No. 24-12826

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

STATE OF FLORIDA, *et al.,*

Plaintiffs-Appellees,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.,*

Defendants-Appellants.

On Appeal from the United States District Court for the Middle District of Florida,

No. 8:24-CV-1080, Hon. William F. Jung, United States District Judge

BRIEF OF HEALTH CARE PROVIDER ORGANIZATIONS AS *AMICI CURIAE*

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CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 26.1 and Eleventh Circuit Rule 26.1-1, *amici curiae* Fenway Health and NO/AIDS Task Force (d/b/a CrescentCare) certify that the certificate of interested persons contained in the Defendants-Appellants' brief is complete, further confirmed in the Statement of Identification below.

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January 8, 2025

STATEMENT OF IDENTIFICATION

Pursuant to Eleventh Circuit Rule 29-2 and Federal Rule of Appellate Procedure 26.1, *amici curiae* Fenway Health and NO/AIDS Task Force (d/b/a CrescentCare) submit this supplemental certificate of interested persons to disclose all those with an interest in the amicus brief and to provide the required information as to their corporate status and affiliations.

Fenway Health and NO/AIDS Task Force (d/b/a CrescentCare) are not subsidiaries of any other corporation, and no publicly held corporation owns ten percent or more of each organization's stock.

No counsel of the appellant or the appellee parties authored this brief in whole or in part. No party or party's counsel, or any other person, other than the *amici curiae* or their counsel, contributed money to fund this brief.

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INTEREST OF *AMICI CURIAE* [1]

Fenway Health is a federally qualified health center whose mission is to provide health care to the LGBTQ+ community and to all people through access to highest quality health care, education, research, and advocacy. A significant part of Fenway Health's patient population is LGBTQ+. About 42% of Fenway Health's patient population has a sexual orientation other than heterosexual, and about 12% of Fenway Health's patient population is transgender. Fenway Health provides treatment for gender dysphoria consistent with the clinical standard of care. Fenway Health's patient population also has limited financial resources. About 36% of Fenway Health's patient population lives at or below the federal poverty line. Fenway Health serves more than 33,000 patients at its two locations in Massachusetts, including many patients who travel from significant distances for care. Through its telehealth program, Fenway Health also provides health care services to people who live outside of the New England region. In this manner, Fenway Health serves patients in more than twenty states, including Maine, New Hampshire, Vermont, Florida, Kansas, South Carolina, Colorado, Illinois, Kansas, Michigan, Missouri, Ohio, Oregon, Texas, and Wisconsin, among others.

[1] All parties have consented to the filing of this *amicus* brief. No counsel of the appellant or the appellee parties authored this brief. No party or party's counsel, or any other person, other than the *amici curiae* or their counsel, contributed money to fund this brief. The authors of this brief acknowledge the contributions of Zeinab Bakhiet, Esin Gumustekin, and Danny Finley.

In addition to its provision of health care, Fenway Health also operates a number of programs focusing on research, training, education, and policy development. These programs develop clinical techniques, training materials, and model policies, and also provide training and technical assistance to health centers and HIV care providers across the nation in order to optimize access to quality health care for LGBTQ+ populations and people living with HIV. For example, Fenway Health's *Evidence-Informed Interventions Coordinating Center for Technical Assistance* operates a federal grant that implements multi-site, evidence-informed interventions designed to improve health outcomes among people living with HIV, including LGBTQ+ people living with HIV.

NO/AIDS Task Force, d/b/a CrescentCare ("CrescentCare"), is a Louisiana-based federally qualified health center whose mission is to strengthen our entire community through whole-person healthcare and education. In 2023, CrescentCare cared for almost 13,000 individuals at two clinical locations. Many people in CrescentCare's service population come from marginalized communities. About 40% of CrescentCare's patient population has a sexual orientation other than heterosexual, and over 8% of CrescentCare's patient population identify as transgender. CrescentCare provides treatment for gender dysphoria consistent with the clinical standard of care. Many of CrescentCare's patients have limited

resources. In 2023, about 48% of CrescentCare's patients lived below the poverty line and 762 patients experienced homelessness.

In addition to providing comprehensive adult primary medical and mental health care, CrescentCare provides services in dentistry, pediatrics, and psychiatry. CrescentCare also operates a number of programs that provide support services. These programs include insurance enrollment, case management, legal services, health education, outreach, food and nutrition services, housing assistance, and peer counseling.

BACKGROUND AND SUMMARY OF ARGUMENT

This appeal deals with the U.S. Department of Health and Human Services' (HHS) interpretation of the nondiscrimination provision of the Affordable Care Act, otherwise known as Section 1557. Section 1557 prohibits discrimination in federally funded health care activities and programs on the basis of sex, race, color, national origin, age or disability. On May 6, 2024, HHS issued a final rule ("May 2024 Rule") interpreting Section 1557, which "affirm[ed] that protections against sex discrimination include protections against discrimination on the basis of sexual orientation and gender identity."[2]

[2] U.S. Dept. of Health and Hum. Servs., *Strengthening Nondiscrimination Protections and Advancing Civil Rights in Health Care through Section 1557 of the Affordable Care Act: Fact Sheet* (Oct. 9, 2024), https://perma.cc/3BPT-EGC8.

The central question before the Court is the validity of enforcing the May 2024 Rule's provisions prohibiting discrimination on the basis of gender identity. The *amici* are providers of health care and other services specifically designed for the needs of the LGBTQ+ community. At issue in this matter is the recognition of federal regulatory prohibitions on gender identity discrimination in federally funded health care, which has deep implications for the treatment of gender dysphoria.

Gender identity has long been well understood and recognized in medicine as an individual's "deep internal sense of being female, male, a combination of both, somewhere in between, or neither."[3] It has a strong biological basis.[4] Everyone has a gender identity. People who are transgender have a gender identity that differs from their assigned birth sex. People who are not transgender have a gender identity that is the same as their assigned birth sex. Gender dysphoria, in turn, is a serious

[3] *See, e.g.,* Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics, 2, tbl.1 (Aug. 2023), https://perma.cc/X5NM-2SW7.

[4] *See* Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline,* 102 J. Clinical Endocrin. & Metabolism 3869, 3874–75 (2017) [hereinafter "Endocrine Guidelines"]; *see also* Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. Transgender Health S1, S44–45 (Sept. 2022) [hereinafter "WPATH Standards of Care"] ("Neuroimaging studies, genetic studies, and other hormone studies in intersex individuals demonstrate a biological contribution to the development of gender identity for some individuals whose gender identity does not match their assigned sex at birth.").

medical condition characterized by distress due to a misalignment between an individual's assigned birth sex and their gender identity.[5]

The district court's injunction, at its heart, relies on harmful and widely discredited views advanced by the plaintiff-appellees related to transgender discrimination and the clinical treatment of gender dysphoria.[6] Prohibition of gender identity discrimination promotes access to health care and the socioeconomic resources required to thrive and be healthy.

A 2023 report from the Center for American Progress found that over one in three LGBTQI+ Americans faced discrimination in the prior year.[7] As a result, "more than 20% of LGBTQI+ Americans report postponing or avoiding medical treatment due to discrimination because of discrimination."[8] This type of discrimination can lead to increased medical mistrust among sexual and gender minority patients, creating a significant barrier to accessing care.[9] For example, the 2022 United States Transgender Survey found that, of the respondents who saw a

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[5] Am. Psych. Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* at 451 (5th ed. text rev. 2022) [hereinafter "Am. Psychiatric Ass'n, DSM-5-TR"].

[6] *See generally Florida v. Dep't of Health & Hum. Servs.*, No. 8:24-CV-1080-WFJ-TGW, 2024 WL 3537510 (M.D. Fla. July 3, 2024); *Tennessee v. Becerra*, No. 1:24CV161-LG-BWR, 2024 WL 3283887 (S.D. Miss. July 3, 2024); *Texas v. Becerra*, No. 6:24-CV-211-JDK, 2024 WL 3297147 (E.D. Tex. July 3, 2024), *modified on reconsideration,* No. 6:24-CV-211-JDK, 2024 WL 4490621 (E.D. Tex. Aug. 30, 2024).

[7] Sean Cahill, *Federal and State Policy Issues Affecting Lesbian, Gay, Bisexual, Transgender, and Queer Older Adults*, 40 Clinics in Geriatric Med. 357, 358 (2024).

[8] *Id.*

[9] *Id.*

healthcare provider within the last 12 months (only 79% of those surveyed), 48% reported "at least one negative experience" of discrimination or abuse as a result of their gender identity.[10] The survey also found that 28% "did not see a doctor due to costs" while another 24% avoided seeking care "due to fear of mistreatment."[11] Most acutely, health care discrimination on the basis of gender identity manifests itself as a barrier to care for the treatment of gender dysphoria.

The standard of care for gender dysphoria has been established by clinicians and expert professional organizations in accordance with decades of research and clinical experience. The provision of health care according to this standard of care is not, as the plaintiff-appellees assert, unproven or experimental, nor is the field of care of greater risk than typical health care interventions. On the contrary, withholding health care treatments that comport with the standard of care poses a serious risk to people with gender dysphoria.

ARGUMENT

I. GENDER DYSPHORIA IS A SERIOUS MEDICAL CONDITION THAT REQUIRES TREATMENT

Medical treatment for gender dysphoria is not new. There is a deep and rich history of transgender people of all ages receiving medical care to align their bodies

[10] Sandy E. James et al., *Early Insights: A Report of the 2022 U.S. Transgender Survey*, National Center for Transgender Equality, Feb. 2024, at 16, https://perma.cc/AND7-4RVR.

[11] *Id.*

with their gender identity, dating back to the early twentieth century.[12] In 1917, a doctor named Alan Hart received "what is thought to be the first documented gender-confirming surgery in the United States."[13] Synthetic testosterone was first synthesized in 1935, and just four years later, Laurence Michael Dillon became the first documented case of a transmasculine person being prescribed testosterone to undergo gender transition.[14] One of the most widely discussed stories of 1953 was that of Christine Jorgensen, a transgender woman and World War II veteran.[15] Jorgensen made headlines after traveling to Denmark to receive hormonal injections and surgery.[16]

Gender dysphoria is a rare but serious medical condition that many transgender people experience. It is formally categorized as a mental health condition by the Diagnostic and Statistical Manual of Mental Disorders, Fifth

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[12] *See, e.g.,* Jeremi M. Carswell et al., *The Evolution of Adolescent Gender-Affirming Care: An Historical Perspective*, 95 Horm Res Paediatr. 649 (Nov. 29, 2022), https://perma.cc/ET45-JC3V.

[13] Kami Horton, *Meet Oregonian Dr. Alan Hart, who underwent the first documented gender-confirming surgery in the US*, Oregon Public Broadcasting (June 30, 2022), https://perma.cc/5BSA-2REQ.

[14] Skailer R. Qvistgaard, *Testosterone and Transgender Men: The Discriminatory Impact of Testosterone's Schedule III Designation on Transgender Men Seeking Medical Care*, 13 J. Health & Biomedical L. 289, 296 (2018), https://perma.cc/4WWB-FPPG.

[15] Francine Uenuma, *Christine Jorgensen made history in 1952 with transgender surgery*, The Washington Post (June 12, 2023), https://perma.cc/CP7P-CT9J.

[16] *Id.*

Edition, Text Revision (DSM-5-TR).[17] The American Psychiatric Association ("APA"), the principal body representing the field of psychiatry in the United States, is "responsible for writing, editing, reviewing, and publishing" the DSM-5-TR.[18] The most recent edition, published in 2022, was developed with input from more than 160 mental healthcare professionals worldwide, including "psychiatrists, psychologists and experts from other professional fields."[19] The DSM-5-TR is the most comprehensive resource available for diagnosing mental health conditions, offering detailed diagnostic criteria for a wide range of disorders, including anxiety, depression, and neurodevelopmental disorders. For its part, the Fifth Circuit has described the DSM-5-TR as the "guiding force" used by clinicians for the diagnosis of mental health conditions.[20]

The DSM-5-TR requires the following for diagnosis of gender dysphoria in adults and adolescents, in relevant part:

[17] *See* Am. Psych. Ass'n, DSM-5-TR, *supra* note 5.
[18] Cleveland Clinic, *What is the DSM-5?* (October 14, 2022), https://perma.cc/3ZX5-JPHD.
[19] *Id.*
[20] *United States* v. *Thompson*, 709 Fed. App'x 758, 764 n.1 (5th Cir. 2017).

a. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration.

b. The condition is associated with clinically significant distress or impairment in social, occupational, or other areas of functioning.[21]

Among the symptoms that may support a gender dysphoria diagnosis are "[a] strong desire to be rid of one's primary and/or secondary sex characteristics," "[a] strong desire for the primary and/or secondary sex characteristics of the other gender," "[a] strong desire to be of the other gender," "a strong desire to be treated as the other gender" and "[a] strong conviction that one has the typical feelings and reactions of the other gender."[22]

It is important to distinguish between being transgender and experiencing "gender-related distress."[23] The DSM-5-TR clarifies that "not all individuals will express distress from [gender] incongruence."[24] In other words, a person who identifies as transgender may not feel distress over the misalignment between their sex assigned at birth and their gender identity. Gender dysphoria is only diagnosed when a person experiences *clinically significant* distress or impairment related to this incongruence. Gender dysphoria – like any other serious health care condition – requires medical treatment.

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[21] Am. Psych. Ass'n, DSM-5-TR, *supra* note 5, at 511.
[22] *Id.*
[23] Meredithe McNamara et al., *A thematic analysis of disinformation in gender-affirming health care bans in the United States,* 351 Soc. Sci. Med. 116943 at *1 (2024), https://perma.cc/6HVX-NFLU.
[24] Am. Psych. Ass'n, DSM-5-TR, *supra* note 5, at 512.

II. THE STANDARD OF CARE FOR TREATING GENDER DYSPHORIA IS WELL ESTABLISHED

In clinical settings, appropriate care for any given medical condition is typically determined through "evidence-based, authoritative guidelines issued by expert panels that inform clinical care."[25] These guidelines are considered "commonplace and well-regarded across medical practice."[26] In addition to referring to established guidelines, healthcare providers take into account the individual circumstances and needs of each patient to deliver "treatment that optimizes gains and fits the patient's needs."[27] Together, clinical guidelines and expert consideration of the patient's unique needs and circumstances define the standard of care for providing effective treatment for a given condition.

Expert medical organizations in the United States recognize the clinical guidelines published by the World Professional Association for Transgender Health ("WPATH") and the Endocrine Society as reflecting the standard of care for treating gender dysphoria.[28] These guidelines are endorsed by the Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, the

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[25] *See* McNamara et al., *supra* note 23 at *2.
[26] *Id.* at *11.
[27] Larry E. Beutler, *Selecting the most appropriate treatment for each patient*, 16 Int. J. Clin. Health Psych. 99 (Oct. 9, 2015), https://perma.cc/W9X5-922K.
[28] *Brandt v. Rutledge*, 677 F. Supp. 3d 877, 889–90 (E.D. Ark. 2023) ("The WPATH Standards of Care and Endocrine Society Guidelines for the treatment of gender dysphoria are recognized as best practices by the major medical and mental health professional associations in the United States.").

American Psychological Association, the American Academy of Child and Adolescent Psychiatry, and the U.S. Department of Health and Human Services Office of Population Affairs."[29]

WPATH is recognized as the "leading association of medical professionals treating transgender individuals."[30] WPATH's Standards of Care for the Health of Transgender and Gender Diverse People ("WPATH Standards") are developed through a systematic, evidence-based approach and reflect the expert consensus of 119 professionals from diverse fields, including "medicine, psychology, law, social work, counseling, psychotherapy, family studies, sociology, anthropology, sexology, speech and voice therapy, and other related fields."[31] The WPATH Standards promote comprehensive and holistic care, detailing social, psychological, medical and surgical interventions for gender dysphoria.[32] The Endocrine Society "represents approximately 18,000 physicians and scientists engaged in the treatment and research of endocrine disorders, such as diabetes, hypertension, obesity,

[29] *Id.*; United States Professional Association for Transgender Health, *USPATH Position Statement on Legislative and Executive Actions Regarding the Medical Care of Transgender Youth* (Apr. 22, 2022), https://perma.cc/M2BT-JRAW.
[30] Brief for Am. Psych. Assoc. as Amicus Curiae, at 8, *United States v. Skrmetti*, No. 23-477 (U.S., filed Sept. 3, 2024), https://perma.cc/8N3N-AYU8.
[31] WPATH, *Mission and Vision* (2024), https://perma.cc/4MC4-JH2G; *See* WPATH Standards of Care, *supra* note 4, at S249.
[32] *Id.*

osteoporosis, endocrine cancers… and thyroid disease."[33] The Endocrine Society's Endocrine Guidelines are likewise developed through a systematic, evidence-based process.[34]

The WPATH Standards and Endocrine Guidelines, along with other medical professional organizations such as the American Medical Association and the American Academy of Pediatrics, classify medical and surgical treatment for gender dysphoria as "medically necessary" in appropriate individual circumstances.[35] Taken together, the WPATH and the Endocrine Society treatment protocols are the "outcomes of iterative, expert-driven assessments of clinical research, and inform care widely endorsed and practiced by most providers."[36] Though some state governments have questioned the credibility of these clinical guidelines, if the "WPATH [Standards] and the Endocrine Society Guidelines are not 'standards of care' in the traditional sense, despite being created in the same manner as any other clinical practice guideline, then few and perhaps no other clinical practice guidelines would stand up to similar criticism."[37]

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[33] *See* Endocrine Soc'y, *Society Highlights Concerns and Provides Suggestions to CMS Regarding 2025 MPFS* (Sept. 4, 2024), https://perma.cc/52WZ-T9CM.
[34] *See* Endocrine Guidelines, *supra* note 4.

[35] *See, e.g., id.;* WPATH Standards of Care., *supra* note 4, at S7; Am. Med. Assoc., *Clarification of Evidence-Based Gender-Affirming Care H-185.927* (2024), https://perma.cc/4X5W-4U6E.

[36] McNamara et al., *supra* note 23 at *4.
[37] *Id.* at *11.

Health insurers are often charged with adjudging whether proposed care is appropriate and consistent with the standard of care. Insurers employ a concept of "medical necessity" to determine whether they will cover a particular intervention in a specific case.[38] To execute such a decision, insurers typically look to whether care is "(a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or disease."[39] "Generally accepted standards medicine," in turn, is defined as "standards that are based on credible scientific evidence published in peer-reviewed medical literature recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment."[40] Withholding medically necessary care recommended by established clinical guidelines—here, the WPATH Standards and Endocrine Guidelines—is a

[38] Cheryl Ulmer et al., Inst. of Med., Perspectives on Essential Health Benefits: Workshop Report 51–52 (2012), https://perma.cc/5DSL-ZJ3T.
[39] *Id.* (italics removed) (citing Janet L. Kaminski, *Defining Medical Necessity*, OLR Research Report (2007), https://perma.cc/5BEM-64H7.
[40] *Id.*

source of significant concern, especially in cases where access to care is limited for an entire patient population.

A. *Standard of Care for Treating Gender Dysphoria in Adults*

The WPATH Standards and Endocrine Guidelines emphasize a comprehensive and individualized approach to treating gender dysphoria. At the primary care level, patients should "receive nonjudgmental care from appropriately trained health care professionals."[41] This care may include "preventative care, mental health and substance use disorder screening, hormone therapy, and education about nonmedical/surgical gender-affirming interventions" when appropriate.[42] Psychotherapy can be beneficial but is not a prerequisite for providing care.[43] However, therapy to revert a patient suffering from gender dysphoria to the gender identity or expression of their sex assigned at birth is considered harmful and may lead to increased suicidal ideation and behavior.[44]

Under the WPATH Standards, treating gender dysphoria may require "medically necessary gender-affirming hormone therapy (GAHT) to achieve changes consistent [with an individual's] embodiment goals, gender identity, or both."[45] Hormonal treatment for adults is recommended when (a) there is "marked

[41] Tonia Poteat et al., *Standards of Care for Transgender and Gender Diverse People*, J. Am. Med. Assoc. Clinical Guidelines Synopsis (May 2023), https://perma.cc/57X9-ZSPV.
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Id.*

and sustained" gender incongruence, (b) the diagnostic criteria for gender incongruence is met, (c) the patient "demonstrates capacity to consent," (d) "other possible causes of apparent gender incongruence have been identified and excluded," (e) "mental health and physical conditions that could negatively impact the outcome of treatment have been assessed, with risks and benefits discussed," and (f) the patient has been informed of the impacts on reproductive health and their fertility options.[46] Notably, feminizing and masculinizing hormone therapy is used to treat many conditions that non-transgender patients experience, such as testosterone therapy for non-transgender men who experience sexual dysfunction and non-transgender women who experience hair loss due to menopause.[47]

Surgical procedures for adults are recommended by the WPATH Standards only after in-depth counseling about the risks and benefits and are withheld where contraindicated.[48] A patient who is stable on their hormonal treatment may be eligible for surgical treatment if they meet the same criteria outlined for hormonal treatment.[49] The same types of surgeries recommended for treating gender dysphoria are also commonly provided to non-transgender patients. For example, non-transgender women may undergo breast reconstruction following a mastectomy to

[46] *See* WPATH Standards of Care, *supra* note 4, at S256.
[47] Theodore E. Schall & Jacob D. Moses, *Gender-Affirming Care for Cisgender People*, 53 Hastings Ctr. Rep. 15, https://perma.cc/Y7M9-C7CY.
[48] *See* WPATH Standards of Care, *supra* note 4, at S256.
[49] *Id.*

treat or prevent breast cancer. Non-transgender men may receive testicular implants as part of testicular cancer treatment. Additionally, non-transgender men with gynecomastia, a condition resulting in the enlargement of breast tissue, may opt for breast reduction surgery to better align with their gender identity.

B. Standard of Care for Treating Gender Dysphoria in Adolescents

As with adults, the WPATH Standards recommend an individualized approach for treating adolescents with gender dysphoria. Treatment is both holistic and tailored to each patient's needs.[50] Prior to initiation of medical treatment, the WPATH Standards recommend that clinicians conduct a "comprehensive biopsychosocial assessment," taking into account an individual's "strengths, vulnerabilities, diagnostic profile, and unique needs to individualize their care."[51] Mental evaluations are undertaken to determine any co-existing conditions such as anxiety, depression, and eating disorders.[52] Co-existing mental health conditions are distinguished from gender dysphoria and treated accordingly.[53]

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[50] *Id.* at S53.
[51] *See Id.* at S50; *see also* Alex R. Dopp et al., *Interventions for Gender Dysphoria and Related Health Problems in Transgender and Gender-Expansive Youth*, RAND (Nov. 26, 2024), https://perma.cc/P7LP-B5QH (providing support for a range of interventions, including psychosocial, surgical, and treatment of co-occurring mental health disorders, following a systematic review of 105 studies related to the treatment of transgender youth).
[52] Jack L. Turban, *Biopsychosocial Assessments for Pubertal Suppression to Treat Adolescent Gender Dysphoria*, J. Am. Academ. Child Adolesc. Psychiatry (Apr. 4, 2024), https://perma.cc/VVX6-ADTV.
[53] *Id.*; *See* WPATH Standards of Care, *supra* note 4, at S32.

Most adolescents with gender dysphoria do not receive medical intervention. In an analysis of insurance claims, it was found that only 2-4% of minors with gender dysphoria receive gonadotrophin-releasing hormone ("GnRH") analogues or hormone therapy.[54] For those for whom it is medically indicated and who choose to pursue medical treatment, care is provided in a multidisciplinary setting that includes professionals from specialties such as adolescent medicine, primary care, endocrinology, psychiatry, and social work.[55]

The development of secondary sex characteristics during puberty may induce significant distress in adolescents and exacerbate their existing gender dysphoria.[56] GnRH analogues suppress endogenous testosterone and estrogen production, thereby pausing puberty and giving the adolescent time to determine next steps in their medical treatment.[57] The effects of GnRH analogues are reversible with puberty resuming upon cessation of use.[58] Further, GnRH analogues have been shown to have an "admirable safety profile."[59] GnRH

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[54] Meredithe McNamara et al., *An Evidence-Based Critique of 'The Cass Review' on Gender-affirming Care for Adolescent Gender Dysphoria*, Yale Law School, 19 (Jul. 2024) https://perma.cc/V8ZW-QQVK.
[55] *See* WPATH Standards of Care, *supra* note 4, at S56.
[56] *Id.* at S64, S112.
[57] Claire A. Coyne et al., *Gender Dysphoria: Optimizing Health care for Transgender and Gender Diverse Youth with a Multidisciplinary Approach*, 19 Neuropsych. Disease & Treatment 483 (2023), https://perma.cc/45SE-XKA2.
[58] Carly Guss & Catherine M. Gordon, *Pubertal Blockade and Subsequent Gender-Affirming Therapy*, JAMA Network Open (Nov. 2022), https://perma.cc/AHX2-YNA3.
[59] Erica A. Eugster, *Treatment of Central Precocious Puberty*, 3 J. Endocrine Soc'y, 965, 967 (Mar. 28, 2019), https://perma.cc/686P-RE2M.

analogues are appropriate when (1) the adolescent's "gender diversity/incongruence is marked and sustained over time"; (2) the adolescent "[m]eets the diagnostic criteria of gender incongruence"; (3) the adolescent "demonstrates the emotional and cognitive maturity required to provide informed consent"; (4) the adolescent's co-occurring medical health conditions have been appropriately addressed; (5) the adolescent is informed of any effects on reproductive health; and (6) the adolescent has reached Tanner stage 2, when physical changes of puberty are first exhibited.[60] GnRH analogues are widely used and are the gold-standard for treating central precocious puberty ("CPP") in non-transgender minors.[61] CPP is marked by the "premature activation of the hypothalamic–pituitary–gonadal ("HPG") axis, resulting in early development of secondary sexual characteristics."[62]

Unlike GnRH analogues, hormone therapy induces feminization or masculinization of secondary sexual characteristics in accordance with the individual's affirmed gender identity.[63] Testosterone is prescribed to transgender adolescents assigned female at birth to masculinize secondary sex characteristics

[60] *See* WPATH Standards of Care, *supra* note 4, at S256.
[61] Melinda Chen & Erica A. Eugster, *Central Precocious Puberty: Update on Diagnosis and Treatment,* 17 Paediatr. Drugs 273–281 (Mar. 27, 2015), https://perma.cc/9E2U-P7MA.
[62] *Id.*
[63] Denise Chew et al., *Hormonal Treatment in Young People with Gender Dysphoria: A Systematic Review*, 141 Pediatrics (April 1, 2018), https://perma.cc/63BS-Y9JB.

and suppress feminine traits.[64] Estrogens are prescribed to transgender adolescents assigned male at birth to feminize secondary sex characteristics.[65] Antiandrogens, which suppress testosterone production, may also be given in conjunction with estrogen.[66] The WPATH Standards urge that the same six criteria described above be met to consider hormonal treatment on an individualized basis.[67]

Hormone therapy is also prescribed to non-transgender adolescents. For example, girls diagnosed with hypogonadism—a condition that can be caused by a variety of conditions, including Turner syndrome, ovarian agenesis, and premature ovarian failure—are treated with estrogen to promote the progression of puberty.[68] Hypogonadism can be caused by a variety of conditions including Turner syndrome, ovarian agenesis, and premature ovarian failure.[69] Similarly, non-transgender boys with hypogonadism are treated with testosterone.[70]

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[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] *See* WPATH Standards of Care, *supra* note 4, at S257; *see also* Endocrine Guidelines, *supra* note 4; Rafferty et al., *supra* note 3.
[68] *See* Karen O. Klein & Susan A Phillips, *Review of Hormone Replacement Therapy in Girls and Adolescents with Hypogonadism,* 32 J. Pediatr. Adolesc. Gynecol. 460 (Oct. 2019), https://perma.cc/E7BN-PHTK; Maria Vogiatzi et al., *Testosterone Use in Adolescent Males: Current Practice and Unmet Needs, 5* J. Endocrine Soc'y 1 (Oct. 30, 2020), https://perma.cc/N8RE-JL2S.
[69] Klein & Phillips*, supra* note 68.
[70] *Brandt v. Rutledge*, 677 F. Supp. 3d 877, 893 (E.D. Ark. 2023) (noting that "[g]enital surgeries for adolescents are extremely rare" and, according to the Endocrine Society, not recommended until after age 18).

Gender-affirming surgery is exceedingly rare in adolescents.[71] Notably, "[i]n the rare instance that an adolescent has gender-affirming surgery, the overwhelming majority of surgeries are chest surgeries for adolescent transgender males."[72] Some of these surgeries, such as the reduction of chest reduction surgery for gynecomastia, are also utilized for non-transgender adolescents in certain situations.[73]

III. DISINFORMATION PERPETUATES HARMFUL MYTHS ABOUT TRANSGENDER INDIVIDUALS AND GENDER DYSPHORIA

Recent positions advanced in legislatures and courts regularly rely on harmful myths to justify limiting access to treatments for gender dysphoria.[74] These myths are often presented under the guise of protecting children, even though they result in denying critical care for children and adults alike. Such "state-sponsored disinformation about [transgender and gender expansive]

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[71] Dannie Dai et al., *Prevalence of Gender-Affirming Surgical Procedures Among Minors and Adults in the US*, JAMA Netw. Open (Jun. 27, 2024), https://perma.cc/8CW3-U3BH.

[72] *Brandt v. Rutledge*, 677 F. Supp. 3d 877, 893 (E.D. Ark. 2023) (citing expert testimony).

[73] Valerie Lemaine et al., *Gynecomastia in Adolescent Males*, 27 Semin. Plast. Surg. 56 (2013), https://perma.cc/3VAY-FBHZ

[74] *See, e.g.,* Complaint for Declaratory Relief and Preliminary and Permanent Injunctive Relief at 32–33, *Florida v. Dep't of Health & Hum. Servs.*, No. 8:24-CV-1080-WFJ-TGW, 2024 WL 3537510 (M.D. Fla. July 3, 2024), Complaint at 21–22, *Texas* v. *Becerra*, No. 6:24-CV-211-JDK, 2024 WL 3297147 (E.D. Tex. July 3, 2024), *modified on reconsideration,* No. 6:24-CV-211-JDK, 2024 WL 4490621 (E.D. Tex. Aug. 30, 2024); Complaint for Injunctive and Declaratory Relief at 30–31, *Tennessee v. Becerra*, No. 1:24CV161-LG-BWR, 2024 WL 3283887 (S.D. Miss. July 3, 2024); McNamara et al., *supra* note 23.

identities and [gender-affirming care] contribute to a well-described pattern of "institutional and informational erasure" of transgender people."[75]

Inaccurate claims about "desistance"—i.e., the notion that gender dysphoria will resolve over time without treatment—are relied upon to challenge the use of hormonal and surgical treatment, particularly for transgender adolescents.[76] In reality, de-transitioning is a rare occurrence, and "the evidence suggests that the vast majority of adolescents who are diagnosed with gender dysphoria will persist in their gender identity and will benefit from gender affirming medical care."[77]

There are also widespread myths that gender dysphoria is the result of "social contagion." For example, in a study analyzing five legal filings in support of health care bans restricting the treatment of gender dysphoria, the majority of documents included false claims that transgender adolescents are experiencing

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[75] McNamara et al., *supra* note 23 at *8.

[76] *See* Complaint for Declaratory Relief and Preliminary and Permanent Injunctive Relief at 29, *Florida v. Dep't of Health & Hum. Servs.*, No. 8:24-CV-1080-WFJ-TGW, 2024 WL 3537510 (M.D. Fla. July 3, 2024), Complaint at 22, *Texas* v. *Becerra*, No. 6:24-CV-211-JDK, 2024 WL 3297147 (E.D. Tex. July 3, 2024), *modified on reconsideration,* No. 6:24-CV-211-JDK, 2024 WL 4490621 (E.D. Tex. Aug. 30, 2024).

[77] *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* at 18 (Apr. 28, 2022) (publication forthcoming), https://perma.cc/RW2Z-XE6M ("In a Dutch study, among 70 adolescents diagnosed with gender dysphoria and treated with puberty-suppressing hormones, 100% opted to continue with gender-affirming treatment. A recent U.S. study found a consistent pattern. Following a large cohort of U.S. young people who reported some evidence of gender dysphoria but had not yet been formally diagnosed, the study found that adolescents were far more likely than prepubertal children to go on to a formal diagnosis of gender dysphoria and to receive gender-affirming treatment.").

"rapid-onset gender dysphoria" acquired through "social contagion."[78] Four of the legal briefs rely upon a "heavily corrected study" involving "anonymous respondents claiming to be parents of [transgender and gender expansive] youth from websites that were hostile to providing [care for gender dysphoria]—while explicitly informing [respondents] of the study hypothesis."[79] To date, there is "no empirical support" for these findings, and other study results dispute these findings. [80]

Similarly, the standard of care for treating gender dysphoria has been attacked as "experimental" due to misleading contentions that it is derived from "low quality" evidence.[81] Common usage affords more meaning to the term than is warranted. Low quality evidence "is a technical term used in clinical research to describe evidence not derived from randomized controlled trials ("RCTs")."[82] However, the reliance

[78] McNamara et al., *supra* note 23 at *8.
[79] *Id*.
[80] *Id.*
[81] *See, e.g.,* Complaint for Declaratory Relief and Preliminary and Permanent Injunctive Relief at 32–33, *Florida v. Dep't of Health & Hum. Servs.*, No. 8:24-CV-1080-WFJ-TGW, 2024 WL 3537510 (M.D. Fla. July 3, 2024); Complaint, *Texas v. Becerra* at 21–22, No. 6:24-CV-211-JDK, 2024 WL 3297147 (E.D. Tex. July 3, 2024), *modified on reconsideration,* No. 6:24-CV-211-JDK, 2024 WL 4490621 (E.D. Tex. Aug. 30, 2024) (claiming that "the evidence purporting to show the benefits of [WPATH-recommended] procedures is woefully inadequate" and "low quality"); Complaint for Injunctive and Declaratory Relief at 33, *Tennessee v. Becerra*, No. 1:24CV161-LG-BWR, 2024 WL 3283887 at 33 (S.D. Miss. July 3, 2024) (contending that treatments for gender dysphoria in minors "are experimental in nature and not supported by high-quality, long-term medical studies."); Endocrine Guidelines, *supra* note 4; McNamara et al., *supra* note 23.

[82] *Id.* at *9; *see also* Padhraig S. Fleming et al., *High quality of the evidence for medical and other health-related interventions was uncommon in Cochrane systematic reviews*, 78 J. Clinical Epidemiology 34 (2016) https://perma.cc/W9AP-KLAH.

on RCTs is not unique to the treatment of gender dysphoria. In fact, the "majority of clinical care (85%) is based on such "low quality" evidence."[83]

Furthermore, RCTs—the gold standard for evidence-based research—may be "unethical and methodologically inappropriate" for treating gender dysphoria, especially for adolescents.[84] This is because it is impossible for a RCT to achieve clinical equipoise, i.e., "intervention and no intervention being theoretically equivalent."[85] Providing no intervention would be withholding critical treatment for people experiencing gender dysphoria, which can have dangerous consequences on mental health. Furthermore, because gender-affirming care "is a highly sought after and difficult to access intervention, a hypothetical RCT on [gender-affirming care] would likely be coercive to [transgender] people who cannot access" such care. [86] Again, these concerns about the use of RCTs are not unique to the treatment of gender dysphoria.[87] For example, relying on RCTs to develop treatments for rare diseases is often inappropriate due to the limited patient pool available and ethical concerns about providing a placebo to patients with limited options.

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[83] McNamara et al., *supra* note 23 at *9.
[84] Joanna Wuest & Briana S. Last, *Agents of scientific uncertainty: Conflicts over evidence and expertise in gender-affirming care bans for minors*, 334 Soc. Sci. & Med. (Mar. 2024), https://perma.cc/8JF3-THWK; Florence Ashley et al., *Randomized-controlled trials are methodologically inappropriate in adolescent transgender healthcare*, 25 Int. J. of Trangend. Health 407 (Jun. 24, 2023), https://perma.cc/8A8F-TZXR.
[85] McNamara et al., *supra* note 23 at *11.
[86] *Id.*
[87] Angus Deaton & Nancy Cartwright, *Understanding and misunderstanding randomized controlled trials*, 210 Soc. Sci. Med. 2 (August 2018), https://perma.cc/ZP7L-AHP5.

IV. WITHHOLDING TREATMENT LEADS TO ADVERSE OUTCOMES FOR PEOPLE WHO EXPERIENCE GENDER DYSPHORIA

Preventing access to treatment because of gender identity discrimination contravenes the established standard of care. Major professional organizations including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the American Academy of Child, and Adolescent Psychiatry have categorically opposed efforts that attempt to limit medical care for gender dysphoria.[88] Where it is permitted, discrimination on the basis of gender identity not only prevents access to evidence-based care but also interferes with the medical autonomy of both physicians and patients.[89]

Withholding treatment because of gender identity discrimination carries significant risks. The psychological and social impacts of not receiving treatment for gender dysphoria have been examined and found to be harmful.[90] Transgender adults are more likely to rate their health as "fair/poor" compared to non-transgender individuals and experience depression and anxiety at rates as high as

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[88] Katherine L. Kraschel et al., *Legislation restricting gender-affirming care for transgender youth: Politics eclipse healthcare*, Cellular Reps. Med. (Aug. 16, 2022), https://perma.cc/YQ3T-TJN6.

[89] Jack L. Turban et al., *Legislation to Criminalize Gender-Affirming Medical Care for Transgender Youth*, 325 JAMA 2251 (May 24, 2021).

[90] *See* WPATH Standards of Care, *supra* note 4, at S18 ("There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures, properly indicated and performed as outlined by the Standards of Care (Version 8), in [transgender] people in need of these treatments.") (citing studies).

84% and 68%, respectively.[91] Additionally, a study published in the American Academy of Pediatrics found that transgender young adults who had received treatment for gender dysphoria during adolescence exhibited improvements in psychological functioning and well-being, comparable or better than same-age non-transgender adults in the general population.[92] Patients reported improved quality of life and subjective happiness.[93] Of the 55 people enrolled in the study, none regretted receiving treatment.[94]

Transgender minors are at a higher risk of exhibiting suicidal behavior than their non-transgender counterparts. A 2024 survey of more than 18,000 individuals aged 13 to 24 revealed that 46% of transgender and nonbinary young people considered attempting suicide in the past year.[95] Limiting access to care leads to a heightened risk of self-harm, suicide attempts, and suicidal ideation.[96] Alignment

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[91] Jamie L. Feldman et al., *Health and health care access in the US transgender population health (TransPop) survey*, 9 Andrology 1707–1718 (Jun. 10, 2021), https://perma.cc/8NXK-RDU7; Arjee Restar et al., *Antitrans Policy Environment and Depression and Anxiety Symptoms in Transgender and Nonbinary Adults*, JAMA Netw. Open (Aug. 22, 2024), https://perma.cc/XP4Z-UP9S.
[92] Annelou L. C. de Vries et al., *Young adult psychological outcome after puberty suppression and gender reassignment*, 134 Pediatrics 696–704 (Oct. 2014), https://perma.cc/JG2V-R8RS.
[93] *Id.* at *7.
[94] *Id.* at *5
[95] Trevor Project, 2024 *U.S. National Survey on the Mental Health of LGBTQ+ Young People* at 2 (2024), https://perma.cc/TQB7-L4VS.
[96] Selene Mezzalira et al., *Gender Felt Pressure, Affective Domains, and Mental Health Outcomes among Transgender and Gender Diverse (TGD) Children and Adolescents: A Systematic Review with Developmental and Clinical Implications*, 20Int'l J. of Env't Rsch. & Pub. Health at 2 (Dec. 31, 2022), https://perma.cc/267J-YG4R.

of an adolescent's physical characteristics with their affirmed gender identity has shown positive results. "A solid body of reliable research has shown that . . . [medical] care for adolescents with gender dysphoria—puberty-blocking medications and hormone therapy—have major mental-health benefits, including higher levels of general well-being and significantly decreased levels of suicidality."[97] Furthermore, a decrease in the rate of depression has been observed.[98]

A. Watchful Waiting is a Harmful Approach to Treating Gender Dysphoria.

Several state governments and some European countries, including Finland, Sweden and the U.K., recommend "watchful waiting" over medical treatment for gender dysphoria, but this approach is not evidence-based.[99] "Watchful waiting" is the practice of delaying care, usually until pubertal onset.[100] It relies on the inaccurate assumption that the majority of children will revert to a gender identity

[97] Susan D. Boulware et al., *supra* note 77, at 14.
[98] Diana M. Tordoff et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5(2) JAMA Network Open (Feb. 1, 2022). https://perma.cc/2V76-D8AG.
[99] *See, e.g.*, Complaint for Declaratory Relief and Preliminary and Permanent Injunctive Relief at 21, *Florida v. Dep't of Health & Hum. Servs.*, No. 8:24-CV-1080-WFJ-TGW, 2024 WL 3537510 (M.D. Fla. July 3, 2024); Complaint for Injunctive and Declaratory Relief at 23, *Tennessee v. Becerra*, No. 1:24CV161-LG-BWR, 2024 WL 3283887 (S.D. Miss. July 3, 2024); Complaint at 22–23, *Texas v. Becerra*, No. 6:24-CV-211-JDK, 2024 WL 3297147 (E.D. Tex. July 3, 2024), *modified on reconsideration,* No. 6:24-CV-211-JDK, 2024 WL 4490621 (E.D. Tex. Aug. 30, 2024); Jennifer Block, *Paediatric leaders back gender affirming approach while also ordering evidence review*, British Med. J. (Aug. 14, 2023), https://perma.cc/PK9Y-ZRSV.
[100] *See* Rafferty et al., *supra* note 3.

consistent with the sex assigned at birth upon reaching puberty.[101] The experience of puberty associated with the sex assigned at birth, including permanent bodily changes, can exacerbate the symptoms of gender dysphoria. The American Academy of Pediatrics adamantly opposes the practice of "watchful waiting," labeling it as an "outdated approach [that] does not serve the child as critical support is withheld."[102] The AAP further asserts that such an approach is "influenced by a group of early studies with validity concerns, methodological flaws, and limited follow-up." [103] More recent research suggests that embracing an individual's gender identity "fosters secure attachment and resilience" for both the child and their family. [104]

CONCLUSION

The district court's injunction relies on harmful and widely discredited views related to transgender discrimination and the clinical treatment of gender dysphoria. The *amici* parties offer this brief to aid this Court's understanding of gender dysphoria as a serious medical condition that requires treatment in accordance with the established standard of care, to counter harmful myths about

[101] Diane Ehrensaft et al., *Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens*, 19 Int'l J. of Transgenderism 251 (Mar. 9, 2018), https://perma.cc/L47N-Z5CP.
[102] *See* Rafferty et al., *supra* note 3 at *4.
[103] *Id.*
[104] *Id.*

gender dysphoria and transgender people, and to illustrate the harm associated with withholding appropriate medical care.

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This brief complies with the type-volume limitation of Federal Rules of Appellate Procedure 29(a)(5) and 32(a)(7)(B) because it contains 6411 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f).

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing *amici curiae* brief with the Clerk of the Court for the U.S. Court of Appeals for the Eleventh Circuit by using the CM/ECF system on January 8, 2025. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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