

United States Court of Appeals for the Eighth Circuit

DYLAN BRANDT, ET AL.,
PLAINTIFFS-APPELLEES,

v.

LESLIE RUTLEDGE, ET AL.,
DEFENDANTS-APPELLANTS.

*APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF ARKANSAS,
NO. 21-CV-450, HON. JAMES M. MOODY, JR., PRESIDING*

**BRIEF OF FAMILY RESEARCH COUNCIL
AS *AMICUS CURIAE* SUPPORTING
REHEARING EN BANC**

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CORPORATE DISCLOSURE STATEMENT

The Family Research Council is a nonprofit corporation that does not have a parent corporation and is not publicly held.

TABLE OF CONTENTS

	Page
Corporate Disclosure Statement	i
Table of Authorities	iii
Interest of <i>Amicus Curiae</i>	1
Introduction	2
Argument.....	6
I. Constitutional law should not be outsourced to medical interest groups.	6
II. “Robust” evidence does not support sterilizing interventions in children.	10
Conclusion	13

TABLE OF AUTHORITIES

	Page(s)
CASES	
<i>Dep’t of Com. v. New York</i> , 139 S. Ct. 2551 (2019)	6
<i>Dobbs v. Jackson Women’s Health Org.</i> , 142 S. Ct. 2228 (2022)	6
<i>Gibson v. Collier</i> , 920 F.3d 212 (5th Cir. 2019).....	7
<i>Gonzales v. Carhart</i> , 550 U.S. 124 (2007)	6
<i>Marshall v. United States</i> , 414 U.S. 417 (1974).....	11
<i>Wilk v. AMA</i> , 895 F.2d 352 (7th Cir. 1990).....	7
OTHER AUTHORITIES	
Abigail Shrier, <i>Top Trans Doctors Blow the Whistle on ‘Sloppy’ Care</i> , Common Sense (Oct. 4, 2021), https://bariweiss.substack.com/p/top-trans-doctors-blow-thewhistle	8
Adam Cohen, <i>Imbeciles</i> (2016)	7
Anna I.R. van der Miesen, <i>Psychological Functioning in Transgender Adolescents</i> , 66 J. Adolescent Health 669 (2020)	13
Annelou L.C. de Vries, <i>Challenges in Timing Puberty Suppression for Gender-Nonconforming Adolescents</i> , 146 Pediatrics e2020010611 (2020), https://doi.org/10.1542/peds.2020-010611	12
Annelou L.C. de Vries, <i>Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment</i> , 134 Pediatrics 698 (2014), https://doi.org/10.1542/peds.2013-2958	12
Azeen Ghorayshi, <i>More Trans Teens Are Choosing ‘Top Surgery,’</i> N.Y. Times (Sept. 26, 2022), https://www.nytimes.com/2022/09/26/health/top-surgery-transgender-teenagers.html	8, 9
Christina Buttons, <i>WPATH Explains Why They Removed Minimum Age Guidelines</i> , The Daily Wire (Sept. 19, 2022), https://bit.ly/3SmHGjf	8
<i>Correction</i> , 23 Int’l J. of Transgender Health S259 (2022), https://bit.ly/3qSqC9b	8

E. Coleman, *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int’l J. of Transgender Health (2022),
<https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644>..... 4, 11

Federalist No. 106

Julia Mason & Leor Sapir, *The American Academy of Pediatrics ‘ Dubious Transgender Science*, Wall Street Journal (Aug. 17, 2022), <https://on.wsj.com/3BzOuTZ>10

Kaylee White, *Follow the money*, Washington Examiner (Sept. 20, 2022),
<https://tinyurl.com/3jkmvn9r>.....9

Medicine and gender transidentity in children and adolescents (Feb. 2022).4

Michael Biggs, *The Dutch Protocol for Juvenile Transsexuals*, J. Sex & Marital Therapy (2022), <https://bit.ly/3DIUNY3>.....12

Risk of pseudotumor cerebri added to labeling, AAP (July 1, 2022), <https://bit.ly/3xL6KbJ>11

Socialstyrelsen, *Care of children and adolescents with gender dysphoria* (Feb. 2022)..... 3, 11

Stephen Levine, *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, J. Sex & Marital Therapy (Mar. 2022),
<https://www.tandfonline.com/doi/pdf/10.1080/0092623X.2022.2046221>5

Vinay Prasad & Adam Cifu, *Medical Reversal*, 84 Yale J. Biology & Med. 471 (2011).....7

INTEREST OF *AMICUS CURIAE*

Family Research Council (FRC) is a nonprofit research and educational organization that seeks to advance faith, family, and freedom in public policy from a biblical worldview. FRC recognizes and respects the dignity of every human life, which entails protection of the vulnerable.¹

¹ No party's counsel authored this brief. No party or party's counsel, or person other than *amicus* or its counsel, contributed money to prepare or submit this brief.

INTRODUCTION

In enjoining Arkansas’s SAFE Act, which would protect children from sterilizing gender transition drugs and surgeries, the district court relied on claims by the American Academy of Pediatrics, the American Medical Association, the World Professional Association for Transgender Health, and other interest groups (collectively, “AAP”) that “[a] robust body of scientific evidence supports the efficacy of” these interventions for “young people.” R. Doc. 23, at 12. AAP repeatedly made this claim, touting a “robust consensus” and a “robust body of empirical evidence.” *Id.* at 3, 13; *see id.* at 4, 8, 9, 20. This claim became the foundation of the district court’s scrutiny, which cited a single source—AAP’s brief—to come to the remarkable conclusion that “the *only* effective treatment for individuals at risk of or suffering from gender dysphoria is to provide” sterilizing interventions. R. Doc. 64, at 6 (emphasis added). This conclusion, in turn, became the primary “factual finding” that the panel relied on, echoing the district court’s statement (from AAP) that sterilizing transition interventions are “supported by medical evidence that has been subject to rigorous study.” Op. 8.

But AAP’s claim of robust evidence has always been false. How do we know? Because after the State and its *amici* showed here that nearly everyone—other than ideologically-captured American medical interest groups—recognizes the paucity of reliable evidence about sterilizing interventions in minors, AAP quietly deleted

every claim about a “robust body of empirical evidence” from its brief to this Court. Then AAP refused repeated invitations to explain its about-face, instead retreating to meaningless and still-incorrect claims about “a growing body of evidence that indicates the efficacy of” sterilizing children. 8th Cir. Br. 24. AAP’s “growing body” is a handful of slipshod studies that failed to control for relevant variables or to reach statistically or clinically significant results. Regardless, AAP has implicitly conceded that the district court’s AAP-derived conclusion—that a robust body of empirical studies proves that sterilizing interventions are the “only” treatment for gender dysphoria in children—is wrong.

So what does the science actually tell us about using sterilizing interventions on children to transition their gender? To the extent that the available evidence allows any conclusions, official medical authorities—not private interest groups with financial and ideological commitments—have concluded that “[f]or adolescents with gender incongruence,” “the risks of puberty suppressing treatment with [blockers] and gender-affirming hormonal treatment currently outweigh the possible benefits.” Socialstyrelsen, *Care of children and adolescents with gender dysphoria*, 3 (Feb. 2022) (Sweden). England’s National Health Service concluded that there is “limited evidence for the effectiveness and safety of gender-affirming hormones in children and adolescents” and the “long-term safety profile” is “largely unknown.” R. Doc. 45-10, at 50. France’s Académie Nationale de Médecine likewise concluded

that research “is still too rare” and “great medical caution must be taken.”² Finland, Australia, and New Zealand agree. WPATH’s own new Standards of Care, which nonetheless approve chest and genital *surgeries* to transition children regardless of age, say that because “the number of studies” about adolescent treatment “is still low,” “a systematic review regarding outcomes of treatment in adolescents is not possible.”³

The reason to wait for medical interventions—and the reason that the SAFE Act passes any level of scrutiny—is that the consequences of “gender-affirming care” for a minor are drastic. Children who take puberty blockers then cross-sex hormones—the near-universal transitioning pathway—“are expected to become sterile.” R. Doc. 45-3, at 76 (cleaned up). As a result of the district court’s injunction, Arkansas children will be permanently prevented from engaging in intimate relationships, having children of their own, and being able to care for their children.

AAP waves all this away as solvable by consent. Putting aside the impossibility of asking an eleven-year-old girl in psychological pain to meaningfully consent to giving away her reproductive abilities, AAP would not tell the truth about medical knowledge in this case. R. Doc. 23, at 12 (“robust body of scientific evidence”). Why

² *Medicine and gender transidentity in children and adolescents* (Feb. 2022).

³ E. Coleman, *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 *Int’l J. of Transgender Health* S1, S46 (2022), <https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644>.

should anyone expect its doctors—with financial stakes and subject to AAP’s oversight—to tell a little girl and her family what the AAP will not even say in court? As one recent article explained, “the implications of administering a treatment with irreversible, life-changing consequences based on evidence that has an official designation of ‘very low certainty’” are “rarely discussed with the patients,” much less the “risks to fertility, bone, and cardiovascular health.”⁴

That’s why Arkansas had to act: to protect girls and boys from a medical establishment more interested in profit and ideology than the needs of children. Children should not face a lifetime of personal devastation so that AAP can satisfy its self-serving agenda. Given the building evidence of harms to children, combined with the lack of any long-term studies demonstrating the safety and effectiveness of these sterilizing interventions, the SAFE Act is necessary to protect children. This Court should grant rehearing en banc.

⁴ Stephen Levine, *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, J. Sex & Marital Therapy, 4, 7 (Mar. 2022), <https://www.tandfonline.com/doi/pdf/10.1080/0092623X.2022.2046221>.

ARGUMENT

I. Constitutional law should not be outsourced to medical interest groups.

In most areas of the law, courts properly recognize that interest groups with financial stakes in litigation may push a self-interested legal view. *Cf.* Federalist No. 10 (Madison). Such groups can advocate for their positions, but courts “are not required to exhibit a naiveté from which ordinary citizens are free” when it comes to self-interested advocacy. *Dep’t of Com. v. New York*, 139 S. Ct. 2551, 2575 (2019). Yet some courts treat (certain) medical groups differently, letting them drive constitutional interpretation despite ideological and self-interested motivations.

The district court, for example, did not make factual findings based on testimony received, but instead deferred to AAP’s amicus brief—which, as noted, was rife with falsities. The panel purported to “defer” to this finding, which was not a finding at all, but a permission slip for select medical interest groups to preempt the People when it comes to self-government. But “[t]he law need not give [physicians] unfettered choice in the course of their medical practice,” *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). The district court’s approach contradicts our constitutional system. *Cf. id.* at 165 (“The Court retains an independent constitutional duty to review factual findings where constitutional rights are at stake.”); *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2267 (2022) (“[T]he position of the

American Medical Association” does not “shed light on the meaning of the Constitution.” (cleaned up)).

As a historical matter, medical interest groups are hardly paragons of truth or virtue. Not so long ago, for instance, “[t]he most important elite advocating eugenic sterilization was the medical establishment”; “every article on the subject of eugenic sterilization published in a medical journal between 1899 and 1912 endorsed the practice.”⁵ Other examples abound: racist medical experimentation, lobotomies, opioids, thalidomide, and smoking. The AMA’s “systematic, long-term wrongdoing” have led courts to “doubt[] the AMA’s genuineness regarding its concern for scientific method.” *Wilk v. AMA*, 895 F.2d 352, 363, 366 (7th Cir. 1990). Even apart from nefarious motives, the nature of science is that it changes; certainty on any issue—especially an emerging one—risks future contradiction.⁶

Skepticism is even more appropriate here. WPATH’s vaunted Standards of Care—which just substantially changed—“reflect not consensus, but merely one side in a sharply contested medical debate.” *Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019). Dr. Stephen Levine, who authored an early version of WPATH’s guidelines, said “that later versions of WPATH were driven by political considerations” and “conflict” with “scientific” evidence. *Id.* at 222. WPATH’s president

⁵ Adam Cohen, *Imbeciles* 66 (2016).

⁶ Vinay Prasad & Adam Cifu, *Medical Reversal*, 84 *Yale J. Biology & Med.* 471, 472 (2011) (collecting examples).

agreed that WPATH “tr[ie]d to keep out anyone who doesn’t absolutely buy the party line,” leaving “no room for dissent.”⁷

Thus, no one could have been surprised that a mere nine days after WPATH published the latest iteration of its sacred Standards of Care—years in the making—it issued a “correction” eliminating minimum ages for transition surgeries, including genital surgeries.⁸ One author admitted that a “challenge[.]” for the adolescent guidelines “is limited research,” but justified the “correction” because WPATH does not want to “make it more likely that practitioners would be sued” for “malpractice” by devastated children.⁹ Plus, according to WPATH’s president, to “propose” surgeries at defined “younger age[s]” would require “a better political climate.”¹⁰ *Contra* 8th Cir. AAP Br. 15 (WPATH’s Standards “are the product of careful and robust deliberation” “based on the best available scientific evidence”).

Of course, ideology and lawsuits are not the only explanations for WPATH’s child genital surgery backtracking. As a doctor in Vanderbilt’s transition clinic bragged, the hospital started the clinic after being convinced that it would be a “big

⁷ Abigail Shrier, *Top Trans Doctors Blow the Whistle on ‘Sloppy’ Care*, Common Sense (Oct. 4, 2021), <https://bariweiss.substack.com/p/top-trans-doctors-blow-the-whistle>.

⁸ *Correction*, 23 Int’l J. of Transgender Health S259 (2022), <https://bit.ly/3qSqC9b>.

⁹ Christina Buttons, *WPATH Explains Why They Removed Minimum Age Guidelines*, The Daily Wire (Sept. 19, 2022), <https://bit.ly/3SmHGjf>.

¹⁰ Azeen Ghorayshi, *More Trans Teens Are Choosing ‘Top Surgery,’* N.Y. Times (Sept. 26, 2022), <https://www.nytimes.com/2022/09/26/health/top-surgery-transgender-teenagers.html>.

money maker”: hormone interventions “bring[] in several thousand dollars,” while “top” surgeries “bring in” \$40,000, and “female to male bottom surgeries are *huge* money makers” (\$100,000) because they are so “labor-intensive” and “require a lot of follow-up.”¹¹ Why bother with the difficult work of addressing underlying mental health issues through psychosocial support—an approach that many countries mandate but AAP assures “is not recommended” (8th Cir. Br. 27)—when profitable genital surgeries on vulnerable children without threat of lawsuits await?

Thus, notwithstanding the restrictions of previous “standards,” prominent surgeons routinely perform transition surgeries on children as young as 13, falsely dismissing stories like the following from a young woman in Maryland (published in the *New York Times*) as “hoax[es]”: “I realized I lost something about myself that I could have loved, I could have enjoyed, I could have used to feed children.”¹²

As for AAP, its briefs here and in the district court contradict its own policy statement, as *amicus* showed. Even that policy statement is defective. As one researcher meticulously explained, the few “references that AAP cited as the basis of their policy instead outright contradicted that policy,” and AAP “left out” “the actual outcomes [of] research on [gender dysphoric] children”—disregarding 10 of 11

¹¹ Kaylee White, *Follow the money*, Washington Examiner (Sept. 20, 2022), <https://tinyurl.com/3jkmvn9r> (video).

¹² Ghorayshi, *supra* note 10.

existing studies.¹³ “[A]ny assertion that [AAP’s] policy is based on evidence is demonstrably false.”¹⁴

AAP has never responded to this article. Its tactic instead has been to silence dissenting voices and pretend that its “robust consensus” is real. To that end, AAP recently refused to allow the Society for Evidence-Based Gender Medicine to present contrary evidence at its conference. AAP suppressed a resolution calling for more discussion of alternatives to the use of hormone therapies and made up a new policy to shut down comments on a similar resolution this year.¹⁵ Meanwhile, it continues to publish facially flawed studies in its flagship journal.¹⁶

For all these reasons, skepticism is warranted of AAP’s sweeping claims. Instead, the district court elevated AAP’s claims to law. This Court should not subordinate a State’s ability to protect children to the false statements of certain medical interest groups.

II. “Robust” evidence does not support sterilizing interventions in children.

The district court credited AAP’s claim that a “robust body of scientific evidence” shows that childhood sterilizing interventions lead to “improvements” in

¹³ R. Doc. 45-14, at 1.

¹⁴ *Id.* at 1–2, 6.

¹⁵ Julia Mason & Leor Sapir, *The American Academy of Pediatrics’ Dubious Transgender Science*, Wall Street Journal (Aug. 17, 2022), <https://on.wsj.com/3BzOuTZ>.

¹⁶ *Id.*

“overall well-being.” R. Doc. 23, at 12. The only source cited was an opinion piece by a recent college graduate, cited by AAP nine times. AAP’s claims of a “robust consensus” and “body of scientific evidence” have always been false. If anything, as Sweden recently found and many countries have agreed, “the risks” “currently outweigh the possible benefits.” Socialstyrelsen, *supra*, at 3. To the extent any consensus exists, it is on that point. The evidence keeps building: the FDA, for instance, just added another warning to the drugs used as puberty blockers, noting occurrences of severe brain swelling.¹⁷ At a minimum, the science is simply unsettled; and when a State “undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad.” *Marshall v. United States*, 414 U.S. 417, 427 (1974).

AAP’s “robust” consensus for the opposite position—that sterilizing interventions are the “only” treatment for children—is nonexistent. Even WPATH’s just-published Standards emphasize that “the long-term effects of gender-affirming treatments initiated in adolescence are not fully known,” and “[t]he potential neurodevelopmental impact of extended pubertal suppression” “need[s]” “study.”¹⁸ WPATH’s ideological (and financial) decision to sanction these interventions anyway does not change that AAP’s own conspirators agree on the dearth of evidence.

¹⁷ *Risk of pseudotumor cerebri added to labeling*, AAP (July 1, 2022), <https://bit.ly/3xL6KbJ>.

¹⁸ Coleman, *supra* note 3, at S46, S65.

AAP’s primary claim about the benefits of sterilizing interventions can be traced to two Dutch studies whose results have never been successfully replicated. *E.g.*, R. Doc. 23, at 14 n.54; 8th Cir. Br. 20–21. The 2014 study looked at a mere 55 people, drawn with self-selection problems from an initial group of nearly 200 that was concededly “different from the transgender youth in community samples” and omitted one patient who died after genital surgery.¹⁹ The study found that gender dysphoria and “body image difficulties” were *worse* after puberty blockers.²⁰ And the study’s lead author said its protocol may not be relevant to the more recent wave of girls who present as adolescents with gender dysphoria, a “new developmental pathway.”²¹

Yet another instance of AAP’s deception can be seen in its reliance on a study that it cited as an example finding “long-term positive outcomes for transgender people who have undergone puberty suppression.” R. Doc. 23, at 14 & n.54. The study expressly rejected AAP’s characterization, stating that it does “not provide

¹⁹ Annelou L.C. de Vries, *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 *Pediatrics* 698, 702 (2014), <https://doi.org/10.1542/peds.2013-2958>; see Michael Biggs, *The Dutch Protocol for Juvenile Transsexuals*, *J. Sex & Marital Therapy* (2022), <https://bit.ly/3DIUNY3>.

²⁰ de Vries, *supra* note 19, at 699, Tbl. 1.

²¹ Annelou L.C. de Vries, *Challenges in Timing Puberty Suppression for Gender-Nonconforming Adolescents*, 146 *Pediatrics* e2020010611 (2020), <https://doi.org/10.1542/peds.2020-010611>.

evidence about the direct benefits of puberty suppression over time and long-term mental health outcomes.”²²

The evidence is not settled or robust. It does not support using aggressive interventions to transition children. But AAP is pushing practitioners to sterilize children anyway with “huge money maker” interventions. That’s why the SAFE Act passes any level of scrutiny.

CONCLUSION

Rehearing en banc is necessary.

Respectfully submitted,

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²² Anna I.R. van der Miesen, *Psychological Functioning in Transgender Adolescents*, 66 J. Adolescent Health 669, 703 (2020).

CERTIFICATE OF COMPLIANCE

1. This document complies with the type-volume limit of Fed. R. App. P. 29(b)(4) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), this brief contains 2,600 words.

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Dated: October 11, 2022

/s Christopher Mills
Christopher Mills

CERTIFICATE OF SERVICE

I, Christopher Mills, an attorney, certify that on this day a copy of the foregoing Brief was served on all parties via this Court's CM/ECF system.

Dated: October 11, 2022

s/ Christopher Mills
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