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NORTH DAKOTA SUPREME COURT

SUPREME COURT CASE NO. 20260075

IN THE SUPREME COURT OF NORTH DAKOTA

T.D., by and through his parents, DEVON DOLNEY and ROBERT DOLNEY, DEVON DOLNEY, an individual, ROBERT DOLNEY, an individual, PAMELA ROE, by and through her parents, PETER ROE and PAULA ROE, PETER ROE, an individual, PAULA ROE, an individual, JAMES DOE, by and through his parents, JOHN DOE and JANE DOE, JOHN DOE, an individual, JANE DOE, an individual, and DR. LUIS CASAS, an individual, on behalf of himself and his patients,

Plaintiffs-Appellants,

v.

DREW H. WRIGLEY, in his official capacity as Attorney General for the State of North Dakota, KIMBERLEE JO HEGVIK, in her official capacity as State's Attorney for Cass County, JULIE LAWYER, in her official capacity as State's Attorney for Burleigh County, and AMANDA ENGELSTAD, in her official capacity as the State's Attorney for Stark County,

Defendants-Appellees.

BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF APPELLANTS AND REVERSAL

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TABLE OF CONTENTS

Paragraph

TABLE OF AUTHORITIES

Paragraph(s)

STATEMENT OF IDENTITY AND INTEREST OF *AMICI CURIAE*

[¶ 1] *Amici curiae* are the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, 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 Academic Pediatric Association, the American Pediatric Society, the Association of American Medical Colleges, the Endocrine Society, GLMA: Health Professionals Advancing LGBTQ+ Equality, the National Association of Pediatric Nurse Practitioners, the Pediatric Endocrine Society, the Pediatric Endocrinology Nursing Society, the Societies for Pediatric Urology, the Society for Adolescent Health and Medicine, the Society of Pediatric Nurses, and the World Professional Association for Transgender Health.

[¶ 2] *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 about the appropriate treatment for transgender adolescents.[1]

INTRODUCTION AND SUMMARY OF ARGUMENT

[¶ 3] 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 the patient's sex assigned at birth. If not treated or if 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.

[¶ 4] The medical community, including the professional organizations participating as *Amici*, widely recognizes that the appropriate treatment for transgender adolescents

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[1] Pursuant to N.D. R. App. P. 29(a)(4)(D), *Amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *Amici* or their counsel made any monetary contributions intended to fund the preparation or submission of this brief.

diagnosed with gender dysphoria is gender-affirming care.[2] This care supports individuals with gender dysphoria as they explore their gender identity—in contrast with efforts to change individuals' gender identities to match their sex assigned at birth, which are known to be ineffective and harmful.[3]

[¶ 5] For carefully evaluated adolescents with persistent gender dysphoria that worsens with the onset of puberty, that care may include gender-affirming medical care to align their physiology with their gender identity through the prescription of puberty blockers and hormone therapy ("GAMC").[4] Empirical evidence indicates that treating carefully evaluated patients who meet diagnostic criteria with GAMC can alleviate clinically significant distress and lead to significant improvements in mental health and overall wellbeing.[5] For patients who meet the necessary criteria, GAMC is critical, medically

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[2] *See, e.g.*, Jason Rafferty, *AAP Policy Statement: Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents* 2–3 tbl. 1, 142(4) PEDIATRICS e20182162 (2018) [hereinafter, "AAP Policy Statement"]. The American Academy of Pediatrics voted to reaffirm the AAP Policy Statement in 2023. *See* Alyson Sulaski Wyckoff, *AAP Reaffirms Gender-Affirming Care Policy, Authorizes Systematic Review of Evidence to Guide Update*, AAP NEWS (Aug. 4, 2023).

[3] *See, e.g.*, Christy Mallory, Taylor N.T. Brown & Kerith J. Conron, *Conversion Therapy and LGBT Youth: Update*, WILLIAMS INST. (2019), https://perma.cc/HXY3-UX2J.

[4] "GAMC" refers to the use of gonadotropin-releasing hormone (GnRH) analogues and/or hormone therapy to treat gender dysphoria. Because this brief focuses on adolescents, it does not discuss surgeries, which are available primarily to transgender adults.

[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 (2021) (providing an overview of the scientific basis underlying gender-affirming care and its demonstrated effectiveness).

necessary, evidence-based care.

[¶ 6] In 2023, the North Dakota legislature enacted Century Code Chapter 12.1-36.1 (the "Healthcare Ban"), banning healthcare providers from providing GAMC to patients under 18. By denying adolescents' access to this important treatment, the Healthcare Ban puts adolescents who meet the requisite medical criteria at risk of significant harm.

[¶ 7] This brief provides background on gender identity and gender dysphoria. It describes the general standards and best practices used by the medical community when developing clinical treatment recommendations and explains how such recommendations involving GAMC were developed in a manner consistent with the general standards and best practices used in other areas of medicine. It then identifies certain common, but inaccurate, claims made by those who seek to ban GAMC. *Amici* conclude that the Healthcare Ban irreparably harms adolescents with gender dysphoria by denying them access to critical, medically necessary, evidence-based care.

ARGUMENT

I. Understanding Gender Identity and Gender Dysphoria

[¶ 8] 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. Of these individuals, approximately 10% are teenagers aged 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) AM. PSYCHOLOGIST 832, 862 (2015).

[8] *See id.* at 832.

to 17.[9] Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

[¶ 9] Being transgender is a normal variation of human identity.[10] But 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."[11] Gender dysphoria is a formal diagnosis under the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5-TR).[12]

[¶ 10] If left untreated or inadequately treated, gender dysphoria can lead to depression, anxiety, self-harm, and suicidality.[13] 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.[14] Even more troubling, more than 50% of this population reported having seriously considered

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[9] Landon D. Hughes et al., *Gender-Affirming Medications Among Transgender Adolescents in the US, 2018–2022*, 179 JAMA PEDIATRICS 342 (2025).

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

[11] AAP Policy Statement, *supra* note 2, at 3.

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

[13] *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).

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

attempting suicide,[15] and more than one in three transgender adolescents reported having attempted suicide in the preceding 12 months.[16]

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

[¶ 11] Healthcare providers, hundreds of thousands of whom are individual or institutional members of the medical organizations participating here as *Amici*, are ethically and legally obligated to provide medical care in accordance with the standard 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 on comparisons of the potential benefits and risks of any potential treatments, their own clinical judgment as experienced healthcare professionals, their patients' individual circumstances, and informed consent.[17] Below, *Amici* provide an overview of various types of medical evidence relied on in the development of clinical treatment guidelines, the way that evidence is assessed, how those assessments influence treatment recommendations, and the importance of informed consent.

[¶ 12] Clinical studies are the principal evidence that providers consider when evaluating

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[15] *See id*. at 2.

[16] *See* Michelle 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).

[17] *See* INSTITUTE OF MEDICINE COMMITTEE ON STANDARDS FOR DEVELOPING TRUSTWORTHY CLINICAL PRACTICE GUIDELINES, CLINICAL PRACTICE GUIDELINES WE CAN TRUST 109–12 (2011); Yael Schenker & Alan Meisel, *Informed Consent in Clinical Care: Practical Considerations in the Effort to Achieve Ethical Goals*, 305 JAMA 1130 (2011).

treatment recommendations. There are two general types of clinical studies: observational and experimental. In an observational study, the effects of treatment are observed as part of usual clinical practice, whereas in an experimental study (also known as a clinical trial), treatments are assigned to participants with the purpose of testing a particular hypothesis.[18]

[¶ 13] Randomized controlled trials (RCTs) are one form of experimental study in which researchers randomly assign participants either to the experimental group or a control group, with the former receiving the studied treatment and the latter receiving a comparison intervention, such as a different treatment or placebo.[19] Though experimental studies like RCTs are highly regarded, they are not feasible in all contexts and may face difficult ethical considerations.[20] Observational studies are conducted more frequently because they do not face these obstacles, and they provide important data from clinical contexts on the long-term efficacy and safety of a treatment. Observational studies thus form an important pillar of medical evidence.[21]

[¶ 14] Secondary sources in the form of published reviews or analyses are another form of

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[18] *See* David A. Grimes & Kenneth F. Schulz, *An Overview of Clinical Research: The Lay of the Land*, 359 LANCET 57, 58 (2002); Ambika G. Chidambaram & Maureen Josephson, *Clinical Research Study Designs: The Essentials*, 3 PEDIATR. INVESTIGATION 245 (2019).

[19] *Id.*

[20] For example, once a treatment is already shown to be effective through clinical observation, conducting RCTs may violate the principle of "equipoise," which recognizes that it is generally unethical to withhold from patients in a control group the benefit of a treatment that has already been demonstrated to be efficacious in practice. *See* Richard J. Lilford & Jennifer Jackson, *Equipoise and the Ethics of Randomization*, 88 J. R. SOC. MED. 552 (1995); Chidambaram & Josephson, *supra* note 18, at 251.

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

medical evidence. Systematic reviews do not provide new clinical data but are instead analyses of existing study data based on the authors' criteria for which studies to include or exclude.[22]

[¶ 15] Although there is no universal framework for assessing clinical evidence, one rubric commonly used in developing clinical practice guidelines is the "Grading of Recommendations Assessment, Development and Evaluation" (GRADE) system. Through the GRADE system, key clinical questions are identified, existing scientific evidence is evaluated, and criteria for using evidence to inform a particular treatment recommendation are considered. Clinical practice guidelines promulgated by respected medical organizations commonly provide strength-rated treatment recommendations utilizing GRADE or similar frameworks, which healthcare providers then may consider in recommending a treatment plan for their patients.[23]

[¶ 16] The GRADE system recognizes four levels of "certainty" of evidence (also sometimes termed "quality"): "high," "moderate," "low," and "very low." In general, randomized trials typically receive a "high" certainty rating while observational studies receive a "low" certainty rating. These are terms of art; the label "low certainty" does not mean that evidence lacks value.[24]

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[22] *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).

[23] Brian A. Swiglo et al., *A Case for Clarity, Consistency, and Helpfulness: State-of-the-Art Clinical Practice Guidelines in Endocrinology Using the Grading of Recommendations, Assessment, Development, and Evaluation System*, 93 J. CLIN. ENDOCRIN. & METAB. 666, 667 (2008).

[24] Ignacio Neumann et al., *Overview of the GRADE Approach*, at § 2 (*Certainty of evidence*), *in* THE GRADE BOOK (updated Nov. 2025); Gordon H. Guyatt et al., *GRADE:*

(continued on next page)

[¶ 17] GRADE's system for assessing the certainty of evidence embraces many different considerations. For example, one factor that can result in a lower rating is if the percentage of study participants who remain in the study through completion differs depending on the treatment the participants received. Other factors include if the study participant is aware that they are receiving the studied treatment (as opposed to a placebo), including because of the treatment's benefits and side effects, or if the study includes relatively few participants.[25] In general, studies rated as "high" certainty will have fewer such factors.

[¶ 18] GRADE recognizes that "low" certainty studies still provide valid, indeed valuable, information about the benefits and safety of clinical practices. Indeed, "only a minority of outcomes for health care interventions are supported" by high-certainty evidence.[26] Clinical practice is commonly guided by evidence that grading systems deem low certainty.[27]

[¶ 19] Besides the "certainty" of evidence, the GRADE system also acknowledges and incorporates other factors as core components of treatment recommendations, including

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What Is "Quality of Evidence" and Why Is It Important to Clinicians?, 336 BMJ 995, 998 (2008).

[25] H. Schünemann et al., *GRADE Handbook*, ¶ 5.2 (2013), https://perma.cc/B7EM-E73T.

[26] Jeremy Howick 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).

[27] For example, the American Heart Association's guidelines for Pediatric Basic and Advanced Life Support include 130 recommendations, only 1 of which is based on Level A (akin to GRADE's "high certainty") evidence, while the majority are based on what was deemed Level C-LD (akin to "low certainty") 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).

"[t]he balance between desirable and undesirable outcomes and the application of patients' values and preferences."[28] The GRADE system captures a key principle of evidence-based medicine, namely that "evidence alone is never sufficient to make clinical decisions" and "optimal treatment decisions require integration of clinical knowledge and research evidence with patient circumstances, including their values and preferences." [29] Given the various factors that inform clinical practice guidelines, sometimes those guidelines "can make strong recommendations based on low to very low quality evidence."[30]

[¶ 20] The GRADE system thus recognizes that in evaluating potential treatment recommendations for a patient, providers should consider not just the type and certainty of available evidence, but also their own clinical knowledge and patient circumstances.

[¶ 21] Another fundamental element of healthcare practice is securing a patient's informed consent for a treatment. Informed consent includes discussing the potential benefits and risks of a recommended treatment with the patient[31] and, if a minor, the patient's parent(s) or guardian(s).[32] Treatment recommendations reflect not only a careful analysis of the

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[28] Gordon H. Guyatt et al., *GRADE Guidelines: 1. Introduction - GRADE Evidence Profiles and Summary of Findings Tables*, 64 J. CLIN. EPIDEMIOL. 383, 384, 386, 392 (2011); *see also* Mohammed T. Ansari et al., *Grading Quality of Evidence and Strength of Recommendations: A Perspective*, PLOS MEDICINE 6(9):e1000151, 2 (2009).

[29] *See* INSTITUTE OF MEDICINE COMMITTEE, *supra* note 17, at 114–16; Guyatt et al. (2011), *supra* note 28; Gordon H. Guyatt et al., *GRADE: An Emerging Consensus on Rating Quality of Evidence and Strength of Recommendations*, 336 BMJ 924 (2008); David Atkins et al., *Grading Quality of Evidence and Strength of Recommendations*, 328 BMJ 1490 (2004).

[30] Swiglo et al., *supra* note 23, at 669.

[31] RUTH R. FADEN ET AL., A HISTORY AND THEORY OF INFORMED CONSENT (1986).

[32] *See* Aviva L. Katz & Sally A. Webb, *AAP Technical Report: Informed Consent in Decision-Making in Pediatric Practice* (2016), https://perma.cc/G2DC-H7WT.

existing science and clinical experience, but also ensuring that the patient's and caregiver's autonomy and dignity are respected through clinical consultation and informed consent.[33]

[¶ 22] In sum, healthcare providers carefully consider the best available evidence (both directly and through clinical practice guidelines), alongside the balance of the relevant benefits and risks associated with a given treatment, their own clinical experience, and patient values and preferences to tailor treatment recommendations to a patient's needs.

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

[¶ 23] 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. This care greatly reduces the negative physical and mental-health consequences that result when gender dysphoria is untreated.[34] The type and certainty 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. Widely Accepted Guidelines for Treating Adolescents With Gender Dysphoria Provide for GAMC When Indicated

[¶ 24] In certain circumstances, for youths with gender dysphoria that continues into adolescence—that is, after the onset of puberty—GAMC may be indicated in addition to mental health care. Treatment recommendations for gender dysphoria are provided in evidence-based clinical guidelines: (i) the Endocrine Society's Clinical Practice Guidelines for Clinical Treatment of Gender-Dysphoria/Gender Incongruent Persons, and (ii) the

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[33] *See* INSTITUTE OF MEDICINE COMMITTEE, *supra* note 17, at 111.

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

WPATH Standards of Care for the Health of Transgender and Gender-Diverse People.[35] These clinical guidelines set forth an extensive list of requirements addressing when GAMC may be appropriate for 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.[36]

[¶ 25] 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.[37] 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.[38] Puberty blockers can also make pursuing transition later in life easier, because they prevent bodily changes that would otherwise occur, such as Adam's apple protrusion or breast growth.[39]

[¶ 26] Puberty blockers have well-known efficacy and side-effect profiles. Their effects are generally reversible; when a patient discontinues their use, the patient typically resumes

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[35] *See* Wylie Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102(11) J. CLIN. ENDOCRIN. & METAB. 3869, at 3869, 3878, 3880–85 (2017); Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People*, 23 INT'L J. TRANSGEND. HEALTH S1, S48 (8th ed. 2022).

[36] *See* Hembree et al., *supra* note 35, at 3869, 3878, 80-85; Coleman et al., *supra* note 35, at S48.

[37] *See id.*

[38] Martin, *supra* note 5, at 2; Hembree et al., *supra* note 35, at 3880.

[39] *See* AAP Policy Statement, *supra* note 2, at 5.

endogenous puberty.[40] In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty.[41] The risks of serious adverse effects from puberty blockers are exceedingly rare when provided under clinical supervision.[42]

[¶ 27] Later in adolescence and only after careful evaluation, if healthcare providers determine that an adolescent with gender dysphoria meets all the treatment criteria,[43] hormone therapy may be used to initiate puberty consistent with the patient's gender identity.[44] Hormone therapy involves using hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity. 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.[45]

[¶ 28] Of course, as in other areas of medicine, treatment recommendations involving GAMC require healthcare providers to seek and receive informed consent. Clinical practice

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[40] *See* Martin, *supra* note 5, at 2.

[41] *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).

[42] *See, e.g.*, Annemieke Staphorsius et al., *Puberty Suppression and Executive Functioning: An fMRI-Study in Adolescents with Gender Dysphoria*, 6 PSYCHONEUROENDOCRINOLOGY 190 (2015) (no adverse impact on executive functioning); Ken C. Pang et al., *Long-term Puberty Suppression for a Nonbinary Teenager*, 145(2) PEDIATRICS e20191606 (2020) (exceedingly low risk of delayed bone mineralization from hormone treatment).

[43] *See* Hembree et al., *supra* note 35, at 3878-85; Coleman et al., *supra* note 35, at S48.

[44] Martin, *supra* note 5, at 2.

[45] *See* AAP Policy Statement, *supra* note 2, at 5–6.

guidelines for treating adolescent patients with GAMC include express and specific guidance on securing informed consent from patients and parents alike.[46]

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

[¶ 29] Many studies have been published that investigated the use of puberty blockers,[47] and/or hormones,[48] to treat adolescents with gender dysphoria. This body of existing

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[46] *See* Hembree et al., *supra* note 35, 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); Coleman et al., *supra* note 35, at S48 (similar).

[47] A non-exhaustive list includes: 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. PEDIATR. ENDOCRIN. 1–5 (2020); 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); Rosalia Costa et al., *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*, 12(11) J. SEX. MED. 2206–14 (2015); Annelou L.C. de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, 8(8) J. SEX. MED. 2276-83 (2011); Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression And Gender Reassignment*, 134(4) PEDIATRICS 696-704 (2014); Jack L. Turban et al., *Pubertal Suppression For Transgender Youth And Risk of Suicidal Ideation*, 145(2) PEDIATRICS e20191725 (2020); Rosemary Lavender et al., *Impact of Hormone Treatment on Psychosocial Functioning in Gender-Diverse Young People*, 10 LGBT HEALTH 382 (2023).

[48] *See, e.g.*, Achille, *supra* note 47, at 1–5; Luke Allen et al., *Changes in Suicidality Among Transgender Adolescents Following Hormone Therapy: An Extended Study*, 289 PEDIATRICS 114883 (2026); Luke Allen et al., *Well-Being and Suicidality Among*

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research supports the conclusion that, when provided to the adolescent patients for whom it is indicated under the clinical guidelines, GAMC can be provided safely and ethically and can improve short-term (as well as likely long-term) wellbeing.

[¶ 30] Among other benefits, multiple studies have found positive mental-health outcomes for adolescents who receive GAMC, including statistically significant reductions in anxiety, depression, and suicidal ideation.[49] For example, a recently published study following a cohort of 432 transgender patients found that provision of hormone therapy was associated with clinically meaningful reductions in suicidality over time, even across differences in patients' sex assigned at birth, age at start of therapy, and treatment duration. Those findings are consistent with and extend further than prior studies, thereby "suggesting a stable and clinically meaningful association between [hormone therapy] and reduced suicidality."[50]

[¶ 31] As another example, a 2020 retrospective study involved analyzing survey data from 89 transgender adults who received puberty blockers as adolescents and more than 3,400 transgender adults who did not. 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

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Transgender Youth After Gender-Affirming Hormones, 7(3) CLIN. PRAC. PEDIATR. PSYCH. 302 (2019); Diane Chen et al., *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, 388(3) NEW ENG. J. MED. 240 (2023).

[49] 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: A Prospective Cohort Study*, 9 ANDROLOGY 1808 (2021).

[50] *See* Allen et al. (2026), *supra* note 48.

level of family support.[51] Approximately *nine in ten* transgender adults who wanted puberty-blocking treatment but did not receive it reported lifetime suicidal ideation.[52]

[¶ 32] Another study published in 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.[53] And a six-year follow-up study of 55 individuals found that subsequent treatment with hormone therapy followed by surgery in adulthood was associated with statistically significant decreases in depression and anxiety.[54]

[¶ 33] As scientists and researchers, *Amici* always welcome more research, particularly research that continues to consider evolving demographic complexities in the patient population. But the evidence already available demonstrates that GAMC is appropriate and

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[51] *See* Turban et al., *supra* note 47; *see also* Alessandra D. Fisher et al., *Back to the Future: Is GnRHa Treatment in Transgender and Gender Diverse Adolescents Only an Extended Evaluation Phase?*, 109 J. CLIN. ENDOCRIN. & METAB. 1565 (2023) (finding "a significant improvement in psychological functioning, as well as decrease in suicidality" in prospective study of transgender adolescents receiving puberty blockers); 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) (comparing psychosocial function of transgender adolescents prescribed puberty blockers to those that had not, finding "[t]he blocker population was also significantly less likely to report any suicidal thoughts"); Lavender, *supra* note 47, at 385 (observing decrease in self-harm and suicidality as well as improvements in psychological and behavioral outcomes among transgender adolescents after one year of puberty blockers).

[52] *See* Turban et al., *supra* note 47, at 5, 15.

[53] *See* Chen et al., *supra* note 48.

[54] de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, *supra* note 47.

clinically effective for the treatment of gender dysphoria in carefully evaluated patients.

IV. The Healthcare Ban's Proponents Make Factually Inaccurate Claims

[¶ 34] Those who seek to justify denying access to GAMC—including the proponents of North Dakota's Healthcare Ban—rely on various claims that misunderstand the relevant medical evidence or that lack meaningful evidentiary support.

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

[¶ 35] Proponents of banning GAMC for adolescents repeatedly emphasize that the body of evidence supporting GAMC includes evidence deemed "low certainty" or "low quality" under GRADE. As discussed above, however, those terms do not mean that the evidence lacks value or should not be used to develop treatment recommendations. Rather, it simply reflects the fact that many studies in this area are observational, rely on small or specialized patient populations, or involve ethical and practical constraints that make randomized controlled trials infeasible—all factors that may affect how the evidence supporting treatment is assessed under GRADE, but that do not indicate that the evidence cannot help inform clinical practice.

[¶ 36] Indeed, reliance on "low certainty" evidence is not unique to the GAMC context. As discussed above, widely accepted clinical-treatment recommendations across various medical fields commonly rely on evidence that is not rated high certainty.[55]

[¶ 37] Evidence deemed high certainty under GRADE is usually produced through RCTs. But "i[n] transgender clinical research," RCTs "may not always be feasible or ethically acceptable."[56] Given that existing treatment guidelines already recommend GAMC for

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[55] *See, e.g.*, *supra* note 27.

[56] Sari L. Reisner et al., *Advancing Methods for U.S. Transgender Health Research*, 23(2) CURR. OPIN. IN ENDOCRIN. DIABETES OBES.198, 199 (2016).

those with prolonged gender dysphoria, conducting RCTs in which some participants with gender dysphoria would be deprived of GAMC would violate the principle of equipoise.[57] Moreover, the ability to perform patient-blind RCTs is complicated when participants are able to discern their trial placement due to biological changes from treatment.

[¶ 38] The authors of several systematic reviews studying evidence related to GAMC—including Dr. Guyatt, one of GRADE's architects—recently declared it "unconscionable" to deny GAMC just because clinicians rely on evidence deemed "low certainty" under GRADE.[58] 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.... 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.[59]

[¶ 39] As that statement makes plain, it is a grievous mischaracterization of evidence-based medicine to presume that GAMC should be banned simply because the evidence supporting such care includes observational studies.

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[57] *See supra* note 20 (discussing principle of equipoise).

[58] Gordon Guyatt et al., *Systematic Reviews Related to Gender-Affirming Care* (2025), https://hei.healthsci.mcmaster.ca/systematic-reviews-related-to-gender-affirming-care/.

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

B. GAMC Is Not Indicated for Prepubertal Children

[¶ 40] Exemplifying another common misunderstanding, Senator Judy Lee, the Chairwoman of the Senate Committee on Human Services, expressed concern that the Healthcare Ban was needed to protect seven-year-old children from receiving GAMC.[60] But as medical experts testified before her Committee, pre-adolescent (*i.e.*, prepubertal) children are ***not*** eligible for puberty blockers or hormones to treat gender dysphoria under applicable clinical-practice guidelines.[61] Rather, for that patient population, it is recommended that clinicians provide only mental-health care and support for the child and their family, such as through psychotherapy and social transitioning.[62]

[¶ 41] Similar confusion surrounds the concept of "watchful waiting," in which gender dysphoria is monitored but no treatments are provided. Some practitioners use this approach for *prepubertal children* experiencing gender dysphoria, including delaying social transition until the child reaches adolescence.[63] But "watchful waiting" is not recommended for *adolescents* with gender dysphoria.[64] It causes immense harm to categorically deny patients access to evidence-based treatments that could alleviate their distress, and instead

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[60] *Hearing on H.B. 1254 Before S. Comm. on Human Servs.*, 68th Assemb. (N.D. 2023).

[61] *Id.* (testimony of Courtney Koebele, Executive Director of North Dakota Medical Association); *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.

[62] *See* Coleman et al., *supra* note 35, at S73-S74; Hembree et al., *supra* note 35, at 3877-78. "Social transition" refers to a process in which a child is given the opportunity to live in the gender identity that they affirm. Coleman et al., *supra* note 35, at S75.

[63] AAP Policy Statement, *supra* note 2, at 4.

[64] *Id.*; Coleman et al., *supra* note 35, at S112-13.

force them to undergo physical changes that may be reversed—if at all—only through surgery or other invasive procedures.[65]

CONCLUSION

[¶ 42] For the foregoing reasons, *Amici* respectfully submit that the Healthcare Ban irreparably harms adolescents with gender dysphoria by denying them access to medical care designed to improve health outcomes and alleviate suffering, and that is grounded in science and endorsed by the medical community. *Amici* support Appellants' appeal and urge this Court not to credit the erroneous assertions made in support of the Healthcare Ban.

Dated: April 7, 2026

Respectfully submitted,

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[65] AAP Policy Statement, *supra* note 2, at 4.

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with this Court's order of April 10, 2026 granting *Amici*'s motion for leave to file an overlength brief, insofar as this brief contains 26 pages.

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CERTIFICATE OF SERVICE

I hereby certify that on April 10, 2026, I served the foregoing motion on all parties by filing it with the North Dakota Supreme Court through the electronic filing system, which provides service on all counsel of record.

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SUPREME COURT CASE NO. 20260075

IN THE SUPREME COURT OF NORTH DAKOTA

T.D., by and through his parents, DEVON DOLNEY and ROBERT DOLNEY, DEVON DOLNEY, an individual, ROBERT DOLNEY, an individual, PAMELA ROE, by and through her parents, PETER ROE and PAULA ROE, PETER ROE, an individual, PAULA ROE, an individual, JAMES DOE, by and through his parents, JOHN DOE and JANE DOE, JOHN DOE, an individual, JANE DOE, an individual, and DR. LUIS CASAS, an individual, on behalf of himself and his patients,

Plaintiffs-Appellants,

v.

DREW H. WRIGLEY, in his official capacity as Attorney General for the State of North Dakota, KIMBERLEE JO HEGVIK, in her official capacity as State's Attorney for Cass County, JULIE LAWYER, in her official capacity as State's Attorney for Burleigh County, and AMANDA ENGELSTAD, in her official capacity as the State's Attorney for Stark County,

Defendants-Appellees.

CERTIFICATE OF SERVICE

I hereby certify that on April 10, 2026, I served *Brief by Amici Curiae American Academy of Pediatrics and Additional Medical and Mental Health Organizations in Support of Appellants and Reversal* on all parties by filing it with the North Dakota Supreme Court through the electronic filing system, which provided service on all counsel of record.

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