No. 24-11996

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

JANE DOE, ET AL,
Plaintiffs-Appellees,

v.

SURGEON GENERAL, STATE OF FLORIDA, ET AL,
Defendants-Appellants

On Appeal from the United States District Court for the
Northern District of Florida
Case No: 4:23-cv-114-RH-MAF

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

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CERTIFICATE OF INTERESTED PERSONS
AND CORPORATE DISCLOSURE STATEMENT

Per Federal Rule of Appellate Procedure 26.1 and Eleventh Circuit Rule 26.1, *Amici* certify that the following have an interest in the outcome of this case:

1. Abdul-Latif, Hussein, *Amicus*
2. Academic Pediatric Association, *Amicus*
3. Ackerman, Scot, *Defendant*
4. Ahmed, Aziza, *Amicus*
5. Alstott, Anne, *Amicus*
6. American Academy of Child and Adolescent Psychiatry, *Amicus*
7. American Academy of Family Physicians, *Amicus*
8. American Academy of Nursing, *Amicus*
9. American Academy of Pediatrics, *Amicus*
10. American Association of Physicians for Human Rights, Inc., *Amicus*
11. American College of Obstetricians and Gynecologists, *Amicus*
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24. Bartlett, Bruce, *Former Defendant*

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[1] Pursuant to the District Court Final Order (Dkt. 223, at 2–3), the record in this case also relies on the "evidence presented during the trial of a separate case in this court with overlapping issues, *Dekker v. Weida,* No. 4:22cv325-RH-MAF." Thus, the witnesses in the *Dekker* case are included in this CIP. The *Dekker* case is on appeal in this Court. No. 23-12155.

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194. Zanga, Joseph, *Dekker Witness*

Pursuant to Federal Rule of Appellate Procedure 26.1, the undersigned counsel for the American Academy of Pediatrics ("AAP"), the Academic Pediatric Association, the American Academy of Child & Adolescent Psychiatry ("AACAP"), the American Academy of Family Physicians ("AAFP"), the American Academy of

Nursing ("AAN"), the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ+ Equality ("GLMA"), the American College of Obstetricians and Gynecologists ("ACOG"), the American College of Osteopathic Pediatricians ("ACOP"), the American College of Physicians ("ACP"), the American Medical Association ("AMA"), the American Pediatric Society ("APS"), the Association of American Medical Colleges ("AAMC"), the Endocrine Society ("ES"), the Florida Chapter of the American Academy of Pediatrics ("FLAAP"), the National Association of Pediatric Nurse Practitioners ("NAPNAP"), the Pediatric Endocrine Society ("PES"), the Societies for Pediatric Urology ("SPU"), the Society for Adolescent Health and Medicine ("SAHM"), the Society for Pediatric Research ("SPR"), the Society of Pediatric Nurses ("SPN"), and the World Professional Association for Transgender Health ("WPATH") (collectively, "*amici*") certify that:

1. AAP, the Academic Pediatric Association, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP, AAMC, AMA, APS, ES, FLAAP, NAPNAP, PES, SPU, SAHM, SPR, SPN, and WPATH, respectively, have no parent corporation.

2. No corporations hold any stock in AAP, the Academic Pediatric Association, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP, AAMC, AMA, APS, ES, FLAAP, NAPNAP, PES, SPU, SAHM, SPR, SPN, and WPATH.

Per Eleventh Circuit Rule 26.1-2(c), *Amici* certify that the CIP contained herein is complete.

Date: October 9, 2024

s/ Cortlin H. Lannin
Cortlin H. Lannin

Counsel for Amici Curiae

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici curiae are professional medical and mental health organizations seeking to ensure that all adolescents, including those with gender dysphoria, receive the optimal medical and mental health care they need and deserve. *Amici* represent thousands of healthcare providers who have specific expertise with the issues raised in this brief. The Court should consider *amici*'s brief because it provides important expertise and addresses misstatements about the treatment for transgender adolescents.[2]

[2] The parties have consented to the filing of this brief. FRAP 29(a)(2). *Amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* or their counsel made any monetary contributions intended to fund the preparation or submission of this brief. FRAP 29(a)(4)(E).

STATEMENT OF THE ISSUE

Whether the district court correctly enjoined Defendants-Appellants from enforcing Rules 64B8-9.019 and 64B15-14.014 of the Florida Administrative Code.

SUMMARY OF ARGUMENT

Rules 64B8-9.019 and 64B15-14.014 of the Florida Administrative Code (the "Healthcare Ban"), promulgated by the Florida Board of Medicine and the Florida Board of Osteopathic Medicine (the "Boards") prohibit healthcare providers from providing patients under 18 with critical, medically necessary, evidence-based care for gender dysphoria.[3] Denying such evidence-based medical care to adolescents who meet the requisite medical criteria puts them at risk of significant harm. Below, *amici* provide the Court with an accurate description of the relevant treatment guidelines and summarize the scientific evidence supporting the gender-affirming medical care for adolescents that is prohibited by the Healthcare Ban.[4]

Gender dysphoria is a condition that is characterized by clinically significant distress or impairment in social, occupational, or other important areas of functioning due to a marked incongruence between the patient's gender identity (i.e.,

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[3] Rules 64B8-9.019 and 64B15-14.014 prohibit medical treatments that are administered for the purpose of treating gender dysphoria, including "puberty blocking, hormone, and hormone antagonist therapies" which, as discussed in this brief, are medically necessary care for certain adolescents with gender dysphoria. The rules also include a grandfathering clause providing that: "Minors being treated with puberty blocking, hormone, or hormone antagonist therapies prior to the effective date of th[e] rule[s] may continue with such therapies."

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

the innate sense of oneself as being a particular gender) and sex assigned at birth.[5] If not treated, or treated improperly, gender dysphoria can result in debilitating anxiety, depression, and self-harm, and is associated with suicidality. As such, the effective treatment of gender dysphoria saves lives.

The medical community, including the respected professional organizations participating here as *amici*, widely recognizes that the appropriate protocol for treating gender dysphoria in transgender adolescents is "gender-affirming care."[6] Gender-affirming care is care that supports an individual with gender dysphoria as they explore their gender identity—in contrast with efforts to change the individual's gender identity to match their sex assigned at birth, which are known to be ineffective and harmful.[7] For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical care

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[5] *See, e.g.*, Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142(4) PEDIATRICS e20182162, at 2–3 tbl.1 (2018), https://perma.cc/DB5G-PG44 ("AAP Policy Statement"). The AAP recently voted to reaffirm the AAP Policy Statement. *See* Alyson Sulaski Wyckoff, Am. Acad. of Pediatrics, *AAP Reaffirms Gender-Affirming Care Policy, Authorizes Systematic Review of Evidence to Guide Update*, AAP News (Aug. 4, 2023), https://perma.cc/XS4B-WBLH. In addition, AAP has commissioned a systematic review of the existing research, which is part of its normal procedures to perform such reviews on a periodic basis to maintain up-to-date guidelines.

[6] *See, e.g.*, AAP Policy Statement, *supra* note 5, at 10.

[7] *See, e.g.*, Christy Mallory et al., *Conversion Therapy and LGBT Youth*, Williams Inst. (June 2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Update-Jun-2019.pdf.

to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including the prescription of puberty blockers and hormone therapy to carefully evaluated patients who meet diagnostic criteria, can alleviate clinically significant distress and lead to significant improvements in the mental health and overall wellbeing of adolescents with gender dysphoria.[8]

The Healthcare Ban disregards this medical evidence by precluding healthcare providers from providing adolescent patients with treatments for gender dysphoria in accordance with the well-accepted protocol. Accordingly, *amici* urge this Court to affirm the district court's order granting a permanent injunction.

ARGUMENT

This brief first provides background on gender identity and gender dysphoria. It then describes the professionally accepted medical guidelines for treating gender dysphoria as they apply to adolescents, the scientifically rigorous process by which these guidelines were developed, and the evidence that supports the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief corrects multiple inaccuracies regarding the professionally-accepted medical guidelines for treating gender dysphoria and explains how the Healthcare Ban would irreparably harm

[8] *See* Simona Martin et al., *Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, 385 NEJM 579, at 2 (2021), https://www.nejm.org/doi/full/10.1056/NEJMp2106314 (providing an overview of the scientific basis underlying gender-affirming care and its demonstrated effectiveness in "alleviat[ing] gender dysphoria").

adolescents with gender dysphoria by denying crucial care to those who need it.

I. Understanding Gender Identity and Gender Dysphoria.

Gender identity refers to a person's deep internal sense of belonging to a particular gender.[9] Most people are "cisgender:" meaning they have a gender identity that aligns with their sex assigned at birth.[10] However, transgender people have a gender identity that does not align with their sex assigned at birth.[11] In the United States, approximately 1.6 million individuals identify as transgender.[12] Of these individuals, approximately 10% are teenagers aged 13 to 17.[13] Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

Today, there is an increasing acceptance of being transgender as a normal variation of human identity.[14] However, many transgender people suffer from

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[9] AAP Policy Statement, *supra* note 5, at 2 tbl.1.

[10] *See* Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70(9) AMERICAN PSYCHOLOGIST 832, 861–862 (2015), https://www.apa.org/practice/guidelines/transgender.pdf.

[11] *See id.* at 863.

[12] *See* Jody L. Herman et al., *How Many Adults and Youth Identify as Transgender in the United States?*, Williams Inst., at 2 (June 2022), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf.

[13] *See id.* at 3.

[14] James L. Madara, *AMA to States: Stop Interfering in Healthcare of Transgender Children*, Am. Med. Ass'n (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children;
(continued…)

gender dysphoria, a serious medical condition in which the patient experiences significant distress that can lead to "impairment in peer and/or family relationships, school performance, or other aspects of their life."[15] Gender dysphoria is a formal diagnosis under the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5-TR).[16]

If untreated or inadequately treated, gender dysphoria may lead to depression, anxiety, self-harm, and suicidality.[17] In contrast, with treatment, transgender adolescents with gender dysphoria can mature into thriving adults.[18]

II. The Widely Accepted Guidelines for Treating Adolescents with Gender Dysphoria Provide for Gender-Affirming Medical Care When Indicated.

The widely accepted view of the professional medical community is that gender-affirming care is the appropriate treatment for gender dysphoria and that, for

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see also Am. Psychological Ass'n, *APA Resolution on Gender Identity Change Efforts*, 4 (Feb. 2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.

[15] AAP Policy Statement, *supra* note 5, at 5.

[16] *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR* at 512–13 (2022); *see also* World Health Org., International Classification of Diseases, Eleventh Revision (ICD-11) (2019/2021) ("Gender incongruence is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group.").

[17] *See* Brayden N. Kameg & Donna G. Nativio, *Gender Dysphoria In Youth: An Overview For Primary Care Providers*, 30(9) J. AM. ASSOC. NURSE PRAC. 493 (2018), https://pubmed.ncbi.nlm.nih.gov/30095668.

[18] *See infra* Section II.C.

some adolescents, puberty blockers and hormone therapy are necessary.[19] Gender-affirming care greatly reduces the negative physical and mental health consequences that result when gender dysphoria is untreated.[20]

A. The Gender Dysphoria Treatment Guidelines Include Thorough Mental Health Assessments and, for Some Adolescents, Gender-Affirming Medical Care.

The treatment protocols for gender dysphoria are laid out in established, evidence-based clinical guidelines: (i) the Endocrine Society Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transgender and Gender Diverse People (together, the "Guidelines").[21] The Guidelines have been developed by expert clinicians and researchers who have worked with patients with gender dysphoria for many years.

The Guidelines provide that all youth with gender dysphoria should be evaluated, diagnosed, and treated by a qualified health care professional ("HCP").[22]

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[19] *See, e.g.*, Endocrine Soc'y, *Transgender Health: An Endocrine Society Position Statement* (2020), https://www.endocrine.org/advocacy/position-statements/transgender-health.

[20] *See id.*

[21] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (Nov. 2017) ("ES Guidelines"), https://academic.oup.com/jcem/article/102/11/3869/4157558; WPATH, *Standards of Care for the Health of Transgender and Gender Diverse People* (8thVersion) ("WPATH Guidelines"), https://www.tandfonline.com/doi/pdf/10.1080/ 26895269.2022.2100644.

[22] *See infra* Section II.A.2.

Further, the Guidelines provide that each patient who receives gender-affirming care should receive only medically necessary and appropriate care that is tailored to the patient's individual needs and that is based on the best evidence possible along with clinical experience.[23]

1. The Guidelines Do Not Recommend Gender-Affirming Medical Care for Prepubertal Children.

For prepubertal children with gender dysphoria, the Guidelines provide for mental health care and support for the child and their family, such as through psychotherapy and social transitioning.[24] The Guidelines do *not* recommend that prepubertal children with gender dysphoria receive puberty blockers, hormone therapy, or surgeries.[25]

2. A Robust Diagnostic Assessment Is Required Before Gender-Affirming Medical Care Is Provided.

In contrast to prepubertal children, the Guidelines do contemplate the possibility that, for some transgender adolescents with gender dysphoria, gender-affirming medical care may be indicated, provided certain criteria are met.

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[23] *See* WPATH Guidelines, *supra* note 21, at S16–S18; ES Guidelines, *supra* note 21, at 3872–73.

[24] *See* WPATH Guidelines, *supra* note 21, at S73–S74; ES Guidelines, *supra* note 21, at 3877–78. "Social transition" refers to a process by which a child is acknowledged by others and has the opportunity to live publicly, either in all situations or in certain situations, in the gender identity they affirm. *See, e.g.*, WPATH Guidelines, *supra* note 21, at S75.

[25] *See* WPATH Guidelines, *supra* note 21, at S64, S67; ES Guidelines, *supra* note 21, at 3871.

According to the Guidelines, puberty blockers and hormone therapy should be provided only after a thorough evaluation by a HCP who: (1) is licensed by their statutory body and holds a master's degree or equivalent in a relevant clinical field; (2) has expertise and received theoretical and evidence-based training in child, adolescent, and family mental health; (3) has expertise and received training in gender identity development, gender diversity in children and adolescents, can assess capacity to consent, and possesses knowledge about gender diversity across the life span; (4) has expertise and received training in autism spectrum disorders and other neurodevelopmental presentations, or collaborates with a developmental disability expert when working with neurodivergent patients; and (5) continues engagement in professional development in areas relevant to gender diverse children, adolescents, and families.[26]

Prior to developing a treatment plan, the HCP should conduct a robust diagnostic assessment—specifically, a "comprehensive biopsychosocial assessment"—of the adolescent patient.[27] The HCP conducts this assessment to "understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs," so that the resulting treatment plan is appropriately individualized.[28] This assessment must be conducted collaboratively with the patient and their

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[26] *See* WPATH Guidelines, *supra* note 21, at S49.
[27] *Id.* at S50.
[28] *Id.*

caregiver(s).[29]

3. In Certain Circumstances, the Guidelines Provide for the Use of Gender-Affirming Medical Care to Treat Adolescents With Gender Dysphoria.

For youth with gender dysphoria that continues into adolescence—after the onset of puberty—the Guidelines provide that, in addition to mental health care, gender-affirming medical care may be indicated. Before an adolescent may receive any gender-affirming medical care for treating gender dysphoria, a qualified HCP must make a determination that such medical care is indicated. The Guidelines collectively provide that, before prescribing puberty blockers, the HCP must determine that: (1) the adolescent meets the diagnostic criteria of gender dysphoria or gender incongruence according to an established taxonomy;[30] (2) the adolescent has demonstrated a sustained and persistent pattern of gender nonconformity or gender dysphoria; (3) the adolescent has demonstrated the emotional and cognitive maturity required to provide informed consent for treatment; (4) any coexisting psychological, medical, or social problems that could interfere with diagnosis, treatment, or the adolescent's ability to consent have been addressed; (5) the adolescent has been informed of the reproductive effects of treatment in the context of their stage in pubertal development and discussed fertility preservation options;

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[29] *Id.*

[30] ES Guidelines, *supra* note 21, at 3876; WPATH Guidelines, *supra* note 21, at S47, S48.

and (6) the adolescent has reached Tanner stage 2 of puberty to initiate pubertal suppression.[31] Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (7) agree with the indication for treatment, (8) confirm the patient has started puberty, and (9) confirm that there are no medical contraindications.[32]

If all the above criteria are met, and the patient and their parents provide informed consent, gonadotropin-releasing hormone (GnRH) analogues, or "puberty blockers," may be offered beginning at the onset of puberty.[33] The purpose of puberty blockers is to delay the development of permanent secondary sex characteristics—which may result in significant distress for transgender youth—until adolescents are old enough and have had sufficient time to make more informed decisions about whether to pursue further treatments.[34] Puberty blockers also can make pursuing transition later in life easier, because they prevent irreversible bodily changes such as protrusion of the Adam's apple or breast growth.[35] Puberty blockers have well-known efficacy and side-effect profiles.[36] Their effects are generally reversible, and when a patient discontinues their use, the patient resumes

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[31] WPATH Guidelines, *supra* note 21, at S59–65.
[32] ES Guidelines, *supra* note 21, at 3878 tbl.5.
[33] WPATH Guidelines, *supra* note 21, at S61–62, S64; ES Guidelines, *supra* note 21, at 3878 tbl.5; Martin, *supra* note 8.
[34] WPATH Guidelines, *supra* note 21, at S112.
[35] *See* AAP Policy Statement, *supra* note 5, at 5.
[36] *See* Martin, *supra* note 8, at 2.

endogenous puberty.[37] In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty.[38] The risks of any serious adverse effects from puberty blockers are exceedingly rare when provided under clinical supervision.[39]

Later in adolescence—and if the criteria below are met—hormone therapy may be used to initiate puberty consistent with the patient's gender identity.[40] Hormone therapy involves using gender-affirming hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.[41] Hormone therapy is only prescribed when a qualified mental health professional has confirmed: the persistence of the patient's gender dysphoria, the patient's mental capacity to consent to the treatment, and that any coexisting problems have been addressed.[42] A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication, and the patient and their parents must

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[37] *See id.*
[38] *See* F. Comite et al., *Short-Term Treatment of Idiopathic Precocious Puberty with a Long-Acting Analogue of Luteinizing Hormone-Releasing Hormone — A Preliminary Report*, 305 NEJM 1546 (1981).
[39] *See, e.g.*, Annemieke S. Staphorsius et al., *Puberty Suppression and Executive Functioning*, 6 PSCYHONEUROENDOCRINOLOGY 190 (2015), https://pubmed.ncbi.nlm.nih.gov/25837854 (no adverse impact on executive functioning); Ken C. Pang et al., *Long-term Puberty Suppression for a Nonbinary Teenager*, 145(2) PEDIATRICS e20191606 (2019), https://watermark.silverchair.com/peds_20191606.pdf (exceedingly low risk of delayed bone mineralization from hormone treatment).
[40] Martin, *supra* note 8, at 2.
[41] *See* AAP Policy Statement, *supra* note 5, at 6.
[42] ES Guidelines, *supra* note 21, at 3878 tbl.5.

be informed of the potential effects and side effects and give their informed consent.[43] Although some of the changes caused by hormone therapy become irreversible after those secondary sex characteristics are fully developed, others are partially reversible if the patient discontinues use of the hormones.[44]

The Guidelines contemplate that the prescription of puberty blockers and/or hormone therapy be coupled with education on the safe use of such medications and close monitoring to mitigate any potential risks.[45] Decisions regarding the appropriate treatment for each patient with gender dysphoria are made in consultation with the patient, their parents, and the medical and mental health care team. There is "no one-size-fits-all approach to this kind of care."[46]

B. The Guidelines for Treating Gender Dysphoria Were Developed Through a Robust and Transparent Process, Employing the Same Scientific Rigor That Underpins Other Medical Guidelines.

The Guidelines are the product of careful and robust deliberation following the same types of processes—and subject to the same types of rigorous requirements—as other guidelines promulgated by *amici* and other medical organizations.

For example, the ES Guidelines were developed following a 26-step, 26-

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[43] *See id*.
[44] *See* AAP Policy Statement, *supra* note 5, at 5–6.
[45] *See* ES Guidelines, *supra* note 21, at 3871, 3876.
[46] Martin, *supra* note 8, at 1.

month drafting, comment, and review process.[47] ES imposed strict evidentiary requirements based on the internationally recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.[48] That GRADE assessment was then reviewed, re-reviewed, and reviewed again by independent groups of professionals.[49] Reviewers were subject to strict conflict of interest rules, and there was ample opportunity for feedback and debate through the years-long review process.[50] Further, ES continually reviews its own guidelines and recently determined that the 2017 transgender care guidelines continue to reflect the best, most up-to-date available evidence.[51]

First published in 1979, the WPATH Standards of Care are currently in their 8th Edition. The current Standards of Care are the result of a robust drafting, comment, and review process that collectively took five years.[52] The draft

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[47] *See, e.g.*, ES Guidelines, *supra* note 21, at 3872–73.

[48] *See* Gordon Guyatt et al., *GRADE Guidelines: 1. Introduction - GRADE Evidence Profiles and Summary of Findings Tables*, 64 J. CLINICAL EPIDEMIOLOGY 383 (2011), https://ahpsr.who.int/docs/librariesprovider11/publications/supplementary-material/hsr-synthesis-guyatt-2011.pdf; Gordon H. Guyatt et al., *GRADE: An Emerging Consensus on Rating Quality of Evidence and Strength of Recommendations*, 336 BMJ 924 (2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2335261.

[49] Endocrine Soc'y, *Methodology*, https://www.endocrine.org/clinical-practice-guidelines/methodology.

[50] *See id*.

[51] *See* Endocrine Soc'y, ES Statement in Support of Gender-Affirming Care (May 8, 2024), https://perma.cc/J4Y2-RUJ2.

[52] *See* WPATH Guidelines, *supra* note 21, at S247-51.

guidelines went through rigorous review and were publicly available for discussion and debate, receiving a total of 2,688 comments.[53] There were 119 authors ultimately involved in the final draft, including feedback from experts in the field as well as from transgender individuals and their families.[54]

C. Scientific Evidence Indicates the Effectiveness of Treating Gender Dysphoria According to the Guidelines.

Multiple studies indicate that adolescents with gender dysphoria who receive gender-affirming medical care experience improvements in their overall well-being.[55] A number of studies have been published that investigated the use of puberty blockers on adolescents with gender dysphoria,[56] and/or the use of hormone

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[53] *See id*.

[54] *See id.* Inclusion of input from the relevant patient population during development of medical guidelines adheres to national standards and best practices. *See* National Academy of Sciences, *Clinical Practice Guidelines We Trust* at 89–92 (2011).

[55] *See* Martin, *supra* note 8, at 2.

[56] *See, e.g.*, Christal Achille et al., *Longitudinal Impact of Gender-Affirming Endocrine Intervention on The Mental Health and Wellbeing of Transgender Youths*, 8 INT'L J PEDIATRIC ENDOCRINOLOGY 1–5 (2020), https://pubmed.ncbi.nlm.nih.gov/32368216; Polly Carmichael et al., *Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People With Persistent Gender Dysphoria in the UK*, 16(2) PLOS ONE e0243894 (2021), https://pubmed.ncbi.nlm.nih.gov/33529227; Rosalia Costa et al., *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*, 12(11) J. SEXUAL MED. 2206–2214 (2015), https://pubmed.ncbi.nlm.nih.gov/26556015; Annelou L.C. de Vries et al., *Puberty Suppression In Adolescents With Gender Identity Disorder*, 8(8) J. SEXUAL MED. 2276–2283 (2011), https://pubmed.ncbi.nlm. nih.gov/ 20646177; Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression And Gender Reassignment*, 134(4) PEDIATRICS 696–704 (2014), https:// (continued…)

therapy to treat adolescents with gender dysphoria.[57] These studies find positive mental health outcomes for those adolescents who received puberty blockers or

pubmed.ncbi.nlm.nih.gov/25201798; Laura E. Kuper, et al., *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*, 145(4) PEDIATRICS e20193006 (2020), https://pubmed.ncbi.nlm .nih.gov/32220906; Jack L. Turban et al., *Pubertal Suppression For Transgender Youth And Risk of Suicidal Ideation*, 145(2) PEDIATRICS e20191725 (2020), https:// www.ncbi.nlm.nih.gov/pmc/articles/PMC7073269; Anna I.R. van der Miesen, *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared With Cisgender General Population Peers*, 66(6) J. ADOLESCENT HEALTH 699–704 (2020); Diana M. Tordoff et al., *Mental Health Outcomes In Transgender And Nonbinary Youths Receiving Gender-Affirming Care*, 5(2) JAMA NETWORK OPEN e220978 (2022), https:/pubmed.ncbi.nlm.nih.gov/ 35212746/.

[57] *See, e.g.*, Achille, *supra* note 56; Luke R. Allen et al., *Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones*, 7(3) CLINICAL PRAC. PEDIATRIC PSYCH. 302 (2019), https://psycnet.apa.org/record/2019-52280-009; Diane Chen et al., *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, 388(3) NEJM 240–250 (2023); Diego Lopez de Lara et al., *Psychosocial Assessment in Transgender Adolescents*, 93(1) ANALES DE PEDIATRIA 41–48 (English ed. 2020), https://www.researchgate.net/publication/342652073; Vries, *Young Adult Psychological Outcome After Puberty Suppression And Gender Reassignment*, *supra* note 56; Rittakerttu Kaltiala et al., *Adolescent Development And Psychosocial Functioning After Starting Cross-Sex Hormones For Gender Dysphoria*, 74(3) NORDIC J. PSYCHIATRY 213 (2020); Kuper, *supra* note 56; Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, J. ADOLESCENT HEALTH (2021), https://www.jahonline.org/article/S1054-139X(21)00568-1/fulltext; Jack L. Turban et al., *Access To Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, J. PLOS ONE (2022), https://journals.plos.org/plosone/article?id=10.1371/ journal.pone.0261039.

hormone therapy, including statistically significant reductions in anxiety, depression, and suicidal ideation.[58]

For example, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically significant degree after receiving gender-affirming hormone treatment.[59] A study published in January 2023, following 315 participants age 12 to 20 who received gender-affirming hormone treatment, found that the treatment was associated with decreased symptoms of depression and anxiety.[60] Additionally, a 2020 study analyzed survey data from 89 transgender adults who had access to puberty blockers while adolescents and from more than 3,400 transgender adults who did not.[61] The study found that those who received puberty blocking treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support.[62] Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation.[63]

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[58] The data likewise indicates that adults who receive gender-affirming care experience positive mental health outcomes. *See, e.g.*, Zoe Aldridge et al., *Long Term Effect of Gender Affirming Hormone Treatment on Depression and Anxiety Symptoms in Transgender People*, 9 ANDROLOGY 1808–1816 (2021).
[59] *See* Allen, *supra* note 57.
[60] *See* Chen, *supra* note 57.
[61] *See* Turban, *supra* note 56.
[62] *See id*.
[63] *See id.*

Further, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with puberty blockers was associated with decreased depression and improved overall functioning.[64] A six-year follow-up study of 55 individuals from the 2011 study found that subsequent treatment with hormone therapy followed by surgery in adulthood was associated with a statistically significant decrease in depression and anxiety.[65] "Remarkably, this study demonstrated that these transgender adolescents and young adults had a sense of well-being that was equivalent or superior to that seen in age-matched controls from the general population."[66]

As clinicians and scientific researchers, *amici* always welcome more research, including on this crucial topic. However, the available data indicate that the gender-affirming medical care prohibited by the Healthcare Ban is effective for the treatment of gender dysphoria.

III. The State Relies on Factually Inaccurate Claims and Ignores the Recommendations of the Medical Community.

On October 28, 2022, the Boards held a workshop open to the public to discuss

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[64] *See* Vries, *Puberty Suppression in Adolescents with Gender Identity Disorder*, *supra* note 56.

[65] Vries, *Young Adult Psychological Outcome After Puberty Suppression And Gender Reassignment*, *supra* note 56.

[66] Stephen M. Rosenthal, *Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View*, 17(10) NATURE REV. ENDOCRINOLOGY 581, 586 (Oct. 2021), https://pubmed.ncbi.nlm.nih.gov/34376826.

the proposed development of the Healthcare Ban. The workshop included a discussion of the Division of Florida Medicaid's "Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria" (the "GAPMS Report").[67] The GAPMS Report asserts that puberty blockers, gender-affirming hormone therapy, and gender-affirming surgeries are not consistent with professional medical standards and that there is insufficient evidence that these interventions are safe and effective.[68] The State similarly posits in its appellate brief that the evidence upon which the Guidelines rely is unreliable.[69] However, these assertions are premised on speculative and discredited claims about gender dysphoria and mischaracterizations of the Guidelines and scientific research regarding these gender-affirming medical interventions.

A. There is No Evidence That Gender Dysphoria Can Be Caused by Underlying Mental Illness or "Social Contagion."

The GAPMS Report speculates that mental health concerns such as depression and anxiety may cause individuals to develop a gender identity that is

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[67] Available at: https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf (June 2, 2022). The GAPMS report also serves as the basis for Florida Administrative Code Rule 59G-1.010(7). This recently promulgated rule banned Florida Medicaid coverage for medical treatments of gender dysphoria, but it has been permanently enjoined. *See Dekker v. Weida*, 679 F. Supp. 3d 1271 (N.D. Fla. 2023), *appeal docketed*, No. 23-12155 (11th Cir. June 27, 2023).
[68] GAPMS Report, *supra* note 67, at 38.
[69] *See* Dkt. 51 at 7–9.

incongruent with their sex assigned at birth.[70] However, the report cites no evidence for this assertion, and the scientific research suggests that the reverse is true: research has shown that transgender individuals frequently experience discrimination, harassment, and even violence on account of their gender identity,[71] and that these experiences lead to mental health concerns, including, for example, depression and anxiety.[72]

The GAPMS Report also claims that exposure to "peer groups and social media that emphasized transgender lifestyles" can cause "rapid-onset gender dysphoria" in adolescents.[73] However, there is no credible evidence to support this argument. The term "rapid onset gender dysphoria" was coined in 2018 by the author of an anonymous survey of parents of transgender youth, who were recruited

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[70] GAPMS Report, *supra* note 67, at 6 (In light of the "number of adolescents who reported anxiety and depression diagnoses prior to transitioning," the GAPMS Report asserts that "available research raises questions as to whether [individuals'] distress is secondary to pre-existing behavioral health disorders[.]")

[71] *See, e.g.*, Rebecca L. Stotzer, *Violence Against Transgender People*, 14(3) AGGRESSION & VIOLENT BEHAV. 170–179 (2009); Joseph G. Kosciw et al., *The 2017 National School Climate Survey*, GLSEN, at 94 (2018), https://www.glsen.org/sites/default/files/2019-10/GLSEN-2017-National-School-Climate-Survey-NSCS-Full-Report.pdf; *see also* Amit Paley, *The Trevor Project 2020 National Survey*, https://www.thetrevorproject.org/survey-2020/ ("Discrimination & Physical Harm" section) (noting that 40% of transgender students reported being physically threatened or harmed due to their gender identity).

[72] *See* Rylan J. Testa et al., *Suicidal Ideation in Transgender People*, 126(1) J. ABNORMAL PSYCH. 125–136 (2017); Jessica Hunter et al., *Gender Minority Stress in Trans and Gender Diverse Adolescents and Young People*, 26(4) CLINICAL CHILD PSYCH. & PSYCHIATRY 1182–1195 (2021).

[73] GAPMS Report, *supra* note 67, at 12–13.

from websites that promote the belief that "social contagion" causes transgender identity.[74] The survey, which is the only source cited by the GAPMS Report in support of its claim, suffers from numerous flaws and has been widely discredited.[75] Moreover, the journal that published the survey subsequently published an extensive correction stating, among other things, that "[r]apid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis," and that the "report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon."[76] Significantly, the GAPMS Report does not cite or even mention this correction.[77]

Moreover, subsequent peer-reviewed research has not found support "for a

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[74] *Id.* at 12; Lisa Littman, *Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*. 14(3) PLOS ONE e0214157, at 2, 8–9 (Aug. 2018), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330.

[75] *See, e.g.*, Susan D. Boulware et al., *Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims*, 1, 18 (Apr. 28, 2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4102374.

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

[77] The GAPMS Report's reliance on the survey is puzzling because it states studies (such as surveys) that "rel[y] heavily" on participants' subjective responses "likely [have] biased and invalid" results. GAPMS Report, *supra* note 67, at 15.

new etiologic phenomenon of rapid onset gender dysphoria during adolescence."[78] On the contrary, one recent study showed that most adolescents—nearly 70%—referred to a clinic for puberty blockers or hormone therapy had known their gender was different from the one assigned at birth for three or more years.[79] The study also showed no correlation between recent gender knowledge (defined as two years or less having passed since you "realized your gender was different from what other people called you") and support from online friends or transgender friends.[80]

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

The GAPMS Report asserts that "the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex[.]"[81] However, the sources it cites in support of its "desistance" claim—an editorial written by James Cantor and an "assessment" that Cantor prepared for the Florida Agency for Healthcare Administration—state only that "desistance" is common among *prepubertal children* with gender dysphoria.[82] The GAPMS Report

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[78] Greta R. Bauer et al., *Do Clinical Data from Transgender Adolescents Support the Phenomenon of "Rapid Onset Gender Dysphoria"?*, 243 J. PEDIATRICS 224, 225–26 (2022), https://www.jpeds.com/article/S0022-3476(21)01085-4/pdf.
[79] *See id*. at 225 fig.
[80] *Id*. at 224–27.
[81] GAPMS Report, *supra* note 67, at 14.
[82] *See id.* at 20, 27–28, 39; James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. SEX & MARITAL THERAPY 307, 308–09 (2019), https://www.ohchr.org/sites/default/files/
(continued…)

improperly conflates prepubertal children with adolescents, which is an important distinction, as prepubertal children are not eligible under the Guidelines for any of the gender-affirming medical care prohibited by the Healthcare Ban.[83] The Guidelines endorse the use of this medical care only to treat adolescents and adults with gender dysphoria, and only when the relevant criteria are met.[84]

There are *no* studies to support the proposition that adolescents with gender dysphoria are likely to later identify as their sex assigned at birth, whether they receive treatment or not.[85] On the contrary, "[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult."[86]

Moreover, while detransitioning may occur for many reasons, detransitioning is not the same as regret. The State incorrectly assumes that an individual who

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Documents/Issues/SexualOrientation/IESOGI/Other/Rebekah_Murphy_20191214_JamesCantor-fact-checking_AAP-Policy.pdf; James M. Cantor, *The Science of Gender Dysphoria and Transsexualism* (May 17, 2022), GAPMS Report, *supra* note 67, Attach. D ¶¶ 14–16.

[83] *See* Boulware, *supra* note 75, at 18.

[84] *See* ES Guidelines, *supra* note 21, at 3871, 3879; WPATH Guidelines, *supra* note 21, at S32, S48.

[85] *See, e.g.*, Stewart L. Adelson, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Non-Conformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957, 964 (2020), https://pubmed.ncbi.nlm.nih.gov/22917211.

[86] Rosenthal, *supra* note 66, at 585.

detransitions—the definition of which varies from study to study[87]—must do so because they have come to identify with their sex assigned at birth. This ignores other, more common reported factors that contribute to a person's choice to detransition, such as pressure from parents and discrimination.[88]

In addition, while the percentage of adolescents seeking gender-affirming care has increased, that percentage remains very low—only 1.8% of high-school students identify as transgender.[89] Further, research supports that this increase in adolescents seeking care is very likely the result of reduced social stigma and expanded care options.[90]

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

Based on its unsupported claim that many adolescents with gender dysphoria will eventually come to identify as their sex assigned at birth, the GAPMS Report

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[87] Michael S. Irwig, *Detransition Among Transgender and Gender-Diverse People—An Increasing and Increasingly Complex Phenomenon*, J. CLINICAL ENDOCRINOLOGY & METABOLISM 1, 1 (June 2022), https://pubmed.ncbi.nlm.nih.gov/35678284 ("Detransition refers to the stopping or reversal of transitioning which could be social (gender presentation, pronouns), medical (hormone therapy), surgical, or legal.").

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

[89] *See* Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students–19 States and Large Urban School Districts, 2017*, HHS/CDC, 68 MORBIDITY & MORTALITY WKLY. REP. 67, 68 (2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6803a3-H.pdf.

[90] *See* Boulware, *supra* note 75, at 20.

questions the medical necessity of puberty blockers and hormone therapy for adolescents and suggests that a "watchful waiting" approach may be more appropriate. In this regard, some practitioners use a "watchful waiting" approach for *prepubertal* children with gender dysphoria, which involves waiting until the patient reaches adolescence before considering social transition.[91] However, "watchful waiting" is not recommended for adolescents with gender dysphoria.[92] It can cause immense harm by denying these patients the evidence-based treatments that could alleviate their distress, and forcing them to experience full endogenous puberty, resulting in physical changes that may be reversed—if at all—only through surgery.[93]

D. The Evidence Supporting Gender-Affirming Medical Care Is Consistent with the Type of Evidence Relied on in other Clinical Practices throughout the Medical Community.

The State argues that the "studies relied on by proponents of the treatments are ... exceedingly weak."[94] To conclude that these treatments are not supported by evidence ignores a significant body of research, including the research discussed in

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[91] AAP Policy Statement, *supra* note 5, at 4.
[92] *Id.*; WPATH Guidelines, *supra* note 21, at S112–113; *see also Brandt v. Rutledge*, 677 F. Supp. 3d 877, 905 (E.D. Ark. 2023) ("'Watchful waiting' ... [although] used by some health care providers with pre-pubertal children with gender dysphoria ... is not a recognized approach for adolescents with gender dysphoria."), *appeal docketed*, No. 23-2681 (8th Cir. July 21, 2023).
[93] AAP Policy Statement, *supra* note 5, at 4.
[94] Dkt. 51 at 9.

Section II.C above.

In criticizing the studies supporting gender-affirming medical care, the State refers to "high-quality" vs. "low-quality" studies under the GRADE system and the presence (or lack thereof) of randomized controlled trials ("RCTs").[95] Under the GRADE system, evidence may be assessed according to different categories, including "high," "moderate," "low," and "very low."[96] These are terms of art. "Low quality," which does not mean poor quality, generally refers to studies that were not RCTs, which are generally considered "high quality." To suggest that clinical practice predicated on anything but "high" quality evidence is unsafe or uncommon in the medical profession is simply false. Clinical practice across disciplines is commonly guided by evidence that various evidence grading systems might deem "lower quality."[97]

Moreover, with respect to RCTs, such trials are often impossible or unethical,

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[95] *See id.* at 7–9.

[96] *See* Gordon H. Guyatt et al., *GRADE: What Is "Quality of Evidence" and Why Is It Important to Clinicians?*, 336 BMJ 995 (2008); David Atkins et al., *Grading Quality of Evidence and Strength of Recommendations*, 328 BMJ 1490 (2004).

[97] For example, the American Heart Association's guideline for Pediatric Basic and Advanced Life Support includes 130 recommendations for pediatric care, only 1 of which is predicated on "high quality" evidence. Alexis A. Topjian et al., *Pediatric Basic and Advanced Life Support*, 142 CIRCULATION S469 (2020). The majority of the recommendations rely on what was deemed "limited" evidence. *Id.*

especially in the pediatric context.[98] In those instances, as here, clinicians rely on the best evidence possible and clinical experience to provide treatment for their patients. The evidence supporting gender-affirming medical care is consistent with the type of evidence relied on in other clinical practices throughout the medical community.[99]

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

The Healthcare Ban denies adolescents with gender dysphoria in Florida access to medical care that is designed to improve health outcomes and alleviate suffering and that is grounded in science and endorsed by the medical community. The gender-affirming medical care prohibited by the Healthcare Ban can be a crucial part of treatment for transgender adolescents with gender dysphoria and necessary

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[98] *See, e.g.*, Sari L. Reisner et al., *Advancing Methods for U.S. Transgender Health Research*, 23(2) CURR. OPIN. ENDOCRINAL DIABETES OBES. 198, 199 (2016); Richard J. Lilford & Jennifer Jackson, *Equipoise and the Ethics of Randomization*, 88 J. R. SOC. MED. 552, 552 (1995). Moreover, the ability to perform RCTs is complicated where participants may easily discern trial placement due to biological changes from treatment.

[99] *Amici* also are aware of the systematic review submitted to NHS England. *See* Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People*, Cass Review (Apr. 2024), https://perma.cc/A8UR-Q2WD (the "Cass Review"). However, the Cass Review, like other systematic reviews, is simply a summary of some of the existing research, as selected by the author. It does not purport to offer any new studies or findings regarding the efficacy and safety of prescribing gender-affirming medical care for adolescents that conflict with the recommendations in the Guidelines, which themselves are based on the available existing studies and research, as well as clinical experience. *See* Endocrine Soc'y, *supra* note 51.

to preserve their health. Clinicians who are members of the relevant *amici* associations have witnessed the benefits of this treatment as well as the harm that results when such treatment is denied or delayed.

As discussed above, research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life.[100] In light of this evidence supporting the connection between lack of access to gender-affirming medical care and lifetime suicide risk, banning such care can put patients' lives at risk.

CONCLUSION

For the foregoing reasons, the district court's order granting the permanent injunction should be affirmed.

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[100] *See* M. Hassan Murad et al., H*ormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72(2) CLINICAL ENDOCRINOLOGY 214 (Feb. 2010), https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x; *see also* Turban, *supra* note 56.

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CERTIFICATE OF COMPLIANCE

1. I certify that this brief complies with the type-volume limitations set forth in FRAP 32(a)(7)(B)(i). This brief contains 6,480 words, including all headings, footnotes, and quotations, and excluding the parts of the response exempted under FRAP 32(f).

2. In addition, this brief complies with the typeface and type style requirements of FRAP 32(a)(5) and (6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Times New Roman font.

/s/ Cortlin H. Lannin
Cortlin H. Lannin

CERTIFICATE OF SERVICE

I hereby certify that on October 9, 2024, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to counsel of record.

/s/ Cortlin H. Lannin
Cortlin H. Lannin