

No. 23-0697

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**IN THE SUPREME COURT OF TEXAS**

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THE STATE OF TEXAS; OFFICE OF THE ATTORNEY GENERAL; KEN PAXTON, in his official capacity as Attorney General of Texas; THE TEXAS MEDICAL BOARD; and THE TEXAS HEALTH AND HUMAN SERVICES COMMISSION,

*Appellants,*

v.

LAZARO LOE, et al.,

*Appellees.*

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◆

On Direct Appeal from the 201st Judicial District Court, Travis County  
No. D-1-GN-23-003616, Hon. Maria Cantú Hexsel, District Judge

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**BRIEF OF ALABAMA, ARKANSAS, AND 20 OTHER STATES AS *AMICI CURIAE*  
SUPPORTING APPELLANTS AND REVERSAL**

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## INTERESTS OF AMICI CURIAE AND SUMMARY OF ARGUMENT<sup>1</sup>

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

Amici are acutely aware that the American medical establishment has been responsible for both great healing and, at times, great harm. Eugenics, lobotomies, and opioids are just a few examples of scandals sanctioned by America's leading medical organizations. Amici are concerned that another devastating scandal is at hand: the medical establishment's fast-tracking of vulnerable youth suffering from gender dysphoria—and, almost always, a host of other psychiatric co-morbidities—for hormonal and surgical gender-transition procedures that can leave them sterilized. In response, almost two dozen States—including Texas—have generally prohibited these procedures for minors, at least until the evidence can prove their safety and efficacy.<sup>2</sup>

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<sup>1</sup> No person other than amici, their staff, or their counsel made any monetary contribution for the preparation or submission of this brief. Tex. R. App. P. 11(c).

<sup>2</sup> See Ala. Code §26-26-4; Ark. Code Ann. 20-9-1502; Fla. Admin. Code Ann. R.64B8-9.019; Ga. Code Ann. §31-7-3.5; Idaho Code §18-1506C; Ind. Code §25-1-22-13; Iowa Code §147.164; Ky. Rev. Stat. Ann. §311.372; La. Stat. Ann. §40:1098; Miss. Code Ann. §41-141-1-9; Mo. Rev. Stat. Ann. §191.1720; S.B. 99, 68th Leg., 2023 Sess. (Mont. 2023); Neb. Rev. Stat. §72-7301-07; H.B. 808, 2023 Sess. (N.C. 2023); N.D. Cent. Code. §12.1-36.1-02; Okla. Stat. Ann. tit. 63, §2607.1; H.B. 68,

“State[s] plainly ha[ve] authority, in truth a responsibility, to look after the health and safety of [their] children.” *L.W. v. Skrmetti*, 73 F.4th 408, 419 (6th Cir. 2023) (staying injunction of Tennessee’s similar law). Governments have done so “from time immemorial”—regulating the medical profession, restricting access to potentially dangerous medicines, and banning treatments that are unsafe or unproven. *Dent v. West Virginia*, 129 U.S. 114, 121-24 (1889); see *Abigail All. For Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 703-05 (D.C. Cir. 2007) (en banc).

And when it comes to “areas where there is medical and scientific uncertainty,” States have particularly “wide discretion.” *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). So States like Texas can “choose fair-minded caution and their own approach to child welfare” before subjecting their children to irreversible transitioning treatments. *L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 488 (6th Cir. 2023) (vacating preliminary injunctions of similar laws in Tennessee and Kentucky). “Absent a constitutional mandate to the contrary, these types of issues are quintessentially the sort that our system of government reserves to legislative, not judicial, action.” *Eknes-Tucker v. Governor of Ala.*, 80 F.4th 1205, 1231 (11th Cir. 2023) (vacating preliminary injunction of similar Alabama law).

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135th Leg. Sess. (Ohio 2024) (effective April 24, 2024); H.B. 1080, 98th Leg. Sess. (S.D. 2023); Tenn. Code Ann. § 68-33-101; S.B. 14, 88th Leg. Sess. (Tex. 2023); Utah Code Ann. §58-68-502(1)(g); W. Va. Code §30-3-20.

Plaintiffs and their amici ask this Court to treat their favored medical interest groups as the *real* regulators, authoring standards that Texas cannot contradict. They claim that guidelines published by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society “have been recognized as authoritative” by those groups, Tex. Br. Tab C ¶ 30, so it is purportedly *those* standards that the Texas Constitution mandates.

*First*, Texas’s law is presumptively constitutional. While Plaintiffs suggest that heightened scrutiny applies any time a medical regulation depends on a patient’s sex, Tex. Br. 31, that has never been true. “Physical differences between men and women” “are enduring.” *United States v. Virginia*, 518 U.S. 515, 533 (1996). As the U.S. Department of Health and Human Services (HHS) explains, “a woman’s body [is] obviously different from a man’s,” “[s]o it is no surprise that diseases, and the medications and medical devices used to treat them, may affect women differently” from men.<sup>3</sup> Accordingly, HHS regularly oversees health initiatives that are sex specific—from improving breast cancer screening for women to promoting sex-specific approaches to treating heart disease.<sup>4</sup> And Congress routinely recognizes differences in the sexes, as when it made it a felony to perform genital mutilation on a minor

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<sup>3</sup> U.S. Dep’t of Health & Human Servs., Office on Women’s Health, *Addressing Sex Differences in Health*, <https://perma.cc/93H3-66C5>.

<sup>4</sup> *Id.*; see also HHS, *30 Achievements in Women’s Health in 30 Years (1984-2014)*, <https://perma.cc/HXQ3-TRAM>.

girl. 18 U.S.C. § 116. That prohibition is presumed constitutional because it is rooted in biological reality, not stereotype. Indeed, contra Plaintiffs’ reasoning (at 35 n.11), the presence of a penis or XY chromosomes is not a “stereotype.”

Common sense also answers Plaintiffs’ argument. Texas prohibits a physician from providing a vaginoplasty to a minor boy to transition his gender appearance. Plaintiffs complain that “the same treatments” remain legal for other youth and that heightened scrutiny is therefore required. *E.g.*, Pls.’ Br. 51. But there is a world of difference between a vaginoplasty for a female and the “same treatment” for a transitioning male. The former can be performed under local anesthesia, brings “separated muscles together,” and removes “extra mucosa skin” to surgically tighten the vagina and restore normal function, typically following trauma.<sup>5</sup> But the latter is major “surgery to create a vagina” and “involves removing the penis, testicles and scrotum.”<sup>6</sup> These are not the “same treatments.”<sup>7</sup>

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<sup>5</sup> See American Society of Plastic Surgeries, *Aesthetic Genital Plastic Surgery Surgical Options: What Is A Vaginoplasty?*, <https://perma.cc/5WFH-57QP>.

<sup>6</sup> See Fan Liang, Johns Hopkins Medicine, *Vaginoplasty for Gender Affirmation*, <https://perma.cc/RFU9-S72N>.

<sup>7</sup> Lest the Court think this is an absurd example, pending before the Eleventh Circuit is a case in which the United States advances the “same treatments” argument to claim that Title VII requires an employer’s health insurance carrier to cover transitioning “vaginoplasties” for men if it covers reparative vaginal surgery for women. See Brief for the United States as Amicus Curiae at 3, 6, 18, *Lange v. Houston Cnty.*, No. 22-13626 (11th Cir. Mar. 17, 2023).

*Second*, one could scarcely dream up a more radical organization to outsource the regulation of medicine to than WPATH (whose members almost entirely wrote the Endocrine Society guidelines). Putting these groups in charge of regulating medicine would flip the purpose of regulation on its head—making the regulated the regulators. While “Americans are engaged in an earnest and profound debate about” how best to help children suffering from gender dysphoria, *cf. Washington v. Glucksberg*, 521 U.S. 702, 735 (1997), WPATH has included in its latest Standards an entire chapter on self-identified “eunuchs”—individuals “assigned male at birth” who “wish to eliminate masculine physical features, masculine genitals, or genital functioning.”<sup>8</sup> Those Standards rely heavily on the “Eunuch Archive”—a “large online peer-support community” that WPATH boasts contains “the greatest wealth of information about contemporary eunuch-identified people,”<sup>9</sup> plus thousands of stories “focus[ing] on the eroticization of child castration” (though WPATH leaves that part out<sup>10</sup>). They maintain that “castration” may be “medically necessary gender-affirming care” for eunuchs who “wish for a body that is compatible with their eunuch identity.”<sup>11</sup> And, just as with eunuchs, WPATH considers sterilizing gender-

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<sup>8</sup> E. Coleman et al., *WPATH Standards of Care for the Health of Transgender & Gender Diverse People, Version 8*, INT’L J. OF TRANSGENDER HEALTH (Sept. 15, 2022), S88-89 (“SOC 8”).

<sup>9</sup> *Id.* at S88-89.

<sup>10</sup> Genevieve Gluck, *Top Trans Medical Association Collaborated With Castration, Child Abuse Fetishists*, REDUXX (May 17, 2022), <https://perma.cc/5DWF-MLRU>.

<sup>11</sup> *See* SOC 8, *supra*, at S88-89.

transition procedures to be “medically necessary” for *minors* experiencing gender dysphoria.<sup>12</sup>

It is no wonder that European healthcare systems are rejecting the WPATH model of “care.” Having determined through systematic literature reviews that the evidence does not support such an extreme approach, these national authorities have severely curtailed the availability of gender-transition procedures for minors outside controlled research settings. *See infra* at 19-21.

Texas concluded that it would await the results of gender experimentation being conducted elsewhere rather than allow its vulnerable children to be used as guinea pigs. The Texas Constitution does not bar that legislative determination, and this Court should reverse.

## ARGUMENT

### **I. Laws Prohibiting Pediatric Gender-Transition Procedures Do Not Trigger Heightened Scrutiny.**

S.B. 14, like similar laws enacted by many of the amici States, prohibits healthcare providers from performing surgeries on and administering hormones to minors for gender transition. As with “other health and welfare laws,” the law is subject only to rational-basis review. *See Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2284 (2022).

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<sup>12</sup> *Id.* at S43-66.

**A. Laws Prohibiting Pediatric Gender-Transition Procedures Do Not Discriminate Based on Sex.**

Plaintiffs argue that the default rule of rational basis does not apply here because “the sex of the person seeking care determines the legality of the procedure.” Pls.’ Br. 36. But that is false because the prohibition is not sex-based: gender-transition procedures are not permitted for males but forbidden to females (or vice-versa), as both the Sixth and Eleventh Circuits have recently recognized. *See L.W.*, 83 F.4th at 480-81; *Eknes-Tucker*, 80 F.4th at 1228.

Texas’s law regulates gender-transition procedures for *all* minors, regardless of sex. Tex. Health & Safety Code sec. 161.702 (neutrally applicable “[f]or the purpose of transitioning *a child’s* biological sex” (emphasis added)). This “across-the-board regulation lacks any of the hallmarks of sex discrimination” and does not “prefer one sex over the other.” *L.W.*, 83 F.4th at 480 (citation omitted). It does not include one sex and exclude the other. *Cf. Virginia*, 518 U.S. at 519-20. It does not “bestow benefits or burdens based on sex.” *Cf. Michael M. v. Super. Ct.*, 450 U.S. 464, 466 (1981) (plurality op.); *Orr v. Orr*, 440 U.S. 268, 271 (1979). And it does not “apply one rule for males and another for females.” *Cf. Sessions v. Morales-Santana*, 582 U.S. 47, 58 (2017); *Craig v. Boren*, 429 U.S. 190, 192 (1976). The Act’s prohibitions are sex-neutral and treat similarly situated individuals “evenhandedly.” *L.W.*, 83 F.4th at 479-80.

Plaintiffs' contrary view reflects a fundamental misunderstanding both as to how these statutes operate and how heightened scrutiny works. Plaintiffs argue that S.B. 14 discriminates based on sex because, for instance, a parent could fill a testosterone prescription for a child with testosterone insufficiency but not for a child with gender dysphoria. Pls.' Br. 32. But Plaintiffs' logic would "force [States] to *either* ban puberty blockers and hormones for all purposes *or* allow them for all purposes." *Eknes-Tucker*, 80 F.4th at 1234 (Brasher, J., concurring). That is because Plaintiffs erroneously view the administration of testosterone as one monolithic treatment—the "same treatment" regardless of the reason it is administered. But just as with the vaginoplasty example discussed above, these are different treatments.

*First*, common sense tells us that a physician can treat different conditions using the same drug, and that fact does not make the two treatments the same. Indeed, different uses of the same drug or procedure can have different contraindications, different risk profiles, and different goals. Insulin, for example, saves the lives of diabetic patients, but it can be lethal to those suffering hypoglycemia. Similarly, digoxin is administered to treat heart failure, but it has been used to induce abortion, too. Same drug, vastly different treatments.

This same is true here. Puberty blockers are approved for treating precocious puberty, a condition where a child begins puberty at an unusually early age.<sup>13</sup> Unlike gender dysphoria, precocious puberty is a physical abnormality that can be diagnosed through medical tests.<sup>14</sup> The goal is to ensure that children develop at the normal age. But the goal of using these drugs to treat gender dysphoria, on the other hand, is to *block* normal puberty. This distinction impacts the cost-benefit analysis because using puberty blockers well beyond the normal pubertal age can, at minimum, risk a child's bone growth and social development.<sup>15</sup>

Likewise for testosterone and estrogen, which also serve different purposes and carry different risks when given to boys versus girls. Excess testosterone in females can *cause* infertility,<sup>16</sup> while testosterone is used in males to *alleviate* fertility problems.<sup>17</sup> On the other hand, excessive amounts of estrogen in males can *cause* infertility and sexual dysfunction,<sup>18</sup> while estrogen is often given to females to *treat*

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<sup>13</sup> Endocrine Society, *Precocious Puberty* (Jan. 24, 2022), <https://perma.cc/6Q3E-PEMP>.

<sup>14</sup> *Id.*

<sup>15</sup> See Nat'l Inst. for Health & Care Excellence (NICE), *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria* (Mar. 11, 2021), <https://perma.cc/93NB-BGAN>, at 26-32 ("NICE Puberty Blocker Evidence Review").

<sup>16</sup> Jayne Leonard, *What Causes High Testosterone in Women?*, MEDICAL NEWS TODAY (Jan. 12, 2023), <https://perma.cc/BT38-L79X>.

<sup>17</sup> Maria Vogiatzi et al., *Testosterone Use in Adolescent Males*, 5 J. ENDOCRINE SOC'Y 1, 2 (2021), <https://perma.cc/E3ZQ-4PZV>.

<sup>18</sup> Anna Smith Haghghi, *What To Know About Estrogen in Men*, MEDICAL NEWS TODAY (Nov. 9, 2020), <https://perma.cc/B358-S7UW>.

problems with sexual development.<sup>19</sup> Thus, giving testosterone or estrogen to a physically healthy child for gender transitioning has a different purpose and different risks than using the same drugs to treat a genetic or congenital condition that occurs exclusively in one sex.<sup>20</sup> *L.W.*, 83 F.4th at 481. These distinctions, among others, make the use of the same hormones in the different sexes different treatments altogether.

*Second*, a medical regulation does not “classify” on the basis of sex merely by mentioning sex. *Dobbs*, 142 S. Ct. at 2245. A patient’s sex can affect the nature of a treatment, and a State can regulate that treatment without equal-protection liability. The Constitution does not look askance on a hospital offering testicular exams only to boys or pap smears only to girls. And here, “laws banning, permitting, or otherwise regulating [gender-transition procedures] all face the same linguistic destiny of describing the biology of the procedures.” *L.W.*, 83 F.4th at 483. They refer to sex only because the procedures “are themselves sex-based.” *Eknes-Tucker*, 80 F.4th at 1228. And just as States can enact laws concerning abortion, female genital mutilation, testicular cancer, prostate cancer, breastfeeding, cervical cancer, Cesarean

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<sup>19</sup> Karen O. Klein, *Review of Hormone Replacement Therapy in Girls and Adolescents with Hypogonadism*, 32 J. PEDIATRIC & ADOLESCENT GYNECOLOGY 460 (2019), <https://perma.cc/WU36-5889>.

<sup>20</sup> While there may be some instances in which administering testosterone to a female (for instance) could be necessary—say, to treat symptoms of menopause or a gland disorder—doing so would not be the “same medical treatment” as that given to a male.

sections, and in-vitro fertilization without those laws being “presumptively unconstitutional,” so can they regulate experimental gender-transition procedures. *L.W.*, 83 F.4th at 482 (collecting examples).

This is also one reason why, contra Plaintiffs, the reasoning of *Bostock* does not apply. See *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731 (2020). Whatever the merits of the Supreme Court’s “simple test” “in the workplace,” *id.* at 1737, 1743—see *id.* at 1741 (“if changing the employee’s sex would have yielded a different choice by the employer,” the employer has treated the employee differently “because of sex”)—it makes no sense to apply that test to medicine, where males and females are *not* similarly situated. A fertility clinic does not discriminate on the basis of sex by implanting fertilized eggs only in females, even though “changing the [patient’s] sex would have yielded a different choice by the [clinic].” *Id.* There is no stereotype or inequality in the clinic’s policy.

So here. Administering testosterone to bring a boy’s levels into a normal range is not the same treatment as ramping up a young girl’s testosterone levels to that of a healthy boy—ten times that of a girl—or, for that matter, as giving it to a Tour de France cyclist seeking a yellow jersey.

Returning to Plaintiffs’ reasoning, it is *not* true that boys in Texas would receive testosterone *to transition*. Not only is this because no minor—male *or* female—may be prescribed testosterone *to transition*, but biology dictates that a male

cannot use testosterone *to transition* at all. Only females can use testosterone for gender transition—never males. *See L.W.*, 83 F.4th at 481. Although a male can use testosterone for other types of treatment, no amount of testosterone will cause a male to develop female characteristics.

The inverse is true for estrogen. Estrogen can be used for gender transition *only* in males, never the reverse. *Id.* The same goes for the surgical procedures at issue here. Only females would obtain a double mastectomy or a phalloplasty for the purpose of gender transition. And only males would seek breast enlargement surgery or the creation of a neovagina<sup>21</sup> for the purpose of gender transition. These are “medical procedure[s] that only one sex can undergo,” making heightened scrutiny inappropriate. *Dobbs*, 142 S. Ct. at 2245; *see L.W.*, 83 F.4th at 481; *Eknes-Tucker*, 80 F.4th at 1229.

As for puberty blockers, sex does not matter to Texas’s law. “In contrast to cross-sex hormones, puberty blockers involve the same drug used equally by gender-transitioning boys and girls.” *L.W.*, 83 F.4th at 483. Prohibiting their use for the purpose of gender transition does not depend on sex at all.

The pertinent question is whether “those who want to use these drugs to treat a discordance between their sex and gender identity and those who want to use these

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<sup>21</sup> *See* Kenzie Birse et al., *The Neovaginal Microbiome of Transgender Women Post-Gender Reassignment Surgery*, 8 MICROBIOME 61 (2020). <https://doi.org/10.1186/s40168-020-00804-1>.

drugs to treat other conditions” are “similarly situated.” *Eknes-Tucker*, 80 F.4th at 1233 (Brasher, J., concurring). But to ask that question answers it. Texas has discretion to “permit varying treatments of distinct diagnoses” because “things which are different in fact or opinion” should not “be treated in law as though they were the same.” *L.W.*, 83 F.4th at 482-83 (quoting *Tigner v. Texas*, 310 U.S. 141, 147 (1940)).

This leaves Plaintiffs’ complaint that Texas’s law “perpetuates” “discriminatory sex stereotypes,” Pls.’ Br. 35 n.11—as though Texas makes access to gender-transition treatments turn on who “walk[s] more femininely, talk[s] more femininely, dress[es] more femininely, wear[s] make-up, ha[s] [their] hair styled, [or] wear[s] jewelry,” *Price Waterhouse v. Hopkins*, 490 U.S. 228, 235 (1989) (plurality op.).

But to state the obvious, “biological sex ... is not a stereotype.” *Adams by & through Kasper v. Sch. Bd. of St. Johns Cnty.*, 57 F.4th 791, 809 (11th Cir. 2022) (en banc). And characteristics determined by biological sex—hormonal levels or the presence of male or female genitalia—are not stereotypes. Stereotypes are not “immutable characteristics determined solely by the accident of birth.” *Frontiero v. Richardson*, 411 U.S. 677, 686 (1973). The law does not forbid States from accounting for biological reality when regulating medicine.

**B. Transgender Individuals Are Not a Suspect Class.**

Plaintiffs argue that S.B. 14 classifies based on transgender status by prohibiting “treatment that only transgender people seek.” Pls.’ Br. 37. In making that argument, Plaintiffs erase the experiences of a growing number of detransitioners who received gender-transition procedures but later chose to detransition and live in accordance with their biological sex.<sup>22</sup> If detransitioners were never transgender, then it cannot be true that *only* transgender individuals seek the prohibited procedures. And if detransitioners *were* transgender but no longer are, then transgender status cannot be an immutable characteristic. (On this, more below.)

Regardless, heightened scrutiny does not apply simply because people seeking a procedure are disproportionately (or even uniformly) members of a suspect class. *Vacco v. Quill*, 521 U.S. 793, 800 (1997). Classifications based on sex receive intermediate scrutiny, but a classification of “people seeking abortions” does not, even though only women seek abortions. *Dobbs*, 142 S. Ct. at 2245-46.

Individuals who identify as transgender do not constitute a suspect class to begin with. “Transgender status” is not a protected class under the Texas

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<sup>22</sup> *E.g.*, Lisa Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners*, 50 ARCHIVES OF SEXUAL BEHAVIOR 3353 (2021); Pamela Paul, *As Kids, They Thought They Were Trans. They No Longer Do.*, N.Y. TIMES (Feb. 2, 2024), <https://www.nytimes.com/2024/02/02/opinion/transgender-children-gender-dysphoria.html>.

Constitution. *See* Tex. Const. art. I, sec. 3a (protecting equality on the basis of “sex, race, color, creed, or national origin”). And, contra Plaintiffs, the Supreme Court rarely designates suspect or quasi-suspect classes. *See, e.g., City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 442-46 (1985). Indeed, the Court has rejected suspect classification for disability, age, and poverty. *Id.*; *Mass. Bd. of Retirement v. Murgia*, 427 U.S. 307, 313 (1976); *San Antonio Ind. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 28 (1973). That so few classifications rise to the level of “suspect” itself casts “grave doubt” on the assertion that transgender identity does. *Adams*, 57 F.4th at 803 n.5.

Precedent explains why. Classifications are suspect when they single out “distinguishing characteristics” that have historically been divorced from “the interests the State has the authority to implement.” *Cleburne*, 473 U.S. at 441. Sex classifications, for example, are (quasi)-suspect because they often “reflect outmoded notions of the relative capabilities of men and women,” rather than real differences. *Id.* Same for racial classifications. *Murgia*, 427 U.S. at 313-14. Thus, to be “suspect,” a classification must single out a so-called “immutable” characteristic that has historically been the basis for deep discrimination. *See Lyng v. Castillo*, 477 U.S. 635, 638 (1986) (looking for (1) immutable characteristics that define (2) a discrete group, (3) historical discrimination, and (4) political powerlessness).

Transgender status does not check any of these boxes. For one, it is not “an immutable characteristic determined solely by the accident of birth.” *Frontiero*, 411 U.S. at 686. To the contrary, according to Plaintiffs, individuals identify as transgender when their internal perception of who they are departs from the immutable characteristic of their biological sex, a characteristic known since birth. Transgender identification necessarily takes place sometime *after* birth. And many individuals who identify as transgender alternate between gender identifications, be it non-binary, gender fluid, third gender, or their natal gender.<sup>23</sup> If a child can hop in and out of the category based on her “fluid” identity, it makes no sense to use the category for purposes of assessing equal protection under the law.

For similar reasons, transgender status hardly defines a “discrete group.” *Lyng*, 477 U.S. at 638. The term “transgender” can describe “a huge variety of gender identities and expressions,”<sup>24</sup> with recent estimates citing more than 80 types of gender identities that include “aliagender,” “bigender,” “demiboy,” “gender-fluid,” “maverique,” “non-binary,” “polygender,” and many others.<sup>25</sup> Transgender

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<sup>23</sup> See Littman, *Individuals Treated for Gender Dysphoria*, *supra*.

<sup>24</sup> WPATH SOC8, *supra*, at S15.

<sup>25</sup> Chris Drew, *81 Types of Genders & Gender Identities (A to Z List)*, HELPFULPROFESSOR.COM (Mar. 26, 2022), <https://perma.cc/SK4T-J5T4>.

individuals may also “embrace a fluidity of gender identity” or even an “unfixed gender identity.”<sup>26</sup>

Nor are transgender individuals a “politically powerless” group. *Rodriguez*, 411 U.S. at 28. To start, they are quite “unlike” those individuals who were long purposefully denied equal protection under the law due to their race, national origin, or sex. *Murgia*, 427 U.S. at 313-14 (rejecting age as suspect class because elderly persons have not faced discrimination “akin to [suspect] classifications”). To take just some recent examples, from his first day in office, President Biden has prioritized “Preventing and Combating Discrimination on the Basis of Gender Identity.” Exec. Order No. 13,988, 86 Fed. Reg. 7,023 (Jan. 20, 2021). Executive agencies have attempted to impose new gender-identity obligations on the States. *See, e.g., Tennessee v. Dep’t of Educ.*, 615 F. Supp. 3d 807, 838-39 (E.D. Tenn. 2022) (rejecting agency attempts to “go[] beyond the holding of *Bostock*”). And more than a dozen States have enacted laws expressly allowing pediatric gender-transition procedures that Texas law prohibits. *See L.W.*, 83 F.4th at 487. Plaintiffs here have the support of the Department of Justice, many (American) medical organizations, and prestigious law firms.

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<sup>26</sup> Human Rights Campaign, Glossary of Terms, *Gender Fluid*, <https://perma.cc/D4ND-7GEQ> .

State laws regulating gender-transition procedures are recent enactments by policymakers grappling with tough questions about how to protect children from the significant risks posed by still-novel medical interventions for gender dysphoria. To the extent a State’s regulation of those procedures requires focusing on gender-dysphoric youth, such a classification is a “sensible ground for different treatment,” not the sort of irrelevant grouping that warrants heightened scrutiny. *Cleburne*, 473 U.S. at 440.

States have taken varying approaches to these issues. Removing these “trying policy choices” from the “arena of public debate and legislative action” and placing them in the hands of the judiciary “is not how a constitutional democracy is supposed to work—or at least works best—when confronting evolving social norms.” *L.W.*, 83 F.4th at 486-87. Accordingly, “rational basis review applies to transgender-based classifications.” *Id.* at 419.

## **II. Texas’s Law Survives Any Level of Review.**

Even if heightened scrutiny applied, Texas’s law would pass muster. *See Eknes-Tucker*, 80 F.4th at 1235 (Brasher, J., concurring) (finding “exceedingly persuasive justification” for prohibiting pediatric gender-transition procedures).

### **A. Courts Should Defer to Legislatures in the Face of Medical Uncertainty.**

States have “wide discretion” to regulate “in areas where,” as here, “there is medical and scientific uncertainty.” *Gonzales*, 550 U.S. at 163; *accord Marshall v.*

*United States*, 414 U.S. 417, 427 (1974) (“When [a legislature] undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad.”). This deference applies even in cases involving heightened scrutiny. *Gonzales*, 550 U.S. at 163 (stating that “[t]his traditional rule is consistent with [*Planned Parenthood v. Casey*,” 505 U.S. 833 (1992), which involved heightened scrutiny])).

The reason for that is clear: The law requires deference to legislatures unless there are “clear, manageable, and politically neutral” standards for judicial intervention. *Cf. Rucho v. Com. Cause*, 139 S. Ct. 2484, 2498 (2019). Courts are not equipped to choose, as a constitutional matter, between the medical opinions of Plaintiffs’ witnesses and preferred interest groups (on one hand) and the medical opinions of Texas’s witnesses, half a dozen countries in Europe, and the U.S. Agency for Healthcare Research and Quality (on the other). That job is for the legislature. *See Eknes-Tucker*, 80 F.4th at 1235 (Brasher, J., concurring) (“Intermediate scrutiny permits the legislature to make a predictive judgment based on competing evidence.” (cleaned up)). And “the States are indeed engaged in thoughtful debates about the issue.” *L.W.*, 83 F.4th at 471 (citation omitted).

Accordingly, all Texas has to do to prevail even under heightened scrutiny is to show that there is a medical dispute on the issue at hand. It has done that. *See Tex. Br. 7-18*. The U.S. Agency for Healthcare Research and Quality itself admits that

there is uncertainty: “There is a lack of current evidence-based guidance for the care of children and adolescents who identify as transgender, particularly regarding the benefits and harms of pubertal suppression, medical affirmation with hormone therapy, and surgical affirmation.”<sup>27</sup>

Finland’s medical authority likewise concluded that, “[i]n light of available evidence, gender reassignment of minors is an experimental practice,” and “there are no medical treatment[s] that can be considered evidence-based.”<sup>28</sup> So did the United Kingdom’s National Health Service, which recently restricted gender-transition interventions to formal research settings after an independent medical review concluded that there is no evidentiary support for these interventions given the “lack of reliable comparative studies.”<sup>29</sup> Sweden’s National Board of Health and Welfare reached a similar conclusion, finding that “the risk of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh

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<sup>27</sup> AHRQ, *Topic Brief: Treatments for Gender Dysphoria in Transgender Youth* (Jan. 8, 2021), <https://perma.cc/23B5-D7C8>.

<sup>28</sup> *Recommendation of the Council for Choices in Health Care in Finland: Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors*, PALKO/COHERE Finland (2020), <https://perma.cc/VN38-67WT>.

<sup>29</sup> Nat’l Inst. for Health & Care Excellence, *Gender-affirming hormones for children and adolescents with gender dysphoria* (Mar. 11, 2021), <https://perma.cc/M8J5-MXVG> (“NICE Cross-Sex Hormone Review”); NICE Puberty Blocker Evidence Review, *supra*.

the possible benefits.”<sup>30</sup> And earlier this year, the Norwegian Healthcare Investigation Board (Ukom) found “insufficient evidence for the use of puberty blockers and cross sex hormone treatments in young people, especially for teenagers who are increasingly seeking health services.”<sup>31</sup> Thus, “Ukom defines such treatments as utprøvede behandling, or ‘treatments under trial,’”<sup>32</sup>—that is, experimental. Most recently, the World Health Organization recognized that “the evidence base for children and adolescents is limited and variable regarding the longer-term outcomes of gender affirming care for children and adolescents.”<sup>33</sup>

Federal courts of appeal recognize this uncertainty. *See Eknes-Tucker*, 80 F.4th at 1225 (noting that gender-transition drugs provided to minors have “uncertainty regarding benefits, recent surges in use,” “irreversible effects,” and “growing concern about the medications’ risks.” (citations omitted)); *L.W.*, 83 F.4th at 471 (gender-transition procedures for minors is “a vexing and novel topic of medical debate.”). In light of this uncertainty, Texas has “wide discretion” to restrict these

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<sup>30</sup> Sweden National Board of Health and Welfare Policy Statement, SOCIALSTYRELSEN, *Care of Children and Adolescents with Gender Dysphoria: Summary 3* (2022), <https://perma.cc/FDS5-BDF3>.

<sup>31</sup> Jennifer Block, *Norway’s Guidance on Paediatric Gender Treatment is Unsafe, Says Review*, THE BMJ (Mar. 23, 2023), <https://perma.cc/9FQF-MJJ9>.

<sup>32</sup> *Id.*

<sup>33</sup> World Health Org., *Frequently Asked Questions, WHO Dev. of a Guideline on the Health of Trans and Gender Diverse People* (Jan. 15, 2024), <https://perma.cc/P3TC-XUUK>.

interventions to protect the “health and welfare” of children.” *Dobbs*, 142 S. Ct. at 2284.

**B. Plaintiffs Erroneously Rely on American Medical Interest Groups That Are Biased Advocates, Not Neutral Experts.**

Plaintiffs omit any reference to the developments in European countries, which do not allow what Plaintiffs seek—gender transitioning interventions as a matter of general medical practice. Instead, European countries generally confine access to the procedures to formal research protocols befitting their experimental status. But while healthcare authorities in Europe have urged caution, American medical organizations advocate for unfettered access to transitioning treatments even as they admit more research is needed.<sup>34</sup>

In some ways, it is unsurprising that, until recent decisions by the Sixth and Eleventh Circuits, courts repeatedly deferred to these organizations. One would hope that medical societies like American Academy of Pediatrics (AAP), the Endocrine Society, and WPATH would be honest brokers, reviewing the evidence as Europe has done and responding accordingly. And one would hope that organizations like the American Medical Association—which has not published guidelines on this topic but supports the WPATH Standards—would use their institutional goodwill, built up over time, to be the voice of reason and prioritize the safety of children.

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<sup>34</sup> *E.g.*, Azeen Ghorayshi, *Medical Group Backs Youth Gender Treatments, but Calls for Research Review*, N.Y. TIMES (Aug. 3, 2023), <https://perma.cc/N3BJ-TB9J>.

Sadly, this has not happened. As with other institutions, American medical organizations have become increasingly “performative,” treated by their leaders as platforms for advancing the current moment’s cause célèbre.<sup>35</sup> Add to this a replication crisis in scientific literature and the ability of researchers to use statistics to make findings appear significant when they are not,<sup>36</sup> and it is no wonder that medical organizations find it easier to just go with the zeitgeist. (Not to mention that the American interest groups that endorse gender-transition procedures are just that—interest groups, with a strong financial interest in the procedures their members make a living by providing.) Science is *hard*, and there is no reward in the current climate for any organization that questions the safety and efficacy of using sterilizing gender-transition procedures on children.

Take AAP, for instance, which has “decried” “as transphobic” a resolution by its members discussing “the growing international skepticism of pediatric gender transition” and calling for a literature review.<sup>37</sup> Then, when AAP finally acknowledged that there are no systematic reviews supporting the treatments it recommends,

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<sup>35</sup> See generally Yuval Levin, *A Time to Build: From Family and Community to Congress and the Campus, How Recommitting to our Institutions Can Revive the American Dream* (2020).

<sup>36</sup> E.g., Andrew Gelman & Eric Loken, *The Statistical Crisis in Science*, 102 AMERICAN SCIENTIST 460, 460-65 (2014) (noting “statistical significance” can “be obtained even from pure noise” by various tricks of the trade).

<sup>37</sup> Julia Mason & Leor Sapir, *The American Academy of Pediatrics’ Dubious Transgender Science*, WALL ST. J. (Apr. 17, 2022).

the group promised to conduct one—while assuring it would continue to recommend the treatments while awaiting evidence of their safety and efficacy. As Dr. Gordon Guyatt, the father of evidence-based medicine, put it, that “puts the cart before the horse.”<sup>38</sup> AAP member Dr. Julia Mason concluded: “AAP has stifled debate” and “put its thumb on the scale ... in favor of a shoddy but politically correct research agenda.”<sup>39</sup>

Similar concerns have been raised about the Endocrine Society,<sup>40</sup> whose guidelines for treating gender dysphoria the *British Medical Journal* recently exposed as having “serious problems” because—remarkably—the “systematic reviews” the guidelines were based on “didn’t look at the effect of the interventions on gender dysphoria itself.”<sup>41</sup> The Endocrine Society knows that plaintiffs in cases like this one bandy about its Guidelines to justify the procedures its members profit from, yet the Guidelines themselves emphasize that they do not “establish a standard of care.”<sup>42</sup> One member of the Guidelines authoring committee acknowledged, when not testifying in court against the States, that the Endocrine Society did not even

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<sup>38</sup> Ghorayshi, *Medical Group Backs Youth Gender Treatments*, *supra*.

<sup>39</sup> Mason, *supra*.

<sup>40</sup> *E.g.*, Roy Eappen & Ian Kingsbury, *The Endocrine Society’s Dangerous Transgender Politicization*, WALL ST. J. (June 28, 2023).

<sup>41</sup> Jennifer Block, *Gender dysphoria in young people is rising—and so is professional disagreement*, THE BMJ (Feb. 23, 2023), <https://perma.cc/QKB6-5QCR>.

<sup>42</sup> Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLIN. ENDOCRINOL. METAB. 3869, 3895 (2017).

have “some little data”—it “had none”—to justify the language allowing prescription of cross-sex hormones prior to age 16, a change that gave “cover” to doctors to do so.<sup>43</sup>

Then there is WPATH, which at least confesses to being “an advocacy organization[.]” *Boe v. Marshall*, No. 2:22-cv-184-LCB (N.D. Ala.), ECF 208. Ample evidence shows just how true that is. In addition to advocating castration as “medically necessary gender-affirming care” for males whose “gender identity” is “eunuch,” WPATH recently removed most minimum-age requirements for gender-modification procedures from its Standards of Care.<sup>44</sup> According to the lead author of the chapter on children, WPATH did so to “bridge th[e] considerations” regarding the need for insurance coverage with the desire to ensure that doctors would not be held liable for malpractice if they deviated from the standards.<sup>45</sup>

WPATH has also suppressed dissent, including canceling the presentation of a prominent researcher who dared to question the safety of transitioning young children and censuring a board member who went public with concerns that medical providers in America are transitioning minors without proper safeguards.<sup>46</sup>

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<sup>43</sup> Joshua Safer, *State of the Art: Transgender Hormone Care* (Feb. 15, 2019), [https://www.youtube.com/watch?v=m7Xg9gZS\\_hg](https://www.youtube.com/watch?v=m7Xg9gZS_hg) (at 5:38-6:18).

<sup>44</sup> See SOC 8, *supra*, at S43-79.

<sup>45</sup> Videorecording of Dr. Tishelman’s WPATH presentation, <https://perma.cc/4M52-WG4X>.

<sup>46</sup> Emily Bazelon, *The Battle Over Gender Therapy*, N.Y. TIMES MAGAZINE (June 15, 2022), <https://perma.cc/ZMT2-W6DX>.

And just recently, WPATH’s leaders were successful in having a major scientific publishing house, Springer, retract a published paper that dared to examine the growing phenomenon of groups of adolescents suddenly “declar[ing] a transgender identity after extensive exposure to social media and peer influence.”<sup>47</sup> Indeed, WPATH has tried to cancel nearly every researcher that has studied “Rapid Onset Gender Dysphoria,” for the simple reason that, “[e]ven mentioning the possibility that trans identity is socially influenced or a phase threatens [its] claims that children can know early in life they have a permanent transgender identity and therefore that they should have broad access to permanent body-modifying and sterilizing procedures.”<sup>48</sup> More examples abound. *E.g.*, Amicus Br. of Family Research Council at 8-27.

There is, therefore, good reason for the Supreme Court’s observation that medical interest groups’ position statements do not “shed light on the meaning of the Constitution,” *Dobbs*, 142 S. Ct. at 2267, and the same goes for the Texas Constitution. The First and Fifth Circuits had it right when they found that “the WPATH Standards of Care reflect not consensus, but merely one side in a sharply contested medical debate.” *Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019); *see Kosilek v. Spencer*, 774 F.3d 63, 90 (1st Cir. 2014). While medical organizations are

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<sup>47</sup> Leor Sapir & Colin Wright, *Medical Journal’s False Consensus on “Gender-Affirming Care,”* WALL ST. J. (June 9, 2023).

<sup>48</sup> *Id.*

certainly capable of establishing true, evidence-based standards of care, they have utterly failed to act responsibly when it comes to pediatric gender-transition procedures. As a group of respected gender clinicians and researchers from Finland, the UK, Sweden, Norway, Belgium, France, Switzerland, and South Africa recently opined, “medical societies” in the United States should “align their recommendations with the best available evidence—rather than exaggerating the benefits and minimizing the risks.”<sup>49</sup> Until they do so, States like Texas are forced to step in to protect children.

## CONCLUSION

The Court should reverse.

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<sup>49</sup> Riitakerttu Kaltiala et al., *Youth Gender Transition Is Pushed Without Evidence*, WALL ST. J. (Jul. 14, 2023).

Dated: February 29, 2024

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## CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitations of Rule 9.4(i)(2)(B) of the Texas Rules of Appellate Procedure because it contains 6,036 words, excluding the parts of the brief exempted by Rule 9.4(i)(1). This brief complies with the typeface requirements of Rule 9.4(e) because it has been prepared in a conventional typeface using Microsoft Word in 14-point Times New Roman font.

Dated: February 29, 2024

/s/ Bethany S. Rothwell  
Bethany S. Rothwell  
Texas State Bar No. 24106455

## **CERTIFICATE OF SERVICE**

I certify that on February 29, 2024, the foregoing brief was filed and served on counsel of record through the electronic filing manager in accordance with Rule 9.5(b)(1) of the Texas Rules of Appellate Procedure.

/s/ Bethany S. Rothwell  
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Associated Case Party: Family Freedom Project

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### Associated Case Party: Spero Law LLC

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