IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER et al.,

Plaintiffs,

v.

KAY IVEY, et al.

Defendants.

1. AAP, AL-AAP, the Academic Pediatric Association, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP, AMA, APS, APA, AAMC, AMSPDC, the Endocrine Society, NAPNAP, PES, SAHM, SPR, SPN, SPU, and WPATH, respectively, have no parent corporation.

2. No corporations hold any stock in AAP, AL-AAP, the Academic Pediatric Association, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP, AMA, APS, APA, AAMC, AMSPDC, the Endocrine Society, NAPNAP, PES, SAHM, SPR, SPN, SPU or WPATH.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases **Page(s)**

Statutes

STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici curiae are the American Academy of Pediatrics (ñAAPò), the Alabama Chapter of the American Academy of Pediatrics (ñAL-AAPò), the Academic Pediatric Association, the American Academy of Child and Adolescent Psychiatry (ñAACAPò), the American Academy of Family Physicians (ñAAFPò), the American Academy of Nursing (ñAANò), the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality (ñGLMAò), the American College of Obstetricians and Gynecologists (ñACOGò), the American College of Osteopathic Pediatricians (ñACOPò), the American College of Physicians (ñACPò), the American Medical Association (ñAMAò), the American Pediatric Society (ñAPSò), the American Psychiatric Association (ñAPAò), the Association of American Medical Colleges (ñAAMCò), the Association of Medical School Pediatric Department Chairs (ñAMSPDCò), the Endocrine Society, the National Association of Pediatric Nurse Practitioners (ñNAPNAPò), the Pediatric Endocrine Society (ñPESò), the Society for Adolescent Health and Medicine (ñSAHMò), the Society for Pediatric Research (ñSPRò), the

Amici are professional medical and mental health organizations seeking to ensure that all children and adolescents, including those with gender dysphoria, receive the optimal medical and mental healthcare they need and deserve. *Amici* represent thousands of healthcare providers who have sp

particular gender.[5] Most people have a gender identity that aligns with their sex assigned at birth.[6] However, transgender people have a gender identity that does not align with their sex assigned at birth.[7] In the United States, it is estimated that approximately 1.4 million individuals are transgender.[8] Of these individuals, approximately 10% are teenagers aged 13 to 17.[9] Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

While being transgender is a normal variation of human identity,[10] many

If untreated or inadequately treated, gender dysphoria can cause depression, anxiety, self-harm, and suicidality.[12] Indeed, over 60% of transgender adolescents and young adults reported having engaged in self-harm during the preceding 12 months, and over 75% reported symptoms of generalized anxiety disorder in the preceding two weeks.[13] Even more troubling, more than 50% of this population reported having seriously considered attempting suicide,[14] and more than one in three transgender adolescents reported having attempted suicide in the preceding 12 months.[15]

II. The Widely Accepted

evaluation by a

and peers.ò[21] The MHP also must screen for coexisting mental health concerns, [22] which ñneed to be optimally managed prior to, or concurrent with, treatment of gender dysphoria.ò[23] If gender dysphoria is diagnosed, the Guidelines provide that the MHP should discuss treatment for gender dysphoria and any coexisting concerns, including potential risks.[24]

2. The Guidelines Recommend Only Non-Physical Interventions for Prepubertal Children Suffering From Gender Dysphoria.

For prepubertal children suffering from gender dysphoria, the Guidelines provide for mental healthcare and support for the child and their family.[25] The Guidelines do *not* recommend that any physical interventions (such as medications or surgery) be provided to prepubertal children with gender dysphoria.[26]

3. In Certain Circumstances, the Guidelines Provide for the Use of Medical Interventions to Treat Adolescents Suffering From Gender Dysphoria.

For patients whose gender dysphoria continues into adolescenceð after the onset of pubertyð the Guidelines provide that, in addition to mental healthcare, medical interventions may also be indicated. Before an adolescent may receive any

[21] *Id.* at 23-24.
[22] *Id.* at 24

growth.[31] Puberty blockers have well-known efficacy and side-effect profiles.[32] In addition, their effects are generally reversible.[33] In fact, puberty blockers

parents or guardians must give their informed consent.[38] Hormone therapy involves using gender-affirming hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.[39] Although some of these changes become irreversible after those secondary sex characteristics are fully developed, others are partially reversible if the patient discontinues use of the hormones.[40]

The Guidelines contemplate that the prescription of puberty blockers and/or hormone therapy be coupled with education on the safe use of such medications and close monitoring to mitigate any potential risks.[41] Decisions regarding the appropriate treatment for each patient with gender dysphoria are made in consultation with the patient, their parents or guardians, and the medical and mental healthcare team. There is ñno one-size-fits-all approach to this kind of care.ò[42]

B. The Guidelines for Treating Gender Dysphoria Were Developed

requirementsð as other guidelines promulgated by *amici* and other medical organizations.

For example, the Endocrine Societyôs Guidelines were developed following a 26-step, 26-month drafting, comment, and review process.[43] The Endocrine Society imposes strict evidentiary requirements based on the internationally recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.[44] That GRADE assessment is then reviewed, re-reviewed, and reviewed again by multiple, independent groups of professionals. [45] Further, the Endocrine Society continually reviews its own guidelines and recently determined the 2017 transgender care guidelines continue to reflect the best available evidence.

The WPATH standards are the result of a drafting, comment, and review process that took five years.[46] The draft guidelines went through journal peer-review and were publicly available for discussion and debate, including multiple rounds of feedback from experts in the field as well as from transgender individuals.[47] They

---

[43] *See, e.g.*, Endocrine Society Guidelines at 3872-73 (high-level overview of methodology).

[44] *See* Gordon Guyatt et al., *GRADE guidelines: 1. Introduction - GRADE evidence profiles and summary of findings tables*, 64 J. Clinical Epidemiology 383 (2011), https://www.who.int/alliance-hpsr/resources/publications/HSR-synthesis-Guyatt-2011.pdf; Gordon H. Guyatt et al., *GRADE: an emerging consensus on rating quality of evidence and strength of recommendations*, 336 BMJ 924 (2008), https://www.who.int/hiv/topics/treatment/grade_guyatt_2008.pdf.

[45] Endocrine Society, *Methodology*, https://www.endocrine.org/clinical-practice-guidelines/methodology (last visited May 4, 2022).

[46] *See* WPATH Guidelines at 109-10.

[47] *See id.*

reported lifetime suicidal ideation.[54] Additionally, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically-significant degree after receiving gender-affirming hormone treatment.[55]

As another example, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with

treatments prohibited by the Healthcare Ban are effective for the treatment of gender dysphoria. For these reasons, and as

not.[61] On the contrary, ñ[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult.ò[62] In this regard, while some practitioners use ñwatchful waitingòð i.e., waiting until puberty begins before considering social transition[63]ð with prepubertal children, it is not recommended for *adolescents*. Using ñwatchful waitingò with gender-dysphoric adolescents can cause immense harm by denying them treatment that could alleviate their distress and forcing them to experience full endogenous puberty, resulting in physical changes that may be reversedð if at allð only through surgery.

2. Claims That the Medical Community Is "Aggressively Pushing" for Medical Interventions Are False.

The Healthcare Banôs legislative findings assert that ñ[s]ome in the medical community are aggressively pushing for interventions on minors.ò[64] This is falseð adolescents are only provided medical interventions if they meet the rigorous criteria under the Guidelines. While it is true that the number of referrals to gender clinics has increased in recent years, this increase has coincided with a decrease in the

[61] *See, e.g.*, Stewart L. Adelson, *Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents*, 51 J. Am. Acad. of Child & Adolescent Psychiatry 957, 964 (2020), https://pubmed.ncbi.nlm.nih.gov/22917211

stigma against transgender people, an increase in public awareness of the existence of gender dysphoria and the availability of gender-affirming care, and improvements in insurance coverage, all of which likely led more people with gender identity issues to seek help. In any event, not all patients who seek care at gender clinics receive medical interventions. In fact, a 2018 study showed that the percentage of patients who presented to a gender clinic for evaluation and received medical interventions has actually *decreased* over time.[65]

III. The Healthcare Ban

suicide attempts and significant improvement in quality of life.[66] In light of this evidence supporting the connection between lack of access to gender-affirming care and lifetime suicide risk, banning such care can put patientsô lives at risk.

CONCLUSION

For the foregoing reasons, Plaintiffsô motion for a temporary restraining order and preliminary injunction should be granted.

[66] *See* M. Hassan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72(2) Clinical Endocrinology 214 (Feb. 2010), https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x; *see also* Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, *supra* note 50.

CERTIFICATE OF SERVICE

I hereby certify that on May 4, 2022, I electronically filed the foregoing with the Clerk of the Court