychiatrist to evaluate someone who's telling me, "This is how I felt for years."'"[39] Even though the OB-GYN recognized "that this is a relatively experimental area of medicine without a lot

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[37] See Milrod & Karasic, *Age is Just a Number*, 14 J. Sexual Med. 624 (2017).
[38] Jarvie, *This Abortion Doctor is Not Ready to Leave Alabama*, L.A. Times (Apr. 28, 2023), https://perma.cc/Z5ER-WAFY.
[39] *Ibid.*

of data," the article described her first visit with a young girl: she informed the patient "early in their first conversation" via telehealth that she would prescribe testosterone.[40] "[T]he teen's pediatrician and staff at a psychiatric hospital" had declined to prescribe testosterone.[41]

The same story has been told at the academic clinics that supposedly provide the gold standard of care. See U.S. Br. 35. The endocrinologist head of Washington University's gender clinic said he has "no idea how to meet" "intensive interpretations" of SOC-8.[42] Instead, as one patient related, he prescribed testosterone "after one appointment": "There was no actual speaking to a psychiatrist or another therapist."[43]

Things are even worse at the nation's leading churn-and-burn transitioning provider, Planned Parenthood, which also landed on vulnerable children for new revenue. Planned Parenthood has processed tens of thousands of gender-related insurance claims for youths aged 12–17.[44] "[A]t least 40,000 patients went to Planned Parenthood" just last year for transitioning hormones that are often prescribed within 30 minutes on an initial visit. As one Planned

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[40] *Ibid.*
[41] *Ibid.*
[42] Ghorayshi, *How a Small Gender Clinic Landed in a Political Storm*, N.Y. Times (Aug. 23, 2023), https://tinyurl.com/y2m3mrda.
[43] *Ibid.*
[44] Block, *How Did Planned Parenthood Become One of the Country's Largest Suppliers of Testosterone?*, The Free Press (Aug. 7, 2024), https://perma.cc/H3UB-NWCN.

Parenthood handbook explains, "Most of our patients can get a hormone prescription at the end of their first visit with us."[45] Only "sometimes," the handbook continues, does it "make[] sense to wait for lab results or to consult with another provider."[46] A Planned Parenthood medical director explained: "Gatekeeping is not necessary. People are the experts of their own body."[47]

Given all this, no wonder that the founding psychologist of the first U.S. pediatric gender clinic recently lamented that "there are no professional organizations who are stepping in to regulate what's going on."[48] Perhaps that's because "WPATH's lodestar is ideology, not science." *Eknes-Tucker* v. *Governor of Alabama*, 114 F.4th 1241, 1261 (CA11 2024) (Lagoa, J., concurring).

B. AAP

The American Academy of Pediatrics also places ideology above scientific evidence. In 2018, it created its policy statement without any systematic evidence review.[49] A pediatrician still in residency wrote it.[50] It

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[45] Planned Parenthood North Central States, *Gender Affirming Hormone Therapy Patient Handbook* 8 (Aug. 2022), https://perma.cc/R3CL-CCZR.
[46] *Id.* at 8–9.
[47] *How Did Planned Parenthood*, *supra* note 44.
[48] Paul, *As Kids, They Thought They Were Trans. They No Longer Do.*, N.Y. Times (Feb. 2, 2024), http://tinyurl.com/2kefyjrv.
[49] Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics 1 (2018).
[50] *Id.* at 1; Complaint ¶ 26, *Ayala* v. *AAP*, No. PC-2023-05428 (R.I. Super. Ct. Oct. 23, 2023), https://perma.cc/JUN4-J846.

is an ideological document. As one researcher explained, the few "references that AAP cited as the basis of their policy instead outright contradicted that policy," and AAP "left out" "the actual outcomes [of] research on [gender dysphoric] children"—disregarding 10 of the 11 studies on this cohort.[51] "[A]ny assertion that their policy is based on evidence is demonstrably false."[52]

Or take it from AAP's co-*amicus*, WPATH, whose leaders ridiculed "[t]he AAP guidelines that they mention[] so many times" as having "a very weak methodology" and "a one sided," "extremely biased" "narrative," "written by" "friends" at a "very pro-transhealth/gender affirming" organization.[53] WPATH's president was "seriously surprised that a 'reputable' association [like] the AAP is so thin on scientific evidence."[54]

For its part, AAP thinks little more of WPATH's precious standards—notwithstanding the impression given by their joint brief. Though WPATH's unreviewed deletion of minimum ages "led to [AAP] formally not opposing the SOC"—a "highly, highly confidential" fact—AAP has never endorsed those standards.[55]

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[51] Cantor, *Transgender and Gender Diverse Children and Adolescents*, 46 J. Sex & Marital Therapy 307, 307–313 (2019).
[52] *Ibid.*
[53] Ex. 187, *supra* note 8, at 100–01, 191.
[54] *Id.* at 107.
[55] Ex. 188, at 152, *Boe*, Doc. 700-17, https://perma.cc/9EJJ-K8N7; AAP, *Statements of Endorsement*, https://tinyurl.com/bdcrbn7j (last visited Sept. 27, 2024).

So when the medical groups assert that the guidelines are "widely accepted," Br. 8; see U.S. Br. 3, take it with plenty of salt. The *amici* group's leader does not "accept" the guidelines enough to formally endorse them—just enough to mislead courts into thinking that it has. In fact, *no* American medical group appears to have formally endorsed WPATH's standards.[56] And small wonder: as AAP's policy on clinical guidelines says, "evidence-based guideline developers define their methods first and then allow their methods to lead to the results rather than deciding first on the outcome."[57] WPATH took the opposite approach. In all events, "agreement among organized medical leaders alone does not constitute evidence." *Blind Spots*, *supra*, at 211.

Of course, AAP has never responded to published critiques of its own "policy statement." "By 2019," the statement "was eliciting quiet concern among rank-and-file doctors affiliated with the AAP."[58] Rather than address these concerns, AAP's tactic has been to silence dissenting voices. AAP has refused to allow the Society for Evidence-Based Gender Medicine to present evidence at its annual conference and suppressed resolutions calling for discussion of

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[56] See *Boe* Mot., *supra* note 7, at 12; contra APA Br. 8 (labeling WPATH and the Endocrine Society "standard-bearers" while omitting that they have not endorsed those standards).
[57] AAP, *Policy Statement*, 114 Pediatrics 874, 874 (2004).
[58] Sibarium, *The Hijacking of Pediatric Medicine*, The Free Press (Dec. 7, 2022), https://perma.cc/G9Q3-Z99S.

alternatives to hormone therapies.[59] It recently ordered its leaders to communicate using only personal emails to avoid "subpoenas or [FOIA] requests."[60] Meanwhile, AAP continues to publish flawed articles in its flagship journal.[61]

Last year, the AAP finally "commission[ed] a systematic review of medical research on the treatments, following similar efforts in Europe that found uncertain evidence for their effectiveness in adolescents."[62] Yet even as the AAP implicitly acknowledged that it has never done any systematic evidence review, it chose to "reaffirm[] its position from 2018."[63]

The AAP justified sticking to its position while awaiting the evidence because its board had "confidence" in the interventions, while WPATH's president (publicly) said AAP's position was appropriate because "[t]hey know the stories" "[a]necdoctally."[64] (WPATH's actual views about AAP had not yet been revealed.) Considering that the

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[59] *Ibid.*; Mason & Sapir, *The American Academy of Pediatrics' Dubious Transgender Science*, Wall Street Journal (Aug. 17, 2022), https://on.wsj.com/3BzOuTZ.

[60] Letter from Del Monte 2 (Dec. 2023), http://tinyurl.com/mpwy7rhf.

[61] Mason & Sapir, *supra* note 59; see also Singal, *It's Almost 2024 And Doctors Are Still Misleading The Public*, Singal-Minded (Dec. 22, 2023), https://perma.cc/6K6F-PYJ9.

[62] Ghorayshi, *Medical Group Backs Youth Gender Treatments, but Calls for Research Review*, N.Y. Times (Aug. 3, 2023), https://tinyurl.com/3ndvu3dm.

[63] *Ibid.*

[64] *Ibid.*

groups repeatedly rely on Dr. Gordan Guyatt, father of evidence-based medicine, to support their "evidence-based" guidelines, Br. 15, it is thus damning that Guyatt himself recognizes that AAP is "'very clearly putting the cart before the horse'" by "recommend[ing] the treatments for young people before completing a rigorous review."[65] "Based on previous systematic reviews, Dr. Guyatt said, the [AAP's] report will most likely find low-quality evidence for pediatric gender care."[66]

For months, AAP withheld all this from courts.[67] Here, AAP finally owns up to its belated review. According to AAP, its new review "is part of its normal process" "to maintain up-to-date guidelines" (Br. 4 n.4)—as if it were "normal" for a purportedly "evidence-based organization" to have a recent grad work up a policy statement on the fly, and *five years later* check the evidence. Whether that's AAP's "normal" practice or not, it is disqualifying.

AAP's brief here is even more deceptive because it fails to reflect its own policy statement. For instance, AAP's brief asserts that puberty blockers are "generally reversible" and have "well-known efficacy and side-effect profiles," and that "any potential risks" can be "mitigate[d]." Br. 13–14. But AAP's policy statement contradicts these claims:

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[65] *Medical Group Backs*, *supra* note 62.
[66] *Ibid.*
[67] See, *e.g.*, Brief of AAP et al., *Poe* v. *Drummond*, No. 23-5110 (CA10 Nov. 16, 2023).

> Pubertal suppression is not without risks. Delaying puberty beyond one's peers can also be stressful and can lead to lower self-esteem and increased risk taking. Some experts believe that genital underdevelopment may limit some potential reconstructive options. Research on long-term risks, particularly in terms of bone metabolism and fertility, is currently limited and provides varied results.[68]

Making arguments that contradict its own policy statement disqualifies AAP. If AAP does not know what the risks are, it cannot know they can be mitigated. Worse, neither AAP's brief nor its policy statement accounts for the fact that over 95% of children who start on puberty blockers will go on to cross-sex hormones.[69] Thus, the risks of hormones—including sterility—are *also* risks of puberty blockers. AAP tells neither the courts nor families that information.

The past chair of AAP's Committee on Adolescence, Dr. Cora Breuner, recently gave an interview supporting state laws prohibiting children from obtaining tattoos: "It is a permanent mark," "and I don't think kids under 18 have that kind of agency to make a decision."[70] Breuner has explained that during adolescence, "kids' decision-making ability [is] going a

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[68] Rafferty, *supra* note 49, at 5.

[69] *E.g.*, Nos, *Association of Gonadotropin-Releasing Hormone Analogue Use*, 5 JAMA Netw. Open e2239758 (2022), https://perma.cc/QTC8-WFJ7.

[70] S. Nir & K. Berner, *A 10-Year-Old Got a Tattoo*, N.Y. Times (Nov. 13, 2022), https://tinyurl.com/33eanhvj.

little haywire."[71] Yet Breuner—one of the AAP's transitioning policy signatories—says that she wants to make transitioning adolescents "absolutely mainstream."[72] It is unclear how an 11-year-old boy can provide informed consent to sterilizing drugs but not a tattoo.

AAP's claim that gender transition drugs are "only prescribed" after "parents" "give their informed consent" (Br. 14) is particularly egregious given Breuner's suggestion that doctors should withhold information about a child's care from his parents.[73] That accords with AAP's policy statement, which suggests that "legal" authorities be called on families that "deny access to care."[74] And a recent *New York Times* article reported that parents "are routinely warned that to pursue any path" but transitioning "put[s] a gender dysphoric youth at risk for suicide"[75]—a recommendation that "is not based on evidence." *Blind Spots*, *supra*, at 215.

The AAP also calls for its ideological views to be adopted in physician "certifying examinations."[76] Per the *New York Times*, physicians who "feel their hands have been tied by activist pressure and organizational

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[71] Turner & Kamenetz, *What Your Teen Wishes You Knew About Sex Education*, NPR (Feb. 11, 2020), https://perma.cc/ZA8D-7M6F.
[72] McFarling, *Transgender Clinics*, KQED (Apr. 11, 2017), https://perma.cc/KS3G-TQH5.
[73] See Oliver, *Can My Doctor Out Me to My Parents?*, U.S. News & World Reports (Mar. 22, 2017), https://perma.cc/K5XZ-MHNP.
[74] Rafferty, *supra* note 49, at 8.
[75] Paul, *supra* note 48.
[76] Rafferty, *supra* note 49, at 10.

capture" on this issue "have good reasons to be wary."[77] An American gender clinic founder said few of her students are still in the field, observing the widespread license challenges by activists claiming that any deviation from the "gender affirming" model amounts to "conversion therapy."[78]

In short, science—and children—are subordinate to AAP's policy view.

C. Endocrine Society

Many of the concerns raised about WPATH's standards apply also to the Endocrine Society's guidelines, which disclaim "establish[ing] a standard of care."[79] The Society trumpets its "strict evidentiary requirements based on the internationally recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system." Br. 15. GRADE measures the quality of evidence after "an unbiased, thorough, critical systematic review of all the relevant evidence."[80] Though the Society deserves some credit for following GRADE—unlike WPATH[81]—the follow-up questions are (1) what

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[77] Paul, *supra* note 48.

[78] See *ibid.*; see also Pietzke, *I Was Told to Approve All Teen Gender Transitions.*, The Free Press (Feb. 5, 2024), https://perma.cc/RKG3-K8BZ.

[79] Hembree, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102 J. Clinical Endocrinology & Metabolism 3869, 3895 (2017).

[80] Block, *Gender Dysphoria in Young People is Rising*, 380 BMJ 382, at *2 (2023), https://perma.cc/JU5X-CXF4.

[81] *Boe* Mot., *supra* note 7, at 14–15; contra Br. of Clinical Practice Guideline Experts 12 (suggesting SOC-8 follows GRADE).

evidence was considered and (2) what grades the evidence received.

The interest groups do not answer. That is because the Society commissioned only "two systematic reviews": "one on the effects of sex steroids on lipids and cardiovascular outcomes" and "the other" "on bone health."[82] As Dr. Guyatt—who helped develop GRADE—noted, "the systematic reviews didn't look at the effect of the interventions on gender dysphoria itself"—seemingly "the most important outcome."[83] Nor did the Society's reviews consider *any* other risks or potential benefits. Dr. Guyatt described this as a "serious problem[]": making a recommendation without a systematic review "violat[es] standards of trustworthy guidelines."[84]

Turning to the second question about what *grades* the evidence received, all recommendations about "affirming" treatment of adolescents are supported only by low or very low-quality evidence.[85] To justify recommendations based on weak evidence, the Society relied on its own "values and preferences."[86] One author admitted that the then-"new recommendation" to give cross-sex hormones to children under 16 did not come from a "little data"—"we had none"—but was an

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[82] Block, *supra* note 80, at *3.
[83] *Ibid.*
[84] *Ibid.*
[85] *Ibid.*; see Hembree, *supra* note 79, at 3869–3903.
[86] Hembree, *supra* note 79, at 3879–89.

"expert opinion" to give "cover" to clinics.[87] Contra Br. 15 ("strict evidentiary requirements").

A theme of the briefs supporting the United States is that a GRADE score of "low quality" is just "a term of art under medical grading systems" that "does not mean 'poor.'" L.W. Br. 47. "Low quality" evidence, we are told, "simply refers to evidence that is not based on randomized controlled trials." *Ibid.*; see AAP Br. 22. Not to worry, "clinical practice across disciplines is commonly guided by evidence that" might be "deem[ed] 'lower quality.'" AAP Br. 22 & n.70; see Br. for Expert Researchers 19–23; Br. for Professors of Law, etc. 9–12.

Balderdash. As one epidemiologist has explained, low-quality evidence under GRADE "doesn't just mean something esoteric about study design, it means there's uncertainty about whether the long term benefits outweigh the harms."[88] For all the groups' hedging, one acknowledges that "GRADE assesses the statistical degree of certainty that a particular treatment will have its intended effect." Br. of Clinical Practice Guidelines Experts 27. If the evidence is "low" quality, "[t]he true effect may be"—or, for "very-low" quality, "is likely to be"—"substantially different from the estimate of the effect."[89]

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[87] *State of the Art*, YouTube (Feb. 15, 2019), https://www.youtube.com/watch?v=m7Xg9gZS_hg#t=5m25s.

[88] Block, *supra* note 80, at *3.

[89] Balshem, *GRADE Guidelines*, 64 J. Clinical Epidemiol. 401, 404 (2011), https://perma.cc/2KDY-6BW5 (Br. of Professors of Law, etc. 3).

So, when the "expert researchers" (like the Society) claim here that GRADE scores have "highly technical meanings and should not be used interchangeably with colloquialisms like 'weak' and 'poor,'" Br. 20; see AAP Br. 22, they are wrong. Low quality evidence *is* weak evidence, because it means that outcomes may differ from what the evidence suggests.

"High-quality" evidence, meanwhile, does not simply mean "randomized controlled clinical trials." AAP Br. 22; U.S. Br. 39. To be sure, these trials have a starting presumption of quality, but observational studies can "produce moderate or even high quality evidence" when they are "methodologically strong."[90] And "[t]he very low quality of evidence in gender medicine stems not from a lack of randomi[z]ed controlled trials, but from poor study design, inappropriate comparison groups, high attrition, and inadequate follow-up."[91]

The groups' fixation on randomized controlled trials is a red herring anyway: if those trials are "impossible" (AAP Br. 22)—an issue discussed next—then the evidence base is likely to be weaker, no matter *why* trials are not conducted. Though AAP invokes "clinical experience" as a substitute for evidence, Br. 23; see U.S. Br. 38, the United States' *amici*'s own sources explain that "'expert opinion"—derived from anecdotes—"is not evidence" and is "very

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[90] Guyatt, *GRADE: What Is "Quality of Evidence"*, 336 BMJ 995, 997 (2008) (AAP Br. 22 n.69).

[91] Cheung, *Gender Medicine and the Cass Review: Why Medicine and the Law Make Poor Bedfellows*, Archives of Disease in Childhood (2024), at 4.

low quality."[92] Contra. generally Br. of 17 Healthcare Providers.

The medical groups assert that it "may not" be "ethically acceptable" to perform random trials because "preexisting guidelines that recommend gender-affirming care" exist. Br. 22–23 & n.71 (cleaned up). Again, this is non-responsive. Worse, witness their new circular, "intellectually lazy," and "dishonest" method: design evidence-free ideological guidelines, then use those guidelines as a shield against *trying* to obtain evidence. *Blind Spots*, *supra*, at 220.

Whether *other* medical interventions are supported only by low-quality evidence is another red herring. See, *e.g.*, AAP Br. 22 & n.70; U.S. Br. 39. All that means is that the outcomes for those interventions are also likely to be different than would be expected based on the evidence. That *other* interventions are off-label does not help the groups either, especially given that "[a] recent survey of 150 million off-label prescriptions in the United States found that 73% had little or no scientific support" and there is "accumulating evidence of resulting harm" to children.[93]

These comparisons also miss a more fundamental point. Generally, "[t]he failure to ensure concordance between quality of evidence and strength of recommendations violates a key principle of evidence

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[92] Balshem, *supra* note 89, at 401–02.
[93] Gazarian, Off-*Label Use of Medicines*, 185 MJA 544, 544 (2006).

based medicine."[94] But GRADE sometimes permits pairing low-quality evidence with strong treatment recommendations, for instance recommending a treatment with uncertain benefits when faced with "catastrophic clinical situations."[95] So while exceptions like this might justify other clinical recommendations, they cannot help the Society's evidence-free recommendations.

Last, confirming its ideological bent, the Endocrine Society recently sponsored—and the AMA passed—a resolution complaining about laws like Tennessee's. The resolution claims that "[m]edical intervention is reserved for older adolescents and adults."[96] False. The groups' own brief says that puberty blockers are "offered beginning at the onset of puberty"—*i.e.*, ages 9 to 11—with cross-sex hormones shortly thereafter. Br. 12. The resolution also asserts that "[m]ajor medical organizations" "agree on waiting until an individual has turned 18" "to undergo gender-affirming genital surgery."[97] But surgery age limits are exactly what WPATH—the only organization that purports to offer standards of care—*rejected*.

In sum, WPATH, AAP, and the Endocrine Society have motivations other than evidence-based medicine when it comes to medically transitioning minors.

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[94] Yao, *Discordant and Inappropriate Discordant Recommendations*, 375 BMJ e066045, at *2 (2021).
[95] *Ibid.*
[96] Endocrine Soc'y, *AMA Strengthens its Policy on Protecting Access to Gender-Affirming Care* (June 12, 2023), https://perma.cc/395G-VYJ5.
[97] *Ibid.*

II. No high-quality evidence supports sterilizing interventions in children.

The medical interest groups tout their "important expertise" and claim to "address misstatements" and "provide the Court with an accurate" summary of the "scientific evidence." Br. 2–3. But AAP provided *in*accurate information to other courts, so why should this promise of accuracy be trusted? The studies discussed suggest that it should not.

A. Systematic Reviews

Before getting to the studies, it is worth noting the modus operandi of the groups (and the United States and its supporting experts). They make a broad statement, like "studies find positive mental health outcomes for those adolescents who received" transition drugs. Br. 18. Then they drop a load of studies in a footnote. Br. 18 n.56; see also U.S. Br. 37 (App. 290a n.14, J.A. 143–47); Br. of Professors of Law, etc. 10 n.3.

This method is visually impressive, like a roadside landfill. But the studies are, individually, garbage. Poorly designed, poorly controlled, and low-quality in every sense. But citing a dumpster full of them removes the need to defend any one—the groups can fall back on another.

This problem is why we have systematic reviews that look at an entire body of evidence and analyze them—and why such reviews are considered the evidentiary gold standard. See generally Br. of Do No Harm. But the groups here cannot cite a systematic review that supports them, because there is none. So

they ignore the systematic reviews and promote the trash studies.

For proof, consider AAP's remarkable relegation to a footnote of a recent comprehensive U.K. report with *six* systematic reviews. Br. 23 n.72. Those reviews found that "there is insufficient and/or inconsistent evidence about the effects of puberty suppression" and cross-sex hormones "on psychological or psychosocial health."[98] The Report's chair summarized the findings: "The reality is that we have no good evidence on the long-term outcomes of interventions to manage gender-related distress."[99]

Unsurprisingly the United Kingdom then prohibited puberty blockers in new patients, and Scotland prohibited both puberty blockers and cross-sex hormones.[100] Contra L.W. Br. 49 (European countries have simply "expanded research"); Br. of Expert Researchers 9 (researchers from Yale's "Integrity Project" claiming that "[n]o action has been undertaken in the U.K. to restrict cross-sex hormones").

The medical groups here do not even acknowledge these findings. Instead, they say that "like other systematic reviews," the Cass Review "simply" reviews "the existing research"—and their own

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[98] *Cass Review* 176 (Apr. 2024), https://perma.cc/7XAJ-UCRZ; see *id.* at 184.

[99] *Id.* at 13.

[100] *New Restrictions on Puberty Blockers* (May 29, 2024), https://perma.cc/E3LR-XCEP; *Cass Review: Implications for Scotland, Current Context* (July 5, 2024), https://perma.cc/9LYB-LV7N.

guidelines are already "based on the available existing studies." Br. 23 n.72. Nonsense. As discussed, WPATH quashed much of its systematic review from publication—and what little it published did not consider safety, J.A. 373;[101] AAP has *never* conducted a systematic review; and the Endocrine Society did not study relevant outcomes. Tellingly, the U.K. reviews *also* reviewed guidelines themselves—and flunked WPATH's and the Endocrine Society's as "lack[ing] developmental rigour" and "circular[]."[102]

Meanwhile, *amici* "expert researchers"—self-interested transitioning providers—attack the Cass Review foremost on the ground that "researchers have found that [it] inappropriately exclude[d]" studies suggesting "that gender-affirming medications are safe and effective treatments." Br. 4. By "researchers," the *amici* mean themselves; their brief is largely a copy-and-paste job from their lead *amicus*'s unpublished "research" at Yale's "Integrity Project."[103] As has been exhaustively explained elsewhere—including in a just-published peer-reviewed article[104]—that "research" "is an exceptionally misleading, confused, and fundamentally unprofessional document."[105]

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[101] *Boe* Mot., *supra* note 7, at 16–18.
[102] *Cass Review*, *supra* note 98, at 28, 129–32.
[103] See McNamara, *An Evidence-Based Critique of the Cass Review* (2024), https://tinyurl.com/mppm5cjz.
[104] Cheung, *supra* note 91.
[105] Singal, *Yale's "Integrity Project" Is Spreading Misinformation*, Singal-Minded (2024), Parts 1 (https://perma.cc/FQQ4-434M) and 2 (https://perma.cc/8QSP-D6U6).

Their brief here epitomizes the point. Listing three purported "examples," the brief argues that "[t]he most serious error" in the U.K. reviews is "unjustifiably exclud[ing]" studies that "support gender-affirming medications." Br. 13. The problem? All three studies are plainly "included" in the U.K. reviews.[106] The reviews examined all three in extensive tables. If what Yale's "expert researchers" *meant* to say (but did not) was that the reviews included and appraised these studies—then excluded them only from their "narrative synthesis" along with all other "low-quality studies" "[d]ue to high risk of bias"[107]—that would not have *helped* their argument. Sorting trash from treasure is the point of systematic reviews, and these "experts" do not contend that these three studies are anything but low quality. That their lead argument is simultaneously wrong and deceptive is all one needs to know about Yale's "Integrity Project" and its "expert researchers."

B. Individual Studies

With that, turn to the individual studies AAP and its allies cite. In place of the groups' prior claim that a "robust body of scientific evidence" "shows that young people suffering from gender dysphoria who receive the gender-affirming standard of care experience

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[106] See Taylor, *Interventions to Suppress Puberty in Adolescents*, Archives of Disease in Childhood (2024), at 3 nn.25, 43, 52; Taylor, *Masculinising and Feminising Hormone Interventions for Adolescents*, Archives of Disease in Childhood (2024), at 3 n.26, 44, 46.

[107] *Id.* at 2 (both).

improvements in their overall well-being,"[108] they now say that "[e]mpirical evidence *indicates* that" "the prescription of puberty blockers and hormone therapy to *carefully evaluated* patients who *meet diagnostic criteria*" "*can* alleviate clinically significant distress." Br. 5 (emphases added). This new claim borders on meaningless, thanks to all the italicized weasel words. And the only source cited for this claim is the same one they cited for the previous claim, which looks like a *New England Journal of Medicine* article but is an 1,100-word op-ed written by a recent college graduate with the barest citations.[109] AAP's brief relies on the op-ed more than any other (non-guideline) source.

The interest groups next claim that sex-modification procedures "greatly reduce[] the negative physical and mental health consequences that result when gender dysphoria is untreated." Br. 8. Their only citation? A dated "position statement" of the Endocrine Society, filed in the "Advocacy" section of its website. This claim is founded on a false dichotomy: the choice is not whether to leave gender dysphoria "untreated," but whether to use proven, low-risk interventions like psychotherapy for minors instead of permanently sterilizing cross-sex hormones. In many studies, both treatments are provided, but the groups proclaim that any improvement is due to medical interventions. That unscientific approach is implicitly contrary even to the Endocrine Society's "position statement," which says that "the degree of

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[108] *Brandt* Brief, *supra* note 1, at 12.

[109] *Id.* at 5 n.7 (citing Martin, *Criminalization of Gender-Affirming Care*, 385 New Eng. J. Med. 579 (2021)).

improvement as a result of the intervention" is "not yet known."[110]

The studies AAP's brief cites are deeply flawed. Take the lead study in their string-cites of studies about puberty blockers *and* studies about cross-sex hormones. Br. 17–18; see U.S. Br. 37 (same study, App. 290a n.14). The study is a joke. Of 116 participants who entered, less than 50% completed it. 47 participants were given drugs; 3 participants were not. Many participants were older than age 18.[111] A non-randomized control group of three participants is deficient, and the study makes no attempt to compare outcomes between the groups. Because the study makes little effort to control for other relevant variables, the study could not show any causal relationship. Last, per the study, "most predictors did not reach statistical significance."[112]

No entity concerned with evidence-based medicine would *lead* with this study—but AAP has little choice, since the other studies fare no better. See generally J.A. 538–82, 316–473 (demolishing them all). For instance, the groups wave around a study that "analyzed survey data from 89 transgender adults." Br. 19. This is also the only study cited by the AMA's/Endocrine Society's recent "resolution,"[113] and

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[110] Endocrine Soc'y, *Transgender Health* (Dec. 16, 2020), https://perma.cc/6URR-WYE8.

[111] See Achille, *Longitudinal Impact*, 8 Int'l J. Pediatric Endocrinology, at 1, tbl. 1 (2020); *id.* tbl. 2 (24 participants were only given cross-sex hormones).

[112] *Id.* at 3.

[113] *AMA*, *supra* note 96.

the United States' (and the district court's) lead study. U.S. Br. 37; App. 196a. The study's "data" were responses from an online survey drawn from trans-affirming websites. It "excluded those who underwent medical intervention and then subsequently stopped identifying as transgender" and "those who actually committed suicide."[114] "73% of respondents who reported having taken puberty blockers" "said they started on them *after*" age 18—which is not when puberty blockers are prescribed.[115] And the study "does not allow for determination of causation."[116] See generally *Eknes-Tucker*, 114 F.4th at 1269–70 (Lagoa, J., concurring).

The groups' reliance on other studies is just as embarrassing. The study they cite as finding "that suicidality was decreased" (Br. 19; see U.S. Br. 37 (J.A. 144)) involved 47 participants, considered a treatment period of as little as three months, "lacked a control group," and did not control for confounding variables like psychotherapy.[117] WPATH's own review said that "[i]t was impossible to draw conclusions about the effects of hormone therapy on death by suicide."[118]

The 2023 study the groups cite as finding that interventions were "associated with decreased symptoms of depression and anxiety" (Br. 19; see U.S.

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[114] Biggs, *Puberty Blockers and Suicidality*, 49 Archives of Sexual Behav. 2227, 2227 (2020).
[115] *Ibid.*
[116] Turban, *Pubertal Suppression*, 145 Pediatrics 1, 1, 7 (2020).
[117] Allen, *Well-Being and Suicidality*, 7 Clinical Prac. Pediatric Psychol. 302, 303–04, 308–09 (2019).
[118] Baker, *Hormone Therapy*, 5 J. Endocrine Soc'y 1, 1, 12 (2021).

Br. 37 (J.A. 145)) also did not include a control group, did not separate psychiatric interventions, saw 2 (of 307) patients commit suicide (a 0.6% mortality rate within two years), and suspiciously omitted data about *most* of the outcomes that the study set out to examine.[119]

Last, consider the oft-cited Dutch 2014 study that AAP cites as finding a "[r]emarkabl[e]" "statistically significant decrease in depression and anxiety." Br. 20; see U.S. Br. 37 (App. 264a, 290a n.14, J.A. 144). That study looked at a mere 55 people, all of whom had transitioning *surgeries* and were drawn with self-selection problems from a group that was concededly "different" from "community samples"—omitting one patient who died after genital surgery.[120] The study found that gender dysphoria was *worse* after puberty blockers.[121] And the author said its protocol may not apply to the recent wave of girls presenting as adolescents with gender dysphoria.[122] Yet, per the *New York Times*, "the results of th[is] widely criticized Dutch stud[y] are falsely presented to the public as settled science" "in America."[123]

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[119] Chen, *Psychosocial Functioning in Transgender Youth*, 388 New Eng. J. Med. 240, 243, 245–48 (2023); see Singal, *The New, Highly Touted Study*, Singal-Minded (Feb. 7, 2023), https://perma.cc/YCM5-9HM6.

[120] Vries, *Young Adult Psychological Outcome*, 134 Pediatrics 696, 697, 702 (2014); see M. Biggs, *The Dutch Protocol*, 49 J. Sex & Marital Therapy 348, 354–55 (2023).

[121] Vries, *supra* note 120, at 699, tbl. 2.

[122] Vries, *Challenges in Timing*, 146 Pediatrics 1, 1 (2020).

[123] Paul, *supra* note 48.

If the open bias of the American medical interest groups were not enough to warrant skepticism, their repeated reliance on deficient studies confirms that interests other than evidence-based medicine are driving their views.

CONCLUSION

The Court should affirm.

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