In the
Supreme Court of Ohio

MADELINE MOE, *et al.*,	)	Case No. 2025-0472
	)	
Plaintiffs-Appellees,	)	On Appeal from the Franklin County Court of Appeals,
	)	
v.	)	Tenth Appellate District
	)	
DAVE YOST, *et al.*,	)	Court of Appeals
	)	Case No. 24AO-483
Defendants-Appellants.	)	

BRIEF OF *AMICI CURIAE* STATE OF ALABAMA AND 23 OTHER STATES IN SUPPORT OF JURISDICTION

Freda J. Levenson (0045916)
Counsel of Record
Amy Gilbert (100887)
ACLU OF OHIO FOUNDATION, INC.
4506 Chester Ave.
Cleveland, OH 44103
(614) 586-1972
flevenson@acluohio.org
agilbert@acluohio.org

David J. Cary (0088787)
Carlen Zhang-D'Souza (0093079)
ACLU OF OHIO FOUNDATION, INC.
1108 City Park Ave., Ste. 203
Columbus, OH 43206
(614) 586-1072
dcarey@acluohio.org
czhangdsouza@acluohio.org
Counsel for Appellees Madeline Moe et al.

Steve Marshall
Attorney General of Alabama
Edmund G. LaCour Jr. (PHV-29432-2025)
Solicitor General
Counsel of Record
STATE OF ALABAMA
OFFICE OF THE ALABAMA ATTORNEY GENERAL
501 Washington Avenue
Montgomery, AL 36130
(334) 353-2196
edmund.lacour@AlabamaAG.gov
Counsel for State of Alabama as amicus curiae

Dave Yost (0056290)
Ohio Attorney General
T. Elliot Gaiser (0096145)
Solicitor General
Counsel of Record
Erik Clark (0078732)
Deputy Attorney General
Stephen P. Carney (0063460)
Deputy Solicitor General
Amanda Narog (0093954)
Assistant Attorney General
30 East Broad St., 17th Floor
Columbus, OH 43215
(614) 466-8980
thomas.gaiser@ohioago.gov
Counsel for Appellants Dave Yost, et al.

TABLE OF CONTENTS

INTRODUCTION

By its own account, the Tenth District's reasoning rises or falls with WPATH—the World Professional Association for Transgender Health. Based on its cherrypicked reading of amicus briefs in a challenge before the Supreme Court of Tennessee's similar law,[1] the Tenth District concluded that WPATH is "considered the standard-bearer[] in gender-affirming care" and that its guidelines "are the current prevailing standards of care for the treatment of individuals with gender dysphoria." *See Moe v. Yost*, 2025-Ohio-941 (10th Dist.) ("Op."), ¶¶14, 19; *see also* ¶¶13 & n.8, 70 & n.32 (discussing amicus briefs supporting WPATH).[2] The court's legal analysis was based on this factual finding. As it wrote, the court "consider[ed] the constitutional issues in this case by accepting the [WPATH] Guidelines as the prevailing standards of care." Op.¶20.

For all the reasons the Ohio Attorney General explains in his brief, it is dubious that the Ohio Constitution outsources the State's regulation of medicine to the very interest group whose members are being regulated. So the Tenth District's starting premise is almost certainly wrong. If the General Assembly wished to regulate the prescription of opioids, for instance, it could do so in the face of conflicting "guidelines" by the American Pain Society. So, too, could it restrict children's access to opioids—again, even if the American Pain Society, and even if the child's parents, thought differently. So here. This is a substantial constitutional issue that this Court should resolve.

This Court should grant review for another reason. Even under the Tenth District's faulty reasoning, its decision should be reversed because the WPATH guidelines are simply not

[1] *See United States v. Skrmetti*, No. 23-477 (argued Dec. 4, 2024).

[2] The Tenth District also relied on the 2017 Endocrine Society Guidelines, Op. ¶13, but WPATH authored those guidelines, too. *See* Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102 J. CLIN. ENDOCRINOL. & METAB. 3869 (2017), https://perma.cc/NQK3-HYAV. Indeed, as the Cass Review for England's National Health Service explained, pretty much all the "gender-affirming" guidelines in this area are WPATH's in some form or fashion. *See* CASS REVIEW 126-30 (Apr. 2024), https://perma.cc/3QVZ-9Y52.

trustworthy. When Alabama was sued over its similar law by plaintiffs who also pointed to WPATH, Alabama obtained court-ordered discovery from WPATH to learn how its guidelines were actually made.[3] The reality did not match the Tenth District's promise of "evidence-based standards." Op.¶17. Just the opposite. As one author of the guidelines put it in explaining why his chapter was *not* seeking a review of the evidence to inform its recommendations: "Our concerns, echoed by the social justice lawyers we spoke with, is that evidence-based review reveals little or no evidence and puts us in an untenable position in terms of affecting policy or winning lawsuits."[4] As this case confirms, WPATH has been successful at both goals. But the cost of WPATH's success has been far too high: countless families who relied on WPATH to provide "evidence-based standards" and got ideology masquerading as medicine instead. A recent comprehensive review by the U.S. Department of Health and Human Services summed up the situation well: Even though WPATH's guidelines "have been rated among the lowest in quality and have not been recommended for implementation by systematic reviews of guidelines," they are "embedded in nearly all aspects of healthcare" in the United States.[5] The people of Ohio were right to reject these "standards." The Court should accept jurisdiction and reverse.

INTEREST OF *AMICI CURIAE*

Like Ohio, *amici* States determined that sex-change procedures should not be made

[3] *See generally* Brief of Alabama as *Amicus Curiae*, No. 23-477, *United States v. Skrmetti* (U.S. Oct. 15, 2024) (discussing evidence Alabama uncovered in discovery.)

[4] *See* Defs' Ex. 184 at 1-2, *Boe v. Marshall*, 2:22-cv-184 (M.D. Ala.), Doc. 560-24. Throughout this brief, *amici* will reference evidence and briefing Alabama submitted to the district court in its case. Citations will be by exhibit number followed by the docket entry in parenthesis and the internal page number following the colon. E.g., Ex.174(Doc.560-24):1-2. For ease of reference, cited exhibits and briefing are available online: https://www.alabamaag.gov/boe-v-marshall/

[5] *See* Dep't of Health & Human Servs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* (May 1, 2025), https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf.

available to kids. That determination should not be controversial. Until a few years ago, the notion of providing sex-change procedures to children was practically unthinkable. So was the idea that the judiciary is the best branch to sort through the evidence and decide that kids suffering from gender dysphoria must be allowed to take powerful hormones that risk permanently changing their bodies and leaving them sterilized. *Amici* write to share a little about how we got here.

STATEMENT

I. The WPATH Guidelines Are Not Reliable.

WPATH published Standards of Care 8 (SOC-8) in September 2022.[6] Dr. Eli Coleman, a sexologist at the University of Minnesota, chaired the guideline committee, and WPATH hired an outside evidence-review team, led by Dr. Karen Robinson at Johns Hopkins University, to conduct systematic evidence reviews for authors to use in formulating their recommendations.[7] Two WPATH presidents, Dr. Walter Bouman, a clinician at the Nottingham Centre for Transgender Health in England, and Dr. Marci Bowers, a surgeon in California who has performed over 2,000 transitioning vaginoplasties, oversaw development and publication of the guideline.

A. WPATH Intentionally Used SOC-8 to Advance Political and Legal Goals.

WPATH selected 119 authors—all existing WPATH members—to contribute to SOC-8.[8] According to Dr. Bowers, it was "important" for each author "to be an advocate for [transitioning] treatments before the guidelines were created."[9] Many authors regularly served as expert witnesses to advocate for sex-change procedures in court; Dr. Coleman testified that he thought it was "ethically justifiable" for those authors to "advocate for language changes [in SOC-8] to strengthen

---

[6] *See* Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. OF TRANSGENDER HEALTH (2022), https://perma.cc/Y9G6-TP3M.
[7] SOC-8, *supra* note 6, at S248-49.
[8] SOC-8, *supra* note 6, at S248-49; *see* Ex.21(Doc.700-3):201:2–223:24.
[9] Ex.18(Doc.564-8):121:7-11.

[their] position in court."[10] Other contributors seemed to concur. One wrote: "My hope with these SoC is that they land in such a way as to have serious effect in the law and policy settings that have affected us so much recently; even if the wording isn't quite correct for people who have the background you and I have."[11] Another chimed in: "It is abundantly clear to me when I go to court on behalf of TGD [transgender and gender-diverse] individuals" that "[t]he wording of our section for Version 7 has been critical to our successes, and I hope the same will hold for Version 8."[12]

Perhaps for this reason—and because it knew that "we will have to argue it in court at some point"[13]—WPATH commissioned a legal review of SOC-8 and was in regular contact with movement attorneys.[14] Dr. Bouman noted the oddity: "The SOC8 are clinical guidelines, based on clinical consensus and the latest evidence based medicine; [I] don't recall the Endocrine Guidelines going through legal reviews before publication, or indeed the current SOC?"[15] The WPATH Executive Committee discussed various options for the review—"ideas; ACLU, TLDEF, Lambda Legal…"[16]—before apparently settling on the senior director of transgender and queer rights at GLAD (and counsel for plaintiffs in Alabama's case) to conduct the review.[17]

Authors were explicit in their desire to tailor SOC-8 to ensure coverage for an "individual's embodiment goals,"[18] whatever they might be. As Dr. Dan Karasic, one of the plaintiffs' experts in Alabama's case, explained to other contributors: "Medical necessity is at the center of dozens

[10] Ex.21(Doc.700-3):158:17-25.
[11] Ex.184(Doc.700-13):24.
[12] Ex.184(Doc.700-13):15.
[13] Ex.182(Doc.700-11):152.
[14] Ex.4(Doc.557-4):vi.
[15] Ex.182(Doc.700-11):151.
[16] Ex.184(Doc.700-13):14.
[17] SOC-8, *supra* note 6, at S177.
[18] Ex.180(Doc.700-9):11.

of lawsuits in the US right now";[19] "I cannot overstate the importance of SOC 8 getting this right at this important time."[20]

At Dr. Karasic's urging, WPATH thus included a whole section in SOC-8 on "medical necessity."[21] It also made sure to sprinkle the "medically necessary" moniker throughout the guideline, even when doing so revealed it had put the cart before the horse. The adolescent chapter, for instance, notes that "[a] key challenge in adolescent transgender care is the quality of evidence evaluating the effectiveness of medically necessary gender-affirming medical and surgical treatments,"[22] but WPATH never paused to ask (or answer) how such treatments can be considered "medically necessary" if the "quality of evidence" supporting their use is so deficient. At least some authors tacitly acknowledged the question and made sure they wouldn't have to answer it—by following the advice of "social justice lawyers" to avoid conducting evidence reviews.[23]

B. WPATH Changed Its Treatment Recommendations Based on Politics.

Outside political actors also influenced SOC-8. Most notably, Admiral Levine, the Assistant Secretary for Health during the Biden Administration, met regularly with WPATH leaders, "eager to learn when SOC 8 might be published."[24] A few months before SOC-8 was to be published in September 2022 (and long after the public comment period had closed that January[25]), WPATH sent Levine an "Embargoed Copy – For Your Eyes Only" draft of SOC-8 that had been "completed" and sent to the publisher.[26] The draft included a departure from Standards of Care 7,

[19] *Id.* at 64.
[20] Ex.181(Doc.700-10):43.
[21] SOC-8, *supra* note 6, at S18.
[22] *Id.* at S45-46.
[23] Ex.174(Doc.560-24):1-2.
[24] Ex.184(Doc.700-13):54.
[25] *See* Ex.187(Doc.700-16):4-5.
[26] Ex.170(Doc.700-4):61-64.

which, except for so-called "top surgeries," restricted transitioning surgeries to patients who had reached the "[a]ge of majority."[27] The draft SOC-8 relaxed the age minimums: 14 for cross-sex hormones, 15 for "chest masculinization" (i.e., mastectomy), 16 for "breast augmentation, facial surgery (including rhinoplasty, tracheal shave, and genioplasty)," 17 for "metoidioplasty, orchiectomy, vaginoplasty, hysterectomy and fronto-orbital remodeling," and 18 for "phalloplasty."[28]

After reviewing the draft, Levine's office contacted WPATH with a political concern: that the listing of "specific minimum ages for treatment," "under 18, will result in devastating legislation for trans care."[29] WPATH leaders met with Levine to discuss the age recommendations.[30] Levine's solution was simple: "She asked us to remove them."[31]

WPATH initially told Levine that it "could not remove [the age minimums] from the document" because the recommendations had already been approved by SOC-8's "Delphi" consensus process.[32] (Indeed, Dr. Coleman said that consensus was "[t]he only evidence we had" for the recommendations.[33]) But, WPATH continued, "we heard your comments regarding the minimal age criteria" and, "[c]onsequently, we have made changes to the SOC8" by downgrading the age "recommendation" to a "suggestion."[34] Unsatisfied, Levine immediately requested—and received—more meetings with WPATH.[35]

Following Levine's intervention, and days before SOC-8 was to be published, pressure

---

[27] Coleman, *Standards of Care, Version 7*, 13 INT'L J. OF TRANSGENDERISM 1, 25-27 (2012), https://perma.cc/T8J7-W3WC.
[28] Ex.170(Doc.700-4):143.
[29] Ex.186 (Doc.700-15):28.
[30] *See* Ex.186 (Doc.700-15):11, 17; Ex.21(Doc.700-3):287:5–288:6.
[31] Ex.186 (Doc.700-15):11.
[32] *Id.* at 17.
[33] *Id.* at 57.
[34] *Id.* at 17.
[35] *See* Ex.18(Doc.564-8):226:8–229:18; Ex.186 (Doc.700-15):73, 88-91.

from the American Academy of Pediatrics (AAP) tipped the scales when it threatened to oppose SOC-8 if WPATH did not remove the age minimums.[36] WPATH leaders initially balked. One of the co-chairs of SOC-8 complained that "[t]he AAP guidelines … have a very weak methodology, written by few friends who think the same."[37] But the political reality soon set in: AAP was "a MAJOR organization," and "it would be a major challenge for WPATH" if AAP opposed SOC-8.[38] WPATH thus "remove[d] the ages."[39]

That is concerning enough. But perhaps even more worrisome is what the episode reveals. *First*, it shows that politicians and AAP sought, and WPATH agreed, to make changes in a clinical guideline recommending irreversible sex-change procedures *for kids* based purely on political considerations. Dr. Coleman was clear in his deposition that WPATH removed the age minimums without allowing authors to vote on the change and "without being presented any new science of which the committee was previously unaware."[40]

Second, as soon as WPATH made the change, it treated the decision as "highly, highly confidential."[41] Dr. Bowers encouraged contributors to submit to "centralized authority" so there would not be "differences that can be exposed."[42] Having decided the strategy, Bowers then crafted the message, circulating internally the "gist of my[] response to Reuters" about the missing age minimums: "[S]ince the open comment period, a great deal of input has been received and continued to be received until the final release. [I] feel the final document puts the emphasis back on

[36] Ex.187(Doc.700-16):13-14, 109.
[37] *Id.* at 100.
[38] *Id.* at 191.
[39] *Id.* at 338.
[40] Ex.21(Doc.700-3):293:25–295:16.
[41] Ex.188(Doc.700-17):152.
[42] Ex.177(Doc.700-6):124.

individualized patient care rather than some sort of minimal final hurdle that could encourage superficial evaluations and treatments."[43] Another leader responded: "I like this. Exactly—individualized care is the best care—that's a positive message and a strong rationale for the age change."[44] Apparently, it didn't matter that the explanation was false. As Dr. Bowers explained in a similar exchange, "it is a balancing act between what i feel to be true and what we need to say."[45]

C. WPATH Failed to Properly Manage Conflicts of Interest.

At the back of SOC-8 is an appendix with the methodology WPATH said it employed.[46] Among other things, it boasts that WPATH managed conflicts of interest and engaged an evidence-review team to conduct systematic literature reviews.[47] Discovery revealed a different story.

WPATH cites two standards it said it used to manage conflicts of interest: one from the National Academies of Medicine and the other from the World Health Organization.[48] Both standards generally recognize that the experts best equipped for creating practice guidelines are those at arm's length from the services at issue—sufficiently familiar with the topic, but not professionally engaged in performing, researching, or advocating for the practices under review.[49]

At the same time, the standards recognize that a guideline committee typically benefits from *some* involvement by clinicians who provide the services at issue.[50] Accordingly, they suggest ways for committees to benefit from conflicted clinicians while limiting their involvement.

---

[43] Ex.188(Doc.700-17):113.
[44] *Id.*
[45] Ex.177(Doc.700-6):102.
[46] *See* SOC-8, *supra* note 6, at S247-51.
[47] *Id.*
[48] *Id.* at S247.
[49] *Id.*; Institute of Medicine (National Academies of Medicine), *Clinical Practice Guidelines We Can Trust* 81-93 (2011), https://perma.cc/7SA9-DAUM; World Health Organization, *Handbook for Guideline Development* 19-23 (2012).
[50] Institute of Medicine, *supra* note 49, at 83.

The standard from the National Academies recommends that "[m]embers with [conflicts of interest] should represent *not more than a minority* of the [guideline development group]."[51]

WPATH largely ignored these standards. From the get-go, it expressly limited SOC-8 authorship to existing WPATH members—clinicians and other professionals (and non) who were *already* enthusiastic about transitioning treatments.[52] As Dr. Bowers testified, it was "important for someone to be an advocate for [transitioning] treatments before the guidelines were created."[53]

Dr. Bowers's involvement in SOC-8 offers a good illustration of the lack of real conflict checks. According to the National Academies, a "conflict of interest" is "[a] divergence between an individual's private interests and his or her professional obligations such that an independent observer might reasonably question whether the individual's professional actions or decisions are motivated by personal gain, such as financial, academic advancement, clinical revenue streams, or community standing."[54] Bowers should have been subject to that standard, serving not only as a member of the Board that oversaw and approved SOC-8 but as an author of the chapter tasked with evaluating the evidence for transitioning surgeries. So it is notable that Bowers made "more than a million dollars" in 2023 from providing transitioning surgeries, but said it would be "absurd" to consider that a conflict worth disclosing or otherwise accounting for as part of SOC-8.[55] That was WPATH's public position as well: It assured readers that "[n]o conflicts of interest were deemed significant or consequential" in crafting SOC-8.[56]

Privately, WPATH leaders knew everything was not up to par. Dr. Coleman admitted that

---

[51] *Id.* (emphasis added).
[52] SOC-8, *supra* note 6, at S248; *see* Ex.21(Doc.700-3):201:2–223:24.
[53] Ex.18(Doc.564-8):121:7-11.
[54] Institute of Medicine, *supra* note 49 , at 78.
[55] Ex.18(Doc.564-8):37:1-13, 185:25–186:9.
[56] SOC-8, *supra* note 6, at S177.

"most participants in the SOC-8 process had financial and/or nonfinancial conflicts of interest."[57] Dr. Robinson, the chair of the evidence-review team, said the same: She "expect[ed] many, if not most, SOC-8 members to have competing interests."[58] She even had to inform WPATH—belatedly—that "[d]isclosure, and any necessary management of potential conflicts, should take place *prior* to the selection of guideline members."[59] "Unfortunately," she lamented, "this was not done here."[60] No matter: SOC-8 proclaims the opposite ("Conflict of interests were reviewed as part of the selection process"[61]), and Dr. Coleman testified that he did not know of any author removed from SOC-8 due to a conflict.[62]

D. WPATH Hindered Publication of Evidence Reviews.

Though the SOC-8 authors and their advocacy allies didn't seem to have much use for them, the Johns Hopkins evidence-review team "completed and submitted reports of reviews (dozens!) to WPATH" for SOC-8.[63] The results were concerning. In August 2020, the head of the team, Dr. Robinson, wrote to the Agency for Healthcare Research and Quality at HHS about their research into "multiple types of interventions (surgical, hormone, voice therapy…)."[64] She reported: "[W]e found little to no evidence about children and adolescents."[65]

Dr. Robinson also informed HHS that she was "having issues with this sponsor"—WPATH—"trying to restrict our ability to publish."[66] Days earlier, WPATH had rejected

[57] Ex.21(Doc.700-3):230:17-23.
[58] Ex.166(Doc.560-16):1.
[59] *Id.* (emphasis added).
[60] *Id.*
[61] SOC-8, *supra* note 6, at S177.
[62] Ex.21(Doc.700-3):232:13-15.
[63] Ex.173 (Doc.560-23):22-25.
[64] *Id.* at 24.
[65] *Id.* at 22.
[66] *Id.*

Robinson's request to publish two manuscripts because her team failed to comply with WPATH's policy for using SOC-8 data.[67] Among other things, that policy required the team to seek "final approval" of any article from an SOC-8 leader and then from the WPATH Board of Directors.[68]

WPATH justified its oversight by reasoning that it was of "paramount" importance "that any publication based on WPATH SOC8 data [be] thoroughly scrutinized and reviewed to ensure that publication does not negatively affect the provision of transgender healthcare in the broadest sense" (as WPATH defined it).[69] But to make the process *appear* neutral, WPATH imposed one last requirement: Authors had to "acknowledge[]" in their manuscript that they were "solely responsible for the content of the manuscript, and the manuscript does not necessarily reflect the view of WPATH."[70] WPATH eventually allowed the Johns Hopkins team to publish two of its manuscripts. (It's still unclear what happened to the others.[71]) The team dutifully reported that the "authors"—not WPATH—were "responsible for all content."[72]

* * *

Given the space constraints, these episodes are necessarily incomplete, and there is much more to say. Even so, the takeaway is clear: the WPATH Standards are the product of politics and ideology, not best practices of evidence-based medicine. They are not reliable.

II. The General Assembly Rejects The WPATH Model Of "Care," Which The Tenth District Rules It Cannot Do.

In January 2024, the Ohio General Assembly enacted the "Saving Ohio Adolescents from

---

[67] Ex.167(Doc.560-17):86-88.
[68] *Id.* at 37-38, 75-81.
[69] *Id.* at 91.
[70] *Id.* at 38.
[71] *Cf.* Ex.167(Doc.560-17):91.
[72] Baker, *Hormone Therapy, Mental Health, and Qualify of Life*, 5 J. ENDOCRINE SOC'Y 1, 3 (2021); Wilson, *Effects of Antiandrogens on Prolactin Levels Among Transgender Women*, 21 INT'L J. OF TRANSGENDER HEALTH 391, 392 (2020).

Experimentation" Act to prohibit doctors from administering puberty blockers, cross-sex hormones, and sex-change surgeries to minors for the purpose of gender transition. *See* R.C. 3129.02(A)(1), (2). In doing so, the State definitively rejected the WPATH model of "care."

Following a five-day trial, the trial court upheld the State's law against challenge. Com. Pl. Op. 12 (Aug. 6, 2024). The Tenth District reversed on two grounds, both premised on the reliability of the WPATH Standards of Care. *See* Op.¶20 ("[W]e find support for our decision to consider the constitutional issues presented in this case by accepting the Guidelines as the prevailing standards of care for gender dysphoria.").

First, the court held that the Healthcare Freedom Amendment restricted the General Assembly's authority to regulate medicine to instances where the regulation is "in accordance with the prevailing standards of care." Op.¶73. Because the Act's prohibitions on sex-change procedures for minors were *not* in accordance with the WPATH Standards, the court held, the Act violated the Healthcare Freedom Amendment.

Second, the Tenth District held that the Act violates the Due Course of Law Clause because it interferes with "a parent's fundamental right to direct the medical care of their child" in accordance with "medically accepted standards." Op.¶87. Here again, the court reasoned, because WPATH set the "standard," and Ohio departed from WPATH, the Act was unconstitutional.

This appeal followed.

THIS CASE PRESENTS A SUBSTANTIAL CONSTITUTIONAL QUESTION AND IS OF PUBLIC AND GREAT GENERAL INTEREST

This case presents a question of fundamental importance to self-governance: whether the people's representatives in the Ohio General Assembly are bound by guidelines promulgated by interest groups like WPATH or, instead, interest groups like WPATH are bound by medical regulations enacted by the General Assembly. Who regulates whom?

The answer to that question matters in this case because children deserve so much better than the WPATH Standards. After spending years conducting a comprehensive review for the National Health Service in England, Dr. Hilary Cass summed up her findings: "I can't think of another area of paediatric care where we give young people a potentially irreversible treatment and have no idea what happens to them in adulthood."[73] No wonder countries in Europe are restricting minors' access to the "treatments." *See* Lavietes, *Britain Bans Puberty Blockers for Transgender Minors*, NBC NEWS (Dec. 11, 2024), https://perma.cc/3Q4SNV8E; Ghorayshi, *Scotland Pauses Gender Medications for Minors*, N.Y. TIMES (Apr. 18, 2024), https://perma.cc/4YV6- FCX5 (noting Scotland became "the sixth country in Europe to limit" access).

The co-chair of the adolescent chapter of WPATH's SOC-8, Annelou de Vries, doesn't even seem to disagree with Dr. Cass's assessment. Dr. de Vries is a seminal researcher in the field, having co-authored the original "Dutch studies" on which everything else has been built. In a recent essay, she tacitly admitted the truth of "the critique that there is insufficient evidence," and wrote to "question" the "normative assumption" that pediatric sex-change procedures "must necessarily result in 'effective' outcomes in order to be considered legitimate and essential care."[74] She suggested instead that sex-changes for kids be "provided and justified on the basis of personal desire and autonomy," that "effectiveness" be measured by how well the procedures "help individuals achieve their embodiment goals," and that any "experience of regret" be welcomed as "inherent to all lives."[75]

This case asks whether the Ohio General Assembly is powerless to disagree.

---

[73] Abbasi, *"Medication is Binary,"* BMJ (Apr. 2024), https://perma.cc/KUM3-XL2S.

[74] Oosthoek, de Vries, et al., *Gender-affirming Medical Treatment for Adolescents*, 25 BMC MEDICAL ETHICS 154 (2024), https://perma.cc/8W4R-CEG7.

[75] *Id.*

ARGUMENT

***Amici Curiae's* Proposition of Law No. 1:**

The Due Course of Law Clause does not create a parental right to obtain drug-based "gender transitions for a child."

The Tenth District reasoned that Ohio's Due Course of Law Clause is coextensive with the Fourteenth Amendment's Due Process Clause, including its purported right to substantive due process. But there is no right for parents to obtain sex-change procedures for their children that is deeply rooted in our Nation's history and tradition, and the general recognition that parents can direct the medical care of their children does not afford them the ability to subject every restricted treatment to strict scrutiny (and make judges de facto medical regulators in the process). Were it otherwise, parents could unlock access to vaccines before FDA approval and to euthanasia drugs that a State prohibits.

Nor does the Tenth District's restriction to "accepted standards" help matters. Op.¶103. It simply raises another problem: accepted by whom? Not the General Assembly or other government regulators, the Tenth District says, but WPATH. But our nation's "history and tradition" is that governments regulate medical providers, not the other way around. *E.g.*, *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 302 (2022) ("The Constitution does not prohibit the citizens of each State from regulating or prohibiting abortion."). "This country does not have a custom of permitting parents to obtain banned medical treatments for their children and to override contrary legislative policy judgments in the process." *L.W. v. Skrmetti*, 83 F.4th 460, 475 (6th Cir. 2023). Indeed, "[i]f parents could veto legislative and regulatory policies about drugs and surgeries permitted for children, every such regulation—there must be thousands—would come with a springing easement: It would be good law until one parent in the country opposed it," at which point "either the parent would take charge of the regulation or the courts would." *Id.*

***Amici Curiae*'s Proposition of Law No. 2:**

The Health Care Freedom Amendment does not create a parental right to obtain drug-based "gender transitions" for a child.

The Tenth District also wrongly deferred to WPATH when interpreting the Health Care Freedom Amendment. By its express terms, the Amendment "does not … affect any laws calculated to deter fraud or punish wrongdoing in the health care industry." Ohio Const. art. I, §21(d). The Act here does both by rejecting the fraudulent WPATH model of care and protecting minors from unproven, high-risk procedures that are justified by their primary proponents on grounds that *children* have the right to experience "regret."[76] The Health Care Freedom Amendment, enacted to prevent an individual mandate to compel insurance coverage, does nothing to the General Assembly's traditional power to regulate medicine—even when doing so departs from the wishes of the interest groups whose members are being regulated.

CONCLUSION

The Court should accept jurisdiction and reverse the Tenth District's judgment.

Dated: May 16, 2025

Respectfully submitted,

Steve Marshall
Attorney General of Alabama
Edmund G. LaCour Jr. (PHV-29432-2025)
Solicitor General
STATE OF ALABAMA
OFFICE OF THE ALABAMA ATTORNEY GENERAL
501 Washington Avenue
Montgomery, AL 36130
(334) 353-2196
edmund.lacour@AlabamaAG.gov

Counsel for State of Alabama as amicus curiae

[*Additional Counsel Listed Below*]

[76] Oosthoek, *supra* note 74.

ADDITIONAL COUNSEL

TREG TAYLOR
Attorney General
State of Alaska

TIM GRIFFIN
Attorney General
State of Arkansas

JAMES UTHMEIER
Attorney General
State of Florida

CHRIS CARR
Attorney General
State of Georgia

RAÚL R. LABRADOR
Attorney General
State of Idaho

THEODORE E. ROKITA
Attorney General
State of Indiana

BRENNA BIRD
Attorney General
State of Iowa

KRIS W. KOBACH
Attorney General
State of Kansas

RUSSELL COLEMAN
Attorney General
Commonwealth of Kentucky

LIZ MURRILL
Attorney General
State of Louisiana

LYNN FITCH
Attorney General
State of Mississippi

ANDREW BAILEY
Attorney General
State of Missouri

AUSTIN KNUDSEN
Attorney General
State of Montana

MICHAEL T. HILGERS
Attorney General
State of Nebraska

DREW H. WRIGLEY
Attorney General
State of North Dakota

GENTNER DRUMMOND
Attorney General
State of Oklahoma

ALAN WILSON
Attorney General
State of South Carolina

MARTY JACKLEY
Attorney General
State of South Dakota

JONATHAN SKRMETTI
Attorney General & Reporter
State of Tennessee

KEN PAXTON
Attorney General
State of Texas

DEREK BROWN
Attorney General
State of Utah

JASON MIYARES
Attorney General
Commonwealth of Virginia

JOHN B. MCCUSKEY
Attorney General
State of West Virginia

CERTIFICATE OF SERVICE

I certify that on May 16, 2025, a copy of this brief was served by e-mail on the following counsel:

Freda J. Levenson
Amy Gilbert
ACLU OF OHIO FOUNDATION, INC.
4506 Chester Ave.
Cleveland, OH 44103
flevenson@acluohio.org
agilbert@acluohio.org

David J. Carey
Carlen Zhang-D'Souza
ACLU OF OHIO FOUNDATION, INC.
1108 City Park Ave., Ste. 203
Columbus, OH 43206
dcarey@acluohio.org
czhangdsouza@acluohio.org

Counsel for Appellees Madeline Moe et al.

T. Elliot Gaiser
Solicitor General
Erik Clark
Deputy Attorney General
Stephen P. Carney
Deputy Solicitor General
Amanda Narog
Assistant Attorney General
30 East Broad St., 17th Floor
Columbus, OH 43215
(614) 466-8980
thomas.gaiser@ohioago.gov

Counsel for Appellants Dave Yost, et al.

s/ Edmund G. LaCour Jr.
Edmund G. LaCour Jr.