In the
Supreme Court of Ohio

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

BRIEF OF *AMICI CURIAE* INDEPENDENT WOMEN'S FORUM AND CENTER FOR CHRISTIAN VIRTUE IN SUPPORT OF APPELLANTS AND REVERSAL

Freda J. Levenson (0045916)
Counsel of Record
Amy Gilbert (100887)
ACLU OF OHIO FOUNDATION, INC.
4506 Chester Ave.
Cleveland, Ohio 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, Ohio 43206
(614) 586-1972
dcarey@acluohio.org
czhangdsouza@acluohio.org

Counsel for Appellees Madeline Moe et al.

Benjamin M. Flowers (0095284)
Counsel of Record
James S. Kresge (0086370)
Andrew D. McCartney (0099853)
ASHBROOK BYRNE KRESGE FLOWERS LLC
P.O. Box 8248
Cincinnati, Ohio 45249
(614) 705-6603
bflowers@abkf.com

Counsel for Amici Curiae *Independent Women's Forum and Center for Christian Virtue*

Dave Yost (0056290)
OHIO ATTORNEY GENERAL

Mathura J. Sridharan (0100811)
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 Street, 17th Fl.
Columbus, Ohio 43215
(614) 466-8980
mathura.sridharan@ohioago.gov

Counsel for Appellants Dave Yost, et al.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Constitutional Provisions, Statutes, and Regulations

Other Authorities

INTRODUCTION

"Trust the science." Everyone has heard the phrase. Few have paused to consider its incoherence. The people who incant this mantra, often with something approaching religious zeal, typically mean "trust the experts." But science demands skepticism, not trust; it is a method of inquiry, not a collection of settled truths. Science entails an iterative process of forming hypotheses, testing them against evidence, revising conclusions, and remaining perpetually open to the possibility that previously held beliefs may be incorrect.

The scientific process does not end when experts coalesce around a conclusion. Indeed, the consensus view of one era often becomes the fringe view of the next. "Germ theory and handwashing were once the subject of severe scorn and ridicule among 'mainstream' scientists." *Whole Woman's Health v. Paxton*, 10 F.4th 430, 465 (5th Cir. 2021) (*en banc*) (Ho., J., concurring) (capitalization altered). And no shortage of scientific experts supported the eugenics movement, in which governments sought to snuff out the "feeble-minded" and otherwise improve the gene pool through forced sterilizations. Trusting the science, as opposed to trusting the experts, means recognizing that "experts and elites have been wrong before—and they may prove to be wrong again." *United States v. Skrmetti*, 145 S. Ct. 1816, 1849 (2025) (Thomas, J., concurring) (alterations accepted) (quoting *Students for Fair Admissions, Inc. v. President & Fellows of Harvard College*, 600 U.S. 181, 268 (2023) (Thomas, J., concurring)).

It is therefore troubling that, according to the Tenth District's decision below, the democratic process must yield to the present recommendations of unelected, private medical organizations. *See generally Moe v. Yost*, 2025-Ohio-914 (10th Dist.) ("App. Op."). That court held that, because supposedly expert medical groups advise administering puberty blockers and cross-sex hormones to children, the General Assembly has no constitutional authority to prohibit these procedures.

The Tenth District erred. As an initial matter, the expert guidance to which it deferred is unreliable at best and fraudulent at worst—the self-proclaimed experts to whom the Tenth District deferred are activists whose "lodestar is ideology, not science." *Eknes-Tucker v. Governor of Alabama*, 114 F.4th 1241, 1261 (11th Cir. 2024) (*en banc*) (Lagoa, J., concurring). More fundamentally, Ohio's "sovereign prerogative does not bow to 'major medical organizations,'" and the "views of self-proclaimed experts do not 'shed light on the meaning of the Constitution.'" *Skrmetti*, 145 S. Ct. at 1840, 1849 (Thomas, J., concurring) (quoting *id*. at 1870 n.5 (Sotomayor, J., dissenting); *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 273 (2022)).

H.B. 68—the SAFE Act—fully accords with the Ohio Constitution. Because the Tenth District held otherwise, this Court should reverse the judgment below.

STATEMENT OF *AMICI* INTEREST

Independent Women's Forum (IWF) is a non-profit, non-partisan 501(c)(3) organization founded by women to foster education and debate about legal, social, and economic

policy issues. IWF has warned about the risks of "so-called 'gender-affirming care,'" through which "vulnerable children who experience discomfort with their bodies are rushed onto an irreversible path of lifelong medicalization," often through "discredited standards of care" and procedures "carried out with no regard for underlying psychological conditions and documented long-term risks." *Joint Statement on Protecting Children from Gender Ideology*, IWF (March 17, 2025), https://perma.cc/F32Y-NUQ6. IWF supports the challenged SAFE Act provisions, which protect children from the dangers of experimental treatments peddled by self-interested, politicized organizations like WPATH.

Center for Christian Virtue (CCV) is a non-profit, 501(c)(3) organization that seeks the good of its neighbors by advocating for public policy that reflects the truth of the Gospel. CCV opposes the use of puberty blockers, cross-sex hormones, and surgical intervention to treat gender dysphoria in minors. To this end, CCV supported the passage of the SAFE Act provisions here at issue.

STATEMENT OF THE FACTS

A. Standards of care urging the administration of sex-change drugs to minors are the result of political advocacy.

1. Gender dysphoria is a mental illness "characterized by persistent, clinically significant distress resulting from an incongruence between gender identity and biological sex." *Skrmetti*, 145 S. Ct. at 1824 (majority op.). Some afflicted individuals—and perhaps others, too—describe themselves as transgender. This means they live (or would like to live) as though they were the opposite sex.

Historically, gender dysphoria was considered a rare psychiatric condition. As recently as 2013, prevalence estimates ranged from 0.005 to 0.014 percent in adult males and 0.002 to 0.003 percent in females. *See* American Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (DSM-V), p. 454 (2013). No longer. Recent data reveal a dramatic increase in both diagnoses of gender dysphoria and the number of individuals identifying as transgender, particularly among young people. One 2022 study by the Williams Institute at UCLA School of Law found that approximately *1.4 percent* of U.S. teenagers aged 13–17 identify as transgender, compared to 0.5 percent of adults. Jody L. Herman et al., *How Many Adults and Youth Identify as Transgender in the United States?*, at 1, UCLA Williams Institute (June 2022), https://perma.cc/E5YA-YSSY. Clinical diagnoses have surged, too. From 2017 through 2021, over 121,000 children aged 6–17 in the United States were diagnosed with gender dysphoria, with annual diagnoses rising from 15,172 in 2017 to 42,167 in 2021—a nearly threefold jump. *See* Robin Respaut & Chad Terhune, *Putting numbers on the rise in children seeking gender care*, Reuters (Oct. 6, 2022), https://perma.cc/ME7W-8CTC. These figures are drawn from insurance claims data and likely undercount cases not formally diagnosed or treated outside of covered care. *See id*.

The surge of diagnoses coincides with a dramatic alteration of the approach to treating gender dysphoria in minors. "In 1979, the World Professional Association for Transgender Health"—known by the acronym WPATH—"published one of the first sets

of clinical guidelines for treating gender dysphoria with sex transition treatments." *Skrmetti*, 145 S. Ct. at 1824–25 (majority op.). "The standards addressed two treatments in particular: hormonal sex reassignment (the use of hormones to induce the development of physical characteristics of the opposite sex) and surgical sex reassignment (surgery of the genitalia and/or chest to approximate the physical appearance of the opposite sex)." *Id*. at 1825. WPATH's standards "recognized the extensive and sometimes *irreversible* consequences" of these treatments. *Id*. (emphasis added). And WPATH acknowledged that some individuals who undergo these procedures later regret their choice. *Id*. For these and other reasons, WPATH's "standards of care provided that hormonal and surgical sex reassignment treatments should be administered *only* to adults." *Id*. (emphasis added).

In 1998, WPATH departed from this adults-only approach, though only somewhat; the group "revised its standards of care to permit healthcare professionals to administer puberty blockers (designed to delay the development of physical sex characteristics) and hormones to minors in 'rare' circumstances." *Id*. (alteration accepted). These 1998 standards continued to prohibit the use of cross-sex hormones in children under the age of 16. *Id*. at 1844 (Thomas, J., concurring).

But then, WPATH threw caution to the wind. In 2012, it "relaxed its recommendations … and began permitting cross-sex hormones for children under the age of 16." *Id*. "WPATH further relaxed its recommendations when it published the eighth (and current)

version of its standards of care in 2022." *Id*. Those standards "endorse using puberty blockers and cross-sex hormones at the onset of puberty and allowing children to receive many surgical treatments previously reserved for adults." *Id*. In the Tenth District's tendentious phrasing, WPATH's guidelines—along with similar guidelines published by the Endocrine Society—advise that "gender-affirming care can meaningfully improve the health and well-being of transgender adolescents with gender dysphoria" in "appropriate circumstances." App. Op. ¶14. And WPATH takes a broad view of "appropriate circumstances": "During a deposition, an author of the Guidelines confirmed that 'WPATH's official position' is that castration may be 'medically necessary' even where a male who identifies as a eunuch and seeks castration and has 'no recognized mental health conditions' and where 'no finding is made that he's actually at high risk of self-castration.'" *Skrmetti*, 145 S. Ct. at 1844 n.5 (Thomas, J., concurring) (citation omitted). If it is appropriate to remove the testicles of a healthy male who identifies as a man but who wants to live as a "eunuch," in what circumstances is gender transition clearly *in*appropriate?

2. Consider next what the euphemism "gender-affirming care" includes.

Puberty blockers. WPATH and its allies advise administering puberty blockers to pre-pubescent children experiencing gender dysphoria. "Lupron," once used to chemically castrate sex offenders, "is the go-to puberty blocker." Abigail Shrier, *Irreversible Damage* 163 (2020). Lupron and other puberty blockers stop the natural process of

puberty. That is not, however, their approved use. The FDA "initially approved these drugs to treat prostate cancer; endometriosis, a painful disease that causes uterine tissue to grow elsewhere in the body; and the unusually early onset of puberty, also known as precocious puberty." *Skrmetti*, 145 S. Ct. at 1841 (Thomas, J., concurring) (quotations omitted). The FDA has never authorized the drug for use in treating gender dysphoria; doctors who use it to treat gender dysphoria are thus said to administer the drug "off-label." "Although it is neither unusual nor unlawful for drugs to be used off-label, the FDA has recognized that just because a drug has been approved for one class of patients doesn't mean it's safe for another." *Id.* (quotation omitted).

There is ample reason to question the safety of using puberty blockers on children experiencing gender dysphoria, as this form of treatment is experimental and poses known dangers. "The use of drugs to suppress normal puberty has multiple organ system effects whose long-term consequences have not been investigated." *Id*. at 1842 (quotation omitted). And while doctors who advocate for gender-change procedures claim "that halting puberty at onset … is a neutral intervention, or 'pause button,'" that assertion is unsupported by the evidence. Shrier, *Irreversible Damage* at 163. Because "[p]uberty-related hormones have wide ranging effects on brain structure, function, and connectivity," the "suppression of puberty may permanently alter neurodevelopment." Sarah C.J. Jorgensen, *Puberty blockers for gender dysphoric youth: A lack of sound science*, 5 J. Am. Coll. Clin. Pharm. 1005, 1005 (2022). Some recent studies have found evidence that

puberty blockers permanently impair the growth of children's reproductive organs. Varshini Murugesh, *et al.*, *Puberty Blocker and Aging Impact on Testicular Cell States and Function* (2024), https://perma.cc/LLS5-FMZ4. And it remains "unclear whether patients ever develop normal levels of fertility if puberty blockers are terminated after a prolonged delay of puberty." *Skrmetti*, 145 S. Ct. at 1842 (Thomas, J., concurring) (quotations omitted). What is more, puberty blockers impair bone health by decreasing bone-mineral density. Jo Taylor, *et al.*, *Interventions to suppress puberty in adolescents experiencing gender dysphoria or incongruence: a systematic review*, 109 Arch. Dis. Child. s33, s39 (2024). No one knows what this means for long-term bone health.

The other problem with puberty blockers is that they have a self-reinforcing effect. Most children with gender dysphoria will overcome the condition if they are never given puberty blockers. Alex Byrne, *Another Myth of Persistence?* at 1, Archives of Sexual Behavior (2024), https://perma.cc/NE4V-W8CN. But nearly all children placed on puberty blockers will eventually choose (or be made) to receive cross-sex hormones. *See, e.g.*, Annelou L.C. de Vries, *et al.*, *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, 8 J. Sex. Med. 2276, 2276 (2011); Polly Carmichael, *et al.*, *Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK*, 16(2) PLoS ONE at 12 (2021); *Skrmetti*, 145 S. Ct. at 1842 n.4 (Thomas, J., concurring). Cross-sex hormones have permanent and dramatic effects, *see below* 9–10—the treatments' proponents concede that. Thus, even if puberty

blockers were harmless by themselves, they put children on track for, and thus carry all the dangers of, cross-sex hormones.

Cross-sex hormones. Children who progress to hormonal treatment are administered "very high doses" of opposite-sex hormones—levels significantly above what these children would otherwise naturally produce. *Skrmetti*, 145 S. Ct. at 1842 (Thomas, J., concurring) (quotation omitted). "For example, one of the organizations that sets standards for pediatric sex-transition treatment recommends raising transitioning females' levels of testosterone 6 to 100 times higher than native female testosterone levels." *Id*. (quotation omitted). "For males seeking to transition into females, the organization recommends raising levels of estradiol, a type of estrogen, to 2 to 43 times above the normal range." *Id*. (quotation omitted).

These dramatic alterations of normal hormone levels have equally dramatic effects. "In some youth," the use of puberty blockers "followed by exogenous cross-sex hormones has resulted in a *complete absence* of adult sexual function." Jorgensen, *Puberty blockers for gender dysphoric youth*, 5 J. Am. Coll. Clin. Pharm. at 1005 (emphasis added). "Gender transition patients" can thus "lose the ability to orgasm, experience sexual pleasure, reproduce, or breastfeed." Havilah Wingfield and Hadley Heath Manning, *The Risks of Gender-Transition Treatments in Adolescents* at 2, IWF (June 2023), https://perma.cc/2WG5-3N6S. "They are also at higher risk of osteoporosis, seizures (in epileptic patients), cardiovascular problems, stroke, heart attack, and other health problems." *Id*.

Some changes are sex specific. "Introducing high doses of testosterone to female minors increases the risk of erythrocytosis, myocardial infarction, liver dysfunction, coronary artery disease, cerebrovascular disease, hypertension, and breast and uterine cancer." *L. W. by & through Williams v. Skrmetti*, 83 F.4th 460, 489 (6th Cir. 2023) (per Sutton, C.J.) ("*L.W.*"). The use of testosterone in females also causes "irreversible changes to the vocal cords, clitoromegaly and atrophy of the lining of the uterus and vagina, as well as ovarian … cancer." *Skrmetti*, 145 S. Ct. at 1842 (Thomas, J., concurring) (quotations omitted). For boys, "high amounts of estrogen … increases the risk of macroprolactinoma, coronary artery disease, cerebrovascular disease, cholelithiasis, and hypertriglyceridemia." *L.W.*, 83 F. 4th at 489. Administering estrogen also raises the risk of breast cancer. *Skrmetti*, 145 S. Ct. at 1842–43 (Thomas, J., concurring).

Surgical intervention. After receiving cross-sex hormones, some individuals seek surgeries to make them appear more like the opposite sex.

"Sex-transitioning surgeries for girls include the surgical removal of the breasts and phalloplasty, that is, an attempt to create a pseudo-penis by transplanting a roll of skin and subcutaneous tissue from another area of the body to the pelvis." *Id*. at 1843 (quotations and brackets omitted). Phalloplasty further entails "removal of the uterus, ovaries, and vagina, and creation of" a "scrotum with scrotal prostheses." *Lange v. Houston*, 101 F.4th 793, 802 (11th Cir. 2024) (Brasher, J., dissenting) (quotation omitted), *vacated and reh'g en banc granted*, 110 F.4th 1254. This is a "multistage reconstructive procedure." *Id*.

(quotation omitted).

Men who wish to live like women may seek a vaginoplasty. "For a natal man to undergo a vaginoplasty, the testicles will be removed, the urethra will be shortened, and the penile and scrotal skin will be used to line the neovagina, the space between the rectum and the prostate and bladder." *Id*. (quotation omitted). Then, "the patient must undergo an extensive regimen of post-surgery dilatation to prevent the closure of the neovagina." *Id*. (quotation omitted); *accord Skrmetti*, 145 S. Ct. at 1843 (Thomas, J., concurring). "Dilation entails inserting a dilator into the vaginal canal and leaving it in place for 20–30 minutes, in order to stretch out the space and keep it open." *Clark v. Quiros*, 2024 WL 3552472, at *8 (D. Conn. July 26, 2024). Patients "must dilate their [ersatz] vaginal canal for the rest of their life," to keep what amounts to a wound from healing shut. *Id*.

These surgeries "are irreversible, entail significant complications, and, in some cases, result in permanent infertility." *Skrmetti*, 145 S. Ct. at 1843 (Thomas, J., concurring).

3. As "the number of minors requesting sex transition treatments has increased," debates "regarding the relative risks and benefits" of these treatments have intensified. *Skrmetti*, 145 S. Ct. at 1825 (majority op.). And governments the world over have enacted laws and adopted policies that protect children from the risks these procedures pose. Over twenty States have banned sex-transition treatments for minors. *Id*. European governments have adopted safeguards, too. *Id*. As of 2023, "minors in six European

countries—Norway, U.K., Sweden, Denmark, France and Finland—[could] access puberty blockers and cross-sex hormones *only* if they" met "strict eligibility requirements, usually in the context of a tightly controlled research setting." Joshua P. Cohen, *Europe and U.S. Diverge Sharply on Treatment of Gender Incongruence in Minors*, Forbes (Dec. 2, 2023), https://perma.cc/R9EP-83Y4 (comma added).

Perhaps the most notable shift came in Britain, which had long taken a liberal approach to child sex transitions. In 2024, Britain's National Health Service commissioned "The Cass Review" following "a 40-fold increase in the number of referrals … for sex-transitioning services." *Skrmetti*, 145 S. Ct. at 1844–45 (Thomas, J., concurring). That much-awaited report confirmed the absence of evidence establishing the safety of puberty blockers; it concluded that "brain maturation" and bone health "may be temporarily or *permanently* disrupted by the use of puberty blockers"; and, perhaps most significant of all, it announced that a "systematic review" of the evidence failed to support the "widespread" claim "that gender-affirming treatment reduces suicide risk." *See The Cass Review: Independent Review of Gender Identity Services for Children and Young People* at 13, 33, 178, 186 (Apr. 2024) (Cass Review) (emphasis added), https://perma.cc/G3QV-XDNJ. Less than a year later, Britain banned puberty blockers indefinitely and instituted additional safeguards that must be satisfied before administering cross-sex hormones to children under age 18. Dep't of Health and Social Care, *Ban on puberty blockers to be made indefinite on experts' advice* (Dec. 11, 2024), https://perma.cc/9HZB-4RGB.

One might wonder, given all this scientific uncertainty, how WPATH and its fellow travelers settled on their standards of care. Thanks to "recent revelations," we know the answer: "WPATH's lodestar is ideology, not science." *Eknes-Tucker*, 114 F.4th at 1261 (Lagoa, J., concurring). "For example, in one communication, a contributor to WPATH's most recent Standards of Care frankly stated, '[o]ur 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.'" *Id*. Read that again. One of the key contributors to WPATH's standards *conceded* the lack of evidence and then, rather than expressing concerns about the children subjected to these experimental treatments, fretted about the effect such a revelation might have on lawsuits.

WPATH's standards halfheartedly concede the paucity of evidentiary support, though in puzzling fashion. They observe that "the quality of evidence evaluating the effectiveness of medically necessary gender-affirming medical and surgical treatments … over time" poses a "challenge" in "adolescent transgender care." WPATH, *Standards of Care for the Health of Transgender and Gender Diverse People*, S45–46 (Version 8), https://perma.cc/9U6Z-4N5Y. The statement is puzzling because treatments cannot simultaneously be "medically necessary" *and* of dubious "effectiveness." Regardless, WPATH adopted these standards, concluding that doing so was "'ethically justifiable'" because the standards would help "'strengthen'" transgender advocates' "'position in court.'"

Skrmetti, 145 S. Ct. at 1848 (Thomas, J., concurring) (quoting deposition testimony of chair of WPATH committee that wrote the guidelines). Other evidence shows that WPATH was pushed by "external political pressure" to adopt an even more extreme stance than it would have otherwise. *Id*. "Unsealed documents reveal that a senior official in the Biden administration 'pressed [WPATH] to remove age limits for adolescent surgeries from guidelines for care of transgender minors' on the theory that 'specific listings of ages, under 18, will result in devastating legislation for trans care.'" *Id*. at 1848–49 (citation omitted). "Despite some internal disagreement, WPATH acceded and removed the age minimums" previously in place. *Id*. at 1849 (citation and quotation omitted).

WPATH thus faced self-imposed and external pressure to make the "science" say what the transgender movement wanted. In this regard, it is not alone. The blowback faced by those who question the wisdom, safety, or efficacy of subjecting children to sex-change procedures leads to self-censorship. *See* Cass Review at 13. So do the ideological commitments of scientists: last year, one doctor conceded that she declined to publish findings on puberty blockers for fear that her results might be harmful to the transgender movement. Azeen Ghorayshi, *U.S. Study on Puberty Blockers Goes Unpublished Because of Politics, Doctor Says*, New York Times (Oct. 24, 2024), https://perma.cc/JM7X-A3JF. That scientists censor politically incorrect conclusions gives further reason to question the "science" supporting the transitioning of children.

All told, "the WPATH Standards of Care reflect not consensus, but merely one side

in a sharply contested medical debate ...." *Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019). Indeed, WPATH's standards are more political advocacy than anything else. And given the degree to which political considerations shaped WPATH's recommendations, one can fairly assume that other organizations with similar standards—the Endocrine Society, for example—did the same. After all, it is quite unlikely that two similarly situated organizations produced identical outputs without similar inputs.

None of this has stopped doctors from pressuring parents into assenting to their children being mutilated through WPATH-recommended procedures. Around the country, and with disturbing frequency, doctors "pressure and even frighten" parents into consenting to sex-transition treatments with warnings that the failure to administer these treatments could increase suicide risk. *See* Chad Terhune, *et al.*, *As more transgender children seek medical care, families confront many unknowns*, Reuters (Oct. 6, 2022), https://perma.cc/65TB-6PH5. But as detailed above and in the Cass Review, no evidence supports the all-too-common assertion that these treatments reduce suicide risk. *See above* 12. Medical professionals have thus preyed on parents' genuine concern for children enduring an undeniably difficult experience.

*

The ideology-driven push to maim vulnerable children calls to mind Nikola Tesla's (perhaps apocryphal) fears that modern science would yield "man-made horrors beyond []our comprehension." Future generations will, one hopes, view this disturbing chapter

of medical history the way that ours views the eugenics movement. The push to medically transition children is a profound scandal that has dramatically undercut the credibility of the medical profession. It is a scandal that ought to inspire a complete re-evaluation of the degree to which research, some of it publicly funded, has been warped by politics or ideology. This chapter of medical history, therefore, cannot close soon enough. The General Assembly attempted to bring that about, at least in Ohio, by enacting H.B. 68, the SAFE Act. This brief turns now to that law and the Tenth District decision enjoining it.

B. The Tenth District enjoined the SAFE Act, which responds to the dangers posed by medical transitions for minors.

1. In 2024, Ohio joined the global pushback against the medical transitioning of children. *See* App. Op. ¶4. Specifically, Ohio's General Assembly enacted the "Ohio Saving Adolescents from Experimentation (SAFE) Act." This law protects children from numerous aspects of radical gender ideology. For example, to ensure that women can safely and fairly compete in sports, the SAFE Act requires covered schools to offer women's athletics in which men may not compete. *See* R.C. 3313.5320, 3345.562. Of more relevance here, however, the Act forbids any "physician" to "knowingly" (1) perform gender-reassignment surgery on a minor or (2) "[p]rescribe a cross-sex hormone or puberty-blocking drug for a minor individual for the purpose of assisting the minor individual with gender transition." R.C. 3129.02(A)(1)–(2).

2. The plaintiffs—two "transgender adolescents living in Ohio with gender

dysphoria diagnoses," App. Op. ¶2, litigating by and through their parents—sued to enjoin the SAFE Act from taking effect. They claimed that the law violates numerous provisions of the Ohio Constitution, including the Due Course of Law Clause, *see* art. I, §16, and the Healthcare Freedom Amendment, *see* art. I, §21.

The plaintiffs failed before the Franklin County Court of Common Pleas. "Following a trial on the merits of the declaratory action, the trial court entered a judgment … finding the law does not violate any of the constitutional provisions" on which the plaintiffs' challenge rested. App. Op. ¶3.

But the plaintiffs prevailed on appeal at the Tenth District, which held that the SAFE Act's bans on puberty blockers and cross-sex hormones for minors violates both the Due Course of Law Clause and the Healthcare Freedom Amendment. The Tenth District reversed the trial court and enjoined the enforcement of the SAFE Act's bans on puberty blockers and cross-sex hormones.

The Tenth District's decision rests on the premise that the Due Course of Law Clause and the Healthcare Freedom Amendment both foreclose the legislature from limiting parents' ability to secure for their children treatments endorsed by "leading association[s] of medical professionals." App. Op. ¶13. That is worth unpacking in greater detail.

Due Course of Law Clause. Consider first the Tenth District's analysis under the Due Course of Law Clause. That clause guarantees that "[a]ll courts shall be open, and every person, for an injury done him in his land, goods, person, or reputation, shall have

remedy by due course of law, and shall have justice administered without denial or delay." Ohio Const., art. I, §16. Binding precedent treats "this provision as the equivalent of the 'due process of law' protections in the United States Constitution." *Arbino v. Johnson & Johnson*, 2007-Ohio-6948, ¶48. And, according to the U.S. Supreme Court, those due-process protections subject "[g]overnment actions that infringe upon a fundamental right … to strict scrutiny," which means such actions are unconstitutional unless narrowly tailored to serve a compelling government interest. *Stolz v. J & B Steel Erectors, Inc.*, 2018-Ohio-5088, ¶14.

The Tenth District held that the SAFE Act's restrictions on puberty blockers and cross-sex hormones "interfere[] with [parents'] fundamental right to direct the medical care of their children." App. Op. ¶83. Parents, the court explained, have a "right to select, *within reason*, whether and what type of medical care a child will receive." *Id*. at ¶85 (emphasis in original). And according to the court, "a minor's access to puberty blockers and hormone therapy to treat gender dysphoria—as recommended by an independent medical provider and given with the informed consent of their parents, assent of the minor, and in accordance with the prevailing standards of care—*is the type of medical decision* parents have a fundamental interest in making on behalf of their children." *Id*. at ¶100 (emphasis added). The italicized phrases—"within reason" and "the type of medical decision"—recognize *some* limits on the medical treatments that parents have a fundamental right to seek for their children. In light of these phrases, the Tenth District would thus

presumably concede that parents have no fundamental right to have their children lobotomized for the treatment of ADHD, to have their children's healthy limbs amputated for cosmetic purposes, and so forth. But the court concluded that parents *do* have a right to secure puberty blockers and cross-sex hormones for their children, apparently because *those* procedures are consistent with "the prevailing standard of care accepted by a consensus of the medical community in America." *Id*. at ¶101.

In short, the Tenth District held that the Due Course of Law Clause requires the legislature to trust the experts when it comes to the medical treatment of minors.

Healthcare Freedom Amendment. The Tenth District's analysis of the Healthcare Freedom Amendment is of a piece. That Amendment bars the General Assembly from enacting laws that "prohibit the purchase or sale of health care" or "impose a penalty or fine for the sale or purchase of health care …." Ohio Const., art. I, §21(B)–(C). But it preserves the legislature's ability to enact "laws calculated to deter fraud or punish wrongdoing in the health care industry." Ohio Const., art. I, §21(D). The question whether the SAFE Act violates the Healthcare Freedom Amendment thus turns on whether the legislature may categorize as "wrongdoing" the administration of puberty blockers and cross-sex hormones to minors for treatment of gender dysphoria.

The Tenth District held that administering puberty blockers and cross-sex hormones to minors cannot constitute "wrongdoing" because these procedures are permitted by "widely accepted protocols and prevailing standards of care across the United States"—

specifically, the standards announced by WPATH and the Endocrine Society. App. Op. ¶69. Thus, according to the Tenth District, the Ohio Constitution incorporates the views of experts: when experts support the use of a procedure, the People and their elected representatives may not ban those procedures on the ground that they constitute "wrongdoing."

3. Not long after the Tenth District issued its opinion, this Court stayed the Tenth District's order from taking effect. *Moe v. Yost*, 2025-Ohio-1483. This Court then accepted jurisdiction and agreed to review the Tenth District's judgment. *Moe v. Yost*, 2025-Ohio-2537.

ARGUMENT

State Appellants' 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.*

A. Parents have no fundamental right to secure illegal medical treatments for their children.

The Tenth District erred when it held that the Due Course of Law Clause entitles parents to have their gender dysphoric children treated with puberty blockers and cross-sex hormones.

1. The Due Course of Law Clause has been interpreted to protect against government interference with "fundamental rights."

Article I, Section 16 of the Ohio Constitution provides:

> All courts shall be open, and every person, for an injury done him in his land, goods, person, or reputation, shall have remedy by due course of law, and shall have justice administered without denial or delay. Suits may be brought against the state, in such courts and in such manner, as may be provided by law.

This language, considered alone, confers no rights relevant to the plaintiffs' challenge. The text of Article I, Section 16 guarantees a *procedural* right to seek legal redress for injuries, not any *substantive* right such as the right to seek a particular form of medical treatment. Thus, were the Court to decide this case based on "the unique language and historical background" of the Due Course of Law Clause, *Stolz*, 2018-Ohio-5088 at ¶28 (Fischer, J., concurring), it would hold that the Clause confers no substantive rights and reverse the judgment below, *see State v. Aalim*, 2017-Ohio-2956, ¶¶39–50 (DeWine, J., concurring).

Precedent, however, forecloses deciding this case based on the Ohio Constitution alone. (This brief takes no position on whether the precedent ought to be reconsidered.) This Court has long "equated the Due Course of Law Clause in Article I, Section 16 of the Ohio Constitution with the Due Process Clause of the Fourteenth Amendment to the United States Constitution." *Aalim*, 2017-Ohio-2956 at ¶15 (majority op.). And the Supreme Court of the United States has interpreted the Due Process Clause to confer substantive rights. Specifically, the Court has held that the Due Process Clause "provides

heightened protection against government interference with certain fundamental rights …." *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997). Under this "substantive due process" doctrine, governments may burden "a fundamental right" only "by narrowly tailored means that serve a compelling state interest." *Dep't of State v. Munoz*, 602 U.S. 899, 910 (2024). In other words, the government can burden fundamental rights only if it can satisfy strict scrutiny, which it almost never can.

"Identifying unenumerated rights carries a serious risk of judicial overreach …." *Id.* After all, deeming a right "fundamental" means subjecting all restrictions on that right to strict scrutiny, effectively removing from the political process debates affecting the right. "To that end," the Supreme Court has adopted a two-step test that "disciplines the substantive due process analysis." *Id*. The inquiry begins with a "careful description" of the asserted right; courts must avoid describing the right at a high level of generality. *Glucksberg*, 521 U.S. at 721. Next, the court may deem this carefully described right "fundamental" *only if* it is "objectively, deeply rooted in this Nation's history and tradition." *Id*. at 720–21 (quotation omitted); *accord Aalim*, 2017-Ohio-2956 at ¶16.

2. Parents have no "fundamental right" to obtain prohibited medical procedures for their children.

The just-described two-part test makes short work of this case. The Court must start by carefully describing the right the plaintiffs claim: the plaintiffs say that parents have a fundamental right to secure puberty blockers and cross-sex hormones for the treatment of gender dysphoria. But that right is not "objectively, deeply rooted in this Nation's

history and tradition." *Glucksberg*, 521 U.S. at 720–21 (quotation omitted). In hopes of evading this conclusion, the plaintiffs might attempt to ascend a level in generality. They might, for example, describe the right as a right to "control all drug and other medical treatments for [one's] children." *L.W.*, 83 F.4th at 475. But that move is unavailing, because that claimed right is equally novel: "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." *Id*. Instead, we have a long history of regulating medicine, and that history includes prohibitions of procedures deemed unsafe or unethical. States can, and have, prohibited or highly restricted the administration of lobotomies, electroshock therapy, and the use of drugs for disapproved medical purposes. *See below* 29–30 (collecting examples). And the federal government has long prohibited the sale of drugs until their safety and efficacy is proven to the FDA's satisfaction. *See* 21 U.S.C. §355(a). As such, the historical record refutes any argument that parents have a deeply rooted right to secure banned medical treatment for their children. *L.W.*, 83 F.4th at 475. For that reason, every federal circuit court that has confronted the issue has held that parents have no fundamental right to obtain puberty blockers, cross-sex hormones, or related treatments for their gender dysphoric children. *Id*.; *accord Brandt by & through Brandt v. Griffin*, 147 F.4th 867, 885–88 (8th Cir. 2025) (*en banc*); *Poe by & through Poe v. Drummond*, — F.4th —, 2025 WL 2238038, at *9–10 (10th Cir. 2025); *K.C. v. Individual Members of Med. Licensing Bd. of Indiana*, 121 F.4th 604, 623–28 (7th Cir. 2024).

Parents do, to be sure, have a fundamental right "to make decisions concerning the care, custody, and control of their children." *Troxel v. Granville*, 530 U.S. 57, 66 (2000) (plurality op.). But as the just-discussed history shows, that broadly stated right has never been understood to include a right to obtain banned medical interventions for one's child. Indeed, pressing that right to its limits would require tossing out most any regulation of child rearing: if parents had an *unlimited* right to manage the care, custody, and control of their children, laws requiring compulsory schooling and banning child abuse would all be constitutionally dubious. That the plaintiffs' theory would lead to such absurdities is reason enough to reject it.

B. The Tenth District's contrary reasoning, which relies on the opinions of experts, fails.

The Tenth District's opinion acknowledges, but makes no serious effort to apply, the governing legal standard. The court defined the relevant right as the "right of parents to make decisions concerning the care, custody, and control of their children." App. Op. ¶85. But as explained above, that broadly framed right has never included a right to obtain legally prohibited medical treatments.

Even the Tenth District seemed to recognize the issues with its holding, because it tried to cabin the breadth of the rule it announced. Specifically, it claimed that the broad right just quoted includes a "right to select, *within reason*, whether and what type of medical care a child will receive." *Id*. (emphasis in original). That statement is true only insofar as the phrase "within reason" limits the treatments parents might obtain for their

children to *legally permissible* treatments. Again, no deeply rooted right entitles parents to demand the administration of legally prohibited treatments. *L.W.*, 83 F.4th at 475.

The Tenth District saw things differently. It reasoned that the treatments parents may select "within reason" are dictated not by the People or their representatives, but rather by independent, unelected medical organizations. To be sure, the court's opinion never says so expressly. But that logic is clear from the court's opinion: the only reason the court offers for treating puberty blockers and cross-sex hormones differently than other prohibited treatments is that the "use of puberty blockers and hormones to treat gender dysphoria is the prevailing standard of care accepted by a consensus of the medical community in America." App. Op. ¶101. Thus, the court held that parents have a fundamental right to choose not *any* treatment, but rather legally permissible treatments *and* legally impermissible treatments endorsed by a sufficient percentage of the American medical community.

As an initial matter, the factual premise of the court's argument is wrong: "the WPATH Standards of Care reflect not consensus, but merely one side in a sharply contested medical debate," *Gibson*, 920 F.3d at 221, and the standards were crafted to serve ideological rather than medical ends, *see above* 3–16.

In any event, there is no deeply rooted tradition of permitting independent medical organizations to override legislative judgments—neither the plaintiffs nor the Tenth District argue otherwise. The federal and state governments are constituted on the principle

that sovereignty resides in the People. The People have chosen to exercise that sovereignty both directly (through initiatives and referenda) and through elected representatives. And that "sovereign prerogative does not bow to 'major medical organizations.'" *Skrmetti*, 145 S. Ct. at 1849 (Thomas, J., concurring) (quoting *id*. at 1870 n.5 (Sotomayor, J., dissenting)). Just as the Constitution leaves the People and their legislators free to depart from "Mr. Herbert Spencer's Social Statics" in the economic realm, *see Sorrell v. IMS Health Inc.*, 564 U.S. 552, 567 (2011) (quoting *Lochner v. New York*, 198 U.S. 45, 75 (1905) (Holmes, J., dissenting)), it leaves them free to reject the opinions of self-proclaimed medical experts.

State Appellants' 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 additionally erred when it held that the SAFE Act's prohibitions on puberty blockers and cross-sex hormones violate the Healthcare Freedom Amendment. That Amendment, properly understood, preserves the General Assembly's power to protect Ohioans from experimental or otherwise dangerous forms of medical treatment. And the General Assembly rationally concluded puberty blockers and cross-sex hormones fit the bill—indeed, it could not reasonably have concluded otherwise.

A. The Healthcare Freedom Amendment preserves the General Assembly's power to ban medical procedures it deems dangerous or immoral.

In 2011, Ohioans ratified the Healthcare Freedom Amendment. *See* Ohio Const., art.

I, §21. In relevant part, it says:

> (A) No federal, state, or local law or rule shall compel, directly or indirectly, any person, employer, or health care provider to participate in a health care system.
>
> (B) No federal, state, or local law or rule shall prohibit the purchase or sale of health care or health insurance.
>
> (C) No federal, state, or local law or rule shall impose a penalty or fine for the sale or purchase of health care or health insurance.
>
> (D) This section does not affect laws or rules in effect as of March 19, 2010; affect which services a health care provider or hospital is required to perform or provide; affect terms and conditions of government employment; or affect any laws calculated to deter fraud or punish wrongdoing in the health care industry.

The history behind the adoption of this amendment is laid out in the jurisdiction-stage *amicus* brief of former U.S. Attorney General Ed Meese. *See* Br. of *Amicus Curiae* Hon. Edwin Meese III in Support of Jurisdiction at 9–10 (Meese Br.). As AG Meese notes, the Amendment responds to the Affordable Care Act's enactment, and to fears that Ohio might try to implement a similar law at the state level. *See id.*

By way of background, the Affordable Care Act required insurance companies to offer health insurance *without regard* to purchasers' pre-existing conditions. *Id*. at 9. Thus, insurance companies had to accept buyers who were certain or very likely to cause insurance companies to lose money. By itself, a mandate like that would cause rates to skyrocket, as insurance companies would need to raise everyone's rates to cover projected losses from buyers with pre-existing conditions. The Act attempted to avoid this through

an "individual mandate" that required *everyone* to purchase health insurance. Those who refused would be fined. *Id*. This individual mandate, the thinking went, would force healthy individuals who might not otherwise purchase health insurance into the market. By forcing "into the insurance risk pool more healthy individuals, whose premiums on average will be higher than their health care expenses," the Act would "allow[] insurers to subsidize the costs of covering the unhealthy individuals" the coverage mandate required them to accept. *NFIB v. Sebelius*, 567 U.S. 519, 548 (2012) (op. of Roberts, C.J.).

"The individual-mandate laws proved controversial," as did the Affordable Care Act more broadly. Meese Br.9. Many citizens objected to being forced to purchase anything. Further, many were content with their healthcare plans and feared the Act would either devolve into a single-payer system (by driving private insurers out of business) or cause insurance companies to offer less-desirable coverage.

The Healthcare Freedom Amendment responds directly to the public's concerns. Focus in particular on Subsections (A), (B), and (C), which accomplish twin aims. First, these provisions prohibit individual mandates by giving Ohioans a right *not* to purchase healthcare or health insurance. Second, the provisions prohibit single-payer systems—and ensure that those who choose not to buy health insurance are not disabled from purchasing care on an *a la carte* basis—by guaranteeing the right to buy and sell healthcare and health insurance on the open market. The subsections achieve this latter goal by prohibiting laws that punish or ban the "purchase or sale" of healthcare or health

insurance, thereby giving patients and providers a right to buy and sell these services on mutually agreeable terms.

All the while, Subsection (D) preserves the General Assembly's power to otherwise regulate medicine and healthcare markets in other respects. Of most relevance here, Subsection (D) states that the Amendment "does not … affect any laws calculated to deter fraud or punish *wrongdoing* in the health care industry." (emphasis added). Because the Amendment does not define "wrongdoing," the word must be construed to bear its ordinary meaning. *Rockies Express Pipeline, L.L.C. v. McClain*, 2020-Ohio-410, ¶12. The ordinary meaning of "wrongdoing" is "evil or improper behavior or action." Merriam-Webster's Collegiate Dictionary 1447 (11th ed.). Subsection (D) thus permits the legislature to regulate evil or improper behavior in the healthcare industry.

Subsection (D)'s reservation of legislative authority preserves the General Assembly's preexisting power to prohibit dangerous, ineffective, and unethical forms of medical treatment. After all, the administration of unproven, immoral, unnecessary, or unduly dangerous drugs and procedures has long been considered "evil or improper." That is why States restrict or prohibit treatments like electroshock therapy and lobotomies on children. *See* 405 Ill. Comp. Stat. 5/2-110.5; Tenn. Code Ann. §33-8-315. It is why Ohio prohibits using anabolic steroids to enhance athletic performance. Ohio Adm. Code 4731-11-03. These and other procedures are banned (at least in some applications) because they are evil or improper—they constitute "wrongdoing," in the words of Subsection (D).

Ohio's legislature unambiguously had the power to enact such laws before the Healthcare Freedom Amendment's ratification, and Subsection (D) reserves its power to do so today.

None of this is to say that the General Assembly has *unfettered* discretion to classify medical treatments as "wrongdoing." The legislature may well lack the power to prohibit treatments without some basis for questioning their efficacy, morality, necessity, or safety. (Whether there is a judicially administrable test for reviewing those legislative judgments is another matter.) But Subsection (D) preserves *at least* the General Assembly's power to prohibit treatments that can fairly be described as evil or improper.

B. The SAFE Act's regulations of puberty blockers and cross-sex hormones are consistent with the Healthcare Freedom Amendment.

The foregoing principles require this Court to reverse the Tenth District's judgment.

1. The legislature reasonably concluded that treating minors' gender dysphoria with puberty blockers and cross-sex hormones qualifies as "wrongdoing."

As explained in the previous section, the General Assembly's power to regulate "wrongdoing in the health care industry," art. I, §21(D), includes the power to regulate or prohibit evil or improper forms of treatment. Exercising this power, the General Assembly permissibly banned doctors from using puberty blockers and cross-sex hormones to "treat" gender dysphoria in minors. This follows from the fact that these forms of treatment can reasonably be deemed "improper."

Begin with the risks. Puberty blockers and cross-sex hormones threaten harm to

patients, some of it permanent and disfiguring. Puberty blockers, for their part, interfere with children's neurological development and bone growth, stunt (perhaps permanently) the maturation of reproductive organs, and have unknown long-term effects on fertility. *See above* 6–9. Cross-sex hormones—which nearly all children put on puberty blockers go on to receive—can permanently eliminate sexual function and increase the risk of osteoporosis, strokes, heart attacks, cancer, and more besides. *See above* 9–10.

On the other side of the ledger, the benefits of puberty blockers and cross-sex hormones are either uncertain or illusory. A "systemic review" of the evidence offers no support for the common assertion that these drugs decrease suicidality. *See above* 12. Beyond that, we lack long-term data capable of justifying the belief that these drugs are net beneficial in the long run. *See* Cass Review at 33; *see above* 6–10, 12.

All told, puberty blockers and cross-sex hormones are experimental and dangerous. Yet parents around the country have been pressured to serve as guinea pigs for procedures that carry known risks and uncertain benefits, all to treat a condition (gender dysphoria) that most children overcome without treatment. The legislature could rationally conclude that administering such treatments to children is evil or improper—that it constitutes wrongdoing. Thus, when the legislature banned these treatments in the SAFE Act, it responsibly and constitutionally wielded its authority to regulate "wrongdoing in the health care industry." Art. I, §21(D).

2. The Tenth District erred when it held that the SAFE Act violates the Healthcare Freedom Amendment.

The Tenth District recognized that Subsection (D) empowers the General Assembly to regulate "wrongdoing in the health care industry," and correctly observed that "wrongdoing," in this context, means "evil or improper." App. Op. ¶68 (quoting Merriam-Webster Dictionary Online). Nonetheless, the Tenth District denied that the legislature's reserved authority enabled it to prohibit puberty blockers and cross-sex hormones.

Subsections (B) and (C). The Tenth District began on the wrong foot by accepting, at least tentatively, that Subsections (B) and (C) confer a right to purchase illegal healthcare treatments. They do no such thing.

Recall that Subsection (B) invalidates laws that "prohibit the purchase or sale of health care," while Subsection (C) invalidates laws that penalize "the sale or purchase of health care." The State, correctly, argued that these provisions confer a right to purchase (free from penalty) healthcare treatments that doctors may legally provide. *See also above* 26–30. In other words, these Subsections preserve economic liberty in the healthcare industry by creating a right to buy and sell healthcare (and health insurance) on the open market. But an open market is not an unregulated market, and these provisions create no right to buy or sell *prohibited* drugs and treatments.

For at least three reasons, the State's reading is correct.

First, and as explained above, the State's reading accounts for "'the principal evil at which' the Healthcare Freedom Amendment 'was directed.'" Meese Br.8 (quoting

Crawford v. Washington, 541 U.S. 36, 50 (2004)). Again, Ohioans ratified the Amendment to preserve economic liberty in healthcare matters—a liberty many feared the Affordable Care Act would threaten—by creating a right to buy and sell healthcare on the open market. The State's reading, under which Subsections (B) and (C) create a right to purchase otherwise-legal healthcare on mutually beneficial terms, achieves this principal purpose. Critically, however, the open market that Ohioans fought to preserve is not "an unregulated healthcare market in which doctors and non-doctors alike would be free to offer whatever services or drugs they like[d] to any willing buyer." Meese Br.10. No such market existed even before the Affordable Care Act. Accordingly, the destruction of this non-existent unregulated market—the sort of market the Tenth District's interpretation of Subsections (B) and (C) creates—was not among the evils at which the Amendment was directed.

Second, the Tenth District's reading leads to anomalous results. Subsections (B) and (C) confer a right to engage in the "purchase or sale" of healthcare; they confer no right to provide or obtain healthcare outside the context of a commercial transaction. Thus, the Healthcare Freedom Amendment does not even arguably confer a right to provide or obtain treatments on a *pro bono* basis. So, if the Tenth District were right that Subsections (B) and (C) conferred a right to purchase or sell any form of healthcare regardless of its illegality, those provisions would confer a right to buy and sell procedures that no doctor may give away for free. That makes little sense. And the anomaly is avoided by reading

Subsections (B) and (C) as conferring only a right to buy and sell, on the open market, otherwise-legal forms of treatment.

Third, and perhaps most important of all, the State's reading accords with a fundamental principle of legal interpretation, which is that legal texts should be read to effect dramatic policy changes only when they do so expressly. Textualism is not literalism. The good textualist strives to understand the written word according to its ordinary meaning. And deciphering ordinary meaning requires accounting for background expectations that readers bring to bear. *Biden v. Nebraska*, 600 U.S. 477, 511–12 (2023) (Barrett, J., concurring). One such background expectation is this: people speak clearly when they mean to communicate matters of great importance. That is why the corporate board member who says "we need to change how we do business" is naturally understood to call for improved operations, not for the company to cease its operations and begin anew in a different industry. The same principle applies in law. Legal drafters do not "alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—[they do] not, one might say, hide elephants in mouseholes." *Whitman v. Am. Trucking Assns.*, 531 U.S. 457, 468 (2001). Ordinary readers know this. So, they will not understand a legal text to upend entire regulatory structures unless it does so clearly. *See, e.g., FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 160 (2000); *MCI Telecommunications Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 231–32 (1994).

The elephants-in-mouseholes principle applies with full force here. If the Healthcare

Freedom Amendment really meant to strip the government of its longstanding power to prohibit the administration of dangerous, ineffective, immoral, or otherwise improper medical procedures, one would expect the Amendment to say so clearly. Subsections (B) and (C) never do so. Accordingly, they should not be interpreted to effect so massive a change to the longstanding regulatory framework.

All told, these three considerations counsel against reading Subsections (B) and (C) to make Ohio the only State in the Nation with a legislature unable to ban dangerous, ineffective, immoral, and otherwise-improper healthcare treatments.

The Tenth District's analysis does not refute any of these arguments. Indeed, its analysis consists mostly of assertions that its reading accords with the text's plain meaning. The only argument it offers is that the State's reading of Subsections (B) and (C) requires inserting words into the provisions, making the protections for "the sale or purchase of health care" into protections for "the sale or purchase *of otherwise-legal* health care." *See* App. Op. ¶¶54–56. This argument achieves nothing. Subsections (B) and (C) override laws prohibiting or penalizing "the sale or purchase" of "health care." The interpretive question turns on whether this is best read as conferring an economic right to engage in market-based healthcare transactions (the State's reading), or instead a right to buy and sell all *forms* of healthcare (the Tenth District's reading). Neither option requires modifying the text. And the economic-liberty reading is superior for the reasons discussed above.

Subsection (D). The Tenth District's analysis of Subsection (D) illustrates its unease with the logical implications of the way it interpreted Subsections (B) and (C).

If Subsections (B) and (C) really did confer a right to purchase any form of medical care that any doctor were willing to provide, then it would confer a right to buy and sell discredited, dangerous, ineffective, and otherwise immoral procedures. Apparently uncomfortable with this, the Tenth District recognized that *some* such procedures might qualify as "wrongdoing" that the General Assembly may ban under Subsection (D). But the court disclaimed any "need to define the outer edges of 'wrongdoing in the health care industry.'" App. Op. ¶70. Wherever those outer edges are, the court said, "acting in accordance with the prevailing standards of care, following widely accepted treatment protocols, and providing medical interventions in accordance with the practice guidelines published by leading professional groups that reflect the consensus of the professional medical community does not fall within the plain meaning of 'wrongdoing in the health care industry' contemplated by Section 21(D)." *Id*. (footnote omitted).

The Tenth District never did, however, justify this reading: it offered no basis for concluding that medical procedures cease to be "evil or improper" simply because they garner (apparent) consensus support. Nor could the court have justified this reading. Forced sterilizations of the "feebleminded" were evil or improper—they qualified as "wrongdoing"—even when they had widespread expert support. *See* Jeffrey S. Sutton, *51 Imperfect Solutions* 87 (2018). The same goes for bloodletting, trepanation, lobotomies,

thymic irradiation in infants, and thalidomide for treatment of morning sickness—all procedures and drugs that one era's experts promoted and that turned out to be evil or improper. *See* Timothy M. Bell, *A Brief History of Bloodletting*, Vol. 11, No. 4, The Journal of Lancaster General Hospital (Winter 2016), https://perma.cc/7AYB-GAVS; Charles G. Gross, *A Hole in the Head: A History of Trepanation*, The MIT Press Reader (June 11, 2021), https://perma.cc/9Q5E-S7MN; Michael A. Gallea, *A brief reflection on the not-so-brief history of the lobotomy*, Vol. 59, No. 6, British Columbia Medical Journal (July-Aug. 2017), https://perma.cc/R747-CXSW; (Michael) Jacob Adams, *et al.*, *Thyroid Cancer Risk 40+ Years after Irradiation for an Enlarged Thymus: An Update on the Hempelmann Cohort*, NIH Public Access (Dec. 2010), https://perma.cc/MG85-KDTH; Waqas Rehman, *et al.*, *The rise, fall and subsequent triumph of thalidomide: lessons learned in drug development*, Vol. 2, No. 5, Therapeutic Advances in Hematology 291, 291 (2011), https://perma.cc/TGK5-TCUJ. To be sure, the experts might not have *appreciated* the wrongfulness; they believed that these treatments were safe (or at least safe enough), effective, and ethical. But the experts were wrong, and their ignorance on this score did not make improper treatments into proper treatments.

The closest the Tenth District came to defending its interpretation came when it alluded to the surplusage canon, which provides that provisions in legal texts ought not be interpreted to make other provisions nugatory. Antonin Scalia & Bryan A. Garner, *Reading Law*, §26, p.174 (2012). Specifically, the court asserted that the State's reading, under

which Subsection (D) preserves the General Assembly's broad authority to regulate or prohibit treatments it rationally deems "wrongdoing," would transform Subsections (B) and (C) into "nothing more than the right to receive health care subject to the policy preferences of the General Assembly." App. Op. ¶69.

The Tenth District's defense is doubly wrong.

First, this argument rests on the false premise that Subsections (B) and (C) create a right to purchase otherwise-illegal forms of medical treatment. As addressed above, *see above* 26–30, they do not confer such a right; they instead confer the right to purchase (or refuse to purchase) otherwise-legal treatments from physicians on mutually agreeable terms. The State's reading of Subsection (D) does not allow the General Assembly to override that right and thus creates no surplusage problem.

Second, even if Subsections (B) and (C) *did* confer a right to obtain otherwise-illegal medical procedures, they *also* confer a right to purchase (or refuse to purchase) medical treatment on the open market—the Tenth District never claimed otherwise. That undisputed fact defeats the Tenth District's surplusage argument. For as just noted, the State's reading of Subsection (D) would *not* allow the General Assembly to restrict that right to purchase otherwise-legal services on the open market. The State's reading would not, in other words, transform Subsections (B) and (C) into "nothing more than the right to receive health care subject to the policy preferences of the General Assembly." App. Op. ¶69. That is, even if the Tenth District were right about the meaning of Subsections (B)

and (C), the State's reading of Subsection (D) would not cause those provisions to have "no consequence," Scalia & Garner, *Reading Law* at §26, p.174, as they would still confer an unqualified right to purchase healthcare on the open market.

* * *

All told, the Healthcare Freedom Amendment is best construed as responding to the Affordable Care Act by conferring a right for patients and providers to buy and sell, on mutually agreeable terms, otherwise-legal treatments. It does not bar the General Assembly from prohibiting the purchase and sale of medical procedures that can fairly be considered "wrongdoing." And the General Assembly rationally concluded that using puberty blockers and cross-sex hormones to treat gender dysphoria is wrongdoing. The SAFE Act thus comports with the Healthcare Freedom Amendment. The Tenth District erred in holding otherwise.

CONCLUSION

The Court should reverse the Tenth District's judgment.

September 18, 2025

/s/ *Benjamin M. Flowers*
Benjamin M. Flowers* (0095284)
*Counsel of Record
James S. Kresge (0086370)
Andrew D. McCartney (0099853)
ASHBROOK BYRNE KRESGE FLOWERS LLC
P.O. Box 8248
Cincinnati, Ohio 45249
(614) 705-6603
bflowers@abkf.com

Counsel for Amici Curiae *Independent Women's Forum and Center for Christian Virtue*

CERTIFICATE OF SERVICE

On September 18, 2025, I served this brief on the parties' counsel by sending it to the email addresses listed below.

/s/ Benjamin M. Flowers

Freda J. Levenson (45916)
Counsel of Record
ACLU OF OHIO FOUNDATION, INC.
4506 Chester Ave.
Cleveland, Ohio 44103
(614) 586-1972
flevenson@acluohio.org

Counsel for plaintiffs-appellees Madeline Moe et al.

Mathura J. Sridharan (0100811)
SOLICITOR GENERAL
Counsel of Record
mathura.sridharan@ohioago.gov

Counsel for defendants-appellants Dave Yost, et al.