

**IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION**

AUGUST DEKKER, *et al.*,

Plaintiffs,

v.

Case No. 4:22-cv-00325-RH-MAF

JASON WEIDA, in his official
capacity as Secretary of the
Florida Agency for Healthcare
Administration, *et al.*,

Defendants.

_____ /

**DR. JAY W. RICHARDS' MOTION FOR LEAVE
TO APPEAR AS AMICUS CURIAE IN SUPPORT OF
DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

Jay W. Richards, Ph.D, respectfully requests leave to appear as amicus curiae in support of Defendants' Motion for Summary Judgment. The proposed brief is attached to this motion.

Identity and Interest of Amicus Curiae

As amicus curiae, Dr. Richards proposes to offer this Court a unique perspective based on real-world experience that will assist this Court in resolving the important legal issues presented in this case. Dr. Richards' amicus brief will lay

bare the fallacies in Plaintiffs' legal, factual, and scientific positions, which Plaintiffs have inaccurately presented to this Court as beyond dispute.

Dr. Richards is a scholar and researcher who focuses on medical and public policy issues involving gender dysphoria. Dr. Richards is the director of the Richard and Helen DeVos Center for Life, Religion, and Family and the William E. Simon Senior Research Fellow in Religious Liberty and Civil Society at The Heritage Foundation. He is also a senior fellow at the Discovery Institute and Executive Editor of *The Stream*.

Dr. Richards is the author or editor of more than a dozen books, including the New York Times bestsellers *Infiltrated* (2013) and *Indivisible* (2012); *The Human Advantage; Money, Greed, and God* (2009), winner of a 2010 Templeton Enterprise Award; *The Hobbit Party* (2014) with Jonathan Witt; and *Eat, Fast, Feast* (2020). Dr. Richards's articles and essays have been published in *The Harvard Business Review*, *Wall Street Journal*, *Barron's*, *Washington Post*, *The New York Post*, *Newsweek*, *Forbes*, *Fox News*, *National Review Online*, *The Hill*, *Investor's Business Daily*, *Washington Times*, *The Philadelphia Inquirer*, *The Huffington Post*, *The Federalist*, *The Daily Caller*, and many other publications. His work has been covered widely in publications such as *The New York Times*, *The Washington Post*, *The Wall Street Journal*, *The Washington Times*, *Nature*, *Science*,

Astronomy, Physics Today, The Chronicle of Higher Education, and Congressional Quarterly Researcher.

Through his amicus brief, Dr. Richards seeks to provide the Court the benefit of his extensive research in this field, and specifically to demonstrate that the scientific debate is far from settled regarding the efficacy and propriety of pediatric use of puberty blockers, hormonal treatments, and gender re-assignment surgeries. Dr. Richards will also discuss the experience learned from systemic reviews launched by the official health systems of multiple European countries regarding the treatment of minors facing gender dysphoria. Finally, Dr. Richards will discuss critical misunderstandings that frequently arise in debates about gender dysphoria treatments.

Memorandum of Law

This Court should grant Dr. Richards leave to appear as amicus curiae in support of Defendants' Motion for Summary Judgment. Dr. Richards' scholarly interests and experience are relevant to the issues before the Court, and he is in a unique position to provide helpful insight and argument related to those issues. Along with Defendants' Motion for Summary Judgment, the proposed amicus brief will demonstrate that Florida's challenged policy is rooted in sound judgment, and reflects a reasonable—and indeed, mainstream—position in light of the current state of the scientific debate surrounding gender dysphoria treatment.

This Court possesses “the inherent authority to appoint ‘friends of the court’ to assist in their proceedings.” *In re Bayshore Ford Trucks Sales, Inc.*, 471 F.3d 1233, 1249 n.34 (11th Cir. 2006); *accord Resort Timeshare Resales, Inc. v. Stuart*, 764 F.Supp. 1495 (SD. Fla. 1991) (district courts possess inherent authority and discretion to permit participation by amicus curiae). As amicus curiae, Dr. Richards would “participate[] solely for the benefit of the court” as the Court resolves the important issues before it. *Lathrop v. Unidentified, Wrecked & Abandoned Vessel*, 817 F.Supp. 953, 961 (M.D. Fla. 1993).

“Courts have recognized that permitting friends of the court may be advisable where the third parties can contribute to the court’s understanding of the matter in question.” *Conservancy of Sw. Fla. v. U.S. Fish & Wildlife Serv.*, 2:10-cv-00106-FTM-SPC, 2010 WL 3603276, at *1 (M.D. Fla. Sept. 9, 2010). Thus, district courts in Florida routinely recognize the propriety and helpfulness of amicus briefs. *See, e.g., Vazzo v. City of Tampa*, Case No. 8:17-cv-02896-T-36AAS, 2018 WL 1629216, at *6 (M.D. Fla. Mar. 15, 2018) (allowing amicus brief that would provide a “helpful, alternative viewpoint” to the Court’s resolution of the issues); *Brenner v. Scott*, 298 F.R.D. 689, 691–92 (N.D. Fla. 2014) (granting leave to “file a memorandum as amicus curiae on any motion” and noting that while intervention was improper, the movant’s “view as amicus will be welcome”); *A.R. v. Dudek*, No. 13-61576-CIV, 2014 WL 12519764, at *4 (S.D. Fla. Apr. 7, 2014) (explaining that

the Court did not wish to deny proposed intervenor “a voice” or to “extinguish any potential value that its independent investigation into the matter may bring,” and therefore granting permission to “file amicus curiae memoranda as they become relevant”); *Friends of Everglades, Inc. v. S. Fla. Water Mgmt. Dist.*, No. 02-80309-CIV, 2005 WL 8160352, at *1 (S.D. Fla. Nov. 1, 2005) (“Movants’ brief, submitted with their Motion, was timely filed and Movants’ ability to inform the Court concerning their interpretation of the legal issues presented will not harm the adjudication of the summary judgment motions currently before the Court.”).

This Court previously denied motions for leave to file amicus briefs at the preliminary injunction stage “based solely on timing,” and directed “any further proposed amicus brief” to be “submitted by not later than the deadline for the corresponding filing of the party whose position the amicus seeks to support.” ECF No. 43. The instant motion for leave satisfies this requirement, as it (including the accompanying amicus brief) is filed not later than the deadline for Defendants’ motion for summary judgment. *See also Friends of the Everglades, Inc.*, 2005 WL 8160352, at *1 (accepting “timely filed” amicus brief filed alongside motion for leave).

In sum, Dr. Richards’ participation as amicus curiae “would provide the court with [a] ‘helpful, alternative viewpoint’ without causing undue delay or prejudice of the original parties’ rights,” but instead, will “allow the original parties to run their

own case while still permitting [Dr. Richards] to present [his] viewpoint and legal arguments on the matters central to this lawsuit.” *Vazzo*, 2018 WL 1629216 at *6.

Conclusion

In consideration of the important legal issues in this case, the unique interests and experiences of the proposed amicus curiae, and the relevance of the proposed amicus brief, Jay W. Richards, Ph.D, respectfully requests leave to appear as amicus curiae in support of Defendants’ Motion for Summary Judgment.

Certificate of Conferral

Counsel for the proposed amicus curiae have conferred with counsel for all parties regarding the relief sought in this motion. Plaintiffs stated that they “will consent/not oppose the filing” of this brief and will “defer to the court’s discretion on whether the amicus briefs are desirable or proper.” Defendants consent to the requested relief.

Certificate of Word Count

The undersigned certifies that this motion contains 1,082 words.

Dated April 7, 2023.

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, *et al.*,

Plaintiffs,

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JASON WEIDA, *et al.*,

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**BRIEF OF SCHOLAR JAY W. RICHARDS, PH.D.,
AS AMICUS CURIAE IN SUPPORT OF
DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

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IDENTITY AND INTEREST OF AMICUS¹

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

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

Dr. Richards's articles and essays have been published in *The Harvard Business Review*, *Wall Street Journal*, *Barron's*, *Washington Post*, *The New York Post*, *Newsweek*, *Forbes*, *Fox News*, *National Review Online*, *The Hill*, *Investor's Business Daily*, *Washington Times*, *The Philadelphia Inquirer*, *The Huffington Post*, *The Federalist*, *The Daily Caller*, and many other publications. His work has been covered widely in publications such as *The New York Times*, *The Washington Post*, *The Wall Street Journal*, *The*

¹ No party or counsel for any party has authored this brief in whole or in part, nor made any monetary contribution to fund the preparation or submission of this brief.

Washington Times, Nature, Science, Astronomy, Physics Today, The Chronicle of Higher Education, and Congressional Quarterly Researcher.

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

SUMMARY

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

While the Plaintiffs claim a supposed consensus of the “mainstream medical community,”² that consensus is merely the agreement of Plaintiffs’ cherry-picked medical trade groups—none of whom have the unique authority to define the status of scientific evidence. Moreover, it is not clear that these statements even accurately represent the views of members of these organizations.

² Pls.’ Mot. For Preliminary Injunction at 26, ECF No. 11.

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

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

Here at home, the federal government has also been cautious. In 2020, the U.S. Department of Health and Human Services, despite its recent advocacy of “gender-

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

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

affirming care,” noted that the “medical community is divided on many issues related to gender identity, including the value of various ‘gender-affirming’ treatments for gender dysphoria (especially for minors).”⁵ And four years earlier, under the Obama Administration, the U.S. Centers for Medicare and Medicaid Services (“CMS”) concluded that “there is not enough high quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria.”⁶

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

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

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

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

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

Another common myth is that regret and change of course amongst patients subjected to these body- and life-altering treatments are extremely rare. While the Plaintiffs would like to ignore or downplay the existence of such “detransitioners,” their numbers are growing.

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

ARGUMENT

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

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

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

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

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

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

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

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

For the medical industry, this is a gold mine. It’s no wonder that a new industry has emerged to service such demands—including a huge spike in gender surgeries for minors in recent years. Data published in the *Annals of Plastic Surgery* found a thirteen-fold increase in “gender affirming” mastectomies between 2013 and 2020.¹¹ Meanwhile, the number of U.S. clinics that focus on providing hormones and surgeries for minors has surged from one in 2007 to at least 80 today.¹² And evidence suggests that such clinics are fast-tracking children to more aggressive treatments faster than

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

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

before. In a study of teens at Seattle Children’s Hospital’s gender clinic, two-thirds of teens were taking hormones within one year of their initial visit.¹³

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

Over the past 20 to 30 years, several countries in northern Europe have practiced “affirming care” to treat gender dysphoria. This includes the use of social transitioning, puberty blockers, and gender-transition surgeries for minors. The United Kingdom, Sweden^{14,15} and Finland¹⁶ practiced affirmative medicine until they noticed the major

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

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

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

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

increase of teenagers, especially girls with co-existing mental health problems, dominating their clinics. Similar trends have appeared in the United States, according to data published in peer-reviewed journals and, more recently, by Reuters.¹⁷

These European nations responded by conducting systematic reviews of the evidence. They each found that the available evidence did not show the benefits of these procedures outweighed the risks. As a result, they have shifted to a much more conservative approach. The U.K. closed its main pediatric gender clinic—Tavistock¹⁸—in the wake of a critical review.¹⁹ The country’s National Health Service acknowledged that gender dysphoria may be a “transient phase” for many minors with symptoms of gender dysphoria or confusion.²⁰ What’s more, it recognized the “lack of clinical consensus and polarized opinion on what the best model of care for children and young

¹⁷ Chad Terhune, et al., “As More Transgender Children Seek Medical Care, Families Confront Many Unknowns,” *Reuters* (Oct. 6, 2022): <https://www.reuters.com/investigates/special-report/usa-transyouth-care/>.

¹⁸ Jasmine Andersson & Andre Rhoden-Paul, “NHS to close Tavistock child gender identity clinic,” *BBC News* (July 28, 2022), at: <https://www.bbc.com/news/uk-62335665>.

¹⁹ The Cass Review: Independent review of gender identity services for children and young people: Interim report (February 2022), at: <https://cass.independent-review.uk/publications/interim-report/>.

²⁰ NHS England. Interim service specification: specialist service for children and young people with gender dysphoria (phase 1 providers) (October 2022): https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/user_uploads/b1937-ii-specialist-service-for-children-and-young-people-with-gender-dysphoria-1.pdf.

people experiencing gender incongruence and dysphoria should be.”²¹ It noted also a “lack of evidence to support families in making informed decisions about interventions that may have life-long consequences.”²²

Finally, some NHS staff members reported feeling “under pressure to adopt an unquestioning affirmative approach” towards hormonal or surgical sex changes for children, which was “at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters.”²³

Similarly, Sweden’s National Board of Health and Welfare determined in 2022 that the risks of puberty blockers and hormonal treatment “currently outweigh the possible benefits” for children and minors.²⁴ After conducting systematic reviews in 2015 and 2022, Sweden found the evidence on hormonal treatment in adolescents

²¹ *Id.*

²² *Id.*

²³ *Id.* at 17.

²⁴ Socialstyrelsen: National Board of Health and Welfare, “Care of children and adolescents with gender dysphoria,” Report 2022-3-7799: <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf>.

“insufficient and inconclusive.”²⁵ The country prohibits gender-transition surgeries for children.²⁶

Finland also changed course after its Council for Choices in Health Care, a monitoring agency for the country’s public health services, came to similar conclusions. That country called for psychosocial support as the first choice in gender dysphoria treatment, rather than puberty blockers or hormonal intervention.²⁷ And, like its neighbor Sweden, Finland prohibits transition surgeries for children, restricting them to adults.²⁸

The Norwegian Healthcare Investigation Board announced in early March that they deem puberty blockers, cross-sex hormones, and transition surgeries for minors with gender dysphoria to be experimental treatments that lack a strong evidential base. Current protocols for “gender-affirming care,” they have concluded, are not evidence-

²⁵ *Id.*

²⁶ Jennifer Block, “Gender Dysphoria in young people is rising—and so is professional disagreement,” *The BMJ* (Feb. 23, 2023): <https://www.bmj.com/content/380/bmj.p382>.

²⁷ Palveluvalikoima (Council for Choices in Health Care in Finland), “Medical treatment methods for gender dysphoria in non-binary adults—recommendation” (June 2020): https://palveluvalikoima.fi/documents/1237350/22895623/Summary_non-binary_en.pdf/8e5f9035-6c98-40d9-6acd-7459516d6f92/Summary_non-binary_en.pdf?t=1592318035000.

²⁸ Jennifer Block, “Gender Dysphoria in young people is rising—and so is professional disagreement,” *The BMJ* (Feb. 23, 2023): <https://www.bmj.com/content/380/bmj.p382>.

based, and they have recommended that the Norwegian guidelines be reformed to reflect their recommendations. (At the moment, Norwegian guidelines align with the WPATH recommendations.) The Investigation Board criticizes these guidelines for failing to protect pubertal minors who are in precarious state and may later regret their transition.²⁹

Unlike European health authorities in the UK, Sweden, and Finland, neither WPATH nor their allied American medical organizations have conducted systematic reviews of the relevant literature.³⁰ Consider the guidelines published by the American Academy of Pediatrics. These are based on a single, non-peer-reviewed, highly flawed policy statement in its own journal by a doctor who was finishing his residency at the

²⁹ The Norwegian Healthcare Investigation Board (Ukom), “Pasientsikkerhet for barn og unge med kjønnsinkongruens” (March 9, 2023), at: <https://ukom.no/rapporter/pasientsikkerhet-for-barn-og-unge-med-kjonnsinkongruens/sammendrag>.

³⁰ Leor Sapir, “Trust the Experts’ Is Not Enough: US Medical Groups Get the Science Wrong on Pediatric ‘Gender-Affirming’ Care,” Manhattan Institute 5 (Winter 2022), at: <https://www.manhattan-institute.org/how-to-respond-to-medical-authorities-claiming-gender-affirming-care-is-safe>.

time of publication.³¹ The Endocrine Society has rated the quality of evidence behind its own recommendations as “low” or “very low.”³²

The Court should consider the likelihood that medical organizations pushing “gender-affirming care” are not summarizing the state of the scientific literature but are acting as advocacy groups that have been captured by a fashionable ideology.³³ Any court considering their testimony should ask them to cite the long-term studies and randomized control trials on which their guidelines are based. They should be asked to explain what the health authorities in the U.K., Finland, and Sweden have gotten wrong. They should be asked to predict, on the record, that gender-troubled teens in these European countries will have worse long-term outcomes than American teens who receive puberty blockers, cross-sex hormones, and transition surgery. They should be

³¹ Jason Rafferty, “Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents,” *Pediatrics* 142, no. 4 (Oct 2018): <https://doi.org/10.1542/peds.2018-2162>. This statement received a devastating rebuttal by James M. Cantor, “Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy,” *Journal of Sex & Medical Therapy* 46, no. 4 (2020): <https://doi.org/10.1080/0092623X.2019.1698481>.

³² Robin Respaut and Chad Terhune, “Number of transgender children seeking treatment surges in US,” *Reuters* (Oct. 6, 2022): <https://www.reuters.com/investigates/special-report/usa-transyouth-data/>.

³³ James Kirkup, “The document that reveals the remarkable tactics of trans lobbyists,” *The Spectator* (Dec. 2, 2019), at: <https://www.spectator.co.uk/article/the-document-that-reveals-the-remarkable-tactics-of-trans-lobbyists/>.

asked to explain their guidelines for treating detransitioners and should be challenged if they try to dismiss or explain away the experiences of detransitioners.

III. Dangerous Myths

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

There is no robust evidence that puberty blockers, cross-sex hormones and surgeries are necessary to prevent suicide in gender-dysphoric minors.³⁴ Studies conducted prior to the recent explosion in pediatric gender dysphoria have consistently shown that most children with gender distress resolve that distress after passing through puberty.³⁵

Health authorities in Sweden, Finland, and the U.K. have examined this suicidality claim and found it unreliable. Consider Finland's leading expert on pediatric

³⁴ Michael Biggs, "Suicide by Clinic Referred Transgender Adolescents in the United Kingdom," *Archives of Sexual Behavior* (2022), at: <https://pubmed.ncbi.nlm.nih.gov/35043256>.

³⁵ W. Bockting, "Chapter 24: Transgender Identity Development," in D. Tolman & L. Diamond, Co-Editors-in-Chief *APA Handbook of Sexuality and Psychology* (2 volumes) (American Psychological Association: Washington D.C., 2014): 744.

medicine, Dr. Riittakerttue Kaltiala. She recently called the “affirm or suicide” narrative “disinformation” and its dissemination by medical professionals “irresponsible.”³⁶

Consider also a recent analysis by my colleague, Jay Greene, which compared availability of puberty blockers and cross-sex hormones in U.S. states. He found that teen suicides were *higher* in states in which minors could access these drugs without parental consent, than in more restrictive states.³⁷

Here in the United States, multiple studies have reached similar conclusions—including studies commissioned by WPATH itself. A 2021 study published in the *Journal of Endocrine Society*—and funded by a grant from WPATH—examined the evidence that hormonal treatment improved the quality of life, depression, and anxiety among transgender people and concluded that the strength of that evidence was “low.”³⁸ That same WPATH-commissioned study went on to emphasize the need for more research,

³⁶ Annikka Mutanen, “Nuoruusiän sukupuoliähdistusta hoitava professori sanoo ei alaikäisten juridisen sukupuolen korjaukselle,” *Helsingin Sanomat* (January 27, 2023), at: <https://www.hs.fi/tiede/art-2000009348478.html>.

³⁷ Jay Greene, “Puberty Blockers, Cross-Sex Hormones, and Youth Suicide,” Heritage Foundation Backgrounder 3712 (June 13, 2022), at: <https://www.heritage.org/gender/report/puberty-blockers-cross-sex-hormones-and-youth-suicide>.

³⁸ Kellan Baker, et al., “Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review,” *Journal of the Endocrine Society* 5, Issue 4 (April 2021) at: <https://doi.org/10.1210/jendso/bvab011>.

“especially among adolescents.”³⁹ Finally, and significantly, the WPATH-commissioned study determined that “it was impossible to draw conclusions about the effects of hormone therapy” on death by suicide.⁴⁰

The suicide narrative of advocates of the “affirmative” approach distorts the truth. It exploits a very simple causation-correlation fallacy. While there is evidence that teenagers who experience gender discordance have high rates of suicidal thoughts and non-lethal forms of self-harm, there is no evidence that their elevated suicidality is *because* of this discordance. Nor is there evidence that “gender-affirming care” will solve their problems.⁴¹ Put simply, the evidence suggests that teenagers at high risk for suicide are more likely to adopt an identity incongruent with their sex, not the other way around.⁴²

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Polly Carmichael, Gary Butler, et al., “Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK,” *PLOS One* (Feb. 2, 2021): <https://doi.org/10.1371/journal.pone.0243894>.

⁴² J.K. Meyer and D. Reter, “Sex Reassignment Follow up,” *Arch. Gen Psychiatry* 36 (1979): 1010-1015.

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

The use of puberty blockers to treat gender dysphoria has exploded in the U.S. in recent years. Recent analyses indicate that nearly 18,000 U.S. minors began taking puberty blockers or hormones from 2017 to 2021, with the number rising each year.⁴³ The drugs generally suppress the release of the sex hormones testosterone and estrogen.⁴⁴ The U.S. Food and Drug Administration has approved these drugs to treat serious medical conditions such as prostate cancer, endometriosis, and central precocious puberty. But the FDA has *not* approved these drugs to treat gender dysphoria in minors.⁴⁵ As such, any use of these drugs to treat gender dysphoria or promote a sex change are “off label” and lack the “support of clinical trials to establish their safety for such treatment.”⁴⁶

Puberty-blocking drugs work by suppressing sex hormones, which in turn prevents the development of key secondary sex characteristics, such as breast development and menstruation in girls, and block the development of a deeper voice

⁴³ Robin Respaut and Chad Terhune, “Number of transgender children seeking treatment surges in US,” *Reuters* (Oct. 6, 2022): <https://www.reuters.com/investigates/special-report/usa-transyouth-data/>.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.*

and growth of facial hair in boys.⁴⁷ Significantly, the drugs also limit the growth of genitalia for both sexes.⁴⁸ These medications are typically administered as periodic injections or through an implant under the skin of the upper arm.⁴⁹

Contrary to frequent claims, puberty blockers given to minors are not simply reversible.⁵⁰ First, that claim is based on studies done on a very different condition, called precocious puberty, in which puberty starts too early but is always allowed to resume at a developmentally normal time.

Second, these drugs can lead to lower bone density in minors who receive them, which may persist even after the drugs are discontinued.⁵¹

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ Michael Laidlaw, Michelle Cretella and Kevin Donovan, “The Right to Best Care for Children Does Not Include the Right to Medical Transition,” *American Journal of Bioethics* 19 no. 2 (2019): 75-77. <https://doi.org/10.1080/15265161.2018.1557288>.

⁵¹ Janet Y. Yee et al., “Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings From the Trans Youth Care Study,” *Journal of the Endocrine Society* 4, no. 9 (Sep. 1, 2020): <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7433770/>.

Third, when used for minors with gender distress, they are iatrogenic interventions: over 95 % of such minors will move on to cross-sex hormones. This is not reversible.⁵²

Fourth, even when puberty blockers are discontinued, social and psychological harms may remain—since the minor in question will be out of step with the development of his or her peers. Thus, it’s no surprise that New Zealand’s ministry of health recently scrubbed the words “reversible” from its website when discussing puberty blockers.⁵³

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

The last decade has seen a rapid rise in those seeking hormonal and surgical treatments to conform their bodies to a discordant, perceived “gender identity.” Coincident with this rise has been a rise in the number “detransitioners” who come to regret that decision. These are individuals who received “transition” interventions but then came to regret this. In many cases, detransitioners come to accept their sex and

⁵² Sarah C. J. Jorgensen et al., “Puberty blockers for gender dysphoric youth: A lack of sound science,” *Journal of the American College of Clinical Pharmacy* 5, no. 9 (2022): <https://doi.org/10.1002/jac5.1691>.

⁵³ “Puberty Blockers ‘Not Safe & Reversible’ - Ministry of Health,” Family First New Zealand (Sept 21, 2022): <https://familyfirst.org.nz/2022/09/23/puberty-blockers-not-safe-reversible-ministry-of-health/>.

overcome their gender dysphoria. They often argue that these medical interventions caused preventable harm.⁵⁴

The total number of detransitioners is unknown,⁵⁵ as is the ratio of transitioners to detransitioners, because of a current lack of large-scale, long-term research on this growing population.⁵⁶ While WPATH asserts that detransition is “rare,”⁵⁷ at least “two recent studies suggest that as many as 20-30% of patients may discontinue hormone treatment within a few years.”⁵⁸ And a 2021 study found that 75% of detransitioners

⁵⁴ Lisa Littman, “Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners,” *Archives of Sexual Behavior* 50 (Oct. 19, 2021): doi:10.1007/s10508-021-02163-w pmid:34665380.

⁵⁵ R. D’Angelo, E. Syrulnik, S. Ayad, et al., “One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria,” *Arch Sex Behav* (2020): <https://doi.org/10.1007/s10508-020-01844-2>. Citing R. D’Angelo, “Psychiatry’s ethical involvement in gender-affirming care,” *Australasian Psychiatry* 26, no. 5 (2018): 460-463, at: doi: 10.1177/1039856218775216.

⁵⁶ Robin Respaut, Chad Terhune and Michelle Conlin, “Why detransitioners are crucial to the science of gender care,” *Reuters* (Dec. 22, 2022): <https://www.reuters.com/investigates/special-report/usa-transyouth-outcomes/>.

⁵⁷ R. E. Coleman et al., “Standards of care for the health of transgender and gender diverse people, Version 8,” *Int J Transgend Health* 23 (2022, Suppl 1): doi:10.1080/26895269.2022.2100644.

⁵⁸ Jennifer Block, “Gender Dysphoria in young people is rising—and so is professional disagreement,” *The BMJ* (Feb. 23, 2023): <https://www.bmj.com/content/380/bmj.p382>.

never reported their regret and detransition to their doctors.⁵⁹ That means doctors could mistakenly believe that all their patients were satisfied with their transition.

⁵⁹ Lisa Littman, “Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners,” *Arch Sex Behavior* 50 (2021): <https://doi.org/10.1007/s10508-021-02163-w>.

CONCLUSION

Advocates of “gender affirming care” presuppose the highly contested and controversial conceptual framework of gender ideology. This ideology contradicts biological reality at key points. This fact is often obscured, however, because of efforts to associate the notion of “gender identity” with genuine disorders of sexual development. But these are unrelated phenomena. Disorders of sexual development have clear biological definitions grounded in both common sense and empirical evidence. Very few individuals who cite a “gender identity” incongruent with their biological sex have a physical disorder of sexual development. Biologically, almost all these individuals, prior to undergoing “gender transition,” are unambiguously male or female.

Gender ideology reduces sex to “sex assigned at birth” and reduces the person to a subjective notion of “gender identity” for which there can be no verifiable evidence.⁶⁰ Those seized by this ideology tend to dismiss or ignore the social pressures on teenagers—especially girls—to try to escape the naturally distressing phase of puberty. This may be why these advocates avoid language that would imply the reality of biological sex, opting instead for references to “sex assigned at birth.” This betrays the fact that gender ideology is at odds with basic biology.

⁶⁰Quentin Van Meter, “Bringing Transparency to the Treatment of Transgender Persons,” *Issues in Law and Medicine* 34, no. 2 (Fall 2019): 147.

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

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

As recently practiced in the U.S., however, “gender affirming care” for minors is an attempt to treat psychological distress with permanent, draconian, and experimental medical interventions. This is the medical expression of a tendentious ideology that privileges a putative and subjective “gender identity” over the immutable sex of distressed minors.

Medicine, and medical organizations, have, in the past, been captured by ideological fashions. The widespread practice of eugenics during the previous century may be an especially bracing example,⁶¹ but it is hardly unique. Some medical

⁶¹ Edwin Black, *War Against the Weak: Eugenics and America's Campaign to Create a Master Race* (New York: Dialog, Expanded edition, 2012).

institutions have once again been captured by a fashionable ideology that provides strong financial incentives for certain practitioners. In such a situation, it falls to more objective medical authorities, including state regulators, to assess the evidence for these interventions independently. The state medical authorities in Florida have done precisely that in this case. They are right to do so.

Secretary Weida's Motion for Summary Judgment should be granted, and judgment should be entered for the Defendants.

Respectfully Submitted,
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