

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 UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT

**BRIEF OF *AMICUS CURIAE*
DO NO HARM
IN SUPPORT OF PETITIONERS**

ANDREW D. WATKINS
Counsel of Record
JONATHAN P. LIENHARD
M. LOGAN BLAKE
**HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK
PLLC**
15405 John Marshall Highway
Haymarket, VA 20169
(540) 341-8808
awatkins@holtzmanvogel.com
jlienhard@holtzmanvogel.com
lblake@holtzmanvogel.com

J. DYLAN HARPER
**HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK PLLC**
1221 Broadway, Suite 2100
Nashville, TN 37203
(615) 647-8528
dharper@holtzmanvogel.com

Counsel For Amicus Curiae

Counsel for Amicus Curiae

TABLE OF CONTENTS

INTEREST OF <i>AMICUS CURIAE</i>	1
SUMMARY OF ARGUMENT.....	1
ARGUMENT	3
I. SEX-REJECTING PROCEDURES PURPORT TO TREAT A PSYCHOLOGICAL CONDITION THROUGH THE PHYSICAL AND HORMONAL MANIPULATION OF CHILDREN	3
A. SRPs physically manipulate the human body through surgical and medical means.	5
B. SRPs are performed on children.....	6
II. SEX-REJECTING PROCEDURES IN CHILDREN CAN CAUSE NEGATIVE LONG-TERM HEALTH OUTCOMES	9
III. SEX-REJECTING PROCEDURES LACK EVIDENTIARY JUSTIFICATION AND MAY WORSEN PSYCHIATRIC SYMPTOMS	12
A. SRPs have recently received scrutiny from public health and medical authorities.	14

B. SRPs may exacerbate psychiatric morbidity.	16
CONCLUSION	18

TABLE OF AUTHORITIES

Cases	Page(s)
<i>Eknes-Tucker v. Governor of Alabama</i> , 80 F.4th 1205 (11th Cir. 2023)	9
<i>United States v. Skrmetti</i> , 605 U.S. 495 (2025)	9
Statutes and Regulations	
10 U.S.C. § 1079(a)(20)	9
Medicaid Program; Prohibition on Federal Medicaid and Children’s Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children, 91 Fed. Reg. 52406 (Aug. 13, 2026)	9
Sup. Ct. R. 37.6	1
Other Authorities	
Aditi Bhargava et al., <i>Considering Sex as a Biological Variable in Basic and Clinical Studies: An Endocrine Society Scientific Statement</i> , 42 ENDOCRINE REVS. 219 (2021)	4

Alison Clayton, <i>Gender-Affirming Treatment of Gender Dysphoria in Youth: A Perfect Storm Environment for the Placebo Effect—The Implications for Research and Clinical Practice</i> , 52 ARCHIVES SEXUAL BEHAVIOR 483 (2023).....	10
Am. Psychiatric Ass’n, <i>Diagnostic and Statistical Manual of Mental Disorders</i> (5th ed. 2013).....	4
Am. Soc’y Plastic Surgeons, <i>Position Statement on Gender Surgery for Children and Adolescents</i> (Feb. 3, 2026).....	15-16
Anna Miroshnychenko et al., <i>Puberty blockers for gender dysphoria in youth: A systematic review and meta-analysis</i> , 110 ARCHIVES DISEASE IN CHILDHOOD 429 (2025)	5
Council for Choices in Health Care in Finland (PALKO/COHERE Finland), <i>Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors</i>	13
E. Coleman et al., <i>Standards of Care for the Health of Transgender and Gender Diverse People, Version 8</i> , 23(51) INT’L J. TRANSGENDER HEALTH S1 (2022) .	8, 10-11, 13, 17
<i>Endocrine Society</i> , https://perma.cc/BX6K-8T37 (archived Sept. 11, 2026).	7

<i>Get the Facts: Gender-Affirming Care for Young Children,</i> THE NATIONAL SOGIE CENTER	12
Hilary Cass, <i>The Independent Review of Gender Identity Services for Children and Young People: Final Report</i> (Apr. 2024)	11, 13-14
Jason D. Wright et al., <i>National Estimates of Gender-Affirming Surgery in the U.S.,</i> 6(8) JAMA NETWORK OPEN (Aug. 23, 2023)	6
Jo Taylor et al., <i>Masculinizing and feminizing hormone interventions for adolescents experiencing gender dysphoria or incongruence: a systematic review,</i> 109 ARCHIVES DISEASE IN CHILDHOOD s48 (2024)	14-15
Jonas F. Ludvigsson et al., <i>A systematic review of hormone treatment for children with gender dysphoria and recommendations for research,</i> 112 ACTA PAEDIATRICA 2279 (2023)	3-4, 16
Kathleen McDeavitt et al., <i>Pediatric Gender Affirming Care is Not Evidence-based,</i> 17 CURRENT SEXUAL HEALTH REPORTS 11 (2025)	10

Kellan E. Baker et al., <i>Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review</i> , 5(4) J. ENDOCRINE SOC'Y 1 (2021)	17
Laurens D'hoore & Guy T'Sjoen, <i>Gender-affirming hormone therapy: An updated literature review with an eye on the future</i> , 291 J. INTERNAL MED. 574 (2022)	5
Natasha Rappazzo, <i>Gender Affirming Care: Factsheet</i> , PHYSICIANS FOR REPRODUCTIVE HEALTH (June 2025).....	5
NAT'L INSTS. OF HEALTH, OFF. OF RSCH. ON WOMEN'S HEALTH, <i>How Sex and Gender Influence Health and Disease</i>	4
Off. of Pop. Affs., <i>Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices</i> , HHS (Nov. 19, 2025).....	13, 15, 17
Oliver Wendell Holmes, Jr., <i>The Path of the Law</i> , 10 HARV. L. REV. 457 (1897)	1
Robin Respaut & Robin Terhune, <i>Putting numbers on the rise in children seeking gender care</i> , REUTERS (Oct. 6, 2022).....	6

- Sami-Matti Ruuska et al., *Psychiatric Morbidity Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services in Finland in 1996-2019: A Register Study*,
115 ACTA PAEDIATRICA 1545 (2026).....17
- Sarah R. Howard, *Interpretation of reproductive hormones before, during and after the pubertal transition—Identifying health and disordered puberty*,
95 CLINICAL ENDOCRINOLOGY 702 (2021)7
- Stop the Harm Database*, DO NO HARM,
<https://perma.cc/9PAG-C46Z>
(archived Sept. 11, 2026)6
- Stop the Harm Database: Washington*,
DO NO HARM,
<https://perma.cc/3D3P-FRAL>
(archived Sept. 11, 2026)6
- Susan Branje et al., *Dynamics of Identity Development in Adolescence: A Decade in Review*, 31(4) J. RSCH. ON
ADOLESCENCE 908 (2021)6
- Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline*,
102(11) J. CLINICAL ENDOCRINOLOGY
& METABOLISM 3869 (2017)7, 10, 12

INTEREST OF *AMICUS CURIAE*¹

Do No Harm is a nonprofit membership organization that includes over 50,000 physicians, nurses, medical students, patients, and policymakers. Do No Harm is committed to ensuring that the practice of medicine is driven by scientific evidence rather than ideology. In recent years, the practice of sex-rejecting procedures (“SRPs”), euphemistically known as “gender-affirming care,” has become more common despite the serious harm caused by those medical interventions and the complete lack of reliable evidence for any benefit resulting from them. Part of Do No Harm’s mission is to ensure that courts have a proper understanding of the danger of these medical interventions. Do No Harm submits this brief so the Court may fully understand the harm Petitioners are trying to avoid by chilling their parenting style in response to Washington’s laws.

SUMMARY OF ARGUMENT

The law is a system of “prediction[s] that if a man does or omits certain things he will be made to suffer in this or that way” Oliver Wendell Holmes, Jr., *The Path of the Law*, 10 HARV. L. REV. 457, 458 (1897). Law’s predictive power enables individuals to anticipate the consequences of their own and others’

¹ Pursuant to Supreme Court Rule 37.6, no counsel for any party authored this brief in whole or in part. No person or entity other than *Amicus* and the counsel below contributed the costs associated with the preparation and submission of this brief.

conduct, thereby providing a decisional framework that accounts for how others, responding to the same legal incentive structures, may act. Here, Washington's laws grant minors with gender dysphoria the legal right to enter government custody and receive SRPs without parental knowledge or consent. The effect is a transfer of power from parents to children and the state: children may now seek SRPs from the state without parental approval, and parents must adjust their behavior to respond to this threat.

Petitioners (1) are parents of children with gender dysphoria, (2) believe in the binary biological reality of sex, and (3) fear that, if they enforce their beliefs too sternly, their children will abscond and use Washington's laws to receive SRPs without their consent. App. at 1. Petitioners, in response to the incentives created by Washington's laws, have chilled their parenting styles accordingly.

The Ninth Circuit ruled that Petitioners lacked standing to challenge what is a clear violation of their First and Fourteenth Amendment rights to direct the care and upbringing of their children. In so finding, the Ninth Circuit observed that Petitioners' chilling of their parental approaches was "inflicted by their own hand." App. at 15a (citation modified). But as noted by Judge VanDyke, the Ninth Circuit discounted the gravity of the harm Petitioners seek to avoid. Indeed, "would [the Ninth Circuit] fault these parents for complaining of '[d]amages inflicted by [their] own hand' if this case involved . . . 'Medical Assistance in Dying'" instead of so-called gender-affirming care? *See* App. at 47a (citation modified).

Amicus seeks to demonstrate that the harm Petitioners seek to avoid—their children receiving SRPs without Petitioners’ knowledge or consent—is a grave one. *First*, SRPs involve the physical manipulation and disfigurement of young bodies through surgical and medical means—all to treat a psychological condition that has no corresponding physical symptomatology. What is more, these procedures are performed on pubescent children. *Second*, SRPs cause significant long-term negative health consequences in gender-dysphoric youth. *Third*, recent medical evidence belies the notion that SRPs are justifiable treatments for gender dysphoria in children; in fact, recent evidence shows SRPs may even exacerbate its psychological symptoms. Petitioners thus rationally altered the way they parent their gender-dysphoric children to prevent them from utilizing Washington’s laws to obtain harmful interventions disguised as support and care.

ARGUMENT

I. SEX-REJECTING PROCEDURES PURPORT TO TREAT A PSYCHOLOGICAL CONDITION THROUGH THE PHYSICAL AND HORMONAL MANIPULATION OF CHILDREN

SRPs—or so-called “gender affirming care”—aim to ease “gender dysphoria” by manipulating the physical characteristics of the patient’s body to align them “with the individual’s gender identity.” 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 (2023) (hereinafter Ludvigsson). “Gender dysphoria” is “the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender.”² Am. Psychiatric Ass’n, *Diagnostic and Statistical Manual of Mental Disorders*, § 2, p. 451 (5th ed. 2013). Clinically, children may be diagnosed with gender dysphoria if their experience of gender incongruence lasts longer than six months and manifests in certain behaviors, like “a strong desire to be of the other gender,” “a strong dislike of [their] sexual anatomy,” or “strong preferences for playmates of the other gender[.]” *Id.* at 452. Gender dysphoria presents no observable physical symptoms; instead, patients usually demonstrate “clinically significant distress or impairment in social, occupational, or other important areas of functioning.” *Id.* at 453. But SRPs, while used to “treat” an entirely subjective, psychological condition, are crude physical manipulations of the human body.

² Put another way, gender dysphoria is distress caused by believing one’s gender identity is different than his or her sex. Sex is a biological reality dictated by one’s DNA. See NAT’L INSTS. OF HEALTH, OFF. OF RSCH. ON WOMEN’S HEALTH, *How SEX and GENDER Influence Health and Disease*, <https://perma.cc/LK2H-8935> (archived Sept. 17, 2025). Gender identity is totally psychological in nature. Aditi Bhargava et al., *Considering Sex as a Biological Variable in Basic and Clinical Studies: An Endocrine Society Scientific Statement*, 42 ENDOCRINE REVS. 219, 226 (2021).

A. SRPs physically manipulate the human body through surgical and medical means.

SRPs include surgical and hormonal interventions. Surgically, SRPs include but are not limited to feminizing and masculinizing facial surgeries, breast removal or augmentation, hysterectomies, phalloplasties, and vaginoplasties. Natasha Rappazzo, *Gender Affirming Care: Factsheet*, PHYSICIANS FOR REPRODUCTIVE HEALTH (June 2025), <https://perma.cc/C9L5-NTMA>. Hormonally, SRPs include the administration of cross-sex hormones, which, in turn, have feminizing or masculinizing effects. Laurens D’hoore and Guy T’Sjoen, *Gender-affirming hormone therapy: An updated literature review with an eye on the future*, 291 J. INTERNAL MED. 574, 575 (2022). For children at the onset of puberty, (i.e., between the ages of 8–14), hormonal interventions may include the administration of aptly named puberty blockers, which are chemicals that suppress their bodies’ natural production of sex hormones and, by design, interrupt and delay their physical development, ostensibly allowing them to “explore their gender identity without the added stress of unwanted secondary sexual characteristics.” Anna Miroshnychenko et al., *Puberty blockers for gender dysphoria in youth: A systematic review and meta-analysis*, 110 ARCHIVES DISEASE IN CHILDHOOD 429, 430 (2025).

Put another way, SRPs treat the human body as a piece of clay to be molded at will—purportedly “treating” gender dysphoria by forcing patients’ bodies

to conform to and affirm their perceptions of how their bodies *should* be. What is more, SRPs are being performed on children *who do not and cannot* have concrete visions of who they are or who they ought to be.

B. SRPs are performed on children.

Adolescents around the ages of Plaintiffs' children are being subjected to SRPs, all the while at ages at which their perceived identities are ordinarily going through processes of maturation. *See* Susan Branje et al., *Dynamics of Identity Development in Adolescence: A Decade in Review*, 31(4) J. RSCH. ON ADOLESCENCE 908, 920 (2021). Indeed, between 2016 and 2020, 3,678 children between the ages of 12 and 18 received sex-rejecting surgical procedures—3,215 of which were breast removal procedures and 405 were genital modification surgeries. Jason D. Wright et al., *National Estimates of Gender-Affirming Surgery in the U.S.*, 6(8) JAMA NETWORK OPEN (Aug. 23, 2023) at 3–4. And between 2017 and 2021 “[a]t least 14,726 minors started hormone treatment” and 4,780 started puberty blockers. Robin Respaut and Robin Terhune, *Putting numbers on the rise in children seeking gender care*, REUTERS (Oct. 6, 2022), <https://perma.cc/N3RS-BH8L>; *accord Stop the Harm Database*, DO NO HARM, <https://perma.cc/9PAG-C46Z> (archived Sept. 11, 2026) (reporting number of SRPs performed on minors in the United States between 2019 and 2023); *see also Stop the Harm Database: Washington*, DO NO HARM, <https://perma.cc/3D3P-FRAL> (archived Sept. 11, 2026) (reporting number of SRPs performed on minors in Washington State). What is more, leading

so-called authorities on “gender affirming care” actively recommend SRPs for children as young as 8. And, notably, children as young as 13 are old enough to take advantage of Washington’s laws.

First, The Endocrine Society “is a global community of physicians and scientists dedicated to accelerating scientific breakthroughs and improving patient health and well being.” *Endocrine Society*, <https://perma.cc/BX6K-8T37> (archived Sept. 11, 2026). It recommends that “clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty,”³ and it goes further to “recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents...even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years.” Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3871 (2017) (hereinafter Endocrine Society Guidelines).

Second, The World Professional Association for Transgender Health (“WPATH”) recognizes that:

³ “[P]ubertal onset . . . in healthy girls occurs between 8 and 13 years of age, while in healthy boys, the spectrum of pubertal onset . . . is between 9 and 14 years.” Sarah R. Howard, *Interpretation of reproductive hormones before, during and after the pubertal transition—Identifying health and disordered puberty*, 95 CLINICAL ENDOCRINOLOGY 702, 707 (2021).

Adolescence is a developmental period characterized by relatively rapid physical and psychological maturation, bridging childhood and adulthood[]. Multiple developmental processes occur simultaneously, including pubertal-signaled changes. Cognitive, emotional, and social systems mature, and physical changes associated with puberty progress.

E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23(51) INT’L J. TRANSGENDER HEALTH S1, S43 (2022) (hereinafter WPATH Guidelines). Despite its recognition that adolescence is a time of fluidity and change, WPATH suggests so-called healthcare providers give young people SRPs that impose, in many cases, permanent physical changes, including “menstrual suppression agents,” “puberty suppression treatment, hormonal treatment, and gender-related surgery,” including “breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery” because, according to WPATH, even for vaginoplasty, “there may be a benefit for some adolescents to having [this] procedure[] performed before the age of 18.” *Id.* at S53–S65.

To make matters worse, it is widely accepted that SRPs can cause significant and permanent negative health outcomes for gender-dysphoric youth.

II. SEX-REJECTING PROCEDURES IN CHILDREN CAN CAUSE NEGATIVE LONG-TERM HEALTH OUTCOMES

It is undeniable that SRPs cause lasting physical changes on recipient children. Indeed, it is self-evident that surgical procedures to remove breast tissue and alter genitalia would leave permanent changes because that is what, in part, they are intended to do. But even “less invasive” SRPs—*i.e.*, hormonal interventions—can result in permanent negative outcomes. In fact, pediatric hormonal SRPs involve significant risks, are not FDA-approved, and are not medically necessary—or, for that matter, even advisable. Every branch of government has recognized the harms of certain SRPs for minors, including cross-sex hormones. For example, Congress recently amended the TRICARE statute to ban cross-sex hormone coverage for minors. 10 U.S.C. § 1079(a)(20). The Executive Branch implemented similar restrictions for Medicaid, including for the State Children’s Health Insurance Program. *See, e.g.*, Medicaid Program; Prohibition on Federal Medicaid and Children’s Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children, 91 Fed. Reg. 52406 (Aug. 13, 2026) (codified at 42 CFR pts. 441, 457). And courts across the country have underscored the profound harms of hormonal SRPs. *See, e.g., Eknes-Tucker v. Governor of Alabama*, 80 F.4th 1205, 1225, 1230 (11th Cir. 2023); *United States v. Skrmetti*, 605 U.S. 495, 535 (2025) (Thomas, J., concurring). Moreover, the very entities that suggest administering SRPs to minors freely admit that they

can impose negative health outcomes, yet they continue to recommend them anyway.

Pubertal Suppression. As the Endocrine Society put bluntly: “The primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization . . . , compromised fertility if the person subsequently is treated with sex hormones, and unknown effects on brain development.” Endocrine Society Guidelines *supra* at 3882; *accord* WPATH Guidelines *supra* at S114. Moreover, puberty blockers can stunt the development of genitalia particularly in natal males, potentially leading to sexual dysfunction and anorgasmia. Kathleen McDeavitt et al, *Pediatric Gender Affirming Care is Not Evidence-based*, 17 CURRENT SEXUAL HEALTH REPORTS 11, 12 (2025); *accord* WPATH Guidelines *supra* at S119 (“Treating [an] adolescent with functioning testes in the early stages of puberty with [puberty blockers] not only pauses maturation of germ cells but will also maintain the penis in a prepubertal size. This will likely impact surgical considerations if that person eventually undergoes a penile-inversion vaginoplasty as there will be less penile tissue to work with.”). Puberty blockers can have a similar effect on fertility, and, if they “are commenced in early puberty and followed by cross-sex hormones, there are no proven methods of fertility preservation.” 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 BEHAVIOR 483, 485 (2023); *accord* Endocrine Society Guidelines *supra* at 3882–83.

Indeed, puberty blockers—by design—prohibit the release of essential developmental hormones, causing a cascade of negative health outcomes by stunting the child’s physical development. For example, “adolescent sex hormones surges may trigger the opening of a critical period for experience-dependent rewiring of neural circuit underlying executive function If this is the case, brain maturation may be temporarily or permanently disrupted by the use of puberty blockers[.]” Hilary Cass, *the Independent review of gender identity services for children and young people: Final report*, Apr. 2024, at 178 (hereinafter Cass Review). Likewise, “[a] prolonged hypogonadal state in adolescence, whether due to . . . iatrogenic causes such as [puberty blockers] . . . , is often associated with an increased risk of poor bone health later in life.” WPATH Guidelines *supra* at S114. “This is because the skeleton will not have any exposure to adequate levels of sex steroid hormones.” *Id.*

Cross-sex hormones. Just as halting the release of a child’s natural sex hormones has negative physiological consequences, flooding his or her system with the hormones of the opposite sex can also cause permanent physical changes. Cross-sex hormones, like all SRPs, are intended to change the patient’s physical characteristics to align his or her self-identification with a gender identity that differs from his or her natal sex, including identification as the opposite sex or as nonbinary. Thus, when the male sex hormone testosterone is administered to young girls, it results “in clitoromegaly, temporary or permanent decreases in fertility, deepening of the voice, cessation

of menses (usually), and a significant increase in body hair, particularly on the face, chest, and abdomen.” Endocrine Society Guidelines *supra* at 3887. Likewise, feminizing hormones like estrogen can cause, in boys, “the prostate gland and testicles [to] undergo atrophy.” *Id.* at 3888. Moreover, cross-sex hormones can increase a patient’s risk of thromboembolic disease, cancer, liver dysfunction, and coronary artery disease, among other dangerous medical conditions. *Id.* at 3886.

SRPs are significant medical interventions that can permanently and negatively alter children’s bodies, but they are performed anyway under the guise that they reduce the profound mental anguish experienced by children with gender dysphoria. Unfortunately for these children, the available medical evidence now shows that SRPs do little to ease the psychological symptoms of gender dysphoria and might even exacerbate them.

III. SEX-REJECTING PROCEDURES LACK EVIDENTIARY JUSTIFICATION AND MAY WORSEN PSYCHIATRIC SYMPTOMS

Advocates attempt to justify SRPs on the ground they “significantly reduce depression and suicide risk in gender-diverse youth.” *Get the Facts: Gender-Affirming Care for Young Children*, THE NATIONAL SOGIE CENTER, <https://perma.cc/B9PS-SSD5> (archived Sept. 11, 2026). But there is in fact no medical consensus that SRPs are either reasonable or adequate treatments for gender-dysphoric minors.

Off. of Pop. Affs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* 13, 246 HHS (Nov. 19, 2025) (hereinafter HHS Report) (noting that “there is currently no international consensus about best practices for the care of children and adolescents with gender dysphoria” and that “the presuppositions that guide [SRPs] have not been shown to be valid . . . [and] [SRPs] proponents’ estimates of the probability of harm and benefit have not been shown to be reasonable[.]”) In fact, SRPs were barely discussed for minors until there was an exponential rise in cases of gender dysphoria that began ten to fifteen years ago. Cass Review *supra* at 24; see also Council for Choices in Health Care in Finland (PALKO / COHERE Finland), *Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors* at 8, perma.cc/ZU9F-VXBB (archived Apr. 23, 2026) (characterizing “gender reassignment of minors [a]s an experimental practice”). Consequently, many SRPs are (at best) experimental medical procedures that pose a risk of significant harm with only speculative benefits.

Indeed, despite their widespread adoption and recommendation by private medical organizations like WPATH and the Endocrine Society, SRPs lack a recognized, accredited medical subspecialty, unified professional authority, and “comprehensive, up-to-date, evidence-based clinical guidelines covering the full [pediatric medical transition] pathway.” See HHS Report *supra* at 157–58. It is thus no surprise that SRPs for minors have recently received scrutiny from public health and medical authorities alike. Moreover, recent studies have shown that SRPs are—at best—

unproven for treating the psychiatric symptoms associated with gender dysphoria and—at worst—may even exacerbate those symptoms.

A. SRPs have recently received scrutiny from public health and medical authorities.

The governments of the United States and the United Kingdom have released extensive reports criticizing the evidentiary basis for SRPs on youth. Likewise, recent medical authorities—including studies and clinical guidelines—have similarly questioned SRPs for minor children.

Cass Review. England’s National Health Service commissioned an independent review into the administration of gender services for minor children. In its 2024 final report, it found the evidentiary support for the efficacy of SRPs in children to be weak. Indeed, the studies purportedly showing that SRPs improve the psychiatric symptoms of gender dysphoria “had many methodological problems including the selective inclusion of patients, lack of representativeness of the population, and in many of the studies, there were no comparison groups.” Cass Review *supra* at 184. Thus, “[t]here is a lack of high-quality research assessing the outcomes of hormone interventions in adolescents with gender dysphoria/incongruence, and few studies that undertake long-term follow up.” *Id.* at 33 (quoting Jo Taylor et al., *Masculinizing and feminizing hormone interventions for adolescents experiencing gender dysphoria or incongruence: a systematic review*, 109

ARCHIVES DISEASE IN CHILDHOOD s48, s54 (2024)). This means that “[n]o conclusions can be drawn about [SRPs] effect on gender dysphoria, body satisfaction, psychosocial health, cognitive development, or fertility.” *Id.*

HHS Report. In 2025, the United States Department of Health and Human Services published a robust report “summariz[ing], synthesiz[ing], and critically evaluat[ing] the existing literature on best practices for promoting the health and well-being of children and adolescents with,” among other things, gender dysphoria. HHS Report *supra* at 11. It found the evidentiary support for SRPs to be remarkably poor. Indeed, “[m]any primary studies were not adequately designed for measuring or reporting on the outcomes related to [puberty blockers]. *Id.* at 90. Likewise, it found that studies on cross-sex hormones “were not specifically designed to capture the full range of long-term outcomes;” thus, “[k]ey outcomes such as effects on [gender dysphoria], other mental health outcomes, and quality of life have been inconsistently measured,” so “long-term outcomes remain poorly understood.” *Id.* at 91–92. Moreover, across all types of SRPs, “the quality (certainty) of evidence is predominantly limited by lack of methodologically rigorous studies” including “no eligible randomized controlled trials” on puberty blockers. *Id.* at 95.

Medical Authorities. In February 2026, the American Society of Plastic Surgeons issued its *Position Statement on Gender Surgery for Children and Adolescents*. Am. Soc’y Plastic Surgeons (Feb. 3,

2026), <https://perma.cc/ZV5F-Y5ZZ>. Recognizing that, when it comes to SRPs, “[s]ystematic reviews and evidence reassessments have subsequently identified limitations in study quality, consistency, and follow-up alongside emerging evidence of treatment complications and potential harms[,]” it concluded that “there is insufficient evidence demonstrating a favorable risk-benefit ratio for the pathway of gender-related endocrine and surgical interventions in children and adolescents.” *Id.* at 1, 3. Thus, “ASPS recommends that surgeons delay gender-related breast/chest, genital, and facial surgery until a patient is at least 19 years old.” *Id.* at 3. Similarly, a 2023 systematic review noted that the studies that purportedly found positive benefits from hormonal SRPs in gender-dysphoric youth “were limited by methodological weaknesses,” and thus “the long-term effects of hormone therapy on psychosocial and somatic health are unknown.” Ludvigsson *supra* at 2288–90.

In sum, recent medical evidence belies the notion that SRPs demonstrably improve the symptoms of gender dysphoria. Indeed, it is quite possible that gender-dysphoric youths subjected to SRPs actually have worse long-term outcomes than those who were not.

B. SRPs may exacerbate psychiatric morbidity.

It is widely understood that individuals suffering from gender dysphoria experience a “higher prevalence of depression, anxiety, and suicidality.”

WPATH Guidelines *supra* at S171 (citing sources). This is particularly true for children, as “among gender-referred adolescents, the prevalence of mental health problems—most commonly depression and anxiety—ranged from 22% to 78%.” Sami-Matti Ruuska et al., *Psychiatric Morbidity Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services in Finland in 1996-2019: A Register Study*, 115 ACTA PAEDIATRICA 1545, 1546 (2026) (hereinafter Ruuska). But recent analyses have shown that, at best, it is inconclusive whether SRPs have a positive impact on mental health and suicidality. See HHS Report *supra* at 76 (“[T]he evidence for whether [SRPs] reduce[] suicidality-related outcomes in adolescents . . . is inconsistent. When the focus turns to preventing suicide mortality, there is no evidence that hormonal interventions are effective.” (emphasis in original)); see also Kellan E. Baker et al., *Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review*, 5(4) J. Endocrine Soc’y 1, 12 (2021) (“It was impossible to draw conclusions about the effects of hormone therapy on death by suicide.”).

But, at worst, SRPs may worsen patients’ mental health. The 2026 Ruuska study noted above found that, rather than relieving the anguish experienced by these children, SRPs appear to make their psychiatric problems worse. Indeed, “considerable increases in need for psychiatric treatment were seen among those adolescents who had undergone [SRPs].” Ruuska *supra* at 1550. Moreover, when controlling for prior psychiatric morbidity, children that received SRPs

“had a 5- to 6- fold increased need for specialist-level psychiatric treatment . . . compared to the male controls, and 3- to 4-fold greater risk compared to the female controls[.]” *Id.*

In sum, SRPs fail to accomplish even their stated purpose: to improve the mental health of minors with gender dysphoria.

CONCLUSION

SRPs impose significant, long-term risks for children with gender dysphoria while the evidence is too weak to conclude that they produce a corresponding reduction in dysphoria or other psychiatric symptoms. Thus, Petitioners rationally altered their behavior to avoid a significant harm: the physical manipulation of their children’s bodies for no discernible benefit.

Respectfully submitted,

ANDREW D. WATKINS
Counsel of Record
 JONATHAN P. LIENHARD
 M. LOGAN BLAKE
HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK
PLLC
 15405 John Marshall Highway
 Haymarket, VA 20169
 (540) 341-8808
 awatkins@holtzmanvogel.com
 jlienhard@holtzmanvogel.com
 lblake@holtzmanvogel.com

J. DYLAN HARPER
HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK PLLC
 1221 Broadway, Suite 2100
 Nashville, TN 37203
 (615) 647-8528
 dharper@holtzmanvogel.com
Counsel For Amicus Curiae

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