No. 17-2279

In the United States Court of Appeals *for the* Eighth Circuit

Anmarie Calgaro,

Plaintiff-Appellant,

v.

St. Louis County; Linnea Mirsch, individually and in her official capacity as Interim Director of St. Louis County Public Health and Human Services; Fairview Health Services, a Minnesota nonprofit corporation; Park Nicollet Health Services, a nonprofit corporation; St. Louis County School District; Michael Johnson, individually and in his official capacity as Principal of the Cherry School, St. Louis County School District; and E.J.K.,

Defendant-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MINNESOTA, THE HON. PAUL A. MAGNUSON

BRIEF OF AMICUS CURIAE WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH IN SUPPORT OF AFFIRMANCE

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INTEREST OF *AMICUS CURIAE*[1]

The World Professional Association for Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association, is an international interdisciplinary professional association devoted to the health and well-being of transgender people, with a membership of more than 1500 physicians, psychologists, social scientists, and legal professionals. WPATH works to promote the highest standards of evidence-based care, and respect, dignity, and equality for transgender people through education, research, and advocacy. As a central component of its mission, WPATH develops, publishes and promotes medical consensus on best practices in transgender health care. WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (Standards of Care)[2] is widely recognized in the medical community as the authoritative standard for the provision of transgender health care.

WPATH has a specific interest in this case because it involves the provision

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[1] All parties have consented to the filing of this brief. No counsel for a party authored any portion of this brief and no party and no other entity, except *amici* and their counsel, made any monetary contribution toward the preparation or submission of this brief.

[2] WPATH, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (2012) (Standards of Care), *available at* http://www.wpath.org/uploaded_files/140/files/Standards%20of%20Care,%20V7%20Full%20 Book.pdf.

of healthcare to transgender patients, and in particular to transgender youth, issues that are central to WPATH's mission and which it is especially qualified to address. Particularly in light of positions advocated in other amicus filings in this case, it is important to WPATH's membership, and to the patient community they serve, that the Court receive accurate information on the medical consensus concerning gender dysphoria and appropriate, evidence-based standards of care for transgender people.

SUMMARY OF ARGUMENT

Transgender people have been part of every human culture. In the United States, however, the medical community did not recognize the existence of transgender persons until the late nineteenth century. Historically, medical professionals in this country viewed being transgender as a pathology to be corrected or "cured."[3] Today, medical science recognizes that being transgender is a natural part of human diversity and that, with proper support, transgender people are healthy, contributing members of society.[4]

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[3] *See* Ira B. Pauly, *The Current Status of the Change of Sex Operation*, 147 J. Nervous & Mental Disease 460, 465-66 (1968) (discussing how "well-meaning therapists" attempted "to 'cure'" transgender patients by attempting to realign their gender identities with the sex assigned at birth, and in doing so caused harm).

[4] *See, e.g.*, Substance Abuse & Mental Health Servs. Admin., *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* 11 (2015) (SAMHSA, *Ending Conversion Therapy*), *available at* http://store.samhsa.gov/shin/content//SMA15-4928/SMA15-4928.pdf ("[V]ariations in gender identity and gender expression are

Since the 1960s in particular, significant advances in research have affirmed that transgender identity is real, innate and non-pathological. Based on the contemporary scientific understanding of sex, gender identity and gender dysphoria, the medical community understands that the goal of medical care for transgender people should be to support their health and well-being by enabling them to live consistently with their gender identity, just as other men and women do. E.J.K. sought medical care she needed to address her gender dysphoria and to live consistently with her gender.

Society's treatment of transgender persons can either undermine or support the care that the medical community aims to provide. Transgender people, and transgender youth in particular, contend with extraordinary levels of discriminatory treatment and abuse. Affirming transgender identity and supporting the efforts of transgender people to live consistently with their gender identity is not only humane, but also contributes substantially to positive healthcare outcomes for transgender patients.

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a part of the normal spectrum of human diversity and do not constitute a mental disorder.")

ARGUMENT

I. MEDICAL SCIENCE RECOGNIZES THE REALITY OF TRANSGENDER IDENTITY AND THE IMPORTANCE OF SUPPORTING TRANSGENDER PERSONS TO LIVE HEALTHY LIVES CONSISTENT WITH THEIR GENDER IDENTITY.

Gender identity is a person's inner sense of belonging to a particular gender.[5] It is an innate, deeply felt, and core component of human identity that individuals typically become aware of at an early age.[6] At birth, infants are assigned an identity of male or female based on a cursory observation of their external genitalia.[7] That identification is then recorded on the person's birth certificate. For most people, gender identity is consistent with their sex assigned at birth. Transgender people, however, have a gender identity that is different from

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[5] *See* Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 The Am. Psychologist 832, 834 (2015) (APA Guidelines) *available at https://www.apa.org/practice/guidelines/transgender.pdf* ("Gender identity is defined as a person's deeply felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; or an alternative gender.").

[6] *See* Am. Psychological Ass'n & Nat'l Ass'n of Sch. Psychologists, *Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools* (2015), http://www.apa.org/about/policy/orientation-diversity.aspx ("a person's gender identity develops in early childhood"); Endocrine Society, Position Statement on Transgender Health, *available at* http://www.endocrine.org/advocacy/priorities-and-positions/transgender-health ("there is a durable biological underpinning to gender identity") (2017).

[7] APA Guidelines at 862 ("Sex (sex assigned at birth): sex is typically assigned at birth (or before during ultrasound) based on the appearance of external genitalia.")

the sex they were identified as, or assumed to be, at birth.[8]

Gender dysphoria refers to the often severe emotional distress that may result from a difference between gender identity and sex assigned at birth. People diagnosed with gender dysphoria have an intense and persistent discomfort with the primary and secondary sex characteristics of their birth sex. Gender dysphoria is a serious medical condition codified in the *DSM-5*.[9]

Gender dysphoria was previously referred to in the DSM as "gender identity disorder" or "GID." The American Psychiatric Association adopted the term gender dysphoria, along with revised diagnostic criteria, because gender dysphoria "is more descriptive than the previous [DSM] term gender identity disorder and focuses on dysphoria as the clinical problem, not identity per se."[10] All major professional associations of medical and mental health providers today share this view of transgender identity.[11] They recognize that having a gender identity that differs from a person's sex assigned at birth is not in itself a disorder; rather, the severe distress experienced by some transgender persons as a result of the inconsistency between their gender identity and their assigned birth sex is a

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[8] *See id.* at 863 ("Transgender: an adjective that is an umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth.")
[9] *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 451-59 (5th ed. 2013) (*DSM-5*).
[10] *DSM-5*, at 451.
[11] *See* sources cited *infra* note 16.

medical condition requiring appropriate treatment.[12]

II. GENDER TRANSITION IS THE ONLY RECOGNIZED SAFE AND EFFECTIVE TREATMENT FOR GENDER DYSPHORIA.

The established medical consensus holds that the only effective treatment for the traumatic and potentially disabling experience of gender dysphoria is to provide medical and social support to enable a transgender person to live authentically, based on his or her core gender identity.[13] A person's gender identity is an innate, deeply-rooted aspect of who that person is, and cannot be changed. Efforts to realign an individual's gender identity to be consistent with their assigned birth sex are ineffective, unethical, and cause extraordinary harm and anguish. "[C]onversion therapy—efforts to change an individual's sexual orientation, gender identity or gender expression—is a practice that is not supported by credible evidence and has been disavowed by behavioral health experts and associations."[14] Today, medical professionals recognize that treatment

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[12] *DSM-5*, at 451-453; *see also* Cohen-Kettenis at 1893 (many of the problems transgender youth struggle with are "the consequence rather than the cause" of their gender dysphoria).

[13] *See* APA Guidelines at 846 ("Research has primarily shown positive treatment outcomes when [transgender] adults and adolescents receive [transgender]-affirmative medical and psychological services (i.e. psychotherapy, hormones, surgery….)"); SAMHSA, *Ending Conversion Therapy* at 25 ("There is also scientific consensus that for many people, medical intervention in the form of hormone therapy or gender affirming surgeries may be medically necessary to alleviate gender dysphoria.").

[14] SAMHSA, *Ending Conversion Therapy* at 1. Therapy seeking to realign an individual's gender identity has been expressly rejected by the American Medical

must respect the person's gender identity and support the person's ability to live consistently with that identity.

The medical treatment protocol for gender dysphoria is well-established and highly effective in alleviating psychological symptoms and leading to improved quality of life.[15] It provides for a process of medically-supported gender transition

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Association, the American Academy of Pediatrics and all other leading medical professional organizations. *See, e.g.*, Am. Med. Ass'n, Policy No. H-160.991, *Health Care Needs of the Homosexual Population* (2012), https://searchpf.ama-assn.org/SearchML/searchDetails. action?uri=%2FAMADoc%2FHOD.xml-0-805.xml ("Our AMA . . opposes[] the use of 'reparative' or 'conversion' therapy for sexual orientation or gender identity."); Hilary Daniel & Renee Butkus, Am. College of Physicians, *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians*, 163 Annals Internal Med. 135, Appendix (2015), *available at* http://annals.org/article.aspx?articleid=2292051 ("Evidence shows that [so-called reparative therapy] may actually cause emotional or physical harm."); Am. Sch. Counselor Ass'n, *The School Counselor and LGBTQ Youth* 37-38 (2016), https://www.schoolcounselor.org/asca/media/asca/PositionStatements/PS_LGBTQ.pdf; Daniel & Butkus at 37 ("The College opposes the use of 'conversion,' 'reorientation,' or 'reparative' therapy for the treatment of LGBT persons"); Am. Psychoanalytic Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression* (2012), http://www.apsa.org/content/2012-position-statement-attempts-change-sexual-orientation-gender-identity-or-gender ("Psychoanalytic technique does not encompass purposeful attempts to 'convert,' 'repair,' change or shift an individual's sexual orientation, gender identity or gender expression. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes.").

[15] *See* Mohammad Hassan Murad et al., *Hormonal therapy and sex reassignment: a systemic review and meta-analysis of quality of life and psychosocial outcomes*, 72 Clinical Endocrinology 214, 214–231 (2010) (meta-analysis reporting that 80% of participants receiving trans-affirmative care experienced an improved quality of life, decreased gender dysphoria, and a reduction in negative psychological symptoms);

by which transgender patients may live consistently with their core gender identity and, where appropriate for the individual, undergo medical treatments to alter their physical characteristics to align with their gender identity. That treatment protocol, embodied in the Standards of Care developed by WPATH, is evidence-based and widely recognized as the only appropriate treatment approach for gender dysphoria.[16]

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see also Standards of Care, Appendix D, at 107-108 (summarizing outcome research and finding high levels of satisfaction with sex-assignment therapies, increasing steadily along with increasing quality of care); Endocrine Society, Position Statement on Transgender Health.

[16] *See, e.g.*, Am. Med. Ass'n House of Delegates, Resolution 122 (A-08) *Removing Financial Barriers to Care for Transgender Patients* 1 (2008), *available at* http://www.tgender.net/taw/ama_resolutions.pdf ("[WPATH]" is the leading international, interdisciplinary professional organization devoted to the understanding and treatment of gender identity disorders, and has established internationally accepted Standards of Care for providing medical treatment for people with GID [that] are recognized within the medical community to be the standard of care for treating people with GID." (footnotes omitted)); APA Task Force Report at 32 ("The *Standards of Care* reflects the consensus in expert opinion among professionals in this field on the basis of their collective clinical experience as well as a large body of outcome research . . . ."); AAP Technical Report e301 (the Standards of Care "integrate the best available evidence with clinical experience from experts in the field of assisting transgender patients with transition.");Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94(9) J. Clinical Endocrinology & Metabolism 3132, 3136 (2009), *available at* http://bit.ly/2lmCmfO (identifying the Standards of Care as "carefully prepared documents [that] have provided mental health and medical professionals with general guidelines for the evaluation and treatment of transsexual persons"); Cohen-Kettenis 1893 ("[P]rofessionals largely follow the Standards of Care of the [WPATH]. . . ."); *De'Lonta v. Johnson*, 708 F.3d 520, 522-23 (4th Cir. 2013) ("The Standards of Care, published by the World Professional Association for Transgender Health, are the generally accepted protocols for the treatment of [gender dysphoria]"); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 231 (D. Mass. 2012) ("The

Under the Standards of Care, an individualized treatment protocol may include psychotherapy and counseling, support for social role transition, hormone therapy (including hormone blockers, as age appropriate), and a range of surgeries.[17] Social role transition involves bringing a person's gender expression and gender role into alignment with their gender identity. It may include wearing clothes associated with one's gender identity, using a different name and pronouns, and interacting with peers and one's social environment in a manner that matches one's gender identity.[18] A transgender person may also take medications that recalibrate the hormone balance in their bodies to achieve levels consistent with others who share the same gender identity. For example, a transgender man may take medications to stop his body from producing estrogen and replace those hormones with testosterone, which will further masculinize that person's appearance.[19] Lastly, a transgender person may pursue surgical treatment to alleviate the dysphoria associated with the person's primary and secondary sex

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course of treatment for Gender Identity Disorder generally followed in the community is governed by the 'Standards of Care' promulgated by the World Professional Association for Transgender Health ('WPATH')."); *Fields v. Smith*, 712 F. Supp. 2d 830, 838 n.2 (E.D. Wis. 2010) (accepting WPATH's Standards of Care as "the worldwide acceptable protocol for treating GID [gender dysphoria]"), *aff'd* 653 F.3d 550 (7th Cir. 2011).

[17] *See* Standards of Care at 5.

[18] *See id.* at 18-20.

[19] *See id.* at 34-36.

characteristics.[20]

For many, though by no means all transgender people, modifying sex characteristics through hormone treatments and/or surgery is a medically necessary treatment.[21] In all cases, however, the specific medical treatments required to alleviate a particular individual's gender dysphoria will vary based on a person's individualized medical needs.[22] By creating congruity between the person's identity and their appearance, the treatment significantly alleviates the symptoms of gender dysphoria. Notably, treatment does not make a transgender person more of a man or more of a woman; rather, the person's gender identity already exists and defines their gender, just as it does for non-transgender people. Medical treatment enables a transgender person to live consistently with their gender identity and to be seen by others in a way that reflects their true gender.

The amicus brief submitted by the Foundation for Moral Law ("FML") completely ignores the broad medical consensus embodied in the Standards of Care and instead claims that there are "medical, and scientific reasons" for opposing gender transition as medical treatment.[23] Both the clear consensus

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[20] *See id.* at 36.
[21] *E.g.* Standards of Care at 8-9, 33, 54.
[22] *See id.* at 8-9.
[23] The FML brief focuses primarily on purported medical and scientific reasons for opposing sex reassignment surgery in particular, which it asserts to be an issue in E.J.K.'s case. (*See* FML Br. at 9 ("Defendants arranged and paid for a sex-change operation"); 15 (claiming that plaintiff's rights were violated when defendants

among medical experts in this field and current research demonstrate gender transition to be an extremely well-established and medically necessary treatment, leading to marked alleviation of gender dysphoria and improved quality of life for the great majority of properly diagnosed and medically monitored patients.

The FML brief does not cite any medical or scientific sources to justify its rejection of the Standards of Care. Indeed, FML's brief completely fails to recognize at all the well-established, evidence-based legal and medical principles that guide and govern care for transgender people. FML's insistence that transgender people deny "biological reality," is based on a misunderstanding of transgender identity and the medical treatment of gender dysphoria, contradicts a wealth of scientific evidence, and misconstrues fundamental research in this field in numerous ways. FML Br. at 10, 16.

First, the very studies FML cites undermine the foundation's claims. For example, the FML Brief cites a 2011 study conducted by Cecilia Dhejne in support of its contention that sex reassignment is an ineffective treatment. *See* FML Br. at 12 n.11. That longitudinal study did find a higher mortality rate among post-operative transgender people than a control population. But the authors made clear that their study "should not be interpreted" to suggest that sex reassignment was

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provided E.J.K. "with so-called transgender surgery"). The record makes clear though that the medical services provided to E.J.K. did *not* include surgery. *See* Br. of Park Nicollet Health Servs. at 6-7 and record there cited.

ineffective, or the cause of the subject's mortality rate. Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLoS ONE 6(2): e16885, 7 (2011), available at, http://journals.plos.org/plosone/article/asset?id=10.1371/journal.pone.0016885.PDF. By analogy, the authors stated, when considering similarly increased mortality rates for subjects with bipolar disorder and schizophrenia, one could not infer that "mood stabilizing treatment or antipsychotic treatment is the culprit." *Id.* Indeed, the Dhejne study explicitly states that it *cannot* support the claim that sex reassignment is ineffective or unhealthy. To the contrary, the study states that it "is only informative with respect to transsexual[ ] persons health after sex reassignment; [and] no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism," because the same patients could very well have fared far worse *without* sex reassignment. *Id*. The study simply does not—and by design cannot—support the inference that FML asks this Court to make.

Such a conclusion would also be inconsistent with the clinical experience of professionals working with transgender people and the growing body of medical literature that transition-related care improves patient outcomes. For example, a recent study demonstrated that transgender youth who socially transition at an early age "provide clear evidence that transgender children have levels of anxiety

and depression no different from their nontransgender siblings and peers." Kristina Olson, et al., Mental Health of Transgender Children Who Are Supported in Their Identities, 137 Pediatrics 1, 7 (2016). The results of that study further support the conclusion that transgender children's psychological distress is not connected to their transgender status. *Id.* Similarly, a study of seventy transgender youth in Holland found that the cohort was comparable to the general population across nearly all domains of psychological functioning and quality-of-life measures. Annelou L.C. de Vries et al., Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment, 134 Pediatrics 696 (2014).

Second, FML cites research findings regarding rates of depression, anxiety and other mental health issues among transgender patients. The Standards of Care recognize that transgender patients may present with a range of mental health issues that may or may not be related to gender dysphoria and minority stress, and that care should be taken to ensure that gender dysphoria is not better accounted for by other diagnoses. See Standards of Care at 23-25. Despite FML's assertions, there is no support in the scientific literature for the proposition that gender transition itself causes or exacerbates mental health problems. See Standards of Care, at 8, Appendix D at 107. To the contrary, the Standards of Care reflect the careful, considered, consensus judgment of medical professionals as to effective medical treatment that will lead to positive health outcomes.

Third, the scientific literature offers no support for the view that gender dysphoria is treatable by attempts to change a person's gender identity to conform to their sex assigned at birth. Nor does the scientific or medical literature condone ignoring the reality of gender identity, or requiring transgender people such as E.J.K. to conform to their previously assigned sex. Such an approach is not only medically ineffective but also actively harmful and, therefore, unethical.[24]

Fourth and finally, the FML brief miscasts anecdotal reports to suggest that isolated instances of post-transition regret could supply a medical or scientific reason to oppose gender transition and sex-reassignment surgery. In fact, the Standards of Care summarize the scientific literature regarding patient satisfaction, and make clear that (a) overall levels of satisfaction with sex reassignment surgery are high, and (b) satisfaction has steadily increased with increasing quality of care and the adoption of the Standards of Care.[25] Against the weight of this authority, FML invokes opinion pieces and personal anecdotes from commentators and advocates who are not healthcare professionals and whose views lie far outside the mainstream. *See, e.g.,* FML Br. at nn.7,8 (citing the anonymous author of the on-

[24] Standards of Care at 32 (noting that "[t]reatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past, yet without success, [and] is no longer considered ethical) (internal citations omitted); *see also supra* n. 3-4 and sources cited therein.

[25] Standards of Care, Appendix D, at 107-08.

line blog Third Way Trans and the anti-transgender activist Walt Heyer on post-transition regret).[26] Isolated anecdotes by laypersons and outdated theories rife with animus are not a medically or scientifically sound basis on which to deny treatment that is known to alleviate gender dysphoria and to improve quality of life for transgender people.

III. MEDICAL INSTITUTIONS, SOCIAL INSTITUTIONS AND SCHOOLS PLAY A CRUCIAL ROLE IN THE SUCCESS OF GENDER DYSPHORIA THERAPIES.

The Standards of Care recognize that community support from family, co-workers, religious leaders and social and medical institutions is crucial to the success of gender dysphoria treatment.[27] Social actors and institutions that affirm a person's gender identity and support their efforts to live consistently with their gender identity make a significant contribution towards favorable healthcare outcomes. In contrast, rejecting a person's gender identity demeans the individual and exacerbates the dysphoric condition, often leading to serious negative health

[26] FML's reliance on the work of Janice C. Raymond is likewise illustrative of the extent to which it ignores expert research and medical consensus. Raymond is a radical academic theorist and political activist who maintains that transgender identity is an attempt "to colonize feminist identification, culture, politics and sexuality" and that "[a]ll transsexuals rape women's bodies by reducing the real female form to an artifact, appropriating this body for themselves." Janice G. Raymond, *The Transsexual Empire: The Making of the She-Male* 104 (1980). The opinions of outlier cultural commentators like Raymond cannot guide medical decisions that profoundly impact the lives of individuals across the country such as E.J.K., who have genuine medical conditions and need genuine medical care.

[27] Standards of Care at 30-32.

consequences.[28]

For transgender youth and adolescents, the challenges posed by gender dysphoria and the resulting need for medically-appropriate treatment are magnified by their stage of development and their dependence on schools and the other social and medical institutions that govern their lives (all the more so in cases such as E.J.K.'s where they lack a supportive family environment). The Standards of Care recognize that adolescents who are transgender can safely and responsibly be given the opportunity and support to transition so that they can lead healthy and authentic lives, rather than suppress or hide their identity.[29]

Healthcare professionals, religious leaders, educators, and school administrators who respect and affirm the gender identity of transgender students in the face of the substantial discrimination and other challenges faced by transgender youth are not only acting as common humanity dictates, but are helping to promote better healthcare outcomes for the young people in their care.

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[28] *See, e.g.,* Kristie L. Seelman, *Transgender Adults' Access to College Bathrooms and Housing and the Relationship to Suicidality*, 63 J. Homosexuality 1378, 1388-89 (2016), *available at* http://www.tandfonline.com/doi/pdf/10.1080/00918369.2016.1157998?needAccess=true (showing an increased risk of suicidality for transgender college students denied access to the same facilities used by other students).

[29] Standards of Care at 21 (discussing the dangers of not giving transgender adolescents the opportunity to transition).

CONCLUSION

The district court's order should be affirmed.

Dated: October 10, 2017

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of FOURTH CIRCUIT RULE 29(a)(5) because the brief contains 3,958 words, excluding the parts of the brief exempted by FED. R. APP. P. 32(f).

2. 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 a proportionally spaced typeface using Times New Roman, size 14.

Dated: October 10, 2017

COOLEY LLP

BY: */S/*
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Attorneys for Amicus Curiae

CERTIFICATE OF SERVICE

I, Maureen Alger, hereby certify pursuant to Federal Rule of Appellate Procedure 25(d) that I electronically filed the foregoing ***AMICI CURIAE*** brief with the Clerk of the Court of Appeals for the Fourth Circuit by using the appellate CM/ECF system on October 10, 2017. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: October 10, 2017 BY: */S/*
MAUREEN ALGER