No. 26-180

In the Supreme Court of the United States

EDWARD ALLYN HUDACKO,
Petitioner,

v.

REGENTS OF THE UNIVERSITY OF CALIFORNIA, ET AL.,
Respondents.

ON PETITION FOR 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 PETITIONER

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INTEREST OF *AMICUS CURIAE*

The American College of Pediatricians (ACP) 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, ACP is a scientific medical association committed to producing policy recommendations based on the best available scientific research. ACP 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 37.2, the parties' counsel of record received timely notice of the intent to file this brief. 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

This case involves a father seeking to protect his son from unproven, sterilizing gender transition surgeries. While the international medical community has paused such interventions for children suffering from gender dysphoria, many U.S. advocates—including the Defendants here—aggressively use experimental medical interventions beginning at the onset of puberty. As the growing number of detransitioners shows, the dangers from these unproven interventions—including infertility—are significant.

This brief makes three points in support of certiorari. *First*, the implant procedure performed on Mr. Hudacko's son was a *surgery*. The medication itself, medical literature, and insurance coding all describe this procedure as a surgery, and the procedure fits within the standard medical definition of a surgery.

Second, the individual Defendants in this case knew this. They are deeply involved with the gender transitioning industry, centered on the World Professional Association for Transgender Health (WPATH). They played roles in advancing WPATH's promotion of medically transitioning children, despite the lack of supporting evidence—and the certainty of lifelong harms. Their decision to perform a transitioning surgery on Mr. Hudacko's son was neither accidental nor spur-of-the-moment: they intentionally performed an unproven procedure based on their ideological beliefs. And they have repeatedly coded and called that procedure a *surgery*.

Third, gender transition procedures like the implant surgery performed on Mr. Hudacko's son are dangerous. Sound scientific evidence does not support these procedures. And these procedures cause permanent physical and psychological problems—without treating the underlying mental health struggles faced by children suffering from gender dysphoria.

The Court should grant certiorari.

REASONS FOR GRANTING THE WRIT

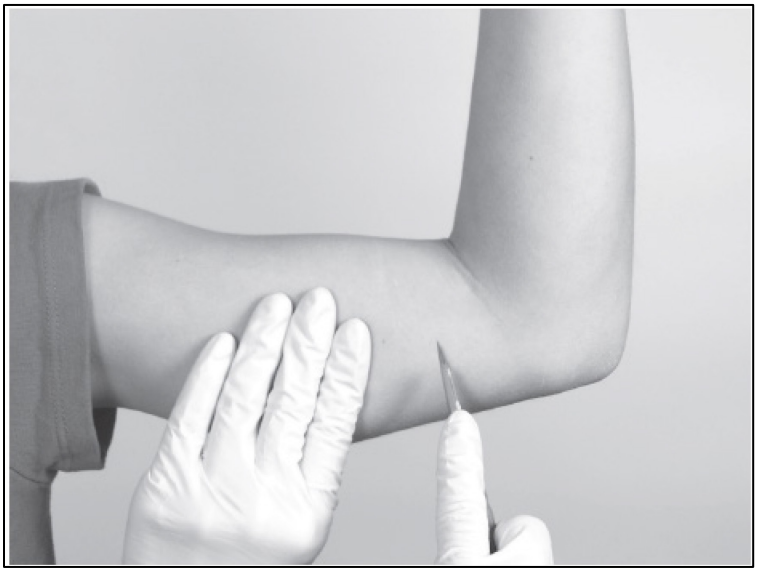
I. Defendants performed a transitioning surgery on Mr. Hudacko's son.

In his post-divorce custody order, Mr. Hudacko retained one parental right: without his consent, his son could not "be permitted to undergo any gender identity related surgery until they are 18 years of age." Pet. 12a. But the Ninth Circuit dismissed this right, believing that "it was not clear the implant procedure fell within Provision 7b's 'surgery' exception." Pet. 5a. That belief was incorrect. Implanting a puberty-blocking device by cutting a child's arm open is undoubtedly a "gender identity related surgery."

The prescribing information accompanying the implant states: "Insertion of the SUPPRELIN LA implant is a surgical procedure." Pet. 202a. That is why "[s]terile gloves and aseptic technique must be used to minimize any chance of infection." *Id.* And Defendants billed insurance for a "SURGERY." Pet. 160a.

This description accords with medical understanding and these Defendants' own notes. The

American Medical Association defines "surgery" as involving "the incision or destruction of tissues," and the definition includes "[i]njection of diagnostic or therapeutic substances."[1] The physician who performed the implant procedure repeatedly used the term "incision" to discuss the surgery, instructing that "the surgical strips" should not be removed. Pet. 194a. The prescribing information's own illustration shows the incision:



Pet. 207a.

[1] AMA, *Definition of Surgery H-475.983* (2023), https://perma.cc/S8UA-ZJB4.

Medical articles about the procedure likewise refer to it as a "minor surgical procedure."[2] Clinical studies about it state that "[a]ll implant procedures were performed by a single pediatric surgeon under local anesthesia"—and emphasize that the "need for surgical procedures present[s] barriers to its use."[3]

In short, surgically implanting a device to suppress puberty as part of a medical gender transition is a "gender identity related surgery."

II. Defendants are experienced transitioning proponents who knew this was a surgery.

These Defendants did not stumble into this field. Their deep involvement in the effort to medically transition minors shows they knew exactly what they were doing to Mr. Hudacko's son.

Stephen Rosenthal, the co-director of the clinic that performed the surgery here, is on WPATH's Board of Directors, and he was an author of WPATH's purported standards of care for medical gender transitions. Pet. 110a. And "recent revelations indicate that WPATH's lodestar is ideology, not science." *Eknes-Tucker* v. *Governor of Alabama*, 114 F.4th 1241, 1261 (CA11 2024) (Lagoa, J., concurring in the denial of rehearing en banc). In particular, these

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[2] Lawrence A. Silverman et al., *Long-Term Continuous Suppression With Once-Yearly Histrelin Subcutaneous Implants for the Treatment of Central Precocious Puberty: A Final Report of a Phase 3 Multicenter Trial*, 100(6) J. Clinical Endocrinology & Metabolism 2354, 2355 (2015).

[3] Katherine A. Lewis et al., *A Single Histrelin Implant Is Effective for 2 Years for Treatment of Central Precocious Puberty*, 163(4) J. Pediatrics 1214 (2013).

revelations show that WPATH "bases its guidance on insufficient evidence and allows politics to influence its medical conclusions." *United States* v. *Skrmetti*, 605 U.S. 495, 543 (2025) (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—like the Defendants here—"financially benefit[]" from medically transitioning children. Pet. 123a. 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."[4]

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."[5] This "consensus" is cover for ideology. After WPATH's commissioned systematic evidence reviews "found little to no evidence about children and adolescents," WPATH's solution—as explained in a comprehensive HHS report—was to publish its guidelines but prohibit Johns Hopkins

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[4] 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.

[5] 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).

from publishing most of the evidence reviews.[6] 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.[7] This displeased WPATH's activists—and the U.S. government 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.[8]

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 standards otherwise.[9] One of the co-chairs of SOC-8 complained that "[t]he AAP guidelines . . . have a very

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[6] U.S. Dep't of Health & Hum. Servs., *Treatment for Pediatric Gender Dysphoria* 165–76 (2025), https://perma.cc/D9Y6-X8GY ("*HHS Report*").

[7] Lisa Selin Davis, *Kid Gender Guidelines Not Driven by Science*, N.Y. Post (Sept. 29, 2022), https://perma.cc/8MDU-VF9Y.

[8] *Correction*, 23 Int'l J. Transgender Health S259 (2022), https://perma.cc/2UJ4-V73E.

[9] 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.

weak methodology, written by few friends who think the same."[10] 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.[11]

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."[12] At the same time, WPATH authors admitted that the ages themselves never "ha[d] any scientific backup," instead justifying them as "consensus based."[13]

Defendant Rosenthal was at the center of this scandal. He was in WPATH's small "URGENT taskforce" that decided how to handle the age recommendations in light of AAP's (and Admiral Levine's) demands.[14] As noted, that taskforce decided to go with politics and ideology, rather than WPATH's supposed expert review process. So it is no surprise that Rosenthal and the other WPATH-affiliated Defendants again put ideology ahead of patient care. "[L]eading voices in this area have relied on questionable evidence, and have allowed ideology to

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[10] Ex. 187, at 100, *Boe*, Doc. 700-16, https://perma.cc/7R2Y-9C7B.
[11] *Id.* at 191, 338; Ex. 186, *supra* note 9, at 32.
[12] Ex. 187, *supra* note 10, at 100–01, 338; Ex. 186, *supra* note 9, at 25.
[13] Ex. 187, *supra* note 10, at 100.
[14] *Id.* at 199–202.

influence their medical guidance." *Skrmetti*, 605 U.S. at 530 (Thomas, J., concurring).

Further, Rosenthal and the other Defendants are well aware that implanting a puberty-blocker device is a surgery. Five years before the procedure on Mr. Hudacko's son, the University of California San Francisco (UCSF) published clinical guidance for transgender adolescents listing Rosenthal as one of the chapter's primary authors. That guidance explained that the puberty blocker used here (histrelin) "is delivered via a time-release implant that is *surgically* inserted in the underside of the upper arm."[15]

In addition, as HHS has revealed, Rosenthal delivered a WPATH training that "explicit[ly] instruct[ed] . . . providers to use the 'Endocrine Disorder' diagnosis as an alternative for the mental health diagnosis of [gender dysphoria]"—to enable easier insurance payments.[16] Tellingly, the "CPT procedure code[]" that Rosenthal told WPATH providers to use for a "[p]lacement of puberty blocker implant (histrelin)"—like the one he used on Mr. Hudacko's son—is 11981,[17] which is in the "Surgery" section of the codes.[18]

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[15] Stephen M. Rosenthal et al., *Health Considerations for Gender Non-Conforming Children and Transgender Adolescents*, in *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* 186, 190 (2d ed. 2016), https://perma.cc/AQ5F-XSE7 (emphasis added).
[16] *HHS Report*, *supra* note 6, at 179.
[17] *Id.* at 180.
[18] See CPT® 11981, Codify, https://perma.cc/DH6F-DPSW.

The other Defendants likewise knew what they were doing. Defendant Janet Lee had already been a principal investigator on multiple projects examining puberty suppression as a means of medically transitioning minors, including NIH-funded research on bone density and a UCSF project titled *Skeletal Effects of Puberty Suppression in Transgender Youth*.[19]

Defendant Diane Ehrensaft has written about this "puberty blocker implant, Supprelin" by name, explained that it remained implanted for a year, and discussed the decision whether to replace it.[20]

Defendant Asaf Orr spent years promoting the interests of "affirming parents in custody disputes around the country,"[21] eagerly promoting puberty suppression in minors. Pet. 112a–13a. His transitioning advocacy has crossed lines before: A three-judge federal panel in Alabama found "without hesitation" that Orr had committed "misconduct" in litigating another case involving medical gender transition of minors by "purposefully attempt[ing] to circumvent the random case assignment procedures" of the courts. *Boe* v. *Marshall*, 767 F. Supp. 3d 1226, 1257 (M.D. Ala. 2025).

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[19] Janet Lee, UCSF Profiles, https://perma.cc/FKY3-6Z4N.

[20] Diane Ehrensaft, *Gender Nonconforming Youth: Current Perspectives*, 8 Adolescent Health, Med. & Therapeutics 57, 66 (2017).

[21] *"Trans* Law: Opportunities and Futures" Panel Discussion*, Univ. of Or. Ctr. for the Study of Women in Soc'y (June 1, 2018), https://perma.cc/FT2D-29MX.

UCSF had built a specialized Child and Adolescent Gender Center around this field, and its providers frequently used surgically placed implants to block minors' pubertal development. UCSF's own 2016 profile identified multiple Center patients with blocker implants. Thirteen-year-old "Kelly" had a "matchstick-sized implant under the skin" on the arm. And fourteen-year-old "Shay" bore a "small circular scar" on the arm where the puberty blocker had been implanted.[22]

In a documentary filmed at UCSF's gender clinic, Shay's provider explained that only a month earlier Shay "had another implant put in." The camera then showed the implant beneath the skin, where there were still "stitches dissolving."[23] UCSF later publicly identified Shay as a Gender Center patient, pictured Shay with Rosenthal, and reported that the family credited Rosenthal and the Center with guiding the family through Shay's treatment.[24] By then, the Center had treated more than 300 patients and was participating in a $5.7 million NIH-funded study examining puberty blockers and cross-sex hormones.[25]

All this evidence makes clear: the Defendants were well versed in this field, and surgical histrelin implantation was routine. These Defendants knew

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[22] Janet Wells, *Free To Be He, She, They*, UCSF Mag. (2016), https://perma.cc/YZ5A-DLZQ.

[23] *Louis Theroux: Transgender Kids* (BBC Two television broadcast Apr. 5, 2015), video available at https://vimeo.com/264094716 (beginning at 12:00).

[24] Wells, *supra* note 22.

[25] *Ibid.*

that implanting a puberty-blocker device in Mr. Hudacko's son was surgery, for the purpose of medical gender transition. They knew that Mr. Hudacko's approval was required before such a surgery. Pet. 118a–19a. But as they had done before, they knowingly elevated an ideological commitment to transitioning vulnerable children above all else.

III. Medical gender transition procedures are dangerous for minors.

Gender transition procedures for minors rest on a false premise: that a child's sex can be changed. On that false premise, transitioning proponents subject children to puberty blockers, cross-sex hormones, and surgeries that lack evidentiary support, inflict permanent physical harm and infertility, and do not treat the mental health conditions underlying gender dysphoria. As 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."[26]

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 almost always easily identifiable at birth (if not

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[26] 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.

before) based upon phenotypic expression of chromosomal complement [XX for female, and XY for male]."[27] 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."[28] So transitioning procedures cannot and do not actually 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."[29] Fortunately, the prevalence rates of gender dysphoria among children have been estimated to be less than 1%.[30] It has long been recognized that "80–95% of the prepubertal

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[27] 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).

[28] *HHS Report*, *supra* note 6, at 34.

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

[30] *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."[31]

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 puberty blockers, cross-sex hormones, or other transitioning procedures to alter the body's physical appearance to look like the opposite (or no) sex.

These physical—and typically permanent—interventions also fail to treat the mental health issue of gender dysphoria. As one leading researcher put it, "[g]ender non-contentedness has previously been

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[31] 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).

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."[32] 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 experienced four or more types, compared with just 7%

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[32] 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 27, 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).

of controls.[33] And it is well accepted that a child's emotional and psychological development is affected by positive and negative experiences beginning in infancy.[34] 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."[35]

Mental health treatment, then, should be the focus for children expressing gender incongruence—not hormonal or surgical interventions. As shown next, such physical, invasive, and irreversible medical interventions are likely to harm children.

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

The first medical 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. Absent these procedures, the overwhelming majority

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[33] *Mental Health in Adolescents*, *supra* note 27, at 7–11.
[34] *Gender Dysphoria in Children*, *supra* note 29, at 6.
[35] *Ibid.* (citing, among others, Kenneth J. Zucker & Susan J. Bradley, *Gender Identity and Psychosexual Disorders*, 3 FOCUS 598 (2005)).

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-approved for treatment of gender dysphoria.[36] And using these drugs for gender transition is "very different" from their approved use, for treating precocious puberty.[37]

"The GnRH agonists used for pubertal suppression in gender dysphoric children include" "leuprolide by intramuscular injection with monthly or once every three month dosing formulations, and histrelin, a subcutaneous implant with yearly dosing."[38] Both have serious consequences: "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

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[36] 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).
[37] Hilary Cass, NHS England, *The Cass Review, Final Report* 173 (2024), https://perma.cc/7XAJ-UCRZ ("*Cass Review*").
[38] *Gender Dysphoria in Children*, *supra* note 29, at 12.

gonadal tissue and mature gametes for the duration of treatment."[39]

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."[40] "Therefore, there is no way of knowing whether the normal trajectory of the sexual and gender identity may be permanently altered."[41] 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

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[39] *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).

[40] *Cass Review*, *supra* note 37, at 178.

[41] *Ibid.*

reconciled with biological sex during the natural course of puberty."[42]

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.[43]

The long-term physical effects of these drugs compound the absence of any mental health benefit. As ACP 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 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."[44]

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

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[42] *HHS Report*, *supra* note 6, at 72 (internal quotation marks omitted).

[43] *Cass Review*, *supra* note 37, at 176.

[44] *Gender Dysphoria in Children*, *supra* note 29, at 10; see also *Mental Health in Adolescents*, *supra* note 27, 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 37, at 194.

sterility."[45] 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."[46] They will not even have "gonadal tissue and gametes for cryo-preservation."[47]

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 blockers "more like a 'gas pedal' that accelerates medical transition."[48]

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-

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[45] Decl. ¶ 5, *Doctors Protecting Children* (2024), https://perma.cc/ESQ5-VA8W.
[46] *Gender Dysphoria in Children*, *supra* note 29, at 13.
[47] *Ibid.*
[48] *HHS Report*, *supra* note 6, at 72; see also *Gender Dysphoria in Children*, *supra* note 29, 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 37, at 176.

term neuropsychological consequences."[49] 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."[50] A study from the Netherlands found that administering puberty blockers to children with precocious puberty resulted in a 7-point drop in intelligence quotient.[51]

C. Cross-sex hormones harm children.

As noted, most children subjected to puberty blockers for purported gender transitioning will be ushered onto cross-sex hormones—just as Mr. Hudacko's son here was. 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

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[49] *Cass Review*, *supra* note 37, at 178.

[50] *Mental Health in Adolescents*, *supra* note 27, at 22 (citing Pilar Vigil et al., *Influence of Sex Steroid Hormones on the Adolescent Brain and Behavior*, 83 Linacre Q. 308 (2016)).

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

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."[52] 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 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."[53]

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."[54] "The results highlight that

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[52] 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).

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

[54] Gomez-Lumbreras & Villa-Zapata, *supra* note 36, at 1089.

[hormone therapies] 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."[55] 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."[56]

For example, "[t]ransgender men [females] predominantly reported idiopathic intracranial hypertension and breast cancer as [adverse drug reactions]."[57] 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

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[55] *Id.* at 1092.

[56] *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.").

[57] *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).

breast cancer being the most common."[58] Unsurprisingly, nearly a third of the adverse drug reactions resulted in hospitalization, and two resulted in death.[59]

For males seeking to "transition," the most common adverse drug reactions were "meningioma and depression."[60] 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."[61]

In addition, "[g]iving high doses of estrogen to boys" like Mr. Hudacko's son "induces 'hyperestrogenemia,' which can produce similarly severe side effects including, among other things, increased cardiovascular risk, breast cancer, and sexual dysfunction." *Skrmetti*, 605 U.S. at 535 (Thomas, J., concurring).

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).

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[58] Gomez-Lumbreras & Villa-Zapata, *supra* note 36, at 1091–92.
[59] *Id.* at 1091 & tbl. 1.
[60] *Id.* at 1092.
[61] *Ibid.*

D. Further transitioning procedures harm children.

Once children start down the path of hormonal interventions, proponents frequently subject them to additional transitioning surgeries. These additional "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." *Id.* at 535–36 (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).

"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."[62] 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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[62] *Gender Dysphoria in Children*, *supra* note 29, 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.

* * *

In sum, unquestioning transition will permanently harm many children, as they will suffer "irreversible hormonal and/or surgical interventions [and] ultimately [will] not continue to identify as transgender."[63] 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.[64] 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 15 years after surgical reassignment. At 30 years of

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[63] *HHS Report*, *supra* note 6, at 74.

[64] *Gender Dysphoria in Children*, *supra* note 29, 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").

follow up, the suicide rate was 19 times that of age-matched controls."[65]

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."[66] Accordingly, the evidence-based approach is to let a child grow up without being medically transitioned into an incongruent gender identity.

CONCLUSION

Because the Defendants knowingly infringed Mr. Hudacko's parental rights by subjecting his son to a dangerous transitioning surgery, the Court should grant certiorari.

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[65] *Mental Health in Adolescents*, *supra* note 27, 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).
[66] *Cass Review*, *supra* note 37, at 22.

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