No. 23-477

In the Supreme Court of the United States

UNITED STATES OF AMERICA,

Petitioner,

v.

JONATHAN SKRMETTI, ATTORNEY GENERAL AND REPORTER FOR TENNESSEE, *et al.*,

Respondents.

On Writ of Certiorari to the
United States Court of Appeals for the Sixth Circuit

BRIEF OF ALABAMA AS *AMICUS CURIAE* SUPPORTING STATE RESPONDENTS

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INTEREST OF *AMICUS CURIAE*

Like Tennessee and half the other States,[1] Alabama determined that sex-change procedures should not be made available to kids. That legislative determination should not be controversial. Until a few years ago, the notion of providing sex-change procedures to children was practically unthinkable. So was the idea that the judiciary is the best branch to sort through the evidence and decide that kids suffering from gender dysphoria must be allowed to take powerful hormones that risk permanently changing their bodies and leaving them sterilized.

How did we get here? Alabama has at least part of the answer. Through years of litigation defending its own age limits against challenges by private plaintiffs and the United States, Alabama has exposed a medical, legal, and political scandal that will be studied for decades to come. The federal government, "social justice lawyers" from prominent activist organizations, and self-appointed experts at the World Professional Association for Transgender Health (WPATH) conspired to abolish age limits for sterilizing chemical treatments and surgeries. Central to their strategy was the WPATH Standards of Care 8 (SOC-8)[2]—a purportedly evidence-based set of recommendations that would be used by their lawyers to convince courts to enshrine in law the previously unimaginable.

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[1] Equality Map (Oct. 10, 2024), https://perma.cc/L46X-NSUR.

[2] Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. OF TRANSGENDER HEALTH (2022).

Their job wasn't easy. When WPATH hired Johns Hopkins to review the evidence behind permanently altering children's bodies to address gender confusion, the team "found little to no evidence about children and adolescents," a fact shared with (and privately acknowledged by) the federal government.[3] Perhaps for that reason, WPATH suppressed publication of most of those reviews. Some SOC-8 authors opted to conduct no systematic evidence reviews precisely because doing so would "reveal[] little or no evidence and put[] us in an untenable position in terms of affecting policy or winning lawsuits."[4] And after finalizing SOC-8, WPATH shared a copy with Admiral Rachel Levine, the Assistant Secretary for Health at the U.S. Department of Health and Human Services. Levine demanded that WPATH remove from the guideline *all* age limits for chemical treatments, chest surgeries, and even surgeries to remove children's genitals. After some initial consternation "about allowing US politics to dictate international professional clinical guidelines,"[5] WPATH obliged.

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[3] *See* Defs' Ex. 173 at 22, *Boe v. Marshall*, 2:22-cv-184 (M.D. Ala.), Doc. 560-23.

Throughout this brief, Alabama will reference evidence and briefing it submitted to the district court. Citations will be by exhibit number (or brief title) followed by the docket entry in parenthesis and the internal page number following the colon. *E.g.*, Ex.173(Doc.560-23):22-23. For ease of reference, cited exhibits and briefing are available online:
https://www.alabamaag.gov/boe-v-marshall/.

[4] Ex.174(Doc.560-24):1-2.

[5] Ex.186(Doc.700-15):32.

The strategy for "winning lawsuits" was initially a success. Like Tennessee, Alabama had its law preliminarily enjoined.[6] And like Tennessee, Alabama had its legislative determination overruled by the United States' appeal to the imprimatur of WPATH. While acknowledging that "[k]nown risks" of transitioning treatments "include loss of fertility and sexual function," the Alabama court dismissed the Legislature's concerns with two words: "Nevertheless, WPATH."[7] "Nevertheless," the court said, "WPATH recognizes transitioning medications as established medical treatments," and interest groups like the American Medical Association and the American Academy of Pediatrics "endorse" the WPATH "guidelines as evidence-based methods for treating gender dysphoria in minors."[8] Because Alabama did not defer to those guidelines, the court held, its law to the contrary had to be enjoined.[9]

Alabama later obtained discovery from WPATH and HHS to test the court's deference.[10] Since Alabama's case was about a year ahead of Tennessee's, discovery in Alabama was winding down when the

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[6] *See Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131 (M.D. Ala. 2022), *rev'd sub nom. Eknes-Tucker v. Governor of Ala.*, 80 F.4th 1205 (11th Cir. 2023), *reh'g en banc denied*, 114 F.4th 1241 (11th Cir. 2024).

[7] *Eknes-Tucker*, 603 F. Supp. 3d at 1139.

[8] *Id.*

[9] *Id.* at 1145, 1148.

[10] *See* Order, *Boe v. Marshall*, 2:22-cv-184 (M.D. Ala. Mar. 27, 2023), Doc.263 (ordering WPATH to produce discovery), Doc.261 (ordering HHS to produce discovery).

Sixth Circuit ruled in *Skrmetti*. As Alabama noted at the time, the United States was a party in both cases and knew from its overlapping attorneys that Alabama's case would soon be headed to trial on a fully developed record.[11] Yet the Department of Justice seemed to strategically choose to seek certiorari in a case with only a preliminary record and no discovery—and then tried to shut down discovery in Alabama on the basis that it had merely filed a cert petition here.[12] Fortunately, the court in Alabama denied the United States' motion and allowed discovery to conclude. Alabama then moved for summary judgment (proceedings are now stayed pending the Court's decision here), and the court unsealed portions of the evidentiary exhibits.

The new evidence suggests clear reasons for why the United States acted as it did—and why it continues to oppose unsealing other evidence Alabama received. Discovery uncovered that not only does the WPATH emperor have no clothes but that senior HHS officials and "social justice lawyers" acted as the organization's tailor. Alabama submits this brief to discuss just some of that evidence showing why the Court should not constitutionalize the WPATH standards.

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[11] *See* Brief of Alabama as *Amicus Curiae* at 1-2, No. 23-477, *United States v. Skrmetti* (U.S. Feb. 2, 2024).

[12] *See* United States' Mot. to Stay All District Court Proceedings, *Boe*, 2:22-cv-184 (M.D. Ala. Dec. 4, 2023), Doc. 387.

SUMMARY OF ARGUMENT

As part of her independent review for England's National Health Service, Dr. Hilary Cass commissioned a team of researchers to assess the various guidelines for treating gender dysphoria in minors. They found that all the guidelines that recommended sex-change procedures for minors flunked the "bedrock" criterion of developmental rigor.[13] The researchers also found that those guidelines were really WPATH's all the way down: WPATH authored the initial guideline, which other groups used as the basis for their recommendations, which WPATH then cited as "evidence" for the next edition of its guideline.[14] "The circularity of this approach," Dr. Cass concluded, "may explain why there has been an apparent consensus on key areas of practice despite the evidence being poor."[15]

There is another "circularity" at work. While the United States points to WPATH's "evidence-based guidelines" to support its disagreement with Tennessee's law, U.S.Br.3, it fails to disclose its own role in the creation of those guidelines—and that its interference caused WPATH authors to complain of "making changes based on current US politics."[16]

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[13] *Cass Review* 126-30 (Apr. 2024), https://perma.cc/3QVZ-9Y52.

[14] *Id.*; *see* Taylor, *Clinical Guidelines for Children and Adolescents*, ARCH. DIS. CHILD 6 (2024), https://perma.cc/2NWP-XKBJ.

[15] *Cass Review*, *supra* note 13, at 130.

[16] Ex.186(Doc.700-15):32.

The United States also ignores its recent and unexplained about-face regarding sex-change surgeries on children. Two years ago, the United States sought to enjoin Alabama's age limits on sex-change surgeries, alleging that for some children "surgery is essential and medically necessary to alleviate gender dysphoria."[17] But then on June 25, 2024, reporting showed that Biden Administration officials had pressured WPATH to remove age limits from its guideline.[18] A few days later, the United States declared that it now also "oppose[s] gender-affirming surgery for minors."[19] Having read the political winds (and reasonably concluded that it didn't wish to bring a surgery case to this Court), the United States glides over its significant departure from SOC-8, which continues to recommend transitioning surgeries like orchiectomy (removal of testicles) and vaginoplasty (inversion of penis to create faux vagina) for minors.[20] Likewise, the United States never explains why age limits for sterilizing surgeries are okay, while age limits for sterilizing chemical treatments are not.

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[17] U.S. Am. Compl., *Boe*, 2:22-cv-184 (M.D. Ala. May 4, 2022), Doc.92 ¶39.

[18] Ghorayshi, *Biden Officials Pushed to Remove Age Limits for Trans Surgery*, N.Y. TIMES (June 25, 2024), https://www.nytimes.com/2024/06/25/health/transgender-minors-surgeries.html.

[19] Rabin, *Biden Administration Opposes Surgery for Transgender Minors*, N.Y. TIMES (June 28, 2024), https://www.nytimes.com/2024/06/28/health/transgender-surgery-biden.html.

[20] *See* SOC-8, *supra* note 2, at S48.

The United States is also mum about other influences on SOC-8. As it learned in discovery (if not before), some WPATH authors, acting on the advice of "social justice lawyers we spoke with," intentionally chose *not* to seek a systematic review of the evidence before making treatment recommendations.[21] The reason? Because "evidence-based review reveals little or no evidence and puts us in an untenable position in terms of affecting policy or winning lawsuits."[22] Other contributors drew on their experiences as expert witnesses in cases like this one to suggest removing "language such as 'insufficient evidence,' 'limited data,' etc." that could "empower" groups "trying to claim that gender-affirming interventions are experimental."[23] The WPATH Board also had litigation in mind, commissioning one of the plaintiff's lawyers in Alabama's case to conduct a legal review of SOC-8.[24] As a former president of WPATH explained, such review was "necessary" "because we will have to argue it in court at some point."[25] So they have. *See* Amicus Br. of AAP, WPATH et al. 8 (asking Court to defer to WPATH guideline).

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[21] Ex.174(Doc.560-24):1-2.

[22] *Id.*

[23] Ex.184(Doc.700-13):55.

[24] *See* SOC-8, *supra* note 2, at S177 (thanking Jennifer Levi for offering "Legal Perspectives"); Jennifer Levi, *GLAD, Legal Advocates & Defenders*, https://www.glad.org/staff/jennifer-levi/.

[25] Ex.182(Doc.700-11):152.

Then there is the lack of evidence underlying the United States' preferred guideline. The federal government promises that SOC-8 is "evidence-based." U.S.Br.3. But well before the United States made that representation, officials at HHS received word from the SOC-8 evidence review team that it "found little to no evidence about children and adolescents"—and that WPATH was "trying to restrict [its] ability to publish" the findings.[26] The United States wrote back to confirm: "Knowing that there is little/no evidence about children and adolescents is helpful."[27] Yet when seeking certiorari, the United States said the exact opposite, assuring this Court that giving gender dysphoric kids "puberty blockers and hormones" was supported by "overwhelming evidence." U.S.Pet.7.

The WPATH scandal confirms the wisdom of leaving policy disagreements to political branches. When courts transfer political power from legislatures to self-appointed experts, they don't end political disputes; they just move them from democratically accountable bodies to opaque institutions. And by conferring such power on these "expert" groups, courts incentivize turning those institutions into sites and then "weapons of political warfare" for those seeking "victories" in court "that elude[] them in the political arena."[28] Power is still exercised, but it's less clear who is pulling the levers, how, or why. That lack of accountability here led to serious abuses, helping

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[26] Ex.173(Doc.560-23):22-23.

[27] *Id.* at 22.

[28] *Alexander v. S.C. State Conf. of the NAACP*, 144 S. Ct. 1221, 1236 (2024).

create what Dr. Cass described as the only "area of paediatric care where we give young people a potentially irreversible treatment and have no idea what happens to them in adulthood."[29]

Yet the United States and WPATH press on, pretending the science is settled, the debate over. They assure anxious parents that sex-change procedures are the only way to help their 13-year-old daughter feeling uncomfortable in her body, and they pose impossible questions to kids who must decide whether to alter their bodies and risk their future fertility by treating their psychological ailments with hormones and surgeries—all before they are old enough to vote. Thankfully, the Tennessee Legislature acted. Kids suffering from gender dysphoria deserve better. In areas like this, "legislative options must be especially broad and courts should be cautious not to rewrite legislation."[30] The Constitution does not mandate that States bow to the dictates of radical interest groups like WPATH. The Court should affirm.

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[29] Abbasi, *"Medication is Binary,"* BMJ (Apr. 2024).

[30] *Marshall v. United States*, 414 U.S. 417, 427 (1974).

ARGUMENT

The United States tells the Court that WPATH is "the leading association of medical professionals treating transgender individuals" and that its SOC-8 is "the accepted standard of care for treating gender dysphoria." U.S.Br.3. But the United States has long known there is much more to the story. It could tell how the United States and "social justice lawyers" influenced the SOC-8 for political ends. How WPATH failed to follow the principles of evidence-based medicine it told the world it obeyed. How WPATH has long prioritized advocacy over scientific inquiry. But the United States stays silent because episodes like these reveal just how empty is its argument that the Constitution empowers groups like WPATH, rather than the open political process, to regulate medicine.

I. WPATH, Joined By The United States And "Social Justice Lawyers," Crafted SOC-8 As A Political And Legal Document.

WPATH published Standards of Care 8 in September 2022. Dr. Eli Coleman, a sexologist at the University of Minnesota, chaired the guideline committee, and WPATH hired an outside evidence-review team, led by Dr. Karen Robinson at Johns Hopkins University, to conduct systematic evidence reviews for authors to use in formulating their recommendations.[31] Two WPATH presidents, Dr. Walter Bouman, a clinician at the Nottingham Centre for Transgender Health in England, and Dr. Marci Bowers, a surgeon

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[31] WPATH, *SOC8 Contributors*, https://perma.cc/X48V-9T8K; SOC-8, *supra* note 2, at S248-49.

in California who has performed over 2,000 transitioning vaginoplasties, oversaw development and publication of the guideline.

A. WPATH Used SOC-8 to Advance Political and Legal Goals.

WPATH selected 119 authors—all existing WPATH members—to contribute to SOC-8.[32] According to Dr. Bowers, it was "important" for each author "to be an advocate for [transitioning] treatments before the guidelines were created."[33] Many authors regularly served as expert witnesses to advocate for sex-change procedures in court; Dr. Coleman testified that he thought it was "ethically justifiable" for those authors to "advocate for language changes [in SOC-8] to strengthen [their] position in court."[34] Other contributors seemed to concur. One wrote: "My hope with these SoC is that they land in such a way as to have serious effect in the law and policy settings that have affected us so much recently; even if the wording isn't quite correct for people who have the background you and I have."[35] Another chimed in: "It is abundantly clear to me when I go to court on behalf of TGD [transgender and gender-diverse] individuals" that "[t]he wording of our section for Version 7 has been

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[32] SOC-8, *supra* note 2, at S248-49; *see* Ex.21(Doc.700-3):201:2–223:24.

[33] Ex.18(Doc.564-8):121:7-11; *Boe*.Reply (Doc.700-1):33.

[34] Ex.21(Doc.700-3):158:17-25.

[35] Ex.184(Doc.700-13):24.

critical to our successes, and I hope the same will hold for Version 8."[36]

Perhaps for this reason—and because it knew that "we will have to argue it in court at some point"[37]—WPATH commissioned a legal review of SOC-8 and was in regular contact with movement attorneys.[38] Dr. Bouman noted the oddity: "The SOC8 are clinical guidelines, based on clinical consensus and the latest evidence based medicine; [I] don't recall the Endocrine Guidelines going through legal reviews before publication, or indeed the current SOC?"[39] When informed by Dr. Coleman that "[w]e had agreed long ago that we would send [the SOC-8 draft] … for legal review," Dr. Bouman replied that he would "check what Rachel Levine's point of view is on these issues" when he met with the Assistant Secretary for Health the following week.[40] The WPATH Executive Committee discussed various options for the review—"ideas; ACLU, TLDEF, Lambda Legal…"[41]—before apparently settling on the senior director of transgender and queer rights at GLAD (now counsel for the plaintiffs in Alabama's case) to conduct the review.[42]

Authors were also explicit in their desire to tailor SOC-8 to ensure coverage for an "individual's

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[36] Ex.184(Doc.700-13):15.

[37] Ex.182(Doc.700-11):152.

[38] Ex.4(Doc.557-4):vi.

[39] Ex.182(Doc.700-11):151.

[40] *Id.* at 150-51.

[41] Ex.184(Doc.700-13):14.

[42] SOC-8, *supra* note 2, at S177; *see supra* note 24.

embodiment goals,"[43] whatever they might be. As Dr. Dan Karasic, one of the plaintiffs' experts in Alabama's case, explained to other SOC-8 authors: "Medical necessity is at the center of dozens of lawsuits in the US right now,"[44] "one or more of which could go to the Supreme Court[] on whether trans care is medically necessary vs. experimental or cosmetic. I cannot overstate the importance of SOC 8 getting this right at this important time."[45] Another author was more succinct: "[W]e need[] a tool for our attorneys to use in defending access to care."[46]

WPATH thus included a whole section in SOC-8 on "medical necessity" and took to heart Dr. Karasic's advice to list the "treatments in an expansive way."[47] It assigned the designation to a whole host of interventions, including but "not limited to hysterectomy," with or without "bilateral salpingo-oophorectomy"; "bilateral mastectomy, chest reconstruction or feminizing mammoplasty"; "phalloplasty and metoidioplasty, scrotoplasty, and penile and testicular prostheses, penectomy, orchiectomy, vaginoplasty, and vulvoplasty"; "gender-affirming facial surgery and

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[43] Ex.180(Doc.700-9):11.

[44] *Id.* at 64.

[45] Ex.181(Doc.700-10):43.

[46] *Id.* at 75.

[47] *Id.* at 66; *see also id.* at 1 (Another author commented: "In essence, the [medical necessity statement] should apply to any trans and gender diverse person, independent of age [and independent of diagnosis]. The problem is—of course—as we all know—that medical practice is based on a diagnosis … so—being a pragmatic person, if anyone can think of a way of avoiding the use of diagnostic criteria please come with suggestions ….").

body contouring"; and "puberty blocking medication and gender-affirming hormones."[48]

One author aptly concluded of the statement: "I think it is clear as a bell that the SOC8 refers to the necessity of treatment (in its broadest sense) for their gender dysphoria (small 'd'); because it refers to the symptom of distress—which is a very very very broad category and one that any 'goodwilling' clinician can use for this purpose (or: in the unescapable medical lingo we, as physicians are stuck with: those who fulfil a diagnosis of Gender Dysphoria and Gender Incongruence as per APA/WHO)."[49]

WPATH also made sure to sprinkle the "medically necessary" moniker throughout the guideline, even when doing so revealed it had put the cart before the horse. The adolescent chapter, for instance, notes that "[a] key challenge in adolescent transgender care is the quality of evidence evaluating the effectiveness of medically necessary gender-affirming medical and surgical treatments,"[50] but WPATH never pauses to ask (or answer) how such treatments can be considered "medically necessary" if the "quality of evidence" supporting their use is so deficient. At least some authors tacitly acknowledged the question and made sure they wouldn't have to answer it—by following the advice of "social justice lawyers" to avoid conducting systematic evidence reviews lest they "reveal[] little or no evidence and put[] us in an untenable position

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[48] SOC-8, *supra* note 2, at S18.

[49] Ex.181(Doc.700-10):36 (second closed parenthesis added).

[50] SOC-8, *supra* note 2, at S45-46.

in terms of affecting policy or winning lawsuits."[51] Others just sought to massage the guideline's language to avoid "empower[ing]" those concerned that the evidence did not support transitioning treatments,[52] all while authors and WPATH leaders raised such concerns internally.[53]

B. The United States Used SOC-8 to Advance Political and Legal Goals.

Outside political actors also influenced SOC-8. Most notably, Admiral Rachel Levine, the Assistant Secretary for Health at HHS, met regularly with WPATH leaders, "eager to learn when SOC 8 might be published."[54] According to one WPATH member who met with Levine, "[t]he failure of WPATH to be ready with SOC 8 [was] proving to be a barrier to optimal policy progress" for the Biden Administration.[55]

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[51] Ex.174(Doc.560-24):1-2.

[52] Ex.184(Doc.700-13):55.

[53] *E.g.*, Ex.176(Doc.700-5):67-68 (Dr. Bowers admitting that "no long-term studies" exist for puberty blockers); Ex.180(Doc.700-9):21 (author admitting that "most of the recommendation statements in SOC8 are not PICO format"—meaning were not supported by systematic evidence reviews—"but consensus based or based on weak evidence"); Ex.180(Doc.700-9):63 (WPATH leader: "My understanding is that a global consensus on 'puberty blockers' does not exist"); *see generally* Ex.4(Doc.557-4):i-iv.

[54] Ex.184(Doc.700-13):54. Evidence indicates that Levine met or communicated with WPATH leaders about SOC-8 on August 12, August 26, and November 22, 2021; and May 2, May 31, June 10, July 1 (at least Levine's chief of staff), July 26, August 5, August 8, and September 3, 2022. *See Boe.*Reply (Doc.700-1) at 61 n.145 (collecting sources).

[55] Ex.184(Doc.700-13):54.

Another member reported: "I am meeting with Rachel Levine and her team," "as the US Department of Health is very keen to bring the trans health agenda forward."[56]

A few months before SOC-8 was to be published in September 2022 (and long after the public comment period had closed that January[57]), WPATH sent Admiral Levine an "Embargoed Copy – For Your Eyes Only" draft of SOC-8 that had been "completed" and sent to the publisher for proofreading and typesetting.[58] The draft included a departure from Standards of Care 7, which, except for so-called "top surgeries," restricted transitioning surgeries to patients who had reached the "[a]ge of majority in a given country."[59] (That guidance was not generally followed by American surgeons affiliated with WPATH—including Dr. Bowers—but that was the guidance.[60]) The draft SOC-

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[56] Ex.185(Doc.700-14):1.

[57] *See* Ex.187(Doc.700-16):4-5.

[58] Ex.170(Doc.700-4):61-64.

[59] Coleman, *Standards of Care, Version 7*, 13 INT'L J. OF TRANSGENDERISM 1, 25-27 (2012), https://perma.cc/T8J7-W3WC.

[60] According to a 2017 paper published by Dr. Karasic, over half of the WPATH-affiliated surgeons surveyed said they "[p]erformed vaginoplasty on [a] transgender minor" in the United States, despite SOC-7 requiring surgeons to "defer orchiectomy and/or vaginoplasty until 18 years of age." Milrod & Karasic, *Age is Just a Number*, 14 J. SEXUAL MED. 624, 625-26 (2017). Dr. Bowers admitted to first performing a "trans-feminine vaginoplasty" "on a patient younger than 18" in "the late 2000s." Ex.18(Doc.564-8):34:19-24. Bowers performed the surgery before knowing of *any* medical literature discussing clinical outcomes of transitioning surgeries for minors. *Id.* at 34:19–36:25. Bowers

8 relaxed the age minimums: 14 for cross-sex hormones, 15 for "chest masculinization" (i.e., mastectomy), 16 for "breast augmentation, facial surgery (including rhinoplasty, tracheal shave, and genioplasty)," 17 for "metoidioplasty, orchiectomy, vaginoplasty, hysterectomy and fronto-orbital remodeling," and 18 for "phalloplasty."[61] Each recommendation was paired with a qualifier that could allow for surgery at an even earlier age: "unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame."[62]

After reviewing the draft, Admiral Levine's office contacted WPATH at the beginning of July with a political concern: that the listing of "specific minimum ages for treatment," "under 18, will result in devastating legislation for trans care."[63] Admiral Levine's chief of staff suggested that WPATH hide the recommendations by removing the age limits from SOC-8 and creating an "adjunct document" that could be "published or distributed in a way that is less visible."[64] WPATH leaders met with Levine and HHS officials to discuss

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said it was a "chicken and the egg question" about whether "evidence from adult populations" applied to minors, so someone would have to perform the surgery on a minor to find out if it is a good idea to perform the surgery on a minor. *Id.* Yet Bowers did not conduct the surgery as part of a formal research protocol and never published any findings about how the patient fared. *Id.*; *Boe*.Reply(Doc.700-1):18 n.31.

[61] Ex.170(Doc.700-4):143.

[62] *Id.*

[63] Ex.186(Doc.700-15):28.

[64] *Id.* at 29.

the age recommendations.[65] According to a WPATH participant, Levine "was very concerned that having ages (mainly for surgery) will affect access to health care for trans youth … and she and the Biden administration worried that having ages in the document will make matters worse."[66] Levine's solution was simple: "She asked us to remove them."[67]

The authors of the adolescent chapter wrestled with how to respond to the request:

- "I really think the main argument for ages is access/insurance. So the irony is that the fear is that ages will spark political attacks on access. I don't know how I feel about allowing US politics to dictate international professional clinical guidelines that went through Delphi."[68]
- "I need someone to explain to me how taking out the ages will help in the fight against the conservative anti trans agenda."[69]
- "I'm also curious how the group feels about us making changes based on current US politics…. I agree about listening to Levine."[70]
- "I think it's safe to say that we all agree and feel frustrated (at minimum) that these political

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[65] *See* Ex.186(Doc.700-15):11, 17; Ex.21(Doc.700-3):287:5–288:6.

[66] Ex.186(Doc.700-15):11.

[67] *Id.*

[68] *Id.* at 32.

[69] *Id.*

[70] *Id.*

> issues are even a thing and are impacting our own discussions and strategies."[71]

WPATH initially told Levine that it "could not remove [the age minimums] from the document" because the recommendations had already been approved by SOC-8's "Delphi" consensus process.[72] (Indeed, Dr. Coleman said that consensus was "[t]he only evidence we had" for the recommendations.[73]) But, WPATH continued, "we heard your comments regarding the minimal age criteria" and, "[c]onsequently, we have made changes to the SOC8" by downgrading the age "recommendation" to a "suggestion."[74] Unsatisfied, Levine immediately requested—and received—more meetings with WPATH.[75]

Following Levine's intervention, and days before SOC-8 was to be published, pressure from the American Academy of Pediatrics (AAP) tipped the scales when it threatened to oppose SOC-8 if WPATH did not remove the age minimums.[76] WPATH leaders initially balked. One of the co-chairs of SOC-8 complained that "[t]he AAP guidelines … have a very weak methodology, written by few friends who think the same,"[77]

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[71] *Id.* at 33.

[72] *Id.* at 17.

[73] *Id.* at 57.

[74] *Id.* at 17.

[75] *See* Ex.18(Doc.564-8):226:8–229:18; *Boe.*MSJ(Doc.619):20; Ex.186(Doc.700-15):73, 88-91; *supra* note 54.

[76] Ex.187(Doc.700-16):13-14, 109 ("The AAP comments asked us to remove age[s]").

[77] *Id.* at 100.

while Dr. Bouman "struggle[d] to find any sound evidence-based argument(s)" in AAP's comments and was "surprised that a 'reputable' association as the AAP is so thin on scientific evidence."[78] But then the political reality set in: AAP was "a MAJOR organization," and "it would be a major challenge for WPATH" if AAP opposed SOC-8.[79] WPATH thus caved and "agreed to remove the ages."[80]

Thanks to the Biden Administration and AAP, SOC-8 does not contain age minimums for any transitioning hormonal or surgical intervention except for one: phalloplasty, the surgical creation of a neopenis. "Given the complexity of" that procedure, SOC-8 states, "it is not recommended this surgery be considered in youth under 18 at this time."[81] WPATH considers all other surgeries and interventions "medically necessary gender-affirming medical treatment[s] in adolescents."[82]

That is concerning enough. But perhaps even more worrisome is what the episode revealed. *First*, it showed that both the United States and AAP sought, and WPATH agreed, to make changes in a clinical

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[78] *Id.* at 107.

[79] *Id.* at 191.

[80] *Id.* at 338. SOC-8 was initially published with the age minimums intact, so WPATH had to quickly issue a "correction" to remove them. *See Correction*, 23 INT'L J. OF TRANSGENDER HEALTH S259 (2022), https://perma.cc/4342-KFEN. Remarkably, WPATH then had the correction itself removed. *See Statement of Removal*, https://bit.ly/3qSqC9b.

[81] SOC-8, *supra* note 2, at S66.

[82] *See* SOC-8, *supra* note 2, at S66.

guideline recommending irreversible sex-change procedures *for kids* based purely on political considerations. Dr. Coleman was clear in his deposition that WPATH removed the age minimums "without being presented any new science of which the committee was previously unaware."[83] In fact, despite assuring that "formal consensus for *all* statements was obtained using the Delphi process (a structured solicitation of expert judgments [of its contributing authors] in three rounds),"[84] WPATH did not send the last-minute change through Delphi.[85] Instead, it treated its decision as "highly, highly confidential."[86]

Second, as soon as WPATH made the change, it began covering it up. Rather than explaining what *actually* happened, WPATH leaders promptly sought for "all [to] get on the same exact page, and PRONTO."[87] Dr. Bowers encouraged contributors to submit to "centralized authority" so there would not be "differences that can be exposed."[88] "[O]nce we get out in front of our message," Bowers urged, "we all need to support and reverberate that message so that the misinformation drone is drowned out."[89]

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[83] Ex.21(Doc.700-3):293:25–295:16.

[84] SOC-8, *supra* note 2, at S250 (emphasis added).

[85] Ex.21(Doc.700-3):293:25–295:16 (Dr. Coleman: "[W]e did not submit that change to Delphi at the end.").

[86] Ex.188(Doc.700-17):152.

[87] *Id.* at 120.

[88] Ex.177(Doc.700-6):124.

[89] *Id.* at 119.

Having decided the strategy, Bowers then crafted the message, circulating internally the "gist of my[] response to Reuters" about the missing age minimums: "[S]ince the open comment period, a great deal of input has been received and continued to be received until the final release. [I] feel the final document puts the emphasis back on individualized patient care rather than some sort of minimal final hurdle that could encourage superficial evaluations and treatments."[90] Another leader responded: "I like this. Exactly—individualized care is the best care—that's a positive message and a strong rationale for the age change."[91] Apparently, it didn't matter that the explanation itself could be considered "misinformation"; as Dr. Bowers explained in a similar exchange, "it is a balancing act between what i feel to be true and what we need to say."[92]

Third, when evidence of Levine's tinkering became public,[93] the federal government immediately flipped positions and "opposed gender-affirming surgery for

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[90] Ex.188(Doc.700-17):113.

[91] *Id.*

[92] Ex.177(Doc.700-6):102. At deposition, Bowers performed another "balancing act," proclaiming that WPATH "opted to remove" the age minimums to "fall back to the more conservative SOC-7 language" that expressly prohibited most surgeries for adolescents. *See* Ex.18(Doc.564-8):115:15-16; *Boe*.Reply(Doc.700-1):2. That is an interesting position given that SOC-8 expressly *recommends* surgeries like "orchiectomy, vaginoplasty, hysterectomy, phalloplasty, [and] metoidioplasty" that SOC-7 prohibited. SOC-8, *supra* note 2, at S48.

[93] Ghorayshi, *supra* note 18.

minors."[94] But it has yet to explain either (1) its past support for such surgeries (even to the point of pressuring WPATH (and suing Alabama) to make them available for kids of any age),[95] or (2) its current disagreement with the very guideline it tells this Court is evidence-based and "reflect[s] the accepted standard of care for treating gender dysphoria." U.S.Br.3.

Given that WPATH's hormonal and surgical recommendations for adolescents are in the same chapter and based on much of the same evidence, this is a serious problem for the United States. Either WPATH is reliable when it says that surgeries are "medically necessary" for gender dysphoric adolescents, or it is not. If the United States agrees with the WPATH position, it should say so—and then explain whether it thinks a public hospital's decision to limit "penile-inversion vaginoplasty" surgeries to males would be a sex-based classification warranting heightened scrutiny. And if it disagrees with WPATH's recommendation, it should explain why it has nonetheless suggested the guideline to the Court as the constitutional standard—and why it believes the federal government can take and leave parts of that standard but Tennessee cannot. Either way, the United States owes the Court an explanation.

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[94] Rabin, *supra* note 19.

[95] U.S. Am. Compl., *supra* note 17, ¶39 ("surgery is essential and medically necessary to alleviate gender dysphoria").

II. WPATH Did Not Follow The Principles Of Evidence-Based Medicine It Said It Followed.

At the back of SOC-8 is an appendix with the methodology WPATH said it employed.[96] It is this appendix that the "Clinical Practice Guideline Experts" rely on—"exclusively"—to assure the Court that "WPATH's process for developing SOC8 was transparent, rigorous, iterative, and methodologically sound." *See* Brief of *Amici Curiae* Clinical Practice Guideline Experts at 6, 8 n.17.[97] Among other things, the appendix states that WPATH managed conflicts of interest, used the GRADE framework to tailor recommendation statements based on the strength of evidence, and engaged the Johns Hopkins evidence review team to conduct systematic literature reviews and create evidence tables for use in SOC-8.[98] Discovery revealed a different story.

A. WPATH Failed to Properly Manage Conflicts of Interest.

WPATH cites two international standards it said it used to manage conflicts of interest: one from the

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[96] *See* SOC-8, *supra* note 2, at S247-51.

[97] *Amici*'s purportedly blind reliance on WPATH's appendix is curious because at least two of the *amici*—Dr. Goodman and Dr. Lightdale—serve as expert witnesses for the plaintiffs in Alabama's case and were confronted months ago with evidence that WPATH did *not* do what it said it did. *See generally* Ex.69(Doc.564-26); Ex.74(Doc.564-32); *Boe* Mot. to Exclude Testimony of Dr. Lightdale (Doc.606-3); *Boe* Mot. to Exclude Testimony of Dr. Goodman (Doc.606-4).

[98] SOC-8, *supra* note 2, at S247-50.

National Academies of Medicine and the other from the World Health Organization.[99] Both standards generally recognize that the experts best equipped for creating practice guidelines are those at arm's length from the services at issue—sufficiently familiar with the topic, but *not* professionally engaged in performing, researching, or advocating for the practices under review.[100] Dr. Cass is a good example: When appointed to conduct the review for England's National Health Service, she was a well-respected pediatrician, but not one who made a living by providing transitioning treatments to minors.[101]

At the same time, the standards recognize that a guideline committee typically benefits from *some* involvement by clinicians who provide the services at issue.[102] Accordingly, they suggest ways for committees

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[99] *Id.* at S247.

[100] *Id.*; Institute of Medicine (National Academies of Medicine), *Clinical Practice Guidelines We Can Trust* 81-93 (2011), https://perma.cc/7SA9-DAUM; World Health Organization, *Handbook for Guideline Development* 19-23 (2012).

[101] Though Dr. Cass is a good example of a disinterested expert used to evaluate an area of medicine she does not make a living by providing, it is important to note that the Cass Review itself is not a clinical guideline and does not pretend to be. *See* Cheung, *Gender Medicine and the Cass Review: Why Medicine and the Law Make Poor Bedfellows*, ARCH. DIS. CHILD 1-2 (Oct. 2024), https://perma.cc/X7CH-NM7U (responding to critiques of the Cass Review by Dr. Meredithe McNamara and others, *see* Br. for *Amici Curiae* Expert Researchers and Physicians).

[102] Institute of Medicine, *supra* note 100, at 83 (recognizing that "a [guideline development group] may not be able to perform its work without members who have [conflicts of interest], such as

to benefit from conflicted clinicians while limiting their involvement. The standard from the National Academies, for instance, recommends that "[m]embers with [conflicts of interest] should represent *not more than a minority* of the [guideline development group]."[103]

Yet aside from citing them in its methodology section, it appears that WPATH largely ignored these standards. From the get-go, it expressly limited SOC-8 authorship to existing WPATH members—clinicians and other professionals (and non) who were *already* enthusiastic about transitioning treatments.[104] Dr. Coleman testified that it was "not unusual at all" "for participants in the SOC-8 process to have many published articles already on topics relating to gender dysphoria."[105] Dr. Bowers agreed it was "important for someone to be an advocate for [transitioning] treatments before the guidelines were created."[106]

Dr. Bowers's involvement in SOC-8 offers a good illustration of the lack of real conflict checks. According to the National Academies, a "conflict of interest" is "[a] divergence between an individual's private interests and his or her professional obligations such that an independent observer might reasonably

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relevant clinical specialists who receive a substantial portion of their incomes from services pertinent to the [clinical practice guidelines]")

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

[104] SOC-8, *supra* note 2, at S248; *see* Ex.21(Doc.700-3):201:2–223:24.

[105] Ex.21(Doc.700-3):228:14-19.

[106] Ex.18(Doc.564-8):121:7-11; *Boe.*Reply(Doc.700-1):34.

question whether the individual's professional actions or decisions are motivated by personal gain, such as financial, academic advancement, clinical revenue streams, or community standing."[107] Bowers should have been subject to that standard, serving not only as a member of the Board that oversaw and approved SOC-8 but as an author of the chapter tasked with evaluating the evidence for transitioning surgeries.

So it is notable that Bowers made "more than a million dollars" last year from providing transitioning surgeries, but said it would be "absurd" to consider that a conflict worth disclosing or otherwise accounting for as part of SOC-8.[108] That was WPATH's public position as well: It assured readers that "[n]o conflicts of interest were deemed significant or consequential" in crafting SOC-8.[109]

Privately, WPATH leaders knew everything was not up to par. Dr. Coleman admitted at his deposition that "most participants in the SOC-8 process had financial and/or nonfinancial conflicts of interest."[110] Another author agreed: "Everyone involved in the SOC process has a non-financial interest."[111] Dr. Robinson, the chair of the Johns Hopkins evidence review team, said the same: She "expect[ed] many, if not most, SOC-8 members to have competing

[107] Institute of Medicine, *supra* note 100, at 78.

[108] Ex.18(Doc.564-8):37:1-13, 185:25–186:9; *Boe*.Reply(Doc.700-1):34-35.

[109] SOC-8, *supra* note 2, at S177.

[110] Ex.21(Doc.700-3):230:17-23.

[111] Ex.174(Doc.560-24):7.

interests."[112] Robinson even had to inform WPATH—belatedly—that "[d]isclosure, and any necessary management of potential conflicts, should take place *prior* to the selection of guideline members."[113] "Unfortunately," she lamented, "this was not done here."[114] No matter: SOC-8 proclaims the opposite ("Conflict of interests were reviewed as part of the selection process"[115]), and Dr. Coleman testified that he did not know of any author removed from SOC-8 due to a conflict.[116]

B. WPATH Was Not Transparent in How It Used GRADE.

WPATH boasted that it used a process "adapted from the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) framework" for "developing and presenting summaries of evidence" using a "systematic approach for making clinical practice recommendations."[117] According to WPATH, Dr. Robinson's evidence review team was to conduct systematic evidence reviews, "assign[] evidence grades using the GRADE methodology," and "present[] evidence tables and other results of the systematic review" to SOC-8 authors.[118]

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[112] Ex.166(Doc.560-16):1.

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

[114] *Id.*

[115] SOC-8, *supra* note 2, at S177.

[116] Ex.21(Doc.700-3):232:13-15.

[117] SOC-8, *supra* note 2, at S250.

[118] *Id.* at S249-50.

Chapter authors were then to grade the recommendation statements based on the evidence.[119] Per WPATH, "strong recommendations"—"we recommend"—were only for situations where "the evidence is high quality," "a high degree of certainty [that] effects will be achieved," "few downsides," and "a high degree of acceptance among providers."[120] On the other hand, "[w]eak recommendations"—"we suggest"—were for when "there are weaknesses in the evidence base," "a degree of doubt about the size of the effect that can be expected," and "varying degrees of acceptance among providers."[121] To "help readers distinguish between recommendations informed by systematic reviews and those not," recommendations were to "be followed by certainty of evidence for those informed by systematic literature reviews":

++++	strong certainty of evidence
+++	moderate certainty of evidence
++	low certainty of evidence
+	very low certainty of evidence[122]

The reality did not match the promise. To begin, as Dr. Coleman wrote, "we were not able to be as systematic as we could have been (e.g., we did not use GRADE explicitly)."[123] Dr. Karasic, the chair of the mental health chapter, testified that rather than

[119] *Id.* at S250.

[120] *Id.*

[121] *Id.*

[122] WPATH, *Methodology for the Development of SOC8*, https://perma.cc/QD95-754H (last visited Oct. 13, 2024).

[123] Ex.190(Doc.700-18):8; *see* Ex.182(Doc.700-11):157-58.

relying on systematic reviews, some drafters simply "used authors … we were familiar with."[124]

WPATH also decided not to differentiate "between statements based on [literature reviews] and the rest,"[125] and ordered the removal of all notations disclosing the quality of evidence for each recommendation. A draft of the hormone chapter illustrates the change and its import. The chapter had initially offered a "weak recommendation" ("we suggest") based on low-quality evidence ("++") that clinicians prescribe cross-sex hormones to gender dysphoric adolescents, "preferably with parental/guardian consent."[126]

At first, WPATH seemed to just remove the evidence notations. But then the recommendations themselves appeared to morph from weak ("we suggest") to strong ("we recommend"). So it was in the adolescent chapter, where all but one recommendation is now "strong"[127]—even as those recommendations are surrounded by admissions that "[a] key challenge in adolescent transgender care is the quality of evidence," with "the numbers of studies … still [so] low" that "a systematic review regarding outcomes of treatment in adolescents" is purportedly "not possible."[128]

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[124] Ex.39(Doc.592-39):66:2–67:5.

[125] Ex.182(Doc.700-11):62; *see* Ex.9(Doc.700-2):¶¶29-36, 43-47.

[126] Ex.182(Doc.700-11):5; *see id.* at 1-40; Ex.9(Doc.700-2):¶¶29-36, 43-47.

[127] SOC-8, *supra* note 2, at S48.

[128] *Id.* at S46-47. In fact, as the United States' expert Dr. Antommaria testified, "a systematic review is always possible." Ex.43(Doc.557-43):134:25–135:3. But WPATH may have had

And so it was in the hormone chapter, where the final version of the above statement transformed into a strong "we recommend."[129]

While this mismatch may not seem like a big deal, the difference between a "strong" and "weak" recommendation is extremely important, particularly when it comes to life-altering interventions like cross-sex hormones. Under GRADE, "low" or "very-low" quality evidence means, respectively, that the true effect of the medical intervention may, or is likely to be, "substantially different" from the estimate of the effect based on the evidence available.[130] Thus, given that the estimated effect is therefore likely to be *wrong* for very low-quality evidence, it is imperative for clinicians to know the quality of evidence supporting a treatment recommendation—and why, with certain exceptions not applicable here, evidence-based medicine warns against "strong" recommendations based

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other incentives for its statement: One of the literature reviews that Johns Hopkins was able to publish—discussed more below, *supra* II.C—found that "[a]mong adolescents" there was "no difference in [quality of life] scores after a year of endocrine interventions" and determined that the "strength of evidence" in this area was "low." Baker, *Hormone Therapy, Mental Health, and Qualify of Life*, 5 J. ENDOCRINE SOC'Y 1, 8 (2021). WPATH strongly recommends the interventions anyway. *See* SOC-8 at S111.

[129] SOC-8, *supra* note 2, at S111.

[130] Balshem, *GRADE Guidelines*, 64 J. CLINICAL EPIDEMIOL. 401, 404 (2011), https://perma.cc/2KDY-6BW5. Given this definition, it is perhaps unsurprising that for all its emphasis (at 20) on GRADE categories having "highly technical meanings," the Brief for *Amici Curiae* Expert Researchers never tells the Court just what "low quality" and "very-low quality" means.

on low-quality evidence.[131] So it is a big deal indeed that WPATH promised clinicians that it followed this system when it actually eschewed transparency and made "strong" recommendations regardless of the evidence.

C. WPATH Hindered Publication of Evidence Reviews.

Though the SOC-8 authors and their advocacy allies didn't seem to have much use for them,[132] the Johns Hopkins evidence review team "completed and submitted reports of reviews (dozens!) to WPATH" for SOC-8.[133] The results were concerning. In August 2020, the head of the team, Dr. Robinson, wrote to the Agency for Healthcare Research and Quality at HHS about their research into "multiple types of interventions (surgical, hormone, voice therapy…)."[134] She reported: "[W]e found little to no evidence about children and adolescents."[135] HHS wrote back: "Knowing that there is little/no evidence about children and adolescents is helpful."[136]

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[131] Yao, *Discordant and Inappropriate Discordant Recommendations*, BMJ (2021), https://perma.cc/W7XN-ZELX.

[132] As of May 2024, Dr. Bowers—the current president of WPATH who regularly publicly advocates for transitioning treatments (and surgeries) for kids—*still* had not seen any evidence reviews conducted for SOC-8. Ex.18(Doc.564-8):185:4-6, 292:12–293:10; *Boe*.Reply(Doc.700-1):58.

[133] Ex.173(Doc.560-23):22-25.

[134] *Id.* at 24.

[135] *Id.* at 22.

[136] *Id.*

Dr. Robinson also informed HHS that she was "having issues with this sponsor"—WPATH—"trying to restrict our ability to publish."[137] Days earlier, WPATH had rejected Robinson's request to publish two manuscripts because her team failed to comply with WPATH's policy for using SOC-8 data.[138] Among other things, that policy required the team to seek "final approval" of any article from an SOC-8 leader.[139] It also mandated that authors "use the Data for the benefit of advancing transgender health in a positive manner" (as defined by WPATH) and "involve[] at least one member of the transgender community in the design, drafting of the article, and the *final approval* of the article."[140] Once those boxes were checked, the WPATH Board of Directors had final authority on whether the manuscript could be published.[141]

This is an alarming amount of editorial control over publication of a systematic review, the entire purpose of which is to provide an objective and neutral review of the evidence. But WPATH justified its oversight by reasoning that it was of "paramount" importance "that any publication based on WPATH SOC8 data [be] thoroughly scrutinized and reviewed to ensure that publication does not negatively affect the provision of transgender healthcare in the

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[137] *Id.*

[138] Ex.167(Doc.560-17):86-88.

[139] *Id.* at 75-81.

[140] *Id.* at 37 (emphasis added).

[141] *Id.* at 38.

broadest sense" (again, as WPATH defined it).[142] But to make the process *appear* neutral, WPATH imposed one last requirement: Authors had to "acknowledge[]" in their manuscript that they were "solely responsible for the content of the manuscript, and the manuscript does not necessarily reflect the view of WPATH."[143]

WPATH eventually allowed the Johns Hopkins team to publish two of its manuscripts. (It's still unclear what happened to the others.[144]) The team dutifully reported that the "authors"—not WPATH—were "responsible for all content."[145]

D. WPATH Recommends Castration as "Medically Necessary" for "Eunuchs."

As if to drive home how unscientific the SOC-8 enterprise was, WPATH included an entire chapter on "eunuchs"—"individuals assigned male at birth" who "wish to eliminate masculine physical features, masculine genitals, or genital functioning."[146] Because eunuchs "wish for a body that is compatible with their eunuch identity," WPATH recommends "castration to better align their bodies with their gender identity."[147]

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[142] *Id.* at 91.

[143] *Id.* at 38.

[144] *Cf.* Ex.167(Doc.560-17):91 ("We were caught on the wrong foot when the Johns Hopkins University Team informed us of wanting to publish 3 papers based on the SOC8 data….").

[145] Baker, *supra* note 128, at 3; *see* Wilson, *Effects of Antiandrogens on Prolactin Levels Among Transgender Women*, 21 INT'L J. OF TRANSGENDER HEALTH 391, 392 (2020).

[146] SOC-8, *supra* note 2, at S88.

[147] *Id.* at S88-89.

That's not an exaggeration. When asked at his deposition whether "in the case of a physically healthy man with no recognized mental health conditions and who presents as a eunuch seeking castration, but no finding is made that he's actually at high risk of self-castration, nevertheless, WPATH's official position is that that castration may be a medically necessary procedure?", Dr. Coleman confirmed: "That's correct."[148]

Dr. Coleman also admitted that no diagnostic manual recognizes "eunuch" as a medical or psychiatric diagnosis.[149] And other SOC-8 authors criticized the chapter as "very high on speculation and assumptions, whilst a robust evidence base is largely absent."[150] Dr. Bowers even admitted that not every board member read the chapter before approving it for publication.[151] No matter: The guideline the United States says States must adopt officially recommends castration for men and boys who identify as "eunuch."

And how did WPATH learn that castration constitutes "medically necessary gender-affirming care"?[152] From the internet—specifically a "large online peer-support community" called the "Eunuch Archive."[153] According to SOC-8 itself, the "Archive" contains "the greatest wealth of information about contemporary

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[148] Ex.21(Doc.700-3):172:19–173:25.

[149] *Id.*

[150] Ex.182(Doc.700-11):96.

[151] Ex.18(Doc.564-8):147:9–148:4; *Boe*.MSJ(Doc.619):16.

[152] SOC-8, *supra* note 2, at S88.

[153] *Id.*

eunuch-identified people."[154] The guideline does not disclose that part of the "wealth" comes in the form of the Archive's fiction repository, which hosts thousands of stories that "focus on the eroticization of child castration" and "involve the sadistic sexual abuse of children."[155] "The fictional pornography" "includes themes such as Nazi doctors castrating children, baby boys being fed milk with estrogen in order to be violently sex trafficked as adolescents, and pedophilic fantasies of children who have been castrated to halt their puberty."[156]

Despite all this, the medical interest groups supporting Petitioner still claim that the WPATH guideline "follow[ed] the same types of processes … as other guidelines promulgated by *amici* and other medical organizations." Br. of AAP et al. 15. Let's hope not.

III. WPATH Acts Like An Advocacy Organization, Not A Medical One.

As is clear by now, though WPATH cloaks itself in the garb of evidence-based medicine, its heart is in advocacy. (Indeed, in its attempt to avoid discovery into its "evidence-based" guideline, WPATH told the district court in Alabama it was just a "nonparty advocacy organization[]."[157]) That was evident after SOC-8 was published, when Dr. Coleman circulated an

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[154] *Id.*

[155] Gluck, *Top Trans Medical Association Collaborated With Castration, Child Abuse Fetishists*, REDUXX (May 17, 2022), https://perma.cc/5DWF-MLRU.

[156] *Id.*

[157] Mot. to Quash at 3, *Boe*, 2:22-cv-184 (M.D. Ala. Dec. 27, 2022), Doc.208.

internal "12-point strategic plan to advance gender affirming care."[158] He began by identifying "attacks on access to trans health care," which included (1) "academics and scientists who are naturally skeptical," (2) "parents of youth who are caught in the middle of this controversy," (3) "continuing pressure in health care to provide evidence-based care," and (4) "increasing number of regret cases and individuals who are vocal in their retransition who are quick to blame clinicians for allowing themselves to transition despite an informed consent process."[159]

To combat these "attacks" from "evidence-based medicine" and aggrieved patients, Dr. Coleman encouraged WPATH to ask other medical organizations to formally endorse SOC-8. He noted that the statement "that the SOC has so many endorsements has been an extremely powerful argument" in court, particularly given that "[a]ll of us are painfully aware that there are many gaps in research to back up our recommendations."[160] Problem was, Dr. Coleman "ha[d] no idea how it was ever said that so many medical organizations ha[d] endorsed" the standards.[161] He suspected that organizations had only "referenced" the guideline, but "never formally endorsed" it.[162]

Dr. Coleman and other WPATH leaders thus made a concerted effort to obtain formal endorsements from

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[158] Ex.190(Doc.700-18):5 (capitalization altered).

[159] *Id.*; *see* Ex.16(Doc.557-16):¶103.

[160] Ex.190(Doc.700-18):5-6.

[161] *Id.*

[162] *Id.* at 6 (spelling corrected).

other organizations. At his deposition in May 2024, Dr. Coleman knew of only two organizations that had endorsed SOC-8: the World Association for Sexual Health and the International Society for Sexual Medicine.[163] The AAP, Dr. Coleman said, rejected WPATH's request.[164] So did the American Medical Association, which told WPATH that it "does not endorse or support standards of care—that falls outside of our expertise."[165] (That didn't stop AMA from filing an amicus brief here based on its purported "specific expertise." *See* Br. of AAP et al. 1-2.) The response caused Dr. Bouman to complain that the AMA is run by "white cisgender heterosexual hillbillies from nowhere."[166]

Then there is WPATH's response to the Cass Review. Rather than embracing one of "the most comprehensive, evidence-based reviews of a medical service from the long history of such independent investigations" in the UK,[167] WPATH seems to view NHS England and the Cass Review as simply more "attacks on access to trans health care." In its public "comment on the Cass Review," for instance, WPATH defends SOC-8 against the Review's harsh assessment by boasting that its guideline was "based on far more systematic

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[163] Ex.21(Doc.700-3):261:5-12, 262:4-8; *see* Ex.190(Doc.700-18):6.

[164] Ex.21(Doc.700-3):261:20-23 ("the American Academy of Pediatrics has never endorsed SOC-8"); Ex.188(Doc.700-17):152.

[165] Ex.189(Doc.560-39):15.

[166] *Id.* at 13; Ex.21(Doc.700-3):259:4-10.

[167] Cheung, *supra* note 101, at 2.

reviews tha[n] the Cass Review."[168] That may or may not be true—Dr. Robinson did say her team had conducted "dozens!" of reviews—but it's a rich claim for WPATH to make given that it went to such great lengths to restrict its own evidence review team from publishing its findings; WPATH did not otherwise make a *single* review or evidence table from SOC-8 available to the public; and SOC-8 states that WPATH found insufficient evidence to even conduct a systematic review for the adolescent chapter. By contrast, the six systematic evidence reviews and two appraisals of international clinical guidelines conducted through an open procurement process by the University of York for the Cass Review are freely available in the peer-reviewed *Archives of Disease in Childhood*.[169] WPATH's critique of the Cass Review is simply not serious.

It is also not unusual. WPATH has long sought to ensure that only one side of the story is told, and it critiques or silences those who offer opposing viewpoints to the public.[170] For instance, at its inaugural conference in 2017, USPATH—WPATH's U.S. affiliate—bowed to the demands of trans-activist protestors and cancelled a panel presentation by a respected researcher, Dr. Ken Zucker, who attempted to present research showing that most children with gender

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[168] WPATH and USPATH Comment on the Cass Review (May 17, 2024), https://perma.cc/B2TU-ALSR.

[169] And online: https://adc.bmj.com/pages/gender-identity-service-series.

[170] *See generally* Ex.16(Doc.557-16).

dysphoria have the dysphoria "desist" by adulthood.[171] A few years later, USPATH formally censured its president, Dr. Erica Anderson, for publicly discussing concerns about "sloppy" care resulting from gender dysphoric youth being "[r]ushed through the medicalization" of transitioning treatments.[172] WPATH even issued a formal statement "oppos[ing] the use of the lay press … as a forum for the scientific debate" over "the use of puberty delay and hormone therapy for transgender and gender diverse youth."[173] As Dr. Bowers explained it: "[T]he public … doesn't need to sort through all of that."[174]

The result of WPATH's flavor of advocacy has been predictable. One of the authors of SOC-8's adolescent chapter was prescient in her concern: "My fear is that if WPATH continues to muzzle clinicians and relay the message to the public that they have no right to know about the debate, WPATH will become the bad guy and not the trusted source."[175]

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[171] *See* Ex.16(Doc.557-16):¶¶9-13; Ex.39(Doc.592-39):187:23–188:5; Ex.178(Doc.700-7):5.

[172] Ex.176(Doc.700-5):107, 113-14; Ex.16(Doc.557-16):¶¶14-17; Shrier, *Top Trans Doctors Blow the Whistle on "Sloppy" Care*, THE FREE PRESS (Oct. 4, 2021), https://perma.cc/R7M3-XTQ3.

[173] Joint Letter from USPATH and WPATH (Oct. 12, 2022), https://perma.cc/X7ZN-G6FS.

[174] Ex.18(Doc.564-8):287:18-22; *Boe.*MSJ(Doc.619):22.

[175] Ex.176(Doc.700-5):152.

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Much more could be said about how untrustworthy the United States' favorite medical organization is.[176] But it is worth emphasizing that WPATH's insistence on advocacy over patient welfare has a human cost that its own leaders have seen firsthand. As Dr. Bowers recounted in a private email to other WPATH leaders (apologizing for going public with concerns about puberty blockers):

> Like my [female genital mutilation] patients who had never experienced orgasm, the puberty blockaded kids did not know what orgasm might feel like and most experienced sensation to their genitalia no differently than if it had been a finger or a portion of their thigh.… My concern culminated during a presurgical evaluation on a young trans girl from a highly educated family whose daughter responded when I asked about orgasm, "what is that?" The parents countered with, "oh honey, didn't they teach you that in school?" I felt that our informed consent process might not be enough.… It occurred to me that how could anyone truly know how important sexual function was to a relationship, to happiness? It isn't an easy question to answer….[177]

So it isn't. That is why States routinely set age limits on risky endeavors, be it driving a car, buying a beer,

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[176] *See* Brief of Alabama, *supra*, at 9-24; *Boe*.Reply(Doc.700-1):20-80.

[177] Ex.176(Doc.700-5):68.

or consenting to a hysterectomy. Undergoing sex-change procedures is no different. As Dr. Coleman privately recognized, "at their age – they would not know what they want."[178]

CONCLUSION

The Court should affirm the judgment of the court of appeals.

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[178] Ex.180(Doc.700-9):59.