Nos. 24-582, 24-612

In the Supreme Court of the United States

UNITED STATES OF AMERICA,
Petitioner,

v.

STEVEN T. MARSHALL,
ATTORNEY GENERAL OF ALABAMA, *et al.*,
Respondents.

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

v.

STEVEN T. MARSHALL,
ATTORNEY GENERAL OF ALABAMA, *et al.*,
Respondents.

On Petitions for Writs of Certiorari to the
United States Court of Appeals for the Eleventh Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

In 2022, the Alabama Legislature determined that using puberty blockers, cross-sex hormones, and sex-change surgeries to treat minors suffering from gender dysphoria carried significant risks such as sterility and sexual dysfunction and had not been shown to resolve the underlying psychological maladies at issue. "For these reasons," the Legislature concluded that "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."

Plaintiffs and the United States challenged Alabama's law and sought a preliminary injunction, which the district court granted on both equal protection and substantive due process grounds. The court acknowledged that "transitioning medications come with risks" like "loss of fertility and sexual function." App.3a.[1] "Nevertheless," the court said, a private advocacy organization—the World Professional Association for Transgender Health (WPATH)—"recognizes transitioning medications as established medical treatments." *Id.* So the court enjoined Alabama's law. App.29a.

The Eleventh Circuit vacated the injunction, holding that the district court erred by applying heightened scrutiny and finding that Alabama's health-and-

[1] Appendix citations are to Plaintiffs' appendix in *Eknes-Tucker*, No. 24-612.

welfare law likely passes rational-basis review. A year later, the court of appeals denied Plaintiffs' petition for rehearing en banc.

While the Eleventh Circuit was deciding the preliminary injunction appeal, Alabama prepared for final adjudication, conducting extensive discovery and moving for summary judgment. That motion is now pending before the district court, but the case has been stayed pending this Court's decision in *United States v. Skrmetti*, No. 23-477 (argued Dec. 4, 2024).

The questions presented are:

1. Whether the Equal Protection Clause of the Fourteenth Amendment forbids States from prohibiting pediatric sex-change procedures for minors.

2. Whether the Due Process Clause provides parents a fundamental right to obtain sex-change procedures for their children that the State otherwise prohibits.

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INTRODUCTION

The primary difference between this case and *United States v. Skrmetti*, No. 23-477 (argued Dec. 4, 2024), is that Alabama enacted its law a year before Tennessee did. The upshot is that Alabama was able to conduct robust discovery to test the carefully curated evidentiary record Petitioners relied on to secure a preliminary injunction.[2] What it found is nothing less than a national medical, legal, and political scandal. If it wasn't clear before, it is now: Pediatric sex-change procedures are not safe, and the interest groups advocating their use have prioritized ideology over the welfare of vulnerable children. *See* Brief of Alabama as *Amicus Curiae*, No. 23-477, *United States v. Skrmetti* (U.S. Oct. 15, 2024) (discussing evidence Alabama uncovered in discovery).

Other countries have come to similar conclusions, as have half the States. Shortly after the Court heard oral argument in *Skrmetti*, the United Kingdom "indefinitely banned new prescriptions of puberty blockers to treat minors for gender dysphoria."[3] Dr. Hilary Cass, the pediatrician who conducted the yearslong independent review for England's National Health Service, concluded: "I can't think of another area of paediatric care where we give young people a

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[2] Respondents use "Plaintiffs" to refer to the private plaintiffs in *Eknes-Tucker* and "Petitioners" to refer to Plaintiffs and the United States collectively.

[3] Matt Lavietes, *Britain Bans Puberty Blockers for Transgender Minors*, NBC NEWS (Dec. 11, 2024), https://perma.cc/3Q4S-NV8E.

potentially irreversible treatment and have no idea what happens to them in adulthood."[4]

That much of this evidence came to light *after* the preliminary injunctions were entered in Alabama and Tennessee makes it unsurprising that the United States sought certiorari in a case without such evidence—and that it then tried to halt discovery in Alabama's case. *See* Brief of Alabama as *Amicus Curiae* at 1-7, No. 23-477, *United States v. Skrmetti* (U.S. Feb. 2, 2024). And it is perhaps understandable that Petitioners now ask the Court to review Alabama's preliminary injunction from nearly three years ago on a stale, incomplete record rather than wait for final adjudication—even though the State's summary judgment motion is pending before the district court and will be resolved once this Court decides *Skrmetti*.

Those are all good reasons to deny certiorari. More fundamentally, the issues presented are simply not worth the Court's review at this time. The Eleventh Circuit's unanimous decision applied blackletter law to correctly hold that States have the authority to regulate risky medical procedures in the face of shifting scientific understanding and debate. The events that have taken place in the years since the district court entered its injunction simply underscore the wisdom of that ruling.

Petitioners attempt to conjure heightened scrutiny from the Equal Protection Clause, but their incantations turn entirely on the "same treatments" fallacy: the idea that using testosterone to treat a boy's

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[4] Kamran Abbasi, *"Medication is Binary,"* BMJ (Apr. 2024), https://perma.cc/KUM3-XL2S.

endocrine disorder is the "same treatment" as using the drug to disrupt the healthy physical development of an adolescent girl suffering from psychological distress. "These are not the same!" *Kadel v. Folwell*, 100 F.4th 122, 188 (4th Cir. 2024) (Richardson, J., dissenting). Though the drug is the same, the differing diagnoses, treatment purposes, and risk-benefit profiles make the treatments altogether different—just as providing the steroid to a Tour de France cyclist would also be a different treatment.

By analogy, consider a drug that could be used *only* for transitioning. As the United States has conceded, banning such a drug would not raise an equal protection issue.[5] But if the drug had another use—say, to treat migraines—Petitioners would cry "same treatments!" and argue that the Constitution mandates heightened review of a law distinguishing between the uses. Yet in neither scenario—whether the drug has one use or two—would any regulation discriminate based on sex. The regulation would be a health and welfare provision subject only to rational-basis review.

Plaintiffs—not joined by the United States—also argue that heightened scrutiny attaches by way of a purported substantive-due-process right of parents to obtain sex-change procedures for their children. There is no such right that is deeply rooted in our Nation's history and tradition, and the general recognition that parents can direct the medical care of their children does not afford them the ability to subject every

[5] Transcript of Oral Argument at 57-58, *United States v. Skrmetti*, No. 23-477 (U.S. Dec. 4, 2024).

restricted treatment to strict scrutiny (and make judges de facto medical regulators in the process). Were it otherwise, parents could unlock access to vaccines before FDA approval and to medical marijuana or euthanasia drugs that a State prohibits.

At bottom, this case is about who decides how States should regulate a quickly evolving area of medicine. The Constitution is clear: "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." App.73a. The Court should deny certiorari after ruling for Tennessee in *Skrmetti*.[6]

STATEMENT OF THE CASE

A. Alabama Enacts the Vulnerable Child Compassion and Protection Act.

On April 8, 2022, Governor Kay Ivey signed into law the Alabama Vulnerable Child Compassion and Protection Act, Ala. Code §§26-26-1 *et seq*. The Act prohibits the prescription or administration of sex-change procedures—puberty blockers, cross-sex hormones, and surgeries—to minors "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

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[6] In the event the Court in *Skrmetti* rules that heightened scrutiny applies to Tennessee's law, the Court should remand this case to the Eleventh Circuit to apply that standard. Under that scenario, Alabama's law would remain in force because the Eleventh Circuit stayed the district court's injunction in a separate order, D.Ct.Doc.400—properly so given Judge Brasher's conclusion that the law likely survives heightened review, App.83a.

is inconsistent with the minor's sex." *Id.* §26-26-4(a). The Act does not limit "mental health professionals from rendering the services for which they are qualified." *Id.* §26-26-6.

Alabama's law was part of a global reckoning on the safety and efficacy of using sex-change procedures to treat gender dysphoria in minors. The practices themselves are of recent vintage. The first cohort study looking at the short-term effects of providing puberty blockers to 12-year-old gender dysphoric patients was published by a team of Dutch clinicians in 2011. Three years later the same team published the first findings from a subset of 55 patients who went on to receive cross-sex hormones (after turning 16) and transitioning surgeries (after turning 18); surgeries included mandatory removal of the ovaries, uterus, and testes, sterilizing the participants. D.Ct.Doc.69-23.

The clinicians were careful to include only patients who had longstanding cross-sex identification from early childhood and to exclude patients with significant psychological comorbidities like severe depression or suicidality. D.Ct.Doc.69-6 ¶75. The participants thus had overall psychological well-being scores comparable to their peers both at the study's outset and its conclusion. *Id.* ¶71. "Of the 30 psychological measurements reported, nearly half showed no statistically significant improvements, while the changes in the other half were marginally clinically significant at best." D.Ct.Doc.69-8 at 10.

Because the study did not include a control group—no patient received sex-change procedures

without psychological counseling or vice versa—the clinicians could not say what caused the modest improvements they reported. D.Ct.Doc.69-2 ¶¶51-55. Other limitations—including the possibility that switching scales in the middle of the experiment may have caused the reported reduction in gender dysphoria—abounded. D.Ct.Doc.69-6 ¶74.

Around the same time, the patient population of minors experiencing gender-related distress both transformed and exploded. The average minor patient shifted from a young, pre-pubescent boy with a long history of gender distress and a stable cross-sex gender identification to a teenaged girl whose incongruent gender identification seemed to appear out of nowhere. These teens were often autistic, often identified as "non-binary," and often had their discordance arise in association with intensive social media use. Pediatric gender clinics saw their patient populations increase by thousands of percent, and many providers prescribed transitioning treatments without the purportedly careful psychological care or exclusions reported by the Dutch team. *See* D.Ct.Doc.69-2 ¶¶58-59, 67-78; D.Ct.Doc.69-6 ¶¶79-88; D.Ct.Doc.69-7 at 16-29; D.Ct.Doc.69-5 ¶72.

The research did not keep up. Even as clinicians increasingly relied on hormones and surgeries to treat children with gender dysphoria, no study could identify a reliable way to determine which children would have their dysphoria desist naturally if not given medical interventions. D.Ct.Doc.69-3 ¶¶41-43. Yet most gender dysphoric kids *do* experience natural resolution if not medically transitioned; per the DSM-5, between 97.8% and 70% of gender dysphoric boys and

between 88% and 50% of gender dysphoric girls have their dysphoria resolve naturally by adulthood. D.Ct.Doc.69-17 at 455; *see* D.Ct.Doc.69-2 ¶¶34-40. A clinician is thus more likely to guess *wrong* and provide transitioning interventions to a child whose dysphoria would otherwise desist than guess *right* and pick out the persister.

Nor was any study able to replicate the negligible success of the Dutch team or otherwise show that providing sex-change procedures to minors is a safe and effective way of treating gender dysphoria. D.Ct.Doc.69-2 ¶¶60-64; D.Ct.Doc.69-6 ¶70. And despite the popular narrative otherwise, no study showed that medical transitioning reduces suicide. D.Ct.Doc.69-2 ¶¶81-86.[7]

On the other side of the ledger, the risks of the interventions are severe, lifelong, and largely undisputed: permanent sterility, loss of sexual function, loss of bone density, heart attack, cancer, the list goes on. D.Ct.Doc.69-3 at 12-19; D.Ct.Doc.78-41. And the risks are not remote. Because a girl has not yet menstruated and a boy has not yet produced sperm when puberty blockers are generally administered, using puberty blockers followed by cross-sex hormones—the near-universal course—means that "the sex glands will be locked in a premature state and incapable of fertility." D.Ct.Doc.69-3 at 9. It has not been demonstrated that minors subject to this hormonal damage can ever recover healthy levels of fertility.

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[7] Counsel for the *Skrmetti* plaintiffs admitted this at oral argument: "[T]here is no evidence … in the studies that this treatment reduces completed suicide." *Skrmetti*.Tr.88.

Sterility is a high price for any child to pay for a medical treatment, but it is particularly shocking here given the paucity of evidence suggesting that sex-change procedures are a safe and effective way to treat gender-related distress. The world eventually took notice. Sweden's National Board of Health and Welfare conducted a systematic evidence review and concluded in 2022 that "the risk of puberty suppression treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits." D.Ct.Doc.69-11 at 3. The UK's National Health Service found that *every* study on the subject was a "small, uncontrolled observational stud[y]," "subject to bias and confounding" with "results … of very low certainty." D.Ct.Doc.69-9 at 13; D.Ct.Doc.69-10 at 13. Finland's Council for Choices in Healthcare concluded that "[t]he reliability of the existing studies" is "highly uncertain." D.Ct.Doc.69-12 at 7.

The Alabama Legislature came to similar conclusions. After multiple hearings, it found that "[t]his unproven, poorly studied series of interventions results in numerous harmful effects for minors" and that "[m]inors, 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." Ala. Code §26-26-2(11), (15). The Legislature thus determined that "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." *Id.* §26-26-2(15), (16).

B. Petitioners Secure a Preliminary Injunction.

1. Two sets of plaintiffs immediately challenged the Act. App.7a-8a. One, led by attorneys from the ACLU, filed in the Middle District of Alabama and sought to relate their challenge to a closed case that Judge Myron Thompson had presided over concerning sex designations on Alabama driver's licenses. *See* Final Report of Inquiry, *In re Amie Vague*, No. 2-22-mc-3977 (M.D. Ala. Oct. 3, 2023), Doc.70 at 6. Despite the attorneys' efforts "to steer the case to Judge Thompson," the challenge was randomly assigned to a different judge. *Id.*

The other challenge was filed in the Northern District by attorneys now representing Plaintiffs here. *Id.* at 4-5. When that case was randomly assigned to Judge Annemarie Axon, the ACLU attorneys consented to have their case transferred to the Northern District. *Id.* at 7. To their surprise, their case was randomly assigned to Judge Liles Burke. *Id.* Shortly after, Judge Axon, who was presiding over a jury trial, transferred her case to Judge Burke so he could handle the emergency claims for relief. *Id.* at 7-8.

Both sets of plaintiffs then dismissed their challenges within minutes of each other. *Id.* at 8. The lawyers here informed the press: "We do plan to refile imminently." *Id.* at 9. Judge Burke noted: "At the risk of stating the obvious, Plaintiffs' course of conduct could give the appearance of judge shopping." *Id.*

Sure enough, the lawyers here found new plaintiffs, "refiled" in the Middle—not Northern—District, and moved to preliminarily enjoin the Act's

prohibition on prescribing puberty blockers and cross-sex hormones. *Id.* at 9-10; App.13a. As relevant here, they claimed that the Act imposes an unconstitutional sex-based classification and violates the substantive-due-process rights of parents to direct the medical care of their children. App.14a. The case was reassigned to Judge Burke, who sat by designation in the Middle District. App.8a.

2. Judge Burke entered an abbreviated briefing schedule on Plaintiffs' preliminary injunction motion and set an evidentiary hearing. App.8a. The United States then moved and was granted leave to intervene as a plaintiff; it initially also challenged the Act's surgery ban but later conformed its complaint to match Plaintiffs'. *Id.* & n.10; D.Ct.Doc.58-3 ¶40 (complaint alleging that sex-change surgery is "essential and medically necessary").

At the hearing, Petitioners relied heavily on the imprimatur of medical interest groups. *E.g.*, D.Ct.Doc.78-14 through 78-32. They argued (as they do here) that pediatric sex-change procedures are "well-established, evidence-based treatments for gender dysphoria"; that the "prevailing clinical practice guidelines governing the treatment of gender dysphoria … were developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society"; and that "[t]he WPATH and Endocrine Society guidelines are recognized as the established standard of care by major medical associations" in the United States. *ET*.Pet.7; *accord* D.Ct.Doc.8 at 16. They promised the court that the interventions are "lifesaving"; that without them gender dysphoria can "lead[] to … suicide"; and that the minor plaintiffs had

been treated pursuant to the then-existing WPATH standards and were flourishing as a result. D.Ct.Doc.8 at 2-9, 12-13.

The State presented counter evidence—expert reports showing study by study how the purported domestic medical consensus was based on low-quality evidence; systematic evidence reviews and policy restrictions by European healthcare authorities; and declaration after declaration from detransitioners and parents of gender dysphoric children who felt betrayed by their doctors' rush to medically transition. *See* D.Ct.Doc.69-1 through 69-39.

One detransitioner, Sydney Wright, testified at the hearing. She had been diagnosed with gender dysphoria in her late teens, prescribed testosterone, and suffered immense physical harms as a result. D.Ct.Doc.105 at 338-55. She later reidentified with her sex and stopped taking the drugs but still suffers health problems from the hormones: a permanently deep voice, tachycardia, and possible infertility. When asked what she needed when she first presented at a gender clinic, she was clear: "I needed counseling," not steroids. *Id.* at 349.

3. The district court preliminarily enjoined enforcement of the Act. App.29a. The court ruled that the Act was subject to and likely failed heightened scrutiny under the Equal Protection and Due Process Clauses of the Fourteenth Amendment. For the former, the court relied on this Court's decision in *Bostock v. Clayton County*, 590 U.S. 644 (2020), to reason that "the Act prohibits transgender minors—and only transgender minors—from taking transitioning

medications" and "therefore constitutes a sex-based classification." App.21a. For the latter, the court found that parents have a "fundamental right to treat their children with transitioning medications subject to medically accepted standards." App.16a.

Turning to its application of heightened scrutiny, the court recognized that "[k]nown risks" of transitioning treatments "include loss fertility and sexual function." App.3a. "Nevertheless," it said, "WPATH recognizes transitioning medications as established medical treatments and publishes a set of guidelines for treating gender dysphoria in minors" that are endorsed by "major medical associations." *Id.* at 3a-4a. Because the Alabama Legislature departed from that purported consensus, the court found that the Act was likely unconstitutional.

C. The Eleventh Circuit Vacates the Injunction and Denies En Banc Review.

The Eleventh Circuit vacated the injunction. App.74a. In a unanimous panel opinion authored by Judge Lagoa and joined by Judge Brasher and Judge Boulee sitting by designation, the court held that the Act was subject only to rational-basis review—a standard "that the law seems to undoubtedly clear." App.63a.

As to equal protection, the court explained that the Act "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." App.67a. The Act's rule, the court said, "applies equally to both sexes" and "'does not prefer one sex to the detriment of the

other.'" App.68a (quoting *L.W. v. Skrmetti*, 73 F.4th 408, 419 (6th Cir. 2023)). As for Petitioners' *Bostock* argument, the court first distinguished *Bostock* as limited to the employment context of Title VII. App.70a. The court then explained that, regardless, "[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]'" for "invidious discrimination." App.71a (alterations in original) (quoting *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 236 (2022)). "And the district court did not find that Alabama's law was based on invidious discrimination." *Id.* The court also rejected the United States' argument that transgender status alone constitutes a quasi-suspect class. *Id.*

As to due process, the court recognized that parents have a fundamental right to "make decisions concerning the care, custody, and control" of their children. App.55a (quoting *Troxel v. Granville*, 530 U.S. 57, 66 (2000)). But the district court went awry, the court wrote, when it failed to "focus on the specific right asserted, rather than simply rely on a related general right." *Id.* The court of appeals explained that the "specific right" at issue is the purported "right to give one's children puberty blockers and cross-sex hormone treatment," *id.*—a right that "almost certainly is not 'deeply rooted' in our nation's history and tradition," App.53a, nor included in "the general right to 'make decisions concerning the care, custody, and control of [one's] children,'" App.55a.

The court concluded that "[S]tates 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." App.62a. Though "there is a strong disagreement between the parties over what is best for those children," the court reasoned, "[a]bsent 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." 73a.

Judge Brasher wrote separately to make two points. First, he explained that, in his view, the Act simply "classified 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." App.77a-78a. Whether these two groups are "similarly situated," he noted, is not a question well "suited to heightened scrutiny review" because any purported remedy would not "equalize burdens or benefits between girls and boys." App.78a-79a. Rather, an injunction along equal-protection principles would "merely force Alabama to *either* ban puberty blockers and hormones for all purposes *or* allow them for all purposes." App.79a.

Second, Judge Brasher explained his view that the Act likely survives heightened scrutiny. "On this record," he wrote, "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." App.83a.

Plaintiffs petitioned for rehearing en banc, which the court of appeals denied. App.86a.

D. Alabama Conducts Discovery and Moves For Summary Judgment.

While the appellate process played out on the preliminary injunction, the parties prepared for final adjudication. Alabama sought discovery into the two major claims Petitioners made at the preliminary injunction hearing: (1) that the care the minor plaintiffs received was medically necessary for them—an essential element of their as-applied challenge; and (2) that the WPATH standards were reliable in claiming the treatments are medically necessary in general—the basis of the district court's ruling. Plaintiffs and their allies threw up obstacles at each turn.

1. The parent plaintiffs claimed a purported right "to obtain medical treatments that are recognized to be safe, effective, and medically necessary to protect their children's health and well-being." D.Ct.Doc.159 ¶98. And to prove that the prohibited procedures were medically necessary *for them*, Plaintiffs presented selective evidence at the preliminary injunction hearing about the minors' medical histories and the purportedly holistic evaluations, diagnoses, and care they received before being prescribed puberty blockers or cross-sex hormones. *See* D.Ct.Doc.215 at 2-10 (compiling examples); *accord ET*.Pet.9 (promising that minors do not begin medical transitioning until a mental health professional "confirm[s] the persistence of gender dysphoria" and "ensure[s] that any coexisting psychological, medical, or social problems" have been addressed).

Yet when Alabama sought medical records to test these claims, Plaintiffs refused, asserting that it was "irrelevant" whether "an individual minor has a correct diagnosis or particularized need." D.Ct.Doc.232 at 7. They argued that it was of "no issue" "whether or not a transgender minor has or has not been properly diagnosed with gender dysphoria" or "whether or not the medical assessments met the requirements of WPATH" because the Act prohibits the interventions regardless. D.Ct.Doc.246 at 33.

The district court saw through the argument and granted the State's motion to compel production of the medical records. D.Ct.Doc.260. As the court explained, Plaintiffs' allegations "involve medical diagnoses, the effectiveness of various medical treatments, and the alleged consequences of being denied those treatments," making their medical records "almost certainly necessary." *Id.* at 5.

2. Alabama also sought discovery into the reliability of the WPATH Standards. As the district court put it, "WPATH's standards for treating gender dysphoria in minors go to 'the very heart' of this case" because they "are part and parcel of Plaintiffs' proposed constitutional standard." D.Ct.Doc.263 at 5, 7.

The State thus subpoenaed relevant documents from WPATH, which the organization challenged before the district court. D.Ct.Doc.208. Following much briefing and multiple hearings, the district court denied WPATH's motion to quash and ordered the organization to produce documents, primarily concerning the creation of its "Standards of Care 8" (SOC-8). D.Ct.Doc.263. The court explained that "[p]roscription

of the discovery Defendants seek would, in essence, amount to acceptance of WPATH's standards as 'established, evidence-based clinical guidelines' on WPATH's word alone." *Id.* at 10 (quoting WPATH's amicus brief). WPATH unsuccessfully challenged the ruling before the Eleventh Circuit, D.Ct.Doc.299, and eventually produced the documents subject to a protective order.

3. Discovery from Plaintiffs, WPATH, and a few other entities—primarily the U.S. Department of Health and Human Services, the pediatric gender clinic at the University of Alabama Birmingham, and Johns Hopkins University—revealed a very different evidentiary picture than the one Petitioners had painted at the preliminary injunction hearing. Respondents discussed some of this evidence in its merits-stage amicus brief in *Skrmetti*.

The landscape has only continued to change. At the preliminary injunction hearing, Petitioners emphasized—and the district court accepted—that "no country in Europe (or elsewhere) has categorically banned treating gender dysphoria in minors with transitioning medications." App.12a. True or not at the time (the restrictions in place came close to a ban in practice), the statement is emphatically not true now. *See, e.g.*, Lavietes, *Britain Bans Puberty Blockers for Transgender Minors*, *supra* note 3; Azeen Ghorayshi, *Scotland Pauses Gender Medications for Minors*, N.Y. TIMES (Apr. 18, 2024), https://perma.cc/4YV6-FCX5 ("Scotland's National Health Service has stopped all new prescriptions of puberty-blocking drugs and other hormone treatments for minors….").

Nor have advances in research helped Petitioners' cause. Just the opposite. Dr. Gordon Guyatt, the godfather of evidence-based medicine, recently published his own systematic evidence reviews and meta-analyses of the safety and efficacy of using puberty blockers and cross-sex hormones to treat gender dysphoria in minors.[8] His conclusion matched every other review on the topic: low-quality evidence yielding only "considerable uncertainty."[9]

That conclusion is not likely to change soon. In October, the head of a large, NIH-funded study admitted to finding that "[p]uberty blockers did not lead to mental health improvements"—and then told the *New York Times* that she has not published the results because she does not want the findings "to be weaponized."[10]

The lead researcher from the Dutch team—who also served as co-chair of the adolescent chapter of the WPATH Standards of Care—went even further. Tacitly admitting the truth of "the critique that there is insufficient evidence," she recently wrote to "question"

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[8] *See* Anna Miroshnychenko, Gordon Guyatt, et al., *Puberty Blockers for Youth Experiencing Gender Dysphoria: A Systematic Review and Meta-Analysis*, ARCH. OF DISEASE IN CHILDHOOD (Jan. 24, 2025), https://perma.cc/AL6T-VGTW; Anna Miroshnychenko, Gordon Guyatt, et al., *Gender-Affirming Hormone Therapy for Individuals With Gender Dysphoria: A Systematic Review and Meta-Analysis*, ARCH. OF DISEASE IN CHILDHOOD (Jan. 24, 2025), https://perma.cc/ABW5-6H6T.

[9] *Id.* at 3.

[10] Azeen Ghorayshi, *U.S. Study on Puberty Blockers Goes Unpublished Because of Politics*, N.Y. TIMES (Oct. 23, 2024), https://perma.cc/8M5A-4M3W.

the "normative assumption" that the interventions "must necessarily result in 'effective' outcomes in order to be considered legitimate and essential care."[11] She argued that "the justification of this care practice should not be conditional" on the "logic of improvement," but may instead be likened to "abortion"—another intervention that "alter[s] healthy physiological states based on an individual's fundamental self-conception and desired life path."[12] "In this view," she reasoned, "healthcare is provided and justified on the basis of personal desire and autonomy," "effectiveness" is measured by how well the interventions "help individuals achieve their embodiment goals," and any "experience of regret" is welcomed as "inherent to all lives."[13] (For its part, WPATH has also seemingly moved beyond the "logic of improvement" and—per the title of a panel at its recent world conference—embraced "the dignity of risk and the right to regret."[14])

Respondents moved for summary judgment in June 2024 and submitted extensive evidence in support. *See* D.Ct.Doc.619 (redacted summary judgment motion); 557-560 (exhibits) & 700-2 through 700-18 (redacted exhibits); 700-1 (redacted reply). Trial was set for August, but the district court stayed the case pending *Skrmetti*. D.Ct.Docs.386 & 633.

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[11] Ezra D. Oosthoek, Annelou de Vries, et al., *Gender-affirming Medical Treatment for Adolescents: A Critical Reflection on "Effective" Treatment Outcomes*, 25 BMC MEDICAL ETHICS 154 (2024), https://perma.cc/8W4R-CEG7.

[12] *Id.*

[13] *Id.*

[14] *See* WPATH 28th Scientific Symposium Schedule (Sept. 2024), https://perma.cc/2SZF-QUMY.

REASONS FOR DENYING THE PETITIONS

The Court should deny certiorari because the Eleventh Circuit got it right. The Constitution does not forbid States from regulating risky areas of medicine, including by prohibiting sex-change procedures for minors. Alabama's law does not create a sex-based classification under the Equal Protection Clause; instead, it regulates based on a patient's age and diagnosis and the risks and benefits of the treatments at issue—all traditional criteria by which States have long regulated medicine. Plaintiffs' parental-rights claim fails for the simple reason that any substantive component of the Due Process Clause does not afford parents the right to override state law to obtain sex-change procedures for their children. And even if these questions were debatable or otherwise worthy of this Court's attention, this case, in this posture, is a poor vehicle to resolve them.

I. The Equal Protection Clause Does Not Prohibit States From Regulating The Provision Of Risky Sex-Change Procedures To Minors.

Though Petitioners do not discuss the merits of their equal protection challenges, it is worth doing so briefly to highlight the extraordinary nature of their claims.

A. Alabama's Law Classifies By Age and Procedure, Not Sex or "Gender Identity."

Alabama's law regulates novel, complex medical procedures that involve significant scientific uncertainty. The law draws distinctions on two bases: age and procedure. Neither is among the suspect

classifications that courts have identified for Equal Protection purposes. *See Gregory v. Ashcroft*, 501 U.S. 452, 470 (1991); *Clark v. Jeter*, 486 U.S. 456, 461 (1988).

Petitioners claim that the law also discriminates based on sex and gender identity, but that is not true. The law forbids subjecting any minor—boy or girl—to a sex-change procedure and thus "applies equally to both sexes." App.68a. Unlike laws to which this Court has subjected heightened scrutiny, the Act does not "prefer one sex over the other," "bestow benefits or burdens based on sex," or "apply one rule for males and another for females." *L.W. v. Skrmetti*, 83 F.4th 460, 480 (6th Cir. 2023) (collecting cases).

This is true for each hormonal intervention at issue. "[P]uberty blockers involve the same drug used equally by gender-transitioning boys and girls." *Id.* at 483. Under the Act, no minor, regardless of sex or gender identity, can be prescribed puberty blockers *to transition*, while any minor, regardless of sex or gender identity, can be prescribed puberty blockers as necessary to treat a different diagnosed condition.

The same logic applies to cross-sex hormones. Though these hormones differ depending on whether the minor is a boy or a girl, that simply reflects that each operation—males taking estrogen or females taking testosterone *to transition*—is one that "only one sex can undergo." *Dobbs*, 597 U.S. at 236; *see* App.67a-68a. But again, no minor, regardless of sex or gender identity, can access cross-sex hormones *to transition*, while any minor could be prescribed

hormones as necessary to treat a different diagnosed condition.

In neither case does the law impose a sex-based classification. That is because, as the United States conceded, the regulation of transitioning procedures by itself does not impose such a classification. Presented with a hypothetical of a new "drug that just has [a] transitioning purpose," with no other "reason to give" it, and asked about a state law restricting access to that drug, the Solicitor General agreed "that would not be a facial sex classification." *Skrmetti*.Tr.57-59.

The Solicitor General's admission dooms Petitioners' argument. To be sure, the drugs at issue do have other uses, which Alabama distinguishes between. But that Alabama's law spells out the relevant cross-sex hormones by sex—because, as the Solicitor General put it, "there are biological differences between males and females" (*id.* at 8)—does not create a facial sex classification that did not exist in the above hypothetical. Otherwise, an abortion law that happened to use "woman" to refer to the mother would be considered sex-based while an identical law that used "person" would not be. That is absurd. *See Skrmetti*, 83 F.4th at 482 (collecting similar examples).

"[T]reatments for gender dysphoria are different for males and for females because of biological differences between" them. App.68a. If regulation of a drug used only for transitioning does not discriminate based on sex, as the United States admits, neither does Alabama's regulation of multi-use drugs when they are used for transitioning. The Court should not apply inapt sex discrimination principles to

constitutionalize regulation of evolving and highly risky medical treatments.

B. Petitioners' "Same Treatments" Fallacy Cannot Conjure a Sex-Based Classification.

Trying to manufacture sex discrimination out of the law's nondiscriminatory rule, Petitioners insist that the fact that the drugs here have unrelated uses makes all the difference. They claim that Alabama "singles out transgender minors in order to deny them medical care, including denying them the *very same* medications available to non-transgender minors." D.Ct.Doc.8 at 22 (emphasis added); *see* D.Ct.Doc.62-1 at 1 (U.S. claiming sex-based classification based on the Act's prohibition of "treatments for transgender minors, while leaving other minors free to receive the *same* procedures and treatments" (emphasis added)).

The argument depends on a version of *Bostock*-like but-for reasoning inaptly force-fit into the Equal Protection Clause: "change one thing at a time and see if the outcome changes." *Bostock*, 590 U.S. at 656.[15] Petitioners attempt to meet the test by purportedly changing only a patient's sex and then concluding that the outcome—the availability of sex-change procedures—also changes. As the United States made the point at the *Skrmetti* argument: "If you change the individual's sex, it changes the result" because "[s]omeone assigned female at birth can't receive medication

[15] *But see* App.69a (noting that "[t]he Equal Protection Clause contains none of the text that the Court interpreted in *Bostock*").

to live as a male, but someone assigned male can." *Skrmetti*.Tr.5.

The problem is that Petitioners change more than "one thing at a time." They also implicitly change the relevant diagnosis, the purpose of the medical intervention, the risks and benefits of the intervention, and more besides. Those changes mean the "treatments" at issue are not the "same"—and that minors being treated for precocious puberty, endocrine disorders, or congenital defects are not similarly situated to minors seeking sex-change procedures. As this Court said in *Bostock*, "[t]o 'discriminate against' a person" would require "treating that individual worse than others who are similarly situated." 590 U.S. at 657. Only "[w]hen those who appear similarly situated are nevertheless treated differently" does "the Equal Protection Clause require[] [some] reason for the difference." *Engquist v. Oregon Dep't of Agr.*, 553 U.S. 591, 602 (2008). Minors who may be subjected to sex-change procedures are not similarly situated to minors who may access surgeries or drugs for other purposes.

Start with the Act's restriction on transitioning surgeries, which WPATH equally declares to be "medically necessary" for adolescents[16] (and which are all

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[16] *See* E. Coleman et al., *WPATH Standards of Care for the Health of Transgender & Gender Diverse People, Version 8*, 23 INT'L J. OF TRANSGENDER HEALTH S18 (listing purportedly "medically necessary" surgical interventions), S257 (providing summary criteria for recommending "breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery" for adolescents) (Sept. 15, 2022), https://perma.cc/Y9G6-TP3M.

too common in other states[17]). The "same treatment" fallacy here is easy to spot.[18] A vaginoplasty, for instance, generally refers to "a procedure designed to tighten the vagina" by surgically "bring[ing] the separated muscles together," typically following trauma like childbirth.[19] But the term has been recently repurposed to refer to a surgery for transitioning males that "involves rearranging tissue in the genital area to create a vaginal canal (or opening) and vulva (external genitalia), including the labia."[20] The surgery begins by "removing the penis, testicles, and scrotum,"[21] and "the penile and scrotal skin" is then "used to line the neovagina, the space between the rectum and the prostate and bladder," *Lange v. Houston Cnty.*, 101 F.4th 793, 802 (11th Cir.) (Brasher, J., dissenting), *reh'g en banc granted, opinion vacated*, 110 F.4th 1254 (11th Cir. 2024). Given that a penile-inversion "vaginoplasty" is not even possible for a female, it should be obvious that these two "vaginoplasty"

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[17] *See* Leor Sapir, *A Consensus No Longer*, CITY JOURNAL (Aug. 12, 2024), https://perma.cc/4KLM-B8MQ (analyzing national insurance database from 2017 and 2023 and finding "evidence of 5,288 to 6,294 'gender-affirming' double mastectomies for girls under age 18").

[18] Though Petitioners have disclaimed any challenge of Alabama's proscription of sex-change surgeries for minors, presumably for strategic reasons, the logic of such a challenge would be the same.

[19] *See* American Society of Plastic Surgeons, *Aesthetic Genital Plastic Surgery Surgical Options: What Is A Vaginoplasty?*, https://perma.cc/5WFH-57QP.

[20] *See* Fan Liang, Johns Hopkins Medicine, *Vaginoplasty for Gender Affirmation*, https://perma.cc/RFU9-S72N.

[21] *Id.*

surgeries have almost nothing in common and are not the "same treatments"—though, remarkably, plaintiffs in other cases have convinced courts otherwise. *See id.*

The same fallacy is at the root of Petitioners' arguments here. Puberty blockers are typically prescribed to children to treat precocious puberty, a condition where a child begins puberty at an unusually early age—typically before age eight in girls and age nine in boys.[22] When puberty blockers are used for that purpose, the aim is to ensure that children go through pubertal development at a healthy age.

But when providers use puberty blockers as a purported treatment for gender dysphoria, the purpose is to *block* normally timed puberty—the exact opposite goal. And blockers are used for this different purpose at a different *time*—after normal puberty begins, around ages 9 to 13.

Unsurprisingly, these differences change the risk-benefit analysis. Using puberty blockers beyond the normal pubertal age can, at minimum, risk a child's bone growth, social and cognitive development, and—particularly on the near-universal pathway of blockers followed by cross-sex hormones—fertility and sexual function. D.Ct.Doc.69-3 at 14-16, 17-19. The benefits differ, too. When used for precocious puberty, the benefit is clear: the child goes through normally timed puberty. When used to treat gender dysphoria, systematic reviews of the evidence reveal that the

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[22] See D.Ct.Doc.69-3 at 13; Craig Alter et al. (eds.), *Precocious Puberty*, ENDOCRINE SOCIETY (Jan. 24, 2022), https://perma.cc/6Q3E-PEMP.

claimed benefits are utterly unproven. D.Ct.Doc.69-9. These are not the "same treatments," any more than using puberty blockers to prolong a boy's singing career would be.

The story is similar for testosterone. "Testosterone therapy is routinely prescribed in adolescent males with constitutional delay of growth and puberty or hypogonadism."[23] In the case of delayed puberty, testosterone is "applied for a limited time, typically 3 to 6 months," to "initiate sexual changes" and "increase growth."[24] "Testosterone replacement in adolescents with primary or secondary hypogonadism is a long-term therapy" to bring and maintain a boy's testosterone levels at a normal range for his age.[25] The aims of both treatments are generally the same: restore healthy biological functioning, promote normal pubertal development, and alleviate infertility and sexual disfunction caused by insufficient testosterone.[26]

Using testosterone to transition an adolescent girl is altogether different. Here, the aim is to "induce the development of the physical sex characteristics" of males. D.Ct.Doc.69-10 at 3. Doctors do that by pushing testosterone levels far *outside* the healthy biological range for females, intentionally creating the diseased state of hyperandrogenism and thereby causing the patient's risk of heart attack to triple, the risk of

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[23] Maria Vogiatzi et al., *Testosterone Use in Adolescent Males: Current Practice and Unmet Needs*, 5 J. ENDOCRINE SOC'Y 1, 2 (2021), https://perma.cc/SZ3D-QE2A (parentheticals omitted).

[24] *Id.* at 2.

[25] *Id.*; *see* D.Ct.Doc.69-3 at 16.

[26] *Id.*

stroke to double, and the likelihood of breast cancer to increase significantly. D.Ct.Doc.69-3 at 17-18; D.Ct.Doc.69-5 at 64, 68. High levels of testosterone in natal females can also cause infertility,[27] particularly when the transitioning patient begins testosterone immediately following puberty blockers. D.Ct.Doc.69-5 at 64-66; D.Ct.Doc.69-8 at 8. And the benefits when used to treat gender dysphoria are unproven. According to Britain's National Institute for Health and Care Excellence, *all* the studies shedding light on the safety and efficacy of testosterone transitioning treatment are "uncontrolled observational studies," "subject to bias and confounding," with results of "very low certainty." D.Ct.Doc.69-10 at 13. As with the other treatments at issue, administering testosterone to bring a boy's levels into a normal range is not the same treatment as ramping up a young girl's testosterone levels to that of a healthy boy, which is ten times that of a healthy girl. *See* D.Ct.Doc.69-3 at 16-17.[28]

The same rationale applies to estrogen, which is generally prescribed to females to treat endocrine disorders. "Girls with either hypo- or hypergonadotropic hypogonadism need treatment with estrogens to initiate puberty and maintain a normal hormonal

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

[28] While there may be some instances in which administering testosterone to a female could be necessary—say, to treat symptoms of menopause or a gland disorder—doing so would not be the "same medical treatment" as that given to a male.

milieu."[29] The aim—and effect—is to restore healthy bodily functioning and alleviate infertility. That is neither the aim nor the effect when estrogen is provided as a transitioning treatment. Instead, transitioning estrogen treatment *causes* infertility, inhibits normal pubertal development, and significantly raises the risk of breast cancer, stroke, and blood clots. D.Ct.Doc.69-3 at 18-19. In fact, when transitioning estrogen treatment is prescribed to a natal boy who started puberty blockers at the first signs of puberty—as both WPATH and the Endocrine Society recommend[30]—the effect is nearly always infertility because the boy's sperm will never mature. D.Ct.Doc.69-3 at 14-15.

These differences in diagnosis, purpose, and risk mean that sex-change procedures are not the "same" as other interventions that happen to use similar chemicals or surgical tools—and individuals subjected to these disparate interventions are not similarly situated. Return to the hypothetical about regulation of a drug used only for transitioning, which the United States concedes would raise no equal protection problem. *Skrmetti*.Tr.57-59. It would make no sense to say that an equal protection problem springs into life if another use of the drug is developed—say, at a low dose to treat migraines. Likewise, as Alabama has pointed out for years, "implanting a fertilized egg in a woman is a treatment for infertility; implanting it in

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[29] Karen O. Klein, *Review of Hormone Replacement Therapy in Girls and Adolescents with Hypogonadism*, 32 J. PEDIATRIC & ADOLESCENT GYNECOLOGY 460 (2019), https://perma.cc/2H7W-5G42.

[30] D.Ct.Doc.69-19 at 3870; WPATH SOC-8, *supra* note 16, at S64.

a man is something quite different." D.Ct.Doc.74 at 5; *see id.* ("[I]t is not unlawful discrimination to offer testicular exams only to boys or pap smears only to girls."). Petitioners have never had a response. Their conflation of different treatments cannot create a viable equal protection challenge.

"Confirming the point is the remedy the plaintiffs seek. They do not ask the States to equalize treatment options by making a procedure given to one sex available to the other." *Skrmetti*, 83 F.4th at 483. In other words, they do not want "the government to treat boys and girls the same." App.79a (Brasher, J., concurring). Rather, they want to "force Alabama to *either* ban puberty blockers and hormones for all purposes *or* allow them for all purposes." *Id.* That demand again shows that "[t]he availability of testosterone, estrogen, and puberty blockers does not turn on invidious sex discrimination but on the age of the individual and the risk-reward assessment of treating this medical condition (as opposed to another) with these procedures." *Skrmetti*, 83 F.4th at 483. And it distinguishes this case from the Court's traditional sex discrimination cases, like *Craig v. Boren*, 429 U.S. 190 (1976). There, males sought to invalidate a "gender-based differential" in Oklahoma's alcohol sales statutes, so that they would be treated the same as female purchasers. *Id.* at 210; *see also Sessions v. Morales-Santana*, 582 U.S. 47, 51 (2017) (involving "a gender-based differential in the law governing acquisition of U.S. citizenship by a child born abroad"). But here, Petitioners' claim hinges on other medical treatments used for different purposes—not sex discrimination.

For similar reasons, the Court's decision in *Loving v. Virginia*, 388 U.S. 1 (1967), does not help Petitioners. There, the Court rejected an argument that miscegenation statutes that facially discriminated on race did not actually discriminate because they "punish[ed] equally both … participants in an interracial marriage." *Id.* at 8. The Court explained that "[t]he statutes proscribe generally accepted conduct if engaged in by members of different races." *Id.* at 11. Here, by contrast, no matter the minor's sex or gender identity, they cannot access sex-change procedures. Testosterone for a boy's endocrine disorder is not the same thing as testosterone to induce external changes in a girl, just as fentanyl for pain control is not the same thing as fentanyl for assisted suicide.

In sum, Petitioners cannot show discrimination between similarly situated persons based on sex or gender identity. Rather, their equal protection claim effectively demands a disparate impact regime for trans-identifying persons. But the Fourteenth Amendment does not cover disparate impact, *Washington v. Davis*, 426 U.S. 229, 238-39 (1976), or "[t]he regulation of a medical procedure that only one sex can undergo," *Dobbs*, 597 U.S. at 236. And in all events, there is no discrimination here: no minor, regardless of sex or gender identity, can be subjected to novel, unproven, and dangerous sex-change procedures in Alabama. That commonsense regulation, adopted by over half the States and supported by a developing worldwide consideration of the available evidence, is within the States' constitutional power to protect citizens' health and welfare.

II. The Due Process Clause Does Not Afford Parents A Fundamental, Deeply Rooted Right To Bypass State Law To Medically Transition Their Children.

Plaintiffs, not joined by the United States, devote a few pages in their petition to their claim that parents have a fundamental, substantive-due-process right to subject all governmental regulations of pediatric medicine to strict scrutiny. *See ET.*Pet.19-22. Review is not warranted on this issue.

To succeed on their substantive-due-process claim, Plaintiffs must first offer a "'careful description' of the asserted fundamental liberty interest," *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997), "focus[ing] on the specific right asserted, rather than simply rely[ing] on a related general right," App.55a. Then they must show that their asserted 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 (cleaned up).

Plaintiffs falter at each step. First, in defining the right at issue, Plaintiffs do not argue—and did not argue below—that a child, a parent, or anyone else has a *personal* substantive-due-process right to sex-change procedures. Indeed, they told the court of appeals that their claim does not depend on "whether the child has an underlying right" to sex-change procedures. Plfs'CA11Br.32.

Instead, Plaintiffs argue that parents have a right *as parents* to unlock access to medical treatments that neither they nor their children have a right to access. But as the Eleventh Circuit noted, "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." App.61a n.18; *see Skrmetti*, 83 F.4th at 475 ("A parent's right to make decisions for a child does not sweep more broadly than an adult's right to make decisions for herself."). Likewise, because a parent's "claim is derivative from, and therefore no stronger than," the child's right at issue, *Whalen v. Roe*, 429 U.S. 589, 604 (1977), Plaintiffs' abandonment of any such claim on behalf of the minor plaintiffs dooms their parental-rights claim as well.

Beyond that, far from providing a "careful description" of the right at issue, Plaintiffs "overstate the parental right by climbing up the ladder of generality to a perch—in which parents control all drug and other medical treatments for their children—that the case law and our traditions simply do not support." *Skrmetti*, 83 F.4th at 475. Like the claimants in *Glucksberg*, Plaintiffs make scant reference to the treatments actually at issue—here, puberty blockers and cross-sex hormones; there, the purported "right to commit suicide with another's assistance," 521 U.S. at 724—and repeat instead that they assert a general right to "direct[] their children's medical care," *ET*.Pet.19; *contra Glucksberg*, 521 U.S. at 723-24 (rejecting framing of general "liberty" right to "basic and intimate exercises of personal autonomy").

Second, no matter how one defines the right at issue, Plaintiffs cannot find hidden within the Due Process Clause a fundamental right of parents to subject any medical regulation to strict scrutiny. Limiting the scope of their purported right to choose from

"medically accepted standards" does not even help, Pet.13, but simply raises another problem: accepted by whom? Not the legislature or other governmental regulators, Plaintiffs say, but medical interest groups like WPATH—whose standards recommend "castration" as "medically necessary gender-affirming care" for boys and men who self-identify as "eunuchs."[31]

That won't do. Our nation's "history and tradition" is that governments regulate medical providers, not the other way around. *E.g.*, *Dobbs*, 597 U.S. at 302 ("The Constitution does not prohibit the citizens of each State from regulating or prohibiting abortion."). "This country does not have a custom of permitting parents to obtain banned medical treatments for their children and to override contrary legislative policy judgments in the process." *Skrmetti*, 83 F.4th at 475. Indeed, "[i]f parents could veto legislative and regulatory policies about drugs and surgeries permitted for children, every such regulation—there must be thousands—would come with a springing easement: It would be good law until one parent in the country opposed it," at which point "either the parent would take charge of the regulation or the courts would." *Id.*

Plaintiffs rely almost exclusively on this Court's decision in *Parham v. J.R.*, 442 U.S. 584 (1979), to attack the Eleventh Circuit's decision, *ET.*Pet.19-22, but "[n]othing in *Parham* supports an affirmative right to receive medical care, whether for a child or an adult, that a state reasonably bans," *Skrmetti*, 83 F.4th at 477. Rather, as the Eleventh Circuit explained, "*Parham* was concerned about the procedures

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[31] WPATH SOC-8, *supra* note 16, at S88-89.

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." App.58a. The procedural right at issue was thus founded on a child's "protectible interest" in "being free of unnecessary bodily restraints," 442 U.S. at 601—unlike here where Plaintiffs have *disclaimed* any right for minors to access the treatments at issue. And in *Parham* the Court emphasized that the treatment at issue was "provided by the state" itself, 442 U.S. at 609—again, unlike here where the treatment is prohibited by state law. "*Parham* therefore offers no support for the Parent Plaintiffs' substantive due process claim." App.58a.

III. This Case, In This Posture, Is A Poor Vehicle For Review.

Left with little argument that the decision below "conflicts with relevant decisions of this Court," S.Ct.R. 10(c), Petitioners have little else to say about why the Court should grant certiorari. And there are at least three additional reasons why the Court should deny review of this case in this posture.

First, Alabama's law would survive any level of review, making the debate about the tiers of scrutiny academic in this case. As the Eleventh Circuit recognized, "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" like "loss of fertility and sexual function." App.62a; *see id.* at 62a n.19 (noting "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* App.80a (Brasher, J., concurring) ("[E]ven if Alabama's statute triggered intermediate scrutiny, it would likely survive that heightened scrutiny.").

Second, when this Court granted certiorari in *Skrmetti* on the equal protection issue, it chose *not* to grant review of related petitions raising the same substantive-due-process parental-rights claim that Plaintiffs bring here. *See Doe v. Kentucky*, No. 23-492 (petition filed Nov. 3, 2023); *L.W. v. Skrmetti*, No. 23-466 (petition filed Nov. 1, 2023). That is unsurprising. The only case Plaintiffs rely on to establish a circuit split is a qualified-immunity decision from the Tenth Circuit that ruled *against* parents claiming a clearly established constitutional right to refuse chemotherapy for their son's life-threatening cancer. *ET*.Pet.22 (citing *PJ ex rel. Jensen v. Wagner*, 603 F.3d 1182 (10th Cir. 2010)). Whatever the merits of that decision when it comes to a parent's right to *refuse* recommended treatments, *Wagner* says nothing at all—and certainly does not endorse Plaintiffs' view—about a purported parental right to *access* prohibited treatments. Plaintiffs are thus left to rely on district court decisions that have either been reversed (like the decision below and the *Skrmetti* and *Doe* decisions in the Sixth Circuit), or that are currently pending before a court of appeals. *ET*.Pet.23 & n.3. There is no circuit split calling for this Court's review. *See* S.Ct.R.10(a).

Third, Plaintiffs barely address the elephant in the room, which is that they are seeking review of a preliminary injunction that is nearly three years old—when discovery has shattered the carefully

constructed evidentiary narrative they presented at the preliminary injunction hearing, the State's summary judgment motion is pending, and trial would have already occurred had it not been stayed pending a decision in *Skrmetti*. Perhaps Plaintiffs have their strategic reasons for doing that, as discussed above. But this Court would not be well served by granting certiorari in such a preliminary posture when a robust evidentiary record awaits just around the corner.

CONCLUSION

The Court should deny certiorari after ruling for Tennessee in *Skrmetti*.

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