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February 23, 2026

John J. Whyte, MD, MPH
CEO and Executive Vice President
American Medical Association
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885
John.Whyte@ama-assn.org

Dear Dr. Whyte:

The American public has long viewed the American Medical Association as a trusted leader in the medical community. When the AMA makes a recommendation, it matters. Patients and doctors listen.

We thus read with appreciation the AMA's recent statement concerning surgical procedures on minors to treat gender confusion: "In the absence of clear evidence, the A.M.A. agrees with [the American Society of Plastic Surgeons] that surgical interventions in minors should be generally deferred to adulthood."¹ According to the *New York Times*, the AMA's position reflects the "sparse research on the risks and benefits of surgical procedures" to treat gender dysphoria in minors.²

On that, we concur. According to the recent umbrella review of systematic reviews conducted by the Department of Health and Human Services, "the certainty of evidence is very low regarding the effect of surgery on [gender dysphoria] or incongruence, improvement in mental health including suicidality and depression, and long-term outcomes such as sexual function, quality of life, and regret."³

¹ Andrew Jacobs, *Doctors' Group Endorses Restrictions on Gender-Related Surgery for Minors*, N.Y. TIMES (Feb. 4, 2026), <https://www.nytimes.com/2026/02/04/health/gender-surgery-minors-ama.html>.

² *Id.*

³ DEP'T OF HEALTH AND HUMAN SERVS., TREATMENT FOR PEDIATRIC GENDER DYSPHORIA: REVIEW OF EVIDENCE AND BEST PRACTICES 92 (Nov. 19, 2025), <https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report.pdf> ("HHS Review");

Our concern is that the evidence base is similarly lacking when it comes to the provision of puberty blockers and cross-sex hormones to treat gender dysphoria in minors. As for puberty blockers, the HHS review found that “the certainty of evidence is very low regarding the effect of PBs on [gender dysphoria] (or gender incongruence), improvement in mental health, and safety,” while “[t]here is high certainty evidence that PBs exert physiological effects (such as sex hormone suppression) and often cause infertility when followed by [cross-sex hormones], depending on the patient’s pubertal stage and sex.”⁴ The review also explained that “[t]he evidence is particularly limited regarding long-term outcomes related to fertility, growth, and neurocognitive development,” and that “[w]hile studies suggest a high proportion of youth proceed to [cross-sex hormones] after puberty suppression, there is minimal evidence on the impact of this combined pathway compared to [cross-sex hormones] alone, or on how this pathway affects longer-term outcomes such as undergoing surgery.”⁵ “Overall,” the review concluded, “the absence of long-term, high-certainty evidence on these critical outcomes (including suicides, fractures, fertility, growth, and neurocognitive development) leaves substantial uncertainty about the effects of PBs.”⁶

see also DEP’T OF HEALTH AND HUMAN SERVS., TREATMENT FOR PEDIATRIC GENDER DYSPHORIA: APPENDIX 4: OVERVIEW OF SYSTEMATIC REVIEWS 107-20 (Nov. 19, 2025), <https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report-appendix.pdf> (“HHS Appendix”).

⁴ HHS Review, *supra* note 3, at 90.

⁵ *Id.* at 90-91 (footnotes omitted).

⁶ *Id.* at 91; *see also* HHS Appendix, *supra* note 3, at 50-78. While some organizations have criticized the review’s findings, we have not found any of the critiques so far to be serious. For instance, the American Psychiatric Association (APA) attempted to discredit the review by purporting to raise concerns about its methodology and suggesting 16 “additional studies and reports for review and consideration.” *See* DEP’T OF HEALTH AND HUMAN SERVS., SUPPLEMENT TO TREATMENT FOR PEDIATRIC GENDER DYSPHORIA: REVIEW OF EVIDENCE AND BEST PRACTICES – PEER REVIEWS AND REPLIES 7-10 (Nov. 19, 2025), <https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report-supplement.pdf>. But as the authors of the review responded, 12 of the 16 studies suggested by the APA were, in fact, already discussed by the review; three of the remaining four studies did not even pertain to youth outcomes or youth gender medicine at all; and the single remaining publication was not publicly released until after the review was published—and it would not have met the review’s inclusion criteria in any event. *Id.* at 60-61. The APA’s reliance on cherry-picked observational studies to counter the review’s reliance on systematic evidence reviews also demonstrated either a fundamental misunderstanding of or intentional departure from traditional tenets of evidence-based medicine. *Id.* at 55-68.

By contrast, two peer reviewers from the Belgian Centre for Evidence-Based Medicine—the Centre’s director and a methodologist—evaluated the HHS review using criteria from the Preferred Reporting Items for Overviews of Reviews (PRIOR). These reviewers found that HHS’s umbrella review “used robust methods,” and noted the review’s “adherence to the Cochrane standards, the comprehensive literature search across multiple databases, and appropriate use of the Risk of Bias in Systematic Reviews (ROBIS) tool and the Grading of Recommendations Assessment, Development and Evaluation (GRADE) framework for assessing risk of bias and certainty of evidence.” They found “no major issues with the Review’s conclusions.” *Id.* at 40-52, 93-95.

Other systematic evidence reviews are in accord. For instance, as part of her independent review for England’s National Health Service, Dr. Hilary Cass commissioned a team of researchers at the University of York to conduct systematic evidence reviews on the use of puberty blockers and cross-sex hormones to treat pediatric gender dysphoria. That review concluded: “There are no high-quality studies using an appropriate study design that assess outcomes of puberty suppression in adolescents experiencing gender dysphoria/incongruence. No conclusions can be drawn about the effect on gender-related outcomes, psychological and psychosocial health, cognitive development or fertility. Bone health and height may be compromised during treatment. High-quality research and agreement on the core outcomes of puberty suppression are needed.”⁷

The evidence on cross-sex hormones is similarly sparse. The HHS review concluded that “[t]he certainty of evidence is very low regarding the effect on [gender dysphoria] or incongruence, improvement in mental health, and safety metrics including fertility and bone health.”⁸ It also warned that “[k]ey outcomes such as effects on [gender dysphoria], other mental health outcomes, and quality of life have been inconsistently measured and, when reported, often are derived from small, observational studies with limited follow-up”; “important long-term outcomes remain poorly understood.”⁹

The literature review conducted for the Cass Review came to a similar conclusion, noting “a lack of high-quality research assessing the outcomes of hormone interventions in adolescents experiencing gender dysphoria/incongruence,” and warning that “[n]o conclusions can be drawn about the effect on gender-related outcomes, body satisfaction, psychosocial health, cognitive development or fertility.”¹⁰

As a result of these findings, healthcare authorities across the world have restricted access to puberty blockers and cross-sex hormones to treat gender dysphoria in adolescents or cautioned against their use. Scotland’s National Health Service “stopped all new prescriptions of puberty-blocking drugs and other hormone treatments for minors.”¹¹ England’s National Health Service provides that “[p]uberty suppressing hormones are not available to children and young people

⁷ Jo Taylor *et al.*, *Interventions to Suppress Puberty in Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review*, 109 ARCH. DIS. CHILD s45 (2024), https://adc.bmj.com/content/archdischild/109/Suppl_2/s33.full.pdf?with-ds=yes.

⁸ HHS Review, *supra* note 3, at 91.

⁹ *Id.* at 90-91; *see also* HHS Appendix, *supra* note 3, at 82 (“In summary, no conclusion could be drawn on the impact of CSH on mental health due to very low certainty evidence.”).

¹⁰ Jo Taylor *et al.*, *Masculinising and Feminising Hormone Interventions for Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review*, 109 ARCH. DIS. CHILD s54 (2024), https://adc.bmj.com/content/archdischild/109/Suppl_2/s48.full.pdf?with-ds=yes.

¹¹ Azeen Ghorayshi, *Scotland Pauses Gender Medications for Minors*, N.Y. TIMES (Apr. 18, 2024), <https://www.nytimes.com/2024/04/18/health/scotland-pauses-hormones-puberty-blockers-transgender.html>.

for the treatment of gender dysphoria or gender incongruence” because “there is not enough evidence on their clinical safety and effectiveness.”¹² Sweden’s “National Board of Health and Welfare currently assesses that the risks of puberty blockers and gender-affirming treatment are likely to outweigh the expected benefits of these treatments.”¹³ Finland’s healthcare authority concluded that, “[i]n light of available evidence, gender reassignment of minors is an experimental practice.”¹⁴ The Norwegian Healthcare Investigation Board found that “[t]he evidence base, especially research-based knowledge for gender-affirming treatment (hormonal and surgical), is insufficient and the long-term effects are not well known.”¹⁵ And New Zealand’s health ministry just recently prohibited new prescriptions of puberty blockers to treat gender dysphoria in minors because of the lack of “high-quality evidence that demonstrates the benefits or risks” of the treatments.¹⁶

We thus find it concerning that the AMA continues to support the use of puberty blockers and cross-sex hormones to treat gender dysphoria in minors.¹⁷ The quality of evidence is the same as it is for surgeries: low and very-low quality. What that means for providers and patients is also the same: evidence that is “low” or “very-low” quality under the GRADE guidelines means, respectively, that the true effect of the medical intervention may, or is likely to be, “substantially different” from the estimate of the effect based on the available evidence.¹⁸ So if you agree that there is insufficient evidence to support using surgical interventions to treat gender dysphoria in minors—as your recent statement indicates—we do not understand how you can find that there is sufficient evidence to support using hormonal interventions to treat gender dysphoria in minors. These interventions have not been shown to be any safer for children than surgeries are, and in fact may be all the more dangerous precisely because they are viewed as not as serious.

¹² National Health Service, *Treatment – Gender Dysphoria*, <https://perma.cc/J4QV-RS5Q> (captured Feb. 5, 2026).

¹³ Socialstyrelsen, *Care of Children and Adolescents with Gender Dysphoria* 16 (Dec. 2022) (unofficial translation), <https://perma.cc/CAD9-EDZ5>.

¹⁴ *Recommendation of the Council for Choices in Health Care in Finland – Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors* 8 (unofficial translation), <https://perma.cc/VN38-67WT>.

¹⁵ UKOM, *Patient Safety for Children and Young People with Gender Incongruence* 4 (Mar. 9, 2023) (unofficial translation), <https://perma.cc/3T2F-6ACX>.

¹⁶ Lucy Craymer, *New Zealand Halts New Puberty Blockers for Young Transgender People*, REUTERS (Nov. 19, 2025), <https://www.reuters.com/business/healthcare-pharmaceuticals/new-zealand-halts-new-puberty-blockers-young-transgender-people-2025-11-19/>.

¹⁷ Jacobs, *supra* note 1.

¹⁸ Howard Balshem *et al.*, *GRADE Guidelines: 3. Rating the Quality of Evidence*, 64 J. CLINICAL EPIDEMIOL. 401, 404 (2011) <https://perma.cc/2KDY-6BW5>.

But hormones can leave a child sterilized just as surely as surgery can—and indeed, that is the near-guaranteed pathway for a boy who begins puberty blockers at Tanner stage 2 and progresses to cross-sex hormones.¹⁹

To be sure, certain advocacy organizations still recommend both surgeries and hormonal interventions for minors suffering from gender dysphoria. The World Professional Association for Transgender Health (WPATH), for instance, recommends both. After (falsely) proclaiming that “a systematic review regarding outcomes of treatment in adolescents is not possible” due to the “low” “number of studies” and the “few outcome studies that follow youth into adulthood,” WPATH relied on “[a] short narrative review” of cherrypicked papers to make its treatment recommendations.²⁰ Those recommendations count as “medically necessary gender-affirming medical treatment[s] in adolescents” every possible transitioning surgical procedure except for one: phalloplasty, the surgical creation of a neopenis, which WPATH recommends not “be considered in youth under 18 at this time” due to the “complexity” of the procedure and the “high rates of complications.”²¹

It is not clear to us whether the AMA endorses the WPATH Standards. On the one hand, the AMA has proclaimed that “medical and surgical treatments for gender dysphoria and gender incongruence ... are medically necessary as outlined by generally-accepted standards of medical and surgical practice.”²² And the AMA has joined legal briefs extolling the WPATH Standards and the Endocrine Society Guideline—also authored by WPATH—as the two relevant “established, evidence-based clinical guidelines” for treating gender dysphoria in minors.²³ The AMA proclaimed that these “standards of care” for “the care of minors” were “based on the current evidence” even though they recommend “gender-affirming surgeries” for youth.²⁴

On the other hand, the AMA’s recent rejection of surgical interventions to treat pediatric gender dysphoria is an unmistakable rejection of the WPATH Standards and a tacit acknowledgment that those Standards are not “evidence-

¹⁹ *E.g.*, HHS Review, *supra* note 3, at 120 (“If the gonads are arrested in an immature state due to prolonged use of PBs, and this is followed by administration of CSH, there is no proven physiological mechanism by which fertility can reliably be reestablished. The likelihood of permanent infertility will be substantially increased.” (footnotes omitted)).

²⁰ Eli Coleman *et al.*, *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT’L J. OF TRANSGENDER HEALTH S46 (2022), <https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644>.

²¹ *Id.* at S66.

²² American Medical Ass’n, *Clarification of Evidence-Based Gender-Affirming Care H-185.927* (2024), <https://perma.cc/GHW3-TLBL>.

²³ Br. of *Amici Curiae* American Academy of Pediatrics *et al.* at 8, *United States v. Skrmetti*, No. 23-477 (U.S. Sept. 3, 2024), <https://perma.cc/HAS7-W97T>

²⁴ *AMA to States: Stop Interfering in Health Care of Transgender Children* (Apr. 26, 2021), <https://perma.cc/BKS6-QFQ8>.

based.” And, based on emails between WPATH and AMA that were produced in court-ordered discovery, we understand that the AMA rejected WPATH’s request to formally endorse SOC-8. AMA told WPATH: “While we appreciate your efforts on the SOC-8, the AMA does not endorse or support standards of care—that falls outside of our expertise.”²⁵

While it seems incongruous to us that the AMA could both decline to endorse the WPATH Standards because assessing the Standards fell “outside” its “expertise” *and*, at the same time, promise courts and the public that those same standards were “based on the current evidence,” we believe that the AMA was—however it reached its decision—right not to formally endorse the WPATH Standards. Indeed, since the AMA made its decision, serious questions have arisen concerning the reliability of both the WPATH and Endocrine Society guidelines.²⁶ Both received failing grades for “rigour of development” by the York evidence-review team that appraised all the guideline documents in this area.²⁷ And it is notable that the Endocrine Society guideline stated that the committee commissioned only two systematic reviews to support its recommendations—“[t]he first one aimed to summarize the available evidence on the effect of sex steroid use in transgender individuals on lipids and cardiovascular outcomes,” while “[t]he second review summarized the available evidence regarding the effect of sex steroids on bone health in transgender individuals.”²⁸ The now-nearly-decade-old review did not do *any* systematic appraisal of whether hormonal interventions helped reduce feelings of gender dysphoria, depression, rate of suicide, or any other pertinent outcome before it recommended their use in adolescents. The committee was at least honest that its recommendations in this area were based on low or very-low quality evidence and were driven by a desire to place a “high value” on altering an adolescent patient’s “physical outcome[s] when secondary sex characteristics have become manifest” and “a lower value on avoiding potential harm from early pubertal suppression.”²⁹

As for the WPATH Standards, documents produced in litigation revealed that WPATH intentionally crafted SOC-8 as “a tool for our attorneys to use in

²⁵ Doc. 560-39 at 15, *Boe v. Marshall*, No. 2-22-cv-00184-LCB (M.D. Ala. May 27, 2024), <https://perma.cc/TNQ9-HCRE>. It might amuse you to learn that the AMA’s response caused the former president of WPATH to complain that the AMA is run by “white cisgender heterosexual hillbillies from nowhere.” *Id.* at 20.

²⁶ *See, e.g.*, THE CASS REVIEW: INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE 126-32 (Apr. 2024), <https://perma.cc/3QVZ-9Y52>.

²⁷ *See* Jo Taylor *et al.*, *Clinical Guidelines for Children and Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review of Guideline Quality (Part 1)*, 109 ARCH. DIS. CHILD. S68-69 (2024), https://adc.bmj.com/content/archdis-child/109/Suppl_2/s65.full.pdf?with-ds=yes.

²⁸ *See* Wylie C. Hembree *et al.*, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLIN. ENDOCRINOL. METAB. 3869, 3873 (Nov. 2017).

²⁹ *Id.* at 3881.

defending access to care.”³⁰ Its evidence-review team “found little to no evidence about children and adolescents.”³¹ Some SOC-8 authors opted *out* of the evidence-review process entirely due to “concerns, echoed by the social justice lawyers we spoke with, ... that evidence-based review reveals little or no evidence and puts us in an untenable position in terms of affecting policy or winning lawsuits.”³² And Admiral Rachel Levine, the former Assistant Secretary for Health at HHS, demanded that WPATH remove from SOC-8 *all* age limits for chemical treatments, chest surgeries, and even surgeries to remove children’s genitals. After some initial consternation “about allowing US politics to dictate international professional clinical guidelines,”³³ WPATH obliged.

Evidence also revealed that WPATH did not follow the principles of evidence-based medicine it said it followed. Among other things, WPATH failed to properly manage conflicts of interest, misled readers and practitioners about how it used the GRADE process in making treatment recommendations, and hindered publication of the evidence reviews it had commissioned.³⁴ Deeply reported pieces in the *New York Times*, *The Economist*, *The Atlantic*, and elsewhere have since confirmed the medical scandal Alabama uncovered in litigation.³⁵ No wonder the president-elect of WPATH recently admitted at trial that the WPATH “Standards of Care” are not, in fact, “considered the standard of care.”³⁶

Given these revelations and the international scrutiny of the evidence base used to justify providing transitioning procedures to minors, it is perhaps unsurprising that the rationale for providing the treatments has shifted. Whereas the AMA has argued that the purpose of providing puberty blockers and cross-sex hormones to children and adolescents suffering from gender dysphoria is to “alleviate clinically significant distress and lead to significant improvements in the

³⁰ Defendants’ Ex. 181 at 75, *Boe v. Marshall*, 2:22-cv-184 (M.D. Ala.), Doc. 700-10. Exhibits are available online: <https://www.alabamaag.gov/boe-v-marshall/>.

³¹ Defendants’ Ex. 173 at 22, *Boe*, *supra* note 30, Doc. 560-23.

³² Defendants’ Ex. 174 at 1-2, *Boe*, *supra* note 30, Doc. 560-24.

³³ Defendants’ Ex. 186 at 32, *Boe*, *supra* note 30, Doc. 700-15.

³⁴ See generally Br. of Alabama as *Amicus Curiae*, *United States v. Skrmetti*, No. 23-477 (U.S. Oct 15, 2024), <https://perma.cc/G5L2-5WU9>.

³⁵ See, e.g., Azeen Ghorayshi, *Biden Officials Pushed to Remove Age Limits for Trans Surgery, Documents Show*, N.Y. TIMES (June 25, 2024), <https://perma.cc/RP5L-QFD9>; Nicholas Confessore, *How the Transgender Rights Movement Bet on the Supreme Court and Lost*, N.Y. TIMES (June 19, 2025), <https://perma.cc/L5A6-ZVAW>; *Research into Trans Medicine Has Been Manipulated*, THE ECONOMIST (June 27, 2024), <https://perma.cc/A942-J2DY>; Helen Lewis, *The Liberal Misinformation Bubble About Youth Gender Medicine*, THE ATLANTIC (June 29, 2025), <https://perma.cc/R4TZ-LS32>; Leor Sapir, “We’re All Just Winging It”: What The Gender Doctors Say in Private, THE FREE PRESS (Dec. 3, 2025), <https://www.thefp.com/p/were-all-just-winging-it-what-the>; see also Steve Marshall, *WPATH, ‘Transgender Healthcare,’ and the Supreme Court*, WALL STREET J. (Dec. 2, 2024), <https://perma.cc/S74A-AFAM>.

³⁶ Benjamin Ryan, *WPATH’s Trans-Care Bible “Is Not Considered the Standard of Care”—Unheard Testimony From the \$2M Detransitioner Lawsuit* (Feb. 16, 2026), <https://perma.cc/VC86-XE3L>.

mental health and overall well-being of adolescents with gender dysphoria,”³⁷ leaders in the field have moved beyond such arguments about the safety and efficacy of the interventions. For instance, Annelou de Vries, a co-author of the seminal “Dutch studies” and co-chair of the adolescent chapter of SOC-8, recently wrote to respond to “the critique that there is insufficient evidence regarding the treatment outcomes for [gender-affirming medical treatment] for youth.”³⁸ In doing so, she did not deny the critique, but said that it did not matter: She “question[ed]” the “normative assumption” that pediatric transitioning procedures “must necessarily result in ‘effective’ outcomes in order to be considered legitimate and essential care.”³⁹ She suggested instead that transitioning procedures for kids be “provided and justified on the basis of personal desire and autonomy,” that “effectiveness” be measured by how well the procedures “help individuals achieve their embodiment goals,” and that any “experience of regret” be welcomed as “inherent to all lives.”⁴⁰

We assume that you disagree with Dr. de Vries’s defense, which is antithetical to principles of evidence-based care and at odds with your own recent statement regarding surgical interventions. But we remain concerned that providers, patients, and their families in our States are being confused or misled by the AMA regarding the safety and efficacy of puberty blockers and cross-sex hormones to treat gender dysphoria in minors. *E.g.*, Letter from AMA to National Governors Ass’n (Apr. 26, 2021), <https://perma.cc/B7AG-ZXJD> (falsely asserting that “the current evidence” supports “gender-affirming hormone therapy” “and/or gender-affirming surgeries” for minors); Endocrine Society, *AMA Strengthens Its Policy On Protecting Access to Gender-Affirming Care* (June 12, 2023), <https://perma.cc/7L98-G277> (reporting that the AMA passed a resolution misleadingly suggesting that “[m]ore than 2,000 scientific studies have examined aspects of gender-affirming care since 1975,” even though the first studies involving minors did not occur until the 1990s; falsely stating that “[m]edical intervention is reserved for older adolescents and adults,” even though puberty blockers are used at the very beginning of puberty; falsely claiming that “[m]ajor medical organizations also agree on waiting until an individual has turned 18 ... to undergo gender-affirming genital surgery,” even though WPATH recommends *every* genital surgery except for one (phalloplasty) as “medically necessary” for minors; and misleadingly suggesting that “[g]ender-affirming care can be life saving for a population with high suicide rates,” even though, as the ACLU was forced to

³⁷ Br. of *Amici Curiae* American Academy of Pediatrics *et al.*, *supra* note 23, at 5.

³⁸ Oosthoek, de Vries, *et al.*, *Gender-affirming Medical Treatment for Adolescents*, 25 BMC MEDICAL ETHICS 153 (2024), <https://perma.cc/8W4R-CEG7>.

³⁹ *Id.* at 154 .

⁴⁰ *Id.*

admit at the Supreme Court,⁴¹ no study has shown a decreased rate of suicide associated with transitioning procedures in minors).

Thus, while we hope to avoid a formal investigation under our consumer protection laws, we do have concerns that the AMA may be violating those laws. Under Alabama law, for instance, it is unlawful for an organization to cause “confusion or misunderstanding as to the ... sponsorship, approval, or certification of goods or services,” Ala. Code § 8-19-5(2); to represent “that goods or services have sponsorship, approval, ... uses, benefits, or qualities that they do not have,” *id.* § 8-19-5(5); to represent “that goods or services are of a particular standard, quality, or grade ... if they are of another,” *id.* § 8-19-5(7); or to engage “in any other unconscionable, false, misleading, or deceptive act or practice in the conduct of trade or commerce,” *id.* § 8-19-5(27).

We thus request that you clarify some issues regarding the AMA’s position on the provision of puberty blockers and cross-sex hormones to minors to treat gender dysphoria. Please answer the following questions and provide explanations or additional information as pertinent:

1. Does the AMA endorse or otherwise recommend to providers or patients the WPATH Standards of Care 8? Why or why not?
2. Does the AMA view the WPATH Standards of Care 8 as evidence-based, reliable, and consistent with the best practices of evidence-based medicine?
3. Does the AMA endorse or otherwise recommend to providers or patients the Endocrine Society Guideline on the Treatment of Gender-Dysphoric/Gender-Incongruent Persons? Why or why not?
4. Does the AMA view the Endocrine Society Guideline as evidence-based, reliable, and consistent with the best practices of evidence-based medicine?

⁴¹ “JUSTICE ALITO: Well, I -- I don’t regard the Cass review as -- necessarily as -- as the Bible or as something that’s, you know, true in every respect, but, on page 195 of the Cass report, it says: There is no evidence that gender-affirmative treatments reduce suicide.

MR. STRANGIO: What I think that is referring to is there is no evidence in some -- in the studies that this treatment reduces completed suicide. And the reason for that is completed suicide, thankfully and admittedly, is rare and we’re talking about a very small population of individuals with studies that don’t necessarily have completed suicides within them.

5. Does the AMA endorse or otherwise recommend the American Academy of Pediatrics' Policy Statement "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents"? Why or why not?
6. Does the AMA view the AAP's Policy Statement as evidence-based, reliable, and consistent with the best practices of evidence-based medicine?
7. Does the AMA endorse or otherwise recommend the provision of puberty blockers to minors to treat gender dysphoria? If so, what is the basis of that recommendation, and how do you distinguish the evidence base for the provision of surgeries versus the provision of puberty blockers?
8. Does the AMA endorse or otherwise recommend the provision of cross-sex hormones to minors to treat gender dysphoria? If so, what is the basis of that recommendation, and how do you distinguish the evidence base for the provision of surgeries versus the provision of cross-sex hormones?
9. Does the AMA contend that puberty blockers provided to minors at Tanner stage 2 to treat gender dysphoria are fully reversible, even if the patient moves on to take cross-sex hormones? If so, what is the basis of that contention?
10. Does the AMA contend that puberty blockers and cross-sex hormones have been proven to be safe and effective at treating gender dysphoria in minors? If so, what is the basis for that contention?
11. How did the AMA decide to join the amicus briefs in *United States v. Skrmetti* and other cases in which the AMA told courts that the WPATH and Endocrine Society guidelines were evidence-based and well-accepted and that the provision of transitioning procedures to minors was safe and effective at treating gender dysphoria and improving well-being?
12. Does the AMA stand by its 2024 policy statement "recogniz[ing] that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary" for minors?
13. Has the AMA conducted a literature review or any systematic appraisal of the evidence concerning the safety and efficacy of using surgeries, puberty blockers, or cross-sex hormones to treat gender dysphoria in minors? If so, who conducted that review, what were its results, and

where may it be found? If not, does the AMA plan to conduct such a review?

14. Does the AMA agree or disagree with Dr. de Vries's suggestion that transitioning procedure for minors be "provided and justified on the basis of personal desire and autonomy," that "effectiveness" be measured by how well the procedures "help individuals achieve their embodiment goals," and that any "experience of regret" be welcomed as "inherent to all lives"? Please explain on what basis the AMA would recommend or not recommend the provision of transitioning procedures to minors and what outcomes in the evidence would be pertinent to that determination.

We know that we share a common goal in wanting to protect patients and their families and ensure that they receive trustworthy information about their medical care. **We look forward to hearing from you and ask for a response within 30 days—by March 25, 2026.** Please send all correspondence to Barrett Bowdre (barrett.bowdre@AlabamaAG.gov) and Michael Dean (michael.dean@AlabamaAG.gov) in the Alabama Attorney General's Office.

Sincerely,



Steve Marshall
Attorney General of Alabama



Tim Griffin
Attorney General of Arkansas



Chris Carr
Attorney General of Georgia



Raúl R. Labrador
Attorney General of Idaho



Theodore E. Rokita
Attorney General of Indiana



Brenna Bird
Attorney General of Iowa



Kris W. Kobach
Attorney General of Kansas



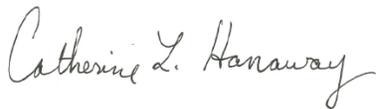
Russell Coleman
Attorney General of Kentucky



Liz Murrill
Attorney General of Louisiana



Lynn Fitch
Attorney General of Mississippi



Catherine L. Hanaway
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