Nos. 23-477

In the Supreme Court of the United States

UNITED STATES OF AMERICA,

Petitioner,

v.

JONATHAN THOMAS SKRMETTI, ATTORNEY GENERAL AND REPORTER FOR TENNESSEE, ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF THE ETHICS AND RELIGIOUS LIBERTY COMMISSION AND THE TENNESSEE BAPTIST MISSION BOARD AS *AMICI CURIAE* SUPPORTING RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

The **Ethics and Religious Liberty Commission** (ERLC) is the moral concerns and public policy entity of the Southern Baptist Convention (SBC), the nation's largest Protestant denomination, with nearly 13 million members in roughly 45,000 churches and congregations. The ERLC is charged by the SBC with addressing public policy affecting such issues as religious liberty, marriage and family, the sanctity of human life, and bioethics.

The **Tennessee Baptist Mission Board** is a state convention entity in partnership with the SBC. It has over 3,200 affiliated churches, and it shares the values and interests of the ERLC.

Amici affirm that God created humans, the crowning work of His creation, as male and female. The gift of sex and gender, being one and the same, is part of the goodness of God's creation. A physical body is an integral part of a human being. The bodies of children, which are sexually differentiated from the moment of conception, naturally develop into sexually mature adult bodies through the process of puberty as part of God's design.

Amici submit this brief because this case implicates fundamental truths[2] that Southern Baptists hold dear,

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[1] Rule 37 statement: No part of this brief was authored by any party's counsel, and no person or entity other than *amici* funded its preparation or submission.

[2] Numerous resolutions and other statements of the Southern Baptist Convention have expressed these ideas drawn from Scripture, most recently in the resolution "The God-Given Rights and Responsibilities of Parents" (June 12, 2024), https://www.sbc.net/resource-library/resolutions/on-the-god-given-rights-and-responsibilities-of-parents/ ("2024 Resolution"). *See also* Genesis 1:26–

which coincide with the legal arguments. First, that biological sex is not only immutable but also part of the goodness of God's creation. Second, that children are a blessing from the Lord. Third, that government has a responsibility to restrain evil and promote the good of its people, including the young and vulnerable.

Accordingly, *amici* have an interest in ensuring that governments protect children's developing healthy bodies, including by prohibiting medical procedures that refashion healthy bodies based on the children's perceived or desired gender.

INTRODUCTION

This lawsuit and the use of the medical interventions at its heart raise existential questions about the nature of humankind. The constitutional analysis depends on obscure and contested medical jargon. With so much at stake, it is easy for the questions to seem intractable, for the conflict to seem like a fight between medicine and politics, and for the answers to seem to depend on how the relevant values are abstracted. Much will not be resolved by this lawsuit.

But critical points can be made plainly, and they are more than enough to resolve the issues here. There are essentially two views about Tennessee's law. Tennessee can rightly say that no physically healthy adolescents receive the medical interventions at issue to change their appearance, regardless of their sex or how they identify. By contrast, the federal government says that because physically ill children receive those same medicines to fix their underlying illnesses, some

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27; Romans 13:1–4; 1 Peter 2:13–14; S. BAPTIST CONV., THE BAPTIST FAITH & MESSAGE (2000).

physically healthy children *must* be permitted to use those medicines to induce illness just for the effects on appearance. The first view protects all children and adolescents equally; the second is ghastly. These simple points make clear that Tennessee's law does not violate the Constitution.

SUMMARY OF ARGUMENT

Tennessee's law, Senate Bill 1 (SB 1), prohibits medical procedures intended to conform a minor's appearance to an identity inconsistent with the minor's biological sex. The federal government claims that denying two medical interventions—so-called "puberty blockers" and cross-sex hormones—to minors with gender dysphoria constitutes sex and transgender-status discrimination. It argues that this violates the Equal Protection Clause because SB 1 denies to minors who identify as transgender treatments they could receive for reasons other than gender dysphoria.

While this lawsuit raises a litany of peripheral issues, only two control the outcome, and the relevant points about both are beyond dispute. First, sex means biological sex for all purposes in this case because the law affects only minors who have no disorders of sex development. Second, the nature of the medical interventions at issue is uncontested. They affect the development of primary and secondary sex characteristics, and they are not normally used on adolescents absent a hormonal imbalance or for birth control.

Additionally, what the purported experts advocating these interventions do not know is also important. Neither the government nor those experts can provide a clear definition of the gender terms at issue. The

ambiguity clears the way for an expansion of the entitlement sought here in the future. Also, even as the parties heavily dispute the benefits and risks of the medical interventions, they do not dispute that both are largely unknown or that the interventions necessarily compromise sexual and reproductive function (for some minors, permanently). The gaps undermine the credibility of the federal government's position.

With this background, the equal protection analysis goes quickly. SB 1 precludes providing healthy adolescents with puberty blockers and cross-sex hormones to make them appear different than their biological sex. But Tennessee law already prevents healthy boys from seeking testosterone to conform them to their sex. Healthy girls do not seek estrogen for that purpose, and neither boys nor girls use puberty blockers for that. So Tennessee does not treat similarly situated adolescents differently. An adolescent's gender dysphoria is irrelevant under this analysis because the law does not hinge on it and neither do any comparisons. And the federal government cannot point to the interventions being used for other endocrine disorders as a rationale to allow physically healthy adolescents to make themselves ill.

The lifelong harm caused by these interventions confirms the wisdom of the Court in not taking up the parental-rights question addressed below. Parents do not have the right to prevent their children from maturing into physically healthy adults by treating gender dysphoria with the medical interventions at issue here.

ARGUMENT

To evaluate the legal merits of the federal government's claim, only two points need be set out up front, in areas where we can say something definite and beyond dispute. Besides that, a few additional points are worth establishing at the start; they further demonstrate that the federal government and the purported experts on which it relies have no more insight than the state of Tennessee. It is then straightforward to show in multiple ways that SB 1 comports with the Equal Protection Clause. Indeed, it equally protects and respects the integrity of all adolescent bodies.

I. THE CORE POINTS NECESSARY TO RESOLVE THE CASE ARE FEW AND NOT IN DISPUTE

A. Sex means biological sex.

The federal government's claims of sex and transgender-status discrimination depend, unsurprisingly, on what sex means. Unlike in other contexts (such as employment discrimination) where facts may be uncontested or simplistic perceptions suffice, here the disputed medical and scientific definitions can control outcomes. The parties do not dispute that much.

The scientific concepts of biological sex and puberty are, after all, foundational to the study and practice of medicine. J.A. 481, 485, 611. Sex is the most significant differentiator between human beings. *See* J.A. 611–12. A patient's sex serves as a critical diagnostic criterion used in every medical setting and practice area. Many medical conditions have different rates of occurrence and presentations in males and females, and indeed, many conditions are effectively or truly unique to only one sex—including some of those used

in arguments in this case. *See* J.A. 611–12. Sexual development in adolescence, puberty, represents one of the most central developmental periods in a human's life. J.A. 485. The experts on both sides agree that a decision to intentionally interfere with this process is a weighty one.

The definition of sex is nevertheless disputed here. Human sex biologically refers to a person's role in reproduction, whether the person produces male or female gametes. *See* J.A. 481, 743. But the production of healthy gametes is determined by multiple biological factors and functions—chromosomal, hormonal, and anatomical. *See* J.A. 743–47 (full discussion of development). The whole human body is designed around and displays the difference, including in primary and secondary sex characteristics. J.A. 485–86. A small portion of the population has disorders of sex development where these complex systems go awry and some biological factors appear to be misaligned. *See* J.A. 482–84. Patients suffering from those rare conditions may externally appear ambiguous or "intersex," though there is no third sex. *See id.*; J.A. 107. Because of this possibility, the government and plaintiffs' experts prefer to speak of "sex assigned at birth" rather than biological sex because a person's apparent sex may not reflect some biological markers. *See* J.A. 378. Patients suffering from such conditions deserve the dignity of being described as male or female despite their compromised biological function. A few such cases does not impugn the necessity and utility of recognizing a robust biological dichotomy that controls human differentiation.

Yet here, this debate is worse than mere pedantry. Neither this case nor the law at issue have anything to

do with intersex conditions or disorders of sex development. They concern only physically healthy minors. SB 1's restrictions do not apply to treating any "congenital defect," physical "disease," or any "disorder of sex development." Tenn. Code Ann. §§ 68-33-102(1); 68-33-103(b)(1). Further, none of the plaintiffs (or envisioned beneficiaries) have any such condition. *See* J.A. 27–37. "Sex assigned at birth" simply means biological sex for all purposes here. The federal government's dogmatic insistence on using the term to suggest ambiguity serves only to strategically obfuscate a core element of the case.

B. All agree about the nature of the relevant medical interventions.

The medical interventions at issue here are the other part of the equation. The federal government and plaintiffs' experts defend two.

First, so-called "puberty blockers"—more formally, gonadotropin-releasing hormone (GnRH) agonists—down-regulate and inhibit the hypothalamic-pituitary-gonadal axis, which reduces the production of the endogenous sex hormones that cause puberty to progress. J.A. 495; 756. Put simply, in adolescents they arrest natural puberty by blocking natural hormonal signaling.

Second, cross-sex hormones are the primary sex hormones from one sex—in males testosterone and in females estrogen—given to the opposite sex. J.A. 769. Natal sex hormones result in the development of reproductive and sexual function in addition to secondary sex characteristics—sex-distinctive physical features not directly involved in reproduction, including fat distribution, body and facial hair, and vocal

register. J.A. 613–14. They also affect all other bodily systems, from brain development to bone development. J.A. 612–14. When given to the opposite sex, they create some of the secondary sex characteristics from the sex that primarily produces them. J.A. 517. Cross-sex hormones cannot make all physical features appear to be fully of the opposite sex, and they cannot create biological functions, including the reproductive function, of the opposite sex. *See* J.A. 517–23; 614. They do not make a biological male into a biological female or vice-versa.

Some people suffer from hormonal imbalances, having sex hormone levels outside the normal range for one's sex. J.A. 519, 770. Many doctors across practices test and prescribe such hormones to restore naturally occurring physiology by fixing those levels. *Id.* As the government and plaintiffs' experts stress, the interventions at issue here are indeed used for many conditions. For instance, primary care physicians and specialists regularly prescribe hormone replacement therapy for males with low testosterone or females with low estrogen. Pediatric endocrinologists prescribe hormonal therapies for children and adolescents with rarer hormonal conditions, including testosterone for delayed puberty in boys and estrogen for primary ovarian insufficiency, hypogonadotropic hypogonadism, or Turner's Syndrome in girls. J.A. 500–01, 519. They also prescribe testosterone suppressants to girls with polycystic ovarian syndrome, which causes excess testosterone and symptoms like excess facial hair. J.A. 100. And they prescribe puberty blockers to treat central precocious puberty (the premature initiation of puberty by the central nervous system). J.A. 120. Additionally, primary care physicians, pediatricians, and gynecologists regularly prescribe certain forms of

estrogen and progesterone to alter women's reproductive function for birth control. J.A. 100.

Although the parties dispute the appropriateness of using these medical interventions to treat gender dysphoria—including the importance of none of them being approved by the FDA for that purpose—two additional points beyond dispute are relevant. First, neither the government nor the experts note any example of these treatments being used on adolescents who do not have a hormonal imbalance (other than, if even relevant, birth control). Second, even though many physicians prescribe these drugs and know their power and danger, only a small subset are willing to use them in the way the federal government seeks.

II. SERIOUS GAPS IN KNOWLEDGE UNDERMINE THE FEDERAL GOVERNMENT'S CREDIBILITY AND ARGUMENTS

A. The federal government exploits the absence of key definitions.

The government and plaintiffs' experts defend the medical interventions at issue as necessary to "treat" a psychiatric condition. As they assert, some adolescents suffer from gender dysphoria, meaning "clinically significant distress resulting from incongruence between [the adolescent's] gender identity and the sex assigned at birth." Pet. Br. at 3; J.A. 380, 998–99. The incongruence must have persisted for at least six months and be accompanied by "clinically significant distress or impairment in social, occupational, or other important areas of functioning." J.A. 125–26.

The federal government and plaintiffs' experts assert that they draw the definition for gender dysphoria straight from the Diagnostic and Statistical Manual of

Mental Disorders (DSM)—the manual used by psychiatrists to diagnose mental disorders. J.A. 60, 125, 380, 1001. But the government and those experts do not define any of the constituent terms further—particularly, "gender," "gender identity," or "transgender"—including because the government's joint appendix inexplicably drops two of the expert declarations that addressed those terms in part below. Instead, we are left with the threadbare allegation in the government's complaint-in-intervention that "[g]ender identity refers to a person's core sense of belonging to a particular gender, such as male or female." J.A. 60. The federal government and plaintiffs' experts dogmatically assert that gender identity is "innate" and "immutable." Pet. Br. at 29; J.A. 1026–27. But they do not know why, only theorizing that there might be an unidentified biological basis. J.A. 1027.

The DSM upon which the federal government bases its case approaches gender issues differently. The "experienced/expressed gender" that conflicts with sex is "the public, sociocultural (and usually legally recognized) lived role." AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, TEXT REV. 511 (5th ed. 2022). "Gender identity" is separately defined, but not used within the definition of gender dysphoria, as "a category of social identity." *Id.* In the DSM, gender and gender identity are largely public, social concepts, and "[b]iological factors are seen as contributing, in interaction with social and psychological factors, to gender development." *Id.*

The federal government's redefinition of gender identity (with no supporting authority) and its failure to define other terms raise many tough questions. For one, how can a socially and culturally contingent role

comprise an internal sense that is innate and immutable? These difficulties magnify that the federal government and the plaintiffs' experts are making a philosophical argument (if not one of belief) rather than a medical or scientific one. The Court has not yet embarked on this journey of discovery. *See Bostock v. Clayton Cnty.*, 590 U.S. 644, 655; *id.* at 686 & n.6, 715 (2020) (Alito, J., dissenting) (noting the lack of legally applicable definition). And it should not do so. These problems overshadow the government's attempts to establish transgender status as entitled to heightened scrutiny, but they more critically undermine its claim to any legal or medical credibility and authority.

Moreover, the federal government's dissembling appears to be strategic and intentional. By deeming the gender identity that causes dysphoria innate and immutable, the government makes gender identity appear closer to a status justifying constitutional entitlement. It makes the condition appear more like a physical one amenable to invasive physiological interventions aimed at organs other than the brain (rather than psychiatric treatment). Simultaneously, the convenient omission of key definitions and testimony appears calculated to avoid criticism. After all, when experts *have* been clearer about gender ideology, their self-contradictions have been exposed.[3]

Neither the federal government nor the "experts" supply good answers to why a mental condition with no known biological basis, which cannot be physically diagnosed, ought to be treated with hormones like a hormonal imbalance. And there is no reason to think

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[3] *See, e.g.*, Br. of Do No Harm as Amicus Curiae Supporting Appellants 14–17, *Loe v. Texas*, No. 23-0697 (Tex.) (Dec. 22, 2023).

that they will not change these amorphous definitions, which serve for now as a convenient litigating position, in the future. Stability is not guaranteed.

Indeed, forces are already at work to ensure that any ground gained here will be expanded beyond recognition. Although the federal government and the few expert declarations it relies upon defend the medical interventions here only for gender dysphoria, many in the "gender-affirming care" movement seek to allow *all* adolescents having incongruence between their gender identity and sex to obtain the interventions at issue here *regardless* of whether they feel any distress at all. J.A. 628. In other words: medical "care" without any underlying medical disorder. The "standard of care" has obviously trended in this direction as the diagnostic and treatment criteria have been relaxed over time. J.A. 510–11. We now know the federal government itself caused some of this movement by pressuring the World Professional Association for Transgender Health. *See* Tenn. Br. at 10. And the multitude of allegations that physicians are not following even these increasingly flexible guidelines, *see, e.g.*, J.A. 595, 628, 790–93, 940–42, suggests that numerous gender-affirming specialists agree that the interventions should be dispensed on demand to any adolescent identifying as transgender.

But some in the medical community have simply stated as much. The World Health Organization publishes the International Classification of Diseases, a diagnosis coding scheme used for medical billing and reimbursement. J.A. 307, 678. Its eleventh revision (ICD-11), introduced in 2018 and slated to be incorporated by U.S. medical authorities in the near future, has redefined gender identity-related diagnostic

categories. They are now labeled "gender incongruence" and no longer part of "mental and behavioral disorders"; they are simply "conditions related to sexual health" instead of "conditions of mental ill-health."[4] In other words, the ICD-11 intends that people classified as transgender may obtain the medical interventions here without any diagnosed disorder or illness at all. At least one of plaintiffs' experts wholly agrees with this approach. Reflecting on these changes, Dr. Aron Janssen and several colleagues argue:

> Requiring [transgender] people to have a diagnosis at all to obtain care, no matter the terminology used, is pathologizing. The practice of requiring a diagnosis continues to put mental health and other medical providers in the position of gatekeeping, continuing the vestigial historical focus on confirming a person's gender identity, rather than trusting that [transgender] people understand their identities better than providers do.[5]

This trend undermines the idea that there has been consistency for "decades," Pet. Br. at 2, much less any implicit promise that there will be stability in the future. The approach of gender care specialists metamorphosizes even while this litigation proceeds.

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[4] World Health Org., Gender Incongruence and Transgender Health in the ICD, https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd. *See also* J.A. 628–29, 697–98.

[5] Travis Amengual et al., *Readiness Assessments for Gender-Affirming Surgical Treatments: A Systematic Scoping Review of Historical Practices and Changing Ethical Considerations*, 13 FRONTIERS IN PSYCHIATRY 1006024 at *12 (Oct. 2022).

B. No one knows enough about the medical interventions at issue to make the conclusions the federal government makes.

Resolution of this case and the legality of SB 1 does not and should not depend on weighing the purported mental health benefits of the medical interventions at issue against the certain and potential harm from them. To accept that narrow framing buys into the controversial philosophical view that a physically healthy human body is of less value than a mental image. But even accepting the government's faulty premises, its conclusions do not follow because the evidence falls short. That is unsurprising. The Dutch Protocol on which the medical interventions here are based came into being barely 25 years ago, and protocols have shifted substantially since. J.A. 510–511. Of course, the calculus for even the dryest of statistical effects for these lifelong interventions will be missing key factors.

The most prominent harms from the medical interventions are harms to sexual and reproductive function. While the parties dispute the frequency and severity, they do not dispute the general risk. Plaintiffs' experts admit that cross-sex hormones of both kinds can reduce or eliminate reproductive function—hence the need for fertility preservation treatments and warnings to adolescents contemplating such interventions. J.A. 124, 430. The hormones also interfere with sexual function, the permanence of which is unknown.[6] J.A. 430.

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[6] Although Christians believe that sexual activities are intended for and should be confined to the marital union, the interventions here in adolescence can have lifelong effects that extend into and interfere with a healthy marriage.

Regarding puberty blockers, plaintiffs' experts assert that they alone cause no permanent effects, though the actual long-term effects of "pausing" puberty are unknown and disputed. J.A. 659. Regardless, using them in conjunction with cross-sex hormones—which almost always occurs—magnifies the loss of function. J.A. 513. Puberty blockers are intended to be administered early in puberty to stop the development of naturally occurring secondary sex characteristics. Pet. Br. at 5; J.A. 119. When they are administered at the start (Tanner stage 2), they fully arrest natural puberty. J.A. 439. When followed by cross-sex hormones, the primary sex organs undergo no sexual maturation at all, trapping them in a pre-pubescent state. *See* J.A. 439; 763. That generally means that the patient will have no sexual or reproductive function. J.A. 429–30; 760–63. Even the Endocrine Society Guidelines touted by plaintiffs' experts require that an adolescent receive a warning about fertility loss in advance of puberty blockers for precisely this reason. *See* J.A. 124. Further, especially for biological males, this stunted development makes later "sex-change" surgery more difficult, dangerous, and ineffective[7]—compromising even some of the purported cosmetic benefits.

Plaintiffs' experts also must acknowledge the limitations of the evidence of efficacy and of other harm. The "data" upon which their conclusions rely is generally of "low quality" and observational. J.A. 111–12; 362–75; 589. Their clinical guidelines and conclusions are developed from the personal experiences of the

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[7] *See* Olivia T. Van Gerwen et al., *Anatomical and Sexual Health Considerations among Transfeminine Individuals Who Have Undergone Vaginoplasty: A Review*, 33 Int'l J. of STD & AIDS 106, 107 (Feb. 2022).

physicians who already accept the validity of gender-affirming hormone therapies. J.A. 114; 450; 976. Because those physicians are already convinced of the necessity, as befitting a philosophical commitment, they also will not and (according to them) cannot conduct higher-quality studies. J.A. 111–14. To them, not using their preferred interventions would be unethical; because they *know* that gender identity is immutable, they know gender dysphoria cannot be treated with psychotherapy or non-physical interventions. *Id.*

Regarding the potential benefit most publicly discussed—reducing suicide risk for troubled teens—plaintiffs' experts can say nothing definite at all. J.A. 992. There are necessarily no long-term studies on the harm or side effects of the interventions because they are new. J.A. 810, 815. But one of plaintiffs' experts does acknowledge that cross-sex hormones medicalize patients for life in the same way as other serious, lifelong medical conditions requiring careful management. J.A. 973. And for the harm that opponents of the interventions identify—such as harm to brain, bone, and cardiac development—the best the plaintiffs' experts can say is that they are not sure. J.A. 966–69.

Thus, even before any constitutional analysis, there should be trepidation with basing legal entitlements on medical arguments that spring more from the federal government's political commitments and the particular beliefs of plaintiffs' experts than the data. Children and adolescents suffering from gender dysphoria deserve more: compassion and care that accords with the reality of their bodies.

III. SB 1 COMPORTS WITH THE EQUAL PROTECTION CLAUSE

The federal government seeks to establish that SB 1 denies to the minor plaintiffs below and others like them the equal protection of the laws. It argues that those suffering from gender dysphoria are prevented from obtaining the very same medical interventions that other adolescents are permitted to obtain for other reasons. And it charges that Tennessee can defend its law only on grounds so generalized as to defeat the purposes of the Equal Protection Clause.

Yet there are simple responses. A focus on two features on the face of the statute makes short work of the equal protection inquiry. And this approach gets around the parties' dispute as to whether the law targets treatments or people. The question does not turn on this. In fact, even taking the government's own test at face value, the inquiry into discrimination ends at the beginning.

A. Only two elements on the face of the statute are critical to consider.

In this facial challenge to SB 1, two elements in the statute itself control the equal protection analysis.

First, the law and the case concern only physically healthy minors. As discussed, the law allows physicians to use the medical interventions at issue to treat any "congenital defect, precocious puberty, disease, or physical injury," including any "disorder of sex development." Tenn. Code Ann. §§ 68-33-102(1); 68-33-103(b)(1). The federal government does not dispute this limitation—in fact, it relies upon it in making its arguments.

The distinction matters. The law does not preclude all transgender minors from receiving puberty blockers or cross-sex hormones, only those who have no physical condition necessitating them. That removes one particularly sympathetic set of patients—those who absent medical intervention (and possibly still after it) might have compromised or no natural sexual or reproductive function—from the discussion. Instead, all those affected are adolescents who have as normal physical, sexual, and reproductive functioning as anyone, transgender or not.

Second, the instrumental purpose of the medical interventions at issue—"puberty blockers" and cross-sex hormones—is cosmetic, *i.e.*, for appearance's sake. To put it more scientifically, the interventions are intended to affect secondary sex characteristics that are otherwise developed through natural puberty. While the federal government argues that the physical changes in appearance will produce mental health benefits, the immediate aim of the interventions is nevertheless to change appearance. As the government puts it, SB1 limits interventions sought to "induc[e] physiological changes, like secondary sex characteristics, that are 'inconsistent with' how society expects boys and girls to appear." Pet. Br. at 22 (quoting Tenn. Code Ann. § 68-33-103(a)(1)(A)). Plaintiffs' experts describe the purpose and intended effect in the same terms. J.A. 126, 975. The minor plaintiffs seek the treatments they do so that they may appear to others as less like their biological sexes. *See* J.A. 27–37. Indeed, researchers created the Dutch Protocol because "cosmetic aspects of medical transition [were] perceived to be better when they occur earlier rather than later in pubertal development." J.A. 443.

The disputed medical interventions do not add any biological, reproductive, or sexual functionality. If anything, as discussed above, puberty blockers and cross-sex hormones cause a *loss* of function.

All these truisms do not to belittle the importance of appearance generally or of appearing to be of one sex or the other. Indeed, everyone in this litigation cares because it is important. For Southern Baptists and many other Christians, that God made humans male and female entails that the biological sexes are different in a myriad of ways that reflect each sex's unique characteristics, including appearance. The government and plaintiffs genuinely feel that appearance should *not* necessarily reflect one's sex. But the distinction matters to the law in at least two ways. It affects the calculus under equal protection by affecting the comparators. And relatedly, it affects the interests involved. Correctly classifying the procedure as cosmetic immediately demonstrates that a constitutional entitlement presents an uphill climb because governments routinely limit and regulate the availability of such procedures, especially for minors.

B. There is facially no discrimination because the medical interventions are never used on physically healthy minors for the purposes here, regardless of sex or transgender status.

On its face, SB 1 prohibits giving puberty blockers and sex hormones to a healthy minor for the purpose of cosmetically aligning the minor's appearance with a gender inconsistent with that minor's sex. The federal government asserts that Tennessee law "permits the very same medical interventions when provided to

assist minors in physically *conforming* to their sex." Pet. Br. at 23 (emphasis in original). Does it? No.

Regardless of whether the asserted inequality turns on sex or transgender status, the comparator for the inequality would be, for sex hormones, 1) a physically healthy male without a hormonal condition being prescribed exogenous testosterone to appear more masculine, or 2) a physically healthy female without a hormonal condition being prescribed exogenous estrogen to appear more feminine. The record lacks any evidence at all that this *ever* occurs. Plaintiffs' experts presumably should know (though their singular expert pediatric endocrinologist is now relegated to a rebuttal declaration). Yet none mention even the possibility of such cosmetic sex-conforming treatments, much less that any physicians practice them.

And for good reason. Obvious ethical problems present themselves when discussion turns to doctors prescribing powerful, primal hormones with life-altering and lifelong consequences to youths so that they may temporarily enhance their appearance. The idea that a teenage bodybuilder longing for larger muscles could get a testosterone prescription just to look better in the mirror seems ludicrous. Common sense says that a doctor so doing might lose his license.

That intuition would be correct. Tennessee has long criminalized prescribing anabolic steroids (like testosterone) for "[e]nhancing performance in an exercise, sport or game" or for "[h]ormonal manipulation intended to increase muscle mass, strength or weight without medical necessity." Tenn. Code Ann. § 39-17-430. In other words, SB 1 did not need to prohibit testosterone "when provided to assist [males] in

physically conforming to their sex" because Tennessee law *already* makes that illegal.

The district court recited a hypothetical that, in light of this, comes out exactly the opposite of what it thought: "Consider an adolescent, perhaps age 16, that a physician wishes to treat with testosterone. Under the challenged statute, is the treatment legal or illegal?" *L.W. ex rel. Williams v. Skrmetti*, 679 F. Supp. 3d 668, 693 (M.D. Tenn. 2023) (quoting *Doe v. Ladapo*, 676 F. Supp. 3d 1205, 1217 (N.D. Fla. 2023)). The key additional question to "know the answer" is, must one "know the adolescent's sex"? *Id.* The actual answer: No. If the testosterone is for cosmetic effects, the answer is always no.

The situation with estrogen differs only slightly. Because exogenous estrogen does not feminize females already having sufficient endogenous estrogen in the same way that testosterone builds muscle, nothing suggests that there is any demand for estrogen by biological (non-transgender) girls seeking feminization. There is no female equivalent of steroids in the locker room for estrogen.

At the same time, many female adolescents have a ready supply of estrogen in the form of birth control. J.A. 100. The estrogen in estrogen-based hormonal birth control is not of the same form or concentration as that given to males in cross-sex hormone therapy, so it does not directly compare. *See* J.A. 518. But assuming it does enough, the general availability for a non-cosmetic reason defeats any inference of inequality. Putting aside the difficulty of probing a teenager's stated rationale for seeking birth control, the Court's own contraception jurisprudence would suggest that efforts by Tennessee to limit such contraception

through fine-grained inquiries into intent would encounter significant legal headwinds. *See, e.g.*, *Carey v. Population Servs.*, 431 U.S. 678 (1977) (invalidating state limitation on contraception for minors based on right to privacy). And given that even with open access no evidence of strictly cosmetic uses appears, there is simply no analogue to the use prohibited by SB 1.

The comparison for puberty blockers resolves even more cleanly. Again, nothing in the record supports the idea that any physically healthy minor ever seeks or uses puberty blockers to look more masculine or feminine. Taken alone, puberty blockers effectively do the opposite of masculinizing males and feminizing females by preventing the puberty that makes each distinctive. And given the dearth of the cosmetic sex hormone uses explored above, a sequential combined use with puberty blockers also makes no sense.

This analysis defeats any idea of inequality or discrimination based on sex or transgender status solely from the face of the statute and the minimal evidence presented. As in cases involving pregnancy or abortion, only one side of the potential inequality needs to or can be regulated. The sex- or status-reflected image that would mark out inequality is hypothetical or illusory, so the inquiry ends. Here, at least one holds in every event: minors of either sex and those who do not identify as transgender do not seek the opposite treatments, legally *cannot* seek some, or would find them pointless.

But even under the federal government's preferred framework, there is no inequality. The government requests that analysis occur under a two-step approach starting with classification and proceeding to justification. *See* Pet. Br. at 25–26. Yet the analysis ends at

step one—there is simply no unequal classification based on sex or transgender status. The Equal Protection Clause demands no more than that "persons similarly situated should be treated alike." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985). And they are here.

The conclusion remains true even if the Court adopts the approach in *Bostock* of switching just the sex or transgender status (which effectively occurs together here) while holding everything else constant. *See* 590 U.S. at 659–60; 671. *Bostock*'s but-for causation analysis from the Title VII context should not govern the broader constitutional text of the Equal Protection Clause. Yet even that exacting standard fails to detect inequality here. No healthy boy seeking testosterone to appear more masculine could get it; no healthy girl would seek estrogen to appear more feminine, and no boy or girl would use puberty blockers for those respective purposes. Transgender status does not change this analysis.

This analysis involves no justification or cost-benefit calculation, so no charge of conflating the merits (Tennessee's interest at step 2) with the initial classification (in step 1) has traction. And because discrimination does not exist, there is also no need to determine whether it would be invidious if it did. Simply put, the basic charge of inequality falls apart based just on the face of the statute.

C. Adding gender dysphoria into the mix only confirms this conclusion.

The federal government uses a different chain of logic. Under SB 1, adolescents with gender dysphoria cannot obtain the same medications for that disorder

as adolescents with physical ailments such as precocious puberty, delayed puberty, hypogonadism, and hyperandrogenism can for those illnesses. It argues that because gender dysphoria is defined in part based on sex, and because only transgender people can suffer from gender dysphoria, the denial of those medications to treat that condition constitutes sex and transgender-status discrimination. The above analysis, independent of these concerns, should already cast doubt on the validity of this argument. But it can also be straightforwardly proven wrong.

SB 1 does not limit the relevant medical interventions *only* for gender dysphoria. Instead, it precludes the use of cross-sex hormones and puberty blockers for cosmetic effects inconsistent with sex, whether because of gender dysphoria or not. Tenn. Code Ann. § 68-33-103(b)(2). Those with gender dysphoria are a subset of those affected. The broader limitation serves an important purpose. As discussed above, a push is already underway to allow these interventions for anyone with gender incongruence—*i.e.*, all adolescents who claim transgender status, without any clinical diagnosis or disorder.

That the prohibition does not affect only those with gender dysphoria removes even more planks from the federal government's claims. The affected adolescents' having gender dysphoria is a necessary, not incidental, element of its arguments. The government and plaintiffs' experts stress the narrowness of the diagnosis and the burdens associated with obtaining it to establish it as a serious medical condition. *See* Pet. Br. at 3–4; J.A. 749–50. Even more, the government stresses the harms of leaving the condition untreated and the "benefits" of treating it to rebut Tennessee's

justifications. Pet. Br. at 34–42. Yet that does nothing to explain why the state cannot ban the interventions at issue for transgender individuals *without* gender dysphoria, who are *not* experiencing clinically significant distress. Because that class of individuals is significant in size (as plaintiffs' experts recognize, *see* J.A. 156) and because there is a concerted push to provide all the same interventions to them, the prohibition is not illusory. So the government should not be able to facially challenge SB 1. *See United States v. Salerno*, 481 U.S. 739, 745 (1987) (holding petitioner "must establish that no set of circumstances exists under which the Act would be valid").

That said, narrowing the focus to only those with gender dysphoria does not help the federal government's position on the law's classification. That no one prescribes these interventions for masculinizing boys or feminizing girls does not change when considering only boys or girls with body dysmorphia (distress over one's appearance). If anything, the approach diverges even further from that for gender dysphoria. Anabolic steroid use by males with body dysmorphia represents a severe cause for concern, something itself to be treated in psychotherapy, not a *treatment* for the condition. *See* J.A. 771, 776–77. More generally, the ethical problems of treating mental disorders with permanent physical alterations that reduce body functionality are well known, and such interventions are at best highly controversial and disfavored.[8] Gender dysphoria represents the only mental disorder for which any significant number of physicians advocate for

[8] *See, e.g.*, Sabine Müller, *Body Integrity Identity Disorder (BIID)—Is the Amputation of Healthy Limbs Ethically Justified?*, 9 AM. J. BIOETHICS 36, 37–43 (2009).

treatments intentionally impairing ordinary, healthy development of bodily functions and organs.

D. Using other endocrine conditions to justify a constitutional entitlement underlines the grisly nature of the argument.

The federal government does not recognize the difference between the medical interventions being used to treat a mental disorder, on the one hand, and physical illness, on the other. Tennessee is correct that they are different "treatments," but this technical or semantic conclusion is unnecessary. The *purpose* of the prohibited interventions is to alter appearance—secondary sex characteristics—by either reducing hormonal function below normal parameters in healthy adolescents (puberty blockers) or by raising the cross-sex hormone (androgens for girls and estrogen for boys) to levels far above normal in healthy adolescents of that sex.

That creates iatrogenic disease. Adolescents who receive the medical interventions challenged here will go from healthy to diseased levels of hormonal functioning that mimic (though are opposite) the diseases being pointed to as comparators. Those formerly healthy adolescents will functionally now have delayed puberty and hypogonadotropic hypogonadism under puberty blockers. J.A. 758–60. And they will functionally experience either hyperandrogenism (mirroring conditions like polycystic ovary syndrome) under exogenous testosterone for girls or hyperestrogenemia under exogenous estrogen for boys. J.A. 794.

The government argues that because adolescents can treat those same diseases with puberty blockers or hormones, adolescents with only gender dysphoria

must be able to, too. Yet when those diseases are treated, instead of created, the puberty blockers or hormones *fix* hormone levels that are biologically too low or high for healthy adolescents. *See* J.A. 100, 756–57, 760, 769–70, 779. They *restore* functionality. None of the conditions used by the government or plaintiffs for comparison purposes lack these features. Even for the one disease noted by any party as having a cosmetic effect fixed by treatment—excess facial hair reduced by testosterone suppression for girls with polycystic ovarian syndrome, Pls.-Resps. Br. at 6—the treatment fixes an underlying hormonal imbalance (excess testosterone) that has many other detrimental effects beyond the mere cosmetic (the same effects as for girls receiving exogenous testosterone, including infertility).

Pointing to the fact that those diseases are treated by the medical interventions sought here as justification for requiring that they be given to patients with only gender dysphoria reveals that the government's position is truly untenable. The government believes the following: physically healthy adolescents have a constitutional right to induce deleterious medical conditions purely for the cosmetic side effects because other adolescents are permitted to treat the very same symptoms by fixing those deleterious medical conditions. Because some adolescents hope to escape illness, other adolescents must have the right to create it.

This path of thinking is horrifically wrong, and tragic. The idea turns the concept of medicine on its head. Objective, scientific differences between the sexes, including different healthy ranges for hormones at appropriate ages, are not "stereotypes." When they are ignored and manipulated, awful things happen.

When hormones are unbalanced, the patient suffers, as all the side effects for hormonal treatments in this case demonstrate. Yet the federal government and plaintiffs seek an entitlement to choose to define "healthy." They argue that they must be able to redefine what is biologically normal to conform it to a patient's mental self-image and that the Constitution compels this result. In other words, the law must allow people to choose their biological realities.

Put this way, the debate is not merely legal, but philosophical, moral, and even religious. The government shies away from acknowledging as much. This unmanageable scope follows from treating a mental disorder without any understandable biological basis on par with physical illness. Recognizing this dynamic is not necessary to resolve the legality of SB 1. But it demonstrates how foolish it is to press the Equal Protection Clause, ratified in 1868, to resolve the question in favor of the government's position. That Clause does not require states to place transhumanist ideals on footing equal or superior to the belief in objective truth that has allowed us to have modern medicine in the first place—especially when the consequences of accepting the premise are permanent and severe for adolescents.

While the conclusions reached here about equal protection do not depend on Tennessee's demonstrating an important or compelling interest, the analysis rebuts charges that the law springs from invidious stereotypes and discrimination. The federal government focuses on two of many purposes in SB 1 as demonstrating ill will toward transgender adolescents: that the state "has a legitimate, substantial, and compelling interest in encouraging minors to appreciate their

sex, particularly as they undergo puberty" and in prohibiting medical procedures that "might encourage minors to become disdainful of their sex." Tenn. Code Ann. § 68-33-101(m).

Tennessee should be allowed to take a stand in the debate by proclaiming that a body functioning healthily and according to its sex is a good thing. But this is not just a philosophical position. As shown, the consequences of a physically healthy adolescent *not* "appreciat[ing]" and instead "disdain[ing]" the adolescent's sex are concrete and severe. It leads to medical interventions that create systemic hormonal imbalances in search of cosmetic side effects. It leads to lost reproductive and sexual function, as well as a host of other lifelong problems that are not fully known. And it leads to lifelong medicalization, for continued hormonal treatments (and post-operative care for invasive sex-change surgery) and for the permanent side effects that may accompany those treatments even if discontinued. J.A. 436–37. Far from uninformed stereotypes, the state's stated purposes show true concern for adolescents at risk of being pushed into the pipeline of "gender-affirming care."

IV. PARENTAL RIGHTS ARE WORTHY OF RESPECT BUT DO NOT CREATE A LEGAL ENTITLEMENT TO THE MEDICAL INTERVENTIONS AT ISSUE

The foregoing analysis also demonstrates the Court's wisdom in not examining whether parental rights through the Due Process Clause require allowing the medical interventions that SB 1 forbids. The Court has long respected the rights of parents in the care, custody, and nurture of their children, including

through religious upbringing. *See, e.g.*, *Stanley v. Illinois*, 405 U.S. 645, 651 (1972); *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 532 (1925). Yet a "state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized." *Parham v. J.R.*, 442 U.S. 584, 603 (1979). Southern Baptists agree that these God-given parental rights and responsibilities "are not absolute, and the state has a compelling interest to intervene in certain situations where children are being abused, neglected, or endangered."[9]

Here, the proposed medical interventions cross numerous lines that justify the limits SB 1 imposes. The potential for abuse in a parent's subjecting an otherwise healthy child to medical interventions that create serious hormonal diseases is patent. The situation worsens when the choice imposes permanent effects. The point of the state's respecting parental rights is to allow parents to guide their children *into adulthood*, when those children have their own, independent rights—including to have their own relationships and bear their own children, *see, e.g.*, *Stanley*, 405 U.S. at 651. The medical interventions here, when started in adolescence, can permanently deprive them of reproductive and sexual function and can medicalize them for life. J.A. 521–22. When parents choose to deprive their children now of opportunity in the future, it creates a tension between parental rights and their corresponding responsibilities. That is especially true when parents seek such permanent medical intervention for mental health. *See Parham*, 442 U.S. at 606. Again, the state need not countenance such harm.

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[9] 2024 Resolution, *supra* n.2.

CONCLUSION

Tennessee was wise not to accept the philosophical precommitments that lead to physicians creating life-long disease in adolescents. The beauty of an integral human body should not be destroyed to chase a mental image. The federal government has not shown that the Constitution requires allowing these medical interventions. Even under the narrowest of inquiries, there is no discrimination, so the law is constitutional.

With SB 1, Tennessee fulfilled the state's obligation to protect life and the vulnerable amongst us, as revealed in Scripture and spoken to by numerous resolutions affirmed at annual gatherings of the Southern Baptist Convention.

The Court should affirm the judgment of the Sixth Circuit.

Respectfully submitted,

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