IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

PFLAG, INC., et al.,

Plaintiffs,

v.

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

Defendants.

Civil Action No. BAH-25-337

BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Civil Procedure 7.1, the undersigned counsel for the American Academy of Pediatrics ("AAP"), the Academic Pediatric Association ("APA"), the American Academy of Child & Adolescent Psychiatry ("AACAP"), the American Academy of Family Physicians ("AAFP"), the American Academy of Nursing ("AAN"), the American College of Obstetricians and Gynecologists ("ACOG"), the American College of Osteopathic Pediatricians ("ACOP"), the American College of Physicians ("ACP"), the American Pediatric Society ("APS"), the Association of American Medical Colleges ("AAMC"), Association of Medical School Pediatric Department Chairs, Inc. ("AMSPDC"), the Maryland Chapter of the American Academy of Pediatrics ("MDAAP"), the Endocrine Society ("ES"), the National Association of Pediatric Nurse Practitioners ("NAPNAP"), the Pediatric Endocrine Society ("PES"), the Society for Adolescent Health and Medicine ("SAHM"), the Society of Pediatric Nurses ("SPN"), and the World Professional Association for Transgender Health ("WPATH") (collectively, "*Amici*") makes the following disclosures:

1. No publicly held corporations hold any stock in AAP, APA, AACAP, AAFP, AAN, ACOG, ACOP, ACP, APS, AAMC, AMSPDC, MDAAP, ES, NAPNAP, PES, SAHM, SPN, or WPATH.

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INTRODUCTION

On January 28, 2025, President Donald Trump signed Executive Order No. 14187 (the "Healthcare Ban"), directing all federal agencies to "immediately take appropriate steps to ensure that institutions receiving Federal research or education grants end" gender-affirming medical care for people under nineteen, which as this brief describes is critical, medically necessary, evidence-based care for gender dysphoria.[1] Effectively denying such evidence-based medical care to adolescents who meet the requisite medical criteria puts them at risk of significant harm. Below, *amici* provide the Court with an accurate description of the relevant treatment guidelines and summarize the scientific evidence supporting the gender-affirming medical care for adolescents that is targeted in the Healthcare Ban.

Gender dysphoria is a condition that is characterized by clinically significant distress or impairment in social, occupational, or other important areas of functioning due to a marked incongruence between the patient's gender identity (i.e., the innate sense of oneself as being a particular gender) and sex assigned at birth.[2] If not treated, or treated improperly, gender dysphoria can result in debilitating anxiety, depression, and self-harm, and is associated with suicidality. As such, the effective treatment of gender dysphoria saves lives.

The medical community, including the respected professional organizations participating here as *amici*, widely recognizes that the appropriate protocol for treating gender dysphoria in

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[1] In this brief, the term "gender-affirming medical care" refers to the use of gonadotropin-releasing hormone (GnRH) analogues and/or hormone therapy to treat gender dysphoria. Because this brief focuses primarily on adolescents, it does not discuss surgeries that are typically available to transgender adults, nor does it discuss the treatment guidelines for gender dysphoria in transgender adults affected by the Healthcare Ban.

[2] *See, e.g.*, Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142(4) Pediatrics e20182162, at 2–3 tbl.1 (2018), https://perma.cc/DB5G-PG44 [hereinafter, "AAP Policy Statement"]. The American Academy of Pediatrics voted to reaffirm the AAP Policy Statement. See Alyson Sulaski Wyckoff, Am. Acad. of Pediatrics, *AAP Reaffirms Gender-Affirming Care Policy, Authorizes Systematic Review of Evidence to Guide Update*, AAP News (Aug. 4, 2023), https://perma.cc/XS4B-WBLH. In addition, AAP has commissioned a systematic review of the existing research, which is part of its normal procedures to perform such reviews on a periodic basis to maintain up-to-date guidelines.

transgender adolescents is "gender-affirming care."[3] Gender-affirming care is care that supports an individual with gender dysphoria as they explore their gender identity—in contrast with efforts to change the individual's gender identity to match their sex assigned at birth, which are known to be ineffective and harmful.[4] For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical care to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including the prescription of puberty blockers and hormone therapy to carefully evaluated patients who meet diagnostic criteria, can alleviate clinically significant distress and lead to significant improvements in the mental health and overall wellbeing of adolescents with gender dysphoria.[5]

The Healthcare Ban disregards this medical evidence by effectively denying adolescents' access to treatments for gender dysphoria in accordance with the well-accepted protocol. Accordingly, *amici* urge this Court to grant Plaintiffs' motion for a preliminary injunction.

ARGUMENT

This brief first provides background on gender identity and gender dysphoria. It then describes the professionally accepted medical guidelines for treating gender dysphoria as they apply to adolescents, the scientifically rigorous process by which these guidelines were developed, and the evidence that supports the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief corrects inaccuracies regarding the professionally-accepted medical guidelines for treating gender dysphoria and explains how the Healthcare Ban would irreparably harm

[3] *Id*. at 10.
[4] *See, e.g.*, Christy Mallory et al., *Conversion Therapy and LGBT Youth*, Williams Inst. (June 2019), https://perma.cc/HXY3-UX2J.
[5] *See* Simona Martin et al., *Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, 385 New Eng. J. Med. 579, at 2 (2021), https://perma.cc/BR4F-YLZS (providing an overview of the scientific basis underlying gender-affirming care and its demonstrated effectiveness in "alleviat[ing] gender dysphoria").

adolescents with gender dysphoria by effectively denying access to crucial care for those who need it.

I. Understanding Gender Identity and Gender Dysphoria.

Gender identity refers to a person's deep internal sense of belonging to a particular gender.[6] Most people are "cisgender:" meaning they have a gender identity that aligns with their sex assigned at birth.[7] However, transgender people have a gender identity that does not align with their sex assigned at birth.[8] In the United States, approximately 1.6 million individuals identify as transgender.[9] Of these individuals, approximately 10% are teenagers aged 13 to 17.[10] Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

Today, there is an increasing acceptance of being transgender as a normal variation of human identity.[11] However, many transgender people suffer from gender dysphoria, a serious medical condition in which the patient experiences significant distress that can lead to "impairment in peer and/or family relationships, school performance, or other aspects of their life."[12] Gender dysphoria is a formal diagnosis under the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5-TR).[13]

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[6] AAP Policy Statement, *supra* note 2, at 2 tbl.1.
[7] *See* Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70(9) AMERICAN PSYCHOLOGIST 832, 861–862 (2015), https://www.apa.org/practice/guidelines/transgender.pdf.
[8] *See id.* at 863.
[9] *See* Jody L. Herman et al., *How Many Adults and Youth Identify as Transgender in the United States?*, Williams Inst., at 2 (June 2022), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf.
[10] *See id.* at 3.
[11] James L. Madara, *AMA to States: Stop Interfering in Healthcare of Transgender Children*, Am. Med. Ass'n (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children; *see also* Am. Psychological Ass'n, *APA Resolution on Gender Identity Change Efforts*, 4 (Feb. 2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.
[12] AAP Policy Statement, *supra* note 2, at 5.
[13] *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR* at 512–13 (2022); *see also* World Health Org., International Classification of Diseases, Eleventh Revision (ICD-11) (2019/2021) (continued…)

If untreated or inadequately treated, gender dysphoria may lead to depression, anxiety, self-harm, and suicidality.[14] In contrast, with treatment, transgender adolescents with gender dysphoria can mature into thriving adults.[15]

II. The Widely Accepted Guidelines for Treating Adolescents with Gender Dysphoria Provide for Gender-Affirming Medical Care When Indicated.

The widely accepted view of the professional medical community is that gender-affirming care is the appropriate treatment for gender dysphoria and that, for some adolescents, puberty blockers and hormone therapy are necessary.[16] Gender-affirming care greatly reduces the negative physical and mental health consequences that result when gender dysphoria is untreated.[17]

A. The Gender Dysphoria Treatment Guidelines Include Thorough Mental Health Assessments and, for Some Adolescents, Gender-Affirming Medical Care.

The treatment protocols for gender dysphoria are laid out in established, evidence-based clinical guidelines: (i) the Endocrine Society Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transgender and Gender Diverse People (together, the "Guidelines").[18]

("Gender incongruence is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group.").

[14] *See* Brayden N. Kameg & Donna G. Nativio, *Gender Dysphoria In Youth: An Overview For Primary Care Providers*, 30(9) J. AM. ASSOC. NURSE PRAC. 493 (2018), https://pubmed.ncbi.nlm.nih.gov/30095668.

[15] *See infra* Section II.C.

[16] *See, e.g.*, Endocrine Soc'y, *Transgender Health: An Endocrine Society Position Statement* (2020), https://www.endocrine.org/advocacy/position-statements/ transgender-health.

[17] *See id.*

[18] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (Nov. 2017) ("Endocrine Soc'y Guidelines"), https://academic.oup.com/jcem/article/102/11/ 3869/4157558; WPATH, *Standards of Care for the Health of Transgender and Gender Diverse People* (8thVersion) ("WPATH Guidelines"), https:// www.tandfonline.com/doi/pdf/10.1080/ 26895269.2022.2100644.

The Guidelines have been developed by expert clinicians and researchers who have worked with patients with gender dysphoria for many years.

The Guidelines provide that all youth with gender dysphoria should be evaluated, diagnosed, and treated by a qualified health care professional ("HCP").[19] Further, the Guidelines provide that each patient who receives gender-affirming care should receive only medically necessary and appropriate care that is tailored to the patient's individual needs and that is based on the best evidence possible along with clinical experience.[20]

1. The Guidelines Do Not Recommend Gender-Affirming Medical Care for Prepubertal Children.

For prepubertal children with gender dysphoria, the Guidelines provide for mental health care and support for the child and their family, such as through psychotherapy and social transitioning.[21] The Guidelines do *not* recommend that prepubertal children with gender dysphoria receive puberty blockers, hormone therapy, or surgeries.[22]

2. A Robust Diagnostic Assessment Is Required Before Gender-Affirming Medical Care Is Provided.

In contrast to prepubertal children, the Guidelines do contemplate the possibility that, for some transgender adolescents with gender dysphoria, gender-affirming medical care may be indicated, provided certain criteria are met. According to the Guidelines, puberty blockers and hormone therapy should be provided only after a thorough evaluation by a HCP who: (1) is licensed by their statutory body and holds a master's degree or equivalent in a relevant clinical

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[19] *See infra* Section II.A.2.
[20] *See* WPATH Guidelines, *supra* note 18, at S16–S18; Endocrine Soc'y Guidelines, *supra* note 18, at 3872–73.
[21] *See* WPATH Guidelines, *supra* note 18, at S73–S74; Endocrine Soc'y Guidelines, *supra* note 18, at 3877–78. "Social transition" refers to a process by which a child is acknowledged by others and has the opportunity to live publicly, either in all situations or in certain situations, in the gender identity they affirm. *See, e.g.*, WPATH Guidelines, *supra* note 18, at S75.
[22] *See* WPATH Guidelines, *supra* note 18, at S64, S67; Endocrine Soc'y Guidelines, *supra* note 18, at 3871.

field; (2) has expertise and received theoretical and evidence-based training in child, adolescent, and family mental health; (3) has expertise and received training in gender identity development, gender diversity in children and adolescents, can assess capacity to consent, and possesses knowledge about gender diversity across the life span; (4) has expertise and received training in autism spectrum disorders and other neurodevelopmental presentations, or collaborates with a developmental disability expert when working with neurodivergent patients; and (5) continues engagement in professional development in areas relevant to gender diverse children, adolescents, and families.[23]

Prior to developing a treatment plan, the HCP should conduct a robust diagnostic assessment—specifically, a "comprehensive biopsychosocial assessment"—of the adolescent patient.[24] The HCP conducts this assessment to "understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs," so that the resulting treatment plan is appropriately individualized.[25] This assessment must be conducted collaboratively with the patient and their caregiver(s).[26]

3. In Certain Circumstances, the Guidelines Provide for the Use of Gender-Affirming Medical Care to Treat Adolescents With Gender Dysphoria.

For youth with gender dysphoria that continues into adolescence—after the onset of puberty—the Guidelines provide that, in addition to mental health care, gender-affirming medical care may be indicated. Before an adolescent may receive any gender-affirming medical care for treating gender dysphoria, a qualified HCP must make a determination that such medical care is indicated. The Guidelines collectively provide that, before prescribing puberty blockers,

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[23] *See* WPATH Guidelines, *supra* note 18, at S49.
[24] *Id.* at S50.
[25] *Id.*
[26] *Id.*

the HCP must determine that: (1) the adolescent meets the diagnostic criteria of gender dysphoria or gender incongruence according to an established taxonomy;[27] (2) the adolescent has demonstrated a sustained and persistent pattern of gender nonconformity or gender dysphoria; (3) the adolescent has demonstrated the emotional and cognitive maturity required to provide informed consent for treatment; (4) any coexisting psychological, medical, or social problems that could interfere with diagnosis, treatment, or the adolescent's ability to consent have been addressed; (5) the adolescent has been informed of the reproductive effects of treatment in the context of their stage in pubertal development and discussed fertility preservation options; and (6) the adolescent has reached Tanner stage 2 of puberty to initiate pubertal suppression.[28] Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (7) agree with the indication for treatment, (8) confirm the patient has started puberty, and (9) confirm that there are no medical contraindications.[29]

If all the above criteria are met, and the patient and their parents provide informed consent, gonadotropin-releasing hormone (GnRH) analogues, or "puberty blockers," may be offered beginning at the onset of puberty.[30] The purpose of puberty blockers is to delay the development of permanent secondary sex characteristics—which may result in significant distress for transgender youth—until adolescents are old enough and have had sufficient time to make more informed decisions about whether to pursue further treatments.[31] Puberty blockers also can make pursuing transition later in life easier, because they prevent irreversible bodily

[27] Endocrine Soc'y Guidelines, *supra* note 18, at 3876; WPATH Guidelines, *supra* note 18, at S47, S48.
[28] WPATH Guidelines, *supra* note 18, at S59–65.
[29] Endocrine Soc'y Guidelines, *supra* note 18, at 3878 tbl.5.
[30] WPATH Guidelines, *supra* note 18, at S61–62, S64; Endocrine Soc'y Guidelines, *supra* note 18, at 3878 tbl.5; Martin, *supra* note 5.
[31] WPATH Guidelines, *supra* note 18, at S112.

changes such as protrusion of the Adam's apple or breast growth.[32] Puberty blockers have well-known efficacy and side-effect profiles.[33] Their effects are generally reversible, and when a patient discontinues their use, the patient resumes endogenous puberty.[34] In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty.[35] The risks of any serious adverse effects from puberty blockers are exceedingly rare when provided under clinical supervision.[36]

Later in adolescence—and if the criteria below are met—hormone therapy may be used to initiate puberty consistent with the patient's gender identity.[37] Hormone therapy involves using gender-affirming hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.[38] Hormone therapy is only prescribed when a qualified mental health professional has confirmed: the persistence of the patient's gender dysphoria, the patient's mental capacity to consent to the treatment, and that any coexisting problems have been addressed.[39] A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication, and the patient and their parents must be informed of the potential effects and side effects and give their informed consent.[40] Although some of the changes caused by hormone therapy become irreversible after those secondary sex characteristics

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[32] *See* AAP Policy Statement, *supra* note 2, at 5.
[33] *See* Martin, *supra* note 5, at 2.
[34] *See id.*
[35] *See* F. Comite et al., *Short-Term Treatment of Idiopathic Precocious Puberty with a Long-Acting Analogue of Luteinizing Hormone-Releasing Hormone — A Preliminary Report*, 305 NEJM 1546 (1981).
[36] *See, e.g.*, Annemieke S. Staphorsius et al., *Puberty Suppression and Executive Functioning*, 6 PSCYHONEUROENDOCRINOLOGY 190 (2015), https://pubmed.ncbi. nlm.nih.gov/25837854 (no adverse impact on executive functioning); Ken C. Pang et al., *Long-term Puberty Suppression for a Nonbinary Teenager*, 145(2) PEDIATRICS e20191606 (2019), https://watermark.silverchair.com/peds_20191606.pdf (exceedingly low risk of delayed bone mineralization from hormone treatment).
[37] Martin, *supra* note 5, at 2.
[38] *See* AAP Policy Statement, *supra* note 2, at 6.
[39] Endocrine Soc'y Guidelines, *supra* note 18, at 3878 tbl.5.
[40] *See id*.

are fully developed, others are partially reversible if the patient discontinues use of the hormones.[41]

The Guidelines contemplate that the prescription of puberty blockers and/or hormone therapy be coupled with education on the safe use of such medications and close monitoring to mitigate any potential risks.[42] Decisions regarding the appropriate treatment for each patient with gender dysphoria are made in consultation with the patient, their parents, and the medical and mental health care team. There is "no one-size-fits-all approach to this kind of care."[43]

B. The Guidelines for Treating Gender Dysphoria Were Developed Through a Robust and Transparent Process, Employing the Same Scientific Rigor That Underpins Other Medical Guidelines.

The Guidelines are the product of careful and robust deliberation following the same types of processes—and subject to the same types of rigorous requirements—as other guidelines promulgated by *amici* and other medical organizations with respect to other areas of medicine, such as treatments for cancer, diabetes, or cardiovascular disease.

For example, the Endocrine Society Guidelines were developed following a 26-step, 26-month drafting, comment, and review process.[44] The Endocrine Society imposed strict evidentiary requirements based on the internationally recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.[45] That GRADE assessment was then reviewed, re-reviewed, and reviewed again by independent groups of professionals.[46]

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[41] *See* AAP Policy Statement, *supra* note 2, at 5–6.
[42] *See* Endocrine Soc'y Guidelines, *supra* note 18, at 3871, 3876.
[43] Martin, *supra* note 5, at 1.
[44] *See, e.g.*, Endocrine Soc'y Guidelines, *supra* note 18, at 3872–73.
[45] *See* Gordon Guyatt et al., *GRADE Guidelines: 1. Introduction - GRADE Evidence Profiles and Summary of Findings Tables*, 64 J. CLINICAL EPIDEMIOLOGY 383 (2011), https://ahpsr.who.int/docs/librariesprovider11/publications/supplementary-material/hsr-synthesis-guyatt-2011.pdf; Gordon H. Guyatt et al., *GRADE: An Emerging Consensus on Rating Quality of Evidence and Strength of Recommendations*, 336 BMJ 924 (2008), https://www.ncbi.nlm.nih.gov/pmc/ articles/PMC2335261.
[46] Endocrine Soc'y, *Methodology*, https://www.endocrine.org/clinical-practice-guidelines/methodology.

Reviewers were subject to strict conflict of interest rules, and there was ample opportunity for feedback and debate through the years-long review process.[47] Further, the Endocrine Society continually reviews its own guidelines and recently determined that the 2017 transgender care guidelines continue to reflect the best, most up-to-date available evidence.[48]

First published in 1979, the WPATH Standards of Care are currently in their 8th Edition. The current Standards of Care are the result of a robust drafting, comment, and review process that collectively took five years.[49] The draft guidelines went through rigorous review and were publicly available for discussion and debate, receiving a total of 2,688 comments.[50] There were 119 authors ultimately involved in the final draft, including feedback from experts in the field as well as from transgender individuals and their families.[51] Each recommendation in the Standards of Care was formally approved using the Delphi process,[52] which is one of the most commonly adopted consensus development strategies for medical clinical practice guidelines.[53]

C. Scientific Evidence Indicates the Effectiveness of Treating Gender Dysphoria According to the Guidelines.

Multiple studies indicate that adolescents with gender dysphoria who receive gender-affirming medical care experience improvements in their overall well-being.[54] A number of studies have been published that investigated the use of puberty blockers on adolescents with

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[47] *See id*.
[48] *See* Endocrine Soc'y, Endocrine Soc'y Statement in Support of Gender-Affirming Care (May 8, 2024), https://perma.cc/J4Y2-RUJ2.
[49] *See* WPATH Guidelines, *supra* note 18, at S247-51.
[50] *See id*.
[51] *See id.* Inclusion of input from the relevant patient population during development of medical guidelines adheres to national standards and best practices. *See* National Academy of Sciences, *Clinical Practice Guidelines We Trust* at 89–92 (2011).
[52] *See* WPATH Guidelines, *supra* note 18, at S247-51.
[53] *See* National Academy of Sciences, *Clinical Practice Guidelines We Trust* at 88 (2011).
[54] *See* Martin, *supra* note 5, at 2.

gender dysphoria,[55] and/or the use of hormone therapy to treat adolescents with gender dysphoria.[56] These studies find positive mental health outcomes for those adolescents who received puberty blockers or hormone therapy, including statistically significant reductions in anxiety, depression, and suicidal ideation.[57]

For example, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically significant degree after receiving gender-affirming hormone treatment.[58] A study published in January 2023, following 315 participants age 12 to 20 who received gender-affirming hormone treatment, found that the treatment was associated

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[55] *See, e.g.*, Christal Achille et al., *Longitudinal Impact of Gender-Affirming Endocrine Intervention on The Mental Health and Wellbeing of Transgender Youths*, 8 INT'L J PEDIATRIC ENDOCRINOLOGY 1–5 (2020), https://pubmed.ncbi.nlm.nih.gov/ 32368216; Polly Carmichael et al., *Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People With Persistent Gender Dysphoria in the UK*, 16(2) PLOS ONE e0243894 (2021), https:// pubmed.ncbi.nlm.nih.gov/33529227; Rosalia Costa et al., *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*, 12(11) J. SEXUAL MED. 2206–2214 (2015), https:// pubmed.ncbi.nlm.nih.gov/26556015; Annelou L.C. de Vries et al., *Puberty Suppression In Adolescents With Gender Identity Disorder*, 8(8) J. SEXUAL MED. 2276–2283 (2011), https://pubmed.ncbi.nlm.nih.gov/ 20646177; Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression And Gender Reassignment*, 134(4) PEDIATRICS 696–704 (2014), https:// pubmed.ncbi.nlm.nih.gov/25201798; Laura E. Kuper, et al., *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*, 145(4) PEDIATRICS e20193006 (2020), https://pubmed.ncbi.nlm .nih.gov/32220906; Jack L. Turban et al., *Pubertal Suppression For Transgender Youth And Risk of Suicidal Ideation*, 145(2) PEDIATRICS e20191725 (2020), https:// www.ncbi.nlm.nih.gov/pmc/articles/PMC7073269; Anna I.R. van der Miesen, *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared With Cisgender General Population Peers*, 66(6) J. ADOLESCENT HEALTH 699–704 (2020); Diana M. Tordoff et al., *Mental Health Outcomes In Transgender And Nonbinary Youths Receiving Gender-Affirming Care*, 5(2) JAMA NETWORK OPEN e220978 (2022), https:/pubmed.ncbi.nlm.nih.gov/ 35212746/.

[56] *See, e.g.*, Achille, *supra* note 55; Luke R. Allen et al., *Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones*, 7(3) CLINICAL PRAC. PEDIATRIC PSYCH. 302 (2019), https://psycnet.apa.org/record/2019-52280-009; Diane Chen et al., *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, 388(3) NEJM 240–250 (2023); Diego Lopez de Lara et al., *Psychosocial Assessment in Transgender Adolescents*, 93(1) ANALES DE PEDIATRIA 41–48 (English ed. 2020), https://www.researchgate.net/publication/342652073; Vries, *Young Adult Psychological Outcome After Puberty Suppression And Gender Reassignment*, *supra* note 55; Rittakerttu Kaltiala et al., *Adolescent Development And Psychosocial Functioning After Starting Cross-Sex Hormones For Gender Dysphoria*, 74(3) NORDIC J. PSYCHIATRY 213 (2020); Kuper, *supra* note 55; Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, J. ADOLESCENT HEALTH (2021), https://www.jahonline.org/article/S1054-139X(21)00568-1/fulltext; Jack L. Turban et al., *Access To Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, J. PLOS ONE (2022), https://journals.plos.org/plosone/article?id=10.1371/ journal.pone.0261039.

[57] The data likewise indicates that adults who receive gender-affirming care experience positive mental health outcomes. *See, e.g.*, Zoe Aldridge et al., *Long Term Effect of Gender Affirming Hormone Treatment on Depression and Anxiety Symptoms in Transgender People*, 9 ANDROLOGY 1808–1816 (2021).

[58] *See* Allen, *supra* note 56.

with decreased symptoms of depression and anxiety.[59] Additionally, a 2020 study analyzed survey data from 89 transgender adults who had access to puberty blockers while adolescents and from more than 3,400 transgender adults who did not.[60] The study found that those who received puberty blocking treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support.[61] Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation.[62]

Further, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with puberty blockers was associated with decreased depression and improved overall functioning.[63] A six-year follow-up study of 55 individuals from the 2011 study found that subsequent treatment with hormone therapy followed by surgery in adulthood was associated with a statistically significant decrease in depression and anxiety.[64] "Remarkably, this study demonstrated that these transgender adolescents and young adults had a sense of well-being that was equivalent or superior to that seen in age-matched controls from the general population."[65]

As clinicians and scientific researchers, *amici* always welcome more research, including on this crucial topic. However, the available data indicate that the gender-affirming medical care targeted in the Healthcare Ban is effective for the treatment of gender dysphoria.

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[59] *See* Chen, *supra* note 56.
[60] *See* Turban, *supra* note 55.
[61] *See id*.
[62] *See id.*
[63] *See* Vries, *Puberty Suppression in Adolescents with Gender Identity Disorder*, *supra* note 55.
[64] Vries, *Young Adult Psychological Outcome After Puberty Suppression And Gender Reassignment*, *supra* note 55.
[65] Stephen M. Rosenthal, *Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View*, 17(10) NATURE REV. ENDOCRINOLOGY 581, 586 (Oct. 2021), https://pubmed.ncbi.nlm.nih.gov/34376826.

III. The Healthcare Ban Relies on Factually Inaccurate Claims and Ignores the Recommendations of the Medical Community.

In attempting to justify effectively denying access to gender-affirming medical care, the Healthcare Ban makes claims which are factually incorrect and contradicted by the available scientific evidence. In particular, the Healthcare Ban states that "[c]ountless children soon regret" receiving gender-affirming medical care. Exec. Order No. 14187 § 1. The Healthcare Ban improperly conflates prepubertal children with adolescents, which is an important distinction, as prepubertal children are not eligible under the Guidelines for any of the gender-affirming medical care targeted in the Healthcare Ban.[66] The Guidelines endorse the use of this medical care only to treat adolescents and adults with gender dysphoria, and only when the relevant criteria are met.[67]

There are *no* studies to support the proposition that adolescents with gender dysphoria are likely to later identify as their sex assigned at birth, whether they receive treatment or not.[68] On the contrary, "[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult."[69]

Moreover, while detransitioning may occur for many reasons, detransitioning is not the same as regret. The Healthcare Ban incorrectly assumes that an individual who detransitions—the definition of which varies from study to study[70]—must do so because they have come to

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[66] *See* Susan D. Boulware et al., *Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims*, 1, 18 (Apr. 28, 2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4102374.
[67] *See* Endocrine Soc'y Guidelines, *supra* note 18, at 3871, 3879; WPATH Guidelines, *supra* note 18, at S32, S48.
[68] *See, e.g.*, Stewart L. Adelson, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Non-Conformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957, 964 (2020), https://pubmed.ncbi.nlm.nih.gov/22917211.
[69] Rosenthal, *supra* note 65, at 585.
[70] Michael S. Irwig, *Detransition Among Transgender and Gender-Diverse People—An Increasing and Increasingly* (continued…)

identify with their sex assigned at birth. This ignores other, more commonly reported factors that contribute to a person's choice to detransition, such as pressure from parents and discrimination.[71]

In addition, while the percentage of adolescents seeking gender-affirming care has increased, that percentage remains very low—only 1.8% of high-school students identify as transgender,[72] and only a small fraction of transgender adolescents are prescribed gender-affirming medical care.[73] Further, research supports that this increase in adolescents seeking care is very likely the result of reduced social stigma and expanded care options.[74]

IV. The Healthcare Ban Would Irreparably Harm Many Adolescents with Gender Dysphoria By Effectively Denying Them Access to the Treatment They Need.

The Healthcare Ban effectively denies adolescents with gender dysphoria in Maryland and throughout the United States access to medical care that is designed to improve health outcomes and alleviate suffering and that is grounded in science and endorsed by the medical community. The gender-affirming medical care targeted in the Healthcare Ban can be a crucial part of treatment for transgender adolescents with gender dysphoria and necessary to preserve their health. Clinicians who are members of the relevant *amici* associations have witnessed the

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Complex Phenomenon, J. CLINICAL ENDOCRINOLOGY & METABOLISM 1, 1 (June 2022), https://pubmed.ncbi.nlm.nih.gov/35678284 ("Detransition refers to the stopping or reversal of transitioning which could be social (gender presentation, pronouns), medical (hormone therapy), surgical, or legal.").

[71] *See id.* (discussing "largest study to look at detransition").

[72] *See* Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students–19 States and Large Urban School Districts, 2017*, HHS/CDC, 68 MORBIDITY & MORTALITY WKLY. REP. 67, 68 (2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6803a3-H.pdf.

[73] Landon D. Hughes, Brittany M. Charlton, Isa Berzansky, *Gender-Affirming Medications Among Transgender Adolescents in the US, 2018-2022*, JAMA Pediatr. (Jan. 6, 2025), https://pubmed.ncbi.nlm.nih.gov/39761053/ (finding that less than 0.1% of transgender adolescents are prescribed puberty blockers or hormone therapy by examining private insurance claims over 5 years)

[74] *See* Boulware, *supra* note 66, at 20.

benefits of this treatment as well as the harm that results when such treatment is denied or delayed.

As discussed above, research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life.[75] In light of this evidence supporting the connection between lack of access to gender-affirming medical care and lifetime suicide risk, banning such care can put patients' lives at risk.

CONCLUSION

For the foregoing reasons, the Court should grant Plaintiffs' motion for a preliminary injunction.

[75] *See* M. Hassan Murad et al., H*ormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72(2) CLINICAL ENDOCRINOLOGY 214 (Feb. 2010), https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x; *see also* Turban, *supra* note 55.

Dated: February 21, 2025

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on February 21, 2025, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to counsel of record.

/s/ Abigail P. Barnes
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The Honorable Lauren King

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

STATE OF WASHINGTON, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 2:25-CV-00244

UNOPPOSED MOTION FOR LEAVE TO FILE BRIEF OF AMICI CURIAE BY AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS

NOTE ON MOTION CALENDAR:
February 25, 2025

Proposed *Amici Curiae* American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations hereby respectfully move for leave to file an amicus brief in support of Plaintiffs' motion for preliminary injunction. Counsel for Plaintiffs and counsel for Defendants both consent to the motion. In furtherance of the motion, proposed *amici* state as follows:

Proposed *amici* are the American Academy of Pediatrics, the Academic Pediatric Association, the American Academy of Child & Adolescent Psychiatry, the American Academy of Nursing, the American College of Obstetricians and Gynecologists, the American College of Osteopathic Pediatricians, the American College of Physicians, the American Pediatric Society,

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the Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, Inc., the Minnesota Chapter of the American Academy of Pediatrics, the Oregon Chapter of the American Academy of Pediatrics, the Washington Chapter of the American Academy of Pediatrics, the Endocrine Society, the National Association of Pediatric Nurse Practitioners, the Pediatric Endocrine Society, the Society for Adolescent Health and Medicine, the Society of Pediatric Nurses, and the World Professional Association for Transgender Health (collectively, "*amici*"). *Amici* are a group of 19 professional medical and mental health organizations seeking to ensure that all individuals, including those with gender dysphoria, receive the optimal medical and mental healthcare they need and deserve. *Amici* include both national and state organizations and represent thousands of health care providers who have specific expertise with the issues raised in the amicus brief.

As a group of well-respected medical and mental health organizations, *amici* seek to offer this Court their scientific views and insights regarding the serious medical condition known as gender dysphoria; the widely-accepted view of the professional medical community that gender-affirming care is the appropriate treatment for individuals (and particularly adolescents) suffering from gender dysphoria; and the harm that effectively denying access to important gender-affirming medical care would cause to such individuals, as would be required by Executive Order No. 14187 (the "Healthcare Ban").

Amici support Plaintiffs' motion for a preliminary injunction. No counsel for a party authored the proposed brief in whole or in part, and no person other than *amici* or their counsel made any monetary contributions intended to fund the preparation or submission of the proposed brief. The Court should consider *amici's* brief because it provides important expertise and addresses misstatements about the treatment for transgender adolescents. District courts have "broad discretion" regarding amicus participation and frequently welcome amicus briefs where, as here "the amicus has unique information that can help the court beyond the help that the

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lawyers for the parties are able to provide." *Wagafe v. Biden*, 2022 WL 457983, at *1 (W.D. Wash. Feb. 15, 2022) (internal quotes omitted).

By submitting an amicus brief in this matter, *amici* seek to assist this Court on an issue of great importance to many transgender individuals, including adolescents and their families, as well as the medical professionals who treat them, namely the prevention and treatment of gender dysphoria. Drawing on empirical research and *amici's* extensive experience and expertise in their respective fields, the proposed amicus brief: (i) provides background on gender identity and gender dysphoria; (ii) describes the professionally accepted medical guidelines for treating gender dysphoria as they apply to adolescents, and the scientifically rigorous process by which these guidelines were developed; (iii) describes the evidence that supports the effectiveness of this care for adolescents with gender dysphoria; (iv) corrects inaccuracies in the purported basis for the Healthcare Ban; and (v) describe the irreparable harm that would be caused to adolescent patients if the Healthcare Ban is not enjoined. *Amici* thus fulfill the quintessential role for amici curiae, and courts routinely authorize the filing of amicus briefs in such circumstances. *See, e.g., Miller-Wohl Co. v. Comm'r of Labor & Indus. State of Mont.*, 694 F.2d 203, 204 (9th Cir. 1982) (describing the "classic role of amicus curiae" as "assisting in a case of general public interest, supplementing the efforts of counsel, and drawing the court's attention" to matters that might otherwise escape consideration).

Courts regularly permit *amici* to file amicus curiae briefs to offer their unique expertise and insight on issues of physical and mental health and welfare, including with respect to transgender youth. For example, district courts in many states considering similar challenges to laws targeting gender-affirming care have accepted and cited amicus briefs filed by many of the same organizations that seek to file a brief here. *See, e.g.*, *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 890 (E.D. Ark. 2021), *aff'd sub nom. Brandt by & through Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022) (citing brief and observing "[t]he consensus recommendation of medical

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organizations is that the only effective treatment for individuals at risk of or suffering from gender dysphoria is to provide gender-affirming care."); *Eknes-Tucker v. Marshall*, 2022 WL 1521889, at *2 (M.D. Ala. May 13, 2022) (citing brief and observing that several major medical organizations "endorse these guidelines as evidence-based methods for treating gender dysphoria in minors."); *see also Doe v. Thornbury*, Case No. 3:23-cv-00230, ECF No. 61 (W.D. Ky. June 28, 2023) (granting motion for leave to file similar amicus brief); *Koe v. Noggle*, Case No. 1:23-cv-02904, ECF No. 104 (N.D. Ga. Aug. 11, 2023) (same); *Poe v. Drummond*, Case No. 4:23-cv-00177, ECF No. 72 (N.D. Okla. June 12, 2023) (same); *see also, e.g.*, *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 594 n.1 (4th Cir. 2020) (crediting "leading medical, public health, and mental health organization[]" amici with helping the court to "develop[] a fact-based understanding of what it means to be transgender"); *Adams by Kasper v. Sch. Bd. of St. Johns Cnty.*, 318 F. Supp. 3d 1293, 1298 n.14 (M.D. Fla. 2018) (granting leave to file an amicus brief in support of a transgender male student and noting that "the position of [amici] as to the appropriate standard of care for gender dysphoria is useful to understanding that diagnosis").

Moreover, there is no downside to granting *amici*'s motion for leave to file the amicus brief. Courts have recognized that "it is preferable to err on the side of" permitting amicus briefs. *Neonatology Assocs., P.A. v. Comm'r*, 293 F.3d 128, 133 (3d Cir. 2002) (Alito, J.). This is so because "[i]f an amicus brief that turns out to be unhelpful is filed, the [court], after studying the case, will often be able to make that determination without much trouble and can then simply disregard the amicus brief." *Id.* "On the other hand, if a good brief is rejected, the [court] will be deprived of a resource that might have been of assistance." *Id*.

CONCLUSION

For the foregoing reasons, proposed *amici* respectfully request that this Court grant their motion for leave to file the attached amicus brief in support of Plaintiffs' Motion for a Preliminary Injunction.

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I certify that this unopposed motion for leave to file brief of *amici curiae* contains 1,127 words, in compliance with Local Civil Rules.

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CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the State of Washington, that the foregoing document was presented to the Clerk of the Court for filing and uploading to the CM/ECF system, which will send notification of such filing to all counsel of record.

DATED this 25th day of February, 2025.

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The Honorable Lauren King

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

STATE OF WASHINGTON, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 2:25-cv-00244

PROPOSED BRIEF OF AMICI CURIAE BY AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS

NOTE ON MOTION CALENDAR:
February 25, 2025

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Civil Procedure 7.1, the undersigned counsel for the American Academy of Pediatrics ("AAP"), the Academic Pediatric Association ("APA"), the American Academy of Child & Adolescent Psychiatry ("AACAP"), the American Academy of Nursing ("AAN"), the American College of Obstetricians and Gynecologists ("ACOG"), the American College of Osteopathic Pediatricians ("ACOP"), the American College of Physicians ("ACP"), the American Pediatric Society ("APS"), the Association of American Medical Colleges ("AAMC"), Association of Medical School Pediatric Department Chairs, Inc. ("AMSPDC"), the Minnesota Chapter, American Academy of Pediatrics ("MNAAP"), the Oregon Chapter of the American Academy of Pediatrics ("ORAAP"), the Washington Chapter of the American Academy of Pediatrics ("WAAAP"), the Endocrine Society ("ES"), the National Association of Pediatric Nurse Practitioners ("NAPNAP"), the Pediatric Endocrine Society ("PES"), the Society for Adolescent Health and Medicine ("SAHM"), the Society of Pediatric Nurses ("SPN"), and the World Professional Association for Transgender Health ("WPATH") (collectively, "*amici*") state that AAP, APA, AACAP, AAN, ACOG, ACOP, ACP, APS, AAMC, AMSPDC, MNAAP, ORAAP, WAAAP, ES, NAPNAP, PES, SAHM, SPN, and WPATH, respectively, have no parent corporation.

No corporations hold any stock in AAP, APA, AACAP, AAN, ACOG, ACOP, ACP, APS, AAMC, AMSPDC, MNAAP, ORAAP, WAAAP, ES, NAPNAP, PES, SAHM, SPN, or WPATH.

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INTRODUCTION

On January 28, 2025, President Donald Trump signed Executive Order No. 14187 (the "Healthcare Ban"), directing all federal agencies to "immediately take appropriate steps to ensure that institutions receiving Federal research or education grants end" gender-affirming medical care for people under nineteen, which as this brief describes is critical, medically necessary, evidence-based care for gender dysphoria.[1] Effectively denying such evidence-based medical care to adolescents who meet the requisite medical criteria puts them at risk of significant harm. Below, *amici* provide the Court with an accurate description of the relevant treatment guidelines and summarize the scientific evidence supporting the gender-affirming medical care for adolescents that is targeted in the Healthcare Ban.

Gender dysphoria is a condition that is characterized by clinically significant distress or impairment in social, occupational, or other important areas of functioning due to a marked incongruence between the patient's gender identity (i.e., the innate sense of oneself as being a particular gender) and sex assigned at birth. *See* Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142(4) Pediatrics e20182162, at 2 3 tbl.1 (2018), https://perma.cc/DB5G-PG44 ("AAP Policy Statement"). If not treated, or treated improperly, gender dysphoria can result in debilitating anxiety, depression, and self-harm, and is associated with suicidality. As such, the effective treatment of gender dysphoria saves lives.

The medical community, including the respected professional organizations participating here as *amici*, widely recognizes that the appropriate protocol for treating gender dysphoria in

[1] In this brief, the term "gender-affirming medical care" refers to the use of gonadotropin-releasing hormone (GnRH) analogues and/or hormone therapy to treat gender dysphoria. Because this brief focuses primarily on adolescents, it does not discuss surgeries that are typically available to transgender adults, nor does it discuss the treatment guidelines for gender dysphoria in transgender adults affected by the Healthcare Ban.

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transgender adolescents is "gender-affirming care." *Id*. at 10. Gender-affirming care is care that supports an individual with gender dysphoria as they explore their gender identity in contrast with efforts to change the individual's gender identity to match their sex assigned at birth, which are known to be ineffective and harmful. *See* Christy Mallory et al., *Conversion Therapy and LGBT outh*, Williams Inst. (June 2019), https://perma.cc/H Y3-U 2J. For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical care to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including the prescription of puberty blockers and hormone therapy to carefully evaluated patients who meet diagnostic criteria, can alleviate clinically significant distress and lead to significant improvements in the mental health and overall wellbeing of adolescents with gender dysphoria. *See* Simona Martin et al., *Criminalization of Gender-Affirming Care Interfering ith Essential Treatment for Transgender Children and Adolescents*, 385 New Eng. J. Med. 579, at 2 (2021), https://perma.cc/BR4F-YL S.

The Healthcare Ban disregards this medical evidence by effectively denying adolescents' access to treatments for gender dysphoria in accordance with the well-accepted protocol. Accordingly, *amici* urge this Court to grant Plaintiffs' motion for a preliminary injunction.

ARGUMENT

This brief first provides background on gender identity and gender dysphoria. It then describes the professionally accepted medical guidelines for treating gender dysphoria as they apply to adolescents, the scientifically rigorous process by which these guidelines were developed, and the evidence that supports the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief corrects inaccuracies regarding the professionally accepted medical guidelines for treating gender dysphoria and explains how the Healthcare Ban would irreparably harm adolescents with gender dysphoria by effectively denying access to crucial care for those who need it.

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I U ders a di Ge der Ide i a d Ge der D s h ria

Gender identity refers to a person's deep internal sense of belonging to a particular gender. AAP Policy Statement at 2 tbl.1. Most people are "cisgender," meaning they have a gender identity that aligns with their sex assigned at birth. Am. Psych. Ass'n, *Guidelines for Psychological Practice ith Transgender and Gender Nonconforming People*, 70(9) AMERICAN PSYCHOLOGIST 832, 861 862 (2015), https://www.apa.org/practice/guidelines/transgender.pdf. However, transgender people have a gender identity that does not align with their sex assigned at birth. *Id.* at 863. In the United States, approximately 1.6 million individuals identify as transgender. Jody L. Herman et al., *o Many Adults and outh Identify as Transgender in the nited States* , Williams Inst., at 2 (June 2022), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf. Of these individuals, approximately 10 are teenagers aged 13 to 17. *Id.* at 3. Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

Today, there is an increasing acceptance of being transgender as a normal variation of human identity. James L. Madara, *AMA to States Stop Interfering in ealthcare of Transgender Children*, Am. Med. Ass'n (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children; Am. Psych. Ass'n, *APA Resolution on Gender Identity Change Efforts*, 4 (Feb. 2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf. However, many transgender people suffer from gender dysphoria, a serious medical condition in which the patient experiences significant distress that can lead to "impairment in peer and/or family relationships, school performance, or other aspects of their life." AAP Policy Statement at 5. Gender dysphoria is a formal diagnosis under the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5-TR). Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental*

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Disorders DSM- -TR at 512 13 (2022); *see also* World Health Org., International Classification of Diseases, Eleventh Revision (ICD-11) (2019/2021) ("Gender incongruence is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group.").

If untreated or inadequately treated, gender dysphoria may lead to depression, anxiety, self-harm, and suicidality. *See* Brayden N. Kameg & Donna G. Nativio, *Gender Dysphoria In outh An vervie or Primary Care Providers*, 30(9) J. AM. ASS'N NURSE PRAC. 493 (2018), https://pubmed.ncbi.nlm.nih.gov/30095668. In contrast, with treatment, transgender adolescents with gender dysphoria can mature into thriving adults. *See infra* Section II.C.

II The Widel A e ed G ideli es r Trea i Ad les e s i h Ge der D s h ria Pr ide r Ge der A ir i Medi al Care Whe I di a ed

The widely accepted view of the professional medical community is that gender-affirming care is the appropriate treatment for gender dysphoria and that, for some adolescents, puberty blockers and hormone therapy are necessary. *See, e.g.*, Endocrine Soc'y, *Transgender ealth An Endocrine Society Position Statement* (2020), https://www.endocrine.org/advocacy/position-statements/transgender-health. Gender-affirming care greatly reduces the negative physical and mental health consequences that result when gender dysphoria is untreated. *See id.*

A The Ge der D s h ria Trea e G ideli es I l de Th r h Me al Heal h Assess e s a d r S e Ad les e s Ge der A ir i Medi al Care

The treatment protocols for gender dysphoria are laid out in established, evidence-based clinical guidelines: (i) the Endocrine Society Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transgender and Gender Diverse People (together, the "Guidelines"). *See* Wylie C.

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Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (Nov. 2017) ("ES Guidelines"), https://academic.oup.com/jcem/article/102/11/3869/4157558; WPATH, *Standards of Care for the ealth of Transgender and Gender Diverse People* (8thVersion) ("WPATH Guidelines"), https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644. The Guidelines have been developed by expert clinicians and researchers who have worked with patients with gender dysphoria for many years.

The Guidelines provide that all youth with gender dysphoria should be evaluated, diagnosed, and treated by a qualified health care professional ("HCP"). Further, the Guidelines provide that each patient who receives gender-affirming care should receive only medically necessary and appropriate care that is tailored to the patient's individual needs and that is based on the best evidence possible along with clinical experience. WPATH Guidelines at S16 S18; ES Guidelines at 3872 73.

The G ideli es D N Re e d Ge der A ir i Medi al Care r Pre er al Childre

For prepubertal children with gender dysphoria, the Guidelines provide for mental health care and support for the child and their family, such as through psychotherapy and social transitioning. WPATH Guidelines at S73 S74; ES Guidelines at 3877 78. ("Social transition" refers to a process by which a child is acknowledged by others and has the opportunity to live publicly, either in all situations or in certain situations, in the gender identity they affirm. WPATH Guidelines at S75.) The Guidelines do *not* recommend that prepubertal children with gender dysphoria receive puberty blockers, hormone therapy, or surgeries. WPATH Guidelines at S64, S67; ES Guidelines at 3871.

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A R s Dia s i Assess e Is Re ired Be re Ge der A ir i Medi al Care Is Pr ided

In contrast to prepubertal children, the Guidelines do contemplate the possibility that, for some transgender adolescents with gender dysphoria, gender-affirming medical care may be indicated, provided certain criteria are met. According to the Guidelines, puberty blockers and hormone therapy should be provided only after a thorough evaluation by a qualified HCP who: is licensed by their statutory body and holds a master's degree or equivalent in a relevant clinical field; has expertise and received theoretical and evidence-based training in child, adolescent, and family mental health; has expertise and received training in gender identity development, gender diversity in children and adolescents, has the ability to assess capacity to consent, and possesses knowledge about gender diversity across the life span; has expertise and received training in autism spectrum disorders and other neurodevelopmental presentations, or collaborates with a developmental disability expert when working with neurodivergent patients; and continues engagement in professional development in areas relevant to gender diverse children, adolescents, and families. WPATH Guidelines at S49.

Prior to developing a treatment plan, the HCP should conduct a robust diagnostic assessment specifically, a "comprehensive biopsychosocial assessment" of the adolescent patient. *Id.* at S50. The HCP conducts this assessment to "understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs," so that the resulting treatment plan is appropriately individualized. *Id.* This assessment must be conducted collaboratively with the patient and their caregiver(s). *Id.*

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I Cer ai Cir s a es he G ideli es Pr ide r he Use Ge der A ir i Medi al Care Trea Ad les e s Wi h Ge der D s h ria

For youth with gender dysphoria that continues into adolescence after the onset of puberty the Guidelines provide that, in addition to mental health care, gender-affirming medical care may be indicated. Before an adolescent may receive any gender-affirming medical care for treating gender dysphoria, a qualified HCP must make a determination that such medical care is indicated. The Guidelines collectively provide that, before prescribing puberty blockers, the HCP must determine that: (1) the adolescent meets the diagnostic criteria of gender dysphoria or gender incongruence according to an established taxonomy; ES Guidelines at 3876; WPATH Guidelines at S47, S48; (2) the adolescent has demonstrated a sustained and persistent pattern of gender nonconformity or gender dysphoria; (3) the adolescent has demonstrated the emotional and cognitive maturity required to provide informed consent for treatment; (4) any coexisting psychological, medical, or social problems that could interfere with diagnosis, treatment, or the adolescent's ability to consent have been addressed; (5) the adolescent has been informed of the reproductive effects of treatment in the context of their stage in pubertal development and discussed fertility preservation options; and (6) the adolescent has reached Tanner stage 2 of puberty to initiate pubertal suppression. WPATH Guidelines at S59 65. Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (7) agree with the indication for treatment, (8) confirm the patient has started puberty, and (9) confirm that there are no medical contraindications. ES Guidelines at 3878 tbl.5.

If all the above criteria are met, and the patient and their parents provide informed consent, gonadotropin-releasing hormone (GnRH) analogues, or "puberty blockers," may be offered beginning at the onset of puberty. WPATH Guidelines at S61 62, S64; ES Guidelines at 3878 tbl.5; Simona Martin et al., *Criminalization of Gender-Affirming Care Interfering ith Essential*

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Treatment for Transgender Children and Adolescents, 385 New Eng. J. Med. 579, at 2 (2021), https://perma.cc/BR4F-YL S. The purpose of puberty blockers is to delay the development of permanent secondary sex characteristics which may result in significant distress for transgender youth until adolescents are old enough and have had sufficient time to make more informed decisions about whether to pursue further treatments. WPATH Guidelines at S112. Puberty blockers also can make pursuing transition later in life easier, because they prevent irreversible bodily changes such as protrusion of the Adam's apple or breast growth. *See* AAP Policy Statement at 5. Puberty blockers have well-known efficacy and side-effect profiles. *See* Martin, 385 New Eng. J. Med. 579, at 2. Their effects are generally reversible, and when a patient discontinues their use, the patient resumes endogenous puberty. *See id.* In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty. *See* F. Comite et al., *Short-Term Treatment of Idiopathic Precocious Puberty ith a Long-Acting Analogue of Luteinizing ormone-Releasing ormone A Preliminary Report*, 305 NEJM 1546 (1981). The risks of any serious adverse effects from puberty blockers are exceedingly rare when provided under clinical supervision. *See, e.g.*, Annemieke S. Staphorsius et al., *Puberty Suppression and E ecutive unctioning*, 6 PSCYHONEUROENDOCRINOLOGY 190 (2015), https://pubmed.ncbi. nlm.nih.gov/25837854 (no adverse impact on executive functioning); Ken C. Pang et al., *Long-term Puberty Suppression for a Nonbinary Teenager*, 145(2) PEDIATRICS e20191606 (2019), https://watermark.silverchair.com/peds 20191606.pdf (exceedingly low risk of delayed bone mineralization from hormone treatment).

Later in adolescence and if the criteria below are met hormone therapy may be used to initiate puberty consistent with the patient's gender identity. *See* Martin, 385 New Eng. J. Med. 579, at 2. Hormone therapy involves using gender-affirming hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity. *See* AAP Policy

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Statement at 6. Hormone therapy is only prescribed when a qualified HCP has confirmed the persistence of the patient's gender dysphoria, the patient's mental capacity to consent to the treatment, and that any coexisting problems have been addressed. Endocrine Soc'y Guidelines at 3878 tbl.5. A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication, and the patient and their parents must be informed of the potential effects and side effects and give their informed consent. *See id*. Although some of the changes caused by hormone therapy become irreversible after those secondary sex characteristics are fully developed, others are partially reversible if the patient discontinues use of the hormones. *See* AAP Policy Statement at 5 6.

The Guidelines contemplate that the prescription of puberty blockers and/or hormone therapy be coupled with education on the safe use of such medications and close monitoring to mitigate any potential risks. *See* Endocrine Soc'y Guidelines at 3871, 3876. Decisions regarding the appropriate treatment for each patient with gender dysphoria are made in consultation with the patient, their parents, and the medical and mental health care team. There is "no one-size-fits-all approach to this kind of care." Martin, 385 New Eng. J. Med. 579, at 1.

B The G ideli es r Trea i Ge der D s h ria Were De el ed Thr h a R s a d Tra s are Pr ess E l i he Sa e S ie i i Ri r Tha U der i s O her Medi al G ideli es

The Guidelines are the product of careful and robust deliberation following the same types of processes and subject to the same types of rigorous requirements as other guidelines promulgated by *amici* and other medical organizations with respect to other areas of medicine, such as treatments for cancer, diabetes, or cardiovascular disease.

For example, the Endocrine Society Guidelines were developed following a 26-step, 26-month drafting, comment, and review process. *See, e.g.*, Endocrine Soc'y Guidelines at 3872 73. The Endocrine Society imposed strict evidentiary requirements based on the internationally

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recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. *See* Gordon Guyatt et al., *GRADE Guidelines . Introduction - GRADE Evidence Profiles and Summary of indings Tables*, 64 J. CLINICAL EPIDEMIOLOGY 383 (2011), https://perma.cc/RE29- T37. That GRADE assessment was then reviewed, re-reviewed, and reviewed again by independent groups of professionals. Endocrine Soc'y, *Methodology*, https://www.endocrine.org/clinical-practice-guidelines/methodology. Reviewers were subject to strict conflict of interest rules, and there was ample opportunity for feedback and debate through the years-long review process. *See id*. Further, the Endocrine Society continually reviews its own guidelines and recently determined that the 2017 transgender care guidelines continue to reflect the best, most up-to-date available evidence. *See* Endocrine Soc'y, Endocrine Soc'y Statement in Support of Gender-Affirming Care (May 8, 2024), https://perma.cc/J4Y2-RUJ2.

First published in 1979, the WPATH Standards of Care are currently in their 8th Edition. The current Standards of Care are the result of a robust drafting, comment, and review process that collectively took five years. *See* WPATH Guidelines at S247-51. The draft guidelines went through rigorous review and were publicly available for discussion and debate, receiving a total of 2,688 comments. *See id*. There were 119 authors ultimately involved in the final draft, including feedback from experts in the field as well as from transgender individuals and their families. *See id.* Inclusion of input from the relevant patient population during development of medical guidelines adheres to national standards and best practices. *See* National Academy of Sciences, *Clinical Practice Guidelines We Can Trust* at 89 92 (2011), https://perma.cc/ 479-TGW3. Each recommendation in the Standards of Care was formally approved using the Delphi process, *see* WPATH Guidelines at S247-51, which is one of the most commonly adopted consensus development strategies for medical clinical practice guidelines, *see* National Academy of Sciences, *Clinical Practice Guidelines We Can Trust* at 88 (2011).

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C S ie i i E ide e I di a es he E e i e ess Trea i Ge der D s h ria A rdi he G ideli es

Multiple studies indicate that adolescents with gender dysphoria who receive gender-affirming medical care experience improvements in their overall well-being. These studies find positive mental health outcomes for those adolescents who received puberty blockers or hormone therapy, including statistically significant reductions in anxiety, depression, and suicidal ideation.

For example, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically significant degree after receiving gender-affirming hormone treatment. Luke R. Allen et al., *Well-Being and Suicidality Among Transgender outh After Gender-Affirming ormones*, 7(3) CLINICAL PRAC. PEDIATRIC PSYCH. 302 (2019), https://psycnet.apa.org/record/2019-52280-009. A study published in January 2023, following 315 participants ages 12 to 20 who received gender-affirming hormone treatment, found that the treatment was associated with decreased symptoms of depression and anxiety. Diane Chen et al., *Psychosocial unctioning in Transgender outh after ears of ormones*, 388(3) NEJM 240 250 (2023). Additionally, a 2020 study analyzed survey data from 89 transgender adults who had access to puberty blockers while adolescents and from more than 3,400 transgender adults who did not. Jack L. Turban et al., *Access To Gender-Affirming ormones During Adolescence and Mental ealth utcomes Among Transgender Adults*, J. PLOS ONE (2022), https://perma.cc/4VEK-7M8N. The study found that those who received puberty blocking treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support. *Id*. Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation. *Id.*

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Further, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with puberty blockers was associated with decreased depression and improved overall functioning. Annelou L.C. de Vries et al., *Puberty Suppression In Adolescents With Gender Identity Disorder*, 8(8) J. SE UAL MED. 2276 2283 (2011), https://pubmed.ncbi.nlm. nih.gov/ 20646177. A six-year follow-up study of 55 individuals from the 2011 study found that subsequent treatment with hormone therapy followed by surgery in adulthood was associated with a statistically significant decrease in depression and anxiety. Annelou L.C. de Vries et al., *oung Adult Psychological utcome After Puberty Suppression And Gender Reassignment*, 134(4) PEDIATRICS 696 704 (2014), https://pubmed.ncbi.nlm.nih.gov/25201798. "Remarkably, this study demonstrated that these transgender adolescents and young adults had a sense of well-being that was equivalent or superior to that seen in age-matched controls from the general population." Stephen M. Rosenthal, *Challenges in the Care of Transgender and Gender-Diverse outh An Endocrinologist's ie* , 17(10) NATURE REV. ENDOCRINOLOGY 581, 586 (Oct. 2021), https://pubmed.ncbi.nlm.nih.gov/34376826.

As clinicians and scientific researchers, *amici* always welcome more research, including on this crucial topic. However, the available data indicate that the gender-affirming medical care targeted in the Healthcare Ban is effective for the treatment of gender dysphoria.

III The Heal h are Ba Relies Fa all I a ra e Clai s a d I res he Re e da i s he Medi al C i

In attempting to justify effectively denying access to gender-affirming medical care, the Healthcare Ban makes claims which are factually incorrect and contradicted by the available scientific evidence. In particular, the Healthcare Ban states that "[c]ountless children soon regret" receiving gender-affirming medical care. Exec. Order No. 14187 1. The Healthcare Ban

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improperly conflates prepubertal children with adolescents, which is an important distinction, as prepubertal children are not eligible under the Guidelines for any of the gender-affirming medical care targeted in the Healthcare Ban. *See* Susan D. Boulware et al., *Biased Science The Te as and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims*, 1, 18 (Apr. 28, 2022), https://papers.ssrn.com/sol3/papers.cfm abstract id 4102374. The Guidelines endorse the use of this medical care only to treat adolescents and adults with gender dysphoria, and only when the relevant criteria are met. *See* Endocrine Soc'y Guidelines at 3871, 3879; WPATH Guidelines at S32, S48.

There are *no* studies to support the proposition that adolescents with gender dysphoria are likely to later identify as their sex assigned at birth, whether they receive treatment or not. *See, e.g.*, Stewart L. Adelson, *Practice Parameter on Gay, Lesbian, or Bise ual Se ual rientation, Gender Non-Conformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957, 964 (2020), https://pubmed.ncbi.nlm.nih.gov/22917211. On the contrary, "[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult." Rosenthal, NATURE REV. ENDOCRINOLOGY 581, 585.

Moreover, while detransitioning may occur for many reasons, detransitioning is not the same as regret. The Healthcare Ban incorrectly assumes that an individual who detransitions the definition of which varies from study to study must do so because they have come to identify with their sex assigned at birth. *See* Michael S. Irwig, *Detransition Among Transgender and Gender-Diverse People An Increasing and Increasingly Comple Phenomenon*, J. CLINICAL ENDOCRINOLOGY & METABOLISM 1, 1 (June 2022), https:// pubmed.ncbi.nlm.nih.gov/35678284 ("Detransition refers to the stopping or reversal of transitioning which could be social (gender

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presentation, pronouns), medical (hormone therapy), surgical, or legal."). This ignores other, more commonly reported factors that contribute to a person's choice to detransition, such as pressure from parents and discrimination. *See id.* (discussing "largest study to look at detransition").

In addition, while the percentage of adolescents seeking gender-affirming care has increased, that percentage remains very low only 1.8 of high-school students identify as transgender, *see* Michelle M. Johns et al., *Transgender Identity and E periences of iolence ictimization, Substance se, Suicide Risk, and Se ual Risk Behaviors Among igh School Students States and Large rban School Districts,* , HHS/CDC, 68 MORBIDITY & MORTALITY WKLY. REP. 67, 68 (2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6803a3-H.pdf, and only a small fraction of transgender adolescents are prescribed gender-affirming medical care, *see* Landon D. Hughes, Brittany M. Charlton, Isa Berzansky, *Gender-Affirming Medications Among Transgender Adolescents in the S,* - , JAMA PEDIATR. (Jan. 6, 2025), https://pubmed.ncbi.nlm.nih.gov/39761053/ (finding that less than 0.1 of transgender adolescents are prescribed puberty blockers or hormone therapy by examining private insurance claims over 5 years). Further, research supports that this increase in adolescents seeking care is very likely the result of reduced social stigma and expanded care options. *See* Boulware, 20.

IV The Heal h are Ba W ld Irre ara l Har Ma Ad les e s i h Ge der D s h ria B E e i el De i The A ess he Trea e The Need

The Healthcare Ban effectively denies adolescents with gender dysphoria throughout the United States access to medical care that is designed to improve health outcomes and alleviate suffering and that is grounded in science and endorsed by the medical community. The gender-affirming medical care targeted in the Healthcare Ban can be a crucial part of treatment for transgender adolescents with gender dysphoria and necessary to preserve their health. Clinicians

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who are members of the relevant *amici* associations have witnessed the benefits of this treatment as well as the harm that results when such treatment is denied or delayed.

As discussed above, research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life. *See* M. Hassan Murad et al., H*ormonal Therapy and Se Reassignment A Systematic Revie and Meta-Analysis of uality of Life and Psychosocial utcomes*, 72(2) CLINICAL ENDOCRINOLOGY 214 (Feb. 2010), https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x; Jack L. Turban et al., *Access To Gender-Affirming ormones During Adolescence and Mental ealth utcomes Among Transgender Adults*, J. PLOS ONE (2022), https://perma.cc/4VEK-7M8N. In light of this evidence supporting the connection between lack of access to gender-affirming medical care and lifetime suicide risk, banning such care can put patients' lives at risk.

CONCLUSION

For the foregoing reasons, the Court should grant Plaintiffs' motion for a preliminary injunction.

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Dated: February 25, 2025

Respectfully submitted,

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I certify that this unopposed motion for leave to file brief of *amici curiae* contains 4,146 words, in compliance with Local Civil Rules.

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CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the State of Washington, that the foregoing document was presented to the Clerk of the Court for filing and uploading to the CM/ECF system, which will send notification of such filing to all counsel of record.

DATED this 25th day of February, 2025.

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The Honorable Lauren King

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON

STATE OF WASHINGTON, et al.,

Plaintiffs

vs.

DONALD J. TRUMP, et al.,

Defendants.

NO. 2:25-cv-00244-LK

[PROPOSED] ORDER GRANTING UNOPPOSED MOTION FOR LEAVE TO FILE BRIEF OF AMICI CURIAE BY AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS

The Court, upon consideration of the Unopposed Motion for Leave to File Brief of Amici Curiae by American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations (the "Motion"), hereby ORDERS:

The Motion is GRANTED.

DATED this ____ day of _____, 2025.

HONORABLE LAUREN KING

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DATED this 25th day of February, 2025.

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