No. 21-2875

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
No. 4:21-CV-00450 JM (Hon. James M. Moody, Jr.)

# Defendants-Appellants' Petition for Rehearing En Banc

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## RULE 35(b)(1) STATEMENT

This case is about the States' power to regulate the practice of medicine to protect children. As the national and international controversy surrounding the use of childhood gender-transition procedures grows, so does the evidence undermining the practice. Due to a lack of clear evidence of any benefit to mental health, along with permanent consequences like infertility, Arkansas judged it best to pause these experimental procedures while this debate is settled, and other states have since followed its lead. The district court preliminarily enjoined that sensible approach on multiple novel constitutional theories.

The panel affirmed on just one of them. It held that prohibiting childhood gender-transition procedures discriminates on the basis of sex because, on its account, it results in unequal treatment between boys and girls. That conclusion eschews traditional equal-protection principles, ignores the statute's text, and puts in jeopardy any regulation of gender-transition procedures whatsoever. It conflicts with the Supreme Court's most recent equal-protection holding in *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2281 (2022). And it rests on the mistaken belief that boys and girls are similarly situated with respect to hormonal treatments that can either promote or destroy healthy biology, depending on the sex of the patient.

This issue is not going away, and this Court should step in and correct the panel's erroneous decision.

## BACKGROUND

1. *Sex, gender, and gender dysphoria.* Clinicians treat sex and gender as distinct concepts. Sex is determined biologically by a person's DNA. App. 172-73; R. Doc. 45-1, at 15-16. Gender depends on "environmental" and "cultural factors." App. 789; R. Doc. 45-21, at 6. Gender discordance occurs when a person's gender does not correspond with their sex, and when coupled with "clinically significant distress," may lead to a "gender dysphoria" diagnosis. App. 180; R. Doc. 45-1, at 23. Until recently, childhood gender discordance has been very rare; over 99% of children's gender corresponds to their sex. App. 173; R. Doc. 45-1, at 16. And for the few children who did experience gender dysphoria, it usually "disappear[ed] before, or early in, puberty." App. 671-73; R. Doc. 45-19, at 16-18.

But recently, reported gender discordance has skyrocketed: The number of Americans self-identifying as transgender has tripled in just the last five years. App. 276-77; R. Doc. 45-2, at 6-7. And the transgender community looks different too. Previously, males with dysphoria outnumbered females 3 or 4 to one. Now, females outnumber males 7:1. App. 176; R. Doc. 45-1, at 19.

2. *Treatments for gender dysphoria.* Children with gender dysphoria may pursue three types of treatments: watchful waiting, psychotherapy, and affirmation. App. 189-99; R. Doc. 45-1, at 32-42. Watchful waiting and psychotherapy generally work together. *Id.* Though these treatments seek to alleviate distress, they avoid hormonal or surgical interventions, recognizing that most children with gender discordance grow out of it. App. 204; R. Doc. 45-1, at 47.

The third treatment, "affirmation therapy," is different. It encourages children to pursue a transgender identity—first socially (by adopting the clothing, pronouns, etc., associated with their transgender identity), then medically. App. 193-96; R. Doc. 45-1, at 36-39.

Medical interventions typically happen in three steps: puberty blockers, then cross-sex hormones, then surgeries. "Puberty blockers" are a class of drug that the FDA has approved to treat precocious puberty. App. 1033; R. Doc. 53-3, at 3. These drugs are not approved for use to halt a normally timed puberty, and there are significant health risks associated with using them for that purpose, including low bone density, abnormal brain maturation, and long-term sexual problems due to sex organs failing to properly mature. App. 411; R. Doc. 45-3, at 76; App. 24; R. Doc. 45-1, at 67. Children who get on this train rarely step back off. Up to 98% of children who go on puberty blockers will proceed to the next stop: cross-sex hormones. App. 1044; R. Doc. 55-3, at 14; App. 303; R. Doc. 45-2, at 33.

Hormonal treatments (testosterone for boys, estrogen for girls) are often used to treat medical conditions such as delayed puberty. App. 34, R. Doc. 1, at 34. Cross-sex hormones (estrogen for boys, testosterone for girls) are not FDA-approved for gender-transition or any other use. App. 291; R. Doc. 45-2, at 21; App. 1035-36; Doc. 55-3, at 5-6. And they have irreversible consequences, including:

- An increased risk of cancer, cardiovascular disease, thrombosis, liver disease, and hypertension, App. 407; R. Doc. 45-3, at 72;
- Permanent voice deepening in girls and permanent loss of muscle mass in boys, App. 225; R. Doc. 45-1 at 68; and
- Permanent sterilization, especially when following puberty blockers, App. 406; R. Doc. 45-3, at 71; App. 1035-36, 1044; R. Doc. 55-3, at 5-6, 14.

Finally, some minors pursue surgery, including mastectomies that that remove healthy breasts and permanently destroy breastfeeding capacity. App. 463, 470-73; R. Doc. 45-4, at 8, 15-18. Genital surgery is another option, which is obviously irreversible. *See* App. 895, 899; R. Doc. 45-27, at 2, 45-28, at 2.

The risks of gender reassignment procedures are high, and they don't appear to be outweighed by the benefits. Two U.K. studies recently showed that gender transition procedures did little to help mental health. App. 643-44; R. Doc. 45-17, at 6-7 (Tavistock clinical trial); App. 541; R. Doc. 45-9, at 13; App. 556; R. Doc.

45-10, at 14. (U.K. National Institute for Health and Care Excellence review). And a recent outcome study—the first long-term study conducted on gender-transition procedures—showed "a spike in suicide attempts" in the year after surgical transition. App. 582, 584; R. Doc. 45-13, at 3, 5. Thus, the best evidence we have is inconclusive at best, and, at worst, demonstrates mental-health harms.

Consistent with lacking evidence of benefits from gender transition, transitioners are often dissatisfied with the results; "[r]egret following transition is not an infrequent phenomenon." App. 230; R. Doc. 45-1, at 73. The record below contains the testimony of three individuals who transitioned as adults, regretted it, and eventually de-transitioned. App. 894-96; R. Doc. 45-27, at 1-3; App. 898-901; R. Doc. 45-28, at 1-4); App. 903-908; R. Doc. 45-29, at 1-6. The potential for regret is heightened for children, who have a reduced capacity to consider long-term consequences. *See* App. 307-09; R. Doc. 45-2, at 37-39 (discussing diminished decisional capacity). The specter of lifelong regret of hastily made decisions is exacerbated by the "patient-driven, on-demand" model practices in many of these gender transition practices. *See* App. 297-300; R. Doc. 45-2, at 27-30.

3. *The SAFE Act.* To mitigate any potential harm, medical institutions and governments are taking steps to limit transition procedures performed on children. *Cf.* App. 526-27; R. Doc. 45-8, at 1-2 (leading Swedish hospital); App. 514-17; R. Doc. 45-5, at 5-8 (Finnish medical institution). Arkansas responded with the

SAFE Act. *See* 2021 Ark. Act 626. That Act doesn't regulate adults' decision-making, and it encourages children with dysphoria to seek mental health care. But the General Assembly recognized that "[t]he risks of gender transition procedures far outweigh any benefit at this stage of clinical study." 2021 Ark. Act 626 sec. 2(15). So the Act presses pause on puberty blockers, cross-sex hormones, and surgery until evidence bears out their safety and efficacy. Ark. Code Ann. 20-9-1501(6)(A).

4. *Procedural history.* Plaintiffs sued, bringing three claims. First, they argued the SAFE Act should be subject to heightened scrutiny under the Equal Protection Clause on the theory that the Act discriminates based on sex and transgender status (a new quasi-suspect class Plaintiffs asked the district court to create). App. 41; R. Doc. 1, at 41. Second, the parents of the minor children claimed a fundamental substantive-due-process right to "seek and follow medical advice." *Id.* at 43. Third, they argued that doctors from referring patients for gender-transition procedures they cannot legally perform violates the doctors' First Amendment rights. *Id.* at 44-46.

Plaintiffs sought a preliminary injunction, which the district court granted from the bench after a brief hearing. *See* App. 1121-31; R. Doc. 60, at 58-68. It didn't discuss expert testimony, nor did it make factual findings about the disputed medical issues in the case. Instead, it simply declared that "the plaintiffs are likely

to succeed on the merits under any form of review." App. 129; R. Doc. 60, at 66. So it enjoined the SAFE Act in its entirety.

About two weeks later the district court entered a "Supplemental Order" fleshing out its bench ruling. It applied intermediate scrutiny to Plaintiffs' equal-protection claims and strict scrutiny to their fundamental-parental-rights claim and the doctors' First Amendment claim. This order too lacked any discussion of the hundreds of pages of expert materials and other evidence submitted in the case. Instead, the district court cited to an amicus brief filed by several medical trade groups, concluding from it that "[g]ender affirming treatment"—though not specifically the pharmaceutical and surgical interventions at issue here—"is supported by medical evidence that has been subject to rigorous study." ADD8. The compelling interests that drove the General Assembly to pass the SAFE Act were thus ignored.

Arkansas appealed the preliminary injunction, and a panel of this Court affirmed—but only on the basis of Plaintiffs' equal-protection theory. The panel held that the SAFE 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. It reasoned that "[a] minor born as a male may be prescribed testosterone or have breast tissue surgically removed, . . . but a minor born as a female" may not. *Id.* It handwaved away the lack of factual findings

supporting the district court's conclusion on intermediate scrutiny, opining that there was sufficient information in the record from which the district court could have found in favor of the Plaintiffs.

## ARGUMENT

### I. The panel's analysis conflicts with the Supreme Court's equal-protection precedents.

The Equal Protection Clause mandates "that all persons similarly situated . . . be treated alike." *Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985). But it does not require ignoring biological sex differences. To the contrary, the Supreme Court has recognized that doing so would make "the guarantee of equal protection superficial, and so disserv[e] it." *Tuan Anh Hguyen v. I.N.S.*, 533 U.S. 53, 73 (2001). Yet that is exactly what the panel did here.

#### A. The SAFE Act does not discriminate on the basis of sex.

The Supreme Court recently reaffirmed in *Dobbs* 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 (quoting *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974) (brackets omitted)). The panel eschewed this approach, instead creating a standard under which any regulations of gender-transition procedures will necessarily be subject to heightened scrutiny.

The Act is facially sex neutral. It prohibits "puberty blocking drugs, cross-sex hormones," and "gender reassignment surgery performed for the purpose of assisting an individual with a gender transition." Ark. Code Ann. 20-9-1501(6)(A).

Boys and girls are treated exactly alike under the statute. Both may be prescribed puberty blockers to treat precocious puberty, but not gender transition. The record below is silent as to any non-gender-transition purpose for which cross-sex hormones might be prescribed to children, but if there were such a treatment, boys and girls may equally access it. And both boys and girls may seek surgical intervention for any purpose save gender transition. There is no sex-based classification to be found.

Instead, to the extent the SAFE Act discriminates, it does so only based on age and procedure. It applies only to minors and not adults due to the General Assembly's determination that children are a particularly vulnerable population. And it targets gender-transition procedures because of their drastic and irreversible consequences and the paucity of scientific evidence establishing their efficacy. But these distinctions easily survive rational basis review.

The panel concluded otherwise only by ignoring both the text of the SAFE Act and biological reality. Under its misreading of the statute, "medical procedures that are permitted for a minor of one sex are prohibited for a minor of another sex." Op. 7. It reasoned that "a male may be prescribed testosterone" while a "female is not permitted to seek the same medical treatment." *Id.* The panel thus concluded that a "minor's sex . . . determines whether or not the minor can receive certain types of medical care." *Id.*

The panel's analysis is wrong at every turn. First, there is no "medical procedure[]" the Act proscribes for one sex yet allows for another. The panel's conclusion to the contrary rested on its stilted and illogical view of what constitutes a "medical procedure." On its telling, "prescribing testosterone" is one medical procedure, no matter the purpose of the treatment.

But that is just not how medicine works. One cannot separate the goal of a treatment from the mechanism a physician uses to achieve it. As Dr. Paul Hruz, a professor of pediatric endocrinology, explained, it is "inaccurate and misleading" to equate gender-transition procedures with traditional medical interventions simply because the same drug may be used. App. 360; R. Doc. 45-3, at 25. It is common sense that prescribing a boy testosterone for a few months to jumpstart a delayed puberty—with the goal being a healthy functioning endocrine system—is a different procedure than prescribing it to a girl for the rest of her life and destroying her otherwise healthy endocrine system. Because prescribing testosterone to a boy is a different procedure, with drastically different effects, than prescribing it to a girl, boys and girls receiving testosterone are not similarly situated for equal-protection purposes.

Second, the panel misread the SAFE Act to prohibit girls from being prescribed testosterone (or boys estrogen). Op. 7. On the contrary, the Act only prohibits prescribing cross-sex hormones for gender-transition purposes. *See* Ark.

Code Ann. 20-9-1501. If testosterone is medically indicated for some other purpose, that treatment is allowed under the Act. The Act does not draw a sex-based classification to determine "whether or not [a] minor can receive certain types of medical care." Op. 7. Rather, it prohibits *any* minors from receiving gender-transition procedures, regardless of the child's sex.

Finally, even if one accepts the panel's classification argument as to cross-sex hormones, it falls apart when applied to other gender-transition procedures. For example, GnRH analogues such as triptorelin are prescribed as puberty blockers to girls and boys alike. *See* App. 531; R. Doc. 45-9 at 3. Even accepting the panel's conception of "medical procedure," there is no difference in the statute's treatment of girls and boys. Both sexes can be prescribed puberty blockers for uses such as treating precocious puberty, and neither can receive them for gender transition. Yet the panel affirmed the district court's injunction even as it applied to puberty blockers.

The Court should grant review and hold that regulating gender-transition procedures does not discriminate based on sex.

B. The SAFE Act survives heightened scrutiny.

Even if the SAFE Act were subject to heightened scrutiny, it survives. The SAFE Act need only be substantially related to a sufficiently important government interest. *See United States v. Virginia*, 518 U.S. 515, 531 (1996). The panel

did not dispute Arkansas's compelling interest in protecting minors, *see Reno v. ACLU*, 521 U.S. 844, 869 (1997), and in promoting medical ethics, *see Gonzales v. Carhart*, 550 U.S. 124, 157 (2007). Nor that the State's power is at its zenith when acting to protect its most vulnerable citizens. *See Washington v. Glucksberg*, 521 U.S. 702, 731 (1997).

The SAFE Act's prohibition of childhood gender-transition procedures is substantially related to those interests because these procedures (1) risk irreversible damage to children; (2) lack evidentiary support as to their efficacy; and (3) may be unnecessary in light of the high likelihood that children's gender dysphoria will resolve itself by adulthood. The General Assembly made numerous findings on these points. *See* 2021 Ark. Act 626, sec. 2(8) (reviewing the risks associated with cross-sex hormones); sec. 2(6)(B) (noting a lack of evidence as to the risks and benefits of puberty blockers); sec. 2(7) (noting a lack of randomized trials on the efficacy or safety of cross-sex hormones); sec. 2(4) (noting that "studies consistently demonstrate that the majority" of children with gender discordance" come to identify with their biological sex in adolescence or adulthood, thereby rendering most physical interventions unnecessary").

And courts ordinarily must "defer to the judgments of legislature" on how best to regulate "areas fraught with medical and scientific uncertainties." *Dobbs*,

142 S. Ct. at 2268 (cleaned up); *Gonzales*, 550 U.S. at 157 (States have "a significant role to play in regulating the medical profession"). Both the district court and the panel gave Arkansas's judgment short shrift.

For one, they failed to even consider the General Assembly's understanding of the evidence. The State presented voluminous expert-witness material to the district court matching exactly what the legislature found. Yet to enjoin the statute, the district court relied solely on an amicus brief submitted by self-interested gender-transition practitioners. *See* ADD8 & nn.4-5. But the Supreme Court has never required states—nor permitted courts—to blindly defer to the judgments of advocacy organizations like the amici in this case. *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").

The panel doubled down on that erroneous approach by imputing to the district court factual findings that it never made and then purporting to defer to them on clear-error review. The panel misconstrues a stray comment by the district court, recognizing that "experts in other sides of this case don't agree," as weighing the evidence presented to it. Op. 8 (citing App. 1102). But at most, this shows that the district court recognized a disagreement between the experts. It did not purport to resolve those disagreements. Instead, the district court simply cited the

practitioners' amicus for the proposition that "[g]ender-affirming treatment is supported by medical evidence that has been subject to rigorous study." Op. 8; ADD8-9 & n5. That deferral cannot count a factual finding based on evidence presented.

The panel ought to have vacated the injunction instead of excusing the district court's failure. Instead, it stepped into the shoes of the district court and engaged in its own factfinding mission on appeal. Cherry-picking a couple of the numerous points of evidentiary disagreement the district court ignored, the panel concluded that "substantial evidence supports" the conclusion the district court eventually reached. Op. 9. But when a preliminary-injunction record is bereft of necessary factual findings, this Court must "vacate the preliminary injunction and remand for further proceedings" rather than make its own findings. *Planned Parenthood of Ark. & E. Okla. v. Jegley*, 864 F.3d 953, 957 (8th Cir. 2017).

## II. The Court should take this case en banc now rather than waiting until after trial.

Trial in this matter is set to begin on October 17, 2022. That should not dissuade the Court from granting en banc review.

First, given the time required to draft post-trial briefing and an opinion, this Court will have plenty of time to consider the legal issues raised in this appeal before the preliminary injunction becomes moot.

Second, granting review at this stage will avoid future piecemeal litigation. If the panel opinion stands, its conclusion that the SAFE Act discriminates on the basis of sex and is therefore subject to heightened scrutiny is law of the case on remand. *See Howe v. Varity Corp.*, 36 F.3d 746, 752 (8th Cir. 1994). It would be unnecessary and, in light of principles of constitutional avoidance, inappropriate for the district court to further consider Plaintiffs' quasi-suspect class and fundamental-parental-rights claims. So a reversal after the bench trial would require a second trial to resolve those claims, unless the Court grants en banc review now and passes upon those legal issues.

## CONCLUSION

For these reasons, this petition should be granted.

Respectfully submitted,

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## CERTIFICATE OF COMPLIANCE

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

*/s/ Dylan L. Jacobs*
Dylan L. Jacobs

## CERTIFICATE OF SERVICE

I certify that on October 6, 2022, 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/ Dylan L. Jacobs*
Dylan L. Jacobs