No. 23-5110

In the United States Court of Appeals for the Tenth Circuit

PETER POE, by and through his parents and next friends, PAULA POE and PATRICK POE, *et al.*,

Plaintiffs-Appellants,

v.

GENTNER DRUMMOND, in his official capacity as Attorney General of the State of Oklahoma, *et al.*,

Defendants-Appellees.

On Appeal from the U.S. District Court for the Northern District of Oklahoma, No. 4:23-cv-00177, Honorable John F. Heil, III, District Judge

BRIEF OF DO NO HARM AND OKLAHOMA COUNCIL OF PUBLIC AFFAIRS AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS-APPELLEES

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and 10th Cir. R. 26.1, *amici curiae* Do No Harm and Oklahoma Council of Public Affairs state that (1) they, respectively have no parent corporation; and (2) no corporations hold any stock in either Do No Harm or the Oklahoma Council of Public Affairs.

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INTEREST OF *AMICI CURIAE*

Amicus Do No Harm is a diverse group of physicians, healthcare professionals, medical students, patients, and policymakers whose goal is to protect healthcare from a radical, divisive, and discriminatory ideology. Basing its name in the ethical underpinnings of the Hippocratic Oath, Do No Harm believes healthcare should be free from experimental procedures that place political agendas ahead of patient well-being.

Amicus Oklahoma Council of Public Affairs (OCPA) is an organization dedicated to promoting the flourishing of the people of Oklahoma by advancing principles and policies that support free enterprise, limited government, individual initiative, and personal responsibility. OCPA believes it is important to protect children and families from medical treatments that are wholly unproven, that cause known harm, and that carry lifelong and irreversible consequences.

Amici submit this brief[1] in support of affirmance of the District Court's denial of Plaintiff-Appellants' motion for a preliminary injunction.

[1] All parties have consented to the filing of this brief. No counsel for any party authored this brief in whole or in part, and no entity or person, aside from *amici curiae*, their members, or their counsel, made any monetary contribution intended to fund the preparation or submission of this brief.

INTRODUCTION

No reliable scientific evidence justifies the use of puberty blockers, cross-sex hormones, and surgeries to treat gender dysphoria in minors. To the contrary, such treatments carry harmful lifelong consequences, including infertility, total loss of adult sexual function, and increased risk of several other serious medical conditions. Despite activists' efforts to stifle dissent, even otherwise sympathetic audiences have begun to raise the alarm over the use of these treatments. In recent exposés, writers for *The Economist* and *The New York Times* have warned that the evidence supporting such treatments is "worryingly weak" and that "it is impossible to justify the current recommendations about gender-affirming care based on the existing data." *The Evidence to Support Medicalised Gender Transitions in Adolescents is Worryingly Weak*, THE ECONOMIST (Apr. 5, 2023), https://econ.st/3GnvET8; *see also* Emily Bazelon, *The Battle over Gender Therapy*, N.Y. TIMES (last updated Dec. 17, 2023), https://nyti.ms/3r6fJ76 ("There is no published research on the physical effects in middle or old age of having transitioned in adolescence[.]").

While public discourse over the appropriate treatments for gender dysphoria in minors has become tragically politicized, a fair-minded reading of the existing medical literature leads to the inescapable conclusion that Oklahoma is justified in prohibiting the practice of experimental gender medicine on minors. Nevertheless, numerous medical interest groups have lined up in opposition to Oklahoma's

commonsense law that protects children and adolescents from the harm and unknown risks that accompany these treatments. Although these groups claim to offer objective analysis, an even cursory glance at the positions these groups have taken elsewhere reveals that they peddle nothing more than political ideology dressed up as "Science."

Amici Do No Harm and OCPA submit this brief to make three points. First, the current scientific evidence reveals that the practice of experimental gender medicine on minors causes significant harm, carries serious unknown risks, and offers no proven benefit. Second, this Court should not hesitate to depart from the purported objective recommendations put forth by politically motivated medical interest groups. And third, even if the Court accepts the characterization of the supposedly "robust" and "rigorous" screening procedures for experimental gender medicine, many advocates—including one of Plaintiffs' own experts—have publicly criticized those (and, really, any) screening procedures as too strict. Thus, the advocates of practicing experimental gender medicine on minors are already trying to move the goalposts *beyond* the standards they describe in polished legal briefs. For all these reasons and the reasons explained by Defendant-Appellees, the Court should affirm the District Court's denial of Plaintiffs' motion for a preliminary injunction.

I. The Practice of Experimental Gender Medicine on Children And Adolescents Causes Harm, Carries Serious Unknown Risks, and Offers No Proven Benefit.

All the treatments at issue—puberty blockers, cross-sex hormones, and gender-transition surgeries—pose significant health risks to patients. These treatments (1) cause known harms, (2) carry entirely unknown risks, and (3) achieve no proven benefit.

A. Puberty Blockers, Cross-Sex Hormones, and Gender-Transition Surgeries Carry Numerous and Severe Known Harms—Including Death.

We first address the safety of puberty blockers, technically labeled GnRH agonists. For minors suffering from gender dysphoria, pharmaceutical interventions commonly begin with the prescription of these drugs to halt the normal course puberty. *See* Chad Terhune et al., *As More Transgender Children Seek Medical Care, Families Confront Many Unknowns*, REUTERS (Oct. 6, 2022), https://reut.rs/42XOrgq. Though advocates suggest puberty blockers merely "pause" puberty and are "fully reversible," the use of puberty blockers has been linked to life-altering side-effects, including decreased bone density, cognitive impairment, polycystic ovarian syndrome, metabolic syndrome, and greater risk of infertility. *See* Michael Biggs, *The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence*, 49 J. SEX & MARITAL THERAPY 348 (2023), https://bit.ly/3Kgax6p; Sarah C.J. Jorgensen et al., *Puberty Blockers for Gender Dysphoric Youth: A Lack of Sound*

Science, 5 J. AM. COLL. OF CLINICAL PHARM. 1005 (2022), https://bit.ly/3RvjA7g; Philip J. Cheng et al., *Fertility Concerns of the Transgender Patient*, 8(3) TRANSLATIONAL ANDROLOGY & UROLOGY 209 (2019), https://bit.ly/3nW2K6p. Moreover, these drugs may permanently diminish adult sexual function in patients. Even the president of the World Professional Association for Transgender Health (WPATH) has acknowledged that individuals who are prescribed puberty blockers by age 11 would likely never have the capacity to attain an orgasm in their lifetime. *See* David Larson, *Duke Health Emerges as Southern Hub for Youth Gender Transition*, THE CAROLINA J. (Aug. 31, 2022), https://bit.ly/3JvXuOy.

After blocking a child's normal puberty, doctors may prescribe cross-sex hormones to artificially induce some of the effects of the puberty of the opposite sex. For males, the use of cross-sex hormones is associated with numerous health risks, such as thromboembolic disease, including blood clots; cholelithiasis, including gallstones; coronary artery disease, including heart attacks; macroprolactinoma, which is a tumor of the pituitary gland; cerebrovascular disease, including strokes; hypertriglyceridemia, which is an elevated level of triglycerides in the blood; breast cancer; and irreversible infertility. E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People*, 23 INT'L J. TRANSGENDER HEALTH S1, S119-23 (2022), https://bit.ly/41c6sHl.

For females, the use of cross-sex hormones is associated with risks of erythrocytosis, which is an increase in red blood cells; severe liver dysfunction; coronary artery disease, including heart attacks; depression; hypertension; infertility; and increased risk of breast, cervical, and uterine cancers. *Id.* at S117. The serious and potentially life-threatening side effects associated with cross-sex hormones shows Oklahoma wisely prohibited the use of these drugs to treat gender dysphoria.

Puberty blockers are also a potential gateway drug. The treatment of gender dysphoria typically culminates in sex reassignment surgeries, which replicate primary or secondary sex characteristics of the opposite sex. Such procedures may involve bilateral mastectomy to remove the breasts, penectomy to remove the penis, vaginoplasty to "create" a vagina, or phalloplasty and scrotoplasty to "create" a penis and scrotum, as well as non-genital procedures like facial feminization or chest masculinization. *See* Jing J. Zhao et al., *Surgical Site Infections in Genital Reconstruction Surgery for Gender Reassignment, Detroit: 1984-2008*, 15 SURGICAL INFECTIONS 99, 99-100 (2014), https://bit.ly/3Uklubu. The known risks of these surgeries include fistulas, chronic infection, atrophy, need for colostomy, and complete loss of sexual sensation. *See* Wouter B. van der Sluis et al., *Clinical Characteristics and Management of Neovaginal Fistulas After Vaginoplasty in Transgender Women*, 127(6) OBSTETRICS & GYNECOLOGY 1118 (2016), https://bit.ly/3CMFyeN; Valentin Maurer et al., *Penile Flap Inversion Vaginoplasty*

in Transgender Women: Contemporary Morbidity and Learning-Curve Analysis from a High-Volume Reconstructive Center, FRONTIERS IN SURGERY (2022), https://bit.ly/3KDJ135; Valeria P. Bustos et al., *Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence,* PLASTIC & RECONSTRUCTIVE SURGERY GLOB. OPEN 1 (2021), https://bit.ly/3JyVKEm; Zhao, *supra*.

Additionally, when minors are prescribed puberty blockers, the drugs inhibit the growth of the minor's genital tissue, which reduces the tissue needed to construct artificial genitalia and thus requires surgeons to borrow tissue from other areas of the body, such as the colon. The need for a second surgical site increases the risk of infection, which has even led to death after a sex-reassignment surgery. *See* Biggs, *supra,* at 355.

Although the transitioning process generally entails three sequential steps that each present their own risks—puberty blockers, cross-sex hormones, and surgery—the harms for all three steps must be considered together because the use of puberty blockers is associated with an *increase in the likelihood* of seeking cross-sex hormones and surgery. In medicine, interventions sometimes create or worsen the problems they are supposed to alleviate, a process known as iatrogenesis. *See* Leor Sapir, *The School-to-Clinic Pipeline*, CITY J. (Autumn 2022), https://bit.ly/42U82Ox. Here, delaying a child's natural puberty while his or her

peers continue to develop the characteristics that come from puberty can actually *worsen* a minor's gender dysphoria. *Id.* The prescription of puberty blockers is thus associated with an increase in the likelihood of *additional* medical intervention with cross-sex hormones and surgery. Indeed, research shows that the vast majority of children (96-98%) who start puberty blockers continue on to use cross-sex hormones. Biggs, *supra*, at 352. This high conversion rate underscores the risks of promoting these treatments.

B. The Full Scope of Harm Resulting From Puberty Blockers, Cross-Sex Hormones, and Gender-Transition Surgeries Is Wholly Unknown.

Beyond the *known* harms and risks of the treatments at issue in this case, the *unknown* risks equally warrant protecting children and adolescents from these treatments. For example, the use of puberty blockers for gender dysphoria has never been approved by the U.S. Food and Drug Administration, and no clinical trial has ever established the safety of using them for this purpose. *See* Terhune, *supra.* To obscure this fact, activists argue the off-label use of puberty blockers is safe because they are also used to treat youth suffering from precocious puberty, meaning puberty that begins too early. *See* Annelou L.C. de Vries et al., *Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach*, 59 J. HOMOSEXUALITY 301 (2012), https://bit.ly/44a01pE. But unlike the treatment of gender dysphoria in young people, the treatment of precocious puberty involves *the*

resumption of normal puberty at an appropriate age—making it an entirely separate condition and course of treatment from using puberty blockers for gender dysphoria.

The unknowns regarding puberty blockers are startling. Specifically, it remains unknown the extent to which puberty blockers impact brain development and cognition. *See* Diane Chen et al., *Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth*, 5 TRANSGENDER HEALTH 246 (2020), https://bit.ly/3COdwzO. In one study, authors were concerned that puberty blockers "may prevent key aspects of development" during adolescence—"a sensitive period of brain organization"—and did not know whether a patient would "catch[] up" to otherwise resume developmentally normal brain functioning. *Id.* at 249. Even more worrying, some have raised concerns that the use of puberty blockers may *contribute to* suicidal ideation and behavior. *See Board of Directors Part One: The Tavistock and Portman*, NHS ENGLAND 53 (2015) (annotated version by Dr. Michael Biggs), https://bit.ly/3v1BneC (noting a statistically significant increase in self-harm after a year of puberty suppression). No treatment can be deemed safe and effective when it remains unknown whether its application could permanently stunt patients' cognitive development or may lead them to suicide.

There are also unanswered questions concerning the correlation between gender dysphoria and other comorbid psychiatric diagnoses. Recent data reveal a

sharp uptick in the number of minors who are being treated for gender dysphoria. *See generally* Robin Respaut & Chad Terhune, *Putting Numbers on the Rise in Children Seeking Gender Care*, REUTERS (Oct. 6, 2022), https://reut.rs/3PNUGAz. And many of the children and adolescents seeking experimental gender medicine today concurrently suffer from depression, anxiety, autism spectrum disorder, or attention deficit hyperactivity disorder. E. Abbruzzese et al., *The Myth of "Reliable Research" in Pediatric Gender Medicine: A Critical Evaluation of the Dutch Studies—and Research That Has Followed*, 49 J. SEX & MARITAL THERAPY 673, 684-85 (2023), https://bit.ly/3r6ewwe. Moreover, evidence suggests these comorbidities both afflict a *substantial* portion of minors treated for gender dysphoria and often *precede* the onset of gender dysphoria. For example, of minors referred to the United Kingdom's gender service, up to one-third were either autistic or otherwise neurodivergent. Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Interim Report*, THE CASS REV. 32 (Feb. 2022), https://bit.ly/3r1OQRw. In a review of patient medical records, Finnish experts found that comorbid mental health diagnoses preceded gender dysphoria in 75% of reviewed cases. Riittakerttu Kaltiala-Heino et al., *Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development*, 9 CHILD & ADOLESCENT PSYCH. & MENTAL HEALTH 1, 5 (2015), https://bit.ly/3r04aye. Without properly understanding the relationship

between gender dysphoria and other comorbid psychiatric diagnoses, minor patients are put at risk of receiving experimental and risky treatments in place of those that may effectively and safely mitigate their *real* underlying mental-health problems.

That risk is especially acute given the lack of adequate explanation for the precipitous and disproportionate rise in adolescent females presenting with gender dysphoria despite no prior history of dysphoria and with high rates of mental-health comorbidities. This new presentation—also referred to as rapid onset gender dysphoria, or ROGD—has led researchers to develop a theory of "social contagion," which posits that peer or online influence could be a significant cause of the recent uptick in gender dysphoria. *See* Lisa Littman, *Parent Reports of Adolescents and Young Adults Perceived To Show Signs of a Rapid Onset of Gender Dysphoria,* 13 PLOS ONE 1, 4 (2018), https://bit.ly/40P6zbY.

Lastly, a growing body of evidence points to individuals who have come to regret irreversible physical changes made to their bodies to treat gender dysphoria. These individuals are commonly referred to as "detransitioners." *See* Lisa Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition who Subsequently Detransitioned: A Survey of 100 Detransitioners,* 50 ARCHIVES OF SEXUAL BEHAVIOR 3353 (2021), https://bit.ly/433UwI2. Currently, there are *zero* reliable, long-term studies on rates of regret and detransition among the new cohort of children and adolescents who were treated under the "gender affirming" model.

Therefore, the extent to which these children and adolescents may come to regret their gender transition, or will otherwise face adverse effects, is completely unknown.

C. There Are No Proven Benefits From Puberty Blockers, Cross-Sex Hormones, and Gender-Transition Surgeries That Outweigh Their Harms and Risks.

Any potential benefits of experimental gender medicine, to the extent they exist, are vastly outweighed by the known harms and risks associated with these treatments for minors. Health authorities in Sweden, Finland, and the United Kingdom have conducted systematic reviews of evidence and, having found that the evidence of benefits is too uncertain to outweigh the risks, have decided to place severe restrictions on medical transition procedures—generally limiting the use of these treatments to *research studies*. Oklahoma has now reached the same reasonable conclusion. And although some countries have decided to permit experimentation with these drugs, nothing in the Constitution compels Oklahoma to make the same choice.

To begin, there is no reliable evidence showing that these treatments result in long-term improvement of minors with gender dysphoria. Currently, there are simply no studies long enough to provide such a finding. This lack of evidence is unsurprising given the fact that more than 90% of the research on gender dysphoria has occurred in the last ten years. *See* Larson, *supra*.

Even though some studies purport to show *short*-term benefits, the effects are so minimal as to be immaterial, and the studies do not control for the confounding effects of psychotherapy or the placebo effect. For example, researchers consistently fail to control for the effects of psychotherapy—*i.e.*, non-pharmaceutical and non-surgical interventions designed to help a child through his or her gender-related distress. Due to this methodological shortcoming, to the extent a study reports benefits of experimental gender medicine, those benefits could be attributed to counseling instead of drugs. Leor Sapir, *'Trust the Experts' Is Not Enough: U.S. Medical Groups Get the Science Wrong on Pediatric 'Gender Affirming' Care*, MANHATTAN INST. 5 (2022), https://bit.ly/3Jw5Wxg. Moreover, there is a strong possibility that any short-term improvement reported in conjunction with experimental gender medicine is the result of a placebo effect. Specifically, the mere fact that an adolescent receives these treatments may lead to a self-reported improvement in his or her psychological outlook—even if the physical effects caused by the treatments are not themselves the cause of that improvement. Conversely, unsupported suggestions of increased risk of depression, anxiety, and suicide if these treatments are *denied* may create a "nocebo" effect—whereby a patient develops negative side effects that he or she *believes* will occur absent treatment. *See* Alison Clayton, *Gender-Affirming Treatment of Gender Dysphoria in Youth: A Perfect Storm Environment for the Placebo Effect—The Implications for*

Research and Clinical Practice, 52 ARCHIVES OF SEXUAL BEHAVIOR 483 (2022), https://bit.ly/44fsBpC.

In addition, advocates of these treatments push the sensational, and unfounded, claim that minors who cannot access the treatments are at imminent risk of suicide. For example, a popular article by one of Plaintiffs' experts cited six studies related to suicidality and the treatment of gender dysphoria. *See* Jack Turban, *The Evidence for Trans Youth Gender-Affirming Medical Care*, PSYCH. TODAY (Jan. 24, 2022), https://bit.ly/3NLkKL6. But these studies are riddled with methodological weaknesses. Indeed, the lead author of one of the studies said that Dr. Turban's article overstated her research and that one "cannot claim that [her] research would have shown that gender affirming hormonal treatment reduces suicidality." Leor Sapir, *The Distortions in Jack Turban's Psychology Today Article on 'Gender Affirming Care,'* REALITY'S LAST STAND (Oct. 7, 2022), https://bit.ly/3PqI4yY. Because gender-dysphoric children also suffer from high rates of other mental-health conditions that are associated with suicidality, a simple comparison between gender-dysphoric and non-dysphoric children cannot show whether a child's gender dysphoria, as opposed to other mental health conditions, increases the risk of suicidality. Michael Biggs, *Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom*, 51 ARCHIVES OF SEXUAL BEHAVIOR 685, 687-88 (2022), https://bit.ly/3Kk3ARL. In fact, when a recent study controlled for mental-health

comorbidities, the differences in suicidality rates between gender-dysphoric and non-dysphoric children were either miniscule or non-existent. *See* Nastasja M. de Graaf et al., *Suicidality in Clinic-Referred Transgender Adolescents*, 31 EUROPEAN CHILD & ADOLESCENT PSYCHIATRY 67 (2022), https://bit.ly/42YZwh9.

Even in the context of heightened suicide risk, however, assertions regarding the alleged benefits of experimental gender medicine generally rely on low-quality evidence. Stephen B. Levine et al., *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults,* 48 J. SEX & MARITAL THERAPY 706, 712-13 (2022), https://bit.ly/3pr6qOr. For example, an expert in evidence-based medicine identified "serious problems" with the current Endocrine Society guidelines, which he criticized for failing to "look at the effect of the interventions on gender dysphoria itself." *See* Jennifer Block, *Gender Dysphoria in Young People Is Rising—and So Is Professional Disagreement*, BMJ INVESTIGATION (Feb. 23, 2023), https://bit.ly/3NXKlRf.

As discussed above, experts in Sweden, Finland, and the UK, have all found that the evidence supporting the benefits of these treatments is poor. *See* Leor Sapir, *Yes, Europe is Restricting "Gender-Affirming Care,"* CITY J. (Feb. 13, 2023), https://bit.ly/3r3PSfZ. As further evidence of the shifting tide, *Amici*'s discussion of the scientific landscape in New Zealand is already outdated. Brief for Foreign Non-Profit Organizations as *Amici Curiae* 20-22. Since this appeal was filed, the "Royal

Australian and New Zealand College of Psychiatrists declined to endorse gender affirming care as the key intervention for children who believe they may be transgender, highlighting an increasingly cautious approach in some European countries amid a lack of evidence for the medical pathway." Natasha Robinson, *Psychiatry Body's Radical Challenge to Transgender Care*, THE AUSTRALIAN (Dec. 13, 2023), https://bit.ly/470NrtT.

The Foreign Non-Profit *Amici* contend that the developments in Europe do not support Oklahoma's law because those countries have not "banned" the use of puberty blockers and cross-sex hormones for treating gender dysphoria in minors. *See, e.g.*, Brief for Foreign Non-Profit Organizations as *Amici Curiae* at 6 ("There is no ban on gender-affirming healthcare for adolescents in the United Kingdom."). But in the UK, for example, puberty blockers may not be used to treat gender dysphoria outside of a formal research protocol. J.A.(Vol.4).556. That is a ban as ordinarily understood; for example, an ordinary person would correctly describe cocaine as "banned" in the United States even if scientists may use cocaine in formal research. More significantly, however, the relevance of the European countries is not necessarily the *policy* they chose but the *reason* for their policies. And Swedish health authorities stated the reason clearly: The "risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently

outweigh the possible benefits." J.A.(Vol.4).560 (quotations omitted). The State of Oklahoma has correctly reached the same conclusion.

II. The Court Should Not Permit Politically Motivated Medical Interest Groups to Set The Constitutional Standard.

The State of Oklahoma has ably explained why the harmful and irreversible practice of experimental gender medicine on minors should be prohibited. *See* Defs.-Appellees 15-53 Br. at 7-17. *Amicus* Family Research Council also recounts the troubling stories suggesting that medical interest groups—including those appearing as *amici* here—stifle dissent and base decisions on ideology, not science, *see* Br. for Family Research Council as *Amicus Curiae* at 6-25. Given these disturbing reports, the Family Research Council argues that these organizations' "self-interested positions should not be substituted for the default rule that the People may govern themselves when it comes to protecting health and welfare." *Id.* at 5. And as the Supreme Court recently explained, "the position of the American Medical Association" and other medical interest groups may be relevant to a "legislative committee," but it does not "shed light on the meaning of the Constitution." *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 272-73 (2022) (quotations omitted).

Amici Do No Harm and OCPA file this amicus brief in part because the Council's examples only scratch the surface. Although the Council addressed the medical interest groups that have authored their own treatment standards for experimental gender medicine, the phenomenon the Council identifies—ideology,

rather than science, driving decision making—is not limited to those three groups. Indeed, the phenomenon is not even limited to those three *amici in this very case*.

Start with the American Academy of Child & Adolescent Psychiatry (AACAP). *See* Brief for Medical and Mental Health Organizations as *Amicus Curiae* ("Medical Interest Group Br."). When it comes to the permanent and lifelong risks of experimental gender medicine, such as sterilization, AACAP believes that children and adolescents can provide informed consent to these treatments. *See id.* at 12 (noting that "the patient" must give "informed consent" for puberty blockers and cross-sex hormones). But when it came to lifetime prison sentences for minors, AACAP had this to say:

> Scientists have found that adolescents as a group, even at later stages of adolescence, are more likely than adults to engage in risky, impulsive, and sensation seeking behavior. This is, in part, because they overvalue short-term benefits and rewards, and are less capable of controlling their impulses, making them susceptible to acting in a reflexive rather than a planned voluntary manner. Adolescents are also more emotionally volatile and susceptible to stress and peer influences. In short, the average adolescent cannot be expected to act with the same control or foresight as a mature adult.

Br. for the Am. Academy of Child and Adolescent Psychiatry et al., as *Amici Curiae* Supporting Neither Party, *Miller v. Alabama*, 567 U.S. 460 (2012) (Nos. 10-9646, 10-9647), 2012 WL 121237 at *2-3. Another *amicus* here, the American Medical Association, *see* Medical Interest Group *Amici* Br. at i, joined AACAP in arguing to the Supreme Court that adolescents "engage in risky, impulsive, and sensation

seeking behavior" and are "more emotionally volatile and susceptible to stress and peer influences," *see Miller v. Alabama* Br., 2012 WL 121237 at *2-3.

Amici Do No Harm and OCPA obviously take no position on the merits of *Miller v. Alabama*. But AACAP's argument to the Supreme Court in that case cannot be squared with its argument to this Court regarding the capacity of children and adolescents to give informed consent to the high risk of sterilization that accompanies the use of puberty blockers and cross-sex hormones to treat gender dysphoria. Instead, one is left with the distinct impression that something more than "science" is driving the bus here. Indeed, the Medical Interest Group *Amici* consist almost entirely of repeat players who issue public policy statements on issue after issue that bears no relation to their purported expertise. Name a hot-button social issue, and they have issued formal positions on it.

Critical race theory? Check. *See Anti-Racism Resource Library*, AM. ACAD. OF CHILD & ADOLESCENT PSYCH. (Jan. 2023), https://bit.ly/42UCKXz; *ACOP Statement Against Structural Racism and Inequality*, AM. COLL. OF OSTEOPATHIC PEDIATRICIANS (June 4, 2020), https://bit.ly/3XqukGi; *Call for Papers on the Effects of Race, Racism, Social Justice, and Health Equity in Child and Adolescent Psychiatry*, J. AM. ACAD. OF CHILD & ADOLESCENT PSYCH. (2023), https://bit.ly/3pr9El1 (calling for papers on "structural racism" and "health equity"); American Academy of Pediatrics Board of Directors, *Truth, Reconciliation, and*

Transformation: Continuing on the Path to Equity, 146 PEDIATRICS 449 (2020), https://bit.ly/3r8kgph (reiterating organization's belief that "racism [i]s a core social determinant of health and a driver of health inequities" and stating its commitment to combatting "structural and systemic anti-Black racism" through its "equity agenda").

Gun control? Check. *See Policy Statement on Children and Guns*, AM. ACAD OF CHILD & ADOLESCENT PSYCH., https://bit.ly/3NqsPn4 (last updated Jun. 2022); Scott C. Denne et al., *Funding for Gun Violence Research: The Importance of Sustained Advocacy By Academic Pediatricians*, 87 PEDIATRIC RSCH. 800 (2020), https://go.nature.com/42YEvTB (from the Academic Pediatric Association, among other groups); *American Academy of Nursing's Statement: Firearm Safety and Violence Prevention*, AM. ACAD. OF NURSING (Oct. 26, 2022), https://bit.ly/3NsYFPT; *The ACOP Supports The Call To ACTION Towards Common Sense Gun Regulation*, AM. COLL. OF OSTEOPATHIC PEDIATRICIANS (Jun. 1, 2022), https://bit.ly/3Xnd05b; Robert M. McClean et al., *Firearm-Related Injury and Death in the United States: A Call to Action From the Nation's Leading Physician and Public Health Professional Organizations*, ANNALS OF INTERNAL MED. (2019), https://bit.ly/3NOi7Im (from the American Academy of Family Physicians, American Medical Association, and other groups); Letter from Susan Bostwick, Academic Pediatric Ass'n President et al., to Representative Stephanie

Murphy (Apr. 2, 2018), https://bit.ly/3Psn377 (from the Association of Medical School Pediatric Department Chairs and other groups); Press Release, Justin Worsley, *NAPNAP Position Statement on Prevention of Firearm Violence and Injury in Children*, NAT'L ASS'N OF PEDIATRIC NURSE PRACTITIONERS (Jan. 12, 2023), https://bit.ly/3Jy3NRA; Letter from AANS/CNS Joint Section on Neurotrauma & Critical Care et al., to Patrick Leahy, U.S. Senate Comm. on Appropriations, Chairman (Apr. 28, 2022), https://bit.ly/3pr1hpu (from the American College of Obstetricians and Gynecologists, American College of Physicians, American Pediatric Society, Pediatric Endocrine Society, Society for Pediatric Research, among other groups).

Immigration? Check. *See AACAP Calls for Swift Congressional Passage of the "Dream Act"*, AM. ACAD. OF CHILD & ADOLESCENT PSYCH. (May 21, 2018), https://bit.ly/441SycG; Press Release, AAP et al., *Leading Pediatric Medical Organizations Respond to Recent Executive Orders Impacting Immigrants and Refugees* (Feb. 14, 2017), https://bit.ly/46pFsre (offering, in part, a policy position on border defenses from the Academic Pediatric Association, Association of Medical School Department Chairs, American Pediatric Society, Society for Pediatric Research, among other groups); *AACAP Statement on DACA Rescission*, AM. ACAD. OF CHILD & ADOLESCENT PSYCH. (Sept. 2017), https://bit.ly/3pnOQuI.

Climate change? Check. *See* Press Release, American Medical Association, *AMA Adopts New Policy Declaring Climate Change a Public Health Crisis* (Jun. 13, 2023), https://bit.ly/3Xt8X7a; *Climate Change and Eco-Anxiety in Youth*, AM. ACAD. OF CHILD & ADOLESCENT PSYCH. (Mar. 2022), https://bit.ly/44abk14; National Association of Pediatric Nurse Practitioners et al., *NAPNAP Position Statement on the Effects of Climate Change on Children's Health: The Role of Pediatric-Focused Advanced Practice Registered Nurses*, 35 J. PEDIATRIC HEALTH CARE 621 (2021), https://bit.ly/441SUQy; Jianhong Liu et al., *Policy Brief on Climate Change and Mental Health/Well-Being,* 68 NURSING OUTLOOK 517 (2020), https://bit.ly/3JxHH1X (from American Academy of Nursing).

Affirmative action? Check. *See* Br. for the Am. Med. Colls. et al., as *Amici Curiae* Supporting Respondents, *Students For Fair Admissions, Inc. v. President & Fellows of Harvard College*, Nos. 20-1199, 21-707 (U.S. July 28, 2022), 2022 WL 3036400 (joined by American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Pediatric Society, among other groups).

And if anyone has ever wondered what the American Academy of Family Physicians thinks about nuclear weapons or biological warfare, the Medical Interest Group *Amici* have that covered too. *See Nuclear, Biological and Chemical (NBC)*

Warfare, AM. ACAD. OF FAM. PHYSICIANS (2020), https://bit.ly/3NN6XU5. Remarkably, AAFP is not the only *amicus* to set forth its nuclear proliferation policy. *See AMA Urges Elimination of Nuclear Weapons*, AM. MED. ASS'N (Nov. 18, 2015), https://bit.ly/3NXSpS1. Indeed, AAP has even promulgated its view on "the pediatrician's role" in "taking a stand against nuclear proliferation." Thomas B. Newman, *Taking a Stand Against Nuclear Proliferation: The Pediatrician's Role,* 121 PEDIATRICS e1430 (2008), https://bit.ly/3Js7msJ (cleaned up).

Lastly, although the American Psychological Association is not serving as *amicus* in this case, the Medical Interest Group *Amici* cite its work. *See* Medical Interest Group Br. at 5 & nn. 9, 13. Perhaps the Association has not joined the Medical Interest Group *Amici* here because it recognizes that its basis for previously opposing the death penalty for 18 to 20-year olds also serves as a basis for opposing the provision of sterilizing treatments to children and adolescents. Just a year ago, the Association adopted a resolution explaining that brains are not fully developed enough—even by age 20—to justify the imposition of the death penalty for eligible crimes:

> WHEREAS developmental neuroscience, including research on both the structure and function of brain development, establishes that significant maturation of the brain continues through at least age 20, especially in the key brain systems implicated in a person's capacity to evaluate behavioral options, make rational decisions about behavior, meaningfully consider the consequences of acting and not acting in a particular way, and to act deliberately in stressful or highly charged emotional environments, as well as continued development of

> personality traits (e.g., emotional stability and conscientiousness) and what is popularly known as 'character.'

APA Resolution on the Imposition of Death as a Penalty for Persons Aged 18 Through 20, Also Known As the Late Adolescent Class at 2, AM. PSYCH. ASS'N (Aug. 2022), https://bit.ly/3JsRyWH (cleaned up). "[I]t is clear," the resolution continued, that "the brains of 18- to 20-year-olds are continuing to develop in key brain systems related to higher-order executive functions and self-control," which includes "planning ahead, weighing consequences of behavior, and emotional regulation." *Id.* This reasoning is as good as any for acknowledging the children and adolescents are incapable of adequately consenting or assenting to the harms and risks associated with these treatments.

In sum, this Court should not permit these medical interest groups to set the constitutional standard. *Amici* Do No Harm and OCPA do not need to overstate the point: medical interest groups, like all other interest groups, are of course entitled to take policy positions on any range of topics—including those beyond the groups' expertise (such as nuclear armament). But it is a different situation altogether when those same groups ask the Court to defer to *their* judgment about the *constitutionality* of particular medical treatments. That is neither the role of medical interest groups nor the role of the Judiciary. *See Dobbs*, 597 U.S. at 272. And given the track record of the Medical Interest Group *Amici* here, *see supra* at 17-24, it is hard to take seriously the proposition that these *amici* come forward to offer their humble opinion

regarding the "science" and then return to their clinics. Rather, their *modus operandi* appears to be reaching a policy decision first and then backfilling the science to achieve their preferred policy outcome.

Therefore, the Court should not hesitate to say what the law is irrespective of what politically motivated medical interest groups insist—no matter how many of them line up to add their name to yet another recycled brief. Under the correct application of the Constitution and Supreme Court precedent, Oklahoma's prohibition on the harmful and irreversible practice of experimental gender medicine on minors is indisputably constitutional.

III. Many Practitioners of Experimental Gender Medicine Oppose *Any* Limitation on Minors Obtaining These Harmful and Irreversible Treatments.

The Court should not embrace the fiction that experimental gender medicine is performed on minors in strict accordance with the "protocol" outlined in legal briefs. Plaintiffs say these harmful and irreversible treatments are provided "only after rigorous assessments of the minor's gender dysphoria and capacity to understand [the] treatment's risks and benefits." Plfs.-Aplts.' Br. 7. The Medical Interest Group *Amici* likewise contend that "a robust diagnostic assessment is required before medical interventions are provided." *See* Medical Interest Group Br. 9. That may indeed be the position that proponents of experimental gender medicine

put forward in legal briefs. But that position is *not* what many practitioners of experimental gender medicine think is appropriate.

Instead, some believe that even the meager "gatekeeping" assessments developed by WPATH are too strict. Indeed, even the term "gatekeeping" has come to be seen as pejorative. For example, radical backlash against WPATH began when a team tasked with updating the organization's standards of care released a draft of the "Standards of Care 8" (SOC-8) in December 2021. Like the final version, the draft standards for the treatment of adolescents included several gatekeeping guidelines, such as recommending an assessment to be conducted by a mental health professional and requiring evidence that symptoms of gender dysphoria had persisted "over time," potentially for "several years." *See* E. Coleman et al., *supra*, at S50, S60; *see also* Draft WPATH Standards of Care Version 8 (Dec. 2, 2021), https://bit.ly/42YDJGm.

These recommendations in the SOC-8 were more than some activists could accept. As the *New York Times* explains, the drafters were branded as "traitors" to the experimental gender medicine movement. *See* Bazelon, *supra*. A practitioner of experimental gender medicine at the Mayo Clinic, Colt St. Amand, wrote that "[t]he adolescent chapter is the worst," on one of the field's more popular online forums. *Id.* Other scholars and practitioners said that the draft "sucks," specifically criticizing

the mental health assessment requirement and calling it "harmful and destructive and abusive and unethical and immoral." *Id.*

This dim view of "gatekeeping" has been underscored by stunning reports of medical professionals declining to adhere even to the lax standards put forth by Plaintiffs and the Medical Interest Group *Amici*. For example, a whistleblower from a prominent St. Louis gender clinic recently reported that the clinic frequently steered children to a preferred list of therapists whom the clinic knew would rubberstamp pre-treatment letters of support, and even made the process easier for the therapists by sending along a template. Jamie Reed, *I Thought I Was Saving Trans Kids. Now I'm Blowing the Whistle*, THE FREE PRESS (Feb. 9, 2023), https://bit.ly/3qYid7f. According to the whistleblower, it typically took a patient 1-2 visits to receive "the green light." *Id.*

That clinic does not appear to be an outlier. The *Los Angeles Times* recently reported on an Alabama provider who brags that a "whisper network" is used to circumvent her clinic's publicly advertised age guidelines, that she does not need "a psychologist or psychiatrist to evaluate" an adolescent who is seeking hormones, and that one of the reasons "she d[oes] her job" is to provide individuals with access to hormones when they have been unsuccessful in acquiring a prescription from other health care professionals. Jenny Harvie, *This Abortion Doctor Is Not Ready To*

Leave Alabama. 'You Don't Want Me Here? That's Why I'm Gonna Stay,' L.A. TIMES (Apr. 28, 2023), https://lat.ms/3CLceVU.

The examples do not stop there. In Texas, video recordings reportedly showed a social worker at Dell Children's Medical Center admitting that puberty blockers can be provided after just one consultation with a prescriber because "it's not something [the clinic] wants to gatekeep." *See* Ari Blaff, *'Mature Enough': Undercover Video Reveals Docs Routinely Approve Puberty Blockers for Kids as Young as Eight*, NAT'L REV. (Apr. 19, 2023), https://bit.ly/3JBG4jB. Separately, clips from a 2020 investigation reportedly show a Boston Children's Hospital doctor explaining the lack of gatekeeping at the clinic: "I've never seen anywhere in medicine as much as I do in this field where I think we as providers get very very very swayed by our patients." *See* Spencer Lindquist, *WATCH: Director of Boston Children's Gender Clinic Says Puberty Blockers Cause Infertility, Are Given Out 'Like Candy,'* BREITBART (Oct. 10, 2022), https://bit.ly/3NuhWkc. She added that puberty blockers were often prescribed "like candy." *Id.*

Even one of Plaintiff's experts, Dr. Turban, admits that gatekeeping procedures like those in the SOC-8 often take the form of a charade: "Like if you're, if you set up this assessment, gatekeeping protocol, people are just going to figure out the answers and then tell you what you want to hear. And you've set up this really kind of like argumentative relationship with your patient or client. And you're like,

why, why even bother? You know?" GenderGP, *How Many People Detransition? Exploring Detransition–Jack Turban* (Mar. 2, 2021), https://bit.ly/44byQuq (cleaned up).

Disdain for "gatekeeping" does not appear to be limited to practitioners on the ground. Advocates have penned articles arguing that "[i]t's time to stop gatekeeping medical transition." *See* Henri Feola, *It's Time to Stop Gatekeeping Medical Transition*, AM. SCIENTIST (Feb. 18, 2022), https://bit.ly/46kWbfh (cleaned up). The elimination of gatekeeping, it has been said, would be a victory because it would allow minors "to access hormone treatment and surgical interventions without undergoing mental health evaluation or referral from a mental health specialist." Sarah L. Schulz, *The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria*, 58 J. HUMANISTIC PSYCH. 72 (2017), https://bit.ly/3NqyZDI. And Dr. Turban has expressed frustration over the fact that "people have had an easier time in adult medicine kind of recognizing that these like assessment, gatekeeping models were a little bit ridiculous and damaging," and he finds it "interesting that not all of the lessons from that have made it into pediatrics yet[.]" *See* GenderGP, *supra*.

In sum, there is every reason to suspect that the WPATH and Endocrine Society standards, as articulated in polished legal briefs, do not govern what is happening on the ground. Moreover, there is every reason to suspect that advocates

of experimental gender medicine on minors do not *intend* for those standards to govern. Put simply: we should not be surprised when the goalposts start moving. And Oklahoma is more than justified in protecacopting children from radical actors who disdain *any* attempt to protect children from these irreversible and harmful treatments.

CONCLUSION

For these reasons, the Court should affirm the decision below.

Dated: December 18, 2023

Respectfully submitted,

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Dated: December 18, 2023 */s/ David H. Thompson*

Counsel for Amici Curiae

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