No. 23-477

In the Supreme Court of the United States

UNITED STATES,
Petitioner,
v.
JONATHAN SKRMETTI, ET AL.,
Respondents.

On Writ of Certiorari to
the United States Court of Appeals
for the Sixth Circuit

BRIEF OF *AMICI CURIAE* THE AMERICAN COLLEGE OF PEDIATRICIANS, ALLIANCE FOR HIPPOCRATIC MEDICINE, AMERICAN ASSOCIATION OF CHRISTIAN COUNSELORS, ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, CATHOLIC MEDICAL ASSOCIATION, AND CHRISTIAN MEDICAL & DENTAL ASSOCIATION IN SUPPORT OF RESPONDENTS

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OCTOBER 15, 2024

TABLE OF CONTENTS

TABLE OF AUTHORITIES iii

INTRODUCTION AND INTEREST OF *AMICI CURIAE* 1

SUMMARY 3

ARGUMENT 5

I. The Arguments By The United States And Their Amici Are Based On A Tragic Misunderstanding Of Gender Incongruence And Dysphoria In Children. 5

A. "Transitioning" to a Different Sex Is Biologically Impossible. 6

B. Gender Incongruence and Dysphoria are Mental Health Issues, Not Body Issues. 9

C. In Natural Puberty, Gender Dysphoria Generally Desists On Its Own, Without Intervention. 12

II. Tennessee's Statute Protects Children. 15

A. Puberty Blockers Harm Children. 15

B. Cross-Sex Hormones Harm Children. 21

C. "Gender Transition" Surgery Harms Children 25

D. Puberty Blockers, Cross-Sex Hormones, and "Gender Transition" Surgery Do Not Lower the Risks of Suicide. 30

E. Children are Unable to Give Informed Consent to "Gender Transition" Procedures. 33

III. Tennessee's Statute Is Consistent With Sound Medical Practice. 36

A. The Proper Standard of Care for Minors with Gender Incongruity or Dysphoria is Mental Health Counseling, Not Hormones and Surgery. 37

B. Scientific Evidence Does Not Support Protocols from Organizations That Promote Hormonal and Surgical Interventions for Children. 40

CONCLUSION 45

APPENDIX:

Statements of Interest of *Amici Curiae* 1a

TABLE OF AUTHORITIES

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INTRODUCTION AND INTEREST OF *AMICI CURIAE*[1]

The world has witnessed an exploding number of gender-dysphoric children. And, while a significant segment of the international medical community has put a pause on hormonal and surgical interventions for children following the comprehensive review of the medical evidence by Dr. Hilary Cass for the National Health Services England ("Cass Review"), many U.S. advocates continue to silence debate around their preferred aggressive experimental medical interventions beginning at the onset of puberty or even earlier. Such interventions include puberty blockers and cross-sex/wrong-sex hormonal intervention followed by radically invasive surgeries for minors experiencing what studies show is most often a temporary issue in young people. And, as the growing number of "detransitioners" attests, their permanent scars and resulting infertility from these unproven interventions cannot be undone, no matter how great their regret. In the statute at issue in this case, Tennessee lawfully acted to protect its children from these enormous risks and harms.

These developments are also of great concern to *Amici,* which include some of the Nation's leading, science-oriented medical organizations. For example, the American College of Pediatricians (the College or ACPeds) is a national organization of nearly 500

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[1] This brief was not authored in whole or in part by counsel for any party and no person or entity other than *amici curiae* or its counsel has made a monetary contribution toward the brief's preparation or submission.

board-certified pediatricians or related specialists with active practices in 47 different states, all dedicated to the health and well-being of children. Formed in 2002, the College is a scientific medical association committed to producing policy recommendations based on the best available scientific research. The College strives to ensure that all children reach their optimal physical and emotional health and well-being. Additional *amici* are described in the Appendix.[2]

Amici'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, *Amici's* members cannot harm or lie to their patients. Based on the Hippocratic Oath and on science, *Amici* categorically exclude providing medical interventions or referrals for "gender transition" procedures because they inherently harm children. *Amici* have a direct interest in the outcome of this case because it affects the vulnerable population *Amici* serves.

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[2] In keeping with these objectives, the American College of Pediatricians, other medical organizations representing over 75,000 physicians and healthcare providers, and over 5,200 individual signatories, recently issued a declaration—the Doctors Protecting Children Declaration—stating that "Medical decision making should respect biological reality and the dignity of the person by compassionately addressing the whole person. * * * [Yet,] [g]ender ideology seeks to affirm thoughts, feelings and beliefs, with puberty blockers, hormones, and surgeries that harm healthy bodies, rather than affirm biological reality." Decl., Doctors Protecting Children (2024), https://doctorsprotecting children.org/.

SUMMARY

As Tennessee's legislature recognized, treatment of children and adolescents with gender incongruity and dysphoria should be based on sound scientific evidence, especially before placing them on hormones that permanently alter their bodies causing sterility and a host of other physical and psychological problems, and prior to altering their natural anatomy.

I. Scientific research shows that children with gender incongruence or dysphoria almost always have significant mental health struggles and adverse childhood events that contribute to if not cause their dysphoria. And multiple studies show that these children almost always grow out of or desist from such gender incongruity while going through puberty.

II. Yet when children are placed on puberty blockers and/or cross-sex hormones, they almost always proceed to "gender transition" surgeries with life-long adverse consequences. Just as alarming is that these children—often 11 years old or even younger—are incapable of making such life-altering decisions.

When it comes to puberty blockers, cross-sex hormones, and "gender transition" surgeries, moreover, there are no long-term, reliable studies on the benefits from starting a child on this pathway. What is known is that children show minimal mental health improvements in the short-term and significant mental health issues in the long-term. It is also clear that such hormonal and surgical interventions do nothing to treat the underlying mental health struggles these children face, even as the "treatments"

themselves create severe adverse health consequences.

And that is one of many reasons the decision below should be affirmed: Tennessee's statute lawfully protects children from these unnecessary harms—to their current and future health, and to their future ability to become parents.

III. Tennessee's law is also consistent with sound medical practice: Rather than push a pre-teen to drugs and permanent body-altering surgery, the appropriate medical treatment is to address the child's underlying mental health issues while allowing the child to go through natural puberty. That is what their bodies were meant to do. And, upon reaching adulthood, the vast majority of children who were not "affirmed" in a gender-incongruent identity will no longer feel any distress in their sex. And there is no way to know whether a child aged eleven is going to be the exceptional case of someone who doesn't simply "grow out of" his or her adolescent gender dysphoria.

The scientific evidence thus undermines and conflicts with the politically motivated guidelines being pushed by various organizations. The lack of an evidence-based foundation for these groups' recommendations not only renders their guidelines useless, but it reveals that they are actually dangerous to the vulnerable children they are supposed to help. Tennessee, by contrast, followed sound science in protecting gender-incongruent and dysphoric children by banning hormonal and surgical interventions for "gender transition" purposes.

ARGUMENT

By prohibiting the use of puberty blockers, cross-sex hormones, and surgical interventions for the purpose of "gender transition," Tennessee properly requires that treatment of children with gender incongruence be based on valid scientific evidence and grounded in biological reality. Respondents persuasively set forth the reasons why Tennessee's SB1 is constitutionally permissible (Respondents' Br. Secs. I-III). And this brief provides additional support for the important and indeed compelling interests served by the Tennessee statute and discussed in Section IV of Respondents' Brief. In short, the scientific evidence demonstrates not just a lack of benefit to children suffering from gender incongruence from the hormonal and surgical interventions Tennessee prohibits, but clearly points to the significant and life-long harms to children who are subjected to hormonal and surgical efforts to change their sex. The decision of the Sixth Circuit upholding Tennessee's SB1 should be affirmed.

I. The Arguments By The United States And Their Amici Are Based On A Tragic Misunderstanding Of Gender Incongruence And Dysphoria In Children.

To understand why many states prohibit the experimental medical procedures at issue here, it is helpful to briefly outline appropriate terminology and what is known about gender incongruence in children.

A. "Transitioning" to a Different Sex Is Biologically Impossible.

We begin with the reality that sex is a biological, immutable characteristic—a scientific fact, not a social construct. As ACPeds has previously pointed out, "[b]iological sex is almost always easily identifiable at birth (if not before) based upon phenotypic expression of chromosomal complement [XX for female, and XY for male]. * * * To describe sex as 'assigned at birth' is inaccurate and misleading."[3] Accordingly, "[f]rom a purely scientific standpoint, human beings possess a biologically determined sex and innate sex differences. No [physician or surgeon] could actually change a person's genes through hormones and surgery. Sex change is objectively impossible."[4]

1. Proponents of gender "transitions"—like the World Professional Association for Transgender Health (WPATH), the American Academy of Pediatrics (AAP), and the Endocrine Society—typically do not dispute these scientific realities. Instead, their strategy has been to hijack the word "gender" and infuse it with a new meaning. This movement is well summarized in the *amicus* brief by the Society for Evidence-Based Gender Medicine

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[3] Am. Coll. of Pediatricians (ACPeds), *Mental Health in Adolescents with Incongruence of Gender Identity and Biological Sex* 2 (2024), https://tinyurl.com/2s3aa6a9 [hereinafter, ACPeds, *Mental Health in Adolescents*] (citing extensive scientific research).

[4] *Ibid.*

(SEGM).[5] And it is against this background that efforts to treat minors who express discomfort with their sex should be understood.

2. The scientific term that best describes the condition of concern here is gender dysphoria. As ACPeds has elsewhere explained, 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."[6] Fortunately, the prevalence rates of gender dysphoria among children has been estimated to be less than 1%.[7]

Such an expression or even desire, however, cannot and does not change the child's sex.

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[5] As ACPeds has elsewhere explained, "John Money, PhD, was among the most prominent of these sexologists who redefined gender to mean 'the social performance indicative of an internal sexed identity.' In essence, these sexologists invented the ideological foundation necessary to justify their treatment of transsexualism with sex reassignment surgery and called it gender. It is this man-made ideology of an innate and immutable 'internal sexed identity' that now dominates mainstream medicine, psychiatry and academia. This linguistic history makes it clear that gender is not and never has been a biological or scientific entity. Rather, gender is a socially and politically constructed concept." Am. Coll. of Pediatricians (ACPeds), *Gender Dysphoria in Children* 3 (Nov. 2018), https://tinyurl.com/4znwftd2 (citing sources; footnote omitted).

[6] *Id*. at 1.

[7] *Id*. at 1 (footnote omitted). 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. Psych. Ass'n, *Diagnostic and statistical manual of mental disorders: DSM-5,* at 454 (5th ed. 2013).

Accordingly, the use of terms such as "transgender" or "cisgender" to 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).

3. An understanding that a child's sex cannot be changed makes it immediately clear that interventions designed to promote or confirm an incongruent gender identity are likely to harm the child. As explained in detail below, there is simply no evidence that a child benefits from social "transition," use of puberty-blockers, cross-sex hormones, or surgery to alter the body's physical appearance to look like the opposite or no sex.

Calling such procedures "gender affirming care," moreover, is a misnomer—as they are specifically designed to *entrench* a mental health condition of gender incongruence or dysphoria. Rather, such interventions are properly understood as "gender-transition" efforts even though it remains impossible to "transition" from one sex to the other by social, hormonal, or surgical interventions.

Finally, rejection of the "gender-affirming care" myth doesn't reflect any form of sex discrimination. Medicine is often sex-specific because males and females often need treatments and pharmaceutical doses specific to their sex. For example, females are scheduled for a pelvic exam as part of a wellness check while males are scheduled for a testicular exam, neither of which is applicable to the other sex. Additionally, if a teenager presents with abdominal pain, a pregnancy test would be appropriate for a

female, but not a male. Further, the use of estrogen or testosterone treatments are themselves sex-specific based on the biological realities of the patient being male or female.[8]

Such sex-specific treatment is not sex discrimination, but sound medicine that recognizes the patient's biological reality.

B. Gender Incongruence and Dysphoria are Mental Health Issues, Not Body Issues.

It follows that gender dysphoria (GD) or, equivalently gender identity disorder (GID), is a problem that resides in the mind, not in the body.

1. In other words, as ACPeds has elsewhere explained:

> Children with GD do not have a disordered body—even though they feel as if they do. Similarly, a child's distress over developing secondary sex characteristics does not mean that puberty should be treated as a disease to be halted, because puberty is not, in fact, a disease. Likewise, although many men with GD express the belief

[8] 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*, Annals of Pharmacotherapy 1, 8 (2024), doi:10.117/10600280241231612 (noting the harms and adverse drug reactions from the use of such therapies in the opposite sex for gender transition purposes).

> that they are a 'feminine essence' trapped in a male body, this belief has no scientific basis." [9]

Indeed, as another leading researcher has put it, "[g]ender non-contentedness has previously been associated with mental health problems and clinical gender dysphoria has been reported to co-occur with diverse psychiatric problems, such as depression and anxiety disorders, eating disorders, and autism spectrum disorder[.]"[10] Accordingly, treating gender

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[9] ACPeds, *Gender Dysphoria in Children*, *supra* note 5, at 9.

[10] Pien Rawee et al., *Development of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 Archives of Sexual Behav. 1813, 1822 (2024) (internal citations omitted), doi.org/10.1007/s10508-024-02817-5; see also ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 3 ("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 Psych. & 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 GD); Gunter Heylens et al., *Psychiatric characteristics in transsexual individuals: multicentre study in four European countries*, 204 Brit. J. Psych. 151, 152 & tbl. 2 (2014), doi:10.1192/bjp.bp.112.121954 (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).

dysphoria, especially in children, as a mental health disorder is the appropriate focus for medical providers.

2. While the cause of gender incongruence remains open to debate, there is no evidence of a hormonal cause for the condition. What is known about children experiencing gender incongruity is that they are two to three times more likely to have suffered from an adverse childhood event such as sexual abuse, emotional neglect, emotional abuse, or a family member with mental illness.[11] Indeed, it is well accepted that a child's emotional and psychological development are affected by positive and negative experiences beginning in infancy.[12]

Further, when evaluating and treating children with gender incongruity, it remains important to recognize, as ACPeds has elsewhere emphasized, that "[t]here is no single family dynamic, social situation, adverse event, or combination thereof that has been found to destine any child to develop GD."[13] Yet "studies suggest that social reinforcement, parental psychopathology, family dynamics, and social contagion facilitated by mainstream and social media,

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[11] ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 5 (citing, among others, Anna Austin et al., *Adverse childhood experiences related to poor adult health among lesbian, gay, and bisexual individuals*, 106 Am. J. Pub. Health 314 (2016); Shelley L. Craig et al., *Frequencies and patterns of adverse childhood events in LGBTQ+ youth*, 107 Child Abuse & Neglect 104623 (2020)).

[12] ACPeds, *Gender Dysphoria in Children*, *supra* note 5, at 6.

[13] *Ibid*. (emphasis omitted).

all contribute to the development and/or persistence of GD in some vulnerable children."[14]

In short, the available, credible science suggests that mental health treatment should be the focus for children expressing gender incongruence and not hormonal or surgical interventions. Avoiding invasive, dangerous, and irreversible medical interventions such as those prohibited by Tennessee benefits children and saves them from serious and life-long harms.

C. In Natural Puberty, Gender Dysphoria Generally Desists On Its Own, Without Intervention.

Fortunately, it has long been recognized that "80-95% of the prepubertal children with GID will no longer experience a GID in adolescence."[15] In a recent study, Pien Rawee and colleagues followed a study

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[14] *Ibid.* (citing, among others, Kenneth J. Zucker & Susan J. Bradley, *Gender Identity and Psychosexual Disorders*, 3 FOCUS 598 (2005)).

[15] Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1893 (2008),https://tinyurl.com/58m8uw3h; Devita Singh et al., *A Follow-Up Study of Boys With Gender Identity Disorder*, 12 Frontiers in Psych. 632784, at 1, 8 (2021), doi:10.3389/ fpsyt.2021.632784 (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 his 2018 paper, *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), https://tinyurl.com/5empbxs3.

group beginning at age 11 through age 25. According to the study, "children and adolescents referred for gender dysphoric feelings had a more negative self-concept compared to the standardization sample of the questionnaire."[16] However, while that was the case early in puberty, any "gender non-contentedness * * * decreased with age."[17] And overall, the scientific evidence is that the vast majority of children who express discomfort with their sex at the start of puberty overwhelmingly express no gender discomfort after going through puberty.[18]

Equally important, while natural desistence predominates, children in such studies who socially "transitioned"[19] in early childhood were more likely to have persisting feelings of gender dysphoria.[20] The same is true for children who are started on puberty blockers to address gender confusion.[21]

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[16] Rawee, *supra* note 10, at 1814.

[17] *Id*. at 1818.

[18] *Ibid.* (in the study, 78% of the children expressed no gender non-contentedness throughout the study with 19% expressing gender non-contentedness at the start of puberty but none by the time they reached age 25, leaving the last 2% who showed a persistence with gender non-contentedness).

[19] Social transitioning "consists of first affirming the child's false self-concept by instituting name and pronoun changes, and facilitating the impersonation of the opposite sex within and outside of the home." ACPeds, *Gender Dysphoria in Children*, *supra* note 5, at 11.

[20] Rawee, *supra* note 10, at 1814 (citation omitted); see also ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 7.

[21] ACPeds, *Gender Dysphoria in Children*, *supra* note 5, at 12 (study of 70 pre-pubertal candidates to receive puberty suppression showed that every child "eventually embraced a

In other words, following WPATH, AAP and the Endocrine Society's recommendations pushes children at age 11 or even younger onto a pathway that will result in life-long hormone interventions, sterilization, and no improved mental health concerns as noted below. Yet, when allowed to go through natural puberty, children overwhelmingly desist such incongruence and accept their biological sex.[22] That is what Tennessee allows to occur with its ban on hormonal and surgical interventions for minors.

Accordingly, the evidence-based approach is to simply allow a child to grow up without being "affirmed" in an incongruent gender identity. This is critical since there is no test to determine which small minority of children experiencing gender incongruence at age 11 will persist in such feelings into adulthood

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transgender identity and requested cross-sex hormones"); Hilary Cass for NHS England, The Cass Review, Final Report 176, § 14.24 (2024), https://tinyurl.com/ysew5cbu [hereinafter, Cass Review].

[22] Ironically, the American Psychological Association in their *Handbook of Sexuality and Psychology* states that "[p]remature labeling of gender identity should be avoided. Early social transition (i.e., change of gender role, * * *) should be approached with caution to avoid foreclosing this stage of (trans)gender identity development." Walter O. Bockting, *Chapter 24: Transgender Identity Development, in* 1 Am. Psych. Ass'n, *APA Handbook of Sexuality and Psychology* 744 (Deborah L. Tolman & Lisa M. Diamond eds., 2014). And as for premature affirmation: "This approach runs the risk of neglecting individual problems the child might be experiencing and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist[.]" *Id.* at 750.

unless forced onto that path by medical intervention or social affirmation.[23]

II. Tennessee's Statute Protects Children.

It is against this background that Tennessee's statute prohibiting hormonal and surgical interventions for minors seeking gender transition needs to be evaluated. Moreover, as shown below, each of the interventions typically used in an effort to "transition" a minor to a different sex poses enormous risks, has not been shown to reduce other risks such as suicide, and cannot be ethically administered to a child who is incapable of making permanent, life-altering decisions such as the decision to become permanently sterile.

A. Puberty Blockers Harm Children.

The first medical intervention recommended by "gender affirming care" proponents for a child who expresses discomfort with his or her sex is hormonal—specifically, delaying or preventing natural puberty with puberty blockers and then moving on to cross-sex hormones. Such procedures are dangerous to a child's mental and physical development. And, rather than giving 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 they would

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[23] See Doctors Protecting Children Decl., *supra* note 2, ¶ 4; Cass Review, *supra* note 21, at 193, § 16.8; ACPeds, *Gender Dysphoria in Children*, *supra* note 5, 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").

most likely never need as the overwhelming majority of children desist with gender incongruity after puberty as noted above.

1. Puberty blockers interrupt the normal process of sexual development in children. As the Cass Review correctly noted, "[p]uberty is triggered when the hypothalamus starts a hormone cascade which results in the ovaries and testes producing oestrogen and testosterone respectively. Both males and females proceed through the 5 stages of puberty known as Tanner stages."[24] And there is no denying that puberty blockers prevent the natural development that occurs during puberty.[25] The issue is the long-term effects of using these drugs for a purpose for which they were never intended, understanding that using such medications for gender transition is "very different" from use when treating precocious puberty.[26]

The principal puberty-blocking medications, known as GnRH agonists, while approved for addressing precocious puberty, are not FDA-approved for treatment of gender dysphoria.[27] In this context, as ACPeds has elsewhere noted, "[t]he GnRH agonists used for pubertal suppression in gender dysphoric children include two that are approved for the treatment of precocious puberty: leuprolide by intramuscular injection with monthly or once every three month dosing formulations, and histrelin, a

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[24] Cass Review, *supra* note 21, at 172, § 14.3.

[25] *Id*. at 175, § 14.20.

[26] *Id*. at 173, § 14.6.

[27] Gomez-Lumbreras & Villa-Zapata, *supra* note 8, at 4.

subcutaneous implant with yearly dosing."[28] But these have serious side-effects: "In addition to preventing the development of secondary sex characteristics, GnRH agonists arrest bone growth, decrease bone accretion, prevent the sex-steroid dependent organization and maturation of the adolescent brain, and inhibit fertility by preventing the development of gonadal tissue and mature gametes for the duration of treatment."[29]

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. Therefore, there is no way of knowing whether the normal trajectory of the sexual and gender identity may be permanently

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[28] ACPeds, *Gender Dysphoria in Children*, *supra* note 5, at 12 (footnote omitted).

[29] *Id* at 12 (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 Studies 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 which his why "GnRHa treatment in children with gender dysphoria should be considered experimental treatment of individual cases rather than standard procedure." See Jonas F. Ludvigsson et al., *A Systematic Review of Hormone Treatment for Children with Gender Dysphoria and Recommendations for Research*, 112 Acta Pediatrica 2279, 2280, 2286-2290 (2023).

altered."[30] This is so because, when placing pre-teens on puberty blockers "[t]heir experience of puberty will then be based on their identified gender, which may have permanent neuropsychological effects."[31] As noted above, this denies the child the opportunity to naturally grow out of the discomfort they feel with their sex at age 11, a desistance that is the norm if they are not "affirmed" in their incongruent identity at such a young age.

2. While blocking a child's natural development, puberty blockers have not been shown to benefit the child psychologically. Rather, studies demonstrate "there is insufficient and/or inconsistent evidence about the effects of puberty suppression on psychological or psychosocial health" of young people.[32] Indeed, as the Cass Review noted, the fact that only very modest and inconsistent improvements in mental health were seen, even in the studies that reported some psychological benefits from the use of puberty blockers, makes it all the more important to assess whether other treatments may have a greater effect on the distress that young people with gender dysphoria are suffering during puberty.[33]

The lack of any real improvement in mental health is only one reason to prohibit the use of puberty blockers in children for gender "transition" purposes. Another reason is the lack of evidence of the long-term effects these drugs have on children. Indeed, as

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[30] Cass Review, *supra* note 21, at 178, § 14.37.

[31] *Id.* at 194, § 16.19.

[32] *Id.* at 176, § 14.28.

[33] *Id.* at 177, § 14.29; see also *id.* at 180, § 14.55.

ACPeds has previously noted, "[t]here is not a single large, randomized, controlled study that documents the alleged benefits and potential harms to gender-dysphoric children from pubertal suppression and decades of cross-sex hormone use. Nor is there a single long-term, large, randomized, controlled study that compares the outcomes of various psychotherapeutic interventions for childhood GD with those of pubertal suppression followed by decades of toxic synthetic steroids."[34] But beyond this, "[t]here are serious long-term risks associated with the use of social transition, puberty blockers, masculinizing or feminizing hormones, and surgeries, not the least of which is potential sterility."[35] These are some of the reasons the Swedish National Board of Health and Welfare, based on a comprehensive review of the evidence-based research addressing gender dysphoria in children, concluded that "the risks of hormonal interventions for gender dysphoric youth outweigh the potential benefits."[36]

Indeed, puberty blockers by themselves often result in the child's becoming sterile. This is because,

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[34] ACPeds, *Gender Dysphoria in Children*, *supra* note 5, at 10; see also ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 8 (referencing McMaster University Department of Health Research Methods systematic review done at request of the Florida Agency for Health Care Administration); Cass Review, *supra* note 21, at 194, § 16.14.

[35] Doctors Protecting Children Decl., *supra* note 2, ¶ 5 (citing numerous sources).

[36] *Summary of Key Recommendations from the Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW), February 2022 update,* Soc'y for Evidence-Based Gender Med. (Feb. 27, 2022), https://tinyurl.com/2je6phjv.

as ACPeds has noted, "GnRH agonists prevent the maturation of gonadal tissue and gametes in both sexes, youth who graduate from pubertal suppression at Tanner Stage 2 to cross-sex hormones will be rendered infertile without any possibility of having genetic offspring in the future because they will lack gonadal tissue and gametes for cryo-preservation. The same outcome will occur if pre-pubertal children are placed directly upon cross-sex hormones."[37] And "[c]hildren who transition will require these hormones for a significantly greater length of time than their adult counterparts."[38]

In addition to making a child sterile, puberty blockers and cross-sex hormones have significant impact on brain development. Indeed, as the Cass Review noted, as a result of such hormones offered for "gender transition" purposes, "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."[39] 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

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[37] ACPeds, *Gender Dysphoria in Children*, *supra* note 5, at 13 (citing Schmidt & Levine, *supra* note 29).

[38] *Ibid.* (citing sources).

[39] Cass Review, *supra* note 21, at 178, § 14.38.

puberty."[40] Indeed, a study from the Netherlands found that administering puberty blockers to children with precocious puberty for one year resulted in a 7-point drop in intelligence quotient.[41]

In short, 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 also called for "an immediate moratorium on the use of puberty blocker drugs because of their unknown long-term effects."[42]

B. Cross-Sex Hormones Harm Children.

Cross-sex hormone interventions are equally dangerous, subjecting a young person to high doses of hormones never intended for their bodies. 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, as one researcher has described, females are typically

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[40] ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 13 (citing Pilar Vigil et al., *Influence of sex steroid hormones on the adolescent brain and behavior*, 83 Linacre Q. 308 (2016)).

[41] Dick Mul et al., *Psychological Assessments Before and After Treatment of Early Puberty in Adopted Children*, 90 Acta Paediatrica 965, 970 (2001).

[42] 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://tinyurl.com/34eya7y8; Am. Coll. of Pediatricians (ACPeds), *Transgender Interventions Harm Children,* https://tinyurl.com/586zp6wh (last visited Oct. 6, 2024); see also Cass Review, *supra* note 21, at 179, § 14.49.

given testosterone to achieve levels "6 to 100 times above normal female circulating testosterone levels"—levels "generally only seen among patients with rare conditions such as benign or malignant androgen producing tumors of the adrenal gland or ovaries orthose who misuse androgens in bodybuilding and other sports.[43] And there are no studies demonstrating that such doses in children is safe or reversible.[44]

Indeed, 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, as the case may be.[45] In their recent study, Ainhoa Gomez-

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[43] Michael Laidlaw & Sarah Jorgensen, Comment, *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*, Annals of Pharmacotherapy 1, 1 (2024) (footnotes omitted), doi:10.1177/10600280241278913.

[44] "In fact, the package insert for Lupron, the number one prescribed puberty blocker in America, lists 'emotional instability' as a side effect and warns prescribers to 'Monitor for development or worsening of psychiatric symptoms during treatment.'" ACPeds, *Transgender Interventions Harm Children*, *supra* note 42.

[45] Such negative adverse reactions are no surprise to WPATH as they have known of serious adverse consequences for some time. 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*." Env't Progress, *WPATH Files Excerpts: Exposing the Realities of Gender Medicine* 7 (italicization and alterations

Lumbreras, MD, PhD, and Lorenzo Villa-Zapata, PharmD, PhD, found there were significant adverse drug reactions to "gender transition" hormone therapy, noting that the drugs used were "unintended for their recipient gender."[46] "The results highlight that hormone therapies for gender reassignment are predominantly administered off-label. Although these therapies were originally approved for addressing hormone-related conditions in one gender, they have been repurposed to assist individuals in trying to "transition" to that gender—a purpose not officially endorsed on their labels."[47] 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."[48]

For example, "[t]ransgender men [females] predominantly reported idiopathic intracranial hypertension and breast cancer as ADRs."[49] The overwhelming majority of adverse drug reactions,

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in original; underscore added), https://tinyurl.com/w23aar2n (last accessed Oct. 6, 2024) [hereinafter, *WPATH Files Excerpts*].

[46] Gomez-Lumbreras & Villa-Zapata, *supra* note 8, at 1.

[47] *Id.* at 4.

[48] *Id.* at 8; see also *id.* at 4 ("The ADRs for hormone treatments are described on the drug labels, but they typically pertain to the opposite sex of those transitioning for gender reassignment.").

[49] *Id.* at 4. Indeed, 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 compared to natal Dutchmen. 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).

nearly 88%, were "deemed serious" and consisted of "injury, poisoning, and procedural complications," "psychiatric disorders" consisting of "anxiety," "depression," and "suicidal ideation," as well as "nervous system disorders" such as "idiopathic intracranial hypertension" and "neoplasms * * * with breast cancer being the most common[.]"[50] Not surprisingly, nearly a third of the adverse drug reactions resulted in hospitalization in addition to two deaths.[51]

For men seeking to "transition" to a woman, the most common adverse drug reactions were "meningioma and depression."[52] Over half of the ADRs were classified "as serious," with over a quarter of ADRs 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[.]"[53]

In addition, the study found that, "[a]s more individuals with gender dysphoria seek gender reassignment treatments, ADRs concerning sexual and reproductive health have become prominent."[54] Such outcomes should be of no surprise given the impacts on a child's fertility.

Finally, those receiving these interventions continue to have serious mental health concerns. For

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[50] *Id.* at 3-4.

[51] *Id.* at 3 & tbl.1.

[52] *Id.* at 4.

[53] *Ibid.*

[54] *Id.* at 7.

example, a recent Finnish study "demonstrated that transgender individuals who underwent medical transition had increased needs for specialist-level psychiatric care compared to those transgender individuals who presented for care but did not receive medical interventions."[55] In short, these hormonal treatments permanently harm children and Tennessee was right to bar them for "gender transition" purposes.

C. "Gender Transition" Surgery Harms Children

So-called "gender transition" surgeries are even more harmful to children. The concept of surgically altering minors suffering from gender dysphoria became accepted in the Netherlands in the early 1980s. This was borne out of the realization that sex reassignment occurring in adulthood failed to relieve the psychological suffering of gender dysphoria. It was surmised that transitioning patients earlier would benefit their psychological well-being and make the surgical changes in a patient's secondary sex characteristics easier. But neither of these two suppositions proved true. In addition, there were no clinical studies to support this notion. Nor were clinical studies designed to answer this question. This gave rise to the phenomenon of "runaway diffusion," where a clinical practice, not fully vetted, is nonetheless associated with the standard of care.

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[55] ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 9; see also Cass Review, *supra* note 21, at 185, § 15.32; *id.* at 186, § 15.34.

As noted above, once a child starts on a path of hormonal interventions, it frequently leads to surgical procedures either before or after the child's 18th birthday. These surgeries sterilize the child and permanently change the child's development. As a result, as ACPeds has elsewhere noted, "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, and it becomes clear that affirming transition in children is about mutilating and sterilizing emotionally troubled youth."[56] Tennessee properly bans these procedures for "gender transition" purposes for minors.

1. Examples of "transitioning" surgeries performed on those with gender dysphoria include:

- Removing healthy breasts, uteruses, or ovaries from females who purport to identify as males, nonbinary, or who otherwise do not identify as females (hysterectomies, mastectomies, and oophorectomies);
- Removing healthy vaginal tissue from females who purport to believe themselves to be males, nonbinary, or otherwise not to be female, and creating for them a faux or cosmetic penis (phalloplasties and metoidioplasties) usually requiring microvascular transplantation of tissue from one part of the body to the other, most commonly the forearm or thigh;

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[56] ACPeds, *Transgender Interventions Harm Children*, *supra* note 42.

- Removing healthy testicles or scrotums from males who purport to believe themselves to be female (orchiectomies or scrotectomies);
- Performing a procedure known as an inversion vaginoplasty whereby the erectile tissue of the penis is amputated and the outer skin of the penis is inverted into a space created between the bladder and the rectum to form a false vagina;
- Removing healthy internal or external genitals from any person to create a "smooth gender-neutral look" (nulloplasties or nullification surgeries); and
- Performing other procedures sought to make a person resemble the opposite sex or no sex, such as facial, chest, neck, skin, hair, or vocal modification.

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 (someone who identifies as disabled even though they have a fully capable body), so also surgery to "transition" a child's sex should be considered unethical, unscientific, and malpractice.

And it goes without saying that "transgendered individuals who undergo sex reassignment surgery and have their reproductive organs removed are

rendered permanently infertile."[57] This too inflicts permanent, irreversible harm on a child's future possibilities of biological parenthood.

2. Additionally, published data show that the complications of transgender surgery, which by its very nature is elective and cosmetic, far exceed the complication rates of other cosmetic operations. For example, a review of 125 articles on vaginoplasty revealed a complication rate of 32.5%.[58] Similarly, the largest single-surgeon experience in vaginoplasty is from the Crane Center in San Francisco, who reported a total complication rate of 70%.[59]

The complication rates for phalloplasty are equally disturbing. These operations are technically difficult and require the transplantation of tissue from one part of the body to the groin, usually from the forearm or the thigh. An operating microscope and suture material finer than hair are utilized to reconnect the small arteries and veins.

Perhaps the most experienced and skilled surgeons performing this procedure are in the Netherlands. Despite their experience, the reported complication rates are high: Following the formation

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[57] ACPeds, *Gender Dysphoria in Children*, *supra* note 5, at 13 (citing among others Jeffreys, *supra* note 29).

[58] Paulette Cutruzzula 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, 193-194 & tbl. 1 (2018).

[59] Jonathan P. Massie et al., *Predictors of Patient Satisfaction and Postoperative Complications in Penile Inversion Vaginoplasty*, 141 Plastic Reconstructive Surgery 911e, 915e-916e & tbl. 2 (2018).

of a false penis, their patients have experienced a urethral stricture rate (unable to void due to scarring in the urethra requiring catheterization to void) of 63%, and a urethral fistula rate (leaking urine from the base of the false penis, requiring diapers) of 27-50%. They also reported a revisional surgery rate of 73%.[60] These are extremely high surgical complication rates. And it can only be assumed the rates are higher in adolescents who have underdeveloped genitals from years of cross-sex hormones.

3. Given these widespread complications, it came as no surprise that, in July 2024, the American Society of Plastic Surgeons (representing 90% of board-certified plastic and reconstructive surgeons in the United States and Canada) cautioned that there is "considerable uncertainty as to the long-term efficacy for * * * chest and genital surgical inventions" for youth."[61] And Dr. Steven Williams, the president of the American Society of Plastic Surgeons has recently publicly stated that he would not "even entertain" surgically transitioning minors because there is a lack of data to support it.[62]

Indeed, research shows that every medical gender intervention being offered to minors from puberty

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[60] H. Veerman et al., *Functional Outcomes and Urologic Complications After Genital Gender Affirming Surgery With Urethral Lengthening In Transgender Men*, 204 J. Urology 104, 104, 107 (2020).

[61] Leor Sapir, *A Consensus No Longer*, City J. (Aug. 12, 2024), https://tinyurl.com/2zt898sr.

[62] Rich McHugh, *'No Good Evidence' for Teen Gender Surgery: Plastic Surgeons Head,* NewsNation (Sept. 2, 2024), https://tinyurl.com/bdhr8s39.

blockers to surgical removal of healthy organs, is irreversible and is likely to have serious adverse consequences. In addition to infertility, surgical risks, and the harms of ongoing cross-sex hormones noted above, there is the severe ongoing mental distress. Indeed, a Swedish study that followed patients from 1973 to 2003, found that "Sex-reassigned 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 follow up, the suicide rate was 19 times that of age-matched controls."[63]

From a medical and scientific standpoint, then, Tennessee acted prudently in seeking to protect its children from these enormous risks and harms.

D. Puberty Blockers, Cross-Sex Hormones, and "Gender Transition" Surgery Do Not Lower the Risks of Suicide.

Notwithstanding these serious health risks, proponents of hormonal and surgical interventions claim they help reduce the risk of suicide among gender dysphoric children. Indeed, as ACPeds' members have observed, "many parents are specifically told that if they do not accept their children's gender identity via social transition, medical treatment, and surgical operations, they risk losing their children to suicide."[64] Yet the scientific

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[63] Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLoSOne e16885, e16885 (2011); ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 9-10 (emphasis added).

[64] ACPeds, *Mental Health in Adolescents, supra* note 3, at 3.

evidence does not support such a claim, which only guilts or scares a parent into authorizing "gender transition" treatments.

1. For example, addressing this very issue, the Cass Review did a detailed analysis of studies on the relationship between gender dysphoria and suicide. The review found that the studies did not support a claim that a "medical pathway * * * [of] gender-affirming treatment reduces suicide risk."[65]

To the contrary, it is by now well established that, as ACPeds has elsewhere summarized, "over 90 percent of people who die of suicide have a diagnosed mental disorder. There is no evidence that gender-dysphoric children who commit suicide are any different. Therefore, the cornerstone for suicide prevention should be the same for them as for all children: early identification and treatment of psychological co-morbidities."[66]

This point was illustrated in a recent Finnish study among a population of 2,083 "gender-referred adolescents," which revealed that the suicide rate in these adolescents was equal to the suicide rate in 16,643 controls when the groups were matched for

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[65] Cass Review, *supra* note 21, at 186, § 15.36; see generally *id.* at 186-187, §§ 15.36-15.43.

[66] ACPeds, *Gender Dysphoria in Children*, *supra* note 5, at 10 (footnote omitted); Matthew K. Nock et al., *Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: results from the National Comorbidity Survey Replication Adolescent Supplement*, 70 JAMA Psych. 300 (2013); Jonathan Cavanagh et al., *Psychological autopsy studies of suicide: a systematic review*, 33 Psych. Med. 395 (2003), https://tinyurl.com/mr32h8vb.

underlying mental disorders.[67] In other words, the underlying mental disorder was the cause of the suicide.[68] And, as the Cass Review concluded, "Tragically deaths by suicide in trans people of all ages continue to be above the national average, but there is no evidence that gender-affirmative treatments reduce this. Such evidence as is available suggests that these deaths are related to a range of other complex psychosocial factors and to mental illness."[69]

2. Those other factors are clearly borne out in the research, which demonstrates that "gender transition" services generally do not address or resolve the underlying mental health and psychosocial issues that contributed to the feelings of gender incongruity in the first place. While those who identify as transgender have "significantly higher rates of suicide attempts, suicide mortality, suicide-unrelated mortality, and all-cause mortality,"[70] studies show that puberty blockers do not address these issues, but may actually make them worse.

For example, when discussing an experimental trial of puberty blockers in the U.K., Oxford University Professor Michael Biggs wrote, "There was no

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[67] Cass Review, *supra* note 21, at 96, § 5.66.

[68] Sami-Matti 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, 3 & tbl. 1 (2024).

[69] Cass Review, *supra* note 21, at 195, § 16.22.

[70] ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 10 (citing Annette Erlangsen et al., *Transgender Identity and Suicide Attempts and Mortality in Denmark*, 329 *JAMA* 2145 (2023)).

statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. In addition, there is unpublished evidence that after a year on [puberty blockers] children reported greater self-harm, and the girls also experienced more behavioral and emotional problems and expressed greater dissatisfaction with their body—so puberty blockers exacerbated gender dysphoria."[71]

In short, in the long term, sex reassignment surgery does not result in a level of health equivalent to that of the general population—with studies finding "considerably lower general health and general life satisfaction" and that "the rate of suicide among post-operative transgender adults was nearly twenty times greater than that of the general population."[72] Taken together, the evidence indicates that sex reassignment does not give the patient a level of mental health on par with the general population.

E. Children are Unable to Give Informed Consent to "Gender Transition" Procedures.

As if the inherent harms and lack of benefits from the procedures themselves were not enough to justify their ban for "gender transition" purposes in minors, children with gender incongruence are not even capable of giving informed consent to such interventions.

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[71] ACPeds, *Transgender Interventions Harm Children*, *supra* note 42.

[72] ACPeds, *Gender Dysphoria in Children*, *supra* note 5, at 15 (citing Dhejne, *supra* note 63).

1. This is obvious when considering the known medical evidence on the development of the juvenile brain and understanding that these "treatments" do nothing to address the child's underlying mental health concerns.

As ACPeds has elsewhere noted, "[t]he immaturity of the adolescent brain has been well described for the past 20 years, and newer research demonstrates how the immaturity affects decision-making. Studies confirm that adolescents, when faced with real life decisions, are much more likely to depend upon their emotions and peer pressure, with less use of their cognitive reasoning skills and with less concern for future consequences. The rise of rapid-onset gender dysphoria in adolescent girls who are high users of social media is evidence of this."[73] For juveniles, "their prefrontal cortex (the brain's inhibition center) is not yet fully mature[.]"[74]

In short, adolescents are not sufficiently mature to make significant irreversible medical decisions. Indeed, the adolescent brain does not achieve the capacity for full risk assessment until the early to mid-twenties.[75]

2. As a consequence, there is a serious ethical problem with allowing minors to receive life-altering

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[73] ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 13 (footnote omitted) (citing Douglas S. Diekema, *Adolescent brain development and medical decision-making*, 146 Pediatrics e20218F (2020)).

[74] *Ibid*. (citing Linda P. Spear, *Adolescent Neurodevelopment*, 52 J. Adolescent Health S7 (2013)).

[75] ACPeds, *Gender Dysphoria in Children*, *supra* note 5, at 13.

medical interventions, including cross-sex hormones and, in the case of girls, bilateral mastectomy, when they are incapable of providing informed consent for themselves.[76]

This is confirmed in the Doctors Protecting Children Declaration cited above: "Responsible informed consent is not possible in light of extremely limited long-term follow-up studies of interventions, and the immature, often impulsive, nature of the adolescent brain. The adolescent brain's prefrontal cortex is immature and is limited in its ability to strategize, problem solve and make emotionally laden decisions that have life-long consequences."[77]

Indeed, because doctors do not know the long-term effects of the drugs they prescribe or of the surgeries they perform for "gender transition" purposes, they cannot even provide the necessary information for a child or their parents to give informed consent. As the Cass Review noted: "The duty of information disclosure is complicated by many 'unknown unknowns' about the long-term impacts of puberty blockers and/or masculinising/feminising hormone during a dynamic developmental period when gender identity may not be settled."[78]

3. WPATH members are themselves well aware of the inability of a child to give informed consent, as evidenced by their description when trying to explain the consequences of the procedures they are about to

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[76] *Id.* at 14.

[77] Doctors Protecting Children Decl., *supra* note 2, ¶ 2.

[78] Cass Review, *supra* note 21, at 194, § 16.18; see also *id.* at 195-196, §§ 16.25-16.31; *id.* at 196, § 16.34.

prescribe or perform. As one Canadian endocrinologist put it:

> *"It's always a good theory that you talk about fertility preservation with a 14-year-old, but I know I'm talking to a blank wall. They'd be like, ew, kids, babies, gross* * * *
>
> *"I think now that I follow a lot of kids into their mid-twenties, I'm like, Oh, the dog isn't doing it for you, is it?" They're like, 'No, I just found this wonderful partner, and now want kids* * * *' *So* * * * *[m]ost of the kids are nowhere in any kind of a brain space to really talk about [fertility preservation] in a serious way.*[79]

In other words, no doctor can obtain genuine, meaningful informed consent from an adolescent to any health-care intervention that could or would render the adolescent infertile for life. And that is another powerful reason that Tennessee acting in accordance with good science when it decided to protect its children—and its doctors—from these ill-conceived interventions.

III. Tennessee's Statute Is Consistent With Sound Medical Practice.

In short, Tennessee has taken rational and necessary steps to protect children from a lifetime of severe consequences that do nothing to address the underlying mental health issues that precipitated a child's gender non-contentedness. The proper pathway

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[79] *WPATH Files Excerpts*, *supra* note 45, at 4 (italicization and alterations in original; underscore added).

is offering appropriate psychological counseling to address the child's mental health concerns while allowing the natural development of puberty to take the child through adolescence into adulthood.

A. The Proper Standard of Care for Minors with Gender Incongruity or Dysphoria is Mental Health Counseling, Not Hormones and Surgery.

As set out in the Doctors Protecting Children Declaration:

> Psychotherapy for underlying mental health issues such as depression, anxiety, and autism, as well as prior emotional trauma or abuse should be the first line of treatment for these vulnerable children experiencing discomfort with their biological sex.
>
> [Indeed,] England, Scotland, Sweden, Denmark, and Finland have all recognized the scientific research demonstrating that the social, hormonal and surgical interventions are not only unhelpful but are harmful. So, these European countries have paused protocols and are instead focusing on evaluating and treating the underlying and preceding mental health concerns.[80]

In addition to these considerations, the dramatic rise of "rapid onset gender dysphoria" seen today in teens, particularly teenage girls, is yet another reason to avoid a drugs-first approach for these minors.

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[80] Doctors Protecting Children Decl., *supra* note 2, ¶¶ 7-9 (citing sources).

Indeed, with the dramatic rise in claims of gender incongruity, as well as the social transition and "gender-affirming therapy" provided to young adolescents whose brains are not yet mature, there is less long-term data regarding how many individuals later regret their transition decisions.

Still, citing five articles, one researcher recently stated that "[r]ecent data, capturing the upsurge in the predominant adolescent-onset variant of gender dysphoria, suggest that detransition and/or regret could be more frequent than previously reported."[81] Accordingly, addressing the underlying mental health issues rather than "affirming" an incongruent identity is the proper standard of care—as adopted by Tennessee in the law at issue here.

This conclusion finds ample support in what has come to be called the Cass Review. As referenced extensively above, the National Health Service England commissioned a report by Dr. Hilary Cass, who came to the following conclusions, among others, in April 2024 about "gender transitions." First, systematic evidence reviews demonstrated the poor quality of the research in this field, meaning that there is no reliable evidence base upon which to make clinical decisions.[82] Second, the rationale for early puberty suppression remains unclear, with weak evidence regarding the impact on gender dysphoria, mental or psychosocial health, and its effect on

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[81] ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 11 (citing Sara C. J. Jorgensen, *Transition regret and detransition: Meanings and uncertainties*, Archives of Sexual Behav. (2023), https://doi.org/10.1007/s10508-023-02626-2).

[82] Cass Review, *supra* note 21, at Annex A, 1.2.

cognitive and psychosexual development remains unknown.[83] Third, the use of masculinizing/feminizing hormones in those under 18 presents many unknowns.[84] Fourth, clinicians are unable to determine with certainty which children and young people will go on to have an enduring trans identity.[85] These findings, in addition to those discussed above, demonstrate the lack of any evidence-based justification for protocols for gender dysphoric children being pushed by WPATH, AAP, and the Endocrine Society.

Taking heed of findings consistent with those in the Cass Review, countries in Europe such as Sweden,[86] Norway,[87] Finland,[88] Germany,[89]

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[83] *The Cass Review, Final Report, Overview of Key Findings,* The Cass Review, https://tinyurl.com/ysew5cbu (last visited Oct. 6, 2024).

[84] *Ibid.*

[85] *Ibid.*

[86] Socialstyrelsen, Swedish Nat'l Bd. of Health & Welfare, *Care of Children and Adolescents with Gender Dysphoria: Summary of National Guidelines* 3-4 (Dec. 2022), https://tinyurl.com/5349b4pk.

[87] Jennifer Block, *Norway's Guidance on Paediatric Gender Treatment is Unsafe, Says Review,* 380 BMJ 697 (2023), doi:10.1136/bmj.p697.

[88] Council for Choices in Health Care [Finland], *Summary of a Recommendation by Council for Choices in Health Care in Finland: Medical treatment methods for dysphoria associated with variations in gender identity in minors—recommendation* 2 (June 16, 2020), https://tinyurl.com/47vraxmh.

[89] Resolution Ic-048, Treatment of gender dysphoria in minors, 128th German Med. Assembly (passed May 2024), available at https://tinyurl.com/2jkrjazm.

Scotland,[90] and others have determined in recent years that there is no solid evidence to support many of these interventions on minors. Additionally, professional groups and governing agencies in Switzerland, New Zealand, Australia, Chile, Netherlands, France, Belgium, and Italy have called for stringent reviews of transgender protocols in their countries.[91] And yet organizations such as WPATH, AAP, and the Endocrine Society ignore the evidence and double down on their dangerous "protocols," going so far as to eliminate any minimum age before starting medical interventions as discussed below.

B. Scientific Evidence Does Not Support Protocols from Organizations That Promote Hormonal and Surgical Interventions for Children.

In spite of all of the evidence, which is only touched on above, WPATH, the AAP, and the Endocrine Society continue to promote experimental and dangerous hormonal and surgical interventions for gender dysphoric children. Instead, these organizations have abandoned science and adopted a political ideology, allowing the current Administration to push them so far as to remove any minimum age requirements for their recommended "treatments". Indeed, their "protocols" and "guidelines" do not come

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[90] Mary McCool, *Scotland's under-18s gender clinic pauses puberty blockers*, BBC (Apr. 18, 2024), https://tinyurl.com/4fsyxmny.

[91] Christina Buttons, *The Global Response to the Cass Review: June 2024 Update*, buttonslives (May 13, 2024), https://tinyurl.com/y67b8e8k.

close to qualifying as the standard of care, which requires that the therapy "must be 'accepted as safe, effective and beneficial; and [have] known and acceptable side [adverse] effects.'"[92] As noted above, these organizations cannot come close to satisfying this basic definition.

1. As for WPATH, leaked emails reveal that, during the preparation of the current version of its Standards of Care (SOC 8), HHS officials in the office of Rachel Levine, HHS Assistant Secretary for Health, and the Administration's most prominent transgender person, successfully directed WPATH (over WPATH member objections) to remove all age limits from SOC 8 because HHS feared any age limits could support state laws restricting gender-transition procedures for minors.[93] These emails show that Levine spoke to WPATH and was "very eager for [the SOC 8 guidelines'] release—so to ensure integration in the US health policies of the Biden government."[94] WPATH emails show that WPATH complied with HHS's charge: "[W]e heard your [Dr. Levine's] comments regarding the minimal age criteria for transgender healthcare adolescents; the potential negative outcome of these minimal ages as

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[92] Laidlaw & Jorgensen, *supra* note 43, at 1.

[93] Azeen Ghorayshi, *Biden Officials Pushed to Remove Age Limits for Trans Surgery, Documents Show*, N.Y. Times (June 25, 2024), https://tinyurl.com/yr79bndh.

[94] App'x A to Suppl. Expert Rep. of James Cantor, Ph.D., ¶138, *Boe v. Marshall*, No. 2:22-cv-00184-LCB-CWB (M.D. Ala. June 24, 2024), ECF No. 591-24.

recommendations in the US [* * *] Consequently, we have changes to the SOC 8 in this respect."[95]

Similarly, emails revealed that WPATH commissioned studies from Johns Hopkins University and then attempted to stop Johns Hopkins from publishing its findings because the studies found little to no evidence about transitions for children and adolescents.[96] WPATH thus pushes a narrative, not the medically appropriate treatment for minors. Indeed, with its membership plummeting and its abandonment of evidence-based guidelines, WPATH has been discredited as a medical organization.[97]

2. The AAP has likewise given in to ideology and abandoned science when it comes to treatment of minors struggling with gender incongruence. Indeed, AAP's 2018 guidelines, which it reaffirmed in August 2023, and which clearly note it is "not * * * a standard of medical care,"[98] were written by mostly nonphysicians. Only five of the twelve authors were medical doctors, and the lead author was a researcher

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[95] *Id.* ¶ 139.

[96] Attach. to U.S. Dep't of Health & Hum. Servs. Resp. to Mots. to Seal at 1, *Voe v. Mansfield*, No. 1:23-cv-00864-LCB-LPA (M.D.N.C. May 13, 2024), ECF No. 100-1.

[97] *Breaking News: What Future for WPATH as Membership Plummets?*, Critical Therapy Antidote (Jan. 17, 2024), https://tinyurl.com/yhb3yaps; Mia Hughes, *The WPATH Files: Pseudoscientific Surgical and Hormonal Experiments on Children, Adolescents, and Vulnerable Adults* 9, Env't Progress (2024), https://tinyurl.com/2p8y8yua.

[98] See Am. Acad. of Pediatrics, *Policy Statement, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics e20182162, at 1 (2018, re-aff'd 2023), https://tinyurl.com/4sexuzer.

from the Human Rights Campaign advocacy group. The drafters predictably focused on "gender affirming" interventions consisting of medical procedures.

Soon after AAP published its policy statement, University of Toronto psychologist Dr. James Cantor reviewed that policy and largely discredited its findings.[99] Dr. Cantor described the AAP's approach as "a systematic exclusion and misrepresentation of entire literatures."[100] Among other serious flaws, Dr. Cantor found the AAP misrepresented references that actually contradicted its pro-transition policy and omitted the critical fact that desistance over puberty was the norm for gender dysphoria in minors.[101] According to Dr. Cantor, the references the AAP cited as the basis of its policy not only contradicted a policy of affirmative care but repeatedly endorsed watchful waiting.[102]

The AAP's statement was also "remarkable in what it left out," namely, that every follow-up study of gender dysphoric children found the same thing: Over the course of puberty, the majority of gender dysphoric children ceased to want to transition.[103] Dr. Cantor's conclusion was that the AAP not only failed to provide evidence supporting its recommendations, but that the

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[99] James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46 J. Sex & Marital Therapy 307 (2020), doi:10.1080/0092623X.2019.1698481.

[100] *Id.* at 312.

[101] *Id.* at 312.

[102] *Id.* at 309.

[103] *Id.* at 307.

recommendations were made *despite* the existing evidence.[104]

In addition to omitting key scientific findings, the AAP also deliberately suppresses debate and prevents review of its drugs-and-hormones-first approach to treatment, as documents recently leaked by a whistleblower show.[105] Leaked papers expose that rank-and-file AAP members recognize the organization's drugs-and-hormones first policy is based on scant evidence and shoddy science.[106] Members also claim AAP used strong-arm tactics to change its rules and block a member-drafted resolution to review that policy.[107]

3. The Endocrine Society likewise has chosen to ignore the scientific research and demonstratable harms to children in its wholesale rejection of the Cass Review, and instead has chosen to reaffirm its policies that research has shown to be without scientific support.[108] Such blatant politicization of health care

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[104] *Ibid.*

[105] Julia Mason & Leor Sapir, Opinion, *The American Academy of Pediatrics' Dubious Transgender Science*, Wall Street J. (Aug. 17, 2022), https://tinyurl.com/vx8xsywx.

[106] *Ibid.*

[107] James Reinl, *EXCLUSIVE: Leaked files expose how U.S. pediatricians accuse their own professional body of pushing a 'harmful' drugs-first approach on trans teens—and of deliberately BLOCKING moves to change the rules,* Daily Mail (Aug. 11, 2022), https://tinyurl.com/44vtz4z3.

[108] Doctors Protecting Children Decl., *supra* note 2; Press Release, Endocrine Soc'y, Statement in Support of Gender-Affirming Care (May 8, 2024), https://tinyurl.com/mpc5dvbz.

for vulnerable children should be given no consideration.

Moreover, while there is no evidence that such "treatments" actually benefit vulnerable children, there is plenty of evidence these interventions financially benefit those who perform them. The American Principles Project has determined, through data provided by the Grand View Research, that what they called the "*Gender Industrial Complex*" is a multi-billion-dollar enterprise. They estimate that, in 2025, $1.8 billion dollars will be spent on hormones and $3.4 billion dollars on surgery. By 2030, those numbers are expected to rise to 2.8 billion and 5.6 billion dollars, respectively.[109] Tennessee properly placed the welfare of its children over the profits of gender theory advocates.

CONCLUSION

Sound medical ethics alone demands an end to the use of puberty blockers, cross-sex hormones, and sex reassignment surgeries in children and adolescents. Tennessee was right—both as a matter of law and as a matter of sound science—to protect its young people from such unsupported, dangerous interventions.

The judgment of the Court of Appeals should be affirmed.

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[109] Am. Principles Project, *The Gender Industrial Complex* 43 fig. 3 (July 2, 2024), https://tinyurl.com/5fsu284j.

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OCTOBER 15, 2024

APPENDIX

APPENDIX

Statements of Interest of *Amici Curiae*

Alliance for Hippocratic Medicine

Alliance for Hippocratic Medicine is a nonprofit alliance of membership organizations that uphold and promote the fundamental principles of Hippocratic medicine: protecting the vulnerable at the beginning and end of life; seeking the ultimate good for the patient with compassion and moral integrity; and providing health care with the highest standards of excellence based on medical science. Alliance for Hippocratic Medicine organizational members include the American Association of Pro-Life Obstetricians and Gynecologists, the American College of Pediatricians, the Coptic Medical Association, the Catholic Medical Association, the Christian Medical and Dental Association, the Canadian Physicians for Life, the American College of Family Medicine, the Euthanasia Prevention Coalition, the National Association of Pro-Life Nurses, and the Hippocratic Registry, together representing over 30,000 medical professionals who uphold and promote the fundamental principles of Hippocratic medicine, which includes first doing no harm to patients.

American Association of Christian Counselors (AACC)

The American Association of Christian Counselors (AACC), an American/global membership and service organization, is the world's largest faith-based behavioral health organization. It is committed to encouraging, strengthening and serving Christian

behavioral health professionals including psychiatrists, psychologists, social workers, psychotherapists, marriage and family therapists, addictions counselors, as well as Christian life and mental health coaches, pastors, lay counselors and the community at large. It equips leaders in the helping professions by integrating research-based biopsychosocial principles with spiritual truths to aid in counseling and ministering to those who seek assistance in achieving mental wellness, personal wholeness, interpersonal competence, and spiritual maturity. Concerned about religious liberty issues in behavioral health education and services, AACC is an active leader in protecting the right of conscience and religious liberty for faith-based behavioral health clinical educators and providers.

Association of American Physicians & Surgeons (AAPS)

Founded in 1943, the Association of American Physicians & Surgeons is a membership organization of more than a thousand physicians nationwide dedicated to preserving ethical medicine and the patient-physician relationship. In addition to participating at the legislative and administrative levels in national, state, and local debates on health issues, AAPS often participates in litigation, both as a party and as an amicus. *See, e.g.*, *Stenberg v. Carhart*, 530 U.S. 914, 933 (2000); *District of Columbia v. Heller*, 554 U.S. 570, 704 (2008) (Breyer, J., dissenting).

Catholic Medical Association (CMA)

The Catholic Medical Association (CMA), founded in 1932, is the largest association of Catholic individuals in healthcare. Its membership includes more than 2,700 physicians, nurses, and physician assistants nationwide, including two member guilds and 171 members in Tennessee. CMA's mission is to inform, organize, and inspire its members to uphold the Catholic faith in the science and practice of medicine. CMA opposes the medical and surgical transitioning of gender confused children and adolescents because it violates the teaching and tradition of the Catholic Church, Christian anthropology, Judeo-Christian medical ethics, and the best interests of patients and their families, and because such transitioning is not supported by sound clinical science.

Christian Medical & Dental Associations (CMDA)

The Christian Medical & Dental Associations (CMDA) is the world's largest Christian professional healthcare association. CMDA exists to educate, encourage, and equip Christian healthcare professionals to glorify God. CMDA has nearly 13,000 members and 365 chapters.