

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 a Writ of Certiorari to
the United States Court of Appeals
for the Ninth Circuit**

**BRIEF OF DO NO HARM AS *AMICUS CURIAE*
IN SUPPORT OF PETITIONER**

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INTEREST OF *AMICUS CURIAE*¹

Do No Harm is a nonprofit membership organization that includes over 54,000 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-denying interventions, euphemistically known as “gender-affirming care,” has become more common despite the serious harm caused by those interventions and the complete lack of reliable evidence for any benefit resulting from them. This is a medical scandal. And Do No Harm’s brief shows the need for this Court to resolve the rules by which parents can prevent their children from becoming the next victims.

SUMMARY OF THE ARGUMENT

Ted Hudacko rightly rejects both (I) the theoretical and (II) the empirical basis for the sex-denying procedure performed on his child. Because other parents will continue to do the same, this Court should grant the petition.

I. Scientific facts do not change with the winds of cultural ideology. Human beings, like every mammal, are divided into two sexes—male and female.

A. An individual’s sex is determined by his or her body’s role in reproduction as evidenced by his or her

¹ Do No Harm certifies that no counsel for any party authored this brief in whole or in part, no party or party’s counsel made a monetary contribution to fund its preparation or submission, and no person other than Do No Harm or its counsel made such a monetary contribution. Counsel of record for the parties received timely notice of Do No Harm’s intention to file this brief.

chromosomes, gonads, and anatomy. Put simply, sex is objective and binary.

B. Gender identity, in contrast, is a *psychological* concept. It refers to an individual's perception of himself or herself. And it can be determined only by asking an individual about it. Unlike sex, gender identity is subjective, nonbinary, and mutable.

C. Some individuals report distress from a perceived discordance between their sex and gender identity. This can lead to a diagnosis of "gender dysphoria." Data reveal a recent spike in young people with symptoms of gender dysphoria, which may be linked to social influence.

II. Some practitioners promote sex-denying drugs and surgeries to "treat" gender dysphoria. These interventions involve halting a minor's normal puberty and altering the minor's bodily appearance—for example, making a girl's body look like a boy's body and a boy's body look like a girl's body. But these experimental procedures lack reliable evidentiary support.

A. In evaluating the evidence, one should start with systematic reviews, which are studies of studies. Systematic reviews are the most robust method to determine the quality of the evidentiary support for a particular intervention.

B. Yet all well-designed systematic reviews—conducted by experts in Finland, England, Sweden, and elsewhere—conclude that the evidence for sex-denying interventions in minors is weak.

C. Experts (and even some commendably candid, though reckless, proponents of these so-called "treatments") catalogue the various risks of sex-denying

interventions, which demonstrate the danger of subjecting young people to them. These risks include harm to fertility, unknown impact on an individual's brain development, and more.

The takeaway is this: Practitioners of these procedures reject the scientific foundations of medicine in favor of the shifting sands of gender ideology. And sometimes, as here, these actors also violate the rights of parents like Hudacko. The Court should grant the petition and set the standards under which such practitioners' conduct will be litigated.

ARGUMENT

For two reasons, parents like Ted Hudacko wisely object to sex-denying interventions—*i.e.*, medical procedures that alter a minor's body to align with that minor's self-reported gender identity when that identity differs from the minor's sex.² First, these

² The Court may take notice of the scientific evidence in this brief. These materials are legislative facts, “which have relevance to legal reasoning and the lawmaking process.” FED. R. EVID. 201(a) advisory committee's note to 1972 proposed rules. Legislative facts contrast with adjudicative facts—“the facts of the particular case.” *Id.* Crucially, “the ordinary limits on judicial notice hav[e] no application to legislative facts.” *Daggett v. Comm'n on Governmental Ethics & Election Pracs.*, 172 F.3d 104, 112 (1st Cir. 1999); see *Wiesmueller v. Kosobucki*, 547 F.3d 740, 742 (7th Cir. 2008) (Posner, J., in chambers) (noting existence of “‘legislative’ facts” that “lie outside the domain of rules of evidence”). This Court has previously considered scientific evidence from *amici*. In *Roper v. Simmons*, the Court referenced “studies [presented by] respondent and his *amici*” to support the claim that juveniles lack maturity. 543 U.S. 551, 569 (2005). Thus, this brief offers legislative facts like those the Court has relied on before.

interventions rest on radical gender theory. Second, these interventions are not supported by medical evidence. Given these flaws, parents like Hudacko oppose sex-denying interventions. That opposition will manifest in future legal disputes like Hudacko's. Thus, this Court should grant the petition to answer doctrinal questions that will govern those disputes.

I. Sex And Gender Identity Are Distinct.

Respondents are proponents of a radical ideology that erases sex and enshrines gender identity. That ideology defies science, and parents like Hudacko correctly reject it. Sex is an objective, binary, biological reality. Gender identity, on the other hand, is a subjective, nonbinary, mutable self-perception. Likewise, these parents can be rightly skeptical when their children receive diagnoses of “gender dysphoria,” especially because the number of minors reporting symptoms of gender dysphoria has risen sharply in recent years for reasons that warrant concern.

A. Sex Is A Scientific Fact.

Sex is a biological classification that is “encoded in our DNA.” *How SEX and GENDER Influence Health and Disease*, NAT'L INSTS. OF HEALTH, OFF. OF RSCH. ON WOMEN'S HEALTH, <https://perma.cc/LK2H-8935>. That means that a person's sex can be objectively determined. And sex is binary—that is, it can be male or female. As Justice Thomas has explained, sex “is an immutable ‘biological’ characteristic; it is binary; and ‘man’ and ‘woman,’ ‘boy’ and ‘girl,’ are the terms that correspond to adults and children of each sex.” *West Virginia v. B.P.J.*, 146 S. Ct. 2356, 2382 (2026) (Thomas, J., concurring) (citation omitted).

Objective. Sexual traits are “controlled by the presence of XX or XY chromosomes,” which determine the “type of gonads” a person possesses. Aditi Bhargava et al., *Considering Sex as a Biological Variable in Basic and Clinical Studies: An Endocrine Society Scientific Statement*, 42 ENDOCRINE REVS. 219, 221 (2021), <https://perma.cc/7U6B-HB6U>. An individual’s gonads, in turn, generate particular “secretions” that “regulate formation of female or male reproductive tissues.” *Id.* Specifically, gonadal secretions determine such characteristics as “external genitalia,” the presence of a “uterus and oviducts” or “sperm ducts,” and even “facial hair and pitch of voice.” *Id.* Given the nature of the human body, “sex differences exist at molecular and cellular levels.” *Id.* at 245; NAT’L INSTS. OF HEALTH, *supra* (“Every cell in your body has a sex—making up tissues and organs, like your skin, brain, heart, and stomach.”). Sex is thus a biological reality.

Binary. Sex “is dichotomous because of the different roles of each sex in reproduction.” Bhargava, *supra*, at 221. Specifically, the “classical biological definition of the 2 sexes is that females have ovaries and make larger female gametes (eggs), whereas males have testes and make smaller male gametes (sperm).” *Id.* These “2 gametes fertilize to form the zygote, which has the potential to become a new individual.” *Id.* “Each cell” in an individual’s body “is either male or female depending on whether” that person is “a man or a woman.” NAT’L INSTS. OF HEALTH, *supra*. Thus, sex is “dichotomous.” Bhargava, *supra*, at 220. True, some people experience “atypical” sexual development. Peter A. Lee et al., *Global Disorders of Sex Development Update Since 2006: Perceptions, Approach and Care*, 85 HORMONE RSCH. PAEDIATRICS

158, 159 (2016), <https://perma.cc/CP72-X8TC>. Some variations are serious enough to be “termed disorders of sexual development (DSD).” Bhargava, *supra*, at 225 (emphasis omitted). But DSD prevalence is low, with estimates varying according to the definitions used. For example, cases of ambiguous genitalia at birth are incredibly rare—though calculation is difficult, the number has been estimated at roughly 0.02% of the population. *See* Lee, *supra*, at 159. And “only a small fraction of those with DSDs” require detailed assessment to determine the individual’s sex. *Id.* This fraction does not—indeed, could not—change the reality that “sex is dichotomous.” Bhargava, *supra*, at 221.

B. Gender Identity Is A Feeling.

In contrast to sex, *gender identity* is based on an individual’s psychological state. Three features of gender identity show that it lacks any relation to sex: it is subjective, nonbinary, and mutable.

Subjective. Unlike the verifiable reality of sex, an individual announces his or her gender identity, which no one can second-guess. While sex is a biological characteristic, identity “is a psychological concept that refers to an individual’s self-perception.” Bhargava, *supra*, at 226. In other words, and as one of Respondents’ colleagues at the University of California San Francisco has written, “gender identity” is a “feeling.” Jack Turban, *I’m a Psychiatrist. Here’s How I Talk to Transgender Youth and Their Families About Gender Identity*, N.Y. TIMES (July 8, 2024), <https://perma.cc/4AQE-3F9Y>; *see also* Jack Turban, MD, MHS, UNIV. OF CAL. S.F., PHILIP R. LEE INST. FOR HEALTH POL’Y STUD., <https://perma.cc/8L7H-HDSR>. That colleague explained that “the most basic part of

gender identity” is an individual’s “transcendent sense of gender.” Turban, *supra*. Although that colleague believes “it’s hard to describe this transcendent feeling in words,” he claimed that patients can express this feeling in other ways: he said that some of his “young patients draw themselves as a certain gender and have a ‘wow, this is me’ feeling.” *Id.*

Nonbinary. Whereas only two sexes exist, an individual may claim many different identities. In one online survey, participants wrote in over 3,500 unique gender identity terms. See *Gender Census 2020: Identity Words*, GENDER CENSUS, <https://perma.cc/U636-V2MB>. Diane Ehrensaft and Stephen Rosenthal—two of the Respondents—have said that “gender identity itself is multiple in its possibilities, and can be paired with infinitely varied presentations.” Marco A. Hidalgo et al., *The Gender Affirmative Model: What We Know and What We Aim to Learn*, 56 HUM. DEV. 285, 287 (2013), <https://perma.cc/43E8-XFJR>. They claim there can be “an infinite variety of authentic gender selves, whether it be in identity, expression, or both.” *Id.* at 288. On this view, a male could identify as a boy, a girl, both, or neither. Thus, that male’s gender identity bears no relation to his biology.

Mutable. Sex lasts a lifetime, but a person’s gender identity can change. “Accordingly, transgender status does not turn on an ‘immutable characteristic.’” *United States v. Skrmetti*, 605 U.S. 495, 551 (2025) (Barrett, J., concurring) (ellipsis and brackets omitted). While proponents of gender ideology have been inconsistent in their claims about the extent to which a gender identity is fixed, some prominent supporters—including Respondents Diane Ehrensaft and

Stephen Rosenthal—have rejected the “[m]yth” that “gender identity and gender expression are immutable,” noting instead that “children should be comfortable to freely explore a range of gender identities.” Hidalgo et al., *supra*, at 288; see also *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices*, at 37 & n.28, U.S. DEP’T OF HEALTH & HUM. SERVS., OFF. OF POPULATION AFFS. (Nov. 19, 2025), <https://perma.cc/3W5Q-TQC6> (“HHS Review”) (noting proponents’ inconsistency). So, in one moment a female child could identify as a boy, the next a girl, and the following as something else entirely.

Because gender identity is not a biological concept, there is no method to determine individuals’ identity other than by asking them. This reality explains why “gender is a human phenomenon” while sex “is an essential part of vertebrate biology.” Bhargava, *supra*, at 228. In sum, sex and gender identity are fundamentally distinct.

C. Gender Dysphoria Is A Diagnosis.

Some individuals report an inconsistency between their sex and their gender identity. This perceived inconsistency can lead to psychological distress, resulting in a diagnosis of “gender dysphoria.” AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 451–52 (5th ed. 2013). But for many good reasons, parents of children with symptoms of gender dysphoria may approach such a diagnosis with skepticism.

First, as officials in both the United States and the United Kingdom have warned, the population of minors with symptoms of gender dysphoria has skyrocketed. In recent years, “the number of children and

adolescents reporting symptoms of” gender dysphoria “and seeking medical intervention surged—a trend that has since become widespread across Western countries.” HHS Review, *supra*, at 59; *see* Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report* at 85, THE CASS REV. (2024), <https://perma.cc/V9HV-MFJA> (“Cass Review”). At the very least, this sudden increase may make parents question its causes.

Second, alongside this explosion in the number of minors reporting symptoms of gender dysphoria, experts have observed that minors who display symptoms of gender dysphoria also struggle with other mental health conditions. As officials have explained, the “current patient population has a high rate (relative to the general population)” of other “mental health problems,” as well as “autism spectrum disorder.” HHS Review, *supra*, at 68; *see* Cass Review, *supra*, at 90–97. Accordingly, parents may wonder about the extent to which their child’s symptoms relate to the child’s other conditions.

Third, not only are minors with symptoms of gender dysphoria increasing in number and experiencing comorbid mental health issues, but the “role of social influence is a likely factor” in changes to the patient population. HHS Review, *supra*, at 69; *see also id.* at 67–70 (documenting other changes in the patient population). Thus, parents may reasonably suspect that, for example, the media and peers affect their child’s reported symptoms of gender dysphoria.

Fourth, those reported symptoms of gender dysphoria may not last. Some recent evidence “has called into question the assumptions regarding the

permanence of adolescent” gender dysphoria. *Id.* at 71. Put differently, many minors with symptoms of gender dysphoria eventually “come to terms with their bodies.” *Id.* at 10. So, parents might reasonably believe that any approach to their child’s struggles should be grounded in patience.

The upshot is that parents who express skepticism about their child’s gender dysphoria diagnosis—in addition to the theoretical basis for gender ideology more broadly—do so for reasons grounded in science.

II. Sex-Denying Procedures Are Unproven.

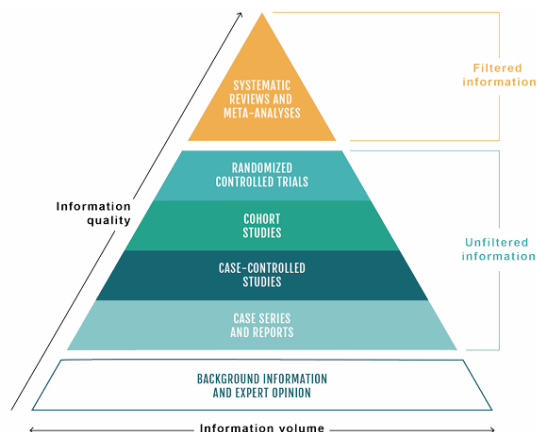
The increase in gender dysphoria symptoms parallels another concerning trend: some practitioners support *physical* interventions to treat these *psychological* symptoms. Such interventions include stopping puberty (puberty blockers) and inducing traits associated with the opposite sex (cross-sex hormones), as well as procedures that range from removing healthy organs to replacing them with approximations of body parts belonging to the opposite sex. *See* HHS Review, *supra*, at 9–11, 91, 116, 125, 128–29. As explained below, these interventions lack evidentiary support and pose many risks to minors.

Despite the risks, doctors subject an alarming number of minors to these procedures. Do No Harm has developed a database showing that nearly 14,000 minors were subjected to sex-denying interventions in the United States between 2019 and 2023. *See* Press Release, *Do No Harm Launches First National Database Exposing the Child Trans Industry*, DO NO HARM (Oct. 8, 2024), <https://perma.cc/JW24-3J6V>. Given these numbers, cases like Hudacko’s—*i.e.*, where parents object to unproven and unsafe procedures that

are performed on their children—will become more common, which makes it important for this Court to resolve the legal issues that will decide those cases.

A. Systematic Reviews Are Gold Standard Medical Evidence.

Although the proper practice of medicine is driven by evidence, not all evidence is created equal. Researchers have thus spent decades refining the process that clinicians use to assess the medical evidence supporting a particular medical intervention. That process—often referred to as the practice of “evidence-based medicine”—outlines a hierarchy of evidence based on the confidence a clinician can place in a particular source of evidence. See Gordon Guyatt et al., *Users’ Guides to the Medical Literature: Essentials of Evidence-Based Clinical Practice* 15 fig. 2-3, JAMA EVIDENCE (3d ed. 2015) (“Evidence-Based Medicine User Guide”). The “pyramid of standards of evidence” reflects the hierarchy of evidence in medicine:



See Cass Review, *supra*, at 55. As the pyramid shows, “systematic reviews” are at the top of the hierarchy of evidence. At the bottom is clinical experience—*i.e.*,

“the unsystematic observations of individual clinicians.” Evidence-Based Medicine User Guide at 15.

Well-conducted systematic reviews provide the greatest insight into the medical evidence underpinning a particular intervention because they seek to account for all relevant studies, assess those individual studies for areas of potential scientific bias, and then assess the *reliability* of the *entire* evidence base. *See id.* at 274–76. To determine the certainty of the evidence, researchers frequently use tools such as the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) method. *See id.* at 16–17. In the GRADE system, researchers rate the evidence using specified criteria. “In the context of a systematic review, the ratings of the quality of evidence reflect the extent of our confidence that the estimates of the effect are correct.” Howard Balshem et al., *GRADE Guidelines: 3. Rating the Quality of Evidence*, 64 J. CLINICAL EPIDEMIOLOGY 401, 403 (2011). This resulting rating of the evidence is either “high, moderate, low, or very low.” Evidence-Based Medicine User Guide at 16. The following definitions explain what the various levels mean:

High Quality Evidence: “We are *very confident* that the true effect lies close to that of the estimate of the effect.”

Moderate Quality Evidence: “We are *moderately confident* in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.”

Low Quality Evidence: “Our *confidence* in the effect estimate *is limited*: The true

effect may be *substantially different* from the estimate of the effect.”

Very Low Quality Evidence: “We have *very little confidence* in the effect estimate: The true effect *is likely to be substantially different* from the estimate of effect.”

Balshem, *supra*, at 404 tbl.2 (emphasis added). Thus, when evidence is deemed “low” or “very low” quality, that means researchers have “limited” or “very little confidence” that the results of studies reflect the truth; indeed, the truth may or likely will turn out “to be substantially different” from what the studies say.

Finally, after analyzing the studies, researchers will “summarize the results.” Evidence-Based Medicine User Guide at 275. This process can include a quantitative synthesis or “meta-analysis” of data that provides an overview to clinicians. *See id.* at 275–76. The result is a study of studies—a comprehensive look at the evidence that accounts for the reliability of the studies forming the evidence base. In short, systematic reviews are the most reliable medical evidence.

B. Systematic Reviews Do Not Support Sex-Denying Procedures.

Several entities have conducted well-designed systematic reviews to assess the evidence underlying the use of puberty blockers and cross-sex hormones on minors with gender dysphoria. All have concluded that the evidence underlying medical interventions for gender dysphoria in minors is weak; zero have come out the other way.

1. *Finland*. The first national health authority to conduct a systematic review was Finland’s Council for

Choices in Health Care, which completed its review in 2019. Finland’s healthcare authority concluded that “gender reassignment of minors is an experimental practice.” *Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors* at 8, PALVELUVALIKOIMA (Nov. 6, 2020), <https://perma.cc/PF72-H654> (unofficial translation by the Society for Evidence Based Gender Medicine). This conclusion was because the “reliability of the existing studies” is “highly uncertain.” *Id.* at 7.

2. *The Cass Review Interim Report.* Next, in 2020, the United Kingdom’s National Institute for Health and Care Excellence (NICE) completed its review of the evidence for using puberty blockers and cross-sex hormones on minors with gender dysphoria, which informed the Cass Review, an independent review commissioned by the United Kingdom’s National Health Service. *See NICE Evidence Reviews, THE CASS REV.*, <https://perma.cc/APZ2-W8MS>. The result was two separate systematic reviews—one for puberty blockers and one for cross-sex hormones. *Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria*, NAT’L INST. FOR HEALTH & CARE EXCELLENCE (Oct. 2020), <https://perma.cc/F9FF-ZPFR> (“NICE – Review of Puberty Blockers”); *Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria*, NAT’L INST. FOR HEALTH & CARE EXCELLENCE (Oct. 2020), <https://perma.cc/U49T-JLGJ> (“NICE – Review of Cross-Sex Hormones”). The review of puberty blockers concluded that the relevant studies were “all small, uncontrolled observational

studies, which are subject to bias and confounding, and all the results are of very low certainty using” a “modified GRADE” methodology. NICE – Review of Puberty Blockers at 13. Similarly, in the review of cross-sex hormones, NICE concluded that the relevant studies were “uncontrolled observational studies, which are subject to bias and confounding and were of very low certainty using” a “modified GRADE” methodology. NICE – Review of Cross-Sex Hormones at 13.

3. *The State of Florida*. In 2022, researchers at Canada’s McMaster University—a world-renowned institution in evidence-based medicine—completed a systematic review at the request of the Florida Agency for Health Care Administration. See Romina Brignardello-Petersen & Wojtek Wiercioch, *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence* 5 (May 16, 2022), <https://perma.cc/S4A3-NKDY>. They too found that the evidence for these interventions was weak. “Due to the important limitations in the body of evidence,” they concluded, “there is great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people with gender dysphoria.” *Id.*

4. *Sweden*. In 2023, Swedish researchers published a systematic review that was commissioned by Sweden’s Agency for Health Technology Assessment and Assessment of Social Services. See Jonas F. Ludvigsson et al., *A Systematic Review of Hormone Treatment for Children with Gender Dysphoria and Recommendations for Research*, 112 ACTA PAEDIATRICA 2279–80 (2023), <https://perma.cc/E7S9-7CLB>. The review concluded that the “[e]vidence to assess

the effects of hormone treatment” on (among other things) mental health in minors “with gender dysphoria is insufficient.” *Id.* at 2280. Specifically, it noted that “[l]ong-term effects of hormone therapy on psychosocial health are unknown,” and using puberty blockers to treat gender dysphoria “should be considered experimental treatment.” *Id.*

5. *The Cass Review Final Report*. More recently, researchers from the University of York published a series of systematic reviews as part of the Cass Review. The researchers conducted systematic reviews for both puberty blockers and cross-sex hormones. See Jo Taylor et al., *Interventions To Suppress Puberty in Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review*, ARCHIVES DISEASE CHILDHOOD 1 (2024), <https://perma.cc/UFL5-7RPB> (“Taylor – Puberty Blockers”); Jo Taylor et al., *Masculinising and Feminising Hormone Interventions for Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review*, ARCHIVES DISEASE CHILDHOOD 1 (2024), <https://perma.cc/YCP9-WWSG> (“Taylor – Cross-Sex Hormones”). In the puberty blockers review, researchers determined that their “findings add to other systematic reviews in concluding there is insufficient and/or inconsistent evidence about the effects of puberty suppression on gender dysphoria, body satisfaction, psychological and psychosocial health, cognitive development, cardiometabolic risk and fertility.” Taylor – Puberty Blockers at 12. Similarly, in the review for cross-sex hormones, researchers concluded that their “findings add to other systematic reviews in concluding there is insufficient and/or inconsistent evidence about the risks and

benefits of hormone interventions in this population.” Taylor – Cross-Sex Hormones at 6.

6. *U.S. Department of Health and Human Services*. Last year, HHS published an overview of systematic reviews (an “umbrella review”) that “found the overall quality of evidence concerning the effects of” pediatric sex-denying procedures “on psychological outcomes, quality of life, regret, or long-term health, is very low.” HHS Review, *supra*, at 13. And “there is increasing recognition of the risks and harms associated with” sex-denying procedures, as evidenced “by clinical research or grounded in established biological theory.” *Id.* at 227. The review concluded that “there is considerable uncertainty regarding” the “psychological and long-term health outcomes” of those who are subjected to sex-denying procedures. *Id.* at 100.

In sum, all these reviews concluded the same thing: there is no reliable evidence to justify the use of sex-denying interventions as a treatment for gender dysphoria in minors. And a critical study issued just months ago underscores this conclusion. See 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*, ACTA PAEDIATRICA 1 (2026), <https://perma.cc/86EP-YAQB>. In a massive study of over 2,000 individuals under the age of 23 who were referred to Finland’s gender clinics, researchers found that, among “adolescents who underwent medical gender reassignment, psychiatric morbidity increased markedly” and that “[p]sychiatric needs do not subside after medical gender reassignment.” *Id.* at 1. “The results are a rebuke to those who call for irreversible

interventions for children.” Editorial Board, *Finland’s Lessons on Transgender Children*, WALL ST. J. (Apr. 16, 2026), <https://perma.cc/3TR4-EMMZ>.

C. Sex-Denying Procedures Are Unsafe.

Not only do sex-denying interventions lack evidentiary support, but experts and even proponents of these procedures agree that they can lead to long-term health consequences. These include adverse effects on fertility, brain development, bone health, and more.

1. *Fertility*. To start, the combination of puberty blockers, cross-sex hormones, and procedures to remove and sometimes replace healthy body parts sterilizes minors. This harm underlies the Cass Review’s recommendation that all “children should be offered fertility counselling and preservation prior to going onto a medical pathway.” Cass Review, *supra*, at 35.

The Endocrine Society—a medical society whose members specialize in the study of hormones and treatment of hormone-related conditions—explains in its treatment guidelines for gender dysphoria that “if puberty is suppressed at an early stage and the individual completes phenotypic transition with the use of sex hormones,” such an individual “may want to preserve fertility, which may be otherwise compromised.” 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, 3882–83 (2017), <https://perma.cc/3FEZ-JX95> (“Endocrine Society Guidelines”).

The World Professional Association for Transgender Health (WPATH)—a group that

advocates for sex-denying interventions—offers the same warning. WPATH’s guidelines stress that loss of fertility is something that must be discussed with minors who seek sex-denying procedures. See Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People*, 23 INT’L J. TRANSGENDER HEALTH S1, S57 (2022), <https://perma.cc/58A7-BRN6> (“WPATH Standards of Care 8”).

2. *Brain Development.* Next, the effect of pubertal suppression on an individual’s brain development is entirely unknown. As England’s experts explained in the Cass Review, “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.” Cass Review, *supra*, at 178. The neurological harms that potentially result from pubertal suppression may also complicate subsequent decision-making regarding further interventions, like cross-sex hormones, because minor patients who are “already on puberty blockers” will need to consider that decision “when their psychosexual development has been paused, and possibly with little experience of their biological puberty.” *Id.* at 196.

3. *Physical Harms.* Sex-denying interventions may also lead to known physical harms for those subjected to them. Start with puberty blockers. The Cass Review highlights the risk of “detrimental impact to bone density,” *id.* at 170, referencing studies that “found that bone density is compromised during puberty suppression, and height gain may lag behind

that seen in other adolescents,” *id.* at 178. England’s experts also note possible effects “on metabolic health and weight.” *Id.* at 179.

Cross-sex hormones likewise cause serious physical harm. For males, the use of cross-sex hormones is associated with numerous health risks, such as thromboembolic disease (blood clots); cholelithiasis (gallstones); coronary artery disease, including heart attacks; macroprolactinoma (tumor of the pituitary gland); cerebrovascular disease, including strokes; hypertriglyceridemia (elevated level of triglycerides in the blood); infertility; and breast cancer. *See* Endocrine Society Guidelines, *supra*, at 3886–87 & tbl.10; WPATH Standards of Care 8, *supra*, at S119–23, S254. For females, the use of cross-sex hormones is associated with risks of erythrocytosis (increase in red blood cells); severe liver dysfunction; coronary artery disease, including heart attacks; hypertension; infertility; and increased risk of cancer. *See* Endocrine Society Guidelines, *supra*, at 3886–87 & tbl.10; WPATH Standards of Care 8, *supra*, at S117–19, S254.

Finally, procedures ranging from the removal of healthy organs to their replacement with approximations of body parts belonging to the opposite sex also carry serious physical risks. For males, complications of vaginoplasty include hair growth inside a surgically constructed “neo-vagina.” *See* WPATH Standards of Care 8, *supra*, at S87, S132, S134, S232. Also, most seriously, complications associated with this surgery have led to death. *See* Michael Biggs, *The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence*, 49 J. SEX & MARITAL THERAPY 348, 355 (2023), <https://perma.cc/XDP7-XYGQ>; Vera L. Negenborn et

al., *Lethal Necrotizing Cellulitis Caused by ESBL-Producing E. Coli After Laparoscopic Intestinal Vaginoplasty*, 30 J. PEDIATRIC & ADOLESCENT GYNECOLOGY e19 (2017). For females, complications of phalloplasty/metoidioplasty (surgery to construct a phallus/penis) include urethral strictures (narrowing of the urethra); urethral fistulae (abnormal openings through which urine improperly leaks); hair growth within the “neourethra”; lack of sensation; and difficulty achieving orgasm. See WPATH Standards of Care 8, *supra*, at S133. And again, complications can lead to “morbidity.” *Id.* at S134.

Crucially, the sequential nature of sex-denying interventions—puberty blockers to cross-sex hormones to removal and/or replacement of healthy body parts—means that the harms and risks of the later procedures cannot be dissociated from the earlier interventions (like puberty blockers). This is because, as England’s experts state in the Cass Review, “given that the vast majority of young people” who take puberty blockers “proceed from puberty blockers to masculinising/feminising hormones,” there is a concern that puberty blockers “may change the trajectory of psychosexual and gender identity development”—meaning that, rather than “buy time to think,” puberty blockers may instead alter a minor’s perception of himself or herself. Cass Review, *supra*, at 32.

* * *

Nothing justifies these risks to America’s young people. Suggesting otherwise, proponents of sex-denying interventions often seek to scare parents into consenting to these interventions for their children by suggesting that without them, a young person with

gender dysphoria will commit suicide. See Jay Greene & Ian Kingsbury, *The Effect of State Bans on Gender Interventions for Minors on Teen Suicide Rates* at 4–15, DO NO HARM, <https://perma.cc/SVK7-PMA3>. But the suicide claim lacks any basis in truth. *Id.* at 15–21. If sex-denying interventions were necessary to prevent suicide, one would expect an elevated suicide rate in places where such interventions are restricted. But there is “no statistical support for the claim that state bans on gender interventions for minors have led to a spike in suicide rates.” *Id.* at 3. At bottom, dangerous interventions like the ones objected to by Ted Hudacko are unjustified. Like Mr. Hudacko, parents across this country will continue to seek to protect their children from this medical scandal. And their parental rights to do so should be adjudicated under uniform rules established by this Court.

CONCLUSION

For these reasons, the Court should grant the petition for a writ of certiorari.

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