

No. 21-2875

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UNITED STATES COURT OF APPEALS  
FOR THE EIGHTH CIRCUIT

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DYLAN BRANDT, et al.,  
Plaintiffs-Appellees,

v.

LESLIE RUTLEDGE,  
in her official capacity as the Arkansas Attorney General, et al.,  
Defendants-Appellants.

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On Appeal from the United States District Court for the  
Eastern District of Arkansas  
No. 4:21-CV-00450 JM (Hon. James M. Moody, Jr.)

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**Brief of Defendants-Appellants**

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## **SUMMARY AND STATEMENT REGARDING ORAL ARGUMENT**

This case is about the States' power to regulate the practice of medicine. A growing body of scientific evidence undermines the claim that gender-transition procedures benefit patients. Yet each of the typically used procedures has well-settled, irreversible consequences: Puberty blockers lead to lower bone density and, if used long enough, permanently immature sex organs. Cross-sex hormones cause lifetime infertility. And the most common surgery, a double mastectomy, destroys a young woman's otherwise healthy breasts. Arkansas decided that the scant evidence of benefit does not justify these irreversible consequences. So the State outlawed gender-transition procedures for anyone under eighteen.

Before Arkansas's new law could take effect, the district court below preliminarily enjoined a group of officials from enforcing it. In a thirteen-page order, it created a new suspect class under the Equal Protection Clause; established a new fundamental, substantive-due-process right under the Fourteenth Amendment; and subjected any state law to strict scrutiny that regulates the treatments for which medical practitioners may provide referrals. That order did not even acknowledge the ongoing international debate about the propriety of the outlawed procedures.

This Court should now reverse the injunction and remand with instructions to dismiss. Given the complex legal and medical issues in this case, Defendants request 20 minutes of oral argument.

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## STATEMENT OF JURISDICTION

The district court had jurisdiction under 28 U.S.C. 1331. On July 21 and August 2, 2021, the district court entered orders denying Defendants’ motion to dismiss and granting Plaintiffs’ motion for a preliminary injunction. *See* Add. 14, R. Doc. 64, at 13; Add. 1, R. Doc. 59. On August 20, Defendants timely filed a notice of appeal. App. 1134, R. Doc. 67.

Because the orders granted a preliminary injunction, this Court has jurisdiction pursuant to 28 U.S.C. 1292(a)(1). And because the “denial of [Defendants’] motion to dismiss” was “‘inextricably intertwined’ with the resolution of the court’s ruling on the preliminary injunction,” this Court has “pendent appellate jurisdiction over the district court’s denial of the motion to dismiss.” *Angelotti Chiropractic, Inc. v. Baker*, 791 F.3d 1075, 1087-88 (9th Cir. 2015); *see Newton Cnty. Wildlife Ass’n v. U.S. Forest Serv.*, 113 F.3d 110, 116 (8th Cir. 1997).

## STATEMENT OF THE ISSUES PRESENTED

1. Because gender-transition procedures have irreversible consequences, including lifelong infertility, and lack any scientifically proven benefits, Arkansas prohibited them for minors. Should the district court have enjoined Arkansas's prohibition?

**Apposite Authority:** *Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 138 S. Ct. 2361 (2018); *Gonzales v. Carhart*, 550 U.S. 124 (2007); *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432 (1985).

2. To prevail, Plaintiffs must persuade the courts to expand current First and Fourteenth Amendment doctrine. Should the district court have applied binding precedent and dismissed the complaint?

**Apposite Authority:** *Gonzales*, 550 U.S. 124; *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Kowalski v. Tesmer*, 543 U.S. 125 (2004).

## STATEMENT OF THE CASE

Responding to scientific evidence about the long-term harm from gender-transition procedures, the Arkansas General Assembly barred practitioners from performing those procedures on children. The district court disagreed with the General Assembly's judgment and substituted its view for that of the people of Arkansas. In the process, it ignored basic equal-protection principles, created a new fundamental right, and expanded basic First Amendment law. This Court should reverse.

### **I. Factual Background**

Understanding Arkansas's prohibition of gender-transition procedures requires background in the science of sex and the international controversy concerning gender-transition procedures.

#### **A. Sex, Gender, and Gender Discordance**

Every human cell that has a nucleus is chromosomally encoded as either female or male: two X chromosomes for females; one X and one Y for males. App. 172-73; R. Doc. 45-1, at 15-16. A person's sex, therefore, is determined by DNA. Despite that, some people with normal, healthy sex organs experience gender discordance. *Id.* Discordance that causes "clinically significant distress" may lead to a "gender dysphoria" diagnosis. App. 180; R. Doc. 45-1, at 23.

The current version of the *Diagnostic & Statistical Manual*, the DSM-5, distinguishes early- and late-onset gender dysphoria. App. 871-72; R. Doc. 45-24, at 4-5. Late-onset is marked by a “strong desire” to acquire characteristics of the opposite sex, or a “conviction that one has the typical feelings and reactions of the other gender.” *Id.* Early-onset is more often identified on the basis of a child’s play. In children, the diagnostic criteria include: whether a child rejects “typically masculine” or “typically feminine toys, games, and activities”; whether a child prefers “playmates of the other gender” and “toys, games, or activities” associated with “the other gender”; or whether a child enjoys “cross-gender roles in make-believe play.” *Id.* Diagnosing dysphoria thus hinges on sex-stereotypical behaviors.

Both the World Professional Association for Transgender Health (“WPATH”) and the Endocrine Society—on whose guidelines Plaintiffs heavily rely, *see, e.g.*, App. 11-15; R. Doc. 1, at 11-15—refuse to equate gender dysphoria with being transgender. Both groups explain that “transgender” is “an umbrella term,” App. 790; R. Doc. 45-21, at 7, that includes “a diverse group of individuals,” App. 758; R. Doc. 45-19, at 103. It includes, for example, those who “experience themselves as having both a male and female gender identity,” or neither. App. 788; R. Doc. 45-21, at 5.

These and other similar sources also make clear that transgender status, which hinges on “gender identity,” is not an immutable or biologically determined

characteristic. These characteristics are necessarily indexed to “culturally defined categories of gender,” App. 758; R. Doc. 45-19, at 103, and reflect “environmental” or “cultural factors,” App. 789; R. Doc. 45-21, at 6. Indeed, transgender status is said to depend only on whether individuals’ “name, pronouns, clothing, haircut, behavior, voice, or body characteristics” (*i.e.*, their “gender expression”) differ “from what is typically associated with their sex”—*regardless* of their self-identification. App. 790; R. Doc. 45-21, at 7; *see* App. 850; R. Doc. 45-22, at 32.

Transgender status thus is not rooted in biology, but in “what is normative” in a particular “culture and historical period.” App. 757-58; R. Doc. 45-19, at 102-03.

Unsurprisingly, then, many organizations deny that gender identity (and thus transgender status) is an immutable characteristic. *See* App. 870; R. Doc. 45-24, at 3 (“Transgender refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender.”). “[F]or some transgender individuals, gender identity may remain somewhat fluid for many years,” according to WPATH. App. 776; R. Doc. 45-20, at 1; *see* App. 823; R. Doc. 45-22, at 5 (American Psychological Association) (“some people also experience their gender identity as fluid”). In the Endocrine Society’s words, some experience “a continuous and rapid involuntary alternation between a male and female identity.” App. 788; R. Doc. 45-21, at 5.

Particularly regarding children, these organizations make clear that transgender status is not immutable. “[N]ot all young gender nonconforming children will ultimately express a gender identity different from that assigned at birth.” App. 830; R. Doc. 45-22, at 12. “In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and there is greater fluidity and variability in outcomes, particularly in prepubertal children.” App. 671-73; R. Doc. 45-19, at 16-18. “In most children, gender dysphoria will disappear before, or early in, puberty.” *Id.*; *see* App. 678; R. Doc. 45-19, at 23 (acknowledging “relatively low persistence rates of childhood gender dysphoria”).

While medical professionals know that in most children gender dysphoria will desist, they “cannot predict the psychosexual outcome for any specific child.” App. 791; R. Doc. 45-21, at 8.

#### B. Treatment Models for Gender Dysphoria

The mental-health community has developed three primary treatment models for dysphoria: watchful waiting, psychotherapy, and affirmation. App. 189-99; R. Doc. 45-1, at 32-42. The watchful-waiting model takes a cautious approach to interventions, monitoring a child’s development and avoiding hormonal interventions during adolescence. *Id.* It is often combined with psychotherapy designed to alleviate any distress. *Id.* These treatment methods reflect consistent findings that

a majority of children will cease to suffer from dysphoria by the time they reach puberty. App. 204; R. Doc. 45-1, at 47.

Other practitioners employ an “affirmation therapy” model. Under it, a child experiencing gender dysphoria is actively encouraged to pursue a transgender identity. App. 193-96; R. Doc. 45-1, at 36-39. This often begins by encouraging a child to socially transition (*e.g.*, “by means of consistent use of clothing, toys, pronouns, etc. associated with transgender identity”) and then to medically, or even surgically, transition. *Id.* Many studies show that “early social transition to living as the opposite sex severely reduces the likelihood that the child will revert to identifying with the child’s natal sex.” App. 204; R. Doc. 45-1, at 47. Absent transition, gender dysphoria will desist in 80-98% of children, but that figure may be as low as 20% in children who socially transition prior to puberty. *Id.*

Medical transition begins with puberty blockers to indefinitely halt normal puberty. App. 356, 411; R. Doc. 45-3, at 21, 76. Puberty blockers are FDA-approved *only* to treat precocious puberty, which is not the same as a gender-transition procedure. *See* App. 1033; R. Doc. 55-3, at 3 (“It is erroneous to draw conclusions on the purported safety of puberty blockers in adolescents with normally timed puberty based upon data collected in children treated for precocious puberty.”); *accord* App. 1044; R. Doc. 55-3, at 14.

Puberty blockers do not simply “pause[] puberty.” App. 28; R. Doc. 1, at 28. They lead to slower growth rates and an elevated risk of low bone density, and may also cause “alteration of normal adolescent brain maturation.” App. 411; R. Doc. 45-3, at 76; *accord* App. 1034-35, 1045; R. Doc. 55-3, at 4-5, 15. And puberty blockers prevent sex organs from maturing, causing long-term sexual problems. *See* App. 224; R. Doc. 45-1, at 67.

“[T]he vast majority” of children on puberty blockers will proceed to cross-sex hormones. App. 1044; R. Doc. 55-3, at 14; *see* App. 303; R. Doc. 45-2, at 33 (reporting 98% proceed to hormones). Hormonal treatments are often used for other procedures in adolescents, for example to initiate delayed puberty. *See* App. 34; R. Doc. 1, at 34. But they are not FDA-approved as a gender-transition procedure and have irreversible consequences. *See* App. 291; R. Doc. 45-2, at 21; App. 1035-36; R. Doc. 55-3, at 5-6. “[P]otential adverse effects include disfiguring acne, high blood pressure, weight gain, abnormal glucose tolerance, breast cancer, liver disease, thrombosis, and cardiovascular disease.” App. 407; R. Doc. 45-3, at 72. In girls who take testosterone, this can include permanent voice deepening; in boys on estrogen, permanent loss of muscle mass. App. 225; R. Doc. 45-1, at 68.

Often, hormones cause irreversible sterilization. App. 406; R. Doc. 45-3, at 71. Although gender-transition practitioners “counsel patients on fertility preservation prior to starting this intervention,” adolescents who have never undergone

puberty “because of a pubertal blockade” will have immature reproductive organs and thus no fertility to preserve. App. 1035-36, 1044; R. Doc. 55-3, at 5-6, 14.

Finally, some pursue surgery. Plaintiffs focus on double mastectomies. During that procedure, healthy breasts are removed, thereby destroying functioning organs, including permanently destroying breastfeeding capability. App. 463, 470-73; R. Doc. 45-4, at 8, 15-18. Others undergo genital surgery, with obvious irreversible effects. *See* App. 895; R. Doc. 45-27, at 2 (describing one witness’s “penile inversion” surgery); App. 899; R. Doc. 45-28, at 2 (same, another witness).

### C. Recent Boom in Gender Discordance

Recently, there has been an exponential increase in reports of gender discordance. App. 176-79; R. Doc. 45-1, at 19-22 (4,000% increase). Some data suggest that those self-identifying as transgender in America ballooned from 0.3% in 2011 to 0.6% in 2016—doubling over 5 years. App. 276-77; R. Doc. 45-2, at 6-7. Since 2016, the pace quickened. Estimates now range from 1.8% to just under 3%. *Id.* Even the lower number would mean that transgender self-identifications have tripled in five years. In the United Kingdom, in 2009-2010, the leading gender-transition facility for minors saw 32 female and 40 male patients. *Id.* Five years later, it saw 399 females and 250 males. *Id.* And in 2018-2019, it saw 1,740 females and 624 males. *Id.*

As these numbers demonstrate, a sex-ratio flip has accompanied the uptick. Throughout the 20th century, that ratio was around 3:1 or 4:1, males over females. Many clinics now report a ratio of 7:1, females over males. App. 176; R. Doc. 45-1, at 19. And though transgender self-identification has increased among both sexes, the increase is particularly pronounced among females. The U.K. numbers discussed above, for example, show females' diagnoses have increased fiftyfold since 2009. This sudden shift is inconsistent with "[b]iological theories of gender dysphoria." *Id.* And because it is limited to adolescents, it "cannot be simplistically attributed to 'pent-up demand.'" App. 279; R. Doc. 45-2, at 9.

Given that "[r]egret following transition is not an infrequent phenomenon," the gender-discordance boom will likely cause another boom—of post-transition regret. App. 230; R. Doc. 45-1, at 73. The record contains stories of such regret. Billy Burleigh's gender discordance began early, and after a "penile inversion" surgery that led to profuse bleeding and a three-week hospitalization, he lived as a woman for seven years, only to eventually detransition. App. 894-96; R. Doc. 45-27, at 1-3. Walt Heyer's story is similar, although he had genital surgery in middle age, after marriage and two children. App. 898-901; R. Doc. 45-28, at 1-4. He lived as a woman for eight years before detransitioning. *Id.* Laura Perry also experienced persistent dysphoria, which she traces in part to her mother's stated preference for boys and to childhood abuse. App. 903-08; R. Doc. 45-29, at 1-6. In

early adulthood, she lived as a man, taking testosterone, changing her name, and undergoing a hysterectomy—though she would eventually detransition. *Id.*

Each of these people experienced early-onset dysphoria that persisted into adulthood, when they underwent gender-transition procedures. Each regretted it. Adolescents have a reduced capacity to consider long-term consequences, so allowing them to undergo transition will likely increase stories of post-transition regret. *See* App. 307-09; R. Doc. 45-2, at 37-39 (discussing adolescents’ diminished decisional capacity). This likelihood is made still more troubling by the “patient-driven, on-demand” model practiced in many newly minted gender-transition facilities. *See* App. 297-300; R. Doc. 45-2 at 27-30.

D. International Controversy Surrounding Gender Transition for Minors

The rise in transgender self-identifications among children has led to a swell of international concern. In particular, scientific reviews in Sweden, Finland, and the United Kingdom have raised concerns about the lack of evidence that gender-transition procedures benefit children. *See* App. 211-13, 243; R. Doc. 45-1, at 54-56 & nn.48-52, 86 & n.85 (discussing findings); App. 287-90, 309-12; R. Doc. 45-2, at 17-20, 39-42 (same); App. 344-48; R. Doc. 45-3, at 9-13 (same).

A 2019 Swedish government review found no explanation for the increase and “sparse” literature about the “long-term effects in children” of gender-transition procedures. App. 522; R. Doc. 45-6, at 2. Then, effective May 1, 2021, a

leading Swedish children’s hospital banned the use of puberty blockers and hormones on children and adolescents. App. 526-27; R. Doc. 45-8, at 1-2. It said the existing studies offer only “low quality evidence that the treatments have the desired effect,” *i.e.*, the alleviation of distress associated with gender dysphoria. *Id.* Citing irreversible consequences already discussed, including osteoporosis and infertility, *see id.*, it banned puberty blockers and hormones for children under 16, and limited them to certain clinical trials in children between 16 and 18, App. 524; R. Doc. 45-7, at 1.

In June 2020, a Finnish medical institution published similar guidelines. App. 514-17; R. Doc. 45-5, at 5-8. Having reviewed “available evidence,” it concluded “gender reassignment of minors is an experimental practice.” *Id.* “As far as minors are concerned, there are no medical treatment[s] that can be considered evidence-based.” *Id.* The Finnish institution found that a “reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions.” *Id.* Thus, claims of psychiatric benefit are “not a valid justification for gender reassignment.” *Id.*

Similarly, in the United Kingdom, concern about gender-transition procedures has been growing since at least 2019. Concern centered on the Tavistock Gender Identity Development Service operated by the National Health Service. A sociologist at Oxford raised the alarm after results from a trial performed by the

Tavistock clinic became public. Those results showed young people undergoing gender-transition procedures experienced “a significant increase” in attempts “to hurt or kill self.” App. 643-44; R. Doc. 45-17, at 6-7. Simultaneously, those results provided “no evidence that puberty blockers improve psychosocial functioning.” *Id.*

Then, in March 2021, the U.K. National Institute for Health and Care Excellence (“NICE”) published systematic evidence reviews investigating whether puberty blockers or hormones effectively treated dysphoria in minors. The reviews’ results were similar—and similarly skeptical of gender-transition procedures. NICE’s puberty-blocker review found that all the studies were “small, uncontrolled observational studies” that “reported physical and mental health comorbidities and concomitant treatments very poorly.” App. 541; R. Doc. 45-9, at 13. Overall, NICE found “little change” in “the critical outcomes of gender dysphoria and mental health.” *Id.* Regarding cross-sex hormones, NICE likewise concluded: “Any potential benefits of gender-affirming hormones must be weighed against the largely unknown long-term safety profile of these treatments in children and adolescents with gender dysphoria.” App. 556; R. Doc. 45-10, at 14.

Around the same time, Cochrane (a U.K.-headquartered network of around 50,000 researchers across 130 countries<sup>1</sup>) published a systematic review that “aimed to assess the efficacy and safety of hormone therapy” for male-to-female transitioners. App. 559; R. Doc. 45-11, at 3. Despite “more than four decades” of practitioners performing gender-transition procedures, Cochrane “found that no [randomized controlled trials] or suitable cohort studies have yet been conducted to investigate the efficacy and safety of hormonal treatment approaches.” App. 568; R. Doc. 45-11, at 12. It found only “a gap between current clinical practice and clinical research.” *Id.* Because there were no suitable studies, Cochrane could not analyze the safety and effectiveness of hormones. *See* App. 566-69; R. Doc. 45-11, at 10-13.

Hoping to fill that research gap, Richard Bränström and John E. Pachankis published the first long-term outcome study. They claimed that gender-transition procedures improve long-term mental health outcomes.<sup>2</sup> But the study’s methodological errors prompted a series of letters from prominent researchers. *See* App. 580-86; R. Doc. 45-13, at 1-7. Their data proved just the opposite of what they

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<sup>1</sup> *See* Cochrane, *About Us*, <https://www.cochrane.org/about-us>.

<sup>2</sup> *See* Richard Bränström and John E. Pachankis, *Reduction in Mental Health Treatment Utilization among Transgender Individuals after Gender-affirming Surgeries: A Total Population Study*, 177 *Am. J. of Psychiatry* 727 (2020).

had claimed. Not only was there “a spike in suicide attempts” in the year after surgical transition, gender-reassignment surgery increased “the risk of being hospitalized for a suicide attempt” by “2.4 times.” App. 582, 584; R. Doc. 45-13, at 3, 5. In the end, a “Correction to Bränström and Pachankis” was published. *See* App. 579; R. Doc. 45-12. Consequently, the only long-term outcome study of gender-transition procedures to date is inconclusive at best, and, at worst, demonstrates mental-health harms.

E. Criticism of Advocacy Groups Cited by Plaintiffs

The district court did not acknowledge this swirling international controversy but did refer in a single footnote to the clinical guidelines published by WPATH and the Endocrine Society. Add. 7; R. Doc. 64, at 6 n.2. These guidelines are not scientific evidence. They result from a consensus-seeking process (*i.e.*, voting by members of a committee) instead of an evidence-based scientific research process. *See* App. 197-202; R. Doc. 45-1, at 40-45 (describing WPATH’s process); App. 381-83; R. Doc. 45-3, at 46-48 (distinguishing consensus-based processes from research process). Because of this, such guidelines may recommend “sub-optimal” treatments to “serve societal needs, or protect special interests (those of doctors, risk managers, or politicians, for example).” App. 654; R. Doc. 45-18, at 3. Worse, they are “subject to misuse by proponents and advocacy

groups giving the public (and health professionals) the wrong impression about . . . the effectiveness of interventions.” *Id.*

WPATH expressly acknowledges that its “mission” is transgender-related “advocacy.” App. 662; R. Doc. 45-19, at 7. Dr. Stephen B. Levine, the former Chairman of the WPATH Standards of Care Committee, explained below how he witnessed WPATH’s focus on advocacy instead of research. He recalled seeing transition-skeptical questions during meetings shouted down by activists, leading him to reluctantly resign. *See* App. 197-202; R. Doc. 45-1, at 40-45. In fact, most psychiatrists and psychologists who treat patients seeking inpatient psychiatric care for gender dysphoria are not members. *Id.*

Refusing to defer to WPATH or the Endocrine Society, in 2020, U.K. courts stepped into the debate. A group of claimants sought judicial review of the Tavistock clinic’s use of puberty blockers. *See Bell v. Tavistock & Portman Nat’l Health Serv. Found. Tr.* [2020] EWHC (Admin) 3274 [¶ 2].<sup>3</sup> In response, the Tavistock clinic claimed compliance “with the international frameworks of WPATH and the Endocrine Society.” *Id.* ¶ 97. But those organizations, the court said, relied only on evidence related to “the treatment of precocious puberty”—“a different condition from [gender dysphoria].” *Id.* ¶ 60. With puberty blockers for

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<sup>3</sup> <https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf>.

gender transition, there is “real uncertainty over the short and long-term consequences” and “very limited evidence as to its efficacy.” *Id.* ¶ 134 That said, it was clear that “the consequences of the treatment are highly complex and potentially lifelong and life changing in the most fundamental way imaginable.” *Id.* ¶ 133. Though the court did not find that the Tavistock clinic’s procedures were illegal, it established guidance for judicial involvement when minors sought puberty blockers. *See id.* ¶¶ 151-53.

Since then, the Tavistock clinic appealed. *See Bell v. Tavistock & Portman NHS Found. Trust* [2021] EWCA (Civ) 1363.<sup>4</sup> The Court of Appeal ultimately set aside the lower court’s decision. *See, e.g., id.* ¶¶ 59, 94. But that court agreed that experts with “strongly held contrary views” oppose WPATH. *Id.* ¶ 75. It concluded that “treatment of children for gender dysphoria is controversial”—fraught with “not only clinical medical issues but also moral and ethical issues, all of which are the subject of intense professional and public debate.” *Id.* ¶ 3. In the end, “[m]edical opinion is far from unanimous about the wisdom of embarking on treatment before adulthood.” *Id.*

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<sup>4</sup> <https://www.judiciary.uk/wp-content/uploads/2021/09/Bell-v-Tavistock-judgment-170921.pdf>.

## II. Statutory Background

Responding to growing international concern over the explosion in experimental gender-transition procedures, Arkansas enacted the Save Adolescents from Experimentation (“SAFE”) Act. *See* 2021 Ark. Act 626 (enacting Ark. Code Ann. 20-9-1501 through -1504). The Act’s legislative findings echoed the research discussed above, highlighted the lack of evidence about gender-transition procedures’ safety, stressed those procedures’ irreversible consequences, and concluded that “[t]he risks of gender transition procedures far outweigh any benefit at this stage of clinical study.” *Id.*, sec. 2(6)-(8), (15).

The SAFE Act therefore prohibited practitioners from performing such procedures on children or referring children for such procedures. Ark. Code Ann. 20-9-1502. The Act defines “gender transition procedures” as “any medical or surgical service . . . including . . . puberty-blocking drugs, cross-sex hormones, . . . or genital or nongenital gender reassignment surgery performed for the purpose of assisting an individual with a gender transition.” *Id.* 20-9-1501(6)(A). It does not prohibit any gender-transition procedure for adults. *See id.* 20-9-1502(a). And it does not prohibit—indeed, it encourages—providing children mental health services to address their psychological distress. *See* SAFE Act, 2021 Ark. Act 626, sec. 2(4).

### **III. Procedural Background**

A. Plaintiffs sued. Ignoring the international controversy, they claimed “a well-established medical consensus” supports them. App. 2; R. Doc. 1, at 2.

They sought a vast expansion of various constitutional doctrines. First, they asked the district court to declare transgender status a suspect classification “subject to at least heightened scrutiny” under the Equal Protection Clause. App. 41; R. Doc. 1, at 41. Second, they claimed a heretofore unannounced fundamental right “of parents to seek and follow medical advice.” App. 43; R. Doc. 1, at 43. Third, they advocated expanding doctors’ First Amendment rights, so that any law that prohibited a particular medical procedure would trigger strict scrutiny if it also incidentally prohibited doctors from sending patients to out-of-state doctors for the prohibited procedure. App. 44-46; R. Doc. 1, at 44-46.

Plaintiffs sought a preliminary injunction. App. 48; R. Doc. 11. Defendants moved to dismiss. App. 157; R. Doc. 17.

B. After a brief hearing, the district court ruled from the bench. *See* App. 1121-31; R. Doc. 60, at 58-68. It made no findings about the medical issues, but simply declared “that the plaintiffs are likely to succeed on the merits under any form of review.” App. 1129; R. Doc. 60, at 66. When the parties asked whether to expect a written order reflecting findings that would support this determination, the court responded that it did not intend to enter one. App. 1133; R. Doc. 60, at 70.

Later that day, the district court entered a one-sentence order granting the preliminary-injunction motion and denying dismissal. Add. 1; R. Doc. 59.

C. About two weeks later, the district court entered a “Supplemental Order.” Add. 2-14; R. Doc. 64. Although this order provided some detail on the court’s reasoning, it still did not acknowledge—let alone consider—Defendants’ evidence contradicting Plaintiffs’ factual allegations. Defendants had offered hundreds of pages of scientific evidence, including declarations by four experts:

- Dr. Stephen Levine, a psychiatrist who formerly served on WPATH’s Standards of Care Committee and on whom courts often rely, App. 158; R. Doc. 45-1; *see, e.g., Gibson v. Collier*, 920 F.3d 212, 222 (5th Cir. 2019); *Tavistock*, [2020] EWHC (Admin) 3274 [¶ 64]; *see also* App. 1004; R. Doc. 55-1 (rebuttal);
- Dr. Mark Regnerus, a professor of sociology at the University of Texas at Austin, App. 271; R. Doc. 45-2; *see* App. 1016; R. Doc. 55-2 (rebuttal);
- Dr. Paul Hruz, a professor of pediatric endocrinology at Washington University School of Medicine, App. 336; R. Doc. 45-3; *see* App. 1031; R. Doc. 55-3 (rebuttal); *see also Tavistock*, [2020] EWHC (Admin) 3274 [¶¶ 49, 51, 64, 76] (relying on Dr. Hruz); and,
- Dr. Patrick Lappert, a plastic surgeon who, among other distinctions, served as the founding director of the Wound Care Center at the Naval Hospital in Portsmouth, Virginia, App. 456; R. Doc. 45-4.

Instead of discussing the evidence, the district court relied entirely on an amicus brief. *See* Add. 7-9; R. Doc. 64, at 6-8 & nn. 3-6. It first created a new suspect classification: transgender status. Add. 5; R. Doc. 64, at 4. Then, without citing any evidence, it concluded that the SAFE Act was insufficiently tailored to Arkansas’s compelling interests in protecting children and medical ethics. Add. 8-

9; R. Doc. 64, at 7-8. Next, relying on precedent about parents’ right to direct their children’s education or control who has visitation rights, the district court created a fundamental right to “make a judgment that medical care is necessary” for a child. Add. 10-11; R. Doc. 64, at 9-10. Finally, the district court granted doctors a new First Amendment right to send patients to other doctors for procedures prohibited by state law. Add. 12-13; R. Doc. 64, at 11-12.

Cross-referencing its preliminary-injunction reasoning, it also denied Defendants’ motion to dismiss. *Id.* They timely appealed both decisions. App. 1134; R. Doc. 67. While this case is pending before this Court—and over Defendants’ objection, *see* R. Doc. 74—the district court has set this case to proceed to a July 2022 bench trial. *See* R. Doc. 76.

## SUMMARY OF THE ARGUMENT

This Court should reverse the preliminary injunction and denial of Defendants' motion to dismiss, and remand with instructions to dismiss. For starters, Plaintiffs have not established their standing to challenge certain SAFE Act provisions that their claims do not implicate, nor have the practitioners shown they can assert third-party standing on behalf of their patients.

On the merits, Plaintiffs are unlikely to succeed on their equal-protection claim. The SAFE Act does not draw a suspect classification, so it is subject to rational-basis review, not heightened scrutiny. It distinguishes on the basis of age and medical procedure, which are not suspect classifications, and not on the basis of either sex or transgender status (which is not a suspect classification). And if the Act triggered heightened scrutiny, it would survive, because it is substantially related to Arkansas's important interests in protecting children and safeguarding medical ethics.

Plaintiffs are also unlikely to succeed on the merits of their substantive-due-process and First Amendment claims. Parents have no fundamental right to unsafe, experimental gender-transition procedures. And the First Amendment does not grant practitioners a right to refer children for gender-transition procedures. In either case, the SAFE Act would satisfy strict scrutiny, if it applied.

## ARGUMENT

### *Standard of Review*

Plaintiffs failed to meet their burden of making “a clear showing” that each preliminary-injunction factor favors them. *Winter v. Nat. Res. Def. Council*, 555 U.S. 7, 22 (2008); *Dataphase Sys., Inc. v. CL Sys., Inc.*, 640 F.2d 109, 114 (8th Cir. 1981) (en banc). Their failure to show a likelihood of success on the merits is particularly apparent, given their need to make a “more rigorous showing” than usual “that [they are] likely to prevail on the merits” to obtain the injunction that would prevent “implementation of a duly enacted state statute.” *Planned Parenthood Ark. & E. Okla. v. Jegley*, 864 F.3d 953, 957-58 (8th Cir. 2017) (quotation marks omitted).

This Court reviews both the district court’s legal determinations underlying its preliminary-injunction order and its denial of the motion to dismiss de novo. *Lankford v. Sherman*, 451 F.3d 496, 504 (8th Cir. 2006); *Angelotti Chiropractic, Inc. v. Baker*, 791 F.3d 1075, 1087-88 (9th Cir. 2015).

### **I. Plaintiffs lack standing.**

Plaintiffs have not established their standing to pursue all their claims. Their allegations do not implicate certain SAFE Act provisions, so they lack standing to challenge them. And Plaintiffs who are gender-transition practitioners lack third-party standing to assert their patients’ rights.

A. Plaintiffs do not allege that gender-reassignment surgery is performed on minors in Arkansas, nor that, if it were, they would seek it. They also do not allege that Defendants have any connection with enforcing the SAFE Act’s private right of action. To rule on either issue, therefore, would be to resolve a “hypothetical or abstract dispute[.]” *TransUnion LLC v. Ramirez*, 141 S. Ct. 2190, 2203 (2021). So this Court should remand with instructions to dismiss Plaintiffs’ claims on these issues.

According to Plaintiffs, none of the children in this case seek to undergo gender-reassignment surgery before their eighteenth birthday, and none of the practitioners perform it on children. *See generally* App. 7-8, 18-32; R. Doc. 1, at 7-8, 18-32. Yet the district court blocked the SAFE Act’s prohibition of gender-reassignment surgery. *See* Add. 14; R. Doc. 64, at 13. This violates the rule that Plaintiffs needed standing for “each claim they bring” and also “for each form of relief they seek.” *Webb ex rel. K.S. v. Smith*, 936 F.3d 808, 814 (8th Cir. 2019).

Plaintiffs also lack standing to sue Defendants to challenge the SAFE Act’s private right of action, *see* Ark. Code Ann. 20-9-1504(b), because Defendants have no “*methods of enforcement*” of any such action, *Church v. Missouri*, 913 F.3d 736, 749 (8th Cir. 2019). State officials cannot be sued for an injunction against lawsuits by private parties. *See, e.g., Dig. Recognition Network, Inc. v.*

*Hutchinson*, 803 F.3d 952, 958 (8th Cir. 2015) (affirming dismissal of state officials from lawsuit challenging law that “provide[d] for enforcement only through private actions”); *Whole Woman’s Health v. Jackson*, 13 F.4th 434, 438 (5th Cir. 2021) (holding Texas officials “not amenable to suit” challenging law that “preclude[d] enforcement by any state, local, or agency officials), *cert. granted*, No. 21-463, 2021 WL 4928617 (arg. held Nov. 1, 2021).

The district court did not discuss these principles. Instead, it purported to quote a contrary holding from *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). *See* Add. 3-4; R. Doc. 64, at 2-3 (citing 505 U.S. at 887-88). But *Casey* held no such thing. The quoted material comes instead from Plaintiffs’ briefing below. *Compare id.*, with R. Doc. 33, at 18 (containing quoted language). And courts have not interpreted *Casey* in the same way as Plaintiffs. *See Hope Clinic v. Ryan*, 249 F.3d 603, 605 (7th Cir. 2001) (en banc); *see also Whole Woman’s Health v. Jackson*, 141 S. Ct. 2494, 2495-96 (2021).

Defendants have no method of enforcing private lawsuits brought under the SAFE Act, so Plaintiffs have no standing to seek an injunction against them.

B. Separately, the practitioners lack third-party standing. Relying on decisions allowing abortion practitioners generally to assert third-party standing, the district court granted gender-transition practitioners third-party standing on behalf of their patients. Add. 4; R. Doc. 64, at 3 (citing *June Med. Servs. L.L.C. v. Russo*,

140 S. Ct. 2103 (2020), and *Singleton v. Wulff*, 428 U.S. 106 (1976)). That abortion-specific exception does not apply here. *See, e.g., Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2322 (2016) (Thomas, J., dissenting) (“Above all, the Court has been especially forgiving of third-party standing criteria for one particular category of cases: those involving the purported substantive due process right of a woman to abort her unborn child.”). Instead, this Court should hold that these practitioners lack third-party standing under the usual rules.

1. The practitioners cannot assert third-party rights under Section 1983. Litigants “may not base [a] Section 1983 action on a violation of the rights of third parties.” *Garrett v. Clarke*, 147 F.3d 745, 746 (8th Cir. 1998). Section 1983 “plainly authorizes suit by anyone alleging that he has been deprived of rights under the Constitution or federal law, and by no one else.” David P. Currie, *Misunderstanding Standing*, 1981 Sup. Ct. Rev. 41, 45. The practitioners’ third-party claims may proceed—if at all—only under the implied right of action established by the Supremacy Clause. *See Planned Parenthood of Hous. & Se. Tex. v. Sanchez*, 480 F.3d 734 (5th Cir. 2007).

2. Add to that statutory problem the principle that litigants generally “cannot rest [their] claim[s] to relief on the legal rights or interests of third parties.” *Kowalski v. Tesmer*, 543 U.S. 125, 129 (2004) (quotation and citation omitted). The only exception is for a litigant with a “close relationship” to third parties who

face a “hindrance” to asserting their own rights. *Id.* at 130 (quotation marks omitted). The practitioners do not meet this exception.

The district court did not explain why it thought the practitioners have the sort of “close relationship with their patients” that justifies third-party standing. Add. 4; R. Doc. 64, at 3. One reason they do not is their interests are, at least, “potentially in conflict” with their patients’ interests. *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 15 (2004). As would be true in any industry, these practitioners have a personal interest in reducing the number of legal requirements with which they must comply; that is, an interest in avoiding compliance with Arkansas law. *Cf.* App. 298-300; R. Doc. 45-2, at 28-30 (gender-transition business is lucrative). But their patients have an interest in seeing the SAFE Act enforced to protect them. That conflict defeats third-party standing. *See Newdow*, 542 U.S. at 15.

Additionally, the practitioners lack third-party standing because they have not established that potential plaintiffs face any hindrance to pursuing their own claims. *See Kowalski*, 543 U.S. at 130. The district court said otherwise, stating without evidentiary support that “the risk of discrimination” and a “desire to protect their privacy” created a hindrance. Add. 4; R. Doc. 64, at 3. But four patients and their families are parties to this lawsuit, which undermines the district court’s assertion. *See* App. 18-27; R. Doc. 1, at 18-27. The lack of a close relationship or any hindrance defeats the practitioners’ claim to third-party standing.

3. The district court also concluded that the practitioners have first-party standing to challenge “unequal treatment between healthcare providers.” Add. 4; R. Doc. 64, at 3. But there is no fundamental right to perform experimental procedures, nor are gender-transition practitioners a suspect classification. *Cf., e.g., Planned Parenthood of Mid-Mo. & E. Kan., Inc. v. Dempsey*, 167 F.3d 458, 464 (8th Cir. 1999) (rejecting “the notion that physicians and clinics have a fundamental constitutional right to provide abortion services”); *accord Planned Parenthood of Greater Ohio v. Hodges*, 917 F.3d 908, 912 (6th Cir. 2019) (en banc). So any first-party, practitioner equal-protection claim receives only rational-basis review. *See Birchansky v. Clabaugh*, 955 F.3d 751, 757 (8th Cir. 2020). And as explained below, the SAFE Act is related to a legitimate end.

## **II. Plaintiffs are unlikely to succeed on the merits of their equal-protection claim.**

By default, the SAFE Act, like any other law, “is accorded a strong presumption of validity.” *Heller v. Doe ex rel. Doe*, 509 U.S. 312, 319 (1993). For another rule to apply, Plaintiffs must establish that the SAFE Act “involv[es] fundamental rights” or “proceed[s] along suspect lines.” *Id.* Plaintiffs do not assert a fundamental-rights claim under the Equal Protection Clause. *See* App. 41-43; R. Doc. 1, at 41-43. (The parents assert a separate fundamental-rights, substantive-due-process claim, discussed *infra* pp. 48-52.) They do attempt to show that the SAFE Act draws lines according to a suspect classification. But this attempt fails,

because the Act classifies by age and medical procedure, which are not suspect. Therefore, only rational-basis review applies, and the Act is constitutional, for “it bears a rational relation to some legitimate end.” *Vacco v. Quill*, 521 U.S. 793, 799 (1997) (cleaned up). Even if intermediate scrutiny applied, it would survive.

A. The SAFE Act is subject to rational-basis review, not heightened scrutiny.

On its face, the SAFE Act draws distinctions on two bases: age and procedure. Neither is among the “suspect or quasi-suspect classifications” that courts have identified. *Gallagher v. City of Clayton*, 699 F.3d 1013, 1018 (8th Cir. 2012); see *Clark v. Jeter*, 486 U.S. 456, 461 (1988). The district court was wrong to conclude that the Act distinguishes on the basis of transgender status, which it incorrectly concluded is a novel quasi-suspect class. Add. 5; R. Doc. 64, at 4. And it was wrong to conclude that the Act amounts to constitutionally suspect sex discrimination. This Court should reverse.

1. The SAFE Act distinguishes on the basis of age and medical procedure.

Neither age nor medical procedure are suspect classifications that trigger heightened scrutiny.

i. The SAFE Act clearly distinguishes between Arkansans who are over and under eighteen. Ark. Code Ann. 20-9-1502(a). Adults remain free to undergo the same experimental procedures that the Act prohibits for minors. For example,

a practitioner cannot perform a gender-transition procedure on a girl one month *before* her eighteenth birthday but can perform it one month *after* her eighteenth birthday. Indeed, Plaintiffs’ claims are shot through with age-based language, consistently referring to “youth,” “adolescents,” or “minors.” *See generally* App. 1; R. Doc. 1. Their own statements, therefore, show that the SAFE Act distinguishes children from adults.

The Supreme Court “has said repeatedly that age is not a suspect classification under the Equal Protection Clause.” *Gregory v. Ashcroft*, 501 U.S. 452, 470 (1991). Arkansas “need therefore assert only a rational basis for its age classification.” *Id.*

ii. The SAFE Act also classifies on the basis of procedure. And people-seeking-a-particular-medical-procedure is not a class that triggers heightened scrutiny. *Cf. Bray v. Alexandria Women’s Health Clinic*, 506 U.S. 263, 269 (1993) (“‘Women seeking abortion’ is not a qualifying class” for purposes of the civil-rights conspiracy statute). Laws like the SAFE Act that distinguish between dissimilar procedures do not “treat anyone differently from anyone else or draw any distinctions between persons” but simply prohibit certain procedures while allowing others. *Vacco*, 521 U.S. at 800. Therefore, rational-basis scrutiny applies.

Although Defendants submitted hundreds of pages of medical evidence in opposition to the preliminary-injunction motion, the district court cited none of it.

Instead, it concluded without citation that Arkansas “allows the same treatment for cisgender minors as long as the desired results conform with the stereotype of their biological sex.” Add. 8; R. Doc. 64, at 7. This is not true.

Consider puberty blockers. Practitioners use the same drugs for gender transition and to treat precocious puberty. *See* App. 33; R. Doc. 1, at 33. But in the latter circumstance, those drugs are FDA-approved, App. 291; R. Doc. 45-2, at 21, and only used to temporarily delay puberty for children in whom it begins early, with the goal of allowing a child to begin puberty normally, *see* App. 411-12; R. Doc. 45-3, at 76-77. By contrast, gender-transition practitioners use puberty blockers to indefinitely stop normally timed puberty—a use for which they are not FDA-approved. *Id.* Thus, precocious puberty “is a different condition from [gender dysphoria], and where [puberty blockers] are used in a very different way.” *See Tavistock*, [2020] EWHC 3274, ¶ 60.

A similar principle distinguishes sex-hormone procedures that the SAFE Act permits and those it prohibits. For example, the Act permits testosterone for boys to initiate delayed puberty. App. 34; R. Doc. 1, at 34. This procedure allows a boy to develop normally, when a verifiable physiological disorder prevents that. *See* App. 356-57; R. Doc. 45-3, at 21-22; *see also id.* (similar point for use of estrogen in girls versus its use in boys). Testosterone therapy as a gender-transition procedure for a girl will have a much different effect, disrupting normal development

and likely rendering her infertile. App. 406-09; R. Doc. 45-3, at 71-74. Arkansas banned for minors only the hormonal procedures that present particular risks, most notably, infertility. Again, though there may be both permitted and prohibited uses of the same drugs, they are not the same treatment.

Finally, chest surgery performed on a boy is not the same treatment as a double mastectomy performed on a girl. A boy suffering from gynecomastia has an “objectively diagnosed” condition that causes him to abnormally develop “female type breast gland tissue,” which can be painful and “disfiguring.” App. 470; R. Doc. 45-4, at 15. Only abnormal tissue is removed. *Id.* A double mastectomy performed on a girl, however, destroys ordinary breast function. App. 472-73; R. Doc. 45-4, at 17-18. That is, it “completely and irreversibly sacrifice[s]” breast function for “a cosmetic result (a masculine appearing chest).” *Id.* These procedures are not even similar.

Inversely, breast augmentation in a girl is not the same procedure as creating the appearance of breasts on a boy. In a girl, everyone agrees that breast augmentation is a cosmetic procedure. *See* App. 479-82; R. Doc. 45-4, at 24-27; App. 725; R. Doc. 45-19, at 64. But Plaintiffs claim that boys seek augmentation “to reduce psychosocial distress.” R. Doc. 12, at 45. Different purposes make these different procedures. *See* App. 474; R. Doc. 45-4, at 19 (“[T]he only way of distinguishing

cosmetic breast surgery from ‘medically indicated’ surgery is based upon the diagnosis of underlying pathology.”). That is, a procedure performed according to the well-settled guidelines governing cosmetic procedures is not the same procedure as one performed according to the disputed premise that gender-transition procedures relieve psychological distress. *See* App. 462-65; R. Doc. 45-4, at 7-10 (gender-reassignment surgery leads to worse outcomes).

This evidence required the district court to determine that the SAFE Act draws distinctions based on medical procedure, not sex stereotypes or transgender status. Because the SAFE Act distinguishes on the basis of medical procedure, only rational-basis review applies.

2. Transgender status is not a suspect classification.

Even if the SAFE Act classified on transgender status, such a classification is not subject to heightened scrutiny. Neither the Supreme Court nor this Court has ever treated transgender status as a suspect or quasi-suspect classification. Despite that, the district court offered no rationale for creating a novel suspect classification based on transgender status, instead simply quoting another court without elaboration. Add. 5; R. Doc. 64, at 4. None of the relevant factors favor this novel classification. *See Lyng v. Castillo*, 477 U.S. 635, 638 (1986) (factors are: (1) history of discrimination; (2) distinguishing characteristics that are (3) immutable; and (4) political powerlessness).

i. Plaintiffs have merely asserted that people who identify as transgender have “been subjected to discrimination.” *Id.* But it is not enough to assert or even prove that “the treatment of” those who identify as transgender “in this Nation has not been wholly free of discrimination.” *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 313 (1976) (per curiam). Rather, Plaintiffs must prove “a ‘history of purposeful unequal treatment.’” *Id.* They based their argument entirely on statistics drawn from judicial opinions outside this Circuit—not record evidence. *See, e.g.*, R. Doc. 12, at 36-37. In fact, Plaintiffs have not even alleged a history of purposeful discrimination. *See* App. 41; R. Doc. 1, at 41 (reciting test without offering factual support).

ii. Similarly, Plaintiffs failed to offer any proof that those who identify as transgender share any “distinguishing characteristics” unrelated “to interests the State has the authority to implement.” *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 441 (1985). More than that, the evidence from WPATH and other organizations Plaintiffs tout shows that there is no distinguishing characteristic that defines being transgender a discrete class.

Those who identify as transgender are not monolithic, nor is there a stable characteristic that distinguishes them. As discussed, “a diverse group of individuals” falls within the “umbrella term” of “transgender.” App. 790; R. Doc. 45-21, at

7; App. 758; R. Doc. 45-19, at 103. There are also important clinical distinctions between different populations. *See supra* pp. 4-6.

Much of this evidence comes from statements by organizations to which Plaintiffs argue the States ought to defer, like WPATH and the Endocrine Society. These statements demonstrate that there is no distinguishing characteristic that defines a stable class of “transgender individuals.”

iii. Relatedly, Plaintiffs cannot establish that people who identify as transgender share any “immutable characteristic determined solely by the accident of birth.” *Gallagher*, 699 F.3d at 1018 (cleaned up). For one thing, the recent boom in transgender self-identifications “should be enough to dissuade anyone from the idea that transgender self-identification is a biologically determined condition.” App. 487; R. Doc. 45-4, at 32; *see* App. 278-82; R. Doc. 45-2, at 8-12 (explaining demographic trend). Such a sharp uptick is inconsistent with claims that transgender status has an immutable, biological basis. App. 176-79; R. Doc. 45-1, at 19-22.

Evidence from groups like WPATH also establishes that identifying as transgender is not an immutable characteristic. *See, e.g.*, App. 776; R. Doc. 45-20, at 1 (“for some transgender individuals, gender identity may remain somewhat fluid”). Plaintiffs’ own complaint alleges that biology is only one “component to gender identity.” App. 9; R. Doc. 1, at 9. WPATH and the Endocrine Society also

maintain that a person’s “gender identity” is necessarily indexed to “culturally defined categories of gender,” App. 758; R. Doc. 45-19, at 103, or to “environmental” and “cultural factors,” App. 789; R. Doc. 45-21, at 6. Given this, it is no wonder that the APA says some people “experience their gender identity as fluid.” App. 823; R. Doc. 45-22, at 5. Some who identify as transgender are said to have “a continuous and rapid involuntary alternation between a male and female identity.” App. 788; R. Doc. 45-21, at 5.

Separately, Plaintiffs do not account for desistance, which is a well-documented phenomenon. *See, e.g.*, App. 202-06; R. Doc. 45-1, at 45-49; App. 302-04; R. Doc. 45-2, at 32-34; App. 884-85; R. Doc. 45-25, at 6-7. The DSM-5 acknowledges that at least some identify as transgender only “transiently.” App. 870; R. Doc. 45-24, at 3. And WPATH concedes that “children and adolescents” face “greater fluidity and variability in outcomes,” thus admitting the chance of desistance. App. 671-73; R. Doc. 45-19, at 16-18. In fact, there is no dispute that “[i]n *most children*, gender dysphoria will disappear before, or early in, puberty.” *Id.* The Endocrine Society agrees and emphasizes that “we cannot predict the psychosexual outcome for any specific child,” which is to say we cannot know in which children dysphoria will desist. App. 791; R. Doc. 45-21, at 8.

Thus, according to the very organizations to which Plaintiffs argue Arkansas must defer, “gender identity” is culturally determined, can remain “fluid,” and can

even rapidly toggle between different identities. This is the opposite of an immutable characteristic.

iv. Finally, those who identify as transgender are not “politically powerless.” *Lyng*, 477 U.S. at 638. Plaintiffs offered no evidence on this point.

In fact, Plaintiffs largely claim that the SAFE Act should fall because it is out-of-step with the political mainstream. The crux of Plaintiffs’ equal-protection claim is that politically powerful groups like WPATH and the Endocrine Society disagree with the Act. *See, e.g.*, App. 11-14; R. Doc. 1, at 11-14. Not only that, the Department of Justice, 19 health-policy advocacy organizations, and business interest groups stand alongside Plaintiffs and against Arkansas here. *See* R. Doc. 19, at 1-3; R. Doc. 30, at 29-35 (advocacy organizations); R. Doc. 43, at 7-9 (business leaders). The circumstances surrounding this case disprove the notion that people identifying as transgender warrant “extraordinary protection from the majoritarian political process.” *Gallagher*, 699 F.3d at 1018 (cleaned up).

This institutional support for Plaintiffs, from all levels of American society, is inconsistent with Plaintiffs’ political-powerlessness argument. Because Plaintiffs are unlikely to meet this or any other prong for establishing a new suspect classification, this Court should apply rational-basis review.

3. The SAFE Act does not discriminate based on sex.

In the same sentence that the district court announced that transgender status is a suspect classification, it determined that the SAFE Act amounts to sex discrimination that triggers heightened equal-protection scrutiny. Add. 5; R. Doc. 64, at 4. But it identified no “sex-based classifications” apparent on the face of the Act. *Id.* There are none, so rational-basis review applies.

The SAFE Act contains no sex classifications, only medical-procedure classifications. The district court tried to avoid this conclusion by reducing these medical-procedure classifications to “stereotype[s]” based on a patient’s “biological sex.” Add. 8; R. Doc. 64, at 7. Such “[m]echanistic classification of all our differences as stereotypes,” however, “obscure[s] those misconceptions and prejudices that are real.” *Tuan Anh Nguyen v. INS*, 533 U.S. 53, 73 (2001). In other words, the SAFE Act does not raise constitutional problems simply because it, at some level, recognizes sex differences.

Sex discrimination under the Equal Protection Clause exists only when members of one sex are disadvantaged relative to the other sex. *United States v. Virginia*, 518 U.S. 515, 519-20 (1996), is the paradigmatic example, where a state-run school barred women. But other cases finding unconstitutional sex discrimination had similarly clear sex-based disadvantages. *See, e.g., Sessions v. Morales-*

*Santana*, 137 S. Ct. 1678, 1686, 1689 (2017) (longer physical-presence requirement for men to pass citizenship to their children); *Craig v. Boren*, 429 U.S. 190, 191-92 (1976) (higher drinking age for men); *Frontiero v. Richardson*, 411 U.S. 677, 678-79 (1973) (plurality op.) (higher standard for servicewomen to prove spousal dependency); *Reed v. Reed*, 404 U.S. 71, 73-75 (1971) (preference for men administering estates).

All of those cases involve *unequal treatment* of one sex relative to the other—a woman is disadvantaged when compared to a similarly situated man, or vice versa. The SAFE Act does not treat similarly situated people differently on the basis of sex. A child taking puberty blockers as a treatment for precocious puberty is not similarly situated to one taking them as a gender-transition procedure. The two procedures have dramatically different consequences for the child. *See* App. 357, 411-12; R. Doc. 45-3, at 22, 76-77. The same is true for cross-sex hormones and surgery. *See id.*; App. 472-73; R. Doc. 45-4, at 17-18. In each case, while the purpose of the procedure depends on the child’s sex, the SAFE Act distinguishes only on the basis of the procedure itself.

Drawing distinctions between procedures does not, contrary to the district court, trigger heightened scrutiny. *See* Add. 5; R. Doc. 64, at 4 (citing *Bostock v. Clayton Cnty., Ga.*, 140 S. Ct. 1731 (2020)). In *Bostock*, the Court interpreted specific language in Title VII: “discriminate against any individual . . . because of

such individual’s . . . sex.” 140 S. Ct. at 1738 (quoting 42 U.S.C. 2000e-2(a)(1)). That “starkly broad” language, it held, *id.* at 1753, required “a sweeping standard” for causation under Title VII, *id.* at 1739. Under that standard, the Court said that “fir[ing] someone simply for being homosexual or transgender” amounted to “discriminat[ion] against that individual ‘because of such individual’s sex.’” *Id.* at 1753.

The Court gave no indication that lower courts should import *Bostock*’s statutory causation standard into the constitutional analysis. For one thing, it expressly refused to “prejudge” similar arguments under “other federal or state laws that prohibit sex discrimination.” *Id.* And the broad language that drove *Bostock* does not appear in the Equal Protection Clause, which explains why the Supreme Court has not equated Title VII’s and the Constitution’s standards. *See Washington v. Davis*, 426 U.S. 229, 239 (1976) (“We have never held that the constitutional standard for adjudicating claims of invidious racial discrimination is identical to the standards applicable under Title VII, and we decline to do so today.”); *see also Fitzgerald v. Barnstable Sch. Comm.*, 555 U.S. 246, 256-58 (2009) (detailing distinctions between Title IX and constitutional standards). The Department of Justice said it best: “In short, there is no indication that the Supreme Court will apply

its literal and context-free mode of interpretation to the Constitution, as doing so would upend over two centuries of precedent.”<sup>5</sup>

An Arizona district court recently came to a similar conclusion when asked to apply *Bostock* to Arizona’s refusal to provide Medicaid coverage to young women for “‘male chest reconstruction surgery’—that is, the permanent removal of their breasts.” *Hennesy-Waller v. Snyder*, 529 F. Supp. 3d 1031, 1034 (D. Ariz. 2021). That court found that mastectomies used as a gender-transition procedure were not the “same” as chest surgeries performed as other treatments. *See id.* at 1043. As a result, the court concluded that the plaintiffs “ha[d] not clearly shown” that Arizona “denies coverage on the basis of sex and not on the basis of some other permissible rationale.” *Id.* at 1045.

Like *Hennesy-Waller*, this Court should find that the SAFE Act does not classify on the basis of transgender status or sex. Therefore, this Court should apply rational-basis review. *See Romer v. Evans*, 517 U.S. 620, 632 (1996).

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<sup>5</sup> John B. Daukas, Dep’t of Justice, Civ. Rights Div., Memorandum re: Application of *Bostock v. Clayton County* 22 (Jan. 17, 2021), <https://web.archive.org/web/20210120125231/https://www.justice.gov/crt/page/file/1356531/download>. The day after President Biden’s inauguration, DOJ rescinded this memorandum and scrubbed it from the internet. App. 312-13; R. Doc. 45-2, at 42-43.

B. The SAFE Act satisfies rational-basis review.

Because the SAFE Act is only subject to rational-basis review, “if any state of facts reasonably may be conceived to justify” it, then it is constitutional.

*McGowan v. Maryland*, 366 U.S. 420, 426 (1961). It must be only “rationally related to a legitimate state interest.” *Kimel v. Fla. Bd. of Regents*, 528 U.S. 62, 83 (2000). The district court merely stated, without analysis, that the SAFE Act “would not even withstand rational basis scrutiny if it were the appropriate standard of review.” Add. 9; R. Doc. 64, at 8. But it did not discuss Arkansas’s interests in protecting minors, *see Reno v. ACLU*, 521 U.S. 844, 869 (1997), nor the vulnerable more generally, *see Washington v. Glucksberg*, 521 U.S. 702, 731 (1997), nor Arkansas’s interest in promoting medical ethics. *See Gonzales v. Carhart*, 550 U.S. 124, 157 (2007). Those interests are undisputedly legitimate.

The district court believed that Arkansas’s “health concerns” were not “genuine,” because it “allows the same treatment” if the result conforms to sex “stereotype[s].” Add. 8; R. Doc. 64, at 7; *see* App. 16; R. Doc. 1, at 16 (alleging inaccurately that “[n]ot a single doctor” supported the Act). That’s not true. As already detailed, there are critical differences between procedures the SAFE Act prohibits and those that it permits. *See supra* pp. 30-33.

Plaintiffs did not carry their burden to rebut “the presumption of legislative good faith.” *Abbott v. Perez*, 138 S. Ct. 2305, 2324 (2018). The legislature heard

testimony supporting the Act from, among others, Dr. Roger Hiatt and Dr. Charles Lewis, both Arkansas psychiatrists with experience treating patients with gender dysphoria. App. 879-81; R. Doc. 45-25, at 1-3. Another Arkansas psychiatrist later voiced her support, and these psychiatrists were eventually joined by Arkansas doctors from a variety of specialties in a letter urging the Act’s passage. *Id.*

The General Assembly credited this testimony rather than conflicting testimony Plaintiffs preferred. Choosing whom to credit when faced with conflicting medical testimony is within a legislature’s “wide discretion to pass legislation in areas where there is medical and scientific uncertainty.” *Gonzales*, 550 U.S. at 163. “The only direct evidence” is that the “Legislature’s intent was legitimate,” given the focus in the legislative findings on safety concerns. *Abbott*, 138 S. Ct. at 2327. And the SAFE Act “appl[ies] evenhandedly to all” children, protecting them from harmful experimentation. *Vacco*, 521 U.S. at 800. It thus singles out no one and satisfies rational-basis review.

C. The SAFE Act would additionally pass heightened scrutiny.

The district court implicitly acknowledged intermediate scrutiny is the highest level of equal-protection scrutiny even potentially applicable to the SAFE Act. *See* Add. 5; R. Doc. 64, at 4. It survives intermediate scrutiny, because it is “substantially related” to Arkansas’s “important governmental objectives” of protecting children and regulating the medical profession. *Virginia*, 518 U.S. at 524.

The district court did not disagree that Arkansas has important—indeed, compelling—interests at stake. Arkansas has an interest in protecting the vulnerable, in general, *Glucksberg*, 521 U.S. at 731, and children, in particular, *Reno*, 521 U.S. at 869. Separately, it has an interest in regulating medicine, including medical ethics. *Gonzales*, 550 U.S. at 157; see *England v. La. State Bd. of Med. Exam'rs*, 263 F.2d 661, 674 (5th Cir. 1959) (discussing State’s “power to regulate, reasonably and rationally, all facets of the medical field”).

The only question, therefore, is whether the SAFE Act is substantially related to Arkansas’s interests. In a single paragraph, the district court concluded that it is not. See Add. 8; R. Doc. 64, at 7. But that paragraph did not even acknowledge the existence of the hundreds of pages of medical evidence showing the Act’s substantial relationship to Arkansas’s interests and demonstrating that gender-transition procedures have (1) irreversible consequences, and (2) no discernible mental-health benefits. Banning these procedures is substantially related to Arkansas’s important interests.

1. Arkansas has banned only experimental gender-transition procedures with certain irreversible consequences. The district court responded by asserting that “the same medical treatments” remain available to “non-transgender adolescents for any other purpose.” *Id.* But it failed to acknowledge evidence about the key differences between the procedures that the SAFE Act permits and those it

prohibits. The Act prohibits only procedures that lead to particularly troubling long-term consequences, like infertility. The differences between the prohibited procedures and other procedures have already been discussed in detail. *See supra* pp. 30-33.

The district court pointed to no other experimental procedures with similar irreversible consequences the SAFE Act allows on minors. And it did not even acknowledge Defendants' evidence on this point. That failure alone justifies reversal. *Cf. Planned Parenthood of Ark. & E. Okla. v. Jegley*, 864 F.3d 953, 957 (8th Cir. 2017) (district courts abuse their discretion when they “fail[] to consider a relevant factor that should have been given significant weight”).

Further, even if the district court's short discussion were deemed a factual finding, it is clearly erroneous. Reviewing “the entire evidence” should leave this Court with “the definite and firm conviction,” *Easley v. Cromartie*, 532 U.S. 234, 242 (2001), that Arkansas has prohibited only procedures with certain irreversible consequences. The “same treatments” do not remain available for other purposes.

2. Add to those grave physical effects the fact that there is “very limited evidence” of these procedures' “efficacy.” *Tavistock*, [2020] EWHC 3274, ¶ 134. This combination—profound physical effects plus limited evidence of benefit—means these procedures are “properly described as experimental treatment.” *Id.* International authorities have found no reliable evidence demonstrating benefits

from gender-transition procedures, as Defendants’ evidence made clear. Yet again, the district court failed to acknowledge this evidence, simply declaring gender-transition procedures “potentially lifesaving.” *See* Add. 6-8; R. Doc. 64, at 5-7.

The evidence disproves the basis for the claim that these procedures are “potentially lifesaving.” Most concerning, data is mounting that gender-transition procedures actually *increase* the risk of suicide. *See* App. 218-19; R. Doc. 45-1, at 61-62. And since 2019, reports finding no evidence of gender-transition procedures’ benefits have been issued by nationalized health services in Sweden, Finland, and the United Kingdom. *See supra* pp. 11-15.

The district court did not acknowledge the worldwide controversy surrounding gender-transition procedures. Instead, it purported to identify a contrary “consensus” but cited only WPATH and the Endocrine Society, and an amicus brief filed below. *See* Add. 7-8; R. Doc. 64, at 6-7 & nn.2-5.

Nothing requires Arkansas to defer to the views of WPATH, the Endocrine Society, or any other advocacy organization. *See City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 456 (1983) (O’Connor, J., dissenting) (criticizing rule requiring courts “to revise [their] standards every time [ACOG] or [a] similar group revises its views about what is and what is not appropriate”); *Stenberg v. Carhart*, 530 U.S. 914, 1018 (2000) (same) (Thomas, J., dissenting). States get to make their own policy judgments about appropriate medical care. *Gonzales*, 550

U.S. at 163. And the Court itself has rejected positions taken by advocates like WPATH and the Endocrine Society. *See EMW Women’s Surgical Ctr., P.S.C. v. Beshear*, 920 F.3d 421, 438 (6th Cir. 2019) (recounting how *Casey* and *Gonzales* upheld laws that “conflicted with official positions of ACOG”).

It would be particularly inappropriate to rely on WPATH or the Endocrine Society to contradict the growing scientific literature that gender-transition procedures lack any benefits. As discussed above, *see supra* pp. 15-16, their guidelines are advocacy pieces—not scientific evidence. In fact, WPATH openly admits that “advocacy” is its “mission.” App. 662; R. Doc. 45-19, at 7. And the Endocrine Society, unable to “recommend” puberty blockers, merely “suggest[s]” their use, which it elsewhere explains to mean it is not confident that those “who receive [them] will derive, on average, more benefit than harm.” App. 787, 795; R. Doc. 45-21, at 4, 12. The district court should not have concluded that there is consensus supporting gender-transition procedures for children based on these advocacy pieces. *See* App. 296; R. Doc. 45-2, at 26 (“[D]espite the fact that American professional associations have endorsed the ‘affirmative’ approach to treating dysphoric adolescents, there is no wide, international consensus about its superiority.”). It was clear error for the district court to ignore Defendants’ evidence that gender-transition procedures lack any benefits and cite instead advocacy pieces.

Given the evidence that gender-transition procedures lack discernable benefits while carrying lifelong consequences, prohibiting them for minors is substantially related to Arkansas’s important interests.

**III. The parents are not likely to succeed on their substantive-due-process claim.**

Courts of appeals have consistently rejected claims—even by terminally ill patients—that there is a substantive-due-process right to experimental medical procedures. *See, e.g., Morrissey v. United States*, 871 F.3d 1260, 1269 (11th Cir. 2017); *Raich v. Gonzales*, 500 F.3d 850, 864 (9th Cir. 2007); *Abigail All. for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 710 n.18 (D.C. Cir. 2007) (en banc); *Rutherford v. United States*, 616 F.2d 455, 456 (10th Cir. 1980). Thus, there is no question that the children here would have no substantive-due-process right to experimental, gender-transition procedures.

So the district court created a new substantive-due-process right: “a fundamental right” of parents “to seek medical care for their children and, in conjunction with their adolescent child’s consent and their doctor’s recommendation, make a judgment that medical care is necessary.” Add. 11; R. Doc. 64, at 10. But there is no precedent for such a right.

A. There is no fundamental right to subject a child to experimental medical procedures.

Given that children themselves have no substantive-due-process right to access gender-transition procedures, it is difficult to understand how their parents have a substantive-due-process right of access on behalf of their children.

The Supreme Court precedent cited by the district court does not support its vision of parental rights. *See* Add. 10-11; R. Doc. 64, at 9-10 (citing *Troxel v. Granville*, 530 U.S. 57 (2000), and *Parham v. J.R.*, 442 U.S. 584 (1979)). In *Troxel*, the Court considered a “breathtakingly broad” statute that “effectively permit[ted] any third party seeking visitation to subject any decision by a parent concerning visitation of the parent’s children to state-court review.” *Troxel*, 530 U.S. at 67 (plurality opinion). In that way, the statute struck at the heart of the parent-child relationship—usurping the parents’ power to determine who spent time around their children. The Court nowhere suggested parents have, by default, the power to choose any experimental medical procedure a practitioner recommends.

*Parham* concerned the question whether a State had given parents *too much* autonomy over their children, not too little. *See* 442 U.S. at 606-07. The Court held “that the risk of error inherent in the parental decision to have a child institutionalized for mental health care is sufficiently great that some kind of inquiry should be made by a ‘neutral factfinder’” to determine whether there was a “need

for commitment.” *Id. Parham*, in other words, rejected the district court’s vision of unrestrained parental autonomy.

Additionally, discussions of parental rights in other contexts undermine the district court’s theory. The Supreme Court, for instance, has rejected arguments that parents have a right to decide whether their children may have abortions. *See Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 72 (1976). To the contrary, it has said States must establish parental-consent bypass procedures. *See Bellotti v. Baird*, 443 U.S. 622, 647-48 (1979). Thus, as relevant here, abortion cases—on which Plaintiffs’ arguments heavily depend—have rejected the exact substantive-due-process argument they now advance.

Finally, the Sixth Circuit’s decision in *Kanuszewski v. Mich. Dep’t of Health & Hum. Servs.*, 927 F.3d 396 (6th Cir. 2019), provides no support for unfettered parental access to medical procedures. For one thing, that decision acknowledged “limitations on parents’ control over their children are particularly salient in the context of medical treatment.” *Id.* at 419. Regardless, that case was about Michigan’s program for “screening” and then “stor[ing]” children’s blood “samples indefinitely for further use by the state or third parties.” *Id.* at 420. Whether parents have a fundamental right to control their children’s blood samples has little bearing on whether they have a fundamental right to subject their children to experimental procedures that result in lifelong infertility.

B. The SAFE Act survives any level of scrutiny.

Relying on *Glucksberg*—a case that rejected a novel fundamental-rights claim—the district court applied strict scrutiny. *See* Add. 11; R. Doc. 64, at 10 (citing *Glucksberg*, 521 U.S. at 719-20). But nothing in the cited passage supports applying strict scrutiny here. And this brief has already explained why the SAFE Act would satisfy rational-basis or intermediate scrutiny. *See supra* pp. 42-48. The analysis is the same for this claim.

Even if strict scrutiny were the appropriate standard, the Act would survive. The district court stated, without analysis, that “Defendants ha[d] not met their burden of showing that Arkansas has a compelling state interest.” Add. 11; R. Doc. 64, at 10. But precedent is clear that Arkansas has compelling interests in protecting children and safeguarding medical ethics. *See, e.g., Gonzales*, 550 U.S. at 157; *Reno*, 521 U.S. at 869; *Glucksberg*, 521 U.S. at 731. And whatever rights parents have regarding gender-transition procedures for their children, those rights are “limited by the state’s compelling interest in protecting a child.” *Stanley v. Hutchinson*, 12 F.4th 834, 840 (8th Cir. 2021) (cleaned up). The district court legally erred in refusing to acknowledge Arkansas’s compelling interests.

Separately, it stated, without analysis, that the SAFE Act is not “narrowly tailored to serve [Arkansas’s] interest.” Add. 11; R. Doc. 64, at 10. This was also

legal error. Only gender-transition procedures present problems that implicate Arkansas’s compelling interests in protecting children and the medical profession. So Arkansas has banned only those procedures. And it has banned them only when performed on minors. All other treatments for gender dysphoria remain available. *See* App. 189-96; R. Doc. 45-1, at 32-39 (discussing other treatments). Of course, “perfect tailoring” is “impossib[le],” but the SAFE Act comes close to perfect. *Williams-Yulee v. Fla. Bar*, 575 U.S. 433, 454 (2015). Therefore, the Act would satisfy even strict scrutiny, and Plaintiffs are not likely to succeed on their substantive-due-process claim.

#### **IV. Plaintiffs are not likely to succeed on their free-speech claim.**

Closing a potential loophole, the SAFE Act also prohibits Arkansas practitioners from sending children out-of-state for gender-transition procedures. Ark. Code Ann. 20-9-1502(b). Plaintiffs claim this prohibition violates practitioners’ right to speak and their patients’ “right to hear.” App. 44-45; R. Doc. 1, at 44-45. But the practitioners have no First Amendment claim (and thus neither do their patients<sup>6</sup>). The SAFE Act prohibits only conduct—not speech. Whatever speech it might affect is incidental to the Act’s regulation of medicine. And it would satisfy

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<sup>6</sup> The patients’ First Amendment claim hinges on the practitioners’ claim, because “the right to receive speech is entirely derivative of the rights of the speaker.” *Pa. Fam. Inst., Inc. v. Black*, 489 F.3d 156, 165 (3d Cir. 2007) (cleaned up); *accord Spargo v. N.Y. State Comm’n on Jud. Conduct*, 351 F.3d 65, 83 (2d Cir. 2003).

strict scrutiny anyway. Allowing practitioners to send children out-of-state for banned procedures would create a serious loophole.

A. The SAFE Act’s central provision prohibits two types of conduct. Under subsection (a), practitioners “shall not provide gender transition procedures” to a child; under subsection (b), they “shall not refer” a child “to any healthcare professional for gender transition procedures.” Ark. Code Ann. 20-9-1502. Banning referrals isn’t banning speech. WPATH’s own statements make clear that a referral is not merely speech but is conduct: “provid[ing] documentation—in the chart and/or referral letter—of the patient’s personal treatment history, progress, and eligibility” for a requested procedure. App. 687-88; R. Doc. 45-19, at 32-33. All that subsection (b) prohibits, therefore, is the conduct of sending a child to another practitioner for a gender-transition procedure, not speech.

The district court did not refute this but simply asserted that banning referrals “is a regulation of speech.” Add. 12; R. Doc. 64, at 11. If that were right, however, the referral ban would still fall within the States’ power to “regulate professional conduct, even though that conduct incidentally involves speech.” *Nat’l Inst. of Fam. & Life Advoc. v. Becerra* (“NIFLA”), 138 S. Ct. 2361, 2372 (2018). Arkansas “does not lose its power to regulate” practitioners’ conduct of referring children to others for gender-transition procedures simply because “speech is a component of that activity.” *Ohralik v. Ohio State Bar Ass’n*, 436 U.S. 447, 456

(1978). This power is particularly acute here, because the practitioners claim a right to speak “only as part of the practice of medicine, subject to reasonable licensing and regulation by the State.” *Casey*, 505 U.S. at 884 (plurality op.).

Contrary to the district court’s understanding, the SAFE Act does not prevent dissemination of “truthful information.” Add. 13; R. Doc. 64, at 12. If asked for a referral, practitioners could decline to provide one without providing any information, or they could explain that state law prohibits such referrals. This discloses nothing more than “the terms under which [the practitioner’s] services will be available.” *Zauderer v. Off. of Disciplinary Couns. of Sup. Ct. of Ohio*, 471 U.S. 626, 651 (1985). Practitioners’ “constitutionally protected interest in *not* providing any particular factual information” to their patients “is minimal.” *Id.* Because the SAFE Act requires practitioners only to “disclose factual, noncontroversial information,” it receives “more deferential review.” *NIFLA*, 138 S. Ct. at 2372; *see Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889, 893 (8th Cir. 2012) (en banc).

Finally, the district court tellingly did not discuss *Rust v. Sullivan*, 500 U.S. 173 (1991). There, the Court upheld a funding restriction for abortion facilities, in part, because employees of funding recipients “remain[ed] free . . . to pursue abortion-related activities when they are not acting under the auspices of the [federally funded] project.” *Id.* at 198. The SAFE Act leaves gender-transition practitioners

with even more freedom than the funding restriction in *Rust*. In the course of treating children with gender dysphoria, practitioners remain free to pursue any model of treatment except experimental procedures. *See* App. 189-96; R. Doc. 45-1, at 32-39 (discussing other treatments). And practitioners remain free to *advocate for* a prohibited gender-transition procedure. The only thing the referral ban prohibits is conduct—sending a child to another practitioner for a prohibited procedure.

B. Not only was the district court wrong to conclude that the referral ban regulates speech, it was also wrong to conclude that the referral ban “cannot survive strict scrutiny or even rational scrutiny.” Add. 13; R. Doc. 64, at 12. It engaged in no analysis on this point. It is easy to see why the referral ban passes rational basis. Arkansas determined that gender-transition procedures are inappropriate for minors, so it banned them. Additionally banning out-of-state referrals is rationally related to Arkansas’s legitimate interest in regulating medicine.

The referral ban would also survive strict scrutiny. Arkansas does not assert a compelling interest in preventing its citizens from “making a bad decision,” as the district court suggested. *Id.* Arkansas asserts instead its well-established compelling governmental interests in protecting children from experimental gender-transition procedures and safeguarding medical ethics. *See, e.g., Gonzales*, 550 U.S. at 157; *Reno*, 521 U.S. at 869; *Glucksberg*, 521 U.S. at 731. The SAFE Act

protects children by safeguarding them from experimental procedures that irreversibly destroy the function of their sex organs. *See supra* pp. 7-9, 30-33. A more compelling interest is hard to imagine. And the referral ban is sufficiently tailored to Arkansas's compelling interests. Allowing practitioners to avoid the SAFE Act's prohibition by outsourcing the procedure would drastically undermine the Act's protections.

**V. The other factors did not support the preliminary injunction.**

The district court viewed its preliminary injunction as a neutral intervention that would maintain the status quo while this case proceeds. *See, e.g.*, Add. 11; R. Doc. 64, at 10. But far from maintaining the status quo, the district court's injunction opens the door to procedures that will undisputedly cause children to undergo irreversible biological changes. And the injunction harms Arkansans' interest in seeing their duly enacted law prohibiting these procedures take effect. Finally, by facially enjoining the SAFE Act, the district court failed to tailor relief to Plaintiffs' claims.

A. Because of the preliminary injunction, more Arkansas children are undergoing gender-transition procedures. More children will be given puberty blockers, suffer a loss in bone density, and face the prospect of permanently immature sex organs. More children will take cross-sex hormones and become infertile. The preliminary injunction is irreparably changing the lives of children. Nowhere did

the district court consider this harm. Instead, it focused on Plaintiffs' claimed harm of "undergo[ing] endogenous puberty." Add. 9-10; R. Doc. 64, at 8-9. But it cited no authority for the idea that a law irreparably harms children by ensuring that they undergo puberty normally. It is no answer to point to a "risk of gender dysphoria and lifelong physical and emotional pain." *Id.* There is no evidence that gender-transition procedures relieve any of those symptoms. The evidence suggests just the opposite—that gender-transition procedures lead to *more significant* distress and other mental-health problems. *See supra* pp. 14-15, 45-46.

Reversing the preliminary injunction will halt the ongoing harm to Arkansas children. Then, practitioners in Arkansas could begin to safely ramp down their patients' gender-transition medications, a process that Plaintiffs' own expert said takes only "about six weeks." App. 107; R. Doc. 11-11, at 17. Prescribing these medications to safely *end* a gender-transition procedure does not fall within the SAFE Act's prohibition. *See* Ark. Code Ann. 20-9-1501(6)(A), -1502(a).

B. Reversing the preliminary injunction would also end the ongoing harm to the people of Arkansas. They decided through their elected representatives that the harms of gender-transition procedures outweigh any hypothetical benefits when performed on minors. Arkansas's "inability to enforce its duly enacted plans clearly inflicts irreparable harm on the State." *Abbott*, 138 S. Ct. at

2324 n.17. A State always suffers irreparable harm when it is “precluded from applying its duly enacted legislation.” *Org. for Black Struggle v. Ashcroft*, 978 F.3d 603, 609 (8th Cir. 2020). The district court conflated the question of irreparable harm with the merits. *See* Add. 10; R. Doc. 64, at 9. But its approach would make the irreparable-harm inquiry irrelevant in lawsuits challenging state laws. And it disregards the harm to Arkansas of the injunction right now. *See Hand v. Scott*, 888 F.3d 1206, 1214 (11th Cir. 2018) (holding that State “would be harmed if it could not apply its own laws . . . now, even if it might later be able to” apply altered version of law).

Relatedly, by preventing legislation from taking effect, the district court failed to preserve the status quo. Whenever a plaintiff seeks to enjoin legislation, “the status quo is that which the People have wrought, not that which unaccountable federal judges impose upon them.” *Planned Parenthood of Blue Ridge v. Camblos*, 116 F.3d 707, 721 (4th Cir. 1997) (Luttig, J., staying injunction in single-judge order). The preliminary injunction not only ignored the harm it caused Arkansas, it also upset the status quo.

C. Finally, the district court should not have facially enjoined the SAFE Act. *See* Add. 14; R. Doc. 64, at 13. To justify a facial injunction, Plaintiffs needed to “establish that no set of circumstances exists under which the Act would be valid.” *United States v. Salerno*, 481 U.S. 739, 745 (1987). Based on their own

expert’s claims, they could not meet that standard. According to her, “[t]he precise treatment for gender dysphoria depends on each person’s individualized need.” App. 96; R. Doc. 11-11, at 6. Thus, even assuming Plaintiffs would be harmed by the SAFE Act, that does not demonstrate that every child facing gender dysphoria would likewise suffer harm. *Cf. Brakebill v. Jaeger*, 932 F.3d 671, 678 (8th Cir. 2019) (“[E]ven assuming that a plaintiff can show that an election statute imposes excessively burdensome requirements on *some* voters, that showing does not justify broad relief that invalidates the requirements on a statewide basis as applied to *all* voters.” (cleaned up)). This Court should reverse.

## CONCLUSION

For these reasons, the district court's order granting a preliminary injunction should be reversed, its order denying Defendants' motion to dismiss should be reversed, and this case should be remanded with instructions to dismiss Plaintiffs' claims with prejudice.

Respectfully submitted,

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## CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 12,925 words, excluding the parts exempted by Fed. R. App. P. 32(f).

I also certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5)-(6) because it has been prepared in 14-point Times New Roman, using Microsoft Word.

I further certify that this PDF file was scanned for viruses, and no viruses were found on the file.

*/s/ Vincent M. Wagner*

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Vincent M. Wagner

## CERTIFICATE OF SERVICE

I certify that on November 12, 2021, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which shall send notification of such filing to any CM/ECF participants.

*/s/ Vincent M. Wagner*

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Vincent M. Wagner