No. COA 26-132 DISTRICT 38

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NORTH CAROLINA COURT OF APPEALS

****

CHARLIE MOSLEY, a.k.a.
PRISHA MOSLEY, a.k.a.
ABIGAIL MOSLEY,

Plaintiff-Appellant,

v.

ERIC T. EMERSON, M.D.; PIEDMONT PLASTIC SURGERY AND DERMATOLOGY, P.A.; BRIE KLEIN-FOWLER; FAMILYSOLUTIONS, PLLC; SHANA GORDON; TREE OF LIFE COUNSELING, PLLC; MARTHA FAIRBANKS PERRY, M.D.; THE MOSES CONE MEMORIAL HOSPITAL OPERATING CORPORATION D/B/A CONE HEALTH,

Defendants-Appellees.

From Gaston County
23CVS002375-350

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BRIEF OF AMICUS DO NO HARM IN SUPPORT OF APPELLANT

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INTEREST OF AMICUS CURIAE[1]

Do No Harm, Inc., is a nonprofit membership organization that includes over 50,000 physicians, nurses, medical students, patients, and policymakers. Do No Harm is committed to ensuring that the practice of medicine is driven by scientific evidence rather than ideology. In recent years, the practice of biology-denying interventions, euphemistically known as "gender-affirming care," has become more common despite the serious harm caused by those medical interventions and the complete lack of reliable evidence for any benefit resulting from them. Part of Do No Harm's mission is to ensure that courts have a proper understanding of the danger of these medical interventions. Do No Harm submits this brief so the Court may fully understand the scientific support for Ms. Mosley's fraud claim.

ISSUES ADDRESSED IN THE BRIEF

This brief addresses the science regarding the harm caused by biology-denying interventions and the lack of reliable evidence justifying their use, which supports the fraud claim on which Ms. Mosley is seeking reversal of the district court's grant of summary judgment.

ARGUMENT

"Gender-affirming care" is a medical scandal. This purported "treatment" calls for a host of biology-denying medical interventions from puberty blockers to cross-sex hormones to genital surgeries. All this to treat a *psychological* condition. These interventions inflict grave harms, and there is no reliable evidence demonstrating that they improve, much less resolve, gender dysphoria.

The lack of evidence of benefit from these interventions has been established in every systematic review to analyze the question. These reviews—which represent the highest form of

[1] Pursuant to N.C. R. APP. P. 28.1(b)(3)(c), amicus certifies that no person or entity other than amicus curiae, its members, or counsel helped write this brief or contributed money for its preparation.

medical evidence—have been conducted by various entities and researchers, including health authorities in Finland, Sweden, the U.K., and expert researchers hired by the health authority in the State of Florida and the U.K.'s National Health Service. All of them have concluded that no reliable evidence demonstrates that these interventions help resolve gender dysphoria.

The science thus supports Ms. Mosley's fraud claim. As her brief recounts, Defendants told her (among other things) that "testosterone and breast surgery were necessary, beneficial treatments for which there was no alternative," that she "would be cured of her mental health conditions with testosterone," and that "breast surgery was medically necessary and would benefit her." Br. of Pl.-Appellant at 21 (Apr. 13, 2026). These assertions are false. Do No Harm submits this brief to explain why.

I. Biology-Denying Interventions To Treat Gender Dysphoria Are Dangerous And Unproven.

A. Gender Dysphoria Is Severe Psychological Distress Resulting From An Individual's Perceived Inconsistency Between Her Sex And "Gender Identity."

A person's sex is distinct from his or her "gender identity." Sex is a biological classification that is "encoded in our DNA." *See* Nat'l Insts. of Health, Off. of Rsch. on Women's Health, *How SEX and GENDER Influence Health and Disease*, https://perma.cc/LK2H-8935. Sexual traits are "controlled by the presence of XX or XY chromosomes," which determine the "type of gonads" a person possesses. Aditi Bhargava et al., *Considering Sex as a Biological Variable in Basic and Clinical Studies: An Endocrine Society Scientific Statement*, 42 Endocrine Revs. 219, 221 (2021), https://perma.cc/7U6B-HB6U. An individual's gonads, in turn, generate particular "secretions" that "regulate formation of female or male reproductive tissues." *Id.* Specifically, gonadal secretions determine sex characteristics such as "external genitalia," the presence of a "uterus and oviducts" or "sperm ducts," and even "facial hair and pitch of voice." *Id.* Given the nature of the human body, "sex differences exist at molecular and cellular levels." *Id.* at 245; Nat'l Insts. of

Health, *supra* ("Every cell in your body has a sex—making up tissues and organs, like your skin, brain, heart, and stomach."). An individual's sex is thus a biological reality.

For humans, there are two sexes—male and female. Sex "is dichotomous because of the different roles of each sex in reproduction." Bhargava, *supra*, at 221. Specifically, the "classical biological definition of the 2 sexes is that females have ovaries and make larger female gametes (eggs), whereas males have testes and make smaller male gametes (sperm)." *Id.* These "2 gametes fertilize to form the zygote." *Id.* From this single cell, the developing individual arises. *Zygote*, Merriam-Webster, https://perma.cc/7ZCV-4RVW. "Each cell" in an individual's body "is either male or female depending on whether" that person is "a man or a woman." Nat'l Insts. of Health, *supra*. Thus, sex is not only "biological," but also "dichotomous." Bhargava, *supra*, at 220.

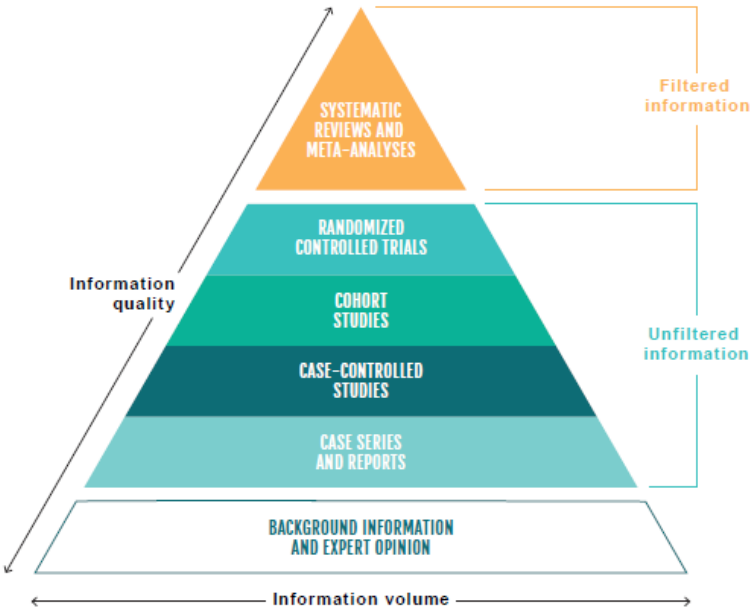
In contrast to sex, "gender identity" is based on an individual's psychological state. While sex is a biological characteristic, gender identity "is a psychological concept that refers to an individual's self-perception." *Id.* at 226. The fact that "gender identity" is a psychological concept rather than a biological condition is further demonstrated by the existence of "detransitioners" such as Ms. Mosley—*i.e.*, the growing number of people who have undergone biology denying interventions only to later regret receiving these treatments and resume identifying as their natal sex. *See L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 487 (6th Cir. 2023) (Sutton, C.J., for the court). It is also demonstrated by evidence that the recent explosion in the number of young people diagnosed with gender dysphoria is the result of social contagion. *See id.* at 468 (noting that the percentage of youth identifying as transgender has doubled in the past few years).

Because "gender identity" is not a biological concept, there is no method to determine individuals' identity other than asking them. This reality explains why "gender identity" is an exclusively "human phenomenon" while "[s]ex is an essential part of vertebrate biology."

Bhargava, *supra*, at 228. Some individuals report an inconsistency between their sex and their gender identity. This perceived inconsistency can lead to psychological distress, resulting in a diagnosis of "gender dysphoria." Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 451–52 (5th ed. 2013). The question, then, is how to treat gender dysphoria.

B. No Reliable Scientific Evidence Justifies The Use Of Cross-Sex Hormones Or Surgery To Treat Gender Dysphoria.

Although the proper practice of medicine is driven by evidence, not all medical evidence is created equal. Researchers have thus spent decades refining the process that clinicians use to assess the medical evidence supporting a particular medical intervention. That process—often referred to as the practice of "evidence-based medicine"—outlines a hierarchy of medical evidence based on the confidence a clinician can place in a particular source of evidence. *See* Gordon Guyatt et al., Users' Guides to the Medical Literature: Essentials of Evidence-Based Clinical Practice 15 fig. 2-3, JAMAevidence (3d ed. 2015) ("Evidence-Based Medicine User Guide"). The "pyramid of standards of evidence" reflects the hierarchy of reliability for evidence in medicine:



See Independent Review of Gender Identity Services for Children and Young People: Final Report at 55, Nat'l Health Serv. Eng. (Apr. 2024), https://perma.cc/KM5C-49EZ ("Cass Review"). As the pyramid shows, "systematic reviews" are at the top of the hierarchy of medical evidence. At the bottom of the hierarchy is clinical experience—*i.e.*, "the unsystematic observations of individual clinicians." Evidence-Based Medicine User Guide at 15.

Systematic reviews provide the greatest insight into the medical evidence underpinning a particular intervention because they account for all relevant studies, assess those individual studies for areas of potential scientific bias, and thus assess the *reliability* of the *entire* evidence base. *See id*. at 274-76. To determine the certainty of the evidence, researchers frequently use tools such as the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) method. *See id.* at 16-17. In the GRADE system, researchers rate the evidence using specified criteria. "In the context of a systematic review, the ratings of the quality of evidence reflect the extent of our confidence that the estimates of the effect are correct." Howard Balshem et al., *GRADE Guidelines: 3. Rating the Quality of Evidence*, 64 J. Clinical Epidemiology 401, 403 (2011). This resulting rating of the evidence is either "high, moderate, low, or very low." Evidence-Based Medicine Users Guide at 16. The following definitions explain what the various levels mean:

> High Quality Evidence: "We are *very confident* that the true effect lies close to that of the estimate of the effect."
>
> Moderate Quality Evidence: "We are *moderately confident* in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different."
>
> Low Quality Evidence: "Our *confidence* in the effect estimate *is limited*: The true effect may be *substantially different* from the estimate of the effect."
>
> Very Low Quality Evidence: "We have *very little confidence* in the effect estimate: The true effect *is likely to be substantially different* from the estimate of effect."

Balshem, *supra*, at 404 tbl.2 (emphasis added). Thus, when evidence is deemed "low" or "very low" quality, that means researchers have "limited" or "very little confidence" that the results of the study reflect the truth; indeed, the truth may or *likely* will turn out "to be substantially different" from what such studies say.

Finally, after analyzing all relevant studies, the researchers will "summarize the results." Evidence-Based Medicine User Guide at 275. This process can include a quantitative synthesis or "meta-analysis" of data that provides an overview to clinicians. *See id.* at 275-76. The end result is a study of studies—a comprehensive look at the evidence on a given question that accounts for the reliability of the studies forming the evidence base.

In short, systematic reviews are the most reliable form of medical evidence. And for several reasons, they are substantially more reliable than narrative reviews. First, unlike systematic reviews, narrative reviews "have no explicit criteria for selecting the included studies." *Id.* at 273. Therefore, narrative reviews can cherry-pick examples and individual studies—discussing only those that support their conclusions and ignoring those that do not. Systematic reviews do not suffer from this flaw.

Second, narrative reviews "do not include systematic assessments of the risk of bias associated with primary studies." *Id.* (emphasis omitted). Thus, narrative reviews may stress that several studies all support the same conclusion, but "[c]onsistent results are less compelling if they come from studies with a high risk of bias than if they come from studies with a low risk of bias." *Id.* at 283. Systematic reviews account for this principle; narrative reviews do not. For these reasons (among others), systematic reviews represent the highest form of medical evidence, and "optimally effective evidence-based practice dictates bypassing the critical assessment of primary

studies and, if they are available, moving straight to the evaluation of rigorous systematic reviews." *Id.* at 4 (emphasis omitted).

Several entities and institutions have conducted systematic reviews to assess the evidence underlying the use of puberty blockers and cross-sex hormones as a treatment for minors with gender dysphoria. All have concluded that the evidence underlying medical interventions for gender dysphoria in minors is weak; zero have come out the other way.

1. Finland. The first systematic review came in 2019 when Finland's Ministry of Social Affairs and Health completed its review of the medical evidence. In light of this evidence review, Finland's healthcare authority concluded that "gender reassignment of minors is an experimental practice." *Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors* at 8, Palveluvalikoima (Nov. 6, 2020), https://perma.cc/PF72-H654 (unofficial translation by the Society for Evidence Based Gender Medicine (SEGM)). This conclusion was based on the fact that "[t]he reliability of the existing studies" is "highly uncertain." *Id*. at 7.

2. The Cass Review Interim Report. Next, in 2020, the United Kingdom's National Institute for Health and Care Excellence (NICE) completed its review of the evidence for using puberty blockers and cross-sex hormones on minors with gender dysphoria to aid the Cass Review, an independent review commissioned by the United Kingdom's National Health Service. *See NICE Evidence Reviews*, The Cass Rev., https://perma.cc/APZ2-W8MS. The result was two separate systematic reviews—one for puberty blockers and one for cross-sex hormones. *Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria*, Nat'l Inst. for Health & Care Excellence (Oct. 2020), https://perma.cc/F9FF-ZPFR ("NICE – Review of Puberty Blockers"); *Evidence Review: Gender-Affirming Hormones for*

Children and Adolescents with Gender Dysphoria, Nat'l Inst. for Health & Care Excellence (Oct. 2020), https://perma.cc/U49T-JLGJ ("NICE – Review of Cross-Sex Hormones"). The review of puberty blockers concluded that the relevant studies were "all small, uncontrolled observational studies, which are subject to bias and confounding, and all the results are of very low certainty using [a] modified GRADE" methodology. NICE – Review of Puberty Blockers at 13. Similarly, in the review of cross-sex hormones, NICE concluded that the relevant studies were "uncontrolled observational studies, which are subject to bias and confounding and were of very low certainty using [a] modified GRADE" methodology. NICE – Review of Cross-Sex Hormones at 13.

3. *The State of Florida*. In 2022, researchers at Canada's McMaster University—a world-renowned institution in evidence-based medicine—completed a systematic review at the request of the Florida Agency for Health Care Administration. *See* Romina Brignardello-Petersen & Wojtek Wiercioch, *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence* 5 (May 16, 2022), https://perma.cc/S4A3-NKDY. They too found that the evidence supporting these interventions was weak. "Due to the important limitations in the body of evidence," they concluded, "there is great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people with gender dysphoria." *Id*.

4. *Sweden*. In 2023, Swedish researchers published a systematic review that was commissioned by Sweden's Agency for Health Technology and Assessment of Social Services. *See* Jonas F. Ludvigsson et al., *A Systematic Review of Hormone Treatment for Children with Gender Dysphoria and Recommendations for Research*, 112 Acta Paediatrica 2279 (2023), https://perma.cc/E7S9-7CLB. The review concluded that the "[e]vidence to assess the effects of hormone treatment" on (among other things) mental health in minors "with gender dysphoria is

insufficient." *Id.* at 2280. Specifically, it noted that "[l]ong-term effects of hormone therapy on psychosocial health are unknown," and using puberty blockers to treat gender dysphoria "should be considered experimental treatment." *Id.*

5. The Cass Review Final Report. Most recently, researchers from York University published a series of systematic reviews as part of the Cass Review. The York University researchers conducted systematic reviews of the evidence for both puberty blockers and cross-sex hormones. *See* Jo Taylor et al., *Interventions To Suppress Puberty in Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review*, Archives Disease Childhood 1 (2024), https://perma.cc/UFL5-7RPB ("Taylor – Puberty Blockers"); Jo Taylor et al., *Masculinising and Feminising Hormone Interventions for Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review*, Archives Disease Childhood 1 (2024), https://perma.cc/ACK3-XB8D ("Taylor – Cross-Sex Hormones"). In their review of puberty blockers, the researchers determined that their "findings add to other systematic reviews in concluding there is insufficient and/or inconsistent evidence about the effects of puberty suppression on gender dysphoria, body satisfaction, psychological and psychosocial health, cognitive development, cardiometabolic risk and fertility." Taylor – Puberty Blockers at 12. Similarly, in their review for cross-sex hormones, the researchers concluded that their "findings add to other systematic reviews in concluding there is insufficient and/or inconsistent evidence about the risks and benefits of hormone interventions in this population." Taylor – Cross-Sex Hormones at 6.

To summarize, all these systematic reviews concluded the same thing: there is no reliable evidence to justify the use of puberty blockers and cross-sex hormones as a treatment for gender dysphoria in minors. And a critical study issued just last this month underscores this conclusion.

See Sami-Matti Ruuska et al., *Psychiatric Morbidity Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services in Finland in 1996-2019: A Register Study*, Acta Paediatrica (2026), https://perma.cc/86EP-YAQB. In a massive study of over 2,000 individuals, aged 23 and under, who were referred to Finland's gender clinics, researchers found that, "[a]mong adolescents who underwent medical gender reassignment, psychiatric morbidity *increased markedly*" and that "[p]sychiatric needs do not subside after medical gender reassignment." *Id.* (emphasis added). As the Wall Street Journal put it: "The results are a rebuke to those who call for irreversible interventions for children." Editorial Board, *Finland's Lessons on Transgender Children*, Wall St. J. (Apr. 16, 2026), https://perma.cc/3TR4-EMMZ.

The same is true of surgery. In February, the American Society of Plastic Surgeons (ASPS) released a statement outlining its position that adolescents should not receive "gender-affirming surgery" as a treatment for gender dysphoria. *See* Am. Soc. of Plastic Surgeons, *Position Statement on Gender Surgery for Children and Adolescents* (Feb. 3, 2026), https://perma.cc/KNZ5-TBT8. The ASPS stated that "the overall evidence base for gender-related endocrine and surgical interventions is low certainty," "recent publications report[ed] very low/low certainty of evidence regarding mental health outcomes," and there were "emerging concerns about potential long-term harms and the irreversible nature of surgical interventions in a developmentally vulnerable population." *Id.* Thus, ASPS concluded that surgeons should not offer "gender-related breast/chest" surgery for adolescents.

C. A Systematic Review Found That The Only Reliable Clinical Guidelines Recommend Psychosocial Support For Minors With Gender Dysphoria.

As part of the Cass Review commissioned by the U.K.'s National Health Service, researchers from York University conducted a series of systematic reviews for questions related to the treatment of gender dysphoria in minors. One of those reviews assessed the reliability of the

existing clinical guidelines for treating minors with gender dysphoria. *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 Archives Disease Childhood s65 (2024), https://perma.cc/ULJ7-UTE4 ("Taylor Review Part I"); Jo Taylor et al., *Clinical Guidelines for Children and Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review of Recommendations (Part 2)*, 109 Archives Disease Childhood s73 (2024), https://perma.cc/SWF4-YRMW ("Taylor Review Part II"). This review identified 23 sets of clinical guidelines that related to treatments for gender dysphoria in minors. Taylor Review Part I at s65. The researchers then used a validated instrument to assess the quality of these guidelines across six different domains, including the rigor of development. *Id.* at s66. Three independent reviewers appraised each guideline and determined whether the reviewer would recommend the guideline for use in practice. *Id.* at s66-67.

"Only two guidelines were recommended for practice by all three appraisers: the Swedish and Finnish guidelines." *Id.* at s69 (citations omitted). These two guidelines ranked the highest "for rigour of development due to their evidence-based approach and transparent reporting of" their methodology. *Id.*; *see also id.* at s70 ("These are the only guidelines to publish details of how developers reviewed and utilized the evidence-base and the decision-making behind their recommendations."). "They were also the only guidelines" that "included a formal ethics review." *Id.* at s69.

But their quality is not the only thing that set these two guidelines apart. The Swedish and Finnish guidelines—*i.e.*, the only guidelines to adequately follow principles of evidence-based medicine—are also the only two guidelines to list psychosocial care as the "first-line treatment for childhood gender dysphoria/incongruence." Taylor Review Part II at s78. Relatedly, both the

Swedish and Finnish guidelines recommend that *medical* transitions (*i.e.*, the use of puberty blockers and cross-sex hormones) be limited to the research context. *Id.* at S80; *see also* Taylor Review Part I at s69.

England has now also reached the same conclusion through the same process. As mentioned, this systematic review was performed by researchers at York University in support of the Cass Review, and the UK has now joined Sweden and Finland in recommending psychosocial support as the primary approach for helping minors suffering from gender dysphoria. The United States Department of Health and Human Services recently cataloged the position of each health authority:

- Per England's National Health Service (NHS): "The primary intervention for children and young people . . . is psychosocial (including psychoeducation) and psychological support and intervention; the main objective is to alleviate distress associated with gender dysphoria and promote the individual's global functioning and wellbeing."

- Per Finland's Council for Choices in Health Care in Finland (COHERE): "The first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders."

- Per Sweden's National Guidelines: "The psychosocial care of young people with gender dysphoria needs to be adapted to the needs of the individual adolescent. Psychosocial support that helps adolescents deal with natal puberty without medication needs to be the first option when choosing care measures. For those suffering from mental health problems, measures such as supportive counseling, psychotherapy, child psychiatric treatment, and suicide prevention need to be offered and adapted to the nature and severity of the mental health problem and the young person's overall situation."

Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices, U.S. Dep't of Health & Hum. Servs. 246-47 (May 1, 2025), https://perma.cc/8WKX-BPSK (citations omitted). Therefore, the guidelines and recommendations that are based on an assessment of the available scientific evidence all recommend psychosocial support as the primary approach for helping minors with gender dysphoria.

CONCLUSION

The Court should reverse the decision below.

Respectfully submitted this 20th day of April, 2026.

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 28(j)(2) of the North Carolina Rules of Appellate Procedure, the undersigned counsel certifies that the foregoing Brief of Amicus Curiae Do No Harm, which was prepared using 12-point proportionally spaced Times New Roman font, is less than 3,750 words (excluding covers, captions, indexes, tables of authorities, counsel's signature block, certificates of service, this certificate of compliance, and appendixes), as reported by Microsoft Word.

/s/ Nicole J. Moss
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CERTIFICATE OF SERVICE

The undersigned counsel for *amicus curiae* hereby certifies that a copy of the foregoing was served on parties of record to this action via electronic filing on April 20, 2026.

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