No. SC100933

In the Supreme Court of Missouri

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

Appellants,

v.

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

Respondents.

Appeal from the Circuit Court of Cole County
The Honorable R. Craig Carter

RESPONDENTS' BRIEF

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases Page(s)

Constitutional Provisions and Statutes

Rules

JURISDICTIONAL STATEMENT

Under article V, section 3 of the Missouri Constitution, this Court has "exclusive appellate jurisdiction in all cases involving the validity . . . of a statute . . . of this state." *Goodman v. Saline Cnty. Comm'n*, 699 S.W.3d 437, 439–40 (Mo. banc 2024). "[W]here any party properly raises and preserves in the trial court a real and substantial (as opposed to merely colorable) claim that a statute is unconstitutional, this Court has exclusive appellate jurisdiction over any appeal in which that claim may need to be resolved." *Boeving v. Kander*, 496 S.W.3d 498, 503 (Mo. banc 2016).

Appellants brought this case in the trial court, arguing that §§ 191.1720 and 208.152 violate article I, sections 2 and 10 of the Missouri Constitution. D185 at 38–39 (Appellants' Appendix 1). The issues in this appeal are whether the trial court erred in rejecting Appellants' arguments and concluding that the provisions are constitutional. Hence, this case centrally addresses the "validity…of a statute…of this state." *Goodman*, 699 S.W. 3d at 439–40.

For the reasons explained in response to Point I raised by Appellants, this Court lacks jurisdiction determine the validity of § 208.152.15, R.S. Mo. in this suit because Appellants have not demonstrated standing to challenge that provision.

INTRODUCTION

As this Court has long recognized, "in areas fraught with medical and scientific uncertainties, legislative options must be especially broad." *State v. James*, 534 S.W.2d 41, 43 (Mo. 1976) (citation omitted); *see also Gonzales v. Carhart*, 550 U.S. 124, 163 (2007) ("The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty."). That holding fits this case's topic—gender transition procedures for children—like a glove. Many medical professionals strongly question the safety and ethics of these procedures—which often fail to treat gender dysphoria and render children irreversibly sterile. Hence, several European countries—including the United Kingdom, Sweden, and Finland—have generally prohibited doctors from giving these gender-transition treatments to children. And twenty-seven States have followed suit. Consistent with that growing trend, the General Assembly enacted the bipartisan Save Adolescents from Experimentation (SAFE) Act—which also generally prohibits children from accessing gender-transition treatments.

Appellants ask this Court to strike down the SAFE Act—and to handcuff the General Assembly's authority to regulate areas "fraught with medical and scientific uncertainties." *Id.* (citation omitted). Appellants' primary theory is that the SAFE Act violates the Equal Protection Clause by discriminating on the basis of sex or, in the alternative, transgender status. But this is wrong.

As the U.S. Supreme Court and the U.S. Court of Appeals for the Eighth Circuit recently found when analyzing nearly-identical laws, the SAFE Act merely employs age- and medical-treatments-based distinctions. *United States v. Skrmetti*, 145 S. Ct. 1816, 1837 (2025); *Brandt ex rel. Brandt v. Griffin*, No. 23-2681, 2025 WL 2317546, at *7 n.4 (8th Cir. Aug. 12, 2025) (en banc) (abrogating *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022)). Thus, the SAFE Act is subject only to rational-basis review. *See Skrmetti*, 145 S. Ct. at 1835.

And the Safe Act easily satisfies rational-basis—or even heightened—scrutiny. After all, "when legislatures deal with areas 'fraught with medical and scientific uncertainties, legislative options must be especially broad.'" D185 at 2[1] (quoting *Carhart*, 550 U.S. at 163).

In maintaining otherwise, Appellants assert that a broad consensus exists that gender-transition treatments for children are safe and effective. *See, e.g.*, Opening Br. 79 (stating that a "well-established consensus (or at least, overwhelming majority view) in the medical profession" exists for these protocols). But after a nine-day trial and hearing from thirty-four witnesses,

[1] The circuit court's decision is contained in Appellants' appendix to their opening brief. For ease, this brief solely refers to the circuit court's docket number, D185, when referencing the decision. All other appendix cites in this brief will refer to the page numbers of Appellants' appendix. Standalone references to "Tr." will refer to the trial transcript. Any references to the transcript of the preliminary-injunction hearing appear as "PI Tr."

the circuit court roundly rejected Appellants' claims. *See generally* D185 at 5–37. Indeed, Appellants' own expert witnesses acknowledged that there is no consensus in favor of gender-transition procedures for children. *See, e.g.*, Tr. 803:7–9. Those same expert witnesses also conceded at trial that Appellants' view has been rejected by European health authorities, the World Health Organization, and the U.S. Department of Health and Human Services, among others. *See, e.g.,* Tr. 457:17–458:2. The national medical authority in the United Kingdom, for example, recently barred these interventions because a comprehensive medical report—which conducted numerous studies and surveyed all medical literature on the topic—concluded that the evidence supporting gender transition interventions is "remarkably weak." The Cass Review, Independent Review of Gender Identity Services for Children and Young People 13 (Apr. 2024) [hereinafter Cass Report]; *see United States v. Skrmetti*, 145 S. Ct. 1816, 1845 (2025) (Thomas, J., concurring) (citing the Cass Report).

The clear weakness in Appellants' equal-protection argument helps explain why they now pivot to their backup arguments. *See, e.g.* Opening Br. 81–122 (spending forty pages arguing evidentiary issues). But those claims are likewise doomed. With respect to their claim about Medicaid funding, Appellants lack standing; they also failed to adequately plead and develop this claim below. D185 at 45–48. Appellants' due-process claims likewise fail given

the State's clear *parens patriae* interest in protecting children. *See Schall v. Martin*, 467 U.S. 253, 265 (1984). They also do not articulate a basis for their hyperbolic claiming that the SAFE Act imposes "workplace slavery" on treatment providers. D185 at 71. Finally, Appellants fail to articulate how any supposed error by the circuit court in admitting or considering evidence or testimony completely excludes the possibility of the General Assembly's having a legitimate basis for enacting the SAFE Act. *See Brandt*, 2025 WL 2317546, at *6–7 (describing the operation of rational-basis review in similar contexts).

In the end, Appellants lose unless they can sweep the field. They have to convince this Court that no "conceivable state of facts supports the Act," *id* at *7, that the circuit court's litany of factual findings are "clearly erroneous," that the circuit court's facial analysis was wrong three times over, that Appellants submitted sufficient evidence at trial, that the State is constitutionally required to fund a procedure that Appellants' own experts concede has been determined to be experimental, and that this Court should overturn its precedent interpreting Missouri-constitutional clauses in tandem with similarly worded clauses in the U.S. Constitution. Appellants cannot prevail on even one of these questions, much less all of them.

Fundamentally, Appellants have brought their grievances to the wrong building. They misunderstand that questions of "access to [what they call] gender-affirming health care services" are "questions of policy [that] should be

left to the general assembly as the policy-making branch." *R.M.A. v. Blue Springs R-IV Sch. Dist.*, 717 S.W.3d 187, 201 (Mo. banc 2025) (Wilson, J., dissenting). And as Justice Barrett explained, courts' "second-guessing legislative choices in this area should set off alarm bells." *Skrmetti*, 145 S. Ct. at 1852 (Barrett, J., concurring). The Court should affirm.

STATEMENT OF FACTS

I. Factual Background

Over the past decade, debates about the treatment of minors claiming to be transgender have exploded onto the scene. *See* D185 at 15 (explaining that "the presentation rate of individuals with gender dysphoria has skyrocketed in the last decade," with even WPATH recognizing "the exponential growth in adolescent referral rates");[2] Tr. 152:19–25, 440:16–20 (describing the increase); *accord Skrmetti*, 145 S. Ct. at 1825 ("In recent years, the number of minors requesting sex transition treatments has increased."). In response, some doctors have sought to provide certain gender-transition procedures to minors. *See, e.g.*, Tr. 1604:18–1605:24 (describing the growth of Washington

[2] WPATH stands for the "World Professional Association of Transgender Health" that "describes itself as an 'interdisciplinary professional and educational organization devoted to transgender health.'" Hannah Barnes, *Why Disturbing Leaks from US Gender Group WPATH Ring Alarm Bells in the NHS*, Guardian (Mar. 9, 2024), https://www.theguardian.com/commentisfree/2024/mar/09/disturbing-leaks-from-us-gender-group-wpath-ring-alarm-bells-in-nhs.

University's Pediatric Transgender Center). They have prescribed puberty blockers, which are drugs that inhibit normally-timed puberty. *See* Tr. 280:4–24, 311:13–18. They have prescribed cross-sex hormones, which seek to induce physical changes so that patients begin to resemble the opposite sex. *Id.* And some doctors have even performed surgeries to alter permanently children's chests and genitalia. *See, e.g.*, Tr. 1590:12–16 (confirming that such surgeries occurred in Missouri).

All of these things have happened in Missouri, with controversies centering on Washington University's prominent "Pediatric Transgender Center." Tr. 1590:19–21. The General Assembly and the trial court both heard testimony from Jamie Reed, a former employee of the Center who blew the whistle and denounced various ongoing unethical practices. D185 at 31, 45. Among other issues, the Center's practitioners would pressure parents into consenting to gender-transition treatments by asking them—in front of their children—"Do you want a dead son or a live daughter?" Tr. 1630:6–23; *accord* Tr. 1631:15–16 ("Would you rather have a dead daughter or a living son?"). As a former employee of the Center described it, what started out as a mental-health resource "ended up also becoming about giving kids testosterone." Tr. 1607:17–19.

The Center also "departed starkly from the standards that [Appellants'] experts say are required." D185 at 29. It would prescribe hormone treatments

without a gender-dysphoria diagnosis or a mental-health assessment—and even against the advice of psychiatrists. D185 at 29–30; Tr. 1615:6–7, 22–23; Tr. 1625:20–22. The Center also dispensed drugs with known potential long-term health risks. *See, e.g.*, Tr. 1660:8–21 (explaining that the Center would prescribe Bicalutamide, a prostate-cancer drug, to help grow breast tissue despite its having "a known liver toxicity element"). The Center even facilitated "getting minors surgery." Tr. 1654:4. Yet, the Center did not have procedures to ensure that children's parents or legal guardians consented to interventions. Tr. 1632:11–16. And to make sure that "trans care for minors" was covered by Missouri health-insurance plans, the Center "would intentionally miscode" the treatment performed. Tr. 1657:23–25; *accord* Tr. 1658:7–11 (describing how employees "would fraudulently backtrack" to ensure insurance covered treatments).

In response to uproar about the Center's activities and out of concern for the potential negative impact on children and adolescents for unproven gender dysphoria treatments,[3] the General Assembly passed the SAFE Act. D185 at 30–32. The General Assembly heard testimony regarding the activities of Washington University's Center—including that (contrary to false testimony

[3] Gender dysphoria refers to "a marked incongruence between one's experienced/expressed gender and assigned gender of at least six months." D185 at 9 (citing the Diagnostic and Statistical Manual of Mental Disorder, 5th ed.).

by two of the Center's doctors to the legislature) "the institution has in fact recently performed surgeries on minors and enabled minors to find surgeons outside of Washington University." D185 at 31. The SAFE Act eventually took shape as a bipartisan compromise—notably including a 2027 sunset provision to overcome a Senate filibuster. D185 at 32. The Act passed by wide margins in both Houses of the General Assembly. D185 at 32.

The SAFE Act bars health-care providers from performing gender-transition surgeries on minors. Mo. Rev. Stat. § 191.1720.3. The SAFE Act also forbids health care providers to "knowingly prescribe or administer cross-sex hormones or puberty-blocking drugs for the purpose of a gender transition for any individual under eighteen years of age," but this does not apply with respect to any individual who received "such hormones or drugs prior to August 28, 2023, for the purpose of assisting the individual with a gender transition." Mo. Rev. Stat. § 191.1720.4. Thus, adolescents receiving an intervention before the effective date of the law are "grandfathered in." D185 at 32. As for enforcement, the Act authorizes the licensing board to revoke a medical license, and it permits individuals to bring a private cause of action for damages. Mo. Rev. Stat. § 191.1720.5–6. The Act also bars the State from paying for these procedures via its Medicaid program, Mo. Rev. Stat. § 208.152.15, and prohibits the Department of Corrections from providing gender transition surgeries to prisoners, *id.* § 217.230.

The Act does not regulate adults seeking these interventions. D185 at 33. And the Act "makes clear that it does not apply to the rare individuals who have 'disorders of sex development' (such as chromosomal abnormalities), does not apply to treatments to resolve complications caused by gender transition interventions, and does not apply when an individual's life would be in danger 'or impairment of a major bodily function' would occur absent the intervention." *Id.* (quoting Mo. Rev. Stat. § 191.1720.8).

To be clear, the SAFE Act does not forbid well-established treatments of gender dysphoria in minors—counseling remains permitted. *See generally* Mo. Rev. Stat. § 191.1720. The circuit court found broad agreement that counseling should be the primary method of treatment for gender dysphoria. D185 at 10. Likewise, more drastic interventions, such as hormone treatments and surgical operations, remain permitted for adults. Mo. Rev. Stat. § 191.1720.3.

Missouri is not alone in sharing concerns about gender-transition procedures for children. "[A] majority of U.S. states have now passed laws restricting these interventions in minors." D185 at 5; *accord Skrmetti*, 145 S. Ct. at 1825 ("In the last three years, more than 20 States have enacted laws banning the provision of sex transition treatments to minors, while two have enacted near total bans."). In 2021, the U.S. Department of Health and Human Services found "a lack of current evidence-based guidance for the care of children and adolescents who identify as transgender, particularly regarding

the benefits and harms of puberty suppression, medical affirmation with hormone therapy, and surgical affirmation." D185 at 22 (quoting Ex. 1208). And international consensus—including from several politically progressive countries—is moving in the direction of restricting the use of these interventions on children and adolescents. D185 at 20–21; *accord Skrmetti*, 145 S. Ct. at 1825–26 (explaining that "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").

Appellants' experts conceded that "puberty blockers are now prohibited in the United Kingdom outside of formal clinical research protocols"—and those "protocols have [not] started yet." D185 at 20; *accord* Tr. 759:15–18. The Cass Report (a comprehensive expert review of gender medicine) helped prompt the United Kingdom's directional shift—with the Report finding "no evidence that puberty blockers improve body image or dysphoria, and very limited evidence for positive mental health outcomes, which without a control group could be due to placebo effect or concomitant psychological support." *See* D185 at 20 (quoting Cass Report 179). The Cass Report also concluded that "[n]o conclusions can be drawn about the effect on gender dysphoria, body satisfaction, psychosocial health, cognitive development, or fertility." *Id.* (quoting Cass Report 184). Finland and Sweden have imposed similar

restrictions. D185 at 21; *see* Tr. 749:24–25; Tr. 1792:21–1793:8. Even the World Health Organization has declined to endorse puberty blockers, hormone treatments, and surgery to treat gender dysphoria in minors given that "the evidence base for children and adolescents is limited and variable." D185 at 21 (quoting Ex. 1024).

II. Procedural History

Appellants filed this suit in July 2023 and requested a preliminary injunction. D185 at 37. In their petition, they requested declaratory and injunctive relief predicated on, as relevant here, violations of the Missouri Constitution's Equal Protection, Due Process, and Gains of Industry Clauses. App. 278–88. The first-assigned judge denied preliminary relief—concluding that Appellants were not likely to succeed on the merits. D185 at 37–38. After Appellants moved for a change of judge, the circuit court conducted a nine-day trial with extensive testimony and exhibit submissions. D185 at 9, 37.

A. Trial Testimony.

1. Appellants' Witnesses.

Testimony included both lay and expert witnesses. One witness, Dr. Daniel Shumer, was offered as an expert in endocrinology—"the science of hormones." Tr. 300:21–22. Dr. Shumer described the effects that medical interventions have on the human body—including bringing about permanent changes. *See* Tr. 355:4–356:21 (explaining how the effects on voice, hair, and

breast development are permanent). However, Dr. Schumer recognized that about "half" of his patients "meet clinical criteria for depression or anxiety as the most common co-occurring mental health problems" with gender dysphoria. Tr. 446:13–17. He also agreed a shift is occurring in how younger people seeking treatment think about gender—"a lot of young people are thinking about gender in a nonbinary way." Tr. 402:22–23.

Appellants also called Dr. Armand Antommaria, a bioethicist. Tr. 710:8–9. Much of Dr. Antommaria's testimony focused on whether enough reliable information existed to support claims that medical and surgical transgender interventions actually help children—with much discussion regarding whether WPATH could ethically recommend treatment guidelines unmoored from "systemic reviews." Tr. 773:4–776:5. He agreed that any guidelines governing such treatments "are supposed to be based on systemic reviews"—but that organizations like WPATH have issued guidance without such reviews. D185 at 23. He explained that conclusions relying on "non-systematic methods compromises the validity and reliability of the evidence to inform guideline recommendations." Tr. 775:16–18. And he conceded that WPATH could, in fact, "conduct such a systematic review, and there are others like systematic reviews in the literature." Tr. 774:7–9. Like Dr. Shumer, Dr. Antommaria recognized that interventions can be "irreversible." Tr. 757:21–22.

Another expert for Appellants, Dr. Johanna Olson-Kennedy, agreed with Dr. Antommaria that there are "questions about the credibility of currently available guidance" regarding transgender medical and surgical interventions for minors. Tr. 631:6–18. Yet Dr. Olson-Kennedy is herself a prominent practitioner to transgender minors—having treated "about 1200" patients. Tr. 493:2–494:22. Dr. Olson-Kennedy also agreed about a growing disparity in treatment demographics with currently two-thirds of patients "designated female at birth," comparted to "about 50/50 in 2015." Tr. 606:17–19.

2. Expert Witnesses Favoring the Act.

The State introduced testimony from several expert witnesses who support the SAFE Act. An expert ethicist, Dr. Farr Curlin, described how transgender medical and surgical interventions are not in keeping with the functioning of the human body and outside important medical norms. *See* Tr. 2364:10–13 (explaining that medicine should not "act in a way that is objectively . . . hostile to the well-working of the organism . . . to try to resolve that that perception. So this is an outlier practice."). Dr. Curlin expressed particular concern about the ethical issues of "informed consent" with minors who have not thought through the long-term consequences of interventions—and who often do not receive sufficient warning from practitioners. D185 at 35; *accord* Tr. 2382:12–2384:4.

An expert psychiatrist, Dr. Stephen Levine, also testified in support of the law. Tr. 2418:9–19. Dr. Levine was previously a member of WPATH and had assisted with drafting the organization's previous standards of care, but left because "the organization had become an advocacy organization, rather than a scientific organization." Tr. 2421:2–2422:17. He maintains his concern that existing recommendations for transgender treatment of children are "based on politics" rather than "on observation of science." Tr. 2428:11–12. He also expressed concern that the relationship between gender dysphoria and other psychological co-morbidities has been largely overlooked—with the potential being that "the co-morbidities, the pain of the co-morbidities, may, in fact, be the source of the gender dysphoria." Tr. 2428:10–20. Thus, he explained that there is "a great disagreement among professionals about whether the gender dysphoria is the product of pre-existing psychiatric problems or merely the consequence." Tr. 2428:21–24.

Finally, Dr. Patrick Lappert, an experienced plastic surgeon, testified about what transgender surgeries entail. Tr. 2490:5–19, 2505:4–14. He described the ethical concerns and risks inherent in transgender surgery—namely the removal of healthy, functioning body parts for constructed parts that are often nonfunctional, even for urination. D185 at 37; *accord* Tr. 2579:1–2581:17. He also explained that unique problems arise in conducting

surgeries on minors because "there isn't sufficient tissue" to construct safely gender-affirming surgery on minors. Tr. 2602:9–18.

3. Detransitioners Favoring the Act.

Several detransitioners testified in favor of the SAFE Act. *See* Tr. 2254:12–2334:10, 2617:19–2692:25. One witness, Chloe Cole, described how she regrets having transitioned from female to male as a minor. D185 at 33. Ms. Cole had a double-mastectomy at fifteen and took testosterone for about seven years. *Id.*; *see* Tr. 2618:25–2619:3. She immediately regretted the mastectomy. Tr. 2658:22–25. Ms. Cole continues to suffer the impacts of her transition—including "discharges from wounds in her breasts that never properly healed." D185 at 42; Tr. 2671:6–2672:8. She now wants to live as a woman and have children, but fears the permanent changes made to her body because of the interventions she received. D185 at 34.

Similarly, Zoe Hawes dealt with body-image and anxiety issues as a child—including suicidality. Tr. 2314:1–2316:24. She began wanting to identify as a boy, received affirmation from a gender therapist and LGBT support groups, and began medically transitioning with testosterone. Tr. 2317:4–2318:25. The testosterone did not help—her anxiety and suicidality remained. Tr. 2322:20–2323:3. She socially withdrew and even dropped out of high school. Tr. 2325:13-16. She stopped taking the testosterone over five

years ago, but still has to shave facial hair every day and her menstrual cycle has never returned to normal. Tr. 2324:22–2325:8, 2328:22–24.

4. Testimony Regarding Washington University's Center.

Jamie Reed, the Washington University Pediatric Transgender Center whistleblower, also testified about unethical practices at the Center. Tr. 1590:19–21. Ms. Reed, herself a member of the LGBT community, worked at the Center for nearly five years but left the center because of "serious" ethical concerns. Tr. 1590:22–1591:16. She explained that the Center was supposed to take only about fifty patients at a time, Tr. 1604:18–24, but the Center often served significantly more than that. Tr. 1709:13–17. This translated into "perfunctory, basic check-the-box" psychological evaluations of children. Tr. 1616:11–22. Meanwhile, the Center would freely dispense cross-sex hormones and puberty blockers without regard to patients' mental health. *See* Tr. 1615:12–14 ("The endocrinologist that was prescribing these things did not care if [the patient] met criteria, did not care if [the patient] had distress.").

Ms. Reed also described a sex-disparity in treatment: "73% of all of the new patients were girls and 26% of the patients were boys, which was a complete sex reversal from what we should have been seeing." Tr. 1606:8–10. She recounted the devastating side effects some children experienced following treatments at the Center. Tr. 1669:4–22 (recounting such an incident by a minor who suffered a "vaginal laceration" that required emergency surgery).

She even explained that the Center would begin protocols on children against the advice of psychiatrists. Tr. 1625:20–1626:8. And she confirmed that the Center helped facilitate surgeries for minors. Tr. 1653:13–17.

B. The Circuit Court's Decision.

The circuit court easily found that the General Assembly had cause for enacting the SAFE Act. D185 at 9–10. And the court rejected the equal-protection and due-process claims given the "substantial medical dispute over the safety and efficacy of these interventions." D185 at 49. Based on the evidence presented at trial, the court found a lack of "any high quality—or even moderate quality—evidence" showing the effects of "chemical and surgical interventions." D185 at 19.

To begin with, the court highlighted how all experts at trial agreed no minor should receive surgical interventions on genitals or reproductive organs. D185 at 10. Nonetheless, the Court recognized the deep divide within the medical community over the science and ethics regarding transgender medical and surgical treatments on minors: It reiterated how Dr. Antommaria had agreed that any guidelines governing such treatments "are supposed to be based on systemic reviews"—but that organizations like WPATH have issued guidance without such reviews. D185 at 23. The court also noted how the United Kingdom, Finland, and Sweden had restricted the use of chemical and surgical interventions on minors. D185 at 20–21.

The court additionally identified the serious medical risks inherent in gender-transition medical protocols for children—it emphasized how hormone treatment involved "elevat[ing] a person's hormones to 10 to 20 times what that person's healthy body is able [to] produce and sustain"—increasing "risks of premature mortality, hypertension, cardiovascular disease, and cancer, among other things." D185 at 24. And the court explained how the "effects of puberty blockers, cross-sex hormones, and 'gender-affirming' surgeries are often times not reversible." D185 at 10. "The longer a person stays on the medicines, the more dramatic the effects will be"—including, stunting growth, hampering development of "secondary sex characteristics" (such as vocal development), and "possible infertility." *Id.* It also recounted testimony of one recipient of cross-sex hormones being "sent to the emergency room because [the] hormones compromised their genital tissue so much that they began bleeding profusely." D185 at 25; *accord* Tr. 1669:4–22 (Ms. Reed describing incident involving a minor that required emergency surgery). And the court highlighted evidence—including explanations from one of Appellants' experts—that interfering with natural puberty can negatively impact brain development and decrease the patient's IQ by an average of seven points. D185 at 26; *accord* Tr. 1636:13–24 (recounting concerns about children on puberty blockers not meeting "developmental milestones").

And the court explained the cascading effects of being placed on a transgender-treatment protocol: Nearly every child placed on puberty blockers is later placed on cross-sex hormones. *See* PI Tr. 199 ("96 to 98 percent"); Tr. 1639:6–8 (recounting a 99% figure). And anyone who chooses drug or surgical interventions for gender dysphoria will "have a long-term need for continued psychological care." D185 at 10.

But the court explained how these interventions may be unnecessary for many individuals: Evidence showed that around 30% of those who undertook interventions eventually detransition. D185 at 26. The court highlighted how even WPATH recognized that "susceptibility to social influence impacting gender may be an important differential to consider" in why gender dysphoria may persist in some minors. D185 at 17. Yet, as shown by statistics, "an overwhelming percentage of adolescents who complain of gender dysphoria will eventually and naturally grow out of the symptoms." D185 at 9; *see also* D185 at 17 (citing the Diagnostic and Statistical Manual for reporting up to 98%).

Given that mountain of evidence, the trial court found that the SAFE Act survived both rational-basis and heightened scrutiny—because "States have 'wide discretion' to regulate 'in areas where there is medical or scientific uncertainty.'" D185 at 50. The court emphasized how Appellants' "experts

conceded that there is an entrenched medical dispute" at issue and courts cannot "choose between one medical authority and another." D185 at 50–51.

Although the circuit court found it unnecessary to decide what level of scrutiny applied, it nonetheless considered and rejected Appellants' arguments that the SAFE Act engaged in sex-based discrimination requiring heightened scrutiny. D185 at 62–63. Like the U.S. Supreme Court in *Skrmetti*, the court concluded that the Act prohibits certain forms of treatment "in both female and male patients." D185 at 63. Namely, the Act prohibits the receipt of treatment in boys and girls "for [the] purpose of gender transition." D185 at 64. Meanwhile, the Court explained that Appellants' theory would require nullification of a federal statute forbidding female genital mutilation because that law has "female-specific" impacts. D185 at 66 (citing 18 U.S.C. § 116(a)(1)). Ultimately, the court found that the SAFE Act satisfied rational-basis review because it was not "arbitrary or irrational" and was well supported by the evidence. *Id.*

The court likewise found Appellants' remaining claims lacking. It found no due-process right to particular medical treatments. D185 at 69–70. It also concluded that the Act did not impose "workplace slavery" on providers in violation of the Gains of Industry Clause. D185 at 71.

SUMMARY OF ARGUMENT

In the wakes of *Skrmetti* and *Brandt*, this is an easy case. Under those cases, legislatures do not create a sex-based classification warranting heightened scrutiny by regulating gender transition procedures for children. As such, the General Assembly has broad authority to regulate in this area, and it acted perfectly sensibly in generally prohibiting gender-transition procedures for children.

Nonetheless, in the face of a devastating record and now several on-point cases cutting against them, Appellants maintain that the SAFE Act violates Missouri's Constitution. Their arguments are foreclosed by both the law and the factual record.

To start, the circuit court appropriately rejected Appellants' challenges to the SAFE Act's Medicaid provision on procedural grounds. Appellants lack standing because they have failed to identify any litigant who will be concretely harmed. And, independently, these challenges fail because Appellants failed to properly plead and develop these claims.

Appellants' various constitutional arguments against the SAFE Act's general prohibition on gender-transition procedures for children also fail. To start, the SAFE Act easily passes equal-protection muster under *Skrmetti* and *Brandt*—it prohibits the use of medications and surgeries to facilitate "a gender transition procedure." *Brandt*, 2025 WL 2317546, at *3. Because "*no*

minor" may be given these treatments, the SAFE Act does not act as a sex-based classification. *Skrmetti*, 145 S. Ct. at 1831. It therefore need only satisfy rational-basis review.

No other grounds justify finding an equal-protection violation. This Court has already rejected the premise that "consideration of genitalia is inherently sex-related"—such that it can give rise to a sex-discrimination claim. *R.M.A.*, 717 S.W.3d at 197. Appellants also point to no history, tradition, or Missouri precedent suggesting that a law (supposedly) classifying persons based on "transgender status" receives heightened scrutiny. Nor have Appellants defined how persons of "transgender status" should be accorded special classification warranting heightened scrutiny given the reticence courts have in creating new and potentially amorphous classes. *See Skrmetti*, 145 S. Ct. at 1851-52 (Barrett, J., concurring). Doing so would hamstring the legislature's "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Carhart*, 550 U.S. at 163. With no jurisprudential mooring, Appellants' equal protection claims fail.

The same goes for their remaining constitutional claims. Appellants' contention that parents have the right to subject their children to procedures that the legislature deems dangerous finds no basis in due-process jurisprudence. Likewise, due-process liberty interests do not prevent the State from protecting children from risky procedures. Appellants also cannot claim

that the SAFE Act subjects practitioners to servile conditions in violation of the Benefits of Industry Clause.

Finally, Appellants' efforts to comb the trial record for error meets with failure. Even if Appellants could identify some evidentiary errors (which they have not), ample evidence still exists in the record to show "medical and scientific uncertainty" about the propriety of gender-transition procedures for children. *Gonzalez*, 550 U.S. at 163. That is sufficient to sustain the Act.

ARGUMENT

I. Appellants Failed to Demonstrate Standing to Challenge the SAFE Act's Medicaid Provision (Response to Point Relied On I).

Standard of Review: "Because standing is a question of law, review of the issue on appeal is de novo." *Schweich v. Nixon*, 408 S.W.3d 769, 773 (Mo. banc 2013). "The requirement that a party have standing to bring an action is a component of the general requirement of justiciability." *Harrison v. Monroe County*, 716 S.W.2d 263, 265 (Mo. banc 1986). The burden to demonstrate standing rests solely with the plaintiff, who must show "a 'legally protectable interest in the litigation so as to be directly and adversely affected by its outcome.'" *Weber v. St. Louis County*, 342 S.W.3d 318, 323 (Mo. banc 2011). "A legally protectable interest exists if the plaintiff is directly and adversely affected by the action in question or if the plaintiff's interest is conferred by statute." *Ste. Genevieve Sch. Dist. R–II v. Bd. of Alderman of Ste. Genevieve*, 66 S.W.3d 6, 10 (Mo. banc 2002). "If a party is without standing to bring a particular claim, a court shall dismiss the claim because the court lacks the authority to decide the merits of the claim." *Weber*, 342 S.W.3d at 323.

A. Appellants have failed to show that any individual plaintiff has standing to challenge the SAFE Act's Medicaid Provision.

Appellants constructed this case and their claims around challenging the SAFE Act's prohibiting minors from receiving medical and surgical intervention. In doing so, they built neither a narrative nor a record

demonstrating how the SAFE Act's prohibition against using State Medicaid funds to pay for "gender transition surgeries, cross-sex hormones, or puberty-blocking drugs" affects a single plaintiff here. Mo. Rev. Stat. § 208.152.15.

As noted, "Missouri courts require that the plaintiff have a legally protectable interest at stake in the outcome of the litigation." *Ste. Genevieve Sch. Dist.*, 66 S.W.3d at 10. And it is the *plaintiff* who must build a record showing "the requisite 'personal stake arising from a threatened or actual injury' from application of the statute." *Labrayere v. Bohr Farms, LLC*, 458 S.W.3d 319, 333 (Mo. banc 2015). Courts cannot assume given harms will befall individual plaintiffs based on a statute's general operation—any claim "premised on a theoretical possibility rather than the record of undisputed facts in this case" must be dismissed. *Id.*

Appellants have never explained how the Medicaid provision directly injures any of them. Appellants never alleged, and still do not assert, that any of the minor plaintiffs involved in this suit would be covered by Medicaid. *See* Opening Br. 40–41 (failing to explain so); App. 244–45 (failing to make any allegations about the receipt of Medicaid for "Family Plaintiffs"). Nor has any adult-transgender plaintiff receiving Medicaid and seeking gender-transition treatments (which, again, remain legal for adults) been plaintiff in this litigation. *See* App. 244–45.

And the testimony that the medical-provider plaintiffs serve transgender patients on Medicaid cannot, by itself, carry the day for Appellants. *See* Opening Br. 41. Critically, these plaintiffs still have neither asserted that they are imminently at risk of losing money as a result of the Act's Medicaid provision nor explained how that loss would result. *See id.* (citing transcript discussions devoid of such details); *see Schweich*, 408 S.W.3d at 774 (emphasizing how "a personal stake" requires "a threatened or actual injury"). Courts cannot guess for them. *See, e.g.*, *Mathews v. Fieldworks, LLC*, 696 S.W.3d 382, 392 (Mo. W.D. App. 2024) ("Challenges to standing thus require a court to consider the petition along with any other non-contested facts to determine whether the petition should be dismissed due to a lack of standing."). And generalized fears about a law's potential impacts do not confer standing. *See Labrayere*, 458 S.W.3d at 333 ("This Court will not declare a statute unconstitutional absent an actual or threatened application of the statute to a party challenging the statute."); *see also Brooks v. State*, 128 S.W.3d 844, 851 (Mo. banc 2004) ("At some time in the future plaintiffs' hypotheticals might arise as actual disputes; however, at this time they are merely conjecture."). The circuit court therefore did not err in concluding that individual Appellants lacked standing.

B. Appellants have not shown third-party standing to challenge the Medicaid provision.

Provider plaintiffs likewise failed to articulate how they have third-party standing to challenge the Act's Medicaid provision. In order to possess third-party standing, a plaintiff must assert "some hindrance to the third party's ability to protect its own interests." *State ex rel. Delmar Gardens N. Operating, LLC v. Gaertner*, 239 S.W.3d 608, 610 (Mo. banc 2007). Appellants contend that the provider plaintiffs can represent the interests of their patients who will not receive Medicaid. And they point to precedent where courts have upheld the right of patients to receive medical treatment. Opening Br. 42–43.

But this claim is not about the *receipt* of treatment; it's about *payment* for the treatment—nothing in the Medicaid provision forbids access to treatment for adults or minors. Mo. Rev. Stat. § 208.152.15. And provider plaintiffs explained that they would continue providing treatment to (hypothetically impacted) Medicaid recipients. Tr. 1019:5–16. Hence, based on the record, it is not clear what actual injury to patients the provider plaintiffs are able to prosecute against the Medicaid provision.

C. Association Appellants have not articulated standing.

For all the same reasons, the association plaintiffs did not establish standing. There is no allegation or evidence of an actual or imminent threat to any member of the associations. For example, Appellants point to a member of

PFLAG "who received health coverage through Medicaid." Opening Br. 43. But there is nothing in the testimony indicating what kind of treatment this member received and whether this member will seek further treatment. Tr. 1337:14–22. And, as with the provider plaintiffs above, GLMA never articulated how the Medicaid provision will affect its members. Tr. 994:16–996:10; 981:22–982:5. Because the circuit court could not read between the lines to find standing, it properly dismissed the Medicaid claims. *See State v. Richard*, 298 S.W.3d 529, 533 (Mo. banc 2009) (explaining that standing cannot arise from "hypothetical instances in which the statute might be applied unconstitutionally").

II. The Circuit Court Correctly Concluded that Appellants Failed to Plead and Prove Challenges to the SAFE Act's Medicaid Provision (Response to Point Relied On II).

Standard of Review: This Court reviews a circuit court's dismissal of a claim "*de novo*." *Matthews v. Harley-Davidson*, 685 S.W.3d 360, 365 (Mo. banc 2024). Contentions that a plaintiff has failed "to state a claim tests the adequacy of a plaintiff's petition." *Avery Contracting, LLC v. Niehaus*, 492 S.W.3d 159, 162 (Mo. banc 2016). The plaintiff must have "alleged facts that meet the elements of a recognized cause of action or of a cause that might be adopted in that case." *Conway v. CitiMortgage, Inc.*, 438 S.W.3d 410, 414 (Mo. banc 2014). Failure "to allege facts essential to a recovery" warrants dismissal. *Klemme v. Best*, 941 S.W.2d 493, 495 (Mo. banc 1997).

A. Appellants did not plead a challenge to the SAFE Act's Medicaid provision.

Assuming Appellants somehow articulated standing, the circuit court correctly concluded that they did not properly plead a challenge to the Act's Medicaid provision. D185 at 45–48. Liberal construction of a petition does not equate to a court's surmising factual allegations plaintiffs never made or assuming evidence never submitted. *See Gibson v. Brewer*, 952 S.W.2d 239, 245 (Mo. banc 1997) ("Pleadings must contain a 'short and plain statement of the facts showing that the pleader is entitled to relief.'"); *Brown v. Brown*, 645 S.W.3d 75, 82 (Mo. W.D. App. 2022) (explaining that parties cannot leave the court and opponents "left guessing at the nature of [the] argument"). Appellants' petition contained no allegations that the State is without authority to constrain how it spends its limited pool of Medicaid dollars. *See* App. 248–78 (focusing on the impact of the Act on minors and their families and failing to develop allegations as to the Medicaid provision).

B. Appellants failed to prosecute a challenge to the SAFE Act's Medicaid provision.

Even if Appellants stated a claim in their petition, they must develop and prosecute the claim or risk dismissal. *See Lim v. Chong*, 66 S.W.3d 97, 102 (Mo. E.D. App. 2001) (noting the trial court's "wide discretion in dismissing an action for failure to prosecute"). As discussed above regarding standing, appellants failed to submit any evidence at trial regarding the impact of the

Medicaid provision on the availability of treatment. *See* D185 at 48 (describing the lack of evidence or testimony regarding impact); Opening Br. 47 (lacking a citation to any such evidence). The circuit court did not err in finding the challenge to the SAFE Act's Medicaid provision undeveloped.

III. Appellants' Constitutional Challenges to the SAFE Act Fail (Responses to Points Relied On III, IV, V, VI, and X).

Standard of Review: Following a bench trial, "[t]his Court reviews *de novo* a challenge to the constitutional validity of a statute." *Priorities USA v. State*, 591 S.W.3d 448, 452 (Mo. banc 2020). Where, as here, a suit challenges laws enacted by the legislature and approved by the governor, those laws have a strong presumption of constitutionality. *Stroh Brewery Co. v. State*, 954 S.W.2d 323, 326 (Mo. banc 1997). The party challenging the constitutionality of a statute must plead facts in support of the attack, *City of St. Louis v. Butler Co.*, 219 S.W.2d 372 (Mo. banc 1949), and the burden of proof is on the party attacking the statute, *Atkins v. Dep't of Building Regs.*, 596 S.W.2d 426, 434 (Mo. banc 1980). The Court must "resolve all doubt in favor of the act's validity, and in so doing . . . make every reasonable intendment to sustain the constitutionality of the statute." *Westin Crown Plaza Hotel Co. v. King*, 664 S.W.2d 2, 5 (Mo. banc 1984). That is because "[a] statute is presumed constitutional and will not be found unconstitutional unless it *clearly and undoubtedly* violates the constitution." *Fowler v. Mo. Sheriffs' Retirement Sys.*,

623 S.W.3d 578, 584 (Mo. banc 2021) (citation omitted) (emphasis added). Findings of fact are reviewed for clear error. *Faire v. Burke*, 252 S.W.2d 289, 290 (Mo. 1952).

A. Appellants' cannot prevail under the Missouri Constitution's Equal Protection Clause (Response to Point VI).

Nothing in the text, history, and precedent regarding Missouri's Equal Protection Clause supports Appellants' claim that the SAFE Act is unconstitutional. Like the challengers in *Skrmetti* and *Brandt*, Appellants contend that the legislature has wrongfully created a sex-based classification. *See* Opening Br. 68–72. Appellants also argue that the Act unconstitutionally targets "transgender people" and therefore must be subjected to heightened scrutiny. Opening Br. 64. But the U.S. Supreme Court and U.S. Court of Appeals rejected these arguments, and this Court should too. Regulating novel medical treatments neither impermissibly classifies on the basis of sex nor discriminates against a recognizable protected class. Thus, rational basis review applies. And the record in this case amply justifies the SAFE Act—under any standard of review. Hence, the circuit court correctly rejected Appellants' equal-protection claim.

1. The SAFE Act does not create a sex-based classification.

The Missouri Constitution provides "that all persons are created equal and are entitled to equal rights and opportunity under the law." Mo. Const. art.

I, § 2. This Court interprets Missouri's equal-protection and due-process clauses "consistently with their interpretation under federal law." *Doe v. Phillips*, 194 S.W.3d 833, 841 (Mo. banc 2006). To the extent that Appellants seek to expand Missouri's equal-protection jurisprudence, their efforts fail because "Missouri's equal protection clause provides the same protections as the United States Constitution." *State v. Young*, 362 S.W.3d 386, 396 (Mo. banc 2012).

Appellants try to heighten the level of scrutiny and assert that the SAFE Act treats individuals differently on the basis of sex. Opening Br. 62–65. It does no such thing; it applies the same to boys and girls, males and females. The Act specifically prohibits providing any chemical to any minor—male or female—"for the purpose of a gender transition." Mo. Rev. Stat. § 191.1720.4. Hence, the Act does not distinguish on the basis of sex—but only "on the basis of medical use." *Skrmetti*, 145 S. Ct. at 1829. Puberty blockers and hormone drugs can still be used for well-established purposes (such as treating precocious puberty) but not for experimental purposes. *See, e.g.*, Tr. 338–39 (describing such treatments).

Recent litigation involving nearly identical bans by Tennessee and Arkansas reinforce that the SAFE Act does not include a gender-based classification warranting heightened scrutiny. *United States v. Skrmetti* involved a challenge to Tennessee's law, which "prohibits a healthcare provider

from '[s]urgically removing, modifying, altering, or entering into tissues, cavities, or organs of a human being,' or '[p]rescribing, administering, or dispensing any puberty blocker or hormone,'" for the purpose of enabling the minor to transition to another sex. 145 S. Ct. 1816, 1826 (2025) (alterations in original). Like Appellants here, *see* Opening Br. 68–72, the *Skrmetti* challengers claimed that banning "sex transition treatments" required consideration of one's sex and hence amounted to a classification on the basis of sex—requiring heightened scrutiny under the U.S. Constitution's Equal Protection Clause. 145 S. Ct. at 1827. The U.S. Supreme Court rejected their argument. It held that Tennessee's law "classifies on the basis of age" (that it banned procedures on minors) and "on the basis of medical use" (using treatments for gender dysphoria and other disorders). *Id.* at 1829. The court readily concluded that neither classification "turns on sex." *Id.*

The U.S. Supreme Court rejected the challengers' argument that the law "creates facial sex-based classifications by defining the prohibited medical care based on the patient's sex" and then by prohibiting puberty blockers and hormones to present as the opposite sex. *Id.* *Skrmetti* explained that "the law does not prohibit conduct for one sex that it permits for the other." *Id.* at 1831. It emphasized that "*no* minor may be administered puberty blockers or hormones to treat gender dysphoria, gender identity disorder, or gender

incongruence; minors of *any* sex may be administered puberty blockers or hormones for other purposes." *Id.*

Skrmetti also dispatched a core argument that Appellants make here. Appellants contend that the SAFE Act "targets transgender people and explicitly enforces sex stereotypes and gender conformity." Opening Br. 73. The *Skrmetti* challengers likewise claimed that Tennessee's law "enforces a government preference that people conform to expectations about their sex." 145 S. Ct. at 1832 (quoting the challengers' brief). They even highlighted the law's statutory findings that "Tennessee has a compelling interest in 'encouraging minors to appreciate their sex' and in prohibiting medical care 'that might encourage minors to become disdainful of their sex.'" *Id.* The court, however, saw no impermissible stereotyping; it instead explained how Tennessee was looking to prevent risky and experimental treatments on children—which could lead to future regret. *Id.*

Finally, *Skrmetti* rejected a sweeping application of *Bostock v. Clayton County*, 590 U.S. 644 (2020)—and the notion that Tennessee's law engaged in sex stereotyping. *Contra* Opening Br. 70. Core to *Bostock* is the premise that an employer engages in unlawful discrimination under Title VII against transgender employees if "the employer has penalized a member of one sex for a trait or action that it tolerates in members of the other." *Skrmetti*, 145 S. Ct. at 1834. The *Skrmetti* challengers contended that Tennessee's law "prohibits a

minor whose biological sex is female from receiving testosterone to live as a male but allows a minor whose biological sex is male to receive testosterone for the same purposes (and vice versa)." *Id.*; *cf.* Opening Br. 70 (same argument). The U.S. Supreme Court, however, explained that the law still treated male and female minors equally—allowing puberty blockers and hormones for certain treatments, but proscribing them for others. *Skrmetti*, 145 S. Ct. at 1834. ("For reasons we have already explained, changing a minor's sex or transgender status does not alter the application of SB1.").

Appellants bravely try to distinguish *Skrmetti*, but the *en banc* U.S. Court of Appeals for the Eighth Circuit recently rejected similar attempts to distinguish *Skrmetti* and upheld the Arkansas equivalent to the SAFE Act. *See Brandt ex rel. Brandt v. Griffin*, No. 23-2681, 2025 WL 2317546 (8th Cir. Aug. 12, 2025) (en banc). Notably, the full Eighth Circuit abrogated an earlier panel decision preliminarily enjoining the Arkansas law discriminated on the basis of sex. *See id.* at *7 n.4 (abrogating *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022)).[4] As in *Skrmetti*, the *Brandt* court concluded that the law "does not classify based on sex." *Id.* at *3. In the court's words, "Because "*no* minor may be administered puberty blockers or hormones" as gender-

[4] Appellants extensively rely on the earlier *Brandt* opinion and the district-court decision throughout their brief. *See, e.g.*, Opening Br. 37, 69, 105–06, 113, 116. These citations are now inapposite.

transition procedures, but 'minors of *any* sex may be administered puberty blockers or hormones for other purposes,' the Act does not classify based on sex." *Id.*

In reaching its conclusion, the *Brandt* court rejected several key arguments—mirroring Appellants' positions here. The *Brandt* plaintiffs argued that *Skrmetti* did not apply because the Arkansas law broadly proscribed "'any' medical or surgical service that seeks to accomplish the goals described in the Act's definition of 'gender transition procedures.'" *Id.* Meanwhile, Tennessee's law had only limited treatments for "the specific conditions 'gender dysphoria, gender identity disorder, gender incongruence,'" and hence the *Brandt* plaintiffs argued that the Tennessee law was only discriminating on medical condition. *Id.* The court disagreed. Despite these differences in verbiage, the court still concluded the law "classifies based on age and medical procedure, not sex." *Id.*

The *Brandt* plaintiffs also argued that *Bostock* applied and the statute discriminated on the basis of sex "because it would otherwise be impossible to distinguish whether a drug or surgery for a minor was permitted or prohibited." *Id.* at *4. The Eighth Circuit rejected this point too, explaining that the law "prohibits providing medical treatment for certain purposes, and these prohibitions apply even if one switches the sex of a hypothetical minor." *Id.* The court also dispatched the argument that the law reinforces stereotypes,

explaining that a legislature's "concern about potentially irreversible medical procedures for a child is not a form of stereotyping." *Id.* at *5 (citation omitted).

All told, *Skrmetti* and *Brandt* teach that because persons of *both sexes* can experience the desire to have attributes of the opposite sex, the law does not impermissibly target on the basis of sex. *See id.* (explaining that the statutes in both cases regulated "a class of procedures, not people"). This Court has said similarly. As the Court recently explained, the ordinary public meaning of the word "sex" "is not meant to extend beyond biological sex" and include gender identity. *R.M.A. v. Blue Springs R-IV Sch. Dist.*, 717 S.W.3d 187, 201 (Mo. banc 2025). The Court also rejected the assertion that "consideration of genitalia is inherently sex-related." *Id.* at 197. Hence, this Court rejected the "novel argument" that a transgender individual could maintain a claim of sex discrimination for refusal to be treated as the opposite biological sex. *Id.* at 194.

Appellants also offer no precedent of this Court suggesting that the Missouri Constitution evaluates sex-based classifications in a way that materially differs from the Federal Constitution—such that *Skrmetti* and *Brandt* do not control. *R.M.A.*, meanwhile, tracks the logic of *Skrmetti* and *Brandt*, by dispatching the contention that denying a transgender person access to a restroom conforming with the person's gender identity automatically gives rise to a sex-discrimination claim. *See id.* at 195–96 (rejecting the claim).

Tellingly, Appellants' attempt to write off *R.M.A.* as a narrow statutory decision. *See* Opening Br. at 79 n.25. But the law's traditional understanding of the word "sex" for the purpose of deducing what qualifies as sex discrimination speaks plainly to this Court's understanding of Missouri's Equal Protection Clause. *See R.M.A.*, 717 S.W.3d at 194–95 (looking to dictionary definitions and legislative construction to arrive at the conclusion that a transgender student was not discriminated against on the basis of sex by being denied access to accommodations of the opposite biological sex).

Finally, Appellants have no argument for why the Missouri Constitution should offer more protection than the U.S. Equal Protection Clause in this particular area. They point to no holding of this Court. *See* Opening Br. 75–78. And as this Court has explained, "analysis of a section of the federal constitution is 'strongly persuasive in construing the like section of our state constitution.'" *Phillips*, 194 S.W. at 841. At the very least, Appellants should be able to point to something more than an academic disagreement with the U.S. Supreme Court before suggesting that Missouri's constitutional jurisprudence starkly differs.

Given *Skrmetti* and *Brandt*, this Court should extend the logic of *R.M.A.* Appellants present no evidence that Missouri's Equal Protection Clause was originally understood to apply in cases like this. Nor do they present any evidence from the Clause's history and tradition. Opening Br. 76–77. With

nothing in this Court's equal-protection jurisprudence to suggest a different result, *Skrmetti* and *Brandt* show the way. The Court should therefore reject Appellants' arguments and affirm that the SAFE Act does not generate a sex-based classification.

2. The SAFE Act does not target a discrete protected class.

With Appellants unable to articulate a claim that avoids the rationales of *Skrmetti*, *Brandt*, and *R.M.A.*, they try to push the envelope and create a new protected class of individuals—"transgender people." Opening Br. 64. But these efforts fail too.

Winning recognition for a new "suspect class" is exceedingly difficult. *Skrmetti*, 145 S. Ct. at 1851 (Barrett, J., concurring). For one thing, the law must actually target a specific group. *Id.* at 1833 (majority opinion). If it does, the question then becomes whether the group is a "'suspect class' akin to the canonical examples of race and sex." *Id.* at 1851 (Barrett, J., concurring). Answering this examines "whether members of the group in question 'exhibit obvious, immutable or distinguishing characteristics that define them as a discrete group,' whether the group has, '[a]s a historical matter, . . . been subjected to discrimination,' and whether the group is 'a minority or politically powerless.'" *Id.* (alterations in original) (quoting *Lyng v. Castillo*, 477 U.S. 635, 638 (1986)). In exemplifying how demanding the test is, the U.S. Supreme Court has "*never* embraced a new suspect class under this test." *Id.*

This Court has likewise shared the hesitation of adopting new suspect classes. *See, e.g.*, *Ambers-Phillips v. SSM DePaul Health Ctr.*, 459 S.W.3d 901, 911 (Mo. banc 2015) (rejecting an argument that "the elderly or poor are a suspect class in any context"). Given the problems inherent in justifying and defining a protected class for transgender individuals, this Court should decline Appellants' invitation. The Court should continue following the well-trodden path of declining to recognize new suspect classifications.

a. The Act does not target transgender individuals.

For starters, the SAFE Act does not discriminate against transgender individuals. *Contra* Opening Br. 72–74. Indeed, *Skrmetti* rejected an identical argument. The U.S. Supreme Court recognized that a law banning puberty blockers and cross-sex hormones to treat gender dysphoria, gender identity disorder, and gender incongruence impacted only transgender individuals. *Skrmetti*, 145 S. Ct. at 1833. Nonetheless, the court explained that, when a law targets treatment that impacts only one group, it does not automatically create a classification warranting heightened scrutiny when members of the group can find themselves on both sides of the legislature's line. *See id.* (citing *Geduldig v. Aiello*, 417 U.S. 484 (1974)).[5] Here, the fact that transgender individuals

[5] Appellants contend at this Court cannot follow *Skrmetti* because it relied on *Geduldig*. Opening Br. 76–77. According to Appellants, this Court foreswore *Geduldig* by accepting the argument that pregnancy discrimination qualified as gender discrimination. *See Midstate Oil Co. v. Mo. Comm'n on Human*

(along with everyone else) can still use puberty blockers and hormones for reasons other than sex changes means that the legislature has not created a transgender-based classification. *Id.*

Appellants resist this understanding of *Skrmetti*, saying that the SAFE Act differs substantially from Tennessee's law because the act prohibits "gender transition" rather than prohibiting certain treatments for certain disorders. Opening Br. 75. Holding as much would reduce *Skrmetti* to mere drafting guidelines at the expense of the case's bottom-line holding that a law treating both sexes the same cannot qualify as a sex-based classification. *See* 145 S. Ct. at 1834 (discussing the law's application).

Moreover, *Brandt* eviscerates Appellants' argument: The Arkansas statute, like the SAFE Act, targets "gender transition procedures" by name. 2025 WL 2317546, at *2; *see* Mo. Rev. Stat. § 191.1720.2(4) (using the phrase

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Rights, 679 S.W.2d 842, 846 (Mo. banc 1984). But this Court has never expressed disagreement with *Geduldig*—the *Midstate Oil* Court did not consider and reject *Geduldig* in its opinion. *See id.* (never grappling with *Geduldig*). Moreover, how this Court interprets a specific statute sheds no light onto how the State's Constitution should be interpreted—especially given the presumption that the Missouri Constitution's provisions are interpreted "consistently with their interpretation under federal law." *Phillips*, 194 S.W.3d at 841. Just as the U.S. Supreme Court itself declined to have interpretations of Title VII predestine the meaning of the federal Equal Protection Clause, so too should this Court decline Appellants' invitation to have a single judicial interpretation of a (now repealed) Missouri-employment statute control the meaning of Missouri's Equal Protection Clause. *See Skrmetti*, 154 S. Ct. at 1834 ("We have not yet considered whether Bostock's reasoning reaches beyond the Title VII context, and we need not do so here.").

"Gender transition"). That verbal detail did not change the analysis; the Eighth Circuit specifically rejected the argument that the law's defining and using the phrase "gender transition" meant that "the act classifies based on transgender status." *Brandt*, 2025 WL 2317546, at *5. The court explained that the Arkansas law, like the Tennessee law, merely divided people "into two groups"—with transgender individuals falling on both sides of the line. *Id.* Hence, the Arkansas law, "like the Tennessee law, regulates a class of procedures, not people." *Id.* The same goes for the SAFE Act. *See* Mo. Rev. Stat. § 191.1720.5–.6 (proscribing medical interventions and surgeries for "gender transition" by minors).

b. Transgender individuals lack an immutable characteristic.

Even if the SAFE Act did target transgender individuals, there is no basis for interpreting the Missouri Constitution to treat such individuals as a protected class. To start, as Justice Barrett explained, "transgender status is not marked by the same sort of 'obvious, immutable, or distinguishing characteristics' as race or sex." 145 S. Ct. at 1852 (Barrett, J., concurring). It is not a "trait" that is ascertainable at birth. *Id.* Indeed, as the record in this case amply demonstrates, people "began to experience gender dysphoria at varying ages—some from a young age, others not until the onset of puberty." *Id.* And the fact "that some transgender individuals 'detransition' later in life—

in other words, they begin to identify again with the gender that corresponds to their biological sex"—precludes concluding that transgender status is immutable. *Id.*; *see, e.g.*, Tr. 2135:17–24 (parent witness explaining that the child "[a]t one point . . . identified as transgender" but that it was at trial unclear how the child identified). Similarly, because transgender is "an 'umbrella term' 'to describe . . . varied groups' with "'many diverse gender experiences,'" the transgender population cannot qualify as a "discrete group." 145 S. Ct. at 1851–52 (Barrett, J., concurring) (alterations in original) (quoting Brief in *Amicus Curiae* of the American Psychological Association); *see, e.g.*, Tr. 1992:1–5 (describing a child as "omnisexual" and "gender fluid").

Consequently, transgender individuals cannot qualify for protected group status under the Missouri Equal Protection Clause. *See generally Ambers-Phillips*, 459 S.W.3d at 911.

c. Appellants have not shown historical discrimination.

The claim that the transgender community represents a "suspect class" in need of extra judicial protection also fails because Appellants have not shown a requisite lack of power to protect members of the transgender community. *Skrmetti*, 145 S. Ct. at 1853 (Barrett, J., concurring). Whether a class can claim "suspect" status must "focus on *de jure* discrimination." *Id.* at 1854. Appellants attempt to circumvent this problem by pointing to past and present governmental actions that discriminated against the transgender community.

Opening Br. 66-67. But maintaining such a contention requires that the legal discrimination be "longstanding." 145 S. Ct. at 1855 n.5 (Barrett, J., concurring). Cross-dressing bans (assuming that they targeted the transgender community as Appellants understand it) provide no help because they have gone "relatively unenforced." Note, *Drag Queens, the First Amendment, and Expressive Harms*, 137 Harv. L. Rev. 1469, 1483 n.122 (2024). Indeed, many were found unconstitutional decades ago. *See, e.g.*, *Doe v. McConn*, 489 F. Supp. 76, 80–81 (S.D. Tex. 1980). The other examples Appellants give are hardly "longstanding" because they are new and often imposed or retracted based on which political party controls the levers of government.

As Justice Barrett explained when, trying to assess "what 'political powerlessness' means for our recognition of *new* suspect classes" proves inherently problematic given its subjectivity. *Skrmetti*, 145 S. Ct. at 1854–55 (Barrett, J., concurring). Even still, ample testimony at trial showed that transgender issues garner significant support from elite elements of society. For example, transgender individuals enjoy significant political and economic status—and have used it to support transgender causes. *See, e.g.*, Tr. 780:2–10 (referencing the Tawani Foundation and Jennifer Pritzker). As one witness who regrets having transitioned put it, since 2015, there was a "cultural zeitgeist" with the media and key cultural institutions celebrating transgenderism. Tr. 2276:1–15; *accord id.* at 2283:8–13 (referencing the

coverage of Katelyn Jenner). This witness said that he felt like transitioning had become "the consensus opinion" on popular "social media websites" and through Google search results. Tr. 2278:15–18, 2279:5–6.

The State's medical-ethics expert also testified that doctors and medical ethicists fear questing gender-transition practices. Tr. 2368:2–2370:7 (describing a "censorious climate" on matters involving gender transition). And, indeed, the transgender community enjoys the support of one of the two major political parties—which filibustered the SAFE Act and negotiated for the inclusion of its 2027 sunset provision. *See* D185 at 32 (describing the process for passing the Act). Thus, the contention "that transgender people are politically powerless" is wrong. Opening Br. 66.

For these reasons, Appellants' expansive equal-protection arguments should be rejected.

3. The SAFE Act survives judicial scrutiny.

Given the record in this case, the SAFE Act easily survives judicial scrutiny. Because the Act neither discriminates on the basis of sex nor targets a suspect class, the legislation need only survive rational-basis review. *Phillips*, 194 S.W.3d at 845 (citing *Romer v. Evans*, 517 U.S. 620, 631 (1996)). Appellants assert that the State has failed to prove its case because the State "presented no evidence at trial—no testimony from any representatives of the state as witnesses, nor any documentary evidence or statements attributable to the

government from which any specific state interests could be inferred." Opening Br. 74. As detailed below, the State introduced substantial evidence supporting the SAFE Act's restrictions. *See infra* pp. 66–90.

But more fundamentally, Appellants overstate the State's burden. As this Court has long held, "If there is any reasonable basis upon which the legislation may constitutionally rest, the court must assume that the legislature had such fact in mind and passed the act pursuant thereto." *Poole & Creber Market Co. v. Breshears*, 125 S.W.2d 23, 31 (Mo. 1938). Moreover, the Court further explained, "All facts necessary to sustain the act must be taken as conclusively found by the legislature, if any such facts *may be reasonably conceived in the mind of the court*." *Id.* (emphasis added). In other words, an enactment "will withstand rational basis review 'if any set of facts can be reasonably conceived to justify it.'" *Doe v. Olson*, 696 S.W.3d 320, 328 (Mo. banc 2024); *accord Brandt*, 2025 WL 2317546, at *6–7 (declining to remand additional fact finding given that the court could ascertain a rational basis).

The voluminous record in this case easily satisfies Missouri's standard of rational-basis review. The circuit court heard testimony from Jamie Reed, a former employee of Washington University's Pediatric Transgender Center. Ms. Reed blew the whistle on the Center's activities, explaining how the Center would freely dispense cross-sex hormones and puberty blockers without regard to patients' mental health. *See* Tr. 1615:12–14 ("The endocrinologist that was

prescribing these things did not care if [the patient] met criteria, did not care if [the patient] had distress."); Tr. 1616:8–1617:8, 1619:8–12 (describing a hurried, "check-the-box" system for getting children "hormones"). She even explained that the Center would begin protocols on children against the advice of psychiatrists. Tr. 1625:20–1626:8. And Ms. Reed confirmed that the Center facilitated minors getting transition surgeries. Tr. 1654:4. As the circuit court noted, Ms. Reed's publicizing the Center's activities helped spur the General Assembly's passage of the SAFE Act. D185 at 31.

Ms. Reed's story alone would suffice to show a rational basis—but it's just the tip of the iceberg. The circuit court also heard testimony from several individual witnesses who had undergone transgender treatments as minors—including surgery, but who came to regret it and now live with lifelong consequences. *See, e.g.*, Tr. 2658:22–25 (Ms. Cole describing her mastectomy). More broadly, the circuit court heard evidence that a substantial percentage of children who receive gender-transition procedures eventually regret them. Tr. 1947:10–13; 2438:5–10.

The trial court also heard substantial evidence suggesting that gender-transition procedures are not safe and pose significant risks. For example, the court heard from a plastic surgeon who described—in excruciating detail—the risks associated with such operations generally and especially on minors. *See, e.g.*, Tr. 2602:5–18 (describing issues on operating on minors). There was also

testimony—from both sides—regarding the questionable quality of the scientific evidence supporting these procedures, the risk that children would be rendered permanently sterile, and the experiences in Finland, Sweden, and the United Kingdom—who have now restricted these treatment on minors. *See* D185 at 14–21.

Any of these reasons more than suffices to show a "reasonable basis upon which the legislation may constitutionally rest." *Poole & Creber*, 125 S.W.2d at 31. The *Brandt* court upheld the Arkansas equivalent to the SAFE Act based on a record containing similar evidence. *See* 2025 WL 2317546, at *7–8 (highlighting similar findings to the circuit court). The *Brandt* court even affirmed—despite both contrary factual findings by a district court and a contention "that legislators were motivated by negative attitudes about transgender people." *Id.* at *7.

Brandt was correct in upholding Arkansas's law without remand; even if some heightened justification were needed, the evidence here would still support the SAFE Act. As the U.S. Supreme Court has explained, even in situations involving heightened scrutiny, legislatures have "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). This Court has agreed—explaining that even within the context of due process and equal protection, "in areas fraught with medical and scientific uncertainties, legislative options must

be especially broad and courts should be cautious not to rewrite legislation." *State v. James*, 534 S.W.2d 41, 43 (Mo. 1976).

Appellants boldly assert that only "animus towards transgender people" can explain why the General Assembly passed the SAFE Act. Opening Br. 72 (citation omitted). But as the circuit court explained and the record demonstrates, medical science is deeply divided over the safety and efficacy of medical and surgical transition protocols on children. *See* D185 at 19–23 (describing the evidence and recommendations by leading authorities). And there can be no denying that the "State's interest in 'safeguarding the physical and psychological well-being of a minor' is 'compelling.'" *New York v. Ferber*, 458 U.S. 747, 756–57 (1982). At bottom, protecting children is exactly what the SAFE Act intends to do. Thus, even if some elevated scrutiny applies, the SAFE Act still satisfies it.

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As Members of this Court have noted, "access to gender-affirming health care services, who should be allowed to play on what sports teams, or any of the myriad of difficult policy questions involving transgender people" are "questions of policy [that] should be left to the general assembly as the policy-making branch." *R.M.A.*, 717 S.W.3d at 201 (Wilson, J., join by Powell, J., dissenting). The SAFE Act squarely fits this description—bipartisan legislation looking to make sure that the long-term safety and health of this State's children are not

compromised by novel procedures. Nothing in the Missouri Equal Protection Clause requires otherwise. The Court should therefore affirm.

B. Parents do not have a due-process right to subject their children to transgender surgical and medical interventions (Response to Point IV).

Appellants' contention that parents have an absolute right to subject their children to procedures and treatments that the State deems dangerous or harmful lacks merit. Opening Br. 53–56. Core to parental rights is "the liberty of parents and guardians to direct the upbringing and education of children." *Pierce v. Society of Sisters of the Holy Names of Jesus and Mary*, 268 U.S. 510, 534 (1925). But "[t]he 'rights of parenthood' are not 'beyond limitation.'" *Brandt*, 2025 WL 2317546, at *8 (quoting *Prince*, 321 U.S. at 166).

Axiomatically, parental rights are at their nadir when the child's physical wellbeing is at stake. *See, e.g.*, *Ginsberg v. New York*, 390 U.S. 629, 639–40 (1968) (recognizing states' interest in protecting the general well-being of minors); *Prince v. Massachusetts*, 321 U.S. 158, 167 (1944) (holding that "the state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare"). For example, a State is not forced to sit idly by and allow parents to forego medically necessary treatments for children. *See Brandt*, 2025 WL 2317546, at *8 ("Parents do not have unlimited authority to make medical decisions for their children."); *see, e.g.*, *Novak v. Cobb Cnty.-Kennestone Hosp. Auth.*, 849 F. Supp. 1559, 1566–67 (N.D. Ga. 1994) (finding

no due-process violation for state intervention over a Jehovah's Witness parent who would not permit a blood transfusion for child). Indeed, every State "includes failure to provide necessary medical care as child neglect or abuse." *Brandt*, 2025 WL 2317546, at *8.

As *Brandt* explained, "Parents do not have unlimited authority to make medical decisions for their children." *Id.* It said that a state has unquestionable authority "to regulate the medical profession to 'provide for the general welfare of its people.'" *Id.* at *8 (quoting *Dent v. West Virginia*, 129 U.S. 114, 122 (1889)). This even includes the power "to prohibit certain medical treatments, despite a doctor finding them 'both advisable and necessary.'" *Id.* (quoting *Lambert v. Yellowley*, 272 U.S. 581, 596 (1926)). Because of the historical understanding that "states can prohibit medical treatments for adults and children, and . . . parents cannot automatically exempt their children from regulations," the *Brandt* court found no basis for a claim that parents can override a state's conclusion that a medical intervention is dangerous and proscribed for children. *Id.*

Given these well-founded limitations, Missouri broke no new ground here. Missouri's banning "gender-affirming care" for children and adolescents follows from its broader authority to protect children by banning their sexual exploitation or requiring provision of necessary medical care. The SAFE Act follows from the State's broader *parens patriae* authority to protect children

from actions it deems harmful. *See Schall v. Martin*, 467 U.S. 253, 265 (1984); *Brandt*, 2025 WL 2317546, at *9. Holding that parental rights overcomes this bedrock state authority would necessarily undermine the State's ability to protect children from other potential harms. Namely, if the State cannot prohibit irreversible alterations to a child's sexual anatomy, then the State's authority to proscribe children's engaging in parentally approved sexual activity, use of controlled substances, or foregoing necessary medical intervention becomes open to question. *See Ginsberg*, 390 U.S. at 640–41 (recognizing the interest of the state in the safeguarding of children from abuse and from negative influences).

Appellants invoke *Parham v. J.R.*, 442 U.S. 584, 602 (1979), *see* Opening Br. 54, but that case lends them no help. *Parham* involved "Georgia's voluntary commitment procedures for children under the age of 18"—there was no question that involuntary commitment was a valid treatment option that the state was not looking to proscribe. *Parham*, 442 U.S. at 588. And where the choice is between *valid* treatment options, parents have "plenary authority" to decide how to treat their child. *Id.* But "a state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized." *Id.* at 603.

Despite Appellants' contrary claim, the State has broad authority "to act in areas fraught with medical and scientific uncertainties." *James*, 534 S.W.2d

at 43 (citation omitted). And, indeed, the State has "a 'compelling' interest in 'safeguarding the physical and psychological well-being of a minor.'" *Brandt*, 2025 WL 2317546, at *5 (quoting *Ferber*, 458 U.S. at 756–57). The General Assembly has concluded—based on an ongoing medical debate—that the SAFE Act's requirements are necessary to protect the wellbeing of children. This "medical and scientific uncertainty" sufficiently validates the Act. *Carhart*, 550 U.S. at 163.[6]

C. A due-process right of autonomy does not mandate access to novel surgical or medical interventions by minors (Response to Point V).

Appellants' passing argument that minors have a personal-autonomy right to make life-changing medical decisions that the State has found dangerous enjoys no support in history or precedent. Opening Br. 59–60. As *Brandt* explained, "the [U.S.] Supreme Court has recognized that a state's 'authority over children's activities is broader than over like actions of adults.'" 2025 WL 2317546, at *9 (quoting *Prince*, 321 U.S. at 168). That is, States have a broader *parens partriae* authority to promote the welfare of children. *See Schall*, 467 U.S. at 265. And when States exercise such authority over children,

[6] Appellants misleadingly suggest that the SAFE Act requires transgender individuals who were already receiving treatments to discontinue them midstream. Opening Br. 58. This is false, as the SAFE Act exempts "any individual under eighteen years of age who was prescribed or administered such hormones or drugs prior to August 28, 2023." Mo. Rev. Stat. § 191.1720.4(2).

courts will not scrutinize the action with exactitude. *See Ginsberg*, 390 U.S. at 642–43 ("We do not demand of legislatures 'scientifically certain criteria of legislation.'").

This case is even easier because, even if Appellant children were adults, they still would not have the right to claim access to specific medical procedures. Repeatedly, courts have refused to recognize a personal-autonomy right to access treatments that governments have proscribed. *See Brandt*, 2025 WL 2317546, at *7 (collecting cases); *Abigail All. for Better Access to Developmental Drugs v. Von Eschenbach*, 495 F.3d 695, 710 (D.C. Cir. 2007) (en banc) ("[C]ourts have rejected arguments that the Constitution provides an affirmative right of access to particular medical treatments reasonably prohibited by the Government.").

Appellants' only response in the face of well-settled doctrine is to invoke this Court's decision in *Cruzan v. Harmon*. The case is inapposite—it dealt with individuals' rights to seek (or in that case, refused) *legal* medical treatments. *See* 760 S.W.2d 408, 410 (Mo. banc 1988), *aff'd* 497 U.S. 261 (1990). Here, Appellants, however, are seeking the right to treatment that the legislature has proscribed. Due process affords them no such right. *See Abigail All.*, 495 F.3d at 710 (noting consistent rejection of "arguments that the Constitution provides an affirmative right of access to particular medical treatments reasonably prohibited by the Government").

D. Appellants' constitutional claims as to the SAFE Act's Medicaid provision fail (Response to Point III).

Assuming that Appellants have shown standing, pleaded, and fully developed a claim challenging the Medicaid provision, Mo. Rev. Stat. § 208.152(15), it fails for the same reasons as the rest of their challenges. As with the rest of the SAFE Act, there is no equal-protection violation because the restriction applies equally to both sexes and it does not target a cognizable disfavored group. *See supra* pp. 35–49. The provision also does not impact any adult's due-process rights because adults in Missouri remain free to seek the procedures that the SAFE Act proscribes for children. *See Rust v. Sullivan*, 500 U.S. 173, 201 (1991) (explaining that there is no constitutional requirement for the government to expend money in aid of in individual's liberty interests).

Contrary to Appellants' contention, Opening Br. 50–51, the record *does* contain reasons supporting the General Assembly's decision not to expend limited state funds on transgender treatments. For one thing, around 30% of treatment recipients detransition. D185 at 26. Meaning, in 30% of cases, Medicaid dollars would have been expended on treatments the recipient regretted. The evidence also showed potential elevated health risks from hormone treatments. D185 at 24. Hence, that creates a risk to Medicaid coffers from follow-on effects later in life.

Likewise, the State had reasons for not wanting Medicaid recipients to undertake costly, unproven, and life-altering measures. Among other things, many who choose drug or surgical interventions for gender dysphoria will "have a long-term need for continued psychological care." D185 at 10. And even if a patient only uses hormonal interventions, "he/she most remain on the cross sex hormones." *Id.*; *see* Tr. 339:21–340:17 (describing potential effects of ceasing drug treatment). The General Assembly could therefore rationally conclude that the potential burden on the State's limited Medicaid coffers was too much to justify coverage for drastic interventions. These record details are more than sufficient to satisfy this Court's articulation of rational-basis review. *See Olson*, 696 S.W.3d at 328 (explaining that a law "will withstand rational basis review 'if any set of facts can be reasonably conceived to justify it'").

E. The Missouri Constitution's Gains of Industry Clause does not provide practitioners a right to engage in novel medical treatments on children (Response to Point X).

Appellants next contend that the SAFE Act violates the Gains of Industry Clause, Mo. Const. art. I, § 2. *See* Opening Br. 121–22. As this Court has concluded, the clause was enacted to prohibit "workplace slavery." *Fisher v. State Hwy. Comm'n of Mo.*, 948 S.W.2d 607, 610 (Mo. banc 1997). Drafted and enacted in 1865, the clause was meant to protect recently freed former slaves. *See id.* at 609 (discussing the clause's relation to a provision adopted by the Maryland Constitution). Indeed, the clause functions as the equivalent to

the Thirteenth Amendment to the U.S. Constitution—no other provision in the "Missouri Constitution expressly prohibits slavery or involuntary servitude." *Id.* The clause does not divest the State of authority "to prescribe regulations affecting the public health." *Moler v. Whisman*, 147 S.W. 985, 986–87 (Mo. 1912).

Appellants' contention that they are entitled to sell "a lawful product" is inapposite. Opening Br. 122. The only circumstance where forbidding the sale of the product can implicate the Gains of Industry Clause is when a government "definitely and distinctly forbids any one to deal in a product which the statute declares to be lawful." *State ex rel. Knese v. Kinsey*, 282 S.W. 437, 439 (Mo. banc 1926). However, nothing limits the legislature's ability to declare products unlawful or to impose "conditions which insure the purity of the product." *Id.* In the SAFE Act, the General Assembly has declared that providing certain procedures to minors is unlawful due to safety concerns. It has not generally proscribed anyone to sell "a product which the Legislature authorizes as a lawful product and which admittedly is healthful and harmless." *Id.*

Ultimately, the legislature has chosen to regulate and curtail certain forms of experimental medical treatment. "The prospect of courts second-guessing legislative choices in this area should set off alarm bells." *Skrmetti*, 145 S. Ct. at 1852 (Barrett, J., concurring) (citing *Lochner v. New York*, 198 U.S. 45, 72 (1905) (Harlan, J., dissenting)). This Court has never suggested that the

Gains of Industry Clause enshrines *Lochner*-like checks on the General Assembly's exercising "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Id.* (citation omitted). It should not accept Appellants' current invitation to instantiate such restrictions.

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Appellants sincerely believe that children and adolescents need the protocols banned by the SAFE Act. But the people of Missouri—through their elected representatives—have taken a different view in this area "fraught with medical and scientific uncertainties." *James*, 534 S.W.2d at 43. Nothing in the Missouri Constitution bars that choice.

IV. The Circuit Court Did Not Err in Concluding that Appellants Sought Only Facial Relief and Failed to Clear the Heavy Burden for Obtaining Facial Relief (Response to Point Relied On IX).

Standard of Review: The standard of reviewing constitutional challenges is the same as described in response to Points IV, V, VI, and X above. When a party requests injunctive relief in the context of a constitutional challenge to a statute, the decision whether to issue that relief "rests largely with the sound discretion of the trial court." *Priorities USA*, 591 S.W.3d at 452 (citation omitted). "The circuit court 'is vested with a broad discretionary power to shape and fashion relief to fit the particular facts, circumstances and equities of the case before it.'" *Id.*

A. Appellants only brought a facial challenge.

Appellants asserted that the circuit court erred in concluding that Appellants brought only a facial challenge to the Act. Opening Br. 114–15. They claim they also brought as-applied challenges. *Id.* As masters of their Petition, it was incumbent on Appellants to state clearly the grounds upon which they sought relief. *See* Mo. Ct. R. 55.05. Appellants all but concede that they never specified that they were bringing as-applied challenges to the Act. *See* Opening Br. 114 (stating that their Petition can be interpreted to bring an as-applied challenge). And sure enough, a review of their Petition shows an absence of an as-applied request for relief. *See* App. 287–88 (Petition Prayer for Relief) (failing to request for relief as-applied to Appellants).

Given Appellants' failure to articulate plainly that they were asserting as-applied challenges, the circuit court appropriately concluded they brought only facial challenges. *See Aldridge v. Hoskin*, 645 S.W.3d 101, 104 (Mo. S.D. App. 2022) ("Under Missouri pleading rules, to state a claim, a petition must invoke substantive principles of law entitling the plaintiff to relief . . . ." (citation omitted)). The circuit court also recognized that Appellants were broadly attacking the SAFE Act. *See* D185 at 42–43 (explaining that Appellants "cannot use the tiny incision related to puberty blockers as a Trojan Horse to attack a law prohibiting surgeries with much more substantial, significant, and permanent side effects").

B. The circuit court did not err in denying facial relief.

Faced only with facial challenges, the circuit court did not misapply the facial-validity standard and uphold the SAFE Act based on imaginary hypotheticals—as Appellants contend. Opening Br. 115–16. On the contrary, the circuit court grounded its conclusions about the SAFE Act's validity in the record. Notably, the court noted how the law would protect children from drugs like bicalutamide, D185 at 41, which one witness explained was prescribed to children by Washington University's Clinic. *See* Tr. 1660:4–13. The same goes for the court's conclusion as to the law's protecting children from other drastic interventions. *See* D185 at 43–45 (rooting its analysis in testimony about Washington University's Clinic). Thus, the circuit court was focused on specific "applications of the statute in which it actually . . . prohibits conduct." *City of Los Angeles v. Patel*, 576 U.S. 409, 418 (2015).

Appellants' reliance on this Court's decision in *No Bans on Choice v. Ashcroft*, 638 S.W.3d 484, 491–92 (Mo. App. 2022), is misplaced. Opening Br. 116. There, this Court addressed an argument by the State that challengers to restrictions on ballot initiatives failed to show that the restrictions would totally foreclose successful ballot initiatives. *See No Bans*, 638 S.W.3d at 491–92. The Court did not—as Appellants suggest, Opening Br. 116—reject the standard set by *United States v. Salerno*, 481 U.S. 739, 745 (1987) ("A facial challenge to a legislative Act is, of course, the most difficult challenge to mount

successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid."). To the contrary, this Court found the standard met because the restrictions, in every conceivable circumstance, interfered with and impeded "the right of referendum itself." *No Bans*, 638 S.W.3d at 492; *accord id.* ("Consequently, because [the restrictions] 'interfere with and impede' the right of referendum, they can *never* be constitutionally applied."); *see also Donaldson v. Mo. State Bd. of Registration & Healing Arts*, 615 S.W.3d 57, 66 (Mo. banc 2020) (reiterating that a facial challenge requires that "the challenger must establish that no set of circumstances exists under which the [statute] would be valid" (alteration in original) (citation omitted)). Appellants' effort to find daylight between this Court's jurisprudence and the *Salerno* standard fails. *See Donaldson*, 615 S.W.3d at 66 (reiterating the demanding standard for facial challenges).

The remainder of Appellants' arguments about properly adjudicating a facial challenge are beside the point—and a transparent attempt to bluster their way out of a loss. *See* Opening Br. 116–21. Even assuming Appellants are right that something less than the *Salerno* standard applies—and they are not—they lose on the merits under any standard. Any supposed errors that Appellants highlight, *see* Opening Br. 117–19, are offset by the record as a whole and by the fact that the General Assembly enjoys "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Carhart*,

550 U.S. at 163; *see also James*, 534 S.W. 2d at 43 (explaining similarly). Hence, Appellants are not entitled to the declaratory and injunctive relief they requested.

V. The Circuit Court Made No Factual Findings Contradicted by the Weight of the Evidence (Response to Point Relied On VII).

Standard of Review: A "circuit court 'enjoys considerable discretion in the admission or exclusion of evidence.'" *Shallow v. Follwell*, 554 S.W.3d 878, 883 (Mo. banc 2018). "The evidence and all reasonable inferences therefrom are viewed in the light most favorable to the verdict, disregarding any evidence and inferences contrary to the verdict." *State v. Twitty*, 506 S.W.3d 345, 346 (Mo. banc 2017); *see White v. Director of Revenue*, 255 S.W.3d 571, 576 (Mo. S.D. App. 2008) (applying the same standard in civil cases). And for any given "evidentiary error to cause reversal, prejudice must be demonstrated." *State v. Reed*, 282 S.W.3d 835, 837 (Mo. banc 2009).

In reviewing a court-tried case, this Court "will affirm the circuit court's judgment unless there is no substantial evidence to support it [or] it is against the weight of the evidence." *Ivie v. Smith*, 439 S.W.3d 189, 198–99 (Mo. banc 2014). "The against-the-weight-of-the evidence standard serves only as a check on a circuit court's potential abuse of power in weighing the evidence, and an appellate court will reverse *only in rare cases*, when it has a firm belief that the decree or judgment is wrong." *Id.* at 206 (emphasis added). "[T]his Court defers

to the circuit court's findings of fact when the factual issues are contested and when the facts as found by the circuit court depend on credibility determinations." *Id.* The "court's judgment is against the weight of the evidence only if the circuit court could not have reasonably found, from the record at trial, the existence of a fact that is necessary to sustain the judgment." *Id.* If "the evidence poses two reasonable but different conclusions, appellate courts must defer to the circuit court's assessment of that evidence." *Id.*

A. Appellants fail to show any evidentiary error warranting reversal.

Because rational-basis review controls, and because the SAFE Act reasonably protects minors from novel medical procedures, the Court need not detain itself with disputes over particular evidence. *See Brandt*, 2025 WL 2317546, at *6 ("[T]his court can determine here that the Act survives rational basis review."); *Poole & Creber*, 125 S.W.2d at 1147 (confirming that if this Court can conceive of "any reasonable basis upon which the legislation may constitutionally rest the court must assume that the legislature had such fact in mind" and uphold the law). Nonetheless, Appellants' arguments that the circuit court engaged in erroneous fact findings fail one by one. And even if the circuit court erred on some evidentiary matters, its errors were harmless given that ample evidence here demonstrates an area "fraught with medical and scientific uncertainties." *James*, 534 S.W.2d at 43.

1. The circuit court did not impermissibly rely on exhibits.

Appellants begin by contending that the circuit court impermissibly relied on exhibits that were not formally admitted into evidence—though they never claim the information in those exhibits is erroneous. Opening Br. 84–86. To the extent that there was any error here, the error was harmless because the relevant information is judicially noticeable or otherwise admissible.

Courts are free to take judicial notice "of a fact which is common knowledge of people of ordinary intelligence, and it may be taken of a fact, not commonly known, but which can be reliably determined by resort to a readily available, accurate and credible source." *Whitmoor Realty, LLC v. Beckerle*, 588 S.W.3d 573, 579 (Mo. E.D. App. 2019). Notably, Appellants gripe about the circuit court's citations to a World Health Organization document and guidelines from foreign governments. Opening Br. 84–87. But these documents paradigmatically qualify as coming from a "credible source" from which the court could take judicial notice. *Id.* Indeed, this information is akin to (and overlapping with) actions by foreign governments cited by the U.S. Supreme Court in *Skrmetti*. *See* 145 S. Ct. at 1825–26. And, of course, documents by foreign governments fall under the "the 'public documents' exception to the hearsay rule." *Gordon v. Monsanto Co.*, 702 S.W.3d 506, 513 (Mo. E.D. App. 2024). Meanwhile, information regarding neurological functioning "can be

reliably determined by resort to a readily available, accurate and credible source." *Whitmoor Realty*, 588 S.W.3d at 579.

2. The court did not improperly rely on the Cass Report.

Appellants also object to reliance upon the Cass Report, which they say was not admitted as "part of the record." Opening Br. 85. That is a misstatement. The trial court *did* admit it into the record. *See* Tr. 401:22–25 ("I will admit [the Cass Report] for purposes when this thing goes up . . . whoever is reviewing this thing will be able to just pull it out of evidence versus having to guess about what it said."); Tr. 1813:6–7 (similar).

Additionally, the circuit court was free to rely on the Cass Report because both sides' expert witnesses relied on it, cited it in their writings, and discussed it during their testimony. *See, e.g.*, Tr. 208:3–9; Tr. 282:21–25; Tr. 283:18–23; Tr. 375:16–377:5; Tr. 400:10–24; Tr. 747:17–748:17; Tr. 787:1–19; Tr. 1700:1–25; Tr. 1800:22–1801:21; Tr. 1805:7–1807:15; Tr. 1847:17–1849:13; Tr. 1855:10–1856:22. This was appropriate. Evidence—including hearsay—is admissible when it provides a basis for an expert's opinion. *State v. Brown*, 998 S.W.2d 531, 549 (Mo. banc 1999) ("Generally, an expert may rely on hearsay evidence as support for opinions, as long as that evidence is of a type reasonably relied upon by other experts in the field; such evidence need not be independently admissible."). Here, multiple experts relied on the Cass Report, which is why the circuit court discussed the Cass Report when rebutting

Appellants' experts. *See* D185 at 20–21 (concluding, contrary to Appellants' experts, that there was insufficient evidence supporting chemical and surgical interventions for children). Indeed, Dr. Olson-Kennedy co-authored a paper—discussed in her testimony—criticizing the Cass Report. Tr. 618:3–11, 624:5–625:13, 628:14–629:10. And learned treatises may be used "to test or challenge an expert's testimony." *Coats v. Hickman*, 11 S.W.3d 798, 803 (Mo. W.D. App. 1999) (citation omitted). Sure enough, the State used the Cass Report in just that manner below. *See, e.g.*, Tr. 759:5–12; 773:13–14; 787:25–788:13.

Independently, the Court can take judicial notice of the Cass Report because it is sufficiently authoritative. *See Kansas City v. Dugan*, 524 S.W.2d 194, 197 (Mo. W.D. App. 1975) (explaining that a court may "take judicial notice that the article or treatise is authoritative"); *cf. Skrmetti*, 145 S. Ct. at 1835; *accord id.* at 1842-43 (Thomas, J., concurring) (citing other evidence); *Eknes-Tucker v. Governor of Alabama*, 114 F.4th 1241, 1268–69 (11th Cir. 2024) (Lagoa, J., concurring) (discussion of more evidence on this point). The Cass Report is appropriately authoritative. To develop the report, the authors commissioned a series of systematic reviews of the available scientific evidence—all of which were published in peer-reviewed journals in conjunction with its publication—ensuring they had the "best available collation of published evidence relevant" to the efficacy and risks associated with medical interventions. Cass Report 52–53. The Cass Report itself came out of wild

uncertainty regarding the efficacy of these interventions: The resignation of thirty-five psychologists from a United Kingdom clinic promoted the report's in-depth examination of diagnosing and treating gender dysphoria.[7] England's National Health Service commissioned the report, which was "strictly focused on the clinical services provided to children and young people who seek help from the NHS to resolve their gender-related distress." Cass Report 16. Dr. Cass herself was also previously the head of the Royal College of Pediatrics and Child Health. Tr. 786:5–7. As such, the report merited judicial notice.

And, if nothing else, the Cass Report refutes any contention that the General Assembly could not have possessed "any reasonable basis" for limiting the availability for transgender treatment. *Poole & Creber*, 125 S.W.2d at 1147. The Cass Report amply dispatches the notion that medical and surgical transgender interventions on minors are indisputably safe and effective. The circuit court—like all the other courts that have referenced the Cass Report—could therefore cite the report to show a valid, rational legislative basis for adopting the SAFE Act. *See Carhart*, 550 U.S. at 163 (emphasizing how "legislatures [have] wide discretion to pass legislation in areas where there is medical and scientific uncertainty"); *James*, 534 S.W.2d at 43 (same).

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[7] *See* Laura Donnelly, *Children's Transgender Clinic Hit by 35 Resignations in Three Years as Psychologists Warn of Gender Dysphoria 'Over Diagnosis,'* Telegraph (Dec. 12, 2019), https://www.telegraph.co.uk/news/2019/12/12/childrens-transgender-clinic-hit-35-resignations-three-years/.

3. The court did not wrongly discount WPATH's credibility.

Appellants also chastise the circuit court's statement "suggesting that WPATH has suppressed research unfavorable to its agenda." Opening Br. 87 (quoting D185 at 54). But the circuit court is not alone in being skeptical about WPATH. As a concurring opinion in *Skrmetti* noted, WPATH appears to be driven by ideology rather than science. *See* 145 S. Ct. at 1848 (Thomas, J., concurring) ("[N]ewly released documents suggest that WPATH tailored its Standards of Care in part to achieve legal and political objectives."). Indeed, the New York Times has reported that the Biden Administration pressured WPATH to remove age limits on adolescent surgeries. *See id.* at 1848–49 (quoting Azeen Ghorayshi, *Biden Officials Pushed to Remove Age Limits for Trans Surgery*, N.Y. Times, June 27, 2024, https://www.nytimes.com/2024/06/25/health/transgender-minors-surgeries.html.). And Justice Thomas's concurring opinion does not stand alone; several other judicial opinions have raised concerns "that WPATH's lodestar is ideology, not science." *Eknes-Tucker*, 114 F.4th at 1261 (Lagoa, J., concurring in denial of rehearing en banc) (citing additional opinions). Hence, judicially noticeable information supports the circuit court's conclusion that "WPATH has suppressed research unfavorable to its agenda." *See Whitmoor Realty*, 588 S.W.3d at 579 (recognizing that facts published in newspapers of record are judicially noticeable). And, in fact, the circuit court did take notice

of judicial opinions in describing WPATH's shortcomings. *See* D185 at 54 (citing cases).

4. The trial court did not wrongly view the medical evidence supporting transgender treatments on minors as low-quality.

Appellants similarly fail to articulate any reversible error with respect to the circuit court's conclusion as to treatment "GRADE." Opening Br. 87–89. For one thing, they overstate the court's discussion of evidence quality. True, the court mentioned that studies regarding the "benefits from gender transition interventions are of 'very low' quality." D185 at 51. However, more broadly, the circuit court explained "that there is an entrenched medical dispute" regarding the efficacy of medical and surgical transgender interventions on children. D185 at 50; *accord* Tr. 618:23–619:5 (Dr. Olson-Kennedy conceding that the medical evidence supporting transgender treatments for minors is "less-than-high-quality evidence (by definitional standards)"); Tr. 798:13–21 (same for Dr. Antommaria).

It is because of this broader dispute that the circuit court concluded that it "must defer to the legislature under any level of scrutiny." D185 at 51. Appellants' quibbling about the grading of medical evidence is therefore a red herring—they ultimately cannot dispute the mountain of conflicting evidence and testimony showing that there is no clear consensus on the efficacy or ethics of the interventions that the SAFE Act restricts. *See* D185 at 50–51

(emphasizing how Appellants' experts disagree with other American and European medical authorities). Thus, for the reasons already explained, the General Assembly was free to account for the risks presented by gender-transition treatments and act accordingly. *See supra* pp. 49–53. And even if these treatments had a GRADE in line with other less-controversial treatments, the legislature still can articulate a rational basis for banning its use on minors. *See Brandt*, 2025 WL 2317546, at *6; *James*, 534 S.W.2d at 43.

5. Appellants cannot ask this Court to reweigh Dr. Antonmmaria's testimony.

Appellants also object to the circuit court's "claim[] that Dr. Antommaria 'acknowledged that guidelines are supposed to be based on systematic reviews—but that WPATH's guidelines are not.'" Opening Br. 89. Appellants are attempting to relitigate how the circuit court weighed evidence before it. Appellants say that Dr. Antommaria explained that only one-third of medical evidence is based on systemic reviews. Opening Br. 89. But the circuit court emphasized how Dr. Antommaria had also conceded that systemic reviews are possible in this context. D185 at 23. That in no way mischaracterizes Dr. Antommaria's testimony. *See* Tr. 774:7–9 ("It would be possible to conduct such a systemic review, and there are others like systemic reviews in the literature.").

And sure enough, Dr. Antommaria conceded that "using non-systemic methods compromises the validity and reliability of evidence to inform guideline recommendations." Tr. 775:16–18. Hence, he agreed it was "bad" that WPATH's guidelines were not rooted in systemic reviews. Tr. 775:22. Appellants thus err in inviting this Court to reweight the trial court's weighing of Dr. Antommaria's testimony. *See Davis v. Dir. of Revenue*, 346 S.W.3d 319, 322 (Mo. E.D. App. 2011).

6. The court did not err in describing WPATH's guidelines.

Appellants next mischaracterize the circuit court's referencing the WPATH "limitations." Opening Br. 89. They contend that the court relied on several "limitations" that do not apply to gender transitions. *Id.* But that is not what the circuit court did. The court simply said, "WPATH at times acknowledges limits, stating, for example"—and then listed the limits. D185 at 22. Note what the court did not say: that these are all limits of gender-affirming medical care. Nor did the court go on to erroneously rely on an inapplicable limitation. D185 at 22–23. Instead, it was merely reciting record evidence.[8]

[8] It was appropriate for the court to mention these limitations because the WPATH "Standards of Care" were frequently referenced in trial testimony. *See e.g.*, Tr. 312:2–22; Tr. 622:3–12; Tr. 623:18–23. Given this testimony, there can be no disputing that WPATH Standard 8 is relevant and the court did not include any inapplicable limitations in its analysis of the testimony regarding Standard 8. *See* D185 at 23 (describing the testimony of Appellants' experts).

7. The court did not mischaracterize psychological evaluations.

For psychological evaluations, the court did not mischaracterize the evidence or simply accept "Respondents' framing." Opening Br. 91. On the contrary, the court *directly quoted* questions asked *by the court* of witnesses. *See* D185 at 44–45. The court then went on to recount the testimony of Jamie Reed, the former employee of Washington University's Pediatric Transition Center, who recounted how the Center was "under resourced," Tr. 1616:25, and hence would not ensure that each patient received a comprehensive mental-health assessment before beginning treatment. D185 at 45.

8. The circuit court did not err in considering fertility impacts.

Contrary to Appellants' assertion, Opening Br. 91-92, the circuit court was able to conclude that the treatments at issue here can render children permanently infertile. *See, e.g.*, 2058:2–25; *see also* D185 at 25 (recounting testimony of how a person must go through "natural puberty" to conceive, but that puberty blockers and hormones interfere with this process); D185 at 25–26 (recounting testimony of women witnesses who detransitioned and now experience "highly variable, inconsistent cycles"). So too does the *Skrmetti* decision. *See* 145 S. Ct. at 1835 (crediting evidence that such treatments render children sterile).

Appellants' own expert conceded that medical interventions do impact fertility and that—at best—there is no data showing the actual long-term

effects of treatment on fertility. Tr. 339:12–20. Hence, at the very least, the "medical and scientific uncertainties" regarding long-term effects on fertility gave the legislature a rational basis for restricting medical interventions per the SAFE Act. *James*, 534 S.W.2d at 43; *see* Cass Report 184 (discussing lingering uncertainties regarding the effects of treatments on fertility and overall health).

9. This Court cannot reweigh the credibility of Ms. Reed's testimony.

Given her damning testimony regarding the Washington University Clinic, Appellants unsurprisingly attempt to discredit Jamie Reed's testimony. Opening Br. 96–98. They overplay their hand. Ultimately, Appellants' complaints go to the credibility of Ms. Reed's accounts and how much value should have been accorded her statements. *Id.* Appellants' efforts to relitigate the particulars of her testimony fall flat. *See Care & Treatment of Barlow v. State*, 250 S.W.3d 725, 733 (Mo. W.D. App. 2008) ("Matters of credibility and weight of testimony are for the factfinder to determine.").

10. This Court cannot generally reweigh portions of evidence.

Appellants fault the circuit court for rejecting their evidence regarding suicidality. Opening Br. 92–93. They also quibble with the court's conclusion that the majority of children complaining of gender dysphoria will outgrow the symptoms. *Id.* at 94–96. They likewise assert that the trial court "overread[]"

testimony regarding "lax treatment protocols." *Id.* at 96–98. And Appellants attack the circuit court's finding that a lack of consensus exists regarding the ethics of subjecting adolescents to transgender treatments. Opening Br. 99–101. But, as is all-to-well established, "courts are free to believe any, all, or none of the evidence presented at trial." *Ivie*, 439 S.W.3d at 200; *accord Chan v. Chan*, 704 S.W.3d 761, 768 (Mo. W.D. App. 2025) ("[T]he factfinder is not required to accept all evidence uncritically or weigh all evidence equally; rather, the factfinder is entitled to believe all of the evidence, some of the evidence, or none of the evidence and to resolve contradictory evidence.").

Appellants' gripes that the trial court chose not to credit particular bits of evidence go nowhere. *See Davis*, 346 S.W.3d at 322 ("If facts are contested, [the appellate court is] obliged to defer to the trial court's determination of those facts."). And indeed, WPATH itself has said "that psychotherapy is an appropriate treatment, calling it 'highly recommended' and saying it can 'greatly facilitate the resolution of gender dysphoria' because, through this therapy, individuals can 'integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body." D185 at 11–12 (quoting Ex. 1008, WPATH Standards of Care). Moreover, testimony in the record by Appellants' witnesses demonstrated that suicidality can remain a risk, even for those undergoing transgender treatments. *See, e.g.*, Tr. 563:18–25; Tr. 635:3–10; Tr. 687:18–23.

And another witness described how both testosterone and estrogen come with side effects, including "increased anxiety, increased suicidality." Tr. 2199:15-17. Hence, the court was not without evidence to credit the State's arguments regarding suicidality.

11. Appellants' arguments regarding rapid-onset-gender-dysphoria and bicalutamide fail.

Appellants oddly contend that the circuit court made "several findings based upon the discredited theory of 'rapid onset gender dysphoria.'" Opening Br. 93. But they fail to include a single citation to where the circuit court made such findings—instead simply relitigating why the theory is (supposedly) wrong. *See id.* at 93–94. The same goes for a discussion of bicalutamide. *See id.* at 99. By not pointing to instances where the trial court erred on these points, Appellants, "fail[ed] to develop any argument as to why" the court (as opposed to the contrary evidence) was wrong—hence the points are waived. *Cohen v. Cohen*, 73 S.W.3d 39, 52 (Mo. W.D. App. 2002).

And regardless, their arguments fail. Regarding bicalutamide, one of Appellants' expert witnesses noted "concern about potential liver problems" from taking bicalutamide and explained that these concerns were why WPATH has not fully endorsed its use. Tr. 408:10–13. And with respect to the increase and changes in populations seeking transgender treatments, Dr. Olson-Kennedy acknowledged that such changes were occurring. Tr. 606:15–22. Ms.

Reed also testified that the Washington University Clinic treated approximately 73% natal females compared to 26% natal males—a reverse of historical patterns. Tr. 1606:5–10; *accord* Tr. 1803:6–1804:8 (expert testimony noting the reversal and differences in ages).[9] The causal question is yet another issue around which "uncertainty persists." *See Carhart*, 550 U.S. at 163; *see also Mo. State Conf. of Nat'l Ass'n for the Advancement of Colored People v. State*, 607 S.W.3d 728, 733 (Mo. banc 2020) ("This Court should not second-guess the wisdom or policy of a legislative enactment.").

12. The court did not err in its findings regarding surgery.

Appellants make scattershot points regarding record evidence pertaining to surgery. Opening Br. 98–99. They first fault the trial court for saying that experts agree "that no person under eighteen years of age should receive surgical treatment for gender dysphoria." D185 at 10. Appellants say that this statement is factually incorrect given record evidence that refers to chest-masculinizing surgery and implants of puberty blockers. Opening Br. 98. Appellants' critique of the court's phrasing is misplaced. The cited language is somewhat ambiguous and can be understood in context to refer to the more drastic surgical interventions regarding genitalia. Read that way, there is no

[9] Appellants once again take issue with the circuit court's reliance on the Cass Report. As already explained, other judicial authorities have relied on the Cass Report—making it appropriate for judicial notice.

contradiction with the record—dispensing with Appellants' nitpick of the decision. *See* Tr. 332:5–8 (Appellants' expert agreeing that genital surgical interventions are "reserved for adults").

Appellants also take issue with the trial court's statement that they did not provide "any evidence about the safety or efficacy of various surgeries." D185 at 42. Appellants say that Drs. Olson-Kennedy and Janssen testified about the beneficial impact of surgeries. Opening Br. 98–99. That misses the point of what the circuit court found: The court's focus was on the risks posed by surgery, not its supposed benefits. D185 at 42. Appellants point to no record evidence showing that the court's concerns regarding safety and long-term negative impacts were unfounded. *See* Opening Br. 98–99. Once again, the trier of fact was free to weigh the evidence before it—here, describing the experience of a detransitioner witness—and disregard evidence proffered by the Appellants. *See Cohen*, 73 S.W.3d at 52.[10]

[10] The circuit court was well within its discretion to doubt the credibility of Dr. Olson-Kennedy as a witness. Among other issues, Dr. Olson-Kennedy has refused to publish studies and regularly told parents that if they did not agree with allowing their child to transition, the child "would commit suicide." Priscilla DeGregory, *Prominent Doctor Accused of Pushing Pre-Teen into Puberty Blockers, Mastectomy Sued for Medical Negligence*, N.Y. Post (Dec. 6, 2024), https://nypost.com/2024/12/06/us-news/la-dr-johanna-olson-kennedy-accused-of-pushing-pre-teen-into-puberty-blockers-mastectomy-sued-for-medical-negligence; *accord* Nicholas Confessore, *How the Transgender Rights Movement Bet on the Supreme Court and Lost*, N.Y. Times Mag. (June 19, 2025), https://www.nytimes.com/2025/06/19/magazine/scotus-transgender-care-tennessee-skrmetti.html. Dr. Olson-Kennedy also admitted in her

13. The court did not err in describing the Dutch Protocol.

Appellants also take issue with the trial court's descriptions of the "Dutch Protocol." *See, e.g.*, D185 at 12, 14–15. Appellants' scattershot complaints about the court's discussion of the protocol are perplexing because the court merely cited the protocol in its discussion of the historical development of gender-dysphoria treatment. *See id.*; *see also* D185 at 51–52. And the Protocol's importance was discussed at length by Appellants' own expert, Dr. Olson-Kennedy. *See* Tr. 508:6–16, 510:3–511:17. Other testimony also noted "numerous limitations, scientific limitations of the Dutch protocol." Tr. 2432:25–2433:1. The Cass Report itself noted, "Today's population is different from that for which clinical practice was developed with a higher proportion of birth-registered females presenting in adolescence." Cass Report 97. The court did not err in looking to these discussions of the Dutch Protocol.

14. Appellants remaining contentions would change nothing.

Finally, Appellants lodge several nitpick errors that they claim lack record support. They include either disputed issues of fact where the trial court chose not to credit Appellants' evidence—such as whether a medical consensus

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testimony, "I've always been involved in social-justice movements, and this idea that my training as a physician could play a role in a human-rights movement was very compelling to me." Tr. 696:21–697:4. Hence, the court had a basis for concluding that Dr. Olson-Kennedy's opinions were colored by social ideology rather than scientific analysis.

exists for the treatment of adolescents—and other disputes about unadmitted exhibits. *See* Opening Br. 102–03. Assuming that any of these qualify as error (as opposed to the circuit court's declining to credit Appellants' evidence), they are too minor to affect the judgment in this case. A putative error cannot "constitute reversible error" when "other competent evidence supported the judgment." *T.R.P. v. B.B.*, 553 S.W.3d 398, 403 (Mo. E.D. App. 2018). Appellants never explain how any of these "more discrete examples of error," Opening Br. 102, tipped the balance of this case—especially given all the other evidence that the court was indisputably free to weigh or otherwise consider.

B. Even if the court did err in considering particular evidence, there is no basis for reversal.

Because—at most—the evidence "poses two reasonable but different conclusions," this Court "must defer to the circuit court's assessment of that evidence." *Ivie*, 439 S.W.3d at 206. For all the reasons explained, Appellants have failed to show that "the circuit court could not have reasonably found" any of the factual matters discussed—let alone a sufficient number of them to undermine the circuit court's judgment. *Id.*

But all told, Appellants' sifting the trial-court's decision for error also proves an unqualifiedly futile exercise. So long as the General Assembly had some conceivable basis for enacting this legislation, it passes constitutional muster. *See Poole & Creber*, 125 S.W.2d at 1147 (providing that so long as the

court can conceive of "any reasonable basis upon which the legislation may constitutionally rest," then the legislation is upheld). Even if the circuit court committed some evidentiary errors, the record as a whole would still show scientific and medical disagreement giving a rational basis for looking to protect children from controversial and potentially devastating medical treatments. *See Brandt*, 2025 WL 2317546, at *6–7 (noting the same for the record in that case). Nothing more is needed to sustain the judgment—and a reversal and remand would be a cumbersome and pointless waste of judicial resources. *See id.* (declining to remand for further factual findings); *see also Bigelow v. Virginia*, 421 U.S. 809, 826–27 (1975) (explaining that remand is unnecessary when "the outcome is readily apparent").

VI. The Circuit Court Did Not Err in Admitting and Relying Upon Testimony Offered by Respondents' Experts (Response to Point Relied On VIII).

Standard of Review: "This Court reviews a circuit court's decision to admit or exclude expert testimony for an abuse of discretion." *Spalding v. Stewart Title Gnty. Co.*, 463 S.W.3d 770, 778 (Mo. banc 2015). Experts may provide testimony if, *inter alia*, they possess "scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence." Mo. Rev. Stat. § 490.065. "A circuit court abuses its discretion when its 'ruling is clearly against the logic of the circumstances then before the court and is so unreasonable and arbitrary that it shocks the sense of justice and indicates a

lack of careful, deliberate consideration.'" *Shallow*, 554 S.W.3d at 881. And this Court will "not reverse a circuit court's judgment unless the error materially affected the merits of the action." *Id.*

A. The court properly admitted testimony by Dr. Curlin.

Appellants contend that the circuit court erred in permitting expert testimony by Dr. Curlin. Opening Br. 108-10. For the reasons detailed below, the court did not impermissibly accept and credit his testimony. But even if the circuit court erred in admitting such testimony, that would not change the outcome of this case. Again, because this Court can conclude that the legislature had a rational basis for passing the laws at issue from the record already before it, *see Brandt*, 2025 WL 2317546, at *6–7, the Court need not detain itself with Appellants' claims that the State's experts were not qualified to testify. Opening Br. 108–13.[11]

Appellants take issue with Dr. Curlin's testifying as an expert respecting medical ethics because "he has 'little or no experience treating transgender patients and no specialized training in the field.'" Opening Br. 110–11. But Dr.

[11] Appellants also engage in a smear campaign against other expert witnesses, including Dr. Cantor. They accuse him of expressing homophobic and transphobic views by saying that those with a pedophilic orientation "should be included within the LGBT+ umbrella." Opening Br. 32. But Dr. Cantor is himself a gay man. Tr. 1877:15. And Appellants fail to articulate how Dr. Cantor's desire "to help [pedophiles] manage" their attractions and thus protect children exhibits some deep-seated bias against the transgender community. Tr. 1878:13–19.

Curlin was not called to opine on how to treat transgender patients—he was retained to opine on the significant ethical issues surrounding subjecting children and adolescents to unproven treatments with long-term, life altering consequences. *See* Tr. 2344:19–20 (explaining that the principles he applied to the questions raised here "apply broadly across the practice of medicine). He was eminently qualified to do so—having studied, taught, written, and consulted on medical ethics in a variety of contexts. *See* Tr. 2336:9–2341:3.

Even Dr. Curlin's practice experience in hospice and palliative care, which Appellants disparagingly highlight, Opening Br. 108, has allowed him to refine and apply his understanding of medical ethics in actual practice. *See Liberty Fin. Mgmt. Corp. v. Beneficial Data Processing Corp.*, 670 S.W.2d 40, 55 (Mo. E.D. App. 1984) ("Any expert witness represents the distillation of the total of his personal experiences, readings, studies and learning in his field of expertise; and he may rely on such background, hearsay or not, as basis for his opinion."); Tr. 2405:18–2406:22 (offering assessment based on his experience). Appellants' belated efforts to question his expert credibility therefore go nowhere.[12]

[12] Appellants did not raise these concerns during their voir dire examination of Dr. Curlin or otherwise oppose his testimony as an expert in medical ethics. Tr. 2342:12–2343:16.

Appellants' assertion that Dr. Curlin's opinion is unsupported by "a single major American medical association," Opening Br. 110, hardly disqualifies him as an expert in this context.[13] The U.S. Supreme Court has recognized the "rising debates regarding the relative risks and benefits of such [transgender] treatments." *Skrmetti*, 145 S. Ct. at 1825. Sadly, vogue politics—not dispassionate science—have come to prescribe the orthodoxy that "major American medical association[s]" follow on transgender matters. *See id.* at 1848–49 (Thomas, J., concurring) (describing the political and ideological pressure brought to bear on WPATH in setting its guidelines). Given this unfortunate reality, Dr. Curlin's position as a dissenting voice on the ethical questions at stake here does not disqualify him. What matters instead is that the expert "give opinions based on facts and data reasonably relied upon by

[13] Appellants' assertion is also factually untrue. The American Society for Plastic Surgeons has acknowledged "that there is considerable uncertainty as to the long efficacy" of gender transition medical treatments and that "the existing evidence base is viewed as low quality/low certainty." ASPS Statement to Press Regarding Gender Surgery for Adolescents (August 14, 2024), https://www.plasticsurgery.org/for-medical-professionals/publications/psn-extra/news/asps-statement-to-press-regarding-gender-surgery-for-adolescents. The American College of Pediatricians and the American Association of Physicians and Surgeons also do not affirm medical or surgical interventions on minors for treatment of gender dysphoria. Tr. 2078:1–15. Hence, members of the American medical establishment do support Dr. Curlin's position that transgender medical treatments for minors raises serious medical-ethics concerns.

experts in the field." *Moheet v. State Bd. of Registration for Healing Arts*, 154 S.W.3d 393, 403 (Mo. W.D. App. 2004).

Appellants make no claim that Dr. Curlin departed from how other medical ethicists would evaluate the issues here. Opening Br. 108–11. And, sure enough, countries and institutions willing to follow the science have found themselves in agreement with Dr. Curlin. *See Skrmetti*, 145 S. Ct. at 1825–26 ("Meanwhile, 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. . . . [T]he Norwegian Healthcare Investigation Board concluded that the 'research-based knowledge' for hormonal sex transition treatments for minors is 'insufficient,' while the 'long-term effects are little known.'"). Thus, Appellants fail to show that Dr. Curlin's testimony was impermissible.

B. The trial court properly admitted testimony by Dr. Lappert.

Appellants likewise claim error in permitting Dr. Lappert to testify. Opening Br. 111–13. Their attempt to tarnish Dr. Lappert fails for much the same reasons—the fact that he dissents from the American-medical establishment does not preclude his ability to serve as an expert witness. Dr. Lappert is an experienced plastic and reconstructive surgeon, hence why the State offered him to opine on the ethical and practical issues raised by surgical

transgender interventions. *See* Tr. 2527:12–2528:3. He went on to explain (in graphic detail) how healthy components of the body are removed and the complications that can follow surgery. In the case of chest surgery, a natal female who undergoes a mastectomy will permanently lose her ability to breastfeed and face the potential for "varying degrees of numbness" or hypersensitivity in the chest. Tr. 2549:1–2552:18.

Dr. Lappert likewise graphically explained the harmful and irreversible outcomes that can follow removal and construction of genitalia—namely infection risk and urinary complications, among other unpleasant potential outcomes related to bodily functions. Tr. 2562:4–2565:7, 2568:4–25, 2569:20–2571:16 (male to female transition); Tr. 2579:1–2581:17 (female to male transition). Dr. Lappert even highlighted an increased cancer risk following these surgeries because the combination of stem cells associated with healing chronic wounds and increased sex hormones can create malignancies. Tr. 2565:10–2566:9. He also testified about how those who have not reached sexual maturity because of puberty-blocker use do not "develop enough tissue" for surgeons to perform these surgeries properly. Tr. 2602:2–18. He explained that any surgeon who would attempt such a surgery would need to engage in more novel surgeries (such as using colon tissue) with greater risks of complications. Tr. 2603:2–2604:1. Dr. Lappert also emphasized how plastic surgeons have lost certification for unethically removing healthy limbs of patients with body-

identity disorder. Tr. 2595:8–17. The excruciating details of the surgeries and their potential complications only underscore why the legislature—under any level of scrutiny—can ban such procedures on minors.

Appellants also try to character-assassinate Dr. Lappert as a zealous opponent of transgender care. Opening Br. 112. Context rebuts their effort. When confronted with his prior statements, Dr. Lappert made clear that he felt strongly that these procedures are based "on a lack of scientific information" and that they will only inflict "harms to people that are not supported by benefits." Tr. 2611:9–15. Those are hardly the sentiments of a bigot, but merely an embrace of the core medical commitment to do no harm. Appellants therefore fail to show that the court erred in permitting Dr. Lappert's testimony.[14]

CONCLUSION

For the reasons explained above, this Court should affirm the circuit court's decision and uphold Missouri's SAFE Act as constitutional.

[14] Appellants' contention that Dr. Lappert has exhibited impermissible "bias" is quite rich given the noted issues with Dr. Olson-Kennedy. *See supra* note 9. If Dr. Lappert's prior statements exhibit disqualifying bias, then so too do Dr. Olson-Kennedy's. *See* Azeen Ghorayshi, *U.S. Study on Puberty Blockers Goes Unpublished Because of Politics, Doctor Says*, N.Y. Times (Oct. 23, 2024), https://www.nytimes.com/2024/10/23/science/puberty-blockers-olson-kennedy.html (explaining that Dr. Olson-Kennedy was withholding publication of a study because it could be used to confirm that "we shouldn't use blockers").

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief contains 21,067 words, is in compliance with Missouri Supreme Court Rule 84.06(b), includes the information required by Rule 55.03, and includes information on how the brief was served on the opposing party.

/s/ Louis J. Capozzi III

CERTIFICATE OF SERVICE

I hereby certify that, on September 2, 2025, a true and correct copy of the foregoing was filed with the Court's electronic filing system to be served by electronic methods on counsel for all parties entered in the case.

/s/Louis J. Capozzi III