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SUPREME COURT OF TEXAS
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No. 23-0697

In the Supreme Court of Texas

THE STATE OF TEXAS, ET AL.,
APPELLANTS,

v.

LAZARO LOE, ET AL.,
APPELLEES,

APPEAL FROM THE 201ST JUDICIAL DISTRICT COURT, TRAVIS COUNTY,

BRIEF OF DO NO HARM AS *AMICUS CURIAE* SUPPORTING APPELLANTS

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TABLE OF CONTENTS

TABLE OF CONTENTS i
TABLE OF AUTHORITIES iii
INTEREST OF *AMICUS CURIAE* 1
INTRODUCTION 2
ARGUMENT 3
I. Some Fundamental Elements of Gender Dysphoria and Plaintiffs' Suggested Interventions are Well Known by Medical Professionals. 5
A. Sex is a concept central to the practice of medicine in every field. 5
B. Dysphoria about gender is also widely known and is diagnosable by any medical professional. 8
C. Hormones and puberty blockers are also well known to a variety of medical professionals, as are their side effects. 10
II. The Plaintiff Physicians and Their Experts Have No Special Insight and Are Proceeding with Experimental Treatments that Are Inconsistent with the Basic Standards of Medicine and Medical Ethics. 13
A. The core concept of "gender" dysphoria is unclear, and Plaintiffs and similar practitioners exploit this. 14
B. Plaintiffs' fundamental goal requires a mismatch between the condition and the intervention. 18
C. Plaintiffs' treatments for gender dysphoria are experimental and without justification. 23
III. Transgender Interventions as Practiced in Texas Fall Short of the Core Commitments of Medical Ethics. 35
A. TCH and plaintiff physicians have not been forthright about when and how their preferred interventions are practiced. 36

B. Plaintiff physicians and TCH have undermined the respect they claim to show for informed consent in other recent statements............ 40

C. Plaintiff physicians and TCH have implicitly coerced other healthcare providers to assist with transgender interventions regardless of their ethical objections. 45

CONCLUSION 49

CERTIFICATE OF COMPLIANCE 51

CERTIFICATE OF SERVICE 51

TABLE OF AUTHORITIES

CODES

AM. MED. ASS'N, CODE OF MEDICAL ETHICS (REV. 2001) 45, 50, 55

OPINIONS

Tex. Attorney Gen., Attorney General Opinion No. KP-0401 (Feb. 18, 2022) 46

BOOKS

AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, TEXT REVISION (5th ed. 2022) .... passim

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COUNCIL FOR CHOICES IN HEALTH CARE IN FINLAND, MEDICAL TREATMENT METHODS FOR DYSPHORIA ASSOCIATED WITH VARIATIONS IN GENDER IDENTITY IN MINORS (2020) 34

NAT'L INST. FOR HEALTH AND CARE EXCELLENCE, EVIDENCE REVIEW: GENDER-AFFIRMING HORMONES FOR CHILDREN & ADOLESCENTS WITH GENDER DYSPHORIA (2020) 34, 40

NAT'L INST. FOR HEALTH AND CARE EXCELLENCE, EVIDENCE REVIEW: GONADOTROPHIN RELEASING HORMONE ANALOGUES FOR CHILDREN & ADOLESCENTS WITH GENDER DYSPHORIA (2020) 34

SOCIALSTYRELSEN, CARE OF CHILDREN & ADOLESCENTS WITH GENDER DYSPHORIA (2022) 34

INTEREST OF *AMICUS CURIAE*

Do No Harm is a diverse group of physicians, healthcare professionals, medical students, patients, and policymakers whose goal is to protect healthcare from a radical, divisive, and discriminatory ideology. Basing its name in the ethical underpinnings of the Hippocratic Oath, Do No Harm believes healthcare should be free from experimental procedures that place political agendas ahead of patient well-being.[1]

[1] No party's counsel authored, and no one other than *amicus* and its counsel contributed money for, this brief.

INTRODUCTION

In this lawsuit, the plaintiff physicians and their experts present themselves as the voice of the medical field generally and the expert establishment treating gender dysphoria specifically. This posturing makes this lawsuit appear to be a conflict between medicine and politics. But the views that they represent regarding medical interventions for adolescent gender dysphoria are those of a small minority of providers—the ones willing to engage in these purported "treatments." The interventions they seek, and the justifications for such interventions, diverge from the standards and practices of the larger medical community.

The physician plaintiffs and their experts do not hold any special knowledge that other physicians lack. Indeed, they freely admit that no one has much insight, even while asserting that they alone have the only solutions. The misrepresentations that they make in defending their preferred medical interventions run counter to basic medical standards and ethics, and those misrepresentations appear to have affected even the basic elements of their medical practice in Texas. The real tension is between the larger medical community, familiar with the biological

reality of sex, puberty, hormonal treatments, and the standards required of evidence-based medicine, and the small group of providers pushing these experimental interventions.

ARGUMENT

Adolescent gender dysphoria and its treatment are at the heart of this case. According to Plaintiffs, adolescent gender dysphoria is a "diagnostic term" for "clinically significant distress resulting from the lack of congruence between [the adolescent's] gender identity and the sex assigned to [the adolescent] at birth."[2] The "incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning."[3] Plaintiffs then defend several medical interventions for adolescent gender dysphoria, though only two—"puberty blockers" and cross-sex hormones—are primarily at issue, with surgery playing at most a minor role.[4]

[2] Complaint ¶ 25, *Loe v. Texas*, No. D-l-GN-23-003616 (Dist. Ct. Aug. 11, 2023) ("Compl.").
[3] *Id.*
[4] None of the plaintiff physicians are surgeons, nor do they discuss the role of surgery in their practice.

While Plaintiffs assert that their definition of gender dysphoria is drawn simply from the Diagnostic and Statistical Manual of Mental Disorders,[5] even in their purported recapitulation, Plaintiffs have already made a key revision to support their preferred medical interventions. But before getting to the controverted and controversial points, it is worth exploring what is not because the latter illuminates the former. Some of the principles involved in this case—the biological reality of sex, puberty, hormones, the administration of puberty blockers and hormones, and the understanding of evidence-based medicine—are well known to many or all physicians. That base of knowledge throws into relief what is not well known and what is claimed to be the particular ken of gender-affirming care specialists. As will be seen, that remainder is not, in fact, known even by those purported specialists. They have no special justification for their preferred treatments. Their willingness to pursue invasive, experimental treatments without knowledge is contrary to basic standards of medical practice, and that willingness bleeds into the practice of the plaintiff physicians.

[5] Compl. ¶ 25 n.8 (citing AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, TEXT REVISION F64.0 (5th ed. 2022) ("DSM 5-TR")).

I. Some Fundamental Elements of Gender Dysphoria and Plaintiffs' Suggested Interventions are Well Known by Medical Professionals.

Any physician (and nearly any medical professional), by virtue of medical training, understands the basics of biological sex. Most physicians and other care providers understand adolescent dysphoria about one's sex, and increasingly all are attuned to looking for it. And all physicians understand the fundamentals of sex hormones, with many physicians prescribing and administering the same treatments affecting sex hormones at issue here in different contexts. If there were an evidence-based justification for using these treatments for adolescent gender dysphoria, most medical professionals could immediately grasp the rationale.

A. Sex is a concept central to the practice of medicine in every field.

The scientific concept of sex is foundational for the practice of medicine, and all physicians necessarily understand it. Indeed, they are expected to understand the biological concept of sex and sexual differentiation in humans as part of what they must know even to be accepted to medical school. It is tested on the Medical College Admission

Test.[6] And human sexual development is taught as part of the basic curriculum of medical school.[7]

This knowledge is necessary because sex affects all facets of medicine and is the most significant differentiator between human beings.[8] Thus, a patient's sex is one of the first pieces of information and diagnostic criteria noted by doctors treating patients in every medical setting, regardless of practice area. Many medical conditions have different rates of occurrence and presentations in males and females, and indeed, many conditions are essentially unique to only one sex.[9] It therefore heavily affects or determines the diagnosis, prognosis, and treatment of many conditions.[10] Failure to account for sex would in many cases amount to medical malpractice and could prove fatal. Physicians

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[6] Ass'n of Am. Medical Colleges, Biological and Biochemical Foundations of Living Systems: Content Category 3B, https://students-residents.aamc.org/biological-and-biochemical-foundations-living-systems-foundational-concept-3/biological-and-biochemical-foundations-living-systems-content-category-3b.

[7] Ass'n of Am. Medical Colleges, Curriculum Topics in Required and Elective Courses at Medical School Programs, https://www.aamc.org/data-reports/curriculum-reports/data/curriculum-topics-required-and-elective-courses-medical-school-programs.

[8] *See* Martha L. Blaire, *Sex-based Differences is Physiology: What Should We Teach in the Medical Curriculum*, 31 ADVANCES IN PHYSIOLOGY EDUC. 23, 23–25 (2007).

[9] *See* Eileen M. Crimmins et al., *Differences between Men and Women in Mortality and the Health Dimensions of the Morbidity Process*, CLIN CHEM. 135, 145 (2019).

[10] *Id.*

and health care providers must understand the scientific and biological concept of sex to perform their roles.

There are disorders and diseases of sexual development involving abnormalities in chromosomes or hormones,[11] but this case does not involve any of them.[12] While sex is still a rigorous differentiator even for individuals suffering from such disorders,[13] absent such a disorder, sex is readily ascertainable even before birth based on external genitalia and other biological markers. Plaintiffs are suing over medical interventions only for adolescents without any such diseases or disorders. So any medical provider understands at least half of the incongruence within the definition of gender dysphoria that Plaintiffs use because they understand biological sex and the ordinary presentation of it.

Similarly, every medical professional understands the critical process that puberty plays in human development. While some types of physicians may be domain experts in this field, all understand that puberty is the most central developmental period in a human's life

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[11] *See, e.g.*, Mary García-Acero, *Disorders of Sexual Development: Current Status and Progress in the Diagnostic Approach*, 13 Curr Urol. 169, 169–178 (Jan. 2020).
[12] Even according to Plaintiffs, the legislation they are challenging does not affect treatment for adolescents suffering from such conditions. Compl. ¶ 52.
[13] *See, e.g.*, Wolfgang Goymann et al., *Biological Sex Is Binary, Even Though There Is a Rainbow of Sex Roles*, 45 BIOESSAYS e2200173 (Feb. 2023).

outside development in utero.[14] Any significant disruption to the ordinary process of puberty justifies urgent intervention.[15] If puberty goes awry, that can have lifelong and life-altering effects.[16] And medical professionals further understand that any decision to intentionally interfere with this process is a weighty one requiring a demonstration of immense long-term benefits.[17]

B. Dysphoria about gender is also widely known and is diagnosable by any medical professional.

Despite the basic definitional issues with gender dysphoria, the condition is well known to many medical professionals—increasingly more so in the last few years, with its rise in prominence within discussions of bioethics, medicine, and public policy. No reasonable healthcare provider disputes that adolescents beginning to go through puberty can feel significant distress based on feeling poorly aligned with their sex and the development of primary and secondary sex

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[14] CHILD AND ADOLESCENT HEALTH AND DEVELOPMENT 1171 (Donald A.P. Bundy et al. eds., 3rd ed. 2017).
[15] *See id.*
[16] *See id.*
[17] This is found in the Court Reporter's Record for the Temporary Injunction Hearing in the District Court, referred to hereinafter by volume and page. *See* 3.CR.104 (testimony of Dr. James Cantor); *id.* at 38 (testimony of Michael K. Laidlaw, M.D.).

characteristics.[18] And while healthcare providers and researchers dispute the cause of increasing diagnoses of gender dysphoria, they do not dispute that there are increasingly many adolescents who present with such distress.[19] Most medical systems, including the ones involved here (*infra*), screen for the condition.

Even Plaintiffs and their experts agree that any licensed medical professional can recognize and diagnose gender dysphoria from the DSM.[20] And they actively encourage a variety of medical professionals to do so. Indeed, screening for gender dysphoria has become common in many practices, including pediatric practices, and physicians are increasingly pushing for universal evaluation for it.[21] Basic knowledge about the symptoms and diagnosis is therefore well known within the medical profession and does not require specialized or clinically developed diagnostic abilities.

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[18] *See* 3.CR.202 (testimony of Alan Hopewell, Ph.D.).

[19] *See, e.g.*, *id.*

[20] 2.CR.136 (testimony of Johanna Olson-Kennedy, M.D.)

[21] *See, e.g.*, Josephine S. Lau et al., *Screening for Gender Identity in Adolescent Well Visits: Is It Feasible and Acceptable?*, 68 J. ADOLESC HEALTH 1089, 1089–95 (Jun. 2021).

C. Hormones and puberty blockers are also well known to a variety of medical professionals, as are their side effects.

Lastly, the medications used by Plaintiffs to treat gender dysphoria in minors—hormones and puberty blockers—are well known outside the niche area of gender-affirming medicine.

Sex hormones and their effects are well known to all physicians. Again, the MCAT tests on them for entrance to medical school, and they are part of a foundational medical school curriculum.[22] Sex hormones affect and control all phases of human development and aging. They control the phenotypic presentation of sex through development in utero and the development of primary and secondary sex characteristics, and they affect all other bodily systems, from brain development to bone development.[23]

The effects of sex hormonal imbalances, meaning sex hormone levels outside the normal range for one's sex, are likewise well known in the general practice of medicine. They result in many doctors across fields testing and prescribing such hormones. Many medical scenarios require

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[22] See sources cited *supra* nn.6–7.

[23] Paul W. Hruz et al., *Growing Pains: The Problems with Puberty Suppression in Treating Gender Dysphoria*, 52 NEW ATLANTIS 3, 8–10 (Spring 2017).

the prescription of these hormones to restore naturally occurring physiology, to treat physical ailments, or to achieve necessary reproductive goals. For instance, primary care physicians and specialists regularly prescribe testosterone replacement therapy for males with low testosterone to restore normal physiological levels of the hormone.[24] Primary care physicians and specialists regularly prescribe estrogen and other female sex hormones for birth control.[25] Gynecologists prescribe estrogen and progesterone for many problems, from menopausal problems to polycystic ovarian syndrome.[26] And pediatric endocrinologists prescribe such hormonal therapies for children with rare hormonal imbalances.[27]

These medical professionals must be informed of the risks and dangers of prescribing these hormones and of hormonal imbalances caused by endogenous or exogenous hormones. Thus, all physicians

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[24] Ryan C. Petering et al., *Testosterone Therapy: Review of Clinical Applications*, 96 AM FAM PHYSICIAN 441, 442–46 (Oct. 2017).

[25] Amanda Valdez & Tushar Bajaj, *Estrogen Therapy*, NATIONAL LIBRARY OF MEDICINE – STATPEARLS PUBLISHING (Jan. 2023), https://www.ncbi.nlm.nih.gov/books/NBK541051/.

[26] *Id.*; 3.CR.46 (testimony of Michael Laidlaw, M.D.).

[27] *See, e.g.*, Zeina Nabhan & Erica A. Eugster, *Hormone replacement therapy in children with hypogonadotropic hypogonadism: where do we stand?*, 19 ENDOCRINOLOGY PRAC. 968, 968–71 (Nov. 2013).

understand these hormones, and many are readily familiar with prescribing them as a treatment for other conditions.

Likewise, so-called "puberty blockers"—more formally, gonadotropin-releasing hormone (GnRH) agonists—are also prescribed and generally understood in the broader medical field. Their mechanism of action—down-regulation and inhibition of the hypothalamic-pituitary-gonadal axis and corresponding reduction in endogenous sex hormones—and effects are well known.[28] For many years, they have been used by pediatric endocrinologists for rare cases of central precocious puberty, where puberty begins too early.[29] But they are also prescribed by a variety of physicians, including gynecologists and oncologists, to treat other diseases even in adults, including endometriosis, prostate cancer, and breast cancer, through stopping the production of sex hormones that exacerbate these diseases.[30] But these uses are extreme cases, often involving debilitating or life-threatening conditions that make intrusive

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[28] *See* Hruz et al., *supra* n.23.

[29] *Id.*

[30] Patrizia Limonta et al., *GnRH Receptors in Cancer: From Cell Biology to Novel Targeted Therapeutic Strategies*, 33 ENDOCRINE REVS. 784, 784–811 (Oct. 2012); Anna Maria Rzewuska et al., *Gonadotropin-Releasing Hormone Antagonists—A New Hope in Endometriosis Treatment?*, 12 J. CLIN. MED. 1008 (Jan. 28, 2023); United States Food and Drug Administration, Full Prescribing Information for Lupron Depot-Ped, https://www.accessdata.fda.gov/drugsatfda_docs/ label/2011/020263s036lbl.pdf.

intervention necessary. Puberty blockers are not approved by the FDA to treat gender dysphoria.[31] And they are not prescribed to physically healthy individuals with properly functioning bodily systems except in the context of gender-affirming medicine.[32] These medicines too are well known to a variety of medical practitioners, but their use to treat gender dysphoria by a small group of gender-affirming specialists represents an extreme departure from ordinary practice and care.

II. The Plaintiff Physicians and Their Experts Have No Special Insight and Are Proceeding with Experimental Treatments that Are Inconsistent with the Basic Standards of Medicine and Medical Ethics.

While many basics of gender dysphoria and its associated treatments are not obscure, only a small fraction of physicians promote and practice the medical interventions at issue here. Plaintiffs represent that this is because they are the experts who alone understand the issues. But a more reasonable explanation is that the interventions they pursue are inconsistent with the basic standards of medicine.

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[31] Carla M. Lopez et al., *Off-Label use of GnRH Agonists Among Pediatric Patients in the United States*, 57 CLINICAL PEDIATRICS 1432, 1432–35 (2018).
[32] *See id.*

A. The core concept of "gender" dysphoria is unclear, and Plaintiffs and similar practitioners exploit this.

The concept of "gender identity"—"a person's internal sense of belonging to a particular gender"—is at the heart of Plaintiffs' definition of gender dysphoria. Plaintiffs' experts describe it as the "core sense of belonging to a particular gender, such as male or female,"[33] "one's internal sense of being male or female (or rarely, both or neither),"[34] or "a person's internal, innate sense of belonging to a particular sex."[35] Plaintiffs and their experts stress that this "sense" is "internal,"[36] "innate,"[37] and "immutable,"[38] which indicates that it has a "significant biological component" or basis.[39] One expert further opines that gender identity is a sex characteristic akin to other entirely physical, biological characteristics.[40] According to Plaintiffs, "a person's gender identity is durable and cannot be altered voluntarily or changed through medical intervention."[41] And while Plaintiffs do not actually define "gender," two

[33] Compl. Ex. 16, ¶ 30.
[34] Compl. Ex. 17, ¶ 24.
[35] Compl. Ex. 15, ¶ 28.
[36] Compl. ¶ 17; Ex. 15, ¶ 28; *id.* Ex. 17, ¶ 24.
[37] Compl. Ex. 15, ¶ 28; *id.* Ex. 16, ¶¶ 34–35.
[38] Compl. Ex. 16, ¶35.
[39] Compl. ¶ 18; *id.* Ex. 15, ¶¶ 28–29; *id.* Ex. 16, ¶ 34; Compl. Ex. 17, ¶ 24.
[40] Compl. Ex. 16, ¶ 16, 31
[41] Compl. ¶¶ 18–19.

of Plaintiffs' experts have effectively equated gender and gender identity.[42] This vagueness appears to disarmingly render the definitions either circular or redundant. But it instead serves as a deliberate departure from Plaintiffs' own cited standard, the DSM, in service of their intervention agenda.

The DSM approaches the issue differently, stressing that gender and gender identity are socially defined. In the DSM, the incongruence causing distress is between "experienced/expressed gender" and "assigned gender," the latter also being variously defined as male or female biological sex.[43] The DSM defines gender as "the public, sociocultural (and usually legally recognized) lived role as boy or girl, man or woman, or other gender."[44] "Gender identity" is separately defined, but not used within the definition of gender dysphoria, as "a category of social identity and refers to an individual's identification as male, female, some category in between (i.e., gender fluid), or a category other than male or female (i.e., gender neutral)."[45] In the DSM, gender and gender identity are largely public, social concepts, and "[b]iological

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[42] Compl. Ex. 17, ¶ 25; 2.CR.103 (testimony of Daniel Shumer, M.D.).
[43] DSM 5-TR at F64.0 and 512.
[44] *Id.* at 512.
[45] *Id.*

factors are seen as contributing, in interaction with social and psychological factors, to gender development."[46]

Despite Plaintiffs centrally relying on the DSM to define gender dysphoria,[47] they adopt definitions of gender and gender identity that fundamentally change its meaning. Indeed, one of Plaintiffs' experts goes so far as to implicitly reject the DSM definition (even though he cites it later) by stating that gender identity "does not refer to socially contingent behaviors, attitudes, or personality traits."[48] This deliberate, coordinated effort on behalf of Plaintiffs and their experts to depart from the DSM undermines their own claims to any authority.

The apparent rationale for Plaintiffs' departure is twofold. First, if the gender identity that causes the dysphoria is both innate and biological, it *seems* (perhaps to non-physicians) more like a physical medical condition amenable to invasive interventions aimed at organs other than the brain rather than only to psychiatric interventions. More prosaically, if gender dysphoria is caused by a condition that is more like a hormonal disorder, then it appears that a hormonal treatment is more

[46] *Id.*
[47] Compl. ¶ 25.
[48] Compl. Ex. 15, ¶¶ 28, 29, 37.

straightforwardly appropriate. Second, Plaintiffs must also cull references to gender being in substantial part a social phenomenon, lest the contradiction in a socially determined identity being biologically innate becomes readily apparent.

Plaintiffs' unannounced and unjustified revision undermines the central authority for their position and renders all their claims dubious. There is no reason to believe that their revised terms are more than convenient, coordinated litigating positions. But the departure also accomplishes little because their position on what causes gender dysphoria is in tension with the evidence. There is no specific, known biological basis for gender identity, and the *most* that Plaintiffs' experts can say is that more research is needed.[49] There is no test based on any physical or biological characteristics that can determine what a person's gender identity is, whether it differs from that person's sex, or whether that person has gender dysphoria.[50] While gender dysphoria is accurately considered a mental disorder (necessarily by its inclusion in the DSM), it is not a disease as it has no "specific cause."[51] There is thus no reason at

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[49] 2.CR.43–44 (testimony of Aron Janssen, M.D.).
[50] 3.CR.66 (testimony of Michael Laidlaw, M.D.).
[51] OXFORD CONCISE MEDICAL DICTIONARY 214–15 (8th ed. Oxford Univ. Press 2010).

the outset to think that gender dysphoria is more amenable to physical interventions to other body systems than any other mental disorder that stems from the patient holding socially contingent self-conceptions. It is certainly *not* like a physical ailment.

B. Plaintiffs' fundamental goal requires a mismatch between the condition and the intervention.

Despite the attempts of Plaintiffs to revise the core concepts at issue, there is still no dispute that gender dysphoria is a mental disorder with no clear cause, much less a clear biological one. There are several straightforward and critical implications that follow from this.

To begin, all the interventions at issue in this litigation do not treat, much less cure, the underlying cause of the incongruence that causes distress at the heart of gender dysphoria. Plaintiffs' revision of the DSM makes the very notion incomprehensible. They insist that gender identity cannot be altered and assert that the goal of treatment is not to change a patient's gender identity.[52] At the same time, they make no argument that sex (even, or especially, "sex assigned at birth") can be changed or is changed by treatment. This creates a logical conundrum because, under

[52] Compl. ¶ 29.

those definitions, the incongruence cannot be reduced. So Plaintiffs would have to explain how their proposed interventions treat the distress without touching the incongruence that causes it. They do not. Instead, Plaintiffs appear to ignore their novel definitions when they describe the specifics of treatment.

Under the DSM, the incongruence between experienced/expressed gender and sex is often caused by an incongruence between the primary and secondary sex characteristics the adolescent is developing or will develop and the sex characteristics of the other gender; the adolescent wants to be rid of the characteristics that they have and have those of the other gender.[53] The treatments Plaintiffs seek are designed to prevent natural puberty from occurring, with the development of secondary sex characteristics consistent with that puberty, and to create secondary sex characteristics that may appear more consistent with the other gender. As one of Plaintiffs' experts attested, puberty blockers are administered at the beginning of adolescence (Tanner Stage 2) to "prevent the distress of developing permanent, unwanted physical characteristics that do not

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[53] DSM 5-TR at F64.0.

align with the adolescent's gender identity."[54] Hormone therapy is intended to "facilitate development of sex-specific physical changes congruent with the[adolescent's] gender identity."[55] Simply put, the treatments are specifically intended to impair and halt the normal functioning of an adolescent's endocrine system and body and fundamentally alter it for life in service of treating a psychiatric disorder. These explanations and the DSM do not align with Plaintiffs' rewritten definitions.

Regardless, Plaintiffs' approach is not how medicine works. Problems involving mental health are not treated by targeting and intentionally harming ordinary, healthy development of bodily functions and organs. The case of body dysmorphic disorder or body integrity identity disorder—where one desires the amputation of healthy limbs, paralysis, or other impairment of ordinary body functions[56]—is instructive because it is the closest analogue. The ethical problems of treating that disorder through irreversible physical impairment by

[54] Compl. Ex. 15, ¶ 63.
[55] Compl. Ex. 15, ¶ 72.
[56] DSM 5-TR at 520.

amputation are well recognized.[57] The vast weight of authority sees it as impermissible; instead, causal therapy is recommended to address the root psychological causes of the desire for self-harm.[58]

Indeed, proponents of the interventions at issue here explicitly and implicitly recognize the problem of associating those interventions with the approach to treating body integrity identity disorder that is recognized as unethical. The DSM classifies the conditions as separate.[59] It notes that while body integrity identity disorder can overlap with gender dysphoria, the desire to alter or remove a specific body part because it represents a repudiated assigned gender is not the former.[60] Dr. Marci Bowers, the World Professional Association for Transgender Health (WPATH) President-elect, who has also served on the boards of GLAAD and the Transgender Law Center (counsel for Plaintiffs),[61] has admitted that amputating a healthy limb because of body integrity

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[57] *See, e.g.*, Sabine Muller, *Body integrity identity disorder (BIID)—is the amputation of healthy limbs ethically justified?*, 9 Am. J. Bioeth. 36, 37–43 (2009).
[58] *Id.*
[59] DSM 5-TR at F45.22.
[60] DSM 5-TR at 520.
[61] Marci L. Bowers, M.D., *About Marci Bowers*, (visited December 18, 2023) https://marcibowers.com/dr-bowers/.

identity disorder is out of the question.[62] Yet this limitation sets the proposed treatments for adolescent gender dysphoria apart from those for all other psychiatric conditions because no other psychiatric condition justifies such interventions. Even before questions of efficacy, the practice of stunting or harming a normally developing body to mirror a disordered mental image goes directly against ordinary standards of treatment.

The treatments Plaintiffs tout depart even further from ordinary standards because they functionally reverse the purpose of treatment. Plaintiffs effectively treat puberty, rather than mental distress, as the disease. The normal biological process of puberty is treated as the natural history to be changed by a course of treatment, and the prognosis depends on how successfully the treatment alters that biological process and mirrors (necessarily quite imperfectly) the natural puberty of the other sex. This is contrary to the basics of medicine. Puberty is not a disease because it is not a "disorder," "abnormality or failure to function

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[62] Kaylee McGhee White, *The Three Craziest Moments from Matt Walsh's 'What is a Woman,"* INDEPENDENT WOMEN'S FORUM (June 13, 2023), https://www.iwf.org/2022/06/13/the-three-craziest-moments-from-matt-walshs-what-is-a-woman/.

properly."[63] Yet treating it as a disease itself creates iatrogenic disease by preventing the proper functioning and physiological development of an adolescent's body.[64] That violates the first tenet of the Hippocratic Oath to "do no harm."

These inversions of the standards of medicine and the uniquely harmful manner of treating adolescent gender dysphoria should be sufficient to justify medicine excluding Plaintiffs' approach. Even if they are not, they should set the bar uniquely high for the evidence of benefit from the proposed treatment so that the case for it becomes uniquely compelling. As the next section covers, Plaintiffs' case falls short.

C. Plaintiffs' treatments for gender dysphoria are experimental and without justification.

The evidence in favor of Plaintiffs' preferred interventions is not compelling, and they effectively acknowledge as much. Such interventions are, at best, highly experimental, with great risks of harm (some effectively guaranteed) and uncertain benefits. The calculus is stacked heavily against them.

[63] OXFORD CONCISE MEDICAL DICTIONARY, *supra* note 51, at 214–15.

[64] Kenneth J. Zucker, *Debate: Different Strokes for Different Folks*, 25 CHILD & ADOLESCENT MENTAL HEALTH 1, 1–2 (2020).

1. The treatments lack evidence of their efficacy.

Physicians must understand how to read studies because "optimal clinical decision-making requires" support "from systematic summaries" based on high-quality evidence.[65] Finding and relying on high-quality evidence from studies is critical to medicine.

A key differentiator in the quality of evidence is the research methodology that generated it. Quality is determined "by the reliability of the study," that is, how well it could be expected "that somebody else performing the same study would get the same results."[66] The gold standard of evidence, systematic reviews, are studies that review the other studies by assessing them according to their relative qualities.[67]

Over thirty years of systematic reviews have returned no reliable evidence in support of there being any benefit from the medical interventions sought by Plaintiffs.[68] The few studies that Plaintiffs lean on have major methodological problems.[69] As twenty-one clinicians and

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[65] GORDON GUYATT ET AL., USERS' GUIDES TO THE MEDICAL LITERATURE 10 (McGraw Hill Education, 3rd ed. 2015).
[66] 3.CR.85–86 (Testimony of James Cantor, M.D., Ph.D).
[67] *Id.*
[68] *See* E. Abbruzzese et al., *The Myth of 'Reliable Research' in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed*, 49 J. Sex & Marital Therapy 673 (2023) (analyzing 30 years of systematic studies across various countries and finding support for gender-affirming care unreliable).
[69] *Id.*

researchers from nine countries recently warned, treating gender-dysphoric minors with puberty blockers and cross-sex hormones "is not supported by the best available evidence," despite "the Endocrine Society's claims" to the contrary; "[e]very systematic review of evidence to date, including one published in the Journal of the Endocrine Society, has found the evidence for mental-health benefits of hormonal interventions for minors to be of low or very low certainty."[70] Many reputable sources, such as the British Medical Journal, have compiled evidence demonstrating that Plaintiffs' proposed interventions have little or no support.[71]

These conclusions are certainly noted by prominent physicians. For instance, Dr. Gordan Guyatt, who coined the term "evidence-based medicine," gave content to the paradigm that now dominates medical research,[72] and co-developed the GRADE system for judging evidence

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[70] Riittakerttu Kaltiala et al., *Youth Gender Transition is Pushed Without Evidence*, WALL ST. J., (July 13, 2023), https://perma.cc/5P6X-KNHL.

[71] Jennifer Block, *Gender Dysphoria in Young People is Rising—and so is Professional Disagreement*, 380 BMJ 382, 382–87 (2023), https://www.bmj.com/content/380/bmj.p382?utm_source=substack&utm_medium=email

[72] Ariel L. Zimmerman, *Evidence-Based Medicine: a Short History of a Modern Medical Movement*, 15 VIRTUAL MENTOR 71, 71 (2013), https://journalofethics.ama-assn.org/article/evidence-based-medicine-short-history-modern-medical-movement/2013-01.

employed by entities such as the Endocrine Society, judged the guidelines promoting Plaintiffs' preferred interventions as having "serious problems."[73] And the largest medical institutions of European countries, once at the forefront of championing such practices, have recently reached similar conclusions:

> Sweden's National Board of Health and Welfare, which sets guidelines for care, determined last year that the risks of puberty blockers and treatment with hormones "currently outweigh the possible benefits" for minors. Finland's Council for Choices in Health Care, a monitoring agency for the country's public health services, issued similar guidelines, calling for psychosocial support as the first line treatment. (Both countries restrict surgery to adults.) Medical societies in France, Australia, and New Zealand have also leant away from early medicalisation. And NHS England, which is in the midst of an independent review of gender identity services, recently said that there was "scarce and inconclusive evidence to support clinical decision making" for minors with gender dysphoria and that for most who present before puberty it will be a "transient phase," requiring clinicians to focus on psychological support and to be "mindful" even of the risks of social transition.[74]

Many of these countries based these conclusions on their own systematic reviews of the evidence, including findings under the GRADE system of very low-quality evidence in favor of the medical interventions.[75] Indeed,

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[73] Block, *supra* n.71.
[74] *Id.*
[75] *Id.*; *see also* NAT'L INST. FOR HEALTH AND CARE EXCELLENCE, EVIDENCE REVIEW: GONADOTROPHIN RELEASING HORMONE ANALOGUES FOR CHILDREN & ADOLESCENTS WITH GENDER DYSPHORIA (2020); NAT'L INST. FOR HEALTH AND CARE EXCELLENCE,

even in the Netherlands, where such procedures were pioneered (as the Dutch Protocol), those same procedures have come under increasing scrutiny.[76]

There is thus every reason to doubt the efficacy of Plaintiffs' proposed interventions, even when considered by ordinary standards.

2. Even Plaintiffs' experts and expert organizations acknowledge the experimental nature of the treatment they support.

There is no need to go to the literature to understand the severe limitations on the evidence in favor of Plaintiffs' proposed medical interventions or their experimental nature—Plaintiffs and their experts also recognize it.

The guidelines that Plaintiffs seek to use for treatment[77] acknowledge the limited nature of evidence in favor of those treatments. WPATH recognizes that "[a] key challenge in adolescent transgender care is the quality of evidence evaluating the effectiveness" of the

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EVIDENCE REVIEW: GENDER-AFFIRMING HORMONES FOR CHILDREN & ADOLESCENTS WITH GENDER DYSPHORIA (2020) ("NICE I"); COUNCIL FOR CHOICES IN HEALTH CARE IN FINLAND, MEDICAL TREATMENT METHODS FOR DYSPHORIA ASSOCIATED WITH VARIATIONS IN GENDER IDENTITY IN MINORS (2020); SOCIALSTYRELSEN, CARE OF CHILDREN & ADOLESCENTS WITH GENDER DYSPHORIA (2022).

[76] Joseph Filiolia, *A Ranging Transgender Debate in the Netherlands*, CITY JOURNAL (December 1, 2023), https://www.city-journal.org/article/a-raging-transgender-debate-in-the-netherlands.

[77] Compl. ¶ 30 (relying on the WPATH and Endocrine Society guidelines).

interventions Plaintiffs support; even by its assessment, "the number of studies is still low," "there are few outcome studies that follow youth into adulthood," and (according to it) "a systematic review regarding outcomes of treatment in adolescents is not possible."[78] The Endocrine Society, in preparing its guidelines, commissioned two systematic reviews limited only to effects on cardiac and bone health, and under the GRADE system the quality of evidence for all recommendations on adolescents was judged to be "low" or "very low."[79]

But Plaintiffs' experts and their associated clinics are even more candid about the experimental nature of these treatments and the inadequacy of current studies to back up current practices. Many members of the gender-affirming care field—a small and insular community—are actively receiving government grants to research the efficacy of their practices while claiming that those practices are not only already well within the bounds of established medicine, but that they also comprise the standard of care for gender dysphoria.

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[78] Eli Coleman et al., *World Pro. Ass'n for Transgender Health, Standards of Care for the Health of Transgender and Gender Diverse People* - Version 8, 23 INT'L J. TRANSGENDER HEALTH 546 (Sept. 15, 2022), https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644.
[79] Block, *supra* n.71.

The National Institutes of Health, for instance, is currently funding a series of major grants for leading pediatric gender clinics to study the effects of "gender-affirming" interventions on youth. The most recent extension of this grant was approved on June 1, 2023.[80] Dr. Kennedy, one of Plaintiffs' experts, is the principal investigator on that grant and touts it as one of her core credentials as an authority on treatment for gender dysphoria.[81] The abstract for the study recognizes that adolescents "who experience incongruence between assigned sex at birth and internal gender identity" are "poorly understood and an understudied population in the United States."[82] It further notes that "[s]ince 2008, medical care for transgender youth has generally followed guidelines developed by professional consensus, given the paucity of empirical research" and that "existing models of care for transgender youth" have "limited empirical research to support them."[83] This admission comes from five of the

[80] Nat'l Inst. of Child Health and Human Dev., Award Number: The Impact of Early Medical Treatment in Transgender Youth, https://taggs.hhs.gov/Detail/AwardDetail?arg_AwardNum=R01HD082554&arg_ProgOfficeCode=50

[81] Compl. Ex. 17, ¶ 12.

[82] Johanna Olson-Kennedy et al., *Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study*, 8 JMIR Research Protocols e14434 (Jul. 9, 2019).

[83] *Id.*

leading centers that engage in these practices across the country. So while they testify that the treatments are established medicine and carry them out with adolescents daily, they have also received upwards of $8.7 million in funding by representing the opposite to the federal government.[84]

3. The treatments are not safe and often medicalize adolescents for life.

While the potential harm from the interventions Plaintiffs seek is also understudied (given the paucity of studies generally), some of it is obvious. As discussed above, puberty is a critical and natural stage in the development of humans. Halting the development of secondary sex characteristics through "puberty blockers" also halts the development of primary sex characteristics, meaning that the reproductive system fails to develop along with fertility.[85] This type of intervention used to be considered "chemical castration" based on the capacity for causing sterility.[86]

As such treatment progresses to cross-sex hormones, the goal remains to prevent the adolescent from going through natural puberty

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[84] *See* source cited *supra* n.80.
[85] *See* 3.CR.34 (testimony of Michael Laidlaw, M.D.).
[86] 3.CR.102–103 (testimony of James Cantor, Ph.D.).

and therefore from ever developing the reproductive organs necessary to reproduce.[87] The goal thus necessarily requires lifelong medical intervention and sterility.[88] Even if abbreviated natural puberty occurs and the adolescent develops reproductive capacity, the administration of cross-sex hormones threatens continuing fertility and can also render the individual sterile.[89] And surgery can also further impair basic reproductive functions. Even double mastectomies ("top surgery"), the type of surgery Plaintiffs most readily would consider,[90] remove the capacity to breastfeed.[91] Having children is a major way humans derive meaning from their existence, and losing that capacity is a fundamental harm that adolescents are ill-equipped to understand. There are serious concerns that an adolescent, with a poorly developed prefrontal cortex, cannot give the informed assent (along with a parent's informed consent) necessary under the guidelines and general standards of medicine for treatment with "puberty blockers" or cross-sex hormones.[92]

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[87] *See* Compl. ¶ 28; 2.CR.87-88.
[88] Kaltiala, *supra* n.70; 3.CR. 102–03 (testimony of James Cantor, Ph.D.).
[89] Kaltiala, *supra* n.70; Compl. Ex. 15, ¶ 81.
[90] Compl. ¶ 45; 2.CR.99 (testimony of Daniel Shumer, M.D.)
[91] 3.CR.217 (testimony of John Perrotti, M.D.)
[92] 3.CR.55 (testimony of Michael Laidlaw, M.D.); *id.* at 182–83 (testimony of C. Alan Hopewell, Ph.D.).

Together with harm to reproductive function, other risks are well established, including risks of reduced or nonexistent sexual function,[93] reduced bone density,[94] and harm to cardiovascular health.[95] But the greater effects of lifelong medicalization are simply unknown, though there are hints of substantial problems. One is impaired cognitive development. Puberty and natural sex hormones are necessary for brain development, and studies have shown that "pubertal suppression may prevent key aspects of development during a sensitive period of brain organization."[96] One result is a possible *increase* in suicide,[97] even though suicide risk is often used as a justification for such interventions.

4. The treatments create a Catch-22 and preclude any real study of the issue.

The treatment protocol Plaintiffs seek effectively ensures that no further evidence-based study of the issue can occur. This follows first from their insistence that any attempt to treat an adolescent who wants

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[93] NICE I, *supra* n.75.

[94] *See* Michael Biggs, *The Dutch Protocol for Juvenile Transsexuals: Origins & Evidence*, 49 J. SEX & MARITAL THERAPY 348, 358–360 (2022).

[95] NICE I, *supra* n.75.

[96] *See* Diane Chen et al., *Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth*, 5 Transgender Health 246, 248–49 (2020).

[97] Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLOS ONE e16885 (Feb. 22, 2011).

pharmacological interventions with only psychological support would be unethical.[98] That makes it nearly impossible to study the natural history of the disorder or have a control group for their experimental treatments. But the treatments also remove a potential *cure*. Studies to date have consistently shown that a significant portion of children stop experiencing gender dysphoria during adolescence and with the resolution of puberty.[99] Natural puberty itself resolves gender dysphoria in many adolescents. Treatment that prevents natural puberty necessarily prevents this natural resolution, therefore requiring lifelong medicalization for individuals who would otherwise have no need for it.

This problem is compounded even further by the fact that the demographics of individuals affected by gender dysphoria have rapidly shifted recently.[100] One key change is that female children and

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[98] *See* 2.CR.116 (testimony of Johanna Olson-Kennedy, M.D.)

[99] *See* Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clinical ENDOCRINAL METAB. 3869, 3879 (Nov. 2017); James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46 J. OF SEX & MARITAL THERAPY 307, 307–13 (2020).

[100] L. Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners*. 50 ARCHIVES OF SEXUAL BEHAVIOR 3353 (Nov. 2021). *See also,* Stephen B. Levine et al., *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, 48 J. OF SEX & MARITAL THERAPY 706, 711–714 (2022).

adolescents have presented as transgender at rapidly increasing rates.[101] The cause of these demographic shifts, like the cause of gender dysphoria, is poorly understood.[102] Thus, even as Plaintiffs and their experts criticize studies demonstrating desistence over the course of puberty, the best, though limited, current understanding of the natural history of gender dysphoria for minors no longer reflects the current population of minors experiencing gender dysphoria. Researchers and practitioners have a duty to seek to understand why these rapid shifts are occurring. Plaintiffs' proposed medical interventions stifle medical research when it is needed most.

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While trained medical professionals generally understand many of the core issues involved in adolescents with gender dysphoria, what they do not understand is not better understood by Plaintiffs and their experts. No special expertise is necessary to understand that the treatments at issue are methodologically flawed and against the standards required of evidence-based medicine. The few doctors willing

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[101] *See* Qi Zhang et al., *Changes in size and demographic composition of transgender and gender non-binary population receiving care at integrated health systems*, 27 ENDOCRINOLOGY PRAC. 390, 390–395 (May 2021).
[102] *See id.*

to engage in these experimental and potentially dangerous treatments ought not be considered erudite experts with arcane knowledge justifying them. The decisions remain ones of basic human biology and medical ethics.

III. Transgender Interventions as Practiced in Texas Fall Short of the Core Commitments of Medical Ethics.

The misrepresentations concerning controversial and experimental interventions that Plaintiffs and their experts make more broadly also appear to have effects on how medicine is practiced in Texas. The three physician plaintiffs here are all professors at Baylor College of Medicine (BCM) and practice at Texas Children's Hospital (TCH).[103] TCH is a teaching hospital for BCM—most physicians at TCH are also affiliated with BCM, which uses TCH to educate medical students and conduct research.[104] While these physicians and institutions are all expected to uphold medical ethics, and in fact the plaintiff physicians have invoked medical ethics regarding their view of interventions for adolescent gender

[103] Compl. ¶¶ 98, 101, 104; Ex. 8 at ¶¶ 9, 13; Ex. 9 at ¶ 8; Ex. 10 at ¶ 8.
[104] Texas Children's Hospital, Baylor College of Medicine Affiliation, https://www.texaschildrens.org/ about-us/baylor-college-medicine-affiliation.

dysphoria,[105] their actual practices are, at best, in tension with standards of medical ethics in several ways.

A. TCH and plaintiff physicians have not been forthright about when and how their preferred interventions are practiced.

Physicians have a duty of honesty. The American Medical Association's Principles of Medical Ethics, which describe the "standards of conduct that define the essentials of honorable behavior for the physician," provide that a physician will be "honest in all professional interactions" and will "report physicians" who are "engaging in fraud or deception."[106] Yet the plaintiff physicians and TCH have acted in ways that do not further these standards in order to avoid political and professional scrutiny.

One way that TCH and the plaintiff physicians have been less than forthright is through their statements surrounding a purported halting of their preferred medical interventions. Well before SB 14 was passed, there was concern in Texas that such interventions were inconsistent even with then-current laws. In 2021, the Chair of the Texas House of

[105] 2.CR.170, 187; *see infra.*
[106] Am. Med. Ass'n, *AMA Principles of Medical Ethics*, CODE OF MEDICAL ETHICS (rev. 2001), https://code-medical-ethics.ama-assn.org/principles ("AMA Code").

Representatives Committee on General Investigating requested an opinion from the Texas Attorney General on whether various interventions for minors with gender dysphoria could be considered child abuse under Texas law. On February 18, 2022, the Texas Attorney General responded that certain chemical and surgical interventions done for purposes of gender reassignment, including those that cause temporary or permanent infertility, could violate Texas criminal laws.[107] TCH shortly followed that with a public statement on March 4 that it had "paused hormone-related prescription therapies for gender-affirming services" in order to "safeguard" its healthcare providers from "legal ramifications."[108]

Despite TCH's statement, all evidence points to TCH and plaintiff physicians continuing such procedures without any pause at all. Indeed, from even limited medical records made public by a whistleblower, it appears that a TCH physician surgically implanted a "non-biodegradable

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[107] Tex. Attorney Gen., Attorney General Opinion No. KP-0401 (Feb. 18, 2022), https://www.texasattorneygeneral.gov/sites/default/files/opinion-files/opinion/2022/kp-0401.pdf.

[108] Emily Hernandez & Eleanor Klibanoff, *Attorney General Ken Paxton asks Texas Supreme Court to let investigations into transgender families continue*, THE TEXAS TRIBUNE, Mar. 21, 2022, https://www.texastribune.org/2022/03/21/texas-transgender-investigation-child-abuse-appeals-court/.

drug delivery implant" for an 11-year-old's female-to-male transgender therapy only three days after the statement.[109] Similar procedures continued through 2022 and into 2023, including to provide puberty blockers and hormones to new and established minor patients.[110] At no point before the passage of SB 14 did TCH explain that it was resuming (or had never paused) such procedures. Indeed, if TCH had paused procedures, that experience would inform how hospitals and patients might deal with SB 14. Nevertheless, none of the plaintiffs even mentioned that TCH or any of its physicians had paused any form of intervention. One implied that the changes required by SB 14 are unprecedented.[111] The only plausible conclusion is that TCH never changed course despite its public statement.

Another way that TCH and plaintiff physicians have been less than candid is by keeping even the existence of any official effort by TCH to provide gender-affirming care secret. Indeed, the only acknowledgment of such effort appears to be here, for the purpose of protecting it. Dr.

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[109] See page 8 of the documents ("Documents") found at https://rufo.substack.com/api/v1/file/4a0310a9-11e6-4c4f-8604-dbaf9ea17c95.pdf, linked within Christopher F. Rufo, *Sex-Change Procedures at Texas Children's Hospital*, Substack (May 16, 2023), https://christopherrufo.com/p/sex-change-procedures-at-texas-childrens.

[110] *Id.* at 6–7, 13.

[111] 2.CR. 187-88.

Roberts avers that since 2020, he has served as the BCM and TCH Division of Endocrinology Transgender Care Co-Lead and that, as of 2023, he has also served as "co-Medical Director of the Transgender Care Program, which encompasses the multidisciplinary nature of gender-affirming care, at Texas Children's Hospital."[112] There is, however, no information whatsoever on such a program on TCH's website or any similarly publicly available document other than Dr. Robert's affidavit attached to the complaint. Nor is there any other publicly available information about transgender care at TCH's Endocrinology Division. And it appears that TCH removed even biographies of doctors from its website after it was reported that TCH was still performing transgender medical procedures.[113]

The point of this secrecy is not inscrutable. In 2021, Children's Medical Center Dallas formally dissolved its highly public gender-

[112] Compl. Ex. 8, ¶ 13.
[113] *See* Christopher F. Rufo (@realchrisrufo), Twitter (May 17, 2023 12:51 AM), https://twitter.com/realchrisrufo/status/1658696729519337472?s=21&t=rV2_9wvG49_wYXru5Zi3ZQ. None of the three doctor plaintiffs are currently listed on TCH's website as affiliated with it.

affirming program specifically because it came under public scrutiny.[114] But this level of secrecy and deception is inappropriate for any medical care, much less for experimental care performed at a research hospital by physicians affiliated with a research medical school—the very same kind of care under active grant research. Public scrutiny is particularly appropriate in such circumstances.

B. Plaintiff physicians and TCH have undermined the respect they claim to show for informed consent in other recent statements.

Informed consent "is fundamental in both ethics and law."[115] No one in this litigation has disputed that healthcare providers have an obligation to obtain informed consent for all the care at issue. And no one has disputed that, for minor patients, informed consent must be obtained from the parent(s) alongside assent from the minor patient. In this litigation, the parent and physician plaintiffs, represented by the same counsel, assert that their interests are convergent. The parents assert their "parental rights" and argue that those rights are at their "apex"

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[114] Karen Brooks Harper, *Dallas health care program for transgender kids formally dissolved after becoming target of conservative criticism*, THE TEXAS TRIBUE, Nov. 19, 2021, https://www.texastribune.org/2021/11/19/texas-transgender-children-health-care-program-genecis/.

[115] Informed Consent, AMA CODE, *supra* n.106.

when parents, children, and "the child's medical providers agree" on a course of treatment.[116] Yet the plaintiff physicians and TCH have separately stated that they are suspicious of these same parental rights and may even seek to undermine parents' ability to control care through the requirement of informed consent before an intervention occurs. Beyond undermining Plaintiffs' arguments dependent upon this unity of interests, these statements also undermine core ethical standards in the medical profession.

Dr. Richard Roberts has straightforwardly stated that he does not obtain informed consent before beginning gender transitioning. In a January 13, 2023 Pediatric Grand Rounds Lecture hosted by the TCH Department of Pediatrics and BCM, Dr. Roberts answered a question requesting practical advice for dealing with "tension with the parents in supporting" a different preferred name for their child than the one given at birth.[117] He stated that he "will often ask patients by themselves if there's a name that they use privately and they would like me to use around them and if they are comfortable with me using that name or

[116] Compl. ¶ 178.
[117] Video found at https://drive.google.com/file/d/1ATedrbtXR5W9b9nh3m7YcN_Oke25iNyB/view, linked within Rufo, *supra* n.109.

pronouns with parents."[118] He further explained that he thinks that "asking in private is probably the easiest way to go" because the minor patient may be unable to use their "affirmed name in front of family members or other individuals."[119]

Dr. Katherine Gallagher, a Ph.D. psychologist who is the Clinical Program Director for the Pediatric Health Psychology program at BCM and TCH, presented alongside Dr. Roberts and supported a similar approach. In response to the same question, she stated, "I do tend to ask privately only because I really want to have the utmost respect for the privacy of that child or adolescent" (privacy from the parental informed consent) and if they need to discuss the minor's transgender identity with the parent (apparently not in every case), then she and the minor "can prepare together for how to have that communication."[120] These self-descriptions of practice at TCH also align with an account provided by a TCH staff member working with Dr. Roberts.[121]

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[118] *Id.* 1:06:00.
[119] *Id.*
[120] *Id.* 1:04:00
[121] Christopher F. Rufo, *"They're Wanting to Play God,"* SUBSTACK (May 16, 2023), https://christopherrufo.com/p/theyre-wanting-to-play-god.

Using such a preferred name is a recognized part of a gender transition intervention. Earlier in that same lecture, Dr. Roberts himself explained that using preferred names was part of "social affirmation," one of the five components of the "gender affirmation process," alongside "puberty blockers" and "cross-sex hormone therapy."[122] Even Plaintiffs recognize that social affirmation is a therapeutic intervention.[123] It is associated with, and likely causes, higher rates of completed gender transition rather than desistance.[124] The practice of socially affirming transgender identities without parental notice or consent is currently under challenge in other settings, such as schools.[125] According to Dr. Roberts himself, he begins this therapeutic intervention prior to and regardless of any consent by parents, much less informed consent.

Others affiliated with TCH have also expressed antipathy toward parental rights over gender transition. Dr. Patrick O'Malley did so during a panel discussion as part of an anecdote he shared to describe his general approach with hesitant parents. In reaction to a parent asking

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[122] Video *supra* n.117 at 31:00.
[123] *See, e.g.*, Compl. ¶ 33;
[124] *See* Zucker, *supra* n. 64.
[125] Nate Raymond, *Parents challenge Massachusetts' school district's gender identity policy*, REUTERS (Sept. 13, 2023), https://www.reuters.com/legal/government/parents-challenge-massachusetts-school-districts-gender-identity-policy-2023-09-13/.

about "parental rights" and whether Dr. O'Malley could call the child by the child's preferred pronouns regardless of those, Dr. O'Malley responded, "You do have many parental rights but I have to adhere to my own ethical standards as a physician, and I know the best thing to do for this child, their mental health, and really even their risk of suicide is to show them that respect of using the pronouns they go by."[126]

In that same discussion, Claire Horner, a BCM professor of ethics, lawyer, and clinical ethicist who trains doctors working at TCH, offered a similar opinion.[127] In response to a question about what the panel saw as "the biggest hangups or obstacles in accessing pediatric gender affirming care," she responded that "[t]he biggest hangups are going to be these parental rights issues particularly in Texas."[128] Contrary to their representations here, these healthcare providers and their institutions are, at best, wary of parental rights and the informed consent they require.

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[126] Christopher F. Rufo (@realchrisrufo), Twitter (May 17, 2023 1:39 PM), https://twitter.com/realchrisrufo/status/1658889892762615808?s=21&t=rV2_9wvG49_wYXru5Zi3ZQ

[127] Christopher F. Rufo (@realchrisrufo), Twitter (May 17, 2023 2:29 PM), https://twitter.com/realchrisrufo/status/1658902623339290624?s=21&t=rV2_9wvG49_wYXru5Zi3ZQ

[128] *Id.*

C. Plaintiff physicians and TCH have implicitly coerced other healthcare providers to assist with transgender interventions regardless of their ethical objections.

Medical ethics provide that physicians, nurses, and other staff are not to be forced or pressured to participate in medical interventions that they find unconscionable.[129] Federal law specifically protects all healthcare personnel at institutions like TCH from being required to perform certain procedures, including any "lawful sterilization procedure" (which some treatments discussed above may qualify as), when those procedures are contrary to the workers' religious beliefs or moral convictions.[130] Yet in practice, TCH and similar institutions have not respected healthcare workers' rights, much less provided them an opportunity to practice medicine consistent with their views on the ethics of transgender interventions.

As plaintiff physicians assert, transgender patients are only a minority of the patients they see and treat.[131] Clinical appointments (such as appointments for prescriptions by an endocrinologist) for those patients are interspersed among appointments for patients with other

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[129] *See* Principles 4, 6, AMA Code, *supra* n.106.
[130] 42 U.S.C. § 300a–7.
[131] *See* Compl. Ex. 8 ¶ 11, Ex. 9 ¶ 15, Ex. 10 ¶ 11.

pediatric diseases. Surgeries for implanting devices to provide "puberty blockers" or cross-sex hormones occur in the main operating rooms, before and after surgeries for non-transgender patients.[132] Some of those are the very same surgeries, done for different reasons, including to treat precocious puberty or hormonal disorders. Residents, nurses, and other staff cannot practically choose, in such a setting, to participate in only those appointments and procedures unrelated to treating gender dysphoria.

The institutional backing for transgender interventions by both BCM and TCH has placed residents and nurses under great pressure to assist with such interventions regardless of their personal convictions. The Pediatric Grand Rounds Lecture made this clear. Such lectures are intended to benefit the entire hospital and medical school by presenting faculty role models describing the newest research and treatments. When the lecture presented the "gender affirmation process" as the best practice for dealing with "transgender and gender-diverse youth" and presented no alternatives,[133] BCM and TCH made clear that everyone at

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[132] Documents, *supra* n.109, at 5–6.
[133] Video, *supra* n.117, at 4:45, 30:50.

the school and hospital was to follow it and affirm gender identities through the medical interventions.

Institutional backing was also shown by TCH's statements. When TCH announced its "pause" of hormone-related interventions in 2022, it stated that the "mission of Texas Children's Hospital is to create a healthier future for all children, including transgender children"[134]—casting its support for transgender interventions, not merely care for children with gender dysphoria. When the President and CEO of TCH wrote to TCH staff after the passage of SB 14 that TCH would comply with the law, he again made clear TCH's long-standing position.[135] He described the care TCH currently offered as "gender-affirming," described the changes required by the law as "immensely heart-wrenching," and stated that he wanted to "assure all of you that through this period and after, we all remain dedicated to educating and

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[134] Julian Gill & Gabriel Banks, *Texas Children's Hospital pauses hormone therapies for gender-affirming care after Abbott and Paxton directive*, HOUSTON CHRONICLE, Mar. 6, 2022, https://www.houstonchronicle.com/news/houston-texas/houston/article/Texas-Children-s-Hospital-pauses-hormone-16978565.php.
[135] Christopher F. Rufo (@realchrisrufo), Twitter (May 24, 2023 12:33 PM), https://twitter.com/realchrisrufo/status/1661410083421687808; *see also* Julian Gill, *Texas Children's Hospital to discontinue transgender care in coming months CEO email says*, HOUSTON CHRONICLE, May 27, 2023, https://www.houstonchronicle.com/news/houston-texas/health/article/ceo-texas-children-s-discontinue-trans-care-18117681.php.

amplifying the importance of safe, high-quality transgender medicine programs."[136] He reassured those "who have devoted their lives to gender-affirming care" that they had TCH's "unwavering commitment and support."[137] And while he recognized that there are "many viewpoints and opinions related to this matter," he sought to "remind everyone that our mission is to create a healthier future for **all** children"[138] (his emphasis)—implying that any staff unwilling to support the interventions Plaintiffs seek want something less than that. TCH has expected all staff to toe the line in support of these interventions.

These expectations have been internalized at BCM and TCH. One healthcare provider who works with Dr. Roberts revealed this pressure. That person and several other colleagues have assisted with the interventions despite their contrary personal convictions because they are afraid that they would lose their jobs if they protested.[139] Others, including physicians, have corroborated these accounts of an authoritarian culture and threats to healthcare providers' careers if they

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[136] *Id.*
[137] *Id.*
[138] *Id.*
[139] *See* Rufo, *supra* n.121.

dissent from transgender medical interventions.[140] This atmosphere is inconsistent with medical ethics and with the free and open debate required for any evidence-based medicine, much less for experimental interventions.

* * *

These ethical transgressions severely compromise arguments for Plaintiffs' preferred interventions and the public's faith in the medical profession more generally. Evidence-based medicine requires open and honest debate. A parent's trust in physicians and healthcare providers to treat their child requires that those physicians and healthcare providers obtain informed consent. When parents and the public are left in the dark and physicians are prevented from expressing grave concerns, medical practice risks running afoul of its first commitment to do no harm. Ample evidence shows that this is already happening.

CONCLUSION

There are severe problems with Plaintiffs' approach to describing and treating adolescent gender dysphoria. They depart from the

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[140] Christopher F. Rufo, *Thrown to the Wolves*, SUBSTACK (June 22, 2023), https://christopherrufo.com/p/thrown-to-the-wolves.

standards they cite as the basis for their position. They seek a treatment unique in medicine—the intentional impairment of healthy, necessary bodily development to treat a mental health condition. And they acknowledge that their treatments are poorly supported even by ordinary standards. The willingness of this small group to compromise basic medical principles and ethics and to engage in experimental treatments without oversight should be a basis to disregard their proposed interventions, not to heed them.

Respectfully submitted,

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DECEMBER 22, 2023

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