In the

Supreme Court of Ohio

MADELINE MOE, *ET AL.*,	:	Case No. 2025-0472
Appellees,	:	On appeal from the Franklin County Court of Appeals,
v.	:	Tenth Appellate District
DAVE YOST, *ET AL.*,	:	Court of Appeals Case No. 24AP-483
Appellants.	:	

BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF APPELLEES

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici curiae are the American Academy of Pediatrics, the American Academy of Child & Adolescent Psychiatry, the Association of American Medical Colleges, the American Academy of Family Physicians, 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 Psychiatric Association, the American Pediatric Society, the Endocrine Society, the Northeast Ohio Society of Child and Adolescent Psychiatry, the Ohio Academy of Family Physicians, the Ohio Chapter of the American Academy of Pediatrics, the Ohio Psychiatric Physicians Association, the National Association of Pediatric Nurse Practitioners, the Pediatric Endocrine Society, the Society for Adolescent Health and Medicine, the Society of Pediatric Nurses, the Societies for Pediatric Urology, and the World Professional Association for Transgender Health (collectively, "*amici*").

Amici are professional medical and mental health organizations seeking to ensure that all adolescents, including those with gender dysphoria, receive the optimal medical and mental health care they need and deserve. *Amici* represent thousands of healthcare providers who have specific expertise with the issues raised in this brief. The Court should consider *amici*'s brief because it provides important expertise and addresses misstatements about the treatment for transgender

adolescents.

STATEMENT OF FACTS

On January 24, 2024, the Ohio State Legislature voted to override Governor DeWine's veto on H.B. 68 (the "Healthcare Ban"), enacting a law that bans healthcare providers from providing patients under 18 with gender-affirming medical care ("GAMC"). GAMC refers to critical, medically necessary, evidence-based care for gender dysphoria.[1] Denying this care to adolescents who meet the requisite medical criteria puts them at risk of significant harm. Below, *amici* provide an accurate description of GAMC and the evidence that supports its use when medically indicated for adolescents with gender dysphoria.

Gender dysphoria is a condition 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

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[1] In this brief, the term "gender-affirming medical care" or "GAMC" 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.

[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* (continued…)

treated improperly, gender dysphoria can result in debilitating anxiety, depression, and self-harm, and is associated with suicidality. The effective treatment of gender dysphoria saves lives.

The medical community, including the respected professional organizations participating as *amici*, widely recognizes that the appropriate treatment for transgender adolescents diagnosed with gender dysphoria is gender-affirming care.[3] Gender-affirming care 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 carefully evaluated 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 GAMC, including the prescription of puberty blockers and hormone therapy to carefully evaluated patients who meet diagnostic criteria, can alleviate clinically

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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.

[3] *Id*. at 10.

[4] *See, e.g.*, Christy Mallory et al., *Conversion Therapy and LGBT Youth: Update*, WILLIAMS INST. (June 2019), https://perma.cc/HXY3-UX2J.

significant distress and lead to significant improvements in the mental health and overall wellbeing of adolescents with gender dysphoria.[5] This evidence supporting GAMC is of the same type and quality as the evidence supporting numerous medical treatments.

The Healthcare Ban disregards this medical evidence by denying adolescents' access to treatments for gender dysphoria. *Amici* urge this Court to affirm the judgment of the Court of Appeals.

ARGUMENT

This brief provides:

(1) background on gender identity and gender dysphoria;

(2) an overview of the general standards and best practices used by the medical community when developing clinical treatment recommendations;

(3) a description of how such recommendations involving GAMC were developed in a manner consistent with the general standards and best practices used in other areas of medicine;

(4) an explanation that the Healthcare Ban and its proponents rely on several

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[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).

inaccurate claims to support banning GAMC; and

(5) an explanation of how the Healthcare Ban would irreparably harm adolescents with gender dysphoria by denying crucial care to those who need it.

I. Understanding Gender Identity and Gender Dysphoria.

A person's gender identity is a person's deep internal sense of belonging to a particular gender.[6] Most people have a gender identity that aligns with their sex assigned at birth.[7] Transgender people, however, have a gender identity that does not align with their sex assigned at birth.[8] In the United States, it is estimated that approximately 1.4 million individuals are 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.

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[6] AAP Policy Statement, *supra* n. 2, at 2 tbl.1.

[7] *See* Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70(9) AM. PSYCHOLOGIST 832, 862 (2015), https://perma.cc/JJE6-XUNX.

[8] *See id.* at 832.

[9] *See* Jody L. Herman et al., *Ages of Individuals Who Identify as Transgender in the United States*, WILLIAMS INST., at 2 (Jan. 2017), https://perma.cc/C4TA-NR25.

[10] *See id.* at 3.

Being transgender is a normal variation of human identity.[11] Many transgender people, however, 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]

If untreated or inadequately treated, gender dysphoria can lead to depression, anxiety, self-harm, and suicidality.[14] Over 60% of transgender adolescents and young adults reported having engaged in self-harm during the preceding 12 months, and over 75% reported symptoms of generalized anxiety disorder in the preceding two weeks.[15] Even more troubling, more than 50% of this population reported

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[11] James L. Madara, *AMA to States: Stop Interfering in Healthcare of Transgender Children*, AM. MED. ASS'N (Apr. 26, 2021), https://perma.cc/BKS6-QFQ8; *see also* Am. Psychological Ass'n, *APA Resolution on Gender Identity Change Efforts*, 4 (Feb. 2021), https://perma.cc/78ST-3AVU.

[12] AAP Policy Statement, *supra* n. 2, at 3.

[13] *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR* at 512–13 (2022).

[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* Amit Paley, *The Trevor Project: National Survey on LGBTQ Youth Mental Health 2020*, at 1, https://perma.cc/JB6T-49XF.

having seriously considered attempting suicide,[16] and more than one in three transgender adolescents reported having attempted suicide in the preceding 12 months.[17]

II. General Standards and Best Practices for the Development of Clinical Treatment Recommendations in Medicine

Healthcare providers, hundreds of thousands of whom are individual or institutional members of the respected medical organizations participating here as *amici*, are ethically and legally obligated to provide medical care in accordance with the accepted standards of care. To decide on treatment recommendations for their patients, healthcare providers rely—both directly and through clinical practice guidelines—on the best available evidence in the relevant medical fields, as well as a comparison of the potential benefits and risks of any potential treatments, their own clinical judgment as experienced healthcare professionals, their patients' own individual circumstances, and informed consent.[18] In weighing these considerations,

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[16] *See id*. at 2.

[17] *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*, U.S. Dep't of Health and Human Servs., Centers for Disease Control & Prevention, 68 MORBIDITY & MORTALITY WKLY. REP. 67, 70 (2019), https://perma.cc/7ZKM-F4SS.

[18] *See* National Academy of Medicine, *Clinical Practice Guidelines We Trust* at 109–112 (2011); Yael Schenker & Alan Meisel, *Informed Consent in Clinical Care:* (continued…)

healthcare providers may rely on various types of research and studies, each providing distinct insights into the safety and efficacy of medical treatments. Below, *amici* provide an overview of various types of medical evidence relied on in the development of clinical treatment recommendations, the way that evidence is assessed, how those assessments influence treatment recommendations, and the importance of informed consent.

A. Categories of Medical Evidence

Clinical studies constitute the principal evidence considered by healthcare providers when considering treatment recommendations. Such studies are classified into two general types: observational studies and experimental studies, also known as clinical trials.[19] Broadly speaking, the main distinction between these types of studies is whether the investigators of the study: assign treatments to participants with the express purpose and design of testing a hypothesis (experimental study), or observe the effects of the participants' exposure to the treatment in question as a part

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Practical Considerations in the Effort to Achieve Ethical Goals, 305 JAMA 1130 (2011), https://pubmed.ncbi.nlm.nih.gov/21406651/.

[19] *See* David A. Grimes & Kenneth F. Schulz, *An Overview of Clinical Research: The Lay of the Land*, 359 LANCET 57, 58 (2002), https://pubmed.ncbi.nlm.nih.gov/11809203/; Ambika G. Chidambaram & Maureen Josephson, *Clinical Research Study Designs: The Essentials*, 3 PEDIATR. INVEST. 245 (2019), https://perma.cc/EP4E-FE7C.

of usual clinical practice (observational study).[20] Randomized controlled trials ("RCTs") are a form of experimental study in which researchers randomly assign participants to either receive a particular treatment or a comparison intervention, like a different treatment or a placebo.[21]

When considering the evidence regarding a potential treatment for a patient, healthcare professionals may base their recommendations on both observational and experimental studies. Though experimental studies like RCTs are highly regarded, they are not feasible in all contexts, may face difficult ethical considerations, and can be prohibitively costly.[22] Observational studies are conducted more frequently because they do not face these obstacles, and provide important data from clinical contexts on the long-term efficacy and safety of a treatment, and thus form an important pillar of medical evidence.[23]

In addition to clinical studies, secondary sources of support exist in the form

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[20] *Id.*

[21] *Id.*

[22] In certain circumstances, RCTs would violate the principle of equipoise, which safeguards the rights of trial participants, where it would be unethical to withhold treatments with proven effects from a placebo group in need of medical intervention. *See* Richard J. Lilford & Jennifer Jackson, *Equipoise and the Ethics of Randomization*, 88 J. R. SOC. MED. 552, 552 (1995); Chidambaram & Josephson, *supra* n. 19, at 251.

[23] *See* Ravi Thadhani, *Formal Trials Versus Observational Studies*, *in Fabry Disease: Perspectives From 5 Years of FOS* (2006).

of published reviews or analyses, like systematic reviews. Systematic reviews do not provide any new clinical data but are instead summaries of preexisting studies based on the authors' criteria for which studies to include or exclude.[24]

B. Assessment of Evidence in the Development of Treatment Recommendations

To evaluate a potential treatment recommendation for a patient, healthcare providers must consider not just the scope of available evidence, but also the quality of available evidence. Although there is no universal framework for performing this assessment, Grading of Recommendations Assessment, Development and Evaluation (GRADE) is a commonly used system that provides guidance on assessing the quality of evidence and determining the strength of treatment recommendations.[25] Clinical practice guidelines promulgated by respected medical organizations commonly provide strength-rated treatment recommendations

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[24] *See* Maria J. Grant & Andrew Booth, *A Typology of Reviews: An Analysis of 14 Review Types and Associated Methodologies*, 26 HEALTH INFO. LIBR. J. 91 (2009), https://perma.cc/C6QG-DYPN.

[25] *See* National Academy of Medicine, *supra* n. 18, at 114–16; Gordon H. Guyatt et al., *GRADE Guidelines: 1. Introduction - GRADE Evidence Profiles and Summary of Findings Tables*, 64 J. CLINICAL EPIDEMIOLOGY 383 (2011), https://perma.cc/66FA-6MT6; Gordon H. Guyatt et al., *GRADE: An Emerging Consensus on Rating Quality of Evidence and Strength of Recommendations*, 336 BMJ 924 (2008), https://perma.cc/4J7F-3Z62; David Atkins et al., *Grading Quality of Evidence and Strength of Recommendations*, 328 BMJ 1490 (2004).

utilizing GRADE or similar frameworks, which healthcare providers often consider in determining a recommended plan of treatment for their patients.[26]

The GRADE system identifies four levels of evidence quality: high, moderate, low, and very low.[27] However, it is important to understand that these are terms of art; "low" does not mean that the evidence lacks value.

GRADE's levels of evidence are based on a complex assessment of factors that can influence how study data are interpreted. For example, if different proportions of participants complete a study depending on the treatment they received, this affects the interpretation of the results.[28] Also, if a participant is aware of the treatment because of its unique benefits, side effects, etc., this affects the interpretation of results.[29] Studies rated as "high quality" studies have fewer such factors, but it is well understood in the medical community that "low quality" studies still provide valuable and valid information about the benefits and safety of clinical practices. "[O]nly a minority of outcomes for health care interventions are supported

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[26] *Id.*

[27] Gordon H. Guyatt et al., *GRADE: What Is "Quality of Evidence" and Why Is It Important to Clinicians?*, 336 BMJ 995, 998 (2008), https://perma.cc/X2BE-C9P4.

[28] *See* Holger Schünemann et al., *GRADE Handbook*, at 5.2 (2013), https://perma.cc/B7EM-E73T.

[29] *Id.*

by high quality evidence."[30] Indeed, clinical practice is commonly guided by evidence that evidence grading systems might deem "low quality."[31] In addition, GRADE itself acknowledges the relevance of factors beyond the quality of evidence, such as "[t]he balance between desirable and undesirable outcomes and the application of patients' values and preferences," which should inform treatment recommendations.[32]

In sum, healthcare providers carefully consider the best available evidence, alongside the balance of the relevant benefits and risks associated with a given treatment and their own clinical experience, to tailor treatment recommendations to a patient's individual needs.

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[30] Jeremy Howich et al., *The Quality of Evidence for Medical Interventions Does Not Improve or Worsen: A Metaepidemiological Study of Cochrane Reviews*, 126 J. CLIN. EPIDEMIOL. 154 (2020), https://perma.cc/TKB3-6ZNH.

[31] For example, the American Heart Association's guideline for Pediatric Basic and Advanced Life Support includes 130 recommendations, only 1 of which is predicated on Level A (akin to GRADE's "high quality") evidence. Alexis A. Topjian et al., *Pediatric Basic and Advanced Life Support: 2020 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care*, 142 Circulation S469 (2020). The majority of the recommendations rely on what was deemed Level C-LD (akin to GRADE's "low quality") evidence. *Id*.

[32] Guyatt et al. (2011), *supra* n. 25, at 384, 86, 92; *see also* Mohammed T. Ansari et al., *Grading Quality of Evidence and Strength of Recommendations: A Perspective*, PLOS MEDICINE 6(9):e1000151, 2 (2009), https://perma.cc/4MUS-TBZM.

C. The Importance of Informed Consent

A final essential element of healthcare practice is securing a patient's informed consent for the treatment by discussing the potential benefits and risks associated with the recommended treatment with patients[33]—and in the pediatric context,[34] with the patient's parents or guardians. Obtaining informed consent centers medical care around a patient's autonomy and dignity. Informed consent, combined with a careful analysis of the existing science and clinical experience, are key elements in enabling healthcare providers to adhere to national standards and practices to provide the best possible care to their patients.[35]

III. GAMC Was Developed Using the Same Standards and Best Practices as Other Types of Medical Treatments

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, GAMC is necessary.[36] This care greatly reduces the negative physical and mental-health consequences that result when gender dysphoria is

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[33] *See* Ruth R. Faden & Tom L. Beauchamp, *Foundations in Moral Theory*, *in* A History and Theory of Informed Consent (1986).

[34] *See* Aviva L. Katz, et al., *Informed Consent in Decision-Making in Pediatric Practice* (2016) (report reaffirmed 2023), https://perma.cc/G2DC-H7WT.

[35] *See* National Academy of Medicine, *supra* n. 18, at 111.

[36] *See, e.g.*, Endocrine Soc'y, *Transgender Health: An Endocrine Society Position Statement* (2020), https://perma.cc/7L4P-VWME.

untreated.[37] As explained below, the type and quality of evidence supporting these treatments, and the manner in which that evidence has been evaluated, is consistent with general best practices of the medical community in other clinical disciplines.

A. The Widely Accepted Guidelines for Treating Adolescents With Gender Dysphoria Provide for GAMC When Indicated

For youths with gender dysphoria that continues into adolescence—after the onset of puberty—in certain circumstances GAMC may be indicated in addition to mental health care. The treatment recommendations for gender dysphoria are provided in evidence-based clinical guidelines: (i) the Endocrine Society Clinical Practice Guidelines for Clinical Treatment of Gender-Dysphoria/Gender Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transgender and Gender-Diverse People.[38] These guidelines set forth an extensive

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[37] *See id.*

[38] *See* Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, at 3869, 3878, 80–85 (Nov. 2017); Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People*, 23 INT'L J. TRANSGENDER HEALTH S1, S48 (8th ed. 2022). *Amici* member American Psychiatric Association ("APA") also links to Coleman et al. on its website, which indicates that APA has reviewed these guidelines under the "AGREE" rating framework and scored them as "high quality." *See* American Psychiatric Association, *Clinical Practice Guidelines*, https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines (last visited Sept. 9, 2025); AGREE, *Appraisal of Guidelines for Research & Evaluation* (2017), https://perma.cc/UEX9-4KLK.

list of requirements detailing the circumstances in which GAMC care may be prescribed to adolescents, including a robust diagnostic assessment, stringent guidelines regarding the qualifications of the medical professionals involved in that assessment, and strict patient criteria—including that the patient has demonstrated a prolonged pattern of gender dysphoria.[39]

If, after careful evaluation, healthcare providers determine that an adolescent with gender dysphoria meets all criteria, and the patient and their parent provide informed consent, gonadotropin-releasing hormone (GnRH) analogues, or "puberty blockers," may be offered beginning at the onset of puberty.[40] The purpose of puberty blockers is to delay further pubertal development until adolescents are older and have had sufficient time to make more informed decisions about whether to pursue further treatments.[41] Puberty blockers also can make pursuing transition later in life easier, because they prevent bodily changes such as protrusion of the Adam's apple or breast growth.[42]

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[39] *See* Hembree et al., *supra* n. 38 at 3869, 3878, 80–85; Coleman et al., *supra* n. 38 at S48.

[40] *See id.*

[41] Martin, *supra* n. 5, at 2.

[42] *See* AAP Policy Statement, *supra* n. 2, at 5.

Puberty blockers have well-known efficacy and side-effect profiles.[43] Their effects are generally reversible, and when a patient discontinues their use, the patient typically resumes endogenous puberty.[44] In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty.[45] The risks of any serious adverse effects from puberty blockers are exceedingly rare when provided under clinical supervision.[46]

Later in adolescence, if healthcare providers determine—after careful evaluation—that an adolescent with gender dysphoria meets all the treatment criteria,[47] hormone therapy may be used to initiate puberty consistent with the

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[43] *See* Martin, *supra* n. 5, at 2.

[44] *See id.*

[45] *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 NEW ENG. J. MED. 1546 (1981), https://pubmed.ncbi.nlm.nih.gov/6458765/.

[46] *See, e.g.*, Annemieke S. Staphorsius et al., *Puberty Suppression and Executive Functioning: An Fmri-Study in Adolescents with Gender Dysphoria*, 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 (2020), https://perma.cc/VP47-UA9M (exceedingly low risk of delayed bone mineralization from hormone treatment).

[47] *See* Hembree et al., *supra* n. 38, at 3878, 80–85; Coleman et al., *supra* n. 38, at S48.

patient's gender identity.[48] Hormone therapy involves using hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.[49] 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.[50]

B. The Available Evidence Supports Providing GAMC for Adolescents With Gender Dysphoria When Medically Indicated

Multiple studies have been published that investigated the use of puberty

[48] Martin, *supra* n. 5, at 2.

[49] *See* AAP Policy Statement, *supra* n. 2, at 6.

[50] *See* AAP Policy Statement, *supra* n. 2, at 5–6.

blockers,[51] and/or hormones,[52] to treat adolescents with gender dysphoria. These

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[51] *See, e.g.*, Christal Achille et al., *Longitudinal Impact of Gender-Affirming Endocrine Intervention on The Mental Health and Wellbeing of Transgender Youths: Preliminary Results*, 8 INT'L J PEDIATRIC ENDOCRINOLOGY 1–5 (2020), https://perma.cc/K5SR-EE3G; 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://doi.org/10.1371/journal.pone.0243894; 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: A Prospective Follow-Up Study*, 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://perma.cc/2HAT-GGFV; Jack L. Turban et al., *Pubertal Suppression For Transgender Youth And Risk of Suicidal Ideation*, 145(2) PEDIATRICS e20191725 (2020), https://perma.cc/B2UZ-YR3Q; 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(6) J. ADOLESCENT HEALTH 699–704 (2020), https://pubmed.ncbi.nlm.nih.gov/32273193/; Alessandra D. Fisher, *Back to the Future: Is GnRHa Treatment in Transgender and Gender Diverse Adolescents Only an Extended Evaluation Phase?*, 109 J. CLINICAL ENDOCRINOLOGY & METABOLISM 1565 (2023), https://pubmed.ncbi.nlm.nih.gov/38099569/; Kerry McGregor et al., *Association of Pubertal Blockade at Tanner 2/3 With Psychosocial Benefits in Transgender and Gender Diverse Youth at Hormone Readiness Assessment*, 74 J. ADOLESC. HEALTH 801 (2024), https://pubmed.ncbi.nlm.nih.gov/38099903/; Rosemary Lavender et al., *Impact of Hormone Treatment on Psychosocial Functioning in Gender-Diverse Young People*, 10 LGBT HEALTH 382 (2023), https://pubmed.ncbi.nlm.nih.gov/36989498/.

(continued…)

studies find positive mental-health outcomes for those adolescents who received GAMC, including statistically significant reductions in anxiety, depression, and suicidal ideation.[53]

For example, a 2020 retrospective study analyzed survey data from 89 transgender adults who had access to puberty blockers while adolescents and from

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[52] *See, e.g.*, Achille, *supra* n. 51, at 1–5; 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://www.sciencegate.app/document/10.1037/cpp0000288; Diane Chen et al., *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, 388(3) NEW ENG. J. MED 240-50 (2023), https://www.nejm.org/doi/10.1056/NEJMoa2206297; Diego Lopez de Lara et al., *Psychosocial Assessment in Transgender Adolescents*, 93(1) ANALES DE PEDIATRIA 41–48 (English ed. 2020), https://perma.cc/AQ4G-YJ85; de Vries et al, *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, *supra* n. 51; Rittakerttu Kaltiala et al., *Adolescent Development And Psychosocial Functioning After Starting Cross-Sex Hormones For Gender Dysphoria*, 74(3) NORDIC J. PSYCHIATRY 213 (2020), https://doi.org/10.1080/08039488.2019.1691260; Kuper, *supra* n. 51; 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://doi.org/10.1016/j.jadohealth.2021.10.036; Jack L. Turban et al., *Access To Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, J. PLOS ONE (2022), https://doi.org/10.1371/journal.pone.0261039.

[53] The data likewise indicate 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).

more than 3,4000 transgender adults who did not.[54] 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.[55] Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation.[56] Additionally, a longitudinal study of nearly 50 transgender adolescents found that suicidality decreased by a statistically significant degree after receiving gender-affirming hormone treatment.[57] 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 with decreased symptoms of depression and anxiety.[58]

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[54] *See* Turban, *supra* n. 51.

[55] *See id*; *see also* Fisher (finding "a significant improvement in psychological functioning, as well as decrease in suicidality" in a prospective study of transgender adolescents receiving puberty blockers), *supra* n. 51; McGregor (comparing the psychosocial function of transgender adolescents prescribed puberty blockers to those that had not, finding that "[t]he blocker population was also significantly less likely to report any suicidal thoughts"), *supra* n. 51; Lavender (observing in transgender adolescents "improvements . . . in self-harm and suicidality statements" after one year of treatment with puberty blockers), *supra* n. 51.

[56] *See* Turban, *supra* n. 51.

[57] *See* Allen, *supra* n. 52.

[58] *See* Chen et al., *supra* n. 52.

As another example, 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.[59] 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.[60] "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."[61]

As scientists and researchers, *amici* always welcome more research, including on this crucial topic. The available data, however, indicate that the GAMC targeted by the Healthcare Ban is effective for the treatment of gender dysphoria in carefully evaluated patients.

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[59] *See* de Vries et al, *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, *supra* n. 51.

[60] de Vries et al, *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, *supra* n. 51.

[61] 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.

C. The Evidence Supporting GAMC Recommendations, and the Evaluation of That Evidence, Is Consistent With Other Areas of Medicine

Proponents of the Healthcare Ban have criticized GAMC because it is based in part on evidence that may be deemed "low quality" under GRADE. Such an assertion misapprehends GRADE. And as discussed above in Section II.B, its term of art—"low quality"— does not mean that the evidence lacks value or should not be used to develop treatment recommendations.

Widely accepted clinical-treatment recommendations across various medical fields commonly rely on evidence that is not considered "high quality."[62] Moreover, "high quality" evidence typically refers to RCTs, which often are infeasible or unethical to carry out, particularly in the pediatric context.

"[I]n transgender clinical research individual . . . RCTs . . . may not always be feasible or ethically acceptable."[63] With preexisting guidelines that recommend GAMC for those with gender dysphoria, RCTs would violate the principle of equipoise.[64] Moreover, the ability to perform blinded RCTs is complicated where

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[62] *See supra* n. 31.

[63] Sari L. Reisner et al., *Advancing Methods for U.S. Transgender Health Research*, 23(2) CURR. OPIN. ENDOCRINAL DIABETES OBES. 198, 199 (2016), https://perma.cc/KR8Z-WJA3.

[64] Richard J. Lilford & Jennifer Jackson, *Equipoise and the Ethics of Randomization*, 88 J. R. SOC. MED. 552, 552 (1995), https://perma.cc/7458-SJSC.

participants may be able to easily discern trial placement due to biological changes from treatment.

Recently, the authors of several systematic reviews studying evidence related to GAMC—including Dr. Guyatt, one of the architects of GRADE—published a letter stating that it is "unconscionable" to deny GAMC based on evidence characterized as "low quality" within a specific GRADE category.[65] They wrote:

> We are concerned our findings will be used to justify denying care such as puberty blockers and hormone replacement therapy to [transgender] individuals.
> . . .
> It is profoundly misguided to cast health care based on low-certainty evidence as bad care or as care driven by ideology, and low-certainty evidence as bad science. Many of the interventions we offer are based on low certainty evidence, and enlightened individuals often legitimately and wisely choose such interventions. **Thus, forbidding delivery of gender-affirming care and limiting medical management options on the basis of low certainty evidence is a clear violation of the principles of evidence-based shared decision-making and is unconscionable.** The appropriate use of our work is in ensuring patients receive needed care and in helping [transgender] patients and their clinicians in decision making.[66]

As these authors make plain, it is a grievous mischaracterization of evidence-based medicine to presume that GAMC is bad care, or should be banned, because

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[65] Gordon Guyatt et al., *Systematic Reviews Related to Gender-Affirming Care*, https://hei.healthsci.mcmaster.ca/systematic-reviews-related-to-gender-affirming-care/.

[66] *Id.* (emphasis added).

the evidence supporting such care includes observational studies.

D. Informed Consent is a Core Requirement of GAMC

As with all other areas of medicine, treatment recommendations involving GAMC insist that healthcare providers receive informed consent before care is provided. Clinical practice guidelines for treating adolescent patients with GAMC include express and specific guidance on securing informed consent before treating adolescent patients with GAMC.[67] GAMC is not recommended where informed consent is not given.

IV. The Healthcare-Ban Proponents Make Factually Inaccurate Claims in an Attempt to Support Banning Care

In trying to justify denying access to GAMC, the Healthcare Ban and its proponents make inaccurate claims that are lacking in meaningful evidentiary support. These claims are discussed below.

A. GAMC is Not a Recommended Treatment for Prepubertal Children

The Healthcare Ban purports to protect "children."[68] However, it conflates

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[67] *See* Hembree et al., *supra* n. 38, at 3878 (describing requirement of informed consent from patient and parent or guardian, and ensuring that the adolescent has sufficient mental capacity to give informed consent to the treatments); Coleman et al., *supra* n. 38, at S48 (describing requirement of informed consent and ensuring the adolescent has no mental health concerns that could impact the capacity to consent).

[68] H.B. 68 § 2(A).

prepubertal children with adolescents,[69] which is an important distinction. Prepubertal children are ***not*** eligible under the applicable clinical practice guidelines for the GAMC targeted in the Healthcare Ban.[70] For prepubertal children with gender dysphoria, it is recommended that clinicians provide only mental-health care and support for the child and their family, like through psychotherapy and social transitioning.[71]

B. The Vast Majority of Adolescents Diagnosed With Gender Dysphoria Will Persist Through Adulthood

The Healthcare Ban states that "the vast majority of children who are gender nonconforming or experience distress at identifying with their biological sex come to identify with their biological sex in adolescence or adulthood, thereby rendering most medical health care interventions unnecessary."[72] There are no studies to support the proposition that adolescents with gender dysphoria are likely to later

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[69] *Id.*

[70] *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.

[71] *See* Coleman et al., *supra* n. 38, at S73–S74; Hembree et al., *supra* n. 38, at 3877–78. "Social transition" refers to a process by which a child is acknowledged to have, and has the opportunity to live in, the gender identity they affirm. *See, e.g.*, Coleman et al., *supra* n. 38, at S75.

[72] H.B. 68 § 2(C).

identify as their sex assigned at birth, whether they receive treatment or not.[73] Rather, "[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."[74]

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[75]—must do so because they have come to identify with their sex assigned at birth. This ignores other, more commonly reported factors that contribute to a person's choice to

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[73] *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.

[74] Rosenthal, *supra* n. 61, at 585.

[75] Michael S. Irwig, *Detransition Among Transgender and Gender-Diverse People—An Increasing and Increasingly 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.").

detransition, like pressure from parents and discrimination.[76]

C. There Is No Accepted Protocol of "Watchful Waiting" for Adolescents with Gender Dysphoria

Healthcare Ban proponents have questioned the medical necessity of GAMC for adolescents and suggested that a better approach is "watchful waiting" where no medical treatments are provided. Some practitioners use a "watchful waiting" approach for ***prepubertal children*** with gender dysphoria, which involves waiting until the child reaches adolescence before considering social transition.[77] Yet "watchful waiting" is not recommended for ***adolescents*** with gender dysphoria.[78] It can cause immense harm by denying patients the evidence-based treatments that could alleviate their distress, and forcing them to experience full endogenous puberty, resulting in some physical changes that may be reversed—if at all—only through surgery or other invasive procedures.[79]

D. There is No Evidence That Gender Dysphoria Can Be Caused by "Social Contagion" or "Rapid-Onset Gender Dysphoria"

Healthcare Ban proponents have also claimed that gender dysphoria in

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

[77] AAP Policy Statement, *supra* n. 2, at 4.

[78] AAP Policy Statement, *supra* n. 2, at 4; Coleman et al., *supra* n. 38, at S112–113.

[79] AAP Policy Statement, *supra* n. 2, at 4.

adolescents can be attributed to "social contagion," or "rapid-onset gender dysphoria," from exposure to peer groups and social media.[80] No credible evidence supports this argument. The term "rapid-onset gender dysphoria" was coined in 2018 by the author of an anonymous survey of parents of transgender youth, who were recruited from websites that promote the belief that "social contagion" causes transgender identity.[81] The survey has been widely discredited.[82] Moreover, the journal in which the survey was published subsequently published an extensive correction stating, among other things, that "[r]apid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis," and that the "report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not

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[80] *See* Greta R. Bauer et al., *Do Clinical Data from Transgender Adolescents Support the Phenomenon of "Rapid Onset Gender Dysphoria"?*, 243 J. PEDIATRICS 224, 225–26 (2022), https://pubmed.ncbi.nlm.nih.gov/34793826/.

[81] Lisa Littman, *Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, 14(3) PLOS ONE e0214157, at 2, 8–9 (Aug. 2018), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330 (stating that survey participants were recruited from the websites YouthTransCriticalProfessionals.org, TransgenderTrend.com, and 4thWaveNow.com).

[82] *See, e.g.*, Susan D. Boulware et al., *supra* n. 70, at 18.

validate the phenomenon."[83]

Subsequent peer-reviewed research has not found support for a new etiologic phenomenon of rapid-onset gender dysphoria during adolescence.[84] On the contrary, one study showed that most adolescents—nearly 70%—referred to a clinic for puberty blockers or hormone therapy had known their gender was different from the one assigned at birth for three or more years.[85] The study also showed no correlation between support from online friends or transgender friends and "recent gender knowledge"—defined as realizing that your gender was different from what people called you for two years or less.[86]

E. GAMC Is Provided Infrequently to Adolescents

Healthcare Ban proponents have incorrectly suggested that GAMC is rampantly and carelessly provided to adolescents. This is false. As discussed in Section III.A, it is recommended that GAMC be provided to adolescents only after careful evaluation and only if the adolescent meets an extensive list of specific

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[83] Lisa Littman, *Correction: Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, 14(3) PLOS ONE e0214157 (Mar. 2019), https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0214157.

[84] Bauer et al., *supra* n. 80.

[85] *See id.* at 225.

[86] *Id.* at 224–27.

criteria. Moreover, 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,[87] and only a small fraction of transgender adolescents is prescribed GAMC.[88] Further, research supports that this increase in adolescents seeking care is very likely the result of reduced social stigma and expanded care options.[89]

F. GAMC is Provided Internationally

Healthcare Ban proponents have also suggested that a categorical ban of GAMC is consistent with treatment recommendations in other countries. This is simply untrue. For example, as recently as March 2025, the AWMF—an organization comprising over 150 German medical societies that promulgates healthcare guidelines in Germany—published guidelines upholding its previous findings that the provision of GAMC to adolescents is appropriate when medically

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[87] *See* Johns, *supra* n. 17, at 68.

[88] Landon D. Hughes et al., *Gender-Affirming Medications Among Transgender Adolescents in the US, 2018-2022*, JAMA Pediatr. (Jan. 6, 2025), https://pubmed.ncbi.nlm.nih.gov/39761053/ (finding less than 0.1% of transgender adolescents are prescribed GAMC by examining private insurance claims over 5 years).

[89] *See* Boulware, *supra* n. 70, at 20.

indicated.[90]

Healthcare Ban proponents have relied, in particular, on a systematic review conducted for NHS England by Dr. Cass ("Cass Review") to argue that the international medical community supports categorically banning GAMC.[91] But the Cass Review does no such thing. Instead, NHS England continues to provide GAMC through research protocols, as recommended by the Cass Review.[92] Moreover, like other systematic reviews, the Cass Review is simply a summary of some of the existing research, as selected by the author. It does not offer any new evidence regarding GAMC's efficacy. Finally, the Cass Review has been the subject of much criticism, including that it is not an accurate restatement of the available medical evidence on the treatment of gender dysphoria.[93]

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[90] *Geschlechtsinkongruenz und Geschlechtsdysphorie im Kindes- und Jugendalter – Diagnostik und Behandlung (S2k)*, AWMF (Mar. 2025), https://perma.cc/V623-FW2B (in German).

[91] Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report, Cass Review* (Apr. 2024), https://perma.cc/A8UR-Q2WD.

[92] Cass Review at 35; Meredithe McNamara et al., *An Evidence-Based Critique of the Cass Review on Gender-Affirming Care for Adolescent Gender Dysphoria* (2024) at 4, https://perma.cc/39RR-FAM6 ("Cass Critique").

[93] Cass Critique at 35.

V. The Healthcare Ban Would Irreparably Harm Many Adolescents With Gender Dysphoria By Denying Them the Treatment They Need.

The Healthcare Ban will prevent adolescents with gender dysphoria in Ohio from accessing medical care designed to improve health outcomes and alleviate suffering, and that is grounded in science and endorsed by the medical community. Clinicians who are members of the *amici* associations have witnessed the benefits of this treatment and the harm that results when such treatment is denied or delayed.

As discussed in Part III.B, research shows that adolescents with gender dysphoria who receive GAMC experience less depression, anxiety, and suicidal ideation. Several studies have found that the use of puberty blockers or hormone therapy is associated with reductions in suicidal ideation and significant improvement in quality of life.[94] Given this evidence supporting the connection between lack of access to GAMC and lifetime suicide risk, banning such care can put patients' lives at risk.[95]

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[94] *See* Mohammad 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* n. 51; Fisher, *supra* n. 51; McGregor, *supra* n. 51; Lavender, *supra* n. 51.

[95] Lee et al., *State-level Anti-transgender Laws Increase Past-year Suicide Attempts Among Transgender and Non-binary Young People in the USA*, 8 NATURE HUMAN BEHAVIOR 11 (2024), https://perma.cc/B3HR-3G3S ("Enacting state-level anti-
(continued…)

CONCLUSION

For the foregoing reasons, this Court should affirm the judgment of the Court of Appeals.

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transgender laws was associated with increased incidents of past-year suicide attempts among [transgender and nonbinary] young people by 7–72%.")

Dated: December 9, 2025

Respectfully submitted,

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