NO. 23-477

IN THE

Supreme Court of the United States

UNITED STATES OF AMERICA,

Petitioner,

v.

JONATHAN SKRMETTI, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF AMICI CURIAE THE LARGER DETRANSITIONERS COMMUNITY INCLUDING PUBLIC OFFICIALS, HEALTHCARE PROVIDERS, AND RESEARCHERS IN SUPPORT OF RESPONDENTS

TERRY LEE FOWLER, JD, MAR, RN
ATTORNEY AT LAW
3201 ZAFARNO DR.
SUITE C-378
SANTA FE, NM 87507
505-226-8218
BIOETHICSAMICUS@OUTLOOK.COM

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

***Cases*:**

Statutes and Rules

***Other Authorities*:**

INTEREST OF AMICI CURIAE[1]

Amici encompass the larger detransitioners community which includes individuals who have medically transitioned[2] as minors and as adults and have detransitioned. This group also includes their family members, desisters,[3] as well as the various organizations, medical providers, researchers, and public officials who have championed this issue and have chosen to openly and publicly support the detransitioners' movement. These individuals and organizations have various ideological, political, and social beliefs but have all witnessed how pediatric gender affirming care has destroyed lives. Tennessee Senate Bill 1, as well as several other states' laws, concerning pediatric gender affirming care was created through the grassroot advocacy efforts and testimonies of our amici group because pediatric gender affirming care negatively impacted their individual rights.

---

[1] No counsel for any party authored this brief in whole or in part, and no person other than amici curia, its organizations members, and its counsel made any monetary contribution intended to fund the preparation or submission of this brief.

[2] Medical transitioning is the process of using medical interventions to change sex traits or characteristics, namely through the use of puberty blockers, cross-sex hormones, and surgeries.

[3] Desisters are individuals who formerly identified as transgendered but did not medically transition.

SCOPE OF CERTIORARI'S DIRECT IMPACT ON AMICI

The constitutionality of whether Tennessee Senate Bill 1 violates the Equal Protection Clause also concerns the constitutionality of twenty-five other state laws[4] as they presently stand.

The impact that this Court's decision will have on detransitioners' rights and the detransitioners' community overall are pivotal and historic. Statewide prohibitions on pediatric gender affirming care were enacted to provide *minimal* protections for future detransitioners. Without these prohibitions, minors exploring their gender identities can easily and inevitably be pressured to transition and when they do, they are left without the legal or medical recourse to detransition.

Amici in our group who have transitioned as minors or adults and then detransitioned were not fully aware that they would be medically experimenting with their bodies. As evident in their stories, amicus detransitioners were informed that medically transitioning was their only option for treating gender dysphoria and were ushered into the process without safeguards because medical transitioning is the "standard of care." Yet, unlike a typical medical case where legal liability would apply as standards of care can be disputed, there is no present recourse for anyone harmed by medical transitioning because the physiological changes were intended by the patient. In this sense, medically

---

[4] Movement Advancement Project, Equality Maps: Bans on Best Practice Medical Care for Transgender Youth 2024, https://perma.cc/TZ89-4MRA. (Last visited October 2024).

transitioning is more akin to clinical research or cosmetic reconstruction. Ironically, however, neither standard informed consent protections afforded in clinical research apply,[5] nor do the ethical constraints for consenting[6] to cosmetic reconstruction procedures apply. The ethics of pediatric gender affirming care[7] stress the importance of affirmation without considering the biological harms and the trauma of detransitioning when misdiagnosis or regret occur.

As of October 2024, not a single U.S. detransitioner has been granted any adequate remedy in their lawsuits.[8] A ruling that Tennessee Senate Bill 1 violates the Equal Protection Clause would diminish the chances that detransitioners might prevail in current or future lawsuits.

SUMMARY OF THE ARGUMENT

Tennesse Senate Bill 1 (SB1) does not violate the equal protection clause of the U.S. Constitution because this case is *not* about transgender rights, nor it is about transgender animus. This case is about whether states may regulate or block access to certain healthcare services. This case presents an ethics-based issue about whether medically transitioning

---

[5] 45 C.F.R § 46(d)

[6] Nasrin Nejadsarvari & Ali Ebrahimi, *Different Aspects of Informed Consent in Aesthetic Surgeries*, 3 World J. of Plastic Surgery 81 (2014), https://perma.cc/F8BV-EJXS.

[7] Maura Priest, *Transgender Children and the Right to Transition: Medical Ethics When Parents Mean Well but Cause Harm*, 19 Am. J. Bioethics 45 (2019)

[8] Themis Legal Fund (amicus), *U.S. Detransitioners case*s, https://themisresourcefund.org/detransitioner-cases/ (last visited October, 14, 2024).

helps or hurts minors and whether this process can be regulated or should be prohibited.

This amici brief argues that access to pediatric gender affirming care should be determined by states because states have historically regulated healthcare; healthcare is innately and purposely discriminatory on the basis of sex for good medical reasons; and, regulating or prohibiting access to certain healthcare treatments is not a violation of anyone's individual rights. This amici brief will further examine why *Bostock v. Clayton County* does not apply to this case and how even if SB1 has sex-based discrimination, it would easily pass intermediate scrutiny.

This brief demonstrates how pediatric gender affirming care has profoundly harmed minors, ripped apart families, and negatively impacted communities. There is a lack of evidence and a lack of consensus surrounding the science of pediatric gender affirming care and its effectiveness in treating gender dysphoria. There are also major consent issues inherent in the process of medically transitioning, which is further heightened in cases involving minors. Prohibiting pediatric gender affirming care ultimately protects minors' rights to explore their gender identity while preserving their bodily integrity.

ARGUMENT

I. Statewide regulation, prohibition, and discrimination in healthcare treatment access has historically been permitted by this Court.

A. Style States have historically governed healthcare, especially treatment access.

Gender affirming care, by petitioner's own account, constitutes a category of healthcare.

The 10th amendment provides states with plenary ability to regulate industries that are not within the exclusive power of the federal government. States' powers chiefly include the regulation of healthcare because powers which "'in the ordinary course of affairs, concern the lives, liberties, and properties of the people' were held by governments more local and more accountable than a distant federal bureaucracy." The Federalist No. 45, at 293 (J. Madison), quoting from *Natl. Fedn. of Indep. Bus. v. Sebelius*, 567 U.S. 519, 536 (2012). State laws have historically governed healthcare insurance, healthcare licensing, and the practice of medicine. *Id.*

This Court has held that state laws prohibiting physician-assisted suicide, which constitutes the practice of medicine is constitutional in *Vacco v. Quill*, 521 U.S. 793 (1997). More recently, this Court to correct its own precedence in order that states might be permitted to regulate or fully prohibit access to medical procedures such as abortions in *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022).

SB1 restricts the scope of medical practice of providers using puberty blockers, cross-sex hormones,

or surgeries to treat gender dysphoria in minors. If 'gender affirming care' is 'healthcare', then under *Vacco* or *Dobbs*, Tennessee is well within its rights to regulate or prohibit this medical practice.

B. Healthcare is inherently discriminatory based on sex for good medical reasons.

The outcome of *Dobbs* also inherently discriminated on the basis of sex. Only genetically female patients can be medically impacted by access or lack of access to abortions. Yet, the Court did not regard its decision in *Dobbs* as indicative of sex-based discrimination in healthcare, likely because healthcare is innately and purposely discriminatory on the basis of sex.

Discrimination among sexes in healthcare is necessary because there are clear differences between male and female biology and anatomy, disease susceptibility, and treatment efficacy.[9] There are at least 6,500 gene expressions that manifest differently between males and females.[10] Even common genes shared by both males and females work differently according to sex.[11] Thus, regardless of whether one identifies or has medically transitioned as a man or a woman, there remain immutable sexual

---

[9] Haiko Schurz et al., *The X Chromosome and Sex-Specific Effects in Infectious Disease Susceptibility*, 13 Hum. Genomics 2 (2019), https://doi.org/10.1186/s40246-018-0185-z.

[10] Moran Gershoni & Shmuel Pietrokovski, *The Landscape of Sex-Differential Transcriptome and Its Consequent Selection in Human Adults*, 15 BMC Biology 7 (2017), https://doi.org/10.1186/s12915-017-0352-z.

[11] *Id.*

characteristics with concomitant medical issues attached to their genetic sexual characteristics.

Regardless of whether a patient has medically transitioned, biological sex characteristics dictate medical care. This is evident in procedures from urethral catheter placement to medication dosing. Genetically female patients require lower doses of certain medications due to differences in body composition and metabolism rates.[12] Genetically female patients may also present atypical symptoms during heart attacks, often leading to misdiagnosis when not considered.[13] Hormonal differences between male and female patients dictate how heart disease manifests and progresses[14] and may account for different mental health issues.[15] Genetic females can never achieve the same level of testosterone as genetic males, no matter how much testosterone they are injected with.[16] The National Institutes of Health also

---

[12] Franck Mauvais-Jarvis et al., *Sex- and Gender-Based Pharmacological Response to Drugs*, 73 Pharmacol. Rev. 730 (2021), https://doi.org/10.1124/pharmrev.120.000206.

[13] Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 8 Circ. Cardiovasc. Qual. Outcomes S31 (2015), https://doi.org/10.1161/CIRCOUTCOMES.114.001612.

[14] Saraschandra Vallabhajosyula et al., *Sex Differences in Acute Cardiovascular Care: A Review and Needs Assessment*, 118 Cardiovasc. Res. 667 (2022), https://doi.org/10.1093/cvr/cvab063.

[15] Robert L. Hauger et al., *The Role of Testosterone, the Androgen Receptor, and Hypothalamic-Pituitary-Gonadal Axis in Depression in Ageing Men*, 23 Rev. Endocr. Metab. Disord. 1259 (2022), https://doi.org/10.1007/s11154-022-09767-0.

[16] Joanna Harper et al., *How Does Hormone Transition in Transgender Women Change Body Composition, Muscle Strength and Haemoglobin? Systematic Review with a Focus on*

requires researchers to account for biological sex to assure research reliability and improve patient outcomes.[17]

Thus, sex discrimination in healthcare is inherent and necessary for the individual patient's health and safety. Healthcare discrimination has nothing to do with animus towards any one sex or any one patient. Healthcare discrimination is about respecting the inherent differences between sexes to enhance health outcomes and provide optimal care.

II. The inability to receive pediatric gender affirming care within a state is NOT sex-based discrimination as applied in *Bostock*.

A. Gender dysphoria is not a sex-based characteristic.

Bostock v. Clayton County held that "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex." *Bostock v. Clayton Cnty., Georgia*, 590 U.S. 644, 660 (2020).

Yet as noted earlier, healthcare must be purposely discriminatory on the basis of sex for the patient's own health and safety. Petitioner's certiorari, however, asserts that "SB1 differs [from being necessarily discriminatory]… because it regulates medical procedures that all individuals can

---

the Implications for Sport Participation, 55 Brit. J. Sports Med. 865 (2021), https://doi.org/10.1136/bjsports-2020-103106.

[17] Janine Austin Clayton, *Studying Both Sexes: A Guiding Principle for Biomedicine*, 30 FASEB J. 519 (2016), https://doi.org/10.1096/fj.15-279554..

undergo, regardless of their sex." *See Pet.* at 22. According to the Petitioner's logic, medically transitioning should be accessible and available to *all* patients regardless of their medical condition. Petitioner's logic puts "medically transitioning" in the category of cosmetic reconstruction as this is the only aspect of healthcare not requiring a medical diagnosis. Ironically, if pediatric gender affirming care was cosmetic reconstruction, the medical community at large would have less issues prohibiting it.[18] There would be less dispute that minors should not receive cosmetic procedures because of their inability to consent to such procedures and the permanent nature of such procedures.[19]

For gender affirming care to be considered a medical treatment, it *must* discriminate by medical condition even if it does not discriminate by sex. Thus, a diagnosis of gender dysphoria is typically required for minors to medically transition. While this diagnosis may apply to trans and gender nonconforming (TGNC) individuals, the American Psychological Association (APA) have explicitly stated that *not all* TGNC individuals have this diagnosis nor want to be diagnosed as having gender dysphoria. *See Pet.* at 4. The APA even recognizes that diagnosis is a double-edged sword because it "provides an avenue for treatment, making medical and surgical options available to TGNC people.

---

[18] Derrick Diaz, *Minors and Cosmetic Surgery: An Argument for State Intervention*, 14 DePaul J. Health Care L. 235 (2012)

[19] Diana Zuckerman, *Teenagers and Cosmetic Surgery*, 7 Virtual Mentor, no.3 (2005), https://doi.org/10.1001/virtualmentor.2005.7.3.oped1-0503.

However, it also has the potential to stigmatize TGNC people by categorizing them as mentally ill."[20]

Thus, gender dysphoria is a medical diagnosis for **some** trans-identifying individuals. It is not a sex-based characteristic or a characteristic inherent to all trans-identifying individuals, making gender dysphoria distinctive from a transgender identity. Since a diagnosis of gender dysphoria is necessary to receive pediatric gender affirming care, and this medical condition neither encompasses nor is inherent to trans-people, restrictions on pediatric gender affirming care would not be discriminating against trans people. Similarly, restricting access to pediatric gender affirming care does not mean restricting healthcare access to all trans-persons or solely to trans-identifying individuals.

Hence, *Bostock's* application of sex-based discrimination does not apply in this case because (1) as plaintiff admits, pediatric gender affirming care does not discriminate by sex and (2) as the American Psychological Association position holds, not all trans and gender-nonconforming individuals have gender dysphoria.

B. *Bostock* did not concern the disparate impact of trans-people nor did it make medically transitioning a fundamental right.

*Bostock'*s *legal* analysis and holding was about disparate treatment of sex-based characteristics

---

[20] *Gender Dysphoria Diagnosis*, Am. Psychiatric Ass'n, https://perma.cc/K883-ZD64 (last visited October 2024).

under Title VII. The majority in *Bostock* explicitly limits its discussion to disparate treatment as noted:

> [N]ot because homosexuality or transgender status are related to sex in some vague sense or because discrimination on these bases has some disparate impact on one sex or another, but because to discriminate on these grounds requires an employer to intentionally treat individual employees differently because of their sex. *Bostock v. Clayton Cnty., Georgia*, 590 U.S. 644, 661 (2020).

The previous section of this brief established that while SB1 may discriminate against individuals with gender dysphoria or those who might have gender dysphoria, it does not necessarily discriminate against trans-people.

Any argument that the Bill nevertheless still disparately impacts trans-people because gender dysphoria predominantly affects trans and gender nonconforming individuals is insufficient. As this Court held "disproportionate impact is not irrelevant, but it is not the sole touchstone of an invidious… discrimination forbidden by the Constitution. Standing alone, it does not trigger the rule." *Washington v. Davis*, 426 U.S. 229, 242 (1976).

Equal Protection analysis would, however, be triggered if there exists a fundamental right either to receive desired healthcare services or to medically transition. *Bostock* created neither one of these rights and there is no precedence of it being so.

Bostock ruled that discrimination based on homosexual or transgender status in the workplace was sex-based discrimination under Title VII. *Bostock* did not concern the ability or inability of trans-identified minors to receive the healthcare service they desire, nor did it create a right for transgendered minors or anyone to medically transition. Discrimination that occurs in the workplace because an individual is homosexual or transgendered is completely different from an illness-based discrimination that occurs in healthcare.

III. State prohibition on gender affirming care does not infringe on anyone's rights.

This case is portrayed as a battle between states' rights vs patients' rights. Constitutional protections for patients' rights concern the right to privacy and the right to bodily integrity. Statewide prohibitions of gender affirming care violate neither of these rights.

A. State prohibition does not violate the minor's right to privacy.

The right to privacy concerns the right of individuals to make decisions about their private lives and relationships, namely within a "zone of privacy" as mentioned in *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965). This right to privacy was also explained in *Carey* which held that "If the right of privacy means anything, it is the right of the individual, married or single, to be free of unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." *Carey v. Population Services, Intern.*, 431 U.S. 678, 685 (1977).

This Court in both *Griswold* and *Carey* suggested that the right to privacy was about matters naturally affecting a person and distinguishes it from a permanent medical procedure that must involve licensed healthcare providers. This logic applies even more so when the patient is a minor. This Court has explicitly stated that "there is no logical relationship between the capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion." *H. L. v. Matheson*, 450 U.S. 398, 408 (1981).

In this sense, neither *Griswold* nor *Carey* nor *H.L.* confers the right of privacy in the context of receiving invasive medical procedures to minors, even when the right to receive such procedures was then fundamentally granted by this Court in *Roe*. Thus, statewide prohibitions on pediatric gender affirming care does not violate the minor's right to privacy.

B. State prohibition does not violate the minor's right to bodily integrity.

The right to bodily integrity can be best understood as a right to refuse any unwanted medical treatments or procedures. This court makes specific notice of this right in *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997), where it states that:

> In a long line of cases, we have held that, in addition to the specific freedoms protected by the Bill of Rights, the "liberty" specially protected by the Due Process Clause includes the rights… to bodily integrity…We have also assumed, and strongly suggested, that the Due

> Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment. *Cruzan,* 497 U.S., at 278–279, 110 S.Ct., at 2851–2852.

This Court further explained its rationale for establishing a fundamental right to bodily integrity by stating "given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation's history and constitutional traditions." *Washington v. Glucksberg*, 521 U.S. 702, 725 (1997).

In *Rochin v. California*, 342 U.S. 165, 172 (1952), this Court more broadly interprets this right as a right to reject anything which "shocks the conscience" namely in the application of the medical use of force for whatever the reason. The right to bodily integrity further extended to suspected criminals in *Winston v. Lee*, 470 U.S. 753 (1985) and prisoners in *Skinner v. State of Okl. ex rel. Williamson*, 316 U.S. 535, 541 (1942), making this right broader and more foundational than the right to privacy.

The right to bodily integrity concerns the right to control one's body against any undesired touching or interference in one's being. The right to bodily integrity would not be violated with statewide prohibition of pediatric gender affirming care as this right to bodily integrity concerns the "right to refuse" as opposed to a "right to receive" treatment. On the contrary, states with laws protecting pediatric gender

affirming care[21] may be violating the minor's bodily integrity.

C. Receiving medical treatment by demand is not a legal right.

Petitioner's certiorari and amicus support alludes to a possible right to demand specific medical interventions such as gender affirming care. This Court has implied in its past rulings that no such legal right to demand medical treatment exists.

The Court in *Washington* was confronted with the very question of whether the right to refuse medical intervention confers a right to receive to physician-assisted suicide. This case discusses a broader possibility of whether *any* right to demand a specific medical intervention exists. In addressing this dilemma, the Court explains that:

> The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct…In *Cruzan* itself, we recognized that most States outlawed assisted suicide—and even more do today—and we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow

[21] Movement Advancement Project, *Equality Maps: Transgender Healthcare "Shield" Laws*, https://perma.cc/79YD-LWA7. (visited October 2024)

> transmuted into a right to assistance in committing suicide. *Washington v. Glucksberg*, 521 U.S. 702, 725–26 (1997)

Similarly, in *Vacco v. Quill*, the Court was challenged with an Equal Protection issue for which physicians and patients argued that New York's prohibition on physician-assisted suicide discriminated against their patient's right to die through their chosen method because it allows other patients to die by honoring their refusal of care. This Court held that New York's law was constitutional because:

> [N]either New York's ban on assisting suicide nor its statutes permitting patients to refuse medical treatment treat anyone differently from anyone else or draw any distinctions between persons. *Everyone,* regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide. *Vacco v. Quill*, 521 U.S. 793, 800 (1997)

This Court further explains that the rationale of this case has much to do with distinction between actions and intent since a chosen method of dying is not the same as demanding medical intervention to die. As stated in *Vacco*, "this Court has also recognized, at least implicitly, the distinction between letting a patient die and making that patient die." *Vacco v. Quill*, 521 U.S. 793, 807 (1997).

Although *Washington* and *Vacco* did not explicitly state there is an absence of a legal right to demand

medical intervention, this Court certainly implied it. This implication furthermore is consistent with the ruling in *National Federation of Independent Business v. Sebelius* for which the Court portrays healthcare access as a free-market commercial enterprise in which governments can regulate.

This implication is further echoed by in *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 256 (2022) as the right to an abortion may be construed as procuring a specific healthcare service and such right is not considered foundational on its own.

The argument that there is no legal right to access specific medical services is also consistent with even the congressional expansion of access to emergency medical services like the Emergency Medical Transportation and Labor Act (EMTALA). EMTALA provides a statutory avenue for all patients in need to access emergency stabilizing treatments, as opposed to any or all possible medical treatments that may be available to treat a patient's medical condition. EMTALA, furthermore, does not require hospitals to provide medical services of either the patient's own choosing or beyond the point in which the patient is medically stable. 42 U.S.C.A. § 1395dd. Pediatric gender affirming care, on the contrary, is an ongoing medical and surgical treatment for a specific medical condition which would not be typically considered stabilizing emergency care.

Hence, there is no legal right to access or demand specific medical services like pediatric gender affirming care.

IV. States have a compelling interest in protecting minors' futures and prohibiting pediatric gender affirming care is substantially related to that interest.

On the opposite spectrum of rights, states also have a right to intervene to protect their minor citizens. Tennessee's interest in prohibiting pediatric gender affirming care is motivated by its desire to protect any of its minor citizens from the biological consequences experienced by the amici detransitioners of this brief. Tennessee's interest is substantially supported by current research on gender affirming care.

A. States are entitled to intervene to protect minors' best interests.

This Court has recognized that "the State has 'a parens patriae interest in preserving and promoting the welfare of the child,'" *Schall v. Martin*, 467 U.S. 253, 263 (1984). The doctrine of *parens patriae* allows states to intervene and act to protect dependent citizens, namely minors and mentally unstable individuals, who are unable to make decisions for themselves. Thus, *parens patriae* authority creates an independent right of states to care for minors, especially in cases when minors are vulnerable, alone, or susceptible to being abused.

States' exercise of the doctrine of *parens patriae* are not limited to custody situations, the exercise includes restricting services that might otherwise be available and accessible to minors. By example, in *Hodgson v. Minnesota*, 497 U.S. 417, 444–45 (1990), this Court ruled that the state had an independent

interest in regulating the statutory requirements for parental notification of minors accessing available abortion services and sought to balance this interest against the minor's privacy interest under *Roe v. Wade*. This Court reasoned so because "the State has a strong and legitimate interest in the welfare of its young citizens, whose immaturity, inexperience, and lack of judgment may sometimes impair their ability to exercise their rights wisely." *Hodgson v. Minnesota*, 497 U.S. 417, 444–45 (1990).

The state's basis for intervention rests in the concept of "best interests" for which courts seek to balance the minor's autonomy and competence against other competing interests. As the majority's earlier reasoning notes "an exception from the general rule is necessary to protect the minor from an arbitrary veto that is motivated by the separate concerns of the parent rather than the best interest of the child." *Hodgson v. Minnesota*, 497 U.S. 417, 456 (1990).

This Court historically used the concept of best interests of minors to make determinations on whether access to abortion, considered fundamental under *Roe* at the time, should be restricted or limited for minors. See *Lambert v. Wicklund*, 520 U.S. 292 (1997); *Bellotti v. Baird*, 443 U.S. 622 (1979). If having access to a medical procedure previously deemed fundamental was not *automatically* considered to be in the minor's best interest, then access to a *non-fundamental* medical procedure, such as medical transitioning, would merit deferral to traditional *parens patriae* authority.

Deferral is especially warranted when no fundamental rights are concerned and for which such statutes are intending to preserve the minor's bodily integrity rights. Thus, even though a healthcare provider and a parent may agree that medically transitioning is in the minor's best interest, the state should be permitted to intervene on the minor's behalf and disagree.

B. There is a lack of medical consensus about whether pediatric gender affirming care is in the "best interests" of minors experiencing gender dysphoria.

A growing number of European countries are rejecting the World Professional Association for Transgender Health's (WPATH) approach[22] to medicalizing minors with gender dysphoria. The United Kingdom (U.K.), Sweden, and Finland have either adopted full prohibitions or strong restrictions for minors medically transitioning.

A British Medical Journal standards review[23] noted that U.S. guidelines often over-emphasize medical treatments and lack rigorous evidence to fully support the practice. Systematic reviews from the U.K. and Scandinavia have concluded that there are significant gaps in the evidence supporting youth

---

[22] United States Professional Association for Transgender Health (USPATH), *USPATH Position Statement on Legislative and Executive Actions Regarding the Medical Care of Transgender Youth*, https://perma.cc/Y3DM-H7ZJ

[23] Jennifer Block, *Gender Dysphoria in Young People Is Rising—and So Is Professional Disagreement*, 380 BMJ 382 (2023), https://doi.org/10.1136/bmj.p382.

transitions, with studies rated as "very low" in quality or have significant methodological flaws.[24]

In contrst, a U.K. study which tracked actual outcomes of thousands of minors with gender dysphoria found a massive disconnect between the international clinical experiences and the reported benefits of youth medical gender transitions.[25] Similarly, in a robust (3,754 participant) U.S. retrospective study assessing mental health outcomes of medically transitioning minors, [26] results of showed that mental health visits did not significantly change after initiating hormonal treatments. Instead, the use of psychotropic medication nearly doubled (from a mean of 120 days a year to 212 days a year) after starting hormone therapy. The results tend to suggest that starting hormone therapy leads to worse mental health outcomes.

The medical community may disagree about whether medically transitioning helps minors at all and should be highly restricted or outrightly prohibited. But there is no global medical consensus

---

[24] E. Abbruzzese, Stephen B. Levine & Julia W. Mason, *The Myth of "Reliable Research" in Pediatric Gender Medicine: A Critical Evaluation of the Dutch Studies—and Research That Has Followed*, 49 J. Sex & Marital Therapy 673 (2023), https://doi.org/10.1080/0092623X.2022.2150346..

[25] Michael Biggs, *Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom*, 51 Archives Sexual Behav. 685 (2022), https://doi.org/10.1007/s10508-022-02287-7.

[26] Elizabeth Hisle-Gorman et al., *Mental Healthcare Utilization of Transgender Youth Before and After Affirming Treatment*, 18 J. Sexual Med. 1444 (2021), https://doi.org/10.1016/j.jsxm.2021.05.014.

to suggest that medically transitioning minors is in their best interest.

C. There is no evidence demonstrating suicides are caused by failure to receive pediatric gender affirming care.

Petitioners claim that pediatric gender affirming care is considered medically necessary because of the high prevalence of youth suicides. *See Pet.* at 5, 7, 31. Yet all of petitioner's cited studies are entirely reliant on self-reports, non-probability samples, small sample sizes, short observation periods, or were outright misleading.[27] None of these studies establish causality.[28]

For studies that relied on self-reporting of suicidal thoughts and desire to medically transition,[29] there are likely data issues present. Self-reporting may yield recall bias as research participants may inaccurately recall their memories of past events.[30]

---

[27] Mohammad Hassan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 Clinical Endocrinology 214 (2010), https://doi.org/10.1111/j.1365-2265.2009.03625.x.;

[28] L.R. Allen et al., Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones, 7 Clinical Prac. Pediatric Psychol. 302 (2019). https://psycnet.apa.org/record/2019-52280-009

[29] Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. Adolescent Health 643 (2022), https://doi.org/10.1016/j.jadohealth.2021.10.036;

[30] Anne E. Rhodes & Kinwah Fung, Self-Reported Use of Mental Health Services Versus Administrative Records: Care to Recall?,

Self-reporting can also be compromised by social desirability bias. Furthermore, not all attempted suicides are of the same severity,[31] and non-suicidal self-injury may be mistaken for suicidal attempts.[32] These issues are further magnified when dealing with the mental health comorbidities of gender dysphoria.[33] Thus, self-reported suicidal thoughts are not accurate indicators of suicidal attempts or suicidal completions. And even if a self-reported study can was able to successfully isolate all these factors, most minors who report suicidal thoughts do not actually attempt or complete suicide.[34]

Any evidence to suggest pediatric gender affirming care reduces any risk of suicide cannot be

---

13 Int'l J. Methods Psychiatric Res. 165 (2006), https://doi.org/10.1002/mpr.172.

[31] Marco Liotta, Carmela Mento & Salvatore Settineri, *Seriousness and Lethality of Attempted Suicide: A Systematic Review*, 21 Aggression & Violent Behav. 97 (2015), https://doi.org/10.1016/j.avb.2014.12.013.

[32] Paul Wilkinson, *Non-Suicidal Self-Injury*, 22 Eur. Child & Adolescent Psychiatry 75 (2012), https://doi.org/10.1007/s00787-012-0365-7.

[33] Farzana Faruki et al., *Gender Dysphoria in Pediatric and Transitional-Aged Youth Hospitalized for Suicidal Behaviors: A Cross-National Inpatient Study*, 25 Primary Care Companion for CNS Disorders 22m03352 (2023), https://doi.org/10.4088/PCC.22m03352..

[34] Becky Mars et al., *Predictors of Future Suicide Attempt Among Adolescents with Suicidal Thoughts or Non-Suicidal Self-Harm: A Population-Based Birth Cohort Study*, 6 Lancet Psychiatry 327 (2019), https://doi.org/10.1016/s2215-0366(19)30030-6.David Klonsky et al., *Suicide, Suicide Attempts, and Suicidal Ideation*, 12 Ann. Rev. Clin. Psychol. 307 (2016), https://doi.org/10.1146/annurev-clinpsy-021815-093204;

substantiated and cannot be used as to demonstrate that medically transitioning will prevent minors from committing suicide.

D. The consequences of medically transitioning are ongoing and permanent.

The process of medical transitioning carries substantial medication side effects and risks. The consequences[35] of taking puberty blockers are known to include osteoporosis, impaired fertility, damage to fetuses or abortion, reduced libido, pseudotumors, and lasting neuropsychological effects.[36] The consequences of taking androgens and estrogens for biological male patients includes painful erections, blood clots in lungs, heart attacks, and strokes.[37] The consequences of taking testosterone for biological female patients include vaginal atrophy with discharge, urinary incontinence, painful orgasms, pelvic floor dysfunction, splitting skin, liver tumors,"bottom growth," and hepatocarcinoma.[38]

In addition to medical risks, there is also the possibility for regret as one study alludes that 27% of adults who have transition find their infertility

---

[35] Drug Label Information for Leuprolide Acetate, DailyMed, https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=4838c674-044e-46b2-81e7-c691b99d8fa5&type=display

[36] Sallie Baxendale, *The Impact of Suppressing Puberty on Neuropsychological Function: A Review*, 113 Acta Paediatrica 1156 (2024), https://doi.org/10.1111/apa.17150.

[37] Mia Hughes and the Center for Environmental Progress , *The WPATH files*, https://perma.cc/3FA4-9M2J

[38] *Id.*

troublesome.[39] The lived experiences of detransitioners further echoes the issue of regret as their stories reveal the human toll of their transition.

Amicus detransitioner, Brendan D, who transitioned as a minor, powerfully shares his experience as follows:

> Within my time of healing, I dealt with pain, soreness, and swelling for up to a year after. I had extreme difficulty orgasming, and didn't achieve orgasm for at least seven months, and it felt nothing like how it did prior to surgery. I had so much trouble with orgasming that I asked my hormone provider to remove the Histrelin implant that was still in my arm at this time as I thought that could have also been contributing to the issue…
>
> Initially, my doctor refused to remove my implant. She was ready to just leave it in my body for the rest of my life. She claimed it was too risky to remove since the potential of it breaking during the process was highly likely, and happened to around 30% of her patients.
>
> However, I was persistent in my desire to remove the implant, so she had her medical student colleague perform the removal on me… Thankfully, the implant came out in one piece, but I was

[39] *Id.* at 12

never informed prior to receiving the implant that it could break apart in my body, and that that was at a high risk. I never knew that I essentially would have had the implant within my arm for the rest of my life, even if it did run out of being effective for its original purpose….

I regret transitioning each and every day. I resent the fact I'm infertile over a completely avoidable medical treatment. I feel like they saw I was a gender nonconforming and effeminate boy and that they thought they could mold me into something I wasn't. I feel experimented on. I feel abused. I will never achieve the dreams I had of having a family, I will never have normal sex again. I will always have to mimic the hormone cycles I once naturally had through now taking exogenous testosterone. I will never fully finish puberty and experience the body I was meant to have. Basic aspects of human life that people don't even think twice in their daily life are things that were aspects completely stolen from me.

I want people to know that transitioning, especially as a vulnerable minor, is complicated. It isn't a beautiful, nonchalant process, it's arduous and emotionally taxing. It gives rise to other issues and comorbidities

> one didn't previously deal with, while completely ignoring the issues one may already have.
>
> I was so staunchly convinced that this was the right path for me. It seemed with my personality and mannerisms, my sex-based discomforts from an early age, and my gravitation towards gender nonconformity that it would afford me the best life possible. I completely hated being my sex, I was so deeply dysphoric. I was the textbook case for the kind of child these treatments should work out for, but as an adult I wonder why I wasn't protected by the adults in my life and why I wasn't afforded time to grow within my own body.

Amicus detransitioner, Jade Martin whose voice hurts as she openly explained how she experience persistent throat pain, continued chest atrophy, recurring ovarian cysts which resulted in emergency room visits, and the need to have her gallbladder removed as a complication of her detransition.

Amicus detransitioner, Luka Hein,[40] who is the fifth detransitioner to openly sue mentioned that:

> The medical providers seemed to push all the other issues I was dealing with at

---

[40] *Nebraska Woman Files Lawsuit Against UNMC for Double Mastectomy She Received at 16*, Neb. Examiner (Oct. 9, 2023), https://nebraskaexaminer.com/briefs/nebraska-woman-files-lawsuit-against-unmc-for-double-mastectomy-she-received-at-16/.

> the time to the side once the trans thing was brought up. Suddenly that became the source of all my other issues, even though there were so many other severe things going on in my life at the time.

Amicus detransitioner, Chloe Cole, whose testimony is submitted as a declarant,[41] states how even after detransitioning "my family will never ever be the same again. This has impacted more than just me."

Mitchell Cole, who is Chloe's brother, further shares how he still feels he lost his sister through her transitioning experience, regardless of how many years it has been since she detransitioned.

V. Statewide prohibition on pediatric gender-affirming care ultimately preserves the full autonomy of minors to make medical decisions that they can truly live with.

A. Informed consent is not possible in pediatric gender-affirming care.

Informed consent requires autonomy and capacity to consent. Minors may lack in capacity to consent because they may not to understand what is involved in a medical decision.[42]

Pediatric healthcare professionals recognize that minor patients have limited ability to consent and tailor treatment conversations to parents as opposed

---

[41] *See* Joint Appendix II & III at 92.

[42] David G. Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 Law & Hum. Behav. 431 (1991), https://doi.org/10.1007/BF02074080

to minors for this very reason.[43] In bioethics, there is a recognition minors are afforded "best interests" as opposed to autonomy rights.[44] In clinical research, per Human Subjects Research protocols, minors have the ability to assent or refuse.[45] This extra safeguard of assent works to protect minors who may not be willing to undergo clinical trials even though the adults in their lives want them to.

The WPATH's guidelines also necessitate that minors consent to gender affirming care.[46] But because of lack of decisional capacity, minors may have issues consenting and may also be manipulated or deceived into consenting.[47]

Furthermore, because medical transitioning is considered 'standard of care' for treatment of gender dysphoria, it does not have the same protocols and protections as clinical research.[48] Standards of care

---

[43] Laura Jenkins, Stuart Ekberg & Nan C. Wang, *Communication in Pediatric Healthcare: A State-of-the-Art Literature Review of Conversation-Analytic Research*, 57 Res. on Language & Soc. Interaction 91 (2024), https://doi.org/10.1080/08351813.2024.2305046.

[44] *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 Pediatrics 314 (1995), https://doi.org/10.1542/peds.95.2.314..

[45] 45 C.F.R. § 46(d)

[46] Eli Coleman et al., Standards of Care for the Health of Transgender and Gender Diverse People, 23 Int'l J. Transgender Health S1 (8th ed. 2022) https://doi.org/10.1080/26895269.2022.2100644

[47] Loes Stultiëns et al., *Minors and Informed Consent: A Comparative Approach*, 14 Eur. J. Health L. 21 (2007), https://www.jstor.org/stable/48730470.

[48] Ruth Macklin & Lois Shepherd, *Informed Consent and Standard of Care: What Must Be Disclosed*, 13 Am. J. Bioethics 9 (2013), https://doi.org/10.1080/15265161.2013.849303.

informed consent process may be a general 'blanket consent' or otherwise implied. In this process, parental consent to treatment may also be actively coerced or completely bypassed because parental refusal of any recommended medical treatment or procedure can be considered medical neglect.[49]

Proper informed consent requires a minimal understanding of the risks and benefits involved in undergoing a specific medical procedure or treatment. Not all information pertaining to the treatment must be known to the patient, but the patient must minimally be given the kind of information that a reasonable person would want to know.[50] For anyone medically transitioning, this information should include what the success rates of medical transitioners are, what sorts of changes their body will experience, what are the lasting consequences, what happens if they should regret their decision, as well as what they are giving up. Yet much of this information is simply unknown or unavailable to physicians, to the patient, even to adult patients. Thus, informed consent to medically transition is simply not possible.

---

[49] Carole Jenny & James B. Metz, *Medical Child Abuse and Medical Neglect*, 41 Pediatr. Rev. 49 (2020), https://doi.org/10.1542/pir.2017-0302.

[50] *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972)

B. Minors need to experience natural puberty in order to make identity decisions that they can fully appreciate.

The main developmental task of adolescence is the pursuit of identity,[51] and identity is often found by embracing puberty.[52] It is through the process of puberty that hormonal cascades catalyze rapid cognitive, psychosocial and sexual development.[53] It is through puberty that minors grapple with increasingly complex social expectations and emerge from periods of role confusion with a solidified sense of self. [54]

Puberty causes an adolescent to develop a sexual drive and consolidate their understanding of their sexual orientation.[55] Puberty also markedly appears to resolve sexual distress or gender dysphoria in nearly 98% of all minors.[56] The psychosocial phase of

---

[51] Gabriel A. Orenstein, *Erikson's Stages of Psychosocial Development*, StatPearls (Nov. 7, 2022), https://www.ncbi.nlm.nih.gov/books/NBK556096/.

[52] Jane Kroger, *Identity Development: Adolescence Through Adulthood* (2d ed. 2006).

[53] Sarah-Jayne Blakemore et al., *The Role of Puberty in the Developing Adolescent Brain*, 31 Hum. Brain Mapping 926 (2010), https://doi.org/10.1002/hbm.21052.

[54] Lauren L. Mitchell et al., *Implications of Identity Resolution in Emerging Adulthood for Intimacy, Generativity, and Integrity Across the Adult Lifespan*, 36 Psychol. Aging 545 (2021), https://doi.org/10.1037/pag0000537.

[55] Martha K. McClintock & Gilbert Herdt, *Rethinking Puberty: The Development of Sexual Attraction*, 5 Current Directions Psychol. Sci. 178 (1996), http://www.jstor.org/stable/20182425.

[56] Riittakerttu Kaltiala-Heino et al., *Gender Dysphoria in Adolescence: Current Perspectives*, 9 Adolescent Health, Med. & Therapeutics 31 (2018), https://doi.org/10.2147/AHMT.S135432.Kaltiala-Heino,

undergoing these changes alongside one's peers, is also crucial in identity development.[57]

On the other spectrum, blocking a minor's natural puberty halts not only the development of sex-specific physical traits (such as broad shoulders and body hair, or breasts and hips), it also halts the concurrent bone,[58] organ,[59] and memory development.[60] Increased capacity for memory and learning are aspects of brain development that are crucial for the maturation of sexual feelings and cognitive capacities.[61] In this sense, altering minors' natural puberty may permanently damage their psychosocial development and removes their autonomy to actually explore their identity.

Detransitioners who regret medically transitioning as minors describe still being childlike in their bodies and minds. Some of these

---

[57] Giorgia Picci & K. Suzanne Scherf, *From Caregivers to Peers: Puberty Shapes Human Face Perception*, 27 Psychol. Sci. 1461 (2016), https://doi.org/10.1177/0956797616663142.

[58] Mariska Caroline Vlot et al., *Bone Mineral Density in Transgender Adolescents Treated with Puberty Suppression and Subsequent Gender-Affirming Hormones*, 177 JAMA Pediatrics 1332 (2023), https://doi.org/10.1001/jamapediatrics.2023.4588;

[59] Darios Getahun et al., *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, 169 Ann. Intern. Med. 205 (2018), https://doi.org/10.7326/M17-2785. ;

[60] Denise Hough et al., *Spatial Memory Is Impaired by Peripubertal GnRH Agonist Treatment and Testosterone Replacement in Sheep*, 75 Psychoneuroendocrinology 173 (2017), https://doi.org/10.1016/j.psyneuen.2016.10.016.

[61] Kerstin Konrad et al., *Brain Development During Adolescence: Neuroscientific Insights Into This Developmental Period*, 110 Deutsches Ärzteblatt Int'l 425 (2013), https://doi.org/10.3238/arztebl.2013.0425.

detransitioners have no sexual feelings or sexual function at all. Their unnatural pubertal experience displaces them from achieving relational intimacy with others and they often take several years to regain their sense of self.

Hence, blocking puberty to alleviate sexual discomfort in minors is counterproductive to identity development and removes the minor's autonomy to maturely grow. Any discomfort with the puberty process or with one's biology cannot never be replaced by medically transitioning. As amicus detransitioner Cynthia Breheny states "none of us can run from our bodies, nor should we."

C. Prohibiting pediatric gender-affirming care is the only means of truly safeguarding minors against the susceptibility of social pressure and possibility of coerced medical transitions.

As evident throughout this brief, there are immense medical risks involved with pediatric gender affirming care as well as major consent issues that are inherent to the process. But unlike adults, minors are more easily pressured or otherwise coerced into medical treatment and even clinical trial. Thus, it would not be surprising to find minors pressured or coerced into medically transitioning. Indeed the earliest experiment of medical transitioning was the 'forced transition' case of David Reimer.[62]

---

[62] Phil Gaetano, *David Reimer and John Money Gender Reassignment Controversy: The John/Joan Case*, Embryo

There may also be hidden coercion or family pressure involved with minors medically transitioning. Some parents may want their child to be trans-identify and may psychologically condition their child to be transgendered.[63] This was evident in for one our amicus detransitioner who shared "my mother told me I was meant to be a boy and how horrible it was to be female." Parents might even start transitioning their child as early as three.[64] Some parents go on further to seek out medical transitioning procedures on behalf of their "trans-child" at the first signs of puberty, regardless of whether the child wants it or could even understand why they are getting puberty injections. In fact, getting puberty blockers and cross-sex hormones is inconspicuous and appears like getting vaccines. To a minor, this process looks no different, and they may even be told they have to get it because their doctor ordered it.

In other cases, the process of medically transitioning may appear more attractive and desirable to minors and vulnerable adults alike seeking to escape the power and control of medical institutions. As one of the amicus detransitioner Seth Wolverton shared "when I began my transition, I was

---

Project Encyclopedia (Nov. 15, 2017), https://hdl.handle.net/10776/13009.

[63] Ellen Rettberg Reicher, *The Effect of Semantic Conditioning on Children's Self-Concept* (2000) (Ph.D. dissertation, Fordham University),https://research.library.fordham.edu/dissertations/AAI9964574.

[64] *Can You Really Know That a 3-Year-Old Is Transgender?*, KQED (Nov. 9, 2017), https://perma.cc/5J3U-868K (last visited October 2024).

a teenage boy with no personal autonomy living in a small town in Pennsylvania where I was treated badly for being feminine, gay, and different."

Another amicus detransitioner also shared how he was pressured by his psychiatrist to accept a gender identity, and it was the only means by which he was able to leave the psychiatric facility. He went along with the psychiatrist's recommendation and medically transitioned because it was the only way for him to regain acceptance and control of his life. In this sense, some patients were coerced. Given that medical treatment for minors or mentally unstable individuals are usually controlled by someone else, having control over something such as gender affirming care is desirable.[65]

The process of transitioning also comes with a milieu of supporters in the 'trans community' who might also seek to influence their peers to medically transition.[66] Susceptibility to pressure and coercion makes a trans or gender non-confirming individual's decision to medically transition not simply a personal decision but as a rite of passage to being 'trans' and belonging. As amicus detransitioner Abel Garcia puts "the trans activist groomed me to the point that I was convinced to hate my family… I was pressured to transition when I started to ask questions and tossed to the side by those who I believed cared about me when I asked too many questions." The possibility of

---

[65] Stéphane Cullati et al., *Desire for Autonomy in Health Care Decisions: A General Population Survey*, 83 Patient Educ. & Couns. 134 (2011), https://doi.org/10.1016/j.pec.2010.04.025.

[66] Olena Kornienko et al., *Peer Influence on Gender Identity Development in Adolescence*, 52 Dev. Psychol. 1578 (2016), https://doi.org/10.1037/dev0000200.

regret and the permanency of medically transitioning are usually not accounted for when making such decisions, especially under social pressure.

Hence, the likelihood that someone will make the wrong decision in medically transitioning for themselves is high and there are no safeguards that exist for minors outside of statewide prohibitions. These statewide prohibitions work to protect minors from any peer, family, or medical pressures that might otherwise drive them to medically transition. It also ultimately prevents the worst case scenario - forced transitioning.

CONCLUSION

There are larger ethical questions about pediatric gender affirming care for which thoughtful, well-meaning individuals and medical professionals may passionately disagree. Statewide prohibitions on pediatric gender affirming care reflect such disagreements and drive greater demands for more rigorous research. The history of medicine demonstrates that even medical treatments and procedures determined to be fully safe and effective at their time are prone to abuses. Granted, state authorities and even this Court may create laws that validate such abuses as in the case of *Buck v. Bell*, 274 U.S. 200 (1927). Yet, in our present case, it is states like Tennessee who are attempting to prevent such abuses from occurring in the first place.

There are not enough words to describe the deception and pain experienced by our amici over the issue brought by this case. Amicus detransitioners and their families are courageously sharing their

identities and stories as living proof of how gender affirming care harmed them. Amicus physicians, psychologists, healthcare professionals, and public officials are courageously coming forward, risking their professional reputation to support this brief and speak truth.

In sum, Tennessee Senate Bill 1 does not violate the rights of trans-identifying or gender nonconforming minors. On the contrary, the bill ultimately protects the rights of all minors to explore their gender identities by allowing them to grow into it.

Respectfully submitted,

TERRY LEE FOWLER, JD, MAR, RN
ATTORNEY AT LAW
3201 ZAFARNO DR.
SUITE C-378
SANTA FE, NM 87507
505-226-8218
BIOETHICSAMICUS@GMAIL.COM

OCTOBER 15, 2024

APPENDIX TABLE OF CONTENTS

APPENDIX LIST OF AMICUS CURIAE[1]

Detransitioners Community[2]

Chloe Cole & Mitchell Cole, detransitioner family

Abel Garcia, detransitioner

Luka Hein, detransitioner

Brendan de Bie, detransitioner

Kevin Jones, detransitioner

Jade Martin, detransitioner

Cynthia Breheny, desister

Nicolas Flowers, detransitioner

Richard Anumene, detransitioner

Laura Becker, detransitioner

Emelie Anne Schmidt, desister

Maia Poet, desister & section co-author

Laura Wiley Haynes, desister & section co-author

Alex Freeman, researcher

Stephanie Winn, LMFT counselor

Dr. Richard Curtiss Guggenheim, advocate

Axa Carnes, parent

Dorothy Garland, parent & organizer

Ari DeWolf, organizer

---

[1] Amicus brief was the result of individual citizens coming together and using their network to organize and sign.

[2] Some detransitioners and desisters names may be preferred names or pseudonyms due to personal privacy concerns.

Organizations:

Center for Bioethics & Culture

Democrats for Informed Approach to Gender

Gays Against Groomers

Restore Childhood

Colorado Principled Physicians & Texas Principled Physicians

Public Officials

Lana Loree Theis, Michigan State Senator

Shawn Thierry, Texas State Representative

Sarah Penn, FNP, Wyoming State Representative

Healthcare & Research Scholars:

Johnathan Edwards, MD, Anesthesiologist & section co-author

David Boettger, MD, Pediatrician

Edward E. Waldrep, PhD, MSCP, Psychologist

Jennifer Bauwens, PhD Clinical Social Worker

Paul Terdale, MS, MBA, Health Consumer Advocate

Raheem Williams, MA, Economist & co-author

Julia Schaletzky, Director of CEND,
University of California, Berkeley

Jordan B. Peterson, Professor of Psychology,
University of Toronto

Diana F. Lutfi, JD, MSHCM, CPHQ, primary author & organizer