
**UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT**

◆

DYLAN BRANDT, et al.,
Plaintiffs-Appellees,
v.
LESLIE RUTLEDGE,
in her official capacity as the Arkansas Attorney General, et al.,
Defendants-Appellants.

◆

On Appeal from the United States District Court
for the Eastern District of Arkansas
Case No. 4:21-cv-450 JM (Hon. James M. Moody, Jr.)

**BRIEF OF *AMICI CURIAE* STATES OF ALABAMA, ALASKA, ARIZONA, GEORGIA,
IDAHO, INDIANA, KANSAS, KENTUCKY, LOUISIANA, MISSISSIPPI, MISSOURI,
MONTANA, NEBRASKA, OKLAHOMA, SOUTH CAROLINA, SOUTH DAKOTA,
TENNESSEE, TEXAS, UTAH, AND WEST VIRGINIA IN SUPPORT OF APPELLANTS'
PETITION FOR REHEARING EN BANC**

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CORPORATE DISCLOSURE STATEMENT

As governmental parties, amici are not required to file a certificate of interested persons. Fed. R. App. P. 26.1(a).

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INTERESTS OF AMICI CURIAE AND SUMMARY OF ARGUMENT¹

Amici curiae are the States of Alabama, Alaska, Arizona, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, and West Virginia.

From the Founding, States have exercised their authority to enact health and safety measures—regulating the medical profession, restricting access to potentially dangerous medicines, banning treatments that are unsafe or unproven. *See Abigail All. For Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 703-05 (D.C. Cir. 2007) (en banc). Indeed, independently weighing the harms and benefits of proposed treatments is one of the important roles that States and other governments fulfill. So it was when the federal government required testing of COVID vaccines before approving them for use, first for adults and later for children. And so it was in countries like the UK, Finland, and Sweden, when they recently conducted independent reviews of transitioning treatments and determined, as Sweden did, that “the risks of puberty suppressing treatment ... and gender-affirming hormonal treatment currently outweigh the possible benefits” for “adolescents with gender incongruence.”²

¹ This brief is filed under Federal Rule of Appellate Procedure 29(b)(2).

² Socialstyrelsen, *Care of children and adolescents with gender dysphoria*, at 3 (Feb. 2022), <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf>.

And so it was in Arkansas. Early among the States (others are now catching up³), Arkansas took a sober look at the medical literature and determined that “[t]he risks of gender transition procedures far outweigh any benefit at this stage of clinical study.” See 2021 Ark. Act 626, § 2(15). So it banned the sterilizing treatments for minors. That determination was the State’s to make—no different than if it had banned medical marijuana or euthanasia.

Yet rather than accord the State’s “health and welfare law[]” a ““strong presumption of validity,”” *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2284 (2022) (quoting *Heller v. Doe*, 509 U.S. 312, 319 (1993)), the panel applied heightened scrutiny. “A minor born as a male may be prescribed testosterone,” it reasoned, “but a minor born as a female is not permitted to seek the same medical treatment.” Op. 7. Thus, the panel concluded, the Act “discriminates on the basis of sex” and is “subject to heightened scrutiny.” *Id.*

³ *E.g.*, Alabama Vulnerable Child Compassion and Protection Act, Ala. Code §§ 26-26-1 *et seq.* (banning the prescription of puberty blockers, cross-sex hormones, and surgical procedures for transitioning minors); Prohibition of Irreversible Gender Reassignment Surgery for Minors, Ariz. Rev. Stat. Ann. § 32-3230 (prohibiting physicians from providing “irreversible gender reassignment surgery” to minors); *see also* Division of Florida Medicaid, *Generally Accepted Professional Medical Standard Determination on the Treatment of Gender Dysphoria* (June 2022), <https://ahca.myflorida.com/letkidsbekids/> (conducting evidence review of gender transition procedures and concluding that, “[c]onsidering the weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures when compared to the stronger research demonstrating the permanent effects they cause, these treatments do not conform to [generally accepted professional medical standards] and are experimental and investigational”).

The panel erred in at least two ways. First, the Act prohibits gender transition procedures for *all* minors. No matter their sex, they are treated the same: boys cannot access hormones or surgeries to transition, and neither can girls. That is true no matter what the treatments are. The panel spoke of testosterone, but in doing so it conflated the *drug* at issue with the *treatment* involved. No one would think that giving supraphysiologic doses of testosterone to a boy for bodybuilding is the “same medical treatment” as using the hormone to bring a boy’s testosterone levels up to a natural range. Nor are those the “same medical treatments” as injecting a girl with unnatural amounts of testosterone to transition. The same *drug* may be involved, but the *treatments* are different.

Second, the panel’s blindered view that heightened scrutiny applies whenever sex is used to “distinguish[] between those who may receive certain types of medical care and those who may not” is both absurd and contrary to precedent. Under the panel’s logic, a public hospital’s decision to offer testicular exams only to boys is subject to heightened scrutiny. Same if it offers abortions only to women. The Constitution does not require such absurdities. As the Supreme Court recently reaffirmed, “[t]he regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a ‘mere pretext[t] designed to effect an invidious discrimination against members of one sex or the other.’” *Dobbs*, 142 S. Ct. at 2245-46 (alteration in original) (quoting *Geduldig*

v. Aiello, 417 U.S. 484, 496 n.20 (1974)). The panel thus erred by requiring intermediate scrutiny for any medical procedure that depends on sex. The Court should grant rehearing en banc so the panel’s error does not govern the Circuit.

ARGUMENT

I. The Panel Ignored The “Normal Rule” That Courts Defer To The Judgments Of Legislatures In Areas Fraught With Medical And Scientific Uncertainties.

“[T]he Constitution principally entrusts the safety and the health of the people to the politically accountable officials of the States”—not to the self-interested medical groups to which the district court and panel deferred. *Andino v. Middleton*, 141 S. Ct. 9, 10 (2020) (Kavanaugh, J., concurring) (quotation marks omitted). Indeed, the Supreme Court has recognized that “[t]here is perhaps no profession more properly open to such regulation than that which embraces the practitioners of medicine.” *Watson v. Maryland*, 218 U.S. 173, 176 (1910). “That respect for a legislature’s judgment applies even when the laws at issue concern matters of great social significance and moral substance.” *Dobbs*, 142 S. Ct. at 2284 (collecting cases). “[L]ike other health and welfare laws,” Arkansas’s regulation prohibiting sterilizing transitioning treatments was “entitled to a ‘strong presumption of validity.’” *Id.* (citation omitted).

Not only that, but judicial deference to legislative determinations is particularly important when the science is unsettled or varying factions disagree, as was the

case here. Courts typically should not venture “into unknown questions of science and medicine” when “the democratic branches are better suited to decide the proper balance between the uncertain risks and benefits of medical technology.” *Abigail All.*, 495 F.3d at 713.

The panel rejected such judicial humility. Even though it recognized that “experts on both sides of this case don’t agree,” Op. 8 (alterations omitted), it nevertheless affirmed the district court’s decision to press on as the arbiter of science. But “it is precisely where such disagreement exists that legislatures have been afforded the widest latitude in drafting such statutes.” *Kansas v. Hendricks*, 521 U.S. 346, 360 n.3 (1997). The “normal rule,” ignored by the panel and the district court, is that “courts defer to the judgments of legislatures ‘in areas fraught with medical and scientific uncertainties.’” *Dobbs*, 142 S. Ct. at 2268 (quoting *Marshall v. United States*, 414 U.S. 417, 427 (1974)); *see, e.g., Abigail All.*, 495 F.3d at 697 (upholding federal government’s decision to restrict access to experimental drugs); *Raich v. Gonzales*, 500 F.3d 850, 864 (9th Cir. 2007) (same for medical marijuana).

So, too, did the panel err by unduly crediting Plaintiffs’ amici, which formed the sole basis for the district court’s supposed “factual findings.” Op. 9; *see* R. Doc. 64 at 6 (relying on amicus brief to conclude that transitioning treatments are the “only effective treatment” for gender dysphoria). While the “position of the American Medical Association” and other interest groups may be of interest to “a

legislative committee,” the panel “did not explain why these sources shed light on the meaning of the Constitution.” *Dobbs*, 142 S. Ct at 2267. They do not. “Nothing in the Constitution mechanically gives controlling weight to one set of professional judgments,” *Cameron v. Tomes*, 990 F.2d 14, 20 (1st Cir. 1993), because the “institutional positions” of “professional organizations ... cannot define the boundaries of constitutional rights,” *Otto v. City of Boca Raton*, 981 F.3d 854, 869 (11th Cir. 2020). Instead of deferring to self-interested medical groups, the panel should have deferred to Arkansas’s elected representatives. It erred by doing otherwise.

II. The Panel Erred By Applying Heightened Scrutiny.

Rather than presuming that the Act was valid, as precedent required, the panel subjected the Act to heightened scrutiny on the theory that the Act imposes a discriminatory sex-based classification. Op. 7. That was legal error because (1) the Act does not treat boys and girls differently, and (2) even if it did, regulating medical treatments that only one sex can undergo does not mandate heightened review.

A. The Panel Conflated Medical Treatments with the Drugs the Treatments Use.

The panel concluded that the Act discriminates on the basis of sex because, “under the Act, medical procedures that are permitted for a minor of one sex are prohibited for a minor of another sex.” Op. 7. That is wrong.

Start with puberty blockers. Under the Act, both boys and girls can receive puberty blockers to treat precocious puberty (for instance), but neither boys nor girls

can receive them to transition. Thus, puberty blockers are *not* “permitted for a minor of one sex” while being “prohibited for a minor of another sex.” The panel’s reasoning fails on its own terms.

It also fails when applied to the Act’s ban on cross-sex hormones and transitioning surgeries. The panel reasoned that a boy “may be prescribed testosterone,” while a girl “is not permitted to seek the *same medical treatment.*” *Id.* (emphasis added). But neither boys nor girls may be prescribed testosterone *for the purpose of transitioning*, which is what the Act prohibits. *See* Ark. Code § 20-9-1502(a). And contra the panel’s logic, a boy receiving testosterone to treat an endocrine disorder is not receiving “the same medical treatment” as a girl receiving the hormone to transition. While the same drug may be used, the treatments are different—just as giving testosterone to a Tour de France cyclist seeking a yellow jersey would also be a different treatment.

That the same drug or procedure can constitute different medical treatments is common sense. Implanting a fertilized egg in a woman may be a treatment for infertility; implanting it in a man is something quite different. Likewise, administering morphine can be a treatment for a patient’s pain; it can also be used to assist a patient’s suicide. That doesn’t make euthanasia the “same medical treatment” as pain relief. This same distinction is recognized by the FDA when it differentiates between “approved treatments” for drugs and “off-label” use. Off-label use may be

appropriate in some circumstances, but it remains true, for instance, that using hydroxychloroquine to treat COVID (an off-label use the FDA discourages) is a different treatment from using it to treat malaria (which the FDA approves).⁴ That is the case here: using hormones or surgeries to transition a child is not the “same medical treatment” as using those drugs or procedures to restore a child’s natural health.

This also explains why the reasoning of *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020), does not mandate heightened scrutiny. Of course, that decision does not apply anyway because it concerned only sex-based stereotypes irrelevant to employment decisions under Title VII and did not touch on biological differences that *actually matter*⁵ in the healthcare context under the Equal Protection Clause. *See id.* at 1740-41, 1753 (expressly reserving answering “[w]hether other policies and practices might or might not qualify as unlawful discrimination”). But even under *Bostock*, the Act would not be subject to heightened scrutiny. To use the *Bostock* formulation, it is *not* true that but for a child’s sex he or she could be given sterilizing transitioning treatments under the Act. *No minor*, male or female, can access those treatments. The panel thus erred by applying heightened scrutiny.

⁴ See FDA, *FDA cautions against use of hydroxychloroquine or chloroquine for COVID-19* (Jul. 1, 2020), <https://www.fda.gov/drugs/drug-safety-and-availability/fda-cautions-against-use-hydroxychloroquine-or-chloroquine-covid-19-outside-hospital-setting-or>.

⁵ See, e.g., U.S. Department of Health and Human Services’ Office on Women’s Health, which focuses entirely on issues specific to *women’s* health, <https://www.womenshealth.gov/>.

B. The Equal Protection Clause Does Not Subject Every Medical Procedure That Depends on Sex to Heightened Scrutiny.

Even if the panel were right that Arkansas’s Act uses sex to “distinguish[] between those who may receive certain types of medical care and those who may not,” Op. 7, that would not subject the Act to heightened scrutiny, either. “The Equal Protection Clause ... is essentially a direction that all persons similarly situated should be treated alike.” *Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985). It does not require courts to pretend that men and women are medically interchangeable, which they obviously are not. *See United States v. Virginia*, 518 U.S. 515, 533 (1996) (recognizing that “[p]hysical differences between men and women” are “enduring”). Instead, the Supreme Court has long recognized that “[t]he regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a ‘mere pretext[] designed to effect an invidious discrimination against members of one sex or the other.’” *Dobbs*, 142 S. Ct. at 2245-46 (alteration in original) (quoting *Geduldig*, 417 U.S. at 496 n.20).

A classic example of this rule is abortion, *see id.*, but it applies here, too. To return to the panel’s example of testosterone, only females can be prescribed testosterone *to transition*. A boy receiving testosterone may be using it to treat an endocrine disorder, but it would not be—cannot be—for the purpose of transitioning (and if it were, the Act would proscribe that use as well). Likewise, only a male can be prescribed estrogen *to transition*, even though a female can be given estrogen to treat

other ailments. Because the prohibited treatments are ones that only one sex can undergo, the panel erred by applying heightened scrutiny.

Imagine if it were otherwise. If the panel's opinion holds, heightened scrutiny would apply every time a public hospital in this Circuit uses sex to inform its treatment decisions. Testicular exams only for boys? Pap smears only for girls? Abortions or IVF treatments only for women? All, under the panel's logic, constitutionally suspect. But the Equal Protection Clause does not require such absurdities, and Supreme Court precedent forbids it. The Court should grant rehearing en banc to correct the panel's far-reaching error.

CONCLUSION

The Court should grant rehearing en banc.

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CERTIFICATE OF COMPLIANCE

1. I certify that this brief complies with the type-volume limitations set forth in Fed. R. App. P. 29(b)(4) and 32(a)(7)(B)(i). This brief contains 2,371 words, including all headings, footnotes, and quotations, and excluding the parts of the motion exempted under Fed. R. App. P. 32(f).

2. In addition, pursuant to Fed. R. App. P. 32(g)(1), this brief complies with the typeface and type style requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in a proportionally spaced typeface using Microsoft Word for Office 365 in 14-point Times New Roman font.

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

Dated: October 13, 2022

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CERTIFICATE OF SERVICE

I certify that on October 13, 2022, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which will send notification of such filing to any CM/ECF participants.

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