IN THE SUPREME COURT OF MISSOURI

NO. SC100933

E.N., individually and as a next friend on behalf of her minor child N.N., et al.

***Plaintiffs/Appellants*,**

v.

MIKE KEHOE, in his official capacity as Governor of Missouri, et al.

Defendants/Respondents.

APPEAL FROM THE CIRCUIT COURT

OF COLE COUNTY, MISSOURI

The Honorable R. Craig Carter

AMICUS CURIAE BRIEF OF FAMILY LAW AND CONSTITUTIONAL LAW SCHOLARS SUPPORTING APPELLANTS

FILED WITH CONSENT OF ALL PARTIES

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CONSENT OF ALL PARTIES TO THE FILING OF THE AMICUS CURIAE BRIEF

Pursuant to Missouri Supreme Court Rule 84.05(f)(2), *Amicus Curiae* certify that all parties have consented to the filing of this brief.

JURISDICTIONAL STATEMENT

Amici adopt the jurisdictional statement set forth in Plaintiffs-Appellants' brief.

STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici are legal scholars whose scholarship and teaching focus on family law and the Due Process Clause of the Fourteenth Amendment. These scholars have an interest in ensuring that the Due Process Clauses of the Federal and State Constitutions are interpreted to protect parents' fundamental right to direct their children's medical care. *Amici* include (in alphabetical order):

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The institutional affiliations of *Amici* are supplied for the purpose of identification only and the positions set forth below are solely those of *Amici*.[1]

[1] No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money that was intended to fund preparing or submitting this brief. No person—other than *amici curiae* or their counsel—contributed money that was intended to fund preparing or submitting this brief. All parties consented to the filing of this brief.

STATEMENT OF FACTS

Amici adopt the statement of facts set forth in Plaintiffs-Appellants' brief.

ARGUMENT

The right of parents to direct the upbringing of their children is one of the oldest and most unassailable fundamental rights protected by the Constitution. This fundamental right unequivocally includes parents' right to direct their children's medical care. For over a century, the Supreme Court has vigorously defended this right as promoting the best interests of children and of society more generally, including the traditional values of limited government and the sanctity of the family.

In its decision in *Noe v. Parson* upholding the constitutionality of Missouri's Senate Bill 49 ("SB 49"), the trial court concluded, *inter alia*, that because "there is no medical ethical consensus whatsoever as to whether gender dysphoria treatment should be performed on children and adolescents," SB 49's ban on transgender healthcare for minors does not violate parents' fundamental right to direct the medical care of their children.[2] The State may impose such a ban, says the trial court, so long as there is a "rational basis for the State to act."[3] This analysis is flawed.

Before the recent litigation regarding state bans on transgender healthcare for minors,[4] the closest analogue to the drastic government intervention attempted here

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[2] *Noe v. Parson*, No. 23AC-CC04530, at 56 (Mo. Cir. Ct. Cole County Nov. 25, 2024).

[3] *Id.* at 71.

[4] "Outside the context of gender-affirming drugs and abortion medication, no state has *ever* prohibited . . . off-label prescribing of an FDA-approved drug for a use that constituted the medical standard of care." Lewis Grossman, *Criminalizing Transgender Care*, 110 IOWA L. REV. 281, 313 (2024).

involved cases in which states charged parents with medical neglect to bar them from carrying out the parents' chosen treatment plan. The decisions in those cases demonstrate the errors in the trial court's opinion below. In assessing whether a state may override parents' preferred treatment plan for their child, courts made plain that "[s]tate intervention in the parent-child relationship is only justifiable under compelling conditions."[5] Furthermore, they construed the situations deemed compelling narrowly, demanding the presence of two exceptional circumstances: first, that all responsible medical authorities agree that the state's preferred course of treatment is the appropriate course of treatment for the child—mere disagreement among responsible medical authorities does not justify state intervention; and, second, that the State's course of treatment is likely to result in great benefit and pose few countervailing risks to the child.

Neither of the two compelling circumstances laid out in the medical neglect cases—let alone both—is met. First, the court's finding that medical research regarding transgender healthcare is uncertain, even if it were supported by the evidence, is not enough; in our legal tradition, where there is no medical consensus, it is parents in concert with their chosen doctors—not the State—who properly bear

[5] *Newmark v. Williams*, 588 A.2d 1108, 1117 (Del. 1991); *see also In re Hofbauer*, 393 N.E.2d 1009, 1013 (N.Y. 1979) ("[G]reat deference must be accorded a parent's choice as to the mode of medical treatment to be undertaken.") (citing *Wisconsin v. Yoder*, 406 U.S. 205 (1972)).

the right and heavy responsibility of deciding what care is in their children's best interests. And second, there is compelling evidence that Missouri's ban on transgender healthcare is likely to result in harm to children who need such care. For these reasons, SB 49 violates parents' fundamental right to direct their children's medical care.

By prohibiting parents from accessing established medical care for their children, SB 49 not only violates the fundamental rights of parents but also grants unprecedented power to the State to supervene the decisions of those who know their children best and are best positioned to assess the tradeoffs that come with medical treatment. In doing so, the law obstructs children's access to the health care that parents and their chosen doctors have jointly determined are necessary to protect the children's health.[6]

Importantly, the U.S. Supreme Court's decision in *U.S. v. Skrmetti* upholding Tennessee's ban on transgender healthcare for minors under the Equal Protection Clause "has no impact on the parental rights claim."[7] The *Skrmetti* Court did not

[6] This brief does not speak to the issues of whether and when access to medical care would be appropriate when a mature minor *disagrees* with a parent's preferred care plan.

[7] *United States v. Skrmetti*, No. 23-477 (U.S. Dec. 4, 2024), Tr. of Oral Argument, at 64 (quoting Justice Barrett); *see also id.* at 65 ("[E]ven if [the Court] decided that th[ere] wasn't a sex-based classification that triggered intermediate scrutiny, that would not prevent parents from still asserting the substantive due process right.") (quoting Justice Barrett), 142 ("[T]he parental rights question is not before the Court,

accept review of, and did not address, the question of whether a law banning transgender healthcare for minors violates parents' right to direct their children's medical care.[8]

For these reasons, *Amici* urge this Court to find that SB 49 infringes Plaintiffs-Appellants' fundamental rights under the Due Process Clause of the Missouri Constitution.

I. THE RIGHT OF PARENTS TO DIRECT THEIR CHILDREN'S MEDICAL CARE IS A FUNDAMENTAL RIGHT PROTECTED BY THE FOURTEENTH AMENDMENT.

The Supreme Court has "long recognized" that the Due Process Clause "provides heightened protection against government interference with certain fundamental rights and liberty interests,"[9] including those "deeply rooted in this Nation's history and tradition."[10] According to the Supreme Court, "the interest of parents in the care, custody, and control of their children . . . is perhaps the oldest of the fundamental liberty interests recognized by this Court."[11] In a long line of cases

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so it would be open to parents to continue to press that point in other cases.") (quoting Justice Barrett).

[8] *See United States v. Skrmetti*, No. 23-477, 2025 WL 1698785 (U.S. June 18, 2025); *United States v. Skrmetti*, No. 23-477 (U.S. June 24, 2024) (granting cert.).

[9] *Troxel v. Granville*, 530 U.S. 57, 65 (2000).

[10] *Wash. v. Glucksberg*, 521 U.S. 702, 721 (1997).

[11] *Troxel*, 530 U.S. at 65; *see, e.g.*, *Parham v. J.R.*, 442 U.S. 584, 602 (1979) ("Our jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children. Our cases have consistently followed that course[.]"); *Yoder*, 406 U.S. at 232 ("The history and

dating back a century, the Court has repeatedly confirmed that "[t]he child is not the mere creature of the State," and that parents "have the right, coupled with the high duty, to recognize and prepare [their children] for additional obligations."[12]

Absent threats to the "physical or mental health" of a child, such as "abuse and neglect," the Constitution forbids the State from infringing on parents' "broad . . . authority over [their] minor children."[13] As the Supreme Court has reaffirmed in numerous cases:

> [T]here is a *presumption* that fit parents act in the best interests of their children. . . . [S]o long as a parent adequately cares for his or her children (*i.e.*, is fit), there will normally be no reason for the State to inject itself into the private realm of the family to further question the

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culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition."); *Stanley v. Illinois*, 405 U.S. 645, 651 (1972) ("The right[ ] . . . to raise one's children ha[s] been deemed 'essential' [and one of the] 'basic civil rights of man'") (citations omitted); *accord In re K.A.W.*, 133 S.W.3d 1, 12 (Mo. 2004) ("A parent's right to raise her children is . . . one of the oldest fundamental liberty interests recognized by the United States Supreme Court.") (citing *Troxel*).

[12] *Pierce v. Soc'y of the Sisters*, 268 U.S. 510, 535 (1925); *see also Meyer v. Nebraska*, 262 U.S. 390, 399 (1923) (recognizing fundamental right of parents to "establish a home and bring up children"); *accord Troxel*, 530 U.S. at 66 (recognizing "fundamental right of parents to make decisions concerning the care, custody, and control of their children"); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944) ("It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder. And it is in recognition of this that these decisions have respected the private realm of family life which the state cannot enter." (citation omitted)).

[13] *Parham*, 442 U.S. at 602–03.

ability of that parent to make the best decisions concerning the rearing of that parent's children."[14]

It is well-established that the longstanding right of parents to "make decisions concerning the care, custody, and control of [their] children"[15] includes the "plenary authority to seek [medical] care for their children, subject to a physician's independent examination and medical judgment."[16] Parents' right to direct their children's medical care in concert with their chosen physician stems not only from our constitutional tradition's great respect for parental autonomy, but also from parents' "high duty" to recognize children's physical and mental distress "and to seek and follow medical advice."[17] As the Supreme Court stated in *Parham v. J. R.*, "[t]he law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's

[14] *Troxel*, 530 U.S. at 68–69.
[15] *Id.* at 66.
[16] *See, e.g.*, *Parham*, 442 U.S. at 602 ("[O]ur constitutional system long ago . . . asserted that parents generally 'have the right, coupled with the high duty, to recognize and prepare [their children] for additional obligations.'" (citation omitted)); *PJ ex rel. Jensen v. Wagner*, 603 F.3d 1182, 1197 (10th Cir. 2010) (recognizing parents' right to direct their children's medical care); *see also R.J.D. v. Vaughan Clinic, P.C.*, 572 So. 2d 1225, 1227–28 (Ala. 1990) ("The common law deems parental care for children not only an obligation, but also an inherent right: 'In such matters as deciding on the need for surgical or hospital treatment, . . . [*t*]*he will of the parents is controlling,* except in those extreme instances where the state takes over to rescue the child from parental neglect or to save its life. . . .' The United States Supreme Court followed this common law rule in [*Parham*]." (citations omitted)); 59 Am. Jur. 2d, *Parent and Child*, § 22 (2023).
[17] *Parham*, 442 U.S. at 602.

difficult decisions. More important, historically it has recognized that natural bonds of affection lead parents to act in the best interests of their children."[18] Because of this, it is parents, rather than government, who are best positioned to decide what medical care is in their children's interests.

Although government has a role in dictating the medical care that children receive, its authority to do so is narrowly confined. According to the Supreme Court, "as long as parents choose from professionally accepted treatment options the choice is rarely reviewed in court and even less frequently supervened. . . . The decision to provide or withhold medically indicated treatment is, except in highly unusual circumstances, made by the parents or legal guardian."[19] Furthermore, "[s]imply because the decision of a parent . . . involves risks does not automatically transfer the power to make that decision from the parents to some agency or officer of the state."[20]

The narrow grounds that allow state interference in parental decision-making regarding children's medical care have been articulated most clearly in state neglect proceedings in which government actors seek to intervene with respect to children's medical care. Although these cases address the power of the State to override an

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[18] *Id.*
[19] *Bowen v. Am. Hosp. Ass'n*, 476 U.S. 610, 627 n.13 (1986) (plurality) (quotation marks omitted).
[20] *Parham*, 442 U.S. at 603.

individual parent's right to direct the medical care of their children in a particular proceeding, their reasoning applies with equal force to the power of the State to pass a blanket law that prevents all parents from exercising this right.

To safeguard parents' constitutional right to direct their children's medical care, state courts, relying in part on U.S. Supreme Court parental-rights jurisprudence, have declared that "[s]tate intervention in the parent-child relationship is only justifiable under compelling conditions."[21] While different courts have phrased the narrow grounds that allow intervention in slightly different ways, courts have authorized intervention only when two circumstances are both present. First, courts have required that the State's preferred course of treatment be compelling in the sense that all responsible medical authorities agree that it is the appropriate course of treatment for the child.[22] Second, they have required that the State's preferred course of treatment for the child be both likely to result in great benefit and pose few countervailing risks to the child.[23]

Only when both of these circumstances are present do courts authorize state intervention. Absent such circumstances, as stated by the New York Court of

[21] *Newmark*, 588 A.2d at 1117; *see id.* at 1115 (citing *Stanley*, *Yoder*, and *Pierce*).
[22] *See, e.g.*, *In re Storar*, 420 N.E.2d 64, 73 (N.Y. 1981); *In re Hofbauer*, 393 N.E.2d at 1013; *In re Custody of a Minor*, 393 N.E.2d 836, 846 (Mass. 1979).
[23] *See, e.g.*, *Newmark*, 588 A.2d at 1117–18; *In re Burns*, 519 A.2d 638, 645 (Del. 1986) (citing *Stanley*).

Appeals, "great deference must be accorded a parent's choice as to the mode of medical treatment to be undertaken and the physician selected to administer the same."[24]

Explicating the first requirement, courts hold that situations in which physicians disagree about the correct care plan for the child lack the compelling circumstances to justify state involvement. The reason for this rule is simple. As Yale Law Professor Joseph Goldstein, one of the most influential family law scholars of the twentieth century, noted:

> No one has a greater right or responsibility and no one can be presumed to be in a better position, and thus better equipped, than a child's parents to decide what course to pursue if the medical experts cannot agree. . . . Put somewhat more starkly, how can parents in such situations give the wrong answer since there is no way of knowing the right answer? In these circumstances the law's guarantee of freedom of belief becomes meaningful and the right to act on that belief as an autonomous parent becomes operative within the privacy of one's family.[25]

The New York Court of Appeals applied this principle in the case of *In re Hofbauer*, when it rejected state intervention in parental decision-making despite the unconventionality of the parents' preferred medical treatment for their child.

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[24] *In re Hofbauer*, 393 N.E.2d at 1013 (citing *Yoder*).

[25] Joseph Goldstein, *Medical Care of the Child at Risk: On State Supervision of Parental Autonomy*, 86 YALE L.J. 645, 654–55 (1976–1977); *see also id.* at 653 ("There would be no justification . . . for coercive intrusion by the state in those . . . situations . . . in which there is no proven medical procedure, or . . . in which parents are confronted with conflicting medical advice about which, if any, treatment procedure to follow . . . .").

Government, the *Hofbauer* Court declared, may not "assume the role of a surrogate parent and establish as the objective criteria with which to evaluate a parent's decision its own judgment as to the exact method or degree of medical treatment which should be provided."[26] Instead, the appropriate inquiry is whether the parents "have provided for their child a treatment which is recommended by their physician and which has not been totally rejected by all responsible medical authority."[27]

Massachusetts' highest court has also declared that government intervention is not authorized absent consensus by responsible medical authority about the proper course of treatment. In the case of *In re Custody of a Minor*, the Supreme Judicial Court of Massachusetts ordered a child's chemotherapy continued over the objection of the child's parents, and also ordered them to discontinue the "metabolic therapy" in which they had enrolled the child, precisely because the child's doctors agreed that chemotherapy was the proper treatment.[28] The court distinguished the New York Court of Appeal's holding in *Hofbauer* on the ground that "[t]he medical evidence in that case was sharply conflicting. . . . This is a far cry from the unsupported stance

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[26] *In re Hofbauer*, 393 N.E.2d at 1014; *see also In re Storar*, 420 N.E.2d at 73 ("Of course it is not for the courts to determine the most 'effective' treatment when the parents have chosen among reasonable alternatives."), 69 n.3 ("[A]s a matter of public policy a medical facility generally has no responsibility or right to supervise or interfere with the course of treatments recommended by the patient's private physician . . . .").

[27] *In re Hofbauer*, 393 N.E.2d at 1014.

[28] 393 N.E.2d at 846.

of the parents in the instant case, and the compelling evidence that for this child [the parents' preferred course of treatment] . . . is useless and dangerous."[29] The court went on to state that intervention was appropriate in this case only because of the parents'

> persistence in pursuing for their child a course against *all credible medical advice*[, which] cannot be explained in terms of despair of a cure, or by the suffering of serious side effects of chemotherapy. . . . Under our free and constitutional government, it is only under serious provocation that we permit interference by the State with parental rights. That provocation is clear here.[30]

With respect to the second requirement, even when all responsible medical authority line up against the parents, courts refuse to supervene parental decision-making when the government's proposed course of treatment presents significant risks or lacks a high chance of success.[31] On this ground, the Supreme Court of Delaware refused to order that a child receive a novel form of chemotherapy over his parents' objections.[32] Because the child's "proposed medical treatment was highly invasive, painful, involved terrible temporary and potentially permanent side

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[29] *Id.* at 846.
[30] *Id.* (emphasis added); *see id.* at 843 (citing *Yoder*, *Pierce*, and *Meyer*).
[31] *See* Goldstein, *supra* note 25, at 653 ("There would be no justification . . . for coercive intrusion by the state in those . . . situations . . . in which, even if the medical experts agree about treatment, there is less than a high probability that the nonexperimental treatment will enable the child to pursue either a life worth living or a life of relatively normal healthy growth toward adulthood.").
[32] *See Newmark*, 588 A.2d at 1118.

effects, posed an unacceptably low [40 percent] chance of success, and a high risk that the treatment itself would cause his death," the court held that "[t]he State's authority to intervene in this case, therefore, cannot outweigh the Newmarks' parental prerogative."[33] Concomitantly, courts that have authorized medical treatment for a minor over a parent's objection have noted that intervention would be inappropriate if treatment were inherently dangerous or invasive.[34]

II. RECOGNITION AND PROTECTION OF THE FUNDAMENTAL RIGHT OF PARENTS TO DIRECT THEIR CHILDREN'S MEDICAL CARE FURTHERS THE BEST INTERESTS OF CHILDREN AND SOCIETY.

The Supreme Court's deeply rooted deference to parents' right to direct the upbringing of their children, including their medical care, reflects two normative judgments. The first is that this fundamental right is necessary to protect the interests of children. Generally speaking, children, by dint of their age, must rely on others to make important decisions for them.[35] Because parents—not the State or other adults—are generally in the best position to know what is best for their children, and

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[33] *Id.*; *see also In re Phillip B.*, 156 Cal. Rptr. 48, 52 (Cal. Ct. App. 1979) (refusing state's request to repair child's heart defect over parents' objection based on the risks posed by the surgery).

[34] *See Muhlenberg Hosp. v. Patterson*, 320 A.2d 518, 521 (N.J. 1974) ("[I]f the disputed procedure involved a significant danger to the infant, the parents' wishes would be respected."); *State v. Perricone*, 181 A.2d 751, 760 (N.J. 1962) (strong argument for parents if "there were substantial evidence that the treatment itself posed a significant danger to the infant's life"); *People ex rel. Wallace v. Labrenz*, 104 N.E.2d 769, 773 (Ill. 1952) (same).

[35] *See Troxel*, 530 U.S. at 68; *accord Schall v. Martin*, 467 U.S. 253, 265 (1984).

because "natural bonds of affection" generally "lead parents to act in the best interests of their children," recognition of parental rights benefits children.[36] A contrary approach—one soundly rejected by the Supreme Court—in which the child is the mere "creature of the State" would undermine the interests of the child by delegating child-rearing rights to those less familiar with the child's needs.[37]

Importantly, parents have more than a natural incentive to provide for their children: as the Supreme Court has stated, parents have a *legal duty* to do so.[38] If they fail in this duty, the State may criminally prosecute and incarcerate them for child neglect or abandonment, or it may terminate their parental rights altogether.[39] Recognition of parental rights is therefore the logical corollary to the substantial duties imposed on parents: in order to meet their obligation to provide for their children, the State must not prevent parents from fulfilling this obligation.[40]

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[36] *Parham*, 442 U.S. at 602 (citing 1 William Blackstone, *Commentaries* *447).

[37] *See Pierce*, 268 U.S. at 535; *see also* Clare Huntington & Elizabeth Scott, *The Enduring Importance of Parental Rights*, 90 FORDHAM L. REV. 2529, 2532-33 (2022) ("[D]eference to parental decision-making promotes child wellbeing because, as compared with state actors or third parties granted decision-making authority by the state, parents are generally better positioned to understand a child's needs and make decisions that will further that child's interests.").

[38] *See Pierce*, 268 U.S. at 535 (discussing parents' "high duty . . . to recognize and prepare [their children] for additional obligations").

[39] *See generally Lassiter v. Dep't of Soc. Servs. of Durham Cnty.*, 452 U.S. 18, 32 (1981).

[40] *See Meyer*, 262 U.S. at 400 ("Corresponding to the right of control . . . is the natural duty of the parent to give his children education suitable to their station in life . . . ."); *see also Lehr v. Robertson*, 463 U.S. 248, 257 (1983) ("[T]he rights of the parents are a counterpart of the responsibilities they have assumed.").

The second normative judgment, also backed by centuries of tradition, is that strong parental rights combined with firm limits on government power serve society as a whole. "[T]he Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and tradition."[41] "It is through the family that we inculcate and pass down many of our most cherished values, moral and cultural."[42] "Properly understood, then, the tradition of parental authority is not inconsistent with our tradition of individual liberty; rather, the former is one of the basic presuppositions of the latter."[43]

Beginning a century ago with the invalidation of compulsory public school attendance laws and laws regulating language instruction in private schools, and continuing to the present, the Supreme Court has vigorously protected parents' child-rearing decisions—religious and otherwise—from substitution by State decision-makers.[44] *Wisconsin v. Yoder* is emblematic of the deference accorded to parental rights and the skeptical inquiry that awaits state infringements of those rights.[45] In *Yoder*, the Court invalidated Pennsylvania's compulsory school attendance law that would have exposed Amish children, at a "crucial adolescent stage of development,"

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[41] *Moore v. City of E. Cleveland*, 431 U.S. 494, 503 (1977) (plurality op.).
[42] *Id*. at 503-04.
[43] *Bellotti v. Baird*, 443 U.S. 622, 638 (1979) (plurality op.).
[44] *See, e.g.*, *Pierce*, 268 U.S. at 536; *Meyer*, 262 U.S. at 403; *Farrington v. Tokushige*, 273 U.S. 284, 298 (1927).
[45] 406 U.S. 205.

to worldly influences considered detrimental by their parents and the Amish faith community.[46] By forcing children to accept instruction from public teachers only, the law undermined the "diversity [society] profess[es] to admire and encourage," leaving Amish parents with an impossible choice: "abandon belief and be assimilated into society at large, or be forced to migrate to some other and more tolerant region."[47] According to the Court, "[t]he fundamental theory of liberty upon which all governments in this Union repose excludes any general power of the State to standardize its children" and must yield to the traditional right of parents to control the upbringing of their children.[48]

III. SB 49 VIOLATES PARENTS' FUNDAMENTAL RIGHT TO DIRECT THE MEDICAL CARE OF THEIR ADOLESCENT CHILDREN.

By precluding parents from accessing transgender healthcare for their adolescent children, SB 49 infringes parents' fundamental right to direct their children's medical care. Accordingly, heightened scrutiny applies. For all the reasons explained by Plaintiffs-Appellants, SB 49 cannot satisfy this standard—as every court to have considered similar categorical bans on transgender healthcare under heightened scrutiny has concluded.[49]

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[46] *Id.* at 217–18.
[47] *Id.* at 218, 226.
[48] *Id.* at 233; *see also Meyer*, 262 U.S. at 402 (invalidating legislation that attempted "to foster a homogeneous people" by standardizing language instruction in schools).
[49] *See, e.g.*, *Poe by and through Poe v. Labrador*, 709 F. Supp. 3d 1169, 1198 (D. Idaho 2023); *Brandt v. Rutledge*, 677 F. Supp. 3d 877, 923 (E.D. Ark. 2023).

The state-court medical neglect decisions described above shed further light on the appropriate inquiry over SB 49. As discussed below, transgender healthcare presents *neither* of the two exceptional circumstances that state courts have held are necessary to justify government infringement of parents' fundamental right to direct their children's medical care. Accordingly, SB 49 violates this right.[50]

A. All Responsible Medical Authority Rejects the State's Preferred Course of Treatment.

Contrary to the first requirement—that the State's preferred care plan be compelling in the sense that all responsible medical authority agree that it is the appropriate course of care[51]—the testimony of every medical expert with meaningful clinical experience treating transgender adolescents uniformly supported the availability of transgender healthcare and its use in appropriate cases. Plaintiffs' experts, Drs. Shumer, Olson-Kennedy, Antommaria, Janssen, and Meyer—who have collectively treated thousands of adolescents with gender dysphoria—detailed the significant mental health benefits of transgender healthcare for adolescents that they

[50] *See, e.g.*, *Brandt*, 677 F. Supp. 3d at 923 (concluding, after eight-day bench trial, that transgender healthcare ban infringed parents' "fundamental right to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary").

[51] *See, e.g.*, *In re Hofbauer*, 393 N.E.2d at 1013; *In re Storar*, 420 N.E.2d at 73; *In re Custody of a Minor*, 393 N.E.2d at 846.

have observed clinically.[52] Even the State's expert witness, Dr. Stephen Levine—the only doctor proffered by the Defendants who has treated adolescents with gender dysphoria—testified that transgender healthcare is appropriate for certain adolescents and that the ultimate decision of whether an adolescent with gender dysphoria should undergo medical treatment is best made by the parents and the minor in consultation with treating doctors.[53] In addition to this testimony, transgender healthcare is backed by the research and expertise of specialists in the field and "every major medical association in the United States."[54]

On the other side of this broad consensus is the State's outlier view that transgender healthcare does not improve mental health outcomes.[55] This view relies on the testimony of a handful of Defendants' experts, all but one of whom (a licensed marriage and family therapist)[56] has never treated an adolescent with gender dysphoria and none of whom has conducted original relevant research.[57] Thus, not only is the exceptional circumstance of all responsible medical authority lining up

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[52] Tr. Vol. I, 131:11-20, 142:10-143:18, 258:17-21, 260:24-263:10; Vol. II, 330:8-20; Vol. III, 538:10-17, 549:23-550:10, 751:2-12.
[53] Tr. Vol. IX, 2455:23-2456:3, 2463:2-5, 2465:23-2466:1.
[54] *Brandt*, 677 F. Supp. 3d at 919-20 & n.13; *accord Poe*, 709 F. Supp. 3d at 1182; *see also* Tr. Vol. I, 116:12-117:7 (discussing widespread endorsement of the WPATH and Endocrine Society's guidelines for treating gender dysphoria); Vol. II, 330:8-15 (discussing studies supporting transgender healthcare); Vol. III, 538:10-17 (same).
[55] *See Noe*, No. 23AC-CC04530, at 34-37 (discussing testimony of Drs. Curlin and Lappert).
[56] Tr. Vol. VIII, 2145:14-16.
[57] *See, e.g.*, Tr. Vol. VI, 1874:19-1875:4.

against transgender healthcare *not* present, all responsible medical authority—including every expert in this case with meaningful clinical experience treating transgender adolescents, as well as the medical profession as a whole—lined up in support of this treatment's availability in appropriate cases.[58] When a parent's preferred course of treatment does not run counter to the overwhelming weight of responsible medical authorities, the state may not override that choice.[59]

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[58] Even a prominent review by Dr. Hillary Cass that was commissioned by the United Kingdom's National Health Service (NHS), which questioned the evidence base for the use of pharmaceuticals in treating gender dysphoria in minors, concluded that such care will be appropriate in some cases, although it recommended more cautious assessments prior to considering medical care. *See* H. Cass, Independent Review of Gender Identity Services for Children and Young People: Final Report 20-21, 34-35 (Apr. 2024). As Cass stated in a subsequent interview, "There are young people who absolutely benefit from a medical pathway, and we need to make sure that those young people have access . . . but not assume that that's the right pathway for everyone." Azeen Ghorayshi, *Hilary Cass Says U.S. Doctors Are "Out of Date" on Youth Gender Medicine*, N.Y. TIMES, May 13, 2024.

It should be noted that the conclusions of the Cass report regarding the evidence base have been challenged by other medical experts. *See, e.g.*, Meredithe McNamara et al., An Evidence-Based Critique of "The Cass Review" on Gender-Affirming Care for Adolescent Gender Dysphoria, at 4. Furthermore, the United Kingdom, which has restricted transgender healthcare for minors in the wake of the Cass Report, does not provide parents the broad constitutional protections for medical decision making that the United States has long provided. *See*, *e.g.*, The Children Act, 1989, c. 41, sec. 41 (U.K.) (allowing court to enter care order if "the child concerned is suffering, or is likely to suffer, significant harm").

[59] *See, e.g.*, *Brandt*, 677 F. Supp. 3d at 919-20 (state could not ban transgender healthcare for adolescents, which was supported by "decades of clinical experience and scientific research" and was "widely recognized in both the medical and mental health fields" as "reliev[ing] the clinically significant distress associated with gender dysphoria in adolescents"); *In re Hofbauer*, 393 N.E.2d at 1012-13 (state could not supplant parents' chosen treatment when physicians testified that it was "a beneficial

B. The State's Preferred Course of Treatment is Unlikely to Benefit the Adolescent and Poses Substantial Risks to the Health of Adolescents.

Contrary to the second requirement—that the State's preferred course of treatment for the child must be likely to result in great benefit and pose few countervailing risks to the child[60]—the ban on transgender healthcare poses considerable risks to minors experiencing gender dysphoria. As Plaintiffs' experts testified, gender dysphoria is a serious condition that, if left untreated, can result in other psychological conditions including depression, anxiety, self-harm, and suicidality.[61] Delaying transgender healthcare until those with gender dysphoria reach adulthood, as Missouri would require, will lead to physical changes that are consistent with the patients' sex at birth (i.e., inconsistent with their gender identity),

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and effective mode of treatment") (citing *Yoder*); *compare Pickup v. Brown*, 740 F.3d 1208, 1223, 1236 (9th Cir. 2014), *abrogated on other grounds by Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 585 U.S. 755 (2018) (parents did not have fundamental right to access LGBT conversion practices that state "reasonably deemed harmful" based on the "*well-documented, prevailing opinion* of the medical and psychological community") (emphasis added), 1232 ("Although the legislature . . . had before it some evidence that [LGBT conversion practices are] safe and effective, the *overwhelming consensus* was that [such practices were] harmful and ineffective") (emphasis added); *In re Custody of a Minor*, 393 N.E.2d at 846 (overriding parents' care decision on basis of "uncontested" evidence that their preferred therapy was "useless and dangerous"); *cf. Glucksberg*, 521 U.S. at 723, 731 (no "right to commit suicide" where "the American Medical Association, like *many other medical and physicians' groups*, has concluded that '[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer'") (emphasis added).

[60] *See, e.g.*, *Newmark*, 588 A.2d at 1117–18; *In re Burns*, 519 A.2d at 645.

[61] Tr. Vol. I, 131:11-16, 253:25-254:16; *see also Brandt*, 677 F. Supp. 3d at 888.

which can have the follow-on effect of exacerbating the patients' dysphoria.[62] A preferred care plan (or, more accurately, deprivation of any care) that poses such profound risks to a minor cannot be justified under the heightened standard of review appropriate in this case.[63]

That transgender healthcare carries potential risks does not justify a total ban on such care. The overwhelming weight of the evidence shows that the potential risks of harm from transgender healthcare are rare when provided under medical supervision and are no greater than the risks associated with many other medical treatments for adolescents that are not prohibited by SB 49.[64] Regardless, "few if any" forms of treatment are entirely "without risk."[65]

The fact that transgender healthcare may pose medical risks, in addition to the great benefits many children experience, not only does not justify the State's ban, it properly places the decision-making for children's gender dysphoria squarely on the shoulders of parents. As the Supreme Court stated in *Parham*, the inevitable "risks" involved in any "medical procedure" or treatment only reinforces the conclusion that

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[62] Tr. Vol. I, 119:17-19, 161:7-12; Vol. II, 370:4-15, 381:13-22; Vol. III, 593:19-594:1, 756:5-16.
[63] *Cf. Newmark*, 588 A.2d at 1117-18; *In re Burns*, 519 A.2d at 645.
[64] Tr. Vol. II, 334:7-338:13, 342:16-25, 345:22-347:22, 353:19-354:10, 355:4-356:16; Vol. III, 737:22-738:7.
[65] *United States v. Rutherford*, 442 U.S. 544, 555-56 (1979); *see* Tr. Vol. III, 718:14-15.

"[p]arents can and must make those judgments."[66] It is parents, in consultation with their chosen physicians, who are best positioned to weigh the considerable risks of not obtaining transgender healthcare against the risks of such care in individual cases. Unlike government actors, the parents in this case will have spent virtually every day of their lives with their children and are far better positioned to assess whether the toll of untreated gender dysphoria on their child's health justifies any risks of treatment.[67]

C. *The U.S. Supreme Court's Recognition of Medical Uncertainty as Adequate for Purposes of Rational Basis Review in* U.S. v. Skrmetti *Does Not Meet the Heightened Standard of Review Required for State Infringement of Parental Rights.*

The *Skrmetti* Court's recognition of medical "uncertainty" as a rational basis for banning transgender healthcare for minors under the Equal Protection Clause does not meet the test of medical certainty required for the state to take away a parent's right to direct their children's medical care under due process standards.[68] In order to infringe upon this right, it is not enough for the state merely to show "that there is an ongoing debate among medical experts regarding the risks and benefits

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[66] 442 U.S. at 603 ("Simply because the decision of a parent . . . involves risks does not automatically transfer the power to make that decision from the parents to some agency or officer of the state. The same characterizations can be made for a tonsillectomy, appendectomy, or other medical procedure. . . . Parents can and must make those judgments.").

[67] *See* Huntington & Scott, *supra* note at 37, at 2532-33.

[68] *See Skrmetti*, 2025 WL 1698785, at *13.

associated with" transgender healthcare for minors, or that puberty blockers and hormone therapy "*may* . . . carry greater risks when administered to treat gender dysphoria."[69] When parental rights are implicated, the state must show that its preferred course of treatment—here, banning puberty blockers and hormone therapy—is supported by *all* responsible medical authority and is likely to result in great benefit and pose few countervailing risks to the child. Because the parental rights issue was not before the Court in *Skrmetti*, the Court did not address, much less demand, this showing from the state.[70]

IV. THIS COURT SHOULD REJECT THE TRIAL COURT'S FLAWED UNDERSTANDING OF PARENTS' FUNDAMENTAL RIGHT IN THIS CONTEXT.

For the reasons that follow, this Court should reject the trial court's flawed understanding of parents' fundamental right to direct their children's medical care.

A. The Trial Court Wrongly Applied Rational Basis to the Infringement of a Fundamental Right.

By concluding that parents do not have a constitutional right to access medical treatments for their children that the State has "rational[ly]" banned, the trial court badly misunderstood the nature of the fundamental right at issue in this case.[71] Because parents have a fundamental right to direct their children's medical care,

[69] *Id.* at *13-14 (emphasis added).
[70] *See id.*
[71] *Noe*, No. 23AC-CC04530, at 71.

heightened scrutiny—not rational basis—applies. To suggest, as the trial court did, that parents have a fundamental right to direct their children's medical care *unless* there is "a rational basis for the State to act" reduces the fundamental right to a nullity.[72] For this reason, alone, this Court should disregard the trial court's analysis of the fundamental right at issue.

B. Parents Do Not Assert a Personal Right to Medical Treatment.

The trial court also reasoned that substantive due process recognizes no right to "*obtain* a specific treatment."[73] But whether children or parents have a personal right to medical treatment is not the question; parents have an obligation and the corresponding right to determine their child's medical care regardless of whether they or their child has a fundamental right to medical treatment.[74] The same can be said for parents' other obligations: although the Supreme Court has not recognized a fundamental right to education, shelter, or subsistence,[75] parents have an obligation

[72] *Noe*, No. 23AC-CC04530, at 71; *see also L.W. by and through Williams v. Skrmetti*, 83 F.4th 460, 511 (6th Cir. 2023) (White, J., dissenting) ("[Allowing the state to] simply deem a treatment harmful to children without support in reality and thereby deprive parents of the right to make medical decisions on their children's behalf . . . is tantamount to saying there is no fundamental right.").
[73] *Noe*, No. 23AC-CC04530, at 69.
[74] *Pierce*, 268 U.S. at 535 ("[Parents] have the right, coupled with the high duty, to recognize and prepare [their children] for additional obligations.").
[75] *See San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 37 (1973) (rejecting argument that "education is a fundamental right or liberty" and observing that there is likewise no fundamental right to "decent food and shelter").

and the corresponding right to determine what kind of education their child receives, where they live, and what they eat.[76]

C. The Trial Court's Finding of Medical Uncertainty Supports, Not Undermines, Parents' Fundamental Right.

The trial court below took the view that SB 49 is constitutional on the ground that a "reasonable medical dispute" exists regarding the long-term effects of transition surgery for minors, and that "States have 'wide discretion' to regulate 'in areas where there is medical and scientific uncertainty.'"[77] Accepting for the purposes of argument the trial court's determination regarding the sufficiency of the research supporting transgender healthcare for minors, medical neglect decisions show that the court misunderstood the state's role vis-à-vis parents when it comes to directing children's medical care. Under conditions of medical uncertainty, it is parents, together with their chosen physicians—not the state—who properly weigh the sufficiency of research regarding generally available medical care to determine whether it supports medical care for their children. As the New York Court of

[76] *See, e.g.*, *In re Adoption of C.D.M.*, 39 P.3d 802, 809 (Okla. 2001) (discussing parental obligation to provide education, food, and adequate domicile to child).
[77] *Noe*, No. 23AC-CC04530, at 49-50 (citing *Gonzales v. Carhart,* 550 U.S. 124, 163 (2007)); *see id.* at 57 (acknowledging that "parents should generally have a say in the treatment that children receive," but stating that "treatments that permanently retard or destroy natural human growth or function"—which court deemed transgender healthcare care to do—"are a different discussion entirely"), 58 ("[t]his is another issue wherein medical ethicists offer conflicting opinions as to whether such treatment should be allowed").

Appeals stated, the government may not "assume the role of a surrogate parent and establish as the objective criteria with which to evaluate a parent's decision its own judgment as to the exact method or degree of medical treatment which should be provided."[78] And as Professor Goldstein has noted, "There would be no justification . . . for coercive intrusion by the state in those . . . situations . . . in which there is no proven medical procedure."[79] Only in situations in which research clearly shows that the state's preferred course of treatment is warranted would state interference be justified.

Of course the legislature is entitled to wide deference in situations involving scientific uncertainty where, as in *Gonzales v. Carhart*, the state seeks to protect citizens *generally*.[80] However, where the state seeks to limit the course of medical treatment otherwise available, prohibiting care specifically to minors on the ground of medical uncertainty, the principles that underlie medical neglect law come into play: it is parents, not the state, who have the right to determine whether their children should be able to access otherwise available medical care absent compelling

[78] *In re Hofbauer*, 393 N.E.2d at 1014; *see also In re Custody of a Minor*, 393 N.E.2d at 846 (distinguishing *Hofbauer's* refusal to allow state intervention on the ground that "[t]he medical evidence in that case was sharply conflicting. . . . This is a far cry from . . . the compelling evidence that for this child [the parents' preferred course of treatment] . . . is useless and dangerous.").
[79] Goldstein, *supra* note 25, at 654–55.
[80] *See Gonzales,* 550 U.S. at 163.

evidence that the care plan is incorrect.[81] Neither *Gonzales* nor any of the cases it relied upon involved the regulation of access to medical treatment for minors only—let alone the regulation of access to treatment for some minors but not others.[82] Thus, far from supporting its decision, the trial's court's finding that the research is incomplete properly placed the decision regarding transgender healthcare for minors in parents' hands, undermining the ground for the ban on such treatment.

The trial court's reasoning about the role of parents versus the state when it comes to children's medical care is particularly illuminating in the opinion's discussion of the testimony of the state's expert, Dr. Farr Curlin:

> As to a final point that the Court finds rather fascinating, the Court asked Dr. Curlin about the intersection of the State's concern in preventing a teen from making a bad medical decision with lifelong aftermath, wherein the concern might directly conflict with a teen's family's right to make medical decisions. Initially, Dr. Curlin noted that, except for a very few areas, minors are not treated as having authority to grant or withhold consent. However, today there is in the ethics field an emphasis on soliciting "assent" from children out of respect for them . . . .
>
> So, Dr. Curlin argues, the norm should be the same in child and adolescent gender dysphoria treatment as that which operates throughout pediatric ethics, which is whether the intervention is one that is consistent with the medical best interest of the child. In Dr. Curlin's opinion, we are not at a point where we could find that child and adolescent gender dysphoria treatment are in the minor's best

[81] *See L.W.*, 83 F.4th at 10 (White, J., dissenting) ("Tennessee and Kentucky did not ban treatment for adults and minors alike; they banned treatment for minors *only*, despite what minors or their parents wish.").
[82] *See Gonzales,* 550 U.S. at 163.

> interest, because there is [sic] not enough good data and studies that would allow such a conclusion.
>
> Accordingly, Dr. Curlin opines that children and teens should not even get to have a choice as to gender dysphoria treatment until we have enough evidence to show they are in the best interests of the child.[83]

The trial court's reliance on Dr. Curlin's testimony is misplaced in two respects. First, the court erroneously treats parents' rights to make medical decisions as coextensive with children's. Second, the court erroneously treats the question before it as whether transgender healthcare is within the best interests of the child. But in our system of law, the determination about best interests is not properly the state's—either as determined by the court or by the legislature—when a fit parent is present.[84] What medical care is in the child's best interest is the parents' determination, absent some compelling showing that their decision would harm the child. When the research is not yet clear, no compelling showing exists.

D. The Trial Court's "Floodgates" Concern is Misplaced.

Contrary to the trial court's "floodgates" concern, recognition of parents' right to access transgender healthcare for their adolescent children would not "mean that legislatures could never regulate any drug or medical procedure," and that "[a]ny person—including a minor—could obtain anything from meth, to ecstasy, to

[83] *Noe*, No. 23AC-CC04530, at 35-36.
[84] *See Troxel*, 530 U.S. at 68–69.

abortion so long as a single medical professional were willing to recommend it."[85] As discussed above, where the overwhelming weight of medical authority is against the drug or procedure, and where the drug or procedure is unlikely to result in benefit and poses substantial risks to health, the State may prohibit it.[86]

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Upholding the decision below would deny transgender adolescents the time-honored protections that parental autonomy provides, reducing them to "mere creature[s] of the state" whose health and development are dictated by the State's decrees rather than their parents' values. And it would compel parents to either remain in their home state and risk their children's health and life, or (assuming they have the resources to do so) "migrate to some other and more tolerant region."[87] Forcing parents to make that choice is antithetical to a free society, longstanding American conceptions of the family, and "the diversity we profess to admire and encourage."[88]

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[85] *Noe*, No. 23AC-CC04530, at 70.

[86] Because the Supreme Court explicitly recognized states' ability to "regulate abortion for legitimate reasons," *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215, 300 (2022), upholding a parents' right to access transgender healthcare for their adolescent children would not prohibit legislatures from regulating access to abortion.

[87] *Yoder*, 406 U.S. at 218.

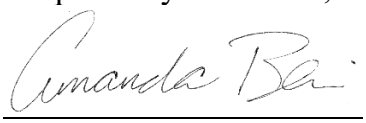
[88] *Id.* at 226.

CONCLUSION

For the foregoing reasons, this Court should reverse the judgment of the trial court.

Date: July 8, 2025

Respectfully submitted,



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CERTIFICATE OF SERVICE AND COMPLIANCE

The undersigned hereby certifies that on July 8, 2025, the foregoing brief was filed electronically and served automatically on the counsel for all parties.

The undersigned further 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(b); and (3) contains 8,208 words (excluding the cover, signature block, table of contents, table of authorities, and this certificate of service and compliance), as determined using the word-count feature of Microsoft Office Word. Finally, the undersigned certifies that the electronically filed brief was scanned and found to be virus-free.

/s/ Amanda Basri
Local Counsel