No. 25-6813

In the United States Court of Appeals for the Ninth Circuit

EMALEE WAGONER,
PLAINTIFF-APPELLEE,

V.

JENNIFER WINKELMAN,
DEFENDANT-APPELLANT.

On Appeal from the United States District Court
for the District of Alaska
Case No. 3:18-cv-00211 (Scoble, J.)

BRIEF OF ETHICS AND PUBLIC POLICY CENTER AS *AMICUS CURIAE* SUPPORTING DEFENDANT-APPELLANT

ERIC N. KNIFFIN
Counsel of Record
MARY RICE HASSON
ETHICS & PUBLIC POLICY CENTER
1730 M Street, N.W.
Suite 910
Washington, DC 20036
(202) 682-1200
ekniffin@eppc.org

Counsel for Amicus Curiae

CORPORATE DISCLOSURE STATEMENT

In compliance with Federal Rule of Appellate Procedure 26.1, I certify that *Amicus* Ethics and Public Policy Center has no parent corporation and no stock.

Dated: March 25, 2026

s/ Eric N. Kniffin
Eric N. Kniffin
Counsel for Amicus Curiae

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

STATEMENT OF INTEREST OF *AMICUS CURIAE*[1]

The Ethics and Public Policy Center (EPPC) is a nonprofit research institution dedicated to applying the Judeo-Christian moral tradition to critical issues of public policy, law, and culture. EPPC's programs cover a wide range of issues, including bioethics and human flourishing, governmental and judicial restraint, personhood and identity, and religious liberty. EPPC has a strong interest in promoting the Judeo-Christian vision of the human person and responding to the challenges of gender ideology.

INTRODUCTION AND SUMMARY OF ARGUMENT

Plaintiff-Appellee Wagoner is currently serving a 60-year sentence for child sexual abuse.[2] Wagoner has been diagnosed with the mental health disorder "gender dysphoria," defined, in this case, by criteria listed

---

[1] All parties have consented to the filing of this brief. Pursuant to Federal Rule of Appellate Procedure 29(a)(4), *Amicus* states that no party's counsel authored this brief in part or in whole, and no person (other than *Amicus*, its members, and its counsel) has contributed money to fund the preparation or submission of this brief.

[2] AK Br. at 14. Wagoner was arrested in 2011 and charged with 50 counts of sexually abusing several children—including his stepchildren, biological daughter, and the daughter of a family friend—over a ten-year period. Wagoner threatened to kill his underage victims if they told anyone that he had sexually abused them.

in the American Psychiatric Association's Diagnostic and Statistical Manual Of Mental Disorders, Fifth Edition ("DSM-5").[3] Wagoner also receives "ongoing treatment" for other mental health issues, including "borderline personality disorder, anxiety, and depression." 1-ER-0029 ¶65. The district court observed that Wagoner engages in "self-harm … on a regular basis," including cutting his penis, attempting to rip his penis open with his fingers, and crushing his testicles. 1-ER-0027 ¶56. In addition, the court noted that Wagoner's efforts to remove his testicles and penis were motivated in part by his desire to be transferred to the women's prison and room with his romantic partner. 1-ER-0026-27 ¶53.

Since 2022, on the recommendation of an outside gender clinician, the Alaska Department of Corrections has addressed Wagoner's gender dysphoria by providing "hormone therapy," which helped Wagoner "feel better." 1-ER-0030 ¶71. The court later concluded that, despite nearly three years of hormone therapy, there was "credible evidence" that

[3] For a discussion of DSM-5 criteria see Jack Drescher, Gender Dysphoria Diagnosis: History, A Guide for Working with Transgender and Gender Nonconforming Patients, American Psychiatric Association, https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis

Wagoner "continues to experience severe emotional and psychological symptoms of gender dysphoria." 1-ER-0046 ¶32.

Alaska denied Wagoner permission for a vaginoplasty over concerns that vaginoplasty was not "medically necessary," there was "insufficient evidence of long-term benefit" from the surgery, concerns that the vaginoplasty would cause Wagoner physical or mental harm, and Wagoner's pattern of non-compliance with medical care. The state also noted the lack of objective evidence that Wagoner's mental health was unstable even on hormones, and thus in need of surgical treatment. 1-ER-0014 ¶9.

The district court held that *Edmo v. Corizon, Inc.*, 935 F.3d 757 (9th Cir. 2019) was controlling precedent, and because the parties agreed that Wagoner experienced "severe gender dysphoria," the court found that the Eighth Amendment precluded Alaska from excluding "the option of a vaginoplasty" as medically necessary treatment. 1-ER-0046 ¶31, 1-ER-0048 ¶41. The court ordered Alaska to "take all actions reasonably necessary" to provide Wagoner with "gender-affirming genital surgery" and file a report on "whether a surgeon has been agreed upon" and "when surgery is expected to occur." 1-ER-0003 ¶¶ 2,4.

This appeal presents significant questions under the Eighth Amendment, including whether the Constitution can be read to require a State to facilitate an irreversible amputation of healthy sexual organs. It also implicates the Eighth Amendment's independent constraints on what the State may do to a prisoner's body—especially where an inmate seeks, and the court orders, irreversible amputation of healthy sexual organs. The district court never grappled with these Eighth Amendment concerns that run the other way. And it compounded that error by treating *Edmo* as a broad mandate and by accepting as "medical necessity" what the current record shows is a contested, weak, and methodologically fragile evidence base—one further distorted by WPATH's non-rigorous, advocacy-tainted "Standards." For those reasons, and those set out in Alaska's opening brief, the Court should reverse and remand with instructions to enter judgment for Alaska.

ARGUMENT

The court below misapplied this Court's precedent and held that the Eighth Amendment *requires* Alaska to provide Wagoner with "gender-affirming genital surgery" and file reports on "whether a surgeon has been agreed upon" and "when surgery is expected to occur." 1-ER-

0003 ¶¶2,4. This was wrong: *Edmo*'s relevant holdings are rooted in conclusions of fact, not law. *See* AK Br. at 50–51.

Properly understood, the Eighth Amendment analysis in this case requires a threshold inquiry the district court missed. The court focused exclusively on whether *denying* Wagoner's request for a vaginoplasty would be "cruel and unusual," without first asking whether—and under what conditions—the Eighth Amendment permits a state to facilitate irreversible amputations of a prisoner's sexual organs. That omission matters. The Cruel and Unusual Punishments Clause imposes independent, objective limits on what the State may do to a prisoner's body, limits that do not disappear because an inmate requests the procedures or a clinician labels it "treatment."

The district court compounded this analytical error by treating this Court's 2019 decision in *Edmo* as a categorical rule that vaginoplasty is "medically necessary" to treat an inmate's "severe gender dysphoria" and by deferring wholesale to WPATH's Standards of Care. Both moves were mistaken. The district was not bound to accept conclusions *Edmo* reached based on that case's factual record, and the record before this Court—unlike the record in *Edmo*—demonstrates that the asserted medical

necessity of sex-rejecting genital surgery rests on a contested, weak, and methodologically fragile evidence base, one further distorted by WPATH's advocacy-driven and now-discredited "Standards."

Alaska's denial of Wagoner's requested vaginoplasty is therefore not "cruel and unusual." It reflects a constitutionally permissible effort to provide medically necessary care while respecting the Eighth Amendment's longstanding safeguards against mutilating and coercive conditions of confinement.

I. The district court failed to consider Eighth Amendment safeguards against surgical castration.

The district court's Eighth Amendment analysis is inadequate because it merely considered whether *denying* Wagoner's request for surgical castration constitutes cruel and unusual punishment. It never asked the antecedent question: whether, or under what conditions, the Eighth Amendment *permits* a state to cut off a sexual predator's non-diseased testicles and penis.

As shown below, the Eighth Amendment's Cruel and Unusual Punishments Clause imposes objective limits on what the State may do to a prisoner's body, whether as punishment or in exchange for better conditions of confinement. Those limits have long been understood to

prohibit castration where there is no medical necessity and especially when prisoners may be enticed to undergo castration for favorable treatment. Alaska's efforts to treat Wagoner's gender dysphoria without amputating his genitals did not violate the Eighth Amendment; to the contrary, it honored our legal system's longstanding safeguards against cruel and unusual conditions of confinement.

A. The Eighth Amendment's limits are objective and cannot be waived.

The Cruel and Unusual Punishments Clause imposes objective limits on what the State may do to a prisoner's body, whether as punishment or in exchange for better conditions of confinement. These limits do not turn on a particular prisoner's wishes and cannot be waived.

The Clause's limits apply to both a court-imposed sentence and the "conditions of confinement"—anything that is part of the "penalty that criminals pay for their offences against society." *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981). This includes the decision to place a prisoner in solitary confinement, the conditions of his housing, and his security level. *Hutto v. Finney*, 437 U.S. 678, 685–88, 685 n.8 (1978). In all such cases, the Eighth Amendment limits "the power of those entrusted with the

criminal law function of government." *Ingraham v. Wright*, 430 U.S. 651, 664 (1977).

In determining whether conditions of confinement are subject to Eighth Amendment scrutiny, courts consider a variety of factors, including whether the measure "involves an affirmative disability or restraint," "whether it has historically been regarded as a punishment," and "whether its operation will promote the traditional aims of punishment," including "deterrence." *Bell v. Wolfish*, 441 U.S. 520, 537–38 (1979) (quoting *Kennedy v. Mendoza-Martinez,* 372 U.S. 144, 168–169 (1963)).

Courts also look to whether the conduct in question "occurs in connection with establishing conditions of confinement." *Wilson v. Seiter*, 501 U.S. 294, 299 (1991). When the State conditions a concrete custodial benefit—such as earlier release, parole eligibility, or better housing—on submission to an irreversible bodily intrusion, that bodily intrusion is no longer just a free-standing medical choice: it becomes part of the State's administration of the sentence. *Id.* at 300. A quid-pro-quo structure can turn what might otherwise look like an elective procedure into a choice

between bodily integrity and favorable treatment. *Cf. Wilson*, 501 U.S. at 300.

Because the Eighth Amendment's constraints are objective, a mutilating procedure does not cease to be "cruel and unusual" just because a prisoner requests it. When the Supreme Court has treated capital punishment as unconstitutional in certain settings—for example, as applied to rape in *Coker v. Georgia*, 433 U.S. 584 (1977)—it would have been unthinkable for a state to defend an execution on the ground that the condemned prisoner had asked to be put to death or had previously attempted suicide; the constitutional bar does not lift for volunteers. By the same logic, states cannot evade the constitutional prohibition on "barbarities" like castration by presenting a written consent form or showing that a prisoner had tried to castrate himself.

Justice Robert Jackson's concurrence in *Skinner v. Oklahoma*, 316 U.S. 535 (1942), underscores the objective nature of constitutional protections for prisoners:

> There are limits to the extent to which a legislatively represented majority may conduct biological experiments at the expense of the dignity and personality and natural powers of a minority—even those who have been guilty of what the majority define as crimes.

316 U.S. 535, 546 (1942) (Jackson, J., concurring). Thus, government may not coerce a disfavored "minority"—including convicted criminals—into participating in "biological experiments" that extinguish their basic human capacities. *Id.* at 547. These constitutional guardrails do not evaporate when prisoners agree, in hopes of obtaining favorable treatment, to serve as the government's test subjects.

That is why efforts to reclassify mutilating procedures as "treatment," or to condition them on a prisoner's "voluntary" request, do not resolve the important public policy concerns the Eighth Amendment is meant to protect.

B. The "original and historical understanding of the Eighth Amendment" marks castration as cruel and unusual punishment.

To answer whether, and under what conditions, the Eighth Amendment permits a state to cut off a sexual predator's healthy testicles and penis, this Court must "examine the original and historical understanding of the Eighth Amendment." *Bucklew v. Precythe*, 587 U.S. 119, 130–32 (2019) (Eighth Amendment forbids punishments that are "unjustly harsh in light of longstanding prior practice"); *see also Kennedy v. Bremerton Sch. Dist.*, 597 U.S. 507, 535–36 (2022) (Establishment

Clause "must be interpreted by 'reference to historical practices and understandings'"). Neither the Supreme Court nor any federal court of appeals appears to have held that the Eighth Amendment permits a State to surgically castrate a prisoner, and the few state statutes authorizing voluntary sterilization only underscore the constitutional sensitivity of any regime that invites prisoners to trade bodily integrity for penal advantage.

In *Weems v. United States*, the Supreme Court recognized "the barbarities of quartering, hanging in chains, castration, etc." as *the baseline measures of constitutional cruelty*—against which lesser sanctions are favorably compared. 217 U.S. 349, 377 (1910). It noted that the whipping post had been upheld precisely because it was mild in comparison with castration. *Id*.

In *Bucklew v. Precythe*, one of the Supreme Court's most recent Eighth Amendment decisions, the Court placed great weight on "the original and historical understanding of the Eighth Amendment," citing Blackstone's Commentaries on the Laws of England, practices at the time of the founding, and early commentary on the Eighth Amendment. 587 U.S. at 130–32. *Bucklew* also cited Professor John Stinneford's

scholarship on the Clause's original meaning and historical context. 587 U.S. at 130–31. Stinneford places castration alongside other "barbarous" procedures "such as drawing and quartering [and] burning at the stake." John F. Stinneford, *Incapacitation Through Maiming: Chemical Castration, the Eighth Amendment, and the Denial of Human Dignity*, 3 U. St. Thomas L.J. 559, 563 n.26 (2006) (citing *Gregg v. Georgia*, 428 U.S. 153, 169 (1976); *Wilkerson*, 99 U.S. at 135; *Weems*, 217 U.S. at 377)). According to Stinneford, "[s]urgical castration is generally considered to be a paradigmatic example of cruel and unusual punishment." *Id*. at 593.

Consistent with this historical analysis, American courts have treated court-ordered castration as legally impermissible. For instance, when a Florida trial court approved a plea agreement requiring surgical castration in exchange for a reduced sentence, the appellate court reversed. *Bruno v. State*, 837 So. 2d 521, 522 (Fla. 1st DCA 2003). The court found court-ordered castration illegal even though the defendant had *consented* to the procedure—illustrating that constitutional and statutory prohibitions against court-ordered castration operate independently of the prisoner's agreement or preference.

Justice Robert Jackson's concurrence in *Skinner v. Oklahoma*, cited above, recognized the constitutional stakes in this context. The "natural power" at issue in *Skinner* was the power to procreate, as the prisoner was challenging a state-ordered vasectomy. 316 U.S. at 546. Under Justice Jackson's framework, a state program of amputating sexual organs outside of medical necessity is a dangerous "biological experiment," not a mere medical option, even when some inmates sign up for the procedure.

This is why even the few modern statutes that purport to authorize state-administered castration are drafted with conspicuous caution. Florida, for example, provides that castration may not be performed "in lieu of" or to "reduce, any other penalty," Fla. Stat. § 794.0235 (2024). Texas likewise forbids the state from requiring castration as a condition of parole or community supervision and emphasizes that the procedure should not influence sentencing. Bill Analysis, Tex. S.B. 123, 75th Leg., R.S. (1997).

These safeguards do not validate these statutes, which have not faced an Eighth Amendment challenge. But they reflect an evident effort to avoid the most obvious constitutional concern: a State-sponsored

bargain. The more the State tolerates a structure that invites a prisoner to trade bodily integrity for penal advantage—such as a shorter sentence, better release terms, or improved terms of confinement—the harder it is to deny that the procedure has become part of the punishment itself. *See Wilson*, 501 U.S. at 300.

C. The surgery the court ordered Alaska to provide Wagoner implicates these Eighth Amendment concerns.

The district court's order that Alaska "shall take all actions reasonably necessary" to provide Wagoner with "gender-affirming genital surgery," 1-ER-0003 ¶¶ 2,4, bears no mark of having wrestled with the Eighth Amendment precedent and "historical practices and understandings" outlined above. This may be partly because the court's use of the terms "vaginoplasty" and "gender-affirming surgery" obscure that these surgeries amputate Wagoner's non-diseased penis and testicles. *See* AK Br. at 7 (citing 2-ER-125:19-25; 3-ER-519:1-5). Indeed, Wagoner explicitly requested the "surgical removal of her [sic] testicles." 1-ER-0038 ¶102.

Surgical castration falls within the class of constitutional barbarities identified in *Weems* and beyond the "line of unnecessary cruelty" marked out in *Wilkerson*. A vaginoplasty goes even further, as it

also requires surgically removing the prisoner's penis. This double amputation has no historical analogue in the Anglo-American tradition except in the medieval codes the Founders specifically invoked as the negative examples the Eighth Amendment was designed to prohibit. *See Wilkerson*, 99 U.S. at 135 (the "humanity of the nation by tacit consent" recoiled from such acts). Under *Bucklew*'s historical test, a challenged procedure with *no* place in longstanding prior practice is *a fortiori* "unjustly harsh in light of" that practice. 587 U.S. at 132. Moreover, as relevant under *Bell v. Wolfish*, these amputations would create "affirmative disability," have "historically been regarded as a punishment," and have been lauded as promoting both specific and general "deterrence."

Moreover, Wagoner's own statements expose the coercive nature of the requested amputations and why this case must not be sanitized into a mere dispute over "medically necessary" treatments. As the State has shown, Wagoner mutilated his genitals and petitioned for amputation because he saw that as his route to women's housing and reunion with his fiancée—the "only way" they could be together. AK Br. at 15, 17. That

is the very definition of coercive exchange: body for benefit, mutilation for transfer, sterilizing surgery for improved confinement.

These circumstances raise important Eighth Amendment concerns, ones the court should have taken into account.

II. The district court erred by accepting *Edmo*'s dated (and false) premises about the medical necessity of vaginoplasty and deference to WPATH's standards.

The district court erred when it concluded that the findings in *Edmo v. Corizon*, 935 F.3d 575 (9th Cir. 2019) were authoritative and compelled the court to order Alaska to approve Wagoner's vaginoplasty. The Court should not have deferred to *Edmo*'s finding that vaginoplasty is an evidence-based and medically necessary treatment for gender dysphoria, nor to *Edmo*'s claims about WPATH's "Standards of Care" ("Standards" or "SOC").

This case differs from *Edmo* in important respects. First, Wagoner's medical and mental health history is complex and involves facts unlike those in *Edmo*—notably Wagoner's diagnosis of borderline personality disorder, AK Br. at 17–18, history of noncompliance with prescribed treatments, *id.* at 44–46, and romantic motivation to be housed with women inmates, *id.* at 49. Second, new evidence challenges *Edmo's* dated

and casebound premises. These premises were flimsy when *Edmo* was decided, based on thin and limited evidence. But they have since been proven false. Current research underscores the significant uncertainty and limited evidence of benefit related to sex-rejecting surgeries. In addition, WPATH has been discredited, and its Standards dethroned from their prior status as an authoritative and trustworthy guide to clinical care for gender dysphoria.

A. New research shows the evidence base for sex-rejecting surgeries is, and always was, weak and unreliable.

Sex-rejecting surgery is by nature controversial and, as judged through the lens of Anglo-American history, barbaric and cruel. By design, vaginoplasty surgically removes healthy male genitals, replacing them with a constructed facsimile of female anatomy. The surgery degrades healthy functioning, creates iatrogenic (physician-induced) harm, and causes permanent and disabling losses—including sterility and loss of sexual function—with no guarantee that gender dysphoria will recede.

Only recently—since this Court decided *Edmo* in 2019—have some gender clinicians openly acknowledged the weak and unreliable evidence

used to justify sex-rejecting surgeries. The first systematic evidence review to offer a comprehensive look at the available "outcomes" evidence for all sex-rejecting surgeries was not published until 2022,[4] many decades *after* these procedures began, and a full decade *after* the WPATH SOC-7 (the WPATH standards *Edmo* relied on) claimed to "promote evidence-based care."[5] This comprehensive review noted that the "high patient satisfaction" reported for vaginoplasties had "little concordance" with study methods, "outcome metrics," and measurement instruments—deviations which undercut the reliability of the reported evidence.[6] For example, the reviewers noted that although "68.7% of genitoplasty papers" reviewed had "addressed patient-centered outcomes

---

[4] Norah Oles, et al., *Gender Affirming Surgery: A Comprehensive, Systematic Review of All Peer-reviewed Literature and Methods of Assessing Patient-centered Outcomes (Part 2: Genital Reconstruction).* 275 Ann. Surg. e67-e74 (2022), https://pubmed.ncbi.nlm.nih.gov/34914663/.

[5] WPATH, Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People, 7th Version (2009), at 1. *See also* Appendix D at 107-108 ("Evidence of Clinical Outcomes for Therapeutic Approaches), which asserts "the vast majority of studies" show "the undeniable beneficial effect of sex reassignment surgery on postoperative outcomes," before hedging, saying, "although the specific magnitude of benefit is uncertain from the currently available evidence."

[6] Oles at e67.

… only 1.0% used metrics validated in the transgender population."[7] Whether the reported outcomes have any predictive value for future patients and procedures is anybody's guess. Across decades of research, numerous methodological problems (sampling bias, lack of standardized outcomes, language, and measurement instruments, and missing or inconsistent follow-up times) render it almost impossible to draw firm conclusions about the risks or benefits of sex-rejecting surgeries.

Another 2022 systematic evidence review, focusing solely on studies of sex-rejecting genital surgery for males, underscored the lack of consistent outcome metrics and study parameters.[8] The reviewers evaluated 93 studies involving 7,681 patients and 2,621 distinct reported outcomes: they discovered that only one-third (32.7%) of those reported outcomes were ever defined, and just 70% of studies mentioned the timeframe over which these outcomes were measured.[9] The missing

---

[7] *Id.*

[8] Thomas E. Pidgeon, et al., *Outcome Measures Reported Following Feminizing Genital Gender Affirmation Surgery for Transgender Women and Gender Diverse Individuals: A Systematic Review*, 24 Int'l J. Transgender Health 149-173 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC10132236/

[9] *Id.*

information is critical: without knowing what outcomes were assessed, how they were defined, and whether they were assessed after 7 days, 7 weeks, or 7 years, a study's reported results are inconclusive at best. Without rigorous research parameters and defined outcomes, it is near-impossible to know whether vaginoplasty yields objective patient benefits or merely self-reported "customer satisfaction."

Research on surgical complications in males undergoing vaginoplasty is similarly weak. Although urinary dysfunction is a predictable risk from vaginoplasty (the surgery dislodges, shortens, and relocates the urethra), and despite decades of vaginoplasties performed on thousands of patients, a 2023 systematic evidence review cautioned that "little literature" evaluated post-vaginoplasty urinary complications.[10] The "available evidence" reported relatively low rates of typical urinary complications, such as "poor/splayed stream (11.7%)," "meatal stenosis (6.9%)," "irritative symptoms (frequency, urgency, nocturia) (11.5%)," "retention requiring catheterization (5.1%),"

[10] Christina Ding, et al., *Urinary Complications After Penile Inversion Vaginoplasty in Transgender Women Systematic Review and Meta-Analysis*, 17 Can. Urol. Ass'n J. 121-128 (2023), https://pubmed.ncbi.nlm.nih.gov/36486178/.

"incontinence (8.7%)," "urethral stricture (4.6%)," and "urinary tract infection (5.6%)." But limited evidence and lack of "standardization of data" leaves many questions unanswered.[11]

In 2025, the uncertain evidence and increased public scrutiny over claimed benefits and harms of sex-rejecting procedures finally spurred prominent gender surgeons to develop a standardized "core outcome set" to improve research consistency and reliability.[12] Put differently, *before* 2025, clinicians performing sex-rejecting genital surgeries freely picked and chose which outcomes to report and how to define and measure them (if at all). The WPATH Standards, meanwhile, touted the "undeniable" benefits of vaginoplasty and related procedures. Most gender clinicians rarely acknowledged (at least in public) what is now clear: there's little hard evidence that sex-rejecting surgeries yield the advertised benefits.

Perhaps the most egregious evidence gap, however, relates to vaginoplasty's presumed positive effect on gender dysphoria.

---

[11] *Id.*

[12] Marleen S. Vallinga, et al., *The Core Outcome Set for Studies on Feminizing Genital Gender-Affirming Surgery: Findings from the GenderCOS Project*, 85 EClinicalMedicine103323 (2025), https://pubmed.ncbi.nlm.nih.gov/40741221/.

Astonishingly, the central justification for vaginoplasty—that this "medically necessary" treatment actually reduces gender dysphoria—remains unproven. No reliable body of research shows, for example, whether undergoing a vaginoplasty is more likely to improve or worsen the patient's gender dysphoria. Indeed, few studies even ask the question. A 2025 systematic evidence review of Canadian hormonal and surgical interventions found that "most studies (61%) did not use patient-reported outcome measures (PROMs)."[13] (PROMs are an essential measure when, as with gender dysphoria, "externally observable patient-important outcomes are rare or unavailable."[14]) The few studies that did record PROMs typically failed to "capture gender-related constructs (e.g., gender dysphoria)."[15] While WPATH and most insurers use a gender dysphoria diagnosis to justify genital surgery as "medically necessary,"

---

[13] Liam Jackman, et al. *Outcome Measurement for Gender-Affirming Care in Canada: A Systematic Review*, 15 BMJ Open e091135 (2025), https://pubmed.ncbi.nlm.nih.gov/40074262/. For specific outcomes measured by the included studies, see the Supplemental Table 3, available in the online version.

[14] Cochrane Handbook for Systematic Reviews of Interventions, Chapter 18.1.2 (2024), https://www.cochrane.org/authors/handbooks-and-manuals/handbook/current/chapter-18#section-18-1-2.

[15] Jackman, et al.

the Canadian review found that only 6% of studies even measured whether surgical interventions reduced gender dysphoria.[16] And only 3% of studies evaluated gender dysphoria using an empirically validated instrument, such as the Utrecht Gender Dysphoria Scale.[17]

Studies also fail to show that vaginoplasties improve mental health or reduce suicidality. For instance, a 2011 longitudinal, population-based study from Sweden assessed mortality and suicidality in individuals "after surgical sex reassignment."[18] Compared to matched controls, "sex-reassigned persons" experienced higher overall mortality, were 4.9 times more likely to attempt suicide, and were 19 times more likely to commit suicide.[19] More recently, a 2020 study that "compared outcomes between

---

[16] *Id.*

[17] *Id.* The Utrecht Gender Dysphoria Scale was published first in 1997, with an updated version published in 2020. Peggy Cohen-Kettenis, et al., *Sex Reassignment of Adolescent Transsexuals: A Follow-up Study*, 36 J. Am. Acad. Child & Adolescent Psych. 263 (1997), https://www.jaacap.org/article/S0890-8567(09)62807-0/abstract. McGuire, J.K., et al., *Utrecht Gender Dysphoria Scale – Gender Spectrum*, in R. R. Milhausen, et al. (eds.), *Handbook of Sexuality-Related Measures* 359-362 (4th ed.) (2020).

[18] Cecilia Dhejne, et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLoS One e16885 (2011), https://pmc.ncbi.nlm.nih.gov/articles/PMC3043071/.

[19] *Id.*

individuals diagnosed with gender incongruence who had received gender-affirming surgical treatments, and those diagnosed with gender incongruence who had not," found "no advantage of surgery in relation to subsequent mood or anxiety disorder-related health care visits or prescriptions or hospitalizations following suicide attempts."

Unfazed by the lack of evidence showing sex-rejecting procedures improve mental health and gender dysphoria, gender clinicians have begun moving the goalposts. For example, several recent studies have argued that the success of sex-rejecting procedures should not be assessed by measuring reduced gender dysphoria or better mental health, but rather by whether individuals "achieve their embodiment goals"[20] or experience "relief and validation from having their physical appearance align with gender identity."[21]

---

[20] Ezra D. Oosthoek, et al., *Gender-Affirming Medical Treatment for Adolescents: A Critical Reflection on "Effective" Treatment Outcomes*, 25 BMC Med. Ethics 154 (2024), https://pubmed.ncbi.nlm.nih.gov/39716168/.

[21] Alyxandra Ramsay, et al., *A Novel and Validated Survey Explores Quality of Life Outcomes in Transgender Women Following Vaginoplasty*, 23 Sex. Health 25169 (2026), https://pubmed.ncbi.nlm.nih.gov/41638691/.

B. WPATH "Standards," now discredited, do not determine "medically necessary" treatment for gender dysphoria.

The district court's determination that it was bound by *Edmo*'s deference to WPATH's Standards was error. Not even WPATH relies on the SOC-7 cited in *Edmo*: WPATH moved on to SOC-8 in 2022. But beyond that, recent developments have shown that WPATH is ideologically driven, its Standards lack developmental rigor, and they rely on weak evidence.

Efforts to alleviate gender dysphoria through sex-rejecting procedures, from hormones to surgeries, have been controversial since the first experimental surgeries emerged in Europe in the early 1900s. Controversy continued as the practice expanded throughout the U.S. in the latter half of the twentieth century. Johns Hopkins University opened the first U.S. gender clinic in 1966, only to shutter it in 1979 after a review of clinical outcomes concluded that "sex reassignment surgery confers no objective advantage," despite patient insistence that the surgeries were "subjectively satisfying."[22] From the start, evidence for so-

[22] Leslie M. Lothstein, *Sex Reassignment Surgery: Historical, Bioethical, and Theoretical Issues*, 139 Am. J. Psychiatry 417 (1982), https://pubmed.ncbi.nlm.nih.gov/7065286/.

called "sex-reassignment surgery" was plagued by "serious methodological problems," and "negative outcomes" included "suicide, psychiatric disturbances, and role-reversal."[23] Nonetheless, "optimistic" surgeons nevertheless continued to champion the practice.[24]

A 1982 research review, covering two decades, discovered that "no single study ha[d] intensively evaluated the global psychological status of postsurgery patients."[25] The review noted that reported "success rates," based predominately on subjective, short-term patient reports, were "misleading."[26]

Despite the thin and decidedly mixed research surrounding sex-rejecting surgeries, the Harry Benjamin International Gender Dysphoria Association (HBIGDA) was launched in 1979 as a professional network for clinicians pursuing "the study and care of transsexualism and gender dysphoria."[27] HBIGDA cast its members as experts in the controversial

---

[23] *Id.*

[24] *Id.*

[25] *Id.* at 423.

[26] *Id.* at 424.

[27] *History of the Association*, WPATH, https://wpath.org/about/history/ (quote is from linked 1979 letter "announcing the formation of the HBIGDA and soliciting members").

field, and soon published "standards of care," establishing "a standard for eligibility for sex reassignment surgery."[28]

By 2007, HBIGDA rebranded as the World Professional Association for Transgender Health[29] ("WPATH") and began publishing successive versions of its "flexible" Standards, culminating in the most recent version, SOC-8, in 2022.[30] Early on, WPATH positioned itself as *the* authoritative leader in "evidence-based care, education, research, public policy, and respect in transgender health,"[31] and projected itself as the lead voice of an international consensus supporting medicalized treatments for gender dysphoria.[32] Over time, as the number of minors experiencing "gender dysphoria" skyrocketed, WPATH embraced and

---

[28] WPATH, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7 (2012), Appendix D, Evidence for Clinical Outcomes of Therapeutic Approaches, World Professional Association for Transgender Health (2009).

[29] *History: International Symposia*, WPATH, https://wpath.org/about/history/international-symposia/.

[30] Eli Coleman, et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. Transgender Health S1-S259 (2022) [WPATH SOC-8].

[31] *Id*. at S3.

[32] *Id*. at S15 (Chapter 2: Global Applicability).

adapted the Dutch medicalized protocol for adolescents with gender dysphoria.[33] WPATH accrued support from major medical associations and insurers for its "gender-affirming" approach (if not its Standards).[34] WPATH leaders also wielded influence with activist lobbies, educators, and physicians, leaning into the cultural celebration of "transgender" identification.

The *Edmo* decision coincided with the high-water mark of WPATH's perceived credibility and influence. Growing public concern over children's vulnerability put the spotlight on WPATH, its Standards, and sex-rejecting procedures more generally, as medical scrutiny of the evidence for sex-rejecting procedures increased. By 2020, cracks appeared in WPATH's façade of expertise and authority. European countries (notably Finland, Sweden, and the UK) were alarmed by explosive increases in the number of children diagnosed with gender dysphoria, reports of harm from medicalized interventions, and the

[33] *Id.* at S43 ff. (Chapter 6: Adolescents).

[34] *The Medical Community Speaks Up for Transgender Patients, Their Essential Healthcare, and Their Profession*, GLAAD (June 2, 2023), https://glaad.org/supporting-transgender-essential-care/.

emergence of de-transitioners.[35] After conducted their own systematic evidence reviews, these countries largely rejected WPATH's breezy, "affirmative" approach to "transitioning" children, and tightened their own policies towards sex-rejecting procedures.[36]

By the time the *Edmo* court denied Idaho's petition for rehearing en banc in 2020, WPATH's political motives and shaky medical recommendations were on display. Judge O'Scannlain's dissent from the court's denial of rehearing *en banc* accurately described WPATH as "a controversial self-described advocacy group that dresses ideological commitments as evidence-based conclusions," *Edmo v. Corizon, Inc.*, 949 F.3d 489, 495 (9th Cir. 2020).

Over the past five years, the evidentiary basis of WPATH's Standards has been challenged—and found wanting—by numerous systematic evidence reviews. WPATH's credibility and status has crumbled in the wake of lawsuits and investigative reporting that

---

[35] Jennifer Block, *Gender Dysphoria in Young People is Rising—and so is Professional Disagreement,* BMJ (Feb. 23, 2023).

[36] Kasia Kozlowska, et al., *Obstacles to Progress in Paediatric Gender Medicine*, Euro. J. Develop. Psychology (2025), https://www.tandfonline.com/doi/full/10.1080/17405629.2025.2546574#abstract.

exposed WPATH's pattern of suppressing unfavorable evidence, its political bias and serious conflicts of interest, and unethical behaviors by many of WPATH's leading clinicians.[37]

C. WPATH Standards are not evidence-based and are not "the standard."

A 2021 systematic review of international guidelines on gender dysphoria (focused on the guidelines themselves, not the underlying studies) was the first rigorous evaluation of WPATH Standards, and the first to expose their weakness.[38] Damningly, the reviewers concluded that "WPATH SOC-7 cannot be considered 'gold standard,'" as they suffer from "incoherence," rendering them unusable as a "benchmark for

---

[37] Hannah Barnes, *Why Disturbing Leaks from US Gender Group WPATH Ring Alarm Bells in the NHS*, The Guardian (Mar. 9, 2024), https://www.theguardian.com/commentisfree/2024/mar/09/disturbing-leaks-from-us-gender-group-wpath-ring-alarm-bells-in-nhs ("WPATH describes itself as an 'interdisciplinary professional and educational organization devoted to transgender health.' Most significantly, it produces standards of care (SOC) which, it claims, articulate "professional consensus" about how best to help people with gender dysphoria. Despite its grand title, WPATH is neither solely a professional body – a significant proportion of its membership are activists – nor does it represent the 'world' view on how to care for this group of people.").

[38] Sara Dahlen, et al. *International Clinical Practice Guidelines for Gender Minority/Trans People: Systematic Review and Quality Assessment*, 11 BMJ Open e048943 (2021), https://pubmed.ncbi.nlm.nih.gov/33926984/

individuals or medical services."[39] The review observed that SOC-7 was "based on lower quality primary research, the opinions of experts and lacks grading of evidence" and "contains no list of key recommendations nor auditable quality standards."[40] Even statements that might have been intended to serve as recommendations, were criticized as "flexible" and "disconnected from evidence."[41]

The UK's 2024 Cass report—a four-year effort that included multiple systematic evidence reviews—characterized the evidence for pediatric sex-rejecting procedures as low-quality and weak.[42] It also noted that WPATH was "highly influential in directing international

---

[39] *Id.*

[40] *Id.*

[41] *Id.*

[42] Hilary Cass, Independent Review of Gender Identity Services for Children and Young People: Final Report (2024) [Cass Review] at 28 (citing Taylor, et al., *Clinical Guidelines for Children and Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review of Guideline Quality* (part 1). 109 Archiv. Dis. Childhood, s65-s72 (2024)) https://webarchive.nationalarchives.gov.uk/ukgwa/20250310143933/https://cass.independent-review.uk/home/publications/final-report/.

practice," even though "its guidelines were found by the University of York appraisal process to lack developmental rigour."[43]

In November 2025, the U.S. Department of Health and Human Services finalized a comprehensive umbrella review of systematic reviews for pediatric "gender medicine."[44] Although largely focused on the practice of medicalized interventions for minors, the HHS Review included an extensive analysis of WPATH and the evidence underlying its Standards. HHS identified areas of deep concern related to WPATH's organizational integrity, conflicts of interest, and stunning misconduct during SOC-8's development.[45] The HHS review warned that SOC-8 lacked "trustworthiness" as a guide to clinical care,[46] and noted that WPATH's guidelines were "rated among the lowest in quality and have not been recommended for implementation by systematic reviews

---

[43] *Id.*

[44] Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices, Office of Population Affairs, HHS (Nov. 2025), https://opa.hhs.gov/gender-dysphoria-report.

[45] *Id.*

[46] *Id.* at 157.

(SRs) of guidelines."[47] Shredding WPATH's claim that its Standards represent a consensus based on objective evidence, the HHS report noted that the apparent consensus supporting sex-rejecting procedures was manufactured through "a marked pattern of 'circular referencing and mutual endorsements' between guidelines … with WPATH and the [Endocrine Society] guidelines influencing all other guidelines and guidance documents."[48] A troubling "pattern of links and influences" emerged between WPATH and the Endocrine Society, including WPATH's "sponsor" role for the Endocrine Society's clinical practice guidelines. (It was unsurprising that the Endocrine Society marched

---

[47] *Id.* ("According to the National Academy of Medicine, trustworthy CPGs … should be *based on a systematic review of the existing evidence*; be developed by a knowledgeable, multidisciplinary panel of experts and representatives from key affected groups; consider important patient subgroups and patient preferences, as appropriate; be based on an explicit and transparent process that *minimizes distortions, biases, and conflicts of interest*; provide a clear explanation of the logical relationships between *alternative care options* and health outcomes, *provide ratings of both the quality [certainty] of evidence and the strength of the recommendations*; and be reconsidered and revised as appropriate when important new evidence warrants modifications of recommendations."

[48] *Id.* at 144.

lockstep with WPATH, strongly recommending hormonal and surgical interventions for gender dysphoria, despite little supporting evidence.[49]

A 2026 "quality assessment" of six WPATH SOC-8 chapters, including the chapter on surgery, identified serious methodological concerns, including lack of rigor in the Standards' development, impaired editorial independence, and poor applicability.[50] Only two of eight reviewers would recommend continued use of WPATH SOC-8.[51]

D. WPATH's credibility is tainted by political advocacy and breaches of integrity.

The WPATH Files, a ground-breaking report released March 4, 2024, by journalist Mia Hughes, revealed that WPATH members were fully aware that the Standards' controversial recommendations were based on weak evidence and ideology, not on rigorous evidence, as claimed.[52] Nevertheless, WPATH clinicians' proved shockingly willing to

---

[49] *Id.*

[50] Zhang, et al. *Quality of the World Professional Association for Transgender Health Guideline Standards of Care 8: An Appraisal Using the AGREE II Instrument*, Arch. Sex. Behav. (2026), https://link.springer.com/article/10.1007/s10508-025-03399-6.

[51] *Id.*

[52] Mia Hughes, *The WPATH Files: Pseudoscientific Surgical and Hormonal Experiments on Children, Adolescents, and Vulnerable*

downplay ethical concerns as they fast-tracked young people towards unproven body-altering procedures with permanent consequences.[53]A 2025 investigative report by *The Free Press* further damaged WPATH's credibility.[54] *The Free Press* obtained video footage of WPATH international conferences, where WPATH officers and member-clinicians "acknowledge[d] performing unproven, seemingly experimental treatments—only it appears there is often no protocol being followed, no formal research being conducted, and no ethics-board approval being sought. These practitioners say their goal is to fulfill the 'embodiment' desires of their patients, whatever these may be, and doing this may require 'deviat[ing] from guidelines."[55] *The Free Press* concluded that WPATH "gender doctors acknowledge they perform life-altering

---

Adults, Environmental Progress (2024), https://environmentalprogress.org/big-news/wpath-files.

[53] *Id.*

[54] Leor Sapir, *We're All Just Winging It: What the Gender Docs Say in Private*, The Free Press (December 3, 2025), https://www.thefp.com/p/were-all-just-winging-it-what-the.

[55] *Id.*

procedures on vulnerable youth with no supportive evidence—and they are proud of it."[56]

Perhaps most damaging to WPATH's credibility were the communications that emerged pursuant to legal discovery in *Boe v Marshall*, 2:22-cv-00184 (M.D. Ala.), which challenged Alabama's law restricting sex-rejecting procedures in minors. The *Boe* plaintiffs cited WPATH's Standards as the determinative medical authority, paving the way for the court to permit discovery on the development of those Standards. The discovery materials became public, providing irrefutable evidence that WPATH pursued an activist, medically unsound agenda, epitomized by WPATH Standards.[57]

For example, WPATH commissioned but later suppressed research results that contradicted its claim that sex-rejecting procedures are safe, beneficial, and evidence-based; WPATH capitulated to Biden administration pressure to remove the Standards' age minimums for hormonal and surgical interventions; and WPATH failed to disclose or

---

[56] *Id.*

[57] *Boe v. Marshall* exhibits, available at https://www.alabamaag.gov/boe-v-marshall/.

prevent author conflicts of interest in developing its Standards.[58] Most troubling—and relevant to this case—WPATH communications revealed that WPATH inserted the phrase "medically necessary" into the Standards' recommendations *not* based on medical evidence, but to achieve political, financial, and litigation advantage.[59] This fact alone should disqualify WPATH's Standards from judicial consideration.

Despite the Standards' documented flaws, WPATH hasn't altered them nor withdrawn its ideologically-driven clinical recommendations. A leading expert in evidence-based medicine, Professor Mark Helfand heavily criticized WPATH's Standards for their failure to tether clinical

---

[58] Leor Sapir, *The Deposition of Eli Coleman*, The City Journal, (December 13, 2024), https://www.city-journal.org/article/the-deposition-of-eli-coleman; Lisa Selin Davis, *Biden Official Lobbied to Remove Age Restrictions on Gender Care*, The Free Press (June 26, 2024), https://www.thefp.com/p/biden-official-lobbied-wpath-age-restrictions; Jennifer Block, *Dispute Arises Over World Professional Association for Transgender Health's Involvement in WHO's Trans Health Guideline*, BMJ (October 30, 2024), https://www.bmj.com/content/387/bmj.q2227.

[59] Aaron Sibarium, *Top Transgender Health Group Said Hormones, Surgeries Were 'Medically Necessary' So That Insurance Would Cover Them, Documents Show*, The Washington Free Beacon (July 23, 2024), https://freebeacon.com/courts/top-transgender-health-group-said-hormones-surgeries-were-medically-necessary-so-that-insurance-would-cover-them-documents-show/.

recommendations to strong evidence.[60] Helfand rejected outright WPATH's claim to "evidence-based" Standards, saying "Don't call them evidence-based," they are not based on "high quality evidence."[61]

Perhaps the final word on the WPATH Standards belongs to Dr. Loren Schechter, the incoming President of WPATH. Testifying in a New York medical malpractice lawsuit over surgical treatment for gender dysphoria, Schechter disavowed the Standards as *the* standard governing treatment for gender dysphoria: "The standard of care by which I'm evaluating this case is what a reasonable physician would do under the set of circumstances."[62] Gesturing to a physical copy of WPATH SOC-7 held by the plaintiff's attorney, Dr. Schechter doubled down: "The actual document you're holding in your hand—that is not considered the standard of care."[63]

---

[60] Jennifer Block, *Gender Dysphoria in Young People is Rising—and so is Professional Disagreement,* BMJ (Feb. 23, 2023).

[61] *Id.*

[62] Benjamin Ryan, *Unheard Testimony from WPATH's President Elect in the Historic Detransitioner Lawsuit: "A Reasonable Surgeon Would Have Put on the Brakes,"* Hazard Ratio Substack (February 22, 2026), https://benryan.substack.com/p/unheard-testimony-from-wpaths-president.

[63] *Id.*

We agree. WPATH Standards are not *the* standard of care, and sex-rejecting genital surgeries are not supported by reliable evidence.

CONCLUSION

The Court should reverse the decision below and remand with instructions to enter judgment for Defendant-Appellant.

Respectfully submitted,
s/ Eric N. Kniffin

ERIC N. KNIFFIN
Counsel of Record
MARY RICE HASSON
ETHICS & PUBLIC POLICY CENTER
1730 M Street, N.W.
Suite 910
Washington, DC 20036
(202) 682-1200
ekniffin@eppc.org

March 25, 2026

CERTIFICATE OF COMPLIANCE

This brief complies with the word limit of Fed. R. App. P. 29(a)(5) and 9th Circuit Rule 29-2(c)(2) because this brief contains 6,672 words, excluding parts of the brief exempted by Fed. R. App. P. 32(f).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in Microsoft Word Version 2508 using a proportionally spaced typeface, 14-point Century Schoolbook.

Dated: March 25, 2026

s/ Eric N. Kniffin
Eric N. Kniffin

CERTIFICATE OF SERVICE

I hereby certify that the foregoing document was filed with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on March 25, 2026. I further certify that service was accomplished on all parties via the Court's CM/ECF system.

Dated: March 25, 2026

s/ Eric N. Kniffin
Eric N. Kniffin