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For The Eighth Circuit
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November 23, 2021

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RE: 21-2875 Dylan Brandt, et al v. Leslie Rutledge, et al

Dear Counsel:

The amicus curiae brief of Family Research Council has been filed. If you have not already done so, please complete and file an Appearance form. You can access the Appearance Form at www.ca8.uscourts.gov/all-forms.

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District Court/Agency Case Number(s): 4:21-cv-00450-JM

United States Court of Appeals for the Eighth Circuit

DYLAN BRANDT, ET AL.,
PLAINTIFFS-APPELLEES,

v.

LESLIE RUTLEDGE, ET AL.,
DEFENDANTS-APPELLANTS.

*APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF ARKANSAS,
NO. 21-CV-450, HON. JAMES M. MOODY, JR., PRESIDING*

**BRIEF OF FAMILY RESEARCH COUNCIL
AS AMICUS CURIAE SUPPORTING
DEFENDANTS-APPELLANTS AND REVERSAL**

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CORPORATE DISCLOSURE STATEMENT

The Family Research Council is a nonprofit corporation that does not have a parent corporation and is not publicly held.

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INTEREST OF *AMICUS CURIAE*

Family Research Council (FRC) is a nonprofit research and educational organization that seeks to advance faith, family, and freedom in public policy from a biblical worldview. FRC recognizes and respects the inherent dignity of every human life, which entails the protection of the vulnerable. Children deserve to live in accordance with their God-given identity. FRC recognizes the proper role of medicine is to “do no harm,” which should lead physicians to heal children rather than harm them.¹

INTRODUCTION

Arkansas has “a compelling interest in protecting the physical and psychological well-being of minors.” *Reno v. ACLU*, 521 U.S. 844, 869 (1997). That important interest is advanced by the SAFE Act, which prohibits the use of puberty blockers, cross-sex hormones, and surgeries on children to transition genders. Given the emerging evidence of harms to children, combined with the lack of any long-term studies demonstrating the safety and effectiveness of these aggressive interventions, the State’s law is necessary to protect children.

¹ All parties consented to this brief. No party’s counsel authored this brief in whole or in part; no party or party’s counsel contributed money intended to fund preparing or submitting the brief; and, no person—other than the *amicus curiae*, its members, or its counsel—contributed money intended to fund preparing or submitting the brief.

A growing body of evidence shows that gender transition drugs and surgeries harm children. Up to 94% of children experiencing gender dysphoria no longer suffer from it by adulthood. But the medical interventions regulated here are often irreversible. Puberty blockers prevent a normal and physically healthy childhood. And once they are used, they almost always lead to the use of sex hormones that permanently alter the child’s body. That is why many countries—the United Kingdom, Sweden, and Finland included—are moving away from these experimental interventions. The protocols for these interventions were designed 15 years ago and have no application to the patient population now presenting with gender dysphoria—overwhelmingly, adolescent girls. In light of this evidence, Arkansas reasonably acted to protect children from irreversible damage.

In holding to the contrary, the district court relied heavily on plaintiffs’ *amici*, various medical advocacy groups like the World Professional Association for Transgender Health (WPATH), the American Academy of Pediatrics (AAP), and the American Medical Association (AMA). These advocacy groups repeatedly touted a “robust” evidentiary “consensus” in favor of giving children gender transition drugs and surgeries. *E.g.*, R. Doc. 23, at 3, 4, 8, 9, 12, 13, 20 (“Br.”). Yet the one common ground in all the literature—including the medical groups’ own policy statements—is that, as an England National Health Service review recently concluded, there is “limited evidence for the effectiveness and safety of gender-

affirming hormones in children and adolescents with gender dysphoria” and the “long-term safety profile of these treatments” is “largely unknown.”²

The few studies cited by the medical advocacy groups were so badly designed and carried out that they cannot be credited. The medical groups’ reliance on such studies to claim a “robust” scientific “consensus” exposes the AMA, the AAP, and others for what they are: policy advocates rather than honest brokers of medical evidence, at least when it comes to issues like this one. And if the medical groups tell this lie about “robust” evidence in federal court, they will push physicians to tell the same lie to children who could face a lifetime of personal devastation so that the AMA and the AAP can satisfy their self-serving agendas. Arkansas can protect children from that fate. This Court should reverse.

ARGUMENT

I. The available scientific evidence supports the State’s efforts to protect children.

Arkansas has protected children by limiting the use of puberty blockers, cross-sex hormones, and surgery in children to transition genders. The scientific evidence shows that all three interventions come with significant risks of harms for children. To be sure, the available evidence is limited, and no reliable long-term studies

² Nat’l Inst. for Health and Care Excellence, *Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria* 50 (2021), <https://bit.ly/3chUxA3>.

analyze these issues. But that is no reason for courts to second-guess a State’s policy decisions. If anything, “medical and scientific uncertainty” makes judicial intervention even less appropriate. *June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103, 2136 (2020) (Roberts, C.J., concurring in the judgment). When a State “undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious.” *Marshall v. United States*, 414 U.S. 417, 427 (1974).

Arkansas’s law is bolstered by evidence that many other countries are now limiting the use of these interventions on children. A U.K. High Court ruling last year served as a catalyst for change. That court emphasized the experimental and irreversible nature of hormone interventions, as well as the dearth of medical evidence supporting them. The court concluded that physicians could not supply adequate information about their use to provide children with the ability to meaningfully consent. *Bell v. Tavistock & Portman Nat’l Health Serv. Foundation Trust*, 2020 EWHC (Admin) 3274, ¶ 150 (“*Tavistock*”). Though the decision was recently reversed on jurisdictional grounds, the appeals court agreed that “[m]edical opinion is far from unanimous about the wisdom of embarking on treatment before adulthood.” *Bell v. Tavistock & Portman Nat’l Health Serv. Foundation Trust*, 2021 EWCA (Civ) 1363, ¶ 3 (“*Tavistock II*”). Other countries have since limited the use of hormones in this context.

Another reason for caution is that the cohort of youth now presenting for gender dysphoria is much different than in the past. When the current guidelines were devised 15 years ago, they were based on children—mostly boys—who presented with gender dysphoria at a young age. But now, adolescent girls are most likely to suffer from gender dysphoria, in dramatically higher numbers. Whatever limited evidence was available for the earlier cohort may not apply to the issues facing Arkansas today.

A. Emerging scientific evidence shows potential harms to children from gender transition drugs and surgeries.

Start with puberty blockers. The medical groups portray them as “well-known” drugs whose “effects are reversible.” Br. 11. But a child blocked from development can never get those years back, and there is evidence that the drugs could have long-term negative effects. At a minimum, as the U.K. High Court found, “there is real uncertainty over the short and long-term consequences of the treatment with very limited evidence as to its efficacy, or indeed quite what it is seeking to achieve.” *Tavistock* ¶ 134; *see id.* ¶ 73 (noting “no overall improvement in mood or psychological wellbeing”). Likewise, England’s recent National Health Service review concluded that no “reliable comparative studies” exist about “the effectiveness

and safety of [puberty blockers] for children and adolescents.”³ Even advocacy groups like the AAP say (though not in their brief here) that puberty blockers may have “long-term risks, particularly in terms of bone metabolism and fertility,” that cannot be assessed by the “limited” research.⁴

Lupron, the most widely prescribed puberty blocker for young girls in America, was once “used in chemical castrations of sex offenders.”⁵ It inhibits the increased production of testosterone or estrogen, thereby preventing the body from developing. The drug’s approval from the FDA was for halting “precocious puberty,” like a four-year-old “spontaneously developing breasts.”⁶ Lupron’s approved use was to “slow puberty down, until [the] child’s brain and peers catch up.”⁷ But the FDA “has not approved Lupron to halt normal puberty in anyone—transgender-identified or otherwise.”⁸ Any use in this context is off label. And its label includes

³ Nat’l Inst. for Health and Care Excellence, *Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria* 40 (2021), <https://bit.ly/3kJF3tc>.

⁴ Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 *Pediatrics* 1, 5 (2018), <https://doi.org/10.1542/peds.2018-2162>.

⁵ Abigail Shrier, *Irreversible Damage* 163 (2020).

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

“emotional lability” as a side effect, warning prescribers to “[m]onitor for development or worsening of psychiatric symptoms during treatment.”⁹

Puberty blockers in adolescents can lead to depression and other emotional disturbances. Some evidence shows “that after a year on [puberty blockers] children reported greater self-harm, and that girls experienced more behavioral and emotional problems and expressed greater dissatisfaction with their body.”¹⁰ And though the medical groups pretend that giving puberty blockers to children “between the ages of eight and 15” is fully “reversible,” Br. 10–11, they ignore that it is often “psychologically taxing” for children to be left behind their peers developmentally.¹¹ And as endocrinologist Dr. William Malone has explained, puberty cannot necessarily be “restart[ed]” later: once “the system ‘goes to sleep,’” “it may not wake up.”¹² Finally, the use of puberty blockers may worsen gender dysphoria by “solidif[ying] the feeling of cross-gender identification.” *Tavistock* ¶ 76.

Puberty blockers can also produce other developmental harms. Lupron may block hormones that contribute to neurological development, “suppressing peak IQ”

⁹ *Lupron Depot-PED Prescribing Information*, AbbVie (2021), <https://www.rxabbvie.com/pdf/lupronpediatric.pdf>.

¹⁰ Michael Briggs, *Tavistock’s Experimentation with Puberty Blockers: Scrutinizing the Evidence*, *Transgender Trend* (Mar. 5, 2019), <https://www.transgender-trend.com/tavistock-experiment-puberty-blockers/>.

¹¹ Shrier, *supra* note 5, at 164.

¹² *Id.* at 165.

levels.¹³ Lupron has also “been associated with and may be the cause of many serious permanent side effects including osteoporosis, mood disorders, seizures, cognitive impairment and, when combined with cross-sex hormones, sterility.”¹⁴ If puberty is suppressed for several years, children’s bones “do not get any stronger at a time when they should be,” potentially hindering future health.¹⁵ For all these reasons, the U.K. High Court found that “the consequences of the treatment are highly complex and potentially lifelong and life changing in the most fundamental way imaginable.” *Tavistock* ¶ 134. “The treatment goes to the heart of an individual’s identity, and is thus, quite possibly, unique as a medical treatment.” *Id.*

The medical groups imply that puberty blockers merely give children “enough time to make more informed decisions about their gender identity.” Br. 10–11. Putting aside the potentially permanent harm from these drugs, this claim strains credibility. As *Tavistock* found, the evidence “shows that practically all children/young people who start [puberty blockers] progress on to [cross-sex hormones].” ¶ 56; *accord Tavistock II* ¶ 64 (the hospital’s own evidence showed that most children on puberty blockers “go on to cross-sex hormones”). Under the aggressive, ideologically driven “treatment” plans of the medical groups here, that is little surprise.

¹³ *Id.* at 164–65.

¹⁴ *Transgender Interventions Harm Children*, Am. Coll. of Pediatricians, <https://ac-peds.org/transgender-interventions-harm-children>.

¹⁵ Briggs, *supra* note 10.

Yet cross-sex hormones and surgeries are even more destructive than puberty blockers. They may “put youth at an increased risk of heart attacks, stroke, diabetes, blood clots and cancers across their lifespan.”¹⁶ And the hormones’ effects can never be reversed. They can permanently destroy a child’s ability to later engage in intimacy, reproduce, and care for their own children. The testimony of those people who regret such irreversible procedures is devastating. *E.g.*, *Tavistock* ¶ 83 (“I cannot reverse any of the physical, mental or legal changes that I went through,” and “I will not be able to breastfeed my children.”).

The medical groups’ only response is to deny that such people exist. *See* Br. 14–15. They call it “demonstrably false” “that an individual’s gender dysphoria will naturally cease” without “medical interventions.” Br. 15. That preposterous claim contradicts the medical groups’ own publications. WPATH’s much-vaunted guidelines say that 73 to 94% of children referred for gender dysphoria have conditions that do not “continue into adulthood.”¹⁷ *Amicus* Endocrine Society “similarly says that [gender dysphoria] does not persist into adolescence in the large majority (85%)

¹⁶ *Transgender Interventions*, *supra* note 14.

¹⁷ World Prof’l Ass’n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Conforming People* 11 (7th vers. 2012), <https://bit.ly/3nrZgpv>.

of pre-pubertal children diagnosed with it.” *Tavistock II* ¶ 28. “[E]very follow-up study of [gender dysphoric] children, without exception, found the same thing.”¹⁸

Many who *are* forced into experimental medical interventions later regret that irreversible decision. One recent study, though limited in design, found that 60% of those who detransitioned “bec[ame] more comfortable identifying as their natal sex” and most “felt that they did not receive an adequate evaluation from a doctor” “before starting transition.”¹⁹

B. Countries have moved away from the aggressive, irreversible interventions advocated by the medical interest groups.

Given all this evidence, several countries have shifted away from the use of hormones and surgeries to treat gender dysphoria. After *Tavistock*, the United Kingdom focuses on therapy instead of puberty blockers.²⁰ In May 2021, Sweden’s leading hospital in gender care stated that it would no longer prescribe hormone blockers

¹⁸ James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46 *J. Sex & Marital Therapy* 307, 307–13 (2019), <https://doi.org/10.1080/0092623X.2019.1698481>; e.g., Madeline S.C. Wallien & Peggy T. Cohen-Kettenis, *Psychosexual Outcome of Gender-Dysphoric Children*, 47 *J. Am. Acad. Child & Adolescent Psychiatry* 1413 (2008), <https://pubmed.ncbi.nlm.nih.gov/18981931/>.

¹⁹ Lisa Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Transitioned*, Nat. Libr. of Med. (2021), <https://pubmed.ncbi.nlm.nih.gov/34665380/>.

²⁰ Roberto D’Angelo, *UK High Court Ruling on the Use of Puberty Blockers in Gender Dysphoric Minors*, Soc’y for Evidence Based Gender Med. (Dec. 3, 2020), https://segm.org/UK_HighCourt_Rules_PubertyBlockers_Experimental.

to children under 18 outside clinic trials.²¹ The hospital said that the treatments are “potentially fraught with extensive and irreversible adverse consequences,” which makes “it challenging to assess the risk/benefit for [each] patient, and even more challenging for the minors or their guardians to be in a position of an informed stance regarding these treatments.”²²

Finland too now generally prohibits the use of puberty blockers and hormones to treat gender dysphoria in children.²³ Because “[i]nformation about the potential harms of hormone therapies is accumulating slowly and is not systematically reported,” Finland has adopted “psychosocial support and, as necessary, psychotherapy” as the “first-line treatment.”²⁴

Arkansas’s law is in line with these careful responses to the available evidence. These countries show that no “robust” “consensus” exists for subjecting children to experimental gender transition hormones and surgeries. The American medical advocacy groups here stand alone in their ideological defiance of the evidence.

²¹ Fredrika Gauffin & Svante Norgren, *Policy Change Regarding Hormonal Treatment of Minors with Gender Dysphoria at Tema Barn - Astrid Lindgren Children’s Hospital* (May 5, 2021), <https://bit.ly/30vyLqy>.

²² *Id.*

²³ Wesley Smith, *Finns Turn against Puberty Blockers for Gender Dysphoria*, National Review (July 25, 2021), <https://www.nationalreview.com/corner/finns-turn-against-puberty-blockers-for-gender-dysphoria/>.

²⁴ *Id.* (cleaned up).

C. The State’s law properly accounts for changes in the population suffering gender dysphoria.

Another important justification for the SAFE Act is that the population of children presenting with gender dysphoria is much different now than it was in the past. Existing medical protocols—namely the Dutch Protocol—do not account for this change in patient population. Under the Dutch Protocol (named for an early study in the Netherlands), children are treated with puberty blockers as early as age 8 and cross-sex hormones at age 16; WPATH’s current guidelines are similar.²⁵ The protocol was designed for children who had experienced signs of gender dysphoria since early childhood. But such cases are no longer the norm in America.

Since 2008, the share of biological female college students identifying as transgender increased 100-fold.²⁶ In a recent reversal, twice as many girls as boys struggle with gender dysphoria.²⁷ Medical professionals have called this rise in female gender dysphoria a “clinical phenomenon” with “uncertain diagnostic significance making up a substantial proportion.”²⁸ Many attribute this change to the rise

²⁵ *Sweden’s Karolinska Ends All Use of Puberty Blockers and Cross-Sex Hormones for Minors Outside of Clinical Studies*, Soc’y for Evidence Based Gender Med. (May 8, 2021), https://segm.org/Sweden_ends_use_of_Dutch_protocol.

²⁶ Am. Coll. Health Ass’n, Undergraduate Student Reference Group (2021), <https://bit.ly/3FpJckx>.

²⁷ Shrier, *supra* note 5, at xxi.

²⁸ D’Angelo, *supra* note 20.

of “rapid onset gender dysphoria.”²⁹ (The professor who coined the phrase was promptly relieved of her position.³⁰)

The lead author of the Dutch study (a researcher cited by the medical groups here) recently cautioned practitioners about using the Dutch Protocol to treat the more recent wave of girls who present as adolescents with gender dysphoria, calling this a “new developmental pathway.”³¹ “According to the original Dutch protocol,” she noted, “one of the criteria to start puberty suppression was a presence of gender dysphoria from early childhood,” while now the dominant cohort of adolescents “experienced gender history events at older ages.”³²

Another of the original Dutch protocol researchers agrees. Thomas Steensma, a researcher at the Center of Expertise on Gender Dysphoria, explained that it is unknown “whether studies we have done in the past can still be applied. Many more children are registering, and [are] also a different type.”³³ Youth “with post puberty

²⁹ Abigail Shrier, *When Your Daughter Defies Biology*, Wall Street Journal (Jan. 6, 2019), <https://on.wsj.com/3nlHUKD>.

³⁰ Abigail Shrier, *Top Trans Doctors Blow the Whistle on ‘Sloppy’ Care*, Common Sense (Oct. 4, 2021), <https://bariweiss.substack.com/p/top-trans-doctors-blow-the-whistle> (hereinafter *Top Trans Doctors*).

³¹ Annelou L.C. de Vries, *Challenges in Timing Puberty Suppression for Gender-Nonconforming Adolescents*, 146 *Pediatrics* e2020010611 (2020), <https://doi.org/10.1542/peds.2020-010611>.

³² *Id.* (cleaned up).

³³ Berendien Tetelepta, *More research urgently needed into transgender care for young people*, *Algemeen Dagblad* (Feb. 27, 2021), <https://bit.ly/3oGIrGF> (translated).

adolescent-onset transgender histories” were not studied in the earlier evaluations.³⁴ Steensma criticized physicians for “blindly adopting [the Dutch] research” without accounting for this change in population.³⁵

Particularly given this new population, Arkansas acted reasonably to prevent medical advocacy groups from pushing experimental treatments on unstudied patient groups. Striking down the State’s reasonable law would harm children, especially girls. As one leading gender transition doctor—a WPATH board member—cautioned, “we’re going to have more young adults who will regret having gone through this process” thanks to doctors “[r]ushing people through the medicalization” and failing “to prepare them for making such a life-changing decision.”³⁶ The State’s law is necessary to further its compelling interest in protecting children from a lifetime of hurt and regret.

II. Medical interest groups claiming a “consensus” for gender transition interventions are acting on ideological impulse, not scientific evidence.

The district court relied heavily on the views of plaintiffs’ *amici* medical interest groups, whose strident brief repeatedly proclaims a “robust” “consensus” supporting puberty blockers, cross-sex hormones, and gender reassignment surgeries for children. Br. 3, 4, 8, 9, 12, 13, 20. But “[t]he law need not give [physicians]

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Top Trans Doctors*, *supra* note 30.

unfettered choice in the course of their medical practice.” *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). To be sure, no business likes to be regulated, and medical advocacy groups like the AMA and the AAP have both financial incentives and ideological commitments in play. But as shown above, no honest broker of scientific evidence could claim that a “robust” “consensus” exists about the experimental treatments Arkansas regulates. These medical interest groups have put ideology above the scientific evidence—and above patients. This Court should discount their views accordingly. When organizations like the AMA and the AAP exercise their influence on education and credentialing to push doctors to prescribe unproven treatments that can irreversibly harm children, the State has both a right and an obligation to protect its most vulnerable citizens.

A. The medical groups’ views are not based on scientific evidence.

Relying on the supposed “consensus” of “major expert medical association[s],” the district court believed that the State’s “health concerns” were not “genuine.” R. Doc. 64, at 6–7. According to the court, “medical evidence” and “rigorous study” show that gender transition drugs and surgeries are “the *only* effective treatment for [children] at risk of or suffering from gender dysphoria.” *Id.* (emphasis added). The supposedly “rigorous” evidence cited by the medical groups belies that extraordinary claim.

Most of the “evidence” produced by the medical interest groups were references to their own policy statements or guidelines. As discussed next, there is little reason to credit those self-serving, ideological statements. The few actual studies the groups cite underscore the error of the district court’s view. As England’s NICE review concluded, the “limited evidence for the effectiveness and safety of gender-affirming hormones in children and adolescents with gender dysphoria” consists entirely of studies that are “uncontrolled,” “observational,” or have “outcomes of very low certainty.”³⁷

Nonetheless, the medical interest groups claim that a “robust body of scientific evidence” “shows that young people suffering from gender dysphoria who receive the gender-affirming standard of care experience improvements in their overall well-being.” Br. 12. The only source cited for this proposition looks like a scientific article published in the *New England Journal of Medicine* this year. *Id.* (citing Simona Martin et al., *Criminalization of Gender-Affirming Care-Interfering with Essential Treatment for Transgender Children and Adolescents*, *New Eng. J. Med.* (2021), <https://bit.ly/3qTCwRm>). But it is an opinion piece written by a recent college graduate. It is not scientific evidence. Yet the medical interest groups cite the op-ed at least nine times, presenting its ideological claims as scientific fact each time.

³⁷ *Evidence Review*, *supra* note 2, at 50.

The medical interest groups next claim that “research has linked gender-affirming care to a significantly lowered risk of depression, anxiety, and other negative mental health outcomes.” Br. 12. For support, they point to “a study of 50 transgender youth undergoing puberty suppression treatment [that] found that the treatment was associated with decreased depression and improved quality of life over time.” Br. 12–13. That study—contrary to the medical group’s claims of “robust” evidence—acknowledged that “there are few data concerning the impact of endocrine intervention on psychological function in transgender youth.”³⁸ And the study’s results are meaningless. Of 116 participants who entered the study, less than 50% completed it. 47 participants were given drugs, and 3 participants were not. Many participants were older than age 18—as old as 25.³⁹ A non-randomized control group of 3 participants is deficient, and the study makes no attempt to compare outcomes between the groups. And because the study makes little effort to control for other relevant variables, the study could not show any causal relationship between gender transition treatments and outcomes. The length of the study—only 12 months—also discounts its findings. Finally, according to the study itself, “most

³⁸ Christal Achille et al., *Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results*, 8 Int’l J. Pediatric Endocrinology (2020), <https://ijpeonline.biomedcentral.com/articles/10.1186/s13633-020-00078-2>.

³⁹ *See id.* Tbl. 1; *id.* Tbl. 2 (noting that apparently 24 participants were only given cross-sex hormones).

predictors did not reach statistical significance.”⁴⁰ No entity concerned with evidence-based medicine would place so much reliance on this study.

The medical groups then claim that “[a] systemic analysis of 25 years of peer-reviewed articles found a robust consensus that gender-affirming treatments, including treatments such as hormone therapy, improve the overall wellbeing of transgender individuals.” Br. 13. Such “systemic analys[e]s”—this one conducted by the Cornell “Center for the Study of Inequality”—are much like exercises in legislative history: “looking over a crowd and picking out your friends.” *Exxon Mobil Corp. v. Allapattah Servs., Inc.*, 545 U.S. 546, 568 (2005). Medical advocacy groups often resort to such “literature reviews” or “systemic analyses” to cover a dearth of actual evidence (or contrary evidence). Yet even this analysis only confirms the lack of any “robust” evidence. The analysis says nothing about gender transition drugs and surgeries *for children*, and it concedes that even as to adults, available evidence is “limited” and seldom involves “prospective studies or randomized control trials.”⁴¹ Again, only those blinded by ideology would call the evidence here “robust.”

Likewise, the medical groups’ insistence that “multiple studies have revealed long-term positive outcomes for transgender people who have undergone puberty

⁴⁰ *Id.*

⁴¹ Cornell University, *What Does the Research Say About the Effect of Gender Transition on Transgender Well-Being?*, What We Know Pub. Pol’y Rsch. Portal (2018), <https://bit.ly/3no2LwR>.

suppression” (Br. 14) ignores that the issue here involves *children*. The medical groups cite a study by van der Miesen et al., but that study explicitly rejected the groups’ proposition, stating that it does “not provide evidence about the direct benefits of puberty suppression over time and long-term mental health outcomes.”⁴² According to the study, “Conclusions about long-term benefits of puberty suppression should thus be made with extreme caution needing prospective long-term follow-up studies with a repeated measure design with individuals being followed over time.”⁴³ Yet again, scientific groups acting in good faith would not say that a study “reveal[s] long-term positive outcomes” (Br. 14) when it expressly repudiates that reading.⁴⁴

Also for supposed “long-term positive outcomes,” the medical groups cite a 2014 study by de Vries et al. Br. 14 n.54. That study looked at a mere 55 people, drawn with self-selection problems from an initial group of nearly 200. *See* Alabama Br. 6–8. The study acknowledged that the self-selected group was “different from the transgender youth in community samples.”⁴⁵ No control group existed. And the

⁴² Anna I.R. van der Miesen et al., *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers*, 66 J. Adolescent Health 669, 703 (2020).

⁴³ *Id.*

⁴⁴ It is also worth noting that the study controls for few variables and relies on self-reported data rather than “a diagnosis of any mental health condition made by clinical assessment.” *Id.*

⁴⁵ Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 698, 702 (2014), <https://doi.org/10.1542/peds.2013-2958>.

study found that gender dysphoria and “body image difficulties persisted through puberty suppression”; in fact, these problems were *worse* after puberty suppression drugs were used than before.⁴⁶ And once again, this study says that “there is only limited evidence available about the effectiveness”⁴⁷ of treatments that the interest groups pretend are supported by “robust” evidence. It is hard to imagine how anyone could conclude that there were “long-term positive outcomes” from this study.

Otherwise, the only other studies cited by the interest groups involve adults or different issues. *See* Br. 4 n.4, 16 nn.60 & 61. For instance, to claim a risk of suicide, they repeatedly cite a study by Turban et al., which used as “data” responses from an online survey drawn from trans-affirming websites. The study is unserious. It “excluded those who underwent medical intervention and then subsequently stopped identifying as transgender,” and “[o]bviously, those who actually committed suicide.”⁴⁸ “73% of respondents who reported having taken puberty blockers” “said they started on them *after* the age of 18 years”—which is even not when puberty

⁴⁶ *Id.* at 699, Tbl. 1.

⁴⁷ *Id.* at 697.

⁴⁸ Michael Biggs, *Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria*, 49 *Archives of Sexual Behavior* 2227, 2227 (2020), <https://link.springer.com/article/10.1007/s10508-020-01743-6>.

blockers are prescribed.⁴⁹ The study itself concedes that it “does not allow for determination of causation.”⁵⁰

In sum, to support their unqualified claims of a “robust” “consensus,” the medical interest groups rely solely and repeatedly on facially deficient studies. The only explanation is that interests other evidence-based medicine are driving their views on this topic.

B. The medical groups are driven by ideological preferences.

A careful examination of plaintiffs’ most prominent medical *amici*—WPATH, the AAP, and the AMA—reveal that these groups are more committed to achieving policy ends than accurately presenting scientific evidence about gender transitioning.

1. WPATH

The World Professional Association for Transgender Health (WPATH), formerly the Harry Benjamin International Gender Dysphoria Association, “publishes the leading clinical guidance on gender dysphoria treatment,” guidance that the medical groups claim (again) is supported by a “robust body of scientific evidence.” Br. 12, 28. But as both the First and Fifth Circuits have explained, WPATH’s guidelines

⁴⁹ *Id.*

⁵⁰ Jack K. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 *Pediatrics* 1, 7 (2020), <https://doi.org/10.1542/peds.2019-1725>.

“reflect not consensus, but merely one side in a sharply contested medical debate.” *Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019); *see Kosilek v. Spencer*, 774 F.3d 63, 78–79 (1st Cir. 2014).

More than anything, WPATH’s guidelines reflect an ideology, not the medical evidence. For proof, look to WPATH’s own leaders. Dr. Stephen Levine, who helped author an early version of WPATH’s guidelines, said “that later versions of WPATH were driven by political considerations rather than medical judgment.” *Gibson*, 920 F.3d at 222. Dr. Levine said that the guidelines are not “politically neutral” because WPATH is “an advocacy group for the transgendered”—which means that its positions “sometimes conflict” with “scientific” evidence and that the group does not “tolerate[]” “[s]kepticism and strong alternate views.” *Id.* Dr. Levine added that the field generally is characterized by a “lack of rigorous research” about “the long-term effects of sex reassignment surgery and other gender dysphoria treatments.” *Id.* (brackets omitted).

WPATH’s own President-Elect (President beginning in 2022) agrees with these criticisms. Dr. Marci Bowers and another of WPATH’s board members, psychologist Erica Anderson, are two of the “most prominent” and “most respected” “providers in the field of transgender medicine.”⁵¹ Dr. Bowers has conducted more than 2,000 gender transition surgeries. About WPATH’s guidelines, Dr. Bowers

⁵¹ *Top Trans Doctors*, *supra* note 30.

said, “I think maybe we zigged a little too far to the left,” for “there was naivete on the part of pediatric endocrinologists who were proponents of early [puberty] blockade thinking that just this magic can happen” without harm.⁵² Dr. Bowers is “not a fan” of putting children on puberty blockers, doubting whether their effects were truly reversible.⁵³ Dr. Bowers even noted that in formulating the guidelines, WPATH “tr[ie]d to keep out anyone who doesn’t absolutely buy the party line that everything should be affirming,” leaving “no room for dissent.”⁵⁴ And Dr. Bowers lamented that many clinics like Planned Parenthood would start giving adolescents cross-sex hormones after just “one visit.”⁵⁵

Finally, WPATH’s vaunted guidelines are not true standards of care. As much as the medical groups try to hide behind these guidelines, no physician must adhere to them. One survey found that 55% of WPATH surgeons did not follow its age recommendations for gender surgeries.⁵⁶ And WPATH can (and has) changed these guidelines at any time. In short, these guidelines are “suggestions or

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ Christine Milrod & Dan H. Karasic, *Age is Just a Number: WPATH-Affiliated Surgeons’ Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States*, 14 J. Sexual Med. 624 (2017), <https://doi.org/10.1016/j.jsxm.2017.02.007>.

recommendations,” not “authoritative, unbiased consensus positions designed to produce optimal outcomes.”⁵⁷ Worse, they are suggestions based on ideology, not evidence.

2. AAP

The American Academy of Pediatrics also places transgender ideology above evidence and its patients. AAP’s argument here is especially deceptive because it fails to accurately reflect its own policy statement. For instance, AAP’s brief asserts that puberty blockers are fully “reversible,” have “well known” effects, and are supported by “long-term data” and “robust” evidence. Br. 11–12, 14. The closest AAP’s brief comes to conceding *any* risks in its statement that “any potential risks . . . can be mitigated.” Br. 12. But AAP’s own policy statement contradicts these claims:

Pubertal suppression is not without risks. Delaying puberty beyond one’s peers can also be stressful and can lead to lower self-esteem and increased risk taking. Some experts believe that genital underdevelopment may limit some potential reconstructive options. Research on long-term risks, particularly in terms of bone metabolism and fertility, is currently limited and provides varied results.⁵⁸

That AAP makes arguments here contradicting its own policy statement is disqualifying. If AAP does not believe its own arguments, no one else should either.

⁵⁷ William J. Malone et al., *Proper Care of Transgender and Gender-diverse Persons in the Setting of Proposed Discrimination*, 106 J. Clinical Endocrinology & Metabolism e3287 (2021).

⁵⁸ Rafferty, *supra* note 4, at 5.

Of course, AAP’s policy statement—written by one person and never voted on by AAP’s members at large—is itself an ideological document. As one researcher meticulously explained, the few “references that AAP cited as the basis of their policy instead outright contradicted that policy,” and AAP “left out” “the actual outcomes [of] research on [gender dysphoric] children”—disregarding 10 of the 11 studies on this cohort.⁵⁹ “[A]ny assertion that their policy is based on evidence is demonstrably false”; instead, “AAP’s statement is a systematic exclusion and misrepresentation” of the literature.⁶⁰

What’s more, the AAP’s statement belies its claims here that gender transition drugs should “always” be prescribed “in consultation with the patient and the patient’s family.” Br. 3. According to AAP’s policy, families that “take issue with providers” who “offer gender-affirming care” and that “deny access to [that] care” should have “legal” authorities called on them for endangering the child’s “welfare and safety.”⁶¹ AAP says that the physician (not the family) must “maintain their primary responsibility for the welfare of the child.”⁶²

As for that physician, AAP will have attempted to indoctrinate her with its ideological views, as AAP calls for those views to be adopted in “certifying

⁵⁹ Cantor, *supra* note 18.

⁶⁰ *Id.*

⁶¹ Rafferty, *supra* note 4, at 8.

⁶² *Id.*

examinations” and “maintenance of certification activities.”⁶³ Physicians who do not toe the AAP line may see challenges to their board certification for supposed “misinformation and disinformation.”⁶⁴

All this depends on AAP’s ideological beliefs not being questioned. To that end, AAP recently refused to allow the Society for Evidence-Based Gender Medicine to present contrary evidence at its conference. AAP does not “want to see any debate on what constitutes evidence-based care for gender-diverse youth.”⁶⁵ AAP thus disregarded the request of over 80% of its members for more discussion of “alternatives to the use of hormone therapies.”⁶⁶ In the words of one researcher, “bias and politicization are preventing an honest scientific debate about interventions that carry lifelong implications for young people.”⁶⁷

AAP’s ideological bias is also shown by the group’s insistence that biological males must be allowed to play in girls’ sports and use girls’ locker rooms and

⁶³ *Id.* at 10.

⁶⁴ Alyson Sulaski Wyckoff, *Board-certified Physicians Who Spread COVID Vaccine Misinformation Risk Certification*, Am. Acad. of Pediatrics (Sept. 10, 2021), <https://publications.aap.org/aapnews/news/15622>.

⁶⁵ *The AAP Silences the Debate on How to Best Care for Gender-Diverse Kids*, Soc’y for Evidence Based Gender Med. (Aug. 9, 2021), https://segm.org/AAP_silences_debate_on_gender_diverse_youth_treatments.

⁶⁶ *Id.*

⁶⁷ Malone, *supra* note 57.

bathrooms.⁶⁸ The group dismisses the harms that these policies cause for girls as mere “stories.”⁶⁹

In sum, AAP has a policy view, and that view subordinates both children and families to AAP’s ideological values. AAP is entitled to those values, as harmful to children as they are. But no one should pretend that the AAP’s view here is based on the evidence. And its view should not block a law that rightfully protects children from these dangerous practices.

3. AMA

The American Medical Association is equally self-interested and ideological. The AMA has a long history of engaging in advocacy that places profit for physicians above the interests of patients. During the Great Depression, it tried to eliminate nonprofit health maintenance organizations for public employees, seeking “to obstruct and destroy such competition” by denying their physicians “professional contact and consultation with other physicians and by coercing the hospitals to deny facilities for the treatment of their patients.” *AMA v. United States*, 317 U.S. 519, 532–33 (1943). Later it conspired with “state societies and local associations to

⁶⁸ See Trisha Koriath, *Pediatricians Say State Bills Would Harm Transgender Youths*, Am. Acad. of Pediatrics (Mar. 9, 2021), <https://publications.aap.org/aap-news/news/12780>; Melissa Jenco, *AAP Calls for Repeal of N.C. Transgender Law*, Am. Acad. of Pediatrics (Apr. 20, 2016), <https://publications.aap.org/aap-news/news/6530>.

⁶⁹ Koriath, *supra* note 68.

restrict competition among physicians.” *AMA v. FTC*, 638 F.2d 443, 447 (2d Cir. 1980). Its “systematic, long-term wrongdoing and long-term intent to destroy” competition have led courts to “doubt[] the AMA’s genuineness regarding its concern for scientific method in patient care.” *Wilk v. AMA*, 895 F.2d 352, 363, 366 (7th Cir. 1990). Instead, “AMA actively lobbies for legislation that it believes may be for the profit of its members.” *FTC*, 638 F.2d at 448.

So it should come as no surprise that the AMA here advocates for intensive treatment plans involving expensive drugs and surgeries. That is especially true since those profitable interventions align with AMA’s ideological views. After Arkansas passed the SAFE Act, the AMA’s CEO sent a letter asserting that “transgender minors be given the opportunity to explore their gender identity under the safe and supportive care of a physician.”⁷⁰ The letter cited a handful of non-rigorous (and mostly irrelevant) studies and failed to acknowledge *any* risks of gender transition drugs in children. Even though all evidence shows that most childhood gender dysphoria does not persist into adulthood, the AMA opposes *any* therapy-based efforts to resolve this condition; instead, experimental sex hormones must be given (and paid for by taxpayers). See *Advocating for the LGBTQ Community*, Am. Med. Ass’n, <https://bit.ly/3Dtm79t> (rejecting the view that “gender identity can be changed”).

⁷⁰ Letter from James L. Madara, Am. Med. Ass’n, to Bill McBride, Nat’l Governors Ass’n (Apr. 26, 2021), <https://bit.ly/3kIVQN5>.

This unscientific approach accords with AMA’s other policy positions in this area, including its opposition to the Pentagon’s regulation of transgender individuals in the military—an opposition that cited only an economic study about the costs of providing medical treatment, and did not explain AMA’s expertise in military matters.⁷¹ Likewise, AMA—apparently a sports expert too—believes that biological males “must be able to publicly identify and compete as female athletes.”⁷² For good measure, the AMA maintains that biological males must be allowed to use girls’ bathrooms and other facilities. *See Advocating, supra* (noting that “avoidance of the restroom can cause physical harm including dehydration”).

Despite the lack of evidence about transitioning children with experimental drugs, AMA too can be expected to enforce its ideological views against dissenting physicians. Just a few days ago, it adopted a policy “aimed at combatting public health disinformation disseminated by health care professionals.”⁷³ And it has recently propounded language guidance for physicians to conform their speech to AMA’s ideological views. Am. Med. Ass’n & Ass’n Am. Med. Colls., *Advancing Health Equity: Guide to Language, Narrative and Concepts* 15 (2021),

⁷¹ Press Release, David O. Barbe, AMA Statement on Transgender Americans in the Military, Am. Med. Ass’n (July 26, 2017), <https://bit.ly/3Hu0Z5C>.

⁷² *State Advocacy Update*, Am. Med. Ass’n (Mar. 26, 2021), <https://www.ama-assn.org/print/pdf/node/66096>.

⁷³ Press Release, AMA Adopts Policy to Combat Disinformation by Health Care Professionals, Am. Med. Ass’n (Nov. 15, 2021), <https://bit.ly/3CoIE69>.

<https://bit.ly/3HvCUeM> (banning terms including “vulnerable group,” “combat,” and “equality”—ironically, all terms used by the medical groups here, *see* Br. 23, Ex. 1, Ex. 2). AMA’s new disinformation policy promises to do “everything we can” to “provid[e] accurate, evidence-based information.”⁷⁴ That is exactly what its brief here does *not* provide. Arkansas has relied on the available evidence to protect children. WPATH, the AAP, and the AMA speak from ideological compulsion, not evidence-based medicine.

CONCLUSION

Nothing in the Constitution prevents Arkansas from protecting children against experimental, dangerous treatments, no matter the self-interested and ideologically motivated opposition of transgender advocacy groups like WPATH, the AAP, and the AMA. The Court should reverse, allowing the State’s law to protect children from irreversible harm.

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⁷⁴ *Id.*

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