No. 25-840

In the Supreme Court of the United States

INTERNATIONAL PARTNERS FOR ETHICAL CARE, INC., ET AL.,
Petitioners,

v.

BOB FERGUSON, GOVERNOR OF WASHINGTON, ET AL.,
Respondents.

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

BRIEF FOR AMERICAN COLLEGE OF PEDIATRICIANS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICUS CURIAE*

The American College of Pediatricians (ACPeds) is a national organization of nearly 500 board-certified pediatricians or related specialists with active practices in 47 states, all dedicated to the health and well-being of children. Formed in 2002, ACPeds is a scientific medical association committed to producing policy recommendations based on the best available scientific research. ACPeds strives to ensure that all children reach their optimal physical and emotional health and well-being.

Amicus's members provide high-quality medical services to children and all patients without discrimination based on sex or any other characteristic prohibited by law. In doing so, *amicus*'s members may not harm or lie to their patients. Providing medical interventions or referrals for "gender transition" procedures inherently harms children and thus violates the Hippocratic Oath. *Amicus* has a direct interest in the outcome of this case because it affects the vulnerable population *amicus*'s members serve.[*]

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

SUMMARY OF THE ARGUMENT

Washington law purports to let runaway children be transitioned—psychologically and medically—while denying their parents even the knowledge that it is happening. As the State concedes, "if a youth seeking" gender transition interventions "arrives at a licensed shelter," the shelter contacts the State rather than "the youth's parents." BIO 5–6 (citing Wash. Rev. Code § 13.32A.082(1)(b)(i)). The State "shall" "[o]ffer to make referrals on behalf of the minor for appropriate behavioral health services," which include "mental health services" like transitioning interventions for gender dysphoria. Wash. Rev. Code § 13.32A.082(3)(b)(i); BIO 6 n.2. The adolescent can be subjected to these interventions—apparently including puberty blockers and cross-sex hormones—"without the consent of the . . . parent." Wash. Rev. Code § 71.34.530. The State instructs the provider of those interventions not to volunteer the treatment to the parents. *Id.* § 70.02.265(1)(a).

The Ninth Circuit affirmed dismissal of Petitioners' complaint because it believed that these parents had not "demonstrated an adequate injury in fact based on future injuries." Pet. 24a. But the court glossed over the drastic, irreversible nature of the transitioning procedures that children could be subjected to under Washington law—without parental consent or even notification. The looming dangers of these interventions confirm that Petitioners' parenting is necessarily affected by the possibility of a state-imposed secret transition. And these dangers are "so severe that relatively modest increments in risk should qualify for standing." *Mountain States*

Legal Found. v. *Glickman*, 92 F.3d 1228, 1235 (CADC 1996); accord *Baur* v. *Veneman*, 352 F.3d 625, 637 (CA2 2003) ("[T]he probability of harm which a plaintiff must demonstrate in order to allege a cognizable injury-in-fact logically varies with the severity of the probable harm.").

The threat that Washington will seek to transition vulnerable youths is not speculative. The State has an ideological belief that, absent transitioning interventions, "transgender children will die."[1] Washington bases this belief on a faulty "consensus" of select American medical organizations.[2] But these organizations and their purported standards for transitioning minors reflect ideological and political goals, not evidence-based medicine.

The scientific evidence shows that the gender transition interventions sought by Washington are dangerous. Puberty blockers arrest bone growth, harm maturation of the adolescent brain, and inhibit fertility. More than 90% of the children given them proceed to cross-sex hormones, and many are left permanently sterile. Some proceed to surgeries that remove healthy organs. Yet most of these children, left alone, would have realigned with their sex.

Washington's policy of "unconsented facilitation of a child's gender transition" "shut[s] [parents] out of participation in decisions regarding their children's

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[1] Plaintiffs' Motion for Preliminary Injunction, *Washington* v. *Trump*, No. 2:25-cv-00244-LK, 2025 WL 1088002 (W.D. Wash. Feb. 19, 2025).
[2] *Ibid.*

mental health" and threatens severe, irreversible consequences. *Mirabelli* v. *Bonta*, 607 U.S. 492, 496–97 (2026) (per curiam). The Court should reverse.

ARGUMENT

I. Washington's embrace of transitioning interventions depends on an ideological and non-existent "consensus."

States like Washington treat ideological medical organizations—particularly the World Professional Association for Transgender Health (WPATH)—as stating the medical consensus for treatment of gender dysphoria in minors. Washington recently told this Court that "every major medical organization to take a position on the issue . . . agrees that puberty blockers and cross-sex hormone therapy are appropriate and medically necessary treatments for adolescents."[3] That is not true of many international bodies—or even all American ones. See *United States* v. *Skrmetti*, 605 U.S. 495, 505 (2025).[4] Washington's eager adoption of a supposed medical consensus about youth gender transition—driven by WPATH, which issues "standards of care"—is badly mistaken.

"[R]ecent revelations indicate that WPATH's lodestar is ideology, not science." *Eknes-Tucker* v. *Governor of Alabama*, 114 F.4th 1241, 1261 (CA11

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[3] Brief for Washington et al. as *Amici Curiae* in Support of Petitioner 6, *United States* v. *Skrmetti*, No. 23-477, 2024 WL 4101407 (U.S. Sept. 3, 2024).

[4] See, *e.g.*, Am. Soc'y of Plastic Surgeons, *Position Statement on Gender Surgery for Children and Adolescents* 3 (Feb. 3, 2026), https://perma.cc/G47K-33U6 ("insufficient evidence").

2024) (Lagoa, J., concurring in the denial of rehearing en banc). In particular, these revelations show that WPATH "bases its guidance on insufficient evidence and allows politics to influence its medical conclusions." *Skrmetti*, 605 U.S. at 543 (Thomas, J., concurring).

Though WPATH suggests that medically transitioning children is "safe and effective," "WPATH appears to rest this conclusion on self-referencing consensus rather than evidence-based research." *Id.* at 544. And this consensus is overwhelmingly driven by providers who financially benefit from medically transitioning children.[5] A recent U.S. Department of Health and Human Services (HHS) report noted "analyses tracking billed charges for [transitioning procedures in] minors from 2019 onward estimate almost $120 million in total hospital and clinic billings nationwide."[6]

The latest, eighth edition of WPATH's standards (SOC-8) admits that the standards are based on not just "the published literature," "but also" "consensus-based expert opinion."[7] This "consensus" is cover for ideology. After WPATH's commissioned systematic evidence reviews "found little to no evidence about

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[5] U.S. Dep't of Health & Hum. Servs., *Treatment for Pediatric Gender Dysphoria* 166–71 (2025), https://perma.cc/D9Y6-X8GY ("*HHS Report*").

[6] U.S. Dep't of Health & Hum. Servs., *Wolves in White Coats: How Doctors and Hospitals Pushed and Profited from the Fraud of "Gender Medicine"* 9 (2026), https://perma.cc/JJ2S-4PQ9.

[7] 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, S8 (2022).

children and adolescents," WPATH's solution—as explained in a comprehensive HHS report—was to publish its guidelines but prohibit Johns Hopkins from publishing most of the evidence reviews.[8] Leaked documents would later show "that WPATH officials are aware of the risks of cross-sex hormones and other procedures yet are mischaracterizing and ignoring information about those risks." *Eknes-Tucker*, 114 F.4th at 1249 (Lagoa, J., concurring in the denial of rehearing en banc).

Along similar lines, SOC-8 initially retained age requirements for surgically transitioning minors.[9] This displeased WPATH's activists—and the Biden Administration and the American Academy of Pediatrics (AAP). Just nine days after WPATH published SOC-8—years in the making—it issued a "correction" eliminating minimum ages for transition surgeries.[10]

Private communications reveal that WPATH retracted the ages—without running that change through its purportedly rigorous process—because Admiral Rachel Levine at HHS told it to for political reasons, and because AAP threatened to oppose the

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[8] *HHS Report*, *supra* note 5, at 165–76.
[9] Lisa Selin Davis, *Kid Gender Guidelines Not Driven by Science*, N.Y. Post (Sept. 29, 2022), https://perma.cc/8MDU-VF9Y.
[10] *Correction*, 23 Int'l J. Transgender Health S259 (2022), https://perma.cc/2UJ4-V73E.

standards otherwise.[11] One of the co-chairs of SOC-8 complained that "[t]he AAP guidelines . . . have a very weak methodology, written by few friends who think the same."[12] But WPATH realized that AAP was "a MAJOR organization," and "it would be a major challenge for WPATH" if AAP opposed SOC-8—so WPATH caved and "remove[d] the ages" without running the change through its "expert" review process.[13]

Privately, WPATH's authors said the change "make[s] a joke of our methodology," and WPATH's president was "disappoint[ed] that politics always trumps common sense and what is best for patients."[14] At the same time, WPATH authors admitted that the ages themselves never "ha[d] any scientific backup," instead justifying them as "consensus based."[15] And very recently, WPATH backtracked on its own standards, defending against an FTC consumer fraud lawsuit by claiming that its statements "are non-actionable opinions about subjects on which there is medical and scientific uncertainty."[16]

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[11] See Ex. 186, at 11, 28–33, 57, *Boe* v. *Marshall*, No. 22-cv-184, Doc. 700-15 (M.D. Ala. Oct. 9, 2024), https://perma.cc/9TB3-2TFP; Ex. 188, at 152, *Boe*, Doc. 700-17, https://perma.cc/9EJJ-K8N7; see also Defendants' Motion for Summary Judgment 19–21, *Boe*, Doc. 619 (June 26, 2024), https://perma.cc/YZ6X-9AJU.
[12] Ex. 187, at 100, *Boe*, Doc. 700-16, https://perma.cc/7R2Y-9C7B.
[13] *Id.* at 191, 338; Ex. 186, *supra* note 11, at 32.
[14] Ex. 187, *supra* note 12, at 100–01, 338; Ex. 186, *supra* note 11, at 25.
[15] Ex. 187, *supra* note 12, at 100.
[16] Leor Sapir, *WPATH: It's Just Our Opinion, Judge*, City J. (Aug. 27, 2026).

In short, "leading voices in this area have relied on questionable evidence, and have allowed ideology to influence their medical guidance." *Skrmetti*, 605 U.S. at 530 (Thomas, J., concurring). But Washington has unblinkingly adopted this guidance and written into law a preference for medical transition of children suffering from gender dysphoria—without bothering to obtain parental consent, or even notify parents. Washington believes that otherwise, "transgender children will die."[17] Contra, *e.g.*, Tr. of Oral Arg. 89, *Skrmetti*, No. 23-477 (Dec. 4, 2024) ("there is no evidence . . . that this treatment reduces completed suicide"); *Cass Review*, *infra* note 39, at 186 ("that gender-affirming treatment reduces suicide risk" "was not supported"). Washington's embrace of WPATH's unscientific "consensus" confirms the risk that runaway children are likely to be subjected to transitioning procedures without notification or consent.

II. Gender transition interventions inflict drastic and irreversible harm on minors.

Gender transition interventions for minors have a high risk of "drastic . . . injury." *Mountain States Legal Found.*, 92 F.3d at 1234. These procedures rest on a false premise: that a child's sex can be changed. On that false premise, proponents subject children to social transitioning, puberty blockers, cross-sex hormones, and surgeries. None of it rests on sound evidence or treats the conditions underlying gender dysphoria. And all of it inflicts permanent harm. As

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[17] Motion, *supra* note 1.

the renowned Swedish psychiatrist Dr. Christopher Gillberg has said, pediatric transition is "'possibly one of the greatest scandals in medical history,'" which is why he called for "an immediate moratorium on the use of puberty blocker drugs because of their unknown long-term effects."[18]

Yet Washington would subject runaway children to transitioning interventions—including social transitioning and apparently hormones and some surgeries—without parental notification or consent. See Wash. Rev. Code § 13.32A.082(3)(b)(i); *id.* § 71.34.530. The severe consequences to children's health from these interventions confirm the impact of Washington's law on Petitioners' parental rights. "The parents should not have to wait until their child has run away to a shelter and received life-altering treatment before they are afforded the opportunity to challenge the law—a law whose very object is to prevent the parents from knowing, in the first place, of their child's arrival at the shelter and his or her receipt of 'gender-affirming' treatment." Pet. 55a (Tung, J., dissenting from denial of rehearing en banc).

A. Sex is a biological reality that cannot be changed.

Sex is a biological, immutable characteristic—a scientific fact, not a social construct. "Biological sex is

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[18] Jonathon Van Maren, *World-Renowned Child Psychiatrist Calls Trans Treatments "Possibly One of the Greatest Scandals in Medical History"*, The Bridgehead (Sept. 25, 2019), https://perma.cc/HQ27-7AYX.

almost always easily identifiable at birth (if not before) based upon phenotypic expression of chromosomal complement [XX for female, and XY for male]."[19] Thus, sex change is objectively impossible. As HHS recently explained, terminology like "sex assigned at birth" obscures this reality, "suggest[ing] an arbitrary decision . . . rather than the observation of a characteristic present long before birth."[20] So transitioning procedures do not change anyone's sex.

Nonetheless, these procedures have been proposed as a treatment for gender dysphoria. Gender dysphoria in children is "a psychological condition in which they experience marked incongruence between their experienced gender and the gender associated with their biological sex. They often express the belief that they are the opposite sex."[21] Fortunately, the prevalence rates of gender dysphoria among children have been estimated to be less than 1%.[22] It has long been recognized that "80–95% of the prepubertal

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[19] Am. Coll. of Pediatricians, *Mental Health in Adolescents with Sex/Gender-Identity Incongruence* 2 (2024), https://perma.cc/WQN8-5FZK ("*Mental Health in Adolescents*") (citing extensive scientific research).

[20] *HHS Report*, *supra* note 5, at 34.

[21] Am. Coll. of Pediatricians, *Gender Dysphoria in Children* 1 (Nov. 2018), https://perma.cc/9LS3-9G6Y ("*Gender Dysphoria in Children*").

[22] *Ibid.* Indeed, "[f]or natal adult males, prevalence ranges from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%." Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, at 454 (5th ed. 2013).

children with [gender identity disorder] will no longer experience [it] in adolescence."[23]

Such an expression or even desire, however, cannot and does not change the child's sex. Accordingly, terms such as "transgender" or "cisgender," which suggest that a person is made up of both a biological sex and a self-proclaimed "gender identity," are false social constructs and not based on the biological reality of a child as either male (boy) or female (girl).

Because a child's sex cannot be changed, interventions designed to promote or confirm an incongruent gender identity harm the child. As explained in detail below, no sound evidence shows that a child benefits from the use of social transitioning, puberty blockers, cross-sex hormones, or other transitioning interventions to alter the body's physical appearance to look like the opposite (or no) sex.

These interventions—often physical and permanent—also fail to treat the mental health issue of gender dysphoria. As one leading researcher put it,

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[23] Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1893 (2008); Devita Singh et al., *A Follow-Up Study of Boys With Gender Identity Disorder*, 12 Frontiers in Psychiatry 632784, at 1, 8 (2021) (finding 87.8% desistance in "largest sample to date of boys clinic-referred for gender dysphoria"). University of Toronto psychologist Dr. Kenneth J. Zucker summarizes and defends the numerous studies showing desistance is common in *The Myth of Persistence: Response to "A Critical Commentary on Follow-Up Studies and 'Desistance' Theories about Transgender and Gender Nonconforming Children" by Temple Newhook et al. (2018)*, 19 Int'l J. Transgenderism 231 (2018).

"[g]ender non-contentedness has previously been associated with mental health problems and clinical gender dysphoria has been reported to co-occur with diverse psychiatric problems, such as depression and anxiety disorders, eating disorders, and autism spectrum disorder."[24] Treating gender dysphoria, especially in children, as a mental health disorder is the appropriate focus for medical providers.

Adults with gender dysphoria report childhood trauma at strikingly higher rates than controls: 90% had experienced some form of trauma, and 56% had

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[24] Pien Rawee et al., *Development of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 Arch. Sexual Behav. 1813, 1822 (2024) (internal citations omitted); see also *Mental Health in Adolescents*, *supra* note 19, at 5 ("Using five independent cross-sectional datasets consisting of 641,860 individuals, researchers found 'transgender and gender-diverse individuals have, on average, higher rates of autism, other neurodevelopmental and psychiatric diagnoses.'"); Riittakerttu Kaltiala-Heino et al., *Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development*, 9 Child & Adolescent Psychiatry & Mental Health art. 9, at 5 (2015) (75% of adolescents seen for gender identity services were or had been undergoing psychiatric treatment for reasons other than gender dysphoria); Gunter Heylens et al., *Psychiatric Characteristics in Transsexual Individuals: Multicentre Study in Four European Countries*, 204 Brit. J. Psychiatry 151, 152 & tbl. 2 (2014) (Four-nation European study found almost 70% of people with gender identity disorder had "a current and lifetime diagnosis."); Tracy A. Becerra-Culqui et al., *Mental Health of Transgender and Gender Nonconforming Youth Compared with Their Peers*, 141 Pediatrics e20173845 (2018) (study finding teens with gender non-conformity significantly more likely to have underlying psychiatric disorders, psychiatric hospitalizations, and suicidal ideation than peers).

experienced four or more types, compared with just 7% of controls.[25] And it is well accepted that a child's emotional and psychological development is affected by positive and negative experiences beginning in infancy.[26] Studies also "suggest that social reinforcement, parental psychopathology, family dynamics, and social contagion []facilitated by mainstream and social media, all contribute to the development and/or persistence of [gender dysphoria] in some vulnerable children."[27] Neurologic conditions can also render children vulnerable to gender distress. Autism, for example, is seven to eight times more prevalent among gender dysphoric youth than among the general population.[28]

In sum, gender dysphoria frequently co-occurs with anxiety, depression, autism spectrum disorder, and trauma.[29] Mental health treatment should be the focus for children expressing gender incongruence—not immediate social and medical transitioning interventions. As shown next, such interventions are likely to harm children.

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[25] *Mental Health in Adolescents*, *supra* note 19, at 7–11.
[26] *Gender Dysphoria in Children*, *supra* note 21, at 6.
[27] *Ibid.* (citing, among others, Kenneth J. Zucker & Susan J. Bradley, *Gender Identity and Psychosexual Disorders*, 3 FOCUS 598 (2005)).
[28] See Fatih Özel et al., *Associations Between Autism, Gender Dysphoria and Gender Incongruence: Insights from the Swedish Gender Dysphoria Study*, 351 Psychiatry Rsch. (2025).
[29] See *supra* note 24.

B. Social transitioning causes persistence of gender incongruence without evidence of benefit.

The first transitioning intervention for minors suffering from gender dysphoria is often social transitioning. According to HHS, "[s]ocial transition involves changing one or more aspects of one's presentation or expression, such as name, appearance, or behavior, with the goal of being perceived and treated as a member of the other sex, or to avoid being perceived and treated as a member of one's own sex."[30] "[I]t is important to view social transition as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning and longer-term outcomes."[31]

Reviewing the evidence, HHS found that "the impact of social transition on long-term [gender dysphoria], psychological outcomes and well-being, and future treatment decisions such as hormones or surgeries remains poorly understood."[32] No sound studies show that social transition of children or adolescents reduces suicide, prevents suicidal ideation, or improves long-term outcomes in those who suffer from gender dysphoria.

At the same time, social transition has grave consequences. As one expert (and former WPATH board member) quoted in a recent decision put it, "a

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[30] *HHS Report*, *supra* note 5, at 89.
[31] *Ibid.* (citation modified).
[32] *Ibid.*

social transition represents one of the most difficult psychological changes a person can experience." *Mirabelli* v. *Olson*, 691 F. Supp. 3d 1197, 1208 (S.D. Cal. 2023) (Dr. Erica Anderson). These changes affect the child's development. While most children with gender incongruence naturally desist with the passage of time, children who socially transitioned in early childhood were significantly more likely to have persistent feelings of gender dysphoria—and to proceed to other medical gender transition procedures.[33] Even medical groups invoked by Washington recognize the connection between social transition and this change in outcomes: the Endocrine Society has said that "[i]f children have completely socially transitioned, they may have great difficulty in returning to the original gender role."[34]

The goal of the typical "affirmative" therapist who suggests social transitioning is to progress to other transitioning interventions. The point of the "affirmative" model is "to qualify the patient for the sequence of social transition, hormones, and surgery."[35] "[O]ften by the second visit" to an "affirming" therapist, "a prescription for hormones is

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[33] See Rawee, *supra* note 24, at 1814; see also *Mental Health in Adolescents*, *supra* note 19, at 12.

[34] 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).

[35] Stephen B. Levine, *What is the Purpose of the Initial Psychiatric Evaluation of Minors with Gender Dysphoria*, 50(6) J. Sex & Marital Therapy 773, 773 (2024).

given or surgery is scheduled."[36] Unsurprisingly, as HHS recently explained, several studies "suggest[] the majority of children who socially transition before puberty progress to medical interventions."[37] Affirmation thus ushers children to irreversible, unproven, and sterilizing sex hormones—and eventually surgeries.

C. Puberty blockers harm children and lead to other destructive procedures.

The next intervention used by gender transition proponents for a child who expresses discomfort with his or her sex is hormonal—specifically, delaying or preventing natural puberty with puberty blockers. Such procedures are dangerous to a child's mental and physical development. And rather than give a child time to consider living as the opposite sex, they send the child down a path to more invasive, dangerous, and life-altering procedures. Again, absent these procedures, the overwhelming majority of children with gender incongruence would realign with their biological sex after puberty. These procedures thereby impose permanent harm.

"[P]uberty blockers are administered to stop puberty throughout the years it would normally occur." *Skrmetti*, 605 U.S. at 533 (Thomas, J., concurring). The principal puberty-blocking medications, known as GnRH agonists, are not FDA-

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[36] *Id.* at 776.
[37] *HHS Report*, *supra* note 5, at 71.

approved for treatment of gender dysphoria.[38] And using these drugs for gender transition is "very different" from their approved use, for treating precocious puberty.[39] "In addition to preventing the development of secondary sex characteristics, GnRH agonists arrest bone growth, decrease bone accretion, prevent the sex-steroid dependent organization and maturation of the adolescent brain, and inhibit fertility by preventing the development of gonadal tissue and mature gametes for the duration of treatment."[40]

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[38] See Ainhoa Gomez-Lumbreras & Lorenzo Villa-Zapata, *Exploring Safety in Gender-Affirming Hormonal Treatments: An Observational Study on Adverse Drug Events Using the Food and Drug Administration Adverse Event Reporting System Database*, 58 Annals of Pharmacotherapy 1089, 1092, 1096 (2024).

[39] Hilary Cass, NHS England, *The Cass Review, Final Report* 173 (2024), https://perma.cc/7XAJ-UCRZ ("*Cass Review*").

[40] *Ibid.* (referencing Lauren Schmidt & Rachel Levine, *Psychological Outcomes and Reproductive Issues Among Gender Dysphoric Individuals*, 44 Endocrinology & Metabolism Clinics N. Am. 773 (2015); Sheila Jeffreys, *The Transgendering of Children: Gender Eugenics*, 35 Women's Stud. Int'l F. 384 (2012); Sara B. Johnson et al., *Adolescent Maturity and the Brain: The Promise and Pitfalls of Neuroscience Research in Adolescent Health Policy*, 45 J. Adolescent Health 216 (2009)). There are long-term studies showing the adverse effects of puberty blockers on bone maturation and bone mineral density. These effects are why "GnRHa treatment in children with gender dysphoria should be considered experimental treatment of individual cases rather than standard procedure." Jonas F. Ludvigsson et al., *A Systematic Review of Hormone Treatment for Children with Gender Dysphoria and Recommendations for Research*, 112 Acta Paediatrica 2279, 2280, 2286–90 (2023).

Moreover, as the Cass Review correctly noted, "[b]locking this experience [of puberty] means that young people have to understand their identity and sexuality based only on their discomfort about puberty and a sense of their gender identity developed at an early stage of the pubertal process."[41] "Therefore, there is no way of knowing whether the normal trajectory of the sexual and gender identity may be permanently altered."[42] HHS has expressed "considerable concern that pubertal suppression may alter the course of gender identity development, essentially locking in a gender identity that may have reconciled with biological sex during the natural course of puberty."[43]

Puberty blockers halt a child's natural development without any demonstrated psychological benefit. Rather, studies demonstrate that "there is insufficient and/or inconsistent evidence about the effects of puberty suppression on psychological or psychosocial health" of young people.[44]

The long-term physical effects of these drugs compound the absence of any mental health benefit. As ACPeds has previously noted, "[t]here is not a single large, randomized, controlled study that documents the alleged benefits and potential harms to gender-dysphoric children from pubertal suppression and decades of cross-sex hormone use. Nor is there a

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[41] *Cass Review*, *supra* note 39, at 178.
[42] *Ibid.*
[43] *HHS Report*, *supra* note 5, at 72 (internal quotation marks omitted).
[44] *Cass Review*, *supra* note 39, at 176.

single long-term, large, randomized, controlled study that compares the outcomes of various psychotherapeutic interventions for childhood [gender dysphoria] with those of pubertal suppression followed by decades of toxic synthetic steroids."[45]

Beyond this, "[t]here are serious long-term risks associated with the use of social transition, puberty blockers, masculinizing or feminizing hormones, and surgeries, not the least of which is potential sterility."[46] Puberty blockers often lead to permanent sterility. Because "GnRH agonists prevent the maturation of gonadal tissue and gametes in both sexes, youth who graduate from pubertal suppression [in early puberty] to cross-sex hormones will be rendered infertile without any possibility of having genetic offspring."[47] They will not even have "gonadal tissue and gametes for cryo-preservation."[48]

And "the vast majority of gender dysphoric children treated with puberty blockers progress to cross-sex hormone treatment." *Skrmetti*, 605 U.S. at 534 n.4 (Thomas, J., concurring). "Several studies have suggested continuation rates from [puberty blockers] to [cross-sex hormones] exceed 90%," making

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[45] *Gender Dysphoria in Children*, *supra* note 21, at 10; see also *Mental Health in Adolescents*, *supra* note 19, at 13 (referencing McMaster University Department of Health Research Methods systematic review done by request of the Florida Agency for Health Care Administration); *Cass Review*, *supra* note 39, at 194.
[46] Decl. ¶ 5, *Doctors Protecting Children* (2024), https://perma.cc/ESQ5-VA8W.
[47] *Gender Dysphoria in Children*, *supra* note 21, at 13.
[48] *Ibid.*

blockers "more like a 'gas pedal' that accelerates medical transition."[49]

Puberty blockers and cross-sex hormones significantly alter brain development. The Cass Review noted that "brain maturation may be temporarily or permanently disrupted by the use of puberty blockers, which could have a significant impact on the young person's ability to make complex risk-laden decisions, as well as having possible longer-term neuropsychological consequences."[50] The impact on brain development arises because "the adolescent brain is also significantly molded as the neurons experience the sex-appropriate hormonal surges experienced with puberty. Brain cells include receptors for estrogen and testosterone, and the brain is structurally and functionally changed during puberty."[51] A study from the Netherlands found that administering puberty blockers to children with precocious puberty resulted in a 7-point drop in intelligence quotient.[52]

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[49] *HHS Report*, *supra* note 5, at 72; see also *Gender Dysphoria in Children*, *supra* note 21, at 12 (study of 70 pre-pubertal candidates to receive puberty suppression showed that every child "eventually embraced a transgender identity and requested cross-sex hormones"); *Cass Review*, *supra* note 39, at 176.

[50] *Cass Review*, *supra* note 39, at 178.

[51] *Mental Health in Adolescents*, *supra* note 19, at 22 (citing Pilar Vigil et al., *Influence of Sex Steroid Hormones on the Adolescent Brain and Behavior*, 83 Linacre Q. 308 (2016)).

[52] Dick Mul et al., *Psychological Assessments Before and After Treatment of Early Puberty in Adopted Children*, 90 Acta Paediatrica 965, 968–70 (2001).

D. Cross-sex hormones harm children.

As noted, most children subjected to puberty blockers for purported gender transitioning will be ushered onto cross-sex hormones—sometimes simultaneously. Cross-sex hormone interventions are also dangerous, subjecting a young person to high doses of hormones never intended for his or her body. By themselves, these hormones often result in infertility, cardiovascular disease, and other chronic illnesses—all visited upon children who are barely teenagers and incapable of giving informed consent to such procedures and their consequences. For example, females are typically given testosterone to achieve levels "6 to 100 times above normal female circulating testosterone levels"—levels "generally only seen among patients with rare conditions such as benign or malignant androgen producing tumors of the adrenal gland or ovaries or those who misuse androgens in bodybuilding and other sports."[53] And there are no studies demonstrating that such doses in children are safe or reversible.

Patients have reported significant and serious adverse reactions to the use of cross-sex hormones for "gender transition" purposes, likely because the patient's body was never intended to have those levels of estrogen or testosterone. These reactions are no surprise to WPATH, which has known of serious

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[53] Michael K. Laidlaw & Sarah Jorgensen, Letter, *Exploring Safety in Gender-Affirming Hormonal Treatments: An Observational Study on Adverse Drug Events Using the Food and Drug Administration Adverse Event Reporting System Database*, 59 Annals of Pharmacotherapy 491, 491 (2025).

adverse consequences for years. As one doctor noted in the leaked files from WPATH, "I have one transition friend/collegue [sic] who, after about 8-10 years of [testosterone] developped [sic] hepatocarcinoma. To the best of my knowledge, it was linked to his hormone treatment . . . it was so advanced that he opted for palliative care and died a couple of months later."[54]

In a recent study, researchers found significant adverse drug reactions to cross-sex hormone use, noting that the drugs used were "unintended for their recipient gender."[55] "The results highlight that [hormones used] for gender reassignment are predominantly administered off-label. Although these therapies are originally approved for addressing hormone-related conditions in one gender, they are repurposed to assist individuals in transitioning to that gender—a purpose not officially endorsed on their labels."[56] Indeed, "drugs such as testosterone and spironolactone frequently used in gender-affirming therapies exhibit divergent ADR [adverse drug reaction] patterns in transgender individuals compared with cisgender counterparts."[57]

For example, "[t]ransgender men [females] predominantly reported idiopathic intracranial

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[54] Env't Progress, *WPATH Files Excerpts: Exposing the Realities of Gender Medicine* 7, https://perma.cc/DGN4-TZYX (citation modified).

[55] Gomez-Lumbreras & Villa-Zapata, *supra* note 38, at 1089.

[56] *Id.* at 1092.

[57] *Id.* at 1096; see also *id.* at 1092 ("The [adverse drug reactions] for hormone treatments are described on the drug labels, but they typically pertain to the opposite sex of those transitioning for gender reassignment.").

hypertension and breast cancer as [adverse drug reactions]."[58] The overwhelming majority of adverse drug reactions, nearly 88%, were "deemed serious" and consisted of "injury, poisoning, and procedural complications," "psychiatric disorders" consisting of "anxiety," "depression," and "suicidal ideation," as well as "nervous system disorders" such as "idiopathic intracranial hypertension" and "neoplasms . . . with breast cancer being the most common."[59] Unsurprisingly, nearly a third of the adverse drug reactions resulted in hospitalization, and two resulted in death.[60]

For males seeking to "transition," the most common adverse drug reactions were "meningioma and depression."[61] Over half of the adverse drug reactions were classified "as serious," with over a quarter of reactions being categorized as "injury, poisoning, and procedural complications" due to "off-label use" of the drugs in addition to reports of meningioma and "prolactin-producing pituitary tumor."[62]

In addition, giving "high doses of testosterone to girls induces hyperandrogenism, which can cause

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[58] *Id.* at 1092. A similar study from the University Medical Center in Amsterdam followed 2,260 transwomen (men) receiving estrogen and found a 46-fold increase in breast cancer. Christel J.M. de Blok et al., *Breast Cancer Risk in Transgender People Receiving Hormone Treatment: Nationwide Cohort Study in the Netherlands*, 365 BMJ l1652, at 1, 3 (2019).
[59] Gomez-Lumbreras & Villa-Zapata, *supra* note 38, at 1091–92.
[60] *Id.* at 1091 & tbl. 1.
[61] *Id.* at 1092.
[62] *Ibid.*

increased cardiovascular risk, irreversible changes to the vocal cords, clitoromegaly and atrophy of the lining of the uterus and vagina, as well as ovarian and breast cancer." *Skrmetti*, 605 U.S. at 535 (Thomas, J., concurring) (citation modified). And "[g]iving high doses of estrogen to boys" "induces hyperestrogenemia, which can produce similarly severe side effects including, among other things, increased cardiovascular risk, breast cancer, and sexual dysfunction." *Ibid.* (citation modified).

Last, as noted, "for girls and boys alike, it is generally accepted, even by advocates of transgender hormone therapy, that hormonal treatment impairs fertility, which may be irreversible." *Ibid.* (citation modified).

E. Cross-sex surgeries are irreversible and increasingly used on youth.

Once children start down the path of hormonal interventions, proponents frequently subject them to transitioning surgeries. Many of these surgeries are done on an outpatient basis—meaning that they potentially could be performed under Washington law on 13-year-olds without parental consent or notification. Wash. Rev. Code § 71.34.530; see *supra* p. 2. One recent study found that over 3,500 transitioning surgeries were performed on minors from 2016 to 2020, and that about 80% of transitioning surgeries occurred in an outpatient setting.[63]

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[63] Jason D. Wright et al., *National Estimates of Gender-Affirming Surgery in the US*, 6(8) JAMA Network Open, at 4, Supplement 1 (2023).

Cross-sex "surgeries for girls include the surgical removal of the breasts and phalloplasty, that is, an attempt to create a pseudo-penis by transplanting a roll of skin and subcutaneous tissue from another area of the body to the pelvis." *Skrmetti*, 605 U.S. at 535–36 (Thomas, J., concurring) (citation modified). "For boys, surgical interventions include removal of the testicles alone to permanently lower testosterone levels, as well as an attempt to create a pseudo-vagina by surgically opening the boy's penis, removing erectile tissue, and then closing and inverting the penis into a newly created cavity in order to simulate a vagina." *Id.* at 536 (citation modified). Many of these are performed on an outpatient basis, including chest surgeries, hysterectomy, testicle removal, scrotoplasty, and metoidioplasty (creation of a "neo-penis").

"These surgical interventions are irreversible, entail significant complications, and, in some cases, result in permanent infertility." *Ibid.* They permanently change the child's development. "[T]ransgendered individuals who undergo sex reassignment surgery and have their reproductive organs removed are rendered permanently infertile."[64] Yet physically healthy transgender-believing girls are being given double mastectomies at 13 and hysterectomies at 16, while their male counterparts are referred for surgical castration and penectomies at 16 and 17, respectively.

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[64] *Gender Dysphoria in Children*, *supra* note 21, at 13.

Each of these procedures removes healthy tissue and body parts and constitutes a surgery for which there is no medical justification, other than the alleged sought-after improvement in psychological well-being. Just as a surgeon should not perform liposuction for anorexia, or amputation or surgically induced paraplegia for body integrity identity disorder (a condition in which a person identifies as disabled despite having a fully capable body), so also surgery to "transition" a child's sex should be considered unethical and unscientific.

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In sum, universal State provision of cross-sex social, medical, and surgical interventions to gender incongruent youth will permanently harm many children. These children will suffer "irreversible hormonal and/or surgical interventions [and] ultimately [will] not continue to identify as transgender."[65] Gender transitioning proponents push children at age 11 or even younger onto a pathway that will result in life-long hormone interventions and likely sterilization—with no improvements in mental health.[66] A Swedish study that followed patients from 1973 to 2003 found that transitioned persons "had an increased risk for suicide attempts . . . and psychiatric inpatient care" with risks "increasing substantially by

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[65] *HHS Report*, *supra* note 5, at 74.

[66] *Gender Dysphoria in Children*, *supra* note 21, at 11–12 ("puberty is suppressed via GnRH agonists as early as age 11 years, and then finally, patients may graduate to cross-sex hormones at age 16 in preparation for sex-reassignment surgery as an older adolescent or adult").

15 years after surgical reassignment. At 30 years of follow up, the suicide rate was 19 times that of age-matched controls."[67]

Yet, when allowed to go through natural puberty, children overwhelmingly desist and accept their biological sex. As the Cass Review found, clinicians "are unable to determine with any certainty which children and young people will go on to have an enduring trans identity."[68] Accordingly, the evidence-based approach is to let a child grow up without being socially and medically transitioned into an incongruent gender identity.

CONCLUSION

Washington's law leads to significant and life-long harms to children subjected to damaging and futile efforts to change their sex, while denying the parents their basic rights to raise and care for their children. Yet under the decision below, "only those parents willing to first subject their child to irreparable injury can ever have their day in court." Pet. 48a (VanDyke, J., dissenting from denial of rehearing en banc). The Court should reverse.

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[67] *Mental Health in Adolescents*, *supra* note 19, at 16 (citation modified); see Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLoS One e16885, at 1 (2011).

[68] *Cass Review*, *supra* note 39, at 22.

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