

No. 21-2875

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UNITED STATES COURT OF APPEALS  
FOR THE EIGHTH CIRCUIT

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DYLAN BRANDT, et al.,  
Plaintiffs-Appellees,

v.

LESLIE RUTLEDGE, in her official capacity  
as the Arkansas Attorney General, et al.,  
Defendants-Appellants.

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Appeal from the United States District Court  
for the Eastern District of Arkansas  
No. 4:21-CV-00450 JM (Hon. James M. Moody)

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**BRIEF OF *AMICI CURIAE* MEDICAL AND MENTAL HEALTH  
PROFESSIONALS SUPPORTING DEFENDANTS-APPELLANTS  
AND URGING THAT THEIR PETITION FOR REHEARING EN  
BANC BE GRANTED**

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## **AUTHORITY TO FILE**

Amici have moved the Court for leave to file this brief per Fed. R. App. P. 29(b)(2).

## **IDENTITY AND INTEREST OF AMICI CURIAE**

Amici Curiae are thoroughly conversant with gender-identity affirmation practices and opine that the legislative findings supporting the Arkansas Save Adolescents From Experimentation Act (“SAFE Act”), Ark. Code Ann. §§ 20-9-1501–1504, are consistent with their experience, knowledge, and training—not “pretextual” as the lower court dismissively labeled those findings.

Quentin L. Van Meter, M.D. is a practicing board-certified Pediatric Endocrinologist with 40 years’ experience in transgender health issues; President of the American College of Pediatricians; fellow of the Endocrine Society; and member of the Pediatric Endocrine Society and of the American Association of Clinical Endocrinologists. He served as Associate Clinical/Adjunct Professor of Pediatrics at Emory University School of Medicine and the Morehouse Medical College.

Michael K. Laidlaw, M.D. is board-certified in Endocrinology, Diabetes, and Metabolism with over 20 years’ experience. He treats

patients who detransitioned from their transgender identity and published numerous articles in peer-reviewed journals and lay publications explaining the harms of gender affirming treatments, spoke to the United Kingdom Parliament on the topic, and is an experienced expert court witness regarding gender identity ideology.

Andre Van Mol, M.D., is a board-certified Family Physician and Co-chair of the Committee on Adolescent Sexuality for the American College of Pediatricians. He works in coalition with other professionals on public policy matters regarding gender identity theory and advises legislators and advocacy organizations internationally on sexuality and gender identity.

Jeffery E. Hansen, Ph.D. is a Pediatric and Adolescent Psychologist and the founder and director of The Center for Connected Living, LLC, in Olympia, WA. He completed a post-doctoral fellowship in pediatric psychology at Madigan Army Medical Center in Tacoma, Washington, where he is a senior Pediatric Psychologist and lead for clinical training and education in the Child and Family Behavioral Health Service. He gains positive results when using psychological techniques grounded in his 38 years' experience to treat gender

dysphoric youth presenting with psychological comorbidities, including resolution of gender dysphoria in some patients.<sup>1</sup>

## ARGUMENT

### **I. The district court failed to defer to the General Assembly’s findings, and the panel perpetuated that error.**

The appellate panel deferentially reviewed the district court’s factual findings, noting “the district court’s institutional advantages in evaluating witness credibility and weighing evidence.” Panel Op. at 8 (cleaned up). Although normally a sound practice, appellate deference here perpetuated the district court’s error of *not* deferring to the General Assembly’s sound findings, instead dismissively branding them as “pretextual.” *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 891 (2021).

Legislatures have broad discretion to analyze and adopt sound evidentiary foundations before setting public policy, especially with debatable issues or evidence of an emerging consensus arises. *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). They are “far better equipped than the judiciary to amass and evaluate the vast amounts of data”

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<sup>1</sup> This brief was not authored in whole or in part by counsel for any party, and no person or entity other than amici curiae or their counsel made a monetary contribution to its preparation or submission.



generated by complex and dynamic issues. *Turner Broad. Sys., Inc. v. F.C.C.*, 512 U.S. 622, 665–66 (1994) (cleaned up). And courts should defer to legislative fact finding even if a legislature makes “deductions and inferences for which complete empirical support may be unavailable.” *Id.* at 665. “Medical uncertainty does not foreclose the exercise of legislative power,” *Gonzales*, 550 U.S. at 164.

Judicial review of legislative finding is deferential, asking only if the Legislature drew “reasonable inferences based on substantial evidence.” *Turner Broad. Sys.*, 512 U.S. at 666. And here are those “reasonable inferences” as the Arkansas General Assembly established:

Section 2: Legislative findings:

The General Assembly finds that:

(1) Arkansas has a compelling government interest in protecting the health and safety of its citizens, especially vulnerable children;

(2)(A) Only a small percentage of the American population experiences distress at identifying with their biological sex.

(B) According to the American Psychiatric Association, “For natal adult males, prevalence ranges from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%.”;

(3) For the small percentage of children who are gender nonconforming or experience distress at identifying with their biological sex, studies consistently demonstrate that the majority come to identify with their biological sex in adolescence or adulthood, thereby rendering most physiological interventions unnecessary;

(4) Furthermore, scientific studies show that individuals struggling with distress at identifying with their biological sex often have already experienced psychopathology, which indicates these individuals should be encouraged to seek mental health services to address comorbidities and underlying causes of their distress before undertaking any hormonal or surgical intervention;

(5) Even among people who have undergone inpatient gender reassignment procedures, suicide rates, psychiatric morbidities, and mortality rates remain markedly elevated above the background population;

(6)(A) Some healthcare providers are prescribing puberty-blocking drugs, such as gonadotropin-releasing hormone analogues, in order to delay the onset or progression of puberty in children who experience distress at identifying with their biological sex.

(B) The prescribing of puberty-blocking drugs is being done despite the lack of any long-term longitudinal studies evaluating the risks and benefits of using these drugs for the treatment of such distress or gender transition;

(7) Healthcare providers are also prescribing cross-sex hormones for children who experience distress at identifying with their biological sex, despite the fact that no randomized clinical trials have been conducted on the efficacy or safety of

the use of cross-sex hormones in adults or children for the purpose of treating such distress or gender transition;

(8) The use of cross-sex hormones comes with serious known risks, such as:

(A) For biological females:

- (i) Erythrocytosis, which is an increase in red blood cells;
- (ii) Severe liver dysfunction;
- (iii) Coronary artery disease, including heart attacks;
- (iv) Cerebrovascular disease, including strokes;
- (v) Hypertension;
- (vi) Increased risk of breast and uterine cancers; and
- (vii) Irreversible infertility; and

(B) For biological males:

- (i) Thromboembolic disease, including blood clots;
- (ii) Cholelithiasis, including gallstones;
- (iii) Coronary artery disease, including heart attacks;
- (iv) Macroprolactinoma, which is a tumor of the pituitary gland;
- (v) Cerebrovascular disease, including strokes;
- (vi) Hypertriglyceridemia, which is an elevated level of tryglycerides in the blood;
- (vii) Breast cancer; and
- (viii) Irreversible infertility;

(9) Genital and nongenital gender reassignment surgeries are generally not recommended for children, although evidence indicates referrals for children to have such surgeries are becoming more frequent;

(10)(A) Genital gender reassignment surgery includes several irreversible invasive procedures for males and females and involves the alteration of biologically healthy and functional body parts.

(B) For biological males, surgery may involve:

- (i) Genital reconstruction including penectomy, which is the removal of the penis;
- (ii) Orchiectomy, which is the removal of the testicles;
- (iii) Vaginoplasty, which is the construction of a vagina-like structure, typically through a penile inversion procedure;
- (iv) Clitoroplasty, which is the construction of a clitoris-like structure; and
- (v) Vulvoplasty, which is the construction of a vulva-like structure.

(C) For biological females, surgery may involve:

- (i) A hysterectomy or oophorectomy;
- (ii) Reconstruction of the urethra;
- (iii) Genital reconstruction including metoidioplasty or phalloplasty, which is the construction of a penis-like structure;
- (iv) Vaginectomy, which is the removal of the vagina;
- (v) Scrotoplasty, which is the construction of a penis-like and scrotum-like structure; and
- (vi) Implantation of erection or testicular prostheses;

(11) The complications, risks, and long-term care concerns associated with genital gender reassignment surgery for both males and females are numerous and complex;

(12)(A) Nongenital gender reassignment surgery includes various invasive procedures for males and females and also involves the alteration or removal of biologically normal and functional body parts.

(B) For biological males, this surgery may involve:

- (i) Augmentation mammoplasty;
- (ii) Facial feminization surgery;
- (iii) Liposuction;
- (iv) Lipofilling;
- (v) Voice surgery;
- (vi) Thyroid cartilage reduction;
- (vii) Gluteal augmentation;
- (viii) Hair reconstruction; and
- (ix) Other aesthetic procedures.

(C) For biological females, this surgery may involve:

- (i) A subcutaneous mastectomy;
- (ii) Voice surgery;
- (iii) Liposuction;
- (iv) Lipofilling;
- (v) Pectoral implants; and
- (vi) Other aesthetic procedures;

(13)(A) It is an accepted principle of economics and public policy that when a service or product is subsidized or reimbursed, demand for that service or product is increased.

(B) Between 2015 and 2016, gender reassignment surgeries increased by nearly twenty percent (20%) in the United States;

(14) It is of grave concern to the General Assembly that the medical community is allowing individuals who experience

distress at identifying with their biological sex to be subjects of irreversible and drastic nongenital gender reassignment surgery and irreversible, permanently sterilizing genital gender reassignment surgery, despite the lack of studies showing that the benefits of such extreme interventions outweigh the risks; and

(15) The risks of gender transition procedures far outweigh any benefit at this stage of clinical study on these procedures.

Act 626, 93rd Gen. Assemb., Reg. Sess. (Ark. 2021).

These detailed findings are scientifically sound—indeed, virtually unassailable—and the en banc Court should correct the panel’s uncritical deference to the lower court’s error.

## **II. The General Assembly’s concern for the health of Arkansas youth is consistent with mainstream medicine.**

The Hayes Corporation—which is relied upon by companies and hospitals that cover 83% of insured Americans when they evaluate the credibility of medical procedures for health-insurance coverage, Hayes, Inc., <https://www.hayesinc.com>, concluded that current evidence does *not* support medical gender affirmation of youth.

After reviewing 21 studies of administering cross-sex hormones to gender dysphoric adolescents and adults, Hayes concluded that the research findings were “too sparse” and “too limited to suggest

conclusions.” Hayes, Inc., *Hormone Therapy for the Treatment of Gender Dysphoria*, Hayes Medical Technology Directory (2014). And reviewing studies evaluating adolescent gender reassignment surgery similarly disclosed only a “paucity of data.” Hayes, Inc., *Sex Reassignment Surgery for the Treatment of Gender Dysphoria*, Hayes Medical Technology Directory (2018). Under Hayes’ rating system, that means that there is “insufficient published evidence to assess the safety and/or impact on health outcomes or patient management.” Hayes, Inc., *The Hayes Rating*, <https://www.hayesinc.com/about-hayes/>.

Similarly, the Centers for Medicare and Medicaid Services (“CMS”) found “inconclusive” clinical evidence regarding gender reassignment surgery, stating in its Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) (Aug. 30, 2016) that it “is not issuing a National Coverage Determination (NCD) at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is inconclusive for the Medicare population.”

When such respected reviews align with the Legislative Findings, the lower court was wrong to label those findings “pretextual.”

### III. At best, there is only low-quality evidence for medical gender affirming treatments for youth.

Medical gender affirming treatment “suffers from a vexing problem: There are no randomized controlled trials (RCT) of different treatment approaches, so the front-line clinician has to rely on lower-order levels of evidence in deciding on what the optimal approach to treatment might be.” Kenneth J. Zucker, *Debate: Different strokes for different folks*, 25 *Child and Adolescent Mental Health* 36–37 (2020).

That “lower order” evidence is typified by *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, Jack L. Turban, Dana King, Jeremi M. Carswell and Alex S. Keuroghlian, 145 *Pediatrics* (2020), which Plaintiffs-Appellees’ expert cites to say that “gender-affirming medical care is linked to favorable mental health outcomes.” Turban Decl. 5-6, R. Doc. 51-1. But “linked” only suggests correlation, *not* causation, and the study’s cross-sectional design inherently cannot establish causal relationships. *Handbook of Survey Methodology for the Social Sciences* 66 (Lior Gideon ed., Springer 2012). And *Pubertal Suppression* suffers other flaws, such as drawing its data from the unreliable 2015 United States Transgender Survey (in which over 70% of respondents claimed to start puberty blockade *after* age 18) and



failing to control for underlying mental health, among many others.

Michael Biggs, *Comment RE: Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation* (Jan. 30, 2020), <https://perma.cc/R8HB-UVZB> (cataloguing flaws).

Similarly, the argument that suicide is likely if gender affirming medical treatments are not readily provided rests on shoddy research. See Turban Decl. 37 n.61, R. Doc. 51-1 (citing Jack L. Turban, N. Beckwith, S. L. Reisner & A. S. Keuroghlian, *Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults*, 77 JAMA Psychiatry 68-76 (2020)). *Recalled Exposure* suffered a “problematic analysis” and used “flawed conclusions” to advance “the misguided notion that anything other than ‘affirmative’ psychotherapy for gender dysphoria (GD) is harmful and should be banned.” Roberto D’Angelo et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, 50 Archives Sexual Behav. 7 (2021).

Another article, Richard Bränström and John E. Pachankis, *Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study*,

177 Am. J. of Psychiatry 727–734 (2019), was heralded by gender identity advocates for finding “a statistically significant relationship . . . that as of 2015, patients who had surgeries further in the past had better mental health than patients whose surgeries were more recent.” Soc’y for Evidence Based Gender Med., *Correction of a Key Study: No Evidence of “Gender-Affirming” Surgeries Improving Mental Health* (Aug. 30, 2020), [https://www.segm.org/ajp\\_correction\\_2020](https://www.segm.org/ajp_correction_2020). Yet that claim had to be withdrawn, while preserving the finding that hormone treatment alone did *not* significantly affect subsequent mental healthcare treatment. *Correction to Bränström and Pachankis*, 177 Am. J. of Psychiatry 727–734 (2020); *see also* Andre Van Mol, Michael K. Laidlaw, Miriam Grossman, & Paul R. McHugh, *Gender-affirmation surgery conclusion lacks evidence*, 177 Am. J. of Psychiatry 765–766 (2020) (critiquing Bränström article).

#### **IV. The General Assembly’s findings track the growing consensus for using psychotherapy as the first-line treatment for gender dysphoric youth.**

The General Assembly’s shift from using medical procedures as the first-line response to gender dysphoric youth is consistent with global practices: “[A]most all clinics and professional associations in the

world use what's called the *watchful waiting* approach to helping [gender dysphoric] children....” James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-checking of AAP Policy*, J. Sex & Marital Therapy, <https://doi.org/10.1080/0092623X.2019.1698481>.

Indeed, rushing gender affirmation “runs the risk of neglecting individual problems the child might be experiencing and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist.” Walter Bockting, *Ch. 24: Transgender Identity Development*, 1 Am. Psych. Ass’n Handbook of Sexuality and Psychology 739, 750 (D. Tolman & L. Diamond eds., 2014).

Failing to address the underlying psychological issues of trans-identifying young people puts them “at risk of receiving potentially damaging medical treatment they may later seek to reverse or come to regret, while their underlying psychological issues remain unaddressed.” Robert Withers, *Transgender medicalization and the attempt to evade psychological distress*, 65 J. Analytical Psych. 865–889 (2020), <https://doi.org/10.1111/1468-5922.12641>.

All this aligns with an emerging consensus illustrated by recent European edicts to *stop* gender affirming medical interventions in minors. Council for Choices in Healthcare in Finland, *Medical treatment methods for dysphoria associated with variations in gender identity in minors—recommendation* (June 11, 2020), [https://bit.ly/Cohere\\_Finland\\_GDAinMinorsRx](https://bit.ly/Cohere_Finland_GDAinMinorsRx) (prioritizing psychotherapy over medical gender affirmation for dysphoric minors); Soc’y for Evidence Based Gender Med., *Sweden’s Karolinska Ends All Use of Puberty Blockers and Cross-Sex Hormones for Minors Outside of Clinical Studies* (May 5, 2021), [https://bit.ly/SEGM\\_SwedenStopsHormones](https://bit.ly/SEGM_SwedenStopsHormones) (restricting puberty blockers or cross-sex hormones for minors to clinical trials).

## CONCLUSION

The district court panned the General Assembly’s detailed findings as “pretextual” when in fact those findings are well supported by the best available science. The en banc Court should grant the petition and reverse the panel’s perpetuation of that grievous error.

Date: October 11, 2022

Respectfully submitted,

/s/ John J. Bursch

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## CERTIFICATE OF COMPLIANCE

Under Fed. R. App. P. 32(g), the undersigned certifies that this brief complies with the type-volume limitations of Fed. R. App. P. 29(b)(4). Exclusive of the sections exempted by Fed. R. App. P. 32(f), the brief contains 2,587 words, according to the word count feature of the software (Microsoft Word 365) used to prepare the brief. The brief has been prepared in proportionately spaced typeface using Century Schoolbook 14 point.

/s/ John J. Bursch  
John J. Bursch

## CERTIFICATE OF SERVICE

I hereby certify that I electronically filed this brief with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit using the Appellate CM/ECF system on October 11, 2022. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the Appellate CM/ECF system.

/s/ John J. Bursch  
John J. Bursch