IN THE CIRCUIT COURT OF COLE COUNTY, MISSOURI

EMILY NOE, individually and as next friend and on behalf of her minor child, NICHOLAS NOE, et al.,	)	
Plaintiffs,	)	Case No. 23AC-CC04530
v.	)	
MICHAEL L. PARSON, in his official capacity as Governor for the State of Missouri, et al.,	)	
Defendants.	)	

JUDGMENT

FINDINGS OF FACT AND CONCLUSIONS OF LAW

From September 23, 2024 through October 3, 2024, the Court held a nine-day bench trial. The parties were represented by counsel of record. After trial, the Court directed the parties, in lieu of closing arguments, to submit proposed findings of fact and conclusions of law. The Court has now received these filings.

Plaintiffs bring a facial challenge to the constitutionality of several provisions of Missouri's SB 49, the Save Adolescents from Experimentation (SAFE) Act. As relevant here, the Act restricts the ability of medical practitioners to perform gender transition surgeries on minors and to use puberty-blocking drugs or cross sex hormones "for the purpose of a gender transition for any individual under eighteen years of age." RSMo § 191.1720.3-4. Individuals obtaining these services before August 28, 2023, are grandfathered in. The restriction on the ability of medical practitioners to prescribe puberty blocking drugs or cross-sex hormones "for the purpose of a gender transition for any individual under eighteen years of age" is temporary; it expires on August

28, 2027. The Act also codifies a preexisting policy of not using State Medicaid funds to pay for any gender transition procedures. RSMo § 208.152.15.

Duly informed, this Court denies all of the Plaintiffs' prayers for relief. The contested statutes deal with state prohibitions for gender-affirming medical treatments for adolescents and children, essentially puberty blockers, cross sex hormones, and sex change surgeries. The United States Supreme Court holds that when legislatures deal with areas "fraught with medical and scientific uncertainties, legislative options must be especially broad". *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). This is true even assuming, for the sake of argument, that judges with more direct exposure to the problem might make wiser decisions. *Marshall v. United States*, 414. U.S. 417, 427 (1974). In reviewing the constitutionality of such a statute, a trial court's review is directed by the United States Supreme Court as follows:

> "A statute is presumed constitutional, and the burden is on the one attacking the legislative arrangement to negative every conceivable basis which might support it, whether or not the basis has a foundation in the record. Finally, courts are compelled under rational-basis review to accept a legislature's generalizations even when there is an imperfect fit between means and ends. A classification does not fail rational-basis review because it is not made with mathematical nicety or because in practice it results in some inequality. The problems of government are practical ones and may justify, if they do not require, rough accommodations---illogical, it may be and unscientific."

Heller v. Doe, 509 U.S. 312, 320-21 (1993) (internal citations omitted).

There are other reasons this Court is required to deny the plaintiffs' prayers for relief. This Court finds an almost total lack of consensus as to the medical ethics of adolescent gender dysphoria treatment. The evidence at trial showed severe disagreement as to whether adolescent gender dysphoria drug and surgical treatment was ethical at all, and if so, what amount of treatment was ethically allowable. States do have abiding interest in protecting the integrity and ethics of the medical profession. *Wash. v. Glucksberg*, 521 U.S. 702, 731 (1997).

The evidence from trial showed that the medical ethics of gender dysphoria treatment for children and adolescents are entirely unsettled. One example of the many confused medical ethics issues described at trial runs like this: Gender dysphoria is classified as a mental disorder. Generally, western medicine treats mental disorders by actually treating the mental aspect, like prescribing Zoloft to treat depression. However, the gender dysphoria treatment prohibited by Missouri uses drugs and surgeries to either inhibit normal healthy human growth or surgically remove and replace healthy human organs. Such an approach to treatment is well outside normal medicine, and medical ethicists are unable to agree on the propriety thereof.

Furthermore, the credible evidence shows that a vast majority of children who are diagnosed with gender dysphoria outgrow the condition. The Endocrine Society guidelines state that approximately 85% of gender dysphoria-diagnosed prepubertal children did not remain gender incongruent later in life. The Diagnostic and Statistical Manual holds that around 98% of these children do not remain gender incongruent. Essentially, it seems that all of this untested, non-emergency, possibly unethical, possibly unnecessary care would be performed on children and adolescents when the vast majority of minors would simply outgrow the condition by the time they reach adulthood. A legislature may prohibit medical treatment for ethical concerns if the medical treatment is shown to be "fundamentally incompatible with the physician's role as healer," or "blurs the time-honored line between healing and harming". *Glucksberg*, 521 U.S. at 731.

As the Missouri Supreme Court has repeatedly declared, "*every* law is entitled to a presumption of constitutional validity." *City of Aurora v. Spectra Comme'ns Grp., LLC*, 592 S.W.3d 764, 780 (Mo. banc 2019) (emphasis added). To prevail, Plaintiffs must establish that the statute "clearly and undoubtedly violates a constitutional provision." *Interest of E.G.*, 683 S.W.3d 261, 265 (Mo. banc 2024) (quoting *State v. Meacham*, 470 S.W.3d 744, 746 (Mo. banc 2015)).

The Plaintiffs' evidence does not satisfy this necessary burden. The plaintiffs argue that the restricted interventions are necessary to treat the mental health condition of gender dysphoria. But as Plaintiffs' experts conceded, there is a substantial medical dispute about the causes and treatments of gender dysphoria. Indeed, the medical dispute has become more fractured in the last year, with even more medical authorities questioning the evidence for these interventions.

As to causes, Plaintiffs' experts acknowledged that they cannot pinpoint why the number of individuals with gender dysphoria has skyrocketed over the last decade, nor why the demographics have shifted markedly. Historically, onset of gender dysphoria occurred in childhood, before puberty. But now most individuals presenting with gender dysphoria did not experience onset until *after* puberty. Also, historically, most individuals presenting with gender dysphoria were born biologically male (referred to as natal males). But now, individuals born biologically female (natal females) outnumber natal males among individuals now presenting with gender dysphoria by as much as 3:1 or 4:1. Explanations for these changes are not well studied and remain poorly understood, but the Endocrine Society and international medical researchers have expressed concern that interventions may in fact be *causing* the skyrocketing rates of gender dysphoria.

As to treatments, there is likewise a medical dispute. The highest quality study in evidence-based medicine is the "systematic review." Every systematic review to assess these interventions has concluded that there is no good evidence that they are safe or effective. Both Plaintiffs' experts and Defendants' experts agree that a 400-page report commissioned by England's National Health Service has concluded that these interventions rest on "remarkably weak evidence." Ex. 1005, Cass Review, at 13. Plaintiffs' experts proffered studies that they believe allow them to infer a different conclusion, but they admitted that there is international medical disagreement on this

issue. In fact, both the U.S. Department of Health and Human Services and the World Health Organization have concluded that there is a lack of good evidence supporting the use of puberty blockers, cross-sex hormones or surgeries. Indeed, as Plaintiffs' side acknowledged during trial, a majority of U.S. states have now passed laws restricting these interventions in minors.

These points conclusively direct the outcome of this case. Critically, Plaintiffs made the strategic decision to bring a facial challenge to the entirety of several provisions, meaning they must establish that "*no set of circumstances* exists under which the [provisions] would be valid." *Donaldson v. Missouri State Bd. of Registration for the Healing Arts*, 615 S.W.3d 57, 66 (Mo. banc 2020) (emphasis added). They chose not to seek an as-applied exception, a carve-out exception, to the regulation. The Constitution does not permit a single judge to nullify the results of democratically enacted legislation where, as here, there is a medical dispute about the safety or efficacy of those interventions. *E.g., L. W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 472 (6th Cir. 2023) ("Prohibiting citizens and legislatures from offering their perspectives on high-stakes medical policies, in which compassion for the child points in both directions, is not something life-tenured federal judges should do without a clear warrant in the Constitution."). Accordingly, the Court now concludes that it must defer to the legislature "in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007); *see also Kansas v. Hendricks*, 521 U.S. 346, 360 n.3 (1997) (same).

FINDINGS OF FACT

I. MISSOURI STATUTORY PROVISIONS AT ISSUE

A. RSMO Section 191.1720

The Plaintiffs have moved this Court to find two separate statutory provisions unconstitutional. The first statute the Plaintiffs dispute is *RSMO Section 191.1720 Gender*

transition---citation of law---definitions---under 18, no surgery or gender transition drugs---license revocation, when---civil action, when, procedure---exceptions. That statute provides:

1. This section shall be known and may be cited as the "Missouri Save Adolescents from Experimentation (SAFE) Act".

2. For purposes of this section, the following terms mean:

(1) "Biological sex", the biological indication of male or female in the context of reproductive potential or capacity, such as sex chromosomes, naturally occurring sex hormones, gonads, and non-ambiguous internal and external genitalia present at birth, without regard to an individual's psychological, chosen, or subjective experience of gender;

(2) "Cross-sex hormones, testosterone, estrogen, or other androgens given to an individual in amounts that are greater or more potent than would normally occur naturally in a healthy individual of the same age and sex;

(3) "Gender", the psychological, behavioral, social, and cultural aspects of being male or female;

(4) "Gender transition", the process in which an individual transitions from identifying with and living as a gender that corresponds to his or her biological sex to identifying with and living as a gender different from his or her biological sex, and may involve social, legal, or physical changes;

(5) "Gender transition surgery", a surgical procedure performed for the purpose of assisting an individual with a gender transition, including, but not limited to:

a. Surgical procedures that sterilize, including, but not limited to, castration, vasectomy, hysterectomy, oophorectomy, orchiectomy, or penectomy;

b. Surgical procedures that artificially construct tissue with the appearance of genitalia that differs from the individual's biological sex, including, but not limited to, medoidioplasty, phalloplasty, or vaginoplasty; or

c. Augmentation mammoplasty or subcutaneous mastectomy;

(6) "Health care provider", an individual who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of his or her profession;

(7) "Puberty-blocking drugs", gonadotropin-releasing hormone analogues or other synthetic drugs used to stop luteinizing hormone secretion and follicle stimulating hormone secretion, synthetic antiandrogen drugs to block the androgen receptor, or any other drug used to delay or suppress pubertal development in children for the purpose of assisting an individual with a gender transition.

3. A health care provider shall not knowingly perform a gender transition surgery on any individual under eighteen years of age.

4. A health care provider shall not knowingly prescribe or administer cross-sex hormones or puberty-blocking drugs for the purpose of a gender transition for any individual under eighteen years of age.

(1) A health care provider shall not knowingly prescribe or administer cross-sex hormones or puberty-blocking drugs for the purpose of a gender transition for any individual under eighteen years of age.

(2) The provisions of this subsection shall not apply to the prescription or administration of cross-sex hormones or puberty-blocking drugs for any individual under eighteen years of age who was prescribed or administered such hormones or drugs prior to August 28, 2023, for the purpose of assisting the individual with a gender transition.

(3) The provisions of this subsection shall expire on August 28, 2027.

5. The performance of a gender transition surgery or the prescription or administration of cross-sex hormones or puberty-blocking drugs to an individual under eighteen years of age in violation of this section shall be considered unprofessional conduct and any health care provider doing so shall have his or her license to practice revoked by the appropriate licensing entity or disciplinary review board with competent jurisdiction in this state.

6. The prescription or administration of cross-sex hormones or puberty-blocking drugs to an individual under eighteen years of age for the purpose of a gender transition shall be considered grounds for a cause of action against the health care provider. The provisions of chapter 538 shall not apply to any action brought under this subsection.

(1) The prescription or administration of cross-sex hormones or puberty-blocking drugs to an individual under eighteen years of age for the purpose of a gender transition shall be considered grounds for a cause of action against the health care3 provider. The provisions of chapter 538 shall not apply to any actions brought under this subsection.

(2) An action brought pursuant to this subsection shall be brought within fifteen years of the individual injured attaining the age of twenty-one or of the date the treatment of the injury at issue in the action by the defendant has ceased, whichever is later.

(3) An individual brining an action under this subsection shall be entitled to a rebuttable presumption that the individual was harmed if the individual is infertile following the prescription or administration of cross-sex hormones or puberty-blocking drugs and that the harm was a direct result of the hormones or drugs prescribed or administered by the health care provider. Such presumption may be rebutted only by clear and convincing evidence.

(4) In any action brought pursuant to this subsection, a plaintiff may recover economic and noneconomic damages and punitive damages, without limitation to the amount and no less than five hundred thousand dollars in the aggregate. The judgment against a defendant in an action brought pursuant to this subsection shall be in an amount of three times the amount of any economic and noneconomic damages or punitive damages assessed. Any award of damages in an action brought pursuant to this subsection to a prevailing plaintiff shall include attorney's fees and court costs.

(5) An action brought pursuant to this subsection may be brought in any circuit court of this state.

(6) No health care provider shall require a wavier of the right to bring an action pursuant to this subsection as a condition of services. The right to bring an action by or through an individual under the age of eighteen shall not be waived by a parent or legal guardian.

(7) A plaintiff to an action brought under this subsection may enter into a voluntary agreement or settlement or compromise of the action, but no agreement shall be valid until approved by the court. No agreement allowed by the court shall include a provision regarding the nondisclosure or confidentiality of the terms of such agreement unless such provision was specifically requested and agreed to by the plaintiff.

(8) If requested by the plaintiff, any pleadings, attachments, or exhibits filed with the court in any action brought pursuant to this subsection, as well as any judgments issued by the court in such actions, shall not include the personal identifying information of the plaintiff. Such information shall be provided in a confidential information filing sheet contemporaneously filed with the court or entered by the court, which shall not be subject to public inspection or availability.

7. The provisions of this section shall not apply to any speech protected by the First Amendment of the United States Constitution.

8. The provisions of this section shall not apply to the following:

(1) Services to individuals born with a medically-verifiable disorder of sex development, including, but not limited to, an individual with external biological sex characteristics that are irresolvably ambiguous, such as those born with 46,XX chromosomes with virilization, 46,XY chromosomes with undervirilization, or having both ovarian an testicular tissue;

(2) Services provided when a physician has otherwise diagnosed an individual with a disorder of sex development and determined through genetic or biochemical testing that the individual does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action;

(3) The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of gender transition surgery or the prescription or administration of cross-sex hormones or puberty-blocking drugs regardless of whether the surgery was performed or the hormones or drugs were prescribed or administered in accordance with state or federal law; or

(4) Any procedure under taken because the individual suffers form a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the individual in imminent danger of death or impairment of a major bodily function unless surgery is performed.

B. RSMo Section 208.152

The Plaintiffs next complain that a portion of this statute, § 208.152, is unconstitutional. Senate Bill 49 also amended RSMo section 208.152, by adding subparagraph 15. The statute now provides, in pertinent part:

RSMo Section 208.152 Medical services for which payment will be made---copayments may be required---reimbursement for services

(15) There shall be no payments made under this section for gender transition surgeries, cross-sex hormones, or puberty-blocking drugs, as such terms are defined in section 191.1720, for the purpose of a gender transition.

II. Summary of the parties' lay and expert witness testimony

This was a nine-day trial, wherein the courtroom was filled with up to 15 attorneys at a time. The Court routinely heard testimony well into the night. The extremely well-prepared attorneys provided the Court with so many binders of evidentiary documents that were piled so high on the bench that the Court's vision was at times obscured. Suffice to say, this was a very lengthy and complex case.

It would be impossible for the Court to make factual findings for each witness. The court reporter's transcript in this case is several thousand pages. Nonetheless, the Court will attempt to summarize the points made by the parties' various fact and expert witnesses. Additionally, the Court will also discuss portions of the testimony of three of the Defendants' witnesses in detail. Finally, due to the large amount of evidence, the Court will have to make some fact findings throughout the body of this judgment.

A. Framework of the issues.

The Missouri legislature passed the statute in question after a nationwide increase in the number of children and teenagers receiving gender dysphoria treatment. The Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition (DSM-V) discusses gender dysphoria as a marked incongruence between one's experienced/expressed gender and assigned gender of at least six months' duration. The DSM-V then lists a series of symptoms that must persist at least six months for a diagnosis to be made.

The statistics show that an overwhelming percentage of adolescents who complain of gender dysphoria will eventually and naturally grow out of the symptoms. Presently, many children and adolescents present with other mental health issues as well as gender dysphoria.

The consensus evidence at trial was that sex is objective, is assigned at birth, and is lifelong. However, gender is mutable, and may change several times over a person's lifetime.

Physicians and health care providers agree that gender dysphoria treatment should follow a progression: first, counseling. Then, puberty blockers. Next, cross sex hormones. The medical and psychiatric professionals at trial agreed that no person under eighteen years of age should receive surgical treatment for gender dysphoria. The evidence at trial showed that the risk of suicide for adolescents with gender dysphoria is low.

There are several different drugs used for both puberty blocking and cross sex hormones. All use of these drugs for such purposes is "off label", meaning that the drugs have never been approved for such use.

The effects of puberty blockers, cross-sex hormones, and "gender-affirming" surgeries are often times not reversible. The longer a person stays on the medicines, the more dramatic the effects will be. Stunted growth from puberty blockers, as well as changed secondary sex characteristics from testosterone or estrogen and possible infertility are just a few of the probable irreversible changes.

Drug treatment for gender dysphoria is life-long, in that as long as a person desires to have cross-sex characteristics, he/she must remain on the cross sex hormones. Also, many people who are diagnosed with gender dysphoria have a long-term need for continued psychological care.

The Court finds that there is no consensus as to proper medical treatment, or the necessity thereof, for adolescents. Some physicians and medical associations opine that the necessity is present and that the treatment has little risk. Other physicians and medical associations opine that the opposite is true. Similarly, medical ethicists also argue whether gender dysphoria treatment is ethical for adolescents.

III. Gender Dysphoria, psychotherapy, and medicalized interventions

Gender dysphoria is a psychiatric condition characterized by distress associated with identifying differently than one's biological sex. For example, an individual born female may identify as a boy and experience distress from the mismatch between that person's subjective experience of identity and that person's body. Gender dysphoria has no physical effect. It cannot be measured objectively through lab or radiographic testing, and individuals who have gender dysphoria are physically just as healthy as anybody else.

Discussions in the medical field about gender dysphoria are new and evolving. As the U.S. Court of Appeals for the Sixth Circuit recently put it, "the concept of gender dysphoria as a medical condition is relatively new and the use of drug treatments that change or modify a child's sex characteristics is even more recent." *L. W. by & through Williams v. Skrmetti*, 83 F.4th 460, 472 (6th Cir. 2023). The term "gender dysphoria" was not used by the American Psychiatric Association until publication of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, in 2013. Before that, the Association used "gender identity disorder" as a diagnostic label. PI Tr. at 59, 94–95. The World Health Organization continued to refer to gender incongruence as a mental disorder until 2019. PI Tr. at 94.

Individuals experiencing gender-related distress have long been treated with traditional psychiatric or psychological methods—most notably mental health counseling (sometimes referred to as psychotherapy or talk therapy). This treatment method remains recommended by Defendants' experts as well as groups that Plaintiffs rely on. For example, Plaintiffs rely on guidelines created by the World Professional Association of Transgender Health (or WPATH). The parties dispute the credibility of that organization, but even WPATH has agreed with Defendants that psychotherapy is an appropriate treatment, calling it "highly recommended" and

saying it can "greatly facilitate the resolution of gender dysphoria" because, through this therapy, individuals can "integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body." Ex. 1008, WPATH, Standards of Care 7, at 8, 25, 28 (2012).

Beginning around 2007, specialized clinics in the United States started to take a different approach with minors. Rather than rely on traditional psychotherapy, they began providing chemical and surgical interventions. This innovation was based on what is called the "Dutch Protocol," an intervention protocol developed in the Netherlands in the early 2000s. That protocol, when used, involves three different procedures.

First, clinicians use drugs to block children from going through puberty. These puberty blockers are used to delay puberty in minors by several years to avoid development of secondary sex characteristics, such as breast development in girls and facial hair in boys. Plaintiffs' experts stated that the same drug or device is used for both girls and boys.

Second, clinicians give individuals hormones and drugs to induce development of secondary sex characteristics typical of the opposite sex. A wide variety of hormones and drugs are used: testosterone, estrogen, bicalutamide, spironolactone, progesterone, and others. None of these drugs or hormones is approved by the Food and Drug Administration ("FDA") to treat gender dysphoria.

Both males and females naturally have testosterone and estrogen, but in substantially different amounts. As Plaintiffs' expert Dr. Daniel Shumer testified, post-pubertal males have 10 to 20 times as much testosterone as females. Similarly, a healthy post-pubertal female has 10 to 20 times as much estrogen as the typical healthy male.

	Male normal levels	Female normal levels (premenopausal)
Testosterone	300–1,000 ng/dL	15–70 ng/dL
Estrogen	10–50 pg/mL	100-200 pg/mL

When testosterone or estrogen is used as an intervention, physicians aim to raise a natal female's testosterone to the normal level of a natal male and raise a natal male's estrogen to the normal level of a natal female. All this is done in an attempt to induce physical changes common to the opposite sex.

Third, clinicians perform gender-transition surgeries. These include but are not limited to double mastectomy (removal of the breasts), hysterectomy (removal of the uterus), and penectomy (removal of the penis). Gender transition surgeries were performed in Missouri on minors before the SAFE Act was passed. These surgeries have been performed across the nation at young ages. One witness, Chloe Cole, testified to receiving a double mastectomy surgery at age 15. Another witness, Jamie Reed, who worked at the largest gender transition center in Missouri for nearly five years, testified that the clinic and hospital in Missouri where she worked regularly facilitated or directly provided sex change surgeries for minors. That clinic, operated by Washington University, has acknowledged that "families were provided with the names of surgeons (including Washington University physicians) who provided such surgeries." Ex. 273 (admitted at Trial). The hospital also admitted that double mastectomies were provided to minors since 2018. *Id.*

None of these interventions corrects any biological or physical abnormality. Rather, the thought process behind these novel procedures is that even though these adolescents are physically healthy, altering their bodies might reduce distress associated with the mismatch between their bodies and how they perceived their identity.

None of these interventions are FDA approved for treating gender dysphoria. Puberty blockers are FDA approved for treating precocious puberty (where a child begins going through puberty very early, like as a toddler) but not for treating gender dysphoria. The FDA has also approved hormones for resolving certain conditions, like gland problems, but not to attempt to transition gender. Drugs, often those with minimal side effects, are sometimes used for secondary, unapproved purposes (called "off-label" use). But the lack of FDA approval means the FDA has not weighed in on whether these drugs are safe for this particular purpose. And the mere fact that drugs may be safe for one purpose does not imply they are safe for others. As Dr. Shumer testified, insulin is safe and effective for individuals with diabetes but is deeply harmful for individuals with hypoglycemia (a condition characterized by producing too much insulin).

IV. Developments since the Dutch Protocol

Plaintiffs' experts rely extensively on studies establishing the "Dutch Protocol." But the demographics of patients involved in the formation of the Dutch Protocol are very different from adolescents presenting to gender clinics today. This is true in at least five ways.

First, the time of onset of gender dysphoria has changed. The Dutch Protocol was developed for individuals who experienced onset of gender dysphoria in childhood, *before* puberty. Now, most individuals presenting at clinics do not experience onset until *after* puberty has begun.

Second, when the Dutch Protocol was developed, the patient cohort was mostly male. Now, the vast majority of individuals presenting at gender clinics are born female. Dr. Johanna Olson-Kennedy, for example, testified that individuals who are born female outnumber individuals born male in her clinic by a ratio of 4:1.

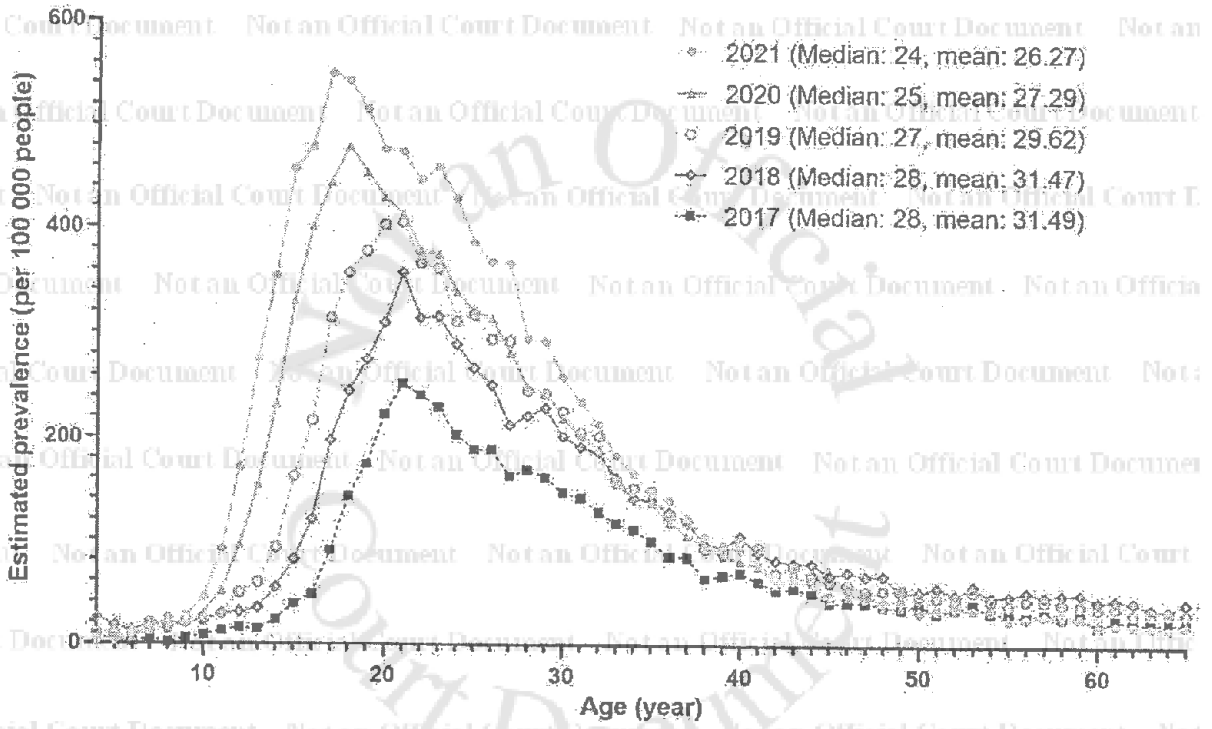
Third, individuals with mental health issues other than gender dysphoria were excluded from the studies underlying creation of the Dutch Protocol. In other words, only individuals who were mentally healthy were permitted to receive those interventions. But now, a substantial proportion of individuals presenting at these clinics have serious mental health comorbidities. And that trend has become worse in more recent years. Dr. Shumer testified that about 45% of the individuals presenting at his clinic in Michigan have serious psychiatric issues. Jamie Reed, the whistleblower who worked at the largest transgender clinic in Missouri for almost five years, presented unrebutted testimony that the vast majority of individuals presenting at that clinic toward the end of her tenure had serious mental health issues.

Fourth, identities have also shifted. While the Dutch Protocol cohort included individuals who identified as boys or girls, the number and variety of identities has skyrocketed in recent years. The largest increase has been for the group identifying as "nonbinary," a term used to refer to individuals who identify as neither male nor female. Dr. Shumer testified that there are far fewer studies concerning nonbinary identity and treatment. Relatedly, individuals presenting at these clinics have begun using "neo-pronouns" where they state that they identify as inanimate objects like a "rock" or a "mushroom" or nonhuman organisms like animals. WPATH and other organizations lack guidelines for how to treat individuals presenting in these ways.

Finally, the presentation rate of individuals with gender dysphoria has skyrocketed in the last decade. Indeed, in its most recent guidelines (published late 2022), WPATH even dedicated a chapter to adolescents precisely because of "the exponential growth in adolescent referral rates." Ex. 5, WPATH, Standards of Care 8, at S43 (2022). For example, as the chart below shows,[1] the

[1] Sun C-F, Xie H, Metsutnan V, et al. The Mean Age of Gender Dysphoria Diagnosis Is Decreasing, General Psychiatry 2023;36:e100972, fig. A; Ex. 11124. This paper is based on a review of a database containing records of 66 million patients.

prevalence of gender dysphoria for 15-year-old adolescents in 2017 was about 20 per 100,000 people. By 2021, that number had skyrocketed to 340 per 100,000 people—nearly 20 times as high. The following chart, reviewed during expert testimony at trial from Exhibit 11124[2] is illustrative of this point:



The cause of this exponential increase is not yet understood. Plaintiffs' experts acknowledged that researchers have raised several hypotheses: (1) greater acceptance of transgender identity, (2) social influence, and (3) the concern that these interventions may in fact *cause* gender dysphoria. Plaintiffs' experts acknowledged that they currently have no way to prove one theory over any other.

Concern about causation is especially salient given the historical understanding that the overwhelming majority of individuals with a gender dysphoria diagnosis before puberty desist—

[2] Portions of this exhibit, including this graph, were reviewed by the Court during expert testimony at trial though the full exhibit was not admitted.

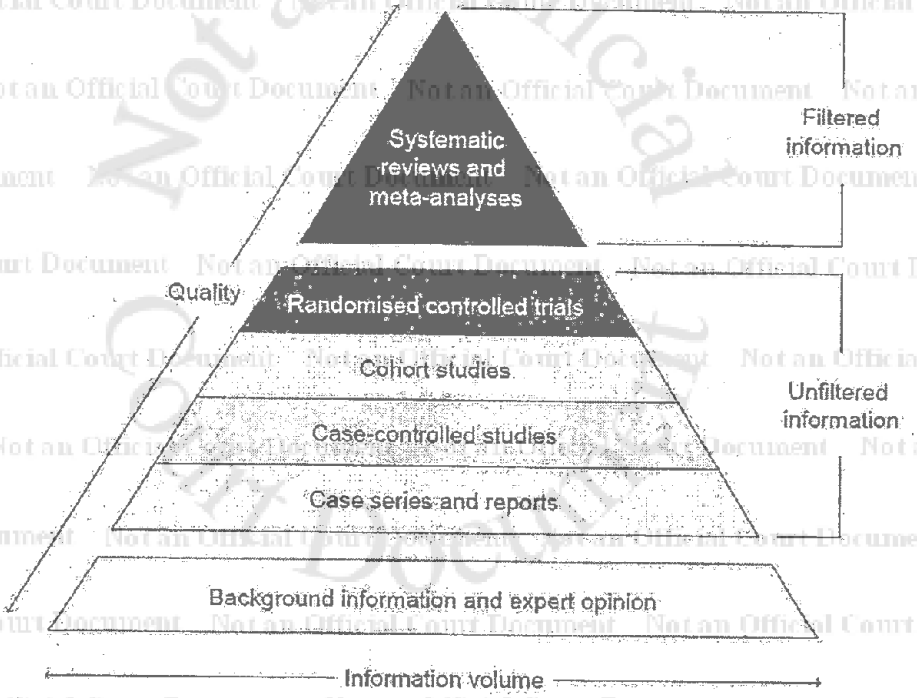
meaning they no longer identify as transgender by adulthood. Plaintiffs offered into evidence the guidelines of the Endocrine Society. Ex. 306 (admitted). Those guidelines state that "the large majority (about 85%) of prepubertal children" with a gender dysphoria diagnosis did not remain gender incongruent later on in life. *Id.* at 3879. The Diagnostic and Statistical Manual reports even higher numbers: up to 98%. Ex. 13, at page 516 (PDF page 719). In other words, left alone (or given mental health care), the vast majority of children who identify as transgender will no longer identify that way by the time they reach adulthood.

But at least some interventions are known to alter the development of gender identity. For example, the Endocrine Society guidelines state that "social transition," among other things, "has been found to contribute to the likelihood of persistence." Pl. Ex. 306, at 3879. Plaintiffs' experts also acknowledged that other sources have expressed concern that puberty blockers and cross-sex hormones may also alter gender identity. Most notably, experts on both sides discussed the Cass Review, a 4-year, 400-page report commissioned by the National Health Service in the United Kingdom, which assessed the evidence base behind these interventions. Plaintiffs' experts acknowledged that this review expresses "concern that they [puberty blockers] may change the trajectory of psychosexual and gender identity development." Ex. 1005 (admitted into evidence), Cass Review, at 32. Similarly, while hypotheses about social influence have not yet been proven or disproven, even groups like WPATH have acknowledged that "susceptibility to social influence impacting gender may be an important differential to consider," and that "[t]here is often a heightened focus on peer relationships, which can be both positive and detrimental." Ex. 5 Standards of Care 8, at S44–45.

V. Both sides acknowledge there is a medical dispute on the safety and efficacy of chemical and surgical interventions.

In evidence-based medicine, there is a hierarchy of evidentiary strength. Studies that survey the entire field—called "systematic reviews"—are at the top of the hierarchy. Expert opinion is at the bottom. Experts on both sides expressed familiarity with a common graphic displaying the hierarchy of evidence.

Pyramid of Standards of Evidence[3]



Evidence is also graded on a scale. One commonly used scale, discussed at trial by experts for both sides, is called the Grading of Recommendations, Assessment, Development, and Evaluations system or "GRADE." That scale ranks the quality of evidence from studies into four categories: high quality, moderate quality, low quality, and very low quality. High quality means

[3] Cass Review, Interim Report 62 (Feb. 2022).

there is high confidence that the true effect lies close to what the study reported. Moderate quality means the true effect is probably close to what the study reported. Low quality means the true effect might be substantially different from the effect reported in the study. And very low quality means the actual result is likely to be substantially different from what the study reported. Plaintiffs' expert Dr. Olson-Kennedy explained that some studies, like randomized control trials, start by default as high quality, but they can be downgraded if the study is determined to be weak. Similarly, she explained that other studies (like observational studies) begin with a lower-quality rating, but they can be upgraded if the studies are carried out in a methodologically sound way.

The parties agree that gender transition interventions lack any high quality—or even moderate quality—evidence base. Under the GRADE system, there is widespread agreement that the quality of evidence for these chemical and surgical interventions is considered "low" or "very low." The Endocrine Society guidelines, for example, provide six clinical recommendations for treating gender dysphoria in adolescents, and Plaintiffs acknowledged that every one of those recommendations is based on "low" or "very low" quality evidence. Ex. 306, Endocrine Society Guidelines, at 3871. That means the actual results of these interventions are likely to be substantially different from what is reported in the studies that Plaintiffs rely on.

Plaintiffs' experts nonetheless believe the amount of clinical evidence they have seen—even though it is of low or very low scientific quality—is sufficient to justify these interventions. But they acknowledge there is a dispute within the international medical community about whether the evidence is sufficient. As explained below, medical organizations in Europe and America have concluded that the evidence base is not sufficient.

A. Several international organizations have concluded there is insufficient evidence to support these interventions.

United Kingdom. Most notably, the parties discussed at length the Cass Review. That 400-page report was commissioned by the National Health Service in the United Kingdom. The National Health Service commissioned Dr. Cass, the former President of the Royal College of Paediatrics, to chair the review, and the NHS specifically picked her because she lacked any financial or reputational interest in the procedures. The Cass Review itself commissioned 8 different systematic reviews, all of which were peer reviewed. Ex. 1005, The Cass Review, at 17, 26. Those 8 systematic reviews form part of the foundation for the Cass Review's findings.

The final report commissioned by the NHS concluded that the interventions at issue in this lawsuit rest on "remarkably weak evidence" and that there is "no good evidence on the long-term outcomes of interventions." Ex. 1005, Cass Review, at 13, 20. For example, with respect to puberty blockers, the Review found "no evidence that puberty blockers improve body image or dysphoria, and very limited evidence for positive mental health outcomes, which, without a control group, could be due to placebo effect or concomitant psychological support." *Id.* at 179. On cross-sex hormones, the review determined that the existing studies were so weak that "[n]o conclusions can be drawn about the effect on gender dysphoria, body satisfaction, psychosocial health, cognitive development, or fertility." *Id.* at 184.

The Cass Review thus recommended restricting the use of puberty blockers and cross-sex hormones, and Plaintiffs' experts acknowledged that the United Kingdom accepted those recommendations. As Plaintiffs' experts acknowledged, puberty blockers are now prohibited in the United Kingdom outside formal clinical research protocols. Plaintiffs' experts also acknowledged that none of those clinical research protocols have started yet.

As for cross-sex hormones, the Cass Review said individuals should "wait[ ] until an individual reaches 18." Ex. 1005, Cass Review, at 35–36. The Cass Review says some exceptions can be made to this rule beginning "from age 16," but these exceptions can occur only under "extreme caution," only after "psychological support," and only as a "tertiary" intervention. *Id.*

Finland and Sweden. Similarly, experts on both sides testified at length about guidelines issued by the Swedish and Finnish medical authorities. The Swedish guidelines say that the harms from these interventions outweigh the benefits. The Finnish guidelines similarly declare these interventions to be experimental. As in the United Kingdom, puberty blockers are prohibited for treating gender dysphoria except in formal clinical research protocols.

The Cass Review took a look at these guidelines, as well as guidelines by other organizations like the Endocrine Society and WPATH. The Cass Review concluded that only the Swedish and Finnish guidelines "could be recommended for use in practice." Ex. 1005, Cass Review at 130. In other words, the only guidelines the Cass Review recommended for use are the guidelines that state that these interventions are experimental and that, on the current evidence base, the harms outweigh the benefits.

World Health Organization. Late last year, the World Health Organization announced it would develop guidelines for treating gender dysphoria. But then, earlier this year, it announced it would not craft guidelines for treating gender dysphoria in adolescents because "the evidence base for children and adolescents is limited and variable." Ex. 1024 (admitted), WHO Development of a Guideline on the Health of Trans and Gender Diverse People (Jan. 15, 2024).

B. Domestic authorities similarly have expressed concern about the evidence base for these interventions.

U.S. Department of Health and Human Services. The court admitted into evidence a report published by the U.S. Department of Health and Human Services' subagency, the U.S.

Agency for Healthcare Research and Quality. That report recently concluded, "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." Ex. 1208, *Topic Brief: Treatments for Gender Dysphoria in Transgender Youth*, AHRQ, Nom. No. 0928, at 1 (2021).[4]

WPATH and Endocrine Society. Plaintiffs rely on guidelines crafted by the Endocrine Society and WPATH. As already explained above, the Endocrine Society acknowledges that every one of its recommendations for treating adolescents with gender dysphoria is based on low or very low quality evidence.

Similarly, WPATH at times acknowledges limits, stating, for example:

- "[T]he number of studies is still low, and there are few outcome studies that follow youth into adulthood" (at S46)
- "Due to the limited research in this area, clinical guidance is based primarily on individual case studies and the expert opinion" (at S41)
- "Little research has been conducted to systematically examine variables that correlate with poor or worsened biological, psychological, or social conditions following transition" (at S42)
- "Currently, there are only preliminary results from retrospective studies evaluating transgender adults and the decisions they made when they were young regarding the consequences of medical-affirming treatment on reproductive capacity. It is important not to make assumptions about what future adult goals an adolescent may have" (at S57)
- "[O]nly limited empirical research exists to evaluate such interventions" (at S75)
- "To date, research on the long-term impact of [Gender Affirming Hormone Treatment or] GAHT on cancer risk is limited … We have insufficient evidence to estimate the prevalence of cancer of the breast or reproductive organs among TGD populations" (at S144)

[4] https://effectivehealthcare.ahrq.gov/system/files/docs/topic-brief-gender-dysphoria.pdf

WPATH in fact had to deviate from the standard way of creating guidelines in creating the current version of its "Standards of Care." Ex. 5, WPATH, Standards of Care 8. Plaintiffs' expert in ethics, Dr. Armand Antommaria, acknowledged that guidelines are supposed to be based on systematic reviews—but that WPATH's guidelines are not. In fact, WPATH said that a systematic review for treatment outcomes in adolescents "is not possible" because "the number of studies is still low and there are few outcome studies that follow youth into adulthood." Ex. 5, Standards of Care 8, at S46. Dr. Antommaria acknowledged that in fact systematic reviews *are* possible and have been done many times, but that WPATH chose to deviate from the standard practice of relying on systematic reviews to craft the SOC-8 guideline. Plaintiffs' experts Dr. Olson-Kennedy and Dr. Antommaria acknowledged that two different systematic reviews have rated the WPATH guidelines as a poor-quality guideline because of this and other issues.

U.S. States. Joining Missouri and countries across Europe are a majority of U.S. States. In just the last few years, more than half of the States in this country have passed laws restricting these interventions. The U.S. Supreme Court is currently reviewing the validity of these laws under the U.S. Constitution, but every federal court of appeals in the last two years to issue an opinion on the question whether these interventions can be restricted for minors has concluded that they can. *E.g.*, *Skrmetti*, 83 F.4th at 489; *L. W. v. Skrmetti*, 73 F.4th 408, 419, 421 (6th Cir. 2023); *Doe I. v. Thornbury*, 75 F.4th 655, 657 (6th Cir. 2023) (per curiam); *Eknes-Tucker v. Gov. of Alabama*, 80 F.4th 1205, 1227, 1231 (11th Cir. 2023); *K.C. v. Individual Members of the Med. Licensing Bd. Of Ind.*, 2024 U.S.App. 28833 (7th Cir. Nov. 2024). In contrast, the Eighth Circuit Court of Appeals held that a similar statute in Arkansas was unconstitutional. *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661, 669-71 (8th Cir. 2022). However, the Eighth Circuit has now agreed to rehear that case

en banc. Order Granting Petition for Initial Hearing En Banc, *Brandt ex rel. Brandt v. Griffin*, No. 23-2681.

VI. The potential harms from these interventions are serious.

Medical interventions are assessed relative to their risk-benefit profile. An intervention with very few risks can more easily be recommended even if the evidence-base for it is weak. For example, at the preliminary injunction hearing, one of the experts noted that there is not great evidence to support the idea that taking a daily aspirin will reduce the risk of heart attack. While the downside of a daily aspirin is virtually zero, the upside (preventing heart attacks) is potentially enormous—even if not yet proven. PI Tr. 369. Similarly, Dr. Antommaria noted that organizations recommend CPR. Even though the evidence base for efficacy of CPR is considered weak, the potential benefit is, again, lifesaving.

Not so with the interventions at issue in this case, which have substantial known harms. Plaintiffs' expert Dr. Shumer testified that there are harms whenever a person is provided "supraphysiological" levels of hormones. That is what cross-sex hormones do. They elevate a person's hormones to 10 to 20 times what that person's healthy body is able to produce or sustain. This increases risks of premature mortality, hypertension, cardiovascular disease, and cancer, among other things. As Dr. Levine testified, the life expectancy for individuals who have received these interventions is 10 to 20 years shorter—although causality on this issue is difficult to measure. PI Tr. at 632–34. And because individuals receiving cross-sex hormones cannot naturally produce hormones in the same levels as members of the opposite sex, individuals taking cross-sex hormones must be medicalized for life to maintain those hormonal levels.

The risks of "supraphysiological" levels of hormones is strikingly clear when it comes to smoking. Smoking is unhealthy for anybody. But Plaintiffs' witnesses acknowledged that the risks

are higher for individuals born male who take estrogen in an attempt to transition to female. In other words, even though that individual has hormone levels that are typical of a female, because the estrogen levels are supraphysiological for an individual born male, the risks are heightened. One of Defendants' witnesses was hospitalized for a pulmonary embolism because of smoking while taking estrogen.

These interventions place individuals at risk in emergency situations. Jamie Reed, the whistleblower, testified that patients have been sent to the emergency room because cross-sex hormones compromised their genital tissue so much that they began bleeding profusely. Plaintiffs' witness Dr. Shumer also acknowledged, in response to the Court's question, that emergency room physicians need to know a person's actual sex in order to properly treat many injuries and diseases. These interventions thus complicate the ability of individuals to receive emergency services promptly.

Fertility is also a serious concern. Dr. Shumer testified that an individual must go through a natural puberty to be able to conceive children. But puberty blockers prevent individuals from going through puberty. And about 98% of individuals placed on puberty blockers are later given cross-sex hormones and thus do not have the opportunity to go through puberty. Dr. Shumer believes it may be possible for individuals to stop cross-sex hormones and go through puberty in their 20s or 30s but admits there are no studies backing his hypothesis.

Even individuals who have already gone through puberty experience reduced fertility from cross-sex hormones, which causes vaginal atrophy and shrinkage of the testes. Individuals who have detransitioned (obtained chemicals or surgeries to transition to an appearance other than their natal sex only to revert and identify with their natal sex) testified that they have experienced

difficulty with fertility. For example, women who have taken testosterone experience highly variable, inconsistent cycles. The court heard direct testimony from several such witnesses.

These drugs also may interfere with normal brain development. Puberty is known to have substantial maturing effects on the brain. What is unknown is whether individuals placed on puberty blockers who are not permitted to go through a natal puberty ever experience this development. The Endocrine Society—an organization Plaintiffs rely on—has acknowledged that "animal data suggests there may be an effect of GnRH analogs [puberty blockers] on cognitive function" and has thus stated "we need more rigorous evaluations of . . . the effects of prolonged delay of puberty in adolescents on . . . the brain (including effects on cognitive, emotional, social, and sexual development)." Ex. 306, Endocrine Society Guidelines 3874, 3882–83. To date, no such rigorous evaluation has been conducted, and there is no evidence in the animal literature that these effects are reversible. Indeed, one human study found that IQ scores among patients decreased by 7 points on average, with drops as high as 15 points. Plaintiffs' expert Dr. Kale Edmiston likewise admitted that these drugs may decrease brain volume and that cross-sex hormones may alter a person's brain structure from what it would have been absent those hormones.

Increasingly, individuals who have gone through these interventions have detransitioned and started identifying with their natal (born with) gender. Dr. Stephen Levine testified that some studies show detransition rates may be around 30%. These rates are extremely difficult to measure because of high loss to follow up—that is, individuals simply stop checking in with those who are conducting the study for unknown reasons. Because detransitioners often have come to regret these interventions, testimony at the hearing established that they often do not inform the clinics that they have detransitioned. Detransitioners also testified at the hearing that as soon as they began

detransitioning, their "trans support groups" abandoned them. Moreover, because many clinics providing these interventions do so only for adolescents, their patients age out, so the clinics have no way of knowing whether an individual who has aged out is going to another clinic or instead has detransitioned.

Plaintiffs contend that, despite these harms, these interventions are "lifesaving." But Plaintiffs' expert Dr. Shumer testified at trial that these interventions "cannot be directly linked to reduction" in loss of life. Plaintiffs have not provided any evidence that these interventions in fact save lives.

VII. The benefits of waiting until age 18

At trial, Plaintiffs' expert Dr. Shumer testified that there are tradeoffs to waiting until an individual turns 18 before starting these interventions. On the one hand, Dr. Shumer contended that it may be socially easier for minors if they begin interventions earlier. On the other hand, Dr. Shumer agreed that waiting comes with the benefit of promoting stability of gender identity. Because gender identity often shifts across time, waiting until age 18 ensures greater opportunity for identity to stabilize. As mentioned above, the Endocrine Society guidelines acknowledge that "the large majority (about 85%)" of prepubertal children with a gender dysphoria diagnosis did not remain gender incongruent later on in life. Ex. 306 at 3879.

Stability is a serious concern. One of Plaintiffs' witnesses, Eliot M., described his/her/their identity as "fluid." Eliot's identity and sexual orientation change every day. Defendants' witness Jamie Reed similarly testified that she observed many patients at the Washington University clinic with unstable gender identities that changed day to day. Withholding irreversible medical interventions until age 18 promotes stability of gender identity.

These interventions can also be finicky if not timed precisely by the patient. Plaintiffs' first witness, for example, testified that testosterone injections for individuals born female must be taken every week at the same time every week and that missing the timing by even just a few hours or a day can have substantial physical consequences. Because minors under 18 are still in the process of maturing, and may not always get the timing of injections perfectly right, the finicky nature of the interventions provides yet more benefits for waiting.

VIII. Evidence of how these interventions have been practiced in Missouri

Plaintiffs provided almost no evidence about how these interventions are practiced in Missouri. Each of their expert witnesses is from out of state. While they provided the perspectives of half a dozen individuals who have received these interventions in Missouri—some of them as adults—those experiences offer only a small snapshot of the thousands of minors who have received these interventions in just the last 5 years.

In contrast, Defendants put on testimony from a former employee of the largest pediatric transgender center in Missouri. Jamie Reed worked at the Washington University center for nearly five years. Reed testified in opposition to continued use of these interventions in Missouri after having been involved in providing them for many years. The Court finds Reed credible; her testimony does not arise from any ideological or other bias. In fact, she is married to a transgender individual, seriously considered transitioning herself, and has a long record of years of advocacy on behalf of transgender individuals. She also provided testimony at great personal and financial cost. As an employee at Washington University, she was entitled to receive roughly $1.5 million in educational benefits for her children, and she gave up those benefits when she left employment with the University due to her grave concerns over the failures of the university's clinic.

Reed offered unrebutted testimony about thousands of patient experiences in Missouri. She testified that the center was expecting to have only about 50 patients at any one time but the actual number proved to be in the thousands. That volume overloaded the capacity of the center, especially the part-time psychiatrist and psychologist who worked with the center. Reed testified that patients routinely presented with severe mental health diagnoses separate from gender dysphoria and that those other issues were not treated. In fact, individuals often were given puberty blockers or cross-sex hormones at the first visit. Reed testified that she and others at the center routinely pressured parents into accepting these interventions. One tactic they used was to tell parents—in front of their children—that their children would kill themselves if the parents did not agree to interventions. Plaintiffs' own experts and other witnesses condemned this tactic as both abusive and inaccurate. (As several of Plaintiffs' experts testified, the death rate by suicide among patients with gender dysphoria, fortunately, is very low, and there is no evidence that puberty blockers, cross-sex hormones, or surgeries decreases the risk of suicide.)

Reed also testified that clinics in Missouri depart starkly from the standards that Plaintiffs' experts say are required. Plaintiffs' experts, for example, insisted that no individual should receive these interventions without a diagnosis of gender dysphoria. But Reed offered unrebutted testimony undiagnosed individuals routinely received these interventions both from the clinic at Washington University and other clinics in Missouri that she worked with closely. Plaintiffs' experts testified that each individual must first receive a comprehensive mental health assessment, which several of those experts testified must include a psychological or psychiatric examination. But Reed offered unrebutted testimony that many patients at the Washington University clinic were not receiving those assessments, which Sara Stockton—a marriage and family counselor who was integral to the initial rollout of the "Dutch protocol" in the United States—testified are

required to be robust in time and scope. Reed testified that many individuals were not receiving these assessments at all. In fact, she testified that other organizations in Missouri that she is familiar with had a policy of not requiring any assessment. One of those organizations is Planned Parenthood, whose website openly stated that no comprehensive mental health assessment is required.

Similarly, Dr. Olson-Kennedy also testified that her clinic discourages the use of "chest binders," which are tight-fitted articles of clothing designed to compress the chest of a natal female to make it look more masculine. In contrast, Reed testified that the clinic where she worked openly encouraged the use of chest binders. Reed also testified that after WPATH published its most recent Standards of Care (version 8) in 2022, which relaxed standards from the previous version, there were meetings at the Washington University clinic about whether the clinic could even meet those relaxed standards.

Plaintiffs chose not to call any other employee at Washington University to rebut this testimony. The only Missouri-based providers they put on the stand were Dr. Michael Donovan and Nicole Carr (a nurse), both employees at Plaintiff Southampton Community Healthcare, who testified that they have cumulatively provided these interventions to minors only four times. Neither had worked at the Washington University Transgender Center. The Court thus concludes that Reed's testimony is unrebutted.

IX. The SAFE Act

Plaintiffs assert that the General Assembly and Governor enacted this law because of animus. The Court thus reviews the background behind the passage of the law.

In April 2022, two physicians from the Washington University transgender center presented testimony to the General Assembly. Video of that testimony was presented and admitted

in court. Those physicians unequivocally denied that any minors have received gender transition surgeries in Missouri. Dr. Sarah Garwood said, "I want to underscore that at no point are surgeries on the table for anyone under the age of 18." She continued, "Surgery for trans youth is not part of anything that is recommended." Ex. 1230. Similarly, Dr. Chris Lewis, speaking just after Garwood, said "Again, surgeries are not an option for anyone below the age of 18 years of age." Ex. 1231.

This testimony was false. Plaintiffs proffered an exhibit from Washington University acknowledging that the institution has in fact recently performed surgeries on minors and enabled minors to find surgeons outside of Washington University. Ex. 273. Reed similarly offered unrebutted testimony to that effect at trial.

In February 2023, Reed issued a public, sworn affidavit, raising 86 paragraphs of allegations. Her allegations included that these two physicians had offered knowingly false testimony to the legislature. Her affidavit also included much of the testimony that she presented in court about the concerns she had with the operation of the largest adolescent transgender clinic in Missouri.

One week later, the Missouri Senate conducted a hearing about this issue.[5] By early March, lawmakers in the Senate had advanced a bill to ban these procedures permanently—as a majority of other States have done. SB49, Senate Committee Substitute.[6] The House similarly introduced (and passed on April 13) a bill to permanently ban these procedures.[7]

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[5] https://senate.mo.gov/23info/BTS_Web/Actions.aspx?SessionType=R&BillID=44407

[6] https://senate.mo.gov/23info/pdf-bill/comm/SB49.pdf

[7] Missouri Save Adolescents from Experimentation (SAFE) Act, HB419, https://documents.house.mo.gov/billtracking/bills231/hlrbillspdf/1203H.02P.pdf

The opposition party in the Senate, however, had enough votes to block both bills by filibuster. Gaul, *After Filibuster, Transgender Care Bills Move Forward in Mo. Senate*, KMOV (Mar. 21, 2023).[8] On March 20, they did so. *Id.* Democrats and Republicans then came together to strike a compromise. "While the filibuster continued on the floor, lawmakers met in closed-door negotiating sessions. As a result of that, both bills will now sunset in 2027, giving lawmakers a chance to take a second look at the legislation." *Id.* In exchange for the sunset clause, the opposition party agreed to drop the filibuster, allowing the Senate to pass the legislation. *Id.* The sunset amendment was reflected in the Senate Substitute bill adopted by the full Senate that day.[9] This became the enacted the text of SB49, the Missouri Save Adolescents from Experimentation (SAFE) Act. The Act was passed by large margins, 24-8 in the Senate and 108-50 in the House.[10]

The Act does three things relevant here. First, it bars health care providers from performing gender transition surgeries on any individual under the age of eighteen. § 191.1720.3., RSMo. Second, it prohibits "knowingly prescrib[ing] or administer[ing] cross-sex hormones or puberty-blocking drugs for the purpose of a gender transition for any individual under eighteen years of age." § 191.1720.4(1), RSMo. But this prohibition does not apply with respect to any individual who received "such hormones or drugs prior to August 28, 2023, for the purpose of assisting the individual with a gender transition," and the provision "expire[s] on August 28, 2027." § 191.1720.4(2)–(3), RSMo. In other words, adolescents receiving an intervention before the effective date of the law were "grandfathered in." As for enforcement, the Act authorizes the licensing board to revoke a medical license, and it permits individuals to bring private causes of

[8] https://www.kmov.com/2023/03/21/after-filibuster-transgender-care-bills-move-forward-mo-senate/

[9] https://senate.mo.gov/23info/BTS_web/amendments/0202S.20F.pdf

[10] Journal of the Senate at 700 (March 23, 2023); Journal of the House at 3178 (May 10, 2023).

action for damages. § 191.1720.5–6, RSMo. Third, the Act codifies a preexisting policy barring the State from paying for these procedures, § 208.152.15, RSMo.

Nothing in the bill regulates adults seeking these interventions. The bill also makes clear that it does not apply to the rare individuals who have "disorders of sex development" (such as chromosomal abnormalities), does not apply to treatments to resolve complications caused by gender transition interventions, and does not apply when an individual's life would be in danger "or impairment of a major bodily function" would occur absent the intervention. § 191.1720.8, RSMo. Nothing in the Act prevents health care providers from engaging in well-established treatments such as psychotherapy or mental-health counseling.

X. Evidence of lack of medical ethical consensus for adolescent gender dysphoria care.

Three especially significant witnesses

The Court, during this nine-day trial, received testimony from extremely intelligent and well-informed witnesses as to the ethics of adolescent gender dysphoria treatment. However, the Court found the testimony of three of the witnesses rather compelling in the context of medical ethics. The Court will attempt to summarize the testimony of each below.

1. Chloe Cole

Ms. Cole, who has always resided in California, began gender transitioning at twelve years of age. At some point, she told her parents that they must either affirm her gender transition or Chloe would commit suicide. She began a social transition at age 12, and her medical transition began at age thirteen.

At age fifteen, doctors performed a double mastectomy on Chloe. Today, at age twenty, she is in the process of detransitioning. She no longer takes testosterone.

Chloe testified that now, she wishes to be a woman, get married, have kids, and breastfeed. While she has stopped taking testosterone and has begun dressing female, she is unsure if she is fertile, due to the amount of testosterone she has taken. Also, she testifies that the testosterone has permanently changed her body. Finally, she will never be able to breastfeed children if she does get pregnant due to the double mastectomy.[11]

2. **Dr. Farr Curlin**

Dr. Curlin is an internal medicine physician. He also teaches medical ethics at Duke Medical School. In addition, Dr. Curlin teaches medical ethics at Duke Divinity School.

One of Dr. Curlin's opinions that the Court finds extremely enlightening is that gender dysphoria, as listed in the DSM-5, is a "disorder of perception". Dr. Curlin notes that in gender dysphoria case, the patient's secondary sex characteristics, i.e. testes and uteruses, are normal and healthy. The disorder comes from the sense that the patient's sex characteristics are out of alignment with what the patient wants his/her gender to be.

This is important because medicine takes the well-working of the human body as its standard. For example, when a person perceives that he is fat when he is not, that perception is the disorder, and the perception is treated. However, with gender dysphoria, the medical and surgical treatments that are prescribed and performed are hostile to the well-working of the human body (the secondary sex characteristics in this case) in order to fix the perception. In Dr. Curlin's opinion, this is an outlier practice that is outside important medical norms.

[11] Ms. Cole testified that she presently has a medical malpractice claim pending in California regarding the issue of health care providers performing gender affirming treatment on her at an early age. While Ms. Cole may or may not recover monetary damages, a civil jury verdict will not allow her to breast feed children after her double mastectomy, nor will it ensure that she is fertile after having been prescribed several years' worth of testosterone.

Dr. Curlin's next opinion that the Court found instructive was his take on the possibility of consent for adolescent gender dysphoria treatment. Dr. Curlin noted that within the field of medical ethics, informed consent includes information, comprehension, and voluntariness. If a person does not have adequate information for a certain likely medical outcome, it is difficult for a person to be sufficiently informed to give an informed consent.

Dr. Curlin complains that we have not had prospective, well-designed studies that have followed children long enough to know what the gender dysphoria medicines and surgeries do over the long-term. The treatments, Dr. Curlin notes, will force these kids to be captive to medical professionals and administration of exogenous hormones for decades. However, the gender dysphoria physicians are not informing the patients of any really serious risks, or that well-established bodies of experts have concluded there is not enough data to support the conclusion that these treatments improved mental health outcomes. Therefore, Dr. Curlin argues that it is impossible for these families and children to give true informed consent in these cases. In his view, our society is better served by continuing to protect adolescents as vulnerable subjects with regard to gender dysphoria medications and surgeries until there is sufficient data to show the treatments are sufficiently beneficial relative to anticipated harms for our states to allow children to undergo the treatment.

As to a final point that the Court finds rather fascinating, the Court asked Dr. Curlin about the intersection of the State's concern in preventing a teen from making a bad medical decision with lifelong aftermath, wherein the concern might directly conflict with a teen's/family's right to make medical decisions. Initially, Dr. Curlin noted that, except for very few areas, minors are not treated as having authority to grant or withhold consent. However, today there is in the ethics field

an emphasis on soliciting "assent" from children out of respect for them, as well as a recognition that children's capacity and maturity is not like an on/off switch, it grows over time.

So, Dr. Curlin argues, the norm should be the same in child and adolescent gender dysphoria treatment as that which operates throughout pediatric ethics, which is whether the intervention is one that is consistent with the medical best interest of the child. In Dr. Curlin's opinion, we are not at a point where we could find that child and adolescent gender dysphoria treatment are in the minor's best interest, because there is not enough good data and studies that would allow such a conclusion.

Accordingly, Dr. Curlin opines that children and teens should not even get to have a choice as to gender dysphoria treatment until we have enough evidence to show they are in the best interests of the child. However, if we get to that point where the data and studies show medical necessity, the logic would tell us that not only "can" a kid receive this treatment, it is that, ethically, a child "should" receive gender dysphoria treatment.

The final question, then, is not just whether the treatment would be efficacious, but is the gender dysphoria treatment efficacious in bringing about health benefits reliably enough, and benefits that are significant and substantial enough, to warrant exposure to foreseen harms and risks associated with the medical and surgical gender dysphoria treatment as known today. Even symptom reversibility would not address the issues, as the treatments are so contrary to the ordinary well-working of the child's/adolescent's health.

3. Dr. Patrick Lappert

Dr. Lappert is a retired military plastic and reconstructive surgeon. Dr. Lappert performed numerous reconstruction surgeries for combat-related injuries. He also performed a significant

number of breast surgeries, both post-cancer as well as functional breast reduction surgeries for active duty sailors.

Initially, the Court found Dr. Lappert's testimony regarding surgical penile and vagina construction educational. Dr. Lappert spent quite some time testifying as to the intricacies of these surgeries. Also, he testified that there was great risk in both surgeries as to post-operative failure and infection. Moreover, he noted that the surgically-constructed penises and vaginas often do not work for urination, and seldom work in any sexual function. In fact, both may be totally numb.

Next, the Court found Dr. Lappert's discussion of body integrity disorder instructive. This disorder is a disorder wherein a patient seeks elective limb amputation because the person identifies as being handicapped. The DSM-5 discusses this disorder, and plastic surgeons have lost licenses and certifications because they performed these surgeries on these patients and performed elective healthy limb amputations. Dr. Lappert testified that removing the limb in this instance is unethical. This is because healthy limb amputation is in the service of a patient's subjective sense of themselves, and is therefore a cosmetic operation. However, it is a cosmetic operation that destroys function. Dr. Lappert then opines that gender affirming drug treatment and surgery on adolescents is, ethically, the same as removing the healthy limb in the body integrity disorder case.

XI. Procedural history

Plaintiffs sued in late July 2023 and filed a motion for a preliminary injunction. About three weeks later, the Court held a multi-day evidentiary hearing, consisting of six expert witnesses and eight fact witnesses. Defendants offered to merge the preliminary injunction hearing with a trial on the merits under Rule 92.02, which would have sped up resolution of this case. Plaintiffs refused. PI Tr. 808. The previously assigned judge then rejected the Plaintiffs' motion for a preliminary injunction, concluding that Plaintiffs' positions are "unpersuasive and not likely to

succeed." Order Denying Preliminary Injunction (Aug. 25, 2023). He made a specific fact-finding that there was a dispute over the scientific and medical evidence, *id.*, and so the legislature had authority to pick sides in that debate.

Between September 23 and October 3, 2024, this Court held a two-week trial that included nearly three dozen witnesses.

STANDARD OF REVIEW

As the Missouri Supreme Court has repeatedly determined, "every law is entitled to a presumption of constitutional validity." *City of Aurora v. Spectra Commun. Group, LLC*, 592 S.W.3d 764, 780 (Mo. banc 2019). To prevail, Plaintiffs must establish that the statute "*clearly and undoubtedly* violates a constitutional provision." *Interest of E.G.*, 683 S.W.3d 261, 265 (Mo. banc 2024) (quoting *State v. Meacham*, 470 S.W.3d 744–45 (Mo. banc 2015)) (emphasis added).

The Court finds that federal caselaw is relevant to this dispute. Although Plaintiffs say they raise claims only under the Missouri Constitution, both sides acknowledge that federal doctrine controls because "the Missouri Constitution's equal protection clause is coextensive with the Fourteenth Amendment." *Glossip v. Mo. Dep't of Transp. & Highway Patrol Emps. Ret. Sys.*, 411 S.W.3d 796, 805 (Mo. banc 2013); *see also Doughty v. Dir. of Revenue*, 387 S.W.3d 383, 387 (Mo. banc 2013) (describing the "due process protections of both our state and national constitutions" as "coextensive"); *Doe v. Phillips*, 194 S.W.3d 833, 841 (Mo. banc 2006) ("This Court rejects the . . . invitation to interpret the Missouri due process . . . clause[ ] more broadly than comparable federal constitutional provisions here.").

CONCLUSIONS OF LAW

Plaintiffs' pretrial brief makes clear that they are challenging three provisions of the SAFE Act: (1) the 4-year temporary moratorium on providing chemical or hormonal interventions to

minors for the purpose of transitioning gender, (2) the prohibition on providing surgeries to minors for the purpose of gender transition, and (3) the provision codifying a policy against the State paying for these interventions when used for the purpose of transitioning gender. Plaintiffs' challenge includes four counts, which allege violations of the Equal Protection, Due Process, anti-slavery, and "special law" clauses in the Missouri Constitution.

The Court concludes that these challenges fail for a variety of independent reasons. First, Plaintiffs made the strategic decision to raise a "facial" challenge rather than an as-applied challenge. That means they must show the three challenged provisions never can be enforced in any circumstance. But their own expert witnesses testified these procedures would be inappropriate in many circumstances. Defendants can at least enforce the laws in those circumstances, so the facial challenge must fail. Second, all of Plaintiffs' claims fail for the simple reason that there is a well-recognized medical dispute over the safety and efficacy of these interventions. Courts must defer to legislatures in areas of scientific and medical uncertainty. Third, and separately, there is no Equal Protection violation because the law treats both sexes equally. It applies a moratorium on gender transition procedures for minors regardless of whether a person is a boy or a girl. Fourth, the Due Process claim fails. Plaintiffs say their claim can only proceed if they prove a medical consensus around these interventions, but they cannot do so. Next, and very importantly, this Court finds that the State of Missouri has a definite interest in protecting the ethics of the medical profession as related to gender dysphoria treatment for minors. Also, the remaining challenges fail because the anti-slavery and "special law" clauses plainly are not applicable.

I. Plaintiffs Cannot Establish Entitlement to Facial Relief.

When a plaintiff challenges the constitutionality of a statute, the plaintiff may do so in two different ways. One way is to attack a provision in its entirety. This is called a "facial" challenge,

and it seeks to render a provision unlawful with respect to every potential plaintiff. The other way is to seek carve-outs to the application of a provision and assert that the provision—though lawful in some contexts—cannot be lawfully enforced in those carve-out situations. This is called an "as-applied challenge." *Black River Motel, LLC v. Patriots Bank*, 669 S.W.3d 116, 123 (Mo. 2023) ("An as-applied challenge requires Appellants to show the statute was unconstitutionally applied to their individual circumstances."). As Plaintiffs have repeatedly made clear, they chose the former: they bring a facial challenge to three provisions. PI Tr. 244, 757–58. But under both Missouri law and federal law, facial challenges are subjected to a much higher standard.

Plaintiffs "chose to litigate these cases as facial challenges, and that decision comes at a cost." *Moody v. NetChoice, LLC*, 144 S. Ct. 2383, 2397 (2024). Because "facial challenges threaten to short circuit the democratic process by preventing duly enacted laws from being implemented in constitutional ways," courts have "made facial challenges hard to win." *Id.* (internal quotation marks omitted).

As the Missouri Supreme Court has held, "'A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that *no set of circumstances* exists under which the Act would be valid.'" *State v. Kerr*, 905 S.W.2d 514, 515 (Mo. banc 1995) (quoting *United States v. Salerno*, 481 U.S. 739, 745 (1987)) (emphasis added); *see also Donaldson v. Missouri State Bd. of Registration for the Healing Arts*, 615 S.W.3d 57, 66 (Mo. banc 2020) (reaffirming "no set of circumstances" test and stating, "[i]t is not enough to show that, under some conceivable circumstances, 'the statute might operate unconstitutionally'") (citation omitted)).

Plaintiffs cannot establish "that no set of circumstances exists under which the Act would be valid." *Kerr*, 905 S.W.2d at 515 (quoting *Salerno*, 481 U.S. at 745). "Challengers bear the

burden of proving constitutional violations." *Salamun v. Camden Cnty. Clerk*, 694 S.W.3d 424, 428 (Mo. banc 2024). For at least three different reasons, the Court concludes that there are at least some circumstances in which the challenged provisions of the SAFE Act can constitutionally be enforced, so Plaintiffs' challenge necessarily fails as a matter of law.

A. Bicalutamide

First, there is no reasonable dispute that the law can constitutionally be enforced with respect to drugs or devices where there is no medical consensus. Plaintiffs focused their arguments on their assertion that there is a medical consensus around the use of testosterone and estrogen for hormonal intervention. The Court finds that there is no medical consensus for those hormones. But even if there were, the statute applies more broadly than to just testosterone or estrogen; it applies to *any* hormone or drug used for the purpose of gender transition.

Plaintiffs' witnesses testified that a host of other chemicals are also used for gender transition purposes, including bicalutamide (a prostate cancer drug). One plaintiff testified to receiving bicalutamide as a standalone drug regimen for the purpose of gender transition.

But there is no medical consensus around the use of bicalutamide for this purpose. Indeed, Plaintiffs rely on WPATH, but WPATH itself says, "Data on the use of bicalutamide in trans feminine populations is very sparse and safety data is lacking." Ex. 5, Standards of Care 8 at S124. "Given that bicalutamide has not been adequately studied in trans feminine populations, we do not recommend its routine use." *Id.*

Thus, even if Plaintiffs were correct about their assertions regarding testosterone and estrogen, there is no reasonable dispute that Defendants can enforce the law when it comes to other drugs or hormones, such as bicalutamide. This is enough to reject Plaintiffs' lawsuit.

B. Surgeries

Plaintiffs' similarly fail on their challenge to the provision concerning surgeries. The Act prohibits "gender transition surgery" and says this term includes surgeries "that sterilize," surgeries that "artificially construct tissue with the appearance of genitalia that differs from the individual's biological sex," and surgeries involving "[a]ugmentation mammoplasty or subcutaneous mastectomy." § 191.1720.2(5), .3, RSMo.

Plaintiffs presented no evidence about any of these surgeries. They provided no testimony that any of their individual plaintiffs are seeking these surgeries, nor that any of the organizational plaintiffs have members who are minors and are seeking these surgeries. Nor did they provide any evidence about the safety or efficacy of various surgeries. In contrast, Defendants put on an expert in Plastic Surgery, Dr. Patrick Lappert, who testified at length about the risks and lack of efficacy of these surgeries. And one of Defendants' detransitioner witnesses, Chloe Cole, testified that, approximately five years after the double mastectomy that her fifteen-year-old self and her parents were hurried into by her doctors, she still suffers daily regret, and regular discharge from wounds in her breasts that never properly healed.

Defendants moved for judgment as a matter of law on this issue, pointing out the evidentiary gaps in Plaintiffs' case. In response, Plaintiffs asserted that puberty blockers can be provided by injection or by implant. And because the implant involves a tiny incision (which requires nothing more than a butterfly bandage), they believe they can use that fact to challenge the surgery provision in its entirety.

This is exactly why the Missouri Supreme Court and the U.S. Supreme Court require plaintiffs who press facial challenges to "establish that no set of circumstances exists under which the Act would be valid." *Kerr*, 905 S.W.2d at 515 (quoting *Salerno*, 481 U.S. at 745). Simply put, a tiny incision for puberty blockers has nothing to do with double mastectomies or surgeries that

remove genitalia. Plaintiffs cannot use the tiny incision related to puberty blockers as a Trojan Horse to attack a law prohibiting surgeries with much more substantial, significant, and permanent side effects than a tiny incision. Plaintiffs' attempt to evade the rules around facial challenges is rejected.

C. The need for a gender dysphoria diagnosis, stability, and comprehensive assessments

Plaintiffs' facial challenge similarly fails because their experts conceded that chemical or surgical intervention is inappropriate in many circumstances.

For example, Plaintiffs' experts testified that these interventions should not be performed on minors who have yet to receive a diagnosis for gender dysphoria. But Jamie Reed offered unrebutted testimony that the clinic where she worked (the largest clinic in the state) provided these interventions without a gender-dysphoria diagnosis. There is no reasonable dispute that Defendants thus can lawfully enforce the Act to prohibit medical practitioners from employing these interventions on minors who have not received a gender dysphoria diagnosis, so Plaintiffs' facial challenge must fail. Their strategic decision to bring a facial claim instead of an as-applied claim dooms their case.

Similarly, Plaintiffs rely on the WPATH standards of care, but those guidelines "require[ ] the presence of marked and *persistent* gender incongruence." Ex. 5, Standards of Care 8 at S36 (emphasis added). There is thus no dispute that Defendants can enforce the Act in situations where a medical practitioner has not first ensured that a person's gender identity is stable. Yet the testimony at trial showed that these interventions have regularly been provided to minors whose gender identities are fluctuating even on a day-to-day basis. One parent testified for Defendants, saying her child's gender identity changed three times in less than a year. Jamie Reed testified about multiple patients whose gender identities change day to day. Even Plaintiffs' witness Eliot

M. testified to having a "fluid" identity that changes day to day—and that witness first obtained chemical interventions in Missouri at age 17.

Finally, Plaintiffs' experts conceded that these interventions are inappropriate where a minor has not first received a comprehensive mental health assessment. A comprehensive mental health assessment goes beyond a gender dysphoria diagnosis; as Plaintiffs' experts testified, these interventions are not appropriate for every individual diagnosed with gender dysphoria. PI Tr. 109. Even WPATH agrees that interventions in circumstances where a person has a gender dysphoria diagnosis but not a comprehensive mental health assessment are experimental: "There are no studies of the long-term outcomes of gender-related medical treatments for youth who have not undergone a comprehensive assessment." Ex. 5, Standards of Care 8 at S51; *see also* PI Tr. 107 (Plaintiffs' expert Dr. Janssen agreeing that "failure to provide a comprehensive assessment would be outside the standard of care").

The testimony reveals that minors in Missouri have been provided these interventions without practitioners first ensuring that the individuals have received a comprehensive mental health assessment. For example, both Doctors Donovan and Antommaria said that a comprehensive assessment should include a psychological assessment. *See also* Olson-Kennedy aff. ¶ 41 (stating that these interventions can be provided only "after a comprehensive psychological evaluation of the patient"); Janssen aff. ¶ 63 ("Puberty-delaying medications and gender-affirming hormones are prescribed *only* after a comprehensive psychosocial assessment by a qualified mental health professional." (emphasis added)). Yet at the preliminary injunction hearing, Plaintiffs were asked whether two of the minor patients had received these assessments. They said no.

> THE COURT: In connection with the Wash U Center, did C.J. undergo a full psychological evaluation?

THE WITNESS: He was seen by a licensed therapist.
THE COURT: Okay. But did he have a psychological evaluation?
THE WITNESS: No.
THE COURT: Did he have a psychiatric evaluation?
THE WITNESS: No.

PI Tr. 304.

Q. Has Nicholas had a full psychological or psychiatric evaluation assessment done?
A. No.

PI Tr. 328.

Jamie Reed likewise offered unrebutted testimony that the clinic at Washington University, the biggest in the State, failed to ensure that each individual receives a comprehensive mental health assessment (despite having a policy requiring those assessments). PI Tr. 515, 568–69. She testified that the center touts itself as a multidisciplinary center that provides not only hormonal interventions, but also psychological and psychiatric care, but that the psychologist and psychiatrist working with the center lacked capacity to treat patients. For several periods each lasting months at a time, Reed was not permitted to send any patients to those disciplines.

Reed also testified that other organizations in Missouri also have a *policy* of not requiring comprehensive mental health assessments and that the Washington University clinic would refer individuals to those other clinics specifically to get around the need for that assessment. Because Plaintiffs do not dispute that the interventions lack any evidentiary basis in these circumstances, the law can be enforced at least in those circumstances. Plaintiffs' claims thus necessarily fail. They chose only to bring facial challenges, not as-applied challenges, and that choice has consequences.

II. Plaintiffs failed to properly plead, argue, or prove their Medicaid claim.

Although Plaintiffs state on page 42 of their pretrial brief that they are challenging the provision barring Medicaid funding of these interventions, none of Plaintiffs' counts clearly

challenge the provision barring Medicaid coverage for gender transition interventions. None of those counts mentions Medicaid. Just one count (Count I) mentions "insurance," but that singular mention is left undeveloped in the 30 paragraphs comprising Count I.

Plaintiffs' pretrial brief does no better. The Medicaid provision differs from the other provisions because it applies to adults and minors. Yet Plaintiffs fail to develop any argument specifically tailored to challenging the Medicaid provision even though the question whether a State must permit a procedure is very different from whether the State must affirmatively *fund* that procedure. For example, States were required to *permit* abortion under *Roe v. Wade*, 410 U.S. 113 (1973), but the U.S. Supreme Court also held that States were under no obligation to *fund* abortion through Medicaid, *Harris v. McRae*, 448 U.S. 297, 316 (1980) (a woman's right to abortion does not carry with it "a constitutional entitlement to the financial resources to avail herself of the full range of protected choices"); *Beal v. Doe*, 432 U.S. 438, 445–47 (1977) (holding that States were not required to fund nontherapeutic abortions through their Medicaid programs); *see also Rust v. Sullivan*, 500 U.S. 173, 193 (1991) (government may "fund one activity to the exclusion of the other").

Much more argument is needed than what Plaintiffs have shown. States have limited resources and are not able to fund everything. Medicaid dollars expended to fund one type of procedure necessarily means other procedures—such as emergency services—are left unfunded or underfunded. "Medicaid was ... designed ... to provide the largest number of necessary medical services to the greatest number of needy people." *Ellis v. Patterson*, 859 F.2d 52, 55 (8th Cir. 1988). If a State has enough funds to cover only one of two different procedures, the State must triage and decide which procedure will lead to the best health outcomes overall. It may choose, for example, to focus resources on procedures that increase life longevity by years rather than

expensive procedures that modestly decrease pain for a short time—even though both procedures are independently worthwhile.

Absent federal preemption, these are policy decisions Missouri is entitled to make. "Medicaid … is designed to advance cooperative federalism." *Wisc. Dep't of Health and Fam. Services* v. *Blumer*, 534 U.S. 473, 495 (2002). Apart from federally established floors, the program "leave[s] to States the decision" of what to cover. *See id.* at 497 (internal quotation marks omitted); *see also Beal*, 432 U.S. at 444 (Medicaid statute "confers broad discretion on the States"). Plaintiffs fail to develop any argument as to why Missouri lacks this discretion. Missouri Medicaid excludes all kinds of procedures that a physician may determine to be medically necessary. *See* Missouri Medicaid Ambulatory Surgical Center Provider Manual 13 (2024).[12] Plaintiffs' failure to properly plead or develop this argument means Defendants and this Court have been "left guessing at the nature of [Plaintiffs'] argument." *Brown v. Brown*, 645 S.W.3d 75, 82 (Mo. App. W.D. 2022) (citation omitted).

For the reasons stated below, the Medicaid argument also fails because of the "evolving nature of the diagnosis and treatment of gender identity disorder and the disagreement regarding the efficacy" of these interventions. *Smith v. Rasmussen*, 249 F.3d 755, 760 (8th Cir. 2001) (holding that Medicaid in Iowa need not cover gender transition surgeries). Federal law in fact *forbids* "payment for medical services 'which are not reasonable and *necessary* for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.'" *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980) (quoting 42 U.S.C. § 1395y(a)(1) (1976)) (emphasis added). As already explained, gender dysphoria does not alter a person's physiology.

[12] https://mydss.mo.gov/media/pdf/ambulatory-surgical-center-provider-manual

And because there is no medical consensus on the safety or efficacy of these interventions, Missouri Medicaid need not pay for them.

Finally, Plaintiffs failed to submit sufficient evidence at trial. None of the Plaintiffs provided evidence that they are on Medicaid. Nicole Carr (a nurse) testified that she has seen patients on Medicaid—but she saw them for purposes other than treating gender dysphoria. Dr. Donovan testified that some of his patients are on Medicaid, but he could not say whether any of his patients had ever used Medicaid to pay for treatments for gender dysphoria rather than other conditions that he and his clinic treat. Similarly, organizational plaintiff GLMA could not say whether any of its few members in Missouri are Medicaid providers or individuals on Medicaid. And the person who testified on behalf of organizational plaintiff PFLAG could not think of a single specific member of PFLAG harmed by the SAFE Act.

Even if Plaintiffs had submitted sufficient evidence, they would not satisfy the stringent standard for facial challenges for the reasons stated earlier. Even if Plaintiffs could prove that Medicaid funding is constitutionally required in *some* circumstances, they have not proved and cannot prove that it is constitutionally required in all circumstances, which is what they must do to satisfy the facial standard. For example, because Missouri can lawfully prohibit these interventions in a number of circumstances (lack of gender dysphoria diagnosis, lack of comprehensive mental health assessment, bicalutamide, surgeries), it necessarily follows that Missouri can decline to pay for those procedures in those circumstances. That is enough to defeat the facial challenge.

III. Plaintiffs Cannot Establish an Equal Protection or Substantive Due Process Violation.

The Court's analysis above is enough to resolve this case. Plaintiffs made a strategic choice to raise only facial challenges, not any as-applied challenges, "and that decision comes at a cost."

NetChoice, 144 S. Ct. at 2397. Because Plaintiffs declined to raise any as-applied challenge and cannot satisfy the heightened standard for facial challenges, the Court must reject their claims. The Court nonetheless also assesses their claims under the Equal Protection and Due Process clauses because their claims easily fail as well.

The SAFE Act does not permanently prohibit individuals from obtaining these interventions. Rather, it simply says children must wait until they turn 18. In that respect, Missouri's law is similar to the dozens of laws across the country prohibiting tattoos for minors, California's law prohibiting certain neurosurgeries for minors (Cal. Welf. & Inst. Code § 5326.6(d)), and countless other laws that treat minors and adults differently.

In the end, Plaintiffs' claims must fail because—as Plaintiffs' experts acknowledged at trial and as the judge previously assigned to this case concluded—there is a substantial medical dispute over the safety and efficacy of these interventions.

A. When there is a reasonable medical dispute, courts must defer to the legislature.

Plaintiffs bring their first count under the Equal Protection Clause of the Missouri Constitution, which provides "that all persons are created equal and are entitled to equal rights and opportunity under the law." Mo. Const. art. I, § 2. This clause is "coextensive" with the Equal Protection Clause in the U.S. Constitution. *Glossip*, 411 S.W.3d at 805.

Claims under that clause are assessed under one of two levels of scrutiny. Under the default level, rational basis, "[t]he statute is presumed to have a rational basis, and this presumption will only be overcome by a 'clear showing of arbitrariness and irrationality.'" *Snodgras v. Martin & Bayley, Inc.*, 204 S.W.3d 638, 641 (Mo. banc 2006) (quoting *Fust v. Att'y Gen. for the State of Mo.*, 947 S.W.2d 424, 432 (Mo. banc 1997)). In contrast, heightened scrutiny applies if the plaintiff proves that "the statute contains a classification that 'operates to the disadvantage of some suspect class or impinges upon a fundamental right explicitly or implicitly protected by the Constitution.'"

Glossip, 411 S.W.3d at 801–02 (quoting *In re Marriage of Kohring*, 999 S.W.2d 228, 231–32 (Mo. banc 1999)). In cases where the plaintiff proves the statute contains a sex-based classification that "operates to the disadvantage of " one sex compared to the other, the burden flips and the state "has the burden of demonstrating that the statute serves important government interests and is substantially related to achieving those interests." *Id.*

The parties dispute the level of scrutiny, but that dispute is irrelevant. Regardless of the scrutiny level, courts must defer to legislatures where, as here, there is a medical or scientific dispute. As the United States Supreme Court has held, States have "wide discretion" to regulate "in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). "When [a legislature] 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). The U.S. Supreme Court has made clear that this rule applies regardless of whether the case involves rational basis review or 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), a case involving heightened scrutiny). So this Court need not even determine the level of scrutiny. Defendants prevail under any level.

As already explained, Plaintiffs' experts conceded that there is an entrenched medical dispute. Dr. Shumer, for example, said that he has looked at the underlying evidence and simply has come to a different conclusion than medical authorities in Europe and the U.S. Agency for Healthcare Research and Quality. And while Plaintiffs' experts rely on their own clinical experience, every country to have conducted a "systematic review," which is the highest form of evidence in evidence-based medicine, has unanimously determined that the reports purporting to

show benefits from gender transition interventions are of "very low" quality—meaning that the true result is likely quite different from the result reported.

The reason courts must defer to the legislature under any level of scrutiny when there is a medical dispute is clear. Neither the Missouri Constitution nor the U.S. Constitution provides any guidance to courts to choose between one medical authority and another. This Court is not equipped to choose, as a constitutional matter, between (on the one hand) the medical opinions of Plaintiffs' expert witnesses and trade organizations and (on the other hand) the medical opinions of Defendants' expert witnesses, half a dozen countries in Europe, and the U.S. Agency for Healthcare Research and Quality. That is a job for the legislature. "Prohibiting citizens and legislatures from offering their perspectives on high-stakes medical policies, in which compassion for the child points in both directions, is not something … judges should do without a clear warrant in the Constitution." *Skrmetti*, 83 F.4th at 472.

A couple examples suffice to show the deeply entrenched medical dispute.

First, Plaintiffs rely on two studies by the author de Vries, who developed the Dutch Protocol. But another study (Carmichael) tried to replicate the de Vries study and found no improvement. And Defendants identify systematic reviews that have graded the quality of the de Vries studies to be "very low"—meaning the actual result of the interventions is likely substantially different from what de Vries reported. There is also agreement on both sides that the demographics of individuals presenting at clinics now are very different than the individuals evaluated during the creation of the Dutch Protocol: the sex ratio is quite different, individuals with mental health issues were excluded from the Dutch Protocol (but are not in these clinics), and all individuals in the Dutch Protocol had a gender dysphoria onset before puberty (whereas a substantial proportion now have onset after). It is not for this Court to determine to what extent

these differences matter or whether to rely on the initial study or the follow-up study that found no improvement.

Similarly, the evidence is all over the map about the potentially serious effects of puberty blockers on brain development. Plaintiffs presented a witness who acknowledged that these blockers can decrease brain volume but tried to dismiss that decrease as not concerning. The Endocrine Society guidelines, in contrast, stated that "there may be an effect of GnRH analogs [puberty blockers] on cognitive function" and urged "more rigorous evaluations," which have not yet occurred. Ex. 306, Endocrine Society Guidelines 3874, 82–83. There was also testimony about studies showing a decrease in IQ of up to 15 points for individuals on puberty blockers and saying that further research in this area is an "urgent" priority. It is not for this Court to decide which if any of these competing medical narratives is correct.

Simply put, the reason courts must defer (regardless of the level of scrutiny) when the medical or scientific evidence is conflicting or unclear is simple: Courts have no expertise or constitutional authority to settle medical debates. *K.C. v. Individual Members of the Med. Licensing Bd. Of Ind.*, 2024 U.S. App. Lexis 28833 (7th Cir. 13 Nov 2024). Where policymakers must make decisions in areas containing legitimate medical debates, courts defer to democracy. "[T]he most deeply rooted tradition in this country is that we look to democracy to answer pioneering public-policy questions." *Skrmetti*, 83 F.4th at 472.

B. Plaintiffs' counterarguments are unpersuasive.

Plaintiffs raise a number of counterarguments. The Court finds them unpersuasive.

First, Plaintiffs acknowledge that medical authorities in other developed countries have declared the evidence base to be "remarkably weak" and "experimental" and have concluded that the harms outweigh the benefits. But Plaintiffs contend these countries' conclusions are irrelevant because the countries have not fully "banned" these interventions, leaving open a narrow window

for formal research protocols. But Plaintiffs are not suing to seek to conduct formal research protocols, and they provided no evidence or argument that the law even forbids research studies. They are suing to administer these interventions as a matter of general medicine.

There is also little relevant difference in accessibility between Missouri and, for example, the United Kingdom.[13] Indeed, it is *easier* to access these procedures for Missouri residents than for residents of the United Kingdom. Residents of the United Kingdom cannot get puberty blockers at all in that country until formal research protocols begin. Plaintiffs, in contrast, testified that they are able to obtain puberty blockers and cross-sex hormones just across the border into Kansas (in the Kansas City metro) and in Illinois just an hour and a half away from St. Louis. Cross-sex hormones are available in the United Kingdom—but only barely. The default rule is that one must "wait[ ] until an individual reaches 18." Ex. 1005, Cass Review, at 35–36. Only in exceptional circumstances can cross-sex hormones be obtained before then, and even then only "from age 16," only under "extreme caution," only after "psychological support," and only as a "tertiary" intervention. *Id.*

The Court also has concerns with deferring to the organizations relied on by Plaintiffs, such as WPATH, which self-describes itself as an organization "committed to advocacy" of certain "policy and legal changes." Ex. 5, Standards of Care 8 at S5. As Plaintiffs' expert Dr. Antommaria acknowledged, WPATH's guidelines have repeatedly been condemned by systematic reviews.

[13] Some of Plaintiffs' experts were dismissive of evidence from other countries, arguing that the experience in other countries is not relevant to what is going on in the United States. The Court finds that problematic for two reasons. First, Plaintiffs provided no evidence that suggests treatment protocols should differ by country. Children in the United States have the same hormones as children in the U.K. or Sweden. Second, Plaintiffs' experts are willing to credit research in other countries when it suits them. For example, they rely extensively on the "Dutch Protocol" and a set of foreign studies about that protocol. Plaintiffs' experts should not rely on foreign studies when it suits them but dismiss evidence from the same or similar countries when it challenges their claims.

Indeed, Dr. Antommaria acknowledged that WPATH did not follow the standard requirements for crafting its guidelines because WPATH did not base its recommendations on systematic reviews. The court also reviewed documents filed in court by the United States suggesting that WPATH has suppressed research unfavorable to its agenda. And the Court heard testimony from Dr. Levine, formerly a chair of WPATH who helped author a previous version of the guidelines, about how he left WPATH because he perceived that the organization had chosen to pursue political ends rather than scientific ends. *See, e.g.*, *Gibson v. Collier*, 920 F.3d 212, 222–23 (5th Cir. 2019) (crediting "Dr. Levine['s] expressed concerns that later versions of WPATH were driven by political considerations rather than medical judgment"). This Court agrees with the Fifth Circuit and "agree[s] with the First Circuit that the WPATH Standards of Care do not reflect medical consensus, and that in fact there is no medical consensus at this time." *Id.*; *see also Kosilek v. Spencer*, 774 F.3d 63, 77–78 (1st Cir. 2014) (en banc) (court-appointed expert Dr. Levine testified that "alternate views are not well tolerated" at WPATH and that WPATH's Standards of Care "is not a politically neutral document").

These concerns are especially significant because the medical providers who are plaintiffs in this case testified that they must rely on guidelines. Quite reasonably, busy clinical practitioners often must rely on research and guidelines conducted by others. Where, as here, the evidence reveals that WPATH departed from ordinary practice for crafting guidelines, it is especially appropriate for the State to intervene. *See Eknes-Tucker v. Gov. of Alabama*, 114 F.4th 1241, 1249 (11th Cir. 2024) (Lagoa, J., concurring in denial of rehearing en banc) ("WPATH officials are aware of the risks of cross-sex hormones and other procedures yet are mischaracterizing and ignoring information about those risks."); *see also id.* at 1261 ("[R]ecent revelations indicate that WPATH's lodestar is ideology, not science.").

Second, Plaintiffs say the State cannot regulate here if the State does not similarly regulate other procedures that carry similar risks. But it has long been settled that the legislature need not "strike at all evils at the same time." *Semler v. Or. Bd. of Dental Exam'rs*, 294 U.S. 608, 610 (1935). It is a strange argument, in complaining about a regulation, to insist that the legislature should have regulated even more. It also is not true that other procedures carry the same benefit-risk profile. Recall, after all, that gender dysphoria is not a physical condition. Plaintiffs identify treatments that cure physical defects, but the interventions at issue here affirmatively *reduce* the physical function of an otherwise perfectly health physical body. And as discussed at length throughout trial by experts and fact witnesses alike, gender transition interventions have substantial, often permanent, side effects. These include diminished or completely impaired fertility, possible decrease in IQ, hypertension, cardiovascular disease, cancer, and premature mortality of as much as 10 or 20 years. Worse, there is some evidence that all these interventions are entirely unnecessary in the first place and may in fact be causing gender dysphoria. Children who start on puberty blockers almost always go on to cross-sex hormones, whereas at least 85% of children who do not undergo medicalized transition will desist by the time of adulthood.

C. The SAFE Act passes constitutional muster as there is no consensus as to the propriety of adolescent gender dysphoria treatment in the context of medical ethics.

This Court heard conflicting testimony as to the ethical propriety of performing various levels of gender-affirming treatment on children and adolescents. Such a conflict within the medical profession itself is cause for alarm, and gives rise to a legitimate basis for a legislature to enact legislation.

The United States Supreme Court reviewed a Washington State statute which prohibited physician-assisted suicide. In affirming the constitutionality of the Washington state law, the Court discussed the State's power to pass laws that concern medical treatment and medical ethics. It held:

> "The State also has an interest in protecting the integrity and ethics of the medical profession. In contrast to the Court of Appeals' conclusion that "the integrity of the medical profession would [not] be threatened in any way by [physician-assisted suicide]," 79 F.3d, at 827, the American Medical Association, like many other medical and physicians' groups, has concluded that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer." And physician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming.

Wash v. Glucksberg, 521 U.S. 702, 731 (1997)(internal citations omitted).

In *Skrmetti*, the 6th Circuit Court of Appeals recently upheld two statutes very similar to the Missouri statute at bar. When discussing a state's regulation of medical ethics, that court cited several prior U.S. Supreme Court cases. The 6th Circuit held:

> "Constitutionalizing new parental rights in the context of new medical treatments is no mean task. On the one side of the ledger, parents generally can be expected to know what is best for their children. On the other side of the ledger, state governments have an abiding interest in "preserving the welfare of children," *Kanuszewski v. Mich. Dep't of Health & Hum. Servs.* 927 F.3d 396, 419 (6th Cir. 2019); *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2284 (2022), and "in protecting the integrity and ethics of the medical profession," *Wash. v. Glucksberg*, 521 U.S. 702, 731 (1997). These interests give States broad power, even broad power to "limit [] parental freedom," *Prince v. Massachusetts*, 321 U.W. 158, 167, (64 S. Ct. 438, 88 L.Ed. 645 (1944); see *Parham v. J.R.*, 442 U.S. 584, 606, 99 S. Ct. 2493, 61 L.Ed. 2c 101 (1979), particularly in an area of new medical treatment. We doubt, for example, that there are many drug-regulatory agencies in the world that, without satisfactory long-term testing, would delegate to parents and a doctor exclusive authority to decide whether to permit a potentially irreversible new drug treatment."

L.W. v. Skrmetti, 73 F.4th 408, 417 (6th Cir. 2023)(cert. granted June 24, 2024).

After reviewing the evidence in this case, this Court is absolutely convinced that there is no medical ethical consensus whatsoever as to whether gender dysphoria treatment should be performed on children and adolescents, and if so, what level should be allowed. The Court will attempt to highlight just a few of the medical ethical issues that are, as of yet, unsolved.

Lack of studies leads to inability to adequately warn children and families

Initially, the parties agree that there is scant evidence as to the efficacy of gender dysphoria treatment for children and adolescents as there are so few short- and long-term studies. It follows that the Court is unsure how a health care provider could accurately inform a patient and family of the risks involved, when there is such a paucity of evidence of the actual risks. There are no long-term studies anywhere, so how can we discuss what treatment success or failure might look like in 1 year or 20 years? The evidence at trial shows that medical ethical authorities have no agreed-upon answers as to this issue.

The ethical question of allowing a child to undergo medical treatment and surgery that will either diminish or destroy natural body function and healthy growth processes

One of the ethicists at trial testified that he was deeply troubled by allowing an adolescent/parent team to request medical treatments and surgeries found in adolescent gender-affirming care. Generally, a parent can take a teenager to the emergency room and freely consent to hospital personnel fixing the teen's broken bone. This would be a medical treatment that does not destroy or diminish natural human function. On the contrary, puberty blockers and cross-sex hormones greatly diminish natural human growth and maturation of body and organs. Sex change surgeries remove natural body parts, and sometimes replace them with either surgically-created parts (penises and vaginas) or insert factory made parts (silicone breast implants).

While this Court agrees that parents should generally have a say in the treatment their children receive, treatments that permanently retard or destroy natural human growth or function are a different discussion entirely. There is a good reason that state and federal law does not allow minors to make certain decision, and it stands to reason that parents might be statutorily prevented from taking a child to a gender care clinic and having a son or daughter undergo these medical and surgical treatments. The Due Process Clause does not afford parents the right to access gender

transition procedures for their children. *K.C. v. Individual Member of the Med. Licensing Bd. Of Ind.*, 2024 U.S. App. Lexis 28833 at 27-36. This is another issue wherein the medical ethicists offer conflicting opinions as to whether such treatment should be allowed.

The vagueness of health care providers offering "transitioning" services

People presently discuss "transitioning" as if a teenager is wholly changing sex from male to female, or vice versa. However, today's medical science does not provide a way for a person to ever fully and permanently change his/her sex. The evidence shows that a physician-crafted penis is never going to function 100% like a natural penis, and the same goes for an operating room-made vagina. Yet healthcare providers and patients call this process "transitioning", as if a human male will fully become a human female.

A result is that adolescent gender dysphoria patients seek treatment, with the child and parents entering a gender clinic to begin a long-term regimen of puberty blockers, cross-sex hormones, and eventually sex change surgery. However, all of this treatment will never result in a full change of sex for the patient. A human born male may receive breast implants and have a vagina crafted, but he will never be able to gestate or breastfeed a baby. A human born female may receive a surgically-crafted penis, but that penis will never be able to fully function as a natural penis, and this patient will never be able to impregnate a human female partner. Nonetheless, gender clinics discuss and request payment for these drugs and surgeries as if they actually do wholly change sex. Worse, patients and families might expect a full sex change, but this never occurs. The adolescent's body is permanently, but not fully, changed. This is another issue the medical ethicists have not yet settled.

The medical ethics of using unapproved and untested drugs for puberty blocking and cross sex hormone therapy.

Another ethical issue that arises from adolescent gender dysphoria treatment is that of using drugs in off-label fashion for puberty blocking and cross-sex hormones. Puberty blocking drugs are prescribed and tested for use in precocious puberty, wherein a child begins puberty at too young an age. However, the puberty blockers have not been tested and approved for use for puberty blocking in the context of gender-affirming treatment for teenagers. There are very few short-term and long-term studies for this use, and the evidence suggests that puberty-blocking drugs have side effects, such as stunted growth, that are irreversible. Nonetheless, gender health care providers are prescribing these drugs to adolescent patients, and the patients are taking the providers at their word that these drugs are safe and efficacious.

The same issues arise for cross-sex hormones. Estrogen and testosterone have many approved medical uses. However, use of these drugs for adolescent gender dysphoria treatment is not approved and not tested. Moreover, the side effects of high dosage estrogen for males, and testosterone for females, are well documented, and very often irreversible. Nonetheless, gender care providers are still using these unapproved drugs on teenagers. Again, medical ethicists debate whether such drug usages are proper.

The inability of adolescents to legally and actually consent to gender affirming treatment.

At trial, the Court heard conflicting testimony as to whether teenagers are capable of making informed decisions. The plaintiffs brought in experts who testified that teenagers should be able to make gender care decisions. This testimony was absolutely unconvincing.

Moreover, Missouri and federal law holds that adolescents are not allowed to make decisions as to a range of issues. Adolescents can't join the military until a certain age is reached, can't vote until age 18, and can't receive a commercial driver's license until 18 years of age. If we don't let a 16-year-old buy a six-pack of beer and a pack of smokes, or let an adult buy those items

for them, should we allow the same kid/parent team to decide to change a teenager's sex forever? The Seventh Circuit Court of Appeals recently held that the Due Process Clause does not afford parents the right to access gender transition procedures for their children. *K.C. v. Individual Member of the Med. Licensing Bd. Of Ind.*, 2024 U.S. App. Lexis 28833 at 27-36. Again, while state and federal law have already answered these types of questions, the medical community has no consensus on the ethics of this gender-affirming care issue.

Gender affirming care becomes a lifelong regimen of treatment

Another ethical issue that arises is that gender-affirming medical and psychiatric care never really ends. If a patient receives the full regimen of care, puberty blockers, cross sex hormones, and sex change surgery, a normal person would assume the trips to the hospital would be over. But, that is not the case. The evidence shows that a patient must stay on cross-sex hormones in perpetuity, or the effects will diminish somewhat. The evidence further shows that people who receive medical treatment stay in some form of psychiatric counseling long-term. So, what was initially discussed as some sort of gender dysphoria "cure" has become a journey that never actually ends.

Patient regret and desisting

Not only does gender dysphoria care never really end, but some patients eventually regret having ever starting the drugs and surgeries. The court heard from witnesses who regretted receiving gender-affirming care. Chloe Cole's care began very early in life, and she now, at twenty years of age, wants to get married, have kids and breast feed. She can get married, but her double mastectomy will prevent her from every breastfeeding, and the large amount of testosterone she took at an early age may prevent her from being fertile. Ms. Cole's adolescent journey to a gender

dysphoria cure now has her wishing she had never set sail in the first place. Once again, the medical ethics experts have no consensus answer as to the ethics of this issue.

The use of untested medical drugs and surgeries on children who would naturally heal without intervention over time

The credible evidence from this case shows that adolescent gender dysphoria usually resolves itself over time. The credible evidence shows that between 80-95 % of child patients diagnosed with gender dysphoria will have the symptoms abate after adolescence. But, it seems patients and healthcare providers still maintain that these gender dysphoria medical treatments, with irreversible side effects, are somehow medically necessary.

Regarding the ethics of adolescent gender-affirming treatment, it would seem that the medical profession stands in the middle of an ethical minefield, with scant evidence to lead it out. Physicians are utilizing unapproved drugs in an off-label fashion, and there are few studies to inform us as to the short- and long-term effects thereof. Adolescent patients are not legally and mentally able to consent to the sex change and gender-affirming treatment, and physicians don't really have enough evidence to adequately warn patients and families of all the possible risks involved. In addition, the present evidence seems to show that a considerable percentage of adolescent patients who are diagnosed with gender dysphoria report that the symptoms naturally resolve on their own after adolescence.

Clearly, Missouri's Senate Bill 49 forces the medical profession to pump the brakes on gender-affirming treatment for children and adolescents. The Court finds that there is very little evidence for the medical profession to base its ethics recommendations on. The medical community is not ready to discuss these ethical issues in a worthwhile manner.

The United States Supreme Court allowed a state to prohibit physician-assisted suicide, by holding that Washington State had an interest in protecting the ethics and integrity of the medical profession. *Glucksberg*, 521 U.S. at 731. The Court reasoned such physician actions of helping a patient commit suicide could be damaging to medical professional ethics by blurring "the time-honored line between healing and harming." *Id.*

This Court is bound to follow this rule of *Glucksberg*. This Court finds that the use of puberty-blocking drugs, cross sex hormones, and sex change surgeries for gender dysphoria treatment for minors is ethically suspect and problematic. Both short-term and long-term evidence as to the efficacy and necessity of these treatments is extremely sparse. Moreover, the idea of children and parents deciding on medical treatments that will irrevocably and possibly unnecessarily change a minor's body is inimical to most American law and thought. Clearly, a sincere legislature could find that this treatment blurred "the time-honored line between healing and harming," or that the treatment, "is fundamentally incompatible with the physician's role as healer," and rationally pass legislation prohibiting such treatment until further study and discussion was had as to the ethics thereof. *Id.*

Accordingly, this Court must find that the above-discussed ethics issues prove that the Missouri statutes at issue are constitutional.

IV. The SAFE Act satisfies rational basis review.

For the reasons stated above, the Court need not even decide which level of scrutiny applies: Defendants prevail regardless. But in any event, Plaintiffs also cannot establish an Equal Protection violation because the Act is subject to rational basis review, in that it does not "contain[ ] a classification that 'operates to the disadvantage of some suspect class.'" *Glossip*, 411 S.W.3d

at 801–02 (citation omitted). Rational basis is satisfied here, and Plaintiffs' counterarguments are unpersuasive.

A. The SAFE Act is subject only to rational basis review because it applies evenly across the board, treating both sexes the same.

The Act is subject only to rational-basis review because it does not disadvantage either sex. This is easiest to see with the provisions pertaining to puberty blockers and surgeries. "[P]uberty blockers involve the same drug used equally by gender-transitioning boys and girls." *Skrmetti*, 83 F.4th at 483. The Act prohibits the use of this same drug in both female and male patients. Similarly, the Act regulates "[s]urgical procedures that sterilize," § 191.1720.2(5)(a), RSMo, a category that applies equally to both sexes. In other words, both female and male patients are treated exactly the same. The Act does not treat males and females differently, much less "disadvantage" one group with respect to the other. *Glossip*, 411 S.W.3d at 801–02.

The same is true for cross-sex hormones. The Act prohibits providing any "cross-sex hormones" to any minor—male or female—"for the purpose of a gender transition." § 191.1720.4, RSMo. And it defines "cross-sex hormones" to include any number of drugs, not just testosterone and estrogen. *Id.* § 191.1720.2(2). In other words, no male or female may receive *any* hormone or drug for the purpose of gender transition. The Act thus treats both male and female patients equally.

As several federal appellate courts in the last year have concluded, this kind of law "lacks any of the hallmarks of sex discrimination. It does not prefer one sex over the other." *Skrmetti*, 83 F.4th at 480 (upholding Tennessee and Kentucky laws). Rather, it "regulate[s] sex-transition treatments for all minors, regardless of sex. Under each law, no minor may receive puberty blockers or hormones or surgery in order to transition from one sex to another." *Id.* This kind of law "is best understood as a law that targets specific medical interventions for minors, not one that classifies on the basis of any suspect characteristic under the Equal Protection Clause." *Eknes-*

Tucker v. Gov. of Alabama, 80 F.4th 1205, 1227 (11th Cir. 2023). That is because "the statute does not establish an unequal regime for males and females." *Id.* at 1228; *see also Corbitt v. Sec'y of the Ala. L. Enf't Agency*, 115 F.4th 1335, 1346 (11th Cir. 2024) (holding that an Alabama law did "not distinguish between males and females in any respect" because it applied "to *all* 'individuals wishing to have their sex changed on their Alabama driver's license'" (emphasis in the original) (alterations adopted)).

Plaintiffs nonetheless contend that the Act allows girls to receive estrogen but not boys, and so is discriminatory. But the Act does no such thing. It permits both sexes to obtain testosterone or estrogen for any medical purpose *other* than "for the purpose of a gender transition." § 191.1720.4, RSMo. Plaintiffs' own expert witness, Dr. Shumer, conceded that the Act does not prohibit "treatments for precocious puberty," "Hypogonadism," or "anything other than" gender transitions. PI Tr. at 190. So a female patient who has low testosterone or estrogen because of a gland problem can receive hormone therapy of either hormone to treat that condition. The same is true for male patients. But neither can receive any drug or hormone for purpose of gender transition.

Thus, it does not matter that clinicians typically choose to use different hormones to transition natal females than natal males. The first group is often given testosterone, the latter estrogen. But that is because giving a male testosterone is a not a gender-transition procedure. (Likewise for giving a female estrogen.) Plaintiffs' experts certainly do not believe they are treating male and female patients differently by using different hormones. To the contrary, Plaintiffs' testified that providing estrogen to a male is the same treatment as providing testosterone to a female.

Medicine *always* takes into account differences in patient physiology. To the diabetic patient, insulin is lifesaving. To the hypoglycemic patient, it can be life ending. Here, one of those differences is the starkly different natural hormone levels in males and females. "These distinct uses of testosterone and estrogen stem from different diagnoses and seek different results." *Skrmetti*, 83 F.4th at 481. To say giving testosterone to a female is the "same treatment" as giving testosterone to a male is like saying testosterone to rectify a gland problem is the same as testosterone to boost a baseball player's chances of hitting a home run. As the U.S. Supreme Court put it two years ago, "[t]he regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny." *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 236 (citing *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974)).

That is because Equal Protection only prohibits "governmental decisionmakers from treating differently persons who are *in all relevant respects* alike.'" *Adams ex rel. Kasper v. Sch. Bd. of St. Johns Cnty.*, 57 F.4th 791, 803 n.6 (11th Cir. 2022) (citation omitted) (emphasis added). "The Equal Protection Clause does not forbid classifications. It simply keeps governmental decisionmakers from treating differently persons who are in all relevant respects alike." *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992). Males and females are not alike with respect to hormone levels.

Indeed, Plaintiffs would surely complain if the legislature passed a bill prohibiting large testosterone infusions in males and females but did not regulate estrogen. And they would be right to complain. Because that law would regulate only testosterone, that hypothetical bill would allow males, but not females, to use hormones in an attempt to transition. To treat both sexes equally, the Act thus must regulate based on procedure, not based on hormone. The Act is neutral with respect to sex because it regulates hormonal gender interventions in both sexes.

Accepting Plaintiffs' argument would lead to absurd results. It would mean that States could not provide insurance coverage for pregnancy, pap smears, or in vitro fertilization, nor criminalize what the U.S. Code refers to as "female genital mutilation," 18 U.S.C. § 116(a)(1), because all these things are female-specific. *Skrmetti*, 83 F.4th at 482. And it would "force [Missouri] to *either* ban puberty blockers and hormones for all purposes or allow them for all purposes." *Eknes-Tucker*, 80 F.4th at 1233 (Brasher, J., concurring). Plaintiffs have no way "to contain the blast radius of their legal theory." *Moore v. United States*, 144 S. Ct. 1680, 1693 (2024).

B. The SAFE Act satisfies rational basis review.

Because rational basis review applies, this Court can easily reject Plaintiffs' claims. Under rational basis review, "[t]he statute is presumed to have a rational basis, and this presumption will only be overcome by a 'clear showing of arbitrariness and irrationality.'" *Snodgras*, 204 S.W.3d at 641 (quoting *Fust*, 947 S.W.2d at 432). There is nothing arbitrary or irrational—much less "clear[ly]" arbitrary or irrational—about putting in place a 4-year pause on interventions that medical authorities across the world have said lack any substantial evidentiary support. "Rational basis review requires only the possibility of a rational classification for a law," and Missouri has "offered considerable evidence about the risks of these treatments and the flaws in existing research." *Skrmetti*, 83 F.4th at 489.

C. Plaintiffs' remaining counterarguments fail.

Plaintiffs principally rely on two additional counterarguments. Neither succeeds.

i. *Bostock* and the sex-stereotyping doctrine do not apply.

Plaintiffs have relied on *Bostock v. Clayton County*, 590 U.S. 644 (2020), and cases discussing statutory bars against "sex stereotyping." These arguments fail.

Bostock is a sex-stereotyping case that by its own terms is strictly limited to the statutory context of Title VII of the Civil Rights Act. *Bostock* held that an employer commits a "*statutory*

violation" under Title VII's prohibition on sex discrimination if the employer discriminates on the basis of transgender status. 590 U.S. at 660 (emphasis added). But *Bostock* expressly limited its reasoning to Title VII, and the Court declined to "prejudge" other laws "that prohibit sex discrimination." *Id.* at 681. Plaintiffs cite no Missouri Supreme Court case that has extended the reasoning of *Bostock* beyond Title VII, and federal courts have recently declined to do so. *E.g.*, *Skrmetti*, 83 F.4th at 484–85; *Pelcha v. MW Bancorp, Inc.*, 988 F.3d 318, 324 (6th Cir. 2021); *Adams*, 57 F.4th at 808–09; *Eknes-Tucker*, 80 F.4th at 1228–29 (holding that *Bostock* "bears minimal relevance to" the U.S. Constitution's Equal Protection Clause).

Indeed, in August the U.S. Supreme Court unanimously concluded that the *Bostock* analysis does *not* apply to a different federal statute, Title IX, which prohibits sex discrimination in educational activities. 20 U.S.C. § 1681(a). The federal government, relying on *Bostock*, promulgated a rule defining sex discrimination in Title IX to "includ[e] discrimination on the basis of sex stereotypes, sex characteristics, pregnancy or related conditions, sexual orientation, and gender identity." 89 Fed. Reg. 33886 (2024). But the U.S. Supreme Court unanimously concluded the federal government was wrong to do so. After a district court enjoined that rule, the Supreme Court concluded, "all Members of the Court today accept that the plaintiffs were entitled to preliminary injunctive relief as to three provisions of the rule, including the central provision that newly defines sex discrimination to include discrimination on the basis of sexual orientation and gender identity." *Dep't of Educ. v. Louisiana*, 144 S. Ct. 2507, 2509–10 (2024). A few justices partly dissented on the ground that unrelated aspects of the rule should go into effect but concurred that "[e]very Member of the Court agrees respondents are entitled to interim relief as to three provisions" including the provision that relied on *Bostock* in "defining sex discrimination." *Id.* at 2510 (Sotomayor, J., concurring in part and dissenting in part).

That makes sense because Title VII is textually different from both Title IX and the Equal Protection Clause. As the author of *Bostock* explained just last year, there are "obvious differences" in text between Title VII and the Equal Protection Clause, which predates Title VII by a century. *Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181, 308–09 (2023) (Gorsuch, J., concurring).

ii. The Act does not classify on any protected status.

Plaintiffs raise a backup argument that contradicts their sex-discrimination argument. They contend that the SAFE Act discriminates not on the basis of sex, but on the basis of "transgender status." But neither the U.S. Supreme Court nor the Missouri Supreme Court has ever recognized "transgender status" as a suspect class. The U.S. "Supreme Court has not recognized any new constitutionally protected classes in over [five] decades, and instead has repeatedly declined to do so." *Ondo v. City of Cleveland*, 795 F.3d 597, 609 (6th Cir. 2015). The U.S. Supreme Court has rejected as suspect classes disability (including mental disability), age, poverty, and close relations. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 441–46 (1985); *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 313 (1976); *San Antonio Ind. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 28 (1973); *Lyng v. Castillo*, 477 U.S. 635, 638 (1986) ("Close relatives are not a 'suspect' or 'quasi-suspect' class."). Indeed, the U.S. Supreme Court has repeatedly bypassed opportunities to hold that any aspect of LGBT status is a suspect class. *See, e.g., Obergefell v. Hodges*, 576 U.S. 644 (2015). And many courts have declined to hold that transgender status, specifically, is a suspect classification. *See Skrmetti*, 83 F.4th at 486–88; *Corbitt*, 115 F.4th at 1347 n.9; *Adams*, 57 F.4th at 803 n.5; *Eknes-Tucker*, 80 F.4th at 1227–30, *K.C. v. Individual Members of the Med. Licensing Bd. Of Indiana, et al.*, 2024 U.S. App. Lexis 28833, at 22-24.

This makes sense because every suspect class recognized by the U.S. Supreme Court is an immutable group, but transgender identity is "[n]ot an immutable group" because people regularly

detransition. *Skrmetti*, 83 F.4th at 487; *Adams*, 57 F.4th at 807–08 (holding that, unlike sex, transgender status is not immutable because it is subject to change). Indeed, WPATH's guidelines say the term "transgender" describes "a huge variety of gender identities and expressions." *Skrmetti*, 83 F.4th at 487 (quoting WPATH, Standards of Care Version 8, at S15 (2022)). And in this very case, Plaintiffs themselves presented evidence that gender identity can change day to day and that the Endocrine Society concluded that gender dysphoria resolves at least 85% of the time before adulthood when children are not given chemical or hormonal intervention. Ex. 306, Endocrine Society Guidelines, at 3879. It is not for this Court to create brand-new suspect classes when neither the Missouri Supreme Court nor the U.S. Supreme Court has done so.

In any event, Plaintiffs' argument also fails because not all individuals identifying as transgender are eligible for or seek puberty blockers, cross-sex hormones, or surgery—as Plaintiffs' experts have already conceded. PI Tr. 109. Many individuals identifying as transgender are thus not affected at all. That makes this case similar to *Geduldig*, where the U.S. Supreme Court ruled that a law making classifications based on pregnancy is not a violation of equal protection even though "only women can become pregnant" because there is a "lack of identity" between pregnancy and women more generally; women are in both the affected group and the unaffected group. *Geduldig*, 417 U.S. at 497 n.20.

V. Plaintiffs' remaining arguments similarly fail.

Plaintiffs raise three other arguments: a violation of due process, a violation of Missouri's anti-slavery clause, and a violation of the "special law" provision. The Court rejects all three.

A. The SAFE Act does not violate substantive due process.

While courts have "assumed" that substantive due process includes a "right to *refuse* unwanted medical treatment," that assumption cannot "be somehow transmuted into a right to" *obtain* a specific treatment. *Washington v. Glucksberg*, 521 U.S. 702, 725–26 (1997) (emphasis

added). "State and federal governments have long played a critical role in regulating health and welfare, which explains why their efforts receive 'a strong presumption of validity.'" *Skrmetti*, 83 F.4th at 473 (quoting *Heller v. Doe*, 509 U.S. 312, 319 (1993)). "[A] state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized." *Parham v. J.R.*, 442 U.S. 584, 603 (1979). This is especially true of Missouri's law because "[t]he state's authority over children's activities is broader than over like actions of adults." *Prince v. Massachusetts*, 321 U.S. 158, 168 (1944).

Consider how strange it would be to conclude that there is a substantive due process right to obtain an intervention that the legislature has taken off the table. It would mean that legislatures could never regulate any drug or medical procedure. Any person—including a minor—would be able to obtain anything from meth, to ecstasy, to abortion so long as a single medical professional were willing to recommend it. Courts, including the U.S. Supreme Court, regularly reject that argument. *E.g.*, *Glucksberg*, 521 U.S. at 725–26 (no right to "assisted suicide"); *Raich v. Gonzales*, 500 F.3d 850, 864 (9th Cir. 2007) (no right to "medical marijuana"); *Abigail All. for Better Access to Developmental Drugs v. Von Eschenbach*, 495 F.3d 695, 697 (D.C. Cir. 2007) (en banc) (no "right to procure and use experimental drugs"); *Pickup v. Brown*, 740 F.3d 1208, 1222 (9th Cir. 2014) (no right to "sexual orientation change efforts" or "conversion therapy"); *Rutherford v. United States*, 616 F.2d 455, 456 (10th Cir. 1980) (no right for mentally ill patients "to take whatever treatment they wished regardless of " FDA). "This country does not have a custom of permitting parents to obtain banned medical treatments for their children and to override contrary legislative policy judgments in the process." *Skrmetti*, 83 F.4th at 475. "If parents could veto legislative and regulatory policies about drugs and surgeries permitted for children, every such

regulation—there must be thousands—would come with a springing easement: It would be good law until one parent in the country opposed it." *Id.*

Recognizing this authority, Plaintiffs admit that that they have no substantive due process right to "obtain whatever drugs they want." Pls.' Pretrial Br. at 54. So instead, they acknowledge they can prevail on this claim *only* if the interventions they seek are so "well-established" that there is no rational basis for the State to act. *Id.* In light of the serious medical dispute about efficacy and the well-known harms from these interventions, the Court rejects Plaintiffs' argument.

B. The SAFE Act does not violate Missouri's anti-slavery or "special law" clauses.

Plaintiffs contend that the SAFE Act violates the right of persons to "the gains of their own industry." Mo. Const. art. I, § 2. This clause was enacted to prohibit "workplace slavery" and thus has no applicability here. *Fisher v. State Hwy. Comm'n of Mo.*, 948 S.W.2d 607, 610 (Mo. banc 1997); *see also Kansas City Premier Apartments, Inc. v. Mo. Real Est. Comm'n*, 344 S.W.3d 160, 174 n.6 (Mo. banc 2011) (Wolff, J., dissenting) (agreeing that the Supreme Court's jurisprudence limits this clause to "a prohibition of slavery"). The SAFE Act does not compel medical providers to issue these interventions without pay. To the contrary, it prohibits providing the interventions at all. The antislavery clause does not divest the State of authority "to prescribe regulations affecting the public health." *Moler v. Whisman*, 147 S.W. 985, 986–87 (Mo. 1912).

No stronger is Plaintiffs' fourth count, which asserts a violation of the prohibition against "any local or special law … where a general law can be made applicable." Mo. Const. art. III, § 40. As Plaintiffs concede, this provision is satisfied if there is any "rational basis" for the law. *City of Crestwood v. Affton Fire Protec. Dist.*, 620 S.W.3d 618, 623 (Mo. banc 2021). This law satisfies rational basis review for all the reasons already stated.

VI. Disagreements between courts as to the constitutionality of similar statutes.

This Court has been referred to decisions rendered by various courts that have considered the constitutionality of similar statutes. The Court has been referred to *L.W. v. Skrmetti*, 73 F.4th 408 (6th Cir. 2023)(cert. granted June 24, 2024). In that case, the 6th Circuit Court of Appeals upheld statutes from Kentucky and Tennessee which were very similar to the present Missouri statute. In *Eknes-Tucker v. Governor of Alabama*, the 11th Circuit Court of Appeals upheld a similar Alabama law. *Eknes-Tucker v. Governor of Alabama*, 80 F.4th 1205 (11th Cir. 2023). Recently, the 7th Circuit Court of Appeals upheld a similar Indiana statute in *K.C. v. Individual Members of the Med. Licensing Bd. Of Ind.*, 2024 U.S.App. 28833 (7th Cir. Nov. 2024).

In contrast, the Eighth Circuit Court of Appeals held that a similar statute in Arkansas was unconstitutional. *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661, 669-71 (8th Cir. 2022). However, the Eighth Circuit has now agreed to rehear that case en banc. Order Granting Petition for Initial Hearing En Banc, *Brandt ex rel. Brandt v. Griffin*, No. 23-2681.

This Court has reviewed these cases. The rationale underlying *Skrmetti, K.C. v. Individual Members of the Med. Licensing Bod. Of Ind* and *Eknes-Tucker* seems both persuasive and in line with previous Missouri Supreme Court holdings. These cases all follow United States Supreme Court precedent, and find that statutes similar to Missouri's do not run afoul of any constitutional protections. Moreover, as the Eighth Circuit has now agreed to hear *Brandt* again en banc, it would seem that the original holding in that case is not final. Accordingly, this Court will follow the rationale in *Skrmetti, K.C. v. Individual Members of the Med. Licensing Bod. Of Ind.*, and *Eknes-Tucker*.

VII. Summary

The Seventh Circuit Court of Appeals recently upheld an Indiana statute that was very similar to the present Missouri statute. This Court finds that opinion very convincing. That Court summarized:

> "That the wisdom of a legislative act is not subject to judicial scrutiny requires no citation." *EEOC v. City of Janesville*, 630 F.2d 1254, 1259 (7th Cir. 1980); FCC. v. *Beach Commc'ns, Inc.*, 508 U.S. 307, 314 (1993), ("[J]udicial intervention is generally unwarranted no matter how unwisely we may think a political branch has acted.'" (quoting *Vance v. Bradley*, 440 U.S. 93, 97 (1978) (footnote omitted))); *Heller*, 509 U.S. at 319; see also *Dandridge v. Williams*, 397 U.S. 471, 487, 90 S. Ct. 1153, 25 L.Ed. 2d 491 (1970). As the Supreme Court has explicitly warned lower courts, when legislatures "act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious not to rewrite legislation, even assuming, arguendo, that judges with more direct exposure to the problem might make wiser choices." *Marshall v. United States*, 414 U.S. 417, 427, 94 S. Ct. 700, 38 L. Ed. 2d 618 (1974); *Gonzales*, 550 U.S. at 163 ("[Legislatures have] wide discretion to pass legislation in areas where there is medical and scientific uncertainty.").
>
> And yet, throughout their briefs, appellees and their amici herald statements from medical authorities on their side of the debate as evidence that the Indiana legislature acted imprudently. **But the federal courts do not mediate medical debates**. The Constitution vests the people and their chosen representatives with that responsibility. This is why "[w]e have consistently deferred to legislative judgment in cases involving the regulation of licensed professions." *DeSalle v. Wright*, 969 F.2d 273, 275 (7th Cir. 1992); *Sutker v. Ill. State Dental Soc'y*, 808 F.2d 632, 635 (7th Cir. 1986). It is also why "health and welfare laws like" [Indiana's] are "entitled to a 'strong presumption of validity.'" *Dobbs v. Jackson Women's Health Org*, 597 U.S. 215, 221 (2022) (quoting *Heller*, 509 U.S. at 319). See *Marshall*, 414 U.S. at 427; *Williamson v. Lee Optical of Oklahoma, Inc.*, 348 U.S. 483, 487-88 (1955); *Maguire v. Thompson* F.2d 374, 378-79 (7th Cir. 1992). **Appellees must take their grievance to the people of Indiana---not the courts."**

K.C. v. Individual Members of the Med. Licensing Bd. of Ind., 2024 U.S. App. Lexis 28833, at 60-61 (this Court's emphasis).

This Court finds the 7th Circuit's words extremely persuasive and is in keeping with the courts' limited role in determining the validity of statutes such as Missouri's in the present case. Accordingly, this Court finds that Missouri SB 49 is constitutional.

CONCLUSION

The Court enters judgment in favor of Defendants on all counts and causes of action in this case. All parties to bear own costs.

Dated: 05/20/2024

So ordered:

Judge R. Craig Carter