No. 23-12155

In the United States Court of Appeals for the Eleventh Circuit

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August Dekker et al.,
Plaintiff-Appellees,

v.

Secretary, Florida Agency for Health Care Administration et al.,
Defendant-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:22-cv-325
(Hinkle, J.)

AMICUS CURIAE BRIEF OF SCHOLAR JAY W. RICHARDS, PH.D., IN SUPPORT OF DEFENDANT-APPELLANTS SECRETARY, FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION ET AL.

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CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Eleventh Circuit Rules 26.1-1 through 26.1-3, Amicus provides this Certificate of Interested Persons and Corporate Disclosure Statement. To the best of amicus's knowledge, the following persons and entities may have an interest in the outcome of this case:

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5. American Academy of Family Physicians, *Amicus*
6. American Academy of Nursing, *Amicus*
7. American Academy of Pediatrics, *Amicus*
8. American College of Obstetricians and Gynecologists, *Amicus*
9. American College of Osteopathic Pediatricians, *Amicus*
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106. Society for Adolescent Health and Medicine, *Amicus*
107. Society for Pediatric Research, *Amicus*
108. Society of Pediatric Nurses, *Amicus*
109. State of Alabama, *Amicus*
110. State of Arkansas, *Amicus*
111. State of California, *Amicus*
112. State of Georgia, *Amicus*
113. State of Indiana, *Amicus*
114. State of Iowa, *Amicus*
115. State of Kentucky, *Amicus*
116. State of Louisiana, *Amicus*
117. State of Mississippi, *Amicus*

118. State of Missouri, *Amicus*
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132. World Professional Association for Transgender Health, *Amicus*

To the best of amicus's knowledge, no other persons, associations of persons, firms, partnerships, or corporations have an interest in the outcome of this case or appeal.

/s/ R. Trent McCotter

R. Trent McCotter

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INTEREST AND IDENTITY OF THE *AMICUS CURIAE*[1]

Amicus Jay W. Richards, Ph.D., is an analytic philosopher who focuses on medical and public policy issues involving gender dysphoria. For identification purposes only, Dr. Richards is the director of the Richard and Helen DeVos Center for Life, Religion, and Family and the William E. Simon Senior Research Fellow in Religious Liberty and Civil Society at The Heritage Foundation. He is also a senior fellow at the Discovery Institute.

Dr. Richards is the author or editor of more than a dozen books, including the New York Times bestsellers *Infiltrated* (2013) and *Indivisible* (2012); *The Human Advantage; Money, Greed, and God* (2009), winner of a 2010 Templeton Enterprise Award; *The Hobbit Party* (2014) with Jonathan Witt; *The Human Advantage* (2018); and *The Price of Panic* (2020).

Dr. Richards's articles and essays have been published in *The Harvard Business Review*, *Wall Street Journal*, *Barron's*, *Washington*

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

Post, *The New York Post*, *Newsweek*, *Forbes*, *Fox News*, *National Review Online, The Hill, Investor's Business Daily*, *Washington Times*, *The Philadelphia Inquirer*, *The Huffington Post*, *The Federalist*, *The Daily Caller,* and many other publications. His work has been covered widely in publications such as *The New York Times, The Washington Post*, *The Wall Street Journal*, *The Washington Times*, *Nature*, *Science*, *Astronomy*, *Physics Today*, *The Chronicle of Higher Education*, and *Congressional Quarterly Researcher*.

Dr. Richards seeks to provide the Court with the benefit of his extensive research in this field, and specifically, to demonstrate that the scientific debate is far from settled regarding the efficacy and propriety of the pediatric use of puberty blockers, cross-sex hormones, and gender transition surgeries as a treatment for gender dysphoria. Dr. Richards will also discuss the results of systematic reviews conducted by the national health systems of northern European countries on this subject. Finally, Dr. Richards will discuss common misunderstandings and myths about these medical interventions.

SUMMARY OF THE ARGUMENT

The State of Florida rightly recognizes that the current trend of treating children struggling with gender dysphoria with puberty blockers, cross-sex hormones, and "transition" surgeries has a very weak basis in scientific evidence and is, at best, experimental. There is profound disagreement within the medical community, both nationally and internationally, over the efficacy and long-term harm resulting from these procedures. This serious disagreement is evident at both the national and international levels. There is much we do not yet know about the long-term effects of these procedures. Thus, the wise path is to hesitate before conducting body-altering, irreversible interventions on children suffering from a form of mental distress that, until recently, usually resolved after such children completed puberty.

In the district court below, the Plaintiffs-Appellees incorrectly claimed a supposed consensus of the "mainstream medical community."[2] That consensus is merely the agreement of Plaintiffs-Appellees' cherry-picked medical trade groups—none of whom have the unique authority to define the status of scientific evidence or the ethical implications of

[2] *See, e.g.*, Pls.' Mot. For Preliminary Injunction at 26, ECF No. 11.

certain medical interventions. Moreover, it is not clear that these statements even accurately represent the views of members of these organizations.

In any case, the scientific debate on this matter is far from settled. Consider one recent example: a peer-reviewed investigative report published in the BMJ,[3] one of the world's oldest and most respected medical journals. It is a bombshell: *Gender dysphoria in young people is rising—and so is professional disagreement*.[4] This peer-reviewed article chronicles the rapid rise of gender dysphoria diagnoses, the medical establishment's move to service and treat those cases, and the professional disagreement that has arisen in the wake of these invasive treatments, particularly overseas. This publication itself undermines the Plaintiffs-Appellees' claim of a supposed consensus.

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[3] The BMJ was formerly known as the British Medical Journal, having shortened its name to *The BMJ* in 2014. It was first published in 1840. *History of The BMJ*, The BMJ (Apr. 4, 2023), https://www.bmj.com/about-bmj/history-of-the-bmj.

[4] Jennifer Block, "Gender dysphoria in young people is rising—and so is professional disagreement," *The BMJ* (Feb. 23, 2022): https://doi.org/10.1136/bmj.p382.

Not only do multiple studies and medical associations disagree with Plaintiffs-Appellees' claim of consensus, but a number of European *national health systems* have expressed serious concern and doubt. These include the United Kingdom, Sweden, Finland, and Denmark. All were previously much closer to the Plaintiffs-Appellees' supposed consensus. But after conducting systematic and other reviews of the relevant scientific literature, they put the brakes on their own policies of "gender affirming" interventions.

Here at home, the federal government has also been cautious. In 2020, the U.S. Department of Health and Human Services, despite its recent advocacy of "gender-affirming care," noted that the "medical community is divided on many issues related to gender identity, including the value of various 'gender-affirming' treatments for gender dysphoria (especially for minors)."[5] And four years earlier, under the Obama Administration, the U.S. Centers for Medicare and Medicaid Services ("CMS") concluded that "there is not enough high quality

[5] Nondiscrimination in Health & Health Education Programs or Activities, 85 Fed. Reg. 37,160, 37187 (Jun. 19, 2020).

evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria."[6]

Where objective observers would expect to find "high quality evidence," they find instead several dangerous myths—dangerous because they can blind doctors, patients, and families to serious long-term consequences.

One particularly pernicious myth is that puberty blockers, cross-sex hormones and surgeries are necessary to prevent suicide in children struggling with gender dysphoria. As discussed below, there is no solid evidence for this claim.

The use of puberty blockers to treat gender dysphoria is similarly fortified by myths, namely, that they are approved by the U.S. Food and Drug Administration for the treatment, and that they are "reversible."

Another common myth is that regret and change of course amongst patients subjected to these body- and life-altering treatments are extremely rare. While the Plaintiffs-Appellees would like to ignore or

[6] Decision Memorandum, *Gender Dysphoria and Gender Reassignment Surgery*, Ctrs. For Medicare & Medicaid Srvs (Aug. 30, 2016): https://go.cms.gov/3Uqw68E.

downplay the existence of such "detransitioners," their numbers are growing.

In summary, the State of Florida is not only within its rights, it is also justified in its determination that the use of puberty blockers, cross-sex hormones, and surgeries to children struggling with gender dysphoria is risky and experimental. The scientific debate on these interventions is nowhere near settled.

ARGUMENT

I. The Rush to Change: The Explosive Growth in Both Gender Dysphoria and Drastic, Body-Altering Interventions to Treat It.

There can be little doubt of the abrupt shift over the past two decades in the way physicians treat pediatric gender dysphoria. This has corresponded to an explosion in the number of minors diagnosed with this condition. According to one major study, "at least 121,882 children ages 6 to 17 were diagnosed with gender dysphoria in the five years to the end of 2021." This includes a spike of 70% between 2020 and 2021 alone.[7]

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[7] Chad Terhune, et al., "As More Transgender Children Seek Medical Care, Families Confront Many Unknowns," *Reuters* (Oct 6, 2022): https://www.reuters.com/investigates/special-report/usa-transyouth-care/.

Consider one other statistic: the DSM-5—published in 2013—reported the prevalence of gender dysphoria at between 0.002 and 0.014 % of the population. But in 2018, a study found that 9.2 % of students at a school district in Pittsburgh reported these symptoms.[8, 9, 10]

This explosion in the number of patients with symptoms of gender dysphoria has occurred alongside the growing popularity of a suite of medical interventions for treating this condition, called "gender affirming care." This protocol typically starts with social transition, followed (for patients not yet beyond Tanner stage two) by puberty blockers, followed by cross-sex hormones, and culminating in gender transition surgeries.

For the medical industry, this is a gold mine. It's no wonder that a new industry has emerged to service such demands—including a huge

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[8] Kacie M. Kidd, et al., "Prevalence of Gender-Diverse Youth in an Urban School District," *Pediatrics* 147, no. 6 (June 2021): https://doi.org/10.1542/peds.2020-049823.

[9] Christina Buttons, "At Least 6% Of Students Identify As Transgender At One California School District, Data Analysis Finds," *The Daily Wire* (January 17, 2023): https://www.dailywire.com/news/at-least-6-of-students-identify-as-transgender-at-one-california-school-district-data-analysis-finds.

[10] Guilia Carbonaro, "Number of Gen Z People Identifying as Transgender Twice That of Millennials," *Newsweek* (February 24, 2023): https://www.newsweek.com/people-who-identify-transgender-doubles-gen-z-1783562.

spike in gender surgeries for minors in recent years. Data published in the *Annals of Plastic Surgery* found a thirteen-fold increase in "gender affirming" mastectomies between 2013 and 2020.[11] Meanwhile, the number of U.S. clinics that focus on providing hormones and surgeries for minors has surged from one in 2007 to at least 80 today.[12] And evidence suggests that such clinics are fast-tracking children to more aggressive treatments faster than before. In a study of teens at Seattle Children's Hospital's gender clinic, two-thirds of teens were taking hormones within one year of their initial visit.[13]

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[11] Anne Tang, J. Carlo Hojilla, Jordan Jackson, Kara A. Rothenberg, Rebecca C Gologorsky, Douglas A. Stram, Colin M. Mooney, Stephanie L. Hernandez, and Karen M Yokoo, "Gender-Affirming Mastectomy Trends and Surgical Outcomes in Adolescents," *Annals of Plastic Surgery* 88, no. 4 (May 2022): https://doi.org/10.1097/SAP.0000000000003135.

[12] C. Terhune, R. Respaut, M. Conlin, "As children line up at gender clinics, families confront many unknowns," *Reuters* (Oct. 6, 2022): https://www.reuters.com/investigates/special-report/usa-transyouth-care/.

[13] Diana Tordoff, et al., "Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care," *JAMA Netw Open* 5, no. 2 (2022): https://doi.org/10.1001/jamanetworkopen.2022.0978.

II. The Science is *Not* Settled: After Blazing a Trail on Child Sex-Trait Modification, European Countries Backtrack Due to New Evidence of Harms.

Over the past 20 to 30 years, several countries in northern Europe have practiced "affirming care" to treat gender dysphoria. This includes the use of social transitioning, puberty blockers, and gender-transition surgeries for minors. The United Kingdom, Sweden,[14,15] Finland,[16] and Denmark[17] practiced affirmative medicine until they noticed the major increase of teenagers, especially girls with co-existing mental health

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[14] The National Board of Health and Welfare (Sweden), "Care of children and adolescents with gender dysphoria" (2022), at: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf.

[15] "Gender dysphoria in children and adolescents: an inventory of the literature," Swedish Agency for Health Technology Assessment and Assessment of Social Services (December 20, 2019), at: https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/.

[16] Riittakerttu Kaltiala, Elias Heino, Marja Työläjärvi & Laura Suomalainen, "Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria," *Nordic Journal of Psychiatry* 74, no. 3 (2020): https://www.tandfonline.com/doi/abs/10.1080/08039488.2019.1691260?journalCode=ipsc20.

[17] Mette Vinther Hansen, Annamaria Giraldi, Katharina Maria Main, Jonas Vrublovsky Tingsgård, & Mette Ewers Haahr, "Sundhedsfaglige tilbud til børn og unge med kønsubehag," *Ugeskr Læger* 185 (July 3, 2023): https://content.ugeskriftet.dk/sites/default/files/2023-06/V11220740_WEB.pdf.

problems, dominating their clinics. Similar trends have appeared in the United States, according to data published in peer-reviewed journals and, more recently, by Reuters.[18]

Sweden, Finland, and the UK responded by conducting systematic reviews of the evidence. They each found that the available evidence did not show the benefits of these procedures outweighed the risks. As a result, they have shifted to a much more conservative approach. The U.K. closed its main pediatric gender clinic—Tavistock[19]—in the wake of a critical review.[20] The country's National Health Service acknowledged that gender dysphoria may be a "transient phase" for many minors with symptoms of gender dysphoria or confusion.[21] What's more, it recognized

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[18] Chad Terhune, et al., "As More Transgender Children Seek Medical Care, Families Confront Many Unknowns," *Reuters* (Oct. 6, 2022): https://www.reuters.com/investigates/special-report/usa-transyouth-care/.

[19] Jasmine Andersson & Andre Rhoden-Paul, "NHS to close Tavistock child gender identity clinic," *BBC News* (July 28, 2022), at: https://www.bbc.com/news/uk-62335665.

[20] The Cass Review: Independent review of gender identity services for children and young people: Interim report (February 2022), at: https://cass.independent-review.uk/publications/interim-report/.

[21] NHS England. Interim service specification: specialist service for children and young people with gender dysphoria (phase 1 providers) (October 2022): https://www.engage.england.nhs.uk/specialised-

the "lack of clinical consensus and polarized opinion on what the best model of care for children and young people experiencing gender incongruence and dysphoria should be."[22] It noted also a "lack of evidence to support families in making informed decisions about interventions that may have life-long consequences."[23]

Finally, some NHS staff members reported feeling "under pressure to adopt an unquestioning affirmative approach" towards hormonal or surgical sex changes for children, which was "at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters."[24]

Similarly, Sweden's National Board of Health and Welfare determined in 2022 that the risks of puberty blockers and hormonal treatment "currently outweigh the possible benefits" for children and

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commissioning/gender-dysphoria-services/user_uploads/b1937-ii-specialist-service-for-children-and-young-people-with-gender-dysphoria-1.pdf.

[22] *Id.*

[23] *Id.*

[24] *Id.* at 17.

minors.[25] After conducting systematic reviews in 2015 and 2022, Sweden found the evidence on hormonal treatment in adolescents "insufficient and inconclusive."[26] The country prohibits gender-transition surgeries for children.[27]

Finland also changed course after its Council for Choices in Health Care, a monitoring agency for the country's public health services, came to similar conclusions. That country called for psychosocial support as the first choice in gender dysphoria treatment, rather than puberty blockers or hormonal intervention.[28] And, like its neighbor Sweden, Finland prohibits transition surgeries for children, restricting them to adults.[29]

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[25] Socialstyrelsen: National Board of Health and Welfare, "Care of children and adolescents with gender dysphoria," Report 2022-3-7799: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf.

[26] *Id.*

[27] *See supra* note 4.

[28] Palveluvalikoima (Council for Choices in Health Care in Finland*),* "Medical treatment methods for gender dysphoria in non-binary adults—recommendation" (June 2020): https://palveluvalikoima.fi/documents/1237350/22895623/Summary_non-binary_en.pdf/8e5f9035-6c98-40d9-6acd-7459516d6f92/Summary_non-binary_en.pdf?t=1592318035000.

[29] *See supra* note 4.

The Norwegian Healthcare Investigation Board announced in early March that they deem puberty blockers, cross-sex hormones, and transition surgeries for minors with gender dysphoria to be experimental treatments that lack a strong evidential base. Current protocols for "gender-affirming care," they have concluded, are not evidence-based, and they have recommended that the Norwegian guidelines be reformed to reflect their recommendations. (At the moment, Norwegian guidelines align with the WPATH recommendations.) The Investigation Board criticizes these guidelines for failing to protect pubertal minors who are in precarious state and may later regret their transition.[30]

Denmark is the latest European country to return to a much more conservative approach. This change was announced quietly in July 2023.[31]

Unlike the European health authorities in the UK, Sweden, and Finland, neither WPATH nor their allied American medical

[30] The Norwegian Healthcare Investigation Board (Ukom), "Pasientsikkerhet for barn og unge med kjønnsinkongruens" (March 9, 2023), at: https://ukom.no/rapporter/pasientsikkerhet-for-barn-og-unge-med-kjonnsinkongruens/sammendrag.

[31] *See supra* note 17.

organizations have conducted systematic reviews of the relevant literature.[32] Consider the guidelines published by the American Academy of Pediatrics. These are based on a single, non-peer-reviewed, highly flawed policy statement in its own journal by a doctor who was finishing his residency at the time of publication.[33] The Endocrine Society has rated the quality of evidence behind its own recommendations as "low" or "very low."[34]

Under intense pressure from critics, the American Academic of Pediatrics finally announced in August 2023 that it, too, would conduct a systematic review of the evidence. But they have not suspended or even

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[32] Leor Sapir, "Trust the Experts' Is Not Enough: US Medical Groups Get the Science Wrong on Pediatric 'Gender-Affirming' Care," Manhattan Institute 5 (Winter 2022), at: https://www.manhattan-institute.org/how-to-respond-to-medical-authorities-claiming-gender-affirming-care-is-safe.

[33] Jason Rafferty, "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents," *Pediatrics* 142, no. 4 (Oct 2018): https://doi.org/10.1542/peds.2018-2162. This statement received a devastating rebuttal by James M. Cantor, "Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy," *Journal of Sex & Medical Therapy* 46, no. 4 (2020): https://doi.org/10.1080/0092623X.2019.1698481.

[34] Robin Respaut and Chad Terhune, "Number of transgender children seeking treatment surges in US," *Reuters* (Oct. 6, 2022): https://www.reuters.com/investigates/special-report/usa-transyouth-data/.

qualified their advocacy of these experimental procedures in the meantime.[35]

The Court should consider the likelihood that medical organizations pushing "gender-affirming care" are not summarizing the state of the scientific literature but are acting as advocacy groups that have been captured by a fashionable ideology.[36] Any court considering their testimony should ask them to cite the long-term studies and randomized control trials on which their guidelines are based. They should be asked to explain what the health authorities in the U.K., Finland, Sweden, and Denmark have gotten wrong. They should be asked to predict, on the record, that gender-troubled teens in these European countries will have worse long-term outcomes than American teens who receive puberty blockers, cross-sex hormones, and transition surgery. They should be asked to explain their guidelines for treating

[35] Azeen Ghorayshi, "Medical Groups Backs Youth Gender Treatments, but Call for Research Review," *The New York Times* (Aug. 3, 2023), https://www.nytimes.com/2023/08/03/health/aap-gender-affirming-care-evidence-review.html.

[36] James Kirkup, "The document that reveals the remarkable tactics of trans lobbyists," *The Spectator* (Dec. 2, 2019), at: https://www.spectator.co.uk/article/the-document-that-reveals-the-remarkable-tactics-of-trans-lobbyists/.

detransitioners and should be challenged if they try to dismiss or explain away the experiences of detransitioners.

III. Dangerous Myths.

a. The Notion that Sex-Trait Modifications Are Necessary to Prevent Suicide is an Unproven Myth.

There is no robust evidence that puberty blockers, cross-sex hormones and surgeries are effective at preventing suicide in gender-dysphoric minors, let alone necessary.[37] Studies conducted prior to the recent explosion in pediatric gender dysphoria consistently showed that most children with gender distress resolved that distress after passing through puberty.[38]

Health authorities in Sweden, Finland, and the U.K. have examined this suicidality claim and found it unreliable. Consider Finland's leading expert on pediatric medicine, Dr. Riittakerttue Kaltiala. She recently called the "affirm or suicide" narrative

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[37] Michael Biggs, "Suicide by Clinic Referred Transgender Adolescents in the United Kingdom," *Archives of Sexual Behavior* (2022), at: https://pubmed.ncbi.nlm.nih.gov/35043256.

[38] W. Bockting, "Chapter 24: Transgender Identity Development," in D. Tolman & L. Diamond, Co-Editors-in-Chief *APA Handbook of Sexuality and Psychology* (2 volumes) (American Psychological Association: Washington D.C., 2014): 744.

"disinformation" and its dissemination by medical professionals "irresponsible."[39]

Consider also a recent analysis by my colleague, Jay Greene, which compared availability of puberty blockers and cross-sex hormones in U.S. states. He found that teen suicides were *higher* in states in which minors could access these drugs without parental consent, than in more restrictive states.[40]

Here in the United States, multiple studies have reached similar conclusions—including studies commissioned by WPATH itself. A 2021 study published in the *Journal of the Endocrine Society*—and funded by a grant from WPATH—examined the evidence that hormonal treatment improved depression, anxiety, and quality of life among people who identified as transgender. Even they concluded that the strength of that

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[39] Annikka Mutanen, "Nuoruusiän sukupuoliahdistusta hoitava professori sanoo ei alaikäisten juridisen sukupuolen korjaukselle," *Helsingin Sanomat* (January 27, 2023), at: https://www.hs.fi/tiede/art-2000009348478.html.

[40] Jay Greene, "Puberty Blockers, Cross-Sex Hormones, and Youth Suicide," Heritage Foundation Backgrounder 3712 (June 13, 2022), at: https://www.heritage.org/gender/report/puberty-blockers-cross-sex-hormones-and-youth-suicide.

evidence was "low."[41] That same WPATH-commissioned study went on to emphasize the need for more research, "especially among adolescents."[42] Finally, and significantly, the WPATH-commissioned study determined that "it was impossible to draw conclusions about the effects of hormone therapy" on death by suicide.[43]

The suicide narrative of advocates of the "affirmative" approach distorts the truth. It exploits a very simple causation-correlation fallacy. While there is evidence that teenagers who experience gender discordance have high rates of suicidal thoughts and non-lethal forms of self-harm, there is no evidence that their elevated suicidality is *because* of this discordance. Nor is there evidence that "gender-affirming care" will solve their problems.[44]

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[41] Kellan Baker, et al., "Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review," *Journal of the Endocrine Society* 5, Issue 4 (April 2021) at: https://doi.org/10.1210/jendso/bvab011.

[42] *Id.*

[43] *Id.*

[44] Polly Carmichael, Gary Butler, 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," *PLOS One* (Feb. 2, 2021): https://doi.org/10.1371/journal.pone.0243894.

Put simply, the evidence suggests that teenagers who are at high risk for suicide are more likely to adopt an identity incongruent with their sex, not the other way around.[45]

b. Claims that Puberty Blockers are "Reversible" and FDA-Approved for Gender Dysphoria are Myths.

The use of puberty blockers to treat gender dysphoria has exploded in the U.S. in recent years. Recent analyses indicate that nearly 18,000 U.S. minors began taking puberty blockers or hormones from 2017 to 2021, with the number rising each year.[46] The drugs generally suppress the release of the sex hormones testosterone and estrogen.[47] The U.S. Food and Drug Administration has approved these drugs to treat serious medical conditions such as prostate cancer, endometriosis, and central precocious puberty--in which the benefits of the drug are likely to exceed the often severe side effects. But the FDA has *not* approved these

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[45] J.K. Meyer and D. Reter, "Sex Reassignment Follow up," *Arch. Gen Psychiatry* 36 (1979): 1010-1015.

[46] Robin Respaut and Chad Terhune, "Number of transgender children seeking treatment surges in US," *Reuters (*Oct. 6, 2022): https://www.reuters.com/investigates/special-report/usa-transyouth-data/.

[47] *Id.*

drugs to treat gender dysphoria in minors.[48] As such, any use of these drugs to treat gender dysphoria are "off label" and lack the "support of clinical trials to establish their safety for such treatment."[49]

Puberty-blocking drugs work by suppressing sex hormones, which in turn prevent the development of key secondary sex characteristics, such as breast development and menstruation in girls, and block the development of a deeper voice and growth of facial hair in boys.[50] Significantly, the drugs also limit the growth of genitalia for both sexes.[51] These medications are typically administered as periodic injections or through an implant under the skin of the upper arm.[52]

Contrary to frequent claims, puberty blockers given to minors are not simply reversible.[53] First, that claim is based on studies done on a very different condition, called precocious puberty, in which puberty

[48] *Id.*

[49] *Id.*

[50] *Id.*

[51] *Id.*

[52] *Id.*

[53] Michael Laidlaw, Michelle Cretella and Kevin Donovan, "The Right to Best Care for Children Does Not Include the Right to Medical Transition," *American Journal of Bioethics* 19 no. 2 (2019): 75-77. https://doi.org/10.1080/15265161.2018.1557288.

starts too early but is always allowed to resume at a developmentally normal time.

Second, these drugs can lead to lower bone density in minors who receive them, which may persist even after the drugs are discontinued.[54]

Third, when used for minors with gender distress, they are iatrogenic interventions: over 95 % of such minors will move on to cross-sex hormones. This is not reversible.[55]

Fourth, no physician can reverse time. Even when puberty blockers are discontinued, social and psychological harms may remain—since the minor in question will be out of step with the development of his or her peers. Thus, it's no surprise that New Zealand's ministry of health

[54] Janet Y. Yee et al., "Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings From the Trans Youth Care Study," *Journal of the Endocrine Society* 4, no. 9 (Sep. 1, 2020): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7433770/.

[55] Sarah C. J. Jorgensen et al., "Puberty blockers for gender dysphoric youth: A lack of sound science," *Journal of the American College of Clinical Pharmacy* 5, no. 9 (2022): https://doi.org/10.1002/jac5.1691.

recently scrubbed the words "reversible" from its website when discussing puberty blockers.[56]

c. The Notion that Detransitioners Do Not Exist is a Myth.

The last decade has seen a rapid rise in those seeking hormonal and surgical treatments to conform their bodies to a discordant, perceived "gender identity." Coincident with this rise has been a rise in the number "detransitioners" who come to regret that decision. These are individuals who receive "transition" interventions but then come to regret this. In many cases, detransitioners come to accept their sex and overcome their gender dysphoria. They often argue that these medical interventions caused preventable harm.[57]

The total number of detransitioners is unknown,[58] as is the ratio of transitioners to detransitioners, because of a current lack of large-scale,

[56] "Puberty Blockers 'Not Safe & Reversible' - Ministry of Health," Family First New Zealand (Sept 21, 2022): https://familyfirst.org.nz/2022/09/23/puberty-blockers-not-safe-reversible-ministry-of-health/.

[57] Lisa Littman, "Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners," A*rchives of Sexual Behavior* 50 (Oct. 19, 2021): https://doi.org/10.1007/s10508-021-02163-wpmid:34665380.

[58] R. D'Angelo, E. Syrulnik, S. Ayad, et al., "One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria," *Arch Sex*

long-term research on this growing population.[59] While WPATH asserts that detransition is "rare,"[60] at least "two recent studies suggest that as many as 20-30% of patients may discontinue hormone treatment within a few years."[61] And a 2021 study found that 75% of detransitioners never reported their regret and detransition to their doctors.[62] That means doctors could mistakenly believe that all their patients were satisfied with their transition.

CONCLUSION

Advocates of "gender affirming care" presuppose the highly contested and controversial conceptual framework of gender ideology. This ideology contradicts biological reality at key points. This fact is often

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Behav (2020): https://doi.org/10.1007/s10508-020-01844-2 (citing R. D'Angelo, "Psychiatry's ethical involvement in gender-affirming care," *Australasian Psychiatry* 26, no. 5 (2018): 460-63, at: https://doi.org/10.1177/1039856218775216).

[59] Robin Respaut, Chad Terhune and Michelle Conlin, "Why detransitioners are crucial to the science of gender care," *Reuters* (Dec. 22, 2022): https://www.reuters.com/investigates/special-report/usa-transyouth-outcomes/.

[60] R. E. Coleman et al., "Standards of care for the health of transgender and gender diverse people, Version 8," *Int J Transgend Health* 23 (2022, Suppl 1): https://doi.org/10.1080/26895269.2022.2100644.

[61] *See supra* note 4.

[62] *See supra* note 57.

obscured, however, because of efforts to associate the notion of "gender identity" with genuine disorders of sexual development. But these are unrelated phenomena. Disorders of sexual development have clear biological definitions grounded in both common sense and empirical evidence. Very few individuals who cite a "gender identity" incongruent with their biological sex have a physical disorder of sexual development. Biologically, almost all these individuals, prior to undergoing "gender transition," are unambiguously male or female.

Gender ideology reduces sex to "sex assigned at birth" and reduces the person to a subjective notion of "gender identity" for which there can be no verifiable evidence, and which is often poorly and even incoherently defined.[63] Those seized by this ideology tend to dismiss or ignore the social pressures on teenagers—especially girls—to try to escape the naturally distressing phase of puberty. This may be why these advocates

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[63] Quentin Van Meter, "Bringing Transparency to the Treatment of Transgender Persons," *Issues in Law and Medicine* 34, no. 2 (Fall 2019): 147; Alex Byrne, "What is gender identity? *Arc Digital* (Jan. 9, 2019): https://philpapers.org/rec/BYRWIG; Alex Byrne, The Origin of 'Gender Identity,'" *Archives of Sexual Behavior* (2023): https://doi.org/10.1007/s10508-023-02628-0.

avoid language that would imply the reality of biological sex, opting instead to refer to "sex assigned at birth." This betrays the fact that gender ideology is at odds with basic biology.

There is, and can be, no scientific confirmation of a gender identity that is independent of the sexed body. What we know, from scientific study and common sense, is that humans, like all mammals, are sexually binary. There are two sexes, corresponding in normal development to two body structures (phenotypes) organized for sexual reproduction, with two corresponding gametes. There is no third gamete.

Some individuals have psychological distress with their sexed body, but this is not independent evidence that individuals have "gender identities," let alone that such theory-laden entities are more fundamental than their biological sex. Such persons should be treated with compassion and should receive medical and psychological treatments consistent with the best scientific evidence.

As recently practiced in the U.S., however, "gender affirming care" for minors is an attempt to treat psychological distress with permanent, draconian, and experimental medical interventions. This is the medical

expression of a tendentious ideology that privileges a putative and subjective "gender identity" over the immutable sex of distressed minors. Medicine, and medical organizations, have, in the past, been captured by ideological fashions. The widespread practice of eugenics during the previous century may be an especially bracing example,[64] but it is hardly unique. Some medical institutions have once again been captured by a fashionable ideology that provides strong financial incentives for certain practitioners. In such a situation, it falls to more objective medical authorities, including state regulators, to assess the evidence for these interventions independently. The state medical authorities in Florida have done precisely that in this case. They are right to do so.

The Court should reverse the district court.

October 13, 2023

Respectfully Submitted,
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By Counsel

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[64] Edwin Black, *War Against the Weak: Eugenics and America's Campaign to Create a Master Race* (New York: Dialog, Expanded edition, 2012).

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CERTIFICATE OF SERVICE

I hereby certify that on October 13, 2023, an electronic copy of the foregoing brief was filed with the Clerk of Court for the United States Court of Appeals for the Eleventh Circuit using the appellate CM/EFC filing system and that service will be accomplished using the appellate CM/ECF system.

/s/ R. Trent McCotter

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the typeface requirements of Rule 32(a)(5) and the typestyle requirements of Rule 32(a)(6) because this brief was prepared in 14-point Century School, a proportionally spaced typeface, using Microsoft Word. Fed. R. App. P. 29(a), 32(g)(1). This brief complies with the type-volume limitation of Rule 29(a)(5) because it contains 4,679 words, excluding the parts exempted under Rule 32(f).

/s/ R. Trent McCotter