

IN THE
Supreme Court of the United States

DONALD J. TRUMP, in his official capacity as President
of the United States, et al.,

Applicants,

v.

ALISHEA SOPHIA KINGDOM, et al.,

Respondents.

On Application to Stay the Order of the United States
District Court for the District of Columbia

**BRIEF OF INDIANA, IDAHO, TWENTY-TWO OTHER STATES,
AND THE ARIZONA LEGISLATURE AS AMICI CURIAE
IN SUPPORT OF APPLICANTS**

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INTEREST OF AMICI CURIAE

Until 2017, no prisoner anywhere in the Nation had received a sex-reassignment surgery while incarcerated. Over the past few years, however, States have faced a stream of lawsuits for refusing to provide surgeries and cross-sex hormones to prisoners who express psychological discomfort with the physical appearance of their bodies. Many courts have rejected those lawsuits. But other federal appellate and district courts have held that the Constitution requires States to provide sex-change surgeries and cross-sex hormones because the World Professional Association for Transgender Health (WPATH) and WPATH-aligned experts label those risky interventions “medically necessary.” *See, e.g., Edmo v. Corizon, Inc.*, 935 F.3d 757, 796 (9th Cir. 2019).

The claims brought against the federal government in this case are little different from the claims that States have faced and continue to face. Here, as in other cases, plaintiffs argue that prison officials must follow WPATH recommendations and address gender dysphoria through cross-sex hormones and invasive sex-reassignment surgeries. Here, as in other cases, plaintiffs argue that there can be no real doubts about the safety and efficacy of their preferred interventions—notwithstanding a “robust and substantial good faith disagreement” within the medical community. *Gibson v. Collier*, 920 F.3d 212, 220 (5th Cir. 2019). And here, as in other cases, a federal court has invoked WPATH and WPATH-aligned experts to declare it “objectively unreasonable” for prison officials to side with medical professionals preferring non-invasive psychotherapy. App. 191a–193a.

This Court should intervene to correct the error. Despite the insistence of WPATH and plaintiffs’ experts on surgeries and hormones, nothing in federal law requires the federal government or States to demand risky, controversial medical procedures of, at best, uncertain benefit to prisoners. And the law certainly does not appoint federal courts to be the referees of “fierce scientific and policy debates about the safety, efficacy, and propriety” of sex-reassignment procedures, especially in the prison setting. *United States v. Skrmetti*, 605 U.S. 495, 525 (2025). The Court should again make clear that authority to resolve those debates rests with politically accountable policymakers at the state and federal levels rather than a private advocacy organization or a district court’s preferred experts.

SUMMARY OF ARGUMENT

As this Court has repeatedly emphasized, federal courts should be loath to countermand policy decisions that require evaluations of evolving medical evidence or that implicate prison management. The mere fact that the Administrative Procedure Act (APA) provides a path to reviewing the challenged Bureau of Prisons (BOP) policy does not authorize a district court to decide for itself what is the best way to care for prisoners with gender dysphoria. In this case, however, the district court improperly second-guessed considered policy judgments because it was persuaded by plaintiffs’ experts that sex-reassignment surgeries and cross-sex hormones are safe and effective. Its decision betrays a troubling tendency by federal courts to shut down legitimate debates by invoking expert opinion on one side—a

tactic other federal courts have used in ordering States to provide sex-reassignment surgeries and cross-sex hormones to prisoners.

Even if it were proper for federal courts to weigh the medical evidence for themselves, the challenged BOP policy is entirely reasonable. Study after study demonstrates that there is considerable uncertainty about whether attempting to alter someone's physical appearance through surgeries and hormones to address discomfort with the person's sex provides any lasting psychological benefit. Indeed, some studies suggest those interventions could contribute to worse mental health. The literature, meanwhile, makes clear that surgeries and hormones carry significant risks, even if one sets aside the very real possibility that prisoners who receive surgeries will later regret them. And even WPATH cannot confidently say that any study supports providing sex-reassignment surgeries to prisoners because no study of prisoners exists. Its insistence on surgery rests on a policy preference.

Safety and security rationales independently support the challenged policy. Administering sex reassignment surgeries or cross-sex hormones exacerbates safety and security issues within the prison system. As States' attempts to house prisoners show, housing transgender-identifying prisoners who look more like the opposite sex in either same-sex or opposite-sex prisons presents significant challenges. It can increase the risk of violence and harassment, compromise the privacy and religious convictions of other inmates, and consume prison resources. This Court should stay the district court's injunction, making clear that federal and state policymakers should be the ones deciding how to manage gender dysphoria in prisons.

ARGUMENT

This case sits at the intersection of two areas in which policymakers should have especially significant leeway—the regulation of medical interventions in an evolving area and the management of federal prisons. But the district court held it was “objectively unreasonable” and “implausible” to withhold sex-change surgeries and cross-sex hormones from prisoners who identify with the opposite sex. App. 191a–192a (citation omitted). That ruling disregards the deference due to policymakers and accountable decisionmakers, defies fundamental principles of administrative law, and elides that no reliable evidence supports addressing gender dysphoria by giving prisoners surgeries and drugs to make their outward appearance more consistent with the opposite sex. And the district court’s ruling improperly discounts the challenges with prison management.

I. The District Court Improperly Countermanded the Considered Judgment of Politically Accountable Policymakers

Since the beginning of the Republic, policymakers have had broad authority over the regulation of medicine, especially in “areas where there is medical and scientific uncertainty.” *United States v. Skrmetti*, 605 U.S. 495, 524 (2025) (quoting *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007)). That deference reflects that “the democratic branches are better suited to decide the proper balance between the uncertain risks and benefits of medical technology,” make value-laden judgments about the acceptable levels of risk, and weigh a procedure’s ethical implications. *Abigail All. for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 713 (D.C. Cir. 2007); see *FDA v. Am. Coll. of Obstetricians & Gynecologists*, 592

U.S. 990, 992 (2020) (“Our Constitution principally entrusts the safety and the health of the people to the politically accountable officials of the States to guard and protect.”) (internal quotation omitted); *Marshall v. United States*, 414 U.S. 417, 427 (1974) (observing that the deference afforded to policymakers must be “especially broad” when they “act in areas fraught with medical and scientific uncertainties”).

The need for deference is enhanced in the prison context. Prison administrators face an unenviable task. They are tasked with “trying to manage a volatile environment,” *Sandin v. Conner*, 515 U.S. 472, 482 (1995), while ensuring the health, safety, and security of prison inmates and staff alike. Because prison administrators “bear a significant responsibility for defining the legitimate goals of a corrections system and for determining the most appropriate means to accomplish them,” their “professional judgment” is “accord[ed] substantial deference” by the courts. *Overton v. Bazzetta*, 539 U.S. 126, 132 (2003). Even where a prison policy affects constitutional rights, any judicial inquiry is highly deferential. *Id.* (citing *Turner v. Safley*, 482 U.S. 78, 89 (1987)). The “operation of our correctional facilities is peculiarly the province of the Legislative and Executive Branches of our Government, not the Judicial.” *Bell v. Wolfish*, 441 U.S. 520, 548 (1979).

In cases like this one, however, some lower federal courts appear to have forgotten their limited remit. Here, the BOP made a rational decision informed by a thorough review of scientific literature, the law, and state policies. The agency examined existing guidelines along with dozens of studies, clinical guidelines, journal articles, news articles, medical manuals, reports, care guides, declarations from

medical professionals, and other medical resources. App. 19a–26a. That review included evidence showing that existing policies rested on guidelines from an organization that pursued “ideology, not science,” App. 31a, and that failed to consider the “special challenges of the inmate population,” App. 31a–33a. It also included independent systematic reviews of the medical literature that concluded no robust evidence supported using surgeries and hormones to address gender dysphoria, especially in women. App. 30a. And it included evidence that “hormone-based interventions for gender dysphoria are fraught with serious risks.” *Id.*

Invoking declarations from experts that were not before the agency or were submitted after the BOP had formulated its policy, however, the district court held that it was “objectively unreasonable” to withhold sex-change surgeries and cross-sex hormones from prisoners with gender dysphoria. App. 191a–193a. But the Administrative Procedures Act (APA) does not authorize a court to decide which expert it thinks most persuasive or which set of prison policies would be best. The standard governing APA claims is “deferential.” *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021). It does not permit a court to “substitute its own policy judgment for that of the agency.” *Id.* Nor, for that matter, does the APA usually permit a court to entertain evidence postdating an agency policy. “[T]he focal point for judicial review should be the administrative record already in existence.” *Camp v. Pitts*, 411 U.S. 138, 142 (1973) (per curiam); see *Dep’t of Com. v. New York*, 588 U.S. 752, 780 (2019) (“[A] court is ordinarily limited to evaluating the agency’s contemporaneous explanation in light of the existing administrative record.”).

As the federal government explains, these departures from fundamental principles of administrative law warrant a stay. *See* Stay Appl. 15–29. But they also betray a more fundamental problem with how a minority of federal courts are approaching cases involving transgender-identifying prisoners: invoking the opinions of WPATH and WPATH-aligned experts to “distort and stifle democratic debate under the guise of scientific judgment.” *Skrimetti*, 605 U.S. at 530–31 (Thomas, J., concurring).

The Ninth Circuit’s decision in *Edmo* represents one of the most egregious (though certainly not only) examples of this tendency. In *Edmo*, the Ninth Circuit invoked WPATH’s “Standards of Care” to become the first court to mandate the provision of sex-change surgery to a transgender-identifying prisoner, holding that it would constitute “cruel and unusual punishment” to withhold the desired surgery. *Edmo v. Corizon*, 935 F.3d 757, 766–67 (9th Cir. 2019). Although *Edmo* arose under the Eighth Amendment, the Ninth Circuit’s decision bears many similarities to the district court’s decision in this case. There, as here, the court “substitute[d] the medical conclusions of federal judges” for that of politically accountable policymakers, allowed a “professional association” to “define what qualifies as . . . acceptable treatment of prisoners,” and disregarded an “ongoing medical debate” about how to address gender dysphoria in prisoners. *Edmo v. Corizon, Inc.*, 949 F.3d 489, 490, 495, 499 (9th Cir. 2020) (O’Scannlain, J., respecting the denial of rehearing en banc).

Even at the time of *Edmo*—several years before recent revelations about WPATH’s pursuit of ideology over science and the emergence of further studies

undermining its recommendations—there was a “sharply contested medical debate over sex reassignment surgery.” 949 F.3d at 497 (O’Scannlain, J., respecting the denial of rehearing en banc) (quoting *Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019)); *see id.* at 498–499. There was also evidence that WPATH had succumbed to “pressure” to be “an advocacy group.” *Id.* (quoting *Kosilek v. Spencer*, 774 F.3d 63, 78 (1st Cir. 2014) (en banc)). Without evidence and “with the express purpose of influencing how courts review gender dysphoria treatments,” WPATH asserted that prisoners desiring sex-reassignment surgeries should not have to meet its usual screening criteria to receive them. *Id.* at 498. Yet the Ninth Circuit allowed WPATH to be the arbiter of what medical care for prisoners is warranted, just like the district court here. *See Edmo*, 935 F.3d at 796–97; App. 192a.

Making clear that policymakers should have substantial leeway to weigh competing medical evidence and consider the unique challenges of the prison environment is critical if the courts are not to short-circuit legitimate democratic debate. Litigation against state policies that restrict cross-sex hormones and sex-reassignment surgeries is pending across the country. *See, e.g., Wagoner v. Winkelman*, No. 25-6813 (9th Cir.); *Allison v. Comm’r, Ind. Dep’t of Corrs.*, No. 1:2024cv00577-RLY-CSW (S.D. Ind.); *Robinson v. Labrador*, No. 1:24-cv-00306-DCN (D. Idaho). Allowing the district court’s injunction against the BOP’s policy to stand would send the wrong message and all but ensure courts will continue to second-guess policymakers.

II. No Reliable Evidence Supports Providing Sex-Reassignment Surgeries and Cross-Sex Hormones to Prisoners

Even if it were appropriate for the district court to forage beyond the administrative record in evaluating the reasonableness of the BOP's policy and evaluate the medical evidence for itself, the evidence does not support its view that “decades of research and clinical experience demonstrat[es] the efficacy of gender affirming care.” App. 192a–193a. In fact, there are “fierce scientific and policy debates about the safety, efficacy, and propriety” of these interventions. *Skrmetti*, 605 U.S. at 525; see *Clark v. Valletta*, 157 F.4th 201, 213 (2d Cir. 2025) (recognizing that the First, Fifth, Eighth, Tenth, and Eleventh Circuits have “rejected deliberate-indifference claims for denial of specific gender-dysphoria treatments”); *Gibson*, 920 F.3d at 220 (observing a “robust and substantial good faith disagreement divid[es]” the medical community over surgeries); *Kosilek*, 774 F.3d at 76 (noting testimony from Johns Hopkins physicians that there are “many people in the country who disagree with” WPATH's surgical recommendations).

A. No reliable evidence supports surgeries and hormones

Consider a few examples. In 2016, the Centers for Medicare and Medicaid Services reviewed studies considering the effectiveness of sex-change surgeries.¹ Of the hundreds of sources reviewed and cited, only six provided useful information regarding surgery. The four best-designed of those six studies “did not demonstrate clinically significant changes or differences in psychometric test results after”

¹ Centers for Medicare & Medicaid Services, *Gender Dysphoria and Gender Reassignment Surgery: National Coverage Analysis Decision Memo*, (Aug. 30, 2016), <https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=282>.

surgery.² A few years later, authors who set out to prove that surgery provides mental-health benefits were forced to retract their study after a reanalysis of their data showed “no advantage of surgery.”³ What is more, the authors affirmatively conceded that there is “a lack of sufficient knowledge to provide evidence-based treatment recommendations” for gender dysphoria.⁴ The effect of sex-reassignment surgery, they admitted, on “long-term mental health is largely unknown.”⁵

Similar concessions are found throughout the medical and scientific literature. A 2025 study concluded that those who undergo sex-change surgeries “are at significantly higher risk for adverse mental health outcomes, including depression, anxiety, suicidal ideation, and substance use disorder, compared to those who do not undergo gender-affirming surgery.”⁶ “This trend persists even after controlling for confounding factors.”⁷ Other researchers have published similar findings. One study reported that surgery has “not been shown to reduce even suicidal ideation.”⁸ A 2011 study of all persons in Sweden who had received surgery over 30 years even reported

² *Id.*

³ R. Bränström et al., *Reduction in Mental Health Treatment Utilization Among Transgender Individuals after Gender Affirming Surgeries: A Total Population Study*, 177 Am. J. Psychiatry 727, 734, Correction (2020).

⁴ R. Bränström & J.E. Pachankis, *Letter to the Editor*, 177 Am. J. Psychiatry 769, 769 (2020).

⁵ R. Bränström et al., *Total Population Study*, *supra* n.3, at 727; *see also* A. Almazan & A.S. Keuroghlian, *Association Between Gender-Affirming Surgeries and Mental Health Outcomes*, 156 JAMA Surg. 611 (2021), <https://doi.org/10.1001/jamasurg.2021.0952>.

⁶ J.E. Lewis et al., *Examining Gender-Specific Mental Health Risks After Gender-Affirming Surgery: A National Database Study*, 22 J. Sexual Med. 645, 650 (2025).

⁷ *Id.*

⁸ S.M. Ruuska et al., *All-Cause and Suicide Mortalities Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services in Finland in 1996–2019: A Register Study*, 27 BMJ Mental Health 1, 5 (2024), <https://doi.org/10.1136/bmjment-2023-300940>.

that trans-identifying patients remained suicidal after surgery at a much higher rate—19.1 times higher—than a control population.⁹ That study “found substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts, and psychiatric hospitalizations in sex-reassigned transsexual individuals compared to a healthy control population.”¹⁰

Even literature claiming psychological benefits reveals uncertain results. One Brazilian study assessed 47 transgender females at least one year before and after genital surgery. It found that psychological state and relationships improved, but physical health and independence deteriorated.¹¹ Past the one-year mark, improvements in mental health regress, too. A Swedish post-surgery study surveyed 190 patients one year, three years, and five years after surgery. It found that patients had lower quality of life than the general population on most items at every interval.¹² Though quality of life metrics improved at the one-year post-surgery interval, they regressed to the preoperative level by the five-year mark.¹³

The BOP’s determination that no reliable evidence supports surgeries is no outlier. A meta-analysis of “all studies published on genital[] surgery from 1950” to

⁹ C. Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLoS One 1, 6 (2011).

¹⁰ *Id.* at 7.

¹¹ Cardoso da Silva Dhjordan et al., *WHOQOL-100 Before and After Sex Reassignment Surgery in Brazilian Male-to-Female Transsexual Individuals*, 13 J. of Sexual Med. 988 (2016), <https://pubmed.ncbi.nlm.nih.gov/27117529/>.

¹² E.K. Lindqvist et al., *Quality of Life Improves Early After Gender Reassignment Surgery in Transgender Women*, 40 Eur. J. of Plastic Surgery 223, 225 (2017), <https://pubmed.ncbi.nlm.nih.gov/28603386/>.

¹³ *Id.*

2020 concluded that the “evidence for [post-surgical] complications and functional outcomes is of low level.”¹⁴ Another systematic review of 28 studies concluded that evidence of positive outcomes from these interventions was “of low quality.”¹⁵ And still another study reported that the guidelines supporting transitioning “lack methodological rigour and rely on patchier, lower-quality primary research.”¹⁶

No reliable evidence supports cross-sex hormones either. A 2020 systematic review of available studies “found insufficient evidence to determine the efficacy or safety of hormonal treatment approaches for transgender women in transition,” concluding that “[t]he evidence is very incomplete.”¹⁷ Another systematic review concluded that it was “impossible to draw conclusions about the effects of hormone therapy on death by suicide” and, generally, the “strength of evidence” for positive effects of hormone therapy was “low.”¹⁸ A third review included studies “that showed an *increase* in suicidality for those who received gender-affirming treatment,”

¹⁴ C. Dunford et al., *Genital Reconstructive Surgery in Male to Female Transgender Patients: A Systematic Review of Primary Surgical Techniques, Complication Profiles, and Functional Outcomes from 1950 to Present Day*, Eur. Urol. Focus 1, 5–6 (2020).

¹⁵ M.H. Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 Clin. Endocrinol. 214 (2009), <https://doi.org/10.1111/j.1365-2265.2009.03625.x>.

¹⁶ S. Dahlen et al., *International Clinical Practice Guidelines for Gender Minority/Trans People: Systematic Review and Quality Assessment*, 11 BMJ Open 1, 2, 6 (2021).

¹⁷ Claudia Haupt et al., *Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women*, 11 Cochrane Database of Systematic Reviews, Art. No. CD013138, at 2, 11 (2020) (“well-designed, sufficiently robust randomised controlled trials (RCTs) and controlled-cohort studies do not exist”).

¹⁸ Kellan E. Baker, et al., *Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review*, 5 J. Endocrine Soc. 1, 12–13 (2021).

including cross-sex hormones, and concluded that all existing studies on the effect of hormone therapy on suicidality suffered from methodological errors.¹⁹

The existence of a genuine debate over the safety and efficacy of sex-reassignment surgeries and cross-sex hormones from what the medical literature says should be clear enough. But what the literature does not include is also important—none of the medical evidence WPATH and its expert use to tout the benefits of sex-reassignment surgeries and cross-sex hormones involves prisoners. *Edmo*, 949 F.3d at 498 (O’Scannlain, J., respecting the denial of rehearing en banc) (observing there is not “any research” on providing prisoners with sex-change surgeries); *id.* at 508 (Bumatay, J., dissenting from denial of rehearing en banc) (observing no “longstanding practice” of providing prisoners with the surgeries exists). Even WPATH admits its evidence does not involve prisoners.²⁰ Its “institutionalized-persons recommendations follow from an ‘ethical principle’” instead. *Edmo*, 949 F.3d at 498 (O’Scannlain, J., respecting the denial of rehearing en banc). But an ethical principle provides no basis for saying that “research and clinical experience” demonstrate plaintiffs’ desired interventions are safe and effective, App. 192a–193a, considering that “much research is not easily generalizable” to prisoners.²¹

¹⁹ Daniel Jackson, *Suicide-Related Outcomes Following Gender-Affirming Treatment: A Review*, 15 *Cureus* 9–13 (2023) (emphasis added).

²⁰ E. Coleman et al., Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, 23 *INT’L J. TRANSGENDER HEALTH SUPP.* 1, S42 (2022), <https://doi.org/10.1080/26895269.2022.2100644>.

²¹ Oscar Neyra, *Limited Access to Research Involving Incarcerated Persons as a Result of Protectionism*, *Voices in Bioethics* (2021), <https://academiccommons.columbia.edu/doi/10.7916/41d5-f690>.

B. Surgeries and hormones carry significant risks

Though the putative benefits of sex-reassignment surgery and cross-sex hormones are, at best, uncertain, the dangers are quite real. Many of those who undergo vaginoplasties face complications such as flap necrosis, rectal and urethral injuries, rectal fistula, vaginal stenosis, and urethral fistula.²² Further, a review of 17 studies following vaginoplasties found high rates of pelvic floor dysfunction: a 1-7.5% rate of pelvic floor prolapse; up to a 15% rate of urinary incontinence; a 25-75% rate of sexual dysfunction; and up to a 20% rate of urinary irritation.²³ Another study of 330 patients found a complication rate of 28.9% and a reoperation rate of 9%.²⁴ Others have found complication and reoperation rates even higher, including one that found a complication rate of 32.5% and reoperation rate of 21.7%.²⁵ A meta-analysis of 46 studies found an average complication rate of 21%.²⁶

The administration of cross-sex hormones also carries serious risks. Males who have been given estrogen have twenty-two times the likelihood of developing breast

²² James J. Drinane & Richard Santucci, *What Urologists Need to Know About Male to Female Genital Confirmation Surgery (Vaginoplasty): Techniques, Complications and How to Deal with Them*, 72 Minerva Urologica e Nefrologica 162 (2020), <https://www.minervamedica.it/en/freedownload.php?cod=R19Y2020N02A0162>.

²³ M. Dominoni et al., *Pelvic Floor and Sexual Dysfunctions After Genital Gender-Affirming Surgery: A Systematic Review and Meta-Analysis*, 22 J. of Sexual Med. 184 (2025), <https://doi.org/10.1093/jsxmed/qdae146>.

²⁴ T.W. Gaither et al., *Postoperative Complications Following Primary Penile Inversion Vaginoplasty Among 330 Male-to-Female Transgender Patients*, 199 J. of Urology 760 (2018), <https://doi.org/10.1016/j.juro.2017.10.013>.

²⁵ P.C. Dreher et al., *Complications of the Neovagina in Male-to-Female Transgender Surgery: A Systematic Review and Meta-Analysis with Discussion of Management*, 31 Clinical Anatomy 191 (2018), <https://doi.org/10.1002/ca.23001>.

²⁶ V.P. Bustos et al., *Regret After Gender-Affirmation Surgery: A Systematic Review and Meta-Analysis of Prevalence*, J. of the Am. Soc'y of Plastic Surgeons (2021), <https://pubmed.ncbi.nlm.nih.gov/33968550/>.

cancer,²⁷ an increased risk of prostate cancer and other forms of cancer,²⁸ and higher risk of retinal vein occlusion,²⁹ strokes,³⁰ and autoimmune disorders.³¹ And females treated with testosterone risk infertility,³² pseudotumor cerebri,³³ and a higher risk of breast cancer³⁴ and heart attacks.³⁵

The negative effects of these treatments are only compounded by “high desistance rates” among those who identify as transgender (particularly youth), which can lead to the tragic ‘regret’ of detransitioners.” *Skrmetti*, 605 U.S. at 517.³⁶ Even WPATH admits that “some . . . adults may decompensate or experience a

²⁷ See Rakesh R. Gurralla et al., *The Impact of Exogenous Testosterone on Breast Cancer Risk in Transmasculine Individuals*, 90 *Annals of Plastic Surgery* 96 (2023).

²⁸ See Khobe Chandran et al., *A Transgender Patient with Prostate Cancer: Lessons Learnt*, 83 *European Urology* 379 (2023).

²⁹ See Christian Nieves-Ríos et al., *Instances of ocular findings in transgender patients undergoing hormonal therapy*, 32 *AM. J. of Ophthalmology Case Reps.* 101965 (2023), <https://pmc.ncbi.nlm.nih.gov/articles/PMC10701352/>.

³⁰ See Talal Alzahrani et al., *Cardiovascular Disease Risk Factors and Myocardial Infarction in the Transgender Population*, 12 *Circulation: Cardiovascular Quality & Outcomes* (2019).

³¹ See Alice A. White et al., *Potential Immunological Effects of Gender-Affirming Hormone Therapy in Transgender People—an Unexplored Area of Research*, 13 *Therapeutic Advances in Endocrinology & Metabolism* 1 (2022).

³² See Kenny Rodriguez-Wallberg et al., *Reproductive Health in Transgender and Gender Diverse Individuals: A Narrative Review to Guide Clinical Care and International Guidelines*, 24 *Int’l J. Transgender Health* 7 (2022).

³³ A buildup of fluid in the skull causing symptoms that mirror a brain tumor. See Naomi E. Gutkind et al., *Idiopathic Intracranial Hypertension in Female-to-Male Transgender Patients on Exogenous Testosterone Therapy*, 39 *Ophthalmic Plastic & Reconstructive Surgery* 449 (2023).

³⁴ See Giovanni Corso et al., *Risk and Incidence of Breast Cancer Risk in Transgender Individuals: A Systematic Review and Meta-Analysis*, 32 *European J. Cancer Prevention* 207 (2023).

³⁵ See Darios Getahun et al., *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, 169 *Annals of Internal Med.* 205 (2018).

³⁶ See Lisa Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners*, 50 *Archives of Sexual Behav.* 3353 (2021); Miroslav L. Djordjevic et al., *Reversal Surgery in Regretful Male-to-Female Transsexuals after Sex Reassignment Surgery*, 13 *J. of Sexual Med.* 1000 (2016).

worsened condition following transition.”³⁷ It says this occurrence is rare.³⁸ But the true number of detransitioners is undercounted and unknown because many (understandably) cut off contact with those promoting transitioning.³⁹ And even WPATH admits that “little research” sheds light on *which* recipients of surgeries and hormones will suffer harm.⁴⁰ This means policymakers can understandably decide that it would be irresponsible to provide those procedures, especially where prisoners cannot take the step that WPATH says will reduce detransition risk—living as the opposite sex for an extended period. *See Edmo*, 949 F.3d at 497–498 (O’Scannlain, J., respecting the denial of rehearing en banc).

Of course, interest groups like WPATH and WPATH-aligned experts like the ones in this case still promote medical interventions for gender dysphoria. But “WPATH’s lodestar is ideology, not science.” *Skrmetti*, 605 U.S. at 545 (Thomas, J., concurring) (quoting *Eknes-Tucker v. Governor of Ala.*, 114 F.4th 1241, 1261 (11th Cir. 2024) (Lagoa, J., concurring in denial of rehearing en banc)). As a contributor to WPATH’s 2022 Standards of Care explained, “[o]ur concerns, echoed by the social justice lawyers we spoke with, is that evidence-based review reveals little or no evidence and puts us in an untenable position in terms of affecting policy or winning

³⁷ E. Coleman et al., Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, *supra* n.20, at S42.

³⁸ *Id.*

³⁹ J. Cohn, *The Detransition Rate is Unknown*, 52 Archives of Sexual Behav. 1937 (2023), <https://link.springer.com/article/10.1007/s10508-023-02623-5>; *See also* Lisa Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners*, 50 Archives of Sexual Behav. 3353 (2021), <https://link.springer.com/article/10.1007/s10508-021-02163-w>.

⁴⁰ E. Coleman et al., Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, *supra* n.20, at S42.

lawsuits.” *Id.* at 544. “Worse, recent reporting has exposed that WPATH changed its medical guidance to accommodate external political pressure,” *id.* at 546—a pressure to which WPATH has buckled in drafting past iterations of its guidance, *see Edmo*, 949 F.3d at 497 (O’Scannlain, J., respecting the denial of rehearing en banc).

Perhaps unsurprisingly, a recent assessment concluded that WPATH’s standards had “significant shortcomings”—“lack of rigor of development, probably compromised editorial independence, and limited applicability.”⁴¹ Neither these guidelines nor the experts endorsing them provide any basis for concluding that the efficacy and safety of gender-transition procedures for prisoners are beyond debate.

And efficacy and safety are only part of the picture. The ethics of cutting off or mutilating healthy tissue to address a psychological condition is questionable. *See Skrmetti*, 605 U.S. at 540–43 (Thomas, J., concurring) (discussing ethical concerns related to sex change procedures for minors). Meanwhile, non-invasive interventions are available; for example, “[s]ocial support and psychotherapy” are “widely recognized approaches.” *K.C. v. Individual Members of the Med. Licensing Bd. of Ind.*, 121 F.4th 604, 610–611 (7th Cir. 2024) (citing Danyon Anderson et al., *Gender Dysphoria and Its Non-Surgical and Surgical Treatments*, 10 Health Psych. Rsch., at 4 (2022)). All of this makes it reasonable for policymakers to decide against providing sex-reassignment surgeries and cross-sex hormones to prisoners.

⁴¹ Yuan Zhang et al., *Quality of the World Professional Association for Transgender Health Guideline Standards of Care 8: An Appraisal Using the AGREE II Instrument*, 55 Archives of Sex Behav. 1845, 1850 (2026), <https://doi.org/10.1007/s10508-025-03399-6>.

III. The Provision of Sex-Reassignment Surgery and Cross-Sex Hormones to Prisoners Presents Significant Safety and Security Risks

In enjoining the BOP policy, the district court gave scant attention to unique challenges that sex-reassignment surgeries and hormones pose in the prison setting. As States' experience shows, however, those challenges are real. Housing transgender-identifying individuals in prison can be an "intractable problem." *Bell*, 441 U.S. at 562. "Recognizing that reasonable concerns would arise regarding a postoperative, male-to-female transsexual being housed with male prisoners takes no great stretch of the imagination." *Kosilek*, 774 F.3d at 93 (en banc). The same goes for housing inmates who take cross-sex hormones. It takes no leap for experienced prison officials to conclude that a male who appears more female will "inevitably become a target for abuse in an all-male prison." *Keohane v. Fla. Dep't of Corr. Sec'y*, 952 F.3d 1257, 1275 (11th Cir. 2020).

The only way to prevent disorder and ensure the safety of a male inmate who undergoes procedures to create a more feminine appearance may be to house the inmate "in a segregated protective custody unit." *Kosilek*, 774 F.3d at 93. But that would require a substantial expenditure of resources for the duration of the inmate's incarceration, and if the federal government or a State were to take that step, it could face claims that "such isolation would amount to a form of extrajudicial punishment that is prohibited by the Eighth Amendment." *Id.* (internal quotation omitted). Requiring prison officials to provide sex-reassignment surgeries and cross-sex hormones while also keeping prison inmates safe just invites further judicial

micromanagement of problems uniquely within the expertise of executive and legislative branch officials.

Housing transgender inmates with the opposite sex presents even worse problems. Those problems redound to the harm of female inmates who (1) have their rights to privacy and dignity compromised by having to sleep and shower with men, (2) are exposed to elevated possibilities of violence or sexual assault, and (3) could be pressured or coerced into using speech reflecting a belief that conflicts with biological reality. *See* App. 29a, 54a–55a. Indeed, instances of sexual violence have been reported in at least six States where transgender-identifying prison inmates are sometimes housed in opposite-sex prisons: California,⁴² Illinois,⁴³ Maine,⁴⁴ New Jersey,⁴⁵ Oregon,⁴⁶ and Washington.⁴⁷ Transgender-identifying prisoners in the United Kingdom and Canada have also been charged with sexual assault after being

⁴² Bob Egelko, *Trump Administration to Investigate California Over Trans Prisoner Policy*, S.F. Chronicle (Mar. 26, 2026), <https://www.sfchronicle.com/politics/article/trans-prisoners-trump-22154216.php>.

⁴³ Matt Masterson, *Lawsuit: Female Prisoner Says She Was Raped by Transgender Inmate*, WTTW News (Feb. 19, 2020), <https://news.wttw.com/2020/02/19/lawsuit-female-prisoner-says-she-was-raped-transgender-inmate>.

⁴⁴ Eesha Pendharkar, *Corrections Department Defends Transgender Inmate Policy in Response to Lawmakers' Concerns*, News From The States (June 18, 2026), <https://www.newsfromthestates.com/article/corrections-department-defends-transgender-inmate-policy-response-lawmakers-concerns>.

⁴⁵ Sophie Nieto-Munoz, *Lawsuit Pins Blame for Assaults on Transgender Policy in New Jersey Prisons*, New Jersey Monitor (Sept. 11, 2024), <https://newjerseymonitor.com/2024/09/11/lawsuit-pins-blame-for-assaults-on-transgender-policy-in-new-jersey-prisons/>.

⁴⁶ Shaanth Nanguneri, *Federal Appeals Court Blocks Ruling for Housing Trans Women in Oregon Prisons*, OPB (Aug. 10, 2026), <https://www.opb.org/article/2026/08/10/oregon-prisons-transgender-women-ruling-federal-appeals-court/>.

⁴⁷ Jake Goldstein-Street, *Washington Transgender Prisoner Policy Lands Before State Supreme Court*, OPB (June 24, 2026), <https://www.opb.org/article/2026/06/24/transgender-prisoner-policy-washington-state/>.

housed in women’s prisons.⁴⁸ And the Department of Justice is actively investigating Maine and California prisons’ housing of biological males in women’s prisons. In California, the investigation centers on “allegations of sexual assault, rape, voyeurism and a pervasive climate of sexual intimidation” in women’s prisons “due to the presence of males;” in Maine, the probe is in response to “allegations that ‘a biological male’ remained housed with women despite complaints that the inmate had assaulted or harassed female inmates.”⁴⁹

Housing transgender-identifying inmates with the opposite sex also can cause immense psychological distress to female inmates and violate the religious sensibilities of those of certain religious faiths that require strict segregation between the sexes. This concern is hardly fanciful. In Washington, a female inmate filed a grievance with prison authorities after a male transgender inmate “stood next to her and washed his scrotum area” in the shower while “making eye contact with her in the mirror,” citing her Islamic faith and the modesty requirements dictated in the Koran.⁵⁰ Women in California have filed similar claims, objecting to their women’s prisons housing biologically male inmates on safety grounds and on the grounds that the policies violated their sincerely held religious beliefs as Catholics and Muslims.

⁴⁸ *Federal Government Admits Two Trans Inmates Charged with Sexual Assault After Transfer to Women’s Prisons*, National Post (Sept. 2, 2026), <https://nationalpost.com/news/canada/transgender-inmates-charged-with-sexual-assault>; *Trans Prisoner Charged with Sexual Assault in Women’s Jail*, BBC NEWS (Apr. 24, 2026), <https://www.bbc.com/news/articles/c4g1ne43101o>.

⁴⁹ Jenna Russell, *Justice Dept. Scrutinizes Transgender Prisoner Housing in California and Maine*, N.Y. Times (Mar. 27, 2026), <https://www.nytimes.com/2026/03/27/us/doj-transgender-prison-housing-california-maine.html>.

⁵⁰ Andrea Mew, *Female Inmate Says Washington’s Trans Prison Policy Has Robbed Her of Her Religious Freedom*, IW Features (Oct. 31, 2024), <https://www.iwfeatures.com/documentary/female-inmate-says-washingtons-trans-prison-policy-has-robbed-her-of-her-religious-freedom/>.

See Chandler v. Macomber, No. 1:21-cv-01657 JLT HBK, 2026 WL 799916 (E.D. Cal. Mar. 23, 2026).⁵¹

In view of these serious challenges, prison administrators can reasonably decide that changing the physical appearance of prisoners who express discomfort with their sex simply presents too great a risk to the safety, security, and order of prisons to continue the practice.

CONCLUSION

The Court should grant the application for a stay.

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⁵¹ See also Eugene Volokh, *Court Rejects Women Inmates' Objections to California Law Related to Housing of "Transgender, Nonbinary, or Intersex" Inmates*, Reason (Mar. 23, 2026), <https://reason.com/volokh/2026/03/23/court-rejects-women-inmates-objections-to-california-law-related-to-housing-of-transgender-nonbinary-or-intersex-inmates/>.

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