No. 25-840

# In the Supreme Court of the United States

INTERNATIONAL PARTNERS FOR ETHICAL CARE, INC.; ADVOCATES PROTECTING CHILDREN; PARENTS 1A, 1B, 2A, 2B, 3A, 3B, 4A, 4B, 5A, AND 5B,
*Petitioners*,

*v.*

ROBERT FERGUSON, GOVERNOR OF WASHINGTON, IN HIS OFFICIAL CAPACITY; NICK BROWN, ATTORNEY GENERAL OF WASHINGTON, IN HIS OFFICIAL CAPACITY; AND TANA SENN, SECRETARY OF THE WASHINGTON DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES, IN HER OFFICIAL CAPACITY,
*Respondents*.

ON PETITION FOR A WRIT OF CERTIORARI TO THE U.S. COURT OF APPEALS FOR THE NINTH CIRCUIT

## BRIEF OF THE MANHATTAN INSTITUTE AND DR. LEOR SAPIR AS *AMICI CURIAE* SUPPORTING PETITIONERS

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February 17, 2026

## QUESTION PRESENTED

Do parents have standing to challenge a law or policy permitting state officials to provide "gender-affirming" treatment to minors without parental knowledge or consent?

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## INTEREST OF *AMICI CURIAE*[1]

The Manhattan Institute (MI) is a nonprofit policy research foundation whose mission is to develop and disseminate ideas that foster individual responsibility and agency. It has sponsored scholarship and filed briefs opposing regulations that interfere with constitutional liberties.

Leor Sapir, Ph.D., is a senior fellow at MI, where his research focuses on pediatric gender medicine and medical policy. His scholarship has appeared in many publications, including *Archives of Sexual Behavior*, and he co-authored a U.S. Department of Health and Human Services report on pediatric gender dysphoria.

*Amici* file this brief because the right to direct the upbringing of one's children is among the most important constitutional liberties protected by this Court. We highlight research demonstrating the known and anticipated risks associated with social transition and "gender-affirming" treatments.

## BACKGROUND AND SUMMARY OF ARGUMENT

Decades of research have consistently shown that most children with gender dysphoria ("GD") and most clinically referred children with gender-variant behavior come to terms with their natal sex ("desist") by adulthood. Minors who are socially transitioned, however, are more likely to persist in their cross-gender feelings and, in time, seek medical interventions in the form of puberty blockers, cross-sex hormones, and surgeries. These interventions carry

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[1] All parties were timely notified of this filing. No part of this brief was authored by any party's counsel, and no person or entity other than *amici* funded its preparation or submission.

known and anticipated risks, including lifelong sterility, sexual dysfunction, mood disorders, and increased risk of cancer and heart disease. *See, e.g.*, *United States v. Skrmetti*, 605 U.S. 495, 534–35 (2025) (Thomas, J., concurring). Social transition is not a neutral act but an active intervention that can lock in a temporary phase of identity development, leading to unnecessary medicalization and iatrogenic harm.

The risks of such unnecessary medicalization are now clearer. On November 19, 2025, the Department of Health and Human Services published the final, peer-reviewed version of its review of evidence and best practices for the treatment of pediatric gender dysphoria (which *amicus* Dr. Sapir co-authored). U.S. Dep't Health & Hum. Servs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* (2025) (hereinafter "HHS Final Review"). The Review's central conclusion—that pediatric medical transition is unsupported by evidence—is neither new nor controversial. It is what health authorities in Sweden, Finland, Denmark, Norway, the United Kingdom, and elsewhere have concluded following multiple systematic reviews of evidence—the gold standard in evidence-based medicine. The Review underscored the extraordinarily weak evidentiary foundation for such medical interventions: "The evidence for benefit of pediatric medical transition is very uncertain, while the evidence for harm is less uncertain." HHS Final Review at 15.

Given the growing international recognition of an unfavorable risk-benefit profile of gender-related medical interventions and concerns about early social transition, decisions on both fronts should, at minimum, fall squarely within parents' basic right to guide their children's healthcare. By permitting these

interventions without parental knowledge or consent, Washington's laws infringe on that right, providing an injury sufficient to confer standing on petitioners. The Court should thus grant cert. to make clear that parents have standing to challenge laws that deny them critical information and decision-making authority over their children's health and well-being.

## ARGUMENT

### I. Social Transition Constitutes a Psychological Intervention for Children Who Would Otherwise Likely Desist in Their Adopted Gender Identity before Adulthood

"Social transition" refers to the use of youths' preferred names and pronouns, access to sex-specific accommodations, and, in some cases, practices such as breast-binding and genital-tucking. Healthcare professionals have recognized social transition as an active psychological intervention. Research suggests that the vast majority of gender-dysphoric children will naturally "desist," growing to feel comfortable with their natal sex. But social transition risks inhibiting this ordinary development, solidifying an otherwise passing phase of identity discordance past adolescence and, in turn, raising the potential for unnecessary medicalization.

In other words, social transition may encourage feelings of gender-related discordance to continue far longer than they would without it. Those who facilitate social transitions thus take part in a psychological intervention with potentially serious ramifications.

HHS examined two systematic reviews evaluating the impact of social transition, concluding: "The results suggest that the impact of social transition on long-term GD, psychological outcomes and well-being,

and future treatment decisions such as hormones or surgeries remains poorly understood. Evidence on regret associated with social transition is extremely limited. The certainty of evidence for these outcomes is very low." HHS Final Review at 89.

### A. Research Suggests That Social Transition Is a Psychological Intervention with Potential Medical Implications for Children and Adolescents

The risks of early social transition were acknowledged by the Dutch clinicians who pioneered pediatric gender transition. Specifically, they recognized the potential for full social transition to lock in what would otherwise prove to be a temporary phase of identity exploration or confusion. Annelou L. C. de Vries & Peggy T. Cohen-Kettenis, *Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach*, 59 J. Homosexuality 301, 320 (2012).

Indeed, the Dutch clinicians envisioned social transition and pharmacological puberty suppression as two components of a prolonged *diagnostic* phase in which an adolescent's identity can continue to be explored. Of note, parents were to be part of this process, consulted throughout for their insights into the patient's development. Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1893 (2008).

#### 1. Childhood gender dysphoria normally remits by adulthood, but social transition may cause it to persist.

The Dutch researchers' cautious approach to social transition and their warnings about its risks are buttressed by decades of research finding that most

children with gender identity issues come to terms with their natal sex, typically during adolescence. Those studies found desistence rates of between 61 and 100 percent, with specific percentages as follows in chronological order of publication: 75; 87.5; 100; 95.5; 90; 98; 87.5; 61; 88; 63; 87.7. James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46 J. Sex & Marital Therapy 307, 313 (2019) (collecting 11 studies from 1972 to 2019).

Of note, the studies found not only that most gender-dysphoric children eventually desist, but that a majority of natal males (63–100 percent) and a substantial minority of natal females (32–50 percent) who desisted later turned out to be gay or lesbian, not transgender. Cross-gender feelings and behaviors in children are thus thought to be more predictive of later same-sex attraction than of lifelong gender dysphoria and trans identity. Early social transition may hinder healthy development of gender-nonconforming homosexual children. *See also* Michael Biggs, *The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence*, 49 J. Sex & Marital Therapy 348, 352 (2022). One study found that childhood social transition was a factor associated with persistence. Thomas D. Steensma et al., *Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study*, 52 J. Am. Acad. Child & Adolescent Psych. 582, 588 (2013).

U.S. medical groups have acknowledged the high rates of desistance among gender-dysphoric children. As early as 2012, the American Psychiatric Association observed that "only a minority" of those diagnosed with childhood gender identity disorder "will identify as transsexual or transgender in

adulthood (a phenomenon termed *persistence*), while the majority will become comfortable with their natal gender over time (a phenomenon termed *desistence*)." William Byne et al., *Report of the APA Task Force on Treatment of Gender Identity Disorder* 4 (2012).

That same year, the American Academy of Child and Adolescent Psychiatry acknowledged "longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood," and warned that "further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed." Steward L. Adelson et al., *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. Am. Acad. Child & Adolescent Psych. 957, 968 (2012). And the Endocrine Society warns that children who socially transition "may have great difficulty in returning to the original gender role upon entering puberty," and that social transition "has been found to contribute to the likelihood of persistence." Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clinical Endocrinology & Metabolism 3869, 3879 (2017).

Proponents of early social transition have pointed to a 2022 study, published in *Pediatrics*, which they claim challenges the conventional wisdom about desistence described above. Kristina R. Olson et al., *Gender Identity 5 Years After Social Transition*, 150 Pediatrics 1, 1 (2022) (special article). Based on their observation of 317 children, psychologist Olson and

her colleagues claim to show that young children who are socially transitioned and "supported" in their new gender identity rarely change their minds. *Id.* at 6.

To be eligible for participation in the study, candidates had to have completed a full, "binary" (male-to-female or female-to-male) social transition. *Id.* at 2. By the end of the study's five-year follow-up term, 3.5 percent of the children had replaced their male or female self-identification with a "non-binary" one, while 2.5 percent had "retransitioned" (*i.e.*, come to terms with and learned to accept their natal sex). *Id.* at 3. For the study's authors and supporters of the "gender-affirmative" approach, this was good news: it confirmed the oft-repeated claim that "trans kids know who they are" and that children benefit from having adults agree with ("affirm") their asserted gender.

The serious problem with this interpretation is that it lacks "equipoise," the requirement that investigators show genuine uncertainty about an intervention's effects. *See, e.g.*, Benjamin Freedman, *Equipoise and the Ethics of Clinical Research*, 317 New Eng. J. Med. 141, 141 (1987). Olson et al. failed to consider alternative explanations for why their findings conflicted with all previous research on persistence. With one partial exception, the children in the earlier studies did not undergo social transition and, with no exception, the studies yielded high rates of desistence. In Olson's study, however, all the children had been fully socially transitioned, and almost none desisted.

One interpretation of this discrepancy, favored by Olson, is that virtually all the children who participated in the 2022 study were "true transgender" children. *See* Olson, *supra*, at 4–6. But another explanation is that social transition itself caused them

to persist, creating a self-fulfilling prophecy. Recall the Dutch clinicians' warnings that social transition can disrupt a child's grasp of reality and make coming to terms with his or her natal sex more difficult. *See* de Vries & Cohen-Kettenis, *supra*, at 308.

When considered alongside decades of desistance research, the Olson study more plausibly suggests that social transition is a powerful psychological intervention with potential to lock in gender incongruence. If true, the consequences are serious: at least 60 percent of the children in the study had commenced hormonal interventions, which carry significant health risks, at the five-year follow-up. Olson, *supra*, at 2. If some of these kids might have desisted and avoided unnecessary medicalization, their social transition caused them medical harm.

**2. Transgender identity in adolescents is also likely unstable.**

Proponents of social and medical gender transition for minors argue that when gender dysphoria begins in childhood and intensifies at the outset of puberty, the chances of desistence are very slim. This belief is not supported by evidence.

First, in the 11 desistence studies discussed above, some of the minors who desisted did so after they had entered adolescence. Cantor, *supra*, at 312–13. That's why the Endocrine Society's guidelines mention that "childhood GD/gender incongruence does not invariably persist into adolescence *and adulthood*." Hembree et al., *supra*, at 3876 (emphasis added). As HHS's Review states, "there are no reliable methods to distinguish which patients will experience long-term GD." HHS Final Review at 73. As we discuss below, the U.K.'s Cass Review came to a similar conclusion.

Second, gender clinics in a variety of countries and researchers who study gender dysphoria in youth have observed a new patient cohort that does not fit the profile of the youth who participated in the original Dutch study and for whom the Dutch pioneered pediatric gender transition. *See* E. Abbruzzese et al., *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 1, 12–13 (2023). This new cohort, which accounts for most of the meteoric increase in the number of minors seeking gender-transition services over the past decade, is comprised of young people who did not have gender-identity issues in childhood and whose gender-dysphoric symptoms began, often suddenly, after the start of puberty. *Id.* Most are natal girls with comorbid mental-health problems. *Id.* The very fact that these teenagers exist suggests that transgender identity is neither innate nor immutable. *See also* Kenneth J. Zucker, *Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues*, 48 Archives Sexual Behav. 1, 7 (2019); Lisa Littman, *Rapid-Onset Gender Dysphoria in Adolescents and Young Adults: A Study of Parental Reports*, 13 PLoS ONE 1, 30–33 (2018).

Third, researchers are increasingly acknowledging the phenomenon of regret and detransition. Claims that regret and detransition are extremely rare—less than 2 percent, by some accounts—are based mainly on studies of adults who transitioned as adults. *See* Valeria P. Bustos et al., *Regret After Gender-Affirmation Surgery: A Systematic Review and Meta-Analysis of Prevalence*, 9 Plastic & Reconstructive Surgery—Global Open 3477, 3510 (Mar. 2021). These studies suffer from high drop-out rates, short follow-

up times, and highly restrictive definitions of detransition. Pablo Expósito-Campos and Roberto D'Angelo, *Letter to the Editor: Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence, 9 Plastic and Reconstructive Surgery—Global Open* 3951 (2021). The very few adolescents included in these statistics were all transitioned under the Dutch protocol, a relatively conservative approach that contrasts with the "affirmative" approach practiced in American clinics. *See* Abbruzzese et al., *supra*, at 14–15.

It is thus irresponsible to say that the extremely low rates of regret/detransition in earlier studies apply to most minors seeking social or medical transition today. These are distinct cohorts with different presentations and clinical needs, and there is no high-quality research on the adolescent-onset group.

Unlike the more conservative Dutch protocol, which requires a childhood diagnosis of GD that intensifies in adolescence and no serious psychological comorbidities, the affirmative approach regards adolescent-onset GD—even when it appears abruptly and develops rapidly—as a valid transgender identity and considers co-occurring mental-health problems as secondary to gender incongruence.

In her interim report to the U.K.'s National Health Service, Dr. Hilary Cass called this problem "diagnostic overshadowing": once the clinician identifies gender as a source of distress, all other problems, including ones that might be causing the gender distress, are ignored. Hilary Cass, *The Cass Review Independent Review of Gender Identity Services for Children and Young People: Interim Report* 17 (2022). Some prominent proponents of the

gender-affirmative model for youth have argued that there should be no "gatekeeping" at all, only "informed consent." *See*, *e.g.*, Florence Ashley, *Gatekeeping Hormone Replacement Therapy for Transgender Patients Is Dehumanising*, 45 J. Med. Ethics 480, 480–81 (2019). Lowering the thresholds for medical treatment is likely to increase the rate of false positives and thus the rate of regret.

Recent studies have shown high rates of regret and detransition. A study using data from the U.S. military healthcare system found that 30 percent of those who started treatments discontinued them within four years. *See* Christina M. Roberts et al., *Continuation of Gender-Affirming Hormones Among Transgender Adolescents and Adults*, 107 J. Clinical Endocrinology & Metabolism 3937, 3937 (2022). Another study from the U.K. found that 10 percent of those treated at an adult transgender clinic detransitioned within 16 months of treatment. Ruth Hall et al., *Access to Care and Frequency of Detransition among a Cohort Discharged by a UK National Adult Gender Identity Clinic: Retrospective Case-Note Review*, 7 BJPsych Open 1, 7 (2021). An additional 22 percent disengaged from the clinic before completing treatment. *Id.* at 5. Another study on adults found a rate of regret or detransition of 12 percent and a rate of discontinuation of 20 percent. Isabel Boyd et al., *Care of Transgender Patients: A General Practice Quality Improvement Approach*, 10 Healthcare 11 (2022). The authors of the study noted that "the detransition rate found in this population is novel and questions may be raised about the phenomenon of overdiagnosis, overtreatment, or iatrogenic harm as found in other medical fields." *Id.* at 13.

In sum, today's evidence suggests that transgender identity is less stable in adolescents than social-transition advocates assert. The true rate of regret and detransition is not known. *See generally* Jay Cohn, *The Detransition Rate Is Unknown*, 52 Archives Sexual Behav. 1937 (2023).

### B. Clinicians Are Unable to Consistently Distinguish between Transgender and Gender-Nonconforming Youths

Some supporters of social transition argue that clinicians can reliably distinguish persisters from desisters in childhood. The Endocrine Society's 2017 guidelines on treatment of gender dysphoric youth recognize, however, that "[w]ith current knowledge, we cannot predict the psychosexual outcome for any specific child." Hembree et al., *supra*, at 3876.

Proponents of "gender-affirming" care point to research showing some factors to be associated with a higher rate of persistence. They argue that children in whom one or more of these factors appear as "true transgender." The problem with this argument is that it tries to infer *individual* predictions from *population* data. As one group of experts explains:

> Factors predictive for the persistence of GD have been identified on a group level, with higher intensity of GD in childhood identified as the strongest predictor for a future gender dysphoric outcome. The predictive value of the identified factors for persistence are, however, on an individual level less clear cut, and the clinical utility of currently identified factors is low.

Jiska Ristori & Thomas D. Steensma, *Gender Dysphoria in Children*, 28 Int. Rev. Psych. 1, 6 (2016) (internal citations omitted).

### C. U.S. Medical Groups That Recommend Social and Medical Transition in Minors Are Out of Step with a Growing International Consensus

The American Academy of Pediatrics has called for automatic gender affirmation (social transition) of minors, regardless of age, since 2018. Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics 1, 5–7 (2018). The AAP analysis has faced thorough criticism for its inaccuracies and misrepresentations, *see* Cantor, *supra*, at 313; Kathleen McDeavitt, *Citation Issues in the American Academy of Pediatrics Policy Statement on Transgender and Gender-Diverse Children and Adolescents (Rafferty, 2018)*, 54 Archives Sexual Behav. 1297, 1300–02 (2025), and contrasts sharply with medical authorities abroad. Even leading members of the World Professional Association for Transgender Health (WPATH) admit that the AAP's statement has "a very weak methodology." Appendix A to Supp. Expert Report of James Cantor, Ph.D., at iv, *Boe v. Marshall*, No. 2:22-cv-00184-LCB-CWB (M.D. Ala. June 24, 2024) (quoting internal email).

Dr. Riittakerttu Kaltiala, chief psychiatrist at Tampere University's pediatric gender clinic in Finland, confirmed that "four out of five" children with GD desist by adulthood. Leor Sapir, *Finland Takes Another Look at Youth Gender Medicine*, Tablet, Feb. 21, 2023, https://bit.ly/3YVwxZp. Asked to comment on a proposed law that would grant minors the ability to define their gender for purposes of official documents, Dr. Kaltiala said that while it is "important to accept [children] as they are," "negating the body" by confirming that a child's gender self-perception is real

can send the child "a message that there is something wrong with him or her." Annika Mutanen, *A Professor Who Treats Adolescent Gender Anxiety Says No to Minors' Legal Gender Correction*, Helsingin Sanomat, Jan. 27, 2023 (translated from Finnish using Google Translate). The Finnish Paediatric Society and Finnish Medical Association both objected to legal gender self-identification for minors, so the proposal was defeated. *See* Sapir, *supra*.

Even the U.S.-based WPATH recognized that "[t]he current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition," and that the desire for social transition "may reflect an expression of their gender identity" but it could also "be motivated by other forces." Because "[a] change back to the original gender role can be highly distressing," parents should rely on "[m]ental health professionals" to help them "make decisions regarding the timing and process of any gender role changes for their young children." Eli Coleman et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7*, 13 Int'l J. Transgenderism 165, 176 (2012).

WPATH's Version 8 now suggests social transition for kids only "when it would be beneficial." Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. Transgender Health S1, S76 (Suppl. 1) (2022). Who determines that? According to WPATH, "health care professionals [should] discuss the potential benefits and risks of a social transition with families who are considering it." *Id.* at S69, S77. WPATH's new posture is not based on systematic reviews of evidence and discuss only the benefits of social transition—but even they emphasize the need for clinical consultation.

## II. The Best Available Evidence Does Not Show That "Gender-Affirming" Medical Treatments Are in a Minor's Best Interests

On its face, this case concerns the constitutional status of Washington state provisions that regulate parental notification and involvement in cases of runaway minors seeking hormonal or surgical interventions to address their discomfort with their sex. Underlying this question, however, is one of greater significance: Are such treatments ever in a minor's best interest, and can they reasonably be considered "healthcare"?

The best available evidence suggests that the answer is no. By failing to correct the lower court decisions, this Court would let stand laws and policies that require harmful medical interventions on vulnerable adolescents. And it would offer states a legal safe harbor to deny parents their right—indeed, their duty—to protect their children against harm.

In *Skrmetti*, this Court acknowledged "fierce scientific and policy debates about the safety, efficacy, and propriety of medical treatments in an evolving field." 605 U.S. at 525. It noted that "health authorities in a number of European countries have raised significant concerns regarding the potential harms associated with using puberty blockers and hormones to treat transgender minors," *id.* at 505, and that "leading voices in this area have relied on questionable evidence, and have allowed ideology to influence their medical guidance," *id.* at 530.

The HHS Review addressed critical gaps in nationally commissioned reviews on medical treatments for pediatric gender dysphoria, including about harms, medical ethics, and psychotherapeutic

alternatives. It discusses clinical realities, focusing on the systematic dismantling of medical safeguards in this area, and it highlights problems of scientific validity related to core concepts of the field.

### A. HHS Conducted an "Umbrella Review" of Systematic Reviews

Decision-making in medicine should be based on "the best available evidence, which ideally will come from systematic summaries of that evidence." HHS Final Review at 82. Systematic reviews ("SRs") sit at the top of evidence-based medicine's hierarchy of evidence because they critically evaluate all available evidence for outcomes of interest using a transparent and reproducible methodology. Numerous systematic reviews had already been done on pediatric medical treatment ("PMT"). For this reason, the authors of the HHS Review conducted an "umbrella review," which "applies the methodology of SRs to SRs themselves, making the SRs the unit of analysis, rather than individual primary studies." *Id.* at 83.

The umbrella review identified 17 systematic reviews dealing with puberty blockers, cross-sex hormones, social transition, psychotherapy, and surgeries for individuals up to age 26. Applying the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) methodology, the umbrella review distinguished the lower quality systematic reviews from the higher quality ones and confirmed that "the quality of evidence for outcomes such as GD [gender dysphoria], mental health, quality of life, and regret remains very low across all intervention types." *Id.* at 95.

### B. Systematic Reviews Have Limitations Regarding Harms from Gender Transition

Systematic reviews have limitations. One is that they are better at assessing evidence for benefits than for harm. In PMT, three additional factors hamper harm-detection through systematic reviews.

First, PMT is a relatively new practice. Most minors who received PMT did so in the last ten years or so, limiting the ability to conduct clinical studies of most anticipated harms.

Second, and relatedly, the body of primary research consists exclusively of low-quality observational studies, typically with short-term follow-up. Especially in the United States, these studies are largely conducted by gender clinicians who believe in the practice and may have intellectual or other conflicts of interest. Unsurprisingly, there has been a strong emphasis on studying benefits while harms are rarely studied or fully reported.

Third, the field of PMT research is affected by publication bias. This refers to the phenomenon, common in other areas as well, in which studies with null or negative findings (especially when they weaken the original hypothesis) go unpublished. Publication bias in gender medicine is well documented. For instance, the principal investigator of the best-funded research on PMT in the United States told the New York Times that she refused to publish disappointing findings on the mental health outcomes from pubertal suppression because she was afraid the results might be "weaponized" by critics of PMT. Azeen Ghorayshi, *U.S. Study on Puberty Blockers Goes Unpublished Because of Politics, Doctor Says*, N.Y. Times, Oct. 23, 2024, https://bit.ly/3ZpLCFv.

Perhaps related to the lack of interest in researching the harms of PMT is the common assertion that the safety profile of puberty blockers is already known based on decades of their use as a treatment for central precocious puberty (CPP). Such claims are specious, however, as CPP is a different indication with a different—and better-understood—risk-benefit profile. *See, e.g.*, HHS Final Review at 115–17. Puberty blockers are used in CPP to delay abnormally timed puberty to its developmentally appropriate time, not to block normal puberty and try to simulate it with hormone regimens. *Id.*

The lack of evidence for harms in systematic reviews thus creates a mistaken impression that there may be none. But absence of evidence is not evidence of absence. Evidence-based medicine calls for the judicious use of the best available evidence in clinical decision-making. *See id.* at 113. Ideally, this evidence comes from systematic reviews, but the scenario described above demands a more careful analysis of expected or plausible harms. To that end, the HHS Final Review draws on evidence from basic science, human development, and pharmacology.

### 1. Puberty and Its Suppression

Puberty is the time during which sexual maturation occurs. For males in particular, arresting puberty in accordance with the Dutch Protocol (Tanner stage 2) is assumed to result in permanent infertility as gonadal maturation and spermatogenesis will not have occurred. Biggs, *supra*, at 351–53. Impacts on females are less certain, but long-term fertility risks are possible. Sexual dysfunction (impaired desire, arousal, and orgasm) is another expected harm. HHS Final Review at 121–22. In 2021,

Marci Bowers, then president-elect of the World Professional Association for Transgender Health, reported that boys whose puberty was blocked at Tanner stage 2 (which starts as early as age 9) and who subsequently received cross-sex hormones were anorgasmic. *Id.* at 122.

It goes without saying that children at this age cannot possibly grasp the implications of foregoing fertility and sexual function for their overall well-being. As a WPATH physician observed, "it's always a good theory that you talk about fertility preservation with a 14-year-old, but I know I'm talking to a blank wall . . . they'd be like, ew, kids, babies, gross." *Id.* at 164–65.

Puberty is also responsible for other critical aspects of human development. Because sex steroid hormones are necessary for bone density accrual, puberty suppression increases the risk of osteopenia, osteoporosis, and fractures of the spine and hip. *Id.* at 117–18. These can lead, in turn, to increased risks of morbidity and mortality. Most children who receive puberty blockers for gender dysphoria go on to cross-sex hormones, which, research suggests, compensate some, but not all, of the loss of bone density accrual. *Id.* at 118. There are no studies on bone health that follow PMT patients into mature adulthood. *Id.*

**2. Cross-Sex Hormones**

Cross-sex hormones are used in PMT to induce sex characteristics typical of the opposite sex (e.g., facial hair and thickening of vocal cords in females, breast tissue growth and fat redistribution in males). *Id.* at 123. Hormones are typically administered at supraphysiologic doses to achieve desired cosmetic goals. *Id.* at 124. For example, a guideline by the

Endocrine Society recommends administering testosterone to females at six to 100 times the normal reference range for their sex, resulting in hyperandrogenism, and estrogen to males at three to 25 times the normal reference range for males, resulting in hyperestrogenemia. *Id.* at 124–25.

Risks of gender transition-related testosterone use in females include reproductive tract cancer, cardiovascular and metabolic disease (including heart attacks and strokes), chronic endometriosis (sometimes "treated" with hysterectomy), vaginal atrophy, pelvic pain, and pelvic floor dysfunction. *Id.* at 125–26. One reported clinical case involved an adolescent female on testosterone who suffered serious bleeding due to vaginal tearing following sexual intercourse. *Id.* at 125 n.64. This profuse bleeding necessitated emergency surgical intervention. Estrogen use in males is associated with increased risk of cardiovascular and metabolic risks—venous thromboembolism and stroke—thyroid and breast cancers, and sexual dysfunction. Id. at 126. Further research is needed to better understand these risks.

## III. Pediatric Medical Transition Is Inconsistent with Widely Accepted Medical Ethics

The fact that the benefits of PMT are unsupported by quality research is no longer seriously in dispute; even the most committed medical advocates of PMT have accepted this finding. *See, e.g.*, HHS Final Review at 79. Advocates have instead shifted to another argument: "most pediatric healthcare is guided by evidence of similar quality and strength." G Nic Rider et al., *Scientific Integrity and Pediatric Gender Healthcare: Disputing the HHS Review*, Sexual Rsch. & Soc. Pol'y. 1, 3 (2025). This argument, too, is

false. *See* HHS Final Review, Appendix 4: Overview of Systematic Reviews Methodology, Evidence Synthesis, Tables 113-18 (2025). PMT remains a unique medical practice in that it offers vulnerable minors with no physical pathology medical interventions with an unfavorable risk-benefit profile based on a subjective diagnosis with poor predictive validity.

Proponents of PMT argue that adolescents and their parents routinely consent to risky medical interventions that carry foreseeable, life-altering consequences. *Id.* at 221. Adolescents and their parents, for example, may consent to aggressive chemotherapy for cancer, despite severe side effects, or to the amputation of a diseased limb. *Id.* In such cases, consent is granted because the intervention is necessary to preserve the patient's overall health, even if it carries serious adverse effects.

Critics of PMT contend that many candidates for puberty blockers, sometimes as young as eight or nine years old, lack the cognitive and emotional maturity to understand the full consequences of medical transition. Even PMT proponents acknowledge that children and adolescents are incapable of deliberating meaningfully about future fertility. *Id.*

Moreover, clinicians often fail to disclose the uncertainty of the evidence supporting medical benefit, while overstating the harms of non-medicalization. They frequently use euphemistic and morally loaded language that may mislead or unduly influence patients and parents. *Id.* at 221–22. Such circumstances cast doubt on the possibility of genuine informed consent in many or even most cases of pediatric GD.

Before consent becomes relevant, a proposed intervention must be ethically permissible, insofar as it offers benefits sufficient to justify the risks, given the condition being treated. *Id.* at 222. Accordingly, the ethical probity of an intervention necessarily precedes consent.

Respect for patient autonomy does not authorize medical professionals to provide unnecessary or nonbeneficial interventions, even when patients request such interventions. *Id.* Indeed, clinicians bear a fundamental ethical obligation to promote patient well-being. *Id.* at 222–23. Autonomy necessarily operates within the bounds of medically justified options. Patient autonomy in healthcare entails the right to refuse treatment, which in no way implies a right to receive nonbeneficial interventions based on personal preference. *Id.* at 223–24.

This principle applies with greater force in pediatrics, given children's lack of full decision-making capacity. Pediatric clinicians have legal and ethical duties to provide care that promotes the child's well-being. *Id.* at 225. Thus, any justification for PMT must rest on a credible showing that the intervention offers benefits sufficient to justify its known and anticipated risks. For the reasons stated above, *supra* Section II, PMT has failed to make this showing. *See also* HHS Final Review at 226–31.

Clinicians' duty to avoid serious and irreversible harm justifies a cautionary approach, particularly where the natural course of the condition is poorly understood and less invasive alternatives exist. *Id.* at 230–31. Unlike many off-label uses in pediatrics, pediatric medical transition lacks a favorable risk–benefit profile and reliable evidence of benefit, and

involves interventions that carry foreseeable and potentially irreversible harms. *Id.* at 231.

## IV. Washington's Laws Prevent Parents from Making Constitutionally Protected Decisions About Social Transition and "Gender-Affirming" Treatments

When the risks of social transition and PMT are properly understood, it becomes clear that Washington law infringes on Petitioners' parental rights in ways sufficient to confer standing.

Decisions with such consequential ramifications over a minor's long-term well-being fall squarely within the ambit of parents' fundamental right to make healthcare decisions for their children. *See, e.g.*, *Stanley v. Illinois*, 405 U.S. 645, 651 (1972) (affirming parents' rights "in the companionship, care, custody, and management" of their children); *Lassiter v. Dep't of Soc. Servs.*, 452 U.S. 18, 27 (1981) (quoting *Stanley* and reaffirming that parents' interest over their children "undeniably warrants deference and, absent a powerful countervailing interest, protection").

This Court has been consistent in stressing that parents or legal guardians are the ones best positioned to understand and address the needs of minors, including unique mental-health needs. *See*, *e.g.*, *Troxel v. Granville*, 530 U.S. 57, 66–69 (2000). Overriding their discretion requires an exceedingly persuasive justification, such as compelling evidence that physical or emotional abuse will ensue if a student's desire for social transition is disclosed. *See Santosky v. Kramer*, 455 U.S. 745, 752–54 (1982).

By facilitating active psychological interventions without parental knowledge or consent, Washington's statutes prevent parents from exercising their right to

determine their children's healthcare. *See Parham v. J.R.*, 442 U.S. 584, 604 (1979) (noting the "substantial, if not the dominant, role" parents have in healthcare decision-making).

Given the known and expected risks associated with social transition and PMT, Washington's laws have usurped parents' constitutionally protected ability to shield their children from such risks.

## CONCLUSION

This case warrants clarification that parents have standing to challenge laws that deny them critical information and decision-making authority over their children's mental health and well-being. The Court should grant certiorari.

Respectfully submitted,

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February 17, 2026