No. 24-___

IN THE

Supreme Court of the United States

PAUL A. EKNES-TUCKER, *et al.*,
Petitioners,

v.

GOVERNOR OF THE STATE OF ALABAMA, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

In 2022, the Alabama Legislature enacted a categorical ban on the use of certain medical treatments for transgender minors. The ban applies when the treatments are used "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex." Ala. Code § 26-26-4(a) (the "Treatment Ban"). A federal district court preliminarily enjoined the Treatment Ban as applied to the use of puberty-blocking medication and hormone therapy for transgender adolescents. The Eleventh Circuit vacated the preliminary injunction, holding that the Treatment Ban was likely to satisfy rational basis review. The questions presented are:

1. Whether Alabama's Treatment Ban triggers heightened scrutiny under the Equal Protection Clause of the Fourteenth Amendment because it discriminates on the basis of sex and transgender status. The Court has already granted certiorari on this question in another case this Term. *See L.W. v. Skrmetti*, 83 F.4th 460 (6th Cir. 2023), *cert. granted*, No. 23-477, 144 S. Ct. 2679 (June 20, 2024).

2. Whether Alabama's Treatment Ban triggers heightened scrutiny under the Due Process Clause of the Fourteenth Amendment because it burdens parents' right to direct the medical treatment of their minor children.

PARTIES TO THE PROCEEDING

Petitioners include two parents of minor children who have been prescribed puberty blocking medications or hormone therapy or who may require these medications: Brianna Boe (individually and on behalf of her minor son, Michael Boe) and Megan Poe (individually and on behalf of her minor daughter, Allison Poe) (collectively, "Parent Petitioners"). Petitioners also include a healthcare provider, Heather Austin, PhD ("Healthcare Petitioner"), who risks felony convictions and imprisonment under Alabama's Treatment Ban.[1] Petitioners were plaintiffs before the district court and appellees before the Eleventh Circuit.[2]

Respondents are Steve Marshall, in his official capacity as Alabama Attorney General; Daryl D. Bailey, in his official capacity as District Attorney for Montgomery County, Alabama; Champ Crocker, in his official capacity as District Attorney for Cullman County, Alabama; Jessica Ventiere, in her official capacity as District Attorney for Lee County, Alabama; James H. Tarbox, in his official capacity as

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[1] Dr. Austin initially sought to proceed pseudonymously, and the original complaint referred to her as Jane Moe, PhD. Before the preliminary injunction was granted, Dr. Austin withdrew her request to proceed pseudonymously. D. Ct. Doc. 57 at 2. The First Amended Complaint identified her by name. D. Ct. Doc. 146.

[2] The plaintiffs before the district court also included Reverend Paul A. Eknes-Tucker, James Zoe (individually and on behalf of his minor son, Zachary Zoe), Kathy Noe (individually and on behalf of her minor son, Christopher Noe), and Rachel Koe, MD. These individuals are no longer included as plaintiffs in the operative pleading before the district court, the Second Amended Complaint, and they do not take part in this petition. *See* D. Ct. Doc. 159, 474.

District Attorney for the 12th Judicial Circuit, Alabama; and Danny Carr, in his official capacity as District Attorney for Jefferson County, Alabama. Respondents were defendants before the district court and appellants before the Eleventh Circuit.[3]

The United States of America was plaintiff-intervenor before the district court and intervenor-appellee before the Eleventh Circuit.

RELATED PROCEEDINGS

United States District Court (M.D. Ala.):

Eknes-Tucker v. Marshall, No. 2:22-cv-00184-LCB-CWB. Preliminary injunction granted May 13, 2022.

United States Court of Appeals (11th Cir.):

Eknes-Tucker v. Governor of the State of Alabama, No. 22-11707. Preliminary injunction vacated August 21, 2023. Rehearing en banc denied August 28, 2024.

[3] Alabama Governor Kay Ivey was also named as a defendant in the original complaint filed with the district court, but she was dismissed from the case by the consent of all parties before the preliminary injunction hearing. *See* D. Ct. Doc. 85 and associated oral order entered on May 5, 2022.

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PETITION FOR A WRIT OF CERTIORARI

Brianna Boe et al. respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit.

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 30a) is reported at 80 F.4th 1205. The opinion and order of the district court (Pet. App. 1a) is reported at 603 F. Supp. 3d 1131.

JURISDICTION

The court of appeals entered its judgment on August 21, 2023. The court of appeals entered its order denying rehearing on August 28, 2024. This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Section 1 of the Fourteenth Amendment to the United States Constitution provides, in relevant part: "No State shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

The full text of Alabama's Treatment Ban is codified at Ala. Code § 26-26-1–9. Most relevant here:

> Ala. Code § 26-26-3(3) provides the following definition of "sex":
>
> > SEX. The biological state of being male or female, based on the individual's sex organs, chromosomes, and endogenous hormone profiles.

Ala. Code § 26-26-4 provides, in relevant part:

> **(a)** Except as provided in subsection (b), no person shall engage in or cause any of the following practices to be performed upon a minor if the practice is performed for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex as defined in this act:
>
> > **(1)** Prescribing or administering puberty blocking medication to stop or delay normal puberty.
> >
> > **(2)** Prescribing or administering supraphysiologic doses of testosterone or other androgens to females.
> >
> > **(3)** Prescribing or administering supraphysiologic doses of estrogen to males. . . . .[1]
>
> **(b)** Subsection (a) does not apply to a procedure undertaken to treat a minor born with a medically verifiable disorder of sex development, including either of the following:
>
> > **(1)** An individual born with external biological sex characteristics that are irresolvably ambiguous, including an individual born with 46 XX chromosomes with virilization, 46 XY chromosomes

[1] Ala. Code § 26-26-4(a)(4)–(6) prohibit certain surgical interventions for minors, which Petitioners do not challenge in this action.

> with under virilization, or having both ovarian and testicular tissue.
>
> **(2)** An individual whom a physician has otherwise diagnosed with a disorder of sexual development, in which the physician has determined through genetic or biochemical testing that the person does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a male or female.
>
> **(c)** A violation of this section is a Class C felony.

The criminal penalties for violating the Treatment Ban are set forth at Ala. Code §§ 13A-5-6(a)(3) and 13A-5-11.

Ala. Code § 13A-5-6(a)(3) provides:

> **(a)** Sentences for felonies shall be for a definite term of imprisonment, which imprisonment includes hard labor, within the following limitations: . . . **(3)** For a Class C felony, not more than 10 years or less than one year and one day.

Ala. Code § 13A-5-11(a)(3) provides:

> **(a)** A sentence to pay a fine for a felony shall be for a definite amount, fixed by the court, within the following limitations: . . . **(3)** For a Class C felony, not more than $15,000.

INTRODUCTION

In 2022, Alabama passed the first law in the nation criminalizing the provision of puberty blockers and hormones to treat transgender people under the age of 19. Ala. Code § 26-26-1–9. Alabama's Treatment Ban prohibits these medications only when prescribed "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's [biological] sex." *Id.* § 26-26-4(a). In other words, it bans the use of transitioning medications only when transgender adolescents need them.

The Treatment Ban is harmful. It singles out transgender adolescents based on their sex and transgender status, categorically denying them medically necessary healthcare that is consistent with widely accepted, evidence-based standards of care. It interferes with parents' autonomy to obtain established medical treatment for their children, bucking this nation's longstanding history and tradition of respecting family medical decision-making. And it puts transgender adolescents at risk of serious harms associated with worsening gender dysphoria, including depression, anxiety, and suicidality.

The district court recognized the extraordinary nature of the Treatment Ban, finding that it both classifies based on sex and interferes with parents' fundamental right to direct their children's medical care. Accordingly, the district court applied heightened scrutiny under the Equal Protection Clause and the Due Process Clause. The Eleventh Circuit reversed, holding that the Treatment Ban is subject only to rational basis review—the lowest possible standard.

The Eleventh Circuit's holding deepens a circuit split on the appropriate standard of review for state laws like the Treatment Ban under the Equal Protection Clause, and it departs from the precedents of this Court and several lower courts under the Due Process Clause. This Court's intervention is necessary to reaffirm longstanding precedent and to clarify the constitutional rights of transgender adolescents and their families in the 26 states that have passed categorical treatment bans. Without this Court's review, more than 100,000 transgender adolescents across the country will continue to be deprived of the only medically accepted treatment for their gender dysphoria. And they will continue to face the stigma created by the Treatment Ban and other state laws that target them for disfavored treatment.

This Court should reverse the judgment of the Eleventh Circuit and hold that the Treatment Ban is subject to heightened scrutiny under both the Equal Protection Clause and the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

STATEMENT OF THE CASE

Petitioners are two parents ("Parent Petitioners"), proceeding individually and on behalf of their minor transgender children, and one healthcare provider ("Healthcare Petitioner"). Petitioners are harmed by Alabama's Treatment Ban and filed this suit challenging its constitutionality. The United States District Court for the Middle District of Alabama applied heightened scrutiny under the Equal Protection Clause and strict scrutiny under the Due Process Clause, and entered a preliminary injunction blocking enforcement of the Treatment Ban. The Eleventh Circuit vacated the preliminary injunction, applying

rational basis review and holding that the Treatment Ban likely satisfied that standard.

A. Gender Dysphoria and Standards of Care

Gender identity is an innate, internal sense of one's sex. Everyone has a gender identity. Most people have a gender identity consistent with their birth sex. Transgender people, however, have a gender identity that differs from their birth sex. Pet. App. 2a.

Many transgender people experience distress based on the incongruence between their gender identity and their birth sex. If this distress is clinically significant, they may be diagnosed with gender dysphoria. The criteria for a diagnosis of gender dysphoria are set forth in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (5th ed. 2013), also known as the "DSM-5." D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶¶ 24–25; *see also* D. Ct. Doc. 8-9 (Moe Decl.) ¶ 8.

Gender dysphoria is a real and serious medical condition that, if left untreated, can result in serious harm. Pet. App. 2a–3a; D. Ct. Doc. 8-1 (Hawkins Decl.) ¶¶ 25–26, 39; D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶¶ 23–24, 26, 36, 45, 55. For example, untreated gender dysphoria can lead to increased anxiety, self-harm, and even suicide. D. Ct. Doc. 8-1 (Hawkins Decl.) ¶ 39; D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶¶ 26, 45, 55.

With prescribed transitioning medications, adolescents with gender dysphoria can thrive. Transitioning medications include puberty-blocking medications and hormone therapy. These different medications may become medically necessary at different stages of an adolescent's development. With the onset of puberty, transgender adolescents often experience worsening gender dysphoria as they begin to experience irre-

versible physical changes that are inconsistent with their gender identity. Thus, puberty-blocking medication may be medically necessary and appropriate after a transgender adolescent reaches puberty to minimize or prevent the exacerbation of gender dysphoria that ongoing puberty would cause. D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶¶ 35–38; D. Ct. Doc. 106 at 23–35. Later in adolescence, hormone therapy may be medically necessary to alleviate gender dysphoria by bringing the adolescent's body into closer alignment with their gender identity. D. Ct. Doc. 8-3 ¶ 9; D. Ct. Doc. 106 at 23–35.

Transitioning medications are well-established, evidence-based treatments for gender dysphoria. Pet. App. 16a–17a; *see also* D. Ct. Doc. 106 at 113. They are recommended for use in appropriate cases by the prevailing clinical practice guidelines governing the treatment of gender dysphoria. D. Ct. Doc. 8-2 (Ladinsky Decl.) ¶ 7; D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶¶ 27–30. These guidelines were developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society. D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶¶ 27–30. They are based on the best available science and clinical experience, and they reflect the consensus of experts in the field of transgender medicine. D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶ 29.

The WPATH and Endocrine Society guidelines are recognized as the established standard of care by major medical associations, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the Pediatric Endocrine Society, and the Society for Adolescent

Health and Medicine. D. Ct. Doc. 8-2 (Ladinsky Decl.) ¶ 7; D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶ 30.

As confirmed by the WPATH and Endocrine Society guidelines, transitioning medications are safe. Like all medications, they are not risk-free. But their benefits outweigh their risks for many transgender adolescents suffering from gender dysphoria. Pet. App. 10a (citing D. Ct. Doc. 104 at 57–58, 121–22, 136, 170). And they have been safely prescribed for decades to treat medical conditions other than gender dysphoria. Pet. App. 17a; D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶ 42; D. Ct. Doc. 106 at 110–12.

Before transitioning medications are prescribed to treat gender dysphoria, minor patients and their parents undergo a thorough screening process and give informed consent. Pet. App. 10a (citing D. Ct. Doc. 104 at 41, 59, 132); *id.* at 18a; D. Ct. Doc. 8-1 (Hawkins Decl.) ¶ 36; D. Ct. Doc. 8-2 (Ladinsky Decl.) ¶¶ 9–10; D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶¶ 48–51; D. Ct. Doc. 8-6 (Zoe Decl.) ¶¶ 10, 12; D. Ct. Doc. 8-8 (Noe Decl.) ¶¶ 14–16; D. Ct. Doc. 106 at 103.

As part of the screening process, a multidisciplinary team of healthcare providers conducts a comprehensive evaluation of the minor patient's individual medical and mental health needs. D. Ct. Doc. 8-2 (Ladinsky Decl.) ¶¶ 10–12; D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶¶ 5, 33, 46; D. Ct. Doc. 106 at 25, 100. This evaluation includes a robust assessment of information from the patient's pediatrician, mental health provider, and a pediatric endocrinologist, as well as in-depth consultation with the patient and their family. D. Ct. Doc. 106 at 25–26, 105; D. Ct. Doc. 8-7 (Poe Decl.) ¶¶ 18–19, 21.

For example, before a transgender adolescent can begin hormone therapy, a mental health professional must: (1) confirm the persistence of gender dysphoria; (2) ensure that any coexisting psychological, medical, or social problems that could interfere with treatment have been addressed, and the minor's situation and functioning are stable enough to start treatment; and (3) verify that the minor has sufficient mental capacity to understand the consequences of the treatment. D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶¶ 48–51; D. Ct. Doc. 8-1 (Hawkins Decl.) ¶ 36; D. Ct. Doc. 8-2 (Ladinsky Decl.) ¶¶ 9–11; D. Ct. Doc. 106 at 25–26, 106–10.

In addition, treatment cannot begin without the informed consent of parents with legal medical decision-making authority and the assent of the patient. D. Ct. Doc. 106 at 107–10; D. Ct. Doc. 8-7 (Poe Decl.) ¶¶ 18–19; D. Ct. Doc. 78-41 (Consent Form). Once treatment begins, parental education and counseling continues alongside ongoing monitoring by the patient's physicians. D. Ct. Doc. 106 at 25–26, 77, 102–03; D. Ct. Doc. 8-7 (Poe Decl.) ¶¶ 18–19, 21; D. Ct. Doc. 8-1 (Hawkins Decl.) ¶¶ 36–37; D. Ct. Doc. 8-2 (Ladinsky Decl.) ¶¶ 10–12; D. Ct. Doc. 8-3 (Rosenthal Decl.) ¶ 47. Transitioning medications are not made available "on demand" or prescribed over the objection of the patient, their parent, or their doctor. D. Ct. Doc 106 at 107–10.

B. Alabama's Treatment Ban

On April 8, 2022, Alabama Governor Kay Ivey signed the Treatment Ban into law. The Treatment Ban prohibits certain enumerated medical treatments from being "performed upon a minor if the practice is performed for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception

is inconsistent with the minor's sex as defined in this act." *Id.* § 26-26-4(a). The prohibited treatments include:

> (1) Prescribing or administering puberty blocking medication to stop or delay normal puberty.
>
> (2) Prescribing or administering supra-physiologic doses of testosterone or other androgens to females.
>
> (3) Prescribing or administering supra-physiologic doses of estrogen to males.

Id. § 26-26-4(a)(1)–(3).[2] A violation of this provision is a Class C felony subject to up to 10 years' imprisonment and $15,000 in fines. *Id.* § 26-26-4(c); *id.* §§ 13A-5-6(a)(3), 13A-5-11. The Treatment Ban became effective on May 8, 2022.

C. Petitioners

Parent Petitioners are two parents of adolescent minors who are diagnosed with gender dysphoria. One of the minors was successfully receiving treatment with transitioning medications before the Treatment Ban went into effect. Extensive record evidence shows that this treatment was beneficial. Petitioner Megan Poe "specifically described the positive effects transitioning treatments . . . had on her fifteen-year-old transgender daughter, Minor Plaintiff Allison Poe." Pet. App. 10a; D. Ct. Doc. 106 at 166–67. In "her early adolescent years, Allison suffered from severe depression and suicidality due to gender

[2] The Treatment Ban also prohibits certain surgical transition treatments for minors. Ala. Code § 26-26-4(a)(4)–(6). Petitioners do not challenge this aspect of the Treatment Ban.

dysphoria." Pet. App. 10a–11a. After taking transitioning medications, Allison was "happy and 'thriving.'" Pet. App. 11a (citing D. Ct. Doc. 106 at 166–67). Megan feared that without these treatments, her daughter would commit suicide. Pet. App. 11a (citing D. Ct. Doc. 106 at 167).

The other minor, Michael Boe, was waiting for an appointment to be evaluated for transitioning medications when the Treatment Ban took effect. When Michael was nine or ten years old, he began speaking regularly to his mother about having a male gender identity. D. Ct. Doc. 8-5 (Boe Decl.) ¶ 5. He was distressed by the mismatch between his inner sense of his gender and the way others saw him, and he became depressed and anxious. *Id.* When Michael was 11 years old, he disclosed to his mother that he was transgender. *Id.* ¶ 7. As he began to experience changes in his body associated with puberty, he felt "anguished, and often debilitated, by the[] physical reminders that his body does not match who he knows himself to be." *Id.* ¶ 6. Michael saw two therapists, including an adolescent gender dysphoria specialist who supported his social transition and prescribed medication to treat his depression and anxiety symptoms. *Id.* ¶¶ 5, 9, 12. But these treatments did not alleviate his gender dysphoria, and he continued to experience severe distress based on the discordance between his physical body and his gender identity. *Id.* ¶¶ 9–12. Based on the recommendation of his therapist, Michael's mother made an appointment for him to be evaluated for transitioning medications to treat his gender dysphoria. *Id.* ¶¶ 9, 14.

Healthcare Petitioner Heather Austin, PhD, is a medical provider who faces felony convictions and imprisonment if she violates the Treatment Ban.

Dr. Austin is a clinical child psychologist with a specialization in child development. D. Ct. Doc. 8-9 (Moe Decl.) ¶ 1–2. She has been practicing in Alabama for over twenty years. *Id.* ¶¶ 1, 3. For the two years before Alabama passed the Treatment Ban, Dr. Austin dedicated part of her practice to working with transgender minors at the gender clinic at the University of Alabama at Birmingham. *Id.* ¶ 4. In that role, she conducted comprehensive mental health assessments to make appropriate diagnoses and, in some cases, evaluate adolescents' eligibility and readiness for transitioning medications. *Id.* ¶¶ 6–11. In addition, she often monitored her patients' progress after beginning medical treatment. *Id.* ¶ 12. In Dr. Austin's experience, transitioning medications "significantly improve[] the mental health and wellbeing" of transgender adolescents with gender dysphoria. *Id.* ¶ 16. Dr. Austin predicted that the Treatment Ban would cause transgender adolescents' mental health to deteriorate and impair their ability to function in their everyday lives. *Id.* ¶ 16. Indeed, after the Treatment Ban's passage, she observed a spike in her patients' distress and anxiety, and she had to work with two patients to develop safety plans to prevent suicide attempts. *Id.*

D. This Litigation

1. District Court

Petitioners filed this lawsuit in the Middle District of Alabama, challenging the Treatment Ban and seeking injunctive relief under the Equal Protection and Due Process Clauses. They originally named as Defendants Alabama Governor Kay Ivey and several Alabama officials with authority to initiate criminal prosecutions to enforce the Treatment Ban. Governor Ivey was subsequently dismissed by agreement.

On May 13, 2022, five days after the Treatment Ban went into effect, the district court granted Petitioners' motion for a preliminary injunction on both Equal Protection and Due Process grounds. Under the Equal Protection Clause, the court found that the Treatment Ban classifies based on sex and triggers heightened scrutiny because it discriminates against transgender minors based on their gender nonconformity. Pet. App. 20a–21a (relying on *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1741 (2020)).

Under the Due Process Clause, the district court held that strict scrutiny applies because the Treatment Ban interferes with Parent Petitioners' "fundamental right to direct the medical care of their children," which "includes the more specific right to treat their children with transitioning medications subject to medically accepted standards." Pet. App. 19a–20a.

The district court then held that the Treatment Ban likely failed both heightened and strict scrutiny. In reaching this conclusion, the court considered "hundreds of pages of medical evidence," Pet. App. 10a, including dozens of exhibits and thirty witness declarations, and testimony from eight witnesses at a two-day evidentiary hearing.

Based on that extensive record, the district court found that gender dysphoria, a condition marked by a "clinically diagnosed incongruence between one's gender identity and assigned gender," is a real and serious condition which may be debilitating if left untreated, Pet. App. 2a–3a; that the use of transitioning medications to treat gender dysphoria in adolescent minors is a "well-established, evidence-based treatment[]" endorsed by "at least twenty-two major medical associations in the United States," Pet. App.

16a–17a; and that parents "undergo a thorough screening and consent process before they may choose these medications for their children," Pet. App. 18a.

The district court further found that no credible evidence supported Respondents' asserted justifications for the Treatment Ban. Specifically, the court concluded that "no credible evidence" supported Respondents' arguments "that transitioning medications are 'experimental'" or "jeopardize the health and safety of minors suffering from gender dysphoria." Pet. App. 16a, 18a; *see generally id.* at 3a–4a, 16a–19a, 22a. Similarly, no evidence supported the Legislature's findings "that healthcare associations are aggressively pushing these medications on minors." Pet. App. 18a, 22a. Without any evidence substantiating the alleged governmental interests underlying the Treatment Ban, the district court held that the Treatment Ban likely could not satisfy either heightened or strict scrutiny. Pet. App. 18a–19a, 22a.

The district court also held that the Treatment Ban likely failed strict scrutiny for another, independent reason: it was not "narrowly tailored" to achieving Respondents' proffered purposes. Pet. App. 19a. Indeed, Respondents "themselves offer[ed] several less restrictive ways" to achieve those purposes. *Id.*

Finally, the district court found that Petitioners would be irreparably harmed by the Treatment Ban; that the imminent threat of harm to Petitioners posed by the Treatment Ban outweighed the harm Alabama would suffer from a preliminary injunction; and that a preliminary injunction would be in the public interest. Pet. App. 26a–28a. The court therefore enjoined Defendants from enforcing the challenged aspects of the Treatment Ban pending trial. Pet. App. 29a.

2. Eleventh Circuit

On appeal, a panel of the Eleventh Circuit vacated the preliminary injunction. The panel decision did not question the district court's factual findings regarding the safety and efficacy of transitioning medications. Rather, it concluded that the Treatment Ban was subject only to rational basis review and would likely satisfy that lenient standard.

As to Petitioners' Equal Protection Clause claim, the panel determined that the Treatment Ban does not discriminate based on sex for three reasons. First, the panel reasoned that the Treatment Ban "does not establish an unequal regime for males and females" and only regulates "medical procedures" that "are themselves sex-based." Pet. App. 67a–68a. Second, the panel held that the Treatment Ban does not "indirectly" discriminate based on sex "by classifying on the basis of gender nonconformity" because it merely regulates "a course of treatment that only gender nonconforming individuals can undergo." Pet. App. 68a–71a. Third, the panel similarly rejected the argument that the Treatment Ban classifies based on transgender status, reasoning that transitioning medications are "a course of treatment that, by the nature of things, only transgender individuals would want to undergo." Pet. App. 71a. The panel also suggested that transgender persons do not "constitute a quasi-suspect class, distinct from sex, under the Equal Protection Clause." *Id.* (citation and internal quotation marks omitted).

As to Parent Petitioners' Due Process Clause claim, the panel concluded that strict scrutiny does not apply because Petitioners did not identify sufficient precedent or other historical evidence specifically establishing a "fundamental right to treat [one's]

children with transitioning medications subject to medically accepted standards." Pet. App. 60a–61a, 63a (internal quotation marks omitted). The panel faulted Petitioners for failing to show that the use of puberty blockers and hormones for transgender adolescents is "deeply rooted" in our nation's history and tradition such that it would have been known to the Framers of the Fourteenth Amendment in 1868. Pet. App. 53a–54a.

In evaluating Parent Petitioners' Due Process claim, the panel distinguished this Court's decision in *Parham v. J. R.*, 442 U.S. 584 (1979), which recognized that parents generally have the right to make decisions about the medical treatment of their children. *Id.* at 602–04. The panel construed *Parham* as a narrow procedural due process case that "offers no support for the Parent [Petitioners'] substantive due process claim." Pet. App. 58a.

Having determined that the Treatment Ban was not subject to heightened scrutiny under the Equal Protection and Due Process Clauses, the panel applied rational basis review and concluded that the Treatment Ban likely passed constitutional muster. The panel cited evidence that transitioning medications pose "*some* risks" and gave credence to "rational speculation that some families will not fully appreciate those risks and that some minors experiencing gender dysphoria ultimately will desist and identify with their biological sex." Pet. App. 62a (emphasis in original); *see also id.* at 72a–73a.

Judge Brasher joined in the panel opinion and wrote a separate concurring opinion to express his view that the Treatment Ban would also likely satisfy intermediate scrutiny under the Equal Protection Clause. Pet. App. 75a.

Petitioners filed a petition for rehearing en banc. The panel stayed the district court's preliminary injunction while the petition was pending. Ultimately, the Eleventh Circuit denied en banc review in a short per curiam order. Pet. App. 86a. The denial generated five separate writings spanning 155 pages. Pet. App. 86a–241a. Judge Wilson, Judge Jordan, Judge Rosenbaum, and Judge Jill Pryor dissented. Pet. App. 151a–241a.

Judge Wilson, joined by Judge Jordan, recognized that the district court and the Eleventh Circuit panel had adopted "divergent descriptions of the fundamental right at issue," and that rehearing en banc would be helpful to "clarify the fundamental right at issue and the protections guaranteed by the Due Process Clause." Pet. App. 151a–152a.

Judge Jordan, joined by Judge Rosenbaum and Judge Jill Pryor, read the panel decision as "asking whether there is a history of recorded uses of transitioning medications for transgender individuals . . . as of 1868, when the Fourteenth Amendment was ratified. Finding no such history, the panel concluded that there is no fundamental right for parents to treat their children with such medications." Pet. App. 156a. In Judge Jordan's view, "the panel asked the wrong question by defining the asserted right in too granular a way, and as a result reached the wrong answer." Pet. App. 157a. After a detailed analysis of this Court's substantive due process precedents, Pet. App. 158a–175a, Judge Jordan concluded that the correct question is "whether parents have a fundamental right . . . to obtain medically-approved treatment for their children," Pet. App. 175a, and the correct answer is "yes." *See* Pet. App. 176a, 178a–179a (citing *Parham*, 442 U.S. at 602–04).

Judge Rosenbaum, joined by Judge Jill Pryor and joined in part by Judge Jordan, similarly read the panel decision as rejecting parents' fundamental right to direct their children's medical care "except for those medical treatments in existence as of 1868." Pet. App. 181a. In Judge Rosenbaum's view, "nothing in the law handcuffs us to nineteenth-century medicine. To the contrary, Supreme Court precedent recognizes parents' fundamental right to direct that their child receive well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment." *Id.* (citing *Parham*, 442 U.S. at 602). Given the district court's extensive factual findings about the safety and effectiveness of transitioning medications, Judge Rosenbaum concluded that treatment with such medications is "squarely within *Parham*'s fundamental right." *Id*.

REASONS FOR GRANTING THE WRIT

A. This Court has already granted certiorari on the Equal Protection question presented by this Petition.

This case presents the same Equal Protection question that the Court has agreed to address in another case this Term. *L.W. v. Skrmetti*, 83 F.4th 460 (6th Cir. 2023), *cert. granted*, No. 23-477, 144 S. Ct. 2679 (June 20, 2024). Again, that question is whether a categorical ban on transitioning medications for transgender adolescents is subject to heightened scrutiny under the Equal Protection Clause of the Fourteenth Amendment because it discriminates based on sex and transgender status. Because the Court has already decided to consider this question in

Skrmetti, Petitioners request that the Court hold this petition in abeyance as to the Equal Protection question until *Skrmetti* is decided.

B. The Eleventh Circuit's decision fundamentally misapplies this Court's long-standing Due Process precedents and profoundly unsettles the law.

The Eleventh Circuit's holding that parents have no substantive due process interest in affirmatively directing their children's medical care runs counter to centuries of common law and this Court's precedent. Parents' authority to care for their children is a "principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental." *Snyder v. Commonwealth of Mass.*, 291 U.S. 97, 105 (1934) (cited in *Washington v. Glucksberg*, 521 U.S. 702, 720–21 (1997)). In *Parham v. J.R.*, this Court held that this principle includes the right "to seek and follow medical advice." 442 U.S. 584, 602 (1979).

Our nation's history and traditions have long recognized that "parental care for children [is] not only an obligation, but also an inherent right." *R.J.D. v. Vaughn Clinic, P.C.*, 572 So. 2d 1225, 1227 (Ala. 1990). "The parents' common law duty to care for their children is widely recognized: It is ordinarily for the parent in the first instance to decide . . . what is actually necessary for the protection and preservation of the life and health of his child," including "[i]n such matters as deciding on the need for surgical or hospital treatment . . . except in those extreme instances where the state takes over to rescue the child from parental neglect or to save its life." *Id.* at 1228 (cleaned up) (quoting 59 Am.Jur.2d *Parent and Child* § 48, at 193–94 (1987)); *accord Ex Parte E.R.G.*, 73 So. 3d 634, 665 (Ala. 2011) (Murdock, J., concurring).

Parham followed this traditional common law rule:

> [O]ur constitutional system long ago rejected any notion that that a child is "the mere creature of the State" and, on the contrary, asserted that parents generally "have the right, coupled with the high duty, to recognize and prepare [their children] for additional obligations."

442 U.S. at 602 (quoting *Pierce v. Society Soc'y of Sisters of the Holy Names of Jesus & Mary*, 268 U.S. 510, 535 (1925)). "Surely, this includes a 'high duty' to recognize symptoms of illness and to seek and follow medical advice." *Id.* at 602. (quoting *Pierce*, 268 U.S. at 535); *see also* Pet. App. 176a–179a, 181a, 194a–198a, 220a–221a; *Skrmetti*, 83 F.4th at 507–09 (White, J., dissenting).

The Eleventh Circuit's effort to trivialize *Parham* as involving only procedural due process misses the point. *See Skrmetti*, 83 F.4th at 511 (White, J., dissenting). In *Parham*, the Court considered "what process is constitutionally due a minor child whose parents or guardian seek state administered institutional mental health care for the child." *Parham*, 442 U.S. at 587. To answer this question, the Court balanced the private and governmental interests at stake. *Id.* at 599. While weighing the parents' interests, the Court recognized that parents generally have the right "to seek and follow medical advice" for their children. *Id.* at 601–04. The Court's articulation of this fundamental liberty interest was necessary to decide the ultimate procedural question presented.

This Court was crystal clear that it was recognizing a substantive parental right in *Parham*. *See Skrmetti*, 83 F.4th at 511 (White, J., dissenting). The decision

relied on other substantive parental rights cases, including *Pierce* and *Meyer v. Nebraska*, 262 U.S. 390 (1923), which both recognized a substantive due process right for parents in the educational context. *Parham*, 442 U.S. at 602–04. Drawing on these cases, this Court concluded that "[n]either state officials nor federal courts are equipped to review . . . parental decisions" about their children's medical care, *id.* at 604, even when such care "involves risks," *id.* at 603. Later, in *Troxel v. Granville*, 530 U.S. 57 (2000), this Court confirmed *Parham*'s importance as a substantive parental rights case. That decision cited *Parham* extensively in evaluating the substantive question whether the state could override a parent's judgment about grandparent visitation. 530 U.S. at 66, 68, 69.

In addition to side-stepping the clear teaching of *Parham*, the Eleventh Circuit erred by applying the wrong legal test to parental rights under the Due Process Clause. According to the panel decision, strict scrutiny does not apply unless Parent Petitioners show that parents in 1868 had a right to obtain puberty blockers and hormones for their children, even though these medications were not used "until well into the twentieth century." Pet. App. 54a. If that were the correct test, the government could likely prohibit other lifesaving medical care that was not available to children in 1868—including the polio vaccine, antibiotics, cardiac surgery, organ transplants, and cancer treatments like radiation and chemotherapy—without having to provide a substantial justification for the prohibition. *See* Pet. App. 156a, 181a, 211a.

Nothing in *Parham* or this Court's other parental rights decisions supports that far-fetched result. The right of parents rather than the government to make medical decisions for their children is based on

"centuries of legal doctrine and practice." *Glucksberg*, 521 U.S. at 723. Following that tradition, this Court has held that parents have a right "to recognize symptoms of illness [in their children] and to seek and follow medical advice." *Parham*, 442 U.S. at 602.

The Eleventh Circuit panel's decision creates unnecessary confusion about the ongoing vitality of a long-standing fundamental right that is protected by the Due Process Clause; adopts a legal test that defies logic; and destabilizes the rule of law. It cannot be allowed to stand.

C. The Eleventh Circuit's decision deepens conflict in the courts about parents' fundamental right to direct their children's medical care.

The Eleventh Circuit's refusal to follow *Parham* also directly conflicts with caselaw from the Tenth Circuit and numerous trial courts, which have consistently concluded that parents have a fundamental right to direct the medical care of their children. Specifically, the Tenth Circuit has recognized that a parent has the "general right to make decisions concerning the care of her child," including, "to some extent, a more specific right to make decisions about the child's medical care." *PJ ex rel. Jensen v. Wagner*, 603 F.3d 1182, 1197 (10th Cir. 2010). Based on this Court's decision in *Parham*, the Tenth Circuit determined that "the Due Process Clause provides some level of protection for parents' decisions regarding their children's medical care." *Id.*

Consistent with the Tenth Circuit's logic, almost every trial court to consider laws like the Treatment Ban have found that such laws unlawfully invade parents' fundamental right to direct the medical care of their children—though some of these decisions were

later reversed by the Sixth Circuit's decision in *Skrmetti* and the Eleventh Circuit's decision below. *See Brandt v. Rutledge*, 677 F. Supp. 3d 877, 922–23 (E.D. Ark. 2023); *Poe v. Labrador*, 709 F. Supp. 3d 1169, 1195 (D. Idaho 2023); *Doe v. Ladapo*, No. 4:23cv114-RH-MAF, 2024 U.S. Dist. LEXIS 105334, at *88 (N.D. Fla. June 11, 2024); *L.W. v. Skrmetti*, 679 F. Supp. 3d 668, 682–85 (M.D. Tenn. 2023), *rev'd*, 83 F.4th at 472–79; *Doe v. Thornbury*, 679 F. Supp. 3d 576, 585–86 (W.D. Ky. 2023), *rev'd sub nom. Skrmetti*, 83 F.4th at 472–79; *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1144–46 (M.D. Ala. 2022), *vacated*, 80 F.4th at 1219–26.[3] *But see Poe v. Drummond*, 697 F. Supp. 3d 1238, 1256 (N.D. Okla. 2023).

D. Review is warranted and urgently needed.

1. This case is a suitable vehicle to resolve the question presented. The fact that this case arises at the preliminary-injunction stage does not counsel against granting certiorari. The Eleventh Circuit decided as a matter of law that rational basis review applied to Parent Petitioners' Due Process claim. The appropriate standard of review is a purely legal question that is squarely presented for this Court's

[3] Appeals are pending in *Brandt*, *Doe v. Ladapo*, and *Poe v. Labrador*. Pending disposition of the appeal in *Doe v. Ladapo*, the Eleventh Circuit granted a stay of the permanent injunction entered by the trial court. *See Doe v. Surgeon Gen.*, No. 24-11996, 2024 U.S. App. LEXIS 21601, at *13–14 (11th Cir. Aug. 26, 2024). By contrast, in *Poe v. Labrador*, the Ninth Circuit declined to stay the district court's preliminary injunction. No. 24-142, Doc. 24 (9th Cir. Jan. 30, 2024). This Court subsequently granted a partial stay to temporarily narrow the scope of the preliminary injunction but declined to stay the injunction as to the individual plaintiffs. *Labrador v. Poe*, 144 S. Ct. 921, 921 (2024).

review. No additional factual development could alter the analysis.

2. Additional percolation in the lower courts is unnecessary. Two federal appellate decisions directly address the question presented, and the issues in this case are fully developed in the Eleventh Circuit's panel opinion, the concurrence, and the five separate opinions respecting denial of rehearing en banc. In addition, numerous district court decisions, catalogued above, have analyzed the appropriate level of scrutiny to apply to similar treatment bans under the Due Process Clause. This Court has all it needs to decide whether Alabama's Treatment Ban is subject to heightened scrutiny under the Due Process Clause.

3. Before 2021, no state banned transitioning medications for transgender adolescents. Today, 26 states have passed treatment bans affecting more than 100,000 transgender adolescents.[4] These laws are profoundly harmful to transgender adolescents and their families who rely on access to this medically necessary healthcare. Abundant scientific evidence demonstrates that transitioning medications improve short- and long-term health outcomes for transgender people, including a significant reduction of suicidality and self-harm. By contrast, treatment bans force adolescents to undergo permanent physical changes that do not align with their gender identity, which

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[4] Movement Advancement Project, *Equality Map: Bans on Best Practice Medical Care for Transgender Youth*, https://www.lgbtmap.org/equality-maps/healthcare_youth_medical_care_bans (last visited Oct. 11, 2024); Elana Redfield et al., UCLA School of Law Williams Institute, *The Impact of 2024 Anti-Transgender Legislation on Youth* 2 (2024), *available at* https://williamsinstitute.law.ucla.edu/wp-content/uploads/2024-Anti-Trans-Legislation-Apr-2024.pdf.

often leads to worsening gender dysphoria, depression, anxiety, and suicidality.

Alabama's Treatment Ban and other laws like it are causing urgent and irreparable harm to transgender youth across the country. Such consequential laws warrant immediate Supreme Court review.

CONCLUSION

The petition for a writ of certiorari should be granted or, in the alternative, should be held in abeyance until the Court issues its decision in *United States v. Skrmetti*, Docket No. 23-477.

Respectfully submitted,

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November 26, 2024

APPENDIX

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APPENDIX A

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

Case No. 2:22-cv-184-LCB

PAUL A. EKNES-TUCKER, *et al.*,

Plaintiffs,

v.

STEVE MARSHALL, *et al.*,

Defendants.

OPINION & ORDER

Several individuals and the United States challenge the constitutionality of the Alabama Vulnerable Child Compassion and Protection Act.[1] In part, the Act restricts transgender minors from utilizing puberty blockers and hormone therapies. Because the Supreme Court and the Court of Appeals for the Eleventh Circuit have made clear that: (1) parents have a fundamental right to direct the medical care of their children subject to accepted medical standards; and (2) discrimination based on gender-nonconformity equates to sex discrimination, the Court finds that there is a substantial likelihood that Section 4(a)(1)–(3) of the

[1] As explained *infra* note 5 and accompanying text, this suit challenges only Section 4(a)(1)–(3) of the Act. For purposes of this opinion, all references to "the Act" refer to these subdivisions unless noted otherwise.

Act is unconstitutional and, thus, enjoins Defendants from enforcing that portion of the Act pending trial. However, all other provisions of the Act remain in effect, specifically: (1) the provision that bans sex-altering surgeries on minors; (2) the provision prohibiting school officials from keeping certain gender-identity information of children secret from their parents; and (3) the provision that prohibits school officials from encouraging or compelling children to keep certain gender-identity information secret from their parents.

I. BACKGROUND

Regarding a child's belief that they might be transgender, Merriam-Webster's Dictionary defines a "transgender" person as one whose gender identity is different from the sex the person had or was identified as having at birth. *Transgender*, MERRIAM-WEBSTER UNABR. DICTIONARY (3rd ed. 2002). The Dictionary defines "gender identity" as a person's internal sense of being a male or a female. *Gender Identity*, MERRIAM-WEBSTER UNABR. DICTIONARY (3rd ed. 2002). These terms and definitions are largely consistent with those used by the parties. Accordingly, the Court relies on these terms throughout this opinion, but recognizes that they might mean different things to different people and in different contexts.

According to the uncontradicted record evidence, some transgender minors suffer from a mental health condition known as gender dysphoria. *Tr.* at 30.[2] Gender dysphoria is a clinically diagnosed incongruence

[2] "*Tr.*" is a consecutively paginated transcript of the two-day preliminary injunction hearing the Court held on May 5–6, 2022. For clarity, the Court cites to the internal pagination of the transcript rather than the ECF pagination.

between one's gender identity and assigned gender. *DSM-5* (Doc. 69-17) at 4. If untreated, gender dysphoria may cause or lead to anxiety, depression, eating disorders, substance abuse, self-harm, and suicide. *Tr.* at 20. According to the World Professional Association for Transgender Health (WPATH), an organization whose mission is to promote education and research about transgender healthcare, gender dysphoria in adolescents (minors twelve and over) is more likely to persist into adulthood than gender dysphoria in children (minors under twelve). *WPATH Standards of Care* (Doc. 69-18) at 17.[3]

In some cases, physicians treat gender dysphoria in minors with a family of medications known as GnRH agonists, commonly referred to as puberty blockers. *Id.* at 24; *Tr.* at 103. After a minor has been on puberty blockers for one to three years, doctors may then use hormone therapies to masculinize or feminize his or her body. *Tr.* at 108–11, 131. The primary effect of these treatments is to delay physical maturation, allowing transgender minors to socially transition their gender while they await adulthood. *Id.* at 105–06, 110–11. For clarity and conciseness, the Court refers to puberty blockers and hormone therapies used for these purposes as "transitioning medications."

Like all medications, transitioning medications come with risks. *Tr.* at 121– 22. Known risks, for example, include loss of fertility and sexual function. *Id.* at 132–33. Nevertheless, WPATH recognizes transitioning medications as established medical treatments and publishes a set of guidelines for treating gender

[3] Plaintiffs, the State, and the United States individually introduced the WPATH standards into evidence during the May 5–6 preliminary injunction hearing.

dysphoria in minors with these medications. *WPATH Standards of Care* (Doc. 69 18) at 19. The American Medical Association, the American Pediatric Society, the American Psychiatric Association, the Association of American Medical Colleges, and at least eighteen additional major medical associations endorse these guidelines as evidence-based methods for treating gender dysphoria in minors. *Tr.* at 97–98; *Healthcare Amici Br.* (Doc. 91-1) at 15.[4]

The Alabama Vulnerable Child Compassion and Protection Act states in pertinent part:

> Section 4. (a) . . . [N]o person shall engage in or cause any of the following practices to be performed upon a minor if the practice is performed for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex as defined in this act:
>
> (1) Prescribing or administering puberty blocking medication to stop or delay normal puberty.
>
> (2) Prescribing or administering supra-physiologic doses of testosterone or other androgens to females.
>
> (3) Prescribing or administering supra-physiologic doses of estrogen to males.
>
> (4) Performing surgeries that sterilize, including castration, vasectomy, hyster-

[4] For a full list of the twenty-two major medical associations that endorse these guidelines, see *infra* note 13.

> ectomy, oophorectomy, orchiectomy, and penectomy.
>
> (5) Performing surgeries that artificially construct tissue with the appearance of genitalia that differs from the individual's sex, including metoidioplasty, phalloplasty, and vaginoplasty.
>
> (6) Removing any healthy or non-diseased body part or tissue, except for a male circumcision.
>
> . . .
>
> (c) A violation of this section is a Class C felony.
>
> Section 5. No nurse, counselor, teacher, principal, or other administrative official at a public or private school attended by a minor shall do either of the following:
>
> (1) Encourage or coerce a minor to withhold from the minor's parent or legal guardian the fact that the minor's perception of his or her gender or sex is inconsistent with the minor's sex.
>
> (2) Withhold from a minor's parent or legal guardian information related to a minor's perception that his or her gender or sex is inconsistent with his or her sex.

S.B. 184, ALA. 2022 REG. SESS. §§ 4–5 (Ala. 2022).[5] The Act defines a "minor" as anyone under the age of nineteen. *Id.* § 3(1); ALA. CODE § 43-8-1(18). The Act

[5] Based on their oral representations during a May 4, 2022 hearing, Plaintiffs seek to enjoin only Section 4(a)(1)–(3) of the Act.

defines "sex" as "[t]he biological state of being male or female, based on the individual's sex organs, chromosomes, and endogenous hormone profiles." S.B. 184, ALA. 2022 REG. SESS. § 3(3) (Ala. 2022).

In support of these prohibitions, the Legislature made several legislative findings. *Id.* § 2. The Legislature found in part that "[s]ome in the medical community are aggressively pushing" minors to take transitioning medications, which the Act describes as "unproven, poorly studied . . . interventions" that cause "numerous harmful effects for minors, as well as risks of effects simply unknown due to the new and experimental nature of these interventions." *Id.* § 2(6), (11). The Legislature went on to find that "[m]inors, and often their parents, are unable to comprehend and fully appreciate the risk and life implications" of these treatments. *Id.* § 2(15). Thus, the Legislature concluded, "the decision to pursue" these treatments "should not be presented to or determined for minors[.]" *Id.* § 2(16).

Alabama legislators passed the Act on April 7, 2022.[6] Governor Kay Ivey signed the Act into law the following day.[7] In the week that followed, civil rights groups filed two lawsuits challenging the Act's

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[6] Jo Yurcaba, *Alabama Passes Bills to Target Trans Minors and LGBTQ Classroom Discussion*, NBCNEWS.COM (Apr. 7, 2022, 4:22 PM), https://www.nbcnews.com/nbc-out/out-politics-and-policy/alabama-passes-bills-targeting-trans-minors-lgbtq-classroom-discussion-rcna23444.

[7] Madeleine Carlisle, *Alabama's Wave of Anti-LGBTQ Legislation Could Have National Consequences*, TIME.COM (Apr. 15, 2022, 11:40 AM), https://time.com/6167472/alabama-anti-lgbtq-legislation/.

constitutionality.[8] In *Ladinsky v. Ivey*, Case No. 2:22-cv-447 (N.D. Ala. 2022), several plaintiffs challenged the Act in the United States District Court of the Northern District of Alabama. The case was randomly assigned to United States District Judge Anna M. Manasco. Judge Manasco recused, and the case was randomly reassigned to United States Magistrate Judge Staci G. Cornelius. After the parties declined to proceed before Judge Cornelius in accordance with 28 U.S.C. § 636(c), the case was randomly reassigned to the Honorable Annemarie C. Axon.

With *Ladinsky* pending, a separate set of plaintiffs challenged the Act in the United States District Court of the Middle District of Alabama. That case, styled *Walker v. Marshall*, Case No. 2:22-cv-167 (M.D. Ala. 2022), was randomly assigned to Chief United States District Judge Emily C. Marks. The *Walker* plaintiffs moved to enjoin enforcement of the Act and moved to reassign the case to United States District Judge Myron H. Thompson, alleging that he had previously presided over a similar case. The parties, however, later consented to transferring the case to the Northern District of Alabama for consolidation with *Ladinsky*. At that time, the *Walker* plaintiffs withdrew their motion to reassign.

On April 15, 2022, Chief Judge Marks transferred *Walker* to the Northern District of Alabama in accordance with the "first-filed" rule and 28 U.S.C. § 1404(a). The case was randomly assigned to this Court. Judge Axon then transferred *Ladinsky* to this Court for consolidation with *Walker*. That same day, at

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[8] *Alabama Law Banning Transgender Medication Challenged in Two Lawsuits*, CBSNEWS.COM (Apr. 11, 2022, 10:05 PM), https://www.cbsnews.com/news/alabama-transgender-law-lawsuits/.

6:24 p.m. CDT, the *Walker* plaintiffs filed a notice of voluntary dismissal without prejudice under Federal Rule of Civil Procedure 41(a)(1)(A)(i). The *Ladinsky* plaintiffs voluntarily dismissed their case nine minutes later. Neither the *Walker* plaintiffs nor the *Ladinsky* plaintiffs explained their respective dismissals, but counsel for *Ladinsky* informed the press: "We do plan to refile imminently[.]"[9]

Sure enough, on April 19, four transgender minors (Minor Plaintiffs), their parents (Parent Plaintiffs), a child psychologist and a pediatrician (Healthcare Plaintiffs), and Reverend Paul A. Eknes-Tucker filed this suit in the United States District Court of the Middle District of Alabama and moved to enjoin the Act's enforcement pending trial. The case was randomly assigned to United States District Judge R. Austin Huffaker, Jr. Due to this Court's familiarity with *Ladinsky* and *Walker*, Judge Huffaker reassigned the case to this Court to expedite disposition of Plaintiffs' motion for preliminary injunction. With the Act set to take effect on May 8, the Court entered an abbreviated briefing schedule and set a hearing on Plaintiffs' motion for May 5–6.

Just days before the hearing, the United States moved to intervene on behalf of Plaintiffs under Federal Rule of Civil Procedure 24.[10] In the process,

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[9] Paul Gattis, *Lawsuits Seeking to Overturn New Alabama Transgender Law Dropped, Could be Refiled*, AL.COM, https://www.al.com/news/2022/04/lawsuits-seeking-to-overturn-new-alabama-transgender-law-dropped-could-be-refiled.html (last updated Apr. 16, 2022, 9:22 PM).

[10] The United States's amended intervenor complaint does not add any additional claims, name any new defendants, or seek to expand the relief sought by Plaintiffs. *Compare Am. Intervenor Compl.* (Doc. 92) at 4–5, 13–14, *with Compl.* (Doc. 1) at 6–8, 28–35.

the United States filed its own motion to enjoin enforcement of the Act and requested to participate in the preliminary injunction hearing. Additionally, fifteen states moved for leave to proceed as *amici curiae*[11] and to file a brief in support of Defendants.[12] Twenty-two healthcare organizations also moved for leave to proceed as *amici curiae* and to file a brief in support of Plaintiffs.[13] Ultimately, the Court granted these motions in full, took the *amici* briefs under advisement, and gave the United States leave to participate during the preliminary injunction hearing.

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[11] *Amici curiae*, Latin for "friends of the court," refers to a group of people or institutions who are not parties to a lawsuit, but petition the court (or are requested by the court) to file a brief in the action because they have "a strong interest in the subject matter." *Amicus Curiae*, BLACK'S LAW DICTIONARY (11th ed. 2019).

[12] The State *Amici* are the States of Arkansas, Alaska, Arizona, Georgia, Indiana, Louisiana, Mississippi, Missouri, Montana, Nebraska, Oklahoma, South Carolina, Texas, Utah, and West Virginia.

[13] The Healthcare *Amici* are the American Academy of Pediatrics; the Alabama Chapter of the American Academy of Pediatrics; the Academic Pediatric Association; the American Academy of Child and Adolescent Psychiatry; the American Academy of Family Physicians; the American Academy of Nursing; the American Association of Physicians for Human Rights, Inc. *d/b/a* Health Professionals Advancing LGBTQ Equality; the American College of Obstetricians and Gynecologists; the American College of Osteopathic Pediatricians; the American College of Physicians; the American Medical Association; the American Pediatric Society; the American Psychiatric Association; the Association of American Medical Colleges; the Association of Medical School Pediatric Department Chairs; the Endocrine Society; the National Association of Pediatric Nurse Practitioners; the Pediatric Endocrine Society; the Society for Adolescent Health and Medicine; the Society for Pediatric Research; the Society of Pediatric Nurses; the Societies for Pediatric Urology; and the World Professional Association for Transgender Health.

During that hearing, the parties submitted hundreds of pages of medical evidence and called several live witnesses. Plaintiffs tendered Dr. Linda Hawkins and Dr. Morissa Ladinsky as experts in the treatment of gender dysphoria in minors. *Tr.* at 16, 92. Dr. Hawkins and Dr. Ladinsky testified that at least twenty-two major medical associations in the United States endorse transitioning medications as well-established, evidence-based methods for treating gender dysphoria in minors. *Id.* at 25, 97–98, 126–27. They opined that there are risks associated with transitioning medications, but that the benefits of treating minors with these medications outweigh these risks in certain cases. *Id.* at 57–58, 121–22, 136, 170. They also explained that minors and their parents undergo a thorough screening process and give informed consent before any treatment regimen begins. *Id.* at 41, 59, 132; *see also Consent Form* (Doc. 78-41) at 1–14. Finally, they testified that, without these medications, minors with gender dysphoria suffer significant deterioration in their familial relationships and educational performance. *Tr.* at 35, 112–13.

Plaintiffs also called Healthcare Plaintiff Dr. Rachel Koe (a licensed pediatrician), Plaintiff Eknes-Tucker, and Parent Plaintiff Megan Poe to testify about their personal knowledge and experiences regarding the treatment of gender dysphoria in minors. *Id.* at 150–51, 170–71, 195. Parent Plaintiff Megan Poe specifically described the positive effects transitioning treatments have had on her fifteen-year-old transgender daughter, Minor Plaintiff Allison Poe. *Id.* at 157–68.

According to Megan, Allison was born a male, but has shown evidence of identifying as a female since she was two-years-old. *Id.* at 153–54. During her early adolescent years, Allisson suffered from severe depression

and suicidality due to gender dysphoria. *Id.* at 156–57. She began taking transitioning medications at the end of her sixth-grade year, and her health significantly improved as a result. *Id.* at 163. Megan explained that the medications have had no adverse effects on Allison and that Allison is now happy and "thriving." *Id.* at 166–67. When asked what would occur if her daughter stopped taking the medications, Megan responded that she feared her daughter would commit suicide. *Id.* at 167.

Intervening on behalf of Plaintiffs, the United States tendered Dr. Armand H. Antommaria as an expert in bioethics and treatment protocols for adolescents suffering from gender dysphoria. *Id.* at 213–26. He reiterated that transitioning medications are well-established, evidence-based methods for treating gender dysphoria in minors. *Id.* at 120–21.

Defendants called two witnesses. *Id.* at 253, 337. First, Defendants tendered Dr. James Cantor—a private psychologist in Toronto, Canada—to testify as an expert on psychology, human sexuality, research methodology, and the state of the research literature on gender dysphoria and its treatment. *Id.* at 253–54. Dr. Cantor opined that, due to the risks of transitioning medications, doctors should use a "watchful waiting" approach to treat gender dysphoria in minors. *Id.* at 281. That approach, according to Dr. Cantor, "refers specifically to withholding any decision about medical interventions until [doctors] have a better idea or feel more confident" that the minor's gender dysphoria will persist without medical intervention other than counseling. *Id.* Dr. Cantor further testified that several European countries have restricted treating minors with transitioning medications due to growing concern about the medications' risks. *Id.* at 296–97.

On cross examination, however, Dr. Cantor admitted that: (1) his patients are, on average, thirty years old; (2) he had never provided care to a transgender minor under the age of sixteen; (3) he had never diagnosed a child or adolescent with gender dysphoria; (4) he had never treated a child or adolescent for gender dysphoria; (5) he had no personal experience monitoring patients receiving transitioning medications; and (6) he had no personal knowledge of the assessments or treatment methodologies used at any Alabama gender clinic. *Id.* at 306–09. Accordingly, the Court gave his testimony regarding the treatment of gender dysphoria in minors very little weight. Dr. Cantor also testified that no country in Europe (or elsewhere) has categorically banned treating gender dysphoria in minors with transitioning medications. *Id.* at 326–28. Unlike the Act, Dr. Cantor added, those countries allow such treatments under certain circumstances and for research purposes. *Id.* at 327–28.

Defendants' other witness was Sydney Wright, a twenty-three-year-old woman who took hormone therapies for gender dysphoria for roughly a year beginning when she was nineteen. *Id.* at 338, 351, 357. She testified that she now believes taking the medication was a mistake and that she no longer believes gender dysphoria is a legitimate medical diagnosis. *Id.* at 348–49, 355. She also testified that she received her treatments in Georgia and never visited a gender clinic in Alabama. *Id.* at 359–61.

II. LEGAL STANDARDS

The purpose of a preliminary injunction "is to preserve the positions of the parties" pending trial. *Bloedorn v. Grube*, 631 F.3d 1218, 1229 (11th Cir. 2011). When a federal court preliminarily enjoins a state law passed by duly elected officials, the court

effectively overrules a decision "of the people and, thus, in a sense interferes with the processes of democratic government." *Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am. v. City of Jacksonville*, 896 F.2d 1283, 1285 (11th Cir. 1990). This is an extraordinary and drastic remedy. *McDonald's Corp. v. Robertson*, 147 F.3d 1301, 1306 (11th Cir. 1998).

To receive a preliminary injunction, a movant must show that: (1) he or she has a substantial likelihood of success on the merits; (2) he or she will suffer irreparable injury absent injunctive relief; (3) the threatened injury to him or her "outweighs whatever damage the proposed injunction may cause the opposing party; and (4) if issued, the injunction would not be adverse to the public interest." *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc). The movant bears the burden of persuasion on each element. *State of Fla. v. Dep't of Health & Hum. Servs.*, 19 F.4th 1271, 1279 (11th Cir. 2021).

III. DISCUSSION

Plaintiffs and the United States seek to enjoin Section 4(a)(1)–(3) of the Act pending trial under Federal Rule of Civil Procedure 65. *Pls.' Mot.* (Doc. 7) at 2; *Intervenor Pl.'s Mot.* (Doc. 62) at 2. Under this rule, a court may issue a preliminary injunction only after giving notice to the adverse party. FED. R. CIV. P. 65(a)(1). Where injunctive relief is appropriate, the movant must give security "to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." *Id.* at 65(c). Here, Defendants have received proper notice. The Court addresses whether Plaintiffs are entitled to preliminary injunctive relief before turning to the issue of security.

A. Substantial Likelihood of Success on the Merits

The Court first considers whether Plaintiffs are substantially likely to succeed on their claims. When a plaintiff brings multiple claims, a reviewing court must consider the plaintiff's likelihood of success on each claim. *See N. Am. Med. Corp. v. Axiom Worldwide, Inc.*, 522 F.3d 1211, 1226 (11th Cir. 2008). Here, Plaintiffs bring five causes of action: four constitutional claims and one preemption claim. The Court begins with Plaintiffs' constitutional claims.

1. Plaintiffs' Constitutional Claims

Plaintiffs' constitutional claims arise under the Civil Rights Act of 1871, 42 U.S.C. § 1983. *Compl.* (Doc. 1) at 28–30, 33–35. That statute guarantees "a federal forum for claims of unconstitutional treatment at the hands of state officials[.]" *Heck v. Humphrey*, 512 U.S. 477, 480 (1994). To state a claim under § 1983, a plaintiff must allege: (1) the defendant deprived him of a right secured under federal law or the Constitution; and (2) such deprivation occurred under color of state law. *Richardson v. Johnson*, 598 F.3d 734, 737 (11th Cir. 2010) (per curiam).

Parent Plaintiffs claim that the Act violates their constitutional right to direct the medical care of their children under the Due Process Clause of the Fourteenth Amendment. *Compl.* (Doc. 1) at 28–29. Minor Plaintiffs assert that the Act discriminates against them based on their sex in violation of the Fourteenth Amendment. *Id.* at 29–30. Plaintiffs collectively allege that the Act is void for vagueness under the Fifth and Fourteenth Amendments. *Id.* at 34–35. Finally, Plaintiffs collectively claim that the Act unlawfully restricts their speech under the First

Amendment. *Id.* at 33–34. The Court addresses Plaintiffs' claims in that order.

i. Substantive Due Process Claim

Parent Plaintiffs assert that the Act violates their constitutional right to direct the medical care of their children under the Fourteenth Amendment. *Compl.* (Doc. 1) at 28–29.[14] The Due Process Clause provides that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. CONST. AMEND. XIV. The Clause protects against governmental violations of "certain fundamental rights and liberty interests." *Washington v. Glucksberg*, 521 U.S. 702, 719–20 (1997). Fundamental rights are "those guaranteed by the Bill of Rights as well as certain 'liberty' and privacy interests implicit in the [D]ue [P]rocess [C]lause and the penumbra of constitutional rights." *Doe v. Moore*, 410 F.3d 1337, 1343 (11th Cir. 2005).

A parent's right "to make decisions concerning the care, custody, and control of their children" is one of "the oldest of the fundamental liberty interests" recognized by the Supreme Court. *Troxel v. Granville*, 530 U.S. 57, 65–66 (2000). Encompassed within this right is the more specific right to direct a child's medical care. *See Bendiburg v. Dempsey*, 909 F.2d 463, 470 (11th Cir. 1990) (recognizing "the right of parents to generally make decisions concerning the treatment to be given to their children").[15] Accordingly, parents

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[14] Based on the record evidence, the Court finds that Parent Plaintiffs have standing to bring their Substantive Due Process Claim. Defendants raise no opposition to this conclusion.

[15] *See also PJ ex rel. Jensen v. Wagner*, 603 F.3d 1182, 1197 (10th Cir. 2010) (explaining that "the Due Process Clause provides some level of protection for parents' decisions regarding their children's medical care").

"retain plenary authority to seek such care for their children, subject to a physician's independent examination and medical judgment." *Parham v. J.R.*, 442 U.S. 584, 604 (1979).

Against this backdrop, Parent Plaintiffs are substantially likely to show that they have a fundamental right to treat their children with transitioning medications subject to medically accepted standards and that the Act infringes on that right. The Act prevents Parent Plaintiffs from choosing that course of treatment for their children by criminalizing the use of transitioning medications to treat gender dysphoria in minors, even at the independent recommendation of a licensed pediatrician. Accordingly, Parent Plaintiffs are substantially likely to show that the Act infringes on their fundamental right to treat their children with transitioning medications subject to medically accepted standards.

The State counters that parents have no fundamental right to treat their children with experimental medications. *Defs.' Br.* (Doc. 74) at 120. To be sure, the parental right to autonomy is not limitless; the State may limit the right and intercede on a child's behalf when the child's health or safety is in jeopardy. *Bendiburg*, 909 F.2d at 470. But the fact that a pediatric treatment "involves risks does not automatically transfer the power" to choose that treatment "from the parents to some agency or officer of the state." *Parham*, 442 U.S. at 603.

Defendants produce no credible evidence to show that transitioning medications are "experimental." While Defendants offer some evidence that transitioning medications pose certain risks, the uncontradicted record evidence is that at least twenty-two major medical associations in the United States endorse

transitioning medications as well-established, evidence-based treatments for gender dysphoria in minors. *Tr.* at 25, 97–98, 126–27. Indeed, according to Defendants' own expert, no country or state in the world categorically bans their use as Alabama has. Certainly, the science is quickly evolving and will likely continue to do so. But this is true of almost every medical treatment regimen. Risk alone does not make a medication experimental.

Moreover, the record shows that medical providers have used transitioning medications for decades to treat medical conditions other than gender dysphoria, such as central precocious puberty, a condition in which a child enters puberty at a young age. Doctors have also long used hormone therapies for patients whose natural hormone levels are below normal. Based on the current record, Defendants fail to show that transitioning medications are experimental. Thus, Parent Plaintiffs are substantially likely to show that the Act violates their fundamental right to treat their children with transitioning medications subject to medically accepted standards.

Statutes that infringe on fundamental rights are constitutional only when they satisfy the most demanding standard of judicial review, strict scrutiny. *Williams v. Pryor*, 240 F.3d 944, 947 (11th Cir. 2001). To satisfy strict scrutiny, a statute must be "narrowly tailored" to achieve "a compelling state interest." *Reno v. Flores*, 507 U.S. 292, 302 (1993). The State's interest in "safeguarding the physical and psychological well-being of a minor is a compelling one." *Globe Newspaper Co. v. Superior Ct. for Norfolk Cnty.*, 457 U.S. 596, 607 (1982) (cleaned up).

Defendants proffer that the purpose of the Act is "to protect children from experimental medical procedures,"

the consequences of which neither they nor their parents often fully appreciate or understand. *Defs.' Br.* (Doc. 74) at 129; *see also* S.B. 184, ALA. 2022 REG. SESS. § 2(13)–(15) (Ala. 2022). Defendants also allege that the Act halts medical associations from "aggressively pushing" transitioning medications on minors. *Defs.' Br.* (Doc. 74) at 114; *see also* S.B. 184, ALA. 2022 REG. SESS. § 2(6) (Ala. 2022).

But as explained above, Defendants fail to produce evidence showing that transitioning medications jeopardize the health and safety of minors suffering from gender dysphoria. Nor do Defendants offer evidence to suggest that healthcare associations are aggressively pushing these medications on minors. Instead, the record shows that at least twenty-two major medical associations in the United States endorse transitioning medications as well-established, evidence-based treatments for gender dysphoria in minors. *Tr.* at 25, 97–98, 126–27. The record also indicates that parents undergo a thorough screening and consent process before they may choose these medications for their children.

Undoubtedly, transitioning medications carry risks. But again, the fact that pediatric medication "involves risks does not automatically transfer the power" to choose that medication "from the parents to some agency or officer of the state." *Parham*, 442 U.S. at 603. Parents, pediatricians, and psychologists—not the State or this Court—are best qualified to determine whether transitioning medications are in a child's best interest on a case-by-case basis. Defendants' proffered purposes—which amount to speculative, future concerns about the health and safety of unidentified children—are not genuinely compelling justifications based on

the record evidence. For this reason alone, the Act cannot survive strict scrutiny at this stage of litigation.

But even if Defendants' proffered purposes are genuinely compelling, the Act is not narrowly tailored to achieve those interests. A narrowly tailored statute employs the "least restrictive means" necessary to achieve its purpose. *Holt v. Hobbs*, 574 U.S. 352, 364 (2015). A statute is not narrowly tailored when "numerous and less-burdensome alternatives" are available to advance the statute's purpose. *FF Cosms. FL, Inc. v. City of Miami Beach*, 866 F.3d 1290, 1299 (11th Cir. 2017). Put differently, "if a less restrictive means is available for the Government to achieve its goals, the Government must use it." *United States v. Playboy Ent. Grp., Inc.*, 529 U.S. 803, 815 (2000).

Defendants applaud the efforts of several European countries to restrict minors from taking transitioning medications, but unlike Alabama's Act, these countries allow minors to take transitioning medications in exceptional circumstances on a case-by-case basis. *Defs.' Br.* (Doc. 74) at 76–82. According to Dr. Cantor, Defendants' own expert witness, no state or country in the entire world has enacted a blanket ban of these medications other than Alabama. *Tr.* at 328. The Act, unlike the cited European regulations, does not even permit minors to take transitioning medications for research purposes, even though Defendants adamantly maintain that more research on them is needed. *Id.* at 326–27; *Defs.' Br.* (Doc. 74) at 116. Because Defendants themselves offer several less restrictive ways to achieve their proffered purposes, the Act is not narrowly tailored at this stage of litigation.

In sum, Parent Plaintiffs have a fundamental right to direct the medical care of their children. This right includes the more specific right to treat their children

with transitioning medications subject to medically accepted standards. The Act infringes on that right and, as such, is subject to strict scrutiny. At this stage of litigation, the Act falls short of that standard because it is not narrowly tailored to achieve a compelling government interest. Accordingly, Parent Plaintiffs are substantially likely to succeed on their Substantive Due Process claim.

ii. Equal Protection Claim

Minor Plaintiffs claim that the Act discriminates against them based on their sex in violation of the Fourteenth Amendment. *Compl.* (Doc. 1) at 29–30.[16] The Equal Protection Clause provides that no State shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. AMEND. XIV, § 1. The Clause's chief purpose "is to secure every person within the State's jurisdiction against intentional and arbitrary discrimination, whether occasioned by express terms of a statute or by its improper execution through duly constituted agents." *Vill. of Willowbrook v. Olech*, 528 U.S. 562, 564 (2000) (per curiam) (quoting *Sioux City Bridge Co. v. Dakota Cnty.*, 260 U.S. 441, 445 (1923)).

As the Supreme Court recently explained, "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex." *Bostock v. Clayton*

[16] Based on the record evidence, the Court finds that Minor Plaintiffs have standing to bring their Equal Protection claim. Defendants raise no opposition to this conclusion. However, Parent Plaintiffs, Healthcare Plaintiffs, and Plaintiff Eknes-Tucker do not explain—nor is it readily apparent—how they have standing to bring an Equal Protection claim and, thus, are not substantially likely to succeed on the merits of their claim.

Cnty., 140 S. Ct. 1731, 1741 (2020). Governmental classification based on an individual's gender nonconformity equates to a sex-based classification for purposes of the Equal Protection Clause. *Glenn v. Brumby*, 663 F.3d 1312, 1320 (11th Cir. 2011). Here, the Act prohibits transgender minors—and only transgender minors—from taking transitioning medications due to their gender nonconformity. *See* S.B. 184, ALA. 2022 REG. SESS. § 4(a)(1)–(3) (Ala. 2022). The Act therefore constitutes a sex-based classification for purposes of the Fourteenth Amendment.

The State views things differently. The State argues that the Act creates two categories of people: (1) minors who seek transitioning medications "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex"; and (2) "all other minors." *Defs.' Br.* (Doc. 74) at 93. (quoting S.B. 184, ALA. 2022 REG. SESS. § 4(a) (Ala. 2022)). Because transgender minors fall into both categories, the State reasons, the Act is not a sex-based classification. *Id.* at 94.

The fundamental flaw in this argument is that the first category consists entirely of transgender minors. The Act categorically prohibits transgender minors from taking transitioning medications due to their gender nonconformity. In this way, the Act places a special burden on transgender minors because their gender identity does not match their birth sex. The Act therefore amounts to a sex-based classification for purposes of the Equal Protection Clause. *See Glenn*, 663 F.3d at 1317 (explaining that "discrimination against a transgender individual because of her gender-nonconformity is sex discrimination").

Sex-based classifications are constitutional only when they satisfy a heightened standard of review known as intermediate scrutiny. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985). To satisfy this standard, a classification must substantially relate to an important government interest. *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982). The State bears the burden to proffer an exceedingly persuasive justification for the classification. *Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1690 (2017). An exceedingly persuasive justification is one that is "genuine, not hypothesized or invented *post hoc* in response to litigation." *United States v. Virginia*, 518 U.S. 515, 533 (1996).

The State again argues that the Act's purpose is to protect minors from experimental medications and to stop medical providers from "aggressively pushing" these medications on minors. *Defs.' Br.* (Doc. 74) at 109–120. As explained above, the State puts on no evidence to show that transitioning medications are "experimental." The record indicates that at least twenty-two major medical associations in the United States endorse these medications as well-established, evidence-based methods for treating gender dysphoria in minors. *Tr.* at 25, 97–98, 126–27. Finally, nothing in the record shows that medical providers are pushing transitioning medications on minors. Accordingly, the State's proffered justifications are hypothesized, not exceedingly persuasive. Thus, Minor Plaintiffs are substantially likely to succeed on their Equal Protection claim.

iii. Void-for-Vagueness Claim

Plaintiffs collectively claim that the Act is void for vagueness under the Fifth and Fourteenth Amendments because it does not sufficiently define "what actions

constitute 'caus[ing]' any of the proscribed activities upon a minor." *Compl.* (Doc. 1) at 34–35. Under the void-for-vagueness doctrine, a penal statute must "define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited and in a manner that does not encourage arbitrary and discriminatory enforcement." *United States v. Marte*, 356 F.3d 1336, 1342 (11th Cir. 2004) (quoting *United States v. Fisher*, 289 F.3d 1329, 1333 (11th Cir. 2002)). A federal court reviews a void-for-vagueness claim only when the litigant alleges a constitutional harm. *Bankshot Billiards, Inc. v. City of Ocala*, 634 F.3d 1340, 1349–50 (11th Cir. 2011).

In this context, constitutional harm comes in two forms: (1) where a criminal defendant violates a vague statute, comes under prosecution, and then moves to dismiss the charges on the grounds that he or she lacked notice that his or her conduct was unlawful; and (2) where a civil plaintiff is "chilled from engaging in constitutional activity" due to a vague statute. *Dana's R.R. Supply v. Att'y Gen.*, 807 F.3d 1235, 1241 (11th Cir. 2015). Here, Plaintiffs' void-for-vagueness claim falls into the second category.

Plaintiffs, however, are not substantially likely to succeed on their claim. Under ALA. CODE § 13A-2-5(a), a person is liable for causing a crime "if the result would not have occurred but for his conduct, operating either alone or concurrently with another cause, unless the concurrent cause was sufficient to produce the result and the conduct of the actor clearly insufficient." The fact that the Act has a scienter requirement greatly weighs against Plaintiffs' void-for-vagueness claim. *See, e.g.*, *Gonzales v. Carhart*, 550 U.S. 124, 149 (2007) ("The Court has made clear that scienter requirements alleviate vagueness concerns."); *Colautti*

v. Franklin, 439 U.S. 379, 395 (1979) ("This Court has long recognized that the constitutionality of a vague statutory standard is closely related to whether that standard incorporates a requirement of mens rea.").

Also weighing against Plaintiffs' claim is the State's interpretation of the Act. During the preliminary injunction hearing, Alabama Solicitor General Edmund LaCour explained that a person must administer or prescribe transitioning medications to violate the Act. *Tr.* at 409–11. General LaCour opined that a person cannot violate the Act simply by advising a minor to take transitioning medications or by driving a minor to a gender clinic where transitioning medications are administered. *Id.* at 410.

Additionally, the statutory scienter requirement and the State's interpretation both align with the modern, plain-language definition of the word cause. According to Merriam-Webster's Dictionary, "cause" means to "effect by command, authority, or force" or "bring into existence" an action. *Cause*, MERRIAM-WEBSTER UNABR. DICTIONARY (3rd ed. 2002). Based on the record evidence, Plaintiffs do not show that they have been chilled from engaging in constitutional activity due to the Act. Plaintiffs are therefore not substantially likely to succeed on their void-for-vagueness claim at this stage of litigation.

iv. Free Speech Claim

Plaintiffs collectively claim that the Act violates their First Amendment right to free speech by prohibiting "any 'person,' including physicians, healthcare professionals, or even parents, from engaging in speech that would 'cause' a transgender minor to receive medical treatment for gender dysphoria." *Compl.* (Doc. 1) at 33–34. The First Amendment provides that "Congress

shall make no law . . . abridging the freedom of speech[.]" U.S. CONST. AMEND. I. At its core, "the First Amendment means that government" generally "has no power to restrict expression because of its message, its ideas, its subject matter, or its content." *Police Dep't of City of Chicago v. Mosley*, 408 U.S. 92, 95 (1972).

The Amendment, however, offers no protection to words that incite or constitute criminal activity. For example, sexually derogatory remarks may violate Title VII's general prohibition of sexual discrimination in the workplace. 42 U.S.C. § 2000-e2; *see also* 29 C.F.R. § 1604.11(a) (explaining that, under certain circumstances, "[u]nwelcome sexual advances, *requests* for sexual favors, and other *verbal* or physical conduct of a sexual nature" are actionable as sexual harassment under Title VII (emphasis added)). Likewise, "[s]peech attempting to arrange the sexual abuse of children is no more constitutionally protected than speech attempting to arrange any other type of crime." *United States v. Hornaday*, 392 F.3d 1306, 1311 (11th Cir. 2004). More examples abound, but the point is this: Where the State "does not target conduct on the basis of its expressive content, acts are not shielded from regulation merely because they express a discriminatory idea or philosophy." *R.A.V. v. City of St. Paul*, 505 U.S. 377, 390 (1992).

As explained *supra* Section III.A.1.iii, the Act does not criminalize speech that could indirectly lead to a minor taking transitioning medications. Rather, the only speech criminalized by Act is that which compels the administration or prescription of transitioning medications to minors. Accordingly, the Act targets conduct (administration and prescription), not speech. Plaintiffs are therefore not substantially likely to succeed on their First Amendment claim.

2. Plaintiffs' Preemption Claim

Parent Plaintiffs, Minor Plaintiffs, and Healthcare Plaintiffs bring their preemption claim under Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116. *Compl.* (Doc. 1) at 31. Section 1557, through its incorporation of the Title IX, prohibits discrimination based on sex and the denial of benefits based on sex in any health program or activity that receives federal funding. 42 U.S.C. § 18116(a); 20 U.S.C. § 1681 *et seq*. Here, Plaintiffs generally rely on the same arguments Minor Plaintiffs made in support of their Equal Protection claim. *Pls.' Br.* (Doc. 8) at 49–52; *Tr.* at 379.

At this stage of litigation, Plaintiffs' preemption claim fails. As explained *supra* Section III.A.1.ii, only Minor Plaintiffs are substantially likely to succeed on their Equal Protection claim. Additionally, Section 1557—by incorporating the enforcement mechanism of Title IX—"is enforceable against institutions and programs that receive federal funds, but does not authorize suits against individuals." *Hill v. Cundiff,* 797 F.3d 948, 977 (11th Cir. 2015). It is presently unclear how Plaintiffs may bring their preemption claim against Defendants who are state officials, not institutions. Due to these concerns, Plaintiffs are not substantially likely to succeed on their preemption claim.

B. Irreparable Harm

The Court next considers whether Parent Plaintiffs and Minor Plaintiffs will suffer irreparable harm absent injunctive relief.[17] Harm "is 'irreparable' only if it cannot be undone through monetary remedies." *Ne.*

[17] *See Church v. City of Huntsville*, 30 F.3d 1332, 1342 (11th Cir. 1994) (explaining that a court need not consider whether a plaintiff shows irreparable harm if he or she does not show a substantial likelihood of success on his or her claims).

Fla. Chapter of Ass'n of Gen. Contractors of Am., 896 F.2d at 1285. An irreparable harm is one that is "actual and imminent, not remote or speculative." *Odebrecht Const., Inc. v. Sec'y, Fla. Dep't of Transp.*, 715 F.3d 1268, 1288 (11th Cir. 2013). The risk of suffering severe medical harm constitutes irreparable harm. *See, e.g.*, *Bowen v. City of New York*, 476 U.S. 467, 483 (1986) (explaining that a risk of suffering "a severe medical setback" is an irreparable injury); *Blaine v. N. Brevard Cnty. Hosp. Dist.*, 312 F. Supp. 3d 1295, 1306 (M.D. Fla. 2018) (finding irreparable harm where doctor plaintiffs could not provide necessary medical care to their patients).

The Act prevents Parent Plaintiffs from treating their children with transitioning medications subject to medically accepted standards. S.B. 184, ALA. 2022 REG. SESS. § 4(a)(1)–(3) (Ala. 2022). The record shows that, without these medications, Minor Plaintiffs will suffer severe medical harm, including anxiety, depression, eating disorders, substance abuse, self-harm, and suicidality. *Tr.* at 20, 167. Additionally, the evidence shows that Minor Plaintiffs will suffer significant deterioration in their familial relationships and educational performance. *Id.* at 35, 112–13. The Court therefore concludes that Parent Plaintiffs and Minor Plaintiffs will suffer irreparable harm absent injunctive relief.

C. Balance of Harms & Public Interests

The Court now considers the final two elements together. To satisfy the third and fourth elements of a preliminary injunction, a plaintiff must show that the harm she will likely suffer without an injunction outweighs any harm that her opponent will suffer from the injunction and that the injunction would not disserve (or be adverse to) the public interest. *Scott v. Roberts*, 612 F.3d 1279, 1290 (11th Cir. 2010). These factors

merge when the State is the opponent. *Swain v. Junior*, 958 F.3d 1081, 1091 (11th Cir. 2020) (per curiam).

This case largely presents two competing interests. On one hand, "preliminary injunctions of legislative enactments—because they interfere with the democratic process and lack the safeguards against abuse or error that come with a full trial on the merits—must be granted reluctantly and only upon a clear showing that the injunction before trial is definitely demanded by the Constitution and by the other strict legal and equitable principles that restrain courts." *Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am.*, 896 F.2d at 1285. On the other hand, "[a] democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies." *Prince v. Massachusetts*, 321 U.S. 158, 168–69 (1944).

Based on the record evidence, the Court finds that the imminent threat of harm to Parent Plaintiffs and Minor Plaintiffs—i.e., severe physical and/or psychological harm—outweighs the harm the State will suffer from an injunction. The Court further finds that an injunction is not adverse to the public interest. To the contrary, enjoining the Act upholds and reaffirms the "enduring American tradition" that parents—not the States or federal courts—play the primary role in nurturing and caring for their children. *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972). Accordingly, the final two factors favor injunctive relief.

IV. SECURITY

Defendants argue that, if injunctive relief is appropriate, the Court should require each Healthcare Plaintiff to post a $1 million security. *Defs.' Br.* (Doc. 74) at 159–

60.[18] Calculating the "amount of an injunction bond is within the sound discretion of the district court." *Carillon Importers, Ltd. v. Frank Pesce Int'l Grp.*, 112 F.3d 1125, 1127 (11th Cir. 1997) (per curiam). Here, the Court finds that a security bond is not necessary for three reasons. First, as explained *supra* Part III, Healthcare Plaintiffs themselves are not entitled to preliminary injunctive relief. Second, Federal Rule of Civil Procedure 65 does not require the United States to pay security. FED. R. CIV. P. 65(c). Finally, Defendants do not allege that they will suffer any cost or economic harm if they are wrongly enjoined from enforcing the Act. *Defs.' Br.* (Doc. 74) at 159–60. The Court therefore relieves Plaintiffs from posting security under Rule 65.

V. CONCLUSION

For these reasons, the Court GRANTS in part Plaintiffs' motion for preliminary injunction (Doc. 7) and ENJOINS Defendants from enforcing Section 4(a)(1)–(3) of the Act pending trial. The Court GRANTS in part the United States's motion for preliminary injunction (Doc. 62) to the same degree and effect. All other provisions of the Act remain enforceable.

DONE and ORDERED May 13, 2022.

/s/ Liles C. Burke
LILES C. BURKE
UNITED STATES DISTRICT JUDGE

[18] According to Defendants, this amount represents that "by which [Healthcare] Plaintiffs will be unjustly enriched should they be allowed to administer profitable (and illegal) medical procedures to kids." *Defs.' Br.* (Doc. 74) at 160.

APPENDIX B

[PUBLISH]

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

[Filed: August 21, 2023]

No. 22-11707

PAUL A. EKNES-TUCKER, Rev., BRIANNA BOE, individually and on behalf of her minor son, Michael Boe, JAMES ZOE, individually and on behalf of his minor son, Zachary Zoe, MEGAN POE, individually and on behalf of her minor daughter, Allison Poe, KATHY NOE, et al., individually and on behalf of her minor son, Christopher Noe,

Plaintiffs-Appellees,

versus

GOVERNOR, OF THE STATE OF ALABAMA, ATTORNEY GENERAL, STATE OF ALABAMA, DISTRICT ATTORNEY, FOR MONTGOMERY COUNTY, DISTRICT ATTORNEY, FOR CULLMAN COUNTY, DISTRICT ATTORNEY, FOR LEE COUNTY, *et al.*,

Defendants-Appellants.

Appeal from the United States District Court
for the Middle District of Alabama
D.C. Docket No. 2:22-cv-00184-LCB-SRW

Before LAGOA, BRASHER, Circuit Judges, and BOULEE,* District Judge.

LAGOA, Circuit Judge:

This appeal centers around section 4(a)(1)–(3) of Alabama's Vulnerable Child Compassion and Protection Act (the "Act"). Section 4(a)(1)–(3) of the Act states that "no person shall engage in or cause" the prescription or administration of puberty blocking medication or cross-sex hormone treatment to a minor "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex." Thus, section 4(a)(1)–(3) makes it a crime in the State of Alabama to take part in providing puberty blockers or cross-sex hormone treatment to a minor for purposes of treating a discordance between the minor's biological sex and sense of gender identity.

Shortly after the Act was signed into law, a group of transgender minors, their parents, and other concerned individuals challenged the Act's constitutionality, claiming that it violates the Due Process Clause and the Equal Protection Clause of the Fourteenth Amendment. As part of that lawsuit, the district court issued a preliminary injunction enjoining Alabama from enforcing section 4(a)(1)–(3) of the Act pending trial, having determined that the plaintiffs are substantially likely to succeed on both of the aforementioned claims. Specifically, as to the due process claim, the district court held that there is a constitutional right to "treat [one's] children with transitioning medications subject to medically accepted standards" and that the restrictions of section 4(a)(1)–(3) likely

* Honorable J. P. Boulee, United States District Judge for the Northern District of Georgia, sitting by designation.

impermissibly infringe upon that constitutional right. As to the equal protection claim, the district court held that section 4(a)(1)–(3) classifies on the basis of sex by classifying on the basis of gender nonconformity and likely amounts to unlawful discrimination under the intermediate scrutiny standard applicable to sex-based classifications.

On review, we hold that the district court abused its discretion in issuing this preliminary injunction because it applied the wrong standard of scrutiny. The plaintiffs have not presented any authority that supports the existence of a constitutional right to "treat [one's] children with transitioning medications subject to medically accepted standards." Nor have they shown that section 4(a)(1)–(3) classifies on the basis of sex or any other protected characteristic. Accordingly, section 4(a)(1)–(3) is subject only to rational basis review. Because the district court erred by reviewing the statute under a heightened standard of scrutiny, its determination that the plaintiffs have established a substantial likelihood of success on the merits cannot stand. We therefore vacate the preliminary injunction.

I. BACKGROUND

The Act was passed by the Alabama Legislature on April 7, 2022, and signed into law by Governor Kay Ivey the following day, thereby set to become effective on May 8, 2022.

A. The Text of the Act

The Act contains eleven sections. For the sake of completeness, each section is described below.

Section 1 establishes the title of the Act.

Section 2 sets forth the following findings by the Alabama Legislature:

> (1) The sex of a person is the biological state of being female or male, based on sex organs, chromosomes, and endogenous hormone profiles, and is genetically encoded into a person at the moment of conception, and it cannot be changed.
>
> (2) Some individuals, including minors, may experience discordance between their sex and their internal sense of identity, and individuals who experience severe psychological distress as a result of this discordance may be diagnosed with gender dysphoria.
>
> (3) The cause of the individual's impression of discordance between sex and identity is unknown, and the diagnosis is based exclusively on the individual's self-report of feelings and beliefs.
>
> (4) This internal sense of discordance is not permanent or fixed, but to the contrary, numerous studies have shown that a substantial majority of children who experience discordance between their sex and identity will outgrow the discordance once they go through puberty and will eventually have an identity that aligns with their sex.
>
> (5) As a result, taking a wait-and-see approach to children who reveal signs of gender nonconformity results in a large majority of those children resolving to an identity congruent with their sex by late adolescence.
>
> (6) Some in the medical community are aggressively pushing for interventions on

minors that medically alter the child's hormonal balance and remove healthy external and internal sex organs when the child expresses a desire to appear as a sex different from his or her own.

(7) This course of treatment for minors commonly begins with encouraging and assisting the child to socially transition to dressing and presenting as the opposite sex. In the case of prepubertal children, as puberty begins, doctors then administer long-acting GnRH agonist (puberty blockers) that suppress the pubertal development of the child. This use of puberty blockers for gender nonconforming children is experimental and not FDA-approved.

(8) After puberty blockade, the child is later administered "cross-sex" hormonal treatments that induce the development of secondary sex characteristics of the other sex, such as causing the development of breasts and wider hips in male children taking estrogen and greater muscle mass, bone density, body hair, and a deeper voice in female children taking testosterone. Some children are administered these hormones independent of any prior pubertal blockade.

(9) The final phase of treatment is for the individual to undergo cosmetic and other surgical procedures, often to create an appearance similar to that of the opposite sex. These surgical procedures may include a mastectomy to remove a female adolescent's breasts and "bottom surgery" that removes a minor's health reproductive organs and creates an artificial

form aiming to approximate the appearance of the genitals of the opposite sex.

(10) For minors who are placed on puberty blockers that inhibit their bodies from experiencing the natural process of sexual development, the overwhelming majority will continue down a path toward cross-sex hormones and cosmetic surgery.

(11) This unproven, poorly studied series of interventions results in numerous harmful effects for minors, as well as risks of effects simply unknown due to the new and experimental nature of these interventions.

(12) Among the known harms from puberty blockers is diminished bone density; the full effect of puberty blockers on brain development and cognition are yet unknown, though reason for concern is now present. There is no research on the long-term risks to minors of persistent exposure to puberty blockers. With the administration of cross-sex hormones comes increased risks of cardiovascular disease, thromboembolic stroke, asthma, COPD, and cancer.

(13) Puberty blockers prevent gonadal maturation and thus render patients taking these drugs infertile. Introducing cross-sex hormones to children with immature gonads as a direct result of pubertal blockade is expected to cause irreversible sterility. Sterilization is also permanent for those who undergo surgery to remove reproductive organs, and such persons are likely to suffer through a lifetime of complications from the surgery, infections,

and other difficulties requiring yet more medical intervention.

(14) Several studies demonstrate that hormonal and surgical interventions often do not resolve the underlying psychological issues affecting the individual. For example, individuals who undergo cross-sex cosmetic surgical procedures have been found to suffer from elevated mortality rates higher than the general population. They experience significantly higher rates of substance abuse, depression, and psychiatric hospitalizations.

(15) Minors, and often their parents, are unable to comprehend and fully appreciate the risk and life implications, including permanent sterility, that result from the use of puberty blockers, cross-sex hormones, and surgical procedures.

(16) For these reasons, the decision to pursue a course of hormonal and surgical interventions to address a discordance between the individual's sex and sense of identity should not be presented to or determined for minors who are incapable of comprehending the negative implications and life-course difficulties attending to these interventions.

Section 3 provides definitions for the terms "minor," "person," and "sex." Section 3(1) incorporates the definition of "minor" established in section 43-8-1 of the Alabama Code, first enacted in 1975, which is "[a] person who is under 19 years of age." Ala. Code § 43-8-1(18). Section 3(2) defines the term "person" to include "[a]ny individual"; "[a]ny agent, employee, official, or contractor of any legal entity"; and "[a]ny agent, employee,

official, or contractor of a school district or the state or any of its political subdivisions or agencies." Section 3(3) defines the term "sex" to mean "[t]he biological state of being male or female, based on the individual's sex organs, chromosomes, and endogenous hormone profiles."

Section 4, in broad terms, makes it a felony to perform certain medical practices on minors for certain purposes, and reads as follows:

> (a) Except as provided in subsection (b), no person shall engage in or cause any of the following practices to be performed upon a minor if the practice is performed for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex as defined in this act:
>
> (1) Prescribing or administering puberty blocking medication to stop or delay normal puberty.
>
> (2) Prescribing or administering supraphysiologic[1] doses of testosterone or other androgens to females.
>
> (3) Prescribing or administering supraphysiologic doses of estrogen to males.

[1] Supraphysiologic means of or pertaining to an amount "greater than normally present in the body." *See Supraphysiologic*, *Merriam-Webster*, https://www.merriam-webster.com/medical/supraphysiological.

(4) Performing surgeries that sterilize, including castration, vasectomy, hysterectomy, oophorectomy, orchiectomy, and penectomy.

(5) Performing surgeries that artificially construct tissue with the appearance of genitalia that differs from the individual's sex, including metoidioplasty, phalloplasty, and vaginoplasty.

(6) Removing any healthy or non-diseased body part or tissue, except for a male circumcision.

(b) Subsection (a) does not apply to a procedure undertaken to treat a minor born with a medically verifiable disorder of sex development, including either of the following:

(1) An individual born with external biological sex characteristics that are irresolvably ambiguous, including an individual born with 46 XX chromosomes with virilization, 46 XY chromosomes with under virilization, or having both ovarian and testicular tissue.

(2) An individual whom a physician has otherwise diagnosed with a disorder of sexual development, in which the physician has determined through genetic or biochemical testing that the person does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a male or female.

(c) A violation of this section is a Class C felony.

Section 5, in broad terms, prohibits certain school employees from withholding certain information about

minor students from their parents and from encouraging or coercing minor students to do the same. The section reads as follows:

> No nurse, counselor, teacher, principal, or other administrative official at a public or private school attended by a minor shall do either of the following:
>
> (1) Encourage or coerce a minor to withhold from the minor's parent or legal guardian the fact that the minor's perception of his or her gender or sex is inconsistent with the minor's sex.
>
> (2) Withhold from a minor's parent or legal guardian information related to a minor's perception that his or her gender or sex is inconsistent with his or her sex.

Section 6 clarifies that, except as provided for in section 4, nothing in the Act shall be construed as "limiting or preventing" certain mental health professionals from "rendering the services for which they are qualified by training or experience involving the application of recognized principles, methods, and procedures of the science and professional of psychology and counseling."

Section 7 similarly clarifies that "[n]othing in this section shall be construed to establish a new or separate standard of care for hospitals or physicians and their patients or otherwise modify, amend, or supersede" certain other laws of the State of Alabama.

Section 8 is a severability clause. It provides that, "[i]f any part, section, or subsection of [the Act] or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect parts,

sections, subsections, or applications of this act that can be given effect without the invalid part, section, subsection, or application."

Section 9 clarifies that the Act "does not affect a right or duty afforded to a licensed pharmacist by state law."

Section 10 clarifies that, "[a]lthough this bill would have as its purpose or effect the requirement of a new or increased expenditure of local funds," it is "excluded from further requirements and application under Amendment 621, as amended by Amendment 890 . . . because [it] defines a new crime or amends the definition of an existing crime."

Section 11, the final section, establishes that the Act "shall become effective 30 days following its passage and approval by the Governor, or its otherwise becoming law."

B. Procedural History

On April 19, 2022, a group of plaintiffs initiated this challenge to the Act seeking declaratory and injunctive relief. The group consisted of transgender minors (the "Minor Plaintiffs"), the parents of those transgender minors (the "Parent Plaintiffs"), healthcare providers who regularly treat transgender youth (the "Provider Plaintiffs"), and Reverend Paul A. Eknes-Tucker, the Senior Pastor at Pilgrim Church in Birmingham, Alabama, who frequently counsels parents of transgender children (collectively, "Plaintiffs").[2]

The original complaint generally alleged that: (1) the Act violates the Due Process Clause of the

[2] Reverend Eknes-Tucker is not included as a plaintiff in the operative pleading, the Second Amended Complaint, nor does he take part in this appeal.

Fourteenth Amendment by depriving the Parent Plaintiffs of their right to direct the upbringing of their children (Count I); (2) the Act violates the Equal Protection Clause of the Fourteenth Amendment by discriminating against the Minor Plaintiffs on the bases of sex and transgender status (Count II); (3) the Act is preempted by section 1557 of the Affordable Care Act (Count III); (4) the Act violates the Free Speech Clause of the First Amendment (Count IV); and (5) the Act is void for vagueness under the Due Process Clause of the Fourteenth Amendment (Count V). That complaint named the Attorney General of Alabama and several state officials (collectively, "Alabama") as defendants.[3]

Two days later, Plaintiffs filed a motion for preliminary injunction, seeking a ruling preventing the enforcement of the Act in advance of its May 8, 2022, effective date.[4] In light of that request, the district court expedited the briefing schedule and scheduled a hearing for the first week of May.

On April 29, 2022, the United States filed a motion to intervene, as well as its own motion for preliminary injunction similarly seeking to prevent enforcement of the Act. Shortly thereafter, fifteen states moved for leave to file an amicus brief in support of Alabama.

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[3] The original complaint also included Governor Ivey as a defendant, but the parties subsequently moved to dismiss her from the action on May 3, 2022, pursuant to a joint understanding that she and her office would be bound by any forthcoming injunctive relief. The district court granted that request.

[4] The motion is styled as a "motion for a temporary restraining order and/or preliminary injunction." However, because Alabama received notice of the request for injunctive relief, the motion subsequently was addressed only as a motion for preliminary injunction.

That was followed by a group of at least twenty-two professional medical and mental health organizations jointly moving for leave to file an amicus brief in support of Plaintiffs. The district court ultimately granted the motion to intervene and the motions to file amicus briefs, giving the United States permission to participate in the preliminary injunction hearing and taking the amicus briefs under advisement.

The three-day hearing on Plaintiffs' motion for preliminary injunction began on May 4, 2022. On that first day, the district court discussed the motion for intervention and heard opening arguments from the parties. At that time, Plaintiffs represented that they were no longer challenging the portions of section 4 that ban surgical intervention, i.e., subsections (a)(4)–(6), and were instead focusing on the portions of section 4 that ban puberty blockers and cross-sex hormone treatment, i.e. subsections (a)(1)–(3). The following day, the parties commenced their presentation of the evidence.

Plaintiffs first tendered Dr. Linda Hawkins and Dr. Morissa Ladinsky as experts in the treatment of gender dysphoria in minors. Dr. Hawkins is the director of the Gender and Sexuality Development Clinic at the Children's Hospital of Philadelphia. She has specialized in treating LGBT youth for roughly twenty-two years and worked with over 4,000 transgender youth. During her testimony, Dr. Hawkins defined "gender identity" as "the internal authentic hardwired sense of one's self as male or female." She further testified that a blanket prohibition on puberty blockers and hormone treatment would be "devastating" for transgender youth, comparing it to "removing somebody's cancer treatment and just expecting them to be okay."

Dr. Ladinsky is an associate professor of pediatrics at the Heersink School of Medicine at the University of Alabama at Birmingham ("UAB") and a board-certified pediatrician at the affiliated hospital. Dr. Ladinsky opened a gender clinic at UAB in the fall of 2015 and, at the time of her testimony, had worked with an estimated 400 to 450 minors suffering from gender dysphoria. Dr. Ladinsky discussed the guidelines on the treatment of gender dysphoria in youth that the UAB gender clinic follows and noted that those guidelines are endorsed by the American Academy of Pediatrics. She also noted that consent forms must be signed by all legal parents and guardians before a minor's hormonal therapy can begin. According to Dr. Ladinsky, puberty blockers pose some risks but, overall, are safe and reversible. She described the risks posed by puberty blockers and cross-sex hormones, related to fertility and sexual function, as "small side effect risks." Dr. Ladinsky also testified that the youngest minor for which she prescribed puberty blockers was an eleven-year-old female and that about 85 percent of her patients who have taken puberty blockers have gone on to take cross-sex hormones. In her opinion, it is "uncommon" for a minor patient taking puberty blockers to stop experiencing gender dysphoria and begin identifying with their biological sex.

Plaintiffs then called Megan Poe (one of the Parent Plaintiffs), Dr. Rachel Koe (one of the Provider Plaintiffs), and Reverend Eknes-Tucker to testify about their personal knowledge and experience regarding gender dysphoria.

Poe is the mother of a biological male who identifies as a female. When asked how her child presents as a female, Poe testified that her child "is very over the top girly," "loves makeup and hair," and "[is] always

worried about her clothes." The child began showing signs of a female gender identity at the age of two, according to Poe, by wanting girl toys and girl clothes. The child started puberty blockers in sixth grade and then started hormone therapy at the age of fourteen. Poe reported that her child now is "so happy" and "thriving" and has not experienced any side effects from the treatment. She insisted that her child is "definitely not [experiencing] a phase" and is "never going to grow out of this." Poe also said she was afraid that her child would commit suicide if the treatments were no longer available.

Dr. Koe is a pediatrician in southeast Alabama. Dr. Koe reported that she treats transgender adolescents but has never treated a patient with gender dysphoria who later desisted or expressed regret about receiving these types of treatments. She also testified that, if the Act takes effect, it will leave her "stuck in a place where [she doesn't] know how to proceed" nor how to provide care for patients with gender dysphoria.

Reverend Eknes-Tucker is the Senior Pastor at Pilgrim Church in Birmingham, Alabama, and has been a pastor for 45 years. Reverend Eknes-Tucker testified that there have been transgender individuals in every congregation that he has served and that he has given advice to parents of transgender children on numerous occasions. He clarified that he has not given medical advice but that he has helped connect parents of transgender children with doctors who provide gender-affirming care.

In addition to this live testimony, Plaintiffs produced as evidence various organizational medical guidelines, sworn declarations, research articles, and other documents.

Next, the United States, as an intervenor on behalf of Plaintiffs, tendered Dr. Armand H. Antommaria as an expert in bioethics and treatment protocols for adolescents suffering from gender dysphoria. Dr. Antommaria is the chair of pediatric ethics and an attending physician at Cincinnati Children's Hospital Medical Center. During his testimony, Dr. Antommaria addressed the dearth of randomized controlled trials for the treatment of minors with puberty blockers and cross-sex hormone therapy and expressed his concern that such trials "would be unethical," given the lack of confidence that the control group and the experimental group would receive equally efficacious treatment. He also expressed concern that any such trials "would have substantial methodological limitations," given the need to recruit enough participants and conduct a blind study. When asked for his opinion regarding the ability of parents and adolescents to adequately understand and give informed consent to the provision of puberty blockers and hormone therapy, Dr. Antommaria answered that those treatments are "comparable to other decisions that parents and their children make in pediatric healthcare on a frequent basis." He further testified that there are no equally effective alternative medical treatments for adolescents with gender dysphoria and that there is not an ethical basis for distinguishing between minors experiencing precocious puberty[5] and minors experiencing gender dysphoria with respect to the provision of puberty blockers and hormone treatment.

Along with Dr. Antommaria's testimony, the United States presented, among other things, various organizations' medical policy statements and guidelines,

[5] Precocious puberty is the premature initiation of puberty.

some research and news articles, and Dr. Antommaria's declaration and curriculum vitae. For example, the United States presented the Standards of Care of the World Professional Association for Transgender Health ("WPATH"), which endorse the use of puberty blockers and cross-sex hormone treatment for minors when certain criteria are met. The United States also offered statements by the Alabama Psychological Association and the American Academy of Pediatrics supporting the use of puberty blockers and cross-sex hormone treatment for minors and opposing the Act. The full record reveals that at least twenty-two professional medical and mental health organizations support the use of such medications.

On cross-examination, Dr. Antommaria acknowledged that "[t]here are risks involved in the treatment course for the treatment of gender dysphoria." He went on to note that, for puberty blockers and cross-sex hormones generally, there is a risk of impaired fertility, and that, for estrogen therapy, there is a risk of change in sexual function. When asked whether he agrees that more research is needed to study the efficacy and the costs and benefits of gender-affirming care, Dr. Antommaria responded that "more research is needed in all areas of health care."

Alabama, for its part, first tendered Dr. James Cantor. Dr. Cantor is a clinical psychologist and neuroscientist who was called as an expert on psychology, human sexuality, research methodology, and the state of research on gender dysphoria. In response to Dr. Antommaria's testimony, Dr. Cantor confirmed that none of the existing studies on puberty blockers and hormone therapies are randomized and opined that there are alternative methodologies that would be more reliable than observational trials, which he

described as the lowest quality of evidence. Dr. Cantor also testified that the existing research does not support the conclusion that the use of puberty blockers and hormone therapy is "the only safe and effective treatment for gender dysphoria." In his opinion, gender dysphoria can be treated with a "watchful waiting approach" whereby decisions about medical interventions are withheld, but therapy is continued, until more information becomes available.

According to Dr. Cantor, clinical guidelines suggest that comorbidities, including mental health issues, should be resolved prior to pursuing puberty blockers and cross-sex hormone treatment. He also noted that some cases of gender dysphoria have turned out to be prepubescent children misinterpreting their same-sex attraction and that blocking puberty in such cases prevents those children from understanding their sexuality.

On cross-examination, Dr. Cantor acknowledged that he is not a medical doctor and that he has not provided care to transgender adolescents under the age of sixteen.

Alabama then called Sydney Wright to testify about her personal experience with gender dysphoria. Wright is a biological female who is married to another woman. At the time of her testimony, Wright was twenty-three years old. She testified that she began identifying as transgender and receiving related treatment when she was seventeen years old, which culminated in testosterone therapy for approximately one year when she was nineteen years old. According to Wright, the testosterone treatment put her at a greater risk of heart attack or stroke and caused her to develop tachycardia. She explained that, after a significant discussion with her grandfather, she stopped identify-

ing as transgender and receiving testosterone therapy. She now believes that her doctors mishandled her treatment and that she simply needed counseling during her teenage years. She also reported that her digestive system is "still messed up" and that she may have fertility issues as a result of the testosterone therapy that she received over three-and-a-half years earlier. When asked what she would tell a young person struggling with gender dysphoria, Wright stated that she would advise them to take "a lot of time," "love [themselves]," and understand that they can act and dress like the opposite sex without "hav[ing] to transition."

In addition to these two witnesses, Alabama produced, among other things, research papers, foreign countries' medical guidelines, and the declarations of various healthcare professionals and individuals with experience related to gender dysphoria. For example, in terms of healthcare professionals, Alabama produced a declaration in which Dr. Quentin L. Van Meter[6] states that comparing the use of puberty blockers for precocious puberty with the use of puberty blockers for gender dysphoria is like "comparing apples to oranges," given the evidence that "normal bone density can't be fully reestablished" in the latter case and the lack of longterm data on bone, gonad, and brain health. Alabama also produced a declaration in which Dr. Patrick Hunter[7] attests that "there is currently no established standard of care for transgender-identified youth" and that "[t]he medical risks of 'gender-

[6] Dr. Van Meter is a board-certified pediatrician and pediatric endocrinologist who currently works in private practice.

[7] Dr. Hunter is a board-certified pediatrician with a master's degree in bioethics who currently holds academic positions at the University of Central Florida and Florida State University.

affirming' interventions are substantial." In terms of individuals with personal experience related to gender dysphoria, Alabama produced the declaration of Corinna Cohn, a biological male who underwent sex reassignment surgery at the age of nineteen—which included the removal of testicles, penectomy, and vaginoplasty—and who, looking back, claims to have been "unprepared to understand the consequences" of seeking such medical interventions as a teenager. Alabama also produced a declaration in which Carol Freitas, a biological female who previously experienced gender dysphoria, claims that "[transitioning] was the biggest mistake [that she] ever made" and that she instead should have been treated for depression and post-traumatic stress disorder related to her "internalized homophobia and childhood abuse." Lastly, in terms of medical opinions from foreign countries, Alabama produced documents showing that public healthcare entities of Sweden, Finland, France, Australia, New Zealand, and the United Kingdom have raised concerns about the risks associated with puberty blockers and cross-sex hormone treatment and supported greater caution and/or more restrictive criteria in connection with such interventions.

On May 13, 2022, the district court granted in part and denied in part the motions for preliminary injunction, enjoining Alabama from enforcing section 4(a)(1)–(3) but allowing the rest of the Act to remain in effect. The ruling was based on, among other things, a determination that Plaintiffs had shown a substantial likelihood of success on the merits as to their substantive due process claim and equal protection claim (Counts I and II), but not as to their other claims. With respect to the substantive due process claim (Count I), the district court recognized a fundamental right of parents to "treat their children with transitioning

medications subject to medically accepted standards," held that the Act infringes upon that fundamental right and concluded that Alabama had not sufficiently demonstrated that the Act is narrowly tailored to achieve a compelling state interest. With respect to the equal protection claim (Count II), the district court held that the Act "amounts to a sex-based classification" and concluded that Alabama had not proffered a sufficiently persuasive justification for that classification.

Alabama filed a timely notice of appeal on May 16, 2022.[8]

II. STANDARD OF REVIEW

"We review the grant of a preliminary injunction for abuse of discretion, reviewing any underlying legal conclusions *de novo* and any findings of fact for clear error." *Gonzalez v. Governor of Georgia*, 978 F.3d 1266, 1270 (11th Cir. 2020). "A district court abuses its discretion if it applies an incorrect legal standard, applies the law in an unreasonable or incorrect manner, follows improper procedures in making a determination, or makes findings of fact that are clearly erroneous." *Id.* (quoting *United States v. Estrada*, 969 F.3d 1245, 1261 (11th Cir. 2020)).

III. ANALYSIS

A district court may grant injunctive relief only if the moving party demonstrates that: "(1) it has a substantial likelihood of success on the merits; (2) irreparable injury will be suffered unless the injunction issues; (3) the threatened injury to the movant

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[8] The operative pleading—the second amended complaint—was filed on September 19, 2022. In terms of counts, the second amended complaint contains only the substantive due process claim and the equal protection claim.

outweighs whatever damage the proposed injunction may cause the opposing party; and (4) if issued, the injunction would not be adverse to the public interest." *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc). "In considering these four prerequisites, [courts] must remember that a preliminary injunction is an extraordinary and drastic remedy which should not be granted unless the movant clearly carries the burden of persuasion" as to these four prerequisites. *Canal Auth. v. Callaway*, 489 F.2d 567, 573 (5th Cir. 1974); *accord Siegel*, 234 F.3d at 1176.[9]

As previewed, the district court determined that these four prerequisites are met with respect to section 4(a)(1)–(3) and thus enjoined Alabama from enforcing that part of the Act. The district court dedicated the bulk of its analysis in the preliminary injunction order to the first prerequisite and ultimately found that Plaintiffs had established a substantial likelihood of success as to their substantive due process claim and equal protection claim. Because the parties' arguments on appeal similarly focus on the likelihood-of-success prerequisite, we do the same. We begin with the substantive due process claim and then turn to the equal protection claim.

A. Substantive Due Process

The Due Process Clause of the Fourteenth Amendment provides that no state shall "deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1. The Supreme Court has held that this language guarantees both procedural and substantive rights. *Dobbs v. Jackson Women's Health*

[9] In *Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc), this Court adopted as precedent the decisions of the former Fifth Circuit rendered prior to October 1, 1981.

Org., 142 S. Ct. 2228, 2246 (2022). Those substantive rights include a "great majority" of the rights guaranteed by the first eight Amendments vis-à-vis the federal government, as well as "a select list of fundamental rights that are not mentioned anywhere in the Constitution." *Id.*; *see also McDonald v. City of Chicago*, 561 U.S. 742, 760–66 (2010) (reviewing the history of the Supreme Court's incorporation of "almost all of the provisions of the Bill of Rights" against the States).

To determine whether a right at issue is one of the substantive rights guaranteed by the Due Process Clause, courts must look to whether the right is "deeply rooted in [our] history and tradition" and "essential to our Nation's 'scheme of ordered liberty.'" *Dobbs*, 142 S. Ct. at 2246 (alteration in original) (quoting *Timbs v. Indiana*, 139 S. Ct. 682, 687 (2019)). The outcome of this analysis determines the amount of leeway that states have to enact laws that infringe upon the right at issue. "Laws that burden the exercise of a fundamental right require strict scrutiny and are sustained only if narrowly tailored to further a compelling government interest." *Lofton v. Sec'y of Dep't of Child. & Fam. Servs.*, 358 F.3d 804, 815 (11th Cir. 2004). Conversely, laws that do not burden the exercise of a fundamental right (and do not discriminate against a suspect class under the Equal Protection Clause) are subject to rational basis review and need only "be rationally related to a legitimate governmental interest." *Jones v. Governor of Florida*, 950 F.3d 795, 809 (11th Cir. 2020). Although not "toothless," rational basis review is "highly deferential to government action." *Id.* (quoting *Schweiker v. Wilson*, 450 U.S. 221, 234 (1981)).

In other words, every time a court recognizes an asserted right as a fundamental right protected by the Constitution, the court, "to a great extent, place[s] the matter outside the arena of public debate and legislative action." *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997). For that reason, the Supreme Court has instructed courts addressing substantive due process claims to "engage[] in a careful analysis of the history of the right at issue" and be "'reluctant' to recognize rights that are not mentioned in the Constitution." *Dobbs*, 142 S. Ct. at 2246–47 (quoting *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992)).

In this case, the district court determined that the "right to treat [one's] children with transitioning medications subject to medically accepted standards" is one of the substantive rights guaranteed by the Due Process Clause and that, therefore, section 4(a)(1)–(3) is subject to strict scrutiny. But the use of these medications in general—let alone for children—almost certainly is not "deeply rooted" in our nation's history and tradition. Although there are records of transgender or otherwise gender nonconforming individuals from various points in history,[10] the earliest-recorded uses

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[10] *See, e.g.*, *Adams ex rel. Kasper v. Sch. Bd. of St. Johns Cnty.*, 57 F.4th 791, 822 n.1 (11th Cir. 2022) (Wilson, J. dissenting) (noting that Justinian's Code, from the early sixth century AD, contains discussion of "hermaphrodites"); Mary Beth Norton, *Founding Mothers & Fathers: Gendered Power and the Forming of American Society* 183–202 (1996) (discussing the case of Thomasine Hall, also known as Thomas Hall, an intersex individual who alternated between identifying as a man and as a woman and who was ordered by a Virginia court in 1629 to wear dual-gendered apparel); Genny Beemyn, *U.S. History*, *in Trans Bodies, Trans Selves: A Resource for the Transgender Community* 501, 501–53 (Laura Erickson-Schroth ed. 2014) (discussing multiple prominent transgender individuals born between 1882 and 1926, including Lili Elbe, formerly known as Einar Wegener; Laurence

of puberty blocking medication and cross-sex hormone treatment for purposes of treating the discordance between an individual's biological sex and sense of gender identity did not occur until well into the twentieth century.[11, 12] Indeed, the district court's order does not feature any discussion of the history of the use of puberty blockers or cross-sex hormone treatment or otherwise explain how that history informs the meaning of the Fourteenth Amendment at the time it was ratified—July 9, 1868.[13] *See Morrissey v. United*

Michael Dillon, formerly known as Laura Maud Dillon; and Christine Jorgensen, formerly known as George William).

[11] Puberty blockers first began being used in the 1980s. *See* Victoria Pelham, *Puberty Blockers: What You Should Know*, Cedars-Sinai Blog (Jan. 16, 2023), https://www.cedars-sinai.org/blog/puberty-blockers-for-precocious-puberty.html; Simona Giordano & Søren Holm, *Is Puberty Delaying Treatment 'Experimental Treatment'?*, 21(2) Int'l. J. Transgend. Health 113 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7430465/.

[12] Estrogen and testosterone were not discovered and characterized until the 1920s and 1930s. *See* Jamshed R. Tata, *One Hundred Years of Hormones*, 6 EMBO Rep. 490, 491 (2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1369102/pdf/67400444.pdf. Laurence Michael Dillon, formerly known as Laura Maud Dillon, began receiving testosterone treatment for purposes of treating the discordance between biological sex and sense of gender identity in 1939 and is thought by some to be the first biological female to receive such treatment. *See* Pagan Kennedy, *The First Man-Made Man: The Story of Two Sex Changes, One Love Affair, and a Twentieth-Century Medical Revolution* (2007). According to the WPATH Standards of Care offered by both Plaintiffs and the United States, health professionals began using hormone therapy as a treatment for gender dysphoria "[i]n the second half of the 20th century." Doc. 78-17 at 14.

[13] *See* Lawrence B. Solum, *The Fixation Thesis: The Role of Historical Fact in Original Meaning*, 91 Notre Dame L. Rev. 1, 6–7 (2015) ("[T]he original meaning ('communicative content') of the

States, 871 F.3d 1260, 1269–70 (11th Cir. 2017) (rejecting the notion that the Constitution protects a right to procreate via in vitro fertilization procedures based on the fact that such procedures are "decidedly modern phenomena" that did not come about until 1978).

Rather than perform any historical inquiry specifically tied to the particular alleged right at issue, the order on appeal instead surmises that the "right to treat [one's] children with transitioning medications subject to medically accepted standards" falls under the broader, recognized fundamental right to "make decisions concerning the care, custody, and control of [one's] children." *E.g.*, *Troxel v. Granville*, 530 U.S. 57, 66 (2000); *Lofton*, 358 F.3d at 812. *But see Morrissey*, 871 F.3d at 1269 (emphasizing that a substantive due process analysis must focus on the specific right asserted, rather than simply rely on a related general right). However, there is no binding authority that indicates that the general right to "make decisions concerning the care, custody, and control of [one's] children" includes the right to give one's children puberty blockers and cross-sex hormone treatment.

The fundamental right to "make decisions concerning the care, custody, and control of [one's] children," as it is recognized today, traces back in large part to *Meyer v. Nebraska*, 262 U.S. 390 (1923). There, the Supreme Court held that a Nebraska law restricting the teaching of foreign languages violated the Due Process Clause. *Id.* at 400–03. In doing so, the Court recognized that the "liberty" guaranteed by the Due Process Clause includes the right "to engage in any of the common occupations of life, to acquire useful knowledge,

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constitutional text is fixed at the time each provision is framed and ratified.").

to marry, establish a home and bring up children, . . . and generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness of free men." *Id.* at 399 (emphasis added).

The Supreme Court elaborated on the fundamental liberty of parents two years later in *Pierce v. Society of the Sisters of the Holy Names of Jesus & Mary*, 268 U.S. 510 (1925). That case addressed Oregon's Compulsory Education Act of 1922, which mandated that parents send their school-aged children to public school (as opposed to private school). *Id.* at 530–31. Citing its decision in *Meyer*, the Court concluded that the Oregon law violated the Due Process Clause on the basis that it "unreasonably interferes with the liberty of parents and guardians to *direct the upbringing and education of children under their control*." *Id.* at 534–35 (emphasis added).

Meyer and *Pierce* ushered in a line of Supreme Court decisions that recognized, and further defined the contours of, parents' liberty interest to control the upbringing of their children.[14] The majority of those

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[14] *See, e.g.*, *Prince v. Massachusetts*, 321 U.S. 158, 166–69 (1944) (recognizing that "the custody, care and nurture of [children] reside[s] first in the parents," but nevertheless upholding Massachusetts child labor laws that restricted the ability of children to sell religious literature in accordance with their parents' wishes based on the state's "authority over children's activities" and "the crippling effects of child employment, more especially in public places" (footnote omitted)); *Stanley v. Illinois*, 405 U.S. 645, 646–59 (1972) (holding that Illinois could not automatically designate the children of unwed parents as wards of the state upon the death of the mother because fathers of children born out of wedlock have a "cognizable and substantial" "interest in retaining custody of [their] children" under the Constitution); *Wisconsin v. Yoder*, 406 U.S. 205, 213– 234 (1972) (holding that Wisconsin could not compel school attendance

cases, however, pertain to issues of education, religion, or custody. The Supreme Court's most extensive discussion of parents' control over the medical treatment received by their children came in *Parham v. J. R.*, 442 U.S. 584 (1979).

In *Parham*, a group of minors brought a Due Process challenge to Georgia's procedures for committing children to mental hospitals. *Id.* at 587–88. At the time, Georgia law provided for the voluntary admission of children upon application by a parent or guardian. *Id.* at 590–91. Thus, the question at issue was whether the minors had a *procedural* due process right to greater procedural safeguards, e.g., a judicial hearing, before their parents could commit them. *Id.* at 610. The Supreme Court concluded that "some kind of inquiry should be made by a 'neutral factfinder' to determine whether the statutory requirements for admission are satisfied," but that the inquiry could be "informal," e.g., conducted by a staff physician, and did not require an adversarial proceeding with a judicial or administrative officer. *Id.* at 606–10. "[R]equiring a formalized, factfinding hearing," according to the Supreme Court, would "[p]it[] the parents and the child" against each other and represent a "significant intrusion into the parent-child relationship." *Id.* at 610; *see also id.* ("It is one

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beyond the eighth grade because doing so would "grave[ly] interfere[] with important Amish religious tenets" and "the traditional interest of parents with respect to the religious upbringing of their children"); *Troxel*, 530 U.S. at 60– 75 (striking down Washington's nonparental visitation statute, which would have permitted any person to petition for visitation rights at any time and courts to grant such rights whenever in the best interest of the child, on the basis that it contravened "the fundamental right of parents to make decisions concerning the care, custody, and control of their children" and "the traditional presumption that a fit parent will act in the best interest of his or her child").

thing to require a neutral physician to make a careful review of the parents' decision in order to make sure it is proper from a medical standpoint; it is a wholly different matter to employ an adversary contest to ascertain whether the parents' motivation is consistent with the child's interests."). In so ruling, the Supreme Court recognized, as a general matter, that "[m]ost children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment," *id.* at 603, and that parents retain "plenary authority" as well as "a substantial, if not the dominant, role" in deciding to pursue lawfully available treatment, like institutionalization, for their children, *id.* at 604; *see also id.* at 609 (concerning "treatment that is provided by the state"). *Parham* was concerned about the procedures a state must afford a child prior to institutionalization when the parent believes such treatment—which is not only lawful but provided by the state itself—is necessary. Notably, *Parham* does not at all suggest that parents have a fundamental right to direct a particular medical treatment for their child that is prohibited by state law. *Parham* therefore offers no support for the Parent Plaintiffs' substantive due process claim.

This Court has issued its own series of decisions outlining the contours of parents' liberty interest to control the upbringing of their children,[15] with the

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[15] *See, e.g.*, *Arnold v. Bd. of Educ. of Escambia Cnty.*, 880 F.2d 305, 312–14 (11th Cir. 1989) (holding that the parent plaintiffs sufficiently alleged a cause of action under 42 U.S.C. § 1983 for violation of the fundamental right to direct the upbringing of one's children against two school officials who allegedly coerced a minor female into undergoing an abortion), *overruled on other grounds by Leatherman v. Tarrant Cnty. Narcotics Intel. & Coordination Unit*, 507 U.S. 163 (1993); *Lofton*, 358 F.3d at 811–

most relevant decision being *Bendiburg v. Dempsey*, 909 F.2d 463 (11th Cir. 1990). In that case, the State of Georgia had obtained temporary custody of a fifteen-year-old boy who was injured in an automobile accident. As the boy's custodian and over the father's wishes,[16] Georgia consented to the use of a Hickman catheter on the boy, which allegedly caused a massive pulmonary embolus and ultimately the boy's death. *Id.* at 466–67. This Court allowed the father's *procedural* due process claims against certain defendants to proceed to trial, noting that "neither the state nor private actors, concerned for the medical needs of a child, can willfully disregard the rights of parents to generally make decisions concerning the treatment to be given to their children" and that "[t]he Due Process Clause prevents government from abusing its power, or employing its power as an instrument of oppression." *Id.* at 470. But, as relevant here, this Court affirmed the determination that the father had no *substantive* due process claim and recognized that "[t]he state has an interest

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15 (declining to extend the parental right of control protected by the Due Process Clause to foster parents); *Robertson v. Hecksel*, 420 F.3d 1254, 1255–60 (11th Cir. 2005) (declining "to further expand the substantive protections of the Due Process Clause" by recognizing that a mother whose son was killed by police during a traffic stop "suffered a deprivation of [a] constitutionally-protected liberty interest in a continued relationship with [him]"); *Frazier ex rel. Frazier v. Winn*, 535 F.3d 1279, 1281–86 (11th Cir. 2008) (holding that Florida's Pledge of Allegiance statute, which requires students to recite the Pledge in the absence of a written request to the contrary by a parent, is constitutional despite restricting the students' freedom of speech because it advances the fundamental rights of parents to direct the upbringing of their children).

[16] The child's mother had been killed in the same automobile accident. *Bendiburg*, 909 F.2d at 466.

in protecting the health, safety, and welfare of children residing within its borders."[17] *Id.* at 468, 470.

In sum, none of the binding decisions regarding substantive due process establishes that there is a fundamental right to "treat [one's] children with transitioning medications subject to medically accepted standards." Instead, some of these cases recognize, at a high level of generality, that there is a fundamental right to make decisions concerning the "upbringing" and "care, custody, and control" of one's children. *See Pierce*, 268 U.S. at 534–35; *Troxel*, 530 U.S. at 66. And those decisions applying the fundamental parental right in the context of medical decision-making do not establish that parents have a derivative fundamental right to obtain a particular medical treatment for their children as long as a critical mass of medical professionals approve. Moreover, all of the cases dealing with the fundamental parental right reflect the common thread that states properly may limit the authority of parents where "it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens." *Wisconsin v. Yoder*, 406 U.S. 205, 233–34 (1972); *see also Prince v. Massachusetts*, 321 U.S. 158, 168–69 (1944); *Parham*, 442 U.S. at 604; *Bendiburg*, 909 F.2d at 470. Against this backdrop, and without any historical analysis specifically tied to the medications at issue, Plaintiffs

[17] It bears emphasizing that *Bendiburg* dealt with a situation wherein a State interfered with a single parent's ability to *refuse* certain lawful medical treatment for his child. *Id.* at 466–67. To the extent that *Bendiberg* supports the proposition that parents have a substantive due process right relating to the medical treatment that their children receive, its reasoning is not equally applicable to situations involving parents' ability to *affirmatively obtain* certain medical treatment for their children that the State prohibits.

have not shown it to be likely that the Due Process Clause of the Constitution guarantees a fundamental "right to treat [one's] children with transitioning medications subject to medically accepted standards."[18] *See L.W. v. Skrmetti*, 73 F.4th 408, 416–17 (6th Cir. July 8, 2023) (recognizing that parents "have a substantive due process right 'to make decisions concerning the care, custody, and control of their children'" but noting that "[n]o Supreme Court case extends it to a general right to receive new medical or experimental drug treatments" (quoting *Troxel*, 530 U.S. at 66)).

Because the Due Process Clause does not guarantee the described right, state regulation of the use of puberty blockers and cross-sex hormone treatment for minors would be subject only to rational basis review and thus afforded "a 'strong presumption of validity.'" *Dobbs*, 142 S. Ct. at 2284 (quoting *Heller v. Doe*, 509 U.S. 312, 319 (1993)). "Under this deferential standard," the question that we ask "is simply whether the challenged legislation is rationally related to a legitimate state interest." *Lofton*, 358 F.3d at 818. Such a relationship may merely "be based on rational speculation" and need not be supported "by evidence or empirical data." *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 315 (1993); *accord Jones*, 950 F.3d at 809 ("When we review a statute for rationality, generally we ask whether there is *any* rational basis for the law, even if the government's proffered explanation is irrational, and even if it fails to offer any explanation at all.").

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[18] This is consistent with the fact that there has been no showing of any historical recognition of a fundamental right of adults to obtain the medications at issue for themselves. As Alabama points out, it would make little sense for adults to have a *parental* right to obtain these medications for their children but not a *personal* right to obtain the same medications for themselves.

We are highly doubtful that section 4(a)(1)–(3) would not survive the lenient standard that is rational basis review. It is well established that states have a compelling interest in "safeguarding the physical and psychological well-being of . . . minor[s]." *Otto v. City of Boca Raton*, 981 F.3d 854, 868 (11th Cir. 2020) (quoting *New York v. Ferber*, 458 U.S. 747, 756–57 (1982)). In the same vein, states have a compelling interest in protecting children from drugs, particularly those for which there is uncertainty regarding benefits, recent surges in use, and irreversible effects.[19] Although rational speculation is itself sufficient to survive rational basis review, here Alabama relies on both record evidence and rational speculation to establish that section 4(a)(1)–(3) is rationally related to that compelling state interest. First, the record evidence is undisputed that the medications at issue present *some* risks. As the district court recognized, these medications can cause "loss of fertility and sexual function." The district court also acknowledged testimony that "several European countries have restricted treating minors with transitioning medications due to growing concern about the medications' risks." Second, there is at least rational speculation that some families will not fully appreciate those risks and that some minors experiencing gender dysphoria ultimately will desist and identify with their biological sex. Section 4(a)(1)–

[19] As Alabama suggests, the opioid epidemic has shown firsthand the need to be skeptical and exercise caution when there is a sudden uptick in prescriptions of powerful, off-label medications, even when some medical and pharmaceutical organizations defend their safety. *See also Skrmetti*, 73 F.4th at 418 ("[I]t is difficult to maintain that the medical community is of one mind about the use of hormone therapy for gender dysphoria when the FDA is not prepared to put its credibility and careful testing protocols behind the use.").

(3) addresses these risks by prohibiting the prescription and administration of puberty blockers and cross-sex hormone treatment to a patient under the age of nineteen for purposes of treating discordance between biological sex and sense of gender identity so that children will have more time to develop their identities and to consider all of the potential consequences before moving forward with such treatments. That connection would be sufficient under rational basis review.

In sum, Plaintiffs' assertion that the Constitution protects the right to treat one's children with puberty blockers and cross-sex hormone therapy is precisely the sort of claim that asks courts to "break new ground in [the] field [of Substantive Due Process]" and therefore ought to elicit the "utmost care" from the judiciary. *See Collins*, 503 U.S. at 125. The district court held that there is a specific right under the Constitution "to treat [one's] children with transitioning medications subject to medically accepted standards," but did so without performing any analysis of whether that specific right is deeply rooted in our nation's history and tradition. Instead, the district court grounded its ruling in an unprecedented interpretation of parents' fundamental right to make decisions concerning the "upbringing" and "care, custody, and control" of one's children. *See Pierce*, 268 U.S. at 534–35; *Troxel*, 530 U.S. at 66. That was error. Neither the record nor any binding authority establishes that the "right to treat [one's] children with transitioning medications subject to medically accepted standards" is a fundamental right protected by the Constitution. And, assuming it is not, then section 4(a)(1)–(3) is subject only to rational basis review—a lenient standard that the law seems to undoubtedly clear. Because the district court erroneously reviewed section 4(a)(1)–(3) with heightened scrutiny, its determination regarding the Parent

Plaintiffs' likelihood of success does not justify the preliminary injunction.

B. Equal Protection

The Equal Protection Clause provides that no state shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1. The Equal Protection Clause is "essentially a direction that all persons similarly situated should be treated alike," *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985), and "simply keeps governmental decisionmakers from treating differently persons who are in all relevant respects alike," *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992).

"In considering whether state legislation violates the Equal Protection Clause . . . we apply different levels of scrutiny to different types of classifications." *Clark v. Jeter*, 486 U.S. 456, 461 (1988). All statutory classifications must, at a minimum, satisfy rational basis review. *Id.* Classifications based on race or national origin, however, are reviewed under the "most exacting" level of scrutiny: strict scrutiny. *Id.* Between rational basis review and strict scrutiny lies "a level of intermediate scrutiny," which applies to classifications based on sex or illegitimacy. *Id.*

Thus, a government policy that distinguishes on the basis of sex is permissible under the Equal Protection Clause "only if it satisfies intermediate scrutiny." *Adams ex rel. Kasper v. Sch. Bd. of St. Johns Cnty.*, 57 F.4th 791, 801 (11th Cir. 2022). Under that standard, the party seeking to uphold the policy carries the burden of "showing that the [sex-based] classification serves 'important governmental objectives and that the discriminatory means employed' are 'substantially related to the achievement of those objectives.'" *Miss.*

Univ. for Women v. Hogan, 458 U.S. 718, 724 (1982) (quoting *Wengler v. Druggists Mut. Ins. Co.*, 446 U.S. 142, 150 (1980)).

"For a government objective to be important, it cannot 'rely on overbroad generalizations about the different talents, capacities, or preferences of males and females.'" *Adams*, 57 F.4th at 801 (quoting *United States v. Virginia*, 518 U.S. 515, 533 (1996)). And for a policy's means to be substantially related to a government objective, there must be "enough of a fit" between the means and the asserted justification. *Id.* (quoting *Danskine v. Mia. Dade Fire Dep't*, 253 F.3d 1288, 1299 (11th Cir. 2001)). However, "the Equal Protection Clause does not demand a perfect fit between means and ends when it comes to sex." *Id.*; *see also Nguyen v. INS*, 533 U.S. 53, 70 (2001) ("None of our gender-based classification equal protection cases have required that the [policy] under consideration must be capable of achieving its ultimate objective in every instance.").

In this case, the district court first held that section 4(a)(1) (3) of the Act classifies on the basis of gender nonconformity and therefore classifies on the basis of sex. In determining that section 4(a)(1)–(3) classifies on the basis of gender nonconformity, the district court reasoned that section 4(a)(1)–(3) "prohibits transgender minors—and only transgender minors—from taking transitioning medications due to their gender nonconformity." And, in holding that a classification on the basis of gender nonconformity necessarily constitutes a classification on the basis of sex, the district court cited the reasoning of *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020), and *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011).

After determining that section 4(a)(1)–(3) of the Act amounts to a sex-based classification subject to

intermediate scrutiny, the district court then found that Alabama had not offered any exceedingly persuasive justification for the classification and thus concluded that that the Minor Plaintiffs are substantially likely to succeed on their equal protection claim.

On appeal, Alabama maintains that section 4(a)(1)–(3) classifies on the bases of age and procedure, not sex or gender nonconformity, and is therefore not subject to any heightened scrutiny above rational basis review. *See Gregory v. Ashcroft*, 501 U.S. 452, 470 (1991) ("[A]ge is not a suspect classification under the Equal Protection Clause."); *Clark*, 486 U.S. at 461 (listing suspect classifications and making no reference to classifications based on procedures). Alabama further argues that section 4(a)(1)–(3) would survive at any level of scrutiny because it "serves the compelling [state] interest of protecting children from unproven, life-altering medical interventions" and because "no other approach would offer children in Alabama adequate protection."

In response, the Minor Plaintiffs argue that section 4(a)(1)– (3) classifies on the basis of sex both directly, by using sex-based terms, and indirectly, by classifying on the basis of gender nonconformity, and that the district court therefore properly applied intermediate scrutiny. The Minor Plaintiffs also argue that, even if the more lenient rational basis standard applies, section 4(a)(1)–(3) does not pass muster. For its part, the United States makes the argument that section 4(a)(1)–(3) "triggers heightened scrutiny" because it "discriminates against transgender persons, who constitute at least a quasi-suspect class" by themselves, distinct from sex.

Having carefully considered all of these positions, we agree with Alabama that section 4(a)(1)–(3) 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. Section 4(a)(1)–(3) is therefore subject only to rational basis review—a standard that it almost undoubtedly satisfies for the reasons discussed. *See supra* Section III.A; *see also Skrmetti*, 73 F.4th at 419 (finding it "highly unlikely" that the plaintiffs could show that Tennessee's substantially similar law "lacks a rational basis"). Because the district court erroneously departed from that standard, its assessment regarding the Minor Plaintiffs' likelihood of success as to their equal protection claim cannot support the preliminary injunction. We reason as follows.

To begin, we reject the view that section 4(a)(1)–(3) amounts to a sex-based classification subject to intermediate scrutiny. As mentioned, one of the Minor Plaintiffs' arguments is that section 4(a)(1)–(3) directly classifies on the basis of sex because it "uses explicitly sex-based terms to criminalize certain treatments based on a minor's 'sex.'" Of course, section 4(a)(1)–(3) discusses sex insofar as it generally addresses treatment for discordance between biological sex and gender identity, and insofar as it identifies the applicable cross-sex hormone(s) for each sex—estrogen for males and testosterone and other androgens for females. We nonetheless believe the statute does not discriminate based on sex for two reasons.

First, the statute does not establish an unequal regime for males and females. In the Supreme Court's leading precedent on gender-based intermediate scrutiny under the Equal Protection Clause, the Court held that heightened scrutiny applies to "official action that closes a door or denies opportunity to women (or to men)." *Virginia*, 518 U.S. at 532. Alabama's law does

not distinguish between men and women in such a way. *Cf. Adams,* 57 F.4th at 800–11. Instead, section 4(a)(1)–(3) establishes a rule that applies equally to both sexes: it restricts the prescription and administration of puberty blockers and cross-sex hormone treatment for purposes of treating discordance between biological sex and sense of gender identity for *all* minors. *See Skrmetti*, 73 F.4th at 419 (explaining that this sort of restriction on puberty blockers and cross-sex hormone treatment "does not prefer one sex to the detriment of the other").

Second, the statute refers to sex only because the medical procedures that it regulates—puberty blockers and cross-sex hormones as a treatment for gender dysphoria—are themselves sex-based. The Act regulates medical interventions to treat an incongruence between one's biological sex and one's perception of one's sex. The cross-sex hormone treatments for gender dysphoria are different for males and for females because of biological differences between males and females—females are given testosterone and males are given estrogen. With regards to puberty blockers, those medications inhibit and suppress the production of testosterone in males and estrogen in females. For that reason, it is difficult to imagine how a state might regulate the use of puberty blockers and cross-sex hormones for the relevant purposes in specific terms *without* referencing sex in some way. Thus, we do not find the direct sex-classification argument to be persuasive.

The Minor Plaintiffs' other sex-based argument is that section 4(a)(1)–(3) indirectly classifies on the basis of sex by classifying on the basis of gender nonconformity. This is the position that the district court adopted, citing *Bostock* and *Brumby*. Neither of

those cases, however, dealt with the Equal Protection Clause as applied to laws regulating medical treatments.

Bostock dealt with Title VII of the Civil Rights Act of 1964, § 701 *et seq.*, as amended, 42 U.S.C. § 2000e *et seq.*, in the context of employment discrimination. *See* 140 S. Ct. at 1737–41, 1754 (holding that "[a]n employer who fires an individual merely for being gay or transgender defies [Title VII]"). After noting that "only the words on the page constitute the law adopted by Congress and approved by the President," *id.* at 1738, the Court in *Bostock* relied exclusively on the specific text of Title VII. The Court "proceed[ed] on the assumption that 'sex' . . . refer[s] only to biological distinctions between male and female." *Id.* at 1739. But the Court reasoned that the combined ordinary meaning of the words "because of," *id.*, "otherwise . . . discriminate against," *id.* at 1740, and "individual," *id.*, led to the conclusion that Title VII makes "[a]n individual's homosexuality or transgender status . . . not relevant to employment decisions," *id.* at 1741.

The Equal Protection Clause contains none of the text that the Court interpreted in *Bostock*. It provides simply that "[n]o State shall . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend XIV. Because *Bostock* therefore concerned a different law (with materially different language) and a different factual context, it bears minimal relevance to the instant case. *See Skrmetti*, 73 F.4th at 420 (finding that the reasoning of *Bostock* "applies only to Title VII"); *see also Brandt ex rel. Brandt v. Rutledge*, No. 21-2875, 2022 VVTL 16957734, at *1 n.1 (8th Cir. Nov. 16, 2022) (Stras, J., dissenting from denial of rehearing en banc) (expressing skepticism that *Bostock*'s reasoning applies to the Equal Protection Clause of the Fourteenth Amendment because the

Fourteenth Amendment "predates Title VII by nearly a century" and contains language that is "not similar in any way" to Title VII's); *see Students for Fair Admissions, Inc., v. President & Fellows of Harvard Coll.*, 143 S. Ct. 2141, 2220 (2023) (Gorsuch, J., concurring) (noting the different language in Title VI and the Equal Protection Clause and explaining "[t]hat such differently worded provisions should mean the same thing is implausible on its face.")

Brumby, on the other hand, did deal with the Equal Protection Clause; but, like *Bostock*, *Brumby* concerned gender stereotyping in the context of employment discrimination. *See* 663 F.3d at 1313–20 (holding that "a government agent violates the Equal Protection Clause's prohibition of sex-based discrimination when he or she fires a transgender or transsexual employee because of his or her gender non-conformity"). So, while *Brumby* did involve the same law at issue here—the Equal Protection Clause—it discussed that law as applied to a particular factual scenario, i.e., one where an employer fired an employee for failing to adhere to certain expectations and stereotypes associated with the employee's sex. That is not the scenario presented here. Section 4(a)(1)–(3) targets certain medical interventions for minors meant to treat the condition of gender dysphoria; it does not further any particular gender stereotype. Insofar as section 4(a)(1)–(3) involves sex, it simply reflects biological differences between males and females, not stereotypes associated with either sex.

To be sure, section 4(a)(1)–(3) restricts a specific course of medical treatment that, by the nature of things, only gender nonconforming individuals may receive. But just last year, the Supreme Court explained that "[t]he regulation of a medical procedure that only

one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a 'mere pretex[t] designed to effect an invidious discrimination against members of one sex or the other.'" *Dobbs*, 142 S. Ct. at 2245–46 (alteration in original) (quoting *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974)); *see also id.* at 2246 (recognizing that "the 'goal of preventing abortion' does not constitute 'invidiously discriminatory animus' against women" (quoting *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 273–74 (1993))). By the same token, the regulation of a course of treatment that only gender nonconforming individuals can undergo would not trigger heightened scrutiny unless the regulation were a pretext for invidious discrimination against such individuals. And the district court did not find that Alabama's law was based on invidious discrimination.

We similarly reject the United States' view that section 4(a)(1)–(3) is subject to heightened scrutiny because it classifies on the basis of transgender status, separate from sex. As we recently explained, "we have grave 'doubt' that transgender persons constitute a quasi-suspect class," distinct from sex, under the Equal Protection Clause. *Adams*, 57 F.4th at 803 n.5. Even if they did, for the reasons discussed with respect to gender nonconformity, section 4(a)(1)–(3)'s relationship to transgender status would not trigger heightened scrutiny. Chiefly, the regulation of a course of treatment that, by the nature of things, only transgender individuals would want to undergo would not trigger heightened scrutiny unless the regulation is a pretext for invidious discrimination against such individuals, and, here, the district court made no findings of such a pretext. For these reasons, we conclude that section 4(a)(1)– (3)'s relationship to transgender status does not warrant heightened scrutiny.

Apart from sex, gender nonconformity, and transgender status, the Minor Plaintiffs and the United States do not claim any other suspect classification. All the parties agree that section 4(a)(1)–(3) draws distinctions on the basis of age. However, "age is not a suspect classification under the Equal Protection Clause." *Kimel v. Fla. Bd. of Regents*, 528 U.S. 62, 83 (2000). As a result, "[s]tates may discriminate on the basis of age without offending the

Fourteenth Amendment if the age classification in question is rationally related to a legitimate state interest." *Id.* And "[t]he rationality commanded by the Equal Protection Clause does not require States to match age distinctions and the legitimate interests they serve with razorlike precision." *Id.*

Here, it seems abundantly clear that section 4(a)(1)–(3) classifies on the basis of age in a way that is rationally related to a legitimate state interest. As discussed, Alabama has a legitimate interest in "safeguarding the physical and psychological well-being of . . . minor[s]," and notably that interest itself distinguishes minors from adults. *Otto*, 981 F.3d at 868 (quoting *Ferber*, 458 U.S. at 756– 57); *see supra* Section III.A. Section 4(a)(1)–(3) furthers that interest by restricting the prescription and administration of puberty blockers and cross-sex hormone treatment to minors for purposes of treating discordance between biological sex and sense of gender identity based on the rational understanding that many minors may not be finished forming their identities and may not fully appreciate the associated risks. Moreover, Alabama's decision to draw the line at the age of nineteen sufficiently approximates the divide between individuals who warrant government protection and individuals who are better able to make decisions for themselves;

it is neither too over- nor under-inclusive. For these reasons, it is exceedingly likely that section 4(a)(1)–(3) satisfies rational basis review as a classification on the basis of age.

Section 4(a)(1)–(3) is therefore subject only to rational basis review—a standard that it is exceedingly likely to satisfy for the reasons discussed. *See supra* Section III.A. The district court erred as a matter of law by applying heightened scrutiny, and that error tainted its assessment of Plaintiffs' likelihood of success. Because that is true with respect to both the due process claim and the equal protection claim, we vacate the preliminary injunction.

* * * *

This case revolves around an issue that is surely of the utmost importance to all of the parties involved: the safety and wellbeing of the children of Alabama. But it is complicated by the fact that there is a strong disagreement between the parties over what is best for those children. Absent a constitutional mandate to the contrary, these types of issues are quintessentially the sort that our system of government reserves to legislative, not judicial, action.

Faced with this difficult and delicate set of circumstances, the district court granted the "extraordinary and drastic remedy" that is a preliminary injunction and enjoined Alabama from enforcing part of the law in dispute. *See Callaway*, 489 F.2d at 573. In doing so, the district court determined that section 4(a)(1)–(3) of the Act is subject to heightened scrutiny on due process and equal protection grounds and therefore the parties challenging the law had a substantial likelihood of success on the merits as to those claims. That was erroneous. With respect to the Parent

Plaintiffs' substantive due process claim, the district court divined, without adequate historical support, that the Due Process Clause of the Fourteenth Amendment protects the right to "treat [one's] children with transitioning medications subject to medically accepted standards." And with respect to the Minor Plaintiffs' equal protection claim, the district court determined that the law classifies on the basis of sex, when in reality the law simply reflects real, biological differences between males and females and equally restricts the use of puberty blockers and cross-sex hormone treatment for minors of both sexes. Because the district court reviewed the law under the wrong standard of scrutiny in connection with both claims, the issuance of the preliminary injunction constituted an abuse of discretion. *See Curling v. Raffensperger*, 50 F.4th 1114, 1121 (11th Cir. 2022) ("[A] court abuses its discretion in granting a preliminary injunction if, in determining whether success is likely, it incorrectly or unreasonably applies the law.").

IV. CONCLUSION

For these reasons, we vacate the district court's preliminary injunction on the enforcement of section 4(a)(1)–(3) of the Act.

VACATED.

BRASHER, Circuit Judge, concurring:

I concur in the Court's opinion. I write separately to focus on the plaintiffs' equal protection claim.

The resolution of an equal protection claim often turns on the level of scrutiny that we apply—rational basis, intermediate, or strict. The plaintiffs argue that the statute classifies based on sex, which warrants intermediate scrutiny. The Court rejects that argument, and, after much deliberation and research, I agree. Alabama's statute does not treat one sex differently than the other. It does not use sex as a proxy for some more germane classification. And it is not based on a sex stereotype. Instead, I think the law is best read to classify—not based on sex—but as between minors who want puberty blockers and hormones to treat a "discordance between their sex and their internal sense of identity," Ala. Code § 26-26-2(2), and those minors who want these drugs to treat a different condition.

But even if the statute did discriminate based on sex, I think it is likely to satisfy intermediate scrutiny. If Alabama's statute involves a sex-based classification that triggers heightened scrutiny, it does so because it is otherwise impossible to regulate these drugs differently when they are prescribed as a treatment for gender dysphoria than when they are prescribed for other purposes. As long as the state has a substantial justification for regulating differently the use of puberty blockers and hormones for different purposes, then I think this law satisfies intermediate scrutiny.

I.

I'll start with the level of scrutiny that applies to this law. We should be cautious when we are asked to extend heightened scrutiny to novel facts like these. As

Justice Stevens explained in one of the Court's leading cases on sex discrimination, the text of the Equal Protection Clause does not subject state laws to different levels of judicial scrutiny. *See Craig v. Boren*, 429 U.S. 190, 211–12 (1976) (Stevens, J., concurring). The Clause "requires every State to govern impartially," and it "does not direct the courts to apply one standard of review in some cases and a different standard in other cases." *Id.*; *see also United States v. Virginia*, 518 U.S. 515, 570 (1996) (Scalia, J., dissenting) (calling tiers of scrutiny "made-up tests"); *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, 638 (2016) (Thomas, J., dissenting) (calling tiers of scrutiny "increasingly meaningless . . . formalism"). Moreover, some of the Supreme Court's most recent (and significant) equal protection precedents don't apply the tiers of scrutiny. *E.g.*, *Obergefell v. Hodges*, 576 U.S. 644, 672–76 (2015).

Nonetheless, the Supreme Court has established the tiers of scrutiny, and lower courts must apply that doctrine the best we can. In doing so, I think we must appreciate that the tiers of scrutiny are "no more scientific than their names suggest." *Virginia*, 518 U.S. at 567 (Scalia, J., dissenting). They should be "guidelines informing our approach to the case at hand, not tests to be mechanically applied." *Williams-Yulee v. Fla. Bar,* 575 U.S. 433, 457 (2015) (Breyer, J., concurring). To that end, when we are asked to apply heightened scrutiny on novel facts, we need to ensure that the purposes of the doctrine warrant that approach.

In my view, many judges have mechanically applied intermediate scrutiny to laws like Alabama's without considering the reasons we subject sex classifications to heightened scrutiny. Consider the Eighth Circuit's decision in *Brandt by & through Brandt v. Rutledge*,

47 F.4th 661 (8th Cir. 2022). There, the court concluded that Arkansas's comparable law discriminates based on sex because, referring to cross-sex hormones, it said that "medical procedures that are permitted for a minor of one sex are prohibited for a minor of another sex." *Id.* at 669. But the court ignored the law's ban on puberty blockers, which applies the same way to both sexes. And, more fundamentally, the court did not explain how applying heightened scrutiny to a law that regulates sex-specific medical interventions is consistent with the reasons the Supreme Court created that standard.

Turning back to this case, Alabama's law is replete with sex-related languag_ge. But, even though the statute uses sex-related language, I think it is wrong to say that the statute *classifies* based on sex. The law regulates drugs that treat a "discordance between [an individual's] sex and their internal sense of identity." Ala. Code § 26-26-2(2). The law defines "sex" as "[t]he biological state of being male or female, based on the individual's sex organs, chromosomes, and endogenous hormone profiles." *Id.* § 26-26-3(3). Then the law prohibits various treatments "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex as defined in this [act]." *Id*. § 26-26-4(a).

I see the word "sex" in this law. But I don't see a sex *classification*—at least, not as the idea of a sex classification appears in our equal-protection caselaw. Instead, it seems to me that this sex-related language classifies between, on the one hand, those minors who want these drugs to treat a "discordance between their sex and their internal sense of identity" and, on the other hand, those minors who want these drugs to

treat a different condition. The Equal Protection Clause "is essentially a direction that all persons similarly situated should be treated alike." *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985). So the right question under the Equal Protection Clause is whether these two groups those who want to use these drugs to treat a discordance between their sex and gender identity and those who want to use these drugs to treat other conditions—are similarly situated.

That question isn't one that seems suited to heightened scrutiny. The Equal Protection Clause prohibits "giv[ing] a mandatory preference to members of either sex over members of the other." *Reed v. Reed*, 404 U.S. 71, 76 (1971). We apply heightened scrutiny to sex classifications because of an intuition that, "[r]ather than resting on meaningful considerations, statutes distributing benefits and burdens between the sexes in different ways very likely reflect outmoded notions of the relative capabilities of men and women." *City of Cleburne*, 473 U.S. at 441. When we apply heightened scrutiny to a statute that classifies based on sex, the point is to ascertain whether the classification is based on "traditional, often inaccurate, assumptions about the proper roles of men and women." *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 725–26 (1982). We are also seeking to ensure that sex is not being used as an "inaccurate proxy for other, more germane bases of classification." *Craig*, 429 U.S. at 198.

None of these rationales apply to the line drawn in Alabama's statute. It doesn't distribute benefits or burdens between men and women or arguably use sex as a proxy for other interests. It bans a course of treatment—puberty blockers and hormones for a particular condition that affects both boys and girls.

Another way to think about it: an injunction against the enforcement of Alabama's law under equal-protection principles will not equalize burdens or benefits between girls and boys. It will not require the government to treat boys and girls the same. It will merely force Alabama to *either* ban puberty blockers and hormones for all purposes *or* allow them for all purposes.

For its part, the district court applied heightened scrutiny on the theory that Alabama's statute discriminates based on a sex stereotype because it targets medical interventions for transgender people, i.e., those who feel a "discordance between their sex and their internal sense of identity." The district court cited *Glenn v. Brumby*, 663 F.3d 1312, 1320 (11th Cir. 2011), for this proposition, but I think it misread that precedent.[1] In *Glenn*, we concluded that a public employer engaged in sex discrimination by firing a transgender employee who was born a man because the employee began wearing stereotypical women's clothing. *Id.* at 1314. The employer allowed biological women to wear stereotypical women's clothing, but not biological men. We held that the employer had engaged in sex discrimination under the Equal Protection Clause—not because it fired a transgender employee—but because it fired an employee "on the basis of gender-based behavioral norms." *Id.* at 1316–17. By ruling against that practice under the circumstances of that case, we required the employer to treat men and women equally, no matter their clothing choices.

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[1] I don't fault the district court for reaching the conclusion that it did. The district court did an admirable job with a difficult case on an expedited timeframe. One of the benefits of the appellate process is that we have more time and resources to assess a legal question, which sometimes yields a different result.

Unlike the employer's decision in *Glenn*, Alabama's statute does not fit the mold of a sex-based stereotype. The statute isn't based on a socially constructed generalization about the way men or women should behave. It does not reinforce an "assumption[] about the proper roles of men and women" in our society. *Hogan*, 458 U.S. at 725–26. And it doesn't reflect society's "notions of the relative capabilities of men and women." *City of Cleburne*, 473 U.S. at 441. To be sure, the statute's classification reflects the government's recognition that, without medical intervention, a healthy child will mature in accord with his or her biological sex. But the recognition of biological reality is "not a stereotype." *Nguyen v. INS*, 533 U.S. 53, 68 (2001).

The district court—viewing this case through the lens of sex stereotyping—did not make any findings on whether the state was justified in treating people differently because they want these drugs to treat a discordance between their sex and gender identity instead of some other condition. But the state has identified many reasons for drawing that line. For example, the record reflects that other countries are regulating the drugs differently for these purposes, and the FDA has not approved them for this purpose although it has for others. I cannot say that those reasons fail the lenient standard of rational basis review. *See Jones v. Gov. of Fla.*, 975 F.3d 1016, 1034–35 (11th Cir. 2020).

II.

Although I believe rational basis scrutiny likely applies, I also think that, even if Alabama's statute triggered intermediate scrutiny, it would likely survive that heightened scrutiny.

Intermediate scrutiny under the Equal Protection Clause does not require us to ask whether a law is good or bad policy, but whether a government has a good reason for using a sex-based classification in a law. The relevant question is whether "*the classification* serves 'important governmental objectives and that *the discriminatory means* employed' are 'substantially related to the achievement of those objectives.'" *Hogan*, 458 U.S. at 724 (quoting *Wengler v. Druggists Mutual Ins. Co.*, 446 U.S. 142, 150 (1980)) (emphasis added). As I discuss above, the purpose of this heightened scrutiny is to ensure that laws based on sex classifications aren't using those classifications because of "outmoded notions of the relative capabilities of men and women." *City of Cleburne*, 473 U.S. at 441. Instead, the use of sex must reflect that it is a "meaningful consideration[]" on which the law is based. *Id.* And so, under intermediate scrutiny, the government's burden is to establish "an 'exceedingly persuasive justification' *for the classification*." *Hogan*, 458 U.S. at 724 (quoting *Kirchberg v. Feenstra*, 450 U.S. 455, 461 (1981)) (emphasis added).

Assuming the classification in this law is subject to intermediate scrutiny, I believe the state probably has an "exceedingly persuasive justification" for regulating these drugs differently when they are used to treat a discordance between an individual's sex and sense of gender identity than when they are used for other purposes. *See Sessions v. Morales-Santana*, 582 U.S. 47, 58 (2017) (quoting *Virginia*, 518 U.S. at 531). The record reflects that the use of puberty blockers and hormones for this purpose specifically carries potentially uncertain risks. The record also reflects that there is uncertainty about how to tell which patients need these interventions for this purpose and which don't. Although further fact finding in this

litigation will test the plausibility of those concerns, Alabama doesn't have to conclusively prove these things to have an important governmental interest. Intermediate scrutiny permits "the legislature [to] make a predictive judgment" based on competing evidence. *Brown v. Entm't Merchs. Ass'n*, 564 U.S. 786, 799–800 (2011) (discussing relative burdens of intermediate and strict scrutiny).

Likewise, I think the state's interest is sufficiently related to the sex classification in the law to the extent there is one. Assuming this statute involves a sex-based classification, it does so because there is no other way to regulate treatments for a "discordance between [an individual's] sex and their internal sense of identity" without drawing such a distinction. Alabama would have to use sex-based language to regulate those treatments even if it wanted to subsidize them instead of banning them. So, if intermediate scrutiny applied here, the "sufficiently related" question collapses into the state interest question: it is whether Alabama has an important governmental interest in regulating the use of puberty blockers and hormones for a "discordance between [an individual's] sex and their internal sense of identity" but not for other uses. Because the record reflects that the state has that kind of interest, the statute's classification likely satisfies intermediate scrutiny.

The plaintiffs argue, in part, that Alabama is not justified in *banning* these treatments because there are less restrictive alternatives to a ban. But I don't think that is how intermediate scrutiny works under the Equal Protection Clause. Consider how the Supreme Court applied intermediate scrutiny in *Craig v. Boren*, 429 U.S. 190 (1976). There, a state law prohibited sales of alcohol to men between the ages of

eighteen and twenty but not women in that age range. *Id.* at 191–92. The Court accepted that the goal of this law—"the enhancement of traffic safety"—is an important interest. *Id.* at 199–200. But it held that the government did not have sufficient evidence that a "gender-based distinction closely serves to achieve that objective." *Id.* at 200. The Court in *Craig* never asked whether the state's decision to *ban* under-21-year-old men from drinking alcohol was justified as compared to some less restrictive, but equally sex-based, alternative—such as making men take additional driving classes or the like. Instead, the Court assessed only whether the *sex-based classification* fit closely enough to the purposes of the law. Likewise, here, I think we can resolve the plaintiffs' equal protection claim by assessing whether the state has an interest in classifying based on sex without also asking whether, even if the state were allowed to classify based on sex, the state could achieve its objective with some lesser restriction.

In short, assuming this law is subject to intermediate scrutiny, I think it likely passes. On this record, it seems clear that the state has an interest in regulating these drugs differently when they are prescribed to treat a discordance between sex and gender than when they are prescribed to treat other conditions. And the state cannot do that without drawing the lines it has drawn in this statute.

III.

Whether rational basis or intermediate scrutiny applies, I believe this appeal comes out the same way: the state will likely prevail on the merits. Future findings of fact in the district court may establish otherwise. But at this stage, the plaintiffs have not

carried their burden entitling them to a preliminary injunction. I concur.

APPENDIX C

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

[Filed: August 28, 2024]

No. 22-11707

PAUL A. EKNES-TUCKER, Rev., BRIANNA BOE, individually and on behalf of her minor son, Michael Boe, JAMES ZOE, individually and on behalf of his minor son, Zachary Zoe, MEGAN POE, individually and on behalf of her minor daughter, Allison Poe, KATHY NOE, et al., individually and on behalf of her minor son, Christopher Noe,

Plaintiffs-Appellees,

versus

GOVERNOR, OF THE STATE OF ALABAMA, ATTORNEY GENERAL, STATE OF ALABAMA, DISTRICT ATTORNEY, FOR MONTGOMERY COUNTY, DISTRICT ATTORNEY, FOR CULLMAN COUNTY, DISTRICT ATTORNEY, FOR LEE COUNTY, *et al.*,

Defendants-Appellants.

Appeal from the United States District Court
for the Middle District of Alabama
D.C. Docket No. 2:22-cv-00184-LCB-SRW

Before WILLIAM PRYOR, Chief Judge, WILSON, JORDAN, ROSENBAUM, JILL PRYOR, NEWSOM, BRANCH, GRANT, LUCK, LAGOA, and BRASHER, Circuit Judges.[*]

BY THE COURT:

A petition for rehearing having been filed and a member of this Court in active service having requested a poll on whether this case should be reheard by the Court sitting en banc, and a majority of the judges in active service on this Court having voted against granting rehearing en banc, it is ORDERED that this case will not be reheard en banc.

WILLIAM PRYOR, Chief Judge, respecting the denial of rehearing en banc:

I agree with the decision not to rehear this appeal en banc and write only to respond to a dissenting opinion. Our respected colleague argues that the "complex[]" doctrine of substantive due process is "hard," Jordan Dissent at 1, but the difficulty is inevitable. The doctrine of substantive due process does violence to the text of the Constitution, enjoys no historical pedigree, and offers judges little more than shifting and unilluminating standards with which to protect unenumerated rights. Unmoored from text and history, the drift of the doctrine—"neither linear nor consistent," *id.* at 20 is predictable. So too is its patchy legacy: unelected judges with life tenure enjoin enforcement of laws enacted by elected representatives following regular procedures, all in the name of fundamental rights that the Constitution never names but allegedly secures. In the absence of clear guidance from the Supreme Court, we should hesitate to expand

[*] Judge Nancy Abudu recused herself and did not participate in the en banc poll.

the reach of this flawed doctrine. And our Court wisely declines to do so here.

As John Hart Ely famously put it, the phrase "substantive due process" is a "contradiction in terms," like "'green pastel redness.'" JOHN HART ELY, DEMOCRACY AND DISTRUST 18 (1980). The Fifth and Fourteenth Amendments prohibit the federal and state governments from depriving any person of life, liberty, or property "without due process of law." That constitutional guarantee is about legal procedures, not the substance of laws. For that reason, the Supreme Court has declared—unanimously—that the "language" of the Due Process Clauses does not "suggest[]," let alone support, the "substantive content" that courts often have poured into them. *Regents of the Univ. of Mich. v. Ewing*, 474 U.S. 214, 225–26 (1985) (citation and internal quotation marks omitted). So, the Due Process Clauses are a "most curious place" to ground all-but-indefeasible protections for fundamental rights. *McDonald v. City of Chicago*, 561 U.S. 742, 809 (2010) (Thomas, J., concurring in part and in the judgment). Yet the doctrine of substantive due process shields individuals from even "general and prospective legislation enforced with all proper procedure." Nathan S. Chapman & Michael W. McConnell, *Due Process as Separation of Powers*, 121 YALE L.J. 1672, 1792 (2012).

In addition to incorporating against the States most of the protections that the Bill of Rights guarantees against the federal government, the doctrine bars state infringement of "fundamental rights that are not mentioned anywhere in the Constitution." *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2246 (2022). That bar is not absolute, at least in theory; a challenged law may deprive an individual of a fundamental right if it satisfies strict scrutiny. *See*

Waldman v. Conway, 871 F.3d 1283, 1292 (11th Cir. 2017). But strict scrutiny does not pertain to either the form of adjudication that must accompany the deprivation or the procedures that the adjudication must observe—that is, to *process*. *See* Ryan C. Williams, *The One and Only Substantive Due Process Clause*, 120 YALE L.J. 408, 419 (2010). The condition rests instead on the importance of the goal of the law and the narrowness of its means—that is, on nonprocedural grounds. *See Waldman*, 871 F.3d at 1292. And even when no fundamental interest is at stake, the doctrine bars *any* "arbitrary and oppressive exercise of government power" and *all* government conduct that "shocks the conscience." *Id.* (citation and internal quotation marks omitted).

The doctrine of substantive due process has "long been controversial," *Dobbs*, 142 S. Ct. at 2246, because its potent strictures on democratic self-governance have "no footing in constitutional text" or history. *Sosa v. Martin County*, 57 F.4th 1297, 1305–06 (11th Cir. 2023) (en banc) (Newsom, J., concurring). Under the "traditional view," the Founders would have understood the Due Process Clause of the Fifth Amendment either not to "constrain the legislature at all" or to "limit the legislature's discretion in prescribing certain modes of judicial procedure." Williams, *supra*, at 454. That traditional view remains dominant. *See, e.g.*, MICHAEL STOKES PAULSEN & LUKE PAULSEN, THE CONSTITUTION 216 (2015) (due process required "executive branch and judicial officials [to] act in accordance with the legal rules—laws—that ha[d] been made in advance of the events at hand"); Chapman & McConnell, *supra*, at 1679; Timothy M. Tymkovich, Joshua Dos Santos & Joshua J. Craddock, *A Workable Substantive Due Process*, 95 NOTRE DAME L. REV. 1961, 1966–67 (2020). Disagreement on the

edges of the scope of the right should not obscure the bottom line: substantive due process is an ahistorical "legal fiction." *McDonald*, 561 U.S. at 811 (Thomas, J., concurring in part and in the judgment). And nothing relevant had changed by 1868. Even then, there was almost no historical support for the policy-second-guessing function that the doctrine performs today. *See* Chapman & McConnell, *supra*, at 1679–80, 1801, 1807; Williams, *supra*, at 499; Tymkovich et al., *supra*, at 1972–73.

Some scholars argue that the phrase "due process of law" was a "legal term of art with substantive content" when the Fourteenth Amendment was ratified in 1868. *See, e.g.*, Williams, *supra*, at 496 (presenting the argument). But that argument is "hardly airtight," *id.*, and "[n]o evidence" establishes that the word "process" "meant something different" in 1868, set aside 1791, from what it does now, *see* ELY, *supra*, at 18. To trained observers no less than the ordinary man, the choice of the phrase "due process of law" to afford constitutional protection to substantive rights would have seemed "very odd." Chapman & McConnell, *supra*, at 1725.

A constitutional doctrine that lacks foundation in text or history must draw its content from another source, and substantive due process has offered judges little more than "scarce and open-ended" platitudes. *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). The doctrine has been said to protect rights that comprise the "essence of a scheme of ordered liberty," *McDonald*, 561 U.S. at 760 (plurality opinion) (citation and internal quotation marks omitted), or to bar state action that "shocks the conscience," *Waldman*, 871 F.3d at 1292 (citation and internal quotation marks omitted). These "vague shibboleths" clarify little. *Sierra v. City of Hallandale Beach*, 996 F.3d 1110, 1128

(11th Cir. 2021) (Newsom, J., concurring). That feature of substantive due process sits dangerously alongside the power that the doctrine gives life-tenured judges: to declare unconstitutional, and enjoin enforcement of, duly enacted laws of elected representatives of the People.

Unconstrained power tempts usurpation. The history of substantive due process bears out that plain truth. In many decisions, the Supreme Court has stated that the approach to constitutional decision-making typified by *Lochner v. New York*, 198 U.S. 45 (1905), was "illegitimate," an "intrusion by the courts into a realm properly reserved to the political branches of government." Cass R. Sunstein, Lochner*'s Legacy*, 87 COLUM. L. REV. 873, 874 (1987). The "freewheeling judicial policymaking" that marked "discredited" decisions like *Lochner* and *Roe v. Wade*, 410 U.S. 113 (1973), *see Dobbs*, 142 S. Ct. at 2248, is a feature, not a bug, of substantive due process. And it discredits the judiciary itself. *See, e.g.*, *Dred Scott v. Sandford*, 60 U.S. (19 How.) 393 (1857).

Because the doctrine can empower judges to "usurp" authority that the Constitution leaves to elected representatives, *see Dobbs*, 142 S. Ct. at 2247, the Supreme Court has sought to discipline its application. The Court has stated, for example, that a right or liberty must be "deeply rooted" in our "history and tradition" to be immune from legislative encroachment. *Washington v. Glucksberg*, 521 U.S. 702, 720–21 (1997) (citation and internal quotation marks omitted). In this analysis, "liberty" must be defined "in a most circumscribed manner," in reference to "specific historical practices." *Obergefell v. Hodges*, 576 U.S. 644, 671 (2015). That is, the asserted right must be "careful[ly] descri[bed]." *Reno v. Flores*, 507 U.S. 292, 302 (1993).

Sometimes courts have defined the asserted unenumerated right at a specific level. In *Reno*, for example, the Supreme Court rejected the proposed general description of the right at issue—"freedom from physical restraint"—and defined the right instead more specifically as the "right of a child who has no available parent, close relative, or legal guardian, and for whom the government is responsible, to be placed in the custody of a willing-and-able private custodian rather than of a government-operated or government-selected child-care institution." *Id.* (quotation marks omitted). And in *Doe v. Moore*, we rejected a "broad framing" of the rights at issue—including the rights "to family association" and to "be free of threats to their persons and members of their immediate families"—for a more "careful" description: the "right of a person, convicted of 'sexual offenses,' to refuse subsequent registration of his or her personal information with Florida law enforcement and [to] prevent publication of this information on Florida's Sexual Offender/Predator website." 410 F.3d 1337, 1343–44 (11th Cir. 2005).

To be sure, the *Glucksberg* test has proved occasional. In *Lawrence v. Texas*, the Supreme Court endorsed the uncircumscribed view that the Due Process Clause protected a "liberty of the person both in its spatial and in its more transcendent dimensions." 539 U.S. 558, 562 (2003). And in *Obergefell*, the Court set aside the *Glucksberg* test and defined the right to marry in a more "comprehensive sense." 576 U.S. at 671.

Yet what judicial creativity gives, a measure of judicial restraint can take away. For example, *Dobbs* did not mention the alternative *Obergefell* method. So I agree with our dissenting colleague that binding precedents like these are "not . . . reconcilable" on the

key question of how narrowly to define the liberty interest. Jordan Dissent at 20.

This inconsistency is unsurprising. It is inevitable. The "controversial nature" of the doctrine of substantive due process—its lack of footing in text or history and the absence of consistent and meaningful legal standards to guide judicial analysis—*make* the caselaw "contradictory" and "imprecise." Tymkovich et al., *supra*, at 1963.

With good reason, the Supreme Court has long counseled "reluctan[ce] to expand the concept of substantive due process." *Collins*, 503 U.S. at 125. Judicial restraint, with its respect for the separation of powers and for federalism, demands "utmost care" before courts interfere. *See id.* We must "guard against the natural human tendency" to conflate what due process requires with "our own ardent views about the liberty that Americans should enjoy." *Dobbs*, 142 S. Ct. at 2247. And we must remember that the amorphous doctrine of substantive due process does not shield every "important, intimate, and personal decision[]" from legislative impairment. *Glucksberg*, 521 U.S. at 727. So, when we consult "jurisprudence as a whole" to glean guidance, Jordan Dissent at 20, we should be skeptical about any argument to extend this misguided doctrine, with its checkered past, to define an unenumerated right at a high level of generality and enjoin enforcement of a law enacted by representatives of the People. Difficult questions of morality, parental rights, and medicine are properly left to democracy, and we should not pretend that the Due Process Clauses give unelected judges the authority to second-guess public policy.

LAGOA, Circuit Judge, Concurring in the denial of rehearing en banc:

Sydney Wright took large doses of cross-sex hormones for a year. In Wright's words, her grandfather "saved [her] life" when he persuaded her to stop. As a teenager, Wright's father kicked her out of the house after he learned that she was attracted to women, and Wright began questioning if she "was really a man" because she "was attracted to girls." Wright saw a counselor who recommended that she begin taking testosterone and undergo a double mastectomy. The counselor never explored the negative effects of Wright's relationship with her parents or the years of sexual molestation that she endured as a child. Wright started testosterone injections after a ten-minute appointment with a physician who told her to learn "on YouTube" how to "give [herself] the shots."

Testosterone caused Wright's voice to deepen, permanently. She also gained fifty pounds and became pre-diabetic. After a year, her blood thickened, her red-blood-cell count increased, and she developed a blood disorder that could lead to heart attack and stroke. She also began experiencing excruciating abdominal pain, which she continues to suffer from. One day, her grandfather who Wright describes as "the most important man in [her] life"—had a "down-to-earth" talk with her. With "tears in his eyes," he expressed concern about her treatment and asked her to take a three-year break to reevaluate her decision. According to Wright, her grandfather was "worried about [her] health," and he "never cared how [she] looked." Wright agreed to take a break, and on further reflection, realized that she needed counseling, not hormone medications. Wright still suffers negative side effects from cross-sex hormones, including digestive problems, tachycardia,

and an increased red-blood-cell count. Her gynecologist also told her that she may never be able to have children.

The record contains many stories of others who were irreversibly harmed by similar medications.[1] The Alabama Legislature decided to respond through Alabama's Vulnerable Child Compassion and Protection ("Act"). In relevant part, section 4(a)(1)–(3) of the Act provides that "no person shall" prescribe or administer puberty blocking medication or cross-sex hormones to a minor "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex." A federal district court preliminarily enjoined enforcement of part of the Act under the Due Process Clause and the Equal Protection Clause of the Fourteenth Amendment. But we reversed. Now, a majority of the active judges on this Court have correctly determined not to rehear this case en banc. The Act, "like other health and welfare laws, is entitled to a 'strong presumption of validity.'" *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215,

[1] *See, e.g.*, Appendix A (KathyGrace Duncan), Appendix B (Carol Frietas), Appendix C (Corinna Cohn). One of the dissents argues that we should disregard Wright's testimony and the testimonies of Duncan, Frietas, and Cohn because all of them were at least eighteen years old when they started to medically transition and because "their 'treatment' did not follow WPATH Standards of Care." Rosenbaum Dis. Op. at 10–11, 10 n.8. But that is not a reason to disregard their testimony, which demonstrates that those who are eighteen or older may fail to understand the dangerous, long-term effects cross-sex hormones and puberty blockers can have. If anything, these testimonies show why a legislative body may choose to restrict the use of these drugs by minors.

301 (2022) (quoting *Heller v. Doe ex rel. Doe*, 509 U.S. 312, 319 (1993)).

Judge Rosenbaum's dissent characterizes the panel opinion as holding that parents do not have a constitutional right to access "life-saving medical care" for their children. Rosenbaum Dis. Op. at 4; *see also* Jordan Dis. Op. at 22 (describing the asserted right as "the right of parents to obtain medically-approved treatment for their children"). But frankly, whether puberty blockers and cross-sex hormones qualify as "life-saving" treatment—or even "medical care"—is a policy question informed by scientific, philosophical, and moral considerations. Neither an unelected district judge nor unelected circuit judges should resolve that debate for the State of Alabama. *See Kadel v. Folwell*, 100 F.4th 122, 196 (4th Cir. 2024) (en banc) (Wilkinson, J., dissenting) ("Self-governance is notably absent when the many voices seeking to provide answers are silenced by federal judges shrouded in an authority of their own design.").

Indeed, "when a legislature 'undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious not to rewrite legislation.'" *Kansas v. Hendricks*, 521 U.S. 346, 360 n.3 (1997) (quoting *Jones v. United States*, 463 U.S. 354, 370 (1983)). And this case only serves to underscore why. While we must evaluate the district court's work on the record it had in front of it at the time, recent revelations confirm the danger that comes from hastening to afford constitutional protection in this area.

For example, in April 2024, Dr. Hillary Cass—the chair of a policy group commissioned by England's National Health Service ("NHS")—published the results of her four-year review of the use of puberty

blockers and cross-sex hormones on minors.[2] Cass found no evidence that puberty blockers improve gender dysphoria and no evidence that cross-sex hormones reduce suicide risk for children suffering from gender dysphoria. *See* The Cass Review, *supra* n.2, at 179, 186, 195. Cass also documented the extensive risks associated with puberty blockers. *See, e.g.*, *id.* at 177–78. In conjunction with the Cass Review, NHS announced "that there is not enough evidence to support the safety or clinical effectiveness of [puberty suppressing hormones] to make the treatment routinely available at this time."[3] And, on May 29, 2024, the United Kingdom's Secretary of State for Health and Social Care and Northern Ireland's Minister for Health issued a temporary emergency order that "prohibits"—with limited exceptions—puberty blockers for people under the age of 18. *See TransActual CIC v. Sec'y of State for Health and Social Care* [2024] EWHC 1936 (Admin), ¶¶ 2, 142–48. On July 29, 2024, the UK's High Court dismissed a legal challenge to the emergency order, citing the Cass Review as "powerful scientific evidence in support of restrictions on the supply of puberty blockers on the grounds that they were potentially harmful." *See id.* ¶¶ 210, 257.

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[2] The Cass Review, *Independent review of gender identity services for children and young people* (2024), https://cass.independent-review.uk/wp-content/up-loads/2024/04/CassReview_Final.pdf [https://perma.cc/9F73-D7BW] (hereinafter, "The Cass Review").

[3] *Clinical Policy: Puberty suppressing hormones (PSH) for children and young people who have gender incongruence/gender dypsphoria [1927]*, Nat'l Health Serv., Eng. (Mar. 12, 2024), https://www.england.nhs.uk/wp-content/up-loads/2024/03/clinical-commissioning-policy-gender-affirming-hormones-v2.pdf [https://perma.cc/383H-LBVX] (hereinafter, "NHS Clinical Policy").

Also, in March 2024, a whistleblower leaked documents and recordings impugning the credibility of the World Professional Association for Transgender Health (WPATH),[4] which promulgates the "Standards of Care" that the district court relied on in its order. *Eknes-Tucker v. Marshall* ("*Eknes-Tucker I*"), 603 F. Supp. 3d 1131, 1138–39 (M.D. Ala. 2022). The leaked documents suggest that WPATH officials are aware of the risks of cross-sex hormones and other procedures yet are mischaracterizing and ignoring information about those risks. *See, e.g.*, *infra* at 47–49. Again, I highlight these developments only to demonstrate the ill-suitedness of this area for judicial intervention.

The propriety of the medications at issue is a quintessential legislative question, not a constitutional one. Judges Jordan and Rosenbaum would have this Court end the debate by judicially fencing off these questions from state legislatures. But our experience with the intersection of the Constitution and these types of issues suggests that this is a misguided effort. *See Roe v. Wade*, 410 U.S. 113 (1973), *overruled by Dobbs*, 597 U.S. at 302 ("return[ing]" "authority to the people and their elected representatives" to regulate abortion). *Compare Buck v. Bell*, 274 U.S. 200 (1927), *with Box v. Planned Parenthood Ind. & Ky., Inc.*, 587 U.S. 490, 499–500 (2019) (Thomas, J., concurring) (noting that *Buck v. Bell* "gave the eugenics movement added legitimacy and considerable momentum"). Our panel opinion correctly declined to remove these issues from the political process by rejecting a

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[4] Mia Hughes, *The WPATH Files*, Environmental Progress (2024), https://static1.squarespace.com/static/56a45d683b0be33df885def6/t/65ea1c1ea42ff5250c88a2f5/1709841455308/WPATH+Report+and+Files%28N%2 9.pdf [https://perma.cc/5HLY-TSUR] (hereinafter, "The WPATH Files").

novel reading of the Fourteenth Amendment that is unmoored from text, history, and tradition.

I. FACTUAL BACKGROUND AND PROCEDURAL HISTORY

The panel opinion provides a thorough summary of the factual background and procedural history. *See Eknes-Tucker v. Governor of Alabama* ("*Eknes-Tucker II*"), 80 F.4th 1205, 1211–19 (11th Cir. 2023). Here, I provide a summary of the relevant provisions of the Act and a brief overview of the procedural history.

A. The Act

The Alabama Legislature passed the Act on April 7, 2022, and Governor Ivey signed it the next day. Section 3(1) incorporates the definition of "minor" found in another part of the code, which is a "person who is under 19 years of age." Ala. Code § 43-8-1(18). And section 3(3) defines "sex" to mean "[t]he biological state of being male or female, based on the individual's sex organs, chromosomes, and endogenous hormone profiles." Section 4(a) then states, in part, that "no person shall engage in or cause" the prescription or administration of (1) "puberty blocking medication to stop or delay normal puberty," (2) "supraphysiologic[5] doses of testosterone or other androgens to females," or (3) "supraphysiologic doses of estrogen to males," "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent

[5] Supraphysiologic means of or pertaining to an amount "greater than normally present in the body." *See Supraphysiologic*, *Merriam-Webster*, https://www.merriam-webster.com/medical/supraphysiological [https://perma.cc/QW8K-882J].

with the minor's sex."[6] Section 4(b), however, provides an exception if "a procedure [is] undertaken to treat a minor born with a medically verifiable disorder of sex development," and includes some examples of such disorders.[7]

B. Procedural History

Shortly after the Governor signed the Act, the Plaintiffs including transgender minors (the "Minor Plaintiffs") and their parents (the "Parent Plaintiffs")—sued several Alabama state officials (collectively, "Alabama"). Relevant to this appeal, the Plaintiffs alleged that the Act violated the Due Process Clause of the Fourteenth Amendment by depriving the Parent Plaintiffs of their right to direct the upbringing of their children, and alleged that the Act violated the Equal Protection Clause by discriminating against the Minor

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[6] Section 4 also forbids performing surgeries that sterilize, performing surgeries that "artificially construct tissue with the appearance of genitalia that differs from the individual's sex," and removing "any healthy or non-diseased body part or tissue, except for a male circumcision." Act § 4(a)(4)–(6). Plaintiffs originally challenged these portions of the Act also, but represented at the beginning of the preliminary-injunction hearing below that they were no longer seeking a preliminary injunction with respect to them. *See Eknes-Tucker I*, 603 F. Supp. 3d at 1139 n.5.

[7] These disorders include: (1)"[a]n individual born with external biological sex characteristics that are irresolvably ambiguous, including an individual born with 46 XX chromosomes with virilization, 46 XY chromosomes with under virilization, or having both ovarian and testicular tissue"; and (2) "[a]n individual whom a physician has otherwise diagnosed with a disorder of sexual development, in which the physician has determined through genetic or biochemical testing that the person does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a male or female." Act § 4(b).

Plaintiffs on account of their sex and transgender status.

The Plaintiffs then moved for a preliminary injunction.[8] After a three-day hearing—at which the district court heard evidence from both sides about the efficacy of the treatments proscribed by the Act, *see Eknes-Tucker II*, 80 F.4th at 1215–18—the district court granted the Plaintiffs' motion with respect to Section 4(a)(1)–(3), *see Eknes-Tucker I*, 603 F. Supp. 3d at 1138, 1151. The district court concluded that the Plaintiffs had a substantial likelihood of success on the merits as to their due-process and equal-protection claims. With respect to the due-process claim, the district court concluded that the Parent Plaintiffs were substantially likely to show that they have a "fundamental right to treat their children with transitioning medications subject to medically accepted standards," and that section 4(a)(1)–(3) violates this right, triggering strict scrutiny. *Id.* at 1144–45. And, in the eyes of the district court, section 4(a)(1)–(3) likely failed to satisfy strict scrutiny. *Id.* at 1146. With respect to the equal-protection claim, the district court concluded that the Act "amounts to a sex-based classification," meaning it needed to satisfy intermediate scrutiny. *Id.* at 1147. Again, the district court found that the Act likely failed to meet this burden. *Id.* at 1148. Alabama subsequently appealed.

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[8] The United States moved to intervene on behalf of the Plaintiffs under Federal Rule of Civil Procedure 24 and filed its own motion to enjoin enforcement of the Act on equal-protection grounds. The district court granted intervention and the United States's motion for injunctive relief to the same extent it granted the Plaintiffs' motion. *Eknes-Tucker I*, 603 F. Supp. 3d at 1151.

II. ANALYSIS

On appeal, the panel unanimously concluded that the district court abused its discretion by preliminarily enjoining Alabama officials from enforcing section 4(a)(1)–(3) of the Act. *Eknes-Tucker II*, 80 F.4th at 1210. We held that the Due Process Clause does not secure "a constitutional right to 'treat [one's] children with transitioning medications subject to medically accepted standards,'" and that the Act does not discriminate "on the basis of sex or any other protected characteristic." *Id.* at 1210–11, 1219–31 (alteration in the original). Thus, we concluded that section 4(a)(1)–(3) was subject only to rational-basis review, and, as a consequence, the district court's "determination that the plaintiffs have established a substantial likelihood of success on the merits [could not] stand." *Id.* at 1210–11; *see id.* at 1231. We therefore vacated the preliminary injunction. *Id.* at 1211, 1231.

Some of my dissenting colleagues interpret the Fourteenth Amendment differently. I respectfully disagree. Below, I first explain why the panel's understanding of the Fourteenth Amendment is consistent with text, history, tradition, and existing precedent. I then explain why Alabama's decision is a rational exercise of its police power.

A. Substantive Due Process

The Due Process Clause of the Fourteenth Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1. Because this Clause makes no express mention of a parent's right to access cross-sex hormones and puberty blockers on behalf of a child, the Parent Plaintiffs "must show that the right is

somehow implicit in the constitutional text." *Dobbs*, 597 U.S. at 235.

"The most familiar office of [the Due Process] Clause is to provide a guarantee of fair procedure in connection with any deprivation of life, liberty, or property by a State." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). But the Supreme Court has said that the Due Process Clause protects "two categories of substantive rights"—a great majority of those enumerated in the first eight Amendments as well as "a select list of fundamental rights that are not mentioned anywhere in the Constitution." *Dobbs*, 597 U.S. at 237. The Supreme Court has long been "reluctant" to add a new right to this list, *Collins*, 503 U.S. at 125, because "[i]dentifying unenumerated rights carries a serious risk of judicial overreach," *Dep't of State v. Muñoz*, 144 S. Ct. 1812, 1821–22 (2024); *cf. United States v. Johnson*, 921 F.3d 991, 1021 (11th Cir. 2019) (en banc) (Rosenbaum, J., dissenting) (recognizing that "the 'doctrine of judicial self-restraint requires us to exercise the utmost care whenever we . . . break new ground'" (alteration in the original) (quoting *Collins*, 503 U.S. at 125)). Otherwise, "the liberty protected by the Due Process Clause" would simply reflect the "policy preferences" of the federal judiciary. *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997).

Out of this cautious approach grew the requirement that a substantive-due-process analysis "must begin with a careful description of the asserted right." *Reno v. Flores*, 507 U.S. 292, 302 (1993). Heeding this directive, the panel opinion's description of the right claimed here came directly from the district court, which concluded that the Parent Plaintiffs likely have a "fundamental right to treat their children with

transitioning medications subject to medically accepted standards." *Eknes-Tucker I*, 603 F. Supp. 3d at 1144.

The dissents take issue with this framing. Judge Jordan describes our analysis as "too simple" and says that we "ignore[] many Supreme Court cases that define fundamental rights at a much more general level without requiring established and precise historical pedigrees." Jordan Dis. Op. at 2. He "cite[s] with confidence to the dissent of Justice Stevens in *McDonald*," *id.* at 7, where Justice Stevens suggested that courts need not "define the asserted right at the most specific level, thereby sapping it of a universal valence and moral force it might otherwise have," *McDonald v. City of Chicago*, 561 U.S. 742, 882 (2010) (Stevens, J., dissenting). Judge Jordan would instead define the right as a parent's right "to obtain medically-approved treatment for their children." Jordan Dis. Op. at 22.

Judge Rosenbaum defines the right at stake as "parents' fundamental right to direct that their child receive well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment." Rosenbaum Dis. Op. at 1. Her opinion also faults our panel for "hyper-narrowly describ[ing] the asserted right." *Id.* at 31.

And Judge Wilson argues that en banc review is justified because of Judges Jordan and Rosenbaum's disagreement with our framing of the supposed right at stake, as well as the fact that the district court also framed the right at a higher level of generality. Wilson Dis. Op. at 1–2.

Respectfully, the panel's framing of the right is squarely within the approach taken by our Circuit, as

Judge Jordan acknowledges. *See* Jordan Dis. Op. at 1 (recognizing that "[t]here is admittedly some support in our cases for the panel's approach"). For example, in *Doe v. Moore*, 410 F.3d 1337 (11th Cir. 2005), the plaintiffs challenged, among other things, Florida's sex offender registration/notification scheme. *Id.* at 1339. The plaintiffs argued that this scheme—under which sex offenders registered and then the state published their information on the internet—violated substantive due process. *Id.* at 1342. Specifically, the plaintiffs alleged that it infringed their "rights to family association, to be free of threats to their persons and members of their immediate families, to be free of interference with their religious practices, to find and/or keep any housing, and . . . to find and/or keep any employment." *Id.* at 1343.

But instead of accepting this broad framing of the supposed rights at stake, this Court "endeavor[ed] to create a more careful description of the asserted right in order to analyze its importance." *Id.* A "careful description of the fundamental interest at issue here," we explained, "allows us to narrowly frame the specific facts before us so that we do not stray into broader 'constitutional vistas than are called for by the facts of the case at hand.'" *Id.* at 1344 (quoting *Williams v. Att'y Gen. of Ala.,* 378 F.3d 1232, 1240 (11th Cir. 2004)). This did not mean, we said, that "cases involving other privacy interests or burdens on those interests" were irrelevant, only that "we must quantify the claimed right in narrow terms before analyzing its historical importance in the second prong where discussion of prior case law is more appropriate." *Id.* at 1344 n.4. So, after reviewing the law and the parties' arguments, we determined that that supposed right at issue there was "the right of a person, convicted of 'sexual offenses,' to refuse subsequent registration of his or

her personal information with Florida law enforcement and prevent publication of this information on Florida's Sexual Offender/Predator website." *Id.* at 1344.

Similarly, in *Morrissey v. United States*, 871 F.3d 1260 (11th Cir. 2017), the plaintiff alleged that the IRS's disallowance of a claimed deduction for IVF-related costs infringed "his fundamental right to reproduce." *Id.* at 1268. We recognized that the Supreme Court had "referred to procreation as 'fundamental to the very existence and survival of the [human] race' and as a 'basic civil right[] of man.'" *Id.* (alterations in the original) (quoting *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942)). But the question in *Morrissey*, we said, was "not whether the Constitution protects a right to 'procreation' generally." *Id.* at 1269. Rather than rest at this level of generality, this Court went further, providing that the pertinent question in the case was "whether a man has a fundamental right to procreate via an IVF process that necessarily entails the participation of an unrelated third-party egg donor and a gestational surrogate." *Id.*

The approach taken by these cases explains our framing of the alleged "right" at issue here.[9] And while it is true that a plurality of the Supreme Court has recognized, at a high level of generality, "the fundamental right of parents to make decisions concerning the care, custody, and control of their children," *Troxel v. Granville*, 530 U.S. 57, 66 (2000) (plurality opinion), there is no accompanying suggestion from the Court

[9] As I discuss below, even if we were to accept the framing offered by either Judge Jordan or Judge Rosenbaum, both still fail to "engage[] in a careful analysis of the history of the right at issue." *Dobbs*, 597 U.S. at 238.

that plaintiffs asserting a supposed right under this umbrella are exempt from the "careful description" requirement found elsewhere in the case law. To the contrary, as a recent decision makes clear, the Court has continued to define alleged unenumerated rights narrowly so as to maintain fidelity to the facts before it in each case. *See Muñoz*, 144 S. Ct. at 1822.[10]

There is also the fact that most of the cases concerning parental rights "pertain to issues of education, religion, or custody." *Eknes-Tucker II*, 80 F.4th at 1222. In *Meyer v. Nebraska*, 262 U.S. 390 (1923), the Supreme Court set aside a schoolteacher's conviction, which was predicated on the violation of a state law forbidding the teaching of most foreign languages before the eighth grade. *Id.* at 396–97, 401–403. Among other things, the Court reasoned that the "liberty" guaranteed by the Due Process Clause included the right to "establish a home and bring up children." *Id.* at 399. Two years later, in *Pierce v. Society of the Sisters of the Holy Names of Jesus & Mary*, 268 U.S. 510 (1925), the Supreme Court concluded that an Oregon law—which required children from ages eight to sixteen to attend public school—"unreasonably interfere[d] with the liberty of parents and guardians to direct the upbringing and education of children under their control." *Id.* at 530, 534–35; *see also id.* at 535 ("The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations.").

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[10] In *Muñoz*, the respondent invoked the "fundamental right of marriage," but the Court pushed further, concluding that the respondent actually "claim[ed] something distinct: the right to reside with her noncitizen spouse in the United States." 144 S. Ct. at 1822 (emphasis omitted).

Child labor laws were at issue in *Prince v. Massachusetts*, 321 U.S. 158 (1944). The petitioner, a Jehovah's Witness, was the aunt and custodian of a nine-year-old girl. *Id.* at 159, 161. After allowing the girl to assist with sidewalk preaching efforts, the petitioner was charged with furnishing the girl with magazines to sell and permitting her to work in violation of the law. *Id.* at 160, 162. Pointing to *Meyer* and *Pierce*, the Court said that it "is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." *Id.* at 166. At the same time, the Court recognized "that the state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare" and that the "state's authority over children's activities is broader than over like actions of adults." *Id.* at 167–68.

In *Wisconsin v. Yoder*, 406 U.S. 205 (1972), the Supreme Court held that Wisconsin's compulsory-school attendance law for students up to the age of sixteen violated the First and Fourteenth Amendments. *Id.* at 234. The Court described the interest at stake as "the fundamental interest of parents . . . to guide the religious future and education of their children." *Id.* at 232; *see id.* at 233 ("[T]he Court's holding in *Pierce* stands as a charter of the rights of parents to direct the religious upbringing of their children."). But even in *Yoder*, the Court made clear that "the power of the parent, even when linked to a free exercise claim, may be subject to limitation under *Prince* if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens." *Id.* at 233–34.

The Supreme Court's other parental-rights cases mostly involve custody issues. *Stanley v. Illinois*, 405 U.S. 645 (1972), for example, concerned an unwed father's challenge to Illinois's procedure for custody determinations upon the death of the mother. *Id.* at 646–47. The Court held that the procedure—which presumed unwed fathers are unfit to raise their children—was at odds with the Fourteenth Amendment. *Id.* at 657–58. Along the way, the Court recognized that the father's interest in "retaining custody of his children is cognizable and substantial" and that a parent's interest "in the companionship, care, custody, and management of his or her children 'come[s] to this Court with a momentum for respect lacking when appeal is made to liberties which derive merely from shifting economic arrangements.'" *Id.* at 651–52 (alteration in the original) (quoting *Kovacs v. Cooper*, 336 U.S. 77, 95 (1949) (Frankfurter, J., concurring)). At issue in *Quilloin v. Walcott*, 434 U.S. 246 (1978), was the constitutionality of the application of Georgia's adoption law "to deny an unwed father authority to prevent adoption of his illegitimate child." *Id.* at 247. While the Court recognized that "the relationship between parent and child is constitutionally protected" and said that "it is now firmly established that 'freedom of personal choice in matters of . . . family life is one of the liberties protected by the Due Process Clause of the Fourteenth Amendment,'" it concluded that Georgia's law was not unconstitutional as applied. *Id.* at 255 (alteration in the original) (quoting *Cleveland Bd. of Educ. v. LaFleur*, 414 U.S. 632, 639–640 (1974)).

In *Santosky v. Kramer*, 455 U.S. 745 (1982), the Supreme Court considered the constitutionality of New York's statutory scheme governing the termination of parental rights in cases of permanent neglect.

Id. at 748–52. The Court held that the parents in that case were deprived of due process, as the statute at issue required only a "fair preponderance of the evidence" to support a finding of permanent neglect. *Id.* at 747, 768. Along the way to that conclusion, the Court referenced the "fundamental liberty interest of natural parents in the care, custody, and management of their child." *Id.* at 753.

And *Troxel* concerned the constitutionality of Washington's statute that afforded "[a]ny person" the ability to petition a court for visitation rights. 530 U.S. at 61 (plurality opinion). A plurality of the Court said that this statute—which allowed a state court to grant such rights if in the best interest of the child, even if the child's parent opposed—unconstitutionally infringed on "the fundamental right of parents to make decisions concerning the care, custody, and control of their children," as applied to facts of the case at issue. *Id.* at 66–67.

We are not free to divorce the facts of these cases from the rules they set forth. *See, e.g.*, *Edwards v. Prime, Inc.*, 602 F.3d 1276, 1298 (11th Cir. 2010) ("[R]egardless of what a court says in its opinion, the decision can hold nothing beyond the facts of that case."); *Watts v. BellSouth Telecomms., Inc.*, 316 F.3d 1203, 1207 (11th Cir. 2003) ("Whatever their opinions say, judicial decisions cannot make law beyond the facts of the cases in which those decisions are announced."); *Ogden v. Saunders*, 25 U.S. (12 Wheat.) 213, 333 (1827) (Marshall, C.J., dissenting) ("[T]he positive authority of a decision is co-extensive only with the facts on which it is made."). As the Supreme Court recently reminded, judicial "opinions dispose of discrete cases and controversies and they must be read with a careful eye to context." *Nat'l Pork Producers*

Council v. Ross, 598 U.S. 356, 373–74 (2023); *accord Illinois v. Lidster*, 540 U.S. 419, 424 (2004) (explaining that courts should "read general language in judicial opinions . . . as referring in context to circumstances similar to the circumstances then before the Court and not referring to quite different circumstances that the Court was not then considering"). Therefore, without an accompanying historical showing justifying such a move, we cannot extend the holdings of these cases to the facts here.

Both Judge Jordan and Judge Rosenbaum rely most heavily on another case, *Parham v. J. R.*, 442 U.S. 584 (1979). But no matter how many times they turn to *Parham*, it does not "control[] the analysis." Rosenbaum Dis. Op. at 29. As we explained in the panel opinion, *Parham* does not provide that the Fourteenth Amendment guarantees parents the ability to disregard state regulations on available medical care. *Eknes-Tucker II*, 80 F.4th at 1222–23. And a sister circuit agrees. *See L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 477 (6th Cir. 2023) ("Nothing in *Parham* supports an affirmative right to receive medical care, whether for a child or an adult, that a state reasonably bans.").

In *Parham*, a group of minors brought a procedural-due-process challenge to Georgia's statutory scheme governing the admission of children to mental hospitals. 442 U.S. at 587–88. Importantly, this scheme allowed parents to apply for their child's hospitalization. *Id.* at 590–91. Judges Jordan and Rosenbaum are correct that the Court considered the interests of the parents in reaching a conclusion as to the procedural protections owed to the plaintiffs under the Due Process Clause. *Id.* at 601–04. Drawing from its precedents, the Court said that a parent's "high duty . . . to recognize and prepare [their children] for additional obligations"

includes a duty to "recognize symptoms of illness and to seek and follow medical advice." *Id.* at 602 (second alteration in the original) (quoting *Pierce*, 268 U.S. at 535). Because of this, the Court said that the presence of disagreement between parent and child as to the proper course of treatment "does not diminish the parents' authority to decide what is best for the child," and does not provide cause for governmental intervention. *Id.* at 603–04. With respect to voluntary commitment, the Court concluded that its precedents "permit the parents to retain a substantial, if not the dominant, role in the decision, absent a finding of neglect or abuse, and that the traditional presumption that the parents act in the best interests of their child should apply." *Id.* at 604. But, in light of "the child's rights and the nature of the commitment decision," the Court also cautioned that "parents cannot always have absolute and unreviewable discretion to decide whether to have a child institutionalized." *Id.* Instead, the Court said, any decision is "subject to a physician's independent examination and medical judgment." *Id.*

The Court ultimately concluded that "some kind of inquiry should be made by a 'neutral factfinder' to determine whether the statutory requirements for admission are satisfied," but it rejected a "formalized, factfinding hearing" because that could lead to a "significant intrusion into the parent-child relationship." *Id.* at 606, 610. "Pitting the parents and child as adversaries," said the Court, "often will be at odds with the presumption that parents act in the best interests of their child." *Id.* at 610.

In determining *Parham*'s relevance to this case, context is again key. *See Nat'l Pork Producers*, 598 U.S. at 373–74. In other words, we must not "rely[] on general statements from [*Parham*] dealing with gov-

ernmental actions not even remotely similar to those involved here." *Parham*, 442 U.S. at 608 n.16. While this case is about a conflict between the Parent Plaintiffs and Alabama over substantive-due-process requirements, *Parham* was concerned with procedural-due-process requirements in a context that could pit parents and children "as adversaries." *Id.* at 610. And in *Parham*, the question before the Court involved a Georgia law *permitting* institutionalization as a state-approved form of medical treatment. As we pointed out in the panel opinion, the question in *Parham* was not whether, under the Fourteenth Amendment, a Georgia law *barring* institutionalization had to give way in light of a parent's desire to institutionalize their child. *See Eknes-Tucker II*, 80 F.4th at 1223. *Parham* did not say, for example, that Georgia was constitutionally forbidden from ending its voluntary commitment scheme if parents disagreed with that decision. In fact, the Court indicated that the opposite was true. *See Parham*, 442 U.S. at 604 ("Parents in Georgia in no sense have an absolute right to commit their children to state mental hospitals; the statute requires the superintendent of each regional hospital to exercise independent judgment as to the child's need for confinement."). The *Parham* Court also recognized that "a state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized." *Id.* at 603.[11]

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[11] Judge Rosenbaum states that this analysis "elementally misunderstands the nature of a fundamental right," as "[c]onstitutional protections are not so susceptible to state-law abrogation." Rosenbaum Dis. Op. at 24; *see also* Jordan Dis. Op. at 23–25. In the abstract, she is of course correct that a state law cannot trump an individual right afforded by the federal constitution. But here, we are tasked with the antecedent question: whether the Parent Plaintiffs are substantially likely to show that they have such a

Importantly, the Supreme Court later rejected an attempt to turn *Parham* into the decision some of the dissenters want it to be. In *Cruzan ex rel. Cruzan v. Director, Missouri, Department of Health*, 497 U.S. 261 (1990), the Court refused to read *Parham*, "a decision which allowed a State to rely on family decisionmaking," as setting forth "a constitutional requirement that the State recognize such decisionmaking." *Id.* at 286. "[C]onstitutional law," according to the Court, "does not work that way." *Id.*

Attempts to distinguish away *Cruzan* come up empty. Judge Rosenbaum reads *Parham* to recognize a fundamental right and then says that *Cruzan*, with its different facts, did not limit that right. *See* Rosenbaum Dis. Op. at 19–23. But *Cruzan* did not distinguish *Parham* on any of the grounds offered by Judge Rosenbaum. Instead, the Court in *Cruzan* disagreed with the petitioner's view of "constitutional law," as evidenced by the petitioner's reading of *Parham*, which is like the reading offered by Judges Jordan and Rosenbaum. *See Cruzan*, 497 U.S. at 286. The panel's refusal to adopt a view of constitutional law rejected by the Supreme Court is hardly "sidestep[ping]" Supreme Court precedent. Rosenbaum Dis. Op. at 23.

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right in the first place. To do so, we must consult text, history, and tradition, as informed by binding precedent, to determine whether the Due Process Clause affords such a right and strips Alabama of the authority to enforce the Act. *See United States v. Comstock*, 560 U.S. 126, 159 (2010) (Thomas, J., dissenting) ("The States . . . are free to exercise all powers that the Constitution does not withhold from them."). The point we made in the panel opinion, *Eknes-Tucker II*, 80 F.4th at 1223, is that *Parham* does not recognize the right claimed by the Parent Plaintiffs, and thus does not stand for the proposition that Alabama lacks the authority to enforce the Act in light of parental dissent.

In short, while some of the dissenters chant *Parham* "like a mantra," they "cannot give [*Parham*] substance that it lacks." *Sec. & Exch. Comm'n v. Jarkesy*, 144 S. Ct. 2117, 2138 (2024). *Parham* does not lead to the conclusion that the Parent Plaintiffs have a constitutional right to override Alabama's decision regarding the availability of the medications prohibited for use by minors under the Act.

Thus, though purporting to simply apply Supreme Court precedent, both Judge Jordan and Judge Rosenbaum would have us mark out new terrain.[12] While the Supreme Court's substantive-due-process precedents do not rule out such a move, they do demand a showing that a right is "deeply rooted in [our] history and tradition" and "essential to our Nation's 'scheme of ordered liberty.'" *Dobbs*, 597 U.S. at 237 (alteration in the original) (quoting *Timbs v. Indiana*, 586 U.S. 146, 150 (2019)). To conduct this inquiry, we must engage "in a careful analysis of the history of the right at issue." *Id.* at 238. This analysis is "essential whenever we are asked to recognize a new component of the 'liberty' protected by the Due Process Clause because the term 'liberty' alone provides little guidance." *Id.* at 239. It also guards against "usurp[ing] authority that the Constitution entrusts to the people's

[12] This Court's decisions similarly provide no support for the understanding of the Due Process Clause shared by Judges Jordan and Rosenbaum, the district court, and the Appellees. *Eknes-Tucker II*, 80 F.4th at 1223–24, 1223 n.15. Judge Jordan criticizes the panel's characterization of *Bendiburg v. Dempsey*, 909 F.2d 463 (11th Cir. 1990), Jordan Dis. Op. at 3–5, but I do not see how his criticism ultimately supports his argument. In other words, even if we assume *Bendiburg* is "largely irrelevant," *id.* at 5, this does not change the fact that this Court's cases do not support Judge Jordan's reading of the Due Process Clause.

elected representatives" and engaging in "freewheeling judicial policymaking." *Id.* at 239– 40.

The approach taken by the district court—and by extension those defending its decision—does not pay "careful 'respect [to] the teachings of history.'" *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977) (plurality opinion) (quoting *Griswold v. Connecticut*, 381 U.S. 479, 501 (1965) (Harlan, J., concurring in the judgment)). The Supreme Court's opinion in *Timbs* traced the right at issue in that case "back to [the] Magna Carta, Blackstone's Commentaries, and 35 of the 37 state constitutions in effect at the ratification of the Fourteenth Amendment." *Dobbs*, 597 U.S. at 238 (citing *Timbs*, 586 U.S. at 151–54). And the Supreme Court's opinion in *Glucksberg* "surveyed more than 700 years of 'Anglo-American common law tradition.'" *Id.* at 239 (quoting *Glucksberg*, 521 U.S. at 711). But the district court failed to point to any ratification-era support for its decision—"no state constitutional provision, no statute, no judicial decision, [and] no learned treatise." *Id.* at 251; *see Eknes-Tucker II*, 80 F.4th at 1221 ("[T]he district court's order does not feature any discussion of the history of the use of puberty blockers or cross-sex hormone treatment or otherwise explain how that history informs the meaning of the Fourteenth Amendment at the time it was ratified—July 9, 1868.").[13]

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[13] A word about the so-called "1868 Methodology." *See* Rosenbaum Dis. Op. at 1–2, 32–37. Judge Rosenbaum mischaracterizes the panel opinion as concluding that parents have the fundamental right to direct that their children receive "medical treatments in existence as of 1868." *Id.* at 1. That issue, of course, was not before the panel. And the panel opinion merely notes the absence of any historical support for the position reached by the district court—a deficiency not cured on appeal.

Judges Jordan and Rosenbaum similarly fail to supply the needed historical support. This holds true even if we assume that they correctly framed the alleged right at stake. Finding the proper level of specificity does not exempt one from "engag[ing] in a careful analysis of the history of the right at issue." *Dobbs*, 597 U.S. at 238. And neither Judge Jordan nor Judge Rosenbaum has demonstrated that the ability to obtain medically-approved or non-experimental treatment, despite state regulation to the contrary, is "deeply rooted in [our] history and tradition." *Id.* at 237 (alteration in the original) (quoting *Timbs*, 586 U.S. at 150). If their understanding of the Due Process Clause was correct, we would expect to see some evidence of such a right's existence before and after the Fourteenth Amendment's ratification. But, at least on the arguments presented in this case, no one comes close to demonstrating the existence of a right "deeply rooted in this Nation's history and tradition" and "implicit in the concept of ordered liberty." *Id.* at 231 (quoting *Glucksberg*, 521 U.S. at 721).

This lack of history should not be surprising given that "States traditionally have had great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons." *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996) (quoting *Metro. Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 756 (1985)); *cf. Muñoz*, 144 S. Ct. at 1823 (refusing to recognize a right under *Glucksberg* when "the through line of history" is recognition of the government's power to regulate). Included within these police powers is the authority to legislate to "preserv[e] and promot[e] the welfare of the child," *Santosky*, 455 U.S. at 766, and to "safeguard[] the physical and psychological well-being of a minor," *Globe Newspaper Co. v. Superior Ct. for Norfolk Cnty.*, 457 U.S. 596, 607

(1982), even if, in some cases, this limits parental discretion, *see Prince*, 321 U.S. at 167. Indeed, the Supreme Court has "sustained legislation aimed at protecting the physical and emotional well-being of youth even when the laws have operated in the sensitive area of constitutionally protected rights." *New York v. Ferber*, 458 U.S. 747, 757 (1982).

Importantly, a state's exercise of this authority is not contingent on the approval of the expert class. The Constitution's contours are not shaped by expert opinion. *See Dobbs*, 597 U.S. at 272–73 (suggesting that the position of groups like the American Medical Association does not "shed light on the meaning of the Constitution"); *Otto v. City of Boca Raton*, 981 F.3d 854, 869 (11th Cir. 2020) (explaining that "institutional positions cannot define the boundaries of constitutional rights"). "[F]rom time immemorial," the states have regulated those who practice medicine. *Dent v. West Virginia*, 129 U.S. 114, 122 (1889); *see Watson v. Maryland*, 218 U.S. 173, 176 (1910) ("It is too well settled to require discussion at this day that the police power of the states extends to the regulation of certain trades and callings, particularly those which closely concern the public health."). And the Due Process Clause does not mandate the opposite arrangement.

Additionally, neither Judge Jordan nor Judge Rosenbaum has assembled a historical record demonstrating that adults themselves possess the constitutional right to access the medications at issue, or any specific medication, for that matter. And the weight of the authority indicates that the opposite is true. Many of our sister circuits "have rejected arguments that the Constitution provides an affirmative right of access to particular medical treatments reasonably prohibited by the Government." *Abigail All. for Better Access to*

Developmental Drugs v. von Eschenbach, 495 F.3d 695, 710 (D.C. Cir. 2007) (en banc); *see id.* at 710 n.18 (collecting cases); *Mitchell v. Clayton*, 995 F.2d 772, 775 (7th Cir. 1993) ("[M]ost federal courts have held that a patient does not have a constitutional right to obtain a particular type of treatment or to obtain treatment from a particular provider if the government has reasonably prohibited that type of treatment or provider."). Instead, "our Nation's history evidences increasing regulation of drugs as both the ability of government to address these risks has increased and the risks associated with drugs have become apparent." *Abigail All.*, 495 F.3d at 711. Because we have recognized that a parent's right to "make decisions for his [son or daughter] can be no greater than his rights to make medical decisions for himself," *Doe ex rel. Doe v. Pub. Health Tr. of Dade Cnty.*, 696 F.2d 901, 903 (11th Cir. 1983), these cases strongly support the result reached by the panel opinion. This is especially true because the "state's authority over children's activities is broader than over like actions of adults." *Prince*, 321 U.S. at 168.

For all these reasons, the panel was correct to conclude that the Parent Plaintiffs have failed to establish the existence of a fundamental right. I write further, though, to highlight additional doubts that I have about the Parent Plaintiffs' arguments.

First, even if the historical record lent credence to the idea that there was a parental right to obtain medically approved or non-experimental medications in the face of governmental prohibition, I am skeptical that this right would be implicated here. "[I]n areas where there is medical and scientific uncertainty," state legislatures are afforded "wide discretion to pass legislation." *Gonzales v. Carhart*, 550 U.S. 124, 163

(2007). And with this wide discretion comes an exceedingly narrow role for federal courts. If it were otherwise, we would often find ourselves answering questions that should be answered by the political branches. Instead of merely "say[ing] what the law is," *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 177 (1803), we would be "decid[ing] the proper balance between the uncertain risks and benefits of medical technology," *Abigail All.*, 495 F.3d at 713, and imposing a "constitutional straightjacket" in the process, *Skrmetti*, 83 F.4th at 473. That is not our role.

Below, the district court extended the Constitution's protections despite considerable uncertainty, based in part on its conclusion that Alabama failed to produce "evidence showing that transitioning medications jeopardize the health and safety of minors suffering from gender dysphoria." *Eknes-Tucker I*, 603 F. Supp. 3d at 1145. But that statement is not quite right.[14] As I explain in my discussion of rational-basis review, Alabama did in fact produce evidence to that effect.[15] *See infra* at 43–47. And recent revelations only serve to confirm the impropriety of the district court's intervention. I make note of them not because they change our review of the district court's order, but because they highlight the issues that often arise

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[14] Indeed, elsewhere in its order, the district court recognized that "transitioning medications" come with "[k]nown risks," including "loss of fertility and sexual function." *Eknes-Tucker I*, 603 F. Supp. 3d at 1139; *see also id.* at 1145 (recognizing that the "Defendants offer some evidence that transitioning medications pose certain risks").

[15] For example, studies suggest that significant health risks may stem from the use of these medications, including sterility, sexual dysfunction, lower bone density, high blood pressure, breast cancer, liver disease, cardiovascular disease, and weight gain.

when courts extend the Constitution's protections to areas subject to all sorts of uncertainty.

For example, when the district court entered the order under review, it concluded that "no country or state in the world categorically bans the[] use" of puberty blockers and cross-sex hormones "as Alabama has." *Eknes-Tucker I*, 603 F. Supp. 3d at 1145. But other countries have started to adopt Alabama's position. In March 2024, England's NHS announced that puberty blockers are no longer available as a routine treatment for English minors suffering from gender dysphoria. NHS "concluded that there is not enough evidence to support the safety or clinical effectiveness" of such drugs "to make the treatment routinely available at this time."[16] NHS Clinical Policy, *supra* n.3, at 3. And as noted earlier, the UK has also temporarily banned puberty blockers (with limited exceptions) through an emergency order, which the UK's High Court recently sustained. *See TransActual CIC* [2024] EWHC 1936 (Admin), ¶¶ 142–48, 257.

The district court also relied heavily on the Standards of Care promulgated by WPATH, *Eknes-Tucker I*, F. Supp. 3d at 1138–39, 1145, which one dissenter considers the "leading authority" in this area. Rosenbaum Dis. Op. at 29. But recent revelations indicate that WPATH's lodestar is ideology, not science. For example,

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[16] NHS has also placed severe restrictions on "gender affirming hormones," allowing for their use only after a child has turned sixteen and meets several other criteria. *See Prescribing of Gender Affirming Hormones (masculinising or feminising hormones) as part of the Children and Young People's Gender Service*, Nat'l Health Serv., Eng., (Mar. 21, 2024), https://www.england.nhs.uk/wp-con-tent/uploads/2024/03/clinical-commissioning-policy-prescribing-of-gender-affirming-hormones.pdf [https://perma.cc/Q2TX-5KWP].

in one communication, a contributor to WPATH's most recent Standards of Care frankly stated, "[o]ur concerns, echoed by the social justice lawyers we spoke with, is that evidence-based review reveals little or no evidence and puts us in an untenable position in terms of affecting policy or winning lawsuits." This only reinforces the district court's improper reliance on the scientific claims of an advocacy organization to craft constitutional law. Indeed, as others have recognized, WPATH's Standards of Care "reflect not consensus, but merely one side in a sharply contested medical debate over sex reassignment surgery." *Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019); *see also Edmo v. Corizon, Inc.*, 949 F.3d 489, 497 (9th Cir. 2020) (O'Scannlain, J., opinion respecting the denial of rehearing en banc) ("The WPATH Standards are merely criteria promulgated by a controversial private organization with a declared point of view.").[17]

These revelations only further underscore the reality that a judge is not fit, in a preliminary posture and on a limited record, to remove matters like this one from an ongoing public debate. Even assuming parents possessed a right to compel access to certain medical treatments for their children, this right certainly does not include the ability to access substances that gravely threaten a child's development. *Cf. Prince*, 321 U.S. at 165 ("It is the interest of youth

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[17] As the Fifth Circuit went on to explain, one of the doctors who helped draft a previous edition of WPATH's Standards of Care testified that the Standards of Care "is not a politically neutral document." *Gibson*, 920 F.3d at 222 (emphasis omitted) (quoting *Kosilek v. Spencer*, 774 F.3d 63, 78 (1st Cir. 2014) (en banc)). Instead, "WPATH aspires to be both a scientific organization and an advocacy group for the transgendered." *Id.* (quoting *Kosilek*, 774 F.3d at 78).

itself, and of the whole community, that children be both safeguarded from abuses and given opportunities for growth into free and independent well-developed men and citizens."). And if it turns out that the substances at issue here have such effects, a judicial ruling to the contrary would facilitate, rather than prevent, irreparable harm.

Some substantive-due-process cases may be hard. Jordan Dis. Op. at 1. This one is not. Judge Jordan reminds us "that it is a constitution we are expounding." Jordan Dis. Op. at 2 (alteration adopted) (quoting *Home Bldg. & Loan Ass'n v. Blaisdell*, 290 U.S. 398, 443 (1934)).[18] But "[p]recisely because 'it is a constitution we are expounding,' we ought not to take liberties with it." *Nat'l Mut. Ins. Co. of Dist. Of Col. v. Tidewater Transfer Co.*, 337 U.S. 582, 647 (1949) (Frankfurter, J., dissenting) (quoting *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 407 (1819)). Our legal tradition rightly entrusts parents with broad authority in the lives of their children. But that tradition also provides no basis for concluding that this authority extends to the circumstances presented by this case. The district court thus erred by applying heightened scrutiny. The Act need only satisfy the rational-basis test, and the Parent

[18] As Justice Scalia explained, this line from Chief Justice Marshall has long been misread to justify interpreting the Constitution in a way that is unmoored from its text and history. *See* Antonin Scalia, *Essay: Assorted Canards of Contemporary Legal Analysis*, 40 Case W. Res. L. Rev. 581, 594–96 (1989); *see also Ogden*, 25 U.S. (12 Wheat.) at 332 (Marshall, C.J., dissenting) (The Constitution's words "are to be understood in that sense in which they are generally used by those for whom the instrument was intended [and] its provisions are neither to be restricted into insignificance, nor extended to objects not comprehended in them, nor contemplated by its framers.").

Plaintiffs do not have a substantial likelihood of success in arguing that it does not. *See infra* at 42–52.

B. Equal Protection

Judge Rosenbaum's and Judge Wilson's dissents also disagree with our equal-protection holding, arguing that the Act discriminates based on sex and transgender status. Rosenbaum Dis. Op. at 46–63; Wilson Dis. Op. at 3–5. But the Act applies equally to everyone regardless of their sex or transgender status. And transgender status is not a classification protected by the Equal Protection Clause. These points are discussed in turn below.

1. The Act does not discriminate based on sex.

Supposedly, the Act unconstitutionally discriminates based on sex because "but for the Minors' birth-assigned sex," they could access puberty blockers and cross-sex hormones. Rosenbaum Dis. Op. at 49. For example, Judge Rosenbaum notes that the Act prohibits a "birth-assigned boy" from "tak[ing] estrogen" for the proscribed purpose while a "birth-assigned girl" can take estrogen to cure "an estrogen deficiency." *Id.* In other words, Judge Rosenbaum argues that the Equal Protection Clause requires Alabama to make cross-sex hormones and puberty blockers available for the proscribed purpose so long as Alabama allows the use of puberty blockers and cross-sex hormones for other purposes.

Therein lies the problem with her reasoning: The Act discriminates based on purpose, not sex. The Act prohibits everyone under the age of nineteen—regardless of their sex—from using cross-sex hormones or puberty blockers "for the *purpose* of attempting to alter the appearance of or affirm [their] perception of [their] gender or sex, if that appearance or perception is

inconsistent with [their] sex." Act § 3–4(a) (emphasis added); Ala. Code § 43-8-1(18). Likewise, the Act allows everyone under the age of nineteen—regardless of their sex—to use cross-sex hormones and puberty blockers for other purposes, such as treating central precocious puberty. Act § 4(b)(2).

True, the Act uses sex-specific terminology. *See* Wilson Dis. Op. at 4–5. The Act prohibits prescribing or administering "supraphysiologic doses of testosterone . . . to females" and prescribing or administering "supraphysiologic doses of estrogen to males." Act § 4(a)(2)–(3). But this sex-specific language actually preserves evenhandedness. Because of biological realities, the cross-sex hormone regimen that one undergoes is necessarily dependent on one's sex. Males cannot use testosterone for the prohibited purpose, and females cannot use estrogen for the prohibited purpose. To the extent that the Act includes provisions that reference only one sex, *see id.*, it simply reflects these realities to equally proscribe cross-sex hormones for both males and females. If the Act restricted only the use of testosterone—but not estrogen—for the proscribed purpose, it would discriminate against females. And if the Act restricted only the use of estrogen—but not testosterone for the proscribed purpose, it would discriminate against males. In other words, the Act uses sex-specific language because it regulates sex-specific medications. And, as noted in our panel opinion, "[t]he regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a 'mere pretex[t] designed to effect an invidious discrimination against members of one sex or the other.'" *Eknes-Tucker II*, 80 F.4th at 1229 (alterations in the original) (quoting *Dobbs*, 597 U.S. at 236).

Judge Rosenbaum and Judge Wilson both invoke *Bostock v. Clayton County*, 590 U.S. 644 (2020). Rosenbaum Dis. Op. at 50, 54–56; Wilson Dis. Op. at 3–4. But the meaning of the Equal Protection Clause was not at issue in *Bostock*, and the Supreme Court expressly declined to "prejudge" whether its reasoning applied to other laws "that prohibit sex discrimination." *Bostock*, 590 U.S. at 681. Notwithstanding *Bostock*'s limited holding, Judge Rosenbaum reads *Bostock* to announce a new principle that applies to every antidiscrimination provision in federal law, including a constitutional provision that was ratified in 1868. Supposedly, after *Bostock*, all classifications "based on transgender status" are classifications "based on sex." Rosenbaum Dis. Op. at 54. That reading ignores the reasoning in *Bostock*.

Bostock relied heavily on the unique text of Title VII particularly, the words "because of," "otherwise . . . discriminate against," and "individual." *Eknes-Tucker II*, 80 F.4th at 1228–29 (alteration in the original) (quoting *Bostock*, 590 U.S. at 656–58); *see* 42 U.S.C. § 2000e-2(a)(1). The Equal Protection Clause does not include any of this language. *See* U.S. Const. amend. XIV, § 1 ("No State shall . . . deny to any person within its jurisdiction the equal protection of the laws."). As Justice Gorsuch—the author of *Bostock*—observed when comparing the text of Title VI and the text of the Equal Protection Clause, it "is implausible on its face" that "such differently worded provisions should mean the same thing." *Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181, 308 (2023) (Gorsuch, J., concurring). Justice Gorsuch's point is no less relevant to Title VII and the Equal Protection Clause. *See Skrmetti*, 83 F.4th at 484 (finding that the reasoning of *Bostock* "applies only to Title VII"); *Brandt ex rel. Brandt v. Rutledge*, No. 21-

2875, 2022 WL 16957734, at *1 n.1 (8th Cir. Nov. 16, 2022) (Stras, J., dissenting from denial of rehearing en banc) (expressing skepticism that *Bostock*'s reasoning applies to the Equal Protection Clause because the Fourteenth Amendment "predates Title VII by nearly a century" and contains language that is "not similar in any way" to Title VII's); *cf. Fowler v. Stitt*, 104 F.4th 770, 801–02 (10th Cir. 2024) (Hartz, J., dissenting in part) (disagreeing with the majority's reflexive application of *Bostock* to the Equal Protection Clause). Because the language of the Equal Protection Clause does not resemble the language of Title VII, *Bostock*'s reasoning does not apply here.

Next, two dissents cite *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011), and both claim that we distinguished *Brumby* by confining it to employment discrimination. Rosenbaum Dis. Op. at 57; Wilson Dis. Op. at 3–4. Respectfully, the majority opinion and Judge Brasher's concurrence explained that *Brumby* is distinguishable because *Brumby* dealt with sex-based stereotypes about how men should dress, not biological realities. *Eknes-Tucker II*, 80 F.4th at 1229 ("Insofar as section 4(a)(1)–(3) involves sex, it simply reflects biological differences between males and females, not stereotypes associated with either sex."); *id.* at 1234 (Brasher, J., concurring) ("Unlike the employer's decision in [*Brumby*], Alabama's statute does not fit the mold of a sex-based stereotype. The statute isn't based on a socially constructed generalization about the way men or women should behave.").

Judge Rosenbaum responds that it is a form of stereotyping to prohibit minors from taking transitioning medications. *See* Rosenbaum Dis. Op. at 52–53. But there is a difference between prohibiting biological men from wearing dresses, *see Brumby*, 663 F.3d at

1314, 1318–19, and prohibiting minor boys from taking estrogen "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his . . . gender or sex, if that appearance or perception is inconsistent with [his] sex," Act § 4(a). The former restriction is a stereotype about how men should dress, the latter restriction is based on physical differences between males and females. And, as the Supreme Court has recognized, "[p]hysical differences between men and women . . . are enduring." *United States v. Virginia*, 518 U.S. 515, 533 (1996). The recognition of those physical differences, which are inherent in the biology of every man and woman, "is not a stereotype." *Nguyen v. I.N.S.*, 533 U.S. 53, 68 (2001); *see also Eknes-Tucker II*, 80 F.4th at 1234 (Brasher J., concurring).

Overall, the Act applies equally to minor males and minor females. Both sexes *can* use puberty blockers and cross-sex hormones to treat a medical disorder, Act § 4(b)(2), but neither sex may use puberty blockers and cross-sex hormones "for the purpose of attempting to alter the appearance of or affirm [their] perception of [their] gender or sex, if that appearance or perception is inconsistent with [their] sex." *Id.* § 4(a). Thus, our panel correctly held that the Act is subject to rational-basis scrutiny, not intermediate scrutiny. *Eknes-Tucker II*, 80 F.4th at 1230.

2. The text of the Act is neutral as to transgender status, and transgender status is not a quasi-suspect classification.

Judge Rosenbaum also claims that the Act triggers intermediate scrutiny because transgender status is a quasi-suspect classification. Rosenbaum Dis. Op. at 58–63. But as our panel opinion explained, even if transgender status is a quasi-suspect classification, the Act would not trigger heightened scrutiny because

it discriminates solely based on "purpose." Act § 4(a); *Eknes-Tucker II*, 80 F.4th at 1228. Under the plain terms of the Act, any minor *can* access puberty blockers and cross-sex hormones for an acceptable purpose, such as treating central precocious puberty. Act § 4(b)(2).[19] To be sure, a facially evenhanded regulation can be subject to heightened scrutiny if it is a mere pretext for invidious discrimination against a protected class. *See Shaw v. Reno*, 509 U.S. 630, 643–44 (1993). But the district court made no findings of such a pretext here. Judge Rosenbaum's argument fails on this point alone.

More generally, transgender status is not a quasi-suspect classification in the first place. While sitting en banc, we already declined to recognize transgender status as a quasi-suspect classification. *See Adams ex rel. Kasper v. Sch. Bd. of St. Johns Cnty.*, 57 F.4th 791, 803 n.5 (11th Cir. 2022) (en banc) (expressing "grave 'doubt' that transgender persons constitute a quasi-suspect class"). Further, the 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). Since 1973, the Supreme Court has declined to recognize poverty, age, and mental disability as suspect or quasi-suspect classifi-

[19] Judge Rosenbaum also states that people are not truly "transgender" if they "experience some form of gender incongruence" but "ultimately embrace their birth-assigned gender or detransition." Rosenbaum Dis. Op. at 59. But if that's true, then not everyone who seeks medications "for the purpose of attempting to alter the appearance of" their "sex," is, in fact, transgender. Act § 4(a). Thus, if Judge Rosenbaum is correct, then the Act does not discriminate based on transgender status—not everyone who seeks the relevant medication for the relevant purpose would, in fact, be transgender.

cations. *See San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 28–29 (1973) (poverty); *Massachusetts Bd. of Ret. v. Murgia*, 427 U.S. 307, 313–14 (1976) (age); *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 442 (1985) (mental disability); *see also Lyng v. Castillo*, 477 U.S. 635, 638 (1986) ("Close relatives are not a 'suspect' or 'quasi-suspect' class.").

Judge Rosenbaum would chart new territory by treating transgender status as a quasi-suspect classification. The district court never held that, *see Eknes-Tucker I*, 603 F. Supp. 3d at 1146–48, and neither Judge Rosenbaum's dissent nor Judge Wilson's dissent cite any record evidence suggesting that transgender persons are a "discrete group" defined by "obvious, immutable, or distinguishing characteristics" and that they are "politically powerless." *Lyng*, 477 U.S. at 638. Unlike race, sex, or national origin, transgender status is not "an immutable characteristic determined solely by the accident of birth." *Frontiero v. Richardson*, 411 U.S. 677, 686 (1973). Studies show that 61% to 88% of children with gender dysphoria become comfortable with their sex "over the course of puberty." A trait is not "immutable" if it is "subject to . . . change." *Adams*, 57 F.4th at 807 (quoting *Immutable*, *Oxford English Dictionary* (2d ed. 1989)).

Furthermore, transgender persons are not a "discrete group" that exhibits "obvious" or "distinguishing" characteristics. *Lyng*, 477 U.S. at 638. WPATH itself defines "transgender" as an "[a]djective" used to describe anyone "who cross[es] or transcend[s] culturally defined categories of gender." Possible gender identities described by WPATH and the American Psychological Association include "boygirl," "girlboy," "genderqueer," "bigender," "pangender," "androgyne," "genderless," "gender neutral," "neutrois," "agender," and "genderfluid," just to name a few.

According to the American Psychological Association, possible gender identities exist on a "wide spectrum" that defies the binary nature of sex. That theory has no practical limits. Also, one of the dissents argues that people are not truly "transgender" if they "experience some form of gender incongruence" but "ultimately embrace their birth-assigned gender or detransition." Rosenbaum Dis. Op. at 59. But if that's true, then someone who currently identifies as a "boygirl," for example, might not actually be transgender based on their future self-perceptions or actions. A classification is neither "obvious" nor "distinguishing" if it turns on a future that is presently unknown. Like *Rodriguez*, this case "comes to us with no definitive description of the classifying facts or delineation of the disfavored class." 411 U.S. at 19.

Finally, transgender people are not "politically powerless." *Lyng*, 477 U.S. at 638. "A national anti-discrimination law, Title VII, protects transgender individuals in the employment setting," and "[f]ourteen States have passed laws specifically allowing some of the treatments sought here." *Skrmetti*, 83 F.4th at 487. The White House recognizes an annual "Transgender Day of Visibility." *See* Proclamation No. 10724, 89 Fed. Reg. 22901 (March 29, 2024). The Department of Justice is devoting considerable time and resources as an intervenor plaintiff in this litigation. Twenty states and the District of Columbia filed an amicus brief in support of the Plaintiffs. And every major law firm that has participated in this litigation has supported the Plaintiffs. All of these facts contradict a notion of political powerlessness. True, Judge Rosenbaum cites statistics about the lamentable harassment that transgender people experience, Rosenbaum Dis. Op. at 60–61, but *Cleburne* is clear that "some degree of prejudice from at least part of the public at large" is

not sufficient. 473 U.S. at 445. Significantly, in *Cleburne*, the Supreme Court rejected the argument that mental disability is a suspect classification, *id.* at 442–46, despite a history of compulsory sterilization, exclusion from public schools, and a system of "state-mandated segregation and degradation" "that in its virulence and bigotry rivaled, and indeed paralleled, the worst excesses of Jim Crow," *id.* at 462–63 (Marshall, J., concurring in the judgment and dissenting in part). And since *Cleburne*, the Supreme Court has never recognized a new suspect or quasi-suspect classification. Neither the Plaintiffs, nor the district court, nor the dissenters have provided a basis for us to do so here.

Because the Act does not discriminate based on a suspect or a quasi-suspect classification, the Act is subject to rational-basis review. *Id.* at 440, 446. To satisfy rational-basis review, Alabama needs only one "conceivable basis" to proscribe cross-sex hormones and puberty blockers for minors. *See Jones v. Governor of Florida*, 975 F.3d 1016, 1034 (11th Cir. 2020) (en banc) (quoting *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 315 (1993)). As explained in the next section, there are many conceivable bases for the Act, and thus, the Plaintiffs lack a substantial likelihood of success on their due process and equal protection claims.

C. Rational-Basis Review

Under rational-basis review, the question "is simply whether the challenged legislation is rationally related to a legitimate state interest." *Lofton v. Sec'y of Dep't of Child. & Fam. Servs.*, 358 F.3d 804, 818 (11th Cir. 2004). Alabama satisfied this remarkably lenient standard for at least five reasons.

First, Alabama provided significant evidence that the medications covered by the Act are dangerous and ineffective. Although the district court disagreed with that evidence, it acknowledged that Alabama "offer[ed] some evidence that transitioning medications pose certain risks." *Eknes-Tucker I*, 603 F. Supp. 3d at 1145. That is sufficient to satisfy the rational-basis test. The Alabama legislature is entitled to look at the competing evidence and draw its own conclusions. *Heller*, 509 U.S. at 319 ("[R]ational-basis review in equal protection analysis 'is not a license for courts to judge the wisdom, fairness, or logic of legislative choices.'" (quoting *Beach Commc'ns*, 508 U.S. at 313)). To be sure, Alabama did not need to cite any "evidence or empirical data" supporting the Act. *Beach Commc'ns*, 508 U.S. at 315. "[R]ational speculation" would have been sufficient. *Id.* Even so, Alabama's evidence of the dangers of cross-sex hormones and puberty blockers was legion.

Alabama provided declarations from six medical experts three endocrinologists (including two pediatric endocrinologists), a clinical psychologist, a psychotherapist, and a pediatrician—who testified to the acute dangers posed to children by these medications. Alabama also submitted six journal articles and public-health reports that documented concerning data and evidence about the proscribed treatments. And Alabama provided written testimony from detransitioners, including Sydney Wright (discussed above), KathyGrace Duncan (Appendix A), Carol Frietas (Appendix B), and Corinna Cohn (Appendix C). Although the district court's order discussed the testimony of Dr. James Cantor and Sydney Wright, the district court never mentioned any of the other evidence described in this paragraph. *See Eknes-Tucker I*, 603 F. Supp. 3d at 1142–43, 1145–46.

Alabama also presented evidence that healthcare authorities and medical organizations in several countries—including England, Finland, and Sweden—urge (and, in some cases, mandate) that doctors rarely prescribe puberty blockers and cross-sex hormones. In Sweden, for example, doctors can provide minors with puberty blockers and cross-sex hormones in "exceptional cases" only. Sweden's National Board of Health and Welfare determined that "the risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits."

The information that has emerged since the panel's opinion only confirms what the panel already concluded: Alabama has a rational basis for the Act. As discussed earlier, in March 2024, for example, England's NHS announced "that there is not enough evidence to support the safety or clinical effectiveness of [puberty suppressing hormones] to make the treatment routinely available" in England. NHS Clinical Policy, *supra* n.3, at 3. And, in April 2024, Dr. Hillary Cass published the results of a four-year review of puberty blockers and cross-sex hormones in minors. *See* The Cass Review, *supra* n.2. While formulating her report, Cass chaired a policy working group that the NHS commissioned in January 2020. *Id.* at 75. The policy working group systematically examined "the published evidence on the use of puberty blockers and [cross-sex] hormones in children and young people" with the goal of "inform[ing] [NHS's] policy position on their future use." *Id.* Cass found "no evidence that puberty blockers improve body image or dysphoria, and very limited evidence for positive mental health outcomes." *Id.* at 179. Cass also concluded that puberty blockers may negatively impact "neurocognitive development" and will likely compromise a patient's "bone density." *Id.* at

178. Regarding cross-sex hormones, Cass's "systematic review" found inadequate evidence supporting the "widespread" view—expressed in Judge Rosenbaum's dissent—that cross-sex hormones "reduce[] suicide risk" for children suffering from gender dysphoria. *Id.* at 186, 195. Cass also provided multiple reasons to question the reliability of WPATH and concluded that the most recent iteration of the Standards of Care "overstates the strength of the evidence" supporting its recommendations. *Id.* at 132; *see also id.* at 129–30 (concluding that WPATH's Standards suffer from a low "[r]igour of development" and the lack of "[e]ditorial independence," among other things).

Second, Alabama had a rational basis to prohibit cross-sex hormones and the other proscribed medications for minors because minors cannot appreciate the life-altering nature of the medical treatments. The law frequently limits the ability of minors to consent to certain activities. And evidence in the record suggests that minors are incapable of knowingly consenting to the use of the proscribed medications. Alabama presented evidence from many detransitioners who uniformly testified that they were not aware of the long-term impacts of the treatments they underwent. Next, Alabama provided declarations from several parents who testified to the negative effects of cross-sex hormones and puberty blockers on their children, even if their children suffered from gender dysphoria and desired medical transition. Furthermore, Alabama presented written testimony from nine parents who said that doctors, therapists, and other practitioners pressured them to start their children on cross-sex hormones and puberty blockers or otherwise circumvented their wishes. For example, when one mother's twelve-year-old daughter said that she was a boy, the mother asked her daughter's gender clinic for a

counseling referral before hormone therapy. But an endocrinologist rebuffed the mother's request, stating in front of the twelve-year-old daughter that the mother needed "to get on board" with providing puberty blockers and hormones if she did not "want [her] daughter to commit suicide."

This record evidence is consistent with information that has come to light after the district court issued its order. As Dr. Cass found in her April 2024 study, we know very little about the longterm risks of these medications, which makes the idea of "informed consent" nearly impossible for anyone, but especially for children and adolescents. *See* The Cass Review, *supra* n.2, at 193–97.

Third, as discussed above, studies show that most children with gender dysphoria grow out of it. As one of Alabama's experts testified, "every study without exception has come to the identical conclusion: Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty—ranging from 61–88% desistance across the large, prospective studies." Alabama also presented evidence that children are starting to identify as transgender because of social contagion, not gender dysphoria. Teenage girls, in particular, are starting to suddenly identify as transgender even if they have no history of gender dysphoria as children. And, according to one of Alabama's experts, "[t]he majority of cases appear to occur within clusters of peers and in association with increased social media use and especially among people with autism or other neurodevelopmental or mental health issues." Even the Plaintiffs' expert, Dr. Linda Hawkins, testified that gender clinics are "seeing an increase in youth . . . who are exploring gender . . . . [T]hat is something that is

gaining popularity right now." Alabama has a legitimate interest in preventing harm to children who often do not suffer from gender dysphoria, and even if they do, likely will grow out of it. It is thus rational to require children to wait to undergo this type of medical treatment until they are adults.

Fourth, notwithstanding assurances from organizations like WPATH, there are significant unknowns about these treatments, which recent developments only serve to highlight. The district court's order relied on WPATH's Standards of Care, *Eknes-Tucker I*, 603 F. Supp. 3d at 1138–39, which claim to provide "the highest standards" for "safe," "effective," and "evidence-based" treatment for people suffering from gender dysphoria. Judge Rosenbaum also suggests that courts should look to WPATH's Standards of Care for narrow tailoring purposes. Rosenbaum Dis. Op. at 44. But a March 2024 leak of documents and audio recordings suggests that WPATH is not genuine in its claim that these treatments are safe, effective, and well understood, particularly for minors. *See* The WPATH Files, *supra* n.4, at 72–241.

For instance, in a leaked recording of a WPATH Panel, Dr. Daniel Metzger—an endocrinologist—frankly discussed the difficulties of helping children and adolescents understand the effects of cross-sex hormones and puberty blockers. *Id.* at 184–85. He acknowledged, "the thing you have to remember about kids is that we're often explaining these sorts of things to people who haven't even had biology in high school yet." *Id.* at 184. Later at the same panel, he said, "it's always a good theory that you talk about fertility preservation with a 14 year old, but I know I'm talking to a blank wall." *Id.* at 192. Another provider at the same panel discussed the difficulty in helping nine-, ten-, and

eleven-year-olds understand the long-term effects of puberty blockers on their fertility. *Id.* at 193. "I'm definitely a little stumped," she admitted. *Id.*

In one of the leaked documents, Dr. Marci Bowers—a gynecological surgeon and WPATH's President—states: "[A]cknowledgement that de-transition exists to even a minor extent is considered off limits for many in our community." *Id.* at 111. Bowers agreed with this practice, continuing, "I do see talk of the [detransition] phenomenon as distracting from the many challenges we face." *Id.* These recent revelations only further confirm the unsettled nature of this field, the risks involved for Alabama's youth, and the need for judicial caution.

Finally, it is rational for Alabama to conclude that there are alternatives to childhood use of cross-sex hormones and puberty blockers. Although the suicide rate is high in the transgender community, Dr. Cass's April 2024 study concluded that "there is no evidence that gender-affirmative treatments reduce [suicidality.]" *See* The Cass Review, *supra* n.2, at 195. The report continued that the available evidence "suggests that these deaths are related to a range of other complex psychosocial factors and to mental illness." *Id.* Alabama could rationally conclude that suicidality—which is a mental-health problem—should be treated with counseling, medication, and other forms of psychotherapy.

Comparatively, none of the studies that Judge Rosenbaum's dissent relies on provide a solid basis for her claim that "studies have repeatedly shown that gender-affirming hormone therapy markedly decreases suicidality and depression among transgender minors who want such care." Rosenbaum Dis. Op. at 41 n.22. Start with the Tordoff study. Judge Rosenbaum claims that puberty blockers and "gender-affirming" hormones

led to a "60% decrease in depression" and a "73% decrease in suicidality." *Id; see* Diana M. Tordoff, et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 J. Am. Med. Ass'n Network Open 1, (2022). But this is misleading, as almost all the participants who did not take puberty blockers or cross-sex hormones dropped out of the study before its conclusion, weakening any potential conclusions. Tordoff, et al., *Mental Health Outcomes*, 5 J. Am. Med. Ass'n Network Open at at 1; Tordoff, et al., *Mental Health Outcomes*, Supplemental Online Content, eTable 2, eTable 3.

Next is the Green study. Judge Rosenbaum claims that this study demonstrates a "40% decrease in depression and suicidality." Rosenbaum Dis. Op. at 41 n.22. It is true that the study represented that receipt of hormone therapy was associated with lowered odds of recent depression and the serious consideration of suicide in the past year. Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide* Among *Transgender and Nonbinary Youth*, 70 J. of Adolescent Health 643, 647 (2022). But significantly, the authors also noted that, because of the study's cross-sectional design, "causation [could not] be inferred." *Id.* at 648.

Judge Rosenbaum next relies on the Turban study, which she claims demonstrates a "statistically significant decrease in suicidal ideation." Rosenbaum Dis. Op. at 41 n.22; *see* Jack L. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 Pediatrics 1, 5–6 (2020). This study pulled data from the 2015 US Transgender Survey, but out of the 3,494 participants in the study, only 89 reported that they received puberty blockers. *Id.* at 3–4. The authors reported that "[t]reatment with pubertal suppression

among those who wanted it was associated with lower odds of lifetime suicidal ideation when compared with those who wanted pubertal suppression but did not receive it." *Id.* at 5. But near the end of their paper, the authors admit that the design of their study "does not allow for determination of causation." *Id.* at 7. Further, as detailed in a review of the study, there are good reasons to question the data set used by the authors, for it "included older respondents who, in fact, had no opportunity to obtain these drugs and so cannot be used for comparison." Michael Biggs, *Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria*, 49 Archives of Sexual Behav. 2227, 2228 (2020). The Turban study also fails to control for preexisting psychological problems. In order to provide true insight, the study would need to measure "the respondent's psychological problems before [the puberty blockers were] prescribed or withheld." *Id.* (emphasis omitted). Without this information, "a negative association found many years after treatment is compatible with three scenarios: puberty blockers reduced suicidal ideation; puberty blockers had no effect on suicidal ideation; [or] puberty blockers increased suicidal ideation, albeit not enough to counteract the initial negative effect of psychological problems on eligibility." *Id.* And finally, England's National Institute for Health and Care Excellence excluded the Turban study from its evidence report because the data for puberty blockers was "not reported separately from other interventions." Therefore, the Turban study, as with the others already discussed, provides no probative causal connection between suicidality and the use of puberty blockers.

Finally, Judge Rosenbaum turns to the Allen study, which she claims documents a "75% decrease in suicidality." Rosenbaum Dissenting Op at 41 n.22; *see* Luke Allen et al., *Well-being and Suicidality Among*

Transgender Youth after Gender-affirming Hormones, 7 Clinical Practice in Pediatric Psychology 302, 306 (2019). But like the other studies, the Allen study's authors could not conclude that the hormone treatments were "causally responsible for the beneficial outcomes observed," because, in this case, the study lacked a control group. *Id.* at 309. The authors also did not screen for whether the patient was actively receiving psychotherapy, which further weakens any inference of causation. *See id.* at 308.

In all, none of these studies provides real support for Judge Rosenbaum's discussion of the supposed benefits of cross-sex hormones and puberty blockers. Nor do they undermine Cass's four-year independent review of the available evidence, which concluded that "there is *no evidence* that gender-affirmative treatments reduce [suicidality.]" *See* The Cass Review, *supra* n.2, at 195 (emphasis added). All of this underscores that this is an issue for the political branches, not the judicial branch.

Ultimately, the Alabama legislature is entitled to review all the available evidence and decide whether to circumscribe cross-sex hormone and puberty blocking medications for the purposes set forth in the Act. On rational-basis review, our role is not "to judge the wisdom, fairness, or logic of [that] legislative choice[]." *Beach Commc'ns*, 508 U.S. at 313. Our role is to simply ask whether there is a "conceivable basis" for Alabama's law. *Id.* at 315. Under this lenient standard, the existing evidence overwhelmingly suggests that Alabama has a rational basis for the Act. Our panel opinion correctly determined that the Act likely satisfies rational-basis scrutiny.

III. CONCLUSION

Alabama enacted an entirely rational law. The Fourteenth Amendment, as informed by text, history, tradition, and our precedents, does not prevent Alabama from doing so. Instead of acting as a "super-legislature," *Day-Brite Lighting Inc. v. Missouri*, 342 U.S. 421, 423 (1952), our Court has correctly allowed Alabama to "safeguard[] the physical and psychological well-being" of its minors, *Globe Newspaper Co.*, 457 U.S. at 607. I therefore concur in the decision to deny rehearing en banc.

Appendix A: KathyGrace Duncan[20]

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction.

2. Alabama's Vulnerable Child Compassion and Protection Act ("VCCAP") is a necessary, potentially life-saving law that will protect vulnerable children and their parents from the heartbreaking regret, irreversible physical changes, sexual dysfunction and emotional pain that I have experienced after undertaking medical and surgical interventions aimed at "transitioning" me from a female to a "male."

3. From a very young age, I was what is called today "gender non-conforming." I preferred male clothing, I thought I was a "boy" and I wanted to live as one.

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[20] The following appendices are reproductions of written declarations submitted by Alabama.

4. I grew up in a dysfunctional family in which my mother was often the victim of my father's emotional and verbal abuse. As a result I internalized the message that "my dad would love me if I were a boy."

5. Sexual abuse by a family member between the ages of 10 and 12 further convinced me that being a girl meant being unsafe and unlovable.

6. In sixth grade, I learned about female to male transsexuals. I believed that my distress was caused by not having the "right" body and the only way to live a normal life was to medically transition and become a heterosexual male.

7. At age 19, I began living as a man named Keith and went to a therapist who formally diagnosed me with gender dysphoria. I began testosterone and a year later had a mastectomy. At the time, I believed it was necessary so that what I saw in the mirror matched what I felt on the inside.

8. I never viewed my condition as touching on mental health issues, and neither did the therapist who diagnosed me. The question of whether my self-perception and desire to transition was related to [my] mental health issues was never explored.

9. After 11 years passing as a man and living what I thought was a relatively "happy" and stable life (which included having a number of girlfriends), I realized that I was living a lie built upon years of repressed pain and abuse. Hormones and surgery had not helped me resolve underlying issues of rejection, abuse, and sexual assault. I came to understand that my desire to live as a man was a symptom of deeper unmet needs.

10. With the help of life coaches and a supportive community, I returned to my female identity and began addressing the underlying issues that had been hidden in my attempt to live as a man. I experienced depression that I had repressed for years and grieved over the irreversible changes to my body.

11. If someone had walked with me through my feelings instead of affirming my desire to transition, then I would have been able to address my issues more effectively and not spend so many years making and recovering from a grave mistake.

12. Alabama's VCCAP Act is necessary and essential because it will give children and adolescents a chance to walk through their feelings and address their underlying issues effectively without being pulled onto the affirmation conveyor belt. Hormones and surgery are irreversible decisions that children and adolescents are incapable of making.

Appendix B: Carol Frietas

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction.

2. Alabama's Vulnerable Child Compassion and Protection Act ("VCCAP") is a necessary, potentially life-saving law that will protect vulnerable children and their parents from the heartbreaking regret, irreversible physical changes, and emotional pain that I have experienced after undertaking medical and surgical interventions aimed at "transitioning" me from a female to a "male."

3. As a youth, I was what today is called "gender non-conforming," but I lived in a household where gender expression was strictly aligned with cultural stereotypes. I was not allowed to wear boys' clothes or play boys' sports.

4. At puberty I realized I was same-sex attracted with crushes on girls. I became depressed and anxiety-ridden as I feared what "being gay" might mean to how I lived my life and my family relationships. I dropped out of school.

5. At age 20, I began to meet other LGBT youth and my life stabilized. However, I also learned that many masculine females, like me, felt that they were "born in the wrong body" and were transitioning, so I adopted that persona.

6. I went to a gender therapist who diagnosed me with gender dysphoria and told me that transition was the only treatment that would alleviate my discomfort and anxiety.

7. However, at that time there were gatekeeping standards for gender transition, which required that I first live as man for six months, including using a male name, showing a male appearance, and using male spaces. I had very large breasts and could not pass for a male in male spaces, so I did not pursue testosterone at that time. I viewed myself as a male trapped in the "wrong body," but my mental health otherwise was stable.

8. In 2014, I revisited the idea of transitioning, believing it would make me feel better because I was undergoing trauma in various forms. My grandmother who had practically raised me died. I had suffered severe abuse and neglect in childhood, and in retrospect believe I was experiencing symptoms of PTSD from

that. I had just become a new mother a couple of months before my brother-in-law committed suicide.

9. I spiraled downward and wanted out. I couldn't commit suicide because I was a mother, so I returned to the idea of transition, believing it would help me feel better. By that time the requirements for testosterone had lessened. I went to Planned Parenthood for testosterone and was given it right away, with no information. I was not given any information on uterine atrophy, vaginal atrophy, or other effects of testosterone and the staff did not talk about any of my emotional or mental health issues.

10. Four months after starting testosterone, I went to a plastic surgeon for a mastectomy. I needed a letter from a therapist and received one from the therapist who had affirmed me and originally recommended transition. As was true with testosterone, I was not given any information about the procedure. Instead I had a consultation with the surgeon, who said "this is what we are going to do," drew on my chest, took pictures and asked me what I wanted out of the surgery. He said "we'll create a masculine looking chest, you'll look great."

11. During the first four months on testosterone menstruation stopped, my sex drive went way up, my voice deepened, and facial and body hair came in. As I continued on testosterone, my personality changed drastically and my verbal abilities declined. Testosterone lowered and muted my emotions and empathy, but also gave me a lot of energy and a sense of a high. My depression and anxiety worsened to the point that I was having such severe panic attacks that I could not leave home. I told my doctors that I thought the testosterone was making the anxiety worse, but they said no.

12. I went to a psychiatrist . . . specifically to deal with the depression and I was provided with an anti-depressant that really worked. I felt mentally stable and able to address the trauma that led me to transition.

13. Within a month of starting the anti-depressant, I realized that I had not needed to transition. It was the biggest mistake I had ever made. I did not detransition for a year because I couldn't believe that it was so easy, *i.e.*, that anti-depressants alleviated my depression and enabled me to think clearly and reason better. This allowed me [to] address my internalized homophobia and childhood abuse through therapeutic means.

14. Meanwhile, my health began going downhill. Before going on testosterone, I had no health problems. After being on it for four years, I was pre-diabetic, had high cholesterol, and had a high red blood cell count to the point that doctors were recommending that I donate blood to reduce the volume.

15. I stopped taking testosterone and four months later my blood work was back down to normal. I thought to myself "How do they [doctors] not know about this?" Going off testosterone allowed me to finally sleep. I felt like I never slept all the time that I was taking testosterone. Going off testosterone also helped with empathy and other emotions. My personal relationships, including my relationship with my wife, were better.

16. I believe that healthcare providers did not ask me about mental health issues because they believed that those issues were caused by gender dysphoria and that transitioning would fix the problem. In fact, the opposite was true.

17. I would have been spared physical, psychological, and emotional losses if I had received a proper diagnosis and treatment for PTSD and depression before undergoing years of medical and surgical interventions. Alabama's VCCAP Act is necessary and essential because it will give children and adolescents the chance to work through and address their underlying issues such as depression or PTSD effectively without being pulled onto the affirmation conveyor belt. Hormones and surgery are irreversible decisions that children and adolescents are incapable of making.

Appendix C: Corinna Cohn

My name is Corinna Cohn. I am over the age of 19, I am qualified to give this declaration, and I have personal knowledge of the matters set forth herein.

In or about 2nd grade, I saw a psychologist for problems related to being bullied and emotional regulation. After less than a year, my parents chose to discontinue therapy. I continued to be bullied and had problems forming friendships. Other boys excluded me from social activities. Later in elementary school I began to pray to be made into a girl, which I thought would allow me to fit in better. This became a fixation for me.

In high school, I confessed to my parents that I wanted to become a woman. They brought me to see the same psychologist I'd had as a child, and she diagnosed me with having gender identity disorder. Upon receiving my diagnosis, my parents again chose to discontinue my therapy. I continued to have problems socializing at school and experienced depression and anxiety on a daily basis.

At the age of 17, I gained access to the Internet. This was prior to the popularization of the World Wide Web, but I was able to use message boards . . . in order to find other members of what today would be called the "trans community." Adult transgender women befriended me, supplied me with validation and support, and provided information on how I could transition to become a transgender woman.

At the age of 18, I resumed my sessions with my psychologist with the goal of receiving a prescription for cross-sex hormones and eventual sex reassignment surgery. Due to my prior relationship with my psychologist, I was able to gain a letter of recommendation to an endocrinologist and was prescribed estrogen. The endocrinologist was referred to me by transgender friends on the Internet. I began living as a woman and had my legal identification updated to reflect my chosen name.

I had sex reassignment surgery in Neenah, Wisconsin in 1994. I was only 19 years old. Securing the appointment required letters from two therapists along with a letter from my endocrinologist. My surgeon told me I was the second-youngest patient he had operated on. The surgery involved the removal of my testicles, penectomy, and vaginoplasty. It was successful and without complication.

After healing from my sex change surgery I thought that my transition journey was over. I discontinued therapy, and I began focusing on my career. I found it was easier to socialize and make new friends with my new confidence and feelings of being my authentic self. As I reached my late twenties, my friends began pairing off and starting families. I discovered that it was very difficult to find a partner who wanted to do the same with me.

Although I was in denial for several years, I eventually realized that my depression and anxiety related to my gender identity had not resolved. It was not unusual for me to spend entire weekends in my room crying and entertaining thoughts of suicide.

In my mid-thirties I became interested in radical feminism. I am not a feminist, nor have I ever been, but I wanted to reconcile how feminist concepts applied to people like myself: males who try to turn ourselves into women. One of the concepts I found pivotal was the feminist criticism of biological essentialism, which challenges the idea that men and women are destined to fulfill rigid sex roles. Once I understood this criticism I realized that my more stereotypically feminine attitudes and behaviors did not therefore make me a woman, but rather a feminine man. In retrospect, my self-perception of being a woman also required that I overlook or discount traits that are more stereotypically masculine. Although it took time for this realization to fully sink in, a side effect was that I stopped having bouts of depression and anxiety related to my gender identity. I have not had any depressive episodes related to gender identity in ten years. As a teenager I was unprepared to understand the consequences of my decision to medicalize my transition despite the rigorous controls that were in place to ensure that patients would not be harmed from gender affirming care.

. . .

I wish I could persuade other boys who wish to become women that the changes they seek are only superficial. Hormones and surgery are unable to reveal an authentic self, and anyone who promises otherwise is, in my opinion, deliberately misleading young people to follow a one-way track to a lifetime of

medicalization. Although some people may choose to transition, and may even enjoy a higher quality of life, there is no reason why this irreversible decision needs to be made in adolescence. Adults who advocate for adolescent transition do so without understanding what tradeoffs early transition entails, which includes the loss of fertility, the likelihood of sexual dysfunction, and the likelihood of surgical complication inflicted at an early age from elective procedures. Unfortunately, I do understand some of these tradeoffs

WILSON, Circuit Judge, dissenting from the denial of rehearing en banc, joined by JORDAN, Circuit Judge:

This case presents numerous questions "of exceptional importance" worthy of en banc review. Fed. R. App. P. 35(a)(2). Seeing that this case implicates the contours of substantive due process, fundamental rights, and equal protection, it is difficult to envision issues of greater importance.

I. Substantive Due Process

The divergent descriptions of the fundamental right at issue and disagreement over whether substantive due process protects that right demonstrate a need for rehearing en banc.

The district court relied on the Supreme Court's decision in *Troxel v. Granville*, among others, which recognized the fundamental right of parents to "make decisions concerning the care, custody, and control of their children." 530 U.S. 57, 66 (2000) (plurality opinion); *see also Pierce v. Soc'y of the Sisters of the Holy Names of Jesus and Mary*, 268 U.S. 510, 534–35 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923). The district court then determined that this recognized fundamental right *includes* the "right to treat [one's] children with transitioning medications subject to medically accepted standards." *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1144 (N.D. Ala. 2022). Judge Rosenbaum takes a parallel approach in her dissent from denial of rehearing. She identifies the fundamental right at issue as one that sits within *Parham v. J.R.*'s more general fundamental right. *See* 442 U.S. 584, 602 (1979). However, her articulation is more specific; she describes the fundamental right at issue as the "right to direct that [one's] child receive well-established, evidence-based, non-experimental

medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment." Rosenbaum Dissent at 1. Meanwhile, Judge Jordan broadly describes the fundamental right as "the right of parents to obtain medically-approved treatment for their children." Jordan Dissent at 22. In contrast, the panel describes the fundamental right at issue as *only* "the right to treat [one's] children with transitioning medications subject to medically accepted standards," which it views as separate and distinct from the fundamental right to "make decisions concerning the 'upbringing' and 'care, custody, and control' of one's children." *Eknes-Tucker v. Governor of Alabama,* 80 F.4th 1205, 1224 (11th Cir. 2023). All four opinions articulate the fundamental right at issue with varying degrees of specificity. Rehearing en banc would have provided us with an opportunity to clarify the fundamental right at issue and the protections guaranteed by the Due Process Clause.[1]

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[1] Incidentally, I note several inconsistencies in Judge Lagoa's Statement. For one, the Statement discusses the facts and introduces new factual material. See Judge Lagoa's Statement at 4–6, 29–31, 44, 48–49. We must respect the district court as the finder of fact. *See Gonzalez v. Governor of Georgia*, 978 F.3d 1266, 1270 (11th Cir. 2020). Neither the panel nor Judge Lagoa can reevaluate factual determinations or consider materials not before us, as the Statement does. *See also* Rosenbaum Dissent at 8 n.7. Further, I struggle with Judge Lagoa's discussion of medical findings, given her pronouncement that "[n]either an unelected district judge nor unelected circuit judge should resolve" policy questions informed by scientific, philosophical, and moral considerations. If this case presents policy questions that courts are ill-suited to resolve, a statement for denial of rehearing en banc is not the place for credibility determinations regarding evidence.

II. Equal Protection

Like Judge Rosenbaum, I am also concerned with the panel's equal protection analysis—particularly its quick and improper dismissal of *Bostock* and *Brumby*. The panel concludes that because *Bostock* and *Brumby* involved gender stereotyping in the context of employment discrimination, their holdings are irrelevant here. I am not so sure.

In *Brumby*, we explained that "[a] person is defined as transgender precisely because of the perception that his or her behavior transgresses gender stereotypes," and accordingly held that "discrimination against a transgender individual because of her gender-noncomformity is sex discrimination." *Glenn v. Brumby*, 663 F.3d 1312, 1316–17 (11th Cir. 2011). Our analysis drew from "foundational cases" in which the Supreme Court "concluded that discriminatory state action could not stand on the basis of gender stereotypes." *Id.* at 1319. But these cases were not limited to the employment context and included examples of gender stereotyping in the provision of social security benefits, military benefits, education, and child support payments. *Id.* at 1319–20. The same is true of *Bostock*, which held that "discrimination based on . . . transgender status necessarily entails discrimination based on sex." *Bostock v. Clayton Cnty.*, 590 U.S. 644, 669 (2020). In reaching this holding, the Supreme Court also relied on precedent describing instances of discrimination more broadly. *See id.* at 677–78. The panel looks only to *Bostock* and *Brumby*'s employment outcome, rather than drawing from the underlying reasoning in each case to determine when gender and sex stereotyping

rises to the level of a constitutional violation.[2] *See Fowler v. Stitt*, 104 F.4th 770, 790 (10th Cir. 2024) ("Although that was the only question the Supreme Court decided, the Court did not indicate that its logic concerning the intertwined nature of transgender status and sex was confined to Title VII.").

Judge Brasher's concurrence, in which he states that the Act does not contain a sex classification, is also indicative of the need for en banc review. *Eknes-Tucker*, 80 F.4th at 1233 (Brasher, J., concurring). The Act is aimed at addressing the treatment of minors who experience "a discordance between the individual's sex and sense of identity." Ala. Code § 26-26-2(16). The word "sex" is not only, as Judge Brasher concedes, riddled throughout the Act, it is used to separate minors who experience a "discordance" between their birth-assigned sex and gender identity from those who do not experience such a "discordance." This seems like a sex-based classification.[3]

The Act as it stands now shapes the way parents of transgender children may care for their children,

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[2] *See, e.g.*, *Price Waterhouse v. Hopkins*, 490 U.S. 228, 251 (1989) (explaining that gender stereotyping can play a role in gender-based discrimination); *City of L.A., Dep't of Water and Power v. Manhart*, 435 U.S. 702, 709–10 (1978) (stating that employment practices which classify people based on sex often "preserve traditional assumptions about groups rather than thoughtful scrutiny of individuals"); *Stanton v. Stanton*, 421 U.S. 7, 14–15 (1975) (finding that "'old notions'" of the traditional roles of men and women did not support Utah's sex-based classification of child support payments).

[3] *See Kadel v. Folwell*, 100 F.4th 122, 146 (4th Cir. 2024) (en banc) ("[G]ender dysphoria is so intimately related to transgender status as to be virtually indistinguishable from it. The excluded treatments aim at addressing incongruity between sex assigned at birth and gender identity, the very heart of transgender status.").

while parents of cisgender children remain unaffected. Should a parent of a child be prevented from seeking medical care *because of* the sex of their child? *See Stanton*, 421 U.S. at 14–15 ("A child, male or female, is still a child."). Reading the Act as though it does not distinguish and classify minors will only lead to future confusion and contradictory results in the interpretation of similar state statutes across the circuit.

* * *

For these reasons, it is difficult to envision issues of greater importance than those presented here. We should have reheard this case en banc. Accordingly, I respectfully dissent from our refusal to do so.

JORDAN, Circuit Judge, joined by ROSENBAUM and JILL PRYOR, Circuit Judges, dissenting from the denial of rehearing en banc.

Substantive due process is hard. Acknowledging the complexity of the doctrine, I write to discuss what I perceive to be some analytical flaws in the panel's opinion.

I

In this case, the panel characterized the liberty interest in part by asking whether there is a history of recorded uses of transitioning medications for transgender individuals (e.g., puberty blockers and cross-sex hormone treatments) as of 1868, when the Fourteenth Amendment was ratified. Finding no such history, the panel concluded that there is no fundamental right for parents to treat their children with such medications. *See Eknes-Tucker v. Governor of Alabama*, 80 F.4th 1205, 1220–21, 1224 (11th Cir. 2023).

The panel's decision necessarily means that the fundamental right of parents to obtain medical treatment for their children extends only to procedures and medications that existed in 1868, and not to modern advances like the polio vaccine (developed in the 1950s), cardiac surgery (first performed in 1893), organ transplants (first successfully completed in 1954), and treatments for cancer like radiation (first used in 1899) and chemotherapy (which started in the 1940s). *See* Judge Rosenbaum Dissent at Part II.A.2. There is admittedly some support in our cases for the panel's approach, *see Morrissey v. United States*, 871 F.3d 1260, 1269–70 (11th Cir. 2017) (holding that a man does not have a substantive due process right to procreate through in-vitro fertilization because that technology was only successfully developed in the

1970s), but that analysis is too simple and ignores many Supreme Court cases that define fundamental rights at a much more general level without requiring established and precise historical pedigrees. *Cf. Obergefell v. Hodges*, 576 U.S. 644, 664 (2015) ("The generations that wrote and ratified the Bill of Rights and the Fourteenth Amendment did not presume to know the extent of freedom in all of its dimensions, and so they entrusted to future generations a charter protecting the right of all persons to enjoy liberty as we learn its meaning."); *Home Bldg. & Loan Ass'n v. Blaisdell*, 290 U.S. 398, 442–43 (1934) ("It is no answer to say that this public need was not apprehended a century ago, or to insist that what the provision of the Constitution meant to the vision of that day it must mean to the vision of our time. If by the statement that what the Constitution meant at the time of its adoption it means today, it is intended to say that the great clauses of the Constitution must be confined to the interpretation of the framers, with the conditions and outlook of their time, would have placed upon them, the statement carries its own refutation. It was to guard against such a narrow conception that Chief Justice Marshall uttered the memorable warning: 'We must never forget, that it is a constitution we are expounding[.]'") (internal citations and quotations omitted).

Some have said that in constitutional law the "[l]evel of generality is everything[.]" *L.W. v. Skrmetti*, 83 F.4th 460, 475 (6th Cir. 2023), *cert. granted*, --- S.Ct. ----, 2024 WL 3089532 (2024). Even if it is not everything, the level of generality is very important and often determinative. In my view, the panel asked the wrong question by defining the asserted right in too granular a way, and as a result reached the wrong answer. *Cf. Ala. Legis. Black Caucus v. Alabama*, 575

U.S. 254, 279 (2015) ("Asking the wrong question may well have led to the wrong answer."). In the pages that follow, I try to explain why.

II

When it comes to challenges to legislation, the substantive component of the Due Process Clause "protects those fundamental rights and liberties which are, objectively, deeply rooted in this Nation's history and tradition, . . . and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed[.]" *Washington v. Glucksberg*, 521 U.S. 702, 720– 21 (1997) (citations and internal quotation marks omitted). But substantive due process also sometimes protects against abusive executive action. In that context the question is whether the conduct at issue constitutes an "abuse of power . . . which shocks the conscience." *County of Sacramento v. Lewis*, 523 U.S. 833, 846 (1998).

The panel here in part relied on the substantive due process aspect of our decision in *Bendiburg v. Dempsey*, 909 F.2d 463, 468 (11th Cir. 1990), calling it the "most relevant" Eleventh Circuit precedent dealing with "parents' liberty interest to control the upbringing of their children." *Eknes-Tucker*, 80 F.4th at 1223. I think the panel incorrectly characterized *Bendiburg* and mistakenly viewed it as the "most relevant" of our cases.

In *Bendiburg*, a father asserted a substantive due process claim based on the involuntary insertion of a certain catheter on his son by private parties allegedly acting in concert with state officials. The district court in *Bendiburg* characterized the substantive due process claim as one alleging abusive *executive* action, and rejected it: "The most widely accepted view is that

substantive due process is violated by government conduct that 'shocks the conscience' or when the government engages in action 'which offends those canons of decency and fairness which express the notions of justice of English speaking peoples.' The question before the court is thus whether the evidence of record suggests state conduct that was so shocking or egregious as to give rise to a claim for damages under the concept of substantive due process. The court finds that it does not." *Bendiburg v. Dempsey*, 707 F. Supp. 1318, 1324 (N.D. Ga. 1989) (citations omitted).

On appeal, the *Bendiburg* panel affirmed the district court's decision and rejected the father's substantive due process claim. But it too viewed the claim as based on allegedly abusive executive action, and not as a challenge to enacted legislation. So it too applied the "shocks the conscience" standard in rejecting the father's claim, agreeing with the district court that the "circumvention of parental authority for a five day period [to install the catheter] did not rise to a level sufficiently egregious or shocking to sustain a substantive due process claim with respect to severance of the parent-child relationship." 909 F.2d at 468.[1]

The panel here should not have viewed *Bendiburg* as the "most relevant" of our cases. First, the "shocks the conscience" standard governs substantive due process claims based on abusive executive action, and not challenges to legislation like we have in this case.

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[1] That the district court and the panel in *Bendiburg* analyzed the case under the "shocks the conscience standard" is not surprising, as the full Eleventh Circuit had held just five years earlier that in the realm of abusive police (i.e., executive) conduct the relevant inquiry is whether the conduct "shocked the conscience." *See Gilmere v. City of Atlanta*, 774 F.2d 1495, 1500 (11th Cir. 1985) (en banc).

Second, we have explained that the "shocks the conscience" standard can apply even when there is no fundamental right at stake: "Where a fundamental liberty interest does not exist, substantive due process nonetheless protects against the arbitrary and oppressive exercise of government power. Executive action is arbitrary in a constitutional sense when it 'shocks the conscience.'" *Waldman v. Conway*, 871 F.3d 1283, 1292 (11th Cir. 2017) (citing *Lewis*, 523 U.S. at 845–46). Third, *Bendiburg* simply did not address whether a parent has a protected liberty interest to determine the medical care for his child, rendering it largely irrelevant for the purposes of the fundamental right analysis.

III

In cases involving substantive due process challenges to legislation, the Supreme Court has required a "careful description of the asserted fundamental liberty interest." *Glucksberg*, 521 U.S. at 721 (citation and internal quotation marks omitted). But "[t]his does not mean that [courts] must define the asserted right at the most specific level, thereby sapping it of a universal valence and moral force it might otherwise have. It means, simply, that we must pay close attention to the precise liberty interest the litigants have asked us to vindicate." *McDonald v. City of Chicago*, 561 U.S. 742, 882 (2010) (Stevens, J., dissenting) (footnote omitted). If we "narrow[ ] the asserted right [to the most specific level available]," we "'load[ ] the dice' against its recognition." *Id.* at 882 n.25. *See also* Geoffrey R. Stone, et al., Constitutional Law 919 (8th ed. 2018) ("If the tradition is defined very narrowly, the legislation at issue will almost always simply illustrate the tradition, thereby depriving the appeal to tradition of any power to check legislative

action. But if the tradition is defined very broadly, judges will be able to appeal to it to invalidate whatever legislation they choose to characterize as inconsistent with tradition.").

In *Michael H. v. Gerald D.*, 491 U.S. 110, 128 n.6 (1989), Justice Scalia, joined only by Chief Justice Rehnquist, advocated for an approach that focused on the "most specific level at which a relevant tradition protecting, or denying protection to, the asserted right can be identified." The other Justices in *Michael H.*, whether concurring in or dissenting from the judgment, either refused to join that aspect of Justice Scalia's plurality opinion or rejected it outright. *See id.* at 132 (O'Connor, J., joined by Kennedy, J., concurring in part); *id.* at 133 (Stevens, J., concurring in the judgment); *id.* at 138–40 (Brennan, J., joined by Marshall & Blackmun, JJ., dissenting). Justice Scalia's "most specific level" formulation is therefore not binding. And, as I will discuss, is not an accurate reflection of the Supreme Court's actual framing of fundamental rights.

The Supreme Court has described the rights of parents vis-à-vis their children generally. It has, for example, referred to those rights as "the fundamental right of parents to make decisions concerning the care, custody, and control of their children." *Troxel v. Granville*, 530 U.S. 57, 66 (2000) (plurality opinion of four Justices) (collecting cases of "extensive precedent" to highlight that "the fundamental right of parents to make decisions concerning the care, custody, and control of their children" is beyond doubt); *id.* at 77 (Souter, J., concurring in the judgment) ("[T]he right of parents to 'bring up children,' and 'to control the education of their own,' is protected by the Constitution.") (citations omitted). *See also Glucksberg*, 521 U.S. at

720 (referring to the right "to direct the education and upbringing of one's children"). This general framing is consistent with the Supreme Court's long-standing approach to defining the liberty interest at issue in other substantive due process cases. What's more, this approach holds even where the Supreme Court has found that the relevant liberty interest was not, in fact, fundamental.

Accordingly, I cite with confidence to the dissent of Justice Stevens in *McDonald*, 561 U.S. at 882, because what he said is demonstrably correct. Over the last 100 years, the Supreme Court has—in more substantive due process cases than not—described the liberty interest in general terms without limiting it to the very specific factual circumstances presented. If the interests in those cases had been defined at a very narrow and specific level—the approach the panel in this case followed—"many a decision would have reached a different result." *Michael H.*, 491 U.S. at 139–40 (Brennan, J., dissenting) (citing a number of illustrative cases). *See also id.* at 132 (O'Connor, J., concurring in part) ("On occasion the Court has characterized relevant traditions protecting asserted rights at levels of generality that might not be 'the most specific level available.'").

A

Let's now review some of the relevant substantive due process cases, starting with *Meyer v. Nebraska*, 262 U.S. 390 (1923), in which the Supreme Court vacated the conviction of an elementary school teacher at a parochial school in Nebraska for teaching the subject of reading in German to a 10-year-old student. The teacher had been convicted of violating a Nebraska law which (a) prohibited the teaching of any subjects in languages other than English, and (b)

allowed foreign languages to be taught as languages only to schoolchildren who had graduated from eighth grade. *See id.* at 396–97.

The Supreme Court held that the law—which the Nebraska Supreme Court had interpreted to apply only to so-called modern languages such as Spanish, French, German, and Italian—violated a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment. The Court concluded that the teacher's "right . . . to teach [German] and *the right of parents to engage him so to instruct their children* . . . are within the liberty of the [Fourteenth] [A]mendment." *Id.* at 400 (emphasis added). It came to this conclusion without examining the historical record to see if there was an enshrined practice and tradition in the United States in 1868 of teaching German to elementary school students.

Having identified a fundamental right, the Court in *Meyer* then turned to Nebraska's justification for the law. The Court thought it insufficient that "the purpose of the legislation was to promote civic development by inhibiting training and education of the immature in foreign tongues and ideals before they could learn English and acquire American ideals." *Id.* at 401. Though "the state may do much, go very far, indeed, in order to improve the quality of its citizens, physically, mentally and morally, . . . the individual has certain fundamental rights which must be respected. The protection of the Constitution extends to all, to those who speak other languages as well as to those born with English on the tongue. Perhaps it would be highly advantageous if all had ready understanding of our ordinary speech, but this cannot be coerced by methods which conflict with the Constitution—a desirable end cannot be promoted by prohibited means." *Id.* The law

was invalid because there was not a sufficient justification for its restrictions: "No emergency has arisen which renders knowledge by a child of some language other than English so clearly harmful as to justify its inhibition with the consequent infringement of rights long freely enjoyed. We are constrained to conclude that the statute as applied is arbitrary and without reasonable relation to any end within the competency of the state." *Id.* at 403.

Next is *Pierce v. Society of Sisters*, 268 U.S. 510 (1925). In that case the Supreme Court addressed the constitutionality of Oregon's compulsory education act, which required the attendance in public schools of all children aged 8–16 (save for some limited exceptions). The Society of Sisters, a Catholic corporation which in part operated religious elementary and high schools, and Hill Military Academy, which ran a private military academy, sued to enjoin the enforcement of the act as violative of the Due Process Clause of the Fourteenth Amendment. *See id.* at 530–33.

Applying *Meyer*, the Court held that the act violated a fundamental liberty interest of the Society of Sisters, of the Hill Military Academy, and of parents:

> Appellees are engaged in a kind of undertaking not inherently harmful, but long regarded as useful and meritorious. Certainly there is nothing in the present records to indicate that they have failed to discharge their obligations to patrons, students, or the state. And there are no peculiar circumstances or present emergencies which demand extraordinary measures relative to primary education. . . . [W]e think it entirely plain that the Act of 1922 unreasonably interferes with *the liberty of parents and guardians to direct*

> *the upbringing and education of children under their control*. As often heretofore pointed out, rights guaranteed by the Constitution may not be abridged by legislation which has no reasonable relation to some purpose within the competency of the state. The fundamental theory of liberty upon which all governments in this Union repose excludes any general power of the state to standardize its children by forcing them to accept instruction from public teachers only.

Id. at 534–35 (emphasis added).

As in *Meyer*, the Court in *Pierce* did not perform a laser-focused historical analysis to see if Catholic or private military schools were ingrained in the fabric of the Republic as of 1868. Indeed, had the Court engaged in such an analysis, it would have discovered that there was no accepted or ingrained practice of Catholic schools at the time the Fourteenth Amendment was ratified. To the contrary, although American Catholics in the 19th Century had "long maintained their own schools," they had to contend with anti-Catholic sentiment and discrimination and had to fight to protect their ability to maintain independent and sectarian religious schools. *See* Matthew Steilen, *Parental Rights and the State Regulation of Religious Schools*, 2009 B.Y.U. Educ. & L.J. 269, 318–30 (2009); Brandi Richardson, *Eradicating Blaine's Legacy of Hate: Removing the Barrier to State Funding of Religious Education*, 52 Cath. U. L. Rev. 1041, 1050–54 (2003); Joseph P. Viteritti, *Blaine's Wake: School Choice, the First Amendment, and State Constitutional Law*, 21 Harv. J.L. & Pub. Pol'y 657, 669 (1998). The Blaine Amendments to the United States Constitution (which failed) and to many state constitutions (which generally

passed) both before and after the ratification of the Fourteenth Amendment were generally meant to prevent government financial aid to Catholic schools. *See* Toby Heytens, *School Choice and State Constitutions*, 86 Va. L. Rev. 117, 137–38 (2000) ("The Blaine Amendments arose out of this historical context, and the conclusion that they were driven by the Protestant/Catholic divide is unmistakable, despite the fact that none of the amendments refer specifically to Roman Catholics or Catholic schools. This appears to be the scholarly consensus."). Had the Court in *Pierce* defined the right as that of a Catholic organization to run its own religious schools in place of otherwise compulsory public education, or to the right of parents to send their children to a Catholic school, it would not and could not have found a fundamental liberty interest, much less a substantive due process violation.

B

Lest anyone think that *Meyer* and *Price*—and their non-specific characterizations of the liberty interests at issue—are relics of a bygone era, there are modern substantive due process cases which engage in the same type of analysis and describe the right at issue in more general terms. I discuss four such cases as examples.

In *Loving v. Virginia*, 388 U.S. 1 (1967), the Supreme Court struck down, on equal protection and substantive due process grounds, a Virginia criminal law prohibiting inter-racial marriages. The Court's substantive due process analysis was short and to the point. Rather than asking whether inter-racial marriages were deeply rooted or ingrained in the fabric of the United States as of 1868, the Court focused more generally on whether marriage—regardless of the races of the spouses—is a fundamental right:

> These statutes also deprive the Lovings of liberty without due process of law in violation of the Due Process Clause of the Fourteenth Amendment. The freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness by free men. Marriage is one of the 'basic civil rights of man,' fundamental to our very existence and survival. To deny this fundamental freedom on so unsupportable a basis as the racial classifications embodied in these statutes, classifications so directly subversive of the principle of equality at the heart of the Fourteenth Amendment, is surely to deprive all the State's citizens of liberty without due process of law. The Fourteenth Amendment requires that the freedom of choice to marry not be restricted by invidious racial discriminations. Under our Constitution, the freedom to marry or not marry, a person of another race resides with the individual and cannot be infringed by the State.

Id. at 12 (citations omitted). Needless to say, *Loving* would have been decided differently if the right at issue had been framed specifically as of 1868, for "interracial marriage was illegal in most [s]tates in the 19th century[.]" *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 847–48 (1992) (plurality opinion).[2]

The Supreme Court conducted the same type of analysis in *O'Connor v. Donaldson*, 422 U.S. 563

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[2] I recognize that *Casey* has been overruled by *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022), insofar as abortion is concerned, but the quoted statement from *Casey* is historically unassailable. I discuss *Dobbs* later.

(1975), a substantive due process case involving the continued involuntary commitment of a person with mental illness who posed no harm to himself or others. The Court identified the fundamental right generally as the liberty interest of a person to not be confined against his will, and not specifically as the liberty interest of a harmless mentally ill person whom authorities had refused to release to be free of involuntary confinement. *See id.* at 575. After identifying the fundamental right at stake in general terms, the Court addressed and rejected the state's justifications for the continued confinement. *See id.* at 575– 76. It concluded that "a [s]tate cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." *Id.* at 576.

Another relevant case is *Lawrence v. Texas*, 539 U.S. 558 (2003), in which the Supreme Court set aside, on substantive due process grounds, the Texas criminal convictions of two adult gay men who had engaged in consensual sodomy in the privacy of the home. In so doing the Court overruled *Bowers v. Hardwick*, 478 U.S. 186 (1986), and said that *Bowers* had "misapprehended" the pertinent liberty interest as the "'fundamental right [of] homosexuals to engage in sodomy.'" *Lawrence*, 539 U.S. at 566–67 (quoting *Bowers*, 478 U.S. at 190). Instead, the proper framing of the issue was whether the "majority may use the power of the [s]tate to enforce [its] views [condemning homosexual conduct as immoral] on the whole society through operation of its criminal law." *Id.* at 571. The Texas statute was violative of substantive due process because it sought "to control a personal relationship that, whether or not entitled to formal recognition in the law, is within the liberty of persons to choose

without being punished as criminals." *Id.* Here is how the *Lawerence* Court—which notably relied on 20th-century developments and decisions by courts in other countries—summarized its holding:

> The case . . . involve[s] two adults who, with full and mutual consent from each other, engaged in sexual practices common to a homosexual lifestyle. The petitioners are entitled to respect for their private lives. The State cannot demean their existence or control their destiny by making their private sexual conduct a crime. Their right to liberty under the Due Process Clause gives them the full right to engage in their conduct without intervention of the government.

Id. at 578. Had the pertinent liberty interest in *Lawrence* been defined at a "very specific level" (as in *Bowers*), there is no way the case would have been decided the way it was. *See* William J. Rich, Modern Constitutional Law: Liberty and Equality § 11.7 (3d ed. 2011) ("In the sexual orientation context . . . a majority of the Justices resolved the doctrinal tension by defining the liberty interest in broad terms that included a right to private choices about sexual intimacy regardless of sexual orientation.").[3]

Then there is *Obergefell*, where the Supreme Court held that same-sex couples have a fundamental right, protected by substantive due process, to marry. The

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[3] One of the decisions *Lawrence* relied on was *Griswold v. Connecticut*, 381 U.S. 479 (1965). *See Lawrence*, 539 U.S. at 564–65. Commentators have noted that before *Griswold* "no specific, court-defined right to engage in private acts had existed[.]" 4 Ronald D. Rotunda & John E. Nowak, Treatise on Constitutional Law § 18:27 (5th ed. 2013 & 2023 supp.).

Court recognized that "[h]istory and tradition guide and discipline [the fundamental rights] in- quiry," but cautioned that they "do not set its outer boundaries.

That method respects our history and learns from it without allowing the past alone to rule the present." *Obergefell*, 576 U.S. at 664. The Court explained that the limitation of marriage to opposite-sex couples "may long have seemed natural and just, but its inconsistency with the central meaning of the right to marry is now manifest." *Id.* at 670–71. It also specifically addressed and rejected the argument that the liberty interest at issue had to be framed at a very different and specific level:

> Objecting that this does not reflect an appropriate framing of the issue, the respondents refer to . . . *Glucksberg*, 521 U.S. [at] 721, . . . which called for a "'careful description'" of fundamental rights. They assert the petitioners do not seek to exercise the right to marry but rather a new and nonexistent "right to same-sex marriage." *Glucksberg* did insist that liberty under the Due Process Clause must be defined in a most circumscribed manner, with central reference to specific historical practices. Yet while that approach may have been appropriate for the asserted right there involved (physician-assisted suicide), it is inconsistent with the approach this Court has used in discussing other fundamental rights, including marriage and intimacy. *Loving* did not ask about a "right to interracial marriage"; *Turner* did not ask about a "right of inmates to marry"; and *Zablocki* did not ask about a "right of fathers with unpaid child support duties to marry." Rather, each case inquired

> about the right to marry in its comprehensive sense, asking if there was a sufficient justification for excluding the relevant class from the right. That principle applies here. If rights were defined by who exercised them in the past, then received practices could serve as their own continued justification and new groups could not invoke rights once denied. This Court has rejected that approach, both with respect to the right to marry and the rights of gays and lesbians.

Id. at 671 (citations omitted and paragraph structure altered). Thus, the Court in *Obergefell* "focused on the individual right to marry" and not on the right of gay persons to marry. *See* Stone, et al., Constitutional Law, at 917.

C

In each of the cases discussed above, the Supreme Court did in fact find that there was a fundamental right. So, for the sake of completeness, I'll discuss two Supreme Court decisions in which the Court did *not* find a fundamental right and yet still defined the rights at issue generally rather than granularly, as done by the panel here.

I'll start with *Glucksberg*. In *Glucksberg*, the Supreme Court was called upon to determine whether a state may constitutionally ban and criminalize physician-assisted suicide. *See Glucksberg*, 521 U.S. at 707–08. Five physicians, three terminally ill patients, and a nonprofit organization sued the state of Washington, seeking a declaration that a state statute criminalizing the promotion of suicide—where a defendant "knowingly causes or aids another person to attempt suicide"—was facially unconstitutional. *See id.* at 707

(citing Wash. Rev. Code § 9A.36.060(1) (1994)). Before the Supreme Court, the physicians and the Ninth Circuit propounded various definitions of the liberty interest at stake, including a "liberty to choose how to die," "a right to die," and a "right to choose a humane, dignified death." *Id.* at 722 (internal quotations omitted). The Court in *Glucksberg* rejected those purported definitions as overly broad and instead held that the question was "whether the 'liberty' specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so." *Id.* at 723. It did not, however, define the right as "a right to commit suicide with another's assistance" via a legal dosage of morphine or other opioids, barbiturates, or benzodiazepines, (such as pentobarbital or secobarbital), or other cardiotoxic agents. Thus, even the more precise formulation in *Glucksberg* of the right at issue—a formulation later Supreme Court cases deemed "circumscribed," *see Obergefell*, 576 U.S. at 671—maintained a level of generality absent from the panel's opinion here.

The Court in *Glucksberg* then went on to address whether the right to suicide and its inherent right to assistance in doing so was deeply rooted in this nation's history, and held that it was not. *See* 521 U.S. at 723–28. The Court's analysis emphasized that what *was* ingrained into this nation's history was a traditional abhorrence of suicide—assisted or not—thus undercutting the idea that such a liberty interest could be deemed fundamental under the Due Process Clause. *See id.* But the Court did not look to 1868 to see what methods of suicide were then prevalent.

Let me next turn to *Dobbs*, the Supreme Court's most recent substantive due process decision. In *Dobbs*, the Court revisited the abortion question once

more. In overruling two of its decisions *Roe v. Wade*, 410 U.S. 113 (1973), and *Casey*—the Court reconsidered its previous decisions that the right to an abortion was a constitutionally protected fundamental right. *See Dobbs*, 597 U.S. at 231–33. It concluded that it was not. *See id.* As in *Glucksberg*, the Court analyzed the historical treatment of abortion and found that throughout the course of our Nation's history, abortion—like suicide—had been condemned and criminalized. *See id.* at 240–50.

But even in *Dobbs*—which overruled previous cases finding a fundamental right to abortion—the Court nonetheless framed the liberty interest at issue generally. Simply put, the right was characterized as the right to obtain an abortion, and the not the right to obtain an abortion through methods common in 1868. *See id.* at 234. In fact, *Dobbs* inherently rejected the notion that the right should be tied to the medical specificity utilized by the panel here. For example, *Dobbs* rejected the *Roe* timeline of viability and made no delineations about whether there is a fundamental right to an abortion via mifepristone and misoprostol (medical abortion), aspiration, or dilation and evacuation. *See id.* at 229–30, 277–80.

The Supreme Court also engaged in an additional step: it "consider[ed] whether a right to obtain an abortion is part of a broader entrenched right that is supported by other precedents." *Id.* at 234. Though it found that the right to obtain an abortion was not in fact entrenched in the broader rights of autonomy and privacy espoused in cases like *Meyer*, *Pierce*, *Loving*, and *Obergefell*, it did so on specific grounds. *See id.* at 256–57. The Court "sharply" distinguished the abortion right from the rights recognized in those cases by noting that abortion "destroys . . . potential life." *Id.* at

257 (internal quotations omitted). Therefore, though the non-abortion cases did not support the right to obtain an abortion, the Court's "conclusion that the Constitution does not confer such a right d[id] not undermine [the non-abortion cases] in any way." *Id.* That the Court engaged in such an inquiry—considering whether abortion was part of a broader entrenched right—gives credence to the notion that proposed rights should not be formulated at their most granular level of specificity.

D

I have selectively chosen the cases summarized above, but have done so for a reason—to make the point that the Supreme Court's substantive due process cases are not always reconcilable and that trying to make sense of them requires consideration of the jurisprudence as a whole. The lower federal courts generally do not have the luxury of picking and choosing their preferred Supreme Court decisions. Our job, difficult as it may sometimes be, is to try to make sense of a jurisprudential landscape which often is neither linear nor consistent. And to do that, we must consider all of the relevant Supreme Court precedent in a given area of law, not just those cases that support a given proposition. Sometimes that may require choosing one set of Supreme Court decisions over another. But if that is the case, we have a dual obligation—an obligation to admit that we are indeed choosing, and an obligation to explain why we have exercised that choice in a certain way. Constitutional adjudication is necessarily an exercise in judgment. *Cf.* Erwin Chemerinsky, *Foreword—The Vanishing Constitution*, 103 Harv. L. Rev. 43, 99 (1989) ("The Court must explain why the value choice made by the constitutional claimant is unworthy of judicial protection

and why the particular decision is better left to the elected branches of government.").

If the panel here was going to demand that the right at issue be defined at a "very specific level" to include the use of specific transitioning medications for transgender individuals—medications which did not exist in 1868—it had to account for how the fundamental right was framed generally in *Meyer* and *Pierce*. And it had to explain why it chose not to follow cases like *Loving*, *O'Connor*, *Lawrence*, and *Obergefell*, and their more general approach to defining liberty interests protected by substantive due process.[4]

IV

As I see this case, the ultimate resolution of the plaintiffs' substantive due process claims depends on two questions. The first is whether parents have a fundamental right, protected by substantive due process, to obtain medically-approved treatment for their children. If the answer to that question is yes, the second inquiry is whether Alabama has shown that its laws are narrowly tailored to serve a compelling interest. *See Glucksberg*, 521 U.S. at 721 ("[T]he Fourteenth Amendment 'forbids the government to infringe . . . "fundamental" liberty interests *at all,* no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest.'").

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[4] Judge Lagoa, in her statement regarding the denial of rehearing en banc, adds a new and lengthy discussion of substantive due process in an attempt to defend the panel's decision. The problem, of course, is that this new discussion is nowhere to be found in the panel opinion and does not constitute precedent. All we have in terms of binding law is the panel's opinion, which is short on analysis and wrong in rationale.

But we are reviewing only the grant of a preliminary injunction, and not a permanent injunction issued after a full trial on the merits. In this procedural posture we do "not concern [ourselves] with the merits of the controversy. . . . No attention is paid to the merits of the controversy beyond that necessary to determine the presence or absence of an abuse of discretion." *Di Giorgio v. Causey*, 488 F.2d 527, 528–29 (5th Cir. 1973). Our task is to determine whether the district court abused its discretion in, for example, concluding that the plaintiffs demonstrated a substantial likelihood of success on the merits. *See, e.g.*, *Ashcroft v. Am. Civ. Liberties Union*, 542 U.S. 656, 666, 669 (2004) (concluding that the district court's determination as to likelihood of success was not an abuse of discretion); *LSSI Data Corp. v. Comcast Phone, LLC*, 696 F.3d 1114, 1120 (11th Cir. 2012) ("The first question . . . is whether the [d]istrict [c]ourt abused its discretion in concluding that LSSI has shown a 'substantial likelihood of success' on the merits of its claim.").

The asserted fundamental right here, properly described, is the right of parents to obtain medically-approved treatment for their children. In my view, the district court did not abuse its discretion in concluding that this right is a fundamental liberty interest that the substantive component of the Due Process Clause protects. *See, e.g.*, *Parham v. J.R.*, 442 U.S. 584, 602 (1979) (the rights of parents "include[ ] a 'high duty' to recognize symptoms of illness and to seek and follow medical advice"); *Kanuszewski v. Mich. Dept. of Health & Human Servs.*, 927 F.3d 396, 418 (6th Cir. 2019) ("Parents possess a fundamental right to make decisions concerning the medical care of their children."); *PJ ex rel. Jensen v. Wagner*, 603 F.3d 1182, 1197–98 (10th Cir. 2010) ("we do not doubt that a parent's general right to make decisions concerning the care of

her child includes, to some extent, a more specific right about the child's medical care," as *Parham* "reasonably suggests that the Due Process Clause provides some level of protection for parents' decisions regarding their children's medical care," though those rights are not absolute); Alexander Van Zijl, *Parens Patriae or Government Overreach: Do Parents Have a Fundamental Right to Control their Children's Medical Care?*, 58 Wake Forest L. Rev. 769, 796 (2023) ("Parents' right to control their children's medical care is deeply rooted in the country's history and traditions, as the survey of Blackstone, tort restatements, Supreme Court precedent, and the common law demonstrate.").

Some courts have incorrectly framed the right as the right of parents to seek medical treatments that the state has banned. *See L.W.*, 83 F.4th at 475 (holding, in a 2-1 decision, that "there is no historical support for an affirmative right" of parents to obtain "banned medical treatments for their children"); *Doe v. Governor of New Jersey*, 783 F.3d 150, 156 (3d Cir. 2015) ("While the case law supports [the] argument that parents have decision-making authority with regard to the provision of medical care for their children, the case law does not support the extension of this right to a right of parents to demand that the state make available a particular form of treatment that the state has reasonably deemed harmful."); *Pickup v. Brown*, 740 F.3d 1208, 1235 (9th Cir. 2014) (the "precise question . . . is whether parents' fundamental rights include the right to choose for their children a particular type of provider for a particular medical or mental health treatment that the state has deemed harmful"). Respectfully, I think these courts have mistakenly conflated "the right with the deprivation." *Abigail Alliance for Better Access to Devel. Drugs v. von*

Eschenbach, 495 F.3d 695, 714 (D.C. Cir. 2007) (en banc) (Rogers, J., dissenting).

One cannot describe the fundamental right at stake (the first step in the substantive due process analysis) by attaching to it the challenged restriction which, at the end of the day, might (or might not) be narrowly tailored to serve a compelling state interest (the second step in the substantive due process analysis). The asserted risks or detriments associated with the right in this context of transgender treatments "[are] properly considered only after the right is deemed fundamental." *Id.* at 716 (Rogers, J., dissenting).

If the right could be defined as including the legal prohibition being challenged under substantive due process, *Meyer* would have characterized the liberty interest as the right to teach a school subject in German when the state had deemed such teaching inappropriate and harmful to the social fabric. But that is not how *Meyer* was decided. The Supreme Court framed the liberty interest more generally as the right to teach a subject in German, and only after identifying that right as fundamental did it consider whether Nebraska had sufficiently justified its prohibition. *See Meyer*, 262 U.S. at 400–01, 403. The same goes for *Pierce*, *Loving*, *O'Connor*, *Lawrence*, and *Obergefell*. *See generally Griswold*, 381 U.S. at 500 (Harlan, J., concurring in the judgment) ("In my view, the proper constitutional inquiry . . . is whether the . . . statute infringes the Due Process Clause of the Fourteenth Amendment because [it] violates basic values 'implicit in the concept of ordered liberty[.]'") (citation omitted).

Again, I see no abuse of discretion by the district court. "[P]arents have, in the first instance, a fundamental right to decide whether their children should (or should not) undergo a given treatment

otherwise available to adults, and the government can take the decisionmaking reins from parents only if it comes forward with sufficiently convincing reasons to withstand judicial scrutiny." *L.W.*, 83 F.4th at 510 (White, J., dissenting). As the Supreme Court wrote in *Parham*, "[s]imply because the decision of a parent is not agreeable to a child or because it involves risks does not automatically transfer the power to make the decision from the parents to some agency or officer of the state. . . . Neither state officials nor federal courts are equipped to review such parental decisions." 442 U.S. at 603–04.[5]

I do not doubt the general authority of the government to take legislative action with respect to the medical care of children. *See Otto v. City of Boca Raton*, 41 F.4th 1271, 1280–82 (11th Cir. 2002) (Jordan, J., dissenting from the denial of rehearing en banc). But a "state cannot simply deem a treatment harmful to children without support in reality and thereby deprive the parents of the right to make medical decisions on their children's behalf." *L.W.*, 83 F.4th at 511 (White, J., dissenting).

To repeat, we are here on appeal of a preliminary injunction. As explained by Judge Rosenbaum in her dissent, the district court made extensive factual findings. *See Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1141–43 (M.D. Ala. 2022); Judge Rosenbaum Dissent at Part I & II.B.2. The panel in this case should have applied clear error review to the district court's factual findings and, once the factual landscape was

[5] Given the strong language used by the Supreme Court, I do not understand how the panel here said that *Parham* "offers *no* support" for the parents' substantive due process claim. *See Eknes-Tucker*, 80 F.4th at 1223 (emphasis added).

settled, should have then considered whether the district court abused its discretion in preliminarily concluding that Alabama had not shown that its laws were narrowly tailored to serve a compelling state interest. *See Lebron v. Secretary*, 710 F.3d 1202, 1218–19 (11th Cir. 2013) (Jordan, J., concurring) (citing Supreme Court and Eleventh Circuit cases for the proposition that generally an appellate court does not decide the merits of a case when reviewing a preliminary injunction). The panel, however, did neither.

By framing the right in a too-specific way, the panel was able to default to the rational basis test, which in turn allowed it to ignore the district court's factual findings and not demand any real justification from Alabama for its laws. And, to compound this error, Judge Lagoa's statement regarding the denial of rehearing en banc now engages in its own evaluation of non-record evidence, provides its own characterization of the facts, and conducts its own weighing of the evidence. That, in my view, is upside-down appellate review.

V

In *Adams v. School Board of St. Johns County*, 57 F.4th 791 (11th Cir. 2022) (en banc), we convened as a full court to address whether a school board's bathroom policy violated the rights of transgender students. If that case was important enough to go en banc, this case is too. I respectfully dissent from the court's decision to not rehear this case en banc.

ROSENBAUM, Circuit Judge, joined by JILL PRYOR, Circuit Judge, and joined as to Sections I and II by JORDAN, Circuit Judge, dissenting from the denial of rehearing en banc:

If ever a case warranted en banc review, this is it. The panel opinion's reasoning strips every parent in this Circuit of their fundamental right to direct that their children receive *any* medical treatment (no matter how well-established and medically endorsed)—except for those medical treatments in existence as of 1868. Yes, 1868—before modern medicine. So in the states of Alabama, Florida, and Georgia, blistering, bloodletting, and leeches are in, but antibiotics, antivirals, and organ transplants are out.

Yet nothing in the law handcuffs us to nineteenth-century medicine. To the contrary, Supreme Court precedent recognizes parents' fundamental right to direct that their child receive well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment. *See Parham v. J.R.*, 442 U.S. 584, 602 (1979). Treatments that do not meet these demanding criteria fall outside the *Parham* right. But for treatments that do, the State cannot interfere with parents' fundamental right to access those treatments for their children without meeting a demanding constitutional burden.

The district court's factual findings—that the treatment at issue here is well-established, evidence based, medically, endorsed, and non-experimental—place that treatment squarely within *Parham*'s fundamental right. *See Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1144–46 (M.D. Ala. 2022) ("*Eknes-Tucker I*"). And the panel opinion didn't find any of the district court's factual findings to be clearly erroneous. So the

panel opinion should have—but did not—apply strict scrutiny in conducting its due-process review. Had the panel opinion done so, it would have had to conclude that it is substantially likely that Alabama's law does not pass muster under the Due Process Clause. Yet the panel opinion neither applies strict scrutiny nor reaches the answer that strict scrutiny demands.

The panel opinion is not just bad for Plaintiffs here. It is disastrous for *all* parents in the Eleventh Circuit. That's so because, in reaching its result, the panel opinion applies an unprecedented methodology that requires us to consider how the particular treatment at issue "inform[ed] the meaning of the Fourteenth Amendment at the time it was ratified—July 9, 1868." *Eknes-Tucker v. Governor of Alabama*, 80 F.4th 1205, 1221 (11th Cir. 2023) ("*Eknes Tucker II*"). I refer to this as the "1868 Methodology."

But of course, no treatment that didn't exist or wasn't discovered by 1868 could hope to "inform[] the meaning of the Fourteenth Amendment at the time it was ratified." *Id.* So the 1868 Methodology imposes a standard that no modern medical treatment can satisfy. And despite its claim to history and tradition, the 1868 Methodology breaks from precedent and the reality of scientific development. It is unsupportable. But because we did not rehear this case en banc, the 1868 Methodology is the law of this Circuit.

The panel opinion does not stop there. Compounding its legal errors, the panel opinion then turns a blind eye to the Alabama law's sex-based classifications, just because they arise in the context of medical treatment. But precedent contains no such exception. To the contrary, it subjects sex-based classifications to heightened constitutional scrutiny. *See, e.g.*, *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982).

And it extends that scrutiny to discrimination based on transgender status. *See Bostock v. Clayton County*, 590 U.S. 644, 660–61 (2020); *Glenn v. Brumby*, 663 F.3d 1312, 1320 (11th Cir. 2011). So in its equal-protection analysis, the panel opinion should have—but did not—apply intermediate scrutiny. Again, had it done so, it would have had to conclude that it is substantially likely that the law is unconstitutional under the Equal Protection Clause. But once again, the panel opinion did neither.

It's substantially likely that the Fourteenth Amendment tolerates neither the due-process nor equal-protection threats that Alabama's law poses and that the panel opinion permits. But the panel opinion distorts the due-process and equal-protection analyses, stacking the deck in the Alabama law's favor. And once the panel opinion concludes (wrongly) that parents have no fundamental right at stake (because transitioning medications weren't around in 1868) and that the Alabama law doesn't discriminate on the basis of sex or transgender status, it deals the rational-basis review card rather than subjecting the Act to strict or intermediate scrutiny, respectively. Then, the game is in the bag for Alabama because the Alabama law—like most legislation—satisfies rational-basis review.

What's more, the Lagoa Statement now tries to engage in a do-over—in some places retreating from and in other places compounding the panel opinion's legal errors. And it relies heavily on materials that were before neither the district court nor the panel. Not only that, but the Lagoa Statement substitutes its own factual findings based on these extraneous and untested outside sources for the district court's factual findings, which the panel opinion did not find to be clearly erroneous. The proper mechanism for a do-over

is the en banc process—not using a statement respecting the denial of rehearing to paper over the panel opinion's flawed reasoning, reinvent the factual record, and disclaim the panel opinion's repercussions.

In short, the panel opinion is wrong and dangerous. Make no mistake: while the panel opinion continues in force, no modern medical treatment is safe from a state's misguided decision to outlaw it, almost regardless of the state's reason. Worse still, if a state bans a post-1868 treatment, no parent has legal recourse to provide their child with that necessary, life-saving medical care in this Circuit. And if an individual can't access a medical treatment because of their sex or transgender status, they are similarly without legal recourse.

Because of the life-altering and unconstitutional consequences the panel opinion inflicts on the parents and children of this Circuit, I respectfully dissent from denial of rehearing en banc.

I. BACKGROUND

Alabama's Vulnerable Child Compassion and Protection Act ("Act") criminalizes the administration of puberty blockers and hormone therapy to minors—but only if that treatment is "performed for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex" and even in that case, only "if *that appearance or perception is inconsistent with the minor's sex*" at birth. S.B. 184, Ala. 2022 Reg. Sess. § 4(a) (Ala. 2022) (emphasis added). Otherwise, administration of puberty blockers and hormone therapy to minors is legal. I refer at times in this dissent to these drugs as "transitioning medications" because that is what the district court called them. *See Eknes-Tucker I*, 603 F. Supp. 3d 1131 at 1139.

Plaintiffs, a group of transgender[1] minors and their parents as well as medical providers and a reverend whose congregation includes transgender minors and their families ("Parents" and "Minors"[2]), sued to challenge the Act. *Id.* at 1141. The United States intervened on behalf of the Parents and Minors. Also in support of the Parents and Minors, twenty-two healthcare organizations filed an amicus brief.[3] *Id.* As

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[1] The district court relied on the following definition of "transgender": "one whose gender identity is different from the sex the person had or was identified as having at birth." *Eknes-Tucker I*, 603 F. Supp. 3d at 1138 (citing *Transgender*, Merriam-Webster Unabr. Dictionary (3d ed. 2002)). We have elaborated on the meaning of "transgender," recognizing that a "transgender" person "consistently, persistently, and insistently identifies as . . . a gender that is different than the sex . . . assigned at birth." *Adams ex rel. Kasper v. Sch. Bd. of St. Johns Cnty.*, 57 F.4th 791, 807 (11th Cir. 2022) (en banc) (cleaned up). Because the panel opinion did not find the district court's definition clearly erroneous and the parties do not challenge it on appeal, my dissent employs the same definition, as informed by our precedent's definition of the term.

[2] For ease of reference, I refer collectively to Plaintiffs as "Parents" when discussing the Parents' asserted due-process right and "Minors" when discussing the Minors' asserted equal-protection right.

[3] These organizations included the American Academy of Pediatrics; the Alabama Chapter of the American Academy of Pediatrics; the Academic Pediatric Association; the American Academy of Child and Adolescent Psychiatry; the American Academy of Family Physicians; the American Academy of Nursing; the American Association of Physicians for Human Rights, Inc. *d/b/a* Health Professionals Advancing LGBTQ Equality; the American College of Obstetricians and Gynecologists; the American College of Osteopathic Pediatricians; the American College of Physicians; the American Medical Association; the American Pediatric Society; the American Psychiatric Association; the Association of American Medical Colleges; the Association of Medical School Pediatric Department Chairs; the Endocrine

for Alabama,[4] fifteen states filed an amicus brief in support of its position and the Act. *Id.*

The Parents and Minors sought a preliminary injunction to halt the Act's operation while the suit was pending. *Id.* Following an evidentiary hearing where the district court received and reviewed reams of medical evidence and heard from several witnesses, the district court concluded that the Parents and Minors were "substantially likely to succeed on their Substantive Due Process claim" and "on their Equal Protection claim." *Id.* at 1146, 1148. Based on these conclusions and the determination that the Parents and Minors had shown each of the other preliminary-injunction factors (they would suffer irreparable harm without an injunction, and the balance of harms and public interests favored the Parents and Minors), the district court preliminarily enjoined the Act. *Id.* at 1151.

In reaching this decision, the district court made several factual findings based on the evidence it saw and heard. I summarize those findings below.

The World Professional Association for Transgender Health ("WPATH") considers "transitioning medications as established medical treatments and publishes a set of guidelines for treating gender dysphoria in minors with these medications." *Id.* at 1139.[5] And as the

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Society; the National Association of Pediatric Nurse Practitioners; the Pediatric Endocrine Society; the Society for Adolescent Health and Medicine; the Society for Pediatric Research; the Society of Pediatric Nurses; the Societies for Pediatric Urology; and the World Professional Association for Transgender Health. *Eknes-Tucker I*, 603 F. Supp. 3d at 1141 n.13.

[4] For ease of reference, I refer to Defendants collectively as "Alabama."

[5] The Lagoa Statement maligns WPATH because, among other functions, WPATH advocates for transgender individuals. Lagoa

district court found, at least 22 major medical organizations—the American Medical Association, the American Academy of Pediatrics, the American Pediatric Society, the Association of American Medical Colleges, and the Association of Medical School Pediatric Department Chairs, to name just a few[6]—in the United States "endorse [the WPATH] guidelines as evidence-based methods for treating gender dysphoria in minors." *Id.* Indeed, the district court noted, Dr. Armand H. Antommaria, an expert in bioethics and treatment protocols for adolescents suffering from gender dysphoria, emphasized that "transitioning medications are well-established, evidence-based methods for treating gender dysphoria in minors." *Id.* at 1142. Not only that, but at the time of the hearing, "according to [Alabama's] own expert, no country or

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St. at 30–31. But many healthcare professionals view an important part of their job as advocating for their community of patients. *See* Mark A. Earnest et al., *Physician Advocacy: What Is It and How Do We Do It?*, 85 Acad. Med. 63, 63 (2010) (noting "widespread acceptance of advocacy as a [medical] professional obligation"). That doesn't mean they don't also take the best possible care of their patients. And in the case of WPATH—"an international interdisciplinary, professional organization"—its stated mission is "[t]o promote *evidence based* care, education, *research*, public policy, and respect in transgender health." *See* World Prof. Ass'n for Transgender Health, *Mission and Vision* (last visited Aug. 19, 2024), https://www.wpath.org/about/mission-and-vision [https://perma.cc/KVJ3-WKDN] (emphases added). At least 22 major medical organizations with the professionals, means, and motivation to evaluate WPATH's work believe it has done just that, and they endorse and rely on the WPATH Standards of Care. The Lagoa Statement's wholesale dismissal of WPATH's work fails to reckon with the professional medical community's embrace of WPATH as an evidence-based expert in the area of transgender medicine.

[6] These organizations are listed in footnote 3 of this dissent.

state in the world categorically ban[ned] their use as Alabama ha[d].”[7] *Id.* at 1145.

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[7] The Lagoa Statement now tries to refute this finding by pointing to guidance from England's National Health Service (“NHS”). Lagoa St. at 4–5, 30–31, 44–45. Three responses. First, fact-finding in a statement respecting the denial of rehearing en banc is improper, and that is especially the case when the panel opinion did not find even one of the district court's factual findings to be clearly erroneous. Second, the UK's actions do not undermine the district court's findings, in any case. The district court's point was that no other countries have “categorically ban[ned]” the use of transitioning drugs. That is still the case. The Lagoa Statement points to only the United Kingdom's revised guidelines to argue otherwise. But even in the UK, “gender affirming hormones” “are available as a routine commissioning treatment option for young people with continuing gender incongruence/gender dysphoria from around their 16th birthday.” *Clinical Commissioning Policy: Prescribing of Gender Affirming Hormones (masculinising or feminising hormones) as part of the Children and Young People's Gender Service*, Nat'l Health Serv. Eng. (Mar. 21, 2024), https://www.england.nhs.uk/wp-content/uploads/2024/03/clinical-commissioning-policy-prescribing-of-gender-affirming-hormones.pdf [https://perma.cc/TB32-VHCV]. Plus, the UK's temporary ban on puberty blockers that will dissolve in September permits current patients to continue their preexisting course of treatment and allows doctors to conduct clinical trials, *TransActual CIC v. Sec'y of State for Health and Social Care* [2024] EWHC 1936 (Admin), ¶ 148—but Alabama's law has no exceptions. Third, it's not clear that the “Cass Review” that the UK relies on would satisfy our courts' evidence-reliability standards. *See* FED. R. EVID. 702, 803(8)(B). “Most of the Review's known contributors have neither research nor clinical experience in transgender healthcare.” Meredithe McNamara et al., An Evidence-Based Critique of “The Cass Review” on Gender-affirming Care for Adolescent Gender Dysphoria 3 (July 1, 2024), https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf [https://perma.cc/N9Q7-AHKS]. Also, at least one commentator has noted that the Review's conclusions are “deeply at odds with the [its] own findings . . . . Far from evaluating the evidence in a neutral and scientifically valid manner, the Review obscures key findings, misrepresents its

esides considering the medical community's views, the district court also recounted that Parent Plaintiff Megan Poe "specifically described the positive effects transitioning treatments have had on her fifteen-year-old transgender daughter, Minor Plaintiff Allison Poe." *Id.* at 1142. As the court explained, "[d]uring her early adolescent years, Allis[]on suffered from severe depression and suicidality due to gender dysphoria." *Id.* But after she started taking transitioning medications at the end of sixth grade, "her health significantly improved as a result." *Id.* Indeed, Megan said her daughter was now "happy and 'thriving.'" *Id.* But Megan "feared her daughter would commit suicide" if she were no longer able to take the medications. *Id.*

For its part, Alabama presented an expert psychologist witness, but after reviewing his testimony, the district court was not impressed. *See id*. at 1142–43. Rather, the district court gave "very little weight" to his testimony, noting that he practiced in Canada (not the United States); that his patients were, on average, thirty years old, and he had never treated minors with gender dysphoria; that he had no personal experience monitoring patients receiving transitioning medications; and that he lacked personal knowledge of the

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own data, and is rife with misapplications of the scientific method." *Id.* at 36; *see also* Chris Noone et al., *Critically Appraising the Cass Report: Methodological Flaws and Unsupported Claims*, OSFPREPRINTS (June 9, 2024), https://osf.io/preprints/osf/uhndk [https://perma.cc/H9N9 N2XK]; D.M. Grijseels, *Biological and Psychosocial Evidence in the Cass Review: A Critical Commentary*, INT. J. TRANSGENDER HEALTH, June 8, 2024, at 1. But then again, the point isn't that the Lagoa Statement relies on inaccurate information—it's that it's not our role to fact-find in the first place.

assessments or treatment methodologies any Alabama gender clinic employed. *Id.*

As for Alabama's other live witness,[8] Sydney Wright—the woman whose malpractice story the Lagoa Statement tells, *see* Lagoa St. at 1–2—the district court found she took transitioning medications for about a year, beginning when she was nineteen

[8] Alabama also submitted eleven declarations. Of the declarations, three were from patients (Corinna Cohn (Appendix C to Lagoa Statement), Carol Freitas (Appendix B to Lagoa Statement), and KathyGrace Duncan (Appendix A to Lagoa Statement)). Freitas and Duncan were adults when they began transitioning medications, and Cohn was eighteen. None of the patients' parents were involved in their decisions to begin transitioning medications. But the point here is that, crediting their declarations, their "treatment" did not follow WPATH Standards of Care. *See*, *e.g.*, Freitas Decl. ¶ 9 (stating she received testosterone just by asking, and the provider gave her "no information" about the medication, its risks, and its side effects; nor did the provider address her underlying "emotional or mental health issues"). In other words, all three involve malpractice cases, a fact the Lagoa Statement ignores, Lagoa St. at 2 n.1. But given that the administering practitioners violated WPATH standards including by failing to obtain informed consent—it makes little sense to rely on these three patients' statements for the proposition that they did not understand the effects of cross-sex hormones and puberty blockers. As for the remaining eight declarations, they are from parents (Barbara F., John Doe, John Roe, Kristine W., Martha S., Jeanne Crowley, Kellie C., and Gary Warner). Some of those also relate stories where the providers did not follow WPATH Standards of Care. *See*, *e.g.*, Warner Decl. Another concedes that no gender-affirming care has been administered to her child because she declined to consent. *See* Decl. of Barbara F. That declaration and others also complain that, because their states don't outlaw transitioning medications, it falls on them to tell their children "no." *See*, *e.g.*, Decl. of Kristine W.; Decl. of John Roe; Decl. of Martha S. Of the eleven declarants, only two state that they were residents of Alabama. And several others admit that they are not from Alabama and that the events they recount did not occur in Alabama.

years old. *See Eknes-Tucker I*, 603 F. Supp. 3d at 1143. Her parents were not involved in her decision to start taking transitioning medications. And even though she was an Alabama citizen, she received none of her treatment in Alabama. *See id.* It's also clear from her testimony (as the Lagoa Statement describes) that the "treatment" Wright received did not come close to following the WPATH Standards of Care. *See*, *e.g.*, Lagoa St. at 1 (noting that Wright saw a counselor who never explored her underlying mental-health and emotional issues but instead told her to begin testosterone and undergo a double mastectomy).[9]

Turning to Alabama's "proffered purposes" for the Act, the district court found them to be "speculative, future concerns about the health and safety of unidentified children." *Eknes-Tucker I*, 603 F. Supp. 3d at 1146. For starters, the district court noted that Alabama justified the Act by describing transitioning medications as "experimental." *Id.* at 1140. But the district court found that, in fact, Alabama "produce[d] no credible evidence to show that transitioning medications are 'experimental.'" *Id.* at 1145; *see also id.* ("[Alabama] fail[s] to show that transitioning medications are experimental."). And more broadly, the district court found that Alabama's stated purposes for

[9] In contrast, the WPATH Standards of Care seek to ensure that the minor's "mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed" before the minor begins to use transitioning medications. *See* E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People*, *Version 8*, INT. J. TRANSGENDER HEALTH, Sept. 15, 2022, at S62 [hereinafter WPATH Standards] [https://perma.cc/FQD7-YSFJ].

the Act were "not genuinely compelling justifications based on the record evidence." *Id.* at 1146.

To the contrary, based on all the evidence, the district court determined that the use of transitioning medications adhered to "medically accepted standards." *Id.* Though the district court recognized that "transitioning medications carry risks," the court reiterated the Supreme Court's determination that "the fact that pediatric medication 'involves risks does not automatically transfer the power' to choose that medication 'from the parents to some agency or officer of the state.'" *Id.* (quoting *Parham*, 442 U.S. at 603). Rather, in the district court's view, "[p]arents, pediatricians, and psychologists—not the State or this Court—are best qualified to determine whether transitioning medications are in a child's best interest on a case-by-case basis." *Id.*

We must accept the district court's factual findings—all of them—as true unless they are clearly erroneous. *See, e.g.*, *Hargray v. City of Hallandale*, 57 F.3d 1560, 1567 (11th Cir. 1995). In vacating the district court's preliminary injunction, the panel opinion found none of the district court's factual findings to be clearly erroneous. Yet it still concluded that the Parents were not likely to succeed on the merits of either their due-process or equal-protection claim, departing from both the record and binding precedent. *See EknesTucker II*, 80 F.4th at 1231. In doing so, the panel committed both legal and factual error.

The Lagoa Statement doubles down on this error. Of course, a statement respecting the denial of rehearing cannot find a district court's factual findings to be clearly erroneous, especially when the panel opinion did not. But that doesn't stop the Lagoa Statement from relying on unvetted sources from outside the

record to argue, contrary to the district court's factual findings, that transitioning medications are not well-established, evidence-based, or non-experimental treatment. This attempted do-over is just as wrong as the panel opinion, as I detail below.

II. The panel opinion wrongly concludes that the Parents are not substantially likely to succeed on the merits of their due-process claim.

The Fourteenth Amendment's Due Process Clause prohibits any state from "depriv[ing] any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1. It guarantees both procedural and substantive rights. *Washington v. Glucksberg*, 521 U.S. 702, 719–20 (1997). Among those guaranteed substantive rights are "fundamental rights and liberties which are, objectively, deeply rooted in this Nation's history and tradition, and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed." *Id.* at 721 (cleaned up).

A law that burdens a fundamental right must survive strict scrutiny, or it is unconstitutional. *See*, *e.g.*, *Lofton v. Sec'y of Dep't of Child. & Fam. Servs.*, 358 F.3d 804, 815 (11th Cir. 2004). Strict scrutiny requires the law to be "narrowly tailored to further a compelling government interest." *Id*. It is hard for laws to survive strict scrutiny's tightly woven filter.

In contrast, we apply rational-basis review to evaluate the constitutionality of a law that interferes with a right that is not fundamental. Rational-basis review is a sieve. It asks only whether "there is any reasonably conceivable state of facts that could provide a rational basis" for the burden. *FCC v. Beach Commcn's, Inc.*, 508 U.S. 307, 313 (1993); *see also Jones*

v. Governor of Fla., 975 F.3d 1016, 1034 (11th Cir. 2020) (holding that under rational-basis review, "we must uphold [a law] if there is any conceivable basis that could justify it"). So it is no surprise that courts "hardly ever strik[e] down a policy as illegitimate under rational basis scrutiny." *Jones*, 975 F.3d at 1034 (quoting *Trump v. Hawaii*, 585 U.S. 667, 705 (2018)); *see also* Lagoa St. at 43 (characterizing rational-basis review as "remarkably lenient").

With this framework in mind, Section A shows that parents' liberty interest in directing that their child receive well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment, is a fundamental right, "deeply rooted in this Nation's history and tradition, and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed," *Glucksberg*, 521 U.S. at 721 (cleaned up). Section B explains why the treatment the Parents seek here falls within that right's scope. And because the Parents' right is a fundamental one, Section C applies strict scrutiny and shows why it is substantially likely that the Act violates substantive due process.

A. Parents' liberty interest in directing that their children receive well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment is a fundamental right.

1. The panel opinion erroneously dismisses Supreme Court precedent recognizing the fundamental right that the Parents assert.

Due-process jurisprudence requires "a 'careful description' of the asserted fundamental liberty interest." *Glucksberg*, 521 U.S. at 721 (quoting *Reno v. Flores*, 507 U.S. 292, 302 (1993)). The Supreme Court has long recognized that "[i]t is cardinal . . . that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944).

As a result, the Due Process Clause provides parents with "the fundamental right . . . to make decisions concerning the care, custody, and control of their children," which is "perhaps the oldest of the fundamental liberty interests recognized by th[e] Court." *Troxel v. Granville*, 530 U.S. 57, 65–66 (2000) (plurality opinion); *see also*, *e.g.*, *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923) ("the right of the individual to . . . bring up children"); *Pierce v. Soc'y of the Sisters of the Holy Names of Jesus & Mary*, 268 U.S. 510, 534–35 (1925) ("the liberty of parents and guardians to direct the upbringing and education of children under their control"); *Quilloin v. Walcott*, 434 U.S. 246, 255 (1978) ("freedom of personal choice in matters of . . . family life" (quoting *Cleveland Board of Education v. LaFleur*, 414 U.S. 632, 639–640 (1974)); *Santosky v. Kramer*, 455 U.S. 745, 753 (1982) ("the fundamental liberty interest

of natural parents in the care, custody, and management of their child").

The Supreme Court has recognized that the umbrella of this fundamental right shelters other, more specific rights. This is where the "careful description" of the right comes in. For instance, the Court has held that a parent's narrower, more carefully described fundamental right to direct the education of his child falls within the fundamental right "of the individual to . . . bring up children." *Meyer*, 262 U.S. at 399; *Pierce*, 268 U.S. at 534–35. The Lagoa Statement dismisses this carefully described right as irrelevant to the issue before us, *see* Lagoa St. at 13–15, but it misses the point: that the Supreme Court has recognized several carefully described fundamental rights that live under the "the fundamental right . . . to make decisions concerning the care, custody, and control of their children," *Troxel*, 530 U.S. at 66.

Another carefully described fundamental right that the Supreme Court has recognized is parents' fundamental right to direct that their child receive well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment. *See Parham*, 442 U.S. at 602.

In *Parham*, minors sought a declaratory judgment that Georgia's voluntary-commitment procedures for children under the age of 18 violated due process, and the minors requested an injunction against the future enforcement of these procedures. *Id.* at 587–88. Under the procedures, a parent could apply for her child's admission for hospitalization. *Id.* at 591. The *Parham* minors challenged these procedures as a violation of their own procedural-due-process rights. *See id.* at 588.

In determining whether the procedures satisfied procedural due process, the Supreme Court first identified the nature of the interests at stake. *See id.* at 599–606. After all, the process due depends largely on the nature of the interest affected. *See Mathews v. Eldridge*, 424 U.S. 319, 334 (1976).

Among other parties' interests to factor into the process-due calculation, the Supreme Court identified "the interests of the parents who have decided, on the basis of their observations and independent professional recommendations, that their child needs institutional care." *Parham*, 442 U.S. at 601–02. To evaluate the weight of that interest—and thus the process due—the Court discussed the interest in more detail.

The Court first observed that "our constitutional system long ago . . . asserted that parents generally have the right, coupled with the high duty, to recognize and prepare their children for additional obligations." *Id.* at 602 (cleaned up). In other words, the Court invoked the umbrella fundamental right of parents to direct the care, custody, and control of their children.

The Court continued, "Surely, this includes a 'high duty' to recognize symptoms of illness and to seek and follow medical advice." *Id.* Indeed, the Court explained, the law "historically . . . has recognized that natural bonds of affection lead parents to act in the best interests of their children." *Id.* Thus, "[s]imply because the decision of a parent . . . involves risks does not automatically transfer the power to make that decision from the parents to . . . the state." *Id.* at 603.

To illustrate this principle, the Court pointed to parents' right to have "tonsillectom[ies], appendectom[ies], or other medical procedure[s]" performed on their children. *Id.* These examples show that the Court

understood a parent's fundamental right to direct the medical care of her child to refer to the category of well-established, evidence-based, non-experimental medical treatments. They also show that, with respect to this category of medical treatments, the Court recognized that a state's invocation of risks, standing alone, does not justify a state's decision to outlaw the treatment.

Ultimately, the Court concluded that parents "retain plenary authority to seek such care for their children, subject to a physician's independent examination and medical judgment." *Id.* at 604. Thus, the Court recognized parents' fundamental right to direct that their child receive well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment.

And the right that *Parham* recognized is the very fundamental right that the Parents here invoke.

That the Supreme Court recognized such a fundamental right makes perfect sense when we consider the principles animating substantive due process. Substantive due process protects only those rights "deeply rooted in this Nation's history and tradition, and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed." *Glucksberg*, 521 U.S. at 721 (cleaned up). It is hard to imagine a right less amenable to sacrifice while liberty and justice still exist than a parent's right to save her child's life with well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment. And what are liberty and justice if not the right of a parent to protect her child from death with

a non-experimental medical treatment, based on a physician's recommendation?

Yet the panel opinion and the Lagoa Statement wave off *Parham* for six reasons. None stands up to examination.

First, the panel opinion dismisses *Parham* as a proceduraldue-process case, not a substantive-due-process case. *See EknesTucker II*, 80 F.4th at 1223. But *Parham* was necessarily both. Only after the Court recognized the nature of the parental right involved could the Court assess the process due to protect against violations of that right. So the Supreme Court's acknowledgment of parents' fundamental right to direct the medical care of their children was just as necessary to the Court's due-process holding as was its analysis of the voluntary-commitment procedures. And we are bound equally by both. *See Powell v. Thomas*, 643 F.3d 1300, 1305 (11th Cir. 2011) ("[H]olding is comprised both of the result of the case and those portions of the opinion necessary to that result by which we are bound." (cleaned up)). As a result, the panel opinion wrongly marginalizes *Parham* as merely a procedural-due-process case.

Second, the Lagoa Statement asserts that a later case undermined *Parham*'s clear application here. Lagoa St. at 22 (citing *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990)). *Cruzan* did no such thing.

In support of its (mistaken) contention, the Lagoa Statement quotes *Cruzan*'s remark, *id.* at 22–23, referring to *Parham*, that the petitioners there sought "to turn a decision which allowed a State to rely on family decisionmaking into a constitutional requirement that the State recognize such decisionmaking."

Cruzan, 497 U.S. at 286. But the Lagoa Statement takes this passage out of context.

In *Cruzan*, the parents of an adult woman who was injured in a car accident and had "virtually no chance of regaining her mental faculties" sought, on the woman's behalf, to terminate her nutrition and hydration. 497 U.S. at 267. The state prohibited them from doing so because the right to refuse treatment was the woman's—not her parents' or any other family members'—and she had not sufficiently memorialized her desire to decline treatment rather than live in a vegetative state. *See id.* at 280, 287 n.12.

In the Supreme Court, the parents argued that the state "must accept the 'substituted judgment' of close family members even in the absence of substantial proof that their views reflect the views of the patient." *Id.* at 285–86. The Supreme Court rejected that because, among other reasons, "[a] State is entitled to guard against potential abuses" by family members who "will not act to protect a patient." *Id.* at 281, 286. Only in that context did the Court dismiss the family members' *Parham* argument as "seek[ing] to turn a decision which allowed a State to rely on family decisionmaking into a constitutional requirement that the State recognize such decisionmaking." *Id.* at 286.

In context, *Cruzan* bears no resemblance to this case. So it makes no difference that "*Cruzan* did not distinguish *Parham* on any of the grounds" I point out. Lagoa St. at 23.

To start, *Cruzan* concerned close family members' rights to direct an *adult's* medical care, not parental rights concerning a minor child. But *Parham* did not purport to recognize a fundamental right of family members of an adult. Indeed, the *Parham* right lives

under the more general, "perhaps . . . oldest of the fundamental liberty interests recognized by th[e] Court": "the fundamental right of parents to make decisions concerning the care, custody, and control of their children." *Troxel*, 530 U.S. at 65–66. This right by its terms and by the precedent it has begotten applies solely to a parent's fundamental right to make decisions about their minor children. And unlike with the right at stake in *Cruzan*, the law "historically . . . has recognized that natural bonds of affection lead parents to act in the best interests of their children." *Parham*, 442 U.S. at 602. In contrast, no constitutional grounds existed for deferring to a relative's decision on behalf of an adult, at least without "competent and probative evidence establish[ing] that the patient herself had expressed a desire that the decision to terminate life-sustaining treatment be made for her by that individual." *Cruzan*, 497 U.S. at 287 n.12. In other words, *Cruzan*, and the grounds on which it distinguished *Parham*, had nothing to do with a minor child's parent's right to access medical care that falls within *Parham*'s scope.

And *Cruzan* involved the right to *withdraw* medical treatment to allow the adult patient to die, not the parents' right to direct potentially *life-saving* medical treatment.

Given these two significant differences, the Court concluded that *Parham* did not control *Cruzan*'s novel facts—the petitioners' asserted right to direct the withdrawal of their adult relative's medical care. But the Court did not purport to limit *Parham*'s fundamental right of a parent to direct that her child receive well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination

and medical judgment. *See Parham*, 442 U.S. at 602. That issue was not even before the Court.

So it is no answer that *Parham* did not elevate familial decision-making—by any close family member—in all circumstances. Here, *Parham* directly applies. And "when a precedent of the Supreme Court has direct application, we must follow it." *United States v. Johnson*, 921 F.3d 991, 1001 (11th Cir. 2019) (en banc) (cleaned up). We cannot, as the Lagoa Statement does, sidestep it.

Third, the panel opinion says, "*Parham* does not at all suggest that parents have a fundamental right to direct a particular medical treatment for their child that is prohibited by state law." *EknesTucker II*, 80 F.4th at 1223; *see also* Lagoa St. at 20–23. Wrong again. That's exactly what it stands for: parents have a fundamental right to direct the care of their child with any medical treatment that satisfies the *Parham* category's requirements. In other words, *Parham* answers what the Lagoa Statement refers to as the "antecedent question": whether parents have a fundamental right to direct the care of their child with certain medical treatments. Lagoa St. at 22 n.11. And states cannot trample that right unless they have a compelling reason to do so and their legislation is narrowly tailored to address that compelling reason.

Nowhere did *Parham* purport to qualify its right with a state-law limitation. Nor would that limitation make sense, or fundamental rights would be meaningless. If the Lagoa Statement were correct, any "fundamental right" would evaporate instantly upon a state's banning of a particular treatment. That is, it would enjoy no protection. And what's a fundamental right if the state can abrogate it at will?

The Lagoa Statement's contrary contention elementally misunderstands the nature of a fundamental right. Constitutional protections are not so susceptible to state-law abrogation.

Fourth, the Lagoa Statement invokes Circuit precedent to suggest we have somehow cabined *Parham*'s right. Lagoa St. at 12– 14 (first citing *Doe v. Moore*, 410 F.3d 1337 (11th Cir. 2005); and then citing *Morrissey v. United States*, 871 F.3d 1260 (11th Cir. 2017)). We haven't, and we couldn't. We are bound by *Parham*. In any case, the precedent the Lagoa Statement invokes does not bear on the analysis here.

In *Doe*, the plaintiffs made only "broad claims that the [challenged law] infringe[d] their liberty and privacy interests." 410 F.3d at 1343. We rejected a "broad category" of due-process rights for which "any alleged infringement on privacy and liberty will be subject to substantive due process protection." *Id.* at 1344. And because the plaintiffs' asserted right was so "broad," we had "to define the scope of the claimed fundamental right" in the first instance. *Id.* By contrast, the Parents do not rely on a "broad category." Rather, they rely on the careful description of the right that *Parham* has already recognized.

Morrissey is similarly uninstructive. There, the plaintiff claimed to assert the "fundamental right to procreate," but he really asserted a right to enlist the state to assist him in procreation by providing a tax write-off for *in vitro* fertilization. *See* 871 F.3d at 1269. The plaintiff there relied on *Skinner v. Oklahoma*, 316 U.S. 535, 536 (1942), which invalidated a law authorizing forced sterilization of individuals with certain criminal convictions. But *Skinner* implicated the right not to have the state affirmatively destroy one's right to procreate (at least not on an inequitable

basis). *See id.* at 541–43. The rights at issue were not the same right, even at the highest level of abstraction. So *Morrissey* does not bear on the case here or on *Parham*. Rather, unlike in *Morrissey*, *Parham* recognized the fundamental right here. And as an inferior court, we lack the power to narrow a fundamental right that the Supreme Court has already recognized.

Fifth, the Lagoa Statement points to yet another inapposite case—this time from outside our Circuit: *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695 (D.C. Cir. 2007) (en banc). *See* Lagoa St. at 27–28.[10] *Abigail Alliance* held that terminally ill patients do not an enjoy a fundamental "right of access to experimental drugs that have passed limited safety trials but have not been proven safe and effective." 495 F.3d at 697. But for the reasons I explain below, that case does not undermine *Parham*'s applicability or the Parents' fundamental right here.

Of course, *Abigail Alliance* does not bind us.

But even if it did, the claimed right in *Abigail Alliance* was different from the right *Parham* recognizes and the Parents here invoke. In *Abigail Alliance*, the terminally ill patients asserted the right to use experimental new drugs that the U.S. Food and Drug Administration ("FDA") had not approved for any use, that were not widely accepted, and that were not the standard of medical care. *See id.* at 700. In contrast,

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[10] The panel opinion itself does not cite *Abigail Alliance*, though it cites *L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 477 (6th Cir. 2023), *cert. granted sub nom. United States v. Skrmetti*, ___ S. Ct. ___, 2024 WL 3089532 (June 24, 2024), which relies in part on *Abigail Alliance* to reach a similar conclusion to the panel here. *See Eknes-Tucker II*, 80 F.4th at 1224, 1225 n.19.

the fundamental right *Parham* recognizes is parents' right to direct the care of their children with well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment.

And as a factual matter, the medical treatment here differs from those at issue in *Abigail Alliance*. The district court here found that transitioning medications (1) were not new drugs, as "medical providers have used transitioning medications for decades to treat medical conditions other than gender dysphoria"; (2) Alabama "produce[d] no credible evidence to show that transitioning medications are 'experimental'"; (3) "the uncontradicted record evidence is that at least twenty-two major medical associations in the United States endorse transitioning medications as well-established, evidence-based treatments for gender dysphoria in minors"; and (4) the use of transitioning medications to treat gender dysphoria in minors is "subject to medically accepted standards." *EknesTucker I*, 603 F. Supp. 3d at 1145. Not only that, but unlike the new and experimental drugs at issue in *Abigail Alliance*, which were not FDA-approved for any purpose, the FDA has approved puberty blockers to treat central precocious puberty, a condition that involves early sexual development in girls and boys.[11] It has also approved the use of hormone therapy for various conditions other than gender dysphoria.[12]

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[11] *See* Cleveland Clinic, *Precocious Puberty / Early Puberty* (last visited Aug. 19, 2024) https://my.clevelandclinic.org/health/diseases/21064-precocious-early-puberty [https://perma.cc/UM5B-BBTK].

[12] *See*, *e.g.*, U.S. Food & Drug Admin., *Menopause: Medicines to Help You* (Aug. 22, 2019), https://www.fda.gov/consumers/free-publications-women/menopause-medicines-help-you [https://perma.

Plus, in pediatric medicine, off-label drug use[13] (such as using FDA-approved puberty blockers and hormones to treat severe gender dysphoria) is not "improper, illegal, contraindicated, or investigational."[14] Kathleen A. Neville et al., *Off-label Use of Drugs in Children*, 133 Pediatrics 563, 563 (2014). Nor is it considered "experiment[al] or research." *Id.* at 565. In fact, off-label medication use by minors is especially common and often necessary because an "overwhelming number of drugs" have no FDA-approved instructions for use in pediatric patients. *Id.* at 563. That is so because the child patient population is "frequently excluded from clinical trials." Furey & Wilkins, *supra*

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cc/UKV5-U6UQ]; U.S. Food & Drug Admin., *FDA Approves Weekly Therapy for Adult Growth Hormone Deficiency* (Sept. 1, 2020), https://www.fda.gov/drugs/news-events-human-drugs/fda-approves-weekly-therapy-adult-growth-hormone-deficiency [https://perma.cc/75VU-T28M]. Besides these FDA-approved uses of hormones in adults, hormone therapies are widely prescribed and administered off-label for minors for intersex pubertal development and conditions such as gynecomastia (the overdevelopment or enlargement of the breast tissue in boys). *See, e.g.*, Garry L. Warne et al., *Hormonal Therapies for Individuals with Intersex Conditions*, 4 Treatments in Endocrinology 19, 19–29 (2012); Ronald S. Swerdloff et al., *Crynecomastia: Etiology, Diagnosis, and Treatment* (last updated Jan. 6, 2023), https://www.ncbi.nlm.nih.gov/books/NBK279105/ [https://perma.cc/EVU2-8C8H].

[13] "'Off-label' drug use commonly refers to prescribing currently available medication for an indication (disease or symptom) for which it has not received FDA approval. Off-label use also includes prescribing a drug for a different population or age range than that in which it was clinically tested and using a different dosage or dosage form." Katrina Furey & Kirsten Wilkins, *Prescribing "Off-Label": What Should a Physician Disclose?*, 18 AMA J. Ethics 587, 588 (2016) (internal citations omitted).

[14] *See also* H. Christine Allen et al., *Off-Label Medication Use in Children, More Common than We Think: A Systematic Review of the Literature*, 111 J. Okla. State Med. Ass'n 776, 781 (2018).

n.13, at 589. And even the Alabama legislature has recognized that "[o]ff-label use of an FDA-approved drug is legal when prescribed in a medically appropriate manner and is often necessary to provide needed care." ALA. CODE § 27-1 10.1(a)(5) (2022).

So neither *Abigail Alliance*'s holding nor its reasoning carries persuasive weight here. Rather, *Parham* controls the analysis. And as I've explained, *Parham* recognizes the Parents' asserted right as fundamental.

Sixth and finally, unable to show that *Parham*'s right doesn't remain intact, the Lagoa Statement tries to remove this case from *Parham*'s reach by suggesting that gender-affirming treatment is not "medical care." *See* Lagoa St. at 3–5. But the record evidence, the medical consensus, the district court's factual findings, and common sense all rebut that. Under the leading authority—the WPATH Standards of Care—treatment "involv[es] holistic inter- and multidisciplinary care between endocrinology, surgery, voice and communication, primary care, reproductive health, sexual health and mental health," including the provision of "hormone therapy."[15] This treatment is indisputably "medical." The Lagoa Statement can't use a patently incorrect characterization to remove this case from *Parham*'s reach.

So it pivots, arguing instead that whether gender-affirming care qualifies as "life-saving" or even as "medical care" is itself a "policy" question for the state. *See* Lagoa St. at 3–5. But that maneuver fails just as certainly. For starters, Alabama does not assert—nor could it—that the Act does not prohibit "medical" care. And no one could rationally claim that medical care that reduces rates of "suicidality" (as well as "self-

[15] WPATH Standards, *supra* n.9, at S7.

harm") is not "life-saving." *Eknes-Tucker I*, 603 F. Supp. 3d at 1150.

But more to the point, courts do not defer to the legislature when the question is whether the conduct at issue falls within the "the scope of [a plaintiff's] constitutional rights." *United States v. Mills*, 138 F.3d 928, 937 (11th Cir.), *opinion modified on reh'g*, 152 F.3d 1324 (11th Cir. 1998). That medical care "involves risks does not automatically transfer the power to make" a medical "decision from the parents to some agency or officer of the state." *Parham*, 442 U.S. at 603. Rather, to transfer that power, the facts must show that the conduct at issue falls outside the scope of Plaintiffs' constitutional rights—that is, that it is not a well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment (or the state's solution must survive strict scrutiny).

It is very much the courts' responsibility to assess whether the state has proved that a treatment it seeks to regulate falls within or outside the fundamental *Parham* category. *See, e.g.*, *United States v. Stevens*, 559 U.S. 460, 468–471 (2010) (placing the burden on the government to show that the speech it is attempting to regulate is unprotected); *New York State Rifle & Pistol Ass'n, Inc. v. Bruen*, 597 U.S. 1, 18 (2022) (placing the burden on the government to show that the challenged regulation falls outside to scope of the Second-Amendment right). Alabama failed to show that the use of transitioning medications isn't within the protected *Parham* category. And the panel opinion didn't find the district court's factual finding to that effect to be clearly erroneous. The Lagoa Statement can't dodge these inconvenient legal realities by trying

to make the state the unchecked fact-finder of what qualifies as "medical care."

In sum, *Parham* recognizes parents' fundamental right to direct the medical care of their children with well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment. And it's the Lagoa Statement's machinations to avoid being bound by *Parham*—not this dissent—that "mark out new terrain." Lagoa St. at 23.

2. The panel opinion unjustifiably imposes an historical requirement that no modern medical treatment could satisfy.

Besides incorrectly sidelining *Parham* itself, the panel opinion and the Lagoa Statement mischaracterize the fundamental right that *Parham* recognizes. First off, the panel opinion and the Lagoa Statement hypernarrowly describe the asserted right the Parents invoke here as the parents' "right to treat one's children with transitioning medications subject to medically accepted standards."[16] *Eknes-Tucker II*, 80 F.4th at 1224 (cleaned up).

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[16] The Lagoa Statement justifies this mischaracterization by deflecting blame on the district court. *See* Lagoa St. at 11 ("[T]he panel opinion's description of the right claimed here came directly from the district court . . . ."). But in context, the district court found that the Parents had a "fundamental right to treat their children with transitioning medications subject to medically accepted standards" only as the natural conclusion of its findings that transitioning medications satisfied *Parham*'s categorical requirements. *Eknes-Tucker I*, 603 F. Supp. 3d at 1144–45 (finding "the uncontradicted record evidence is that at least twenty-two major medical associations in the United States *endorse* transitioning medications as *well-established, evidence-based*

Then, the panel opinion imposes the 1868 Methodology on our jurisprudence governing parents' fundamental right to direct the medical care of their children. *See id.* at 1220–21. It criticizes the district-court order for failing to "feature any discussion of the history of the use of [transitioning medications] or otherwise explain *how that history informs the meaning of the Fourteenth Amendment at the time it was ratified—July 9, 1868*." *Id.* at 1221 (emphasis added); *see also* Lagoa St. at 25–26. Finding no "historical analysis specifically tied to [transitioning medications]," the panel opinion declares parents have no "fundamental right to treat one's children with transitioning medications subject to medically accepted standards." *Eknes-Tucker II*, 80 F.4th at 1224 (cleaned up).

Two responses: first, a by-now old refrain—in *Parham*, the Supreme Court already recognized the fundamental right at issue (parents' fundamental right to direct that their child receive well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment). So our recognition of that right is not optional. For that reason, retreading history to show that *Parham*'s right

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treatments for gender dysphoria in minors," that Alabama "fail[ed] to show that transitioning medications are *experimental*," and that "parents 'retain plenary authority to seek [medical] care for their children, *subject to a physician's independent examination and medical judgment*'" (emphases added) (citations omitted)). In other words, the district court did not establish a new framework for carefully describing the right at issue; it simply applied *Parham*. But even if the district court had narrowly described the right at issue, that wouldn't have fenced in the panel opinion. The point of appellate review is to ensure that the lower court got the analysis right.

is, in fact, fundamental is neither necessary nor appropriate.

And second, as I've explained, it's impossible for any historical discussion of transitioning medications to have "inform[ed] the meaning of the Fourteenth Amendment at the time it was ratified," *id.*, because medicine hadn't discovered transitioning medications as of July 9, 1868, and didn't do so until the twentieth century. The same is, of course, true of all modern medicine. So under the panel opinion's framing of the asserted right—by specific medical treatment sought—parents have only the fundamental right to direct their child's medical treatment with those treatments existing as of July 9, 1868.

Obviously, the 1868 Methodology is wrong. The Framers of the Fourteenth Amendment did not forever tie parents' fundamental right to direct the medical care of their children to nineteenth-century medical treatments. And we don't assess a parent's fundamental right to direct her child's medical care treatment by treatment. *Cf. Vidal v. Elster*, 602 U.S. 286, 311 (2024) (Barrett, J., concurring in part) ("hunting for historical forebears on a restriction-byrestriction basis is [not] the right way to analyze the constitutional question").

Rather, we view constitutional rights at a high enough level of generality to ensure "the basic principles" that define our rights "do not vary" in the face of "ever-advancing technology." *Moody v. NetChoice*, LLC, 144 S. Ct. 2383, 2403 (2024) (quoting *Brown v. Ent. Merchants Ass'n*, 564 U.S. 786, 790 (2011)); *see*, *e.g.*, *Carpenter v. United States*, 585 U.S. 296, 305 (2018) (quoting *Kyllo v. United States*, 533 U.S. 27, 34 (2001)). So if a medical treatment falls within the category of well-established, evidence-based, non-experimental treatment, subject to medically accepted

standards and a physician's independent examination and judgment, a parent has a fundamental right to direct that her child receive it, regardless of when the treatment was invented or discovered. Otherwise, the right is meaningless.[17]

The Lagoa Statement tries to run from the consequences of the panel opinion's plain language imposing the 1868 Methodology. According to the Lagoa Statement's retcon version of the panel opinion, the panel opinion merely "notes the absence of any historical support for the position reached by the district court" because whether parents have the fundamental right to direct that their children receive medical treatments in existence after 1868 "was not before the panel." Lagoa St. at 25 n.13.

I can understand why the Lagoa Statement would like to forget what the panel opinion expressly says—(1) that we must characterize the right at issue as the

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[17] In arguing that the state enjoys police powers to outlaw whatever medical treatments it wants that haven't been shown to have "inform[ed] the meaning of the Fourteenth Amendment at the time it was ratified—July 9, 1868," the Lagoa Statement proves our point. It relies on precedent that shows that a state's police power isn't plenary when it implicates a fundamental right. *See* Lagoa St. at 24–27. In *Globe Newspaper Co. v. Superior Ct. for Norfolk Cnty.*, 457 U.S. 596, 607–08 (1982), for instance, the Court recognized that States have a compelling interest in "safeguarding the physical and psychological well-being of a minor" but concluded that such an interest does not alone "justify a mandatory . . . rule." Rather, when state police powers clash with a fundamental right, a "trial court can determine on a case-by-case basis whether" the state action "is necessary to protect the welfare of a minor victim." *Id.* at 608. In other words, the state must establish a sufficient evidentiary record. Alabama did not do that here, and the panel opinion did not find that the district court clearly erred. The Lagoa Statement cannot engage in a do-over while denying en banc review.

parent's right to direct the medical treatment of their child with the specific treatment at issue— here, transitioning medications, *Eknes-Tucker II*, 80 F.4th at 1220 (characterizing and analyzing the right as the "right to treat one's children *with transitioning medications* subject to medically accepted standards" (cleaned up) (emphasis added)); (2) that the parent must point to "historical support" in the form of "history of *the use of*" the particular medical treatment, *id.* at 1221, 1231 (emphasis added); and (3) that, for a parent to have a fundamental right to direct the medical care of their child with any particular medical treatment, "*the use of*" the medical treatment must have *"inform[ed] the meaning of the Fourteenth Amendment at the time it was ratified—July 9, 1868*," *id.* at 1221, 1231 (emphases added).

But whether the Lagoa Statement owns up to it or not, the panel opinion's express statements and reasoning undeniably mean that, to be covered by the parents' fundamental right to direct their child's medical care, a medical treatment must have existed as of 1868. Even the Lagoa Statement offers no suggestion as to how a medical treatment could have "inform[ed] the meaning of the Fourteenth Amendment at the time it was ratified" if that treatment did not yet exist then. The 1868 Methodology is so clearly wrong that its own author now denies the words she wrote. Unfortunately, it can't be undone that easily. Only this Court sitting en banc (or the Supreme Court) can clean up the panel opinion's mess. But because we will not rehear this case en banc, the 1868 Methodology now governs all of us in the states of Florida, Georgia, and Alabama—despite its author's attempt to disavow it.

The Lagoa Statement also tethers the 1868 Methodology's required analysis to *adults*' historical access to the treatment at issue. *See id.* at 27. But that argument fails for the same reason the panel opinion and the Lagoa Statement's attempts to impose a treatment-by-treatment framework fail: *Parham* has already established that we don't evaluate a parent's fundamental right to direct the medical care of their child treatment by treatment. Rather, under *Parham*, we ask only whether a given treatment falls into the category of well-established, evidence-based, non-experimental medical treatments, subject to medically accepted standards and a physician's independent examination and medical judgment. And if it does, that is the end of the matter because *Parham* recognizes a parent's fundamental right to direct such a treatment for their child's medical care.

Our "venerable and accepted tradition" of parental due-process rights, including *Parham*'s carefully described right, "'is not to be laid on the examining table and scrutinized for its conformity to some abstract principle' of 'adjudication devised by this Court.'" *See United States v. Rahimi*, 144 S. Ct. 1889, 1918 (2024) (Kavanaugh, J., concurring) (quoting *Rutan v. Republican Party of Ill.*, 497 U.S. 62, 95–96 (1990) (Scalia, J., dissenting)); *cf. also Vidal*, 602 U.S. at 324 (Barrett, J., concurring in part) ("[T]he Court's laser-like focus on the history of this single restriction misses the forest for the trees."). Because the 1868 Methodology defies this principle and contravenes precedent, we should have reheard this case en banc and overruled it.

B. The use of transitioning medications is a well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment.

To put the district court's decision in context, I note that in the United States, roughly 300,000 thirteen-to-seventeen-year-olds identify as transgender.[18] Some of those teenagers—like Plaintiff Megan Poe's daughter—experience severe mental-health effects including suicidal thoughts—associated with gender dysphoria. *See Eknes-Tucker I*, 603 F. Supp. 3d at 1138 ("If untreated, gender dysphoria may cause or lead to anxiety, depression, eating disorders, substance abuse, self-harm, and suicide."); *see also* Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 454 (5th ed.) (same). And to put a sharper point on it, in 2022, 58%— more than half—of transgender and non-binary youth in Alabama reported seriously considering suicide in the year before, and about one in five attempted suicide.[19]

Some of these kids inevitably will succeed. That makes effective treatment of severe gender dysphoria critical.

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[18] Williams Institute, UCLA School of Law, *How Many Adults and Youth Identify as Transgender in the United States*? (June 2022), https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/ [https://perma.cc/3SJF-KGWB].

[19] The Trevor Project, *2022 National Survey on LGBTQ Youth Mental Health by State* 3 (2022), https://www.thetrevorproject.org/wp-content/up-loads/2022/12/The-Trevor-Project-2022-National-Survey-on-LGBTQ-Youth-Mental-Health-by-State.pdf [https://perma.cc/2UWR-NY25].

Given these potentially devastating effects of severe gender dysphoria, "[i]n some cases, physicians treat gender dysphoria in minors with . . . puberty blockers" to delay the onset of puberty while the minor socially transitions or decides whether to do so. *Eknes-Tucker I,* 603 F. Supp. 3d at 1138. After between one and three years on puberty blockers, minors whose gender dysphoria persists may receive hormone therapies from their doctors to "masculinize or feminize" their bodies. *Id.*

As I've recounted, the district court's factual findings underscore the widespread medical consensus that using transitioning medications to treat severe gender dysphoria in minors is a well-established, evidence-based treatment that follows medical standards. Yet the panel opinion and Lagoa Statement focus myopically on the treatment's potential (and undisputed) risks.

To be sure, and as the district court recognized and the WPATH Standards of Care acknowledge, transitioning medications—likely nearly every medical treatment—are not without risks. But as the Supreme Court recognized, and as the district court found, the fact that a treatment "'involves risks does not automatically transfer the power' to choose that medication 'from the parents to some agency or officer of the state.'" *Eknes-Tucker I*, 603 F. Supp. 3d at 1146 (quoting *Parham*, 442 U.S. at 603). Here, after considering the record, the district court concluded that Alabama "fail[ed] to produce evidence showing that transitioning medications jeopardize the health and safety of minors suffering from gender dysphoria." *Id.* at 1145.

The Lagoa Statement now questions that factual finding and others. *See*, *e.g.*, Lagoa St. at 43 ("Alabama provided significant evidence that the medications

covered by the Act are dangerous and ineffective."). But the panel opinion never found even one of the district court's factual findings to be clearly erroneous. And given that we have denied en banc rehearing, the Lagoa Statement can't do that now. That is improper.

Worse still, the Lagoa Statement relies on unvetted material from outside the factual record to try to justify its newfound conclusion that the district court clearly erred.[20] Ours is an adversarial system of justice, so if the Lagoa Statement wishes to rely on these materials, the parties must receive the opportunity to test them, and the district court must

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[20] For instance, the Lagoa Statement invokes a document called the *WPATH Files* "report," which it characterizes as a whistleblower's leak of several internal documents impugning the credibility of the WPATH. Lagoa St. at 3–5, 30–31, 47–49. That document was prepared by an organization whose policy platform includes "Escape the Woke Matrix," which, among other things, denies climate change and refers to mask-wearers as "narcissists and psychopaths." Environmental Progress, *Escape the Woke Matrix* (last visited Aug. 19, 2024), https://environmentalprogress.org/escape-the-woke-matrix [https://perma.cc/84D8-89SA]. Environmental Progress does not perform medical research. And a review of the purported WPATH communications does not reveal why the Lagoa Statement asserts that they "impugn[] the credibility of the [WPATH]." Lagoa St. at 5. Nor does it suggest that WPATH officials are "mischaracterizing and ignoring information about" transitioning medications. *Id.* at 5. To the contrary, the WPATH Standards of Care expressly state that a "careful discussion" of "all potential risks and benefits" is a "necessary step in the informed consent/assent process." WPATH Standards, *supra* n.9, at S61–63. And they also caution that the parent or "legal guardian is integral to the informed consent process." *See id.* But in any case, the bottom line is that fact-finding is the district court's job, not ours—and certainly not in a statement respecting the denial of en banc rehearing.

determine their admissibility[21] and relevance.[22] And it must make factual findings about their credibility. None of those things occurred here.

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[21] For example, the Lagoa Statement cherry-picks quotations from the *WPATH Files* "report" that don't accurately characterize the working group's conversation as a whole. *See* Lagoa St. at 4–5, 47–49. And beyond that, it's not even clear that the "report" includes or accurately summarizes the complete source material, *see* FED. R. EVID. 106, 1006, or satisfies any of the hearsay exceptions that secure the reliability of out-of-court statements, *id.* 801–03. If the Lagoa Statement offers the "report" to impeach WPATH's "genuine[ness]," Lagoa St. at 48, the declarants normally must have a chance to explain or deny the statements, FED. R. EVID. 613. Of course, trial courts are in the best position to consider these evidentiary questions in the first instance—a point that the Lagoa Statement's uncritical use of out-of-court statements aptly shows.

[22] Plus, the parties and the district court might find other extra-record evidence more relevant and instructive. For instance, several studies have shown that transitioning medications have, in fact, improved the lives of many teens with gender dysphoria. More specifically, studies have repeatedly shown that gender-affirming hormone therapy markedly decreases suicidality and depression among transgender minors who want such care. *See, e.g.*, Diana M. Tor-doff, et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 JAMA Network Open 1, 6 (2022) (60% decrease in depression and 73% decrease in suicidality); Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. Adolescent Health 643, 647 (2022) (40% decrease in depression and suicidality); Jack L. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 Pediatrics 1, 5–6 (2020) (statistically significant decrease in suicidal ideation); Luke Allen et al., *Well-being and Suicidality Among Transgender Youth After Gender-affirming Hormones*, 7 Clinical Practice in Pediatric Psychology 302, 306 (2019) (75% decrease in suicidality). Similarly, 98%—nearly all—of the over18-year-old respondents to the 2022 U.S. Transgender Survey who were receiving transitioning

Not only that, but the panel opinion and Lagoa Statement effectively substitute their medical judgment for that of the major medical organizations, not to mention the individual clinicians prescribing transitioning medications. Medical professionals have extensive scientific and clinical training. Doctors attend four years of medical school, three to seven years of residency, potential fellowships or research positions, and beyond. And then they practice medicine every day.

We, on the other hand, receive no medical training in law school. We don't go through residencies or fellowships. We don't engage in medical research. And we don't practice medicine at all. In fact, many of us went into the law because, among other reasons, we

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medications at response time "reported that [the treatment] made them either 'a lot more satisfied' (84%) or 'a little more satisfied' (14%) with their life." Sandy E. James et al., *Early Insights: A Report of the 2022 U.S. Transgender Survey*, at 18 (Feb. 2024), https://transequality.org/sites/default/files/2024-02/2022%20USTS%20Early%20Insights%20Report_FINAL.pdf [https://perma.cc/ZHW2-GAK7]. The 2022 U.S. Transgender Survey, which included 92,329 respondents (84,170 people 18 and older, and the remainder 16 or 17 years old), is the largest survey ever conducted of transgender individuals in the United States. *Id.* at 4, 6. It's not clear whether the survey asked 16- and 17-year-old respondents about their satisfaction with hormone treatment. But in any case, transitioning medications have been so beneficial for transgender individuals that 47% of Survey respondents considered moving to another state because their state's government considered or passed legislation like the Act, and 5% had actually moved out of state because of such legislation. *Id.* at 23. All three states in this Circuit—Alabama, Florida, and Georgia—are among the top ten states that respondents reported leaving. *Id.* So if extra-record sources are considered, the parties must have the chance to present whatever other sources they think relevant. And they should have the chance to show why any new proposed sources should not be relied on.

weren't good at math or science. Given our lack of medical expertise, we have no business overriding either the medical consensus that transitioning medications are safe and efficacious or clinicians' ability to develop individualized treatment plans that follow the governing standards of care. "The Constitution's contours" may not be "shaped by expert opinion," Lagoa St. at 27, but medical practice certainly is.

And to the extent that some "particular medical treatments [may] reasonably [be] prohibited by the Government," *Abigail All.*, 495 F.3d at 710, medical expertise plays an important role in our scrutiny of whether the State exercised its powers reasonably. After all, it "would certainly be arbitrary to exclude . . . dentists, osteopaths, nurses, chiropodists, optometrists, pharmacists, and midwives" from the options of healthcare providers available to patients. *England v. Louisiana State Bd. of Med. Examiners*, 259 F.2d 626, 627 (5th Cir. 1958) (per curiam).[23] At a minimum, courts must "hear[] the evidence" to scrutinize the State's determination. *Id.* We should not ignore expert consensus. And that's especially so here—where the panel opinion did not conclude the district court's findings were clearly erroneous. To do otherwise would threaten fundamental parental rights and put the lives of their children at risk.

Because parents have a fundamental right to direct that their children receive well-established, evidence-based, non-experimental medical treatment, subject to medically accepted standards and a physician's independent examination and medical judgment, *see*

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[23] All Fifth Circuit decisions issued by the close of business on September 30, 1981, are binding precedent in this Court. *Bonner v. City of Prichard*, 661 F.2d 1206, 1207 (11th Cir. 1981) (en banc).

Parham, 442 U.S. at 602, and transitioning medications meet those criteria, the Parents have alleged a colorable substantive-due-process claim.

C. It is substantially likely that the Act does not survive strict scrutiny.

Having carefully identified the right at stake here as fundamental, we must apply strict scrutiny to the Act. That means the Act must be "narrowly tailored" to achieve "a compelling state interest." *Reno*, 507 U.S. at 302. The Parents are substantially likely to show that the Act cannot satisfy that standard.

As I've noted, the district court rejected each of the State's purported justifications for the Act. The district court found that the State "fail[ed] to produce evidence showing that transitioning medications jeopardize the health and safety of minors suffering from gender dysphoria." *Eknes-Tucker I*, 603 F. Supp. 3d at 1145. And it determined that the State's "proffered purposes—which amount to speculative, future concerns about the health and safety of unidentified children—are not genuinely compelling justifications based on the record evidence." *Id.* at 1146.

But even if the State's "speculative" justifications were sufficiently "compelling," the Act is not narrowly tailored to achieve those state interests. A categorical ban on gender-affirming medical care for *all* minors is hopelessly overbroad. If the State is concerned with minors' health and safety or with the rigor of the approval process for treatment, it can mandate medical protocols in line with the WPATH Standards of Care and other guidelines. And if it fears that some healthcare professionals have committed malpractice by failing to obtain informed consent or otherwise comply with the governing standards of care, the State

can take tailored enforcement action. Similarly, if a State is worried about minors' ability to consent, *see* Lagoa St. at 45–46, it can require parental consent or otherwise mandate informed-consent procedures like the WPATH Standards of Care require.

In fact, the district court cited record evidence of other less restrictive alternatives, including "allow[ing] minors to take transitioning medications in exceptional circumstances on a case-by-case basis." *Eknes-Tucker I*, 603 F. Supp. 3d at 1146. And if we defer to these findings of fact—as we must because the panel opinion did not rule that they were clearly erroneous—the record supports the district court's conclusion that the Parents are substantially likely to show that the Act fails strict scrutiny.

That does not mean that a state could never prohibit a particular medical treatment for minors. If a state sought to outlaw a course of treatment that was not medically accepted or efficacious and that posed serious risks without benefits, that prohibition would likely clear even strict scrutiny. But that is not the case here. To the contrary, the record shows that *denying* gender-affirming medical care to transgender minors with severe gender dysphoria is more likely to "jeopardize [their] health or safety," *id.* at 1145, by compromising their mental health and putting them at increased risk of suicide.

In sum, when we properly frame the parents' right at issue and apply strict scrutiny, the Parents are substantially likely to succeed on their claim that the Act violates the Fourteenth Amendment's substantive-due-process guarantee. The panel opinion's contrary conclusion is not only legally wrong but dangerous for minors with severe gender dysphoria and their parents—

and for every parent seeking modern medical care for their child in Alabama, Florida, or Georgia.

III. The panel opinion wrongly concludes that the Minors are not substantially likely to succeed on the merits of their equal-protection claim.

The Fourteenth Amendment's Equal Protection Clause guarantees that no state shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1. To evaluate whether a law violates the Equal Protection Clause, "we apply different levels of scrutiny to different types of classifications." *Clark v. Jeter*, 486 U.S. 456, 461 (1988).

For classifications that disadvantage a "suspect class," we apply strict scrutiny. *Mass. Bd. of Retirement v. Murgia*, 427 U.S. 307, 312 (1976). As I've explained in the due-process context, strict scrutiny asks whether the state law is narrowly tailored to further a compelling state interest. The Supreme Court has applied strict scrutiny to classifications based on race, color, and national origin. *See Students for Fair Admissions, Inc. v. Pres. & Fellows of Harvard Coll.*, 600 U.S. 181, 308–09 (2023) (Gorsuch, J., concurring); *Clark*, 486 U.S. at 461. And the Court has explained that a suspect class is one "saddled with such disabilities, or subjected to such a history of purposeful unequal treatment, or relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process." *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 28 (1973).

The second, or middle, tier of review is "intermediate scrutiny." *Clark*, 486 U.S. at 461. To survive intermediate scrutiny, the classification "must be substantially related to an important governmental objective." *Id.*

Intermediate scrutiny applies to classifications based on sex or another quasi-suspect class. *See City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440–42 (1985). Quasi- suspect classes (1) "exhibit obvious, immutable, or distinguishing characteristics that define them as a discrete group," *Lyng v. Castillo*, 477 U.S. 635, 638 (1986); *cf. City of Cleburne*, 473 U.S. at 442–43; (2) have historically endured discrimination, "antipathy," or "prejudice," *City of Cleburne*, 473 U.S. at 440; *Lyng*, 477 U.S. at 638; (3) are a "politically powerless" minority, *City of Cleburne*, 473 U.S. at 445; *Lyng*, 477 U.S. at 638; and (4) have a defining characteristic that "frequently bears no relation to ability to perform or contribute to society," *City of Cleburne*, 473 U.S. at 440–41 (citation and internal quotation marks omitted).

Third, if a classification qualifies as neither suspect nor quasi-suspect under the Equal Protection Clause, we apply rational-basis review. *See Clark*, 486 U.S. at 461. And again, that means the statute must simply be "rationally related to a legitimate governmental purpose." *Id.* Or as our Court has put it, "we must uphold [a law under rational-basis review] if there is any conceivable basis that could justify it." *Jones*, 975 F.3d at 1034.

As I explain below, the Act discriminates based on two quasi-suspect classifications: sex and transgender status. So either classification requires us to apply intermediate scrutiny. When we do that, the Act cannot survive.

But the panel opinion fails to recognize as quasi-suspect the classifications the Act makes. Instead, it incorrectly applies rational-basis review to uphold the Act.

Section A shows that the Act relies on sex-based classifications. Section B explains that the Act also employs the quasi-suspect classification of transgender status. Because the Act uses quasi-suspect classifications, Section C then applies intermediate scrutiny to the Act.

A. The panel opinion fails to recognize that the Act classifies based on sex.

The Act prohibits the prescription or administration of transitioning medications "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex." S.B. 184 § 4(a). In its operation, the Act classifies based on sex in three ways. First, the Act restricts minors' access to puberty blockers and hormones based on the minors' sex. Second, the Act relies on gender stereotyping. And third, the Act discriminates against transgender individuals because they are transgender, and that is necessarily discrimination because of sex.

First, the Act conditions minors' access to puberty blockers and hormone therapy on their sex. The upshot of the Act, then, is that transgender boys and girls are forced to conform to Alabama's view of what birth-assigned girls and boys, respectively, should look like at their ages.

For example, suppose a transgender girl (birth-assigned boy), after consulting her parents and doctors, decides to take estrogen so her biological development reflects her gender identity. Under the Act, she cannot access that medication. But a cisgender girl (birth-assigned girl) with an estrogen deficiency who is prescribed estrogen for the same reason—so her

biological development matches her gender identity—can. Both seek to alter their appearance to match their gender identities, but only the transgender girl is prohibited from using the medication because the desired appearance "is inconsistent with the minor's sex" as assigned at birth. S.B. 184 § 4(b). And a medical professional cannot determine whether the Act prohibits such a treatment "without inquiring into a patient's sex assigned at birth and comparing it to their gender identity." *See Kadel v. Folwell*, 100 F.4th 122, 147 (4th Cir. 2024) (en banc).

In other words, but for the Minors' birth-assigned sex, they could access the same treatment to delay puberty or to ensure that their appearances reflect their gender identities. *See Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661, 669–70 (8th Cir. 2022). So "[s]ex plays a necessary and undisguisable role" in the Act's operation. *Bostock*, 590 U.S. at 652. That is "textbook sex discrimination." *Kadel*, 100 F.4th at 153.

The panel opinion seeks to avoid this straightforward conclusion by asserting that the Act "applies equally to both sexes." *Eknes-Tucker II*, 80 F.4th at 1228. But that the Act discriminates against both transgender boys *and* transgender girls based on sex does not change the fact that the Act discriminates based on sex.

In fact, the Supreme Court rejected a variety of that same argument in *Bostock*. There, the Court considered whether, under Title VII, an employer could lawfully "fire[] a woman . . . because she is insufficiently feminine and also fire[] a man . . . for being insufficiently masculine"—that is, whether the employer could lawfully discriminate, "more or less equally," against both men and women under Title VII. *Bostock*, 590 U.S. at 659. The Court had no trouble

rejecting that defense. *See id.* As the Court explained, "in *both* cases the employer fires an individual in part because of sex." *Id.* So "[i]nstead of avoiding Title VII exposure, this employer doubles it." *Id.*

True, *Bostock* dealt with Title VII, not the Fourteenth Amendment. But *Bostock* concluded that discriminating against both men and women is no defense to Title VII because Title VII prohibits discrimination against "individual[s]," rather than "against women [or men] as a class." *See id.* at 658–59. So too with the Fourteenth Amendment, which guarantees that "[n]o State shall . . . deny *to any person* within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1 (emphasis added).

Without citation to any authority, the panel opinion also contends that the Act does not discriminate based on sex because it "refers to sex only because the medical procedures that it regulates . . . are themselves sex-based." *Eknes-Tucker II*, 80 F.4th at 1228. This attempt to avoid the Act's sex-based classifications fails. First, the Act refers to sex apart from the medical procedures when it restricts use of puberty blockers and hormone therapy for only those minors trying to change their appearance in a way "inconsistent with their sex." S.B. 184 § 4(b). But second, even if we accept the panel opinion's incorrect premise, the mere fact that a law refers to sex-based medical procedures does not somehow insulate it from equal-protection scrutiny. As the Act shows, a law can both "refer[] to sex only because the medical procedures that it regulates . . . are themselves sex-based," *Eknes-Tucker II*, 80 F.4th at 1228, and still discriminate on the basis of sex. Our constitutional protections are not so easily circumvented.

Similarly, the panel opinion invokes *Dobbs*'s pronouncement that "the regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a mere pretext designed to effect an invidious discrimination against members of one sex or the other." *Id.* at 1229 (quoting *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 236 (2022)) (cleaned up). This argument fails.

Unlike abortion, treatment with transitioning medications is not "a medical procedure that only one sex can undergo," *id.* Both boys and girls have sex hormones. And as they have for decades for medical conditions other than gender dysphoria, doctors can prescribe puberty blockers and hormones for both boys and girls. In fact, both male and female bodies produce and use both testosterone and estrogen, though in different quantities.[24] That the hormones doctors prescribe for birth-assigned boys and girls may not be precisely the same does not somehow make the administration of puberty blockers and hormone therapy "a medical procedure that only one sex can undergo," *id*.

Second, the Act employs sex-based classifications through its use of gender stereotypes. Gender stereotypes "presume that men and women's appearance and behavior will be determined by their sex." *Brumby*, 663 F.3d at 1320. The Act prohibits the use of transitioning medications only when they are prescribed or administered to "affirm the minor's perception

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[24] Rex A. Hess, *Estrogen in the Adult Male Reproductive Tract: A Review*, 1:52 Reproductive Biology & Endocrinology 1, 1 (2003) ("Testosterone and estrogen are no longer considered male only and female only hormones. Both hormones are important in both sexes.").

of his or her gender or sex, *if that appearance . . . is inconsistent with the minor's sex*," S.B. 184 § 4(a) (emphasis added)—or to put it more bluntly, if that appearance deviates from Alabama's view of what the minor's appearance should be, based on the minor's birth-assigned sex. We've held that "the Equal Protection Clause does not tolerate gender stereotypes." *Brumby*, 663 F.3d at 1320. Yet that's exactly what the Act's classifications do: they force transgender minors to present as Alabama's view of what boys and girls, respectively, should be and look like. *See Kadel*, 100 F.4th at 153 ("conditioning access to [gender- affirming care] based on a patient's sex assigned at birth stems from gender stereotypes about how men or women should present").

The Lagoa Statement's attempts to pin Alabama's discrimination on "physical differences" falls short. Lagoa St. at 37. In fact, the very case it cites, *United States v. Virginia*, 518 U.S. 515, 533 (1996), makes plain its error. There, the Virginia Military Institute argued it could exclude women because the "psychological and sociological differences" between men and women prevented women from succeeding in its strenuous curriculum. *Id.* at 549. Virginia proffered that those biological differences were "real" and "not stereotypes." *Id.* But the Court rejected that argument. Although Virginia identified some physical differences, the Court explained, its "generalizations" from those differences were stereotypes about "the way most women are" or "what is appropriate for most women." *Id.* at 550 (emphasis omitted).

The Lagoa Statement contains the same flaw. Sure, § 4(a) mentions "physical differences" between boys and girls. But as I've noted, it recognizes those

differences only because they conform to Alabama's view of "what is appropriate" for boys and girls, *id*.[25]

Third, the Act classifies based on transgender status and gender non-conformity, which the Supreme Court and we have found indirectly discriminates based on sex. *See Bostock*, 590 U.S. at 660– 61; *Brumby*, 663 F.3d at 1316. The panel opinion seeks to sidestep *Bostock* and *Brumby* by cabining them to the Title VII and employment-discrimination contexts. Those attempts are unavailing.

Again, the Act prohibits the use of transitioning medications only if prescribed to "affirm the minor's perception of his or her gender or sex, if that appearance . . . is inconsistent with the minor's sex." S.B. 184 § 4(a). In other words, the Act proscribes transitioning medications for transgender minors only. *See Eknes-Tucker I*, 603 F. Supp. 3d at 1138.

As the Supreme Court explained in *Bostock*, "it is impossible to discriminate against a person for being . . . transgender without discriminating against that individual based on sex." 590 U.S. at 660. Because

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[25] This case is a far cry from those where the Court has recognized real, physical differences that survive intermediate scrutiny. In *Tuan Anh Nguyen v. I.N.S.*, 533 U.S. 53, 68 (2001), for example, under intermediate scrutiny, the Court upheld a statutory scheme that automatically granted citizenship to a child born out of wedlock if the mother was the parental citizen but that required proof of paternity if the father was the parental citizen. The Court found that the real difference—that a mother gives birth to her child, and that paternity is not so simply established at the time of birth—justified the statutory distinction in presumed parentage. *Id.* In contrast, the Lagoa Statement identifies a biological difference but does not explain how or why that difference "substantially relate[s]" to Alabama's "important governmental interest." *Id.*

"transgender status [is] inextricably bound up with sex," *id.* at 660–61, discrimination "against . . . transgender [individuals] necessarily and intentionally applies sex-based rules," *id.* at 667. *Bostock*'s rule governs here: because the Act classifies based on transgender status, it classifies based on sex, so it must clear intermediate scrutiny.

The Lagoa Statement aims to circumvent this precedent by conclusorily stating that "[b]ecause the language of the Equal Protection Clause does not resemble the language of Title VII, *Bostock*'s reasoning does not apply here." Lagoa St. at 36; *see also EknesTucker II*, 80 F.4th at 1229. But the Lagoa Statement fails to grapple with the Supreme Court's explanation for why Title VII's text demands *Bostock*'s answer: that Title VII's text prohibits discrimination against "any individual." *See Bostock*, 590 U.S. at 658–59. In comparison, the Fourteenth Amendment prohibits discrimination against "any person." U.S. Const. amend. XIV, § 1. So there's no meaningful difference from the text that motivated the Supreme Court's decision in *Bostock*. The Lagoa Statement has no answer for this.

Rather, the Lagoa Statement blindly pulls out-of-context quotations from Justice Gorsuch's concurrence in *Students for Fair Admissions, Inc. v. President & Fellows of Harvard College*, 600 U.S. 181, 308 (2023). But in fact, Justice Gorsuch's concurrence supports my point. Justice Gorsuch distinguished Title VII and the Equal Protection Clause because they apply "different degrees of judicial scrutiny" and cover "different kinds of classifications." *Id.* at 308. But he did not suggest that they have different definitions of discrimination. Nor could he. Both forbid "treating someone differently because of" a protected characteristic. *Id.* at 220

(Roberts, C.J., majority) (defining discrimination under the Equal Protection Clause); *see Bostock*, 590 U.S. at 658 ("treat[ing] a person worse because of sex . . . discriminates against that person in violation of Title VII").

So whether an employee is fired for being transgender, or a teenager is denied healthcare for being transgender, "[s]ex plays a necessary and undisguisable role in the decision." *Bostock*, 590 U.S. at 652. Indeed, it makes little sense to conclude that discrimination against transgender persons "necessarily and intentionally applies sex-based rules," *id.* at 667, in the Title VII context but has no relation to sex in the Equal Protection Clause context. *See Kadel*, 100 F.4th at 180–81 (Richardson, J., dissenting) (for both Title VII and the Equal Protection Clause, "*Bostock* tells us that to discriminate on the basis of [transgender status] is necessarily to discriminate 'because of' sex").

After all, the Court did not say that "transgender status [is] inextricably bound up with sex" in the workplace alone. *See Bostock*, 590 U.S. at 660–61. Nor did it say that it is "impossible to discriminate" based on transgender status in the workplace "without discriminating . . . based on sex," *id.* at 660, but possible and acceptable to do so outside the workplace. No doubt *Bostock*'s holding was limited to Title VII and employment discrimination, but its reasoning was not. And the "portions of [an] opinion['s rationale that are] necessary to [its] result" are just as binding as the holding itself. *See Powell*, 643 F.3d at 1305.

Plus, *Bostock* is not the only precedent on point here. *Brumby*—which concerned the Fourteenth Amendment's Equal Protection Clause and which we decided before *Bostock*—also controls this analysis. In *Brumby*, we held that "discriminating against [a transgender person]

on the basis of his or her gender non-conformity constitutes sex-based discrimination under the Equal Protection Clause." 663 F.3d at 1316. In so concluding, we found a "congruence between discriminating against transgender . . . individuals and discrimination on the basis of gender-based behavioral norms." *Id*. And we held that discrimination based on gender non-conformity or transgender status is "subject to heightened scrutiny." *Id*. at 1319. *Brumby*'s logic applies with equal force in this context.

The panel opinion tries to avoid this fact by cabining *Brumby*'s reading of the Fourteenth Amendment to "the context of employment discrimination." *See Eknes-Tucker II*, 80 F. 4th at 1229. But *Brumby* suggests no such limitation. And in any case, constitutional protections are not context-specific. For example, it would be absurd to hold that, because *Mississippi University*, 458 U.S. at 733, declared that the Equal Protection Clause protects men from sex discrimination in state-operated nursing schools, the Equal Protection Clause provides men with no protection against sex discrimination in other state programs. But the panel opinion does just that: it asserts that discrimination against transgender persons is unconstitutional sex discrimination only in the workplace. By extension, then, we would afford protection to an employee facing the loss of a job but spurn such protection for a teen facing the loss of medical care that could mean the difference between life and death. Constitutional rights are not so easily disposable.

Finally, the Lagoa Statement perpetuates the fiction that the Act discriminates on the basis of "purpose," not sex or transgender identity. Lagoa St. at 34–35. But in the context of this case, "discriminating on the

basis of [purpose] *is* discriminating on the basis of gender identity and sex." *Kadel*, 100 F.4th at 141. That's because gender dysphoria is "a condition that is bound up in transgender identity," and so too is treatment for that condition. *Id.* at 142. And the Act prohibits puberty blockers and hormone therapy for only the "purpose" of treating gender dysphoria. *See* S.B. 184 § 4(a). We cannot suborn sex and gender-identity discrimination by calling it by a different name.

In short, *Bostock* and *Brumby* are binding precedents that show why the Minors have a substantial likelihood of success on the merits of their equal-protection claim.[26]

B. The panel opinion fails to recognize that the Act classifies based on transgender status, a quasi-suspect class in its own right for purposes of equal-protection analysis.

The previous section explains why the Act discriminates based on sex. But the panel opinion also fails to recognize that transgender status is itself a quasi-suspect classification. *See EknesTucker II*, 80 F.4th at 1230. And the Act's discrimination on the basis of transgender status is an independent ground for applying intermediate scrutiny.

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[26] Applying *Bostock* and *Brumby* does not mean that prohibiting a particular medical treatment based on sex is automatically unconstitutional. As I've mentioned, if a state prohibited a course of treatment for transgender minors that was not medically accepted and that posed serious risks without benefits, that prohibition would likely survive even strict scrutiny. Of course, the Act does not impose that type of a prohibition. And even if we had such a law before us here, we still should have opted to correct the panel opinion's perilous equal-protection analysis.

To be sure, a majority of this Court previously expressed "grave 'doubt' that transgender persons constitute a quasi-suspect class," *Adams*, 57 F.4th at 803 n.5, but this dictum is not a binding holding. And even if it were, most respectfully, it is incorrect, and we should correct it in en banc proceedings. In fact, as my colleague Judge Jill Pryor has shown, transgender individuals meet all four criteria for quasi-suspect-class status, triggering intermediate scrutiny. *Id.* at 848–50 (J. Pryor, J., dissenting). I summarize why below.

First, transgender status is immutable, or, as we have defined it, "consistent[], insistent[], and persistent[]." *See id.* at 807. And those that take puberty blockers or gender-affirming hormones necessarily have a "consistent[], insistent[], and persistent[]" transgender identity. *See id.* That some individuals who experience some form of gender incongruence ultimately embrace their birth-assigned gender or detransition does not alter this reality because those individuals are not "transgender" as our precedent (and medical science) defines the term. *See id.*

Transgender status is also "distinguishing." In fact, it's a specific basis on which the Act distinguishes. The Act prohibits the use of puberty blockers and hormone therapy only "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex,"—in other words, only when the minor is transgender. *See* S.B. 184 § 4(a). Contrary to the Lagoa Statement's assertions, the fact that a "wide spectrum" of non-binary individuals may identify as "transgender," Lagoa St. at 40–41, does not mean that it is not a "distinguishing" label. For instance, a diverse group of individuals may identify with a particular race, religion, or national origin, but

precedent firmly establishes that race, religion, and national origin are suspect classes. *See Clark*, 486 U.S. at 461; *City of New Orleans v. Dukes*, 427 U.S. 297, 303 (1976). The same is true of transgender identity and quasi-suspect-class status. And in any event, even if the umbrella term "transgender" encompasses a "wide spectrum" of diverse people, we can still distinguish those who are "transgender" (those who consistently, persistently, and insistently identify with their non-birth-assigned sex, *see Adams*, 57 F.4th at 807) from those who are not (those who don't).

Second, as the Fourth Circuit has observed, "there is no doubt that transgender individuals historically have been subjected to discrimination on the basis of their gender identity, including high rates of violence and discrimination in education, employment, housing, and healthcare access." *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 611 (4th Cir. 2020) (cleaned up). And that prejudice and discrimination persist today. For instance, 30% of respondents to the 2022 U.S. Transgender Survey reported being "verbally harassed" in the last year because of their gender identity or expression, 9% reported being denied equal treatment or service, and 3% reported being physically attacked. And as relevant here, 80% of adult respondents and 60% of 16- or 17-year-old respondents who were out or perceived as transgender in school experienced bullying, harassment, physical attacks, or other forms of "mistreatment or negative experience."[27]

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[27] *See* James et al., *supra* n.22, at 21–22. These numbers are roughly comparable to the 2015 Survey. *See* Sandy E. James et al., Nat'l Ctr. for Transgender Equal., *The Report of the 2015 U.S. Transgender Survey*, at 5, 13 (Dec. 2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-ReportDec17.pdf [https://perma.cc/5CL3-RG9E]. And while broad-scale quantitative data

Third, transgender persons are no doubt a minority lacking in political power. "Even when we take into account the small proportion of the population transgender individuals comprise, they are underrepresented in political and judicial office nationwide." *Adams*, 57 F.4th at 850 (J. Pryor, J., dissenting).[28] The very passage of the Act, along with similar legislation in other states[29] and governmental action disadvantag-

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from prior periods may not exist, anecdotal evidence of discrimination against transgender persons dates back to the Founding era and beyond. *See, e.g.*, Genny Beemyn, *Transgender History in the United States*, *in* Trans Bodies, Trans Selves (Laura Erickson-Schroth ed., Oxford Univ. Press 2022).

[28] More than 1.3 million transgender adults—roughly 0.5% of the adult population—live in the United States. *See* Williams Institute, *supra* n.18. Yet in 2022, only 45 elected officials—across all political levels in the country, including the local, state, and federal levels—identified as transgender. LGBTQ+ Victory Institute, *Out for America 2022: A Census of LGBTQ Elected Officials Nationwide* (Aug. 2022), https://victoryinstitute.org/out-for-america-2022/ [https://perma.cc/4WQM-D6W3]. And there is not (nor has there ever been) a single openly transgender judge on the federal bench. Lambda Legal, *In a Record-Breaking Year for Judicial Nominations, the Biden Administration Fell Short on LGBTQ+ Representation* (Feb. 1, 2022), https://lambdalegal.org/publication/us_20230412_biden-admin-still-fell-short-on-lgbtq-representation-in-fed-eral-judicial-nominations/ [https://perma.cc/AFG9-7NBR].

[29] Since Alabama passed the Act, more than twenty other states have enacted legislation restricting the provision of gender-affirming hormone therapy and other procedures for transgender minors. *See* Arkansas S.B. 199 (2023); Florida S.B. 254 (2023); Georgia S.B. 140 (2023); Idaho H.B. 71 (2023); Indiana S.B. 480 (2023); Iowa S.F. 538 (2023); Kentucky S.B. 150 (2023); Louisiana H.B. 648 (2023); Mississippi H.B. 1125 (2023); Missouri S.B. 49 (2023); Montana S.B. 99 (2023); Nebraska L.B. 574 (2023); North Carolina H.B. 808 (2023); North Dakota H.B. 1254 (2023); Ohio H.B. 68 (2024); Oklahoma S.B. 613 (2023); South Carolina H.B. 4624 (2024); South Dakota H.B. 1080 (2023); Tennessee S.B. 1

ing transgender people in other contexts (i.e., executive directives barring transgender individuals from military service), evidence this reality. And the fact that a minority of states and the current Presidential administration have acted to support transgender individuals, *see* Lagoa St. at 41–42, cannot efface this widespread and invidious discrimination.[30]

Fourth and finally, transgender status bears no "relation to ability to perform or contribute to society." *Grimm*, 972 F.3d at 612 (cleaned up). Transgender individuals have achieved success across industries, contributed to the American economy, served in the U.S. military, built families, and beyond. Indeed, "[s]eventeen of our foremost medical, mental health, and public health organizations agree that being transgender 'implies no impairment in judgment, stability, reliability, or general social or vocational capabilities.'" *Id.* (quoting Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals* 1 (2012)).

So all four factors show that transgender persons are a quasi-suspect class, and intermediate scrutiny applies. *See Adams*, 57 F.4th at 848–50 (J. Pryor, J., dissenting); *Grimm*, 972 F.3d at 613; *cf. Karnoski v. Trump*, 926 F.3d 1180, 1200 (9th Cir. 2019) ("[T]he

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(2023); Texas S.B. 14 (2023); Utah S.B. 16 (2023); West Virginia H.B. 2007 (2023); Wyoming S.F. 0099 (2024).

[30] Nor is it at all relevant which law firms have "supported the Plaintiffs." Lagoa St. at 41. It is not our role to determine which law firms are "major" or "powerful." And it is not the case that a group with (pro bono) legal representation is not otherwise disenfranchised. To the contrary, many of the preeminent legal organizations in this country (e.g., the NAACP and ACLU) have dedicated themselves to representing minorities lacking in political power.

district court reasonably applied the factors" when determining that transgender persons are a "quasi-suspect class."). Although the Supreme Court has not recently recognized a new quasi-suspect class, *see* Lagoa St. at 39, its precedent does not preclude it or lower courts from doing so when warranted. To that end, the panel opinion's summary dismissal of this argument was error.

C. It is substantially likely that the Act fails intermediate scrutiny.

Because intermediate scrutiny applies, we ask whether the Act serves "important governmental objectives" and employs means "substantially related to the achievement of those objectives." *Miss. Univ.*, 458 U.S. at 724 (quotations omitted). That justification must be "exceedingly persuasive," *id.*, and cannot be "hypothesized," *Virginia*, 518 U.S. at 533.

Alabama invokes the interest of protecting children's safety. And of course, I agree that "[i]t is indisputable 'that a State's interest in safeguarding the physical and psychological well-being of a minor is compelling.'" *Otto v. City of Boca Raton*, 981 F.3d 854, 868 (11th Cir. 2020) (quoting *New York v. Ferber*, 458 U.S. 747, 756–57 (1982)). But when we apply the district court's factual findings—as we must—we cannot conclude that the Act is "substantially related" to that interest.

Just as it is substantially likely that the Act cannot survive strict scrutiny, it is substantially likely that the Act fails intermediate scrutiny as well. Again, the district court found that gender-affirming medical care is not "experimental"—to the contrary, it is widely-endorsed, "well-established, evidence-based treatment[]." *Eknes-Tucker I*, 603 F. Supp. 3d at 1145. So Alabama's interest in "safeguarding the physical and psychological

well-being," *Otto*, 981 F.3d at 868, of its minors does not itself permit Alabama to outlaw transitioning medications on the basis of sex or transgender status. In fact, across-the-board prohibition of access to transitioning medications itself compromises the "physical and psychological wellbeing" of minors with severe gender dysphoria—putting them at greater risk of suicidality and depression.[31]

What's more, the Act permits the use of the very puberty blockers and hormones it outlaws for treatment of gender dysphoria in Minors, for treatment of minors with other conditions. The continued availability of this medication to cisgender minors undercuts the State's purported safety rationale and renders the Act over- and under-inclusive. When we account for the State's asserted rationale, the Act is over-inclusive, as it prohibits gender-affirming hormone therapy for all transgender minors regardless of their medical circumstances. And it is under-inclusive because it does not altogether bar the medications. Rather, it concedes that puberty blockers and hormone therapy are safe and medically advisable in other circumstances. Simply put, the Act's ends and means are not substantially related, and the Minors are substantially likely to show that it fails intermediate scrutiny.

Because the Act unlawfully discriminates against the Minors based on their sex and transgender status, it must satisfy a more exacting standard than rational-basis review. The panel opinion's contrary conclusion essentially rubber-stamps the Act's denial of healthcare to transgender minors despite the State's failure to meet its burden. The consequences will be profound.

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[31] *See supra* n.22.

IV.

The panel opinion jettisons precedent to wrongly conclude that the Parents and Minors are not substantially likely to show that Alabama's law violates two different constitutional rights: parents' fundamental right to direct their children's medical treatment and all individuals' right to equal protection regardless of birth-assigned sex or gender conformity. These legal and constitutional errors are more than academic. They sanction the denial of well-established, medically accepted treatment and leave parents helpless to prevent life-threatening harm. Neither precedent nor the record supports that result. Worst of all, it will needlessly cause parents and their children in the state of Alabama to suffer grievously.

I respectfully dissent from the denial of rehearing en banc.