No. 23-477

In the Supreme Court of the United States

UNITED STATES OF AMERICA,
Petitioner,

v.

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

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

BRIEF OF AMICUS CURIAE ETHICS AND PUBLIC POLICY CENTER IN SUPPORT OF RESPONDENTS

ERIC N. KNIFFIN
Counsel of Record
MARY RICE HASSON
ETHICS AND PUBLIC POLICY CENTER
1730 M Street N.W.
Suite 910
Washington, DC 20036
(202) 682-1200
ekniffin@eppc.org

Counsel for Amicus Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

INTEREST OF AMICUS CURIAE[1]

The Ethics and Public Policy Center ("EPPC") is a nonprofit research institution applying the Judeo-Christian moral tradition to critical issues of public policy, law, culture, and politics. In pursuit of its mission, EPPC equips Americans to address today's ethical, political, and cultural questions with firm commitment to human dignity, natural law, and our constitutional freedoms.

With stunning speed, gender ideology has permeated American culture, influencing medicine, business, media, government, and education. The results are far-reaching, threatening religious liberty and parental rights, stifling free speech, and driving an unprecedented rise in youth "transgender" identification. Demands for irreversible body modifications raise crucial questions of medical ethics, informed consent, patient safety, the appropriate regulation of healthcare, and taxpayer funding.

EPPC Fellows write and advocate on issues related to gender ideology. EPPC Senior Fellow Mary Rice Hasson launched EPPC's Person and Identity Project[2] to equip parents and faith-based institutions to promote the truth of the human person and to meet the challenges of gender ideology. *Amicus* files this

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[1] Pursuant to Rule 37.6, no counsel for any party authored this brief in whole or in part, nor did any such counsel or party make any monetary contribution intended to fund the preparation or submission of this brief.

[2] https://personandidentity.com/.

brief because the issues in this case relate to EPPC's mission and require clear resolution.

INTRODUCTION AND SUMMARY OF ARGUMENT

At the core of Petitioner's arguments against Tennessee Senate Bill 1 (SB1), which restricts medical interventions to "transition" minors, is the claim that Tennessee is unjustly blocking medical professionals from administering procedures that the medical and scientific community have found medically necessary. The United States claims that "gender-affirming care" for minors constitutes "critical medical treatment" according to WPATH's "accepted standard of care," which are recognized by the "Nation's leading medical and mental health organizations." Pet. at 2, 3.

Respondents disagree with Petitioner's framing, noting the growing recognition in Europe that "these interventions pose significant risks with unproven benefits" and that the "accepted standard of care" Petitioner relies on is not supported by scientific evidence. Resp. at 7, 9. It was "ideology, not science" that produced the WPATH standards that serve as the tentpole of Petitioner's case. *Id.* at 9 (quoting *Eknes-Tucker* v. *Governor of Ala.*, 114 F.3th 1241, 1261 (11th Cir. 2024) (Lagoa, J., concurring in the denial of rehearing en banc).

Judge Lagoa got it right. The fundamental disagreements between the parties are not rooted in different assessments of the scientific evidence as much as they are in fundamentally different visions of what a human person is.

That is also how Justice Blacklock of the Supreme Court of Texas framed the matter in *State* v. *Loe*, 692 S.W.3d 215, 239 (Tex. 2024), which upheld Texas' law

that, like SB1, protects minors from "gender-affirming" care. In his concurrence, Justice Blacklock set out two contrasting visions of what it means to be human:

> The first vision—call it the Traditional Vision—holds that a boy is a boy, a girl is a girl, and neither feelings and desires nor drugs and surgery can change this immutable genetic truth, which binds us all. Within the Traditional Vision, human males and females do not "identify" as men and women. We *are* men and women, irreducibly and inescapably, no matter how we feel. * * *
>
> The second vision—call it the Transgender Vision—holds that we all have a "sex assigned at birth," which usually corresponds to our physical traits but which may or may not correspond to our inwardly felt or outwardly expressed "gender identity." It holds that a person's gender identity is a constitutive part of his or her humanity and that when a person's biological sex and gender identity diverge, often gender identity should be given priority."

Loe, S.W.3d at 239-240. These two visions, as Justice Blacklock set out, lead to two "irreconcilably conflicting visions of what it means for doctors to do 'harm or injustice' to children experiencing confusion and distress about the normal biological development of their bodies." *Id.* at 239.

Understanding this dispute in this matter is critical because, as Justice Blacklock noted, "[d]octors have no special expertise in answering moral and

political questions." *Loe*, S.W.3d at 240. The power to make such judgments about moral and political questions resides not in medical schools or in courtrooms but in the legislature. *Ibid.*

This brief draws on the expertise and scholarship of Amicus' Person and Identify Project to detail the profound philosophical differences between these two competing visions of what it means to be human that underlie the disagreement in this case.

Adopting Justice Blacklock's terminology, the Traditional Vision is assumed by and informs pediatric medical care, while the Transgender Vision contradicts biology and is inconsistently applied even by those who claim to hold it. It is legitimate for the Tennessee General Assembly to hold the Traditional Vision of the person, to prevent medical interventions that it believes to be harmful in light of that anthropology, and to protect all minors, of both sexes, from those harmful interventions.

ARGUMENT

I. Differences over how to treat children experiencing identity-related distress are rooted in philosophical differences over the nature of the human person.

The controversy over how best to treat individuals who identify as transgender is not understood best as a debate over science but more fundamentally a disagreement over the nature of the human person. The Traditional Vision holds that a person is a mind-body unity. The Transgender Vision, by contrast, gives

priority to the subjective experience and allows that an individual's sex may not reflect his or her true self.

A. The Traditional Vision of the human person is rooted in science, common experience, and reason.

Americans, including Tennesseans, have long held to the Traditional Vision of the human person, also described as a realist or objective view of the person. This vision holds that the human being is an *embodied* person, which is to say that each human is embodied as male or female from the beginning—from conception. In the words of EPPC President Ryan T. Anderson, "Every newborn child is either a boy or a girl, just as every human adult is either a man or a woman. This is a biological reality."[3] This view is supported by science and experience and known through reason.

1. Affirmed by Science

From a scientific perspective, the fact that humans are embodied as male or female is neither random nor purposeless; it reflects that we are each directed toward reproductive potentiality. The sex classification is based on objective, observable facts indicating the body's organization or design for reproductive purposes. *Sex* does not exist along a spectrum because there are only two kinds of reproductive cells. A male has the kind of body

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[3] Ryan T. Anderson, *Loving Those Caught in Gender Ideology: The Ethics and Metaphysics of Sexual Identity*, Christ Over All (Feb. 15, 2023), https://christoverall.com/article/concise/trans-metaphysical-ethics-loving-those-who-dont-love-their-bodies/.

designed to produce small gametes (sperm) while a female has the kind of body designed to produce large gametes (ova).[4]

> [S]ex is a biological reality, conceptualized and identified based on an organism's organization with respect to sexual reproduction. In human beings, this organization begins to form as a result of the chromosomes we inherit from our parents, as well as the reproductive organs, systems, genitalia, and hormones that develop as a consequence. As there are two reproductive systems, there are two sexes. This primary sexual differentiation in turn gives rise to secondary bodily differences—in terms of height, weight, organ development, musculature, and even psychology. These are not essential differences, but differences in distributional patterns.[5]

Noted evolutionary biologist Richard Dawkins writes, "sex in all animals is defined by gamete size; sex in all mammals is determined by sex chromosomes; and there are two and only two sexes: male and female."[6] Sex is binary because "[t]here are

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[4] Colin Wright, *A Biologist Explains Why Sex is Binary*, Wall St. J. (Apr. 9, 2023), https://www.wsj.com/articles/a-biologist-explains-why-sex-is-binary-gender-male-female-intersex-medical-supreme-court-ketanji-brown-jackson-lia-thomas-3d22237e.

[5] Ryan T. Anderson, *Neither Androgyny nor Stereotypes: Sex Differences and the Difference They Make*, 24 Tex. Rev. L. & Pol. 211, 212–13 (2020).

[6] Alan Sokal & Richard Dawkins, *Sex and gender: The medical establishment's reluctance to speak honestly about biological*

two gametes, two genitals, two sets of reproductive organs, and two reproductive systems. That is, there is sperm and egg, penis and vagina, testicles and ovaries."[7] There is no third sex, no third gamete, and no third participant required for human reproduction.

Given that sex is a fundamental biological reality, it should be no surprise that knowing a patient's sex is critical to sound medical care. Being male or female is an immutable fact about the person, written into every cell of the body and scientifically demonstrable through medical testing. As the U.S. Institute of Medicine (now called the National Academy of Medicine) stated in a 2001 book on the significance of sexual difference, "[e]very [c]ell [h]as a [s]ex."[8] In other words, the entire body bears witness to the truth that the person is either male or female. In 2015, the U.S. National Institutes of Health emphasized the importance of sexual difference to medical research, publishing guidelines to ensure that "sex * * * be factored into research design, analyses, and reporting of vertebrate animal and human studies."[9] The NIH

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reality, Bos. Globe (April 13, 2024), https://www.msn.com/en-us/news/us/sex-and-gender-the-medical-establishment-s-reluctance-to-speak-honestly-about-biological-reality/ar-BB1lfmlt.

[7] See Anderson, n.3, *supra*.

[8] Inst. of Med. (U.S.) Comm. on Understanding the Biology of Sex & Gender Differences, *Exploring the Biological Contributions to Human Health: Does Sex Matter?* (Theresa M. Wizemann & Mary-Lou Pardue eds., 2001), https://www.ncbi.nlm.nih.gov/books/NBK222291.

[9] Leah R. Miller, et al., *Considering sex as a biological variable in preclinical research*, 31 Fed'n of Am. Societies for Experimental Biology J. 29 (2017) (citing NIH Notice NOT-OD-15-102,

recognized that the immutable nature of sex is essential to evidence-based medicine. "The biologic basis for this recommendation is incontrovertible: sex is established genetically at conception, sexual differentiation ensues, and intrinsic existence and extrinsic interactions of an organism are mediated by sex throughout life."[10] Neither developmental disorders nor fertility limitations negate the reality and significance of sex.[11] A female is no less a female after menopause or before puberty, even though she can bear children only between puberty and menopause. A male is no less a male if he suffers from low sperm count or other fertility issues. Tennessee's law adheres to this objective, scientific view, recognizing sex as binary and immutable.[12]

Consideration of Sex as a Biological Variable in NIH-Funded Research (2015),. https://grants.nih.gov/grants/guide/notice-files/not-od-15-102.html.

[10] *Ibid.*

[11] Proponents of medical and surgical interventions for the purpose of changing secondary sex characteristics often cite disorders of sexual development (often called "intersex") as proof of a sex "spectrum." However, disorders of sexual development are disorders of either male or female sexual development, even if the limits of medicine render it challenging to discern the person's sex. The Tennessee law in question allows for medical and surgical interventions designed to heal or address various disorders of sexual development. Tenn. Code Ann. § 68-33-103(b)(1)(A) (permitting treatment for congenital defect or disease, as defined in *id.* §§ 68-33-102(1), 68-33-103(b)(2)). See also Ryan T. Anderson, *Chapter Four: What Makes Us a Man or a Woman*, in *When Harry Became Sally* (2018).

[12] The law defines "sex" as the "immutable characteristics of the reproductive system that define the individual as male or female,

2. Grounded in Experience

Of course, no one needs a biologist or a doctor to understand the differences between the sexes. Common experience does just fine. Humans know themselves as male or female by observing sexual difference and the organization of the body, which follows a natural developmental process geared towards maturity as a male or female.

A young child's basic recognition of bodily difference between the sexes starts early. But this understanding deepens as a child begins puberty. A young person observes how his or her body, and those of his or her peers, changes in ways predetermined by sex. These changes are oriented towards sexual and reproductive maturity *as a male or female.* A girl begins to ovulate, menstruate, and develop breasts capable of nurturing a child. A boy's genitals grow and mature, enabling him to father a child.

These changes also bind women together with other women, and men with other men. During puberty, girls become aware that their female development, physical and emotional, is a natural and inevitable developmental trajectory shared by other girls and previously experienced by adult women. Boys experience a similar realization that their

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as determined by anatomy and genetics existing at the time of birth." Tenn. Code Ann. § 68-33-102(9).

developmental trajectory is shared by male peers and previously experienced by adult men.

Common experience also shows that puberty is a physical reality, not a desire or self-projection requiring affirmation.

3. Grounded in Reason

Throughout history, philosophers have taken seriously the physical experiences of men and women (and boys and girls), and the effects of these experiences on the human soul, as evidence of the unity of body and soul.[13] In Greek philosophy, soul—or *psyche*—simply means the first principle of life, that which makes this body a living body. The relationship of the body and soul is one of organic unity, where experiences in the body (a migraine, for example) can cause spiritual or emotional pain (suffering and distress, for example). Conversely, spiritual or emotional distress can cause pain or fatigue in the body.

A contemporary philosopher describes the relationship of the body and soul this way: as a human being, the person is born with a material, sexed body

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[13] Ancient Greek notions of the soul varied, but there was agreement that the presence of soul differentiated the living body from a dead body. The ancient philosophers took seriously questions such as the various powers of the soul, the relation of the soul to the body, and the immortality of the soul. See Plato's Phaedo and Republic for accounts of the soul, and Aristotle's De Anima. Plato, *Phaedo* (David Gallop ed. & trans., Oxford Univ. Press 2009); Plato, *Republic* (Robin Waterfield trans., Oxford Univ. Press 2008); Aristotle, *De Anima* (Hugh Lawson-Tancred ed. & trans., Penguin Books 1986).

and an immaterial human soul, which are intimately united.[14] From birth, the person's experiences as an embodied human person are marked by the physical reality of his or her body. Each soul is differentiated from other souls because "it is joined with this particular body as its permanent instrument of self-expression."[15] A person's soul is the soul of a person who is embodied male or female and thus has had distinctive experiences. The person develops a unique identity reflecting the unity of this female or male body and this human soul. Each person has unique experiences but also shared experiences with other persons of the same sex. Women who have given birth to a child, for example, share the female experience of pregnancy and childbirth and can reflect on this experience in a way that elicits understanding from other women, but is foreign to men because male bodies cannot experience pregnancy or childbirth.

This philosophical concept of the unity of body and soul reflects common sense and the way people normally talk. If Bobby hits his little brother John, John says, "Ouch you hit *me!*" not "Ouch you hit this body." A hungry toddler cries out, "*I* am hungry," not "This body is hungry."

In the same way, the sexed body (male or female) is central to our understanding of our personhood. A woman shares the news of becoming pregnant by telling others, "I am pregnant," not "This body is pregnant." A teenage boy tells his friends, "I need to

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[14] Norris Clarke, S.J., *The One and the Many: A Contemporary Thomistic Metaphysics* 103-104 (2001).

[15] *Id.* at 103.

shave," not "This face needs to shave." These are common examples of something each person knows intuitively: My body is me.

* * *

The Traditional Vision understands that sexual difference matters. Differences between males and females begin in the womb and are demonstrated in physical development and behavior from infancy.[16] There is no possibility of misalignment between body and soul, because the two are joined at once at conception. It is impossible for a male soul to be in a female body, or a female soul to be in a male body. Rather, the person is either a male or female person, a human soul united with the male or female body. Nor is the body incidental to personhood. Because "my body is me," learning to care for one's body is an important part of growing up. This is the Traditional Vision of the person. See *Loe*, 692 S.W.3d at 239 (Blacklock, J., concurring). Some thinkers call this "realism." To most people, however, this is simply common sense.

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[16] See, *e.g.*, Amber N.V. Ruigrok, et al., *A Meta-Analysis of Sex Differences in Human Brain Structure*, 39 Neuroscience & Biobehav. Revs. 34, 43 (2014); Jonathan C.K. Wells, *Sexual Dimorphism of Body Composition*, 21 Best Prac. & Rsch. Clinical Endocrinology & Metabolism 415 (2007); Larry Cahill, *His Brain, her Brain*, Sci. Am. (2012), https://perma.cc/KR6L-A55T.

B. The Transgender Vision of the human person is rooted in feelings and stereotypes.

Petitioner in this case espouses the Transgender Vision—a radical view of the person informed by an ideology of gender. *Loe*, 692 S.W.3d at 239 (Blacklock, J., concurring). According to this view, the person's embodiment as male or female is inconsequential and subordinate to the person's self-perception or inner "gender identity" experience. The Transgender Vision of the person "holds that a person's gender identity is a constitutive part of his or her humanity and that when a person's biological sex and gender identity diverge, often gender identity should be given priority." *Ibid.*

The Transgender Vision of the person ignores the reality that sex is determined at conception and observed in utero or at birth. Instead, sex is described as an arbitrary label "assigned" at birth, as if "male" or "female" have no objective meaning and little significance to personal identity. In fact, advocates for the Transgender Vision imbue individual self-perception (or "gender identity") with transformative power over reality. As gender clinician Deanna Adkins testified in federal district court in 2016, "From a medical perspective, the appropriate determinant of sex is gender identity."[17] In other words, subjective feelings have the power to redefine objective reality.

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[17] Expert Decl. of Deanna Adkins, MD ¶ 23, *Carcaño* v. *McCrory*, 315 F.R.D. 176 (2016) (No. 16-236), https://www.aclu.org/wp-content/uploads/legal-documents/AdkinsDecl.pdf.

According to Adkins, a child's "assigned" sex is merely a proxy for the child's presumed "gender identity," which is unknowable until the child declares it.[18]

What exactly is gender identity and how does it become known? Answers vary. But a popular definition by the Human Rights Campaign (HRC) defines gender identity as "[o]ne's innermost concept of self as male, female, a blend of both or neither—how individuals perceive themselves and what they call themselves."[19]

In schools, gender clinics, and on social media, children and adolescents are introduced to graphics, such as the "gender unicorn" or "genderbread person," that purport to represent "the human person." These graphics not only explain the Transgender Vision of the person, they function as interactive tools helping children self-define their "gender identity" according to feelings, and select their "gender expression," according to stereotyped preferences.[20] A boy who likes

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[18] *Id* ¶ 24.

[19] Human Rights Campaign, *Sexual Orientation and Gender Identity Definitions*, https://www.hrc.org/resources/sexual-orientation-and-gender-identity-terminology-and-definitions. The American Civil Liberties Union (ACLU) similarly defines gender identity as "a person's internal sense of being a man or a woman (or both or neither)." ACLU, *Transgender People and the Law: Frequently Asked Questions* 19 (2015), https://www.aclu.org/sites/default/files/field_pdf_file/lgbttransbrochurelaw2015electronic.pdf.

[20] For the gender unicorn, see Trans Student Educational Resources, *The Gender Unicorn* (2015), https://transstudent.org/gender/. For the genderbread person, see Sam Killermann, *The Genderbread Person version 4* (2017),

pink and dancing, a girl who dreams of being a car mechanic, a boy who dislikes sports, a teen girl uncomfortable with her developing body—all of these children are vulnerable to the Transgender Vision, which suggests that if the child's preferences do not conform to social stereotypes, then the child has a mismatched gender identity and sex, requiring medical intervention.

Parents, physicians, and even a child's body—the sources that once were regarded as authoritative—consequently have nothing to offer a child on his or her journey of "gender" self-discovery. The child's feelings carry the greatest weight in the pursuit of "gender self-determination," the idea that everyone, including youth, "have a right to define, express, and embody their gender identity as they see fit."[21]

Some physicians, such as Dr. Deanna Adkins, claim "gender identity" is fixed in a child from an early age.[22] Harvard gender clinician Dr. Sabra Katz-Wise disagrees, stating that "Gender fluidity refers to change over time in a person's gender expression or gender identity, or both. That change might be in expression, but not identity, or in identity, but not

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https://www.itspronouncedmetrosexual.com/2018/10/the-genderbread-person-v4/.

[21] Florence Ashley, *Gender self-determination as a medical right*, Medium, (July 3, 2024), https://medium.com/@florence.ashley/gender-self-determination-as-a-medical-right-redux-53bdf4484915.

[22] Adkins Expert Decl. ¶ 21.

expression. Or both expression and identity might change together."[23]

Fixed or fluid, how is a child to declare a "gender identity" when gender clinicians themselves cannot agree on its characteristics? Dr. Robert Garafalo, lead clinician at Lurie Children's Hospital Gender Development Program, candidly admits that gender identity is based on the child's assertion, with no medical tests necessary to back it up. "I mean, sometimes parents will come in and be like, * * * I want to make sure my child's really trans. * * * And I'll turn to the child and be like, 'Yeah, so what gender identity do you have?' There's no form, there's no scale, there's no psychological battery of tests that needs to be done."[24] Garafalo adds that many children come in already convinced of the medical interventions they desire.

Plastic surgeon Dr. Blair Peters explains "It is an important thing to understand with gender identity and exploration of gender identity, there's no right or wrong outcome, and there's no right or wrong destination. We should encourage people to ask questions and to find their own answers, but we

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[23] Sabra L Katz-Wise, *Gender fluidity: What It means and why support matters*, Harv. Health Publ'g (Dec. 3, 2020), https://www.health.harvard.edu/blog/gender-fluidity-what-it-means-and-why-support-matters-2020120321544.

[24] AMAZE Parents, *Supporting Trans Youth: Dr. Robert Garofalo* (video interview), Facebook (July 29, 2020) https://perma.cc/YM4Z-ARXK.

shouldn't be invested in where they land or what is the most authentic version of themselves."[25]

That is a stark statement and one that gives little regard to the growing chorus of detransitioners.[26] For them, submitting to "gender transition" treatments, including surgery to remove primary and secondary sex organs, was a wrong outcome. They wish that their public officials had been more "invested in where they land."

These competing visions of the human person have clear moral implications for society as a whole and for children suffering from gender dysphoria.

II. These philosophical visions lead to different answers to the moral question of how best to care for these children.

Fundamental philosophical differences between the Traditional Vision and the Transgender Vision lead to opposing answers to an important and pressing moral question in our day: *how ought one care for*

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[25] Frances B. Lim Liberty, Keith J. Loud & Jessica A. Smith, *Opinion: The truth about gender-affirming care for youth in NH from Dartmouth Health Children's*, Concord Monitor (Mar. 27, 2024), https://www.concordmonitor.com/My-Turn-Dartmouth-health-care-for-trans-gender-diverse-kids-in-NH-54519929.

[26] See, *e.g.*, Br. of Walt Heyer, Ted Halley, and Clifton Francis Burleigh as Amicus Curiae Supporting Appellees, *Dekker* v. *Secretary, Fla. Agency for Health Care Admin.*, No. 23-12155 (11th Cir. filed Oct. 13, 2023), https://eppc.org/wp-content/uploads/2023/10/Dekker-Amicus-Br-3-detransitioners.pdf.

children who experience identity- or body-related distress or confusion?

A. According to the Traditional Vision, interventions that disrupt a child's biological development cause harm and are unjust.

The Traditional Vision of the person has moral and ethical implications, including for the treatment of children experiencing identity- or body-related distress. First and foremost, "neither feelings and desires nor drugs and surgery can change this immutable genetic truth" that boys are boys and girls are girls, and sex cannot change. *Loe*, 692 S.W.3d at 239 (Blacklock, J., concurring).

Moreover, it is harmful and unjust to use puberty blocking drugs and cross-sex hormones ("masculinizing" hormones in females, "feminizing" hormones in males) in physically healthy children. These interventions disrupt a child's *current* natural sexual and reproductive development to purportedly maximize the speculative *future* odds of a "better cosmetic outcome" or "'passing' better" *if* the child continues to identify as transgender as an adult.[27]

Contrary to Petitioner's claims, pubertal suppression for "gender dysphoria" is neither "reversible" nor a mere "pause" in development. Pet. 6. The Cass Review, a three-year research initiative

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[27] Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report* 174, 176 (2024) (hereafter "Cass Review"), https://cass.independent-review.uk/home/publications/final-report/.

commissioned by the UK's National Health Service that includes multiple substantive evidence reviews, described the use of puberty blockers as more like a developmental lag with unknown consequences than a benign pause: "Once on puberty blockers, [the child] will enter a period when peers are developing physically and sexually whilst they will not be, and they may be experiencing the side effects of the blocker."[28]

Unlike the use of puberty blockers to block "hormones that are abnormally high" in a case of precocious puberty, puberty suppression in a child experiencing identity distress blocks "the normal rise in hormones that should be occurring into teenage years, and which is essential for psychosexual and other developmental processes."[29] Blocking puberty is harmful because it disrupts a healthy child's normal pubertal development and derails sexual, reproductive, and emotional maturation, with "potential adverse effects on bone health and uncertainty regarding cognitive development."[30] Further, new evidence from the Mayo Clinic, based on testicular tissue samples of puberty-blocked children, found that "mild-to-severe sex gland atrophy" and "abnormalities from the histology data raise a potential concern regarding the complete 'reversibility'" of puberty blockers and their effect on

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[28] *Id.* at 196.

[29] *Id.* at 174.

[30] *Ibid.*

future "reproductive fitness."[31] Puberty blockers also fail to deliver a measurable benefit sufficient to justify disabling a healthy body process, especially given the risks and unknown lifelong consequences.[32]

Cross-sex hormones are harmful because they disable normal sexual and reproductive function and development in an otherwise healthy child, while artificially inducing the appearance of unnatural physical characteristics incongruent with the child's sex. Petitioner claims that cross-sex "hormone therapy" can "*induce puberty* consistent with a patient's gender identity" (i.e., contrary to the patient's male or female sex). Pet. at 5 (emphasis added). But puberty, by definition, is sex-specific and leads to sexual and reproductive maturation. Although "masculinizing" or "feminizing" hormones may alter the body's appearance and disable its natural reproductive functions, these cross-sex hormones cannot produce the sexual and reproductive maturation of the opposite sex, and may, in fact, lead to "loss of fertility."[33] The use of cross-sex hormones may make it more difficult to *discern* the person's actual sex, but do not change the person's sex or "induce puberty." "Transgender" hormonal interventions do not enable a person to function

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[31] Varshini Murugesh, et al., *Puberty Blocker and Aging Impact on Testicular Cell States and Function*, bioRxiv (2024), https://doi.org/10.1101/2024.03.23.586441.

[32] Cass Review at 179. The Cass Review also found "no evidence that puberty blockers improve body image or dysphoria, and very limited evidence for positive mental health outcomes, which without a control group could be due to placebo effect or concomitant psychological support. *Ibid*.

[33] Cass Review at 76, 78.

biologically as the opposite sex. These interventions *disrupt* natural, healthy bodily functions, *disable* the person's sexual and reproductive functioning, and *disfigure* the person's (previously) healthy body. The hormonally-induced anatomical changes only mimic, but cannot replicate, the healthy functioning (or appearance) of the other-sex's body.

These interventions are unjust because they carry life-altering and permanent consequences, many of which a minor cannot possibly appreciate. Petitioner acknowledges that doctors must secure a minor's informed consent before proceeding with "gender affirming" care. Pet. at 5. But minors cannot fully understand or consent to becoming infertile or losing sexual function. Children lack experience in adult relationships and the desire for genetically-related children often changes markedly after people reach adulthood. In addition to known risks to bone health, genitalia, sexual function (including sexual pleasure), cardiovascular health, and fertility, many of the long-term consequences of cross-sex hormones are unknown.[34]

The Traditional Vision of the person informs the Tennessee law at issue here. This realist perspective understands that children may suffer distress or

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[34] Alison Clayton, *Gender-Affirming Treatment of Gender Dysphoria in Youth: A Perfect Storm Environment for the Placebo Effect-The Implications for Research and Clinical Practice*, 52 Archives Sexual Behav. 483 (2023); David J. Ley, *Does Affirmative Treatment Impair Sexual Response in Trans Youth?*, Psych. Today (Mar. 20, 2024), https://www.psychologytodaycom/us/blog/women-who-stray/202111/does-affirmative-treatment-impair-sexual-response-in-trans-youth.

experience an inaccurate self-perception because of external factors (e.g., trauma or adverse childhood experiences) or internal factors (e.g., autism or pre-existing mental health issues). In these instances, appropriate therapeutic care addresses the underlying issues and provides psychological support to help the child feel at home in his or her body.[35]

B. According to the Transgender Vision, a subjective gender identity justifies radical, harmful body modifications in otherwise healthy children.

Even if one were to agree that there might be children who should transition, Dr. Hilary Cass noted that clinicians have no way of knowing *which* children would persist in these feelings long term—a fact which should impel caution, not intrusive, permanent body alterations.[36] Those who hold the Transgender Vision, however, dismiss its subjectivity, fluidity, and internal incoherence as inconsequential, minimizing the serious physical effects of "transitioning" children and the horrifying potential for lifelong harm and regret.[37]

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[35] See Roberto D'Angelo, et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, 50 Archives Sexual Behav. 7 (2021).

[36] Clinicians are "unable to determine with any certainty which children and young people will go on to have an enduring trans identity." Cass Review at 22.

[37] Journalist Hannah Barnes describes this kind of insight—that the Tavistock service in the UK was pushing children down an irreversible pathway—as one of the motivating factors that led physicians to quit working for the service. Hannah Barnes, *A*

Perhaps the reason for the casual approach to irreversible changes in the body lies in the Transgender Vision's core belief that there is no necessary connection between a person's sex and that person's identity. The same person's "gender identity," a subjective perception known only to the individual until it is disclosed or declared to others, is viewed as determinative. This rationale underlies the radical paradigm shift in approach towards children who identify as transgender.

The Transgender Vision posits (with scant evidence) that body or identity related distress will be alleviated by "aligning a trans person's physical body & gender presentation with their gender identity."[38] When a minor child experiences distress or confusion about the body, the medical establishment steps in to treat the child's distress by medically manipulating the body to approximate the child's self-perception or desires. These medical and surgical interventions induce changes in the child's body by overwhelming the child's natural pubertal development with supraphysiological levels of hormones (high-dose testosterone in females, and high-dose estrogen in males), or even performing surgeries to remove unwanted but healthy body parts (breasts,

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Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children (2023).

[38] ACLU Tenn., *Trans in Tennessee 101: Supporting Trans People. In Healthcare*, https://www.aclu-tn.org/en/trans-tennessee-101-supporting-trans-people.

reproductive organs, or genitals) or to construct facsimiles of opposite-sex genitalia.

Physicians speak openly about helping their patients achieve their embodiment goals.[39] While "embodiment goals" sounds lofty and aspirational, the sad reality is that these "embodiment goals" often reflect social goals, as when females undergo genital surgeries in hopes of standing to urinate, as if this performative act will relieve their psychological pain.

III. In practice, medical standards of care are generally based on the Traditional Vision, but not for gender dysphoria.

From the first articulation of the Hippocratic Oath in the fifth century B.C., physicians have been duty-bound to do no harm.[40] When a physician loses sight of the relationship between the body and soul, or the relationship between the mind and the body, and when practitioners ignore the importance of respecting the integrity of the body in cases of psychic distress, harm can occur. The history of psychiatry unfortunately contains multiple tragic examples of egregious harm. The lobotomy, for example, attempted to heal a psychic wound by altering the body.[41]

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[39] Eliza Mondegreen, *Gender surgeon promotes bizarre range of 'nonbinary surgeries'*, UnHerd (July 11, 2023), https://unherd.com/newsroom/gender-surgeon-promotes-bizarre-range-of-nonbinary-surgeries/.

[40] Nat'l Libr. of Med., *Hippocratic Oath* (Michael North trans. 2002).

[41] Hugh Levinson, *The Strange and Curious History of Lobotomy*, BBC (Nov. 8, 2011), https://www.bbc.com/news/magazine-15629160. The parallels between lobotomy

Rightly, practices that attempt to address psychiatric wounds by radically altering the body have fallen into disfavor.

Consider how pediatric medicine treats another condition that involves a child's feelings or perceptions about his or her body—anorexia nervosa. Like other eating disorders, anorexia is quite serious, even life threatening. "People with eating disorders are at higher risk for suicide and medical complications and often have other mental disorders (such as depression or anxiety)—but recovery is possible."[42] It is universally accepted that the appropriate treatment for anorexia nervosa is to help the person address the underlying causes of their psychic distress, while working to restore and maintain health. Tennessee based Erlanger Health notes that "Treatment plans are tailored to the individual needs of each patient and may include therapy, medical care, nutritional

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and gender transition medical and surgical interventions are striking. Both involve altering the body to try to heal the mind. Moreover, both involve a rush to embrace a treatment on the basis of anecdotal evidence, and with limited follow-up. One British neurosurgeon noted about lobotomy "It reflected very bad medicine, bad science, because it was clear the patients who were subjected to this procedure were never followed up properly." Limited follow-up and shoddy research characterizes scientific research into transgender medicine in the United States. *Research into trans medicine has been manipulated*, Economist (June 27, 2024), https://www.economist.com/united-states/2024/06/27/research-into-trans-medicine-has-been-manipulated.

[42] Erlanger Health, *Eating disorders: It's not just about food* (Feb. 24, 2021), https://blog.erlanger.org/2021/02/24/eating-disorders-its-not-just-about-food/. The blog entry refers patients to Dr. John Heise, MD, who is one of the adolescent medicine physicians at Children's Hospital at Erlanger.

counseling, and/or medications."[43] Another Tennessee children's hospital, East Tennessee, addresses anorexia in developmental behavioral pediatrics, noting: "Anorexia nervosa is a significant potentially life-threatening eating disorder which includes a severely distorted perception of body image and extreme weight loss. Eating disorders generally require dietary consultation and supportive psychological counseling."[44] Medication is also used to heal the body from the effects of starvation.

For these Tennessee children's hospitals, patient care of children suffering from anorexia is clearly shaped by the Traditional Vision of the person. The child suffers psychic distress, which in turn causes feelings of distress about the body. Appropriate care involves healing the mind with psychotherapy, while nurturing the body and restoring health. The practices of these hospitals are particularly instructive, as they were identified in a recent report as hospitals where children also received hormones or puberty blockers for the purpose of gender transitions.[45] Thus, even in hospitals where these pediatric "transgender" medical interventions are occurring, the Transgender Vision does not dictate medical care except when it comes to children experiencing identity-related distress.

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[43] *Ibid.*

[44] E. Tenn. Child.'s Hosp., *Your Child's Behavioral Health* (2019), https://www.etch.com/app/files/public/97be33c0-4b31-45c2-9248-dc1dc8add39d/Documents/30763%20Your%20Childs%20Behavioral%20Health.pdf.

[45] Stop the Harm Database, *State Breakdown: Tennessee*, https://stoptheharmdatabase.com/state/tennessee/.

If the Transgender Vision of the person were consistently applied in these children's hospitals, then children with anorexia would be offered Ozempic, liposuction, and bariatric surgery, rather than supportive psychiatric care. Instead, and rightly so, they are offered supportive psychiatric care and restorative medical interventions because these Tennessee pediatric physicians are drawing on the Traditional Vision of the person. As this example demonstrates, the Transgender Vision is inconsistently applied by physicians, who seem to bracket off "gender identity" as the sole instance where psychiatric distress is be treated by radically altering the body.

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Petitioner frames its appeal as a settled question of science and medicine, but this framing masks more important and fundamental disputes over the nature of the human person. The United States' disagreement with the State of Tennessee is rooted in the fundamentally moral question over how best to care for children experiencing distress over their sexual identities. The two sides offer different answers to this moral question because they approach it with radically different visions of the human person.

The law at issue reflects the State of Tennessee's considered moral and political judgment, based on its understanding of the human person, that these medical and surgical interventions are not appropriate or ethical interventions for children. These matters, and the State's judgment reflected in SB1, are properly left to the political process.

CONCLUSION

The Court should affirm the judgment of the court of appeals.

Respectfully submitted.

ERIC N. KNIFFIN
Counsel of Record
MARY RICE HASSON
ETHICS AND PUBLIC
POLICY CENTER
1730 M Street, N.W.
Suite 910
Washington, DC 20036
(202) 682-1200
ekniffin@eppc.org

Counsel for Amicus Curiae

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