IN THE SUPREME COURT OF MISSOURI

No. SC100933

E.N., INDIVIDUALLY AND AS NEXT FRIEND AND ON BEHALF OF HER MINOR CHILD N.N., ET AL.,

Appellants,

v.

MIKE KEHOE, IN HIS OFFICIAL CAPACITY AS GOVERNOR FOR THE STATE OF MISSOURI, ET AL.,

Respondents.

On Appeal from the Circuit Court of Cole County
Case No. 23AC-CC04530
Honorable R. Craig Carter

BRIEF OF THE AMERICAN COLLEGE OF PEDIATRICIANS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

This brief is being filed with the consent of all parties

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IDENTITY AND INTEREST OF *AMICUS CURIAE*

In the face of significant pauses by the international medical community in hormonal and surgical "gender affirmations" for children—pauses driven by several comprehensive reviews of the medical evidence—Missouri and numerous other states have passed laws to stop the medical "gender transition" of minors. At issue here are two Missouri statutes: one, RSMo Section 191.1720 (SAFE Act) that prohibits the use of puberty blockers or hormones on individuals under the age of 18 "for the purpose of a gender transition," or performing gender transition surgery on individuals under 18, and two, RSMo Section 208.152.15 that prohibits payments under MO HealthNet "for gender transition surgeries, cross-sex hormones, or puberty-blocking drugs, as such terms are defined in section 191.1720, for the purpose of a gender transition." After an extended trial and detailed analysis of the facts, law, and science, the trial court upheld the statutes. This Court should affirm.

Missouri wisely prohibits aggressive experimental medical interventions for "gender transition" beginning at the onset of puberty or even earlier. Such interventions include administering puberty blockers, cross-sex hormones, and mutilating surgeries to those under 18 to affirm false sexual identities. And, as more and more "detransitioners" attest, the permanent scars and infertility from these interventions cannot be undone.

These developments are of great concern to *Amicus,* the American College of Pediatricians ("the College" or "ACPeds"), a national organization of nearly 500 board-certified pediatricians or related specialists in 46 states, all dedicated to the health and well-being of children. Formed in 2002, the College is a scientific medical association

committed to producing policy recommendations based on the best available scientific research. The College strives to ensure all children reach their optimal physical and emotional health and well-being.

The College's members provide high-quality medical services to children and all patients without discrimination based on sex or any other characteristic prohibited by law. Based on the Hippocratic Oath and on science, the College categorically rejects "gender transition" procedures because they inherently harm children. *Amicus* has a direct interest in the outcome of this case because it affects the vulnerable population it serves, and the medical services the College's members provide.

AUTHORITY FOR BRIEF OF *AMICUS CURIAE*

Amicus is authorized to file this brief by Rule 84.05(f)(2) of the Missouri Rules of Appellate Procedure because all parties have consented to its filing.

SUMMARY OF ARGUMENT

Treatment of children and adolescents experiencing gender incongruity and dysphoria should be based on sound scientific evidence. Consistent with the best medical evidence available, the Missouri SAFE Act seeks to protect such vulnerable children under age 18 by prohibiting hormonal and surgical efforts at "gender transition," RSMo § 191.1720, while the other statute prohibits the use of taxpayer dollars to support such procedures, RSMo § 208.152.15. By prohibiting the use of puberty blockers, cross-sex hormones, and surgical interventions for the purpose of "gender transition," the statutes properly protect minors from harmful, blatantly political "standards" untethered to biological reality and contrary to valid scientific evidence. *See United States v. Skrmetti*,

605 U.S. --, 145 S.Ct. 1816, 1848-49 (2025) (Thomas, J., concurring). The scientific evidence demonstrates both a lack of long-term benefit and significant life-long harms to children subjected to such "gender affirmation" interventions.[1] The trial court's decision upholding the statutes should be affirmed.

Adding confirmation of the trial court's analysis of the applicable science, this brief provides further insights on the central issue in the case by looking at three issues that put the scientific evidence in its proper context.

I. Scientific research shows that children with gender incongruence or dysphoria almost always have significant mental health struggles and/or adverse childhood events that contribute to, if not cause, their dysphoria. And multiple studies show that these children almost always grow out of or desist from such gender incongruity while going through puberty—as long as they are not "affirmed" as being of the opposite sex or gender. Yet when children are placed on puberty blockers and/or cross-sex hormones, they almost always persist in their dysphoria, which can lead to "gender transition" surgeries—all with life-long adverse consequences. The statutes at issue are consistent with this scientific reality, as the trial court properly found.

[1] The American College of Pediatricians, other medical organizations representing over 75,000 physicians and healthcare providers, and over 5,600 individual signatories, recently issued a declaration—the Doctors Protecting Children Declaration—stating that "Medical decision making should respect biological reality and the dignity of the person by compassionately addressing the whole person. … [Yet,] [g]ender ideology seeks to affirm thoughts, feelings and beliefs, with puberty blockers, hormones, and surgeries that harm healthy bodies, rather than affirm biological reality." Decl., Doctors Protecting Children (2024), https://doctorsprotectingchildren.org/.

II. Puberty blockers, cross-sex hormones, and "gender transition" surgeries have known adverse health consequences while having no proven long-term mental health benefits. It is just as alarming that these children—often preteens—are incapable of consenting to such life-altering interventions. Here too the statutes are consistent with the best science.

III. The statutes are also consistent with sound medical practice. The appropriate medical treatment for gender dysphoria is to address the child's underlying mental health issues while allowing the child to go through natural puberty. That is what their bodies were meant to do, and what the statutes require. The statutes ensure that treatment focuses on mental distress while giving healthy bodies the chance to grow up.

ARGUMENT

I. The Trial Court Properly Held the Statutes are Based on an Accurate Understanding of Gender Incongruence and Dysphoria In Children.

To understand why Missouri and many states prohibit the experimental medical procedures Plaintiffs here demand, it is helpful to briefly establish a foundation on what is known about gender incongruence in children. Indeed, the U.S. Supreme Court recently rejected challenges to Tennessee's law containing the same limits on experimental "gender transition" procedures at issue in Missouri's SAFE Act. *See Skrmetti*, 145 S.Ct. at 1825-26, 1837.

A. "Transitioning" to a Different Sex Is Biologically Impossible.

We begin with the reality that sex is a biological, immutable characteristic—a scientific fact, not a social construct. As ACPeds has previously pointed out, "[f]rom a

purely scientific standpoint, human beings possess a biologically determined sex and innate sex differences. No [physician or surgeon] could actually change a person's genes through hormones and surgery. Sex change is objectively impossible."[2] "Gender identity," however, is a *psychological* concept that should be addressed as such.

While rare,[3] gender dysphoria in children is "a psychological condition in which they experience marked incongruence between their experienced gender and the gender associated with their biological sex. They often express the belief that they are the opposite sex."[4] This condition is not evidence of an unhealthy or malformed body but a psychological condition where a person's belief about him/herself is inconsistent with his/her sex.

Thus, as explained in detail below, efforts to "transition" a child using "gender affirming care,"—something Appellants' wrongly assert is "safe and effective" (Appellants' Br. 20)—is a misnomer, as such procedures are specifically designed to *entrench* a mental health condition of gender incongruence while leading to permanent sterility without resolving underlying mental health issues that contributed to the dysphoria in the first place.

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[2] Am. Coll. of Pediatricians (ACPeds), *Mental Health in Adolescents with Incongruence of Gender Identity and Biological Sex* (2024), [hereinafter, ACPeds, *Mental Health*], https://tinyurl.com/24b2mhru (citing extensive scientific research).

[3] Am. Coll. of Pediatricians (ACPeds), *Gender Dysphoria in Children* 1 (Nov. 2018), [hereinafter, ACPeds, *Gender Dysphoria*], https://tinyurl.com/5n8a5ups. Indeed, "[f]or natal adult males, prevalence ranges from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%." Am. Psych. Ass'n, *Diagnostic and statistical manual of mental disorders: DSM-5,* at 454 (5th ed. 2013).

[4] ACPeds, *Gender Dysphoria*, *supra* note 3, at 1.

B. Gender Incongruence and Dysphoria are Mental Health Issues in People with Normal Healthy Bodies.

It follows that gender dysphoria (GD), previously called gender identity disorder (GID), is a problem that resides in the mind, not in the body.

1. As ACPeds has stated: "Children with GD do not have a disordered body—even though they feel as if they do. Similarly, a child's distress over developing secondary sex characteristics does not mean that puberty should be treated as a disease to be halted, because puberty is not, in fact, a disease."[5] Unsurprisingly, such dysphoria is associated with a variety of "diverse psychiatric problems."[6] Accordingly, treating pediatric gender dysphoria as a mental health disorder is the appropriate focus for medical providers.[7]

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[5] ACPeds, *Gender Dysphoria*, *supra* note 3, at 9.

[6] Pien Rawee et al., *Development of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 Archives of Sexual Behav. 1813, 1822 (2024) (internal citations omitted), doi.org/10.1007/s10508-024-02817-5; *see also* ACPeds, *Mental Health*, *supra* note 2, at 3 ("Using five independent cross-sectional datasets consisting of 641,860 individuals, researchers found 'transgender and gender-diverse individuals have, on average, higher rates of autism, other neurodevelopmental and psychiatric diagnoses'"); Riittakerttu Kaltiala-Heino et al., *Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development*, 9 Child & Adolescent Psych. & Mental Health art. 9, at 5 (2015) (75% of adolescents seen for gender identity services were or had been undergoing psychiatric treatment for reasons other than GD); Tracy A. Becerra-Culqui et al., *Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers*, 141 Pediatrics e20173845 (2018) (teens with gender non-conformity significantly more likely to have underlying psychiatric disorders, psychiatric hospitalizations, and suicidal ideation than peers).

[7] To begin with, Appellants assert that "[b]eing transgender is not itself a disorder or condition to be cured." Appellants' Br. 24. In such cases, puberty blockers, cross-sex hormones, or surgical efforts to change a body's appearance are not medically necessary but do carry the significant harms addressed here. Indeed, there is no justification for the use of powerful hormones not meant for the child's body and used solely to force the body to take on an appearance of the opposite sex while leaving the child permanently sterile for no other reason than the child exclaims they wish to be the opposite sex. And for those

2. Children with gender incongruity are two to three times more likely to have suffered from an adverse childhood event such as sexual abuse, emotional neglect, emotional abuse, or a family member with mental illness.[8] Additionally, "studies suggest that social reinforcement, parental psychopathology, family dynamics, and social contagion facilitated by mainstream and social media, all contribute to the development and/or persistence of GD in some vulnerable children."[9] Accordingly, the available credible evidence suggests that mental health treatment should be the focus for children expressing gender incongruence, not harmful hormonal and surgical interventions pushed by Plaintiffs.

C. In Natural Puberty, Gender Dysphoria Generally Desists On Its Own, Without "Gender Affirmation" Interventions.

One reason for this approach is that "80-95% of the prepubertal children with GID will no longer experience a GID in adolescence."[10] In a recent study, Pien Rawee and

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who experience gender dysphoria, which Appellants assert "is a serious condition that, if left untreated, is highly associated with conditions such as depression, anxiety, and suicidality," *id.,* proper treatment is to address the psychological condition, not alter a perfectly healthy body. Administering puberty blockers, cross-sex hormones, and sterilizing surgeries in such cases is not medicine but unethical experimentation on a child who lacks the cognitive ability to consent to such procedures as noted below.

[8] ACPeds, *Mental Health*, *supra* note 2, at 5 (citing, among others, Anna Austin et al., *Adverse childhood experiences related to poor adult health among lesbian, gay, and bisexual individuals*, 106 Am. J. Pub. Health 314 (2016); Shelley L. Craig et al., *Frequencies and patterns of adverse childhood events in LGBTQ+ youth*, 107 Child Abuse & Neglect 104623 (2020)).

[9] ACPeds, *Gender Dysphoria*, *supra* note 3, at 6 (citing, among others, Kenneth J. Zucker & Susan J. Bradley, *Gender Identity and Psychosexual Disorders*, 3 FOCUS 598 (2005)).

[10] Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1893 (2008); Devita Singh et al., *A Follow-Up Study of Boys With Gender Identity Disorder*, 12 Frontiers in Psych. 632784, at 1, 8 (2021),

colleagues followed a study group beginning at age 11 through age 25. According to the study, "children and adolescents referred for gender dysphoric feelings had a more negative self-concept compared to the standardization sample of the questionnaire."[11] However, while that was the case early in puberty, any "gender non-contentedness … decreased with age."[12] The vast majority of children who express discomfort with their sex at the start of puberty overwhelmingly express no such discomfort after going through puberty.[13]

Equally important, while natural desistance predominates, children in such studies who socially "transitioned"[14] in early childhood were more likely (often between 96% and 100% of the time) to have persistent feelings of gender dysphoria.[15] The same is true for children who are started on puberty blockers to address gender confusion.[16]

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doi.org/10.3389/fpsyt.2021.632784 (finding 87.8% desistance in "largest sample to date of boys clinic-referred for gender dysphoria."). *See also* A003 ("the credible evidence shows that a vast majority of children who are diagnosed with gender dysphoria outgrow the condition"), A027 (noting lack of stability in gender identify for those under 18), A061 ("the credible evidence shows that between 80-95% of child patients diagnosed with gender dysphoria will have the symptoms abate after adolescence").

[11] Rawee et al., *supra* note 6, at 1814.

[12] *Id*. at 1818.

[13] *Ibid*.

[14] Social transitioning "consists of first affirming the child's false self-concept by instituting name and pronoun changes, and facilitating the impersonation of the opposite sex within and outside of the home." ACPeds, *Gender Dysphoria*, *supra* note 3, at 11.

[15] Rawee et al., *supra* note 6, at 1814 (citation omitted); *see also* ACPeds, *Mental Health*, *supra* note 2, at 7; A017 (quoting the Endocrine Society guidelines that "social transitioning … has been found to contribute to the likelihood of persistence" with the same being found with use of puberty blockers and cross-sex hormones).

[16] ACPeds, *Gender Dysphoria*, *supra* note 3, at 12 (study of 70 pre-pubertal candidates to receive puberty suppression showed that every child "eventually embraced a transgender identity and requested cross-sex hormones"); Hilary Cass for NHS England, The Cass

In other words, Plaintiffs' transition efforts place children on a path to life-long hormone interventions and sterilization while not resolving their mental health problems. Yet, when allowed to go through natural puberty, children overwhelmingly desist such incongruence and accept their biological sex.[17] That is what the statutes at issue properly requires for those under 18. Contrary to Appellants' suggestion (Appellants' Br. 68), the Missouri statutes are not "premised on the demeaning notion that transgender people do not exist." Rather, the reality of such vulnerable children is acknowledged and becomes the focus of efforts to address the child's distress—the mental health issues contributing to dysphoria in the first place.

The evidence-based approach is to simply allow a child to grow up without being "affirmed" in a false sexual identity. This is critical since there is no test to determine which small minority of children experiencing gender incongruence will persist in such feelings into adulthood without social and "medical" affirmation.[18] The trial court properly

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Review, Final Report 176, §14.24 (updated Dec. 2024) [hereinafter, "Cass Review"], https://tinyurl.com/3643e46w.

[17] Ironically, the American Psychological Association in their *Handbook of Sexuality and Psychology* states that "[p]remature labeling of gender identity should be avoided. Early social transition (i.e., change of gender role, …) should be approached with caution to avoid foreclosing this stage of (trans)gender identity development." Walter O. Bockting, *Chapter 24: Transgender Identity Development, in* 1 Am. Psych. Ass'n, *APA Handbook of Sexuality and Psychology* 744 (Deborah L. Tolman & Lisa M. Diamond eds., 2014).

[18] *See* Doctors Protecting Children Decl., *supra* note 1, ¶4; Cass Review, *supra* note 16, at 193, §16.8; ACPeds, *Gender Dysphoria*, *supra* note 3, at 11-12 ("puberty is suppressed via GnRH agonists as early as age 11 years, and then finally, patients may graduate to cross-sex hormones at age 16 in preparation for sex-reassignment surgery as an older adolescent or adult").

recognized this reality. A017, A027, A061 (noting that gender identity is both unstable in adolescence and overwhelmingly resolves on its own without being affirmed).

II. The Trial Court Properly Upheld the Statutes as they Protect Children.

It is against this background that the statutes' acknowledgement of biological sex and prohibition of efforts at "gender transition" for those under 18 needs to be evaluated—something the trial court did at length. As shown below, each of the medical interventions used to "transition" a child to impersonate the opposite sex poses significant risks, has not been shown to reduce suicide, and cannot be ethically administered to a child who is incapable of making permanent, life-altering decisions such as the decision to become irreversibly sterile. Indeed, a recent survey of the scientific evidence conducted by the U.S. Department of Health and Human Services confirms these conclusions,[19] with the Supreme Court and the trial court here finding likewise. *Skrmetti*, 145 S.Ct. at 1835-26; *id.* at 1841-45 (Thomas, J. concurring); A024-A027.

A. Puberty Blockers Harm Children.

The first medical intervention recommended by "gender affirming care" proponents is hormonal—specifically, delaying or preventing natural puberty with puberty blockers.

1. Puberty blockers interrupt the normal process of sexual development in children. The issue here is not the short-term use of puberty blockers for precocious or early onset puberty, for which they have been approved, but the long-term effects of the off-label use

[19] U.S. Dep't Health Hum. Servs., Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices (as corrected 2025) [hereinafter "HHS Report"], https://tinyurl.com/2x4enzkn.

of these drugs for "gender transition" purposes. These drugs were never intended or approved for "gender transition,"[20] and using them for that purpose is "very different" from use when treating precocious puberty.[21] Denying such use is not "sex discrimination" as the Supreme Court made clear in *Skrmetti.* 145 S.Ct. at 1829-34. The trial court here properly concluded likewise. A063-A066. It is, rather, simply sound science that acknowledges a difference between male and female children and that certain procedures are harmful to a child regardless of the child's sex.[22]

Indeed, these drugs have serious side-effects and should thus be used sparingly: "In addition to preventing the development of secondary sex characteristics, GnRH agonists arrest bone growth, decrease bone accretion, prevent the sex-steroid dependent organization and maturation of the adolescent brain, and inhibit fertility by preventing the development of gonadal tissue and mature gametes for the duration of treatment."[23]

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[20] Ainhoa Gomez-Lumbreras & Lorenzo Villa-Zapata, *Exploring Safety in Gender-Affirming Hormonal Treatments: An Observational Study on Adverse Drug Events Using the Food and Drug Administration Adverse Event Reporting System Database*, 58 Annals of Pharmacotherapy 1089, 1092 (2024).

[21] Cass Review, *supra* note 16, at 173, §14.6.

[22] HHS Report, *supra* note 19, §7.3.

[23] ACPeds, *Gender Dysphoria*, *supra* note 3, at 12 (referencing Lauren Schmidt & Rachel Levine, *Psychological outcomes and reproductive issues among gender dysphoric individuals,* 44 Endocrinology & Metabolism Clinics N. Am. 773 (2015); Sheila Jeffreys, *The transgendering of children: gender eugenics*, 35 Women's Studies Int'l F. 384 (2012); Sara B. Johnson et al., *Adolescent maturity and the brain: the promise and pitfalls of neuroscience research in adolescent health policy,* 45 J. Adolescent Health 216 (2009)); *see also* Jonas F. Ludvigsson et al., *A Systematic Review of Hormone Treatment for Children with Gender Dysphoria and Recommendations for Research*, 112 Acta Paediatrica 2279, 2280, 2286-90 (2023).

Moreover, when it comes to using puberty blockers as "treatment" for gender dysphoria, the Cass Review, conducted by the National Health Services England, correctly noted, "[b]locking this experience [of puberty] means that young people have to understand their identity and sexuality based only on their discomfort about puberty and a sense of their gender identity developed at an early stage of the pubertal process. Therefore, there is no way of knowing whether the normal trajectory of the sexual and gender identity may be permanently altered."[24] This is so because, when placing pre-teens on puberty blockers, "[t]heir experience of puberty will then be based on their identified gender, which may have permanent neuropsychological effects."[25] As noted above, this denies the child the opportunity to naturally grow out of the discomfort they feel with their sex at age 11, a desistance that is the norm if they are not "affirmed" in their incongruent identity at such a young age.

2. While blocking a child's natural development, puberty blockers have not been shown to benefit the child psychologically, contrary to the goal of gender dysphoria treatment.[26] Rather, studies demonstrate "there is insufficient and/or inconsistent evidence about the effects of puberty suppression on psychological or psychosocial health" of young

[24] Cass Review, *supra* note 16, at 178, §14.37.

[25] *Id.* at 194, §16.19.

[26] "In fact, the package insert for Lupron, the number one prescribed puberty blocker in America, lists 'emotional instability' as a side effect and warns prescribers to 'Monitor for development or worsening of psychiatric symptoms during treatment.'" Am. Coll. of Pediatricians (ACPeds), *Transgender Interventions Harm Children,* https://tinyurl.com/4yrj8wbe (last visited Sept. 1, 2025).

people.[27] Indeed, as the Cass Review noted, the fact that only very modest and inconsistent improvements in mental health were seen makes it all the more important to assess whether other treatments may have a greater effect on the distress that young people with gender dysphoria experience during puberty.[28]

Yet, as ACPeds has previously noted, "[t]here is not a single large, randomized, controlled study that documents the alleged benefits and potential harms to gender-dysphoric children from pubertal suppression and decades of cross-sex hormone use. Nor is there a single long-term, large, randomized, controlled study that compares the outcomes of various psychotherapeutic interventions for childhood GD with those of pubertal suppression followed by decades of toxic synthetic steroids."[29]

Beyond this, "[t]here are serious long-term risks associated with the use of social transition, puberty blockers, masculinizing or feminizing hormones, and surgeries, not the least of which is potential sterility."[30] Even the FDA found that use of puberty blockers for gender transition resulted in "increased risk of depression and suicidality, as well as increased seizure risk[.]"[31] And, as if that were not enough, the Cass Review noted that

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[27] Cass Review, *supra* note 16, at 176, §14.28.

[28] *Id.* at 177, §14.29; *see also id*. at 180, §14.55.

[29] ACPeds, *Gender Dysphoria*, *supra* note 3, at 10; *see also* ACPeds, *Mental Health*, *supra* note 2, at 8 (referencing McMaster University Department of Health Research Methods systematic review done at request of the Florida Agency for Health Care Administration); Cass Review, *supra* note 16, at 194, §16.14.

[30] Doctors Protecting Children Decl., *supra* note 1, ¶5 (citing numerous sources); *see also* ACPeds, *Gender Dysphoria*, *supra* note 3, at 13 (citing Schmidt & Levine, *supra* note 23).

[31] Tyler O'Neil, *BOMBSHELL FDA Email Turns Transgender 'Health Care' Narrative on Its Head,* The Daily Signal (Aug. 1, 2024) (reporting on leaked FDA emails noting the

"brain maturation may be temporarily or permanently disrupted by the use of puberty blockers, which could have a significant impact on the young person's ability to make complex risk-laden decisions, as well as having possible longer-term neuropsychological consequences."[32]

These are some of the reasons the Swedish National Board of Health and Welfare concluded that "the risks of hormonal interventions for gender dysphoric youth outweigh the potential benefits."[33] And that is why, as the renowned Swedish psychiatrist Dr. Christopher Gillberg has said, pediatric transition is "possibly one of the greatest scandals in medical history," while calling for "an immediate moratorium on the use of puberty blockers because of their unknown long-term effects."[34]

B. Cross-Sex Hormones Harm Children.

Cross-sex hormone interventions, often the next step in childhood "gender transition," are equally if not more dangerous, subjecting a young person to high doses of hormones never intended for their bodies. By themselves, these hormones often result in

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results of FDA studies on harms from a "safety review of the GnRH agonist class in pediatric patients in 2016/2017"), https://tinyurl.com/huhcjmra.

[32] Cass Review, *supra* note 16, at 178, §14.38; Dick Mul et al., *Psychological Assessments Before and After Treatment of Early Puberty in Adopted Children*, 90 Acta Paediatrica 965, 970 (2001) (finding 7 point drop in intelligence quotient after one year on puberty blockers).

[33] *Summary of Key Recommendations from the Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW), February 2022 update,* Soc'y for Evidence-Based Gender Med. (Feb. 27, 2022), https://tinyurl.com/2je6phjv.

[34] Jonathon Van Maren, *World-renowned child psychiatrist calls trans treatments "possibly one of the greatest scandals in medical history"*, The Bridgehead (Sept. 25, 2019), https://tinyurl.com/34eya7y8; ACPeds, *Transgender Interventions Harm Children, supra* note 26; *see also* Cass Review, *supra* note 16, at 179, §14.49.

infertility, cardiovascular disease, and other chronic illnesses.[35] For example, as one researcher has described, females attempting "gender transition" are typically given testosterone to achieve levels "6 to 100 times above normal female circulating testosterone levels"—levels "generally only seen among patients with rare conditions such as benign or malignant androgen producing tumors of the adrenal gland or ovaries or those who misuse androgens in bodybuilding and other sports."[36] And there are no studies demonstrating that such doses in children is safe or reversible,[37] but there is evidence of their harm.

In their recent study, Ainhoa Gomez-Lumbreras, MD, PhD, and Lorenzo Villa-Zapata, PharmD, PhD, found there were significant adverse drug reactions to "gender transition" hormone therapy, noting that the drugs used were "unintended for their recipient gender."[38] Indeed, "drugs such as testosterone and spironolactone frequently used in

[35] Lauren Schwartz et al., *Emerging and accumulating safety signals for the use of estrogen among transgender women*, 5 Discover Mental Health (2025), https://doi.org/10.1007/s44192-025-00216-3.

[36] Michael Laidlaw & Sarah Jorgensen, Letter, *Exploring Safety in Gender-Affirming Hormonal Treatments: An Observational Study on Adverse Drug Events Using the Food and Drug Administration Adverse Event Reporting System Database*, 59 Annals of Pharmacotherapy 491, 491 (2025), https://tinyurl.com/yh9htw42.

[37] Indeed, such negative adverse reactions are no surprise to WPATH, where one doctor noted, "*I have one transition friend/collegue [sic] who, after about 8-10 years of [testosterone] developped [sic] hepatocarcinoma. To the best of my knowledge, it was linked to his hormone treatment … it was so advanced that he opted for palliative care and died a couple of months later.*" Env't Progress, *WPATH Files Excerpts: Exposing the Realities of Gender Medicine* 7, https://tinyurl.com/w23aar2n (last accessed Sept. 1, 2025) [hereinafter, "*WPATH Files*"].

[38] Gomez-Lumbreras & Villa-Zapata, *supra* note 20, at 1089.

gender-affirming therapies exhibit divergent ADR [adverse drug reaction] patterns in transgender individuals compared with cisgender counterparts."[39]

Finally, those receiving these interventions continue to have serious mental health concerns. For example, a recent Finnish study "demonstrated that transgender individuals who underwent medical transition had increased needs for specialist-level psychiatric care compared to those transgender individuals who presented for care but did not receive medical interventions."[40]

In short, these hormonal treatments permanently harm children and make their psychological conditions worse. Prohibiting the use of hormones in individuals whose bodies, based on their sex, were never intended to have such high levels of those hormones is sound medical practice designed to protect patients from intrinsic harms from the off-label use of powerful medications never intended for such purposes.[41]

C. "Gender Transition" Surgery Harms Children

So-called "gender transition" surgeries are even more harmful to children. The concept of surgically altering minors suffering from gender dysphoria became accepted in

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[39] *Id.* at 1096; *see also id.* at 1092 ("The ADRs for hormone treatments are described on the drug labels, but they typically pertain to the opposite sex of those transitioning for gender reassignment."). A study from the University Medical Center in Amsterdam followed 2,260 transwomen (men) receiving estrogen and found a 46-fold increase in breast cancer compared to natal Dutchmen. Christel J.M. de Blok et al., *Breast Cancer Risk in Transgender People Receiving Hormone Treatment: Nationwide Cohort Study in the Netherlands*, 365 BMJ l1652, at 1, 3 (2019).

[40] ACPeds, *Mental Health*, *supra* note 2, at 9; *see also* Cass Review, *supra* note 16, at 185-86, §§15.32, 15.34.

[41] HHS Report, *supra* note 19, §§7.4, 7.6.

the Netherlands in the early 1980s. It was surmised, wrongly, that transitioning patients earlier would benefit their psychological well-being and make the surgical changes in a patient's secondary sex characteristics easier. Unsurprisingly, neither of these two suppositions, which had no scientific foundation to begin with, proved true.

1. As noted above, once a child starts on a path of hormonal interventions, it can often lead to surgical procedures either before or after the child's 18th birthday. These surgeries sterilize the child and permanently change the child's development.[42] Justice Thomas described examples of such surgeries and their intrinsic harm to the child patient in his concurring opinion in *Skrmetti*. 145 S.Ct. at 1843 (Thomas, J. concurring) ("for girls" "multistage reconstructive procedure" "include[s] … the surgical removal of the breasts and phalloplasty … an attempt to create a pseudo-penis by transplanting a roll of skin and subcutaneous tissue from another area of the body to the pelvis" and creation of a "scrotum with scrotal prostheses," which requires "removal of the uterus, ovaries, and vagina" and "[f]or boys, surgical interventions include removal of the testicles" and an "attempt to create a pseudo-vagina by surgically opening the boy's penis, removing erectile tissue, and then closing and inverting the penis into a newly created cavity in order to simulate a vagina" (cleaned up)).

There is simply no medical justification for these surgeries that remove healthy body parts and tissue from minors. And it goes without saying that "transgendered individuals who undergo sex reassignment surgery and have their reproductive organs removed are

[42] ACPeds, *Transgender Interventions Harm Children*, *supra* note 26.

rendered permanently infertile."[43] Just as a surgeon should not perform liposuction on a person with anorexia who falsely believes he/she is too fat, so also surgery to "transition" a child who expresses feeling of gender incongruence should be considered unethical, unscientific, and malpractice.

2. Additionally, published data show that the complications of transgender surgery far exceed the complication rates of other cosmetic operations. For example, the largest single-surgeon experience in vaginoplasty is from the Crane Center in San Francisco, which reported a total complication rate of 70%.[44]

The complication rates for phalloplasty are equally disturbing. The most experienced surgeons performing this procedure are in the Netherlands. Yet 63% of their patients reported being unable to void due to scarring in the urethra and required catheterization, and 27-50% reported leaking urine from the base of the false penis, requiring diapers. They also reported a revisional surgery rate of 73%.[45] And it can only be assumed the rates are higher in adolescents who have underdeveloped genitals from years of puberty blockers and cross-sex hormones.

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[43] ACPeds, *Gender Dysphoria*, *supra* note 3, at 13 (citing among others Jeffreys, *supra* note 23).

[44] Jonathan P. Massie et al., *Predictors of Patient Satisfaction and Postoperative Complications in Penile Inversion Vaginoplasty*, 141 Plastic Reconstructive Surgery 911e, 915e-916e & tbl. 2 (2018). *See also* Paulette Cutruzzula Dreher et al., *Complications of the Neovagina in Male-to-Female Transgender Surgery: A Systematic Review and Meta-Analysis with Discussion of Management*, 31 Clinical Anatomy 191, 193-194 & tbl. 1 (2018).

[45] H. Veerman et al., *Functional Outcomes and Urologic Complications After Genital Gender Affirming Surgery With Urethral Lengthening In Transgender Men*, 204 J. Urology 104, 104, 107 (2020).

Given these widespread complications, in July 2024, the American Society of Plastic Surgeons (representing 90% of board-certified plastic and reconstructive surgeons in the United States and Canada) cautioned that there is "considerable uncertainty as to the long-term efficacy for … chest and genital surgical interventions" for youth.[46] And Dr. Steven Williams, the Society's president, has publicly stated he would not "even entertain" surgically transitioning minors because there is a lack of data to support it.[47]

D. "Gender Transition" Interventions Do Not Lower the Risk of Suicide.

Notwithstanding these serious health risks, proponents of hormonal and surgical interventions claim they help reduce the risk of suicide among gender dysphoric children. Appellants' Br. 92-93. Indeed, as ACPeds' members have observed, "many parents are specifically told that if they do not accept their children's gender identity via social transition, medical treatment, and surgical operations, they risk losing their children to suicide."[48] Yet the scientific evidence does not support this. *See* A027 ("Plaintiffs have not provided any evidence that these interventions in fact save lives"). And such assertions merely scare a parent into authorizing such harmful interventions.

1. Addressing this very issue, the Cass Review did a detailed analysis of studies on the relationship between gender dysphoria and suicide. The review found that the studies

[46]Leor Sapir, *A Consensus No Longer*, City J. (Aug. 12, 2024), https://tinyurl.com/2zt898sr.

[47] Rich McHugh, *'No Good Evidence' for Teen Gender Surgery: Plastic Surgeons Head,* NewsNation (Sept. 2, 2024), https://tinyurl.com/mtv6657w.

[48] ACPeds, *Mental Health, supra* note 2, at 3.

did not support a claim that a "medical pathway … [of] gender-affirming treatment reduces suicide risk."[49]

This point was illustrated in a recent Finnish study among a population of 2,083 "gender-referred adolescents," which revealed that the suicide rate in these adolescents was equal to the suicide rate in 16,643 controls when the groups were matched for underlying mental disorders.[50] In other words, the underlying mental disorder was the cause of the suicide.[51] And, as the Cass Review concluded, "Tragically deaths by suicide in trans people of all ages continue to be above the national average, but there is no evidence that gender-affirmative treatments reduce this. The available evidence suggests that these deaths are related to a range of other complex psychosocial factors and to mental illness."[52]

2. Those other factors are borne out in the research, which demonstrates that "gender transition" services generally do not alleviate the underlying mental health and psychosocial issues that contributed to the feelings of gender incongruity in the first place. While those who identify as transgender have "significantly higher rates of suicide attempts, suicide mortality, suicide-unrelated mortality, and all-cause mortality,"[53] associated with

[49] Cass Review, *supra* note 16, at 186, §15.36; *see generally id.* at 186-187, §§15.36-15.43.

[50] *Id.* at 96, §5.66.

[51] Sami-Matti Ruuska et al., *All-cause and Suicide Mortalities Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services In Finland In 1996-2019: A Register Study*, 27 BMJ Mental Health 1, 3 & tbl. 1 (2024).

[52] Cass Review, *supra* note 16, at 195, §16.22.

[53] ACPeds, *Mental Health*, *supra* note 2, at 10 (citing Annette Erlangsen et al., *Transgender Identity and Suicide Attempts and Mortality in Denmark*, 329 JAMA 2145 (2023)).

higher incidents of mental health issues, studies show that puberty blockers do not address these issues but may make them worse.[54]

For example, sex reassignment surgery, in the long term, does not result in a level of health equivalent to that of the general population.[55] Taken together, the evidence indicates that "gender transition" services do not relieve the patient's mental health concerns, as advocates claim.

E. Children are Unable to Give Informed Consent to "Gender Transition" Procedures.

As if the inherent harms and lack of benefits from the procedures themselves were not enough to justify the statutes, children with gender incongruence are not even capable of giving informed consent for such interventions. *See Skrmetti*, 145 S.Ct. at 1845-46 (Thomas, J., concurring); A035-A036, A059-A60, A061.

1. This is obvious when considering the known medical evidence on the development of the juvenile brain. As ACPeds has elsewhere noted, "[t]he immaturity of

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[54] ACPeds, *Transgender Interventions Harm Children*, *supra* note 26 (quoting Oxford University Professor Michael Biggs, "There was no statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. In addition, there is unpublished evidence that after a year on [puberty blockers] children reported greater self-harm, and the girls also experienced more behavioral and emotional problems and expressed greater dissatisfaction with their body—so *puberty blockers exacerbated gender dysphoria*." (emphasis added)).

[55] ACPeds, *Gender Dysphoria*, *supra* note 3, at 15 (citing Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLoSOne e16885, e16885 (2011) (finding "considerably lower general health and general life satisfaction" after gender transition services and that "Sex-reassigned persons … had an increased risk for suicide attempts … and psychiatric inpatient care" with "the rate of suicide among post-operative transgender adults was nearly twenty times greater than that of the general population.")).

the adolescent brain has been well described for the past 20 years, and newer research demonstrates how the immaturity affects decision-making. Studies confirm that adolescents, when faced with real life decisions, are much more likely to depend upon their emotions and peer pressure, with less use of their cognitive reasoning skills and with less concern for future consequences. The rise of rapid-onset gender dysphoria in adolescent girls who are high users of social media is evidence of this."[56] Indeed, the adolescent brain does not achieve the capacity for full risk assessment until the early to mid-twenties.[57]

2. There is, moreover, a serious ethical problem with allowing minors to receive life-altering medical interventions when they are incapable of providing informed consent for themselves.[58] Indeed, because doctors do not know the long-term effects of the drugs they prescribe or of the surgeries they perform for "gender transition" purposes, they cannot even provide the necessary information for a child or their parents to give informed consent. As the Cass Review noted, "[t]he duty of information disclosure is complicated by many 'unknown unknowns' about the long-term impacts of puberty blockers and/or masculinising/feminising hormone during a dynamic developmental period when gender identity may not be settled."[59] In other words, no doctor can obtain genuine, meaningful

[56] ACPeds, *Mental Health*, *supra* note 2, at 13 (citing Douglas S. Diekema, *Adolescent brain development and medical decision-making*, 146 Pediatrics e20218F (2020)).

[57] ACPeds, *Gender Dysphoria*, *supra* note 3, at 13.

[58] *Id.* at 14.

[59] Cass Review, *supra* note 16, at 194, §16.18; *see also id*. at 195-96, §§16.25-16.31, 16.34. *See also* Doctors Protecting Children Decl., *supra* note 1, ¶2.

informed consent from an adolescent to any medical intervention that would render the adolescent infertile for life.[60]

III. The Trial Court Properly Found the Statutes are Consistent With Sound Medical Practice.

The statutes take rational and necessary steps to protect gender confused children from a lifetime of severe consequences from unproven, harmful medical interventions that do not address the underlying mental health issues that precipitated a child's gender non-contentedness. A020 (citing Cass Review), A021 (citing guidelines issued by Swedish and Finnish medical authorities finding that "the harms from these interventions outweigh the benefits" and declares the interventions to be "experimental"), A024-A027 (detailing life-long harms from such interventions). The exponential danger these procedures pose is evident with the dramatic rise of "rapid onset gender dysphoria" seen today, particularly in teenage girls, and provides another reason to avoid a drugs-first approach for these minors pushed by Appellants. Indeed, with the significant increase in claims of gender incongruity, as well as the social transition and "gender-affirming therapy" provided to young adolescents whose brains are not yet mature, there is less long-term data regarding how many individuals later regret their transition decisions.

Accordingly, addressing the underlying mental health issues rather than "affirming" an incongruent identity is the proper standard of care[61]—a standard jettisoned by

[60] HHS Report, *supra* note 19, at 159; *WPATH Files*, *supra* note 37, at 4 (a Canadian endocrinologist stated: "*So … [m]ost of the kids are nowhere in any kind of a brain space to really talk about [fertility preservation] in a serious way.*").

[61] Doctors Protecting Children Decl., *supra* note 1, ¶¶7-9 (citing sources).

WPATH.[62] This is clear based on the lack of evidence to support the WPATH "standards of care" for these vulnerable youth.[63] *Skrmetti*, 145 S.Ct. at 1847-49 (Thomas, J., concurring).

Consistent with the Cass Review's findings, "health authorities in a number of European countries have raised significant concerns regarding the potential harms associated with using puberty blockers and hormones to treat transgender minors." *Id.* at 1825.[64] Accordingly, the evidence-based statutes properly prohibit such procedures in the treatment of gender dysphoric children. Such children simply need the opportunity to grow up and the statutes help ensure they get that chance.

[62] As Justice Thomas noted, "WPATH's lodestar is ideology, not science." *Skrmetti*, 145 S.Ct. at 1848 (Thomas, J., concurring) (quoting *Eknes-Tucker v. Governor of Ala.*, 114 F.4th 1241, 1261 (11th Cir. 2024) (opinion of Lagoa, J.)). For example, WPATH attempted to stop Johns Hopkins from publishing its findings from commissioned studies because the results did not support WPATH's predetermined conclusions. *See* Attach. to U.S. Dep't Health & Hum. Servs. Resp. to Mots. to Seal at 1, *Voe v. Mansfield*, No. 1:23-cv-00864-LCB-LPA (M.D.N.C. May 13, 2024), ECF No. 100-1; *see also* A022-A023 (notes that recommendations based on "low or very low quality evidence"), A053-A054 (noting that WAPTH is "committed to advocacy," its recommendations "have repeatedly been condemned by systematic reviews," the "organization has chosen to pursue political ends rather than scientific ends," it "did not follow the standard requirements for crafting its guidelines," and WPATH "has suppressed research unfavorable to its agenda").

[63] Cass Review, *supra* note 16, at Annex A, 1.2; *The Cass Review, Final Report, Overview of Key Findings,* The Cass Review, https://tinyurl.com/ysew5cbu (last visited Sept. 1, 2025).

[64] Christina Buttons, *The Global Response to the Cass Review: June 2024 Update*, buttonslives (May 13, 2024), https://tinyurl.com/y67b8e8k.

CONCLUSION

Sound medical ethics alone demands an end to the use of puberty blockers, cross-sex hormones, and sex reassignment surgeries in children and adolescents—consistent with Missouri statutes §§ 191.1720 and 208.152.15.

The judgment of the trial court should be affirmed.

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CERTIFICATION OF COMPLIANCE

The undersigned certifies that pursuant to Rule 84.06(c), this brief: (1) contains the information required by Rule 55.03; (2) complies with the limitations in Rule 84.06; (3) contains 6,862 words, as determined using the word-count feature of Microsoft Office Word; and (4) has been scanned and found to be virus-free.

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CERTIFICATE REGARDING SERVICE

The undersigned certifies that, on this 2nd day of September, 2025, the foregoing brief was filed electronically with the clerk of the Court in compliance with Rule 84.015 using the Missouri Courts eFiling System, which will cause all attorneys of record to be served electronically by operation of that system.

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