

NO. 20260075

IN THE SUPREME COURT OF NORTH DAKOTA

T.D., by and through his parents, DEVON DOLNEY and ROBERT DOLNEY, DEVON DOLNEY, an individual, ROBERT DOLNEY, an individual, PAMELA ROE, by and through her parents, PETER ROE and PAULA ROE, PETER ROE, an individual, PAULA ROE, an individual, JAMES DOE, by and through his parents, JOHN DOE and JANE DOE, JOHN DOE, an individual, JANE DOE, an individual, and DR. LUIS CASAS, an individual, on behalf of himself and his patients,

Plaintiffs-Appellants

v.

DREW H. WRIGLEY, in his official capacity as Attorney General for the State of North Dakota, KIMBERLEE JO HEGVIK, in her official capacity as State's Attorney for Cass County, JULIE LAWYER, in her official capacity as State's Attorney for Burleigh County, and AMANDA ENGELSTAD, in her official capacity as the State's Attorney for Stark County,

Defendants-Appellees.

On Appeal from Amended Final Judgment Dated December 19, 2025
The Honorable Jackson J. Lofren, District Court Judge
Burleigh County District Court, South Central Judicial District

**BRIEF OF *AMICI CURIAE* STATE OF ALABAMA AND 21 OTHER STATES
IN SUPPORT OF APPELLEES AND AFFIRMANCE**

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TABLE OF CONTENTS

	<u>Page</u>
TABLE OF CONTENTS.....	2
TABLE OF AUTHORITIES	3
	<u>Paragraph</u>
STATEMENT OF IDENTITY AND INTEREST OF <i>AMICI CURIAE</i>	1
INTRODUCTION AND SUMMARY OF ARGUMENT	3
ARGUMENT.....	7
I. WPATH Crafted SOC-8 As A Political And Legal Document.....	7
A. WPATH Used SOC-8 to Advance Political and Legal Goals.	8
B. WPATH Changed Its Treatment Recommendations Based on Politics.	12
II. WPATH Did Not Follow The Principles Of Evidence-Based Medicine It Said It Followed.....	16
A. WPATH Failed to Properly Manage Conflicts of Interest.	20
B. WPATH Was Not Transparent in How It Used GRADE.	26
C. WPATH Hindered Publication of Evidence Reviews.....	32
D. WPATH Recommends Castration as “Medically Necessary” for “Eunuchs.”.....	36
CONCLUSION.....	41

TABLE OF AUTHORITIES

Cases

Boe v. Marshall,

No. 2:22-cv-184 (M.D. Ala. 2022)..... *passim*

Dent v. West Virginia,

129 U.S. 114 (1889)2

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603 F. Supp. 3d 1131, 1139, 1151 (M.D. Ala. 2022), *rev'd sub nom.*4

Eknes-Tucker v. Governor of Ala.,

80 F.4th 1205 (11th Cir. 2023)4

Other Authorities

Azeen Ghorayshi,

Biden Officials Pushed to Remove Age Limits for Trans Surgery, Documents Show,

N.Y. TIMES (June 25, 2024), <https://perma.cc/RP5L-QFD9>5

Dep't of Health and Human Servs.,

Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices

141 (Nov. 19, 2025), <https://perma.cc/F236-84DW>3

E. Coleman,

Standards of Care, Version 7, INT'L J. TRANSGENDERISM 1 (2012),

<https://perma.cc/T8J7-W3WC>.....12

E. Coleman et al.,	
<i>Standards of Care for the Health of Transgender and Gender Diverse People,</i>	
<i>Version 8,</i> 23 INT’L J. OF TRANSGENDER HEALTH (2022), https://perma.cc/Y9G6-TP3M	7
Genevieve Gluck,	
<i>Top Trans Medical Association Collaborated with Castration, Child Abuse Fetishists,</i>	
REDUXX (May 17, 2022), https://perma.cc/5DWF-MLRU	38
Helen Lewis,	
<i>The Liberal Misinformation Bubble About Youth Gender Medicine,</i>	
THE ATLANTIC (June 29, 2025), https://perma.cc/R4TZ-LS32	5
Howard Balshem et al.,	
<i>GRADE Guidelines,</i> 64 J. CLINICAL EPIDEMIOLOG. 401 (2011),	
https://perma.cc/2KDY-6BW5	31
Institute of Medicine (National Academies of Medicine),	
<i>Clinical Practice Guidelines We Can Trust</i> 81-93 (2011),	
https://perma.cc/7SA9-DAUM	20, 21, 23
Kellan Baker et al.,	
<i>Hormone Therapy, Mental Health, and Quality of Life,</i>	
5 J. ENDOCRINE SOCIETY 1 (2021).....	35
L. Wilson,	
<i>Effects of Antiandrogens on Prolactin Levels Among Transgender Women,</i>	
21 INT’L J. TRANSGENDER HEALTH 391 (2020).....	35

Liang Yao <i>et al.</i> , <i>Discordant and Inappropriate Discordant Recommendations</i> , BMJ (2021), https://perma.cc/W7XN-ZELX	31
<i>Methodology for the Development of SOC8</i> , https://perma.cc/QD95-754H	27
Nicholas Confessore, <i>How the Transgender Rights Movement Bet on the Supreme Court and Lost</i> , N.Y. TIMES (June 19, 2025), https://perma.cc/L5A6-ZVAW	5
<i>Research into Trans Medicine Has Been Manipulated</i> , THE ECONOMIST (June 27, 2024), https://perma.cc/A942-J2DY	5
Standards of Care 8 (SOC-8)	<i>passim</i>
<i>The Cass Review: Independent Review of Gender Identity Services for Children and Young People</i> , 130 (Apr. 2024), https://perma.cc/3QVZ-9Y52	3
WPATH, <i>Methodology for the Development of SOC8</i> , https://perma.cc/QD95-754H	27
World Health Organization, <i>Handbook for Guideline Development 19-23</i> (2012).....	20

STATEMENT OF IDENTITY AND INTEREST OF *AMICI CURIAE*

¶ 1] *Amici* are the States of Alabama, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wyoming.¹

¶ 2] Like North Dakota, *amici* States determined that sex-change procedures should not be made available to kids. That determination should not be controversial. *Amici* have always regulated healthcare. See *Dent v. West Virginia*, 129 U.S. 114, 121-24 (1889). And 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. *Amici* write to share a little about how we got here.

INTRODUCTION AND SUMMARY OF ARGUMENT

¶ 3] Plaintiff claims that “gender-affirming care” is “life- and health-saving,” Aplt. Br. ¶61, and that “medical guidelines” confirm that providing cross-sex hormones to minors suffering from gender dysphoria is “safe and effective medical treatment,” *id.* ¶59. Though he does not mention the guidelines by name in his brief, he was clear in his complaint: Plaintiff wants the Court to constitutionalize Standards of Care 8 (SOC-8) by the World Professional Association for Transgender Health (WPATH). *E.g.*, R273:8:¶30 (claiming “SOC 8 is based upon a rigorous and methodological evidence-based approach”).

¹ No party’s counsel authored any part of this brief, and no one other than *amici*, their members, or their counsel contributed money to fund preparing or submitting the brief.

Plaintiff’s amici—medical interest groups including WPATH, the Endocrine Society, and the American Academy of Pediatrics—say the same, offering SOC-8 as one of two “evidence-based clinical guidelines” that recommend the treatments many of their members make a living by providing. AAP Br. ¶24. The other guideline, published by the Endocrine Society in 2017, was also sponsored by WPATH and shared most of its authors with SOC-8, making the guidelines “closely interlinked.”²

[¶ 4] *Amici* are well familiar with these guidelines and the argument that courts should defer to the experts at WPATH as the real regulators. In 2022, for instance, shortly after the Alabama legislature passed a law prohibiting pediatric sex-change procedures, plaintiffs there sought a preliminary injunction based on the promise that WPATH used the “best available science” to develop its “standard of care.” *See* Plaintiffs’ PI Mem., *Boe v. Marshall*, No. 2:22-cv-184 (M.D. Ala. 2022), Doc. 8 at 12-13, 16. The district court believed them. While acknowledging that “[k]nown risks” of transitioning treatments “include loss of fertility and sexual function,” the court preliminarily enjoined enforcement of Alabama’s law because “WPATH recognizes transitioning medications as established medical treatments and publishes a set of guidelines for treating gender dysphoria in minors with these medications.” *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1139, 1151 (M.D. Ala. 2022), *rev’d*, *Eknes-Tucker v. Governor of Ala.*, 80 F.4th 1205 (11th Cir. 2023).

² *The Cass Review: Independent Review of Gender Identity Services for Children and Young People* 130 (Apr. 2024), <https://perma.cc/3QVZ-9Y52>; *see* Dep’t of Health and Human Servs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* 141 (Nov. 19, 2025), <https://perma.cc/F236-84DW>.

[¶ 5] Alabama then sought and obtained discovery from WPATH to test the court’s deference.³ Doing so unveiled a tragic medical scandal. Internal documents from WPATH showed that the organization crafted SOC-8—published in 2022—as “a tool for our attorneys to use in defending access to care.”⁴ Its evidence-review team “found little to no evidence about children and adolescents.”⁵ Some SOC-8 authors opted *out* of the evidence-review process entirely because of “concerns, echoed by the social justice lawyers we spoke with, ... that evidence-based review reveals little or no evidence and puts us in an untenable position in terms of affecting policy or winning lawsuits.”⁶ And Admiral Rachel Levine, the former Assistant Secretary for Health at HHS, demanded that WPATH remove from SOC-8 *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,”⁷ WPATH obliged. This evidence became public in 2024 and has been covered in—and substantiated by—deeply reported

³ See Order, *Boe*, 2:22-cv-184 (M.D. Ala. Mar. 27, 2023), Doc. 263.

⁴ Defendants’ Ex. 181 at 75, *Boe*, 2:22-cv-184 (M.D. Ala.), Doc. 700-10. Throughout this brief, *amici* will reference evidence that Alabama submitted to the court in *Boe*. Citations will be by exhibit number followed by the docket entry in parenthesis and the internal page number following the colon. *E.g.*, Ex.181 (Doc.700-10):75. Exhibits are available online: <https://www.alabamaag.gov/boe-v-marshall/>.

⁵ *Boe* Ex.173(Doc.560-23):22.

⁶ *Boe* Ex.174(Doc.560-24):1-2.

⁷ *Boe* Ex.186 (Doc.700-15):32.

pieces in the *New York Times*, *The Economist*, *The Atlantic*, and elsewhere.⁸

[¶ 6] This evidence confirms the commonsense notion that the people’s representatives in North Dakota, no less than the people’s representatives in *amici* States, are entitled to regulate medicine, just as they have always done. That is true even when the “experts” at WPATH prefer otherwise. The Court should affirm.

ARGUMENT

I. WPATH Crafted SOC-8 As A Political And Legal Document.

[¶ 7] WPATH published Standards of Care 8 (SOC-8) in September 2022.⁹ 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.¹⁰ Two WPATH presidents, Dr. Walter Bouman, a clinician at the

⁸ See, e.g., Azeen Ghorayshi, *Biden Officials Pushed to Remove Age Limits for Trans Surgery, Documents Show*, N.Y. TIMES (June 25, 2024), <https://perma.cc/RP5L-QFD9>; Nicholas Confessore, *How the Transgender Rights Movement Bet on the Supreme Court and Lost*, N.Y. TIMES (June 19, 2025), <https://perma.cc/L5A6-ZVAW>; *Research into Trans Medicine Has Been Manipulated*, THE ECONOMIST (June 27, 2024), <https://perma.cc/A942-J2DY>; Helen Lewis, *The Liberal Misinformation Bubble About Youth Gender Medicine*, THE ATLANTIC (June 29, 2025), <https://perma.cc/R4TZ-LS32>.

⁹ See Eli 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), <https://perma.cc/Y9G6-TP3M>.

¹⁰ *Id.* at S248-49.

Nottingham Centre for Transgender Health in England, and Dr. Marci Bowers, a surgeon 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.

[¶ 8] WPATH selected 119 authors—all existing WPATH members—to contribute to SOC-8.¹¹ According to Dr. Bowers, it was “important” for each author “to be an advocate for [transitioning] treatments before the guidelines were created.”¹² 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.”¹³ 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 ... even if the wording isn’t quite correct for people who have the background you and I have.”¹⁴ Another chimed in: “It is abundantly clear to me when I go to court” that “[t]he wording of our section for Version 7 has been critical to our successes, and I hope the same will hold for Version 8.”¹⁵

[¶ 9] Perhaps for this reason—and because it knew that “we will have to argue it in court at some point”¹⁶—WPATH commissioned a legal review of SOC-8 and was in regular

¹¹ *Id.* at S248-49; *see Boe Ex.21(Doc.700-3):201:2–223:24.*

¹² *Boe Ex.18(Doc.564-8):121:7-11.*

¹³ *Boe Ex.21(Doc.700-3):158:17-25.*

¹⁴ *Boe Ex.184(Doc.700-13):24.*

¹⁵ *Boe Ex.184(Doc.700-13):15.*

¹⁶ *Boe Ex.182(Doc.700-11):152.*

contact with movement attorneys.¹⁷ 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?”¹⁸ The WPATH Executive Committee discussed various options for the review—“ideas; ACLU, TLDEF, Lambda Legal...”¹⁹—before apparently settling on the senior director of transgender and queer rights at GLAD (and counsel for plaintiffs in Alabama’s case) to conduct the review.²⁰

[¶ 10] Authors were explicit in their desire to tailor SOC-8 to ensure coverage for an “individual’s embodiment goals,”²¹ whatever they might be. As Dr. Dan Karasic, one of the plaintiffs’ experts in Alabama’s case, explained to other contributors: “Medical necessity is at the center of dozens of lawsuits in the US right now”;²² “I cannot overstate the importance of SOC 8 getting this right at this important time.”²³ Another author was more succinct: “[W]e need[] a tool for our attorneys to use in defending access to care.”²⁴

[¶ 11] At Dr. Karasic’s urging, WPATH included a section in SOC-8 on “medical

¹⁷ *Boe Ex.4(Doc.557-4):vi.*

¹⁸ *Boe Ex.182(Doc.700-11):151.*

¹⁹ *Boe Ex.184(Doc.700-13):14.*

²⁰ SOC-8, *supra* note 9, at S177.

²¹ *Boe Ex.180(Doc.700-9):11.*

²² *Id.* at 64.

²³ *Boe Ex.181(Doc.700-10):43.*

²⁴ *Id.* at 75.

necessity,” assigning the designation to all sorts of interventions.²⁵ It also sprinkled the 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,”²⁶ but WPATH never paused 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.²⁷

B. WPATH Changed Its Treatment Recommendations Based on Politics.

[¶ 12] Outside political actors also influenced SOC-8. Most notably, Admiral Levine, the former Assistant Secretary for Health, met regularly with WPATH leaders, “eager to learn when SOC 8 might be published.”²⁸ A few months before SOC-8 was to be published in September 2022 (and long after the public comment period had closed²⁹), WPATH sent Levine an “Embargoed Copy – For Your Eyes Only” draft of SOC-8 that had been “completed” and sent to the publisher.³⁰ The draft included a departure from Standards of Care 7, which, except for so-called “top surgeries,” restricted transitioning surgeries to patients

²⁵ SOC-8, *supra* note 9, at S18.

²⁶ SOC-8, *supra* note 9, at S45-46.

²⁷ *Boe Ex.174(Doc.560-24):1-2.*

²⁸ *Boe Ex.184(Doc.700-13):54.*

²⁹ *See Boe Ex.187(Doc.700-16):4-5.*

³⁰ *Boe Ex.170(Doc.700-4):61-64.*

who had reached the “[a]ge of majority in a given country.”³¹ The draft SOC-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.”³²

[¶ 13] After reviewing the draft, Levine’s office contacted WPATH with a political concern: that the listing of “specific minimum ages for treatment,” “under 18, will result in devastating legislation for trans care.”³³ WPATH leaders met with Levine to discuss the age recommendations.³⁴ Levine’s solution was simple: “She asked us to remove them.”³⁵

[¶ 14] 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.³⁶ (Indeed, Dr. Coleman said that consensus was “[t]he only evidence we had” for the recommendations.³⁷) But, WPATH continued, “we heard your comments regarding the minimal age criteria” and, “[c]onsequently, we have made changes to

³¹ E. Coleman, *Standards of Care, Version 7*, 13 INT’L J. TRANSGENDERISM 1, 25-27 (2012), <https://perma.cc/T8J7-W3WC>.

³² *Boe Ex.170*(Doc.700-4):143.

³³ *Boe Ex.186* (Doc.700-15):28.

³⁴ *See Boe Ex.186* (Doc.700-15):11, 17; *Boe Ex.21*(Doc.700-3):287:5–288:6.

³⁵ *Boe Ex.186* (Doc.700-15):11.

³⁶ *Id.* at 17.

³⁷ *Id.* at 57.

the SOC8” by downgrading the age “recommendation” to a “suggestion.”³⁸ Unsatisfied, Levine immediately requested—and received—more meetings with WPATH.³⁹

[¶ 15] 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.⁴⁰ 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.”⁴¹ But the political reality soon set in: AAP was “a MAJOR organization,” and “it would be a major challenge for WPATH” if AAP opposed SOC-8.⁴² WPATH thus “remove[d] the ages.”⁴³

[¶ 16] That is concerning enough. But perhaps even more worrisome is what the episode reveals. *First*, it shows that politicians and AAP sought, and WPATH agreed, to make changes in a 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 allowing authors to vote on the change and “without being presented any new science of which the committee was previously unaware.”⁴⁴

³⁸ *Id.* at 17.

³⁹ See *Boe Ex.18(Doc.564-8):226:8–229:18; Boe Ex.186 (Doc.700-15):73, 88-91.*

⁴⁰ *Boe Ex.187(Doc.700-16):13-14, 109.*

⁴¹ *Id.* at 100.

⁴² *Id.* at 191.

⁴³ *Id.* at 338.

⁴⁴ *Boe Ex.21(Doc.700-3):293:25–295:16.*

[¶ 17] *Second*, as soon as WPATH made the change, it treated the decision as “highly, highly confidential.”⁴⁵ Dr. Bowers encouraged contributors to submit to “centralized authority” so there would not be “differences that can be exposed.”⁴⁶ “[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.”⁴⁷

[¶ 18] 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.”⁴⁸ 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.”⁴⁹ Apparently, it didn’t matter that the explanation itself was “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.”⁵⁰

⁴⁵ *Boe Ex.188(Doc.700-17):152.*

⁴⁶ *Boe Ex.177(Doc.700-6):124.*

⁴⁷ *Id.* at 119.

⁴⁸ *Boe Ex.188(Doc.700-17):113.*

⁴⁹ *Id.*

⁵⁰ *Boe Ex.177(Doc.700-6):102.*

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

[¶ 19] At the back of SOC-8 is an appendix with the methodology WPATH said it employed.⁵¹ Among other things, it boasts that WPATH managed conflicts of interest and engaged an evidence-review team to conduct systematic literature reviews.⁵² Discovery revealed a different story.

A. WPATH Failed to Properly Manage Conflicts of Interest.

[¶ 20] WPATH cites two standards it said it used to manage conflicts of interest: one from the National Academies of Medicine and the other from the World Health Organization.⁵³ 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 dependent on engaged in performing, researching, or advocating for the practices under review.⁵⁴

[¶ 21] At the same time, the standards recognize that a guideline committee benefits from *some* involvement by clinicians with conflicts.⁵⁵ Accordingly, they suggest ways for committees to benefit from conflicted clinicians while limiting their involvement. The standard

⁵¹ See SOC-8, *supra* note 9, at S247-51.

⁵² *Id.*

⁵³ *Id.* at S247.

⁵⁴ *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).

⁵⁵ Institute of Medicine, *supra* note 54, at 83.

from the National Academies recommends that “[m]embers with [conflicts of interest] should represent *not more than a minority* of the [guideline development group].”⁵⁶

[¶ 22] WPATH largely ignored these standards, limiting SOC-8 authorship to existing WPATH members—clinicians and other professionals who were *already* enthusiastic about transitioning treatments.⁵⁷ As Dr. Bowers testified, it was “important for someone to be an advocate for [transitioning] treatments before the guidelines were created.”⁵⁸

[¶ 23] Dr. Bowers’s involvement in SOC-8 offers a good illustration. 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 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.”⁵⁹ 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.

[¶ 24] So it is notable that Bowers made “more than a million dollars” in 2023 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-8.⁶⁰ That was WPATH’s

⁵⁶ *Id.* (emphasis added).

⁵⁷ SOC-8, *supra* note 9, at S248; *see Boe Ex.21(Doc.700-3):201:2–223:24.*

⁵⁸ *Boe Ex.18(Doc.564-8):121:7-11.*

⁵⁹ Institute of Medicine, *supra* note 54, at 78.

⁶⁰ *Boe Ex.18(Doc.564-8):37:1-13, 185:25–186:9.*

public position as well: It assured readers that “[n]o conflicts of interest were deemed significant or consequential” in crafting SOC-8.⁶¹

[¶ 25] Privately, WPATH leaders knew everything was not up to par. Dr. Coleman admitted that “most participants in the SOC-8 process had financial and/or nonfinancial conflicts.”⁶² Dr. Robinson, the chair of the evidence-review team, said the same: She “expect[ed] many, if not most, SOC-8 members to have competing interests.”⁶³ She 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.”⁶⁴ “Unfortunately,” she lamented, “this was not done here.”⁶⁵ No matter: SOC-8 proclaims the opposite (“Conflict of interests were reviewed as part of the selection process”⁶⁶), and Dr. Coleman said he did not know of any author removed from SOC-8 due to a conflict.⁶⁷

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

[¶ 26] 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

⁶¹ SOC-8, *supra* note 9, at S177.

⁶² *Boe Ex.21(Doc.700-3):230:17-23.*

⁶³ *Boe Ex.166(Doc.560-16):1.*

⁶⁴ *Id.* (emphasis added).

⁶⁵ *Id.*

⁶⁶ SOC-8, *supra* note 9, at S177.

⁶⁷ *Boe Ex.21(Doc.700-3):232:13-15.*

clinical practice recommendations.”⁶⁸ 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.”⁶⁹

[¶ 27] Chapter authors were then to grade the recommendation statements based on the evidence.⁷⁰ 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.”⁷¹ 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.”⁷² 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 ^[73]

[¶ 28] The reality did not match the promise. To begin, as Dr. Coleman wrote, “we were

⁶⁸ SOC-8, *supra* note 9, at S250.

⁶⁹ *Id.* at S249-50.

⁷⁰ *Id.* at S250.

⁷¹ *Id.*

⁷² *Id.*

⁷³ WPATH, *Methodology for the Development of SOC8*, <https://perma.cc/QD95-754H>.

not able to be as systematic as we could have been (e.g., we did not use GRADE explicitly).”⁷⁴ Dr. Karasic, the chair of the mental health chapter, testified that rather than relying on systematic reviews, some drafters simply “used authors ... we were familiar with.”⁷⁵

[¶ 29] WPATH also decided not to differentiate “between statements based on [literature reviews] and the rest,”⁷⁶ and ordered the removal of all notations disclosing the quality of evidence for each recommendation. A draft of the hormone chapter illustrates the change. 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.”⁷⁷

[¶ 30] 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”⁷⁸—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.”⁷⁹ And so it was in the hormone chapter, where

⁷⁴ *Boe Ex.190(Doc.700-18):8; see Ex.182(Doc.700-11):157-58.*

⁷⁵ *Boe Ex.39(Doc.592-39):66:2–67:5.*

⁷⁶ *Boe Ex.182(Doc.700-11):62; see Ex.9(Doc.700-2):¶¶29-36, 43-47.*

⁷⁷ *Boe Ex.182(Doc.700-11):5; see id. at 1-40; Ex.9(Doc.700-2):¶¶29-36, 43-47.*

⁷⁸ SOC-8, *supra* note 9, at S48.

⁷⁹ *Id.* at S46-47.

the final version of the above statement transformed into a strong “we recommend.”⁸⁰

[¶ 31] While this mismatch may not seem like a big deal, the difference between a “strong” and “weak” recommendation is important. 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 available evidence.⁸¹ 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 recommendation—and why, with certain exceptions not applicable here, evidence-based medicine warns against “strong” recommendations based on low-quality evidence.⁸² So it is a big deal indeed that WPATH promised clinicians that it followed this system when it actually made “strong” recommendations no matter what the evidence said.

C. WPATH Hindered Publication of Evidence Reviews.

[¶ 32] Though the SOC-8 authors didn’t seem to have much use for them, the Johns Hopkins evidence-review team “completed and submitted reports of reviews (dozens!) to WPATH” for SOC-8.⁸³ 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

⁸⁰ *Id.* at S111.

⁸¹ Howard Balshem *et al.*, *GRADE Guidelines*, 64 J. CLINICAL EPIDEMIOLOGY 401, 404 (2011), <https://perma.cc/2KDY-6BW5>.

⁸² Liang Yao *et al.*, *Discordant and Inappropriate Discordant Recommendations*, BMJ (2021), <https://perma.cc/W7XN-ZELX>.

⁸³ *Boe Ex.173 (Doc.560-23):22-25*.

research into “multiple types of interventions (surgical, hormone, voice therapy...).”⁸⁴ She reported: “[W]e found little to no evidence about children and adolescents.”⁸⁵

[¶ 33] Dr. Robinson also informed HHS that she was “having issues with this sponsor”—WPATH—“trying to restrict our ability to publish.”⁸⁶ 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.⁸⁷ Among other things, that policy required the team to seek “final approval” of any article from an SOC-8 leader and then from the WPATH Board of Directors.⁸⁸

[¶ 34] 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 broadest sense” (as WPATH defined it).⁸⁹ 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.”⁹⁰

⁸⁴ *Id.* at 24.

⁸⁵ *Id.* at 22.

⁸⁶ *Id.*

⁸⁷ *Boe Ex.167(Doc.560-17):86-88.*

⁸⁸ *Id.* at 37-38, 75-81.

⁸⁹ *Id.* at 91.

⁹⁰ *Id.* at 38.

[¶ 35] WPATH eventually allowed the Johns Hopkins team to publish two of its manuscripts. (It’s still unclear what happened to the others.⁹¹) The team dutifully reported that the “authors”—not WPATH—were “responsible for all content.”⁹²

D. WPATH Recommends Castration as “Medically Necessary” for “Eunuchs.”

[¶ 36] 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.”⁹³ 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.”⁹⁴ 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.”⁹⁵

[¶ 37] Dr. Coleman also admitted that no diagnostic manual recognizes “eunuch” as a

⁹¹ Cf. Ex.167(Doc.560-17):91.

⁹² Kellan Baker *et al.*, *Hormone Therapy, Mental Health, and Quality of Life*, 5 J. ENDOCRINE SOC’Y 1, 3 (2021); L. Wilson, *Effects of Antiandrogens on Prolactin Levels Among Transgender Women*, 21 INT’L J. TRANSGENDER HEALTH 391, 392 (2020).

⁹³ SOC-8, *supra* note 9, at S88.

⁹⁴ *Id.* at S88-89.

⁹⁵ *Boe* Ex.21(Doc.700-3):172:19–173:25.

medical or psychiatric diagnosis.⁹⁶ And other SOC-8 authors criticized the chapter as “very high on speculation and assumptions, whilst a robust evidence base is largely absent.”⁹⁷ Dr. Bowers even admitted that not every board member read the chapter before approving it.⁹⁸ No matter: The guideline that Plaintiff relies on to ask this Court to override the legislature’s regulations recommends castration for men and boys who identify as “eunuch.”

[¶ 38] And how did WPATH learn that castration constitutes “medically necessary gender-affirming care”?⁹⁹ From a “large online peer-support community” called the “Eunuch Archive.”¹⁰⁰ According to SOC-8, the “Archive” contains “the greatest wealth of information about contemporary eunuch-identified people.”¹⁰¹ The guideline does not disclose that part of the “wealth” comes from a repository hosting thousands of stories that “focus on the eroticization of child castration” and involve the “sexual abuse of children.”¹⁰² “The fictional pornography” “includes themes such as Nazi doctors castrating children” and “pedophilic fantasies of children who have been castrated to halt their puberty.”¹⁰³

⁹⁶ *Id.*

⁹⁷ *Boe* Ex.182(Doc.700-11):96.

⁹⁸ *Boe* Ex.18(Doc.564-8):147:9–148:4; *Boe*.MSJ(Doc.619):16.

⁹⁹ SOC-8, *supra* note 9, at S88.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² Genevieve Gluck, *Top Trans Medical Association Collaborated with Castration, Child Abuse Fetishists*, REDUXX (May 17, 2022), <https://perma.cc/5DWF-MLRU>.

¹⁰³ *Id.*

[¶ 39] Despite all this, Plaintiff’s *amici* promise the Court that the WPATH guideline was developed “using the same standards and best practices as other types of medical treatments.” AAP Br. ¶23 (header). Let’s hope not.

* * *

[¶ 40] There is much more to be said, but the takeaway is clear: Far from being trustworthy, the guidelines that Plaintiff asks this Court to constitutionalize demonstrate precisely why regulation in this area is so necessary. The Legislative Assembly did not have to defer to WPATH, and neither should this Court.

CONCLUSION

[¶ 41] The Court should affirm.

CERTIFICATE OF COMPLIANCE

[¶ 42] I hereby certify that the forgoing brief complies with N.D.R.App.P. 29(a) and 32(a) and contains 26 pages.

Dated: May 13, 2026

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