The Intrusive State: Restrictions on Gender-Affirming Healthcare for Minors, Exceptions to the Doctrine of Parental Consent, and Reliance on Science and Medical Expertise

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The provision of gender-affirming medical care to transgender or gender diverse ("TGD") youth is currently the subject of substantial controversy despite an overwhelming consensus in the healthcare community as to the safety and potential benefits of recommended treatments. Much of the debate is fueled by misinformation and inaccurate characterization of research and practice. Against this backdrop, twenty-three states enacted restrictions or complete prohibitions on access to gender-affirming medical care for adolescents between 2021 and the time of this writing in early 2024. The policies typically place healthcare practitioners who provide such services at risk of license revocation. Some statutes create rights of enforcement in third parties or the state, some establish criminal penalties, and others restrict financing of services. Minor patients and their parents have sued to prevent enforcement of these policies, alleging violations of the Equal Protection and Due Process Clauses of the Fourteenth Amendment. Many federal and state district courts have issued preliminary injunctions staying enforcement of some or all of the provisions of the reviewed statutes. Some of these injunctions have been reversed or modified on appeal, creating a split in the federal circuits.

This Article reviews and examines the enacted state measures and the litigation challenging those policies. It focuses primarily on Due Process Clause challenges, analyzing the issues through the lens of the law governing healthcare decisionmaking for minors. Guided by federal constitutional law, state statutory and case law, scholarly commentary,

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and the new Restatement of Children and the Law, this Article reviews the doctrine of parental consent and its exceptions. It concludes that the recent state restrictions on access to gender-affirming care for TGD youth do not satisfy the legally recognized exceptions to that doctrine, and that therefore, the intrusions into family decisionmaking authorized by these statutes are unconstitutional under the Due Process Clause.

Proponents of these measures reject the scientific basis for the standards of care and the consensus positions of the healthcare community. In their place, the measures' proponents proffer misinformation and in some instances, disinformation (that is, content disseminated with the intent of creating controversy, confusion, and uncertainty). Of additional concern, some federal appellate courts have given weight to these unsubstantiated assertions and misrepresentations of the scientific literature in reversing lower court decisions that were well-grounded in the science. This phenomenon reflects a broader trend: Politically and ideologically motivated efforts have infused misinformation into public discussions and legal decisionmaking, affecting the outcomes of legal decisions.

As the review of the scientific literature within this Article reveals, the measures—not the treatments they restrict—risk substantial harm to a highly vulnerable group of young persons and their families, isolating these individuals and families from much-needed professional sources of treatment and support. Although the denial of needed treatment is the most obvious harm, the infliction of pain on these children and their families through social stigmatization, rejection, and marginalization is among the many ripple effects of these legal measures.

TABLE OF CONTENTS

INTRODUCTION 717
I. GENDER-AFFIRMING CARE AND THE YOUTH WHO SEEK IT 725
A. TRANSGENDER AND GENDER DIVERSE YOUTH 725
1. *Terminology* 725
2. *Mental Health and TGD Youth* 728
B. GENDER-AFFIRMING CARE 734
1. *The Gender-Affirmative Model* 734
2. *Standards of Practice for Gender-Affirming Care* 736
a. *Social affirmation* 739
b. *Affirmative psychological interventions* 740
c. *Affirmative medical interventions* 741
(1) *Pubertal suppression* 744
(2) *Gender-affirming hormone treatment* 746
(3) *Surgical affirmation* 747
C. DEBATES AND CONTROVERSIES 749
II. THE LAW OF CONSENT FOR MINOR'S HEALTH CARE AND THE ROLE OF MEDICAL AND SCIENTIFIC EVIDENCE IN LEGAL DISPUTES ABOUT PARENTAL AUTHORITY TO DECIDE 753
A. LEGAL FOUNDATIONS FOR PARENTAL AUTHORITY TO DECIDE 754
B. EXCEPTIONS TO THE DOCTRINE OF PARENTAL CONSENT 760
1. *Exceptions to Protect the Public Health* 761
2. *Exceptions to Promote Minors' Access to Necessary Health Care Services in Contexts in Which Some Minors Forego Services if Parental Consent is Required* 761
3. *Exceptions to Protect Minors' Constitutional, Statutory, or Autonomy Interests* 761
4. *Exceptions to Promote Minors' Access to Health Care Services When Parents Are Unavailable* 762
5. *Exceptions to Protect Children from Risk of Serious Harm or Death* 762
a. *Child protective intervention* 763
b. *Legislative restriction of parental authority with respect to specific interventions to prevent serious harm* 768
C. THE ROLE OF MEDICAL AND SCIENTIFIC EVIDENCE IN LEGAL DISPUTES ABOUT PARENTAL AUTHORITY TO DECIDE 773
III. STATE EFFORTS TO RESTRICT ACCESS TO GENDER-AFFIRMING CARE FOR MINORS 777
A. THE MEASURES 778
1. *Services Prohibited or Restricted* 780

2. *Enforcement Mechanisms, Persons or Entities Subject to Enforcement Mechanisms, and Other Obstacles to Service Provision* 782
a. *"Unprofessional conduct" designation and license revocation* 782
b. *Private causes of action or attorney general enforcement* 783
c. *Restriction on use of state funds* 783
d. *Defining the provision of gender-affirming medical or surgical care as criminal conduct* 784
e. *Restrictions and penalties targeting parents and third parties* 785
B. THE LITIGATION 787
1. *The Eighth Circuit* 788
2. *The Sixth Circuit* 794
3. *The Eleventh Circuit* 797
4. *Other Litigation* 801
IV. THE CONSTITUTIONALITY OF MEASURES RESTRICTING ACCESS TO GENDER-AFFIRMING CARE FOR MINORS 803
A. THE SPECTER OF *DOBBS*, "HISTORY AND TRADITION," AND NARROW CIRCUMSCRIPTION OF THE UNDERLYING RIGHT 804
B. THE CONSTITUTIONALITY OF MEASURES RESTRICTING GENDER-AFFIRMING MEDICAL CARE: THE SPLIT IN THE CIRCUITS AND OPINIONS WHOLLY UNTETHERED FROM THE EVIDENTIARY RECORD 809
CONCLUSION 819

INTRODUCTION

Since the passage of Arkansas's Act 626 in 2021,[1] state legislatures have considered well over one hundred bills designed to restrict access to gender-affirming healthcare for minors.[2] Gender-affirming care seeks to meet the "social, mental, and medical health needs and well-being" of persons who experience incongruence between their gender identity and the sex assigned to them at their birth, "while respectfully affirming" those persons' gender identity.[3] Within the framework of this model, gender identity is defined as persons' "deeply felt, internal, intrinsic sense of their own gender."[4] Studies reveal that *transgender* and *gender diverse* ("TGD")[5] minors, that is, minors experiencing gender incongruence, are at high risk for developing mental health and concomitant health disorders and for experiencing gender minority-based

1. Arkansas House Bill 1570, labeled the Arkansas Save Adolescents from Experimentation (SAFE) Act, became law on April 6, 2021, after the legislature overrode Governor Asa Hutchinson's veto. H.B. 1570, 93d Gen. Assemb., Reg. Sess. (Ark. 2021). The law became effective on July 28, 2021. ARK. CODE ANN. §§ 20-9-1501–04 (2021). The statute was temporarily enjoined five days later, on August 2, pursuant to a lawsuit brought by minors, their parents, and health care providers. Brandt v. Rutledge, 551 F. Supp. 3d 882, 894 (E.D. Ark. 2021), *aff'd*, 47 F.4th 661 (8th Cir. 2022), *en banc reh'g denied*, No. 21-2875, 2022 WL 16957734 (8th Cir. 2022). It was held to be unconstitutional and permanently enjoined on June 20, 2023. 677 F. Supp. 3d 877, 922–25 (E.D. Ark. 2023) (holding Arkansas statute unconstitutional and granting permanent injunction).

2. According to a report by the Williams Institute of the University of California at Los Angeles, 126 bills had been proposed in state legislatures by March 2023 in that legislative session. *See, e.g.*, ELANA REDFIELD, KERITH J. CONRON, WILL TENTINDO & ERICA BROWNING, UCLA WILLIAMS INST., PROHIBITING GENDER-AFFIRMING MEDICAL CARE FOR YOUTH 2, 20–24 (2023), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Youth-Health-Bans-Mar-2023.pdf. Based on a contemporaneous tabulation throughout 2023, my research team counted 134 bills proposing restrictions on gender-affirming medical care for minors under consideration in legislatures in 2023. We relied on multiple sources for this count, including searches for proposed legislation in subscription databases and news reports, as well as a database maintained by the American Civil Liberties Union. *See Mapping Attacks on LBGTQ Rights in U.S. State Legislatures*, ACLU, https://www.aclu.org/legislative-attacks-on-lgbtq-rights?impact=health (last visited Mar. 24, 2024) ("filtering by issue" for "healthcare age restrictions") [hereinafter ACLU, *Mapping Attacks*]. At the time of our last visit to the website, on February 4, 2024, the website had shifted to tracking bills under consideration in 2024. As of that date, 63 bills were under consideration in 2024, although some of these bills were "carried over" from 2023 and had not advanced since early 2023. *Id.* In both 2023 and 2024, there are several similar bills proposed within a state. For example, Oklahoma and South Carolina account for an outsized proportion of the 2024 bills. *Id.*

3. *See, e.g.*, E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH S1, S7, S252 (2022) [hereinafter Coleman et al., *SOC8*]. See *infra* Part I for a more comprehensive discussion of the concept of gender-affirming care, the consensus professional recommendations for gender-affirming care for minors, recommended interventions, and supporting research.

4. *Id.*

5. Most recently, key professional associations, such as the World Professional Association for Transgender Health ("WPATH"), and the American Academy of Pediatrics ("AAP") have adopted this broader terminology as more comprehensive and inclusive, and rejected terminology such as "gender nonconforming," which may be viewed as pejorative by some. *See, e.g.*, Coleman et al., *SOC8*, *supra* note 3, at S10; Jason Rafferty, Comm. on Psychosocial Aspects Child & Fam. Health & Am. Acad. Psych. Section on Lesbian, Gay, Bisexual, & Transgender Health & Wellness, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 PEDIATRICS, no. 4, Oct. 2018, at 2 tbl.1, https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for. For further discussion of this terminology and related concepts, see *infra* Part I.A.1.

victimization and violence.[6] Furthermore, findings indicate that that TGD youth consider or attempt suicide at substantially higher rates than do other youth.[7] Investigators have documented multiple sources for this psychological suffering.[8] Social stressors—such as rejection by peers, the wider social community, and often their own families—compound distress youth may experience as a result of the incongruence between their bodies and their gender identity.[9]

The current body of scientific research indicates that gender-affirming care, if provided by competent specialists in a manner consistent with national and international standards of practice, can mitigate this distress for a substantial subset of those experiencing it, often reducing debilitating symptoms and enhancing quality of life.[10] There is a broad consensus across national and world medical and mental health professional organizations that these interventions offer potential benefits when used appropriately.[11]

As in the case of most medical interventions, there are some risks and side effects associated with some of the treatments.[12] Furthermore, the body of knowledge about long-term effects continues to develop. Yet, the overwhelming consensus of medical judgment in pediatrics, endocrinology, and other medical specialties is that these limitations do not render these interventions unsafe and should not be a basis for prohibitions.[13] Careful monitoring and management of cases and ongoing evaluation are recommended to maximize benefits and minimize or mitigate risks and side effects.[14] Like many healthcare interventions for minors, decisions about gender-affirming medical care require thoughtful deliberation by patients and their parents, together with their healthcare providers, with particular attention to the risk-benefit ratio relevant to each individual's personal healthcare needs. The prevailing standards of care emphasize the importance of discussions of these factors with parents and children as part of the informed consent process.[15] Confronting and working through such complexities in healthcare decisionmaking is a fact of life for

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6. *See, e.g.*, Natalie M. Wittlin, Laura E. Kuper & Kristina R. Olson, *Mental Health of Transgender and Gender Diverse Youth*, 19 ANN. REV. CLINICAL PSYCH. 207, 210–12 (2023); Myeshia Price-Feeney, Amy E. Green & Samuel Dorison, *Understanding the Mental Health of Transgender and Nonbinary Youth*, 66 J. ADOLESCENT HEALTH 684, 687–88 (2020); Michael E. Newcomb, Ricky Hill, Kathleen Buehler, Daniel T. Ryan, Sarah W. Whitton & Brian Mustanski, *High Burden of Mental Health Problems, Substance Use, Violence, and Related Psychosocial Factors in Transgender, Non-Binary, and Gender Diverse Youth and Young Adults,* 49 ARCHIVES SEXUAL BEHAV. 645, 654–56 (2020); *see also infra* Part I.A.2.

7. *See* sources cited *supra* note 6; *see also infra* Part I.A.2.

8. *See infra* Part I.A.2.

9. Wittlin et al., *supra* note 6, at 213–15.

10. *See, e.g.*, *id.* at 219–20.

11. *See infra* Part I.B.

12. *See infra* Part I.B.

13. *See infra* Part I.B.

14. *See infra* Part I.B.

15. *See infra* Part I.B.

families whose children have significant health or mental health needs of any type.

The provision of gender-affirming medical care to minors has become the subject of substantial controversy, despite the breadth of consensus in the healthcare community about safety and potential benefits of the recommended treatments, and of the primary role of families in making these decisions together with their healthcare practitioners.[16] Some of the controversy consists of well-informed debates among those knowledgeable and experienced in working with TGD minors.[17] Yet much of the debate is fueled by misinformation and inaccurate characterization of research and practice.[18]

At the time of this writing, twenty-three states have enacted restrictions.[19] These policies prohibit or restrict the availability of a range of gender-affirming interventions by, for example: characterizing provision of such treatment as "unprofessional conduct" that risks professional license revocation; defining provision of such treatment as a criminal offense punishable by up to ten years in prison; creating rights of enforcement by third parties or the state against those who provide or facilitate access to gender-affirming health services; or restricting state funding for the identified service providers or for entities that provide or facilitate the identified services.[20]

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16. *See infra* Part I.B.1.c & Part II.A.

17. *See, e.g.*, Diane Chen, Laura Edwards-Leeper, Terry Stancin & Amy Tishelman, *Advancing the Practice of Pediatric Psychology with Transgender Youth: State of the Science, Ongoing Controversies, and Future Directions*, 6 CLINICAL PRAC. PEDIATRIC PSYCH. 73, 76–80 (2018); Jack L. Turban & Diane Ehrensaft, *Research Review: Gender Identity in Youth: Treatment Paradigms and Controversies*, 59 J. CHILD PSYCH. & PSYCHIATRY 1228 (2018); *see infra* Part I.B.1.c.

18. *See APA Policy Statement on Affirming Evidence-Based Inclusive Care for Transgender, Gender Diverse, and Nonbinary Individuals, Addressing Misinformation, and the Role of Psychological Practice and Science*, AM. PSYCH. ASS'N (2024), https://www.apa.org/about/policy/transgender-nonbinary-inclusive-care.pdf; SUSAN D. BOULWARE, REBECCA KAMODY, LAURA KUPER, MEREDITHE MCNAMARA, CHRISTY OLEZESKI, NATHALIE SZILAGYI & ANNE ALSTOTT, BIASED SCIENCE: THE TEXAS AND ALABAMA MEASURES CRIMINALIZING MEDICAL TREATMENT FOR TRANSGENDER CHILDREN AND ADOLESCENTS RELY ON INACCURATE AND MISLEADING SCIENTIFIC CLAIMS (2022), https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/report%20on%20the%20science%20of%20gender-affirming%20care%20final%20april%2028%202022_442952_55174_v1.pdf [hereinafter BOULWARE ET AL., BIASED SCIENCE]; MEREDITHE MCNAMARA, HUSSEIN ABDUL-LATIF, SUSAN D. BOULWARE, REBECCA KAMODY, LAURA KUPER, CHRISTY OLEZESKI, NATHALIE SZILAGYI & ANNE ALSTOTT, A CRITICAL REVIEW OF THE JUNE 2022 FLORIDA MEDICAID REPORT ON THE MEDICAL TREATMENT OF GENDER DYSPHORIA (July 8, 2022), https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida%20report%20final%20july%208%202022%20accessible_443048_284_55174_v3.pdf [hereinafter MCNAMARA ET AL., A CRITICAL REVIEW]; Heather Boerner, *What the Science on Gender-Affirming Care for Transgender Kids Really Shows*, SCI. AM. (May 12, 2022), https://www.scientificamerican.com/article/what-the-science-on-gender-affirming-care-for-transgender-kids-really-shows; AJ Eckert, *Cutting Through the Lies and Misinterpretations about the Updated Standards of Care for the Health of Transgender and Gender Diverse People*, SCI.-BASED MED. (Oct. 22, 2022), https://sciencebasedmedicine.org/cutting-through-the-lies-and-misinterpretations-about-the-updated-standards-of-care-for-the-health-of-transgender-and-gender-diverse-people. *See also infra* Part I.B.1.c.

19. Some states' policies are not in effect. See *infra* Part III.A for discussion of the current statutes and their legal status. *See also Bans on Best Practice Medical Care for Transgender Youth*, MOVEMENT ADVANCEMENT PROJECT, https://www.lgbtmap.org/equality-maps/healthcare/youth_medical_care_bans (last visited Mar. 24, 2024).

20. *See infra* Part III.

Minor patients and their parents have sued against enforcement of these policies,[21] claiming constitutional violations. The minor plaintiffs challenge these measures as a violation of the Equal Protection Clause, alleging that these restrictions on gender-affirming care discriminate on the basis of sex and on the basis of their status as transgender.[22] The parent plaintiffs raise due process claims, alleging state interference in parental liberty to raise their children according to their own judgment, discretion, and values.[23] Many federal and state district courts hearing challenges have issued preliminary injunctions staying enforcement of some or all of the provisions of the reviewed statutes, concluding that the plaintiffs are likely to succeed on the merits at trial.[24] Some of these injunctions have been reversed or modified on appeal, creating a split in the federal circuits.[25] The Eighth Circuit affirmed the district court's issuance of a preliminary injunction,[26] the Sixth Circuit vacated district court orders affecting the statutes in Kentucky and Tennessee, and the Eleventh Circuit vacated the district court orders affecting the statute in Alabama.[27] Thus far, only the District Court for the Eastern District of Arkansas decided its case on the merits, finding the Arkansas statute unconstitutional, and issuing a permanent injunction.[28]

Our common law and constitutional principles authorize parents to make healthcare decisions for their children in a manner consistent with their family's values, their assessment of their child's needs, and the expertise and recommendations of the medical authorities upon whom they rely.[29] There is

21. In some cases, the plaintiffs include healthcare providers, whose claims this Article discusses briefly later. *See infra* Part III.B.

22. *See, e.g.*, Brandt v. Rutledge, 677 F. Supp. 3d 877, 885, 917–18 (E.D. Ark. 2023) (holding the Arkansas statute unconstitutional and granting permanent injunction); L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 680 (M.D. Tenn. 2023) (granting preliminary injunction), *rev'd*, 83 F.4th 460, 469–70 (6th Cir. 2023), *petition for cert. filed*, 2023 WL 7327440 (Nov. 6, 2023) (No. 23-477).

23. *See, e.g.*, *Brandt*, at 885, 923.

24. *See infra* Part III.B.

25. *See, e.g.*, Brandt v. Rutledge, 551 F. Supp. 3d 882, 894 (E.D. Ark. 2021) (granting temporary injunction), *aff'd*, 47 F.4th 661, 667 (8th Cir. 2022), 677 F. Supp. 3d 877, 885 (E.D. Ark. 2023) (holding Arkansas statute unconstitutional and granting permanent injunction); Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131, 1151 (Ala. 2022) (granting preliminary injunction), *rev'd sub nom.* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1231 (8th Cir. 2023). For discussion of these cases, see *infra* Parts III.B and IV.B.

26. Brandt v. Rutledge, 47 F.4th 661, 669–71 (8th Cir. 2022), *en banc reh'g denied*, No. 21-2875, 2022 WL 16957734 (8th Cir. 2022).

27. *See Skrmetti*, 83 F.4th 460, 491 (6th Cir. 2023) (reversing preliminary injunction), 2023 WL 7327440 (Nov. 6, 2023) (petition for writ of certiorari); *Eknes-Tucker*, 80 F.4th 1205, 1231 (11th Cir. 2023) (vacating preliminary injunction). It is likely that the Eleventh Circuit's decision will also impact preliminary injunctions staying enforcement of the statutes in Florida and Georgia, although at the time of this writing, no such ruling has been issued.

28. *See Brandt*, 677 F. Supp. 877, 885 (E.D. Ark. 2023). Arkansas has appealed to the Eighth Circuit, which had previously affirmed the district court's holding at the preliminary injunction phase.

29. *See, e.g.*, Meyer v. Nebraska, 262 U.S 390, 400 (1923); Pierce v. Soc'y of Sisters, 268 U.S. 510, 535 (1925); Wisconsin v. Yoder, 406 U.S. 205, 232 (1972); Parham v. J.R., 442 U.S. 584, 602 (1979). For a thoughtful statement of the evolution and modern status of this authority, see RESTATEMENT OF CHILD. & THE LAWS ch. 1, intro. note (AM. L. INST., Tentative Draft No. 1, 2018) (emphasizing current vitality of "robust legal and constitutional protection" for parental authority).

broad respect for the "private realm of family life" that shields families from overly aggressive state interference.[30] Parental discretion to exercise decisionmaking authority for their minor children's healthcare is protected as a fundamental dimension of liberty under the Due Process Clause of the Fourteen Amendment.[31] Parents are presumed to act in their children's best interests and their judgment regarding those interests is presumed to be superior to that of the state.[32] In most instances, subject to *limited and narrow* exceptions, the law defers to parental judgment.[33]

Some exceptions to the doctrine of parental consent allow minors to consent to certain limited forms of healthcare independent of their parents.[34] And indeed, some scholars have examined the question of whether such an exception should authorize minors' independent access to gender-affirming care.[35] Yet parents and minors *are aligned* in their legal challenges to the recent state restrictions on gender-affirming care, claiming that the state cannot constitutionally wrest parents of their decisionmaking authority. The minors in those cases do not assert legal claims of independent decisional authority. Therefore, this Article does not address the question of whether minors should be granted legal authority to consent independently to gender-affirming care.[36]

This Article examines state legislation prohibiting or otherwise limiting access by TGD youth and their families to gender-affirming care within the framework of the law governing healthcare decisionmaking for minors. Guided by federal constitutional law, state statutory and case law, scholarly commentary, and the new *Restatement of Children and the Law*, I review the exceptions to the doctrine of parental consent. I conclude that the recent state restrictions on access to gender-affirming care for TGD youth do not satisfy the criteria that justify the intrusions into family decisionmaking authorized by these

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30. Prince v. Massachusetts, 321 U.S. 158, 166 (1944) (asserting that the primacy of the parents in raising their children requires respect for a "private realm of family life which the state cannot enter").

31. Parham v. J.R., 442 U.S. 584, 602–04 (1979); Bellotti v. Baird, 443 U.S. 622, 637–39 (1979). Decisionmaking regarding children's healthcare is one facet of the broader parental decisional authority protected by the Constitution. *See, e.g.*, Troxel v. Granville, 530 U.S. 57, 65–66 (2000).

32. *See Parham*, 442 U.S. at 602–04; *Meyer*, 262 U.S. at 400; *Pierce*, 268 U.S. at 535.

33. *See Parham*, 442 U.S. at 602–04; *see also Bellotti*, 443 U.S. at 637. For a discussion of those exceptions, see *infra* Part II.B.

34. One common exception, at issue in *Bellotti*, involves the transfer of decisional authority to minors in certain limited situations when the minors' interests and preferences do not align with parental judgments. *See infra* Part II.B.3.

35. *See, e.g.*, Emily Ikuta, *Overcoming the Parental Veto: How Transgender Adolescents Can Access Puberty-Suppressing Hormone Treatment in the Absence of Parental Consent Under the Mature Minor Doctrine*, 25 S. CAL. INTERDISC. L.J. 179, 203–05 (2016) (arguing for application of the mature minor doctrine to authorize transgender minors to make independent decisions); Frederica Vergani, Comment, *Why Transgender Children Should Have the Right to Block Their Own Puberty with Court Authorization*, 13 FIU L. REV. 903, 919–28 (2019) (arguing for a judicial by-pass procedure); Samuel Dubin, Megan Lane, Shane Morrison, Asa Radix, Uri Belkind, Christian Vercler & David Inwards-Breland, *Medically Assisted Gender Affirmation: When Children and Parents Disagree*, 46 J. MED. ETHICS 295, 297–98 (2020) (arguing for a range of legal options to overcome parental refusals in some situations).

36. *See infra* Part III.B.

statutes. Although I briefly acknowledge the equal protection arguments and holdings in the challenges to the statutes reviewed herein, my primary focus in this Article is on due process claims.[37]

Proponents of these measures roundly reject the scientific findings supporting the standards of care and consensus positions promulgated by healthcare authorities. In their place, the measures' proponents proffer misinformation and in some instances, disinformation.[38] Surgeon General Vivek Murthy recently issued a report calling attention to the recent increase in the dissemination of health misinformation in our society.[39] With respect to these statutes, misinformation is used to further states' asserted child protective purposes, highlighted with legislation euphemistically titled the "Save Adolescents from Experimentation Act," the "Youth Health Protection Act," and the "Vulnerable Child Compassion and Protection Act."[40] As the review of the scientific literature within this Article[41] concludes, the measures, not the treatments they restrict, risk substantial harm to a highly vulnerable group of young persons and their families, isolating these individuals and families from much-needed professional sources of treatment and support. Although the denial of needed treatment is the most obvious harm, the infliction of pain on these children and their families through social stigmatization, rejection, and marginalization is among the many ripple effects of these legal measures.

Medical expertise, consensus, and scientific evidence have traditionally played special roles in legal determination of whether an exception to parental

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37. For discussion of equal protection claims relevant to these statutes, see, for example, Katie Eyer, *Transgender Constitutional Law*, 171 U. PA. L. REV. 1405, 1440 (2023); Naomi Seiler, Amanda Spott, Mekhi Washington, Paige Organick-Lee, Aaron Karacuschansky, Gregory Dwyer, Katie Horton & and Alexis Osei, *Gender Identity, Health, and the Law: An Overview of Key Laws Impacting the Health of Transgender and Gender Non-Conforming People*, 16 ST. LOUIS U. J. HEALTH L. & POL'Y 171, 182–96 (2023); Note, Romer *Has It*, 136 HARV. L. REV. 1936 (2023); Erik Fredericksen, *Protecting Transgender Youth After* Bostock*: Sex Classification, Sex Stereotypes, and the Future of Equal Protection*, 132 YALE L.J. 1149, 1176–1210 (2023). For an analysis of the equal protection doctrine in relation to challenges of discrimination on the basis of sexuality, gender, or gender identity, see generally, WILLIAM N. ESKRIDGE & NAN D. HUNTER, SEXUALITY, GENDER AND THE LAW 55–108 (5th ed. 2023).

38. "Health misinformation" is "information that is false, inaccurate, or misleading according to the best available evidence at the time. . . . Misinformation can sometimes be spread intentionally to serve a malicious purpose, such as to trick people into believing something for . . . political advantage. This is usually called 'disinformation.'" Vivek H. Murthy, *Confronting Health Misinformation: The U.S. Surgeon General's Advisory on Building a Healthy Information Environment*, U.S. PUB. HEALTH SERV. 4 (2021), https://www.hhs.gov/sites/default/files/surgeon-general-misinformation-advisory.pdf.

39. As Surgeon General Murthy stated:

> [M]isinformation is often framed in a sensational and emotional manner that can connect viscerally, distort memory, align with cognitive biases, and heighten psychological responses such as anxiety. . . . More broadly, misinformation tends to flourish in environments of significant societal division, animosity, and distrust. . . . Growing polarization, including in the political sphere, may also contribute to the spread of misinformation.

Id. at 5.

40. ARK. CODE ANN. §§ 20-9-1501–04, 23-79-1 (2023); N.C. GEN. STAT. § 143C-6-5.6(b) (2023); ALA. CODE §§ 26-26-1–9 (2023).

41. *See infra* Part I.

decisional authority for children's healthcare is permissible.[42] These sources of authority have informed the law as to the risks and benefits of particular courses of action and provided the standards for determining which healthcare decisions create a risk of danger to a child's (or the public's) health.[43] As the decades have passed, and medical practice has become increasingly grounded in science, our expectations have evolved as well, demanding that medical opinions be empirically supported by methodologically sound scientific studies.[44] The rejection of scientific findings and medical expertise by those lawmakers who seek to prohibit gender-affirming care disconnects their lawmaking from the science of healthcare.[45] Such disconnection allows misinformation, together with assumption, unsupported opinion, ideology, and values (personal and political) to fill the void and guide policy.

Part I of this Article reviews the scientific and medical foundations of gender-affirming care. Subpart I.A provides some background on current knowledge about minors who seek such care. Subpart I.B describes the interventions that fall within the rubric of gender-affirming care, reviewing the standards of clinical practice. Finally, Subpart I.C reviews some current questions, debates, and controversies.

Part II examines the law governing consent for the healthcare of minors in the United States. Subpart II.A reviews the common law and constitutional foundations of the doctrine of parental consent. Subpart II.B analyzes the exceptions to that doctrine. It focuses particular attention on one exception, which defines a narrow standard—*substantial risk of serious harm*—as a basis for limiting parental authority in the healthcare context. Lastly, Subpart II.C focuses on the role of scientific evidence and medical expertise in disputes about parental authority to make healthcare decisions for their children.

42. *See infra* Part II.C.

43. *See infra* Part II.C.

44. These expectations are expressed in Federal Rule of Evidence 702 as interpreted by *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 595 (1993), and its progeny. *See* DAVID L. FAIGMAN, EDWARD K. CHENG, JENNIFER MNOOKIN, ERIN E. MURPHY, JOSEPH SANDERS & CHRISTOPHER SLOBOGIN, 1 MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY § 1.1 (2022–2023 ed.); CODE OF MED. ETHICS, op. 9.7.1(j)(i) (AM. MED. ASS'N 2001) (stating that physicians who testify as expert witnesses "must ensure that their testimony reflects current scientific thought and standards of care that have gained acceptance among peers in the relevant field").

45. The proliferation of misinformation, and the rejection of scientific evidence and medical expertise in this context reflects a broader societal phenomenon affecting a range of public and individual health topics. For commentary on this phenomenon, see, for example, Jevin D. West & Carl T. Bergstrom, *Misinformation in and About Science*, PROC. NAT'L ACAD. SCIS., 1 (2021), https://www.pnas.org/doi/epdf/10.1073/pnas.1912444117; TOM NICHOLS, THE DEATH OF EXPERTISE: THE CAMPAIGN AGAINST ESTABLISHED KNOWLEDGE AND WHY IT MATTERS 176 (2017); Sara Prot & Craig A. Anderson, *Science Denial: Psychological Processes Underlying Denial of Science-Based Medical Practices*, *in* MEDICAL MISINFORMATION AND SOCIAL HARM IN NON-SCIENCE-BASED HEALTH PRACTICES: A MULTIDISCIPLINARY PERSPECTIVE 24, 25 (Anita Lavorgna & Anna Di Ronco eds., 2020). For a survey of changing social attitudes about science, see Cary Funk, *Key Findings About Americans' Confidence in Science and Their Views on Scientists' Role in Our Society*, PEW RSCH. CTR. (Feb. 12, 2020), https://www.pewresearch.org/short-reads/2020/02/12/key-findings-about-americans-confidence-in-science-and-their-views-on-scientists-role-in-society.

Part III describes the state statutes, bills, and administrative actions prohibiting or restricting gender-affirming care for minors in the United States. Subpart III.A examines the nature and operation of the measures, including the legal mechanisms employed. Subpart III.B examines the litigation challenging the statutes and administrative actions.

Part IV analyzes the decisions described in Part III, with particular attention to the influence of the Supreme Court's decision in *Dobbs v. Jacksonville Women's Health Organization*[46] on the Sixth and Eleventh Circuit panels. As discussed in Subpart IV.A, *Dobbs* left many questions unanswered about the future of substantive due process analysis in areas other than abortion. In the context of substantive due process analysis, *Dobbs* reinvigorated the "history and traditions" methodology and narrow definitions of the underlying right in determining which rights deserve constitutional protection.[47] In Subpart IV.B, I critique the Sixth and Eleventh Circuit opinions, including the illogic of the Eleventh Circuit's piecemeal application of the history and traditions approach to individual parental health care decisions. The Eleventh Circuit's analysis treats parental authority as fundamental *only if the treatment itself* meets the history and traditions test. By definition, medical *advances* are inapposite to backwards-looking methodologies. I conclude that the court's interpretation would deprive parents of decisional authority for healthcare treatments that reflect recent scientific progress. Subpart IV.B also focuses on the role that misinformation[48] plays both in legislative findings and some courts' reviews of the justifications for the challenged statutes. It examines important scholarly critiques of politically motivated efforts to infuse misinformation into legal decisionmaking on highly polarized issues.

I conclude that state measures restricting gender-affirming care cannot be justified under a scientifically grounded standard requiring the state to demonstrate substantial risk of serious harm to minors. These measures defy well-settled, common law and constitutionally protected principles guiding the allocation of decisional authority for children's healthcare between parents and the state. While parents' authority to choose or reject healthcare interventions for their minor children is subject to limitation, that authority has traditionally been secure against challenge by the state when parental decisions are aligned with the consensus of medical opinion, scientific evidence, and standards of care promulgated by the healthcare establishment. Finally, I reflect on the trends manifested by the legislative and judicial decisions reviewed in this Article, which appear to be motivated by ideology and politics. These trends include unapologetic dissemination of misinformation, and rejection of science and

46. 597 U.S. 215, 231 (2022).

47. *Id.* at 233–50.

48. Or we might more accurately describe the assertions as *disinformation* as intentional dissemination of misinformation "to serve a malicious purpose, such as to trick people into believing something for . . . political advantage." Murthy, *supra* note 38, at 4.

medical expertise. Sadly, these strategies are invoked in this instance to deprive a vulnerable minority group of needed healthcare.

I. Gender-Affirming Care and the Youth Who Seek It

In this Part, I review the scientific literature and standards of care promulgated by interdisciplinary groups of medical and mental health experts specializing in health care for those persons whose care is affected by the statutes discussed below.[49] Subpart I.A describes the population whose care is at issue. Subpart I.B examines the nature of, and scientific evidence relating to, that care.

A. Transgender and Gender Diverse Youth

1. *Terminology*

According to the American Academy of Pediatrics' Committee on Psychosocial Aspects of Child and Family Health, an individual's *gender identity* is "a person's deep internal sense of being female, male, a combination of both, somewhere in between, or neither, resulting from a multifaceted interaction of biological traits, environmental factors, self-understanding, and cultural expectations."[50] This concept is distinct from *sex designated* or *assigned at birth* (alternatively, *birth-designated* or *birth-assigned sex*) which refers to the determination made by others as to a newborn's gender, relying on those visible anatomical differences that typically correspond to differences in chromosomes, internal gonads, external genitalia, and sex hormone levels.[51]

Scientists and healthcare practitioners also differentiate the concept of *gender expression* from that of gender identity. *Gender expression* refers to "how a person enacts or expresses their gender in everyday life and within the context of their culture and society."[52] These various "external" or "outward" manifestations of gender may include, but are not limited to, one's "name, pronouns, mannerisms, clothing, haircut, behavior, voice" or speech patterns, conversational mannerisms, other physical characteristics, activities, and social roles.[53]

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49. *See infra* Part III.A.

50. Rafferty et al., *supra* note 5, at 2, 2 tbl.1; *see* Coleman et al., *SOC8*, *supra* note 3, at S252; *see also* Elizabeth S. Perzanowski, Tony Ferraiolo & Alex S. Keuroghlian, *Overview and Terminology*, *in* PEDIATRIC GENDER IDENTITY: GENDER-AFFIRMING CARE FOR TRANSGENDER & GENDER DIVERSE YOUTH 1, 3 tbl.1.1 (Michelle Forcier, Gerrit Van Schalkwyk & Jack L. Turban eds., 2020) ("A person's inner sense of being a girl/woman, boy/man, some combination of both, or something else, including having no gender at all. This may or may not correspond to the gender assigned at birth."); Scott Leibowitz & Aron Janssen, *Affirming and Gender-Informed Assessment of Gender Diverse and/or Transgender Youth Across Development*, *in* AFFIRMATIVE MENTAL HEALTH CARE FOR TRANSGENDER AND GENDER DIVERSE YOUTH: A CLINICAL GUIDE 1, 4 tbl.1.1 (Aron Janssen & Scott Leibowitz eds., 2018) ("This refers to one's internal, deeply held sense of gender.").

51. Rafferty et al., *supra* note 5, at 2, 2 tbl.1; Coleman et al., *SOC8*, *supra* note 3, at S252.

52. Coleman et al., *SOC8*, *supra* note 3, at S252.

53. Rafferty et al., *supra* note 5, at 2, 2 tbl.1. *See* Coleman et al., *SOC8*, *supra* note 3, at S252; Perzanowski et al., *supra* note 50, at 3, 3 tbl.1.1; Leibowitz & Janssen, *supra* note 50, at 4, 4 tbl.1.1.

Gender incongruence refers to a lack of concordance between a person's gender identity or gender expression and the sex assigned to that individual at birth.[54] The World Professional Association for Transgender Health (WPATH) defines it as "a person's marked and persistent experience of an incompatibility between that person's gender identity and the gender expected of them based on their birth-assigned sex."[55] The experience of such gender incongruence can be associated with some level of psychological distress. In some subset of instances, the level of psychological distress experienced by that person might be severe enough to meet the criteria of *gender dysphoria*, a mental health diagnosis accompanied by "clinically significant" distress or impairment in social, academic, or other aspects of functioning, as described in the Fifth Edition of the American Psychiatric Association's *Diagnostic and Statistical Manual*.[56] The term *cisgender* denotes those persons whose gender identity is concordant with their birth-assigned sex.[57]

Most recently, many scholars and professional associations have adopted the broader term *gender diverse* to refer to those whose gender identity, gender behaviors, or appearances are *incongruent* with those socially, culturally, or stereotypically expected of their birth-assigned sex,[58] or that differ from traditional developmental norms.[59] This term includes persons who identify as one gender, multiple genders, or no gender at all.[60] It also encompasses identities such as transgender, nonbinary, gender fluid, gender expansive, gender creative, genderqueer and others.[61] The term *transgender* may refer to "anyone whose gender identity differs from their sex assigned at birth," and to anyone who "consistently, persistently, and insistently express[es] a binary or non-binary gender [that] is different from their assigned sex."[62] The term *nonbinary* refers

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54. Leibowitz & Janssen, *supra* note 50, at 4, 4 tbl.1.1. In its eleventh edition of the International Statistical Classification of Diseases and Related Health Problems ("ICD-11"), the World Health Organization uses the term "gender incongruence" as a diagnostic category when an individual experiences a lack of concordance between assigned and identified gender. *See Gender Incongruence and Transgender Health in the ICD*, WORLD HEALTH ORG., https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd (last visited Mar. 26, 2024).

55. Coleman et al., *SOC8*, *supra* note 3, at S252.

56. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 511–20 (5th ed., text rev. 2022) [hereinafter DSM-5-TR] ("*Gender dysphoria* . . . refers to the distress that may accompany the incongruence between one's experienced or expressed gender and ones assigned gender."). For more detail on "gender dysphoria," see *infra* Parts I.A.2 and I.B.2.

57. Coleman et al., *SOC8*, *supra* note 3, at S252.

58. *Id.*; Rafferty et al., *supra* note 5, at 2, 2 tbl.1. The American Academy of Pediatrics Committee notes that the term "gender diverse" "replaces the former term 'gender nonconforming,' which has a negative and exclusionary connotation." *Id. See also* Colt Keo-Meier & Diane Ehrensaft, *Introduction to the Gender Affirmative Model*, *in* THE GENDER AFFIRMATIVE MODEL: AN INTERDISCIPLINARY APPROACH TO SUPPORTING TRANSGENDER AND GENDER EXPANSIVE CHILDREN 3, 6 (Colt Keo-Meier & Diane Ehrensaft eds., 2018) (observing that the term gender nonconforming, like the term "gender variant" implies deviance and non-normality, concepts that are inconsistent with a gender-affirmative model).

59. Perzanowski et al., *supra* note 50, at 3, 3 tbl.1.1.

60. *Id.*

61. Rafferty et al., *supra* note 5, at 2 tbl.1.

62. Keo-Meier & Ehrensaft, *supra* note 58, at 6; Rafferty et al., *supra* note 4, at 2 tbl.1.

to gender identifications that are not exclusively female or male, but that may incorporate aspects of both female and male identities, or neither.[63] The term *gender expansive* describes "people who identify or express themselves in ways that broaden the socially and culturally defined behaviors or beliefs associated with a particular sex."[64] In other words, it refers to those whose gender identity or expression differs from what is generally expected within a particular society or culture for males or females.[65]

Some children might be referred to as *gender fluid* as well: "Children who defy the norms of binary gender and either slide along a gender spectrum or weave their own intricate individual patterns along the gender web. The word *fluid* here refers to the potential for movement through further development of one's understanding of their gender."[66] Finally, the term *transition* refers to the process of altering one's gender expression to better match their gender identity.[67] As discussed below in the sections on the gender-affirmative model and gender-affirming care,[68] a social transition may involve changing one's "name, pronoun, clothing, hair styles, and/or the ways that they move and speak."[69]

It is important to note that the concepts of gender identity and gender expression are distinct from that of *sexual orientation*. The latter concept focuses on sexual and romantic attraction to others.[70] These concepts are often conflated by lay persons, professionals less knowledgeable about these issues, parents whose minor children may be gender diverse, or even some youth working toward their own self-understanding.[71] The relationships among these aspects of individuals' subjective sense of themselves and their behavior with respect to these variables are complex and differ among individuals.[72]

The preferred terminology continues to evolve. I employ the broader term—*transgender and gender diverse youth* or *TGD youth*—to refer to the larger population of youth whose care is the subject of this Article and who are affected by state restrictions on gender-affirming care.[73] Furthermore, consistent

63. Leibowitz & Janssen, *supra* note 50, at 4 tbl.1.1.

64. Coleman et al., *SOC8*, *supra* note 3, at S252.

65. Keo-Meier & Ehrensaft, *supra* note 58, at 7.

66. *Id.* at 8. For further discussion of developmental trajectories related to gender identity during childhood, see *infra* Parts I.B &.C.

67. Coleman et al., *SOC8*, *supra* note 3, at S253.

68. *See infra* Part I.B.1.

69. Coleman et al., *SOC8*, *supra* note 3, at S253.

70. Marco A. Hidalgo, Diane Ehrensaft, Amy C. Tilshelman, Leslie F. Clark, Robert Garofalo, Stephen M. Rosenthal, Norman P. Spack & Johanna Olson, *The Gender Affirmative Model: What We Know and What We Aim to Learn*, 56 HUM. DEV. 285, 286 (2013); Am. Psych. Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People,* 70 AM. PSYCH. 832, 835–36 (2015) [hereinafter *APA Guidelines*].

71. *APA Guidelines*, *supra* note 70, at 835–36; Leibowitz & Janssen, *supra* note 50, at 18–19.

72. Hidalgo et al., *supra* note 70, at 286; Keo-Meier & Ehrensaft, *supra* note 58, at 10.

73. *See, e.g.*, Coleman et al., *SOC8*, *supra* note 3, at S252; Rafferty et al., *supra* note 5, at 1; Perzanowski et al., *supra* note 50, at 2.

with more recent conventions, I use the neutral pronouns *they* and *their,* rather than gender-specific pronouns, when referring more generally to persons who fall within this broader TGD group, in recognition of the gender diversity within the group.

2. *Mental Health and TGD Youth*

Studies repeatedly confirm that TGD youth are at substantial risk of experiencing serious mental health challenges.[74] TGD youth, as a group, experience high rates of psychological symptoms and conditions, including depression, anxiety, eating disorders, self-harm, and suicidality compared with cisgender youth,[75] including cisgender youth who are gay, lesbian, or bisexual.[76] Furthermore, TGD youth consider or attempt suicide, or engage in self-harm behaviors at substantially higher rates than do other youth.[77] For example, in one study of students in California high schools, "nearly 35% of transgender youth . . . reported suicidal ideation in the past year: nearly double that of non-transgender youth."[78] In another study of a sample of over 25,000 LBGTQ+ youth, of whom 33 percent identified as transgender or nonbinary, 54 percent of transgender and nonbinary youth reported having considered suicide, and 29 percent reported having attempted to take their own lives.[79] These data are

74. *See* Marijn Arnoldussen & Annelou L. C. de Vries, *Mood, Anxiety, and Other Mental Health Concerns*, *in* PEDIATRIC GENDER IDENTITY, *supra* note 50, at 125, 126–29; Maria E. Eisenberg, Amy L. Gower, Barbara J. McMorris, G. Nicole Rider, Glynis Shea & Eli Coleman, *Risk and Protective Factors in the Lives of Transgender/Gender Non-Conforming Adolescents*, J. ADOLESCENT HEALTH 521, 522, 524-25 (Oct. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5626022/pdf/nihms878334.pdf; Leibowitz & Janssen, *supra* note 50, at 8–9; Newcomb et al., *supra* note 6, at 646–47, 654–56; J. Olson-Kennedy, P. T. Cohen-Kettenis, B.P.C. Kreukels, H.F.L. Meyer-Bahlburg, R. Garofalo, W. Meyer & S.M. Rosenthal, *Research Priorities for Gender Nonconforming/Transgender Youth: Gender Identity Development and Biopsychosocial Outcomes*, CURRENT OP. ENDOCRINOLOGY & DIABETES & OBESITY 172, 175-76 (Apr. 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4807860/pdf/nihms767274.pdf; Amaya Perez-Brumer, Jack K. Day, Stephen T. Russell & Mark L. Hatzenbuehler, *Prevalence and Correlates of Suicidal Ideation Among Transgender Youth in California: Findings from a Representative, Population-Based Sample of High School Students*, 56 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 739, 739, 741 (July 4, 2017); Price-Feeney et al., *supra* note 6, at 684–85, 689; Rafferty et al., *supra* note 5, at 3; SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T HEALTH & HUM. SERVS., PUB NO. PEP22-03-12-001, MOVING BEYOND CHANGE EFFORTS: EVIDENCE AND ACTION TO SUPPORT AND AFFIRM LGBTQI+ YOUTH 42–45 (2023) [hereinafter SAMHSA 2023]; Turban & Ehrensaft, *Gender Identity in Youth*, *supra* note 17, at 1232–33; Wittlin et al., *supra* note 6, at 210–12; Jack L. Turban, Brett Dolotina, Dana King & Alex S. Keuroghlian, *Sex Assigned Birth Ratio Among Transgender and Gender Diverse Adolescents in the United States*, 150 PEDIATRICS, no. 3, Sept. 2022, at 52, https://publications.aap.org/pediatrics/article/150/3/e2022056567/188709/Sex-Assigned-at-Birth-Ratio-Among-Transgender-and?autologincheck=redirected.

75. *See generally* sources cited *supra* note 74.

76. Price-Feeney et al., *supra* note 6, at 684–85.

77. *See generally* sources cited *supra* note 74.

78. Perez-Brumer et al., *supra* note 74, at 741.

79. Price-Feeney et al., *supra* note 6, at 687–88. Due to variations in methodologies and samples, the studies examining suicidality report different rates. For example, summarizing the findings of their meta-analysis, one team of authors calculated a lifetime prevalence of 28 percent for suicidal ideation and 14.8 percent for suicide attempts reported in studies of TGD youth and youth adults. *See* Teresa Surace et al., *Lifetime*

consistent with research that demonstrates high rates of depression and anxiety,[80] as well as suicidal ideation and attempts, in transgender adults when compared with cisgender individuals.[81]

While it is indeed well-established that TGD youth are at greater risk of suffering serious psychological distress, there have been dramatic shifts in the past two decades in explanations of causality. The incongruence between one's gender identity and one's birth-assigned sex had traditionally been viewed within psychiatry as a psychopathological variation.[82] This understanding had been codified in the American Psychiatric Association's *Diagnostic and Statistical Manual* ("*DSM*") as *gender identity disorder*, a diagnosis that embodied that disease-oriented perspective on gender incongruence.[83] In 2013, however, with the publication of the Fifth Edition of the *DSM* ("*DSM-5*"), the Association eliminated the gender identity disorder diagnosis.[84] The Association's current website states the rationale for the shift:

> This change further focused the diagnosis on the *gender identity-related distress* that some transgender people experience (and for which they may seek psychiatric, medical, and surgical treatments) *rather than on transgender individuals or identities themselves*. The presence of gender variance is not the pathology[. The] dysphoria is

Prevalence of Suicidal Ideation and Suicidal Behaviors in Gender Non-Conforming Youths: A Meta-Analysis, 30 EUR. CHILD & ADOLESCENT PSYCHIATRY 1147, 1150–56 (2021). By contrast, the 2023 U.S. National Survey on the Mental Health of LGBTQ Young People found that transgender and nonbinary persons ages 13 to 24 report having considered suicide in the prior year at exceedingly high rates (48% for transgender females, 56% for transgender males, and 48% for nonbinary persons). THE TREVOR PROJECT, 2023 U.S. NATIONAL SURVEY ON THE MENTAL HEALTH OF LGBTQ YOUNG PEOPLE 6 (2023), https://www.thetrevorproject.org/survey-2023/assets/static/05_TREVOR05_2023survey.pdf. The reported rates of attempting suicide in the prior year are similarly strikingly high (16% for transgender females, 23% for transgender males, and 17% for nonbinary persons). *Id.* Yet, despite this variation in findings, all reported estimates support the conclusion that the rates of suicidality in this population far exceed those observed in cisgender youth. *See, e.g.*, Price-Feeney et al., *supra* note 6, at 684–85, 689.

80. *See, e.g.*, Cecilia Dhejne, Roy Van Vlerken, Gunter Heylens & Jon Arcelus, *Mental Health and Gender Dysphoria: A Review of the Literature*, 28 INT'L REV. PSYCHIATRY 44, 53 (2016); Samantha R. Pflum, Rylan J. Testa, Kimberly F. Balsam, Peter B. Goldblum & Bruce Bongar, *Social Support, Trans Community Connectedness, and Mental Health Symptoms Among Transgender and Gender Nonconforming Adults*, 2 PSYCH. SEXUAL ORIENTATION & GENDER DIVERSITY 281, 282 (2015).

81. *See, e.g.*, lore m. dickey & Stephanie L. Budge, *Suicide and the Transgender Experience: A Public Health Crisis*, 75 AM. PSYCH. 380, 381 (2020); Jeremy D. Kidd et al., *Prevalence of Substance Use and Mental Health Problems Among Transgender and Cisgender U.S. Adults: Results from a National Probability Sample*, 326 PSYCHIATRY RSCH. 1, 2, 5–8 (2023); Sarah E. Valentine & Jillian C. Shipherd, *A Systematic Review of Social Stress and Mental Health Among Transgender and Gender Non-Conforming People in the United States*, CLINICAL PSYCH. REV. 24, 35–36 (Dec. 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6663089/pdf/nihms-1028731.pdf; C. M. Wiepjes, M. den Heijer, M. A. Bremmer, N. M. Nota, C. J. M. de Blok, B. J. G. Coumou & T. D. Steensma, *Trends in Suicide Death Risk in Transgender People: Results from the Amsterdam Cohort of Gender Dysphoria Study (1971–2017)*, 141 ACTA PSYCHIATRICA SCANDINAVICA 486, 487 (2020).

82. Wittlin et al., *supra* note 6, at 210.

83. *Gender Dysphoria Diagnosis*, AM. PSYCHIATRIC ASS'N (emphasis added), https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis (last visited Mar. 24, 2024).

84. *Id.*

> from the distress caused by the body and mind not aligning and/or societal marginalization of gender-variant people. . . . The *DSM*-5 articulates explicitly that "gender non-conformity is not in itself a mental disorder."[85]

Concurring with this formulation, the American Academy of Pediatrics states:

> There is no evidence that risk for mental illness is inherently attributable to one's identity of TGD. [The mental health challenges experienced by TGD individuals are] believed to be multifactorial, stemming from an internal conflict between one's appearance and identity, limited availability of mental health services, low access to health care providers with expertise in caring for youth who identify as TGD, discrimination, stigma and social rejection.[86]

Indeed, the understanding that TGD identities are not inherently pathological has been endorsed by all mainstream national health and mental health organizations of scientists and professionals including, but not limited to, the American Psychological Association,[87] the American Academy of Pediatrics,[88] certain key international organizations, such as the World Health Organization,[89] the World Professional Association for Transgender Health,[90] as well as major governmental and non-governmental organizations concerned with health, such as the Substance Abuse and Mental Health Administration of the United States Department of Health and Human Services[91] and the Office of the United Nations High Commissioner for Human Rights.[92]

The understanding elaborated below in the discussion of the gender-affirmative model[93] sees transgender and nonbinary identities and their expressions as "natural and healthy aspects of gender diversity among humans,

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85. *Id.* (emphasis added).

86. Rafferty et al., *supra* note 5, at 3.

87. *APA Guidelines*, *supra* note 70, at 835, 838 ("A person's identification as TGNC can be healthy and self-affirming, and is not inherently pathological. . . . Discrimination can include . . . making the assumption that psychopathology exists given a specific gender identity or gender expression."); APA Res., Gender Identity Change Efforts, AM. PSYCH. ASS'N (as adopted by APA's governing Council of Representatives on Feb. 26, 2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf ("Whereas diversity in gender identity and expression is part of the human experience and transgender and gender nonbinary identities and expressions are healthy, incongruence between one's sex and gender is neither pathological nor a mental health disorder . . . .").

88. Rafferty et al., *supra* note 5, at 3.

89. *See* Off. of the U.N. High Comm'r for Hum. Rts., *The Struggle of Trans and Gender-Diverse Persons*, https://www.ohchr.org/en/special-procedures/ie-sexual-orientation-and-gender-identity/struggle-trans-and-gender-diverse-persons (last visited Mar. 21, 2024)

90. Coleman et al., *SOC8*, *supra* note 3, at S6.

91. SAMHSA 2023, *supra* note 74, at 9 ("Variations in sexual orientation (including identity, behavior, and attraction) and variations in gender (including identity and expression) are part of the normal spectrum of human diversity and do not constitute mental disorders.").

92. *The Struggle of Trans and Gender-Diverse Persons*, *supra* note 89 (concluding that the eleventh edition of the World Health Organization's health diagnostic classification system "depathologizes trans identities and is . . . an important step forward to ensure trans persons can live free from violence and discrimination"). For a discussion of the WHO revision, see *supra* the text contained in note 54.

93. *See infra* Part I.B.1.

rather than a diagnostic entity with assigned pathology."[94] The serious mental health challenges experienced by TGD youth are now seen in a new light, with an emphasis on two sets of contributing factors:

> (1) *internal distress* resulting from the misalignment of one's gender identity and the [sex] assigned at birth, which is typically enhanced at puberty with the development of secondary sexual characteristics; and
>
> (2) *external factors*, such as rejection by family members, peers, and others in the community; bullying, harassment, and violent victimization; social isolation; and ramifications of stigmatization, marginalization, and discrimination, including internalization of pejorative social messages.[95]

Researchers offer various formulations as to the relative contributions and reciprocal interactions among these factors.[96] Empirical research continues to explore and elucidate these contributions.[97]

Modern conceptualizations do not characterize the experience of gender incongruence itself as a mental health condition or disorder.[98] However, individuals may be diagnosed as having *gender dysphoria* under the American

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94. Perzanowski et al., *supra* note 50, at 5.

95. *See* Wittlin et al., *supra* note 6, at 213–19; Perzanowski et al., *supra* note 50, at 5; Rafferty et al., *supra* note 5, at 3. Included within the category of external factors are the deleterious psychological effects of restrictive and stigmatizing legal policies, such as the laws that are the subject of this Article. *See infra* note 117 and accompanying text.

96. Ilan H. Meyer, *Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations*, 129 PSYCH. BULL. 674, 675 (2003) [hereinafter Meyer 2003]; Ilan H. Meyer, *Prejudice and Discrimination as Social Stressors*, *in* THE HEALTH OF SEXUAL MINORITIES: PUBLIC HEALTH PERSPECTIVES ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER POPULATIONS 242, 243 (Ilan H. Meyer & Mary E. Northridge eds., 2007) [hereinafter Meyer 2007]; *see, e.g.*, Christy L. Olezeski & Wendy P. Bamatter, *Minority Stress and the Impact of Acceptance*, *in* PEDIATRIC GENDER IDENTITY, *supra* note 50, at 63–66; Bridgid Mariko Conn et al., *High Internalized Transphobia and Low Gender Identity Pride Are Associated with Depressive Symptoms Among Transgender and Gender-Diverse Youth*, 72 J. ADOLESCENT HEALTH 877, 878–79 (2023); Alexandria M. Delozier, Rebecca C. Kamody, Scott Rodgers & Diane Chen, *Health Disparities in Transgender and Gender Expansive Adolescents: A Topical Review From A Minority Stress Framework*, 45 J. PEDIATRIC PSYCH. 842, 844–45 (2020); Wittlin et al., *supra* note 6, at 213–14; Price-Feeney et al., *supra* note 6, at 685, 689.

97. *See, e.g.*, Wittlin et al., *supra* note 6, at 213–19.

98. In the eleventh edition of the ICD, the classification of gender incongruence was moved from the "mental health" chapter to the chapter on "conditions related to sexual health," a shift that emphasizes that the incongruence need not be accompanied by clinical levels of psychological distress to fit within the classification. Coleman et al., *SOC8*, *supra* note 3, at S59. As noted in WPATH's Standards of Care (8th), "when growing up in a supporting and accepting environment, the distress and impairment criterion, an inherent part of every mental health condition, may not be applicable." *Id.* The WPATH Standards of Care (8th) authors, therefore, conclude that the "ICD-11 classification of gender incongruence may better capture the fullness of gender diversity experiences and related clinical gender needs" than does the DSM-5's classification of gender dysphoria. *Id.* The ICD's definition indicates: "Gender incongruence is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group." *ICD-11 for Mortality and Morbidity Statistics*, WORLD HEALTH ORG. (Jan. 2023), https://icd.who.int/browse11/l-m/en#/http%3A%2F%2Fid.who.int%2Ficd%2Fentity%2F411470068. The ICD-11 changes have been critiqued by some. *See, e.g.*, Jack Drescher, Peggy T. Cohen-Kettenis & Geoffrey M. Reed, *Gender Incongruence of Childhood in the ICD-11: Controversies, Proposal, and Rationale*, 3 LANCET PSYCHIATRY 297, 300–01 (2016).

Psychiatric Association's diagnostic system if they meet certain criteria.[99] To be diagnosed with this condition, individuals must experience a high level of internal suffering as a result of both "a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration" manifested by at least six of eight listed criteria (for children) or at least two of six listed criteria (for adolescents or adults) *and* the association of this incongruence with "clinically significant distress or impairment" in important areas of functioning" such as school, social, or occupational contexts.[100] The "clinically significant distress" may present, for example, as anxiety, depression, or suicidality.[101] Research reveals that various forms of gender-affirming care appropriate to an individual's needs and provided by knowledgeable specialists adhering to national standards of practice offer the potential for reduction of the distress and its manifestations for many of those experiencing gender dysphoria.[102]

The "minority stress model," formulated by psychologist Ilan Meyer in the early 2000s—initially focusing on gay, lesbian, and bisexual populations—facilitates our understanding of the mental health challenges faced by TGD individuals.[103] The model—supported by substantial empirical research—posits that external factors, such as stigma, prejudice, and discrimination, experienced by persons who belong to "stigmatized minority groups," lead to higher rates of mental disorder among persons in these groups.[104] Meyer defined "minority stress" as that "excess stress to which individuals from stigmatized social categories are exposed."[105] He conceptualized that, in addition to prejudicial events—such as discrimination, social exclusion, bullying, victimization, and violence—certain internal processes compound the negative effects on individuals.[106] In particular, individuals might internalize these pejorative social messages and attitudes. For example, one might respond by isolating oneself and concealing one's sexual orientation or identity; or one might experience fear, anxiety, and hypervigilance in expectation of negative social responses.[107] These

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99. DSM-5-TR, *supra* note 56, at 511–20 (delineating one set of criteria for children, and a second set of criteria for adolescents and adults)

100. *Id.* at 512–13

101. *See, e.g.*, Wittlin et al., *supra* note 6, at 219–20; *see also infra* Part I.B.1.

102. *See, e.g.*, Wittlin et al., *supra* note 6, at 219–20; *see also infra* Part I.B.1.

103. *See* Meyer 2003, *supra* note 96, at 674–75. In recent years, Meyer's work has been extended and applied to persons with transgender, nonbinary, and diverse gender identities. *See, e.g.*, Michael L. Hendricks & Rylan J. Testa, *A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model*, 43 PROF. PSYCHOL.: RSCH. PRAC. 460, 462–64 (2012); Olezeski & Bamatter, *supra* note 96, at 63–66; Conn et al., *supra* note 96, at 878–79; Delozier et al., *supra* note 96, at 842–45; Wittlin et al., *supra* note 6, at 213–14; Price-Feeney et al., *supra* note 6, at 685, 689.

104. Meyer 2003, *supra* note 96, at 674–77. In the past two decades, additional studies have demonstrated the links between minority stress and mental health challenges for sexual minorities, and specifically for TGD persons. *See, e.g.*, Valentine & Shipherd, *supra* note 81, at 26–36.

105. Meyer 2003, *supra* note 96, at 675.

106. *Id.* at 679.

107. Meyer 2007, *supra* note 96, at 244–45.

cumulative external and internal experiences take their toll on the individual's mental and physical health.[108]

Scholars examining the well-being of TGD youth (and adults) have applied Meyer's model.[109] Research supports the hypothesis that bullying and other manifestations of prejudice and social rejection are substantial contributors to the psychological distress experienced by TGD youth. For example, Myeshia Price-Feeny, Amy Green, and Samuel Dorison found that higher rates of reported physical victimization and marginalization among TGD youth increased the likelihood of adverse mental health outcomes for these individuals.[110]

Consistent with Meyer's formulations (and more general developments in the field of psychology and other mental health disciplines in recent decades), hypotheses and studies have examined protective factors that may promote resilience in the face of adverse circumstances.[111] Investigators studying TGD youth have focused on these factors as well.[112] For example, studies have revealed that family support and affirmation of gender identity can serve as an important protective factor, reducing the likelihood of adverse mental health outcomes such as depression and suicidality.[113] Not surprisingly, negative parental responses to the child's identity can increase mental health risks.[114]

The challenges experienced by TGD youth are further complicated by the lack of availability of appropriate health and mental health services offered by providers who are knowledgeable about TGD health and the gender-affirmative model. Many providers adhere to an outdated pathology-oriented model or manifest the same biases as do many in the larger society.[115] Some may engage

108. Regarding the impact on physical health, see, for example, David M. Frost, Keren Lehavot & Ilan H. Meyer, *Minority Stress and Physical Health Among Sexual Minority Individuals*, 38 J. BEHAV. MED. 1, 4–6 (2015).

109. *See, e.g.*, Olezeski & Bamatter, *supra* note 96, at 63–66; Conn et al., *supra* note 96, at 878–79; Delozier et al., *supra* note 96, at 842; Wittlin et al., *supra* note 6, at 213–14; Price-Feeney et al., *supra* note 6, at 685, 689.

110. Price-Feeney et al., *supra* note 6, at 689.

111. *See, e.g.*, Ilan H. Meyer, *Resilience in the Study of Minority Stress and Health of Sexual and Gender Minorities*, 2 PSYCH. SEXUAL ORIENTATION & GENDER DIVERSITY 209, 209 (2015) (elaborating the role of resilience in mitigating adverse mental health outcomes); Lois A. Weithorn, *A Constitutional Jurisprudence of Children's Vulnerability*, 69 HASTINGS L.J. 179, 216–17 (2017) (defining modern concepts of, and citing studies relating to, resilience and protective factors in developmental psychology).

112. *See, e.g.*, Eisenberg et al., *supra* note 74, at 524 (examining the impact that various risk and protective factors—family connectedness, teacher-student relationships, feeling of safety in the community, and inner resources—have on mitigating the adverse effects of risk factors).

113. *See infra* Part I.B.2; *see also* SAMHSA 2023, *supra* note 74, at 45–46.

114. SAMHSA 2023, *supra* note 74, at 45–46.

115. *See, e.g.*, JAIME M. GRANT, LISA A. MOTTET, JUSTIN TANIS, JACK HARRISON, JODY L. HERMAN & MARA KEISLING, NAT'L CTR. FOR TRANSGENDER EQUAL. & NAT'L GAY & LESBIAN TASK FORCE, INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 72–77 (2011) (surveying the experiences and perceptions of TGD individuals based on their contacts with healthcare professionals), https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf; Jaclyn M. White Hughto, Sari L. Reisner & John E. Pachankis, *Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions*, 147 SOC. SCI. & MED. 222, 224–25 (2015); *APA Guidelines*, *supra* note 70, at 832–33.

in so-called "therapeutic" efforts to change one's gender identity (sometimes referred to as "conversion therapy," "reparative therapy" or "gender identity change efforts"), which are now viewed by the major mental health professional groups as ineffective and particularly harmful to the persons subjected to them.[116] These interventions, initially developed for the purpose of modifying gay or lesbian sexual orientations, are discussed within, in Part II.B.5.b.

State statutes and administrative actions to restrict access to gender-affirming care not only compound the lack of access to appropriate services, but also communicate painful messages of disapproval and rejection of TGD youth by the state. Initial empirical findings suggest a deleterious impact—anticipated or experienced—of these policies on TGD youth and their families.[117]

B. GENDER-AFFIRMING CARE

1. *The Gender-Affirmative Model*

At its core, the gender-affirmative model considers TGD identities and expressions to be "natural and healthy [variations] among humans, rather than diagnostic entities with assigned pathology."[118] Consistent with this understanding, for example, the World Health Organization, which uses the term "gender incongruence" to describe the experience of TGD individuals, states that gender incongruence is no longer considered a mental or behavioral disorder.[119] Instead, it categorizes gender incongruence within the "[c]onditions related to sexual health" chapter which, it observes, "reflects current knowledge that trans-related and gender diverse identities are not conditions of mental ill-health, and that classifying them as such can cause enormous stigma."[120] WPATH underscores that "childhood gender diversity is an expected aspect of

116. GRANT ET AL., *supra* note 115, at 20–31; Jack L. Turban, Noor Beckwith, Sari L. Reisner & Alex S. Keuroghlian, *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*, 77 J. AM. MED. ASS'N PSYCHIATRY 68, 69 (2020); *see infra* Part II.B.5.b.

117. For some initial perspectives on the practical and symbolic impacts of these laws on TGD youth, see, for example, Roberto L. Abreu, Jules P. Sostre, Kirsten A. Gonzalez, Gabriel M. Lockett, Em Matsuno & Della V. Mosley, *Impact of Gender-Affirming Care Bans on Transgender and Gender Diverse Youth: Parental Figures' Perspective*, 36 J. FAM. PSYCH. 643, 643–45, 647–49 (2022); Landon D. Hughes, Kacie M. Kidd, Kristi E. Gamarel, Don Operario & Nadia Dowshen, *"These Laws Will Be Devastating": Provider Perspectives on Legislation Banning Gender-Affirming Care for Transgender Adolescents*, 69 J. ADOLESCENT HEALTH 976, 4–9 (2021); Kacie M. Kidd et al., *"This Could Mean Death for My Child": Parent Perspectives on Laws Banning Gender-Affirming Care for Transgender Adolescents*, 68 J. ADOLESCENT HEALTH 1082, 1084-87 (2021); Steve N. Du Bois, Wren Yoder, Arryn A. Guy, Kelly Manser & Stephen Ramos, *Examining Associations Between State-Level Transgender Policies and Transgender Health*, 3 TRANSGENDER HEALTH 220, 220–21, 223–24 (2018).

118. Perzanowski et al., *supra* note 50, at 5.

119. *See Gender Incongruence and Transgender Health in the ICD*, *supra* note 54.

120. *Id.* It indicates that the inclusion of gender incongruence in the ICD-11 is important to help "ensure transgender people's access to gender-affirming health care, as well as adequate health insurance coverage for such services." *Id.*

general human development" and is "not of pathology or mental health disorder."[121]

This model rejects the idea that practitioners and others should attempt to change a person's gender identity or gender expression.[122] Rather, this affirmative model of "gender health" supports individuals in living their lives "in the gender that feels most real and/or comfortable" for them and which promotes their ability "to express [their] gender without experiencing restriction, criticism, or ostracism."[123] Consistent with this model, healthcare practitioners working with children and adolescents support youth as those youth discover, and determine how to live in, the gender identity that is most authentic to them.[124]

Approaches and modalities for providing gender-affirming care vary, depending upon the professional disciplines involved, the age of the child, and the needs of the person or family seeking care. Yet, the principles underlying such care are consistent across disciplines. In an influential article, an interdisciplinary team of health and mental health professionals identified the following major premises informing gender-affirming care:

- gender variations are not disorders;
- gender presentations are diverse and varied across cultures, therefore requiring our cultural sensitivity;
- to the best of our knowledge at present, gender involves an interweaving of biology, development and socialization, and culture and context, with all three bearing on any individual's gender self;
- gender may be fluid, and is not binary, both at a particular time and if and when it changes within an individual across time; and
- if there is pathology, it more often stems from cultural reactions (e.g., transphobic, homophobic, sexism) rather than from within the child.[125]

The rationales for gender affirmation are several. In addition to the dignitary and bioethical rationales related to respecting an individual's autonomy by accepting their own sense of who they are and how they wish to be seen and experienced in the world, the model recognizes practical consequences to gender affirmation. It asserts that failure to accept a child's or adolescent's developing sense of gender identity or their gender expressions

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121. Coleman et al., *SOC8*, *supra* note 3, at S67; *see Position Statement: Transgender Health*, ENDOCRINE SOC'Y & PEDIATRIC ENDOCRINE SOC'Y 2 (Dec. 2020), https://www.endocrine.org/-/media/endocrine/files/advocacy/position-statement/position_statement_transgender_health_pes.pdf.

122. Keo-Meier & Ehrensaft, *supra* note 58, at 13. See *infra* Part II.B.5.b for an analysis of sexual orientation change efforts (SOCE), which have also been used to try to alter young persons' gender identity.

123. Keo-Meier & Ehrensaft, *supra* note 58, at 13.

124. *Id.*; Janet Y. Lee & Stephen M. Rosenthal, *Gender-Affirming Care of Transgender and Gender-Diverse Youth: Current Concepts*, 74 ANN. REV. MED. 107, 108 (2023).

125. Hidalgo et al., *supra* note 70, at 285.

creates serious risks to that individual's well-being.[126] Studies indicate that when a child's gender diversity is met with "restriction, aspersion, or rejection" by those important to them (such as parents, peers, and school personnel), they "are at later risk for develop[ing] a downward cascade of psychosocial adversities including depressive symptoms, low life satisfaction, self-harm, isolation, homelessness, incarceration, posttraumatic stress, and suicide ideation and attempts."[127] Particularly damaging to children's well-being are psychological interventions designed to alter their gender identity or expression which, in addition to subjecting children to risk of serious psychological harm, are ineffective.[128]

All major national medical and psychological societies that provide health or mental healthcare services to youth in the United States—including, but not limited to, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the American College of Obstetricians and Gynecologists, the American Psychiatric Association, the American Psychological Association, and the Society for Adolescent Health and Medicine—promote adherence to the *gender-affirmative model* of care.[129] In addition, the detailed practice standards promulgated by WPATH, an international society committed to advancing research and practice related to the health of TGD individuals, and the Clinical Practice Guidelines of the Endocrine Society, are grounded in the gender-affirmative model.[130] Some of the other organizations listed have also disseminated standards of care or guidelines encompassing the gender-affirmative model that are specific to the practice of their specialty.[131]

2. *Standards of Practice for Gender-Affirming Care*

The most recent version of the WPATH Standards of Care (hereinafter "Standards of Care (8th)," promulgated in 2022, asserts that the goal of gender-

126. *Id.*

127. *Id.* at 286.

128. *See infra* Part II.B.5.b.

129. Rafferty et al., *supra* note 5, at 3; *APA Guidelines*, *supra* note 70, at 832; Soc'y for Adolescent Health & Med., *Recommendations for Promoting the Health and Well-Being of Sexual and Gender-Diverse Adolescents Through Supportive Families and Affirming Support Networks*, 70 J. ADOLESCENT HEALTH 692, 694 (2022); Am. Coll. Obstetricians & Gynecologists, *Health Care for Transgender and Gender Diverse Individuals*, 137 OBSTETRICS & GYNECOLOGY e75, e75 (2021) (Committee Opinion 823); Stewart L. Adelson et al., *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957, 957 (2012); *A Guide for Working with Transgender and Nonconforming Patients: Best Practices*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients/best-practices (last visited Mar. 22, 2024).

130. Coleman et al., *SOC8*, *supra* note 3, at S252; Wylie C. Hembree, Peggy T. Cohen-Kettenis, Louis Gooren, Sabine E. Hannema, Walter J. Meyer, M. Hassan Murad, Stephen M. Rosenthal, Joshua D. Safer, Vin Tangpricha & Guy G. T'Sjoen, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3869 (2017) [hereinafter Hembree et al., *Endocrine Society Guidelines*].

131. *See, e.g.*, *APA Guidelines*, *supra* note 70, at 832.

affirming care "is to partner with TGD people to holistically address their social, mental, and medical health needs and well-being while respectfully affirming their gender identity."[132] It explains further that:

> Transgender health care is greater than the sum of its parts, involving holistic inter- and multidisciplinary care between endocrinology, surgery, voice and communication, primary care, reproductive health, sexual health and mental health disciplines to support gender affirming interventions as well as preventive care and chronic disease management. . . . [T]here is no "one-size-fits-all" approach and TGD people may need to undergo all, some, or none of [the available] interventions to support their gender affirmation.[133]

There are many forms that affirmation can take. Some forms can be implemented by families, with or without guidance from professionals. Other forms require the assistance of pediatricians, mental health professionals, endocrinologists, surgeons, or other healthcare professionals. Some interventions are fully reversible, others partially reversible, and others mostly irreversible. The following four major categories of gender-affirming care are discussed here: social affirmation, affirmative psychological counseling or psychotherapy, affirmative medical treatments (such as puberty blockers or gender-affirming hormones), and affirmative surgical interventions.[134]

Although the different forms of intervention are discussed separately below, it is noteworthy at the outset to emphasize that studies "consistently demonstrate improved or stable psychological functioning, body image, and treatment satisfaction" in gender-affirming care outcomes.[135] The treatment must be preceded by careful assessment by a multidisciplinary team of practitioners who possess special expertise in working with TGD youth and their families, and whose recommendations are consistent with the Standards of Practice.[136] Among the benefits of the treatments is reduced suicidality, and these benefits may extend into adulthood.[137] Most medical treatments present the possibility of side effects, discomforts, and risks—and gender-affirming medical interventions are no exception. Yet, experts who have studied the science and practice with TGD youth agree that the ratio of benefits to risks for these treatments supports the continued availability of these interventions in appropriate cases, where the minors and parents are engaged in a fully informed consent process and are capable of making well-considered informed

132. Coleman et al., *SOC8*, *supra* note 3, at S57.

133. *Id.*

134. *See, e.g.*, Wittlin et al., *supra* note 6, at 219–21; Rafferty et al., *supra* note 5, at 6 tbl.2, 6–7.

135. Coleman et al., *SOC8*, *supra* note 3, at S46.

136. *Id.*

137. *Id.*; Jack L. Turban, Dana King, Julia Kobe, Sari L. Reisner & Alex S. Keuroghlian, *Access to Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, PLOS ONE, Jan. 12, 2022, at 5–8.

decisions.[138] The medications that may be prescribed, such as puberty blockers or hormones like estrogen and testosterone, are not new—they have been used safely and effectively for decades with cisgender individuals to address various medical problems.[139] Experts acknowledge that ongoing research is needed to further develop the knowledge base about certain long-term effects of the use of these interventions with TGD youth.[140] These factors are viewed as appropriate for discussion with patients and families, and as guides for continuing medical assessment and monitoring of patients undergoing treatment. They are not, however, seen as a basis for denying treatments that may have substantial benefits to a population in great need of assistance from healthcare professionals.[141]

Researchers and practitioners who specialize in this area of healthcare also point out that "doing nothing" in response to distress manifested by those young people experiencing gender incongruence or gender dysphoria—that is, waiting until adulthood to provide affirmative health and mental health services—is not a neutral decision.[142] This approach is strongly contraindicated by existing studies, which demonstrate the mental health benefits of affirmation of children's and adolescents' gender identity, and the health risks of failing to provide social, psychological, and medical opportunities for affirmation in those cases in which such interventions are clinically indicated.[143]

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138. Coleman et al., *SOC8*, *supra* note 3, at S47 ("Taken as a whole, the data show early medical intervention—as part of broader combined assessment and treatment approaches focused on gender dysphoria and general well-being—can be effective and helpful for many transgender adolescents seeking these treatments."). *See id.* at S49–66; Kathleen Chung, Sarah Rhoads, Alicia Rolin, Andrew C. Sackett-Taylor & Michelle Forcier, *Treatment Paradigms for Adolescents: Gender-Affirming Hormonal Care*, *in* PEDIATRIC GENDER IDENTITY, *supra* note 50, at 187, 199 (noting that gender-affirming hormone therapy "is generally considered safe when followed closely by a medical provider. . .").

139. *See, e.g.*, Erica A. Eugster, *Treatment of Central Precocious Puberty*, 3 J. ENDOCRINE SOC'Y 965, 965 (addressing the use of puberty-blocking drugs to pause puberty for females with early puberty); Alice Scott & Louise Newson, *Should We Be Prescribing Testosterone to Perimenopausal and Menopausal Women?*, 70 BRIT. J. GEN. PRAC. 203, 203 (2020) (discussing the safety and benefits of prescribing testosterone to women experiencing perimenopausal and menopausal symptoms); Theodore E. Schall & Jacob D. Moses, *Gender-Affirming Care for Cisgender People*, 53 HASTINGS CTR. REP. 15, 21–22 (2023) (discussing the use of the medication and procedures used in gender-affirming care with cisgender individuals).

140. Hembree et al., *Endocrine Society Guidelines*, *supra* note 130, at 3855; Coleman et al., *SOC8*, *supra* note 3, at S45–47.

141. *See, e.g.*, Annelou L.C. de Vries & Sabine E. Hannema, *Growing Evidence and Remaining Questions in Adolescent Transgender Care*, 388 NEW ENG. J. MEDICINE. 275, 276–77 (2023); Beth A. Clark, Alice Virani, Diane Ehrensaft & Johanna Olson-Kennedy, *Resisting the Post-Truth Era: Maintaining a Commitment to Science and Social Justice in Bioethics*, 19 AM. J. BIOETHICS W1, W1–W3 (2019). *See generally* Coleman et al., *SOC8*, *supra* note 3; Hembree et al., *Endocrine Society Guidelines*, *supra* note 130, at 3870–71.

142. *See, e.g.*, Chen et al., *supra* note 17, at 74; Keo-Meier & Ehrensaft, *supra* note 58, at 43.

143. Chen et al., *supra* note 142, at 74; Diane Chen, Johnny Berona, Yee-Ming Chan, Diane Ehrensaft, Robert Garofalo, Marco A. Hidalgo, Stephen M. Rosenthal, Amy C. Tishelman & Johanna Olson-Kennedy, *Psychosocial Functioning in Transgender Youth After 2 Years of Hormones*, 388 NEW ENG. J. MED. 240, 245-49 (2023); Mamatha Challa, Caroline Scott & Jack L. Turban, *Epidemiology of Pediatric Gender Identity*, *in* PEDIATRIC GENDER IDENTITY, *supra* note 50, at 15, 22; Clark et al., *supra* note 141, at W1.

a. *Social affirmation*

Social affirmation allows children and adolescents to live in a manner that is more consistent with their gender identity and provides support for them as they move through the self-discovery process.[144] TGD children may prefer to be referred to by a name different from their given name, and by alternative pronouns, and may wish to adopt hairstyles, clothing, or other expressions that are more consistent with their identified gender, rather than their birth-assigned sex.[145] There are, of course, a myriad of social webs and circles involved in any child's life (for example, immediate family, extended family, school, peers, afterschool activities, or religious communities). Depending on the attitudes in one's community, not all persons in the child's life may be willing to affirm the child's gender identity in their interactions with the child. Yet, research indicates that family acceptance of a child's gender identity plays a particularly important role in promoting that individual's well-being.[146] Lower levels of acceptance by parents or siblings are associated with a greater likelihood of negative psychosocial outcomes in TGD youth, such as depressive and anxiety symptoms.[147] In a study that examined family acceptance in adolescence for LGBT youth, such acceptance was found to be associated with positive health outcomes, such as higher levels of self-esteem, social support, and general health in young adulthood.[148] It was also associated with a lower likelihood of negative health outcomes, such as depression, substance abuse, and suicidal ideation and attempts.[149] In another study, 60 percent of TGD youth whose parents were not strongly supportive of them had considered committing suicide in the prior year, and almost all of them reported suicide attempts as well.[150] By contrast, of those TGD youth who described their parents as strongly supportive, 35 percent reported considering suicide, and 4 percent had attempted suicide.[151] The investigators conclude: "While 4% is still far too high, the impact of strong parental support can be clearly seen in the 93% reduction in reported suicide attempts for youth who indicated their parents were strongly supportive of their gender identity and expression."[152] All of these studies underscore the core role

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144. Rafferty et al., *supra* note 5, at 6.

145. *Id.*

146. *See, e.g.*, Emily M. Pariseau, Lydia Chevalier, Kristin A. Long, Rebekah Clapham, Laura Edwards-Leeper & Amy C. Tishelman, *The Relationship Between Family Acceptance-Rejection and Transgender Youth Psychosocial Functioning*, 7 CLINICAL PRAC. PEDIATRIC PSYCH. 267, 267 (2019); Caitlin Ryan, Stephen T. Russell, David Huebner, Rafael Diaz & Jorge Sanchez, *Family Acceptance in Adolescence and the Health of LBGT Young Adults*, 23 J. CHILD & ADOLESCENT PSYCHIATRY NURSING 205, 205 (2010).

147. Pariseau et al., *supra* note 146, at 274.

148. Ryan et al., *supra* note 146, at 210.

149. *Id.*

150. ROBB TRAVERS, GRETA BAUER, JAKE PYNE, KAITLIN BRADLEY, LORRAINE GALE & MARIA PAPADIMITRIOU, TRANS PULSE PROJECT, IMPACTS OF STRONG PARENTAL SUPPORT FOR TRANS YOUTH 3 (2012), https://transpulseproject.ca/wp-content/uploads/2012/10/Impacts-of-Strong-Parental-Support-for-Trans-Youth-vFINAL.pdf.

151. *Id.*

152. *Id.*

that family members play in promoting the mental and physical health of TGD youth through affirming and supporting those youth's gender identity and expressions.

Studies, such as those conducted by psychologists Kristina Olson, Lily Durwood, and their collaborators, demonstrate that TGD children who have socially transitioned do not reveal the same heightened levels of depressive or anxious symptomatology that is typically seen in TGD youth.[153] Rather, these children were more comparable to children in the general population regarding their mental health functioning.[154] Their studies indicate that social affirmation of a child's gender identity has the potential to reduce the likelihood that TGD youth will experience some of the negative mental health outcomes often associated with gender diversity.[155] Research by psychiatrist Jack Turban and his collaborators indicate, however, that the deleterious effects of harassment based on gender identity during childhood can undercut these mental health benefits in the long-term.[156] Some studies, however, have not observed mental health benefits accompanying social transition.[157] As research in this field progresses, future investigations will likely further identify those variables most typically associated with more positive outcomes.

b. *Affirmative psychological interventions*

Affirmative psychological interventions provided by mental health professionals may have any of several components, depending upon the needs of the child and the family. As is often the case for any psychotherapeutic intervention related to children, family involvement is important. In their excellent review, Natalie Wittlin, Laura Kuper, and Kristina Olson emphasize the role of therapy in helping to promote children's resilience and reduce the risk of experiences that can lead to adverse mental health outcomes.[158] Such interventions may include those that educate caregivers about gender diversity and support them in providing a safe and accepting environment for their child.[159] The authors indicate that supportive interventions with youth allow

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153. Kristina R. Olson, Lily Durwood & Katie A. McLaughlin, *Mental Health of Transgender Children Who Are Supported in Their Identities*, 142 PEDIATRICS, no. 2, Aug. 2018, at 4–7 (corrected version); *see* Lily Durwood, Katie A. McLaughlin & Kristina Olson, *Mental Health and Self-Worth in Socially Transitioned Transgender Youth,* 56 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 116, 116–17, 120–21 (2017).

154. Olson et al., *supra* note 153, at 5; Durwood et al., *supra* note 153, at 116.

155. Olson et al., *supra* note 153, at 7.

156. Jack L. Turban, Dana King, Jason J. Li, & Alex S. Keuroghlian, *Timing of Social Transition for Transgender and Gender Diverse Youth, K–12 Harassment, and Adult Mental Health Outcomes*, 69 J. ADOLESCENT HEALTH 991, 996–97 (2021).

157. *See, e.g.*, James S. Morandini, Aiden Kelly, Nastasja M. de Graaf, Pia Malouf, Evan Guerin, Ilan Dar-Nimrod & Polly Carmichael, *Is Social Gender Transition Associated with Mental Health Status in Children and Adolescents with Gender Dysphoria?*, 52 ARCHIVES SEXUAL BEHAV. 1045, 1045 (2023).

158. Wittlin et al., *supra* note 6, at 219–20.

159. *Id.*

them to "explore and affirm their gender identity."[160] Furthermore, if the youth chooses to transition socially, or the youth and family choose to proceed with medically affirming interventions, psychotherapeutic support may facilitate adjustment.[161] WPATH's Standards of Care (8th) emphasize these points as well, based on the theoretical and empirical literature.[162]

Psychologists and other mental health experts also recommend therapeutic approaches that provide individuals with tools to cope adaptively with external sources of stress (such as bullying, stigmatization, social isolation, and discrimination) and internal sources of stress (such as internalized dimensions of minority stress, or gender dysphoria, if present).[163] Mental health interventions consistent with the gender affirming model reject the premise that gender incongruence and the range of variations in gender identity are pathological,[164] and support individuals from a framework integrating the "minority stress model."[165] In addition, mental health interventions may help individuals manage any symptoms (such as anxiety or depression) that flow from such stress or from the incongruence between their assigned sex and their gender identity.[166]

WPATH and other groups emphasize the importance of interdisciplinary teams and collaboration in the provision of the range of services of TGD youth.[167] Mental health professionals ideally serve as members of such a team or work in close collaboration with other clinicians in other disciplines and make appropriate referrals to other specialties as needed.[168]

c. *Affirmative medical interventions*

"[N]ot all TGD [youth] seek gender-affirming medical care. However, for those who do, both cross-sectional and longitudinal research suggest that

160. *Id.* For an influential perspective on supporting children's explorations of gender identity, see Diane Ehrensaft, *Exploring Gender Expansive Expressions Versus Asserting a Gender Identity*, *in* THE GENDER AFFIRMATIVE MODEL, *supra* note 58, at 37, 37–38. *See also* Teresa Daniels & Micaela Condon, *Psychotherapy: A Clinical Perspective*, *in* PEDIATRIC GENDER IDENTITY, *supra* note 50, at 161, 162.

161. Coleman et al., *SOC8*, *supra* note 3, at S77–79, (statement 7.14).

162. *Id.* at S74–79 (Statements 7.9 to 7.15).

163. *See, e.g.*, SAMHSA 2023, *supra* note 74, at 13–15; Daniels & Condon, *supra* note 160, at 163–66.

164. Daniels & Condon, *supra* note 160, at 162.

165. *Id.* at 165–66.

166. *Id.* at 163–65.

167. *See, e.g.*, Coleman et al., *SOC8*, *supra* note 3, at S7 ("Transgender health care is greater than the sum of its parts, involving holistic inter- and multidisciplinary care between endocrinology, surgery, voice and communication, primary care, reproductive health, sexual health and mental health disciplines.").

168. Daniels & Condon, *supra* note 160, at 166–67. For additional perspectives on the role of mental health professionals in providing gender affirming care to children and adults, see generally Scott Leibowitz, *Social Gender Transition and the Psychological Interventions*, *in* AFFIRMATIVE MENTAL HEALTH CARE, *supra* note 50, at 31; SAND C. CHANG, ANNELIESE A. SINGH & LORE M. DICKEY, A CLINICIAN'S GUIDE TO GENDER-AFFIRMING CARE: WORKING WITH TRANSGENDER & GENDER NONCONFORMING CLIENTS 1 (2018); ANNELIESE A. SINGH & LORE M. DICKEY, AFFIRMATIVE COUNSELING AND PSYCHOLOGICAL PRACTICE WITH TRANSGENDER AND GENDER NONCONFORMING CLIENTS 3–4 (A. A. Singh & l. m. dickey eds., 2017).

receiving it can be psychologically beneficial and even life-saving."[169] Studies show that the "emergence or worsening of gender dysphoria with pubertal onset" indicates that the individual is highly likely to persist in their gender incongruence as an adult.[170] Physicians Herbert Bonifacio and Stephen Rosenthal observe that the appearance of secondary sexual characteristics in TGD youth may, for some, be highly traumatic, resulting in "depression, anxiety, social withdrawal, cutting and other self-harming behavior, suicidal ideation, suicide attempts, sexual behavioral risks, and substance use."[171] The goal of gender-affirming medical care is to reduce gender dysphoria through alignment of physical sex characteristics with gender identity, and to minimize the need for surgical interventions to reverse the otherwise permanent physical changes of endogenous puberty.[172]

There are three key categories of *affirmative medical interventions* incorporated into clinical guidelines and standards of care: puberty-suppressing drugs, gender-affirming hormone treatment, and surgical interventions.[173] Although a detailed analysis of the benefits and risks of these treatments is beyond the scope of this Article, available research strongly supports the conclusion that, when provided to youth in accordance with the standards of care and guidelines reviewed here, these interventions can provide patients with substantial relief from the symptoms of gender dysphoria.[174] Furthermore, recent studies indicate that use of gender-affirming medical interventions during

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169. Wittlin et al., *supra* note 6, at 220.

170. Stephen M. Rosenthal, *Challenges in the Care of Transgender and Gender-Diverse Use: An Endocrinologist's View*, 17 NATURE REVS. ENDOCRINOLOGY 581, 585 (2021).

171. Herbert J. Bonifacio & Stephen M. Rosenthal, *Gender Variance and Dysphoria in Children and Adolescents*, 62 PEDIATRIC CLINICS N. AM. 1001, 1006 (2015).

172. Rosenthal, *supra* note 170, at 585.

173. *Id.* at 585–86.

174. *See generally id.*; Wittlin et al., *supra* note 6, at 220–21. Some recent studies prospectively evaluate participants and track their progress on various measures. *See, e.g.*, Diane Chen et al., *Psychological Functioning*, *supra* note 143, at 240 (reporting that youth treated with gender affirming hormones as part of a prospective four-site U.S. study experienced reduced depressive and anxiety symptoms, and increased positivity and life satisfaction two years post commencement of treatment); Luke R. Allen, Laurel B. Watson, Anna M. Egan & Christine N. Moser, *Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones*, 7 CLINICAL PRAC. PEDIATRIC PSYCH. 302, 304 (2019) (reporting that adolescents treated with gender-affirming hormones at a Missouri gender specialty clinic experienced significant reductions in suicidality and increases in feelings of well-being approximately one year after commencement of treatment). Other studies survey youth, typically through online channels, and analyze participants' reports regarding efficacy of treatment. *See, e.g.*, Amy E. Green, Jonah P. DeChants, Myeshia N. Price & Carrie K. Davis, *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. ADOLESCENT HEALTH 643, 647 (2022) (reporting that in a large national online survey of transgender and nonbinary youth, access to gender-affirming hormone therapy was significantly associated with reduced depression and suicidality among transgender and nonbinary youth); Brian C. Thoma, EJ Jardas, Sophia Choukas-Bradley & Rachel H. Salk, *Perceived Gender Transition Progress, Gender Congruence, and Mental Health Symptoms Among Transgender Adolescents*, 72 J. ADOLESCENT HEALTH 444, 447–50 (2023) (observing that findings from an online survey with 1,943 TGD adolescent participants, conducted by psychologists at the University of Pittsburgh, revealed that participants who perceive positive "progress in their gender transition and a higher congruence between their gender expression and gender identity report lower levels of depressive and anxiety symptoms").

adolescence increases the likelihood of positive mental health outcomes in adulthood.[175] Like most healthcare interventions, there is the possibility of adverse effects (that is, risks, side effects, or discomforts) accompanying intervention. To date, studies do not reveal adverse effects serious enough to render commencement of these treatments contraindicated in generally healthy individuals with careful medical monitoring for any such effects.[176] Investigations continue to enhance knowledge about long-term effects.[177] Yet, the consensus within the field, across all disciplines involved in gender-affirming care, is that these treatments have a favorable benefit-risk profile when practitioners follow the standards of care discussed here; that unavailability of these treatments creates substantial risks to patients who are experiencing serious distress related to gender incongruence; and that therefore, these options should be available to patients who meet the criteria.[178] Of course, consistent

175. *See, e.g.*, Annelou L.C. de Vries, Jenifer K. McGuire, Thomas D. Steensma, Eva C.F. Wagenaar, Theo A.H. Doreleijers & Peggy T. Cohen-Kettenis, *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 PEDIATRICS, no. 4, Oct. 2014, at 4–6 (reporting that gender dysphoria improved for adults who had access to gender-affirming medical care as adolescents and to gender affirming surgery as adults, resulting in mental health status comparable to cisgender peers on several indices); Jack L. Turban, Dana King, Jeremi M. Carswell & Alex S. Keuroghlian, *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 PEDIATRICS, no. 2, Feb. 2019, at 5 (concluding that "treatment with pubertal suppression among those who wanted it was associated with lower odds of lifetime suicidal ideation when compared with those who wanted pubertal suppression but did not receive it") [hereinafter Turban et al., *Pubertal Suppression*]; Jack L. Turban et al., *supra* note 137, at 9–12 ("[T]ransgender people who accessed GAH during early or late adolescence had lower odds of past-month suicidal ideation and past-month severe psychological distress in adulthood, when compared to those who desired but did not access GAH . . . ."); Christal Achille, Tenille Taggart, Nicholas R. Eaton, Jennifer Osipoff, Kimberly Tafuri, Andrew Lane & Thomas A. Wilson, *Longitudinal Impact of Gender-Affirming Endocrine Intervention on the Mental Health and Well-Being of Transgender Youth: Preliminary Results*, INT'L J. PEDIATRIC ENDOCRINOLOGY, no. 8, April 30, 2020, at 1, https://ijpeonline.biomedcentral.com/counter/pdf/10.1186/s13633-020-00078-2.pdf (observing that gender-affirming medical care was associated with lower levels of depression and suicidal ideation and higher quality of life scores in sample of adolescents and young adults); *see also* Rosenthal, *supra* note 170, at 586.

176. *See, e.g.*, Rosenthal, *supra* note 170, at 586–88; Simone Mahfouda, Julia K. Moore, Aris Siafarikas, Florian D. Zepf & Ashleigh Lin, *Puberty Suppression in Transgender Children and Adolescents*, 5 LANCET DIABETES ENDOCRINOLOGY 816, 821–23 (2017). For example, some forms of gender-affirming medical care may affect fertility. Puberty-suppressing drugs may affect bone density. Gender-affirming hormone treatment may cause weight gain, mood, or hematologic and lipid profiles. *Id.*; Bonifacio & Rosenthal, *supra* note 171, at 1007–14.

177. *See, e.g.*, Hembree et al., *Endocrine Society Guidelines*, *supra* note 130, at 3874. Such studies are underway, including the creation of the Trans Youth Research Network, a large multi-site collaborative with funding by the National Institutes of Health, evaluating the long-term medical and mental health outcomes of youth receiving medical interventions at The Center for Transyouth Health and Development at Children's Hospital Los Angeles, the Gender Multispecialty Service at Boston Children's Hospital, the Child and Adolescent Gender Center at UCSF Benioff Children's Hospital, and the Gender and Sex Development Program at Lurie Children's Hospital of Chicago. Johanna Olson-Kennedy, Yee-Ming Chan, Stephan Rosenthal, Marco A. Hidalgo, Diane Chen, Leslie Clark, Diane Ehrensaft, Amy Tishelman & Robert Garofalo, *Creating the Trans Youth Research Network: A Collaborative Research Endeavor*, 4 TRANSGENDER HEALTH 304 (2019).

178. Coleman et al., *SOC8*, *supra* note 3, at S47; Hembree et al., *Endocrine Society Guidelines*, *supra* note 130, at 3869–71; Rafferty et al., *supra* note 5, at 10 (Recommendation 1); Press Release, Am. Med. Ass'n, AMA to States: Stop Interfering in Health Care of Transgender Children (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children; Position

with the aforementioned guidelines and standards of care, patients and their parents should be informed about all of the possibilities for adverse effects during the consent process, and the healthcare team should continue to monitor patients throughout the treatment process and thereafter.

(1) *Pubertal suppression*

Characterized as a reversible intervention that "pauses puberty," pubertal suppression provides teens "with additional time for gender identity exploration without the pressure of continued pubertal progression" as it "prevents the irreversible development of 'secondary sex characteristics' associated with puberty that are not aligned with the person's affirmed gender identity."[179] The treatment is characterized as reversible because, once discontinued, puberty resumes and the individual's body develops consistent with their birth-designated sex.[180] The authors of the Endocrine Society Guidelines observe that: "During the past decade, clinicians have progressively acknowledged the suffering of young adolescents with [gender dysphoria]/gender incongruence. In some forms of [gender dysphoria]/gender incongruence, psychological interventions may be useful and sufficient. However, for many adolescents with [gender dysphoria]/gender incongruence the pubertal physical changes are unbearable."[181] As such, commencement of treatment with puberty-suppressing medications early in puberty is often recommended in appropriate cases to prevent the development of secondary sexual characteristics inconsistent with the individual's gender identity, which increases the likelihood of a better psychological outcome than a later start after permanent anatomical changes have occurred.[182]

This intervention also has the benefit of "extending the diagnostic period" for youth experiencing gender incongruence.[183] It allows them time to explore their gender identity, to experience some degree of alignment of their bodies and

Statement, Am. Psychitatric Ass'n, Treatment of Transgender (Trans) and Gender Diverse Youth (July 2020), https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf.

179. Rosenthal, *supra* note 170, at 585 (indicating that these drugs are "considered fully reversible," providing "additional time for gender identity exploration without the pressure of continued pubertal progression," while preventing the "irreversible development" of secondary sex characteristics that are not aligned with the person's gender identity).

180. *See, e.g.*, Chung et al., *supra* note 138, at 192 (noting that "these medications do not alter the patient's pubertal development, but instead temporarily halt the progression of puberty. They are completely reversible and are often considered a "pause button," allowing patients and their families time for further exploration of gender identity and care options . . . .").

181. Hembree et al., *Endocrine Society Guidelines*, *supra* note 130, at 3880.

182. *Id. See* Julia C. Sorbara, Lyne N. Chiniara, Shelby Thompson & Mark R. Palmert, *Mental Health and Timing of Gender-Affirming Care*, 146 PEDIATRICS, no. 4, Oct. 2020, at 4–5 (Oct. 2020) (reporting findings of a study involving 300 TGD youth which revealed that commencement of gender-affirming medical care earlier rather than later in puberty led to better mental health outcomes); Turban et al., *Pubertal Suppression*, supra note 175, at 5–8 (finding that, in a sample of 20,619 transgender adults ages 18 to 36, treatment with pubertal suppression during adolescence was associated with a lower lifetime likelihood of suicidal ideation).

183. Turban & Ehrensaft, *supra* note 74, at 1236.

their inner sense of who they are—while relieving them of some or all of the symptoms of gender dysphoria.[184] Researchers point out that not all youth undergoing this treatment choose to continue on the path of physically affirming a gender identity different from their assigned gender.[185] Yet, studies indicate that, in general, those youth do not regret having had the opportunity to explore their identity as provided by these medications.[186]

WPATH's Standards of Care (8th) emphasize the need for careful interdisciplinary assessment to determine whether gender-affirming medical intervention is appropriate for a particular individual. Among the factors considered prior to making such recommendations are: (i) the findings of diagnostic assessments by an interdisciplinary team, including specialists within the mental health professions with expertise in working with TGD youth, to determine whether the youth is indeed experiencing gender incongruence or gender dysphoria, and whether the incongruence is sufficiently persistent to warrant medical intervention (that is "marked and sustained over time"); (ii) whether there are mental health concerns leading to a lack of diagnostic clarity or creating circumstances in which medically affirmative interventions would be contraindicated; (iii) whether there is sufficient emotional and cognitive maturity evidenced by the minor to allow for adequate participation in the informed consent process; (iv) whether there has been adequate information provision to the minor and family about the benefits and risks of treatment relevant in the individual's case; and (v) whether the individual has reached puberty (Tanner Stage II developmental stage), because commencement of puberty suppressants prior to this stage of development is not needed.[187] The Endocrine Society Guidelines recommend discussing with patients and their parents the effects of gender-affirming medical interventions on future fertility and their options for fertility preservation.[188] Ongoing evaluations are recommended to monitor the child's medical and psychological status on a range of indices,[189] including to identify any possible adverse effects, such as

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184. *Id.*

185. *See, e.g.*, Hembree et al., *Endocrine Society Guidelines*, *supra* note 130, at 3880 (observing that, for some "adolescents with [gender dysphoria]/gender incongruence, psychological interventions may be . . . sufficient").

186. *See, e.g.*, de Vries et al., *supra* note 175, at 701–03; Tessa Brik, Lieke J.J.J. Vrouenraets, Martine C. de Vries & Sabine E. Hannema, *Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria*, 49 ARCH. SEXUAL BEHAVIOR 2611, 2615–17 (2020).

187. Coleman et al., *SOC8*, *supra* note 3, at S43–66.

188. Hembree et al., *Endocrine Society Guidelines*, *supra* note 130, at 3871. Although puberty-suppressing alone drugs do not affect long-term fertility, the Endocrine Society recommends commencing discussions regarding fertility preservation at the onset of such treatment, given the possibility that patients may follow such treatment with gender-affirming hormones, which may affect fertility. *Id.* at 3879–80. *See also* Rosenthal, *supra* note 170, at 587 (noting that puberty may be affected if patients are treated with puberty-suppressing drugs at an early age followed by gender-affirming hormones).

189. Hembree et al., *Endocrine Society Guidelines*, *supra* note 130, at 3871.

decreases in bone density.[190] Research continues to explore possible long-term effects of these treatments related to bone density, brain development, and certain metabolic parameters.[191] To date, however, studies do not reveal serious long-term adverse effects.[192]

(2) *Gender-affirming hormone treatment*

In some cases, after a period of time on pubertal suppression medications, adolescents seeking further affirmation of their gender identity may request pubertal gender-affirming hormone treatment to further decrease the effects of the hormones their bodies are producing, and to promote the development of secondary sexual characteristics of the gender to which they are transitioning.[193] The Endocrine Society Guidelines characterize this treatment as partially irreversible, cautioning that it should only be considered "after a multidisciplinary team of medical and [mental health professionals] has confirmed the persistence of [gender dysphoria]/gender incongruence and sufficient mental capacity to give informed consent."[194] The Endocrine Society generally recommends that minors reach age sixteen before receiving such treatment, although it acknowledges that "there may be compelling reasons to initiate sex hormone treatment before the age of 16 years in some adolescents with" gender diverse or gender incongruence.[195] These treatments promote the physical development of secondary sexual characteristics that are aligned with the adolescents' gender identity.[196] Consistent with their recommendations regarding pubertal suppression, the WPATH authors emphasize the importance of thorough interdisciplinary evaluation, ruling out contraindications, and ensuring that minors have the capacity to provide fully informed consent/assent to the proposed interventions.[197] As with pubertal suppression, patients'

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190. For a discussion of relevant research and potential effects, see, for example, Rosenthal, *supra* note 170, at 586–87.

191. *See* Rosenthal, *supra* note 170, at 586–88.

192. For example, although some reductions in bone density can accompany treatment with puberty-suppressing drugs, studies reveal that after three years of treatment with gender-affirming hormones, bone density levels return to normal. Rosenthal, *supra* note 170, at 587. Further research studying interventions optimizing physical activity, calcium, and vitamin D supplements, is recommended by experts in the field. *See, e.g.*, *id.* For further discussion of research on the range of effects, *see, e.g.*, *id.*; Lee & Rosenthal, *supra* note 124, at 109–111.

193. Caroline Salas-Humara, Gina M. Sequeira, Wilma Rossi & Cherie Priya Dhar, *Gender Affirming Medical Care of Transgender Youth*, 49 CURRENT PROBS. PEDIATRIC ADOLESCENT HEALTH CARE 1, 9–10, 15 (2019), https://pubmed.ncbi.nlm.nih.gov/31735692.

194. Hembree et al., *Endocrine Society Guidelines*, *supra* note 130, at 3871.

195. *Id.*

196. Rosenthal, *supra* note 170, at 585–86.

197. Coleman et al., *SOC8*, *supra* note 3, at S43–66. The term "assent" is frequently used to refer to minors' participation in healthcare decisions for which they are not accorded full legal authority to provide binding "consent," but where their informed decisions, together with those of their parents, are viewed as ethically necessary (and in the context of some research interventions—legally necessary) prior to the commencement of the intervention. *See e.g.*, Merle Spriggs, *Children and Bioethics: Clarifying Consent and Assent in Medical and*

responses to treatment should be monitored for possible adverse effects. Studies reveal, however, that although there may be mild alterations in certain physiological and metabolic parameters in some patients (leading to, for example, weight gain in a minority of patients), there generally do not appear to be "clinically significant adverse effects."[198]

(3) *Surgical affirmation*

Surgical affirmation can involve breast or chest surgery (breast augmentation or male chest construction) or genital surgery (modifying the individual's genitalia to conform with that person's gender identity), as well as other modifications such facial feminization or masculinization and voice surgery.[199] Due to the surgical nature of these interventions, and the irreversibility and impact on future fertility of some of the procedures, practitioners are appropriately cautious about offering these procedures to minors.[200] Critics of gender-affirming care more generally reserve their strongest opposition for surgical procedures.[201] Best practices require that, before practitioners consider providing surgical forms of gender-affirming care, patients undergo extensive interdisciplinary assessment and psychological and medical treatment, have met standards of capacity for informed consent and other stringent requirements, and "experience persistent and significant dysphoria." [202] Vikram Mookerjee, Jonathan Brower, and Daniel Kwan, three surgeons at Brown University's Alpert Medical School, indicate that a patient-centered approach considers all of the cautions regarding these procedures, the "health and safety risks inherent in untreated gender dysphoria," and the recognition that declining to provide some forms of care "could result in harm for certain TGD patients."[203] Even then, as noted below, genital surgery is typically still not recommended or performed when patients are under the age of eighteen.[204]

Research Settings, 145 BRIT. MED. BULL. 110, 114 (Fig.2) (2023); Aviva Katz, Sally Webb & Comm. on Bioethics, *Informed Consent in Decision-Making in Pediatric Practice*, 138 PEDIATRICS e1, e8-e10, e13 (2016). As discussed within, see infra Parts II.A & II.B.3 and accompanying text, adolescents do not have independent legal authority to consent to gender-affirming medical care in U.S. states. The WPATH authors, in Statement 6.12.c, refer to the process of involving minors in decisions regarding gender-affirming care as "informed consent/assent," in apparent recognition of the variations in use of these terms in the medical field when referring to the ethical requirement that minors participate in such decisionmaking. Coleman et al., *SOC8*, *supra* note 3, at S61–63. For a brief discussion of research on the psychological capacities of minors to make or participate in informed treatment decisions, see infra notes 286-288.

198. Rosenthal, *supra* note 170, at 588.

199. For a description of the different forms of surgery, see, for example, Vikram G. Mookerjee, Jonathan P. Brower & Daniel Kwan, *Gender-Affirming Surgical Care*, *in* PEDIATRIC GENDER IDENTITY: GENDER-AFFIRMING CARE FOR TRANSGENDER & GENDER DIVERSE YOUTH 219, 220–21 (M. Forcier, Gerrit Van Schalkwyk & Jack L. Turban eds., 2020).

200. *Id.* at 219–20.

201. *Id.*

202. *Id.* at 227.

203. *Id.* at 220.

204. *Id.* at 227.

Indeed, the Endocrine Society generally recommends against performing surgical affirmation of gender identity with individuals who have not reached the legal age of majority.[205] Endocrine Society Guideline 5.5 reads: "We suggest that clinicians delay gender-affirming genital surgery . . . until the patient is at least 18 years old or legal age of majority in his or her country."[206] For gender-affirming surgery that does not affect fertility—specifically, breast or chest surgery—the Endocrine Society Guidelines indicate that a case-by-case model, based on clinical judgment and the physical and mental health status of the individual, may be most appropriate, given individual variations in patients' needs.[207]

After reviewing existing data, the drafters of the Standards of Care (8th) do not explicitly recommend against performance of all gender-affirming surgeries with minors.[208] Rather, they articulate various principles and considerations, specifying certain procedures that are not recommended for persons under the age of eighteen.[209] The Standards weigh the developmental maturity of the minor, factors related to the minor's treatment needs, and other circumstances that may support earlier intervention.[210] "Higher (i.e., more advanced) ages may be required for treatments with greater irreversibility, complexity, or both" to allow for greater cognitive and emotional maturation on the part of the minor before undertaking these treatments.[211] Both WPATH and the Endocrine Society recognize that empirical data on the long-term benefits and risks of genital surgery on persons under the age of eighteen is limited, which argues further for delaying such procedures until adulthood.[212] By contrast, several studies inform such decisions regarding chest masculinization surgery for transgender males, indicating that in select cases, after careful multidisciplinary patient assessment, such surgery can provide substantial benefit to patients experiencing serious gender dysphoria-related distress.[213] Further, the studies indicate that surgery can lead to good psychological outcomes, with rare instances of post-surgical regret.[214]

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205. Hembree et al., *Endocrine Society Guidelines*, *supra* note 130, at 3893.

206. *Id.* at 3894.

207. *Id.*

208. Coleman et al., *SOC8*, *supra* note 3, at S66.

209. *Id.*

210. *Id.*

211. *Id.* at S65.

212. *Id.* at S66; Hembree et al., *Endocrine Society Guidelines*, *supra* note 130, at 3894–95.

213. Coleman et al., *SOC8*, *supra* note 3, at S66.

214. *Id.*; *see also* Simone Mahfouda, Julia K. Moore, Aris Siafarikas, Timothy Hewitt, Uma Ganti, Ashleigh Lin & Florian Daniel Zepf, *Gender-Affirming Hormones and Surgery in Transgender Children and Adolescents*, 7 LANCET DIABETES ENDOCRINOLOGY 484, 486–88 (2019) (reviewing the literature); Valeria P. Bustos, Samyd S. Bustos, Andres Mascaro, Gabriel Del Corral, Antonio J. Forte, Pedro Ciudad, Esther A. Kim, Howard N. Langstein & Oscar J. Manrique, *Regret After Gender-Affirmation Surgery: A Systematic Review and Meta-Analysis of Prevalence*, 9 PLASTIC & RECONSTRUCTIVE SURGERY GLOB. OPEN 1, 7 (2021) (studying the prevalence of regret).

A recent study providing national estimates of gender-affirming surgery in the United States between 2016 and 2020 revealed that 7 percent of such surgeries were performed on persons eighteen years old and younger, concluding that such surgeries were "relatively uncommon" in that age group.[215] Unfortunately, the data do not indicate what proportion of persons in that age range were eighteen, and therefore, had reached adulthood at the time of the surgery. In addition, most of these surgeries were chest or breast procedures, consistent with the above recommendations that genital surgeries should be delayed until adulthood.[216]

C. Debates and Controversies

Discussions about gender-affirming care have, at times, become flooded with misinformation. Some of that misinformation likely results from good-faith misunderstandings or misinterpretations. Some of it, however, is disseminated with the intent of creating controversy, confusion, and uncertainty.[217] Unfortunately, some myths about TGD individuals and gender-affirming care have become a fixture in the public discourse.[218] These myths dominate the legislative findings of the states that restrict gender-affirming care, are repeated in briefs and expert testimony, and have made their way into some courts' decisions adjudicating the constitutionality of the statutes.[219] Some claims focus on the safety of gender-affirming care, asserting that the interventions are "experimental and unsafe," alleging potentially serious physiological harms resulting from treatment.[220] As the material reviewed in Subpart I.B reveals, scientists studying the effects of gender-affirming medical care have not observed serious health risks resulting from these treatments. As a team of experts in gender-affirming health care point out: "All medical treatments carry risks."[221] WPATH Standards of Care (8th) and the Endocrine Society Guidelines, developed with reference to three decades of research, identify potential risks and side effects, recommend monitoring and mitigation strategies, and underscore the importance of the informed consent process so that patients and their parents can jointly decide, with the advice of their healthcare team, whether the potential benefits of treatment outweigh risks.[222] Although experts in the field acknowledge the need for continuing research, they conclude that there is

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215. Jason D. Wright, Ling Chen, Yukio Suzuki, Koji Matsuo & Dawn L. Hershman, *National Estimates of Gender-Affirming Surgery in the U.S.*, JAMA NETWORK OPEN, Aug. 23, 2023, at 9, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2808707.

216. *Id.*

217. *See infra* Part IV.B.

218. *See, e.g.*, Boerner, *supra* note 18; Eckert, *supra* note 18.

219. *See infra* Part IV.B.

220. Meredithe McNamara, Christina Lepore, Anne Alstott, Rebecca Kamody, Laura Kuper, Nathalie Szilagyi, Susan Boulware & Christy Olezeski, Commentary, *Scientific Misinformation and Gender Affirming Care: Tools for Providers on the Front Lines*, 71 J. ADOLESCENT HEALTH 251, 252 (2022).

221. *Id.*

222. *Id.*

a sufficient foundation of data and clinical experience to offer the interventions safely, consistent with the Standards of Care (8th) and Guidelines.[223]

Researchers cite the need to further develop our understanding of the prevalence of TGD youth and the developmental pathways of variations in gender identity.[224] Not only is such a research goal important to facilitate the most responsive professional services, but it will also help the field address unsubstantiated and potentially misleading theories about both prevalence and development. For example, one author, Lisa Littman, suggested that "social contagion" (that is, social media, peer influences, and social pressures), explains an increase in adolescents seeking gender-affirming care in recent years.[225] This theory, referred to as "rapid onset gender dysphoria" ("ROGD"), impliedly casts doubt on the authenticity of experiences of gender incongruence by those who seek gender-affirming care, and therefore also, their need for such care. The scientific community has criticized the methodology of the research on which it is based, and has been unable to confirm its findings.[226] In response to such criticism, the journal in which Littman's study was published conducted another review, removed the original article, issued a correction, and replaced the article

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223. See reviews of sources in Parts I.A. & I.B. supra.

224. *See, e.g.*, Olson-Kennedy et al., *supra* note 74, at 175–77.

225. Lisa Littman, *Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, 13 PLOS ONE 1, 33–34 (2018) (reporting online survey results and her hypothesis "social and peer contagion" can lead adolescents to believe that they are gender dysphoric or transgender).

226. *See, e.g.*, Coalition of the Advancement & Application of Psychological Science, CAAPS Position Statement on Rapid Onset Gender Dysphoria (ROGD) (2021), https://www.caaps.co/rogd-statement (last visited March 16, 2024) [hereinafter CAAPS Position Statement] (multi-society coalition asserting that there "there exist no sound empirical studies of ROGD and it has not been subjected to rigorous peer-review processes that are standard for clinical science" and "no evidence that ROGD aligns with the lived experiences of transgender children and adolescents"); Greta R. Bauer, Margaret L. Lawson & Daniel L. Metzger, *Do Clinical Data from Transgender Adolescents Support the Phenomenon of "Rapid Onset Gender Dysphoria"?*, 243 J. PEDIATRICS 224, 224–26 (2022) (finding no support for RODG hypothesis in study conducted with adolescents seeking gender-affirming care at ten Canadian clinics); Jack L. Turban, Bret Dolotina, Thomas M. Freitag, Dana King & Alex Keuroghlian, *Age of Realization and Disclosure of Gender Identity Among Transgender Adults*, 72 J. ADOL. HEALTH 852, 854–58 (2023) (finding no support for ROGD hypothesis in secondary analysis of survey conducted with 27,715 TGD in the U.S.).

Some surveys have reported increases over time in the proportion of American youth who identify as transgender or gender diverse. *See, e.g.*, *The Trevor Project Research Brief: Data on Transgender Youth*, TREVOR PROJECT (Feb. 2019) https://www.thetrevorproject.org/wp-content/uploads/2021/08/The-Trevor-Project-Research-Brief-February-2019.pdf (reporting that 1.8 percent of youth identify as transgender, an increase from the previously estimated prevalence of .7 percent). Researchers using more reliable scientific methods are exploring what appear to be increases in the adolescent TGD population. For example, Jae A. Puckett, Samantha Tornello, Brian Mustanski, and Michael E. Newcomb reviewed research on "generational differences in the timing of gender identity milestones." *Gender Variations, Generational Effects, and Mental Health of Transgender People in Relation to the Timing and Status of Gender Identity Milestones*, 9 PSYCHOL. SEX. ORIENTATION & GENDER DIVERSITY 165, 166–67 (2022). They report that, in recent years, "younger generations [are] identifying as transgender and living their affirmed gender [at earlier stages of development] compared with older generations," which includes seeking gender-affirming care. *Id.* We do not yet know whether these apparent increases in young persons' identification as TGD and care-seeking reflect true increases in the population or shifts in developmental patterns related to internal acknowledgement, social expression, and care-seeking behavior of TGD youth.

with a revised version.[227] Furthermore, the author's home university created a webpage to acknowledge and explain the controversy.[228] In 2021, a multi-society and academic coalition published a position statement, vigorously challenging "the use of Rapid-Onset Gender Dysphoria (ROGD) and similar concepts for clinical and diagnostic application given the lack of rigorous empirical support for its existence."[229] Citing the increased attention to this theory, it further emphasized "the significant potential for creating harm" associated with its dissemination and use.[230]

Another challenged assertion relates to the stability or "persistence" of the experience of gender incongruence in youth. Alabama's legislature, among others, claims that the gender incongruence experienced by youth is "not permanent or fixed" and that "the substantial majority of children who experience [this discordance] will outgrow this discordance once they go through puberty and will eventually have an identity that aligns with their sex."[231] Researchers have responded by clarifying what we know about the stability or persistence of children's gender identity. First, experts emphasize that prior to puberty, a child's gender identity trajectory may be difficult to predict.[232] The process is not always linear as prepubescent children develop and learn more about themselves and how they fit into the world—an exploratory process viewed as falling within the range of normal developmental pathways children may take.[233] Thus, fluidity in children's gender identity between earlier childhood and adolescence or adulthood does not demonstrate that those adolescents who experience gender incongruence or dysphoria will outgrow these conditions.

Researchers and the drafters of the Standards of Care (8th) emphasize the importance of careful assessment of the individual as a component of gender-affirming care.[234] The presence of "a consistent, stable articulation of a gender identity that is incongruent with the sex assigned at birth," and the child's expression of "a strong desire or need to transition to the gender they have articulated as being their authentic gender" are among the factors considered in assessing the child's needs. The terms "consistent," "persistent," and "insistent," have been used by some in the field to refer to those children whose initial sense of incongruence between their identified gender and assigned gender will remain

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227. Lisa Littman, *Correction: Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, 14 PLOS ONE e0214157 (2019), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0214157.

228. *Updated: Brown Statements on Gender Dysphoria Study*, BROWN UNIV. (Mar. 19, 2019), https://www.brown.edu/news/2019-03-19/gender.

229. CAAPS Position Statement, *supra* note 226.

230. *Id.*

231. ALA. CODE § 26-26-2(4) (2023).

232. *See, e.g.*, Coleman et al., *SOC8*, *supra* note 3, at S67.

233. *See generally* DIANE EHRENSAFT, THE GENDER CREATIVE CHILD (2016) (describing concepts of gender fluidity in childhood).

234. *See, e.g.*, Coleman et al., *SOC8*, *supra* note 3, at S77.

stable through adolescence and adulthood.[235] The Standards of Care (8th) emphasize that the level of evidence of persistent, marked, and sustained gender incongruence must be increasingly strong when considering potentially irreversible gender-affirming interventions.[236]

Researchers also point to misinterpretation of some early studies that were characterized by methodological flaws.[237] Those studies included children who were not evaluated according to current definitions of gender dysphoria, and thus would not be considered TGD under modern standards.[238] Psychiatrist Jack Turban explains: "These children might have been cisgender boys or girls with gender-atypical interests or expression, rather than children whose gender identity differed from that assigned at birth."[239] Psychologist Diane Ehrensaft suggests that children who are eventually identified as "desisters" were always a completely different group from the group identified as "persisters."[240] Julia Temple Newhook and her coauthors point out that the studies from which the "desistance" data are drawn appear to classify participants for whom there were no follow-up data as "desisters," inappropriately inflating the size of that group.[241] Diane Chen and colleagues observed that the researchers reporting high rates of "desistence" may have misinterpreted participants' decisions not to continue with treatment at that clinic as indicating that those persons' gender incongruence had not persisted.[242] Yet, research reveals that not all transgender individuals pursue gender-affirming medical care, even when their gender incongruence persists.[243] Recent studies employing more rigorous methodological standards have found high rates of persistence of gender identity among children whose gender identities differed from their birth-assigned sex at a five-year follow-up (with 94% reporting persistence),[244] and youth diagnosed

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235. Keo-Meier & Ehrensaft, *supra* note 58, at 6. *See also* Kristina R. Olson*, Prepubescent Transgender Children: What We Do and Do Not Know*, 55 AM. J. CHILD & ADOL. PSYCHIATRY 155, 155 (2016).

236. Coleman et al., *SOC8*, *supra* note 3, at S60.

237. *See, e.g.*, Turban & Ehrensaft, *Gender Identity in Youth*, *supra* note 17, at 1232; Julia T. Newhook, Jake Pyne, Kelley Winters, Stephen Feder, Cindy Holmes, Jemma Tosh, Mari-Lynne Sinnott, Ally Jamieson & Sarah Pickett, *A Critical Commentary on Follow-Up Studies and "Desistance" Theories about Transgender and Gender-Nonconforming Children*, 19 INT'L J. TRANSGENDERISM 212, 212 (2018).

238. Jack L. Turban & Alex S. Keuroghlian*, Dynamic Gender Presentations: Understanding Transition and "De-Transition" Among Transgender Youth*, 57 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 451, 452 (2018).

239. *Id.*

240. Diane Ehrensaft*, Exploring Gender Expansive Expressions Versus Asserting a Gender Identity*, *in* THE GENDER AFFIRMATIVE MODEL: AN INTERDISCIPLINARY APPROACH TO SUPPORTING TRANSGENDER AND GENDER EXPANSIVE CHILDREN, *supra* note 58, at 37, 41.

241. Newhook et al., *supra* note 237, at 216.

242. Chen et al., *supra* note 17, at 76–77.

243. *Id.* at 77.

244. Kristina R. Olson, Lily Durwood, Rachel Horton, Natalie M. Gallagher & Aaron Devor, *Gender Identity 5 Years After Social Transition*, 150 PEDIATRICS, no. 2, Aug. 2022, at 1, 3.

with gender dysphoria at four to nine year follow-up period (with 90.9% reporting persistence).[245]

It is beyond the scope of this Article to review all of the claims made by political opponents of gender-affirming care and the scientific rebuttals. Instead, I refer the reader to sources that review the claims and discuss the state of the research. In particular, a group of physicians and mental health professionals on the faculties of top academic institutions have published several retorts to statutory and administrative measures limiting access to gender-affirming care for minors in Texas, Alabama, and Florida, addressing claims made by the drafters of those measures.[246] In addition to their lengthier reports, they have also published a brief summary of their responses to the claims made in various states' legislative findings.[247] Furthermore, the Standards of Care (8th) and the Endocrine Society Guidelines provide thoughtful and painstaking reviews of the current state of knowledge on most of the issues raised in various states' legislative findings.[248]

Independent of the myths and misconceptions noted above, there remain questions of interest to researchers and those who provide gender-affirming care. Scientists have identified research priorities to guide future decades of study. For example, Johanna Olson-Kennedy and her coauthors observe the need for further research on "the biological underpinnings of gender," the prevalence of TGD identities among children and adolescents, developmental pathways in the development of gender identity, the mental health challenges experienced by TGD children and youth, and the long-term effects of gender-affirming medical interventions.[249] The WPATH Standards of Care (8th) and the Endocrine Society Guidelines likewise, in every area of gender-affirming care reviewed, recommend potentially fruitful lines of future research.[250]

II. The Law of Consent for Minor's Health Care and the Role of Medical and Scientific Evidence in Legal Disputes About Parental

245. Joseph Elkadi, Catherine Chudleigh, Ann M. Maguire, Geoffrey R. Ambler, Stephen Scher & Kasia Kozlowska, *Developmental Pathway Choices of Young People Presenting to a Gender Service with Gender Distress: A Prospective Follow-up Study*, 10 CHILD., no. 2, Feb. 7, 2023, at 1, 13.

246. *See* BOULWARE ET AL., BIASED SCIENCE, *supra* note 18; MCNAMARA ET AL., A CRITICAL REVIEW, *supra* note 18.

247. McNamara et al., supra note 220, at 251–53; *see also* Beth A. Clark, Alice Virani, Diane Ehrensaft & Johanna Olson-Kennedy, Letter to the Editor, *Resisting the Post-Truth Era: Maintaining a Commitment to Science and Social Justice in Bioethics*, 19 AM. J. BIOETHICS W1, W1–3 (2019) (addressing a previous commentary published in the American Journal of Bioethics).

248. *See generally* Coleman et al., *SOC8*, *supra* note 3; Hembree et al., *Endocrine Society Guidelines*, *supra* note 130.

249. Olson-Kennedy et al., *supra* note 74, at 173–77; *see also* Chen et al., *supra* note 242, at 76–81 (highlighting ongoing debates and gaps in current knowledge).

250. *See generally* Coleman et al., *SOC8*, *supra* note 3; Hembree et al., *Endocrine Society Guidelines*, *supra* note 130.

AUTHORITY TO DECIDE

A. LEGAL FOUNDATIONS FOR PARENTAL AUTHORITY TO DECIDE

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.[251]

The family unit has a distinctive place in American society and jurisprudence.[252] One expression of the family's unique position and role is the broad legal authority vested in parents to exercise their discretion in making important decisions affecting the welfare of their minor children.[253] Under American law, parents are authorized to guide their children's development and welfare in most important areas including, but not limited to, educational choices,[254] religious upbringing,[255] discipline,[256] and healthcare decisionmaking.[257] And while modern law allocates some of the authority for governing children's lives to the state, and occasionally, to minors themselves, American law is highly deferential to parental authority, constraining its limitations on that authority.[258]

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251. Wisconsin v. Yoder, 406 U.S. 205, 232 (1972).

252. *See* John Demos, *Images of the American Family, Then and Now*, *in* CHANGING IMAGES OF THE FAMILY 43, 46 (Virginia Tufte & Barbara Myerhoff eds., 1979); LINDA C. MCCLAIN, THE PLACE OF FAMILIES: FOSTERING CAPACITY, EQUALITY, AND RESPONSIBILITY 20–21 (2006); Lois A. Weithorn, *Envisioning Second-Order Change in America's Responses to Troubled and Troublesome Youth*, 33 HOFSTRA L. REV. 1305, 1389–92 (2005).

253. *See, e.g.*, Meyer v. Nebraska, 262 U.S 380, 399–400 (1923); Pierce v. Soc'y of Sisters, 268 U.S. 510, 534–35 (1925); *Yoder*, 406 U.S. at 232; Parham v. J.R., 442 U.S. 601, 602 (1979). For a thoughtful statement of the evolution and modern status of this authority, see RESTATEMENT OF CHILD. & THE LAWS ch. 1, intro. note (AM. L. INST., Tentative Draft No. 1, 2018) (emphasizing current vitality of "robust legal and constitutional protection" for parental authority).

254. *Meyer*, 262 U.S at 400; *Pierce*, 268 U.S. at 535; *Yoder*, 406 U.S. at 235–36. For an overview and analysis of parental authority over their children's education, see, for example, SAMUEL M. DAVIS, ELIZABETH S. SCOTT, LOIS A. WEITHORN & WALTER WADLINGTON, CHILDREN IN THE LEGAL SYSTEM 34–62 (Saul Levmore et al. eds., 6th ed. 2020).

255. Prince v. Massachusetts, 321 U.S. 158, 166 (1944); *Yoder*, 406 U.S. at 235–36. For a discussion of modern parameters of parental authority to guide their children's religious upbringing, see, for example, Robin Fretwell Wilson & Shaakirrah R. Sanders, *By Faith Alone: When Religious Beliefs and Child Welfare Collide*, *in* THE CONTESTED PLACE OF RELIGION IN FAMILY LAW 308, 310–314 (R.F. Wilson ed., 2018).

256. *See, e.g.*, Doriane Lambelet Coleman, Kenneth A. Dodge & Sarah Keeton Campbell, *Where and How to Draw the Line Between Reasonable Corporal Punishment and Abuse*, 73 L. & CONTEMP. PROBS. 107, 136–55 (2010); State v. Wilder, 748 A.2d 444, 456 (Me. 2000) (articulating and applying the constitutional and state law basis for the parental privilege to use reasonable corporal punishment in disciplining children).

257. *See Parham*, 442 U.S. at 584–85 (reinforcing parental authority to make health care decisions for their minor children in the context of inpatient mental health treatment); Bellotti v. Baird, 443 U.S. 622, 635–39 (1979) (acknowledging the importance of parental authority to make health care decisions for their minor children in determining the parameters of minors' independent access to abortion); Newmark v. Williams, 588 A.2d 1108, 1115–16 (Del. 1991) (recognizing legal doctrines requiring deference to parental discretion in health care decisions regarding their minor children).

258. *See infra* Part II.B.

Although parental authority in these realms initially developed through the common law, the protections assumed constitutional status during the 20th Century.[259] Reviewing the constitutional developments in 2000, the U.S. Supreme Court reminded us in *Troxel v. Granville* that "the interest of parents in the care, custody, and control of their children," protected by the Fourteenth Amendment's Due Process Clause, is "perhaps the oldest of the fundamental liberty interests recognized by this Court."[260] Its analysis in *Troxel* reinforced the critical role that state deference to parental decisionmaking plays in constitutional decisionmaking.[261]

The weighty liberty interests animating parental decisionmaking authority in critical areas of their children's welfare also serve to promote a range of governmental goals.[262] Our family law reveals multiple bases on which "[i]nvesting parents with some measure of discretion in decisionmaking regarding their minor children's welfare recognizes the functional role of families in our society."[263] The family forms the "building blocks out of which the larger units of social organization are fashioned."[264] It is the social unit uniquely situated and structured to nurture and socialize children,[265] to respond to each child's individual "needs, talents, and characters," and to personalize and customize that child's upbringing.[266] The Court has emphasized the importance of protecting parental authority to execute these social roles in a manner consistent with their judgment and values, and has cited this theme as a rationale for limiting state intrusion in parental decisions.[267] As the Court asserted in

259. Clare Huntington & Elizabeth S. Scott, *Conceptualizing Legal Childhood in the Twenty-First Century*, 118 MICH. L. REV. 1371, 1381 (2020).

260. Troxel v. Granville, 530 U.S. 57, 65–66 (2000); *see also Prince*, 321 U.S. at 166 (asserting that the primacy of the parents in raising their children requires respect for a "private realm of family life which the state cannot enter").

261. In *Troxel*, the Court held that a state court's application of a nonparent visitation statute violated the Fourteenth Amendment rights of the children's mother, in that the lower court applied a "best interest" test without giving deference to the mother's preferences. 530 U.S. at 69. In writing for the Court, Justice O'Connor stated "the Due Process Clause does not permit a State to infringe on the fundamental right of parents to make child rearing decisions simply because a state judge believes a 'better' decision could be made." *Id.* at 72–73. The analysis in *Troxel*, however, underscored that, in adjudicating constitutional rights in the context of contests among the state, parents, and children, the Court may apply "alternative modes of analysis, such as balancing tests, customized to the particular issues and constellation of parties and interests." Dorit Rubinstein Reiss & Lois A. Weithorn, *Responding to the Childhood Vaccination Crisis: Legal Frameworks and Tools in the Context of Parental Vaccine Refusal*, 63 BUFF. L. REV. 881, 908–09 (2015). In *Troxel*, despite the Court's characterization of the right in question as fundamental, the Court did not apply strict scrutiny. Rather, it held that the family court must accord her preferences *deference* or "special weight." *Id.* at 908–09 & n.123.

262. Lois A. Weithorn & Dorit Rubinstein Reiss, *Providing Adolescents with Independent and Confidential Access to Childhood Vaccines: A Proposal to Lower the Age of Consent*, 52 CONN. L. REV. 771, 789–96 (2020).

263. *Id.* at 790.

264. Demos, *supra* note 252, at 46.

265. Elizabeth S. Scott & Robert E. Scott, *From Contract to Status: Collaboration and the Evolution of Novel Family Relationships*, 115 COLUM. L. REV. 293, 304 (2015) ("Families care for dependent children, prepare them for citizenship, and educate them to be productive members of society.").

266. *Id.*; MICHAEL GROSSBERG, GOVERNING THE HEARTH: LAW AND THE FAMILY IN NINETEENTH-CENTURY AMERICA 8 (1985).

267. *See, e.g.*, Pierce v. Soc'y of Sisters, 268 U.S. 510, 535 (1925).

Pierce v. Society of Sisters in 1925: "The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations."[268]

The Court has recognized as well that the relationships between parents and children are of a special character. It famously observed in *Parham v. J.R.* that the "natural bonds of affection lead parents to act in the best interests of their children."[269] Focusing on the important role that parents play in promoting their children's welfare, the Court continued: "the law's concept of the family rests on a presumption that parents possess . . . the maturity, experience, and capacity for judgment required for making life's difficult decisions" regarding their minor children's welfare, and that parents "can and must make these judgments."[270] This model of family self-governance therefore emphasizes state deference to the judgment of loving parents who are uniquely positioned to make appropriate decisions on behalf of their minor children.

In a recent article, Clare Huntington and Elizabeth Scott emphasize the centrality of promotion of *child wellbeing* to state regulation of the family.[271] They argue that vigorous protection of parental decisional authority yields a range of instrumental benefits that promote child wellbeing, providing "a legal justification" for parental decisional rights.[272] They state further:

> In addition to promoting child wellbeing, robust protection of parental rights also advances society's interests. In a country in which family-state relations are governed by libertarian principles, parents are burdened with the weighty responsibility of raising the next generation of citizens . . . . Strong protection of parental rights shows respect for and deference to parents for the important job they undertake. This deference reinforces parental commitment to undertake the duties of parenthood and facilitates their ability to do so without excessive interference.[273]

The doctrine of parental consent for children's health care constitutes one of several important dimensions of parental authority regarding decisions affecting their children's welfare. As articulated in the *Restatement of Children*

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268. *Id.*

269. Parham v. J.R., 442 U.S. 584, 602 (1979); *see also* Barbara Bennett Woodhouse, *Of Babies, Bonding, and Burning Buildings: Discerning Parenthood in Irrational Action*, 81 VA. L. REV. 2493, 2498 (1995) (speaking to the emotional bonds between parents and children by noting "[p]arenthood in action requires suspending objectivity and adopting an inherently other-centered subjectivity made possible by the blurring of emotional boundaries between self and other").

270. *Parham*, 442 U.S. at 602–03; *see also* Bellotti v. Baird, 443 U.S. at 622, 637 (1979) (citing the "guiding role of parents" as protecting youth "from their own immaturity by requiring parental consent to or involvement in important decisions by minors"). The law presumes that minors' capacity to make important decisions affecting their own welfare is not yet fully matured. *Bellotti*, 443 U.S. at 635–36; *Parham*, 442 U.S. at 602. For a discussion of the contributions of psychological science and neuroscience to our understanding of children's capacities to make important decisions, see note 288.

271. Huntington & Scott, *supra* note 259, at 1414–18.

272. *Id.* at 1418.

273. *Id.* at 1417.

and the Law, "[a] parent or guardian has broad authority to make medical decisions for a child."[274] The flip side of parental authority, of course, is responsibility. Legal parenthood is accompanied by a host of legal duties to protect and provide for their children, and state regulation of child welfare serves as the enforcement mechanism when parental conduct falls below certain minimum standards.[275] In the context of parental obligations to meet their children's need for health care, the Court, in *Parham*, opined that the law imposes upon parents a "'high duty' to recognize symptoms of illness and to seek and follow medical advice."[276]

Parental authority in healthcare decisionmaking and in other realms is not, of course, without limits.[277] The state shares interests in, and responsibility for, the welfare and socialization of the children within its borders. The state's *parens patriae* power refers to its regulatory authority permitting intervention in the lives of individuals, such as children, in order to protect and promote those persons' own welfare.[278] The state's *police power* allows it some measure of oversight over children's lives in order to promote the interests of the community or society, such as advancing its safety, health, and prosperity.[279] Frequently, in the regulation of children's lives, *parens patriae* and police power interests

274. RESTATEMENT OF CHILD. & THE LAWS § 2.30(1)(a) (AM. L. INST., Tentative Draft No. 1, 2018). For an analysis of legal protection for parental rights more generally, and in the context of healthcare decisions specifically, as such protection relates to promoting children's wellbeing, see Huntington & Scott, *supra* note 259, at 1413–18, 1426–29.

275. *See* DAVIS ET AL., *supra* note 254, at 439–600.

276. Parham v. J.R., 442 U.S. 584, 602 (1979).

277. Prince v. Massachusetts, 321 U.S. 158, 166 (1944); Troxel v. Granville, 530 U.S. 57, 65–66 (2000).

278. "*Parens patriae*, literally 'parent of the country,' is the government's power and responsibility, beyond its police power over all citizens, to protect, care for, and control citizens who cannot take care of themselves." Natalie Loder Clark, Parens Patriae *and a Modest Proposal for the Twenty-First Century: Legal Philosophy and a New Look at Children's Welfare*, 6 MICH. J. GENDER & L. 381, 382 (2000). Such regulations typically focus on persons who, like children or persons in other vulnerable or dependent subsets within society, are seen as less able to protect or care for themselves or make decisions in their own interests. Weithorn & Reiss, *supra* note 262, at 797–801.

279. *See Developments in the Law: The Constitution and the Family*, 93 HARV. L. REV. 1156, 1214 (1980) (discussing the state's *parens patriae* and police power interests); Weithorn, *supra* note 252, at 1402–03 (contrasting *parens patriae* and police power). With respect to children, the state has at least two specific police power interests. First, it seeks to promote the socialization of youth into well-adjusted adults who can contribute constructively to society (that is, socialization-oriented police power interests). *Prince*, 321 U.S. at 168 ("A democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies."); *see also* Weithorn & Reiss, *supra* note 262, at 798–99 (describing the use of the state's police power to achieve the state's interests in socializing minors to develop into constructive adult citizens). Second, the state acts to safeguard the public's safety, including public health, and retains authority to intervene in the lives of individuals in order to promote the health of the community (that is, public health and safety-oriented police power interests). *Id.* In *Jacobson v. Massachusetts*, the U.S. Supreme Court emphasized the "social compact" between the state and its citizens, requiring public acquiescence to policies that advance the safety and protection of the citizenry, even when doing so may restrict one's liberty. 197 U.S. 11, 27 (1905). For the classic statement of the state's *parens patriae* and police power interests in intervening in the family to promote children's welfare and healthy socialization, see *Prince*, 321 U.S. at 165–70 ("[T]he family itself is not beyond regulation in the public interest . . . . [N]either rights of religion nor rights of parenthood are beyond limitation. Acting to guard the general interest in youth's well-being, the state as *parens patriae* may restrict the parent's control . . . .").

converge, as they do in the context of compulsory educational policies and child labor restrictions.[280] In these areas and others, the state's interests and those of parents may clash, necessitating constitutional adjudication of parental rights and state interests.[281]

Children's independent interests may also serve as the basis for restricting parental authority.[282] Those interests may be of constitutional stature,[283] or may be grounded in other considerations that a legislature or court determines should be incorporated into the balancing of interests.[284] Dorit Rubinstein Reiss and I synthesized support for two sets of independent interests of children that are relevant to the balance in certain circumstances, particularly in contested areas of healthcare decisionmaking: (1) the interest in health and the preservation of one's life;[285] and (2) the interest in autonomous decisionmaking regarding one's health care, commensurate with their psychological capacities.[286] Requirements for parental consent may therefore be limited if necessary to protect or promote minors' interests in certain circumstances.

I emphasize here that, in the context of the statutes that are the focus of this Article, *the interests and preferences of parents and children are aligned*. Parental authority to make health care decisions for their children may be restricted under American law in limited situations for the purpose of

280. *See* Weithorn, *supra* note 252, at 1402–03. Both sets of policies are seen as promoting children's best interests by equipping children for a more productive and successful future, while protecting them from the dangers of, and time commitment to, the workplace. Children who have received an education and been protected from onerous employment demands are expected to mature into more self-sufficient and productive adult members of society than those who have not had those opportunities or protections. *See* Weithorn & Reiss, *supra* note 262, at 797–801. The state's *parens patriae* and public health goals also frequently converge in the context of children's health, as exemplified by mandatory vaccination policies. Reiss & Weithorn, *supra* note 261, at 901–14.

281. Huntington and Scott observe that traditional characterizations of the allocation of decisional authority for children's welfare views "state authority, parental rights, and children's rights pitted against one another . . . ." Huntington & Scott, *supra* note 259, at 1377. Alternatively, they propose a harmonizing theme, asserting that "legal regulation of children is grounded in the overarching goal of promoting child wellbeing, which knits together the interests of parents, children and the state." *Id.*

282. Weithorn & Reiss, *supra* note 262, at 803–08.

283. *See* Parham v. J.R., 442 U.S. 584, 620 (1979) (assuming a child has a limited liberty and procedural due process rights in the context of parental decisions to admit them to mental hospitals); Bellotti v. Baird, 443 U.S. 622, 634–35 (1979) (recognizing a limited liberty interest of minors who seek an abortion without parental consent).

284. *See, e.g.*, Newmark v. Williams, 588 A.2d 1108, 1116 (Del. 1991) ("All children indisputably have the right to enjoy a full and healthy life."); Custody of a Minor, 379 N.E.2d 1053, 1066 (Mass. 1978) (holding that a child whose parents rejected life-saving chemotherapy treatment had a "long-term interest in leading a normal, healthy life," converging with the state's strong interest in preserving human life).

285. Weithorn & Reiss, *supra* note 262, at 803–05.

286. *Id.* at 805–08. As I detail elsewhere, minors' capacities to make health care decisions are not always relevant, even if the minors satisfy legal standards of capacity. Lois A. Weithorn, *When Does A Minor's Legal Competence to Make Health Care Decisions Matter?*, 146 PEDIATRICS, no. S1, Aug. 2020, at S25, S26. Judgments of competence are not the triggers for shifting decisional authority from adults to minors. *Id.* "Typically, minors' decisional capacities become relevant only after courts or legislatures conclude that the default of parental consent does not achieve important policy goals or protect constitutional rights" or interests, and that authorizing minors to decide serves to best achieve those important policy goals or to protect those constitutional rights. *Id.*

authorizing minors to play a greater role in their own healthcare decisions.[287] Yet, contests between parental and minors' decisional authority *are not at issue* with respect to the statutes reviewed in Part III that restrict gender-affirming care. In these cases, parents and children are co-plaintiffs, jointly seeking the freedom to choose—as a family—whether to pursue a particular course of gender-affirming medical care, as recommended by their healthcare team. Therefore, challenges to parental healthcare decisionmaking authority based on exceptions empowering children to decide independent of their parents do not apply to this context.

From an ethical perspective, the standards of care with respect to gender-affirming interventions require that health care practitioners obtain informed consent from *both parent and child* prior to providing gender-affirming medical care, such as puberty-blocking medications or gender-affirming hormones.[288] Thus, the model is premised on parent-child agreement and collaboration regarding the child's involvement in treatment. While some commentators have argued that minors seeking gender-affirming care should have the legal authority to consent to such treatment independently, even over the opposition of parents, or have an option for judicial by-pass of parental refusal,[289] that question is not

287. *See infra* Part II.B.

288. *See, e.g.*, Coleman et al., *SOC8*, *supra* note 3, at S61 (observing that a legal guardian's informed consent is required together with that of a minor patient, and that minors must demonstrate sufficient emotional and cognitive maturity to provide informed consent). Questions about minors' developing capacities to participate in healthcare decisionmaking, and to meet adult standards of competence to consent, have been considered by behavioral scientists and other scholars. *See, e.g.*, Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589 (1982); Thomas Grisso & Linda Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 PRO. PSYCH. 412, 412–13 (1978); Laurence Steinberg, Elizabeth Cauffman, Jennifer Woolard, Sandra Graham & Marie Banich, *Are Adolescents Less Mature than Adults? Minors' Access to Abortion, the Juvenile Death Penalty, and the Alleged APA "Flip-Flop"*, 64 AM. PSYCH. 583, 592–93 (2009); Grace Icenogle et al., *Adolescents' Cognitive Capacity Reaches Adult Levels Prior to their Psychosocial Maturity: Evidence for A "Maturity Gap" in a Multinational, Cross-Sectional Sample*, 43 L. & HUM. BEHAV. 69, 70–72, 83 (2019). One study has examined this question with particular attention to choices about gender-affirming medical care that might be made by TGD youth. *See* Lieke J.J.J. Vrouenraets, Annelou L.C. de Vries, Martine C. de Vries, Anna I.R. van der Miesen & Irma M. Hein, *Assessing Medical Decision-Making Competence in Transgender Youth*, 148 PEDIATRICS, no. 6, Dec. 2021, at 1, 3. These analyses support the conclusion that by mid-, and in some cases early, adolescence, most minors have developed sufficient capacities to meet adult standards of informed consent. Furthermore, minors' ability to exercise their decisionmaking skills most effectively is enhanced in contexts where they can consult with supportive adults, such as doctors and parents. Icenogle et al., *supra*, at 78 (referring to "the presence of adult consultants and the absence of time pressure" as minimizing the likelihood that tendencies toward immature decisionmaking, such as impulsiveness or detrimental influence by peers, will interfere with minors' abilities to make effective use of their cognitive and intellectual decisionmaking skills). For a review of existing research on minors' capacities to meet adult standards of informed consent, together with analyses of relevant issues, see Weithorn & Reiss, *supra* note 262, at 835–47.

289. *See, e.g.*, Ikuta, *supra* note 35, at 203–05 (arguing for application of the mature minor doctrine to authorize transgender minors to make independent decisions); Vergani, *supra* note 35, at 919–28 (arguing for a judicial by-pass procedure); Dubin et al., *supra* note 35, at 297–98 (arguing for a range of legal options to overcome parental refusals in some situations).

at issue in the litigation challenging the state statutes reviewed in Part III, and therefore, I leave it for another day.[290]

Because a presumption in favor of parental judgment is the starting point for legal analyses of decisional authority regarding children's healthcare, and that presumption is given substantial deference, competing interests must be particularly weighty to override parents' claim to decisional authority.[291] Over the decades, based on these principles, several sets of exceptions to the doctrine of parental consent have developed in which the balance of interests leads to an alternative decisionmaker, or decisionmaking process, that does not rely solely on independent parental discretion. These exceptions are enumerated in Subpart II.B, below.

B. EXCEPTIONS TO THE DOCTRINE OF PARENTAL CONSENT

In the context of healthcare decisionmaking, *exceptions* to the doctrine of parental consent define the limitations of parental authority. "[J]udicial and legislative balancing of competing interests involving constitutional and policy considerations [has led to] a complex web of exceptions to parental control over minor children's health care decisions."[292] I classify the relevant exceptions according to the *rationales* that are invoked to justify these deviations from the doctrine of parental consent. The five categories overlap at times, in that multiple rationales sometimes animate them: (1) protection of the public health; (2) promotion of minors' access to necessary healthcare services in contexts in which some minors forego services if parental consent is required; (3) protection of minor's independent constitutional or statutory interests; (4) promotion of minors' access to health care services when parents are unavailable; and (5) protection of children from parental decisions that place them at substantial risk of serious harm or death. Because legislatures have attempted to justify statutes that restrict gender-affirming care on the basis that these treatments, and parental decisions to access these treatments, are *harmful* to children, I focus most of the analysis on the fifth and final exception: protection of children from parental decisions that create substantial risk of serious harm or death. Before elaborating upon that standard, I first briefly discuss the other exceptions.

290. For commentaries addressing the role of minors in health care decisionmaking, including in circumstances where the interests of parents and children may not be aligned, see, for example, Weithorn, *supra* note 286, at S27; B. Jessie Hill, *Medical Decision Making by and on Behalf of Adolescents: Reconsidering First Principles*, 15 J. HEALTH CARE L. & POL'Y 37, 39–49 (2012); Kimberly M. Mutcherson, *Whose Body Is it Anyway?: An Updated Model of Healthcare Decision-Making Rights for Adolescents*, 14 CORNELL J.L. & PUB. POL'Y 251, 252 (2005); *see also* Weithorn & Reiss, *supra* note 262, at 803–08 (discussing minors' independent interests in health care decisions).

291. Troxel v. Granville, 530 U.S. 57, 65–70 (2000).

292. Weithorn & Reiss, *supra* note 262, at 796.

1. *Exceptions to Protect the Public Health*

Mandatory vaccination requirements in all fifty states exemplify the type of public health-oriented legislation that can limit parental authority to make health care decisions for their children.[293] Decades of research have determined that the required immunizations present substantial benefits and exceedingly low risks to the children who receive them.[294] That basis alone, grounded in the state's *parens patriae* power, would likely not provide sufficient justification to override parental objections to vaccines. By contrast, the state's interest in protecting the *public's* health, together with the personal benefits and low risks for inoculated children, is sufficiently weighty to override parental authority.[295] State policies therefore create substantial disincentives for parental noncompliance.[296] Minors' access to services for diagnosis and treatment of sexually-transmitted diseases provide an example of strong public health rationales, combined with *parens patriae* concerns, that justify overstepping parental authority and allowing minors to access diagnosis and treatment independent of parental consent.[297]

2. *Exceptions to Promote Minors' Access to Necessary Health Care Services in Contexts in Which Some Minors Forego Services if Parental Consent is Required*

Studies and practitioner experience reveal that many minors hesitate to seek or forego necessary healthcare in some contexts if parental consent is required.[298] This risk exists primarily in the context of so-called "sensitive" health problems, such as those related to sexuality and sexual activity, mental health problems, substance use, and sexual assault. In these contexts, minors may be embarrassed about or fearful of disclosing their need for services to their parents.[299] In light of strong interests in promoting minors' health, which at times converges with public health concerns (for example, as in the case of sexually transmitted diseases), states have typically provided some (usually older) minors with access to these services without parental consent.[300]

3. *Exceptions to Protect Minors' Constitutional, Statutory, or Autonomy Interests*

Courts have recognized certain limited constitutional rights of minors to make certain healthcare decisions. Under the U.S. Constitution, the Supreme

293. Reiss & Weithorn, *supra* note 261, at 912.
294. Weithorn & Reiss, *supra* note 262, at 779–85.
295. *See id.* at 830–33.
296. Reiss & Weithorn, *supra* note 261, at 952–80.
297. Weithorn & Reiss, *supra* note 262, at 824.
298. *See id.* at 815–29.
299. *Id.*
300. *Id.*

Court has recognized minors' rights to access contraceptives,[301] and prior to the decision in *Dobbs v. Jackson Women's Health Organization*,[302] it recognized a qualified right of adolescents to consent to abortion independent of parental consent.[303] In addition, some states have interpreted their state constitutions to protect minor's rights to abortion.[304] More generally, some states create statutory rights that authorize minors to make certain healthcare decisions, even when those decisions deviate from those of their parent.[305] These policies promote the minor's autonomy interests, which are particularly weighty when affecting such important personal interests as control over their reproductive processes, freedom from restrictions of liberty attending psychiatric hospitalization or, in special circumstances, decisions whether to refuse life-sustaining treatment.[306]

4. *Exceptions to Promote Minors' Access to Health Care Services When Parents Are Unavailable*

Several other exceptions to the doctrine of parental consent, such as the emergency exception[307] and the mature minor exception,[308] may be justified by the state interest in promoting minors' access to health care when parents are unavailable.

5. *Exceptions to Protect Children from Risk of Serious Harm or Death*

Protection of children from serious harm or death is a powerful expression of the state's *parens patriae* interests. In addition, this goal serves the state's police power interests because the state has a strong interest in promoting minors' well-being in order to facilitate their healthy development into adults who can be constructive and contributing members of society.[309] In the context of healthcare, the most common way in which the state seeks to vindicate these interests is through case by case application of its child protection statutes. A second, and far less common mechanism, is through state-wide legislative restrictions limiting parental authority to choose a specific type of health-related

301. Carey v. Population Servs. Int'l, 431 U.S. 678, 699–700 (1977).

302. Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

303. *See* Bellotti v. Baird, 443 U.S. 622, 648 (1979).

304. *See, e.g.*, Am. Acad. of Pediatrics v. Lungren, 940 P.2d 797, 819 (Cal. 1997).

305. Some states permit minors to consent to outpatient mental health. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 124260 (West 2019). Other states authorize minors to register dissent to inpatient mental health treatment, thereby triggering certain limited due process protections, even when hospitalization is sought by a minor patient's parents. *See, e.g.*, VA. CODE ANN. § 16.1-339 (2015).

306. *See, e.g.*, *In re* E.G., 549 N.E.2d 322, 328 (Ill. 1989) (holding that a 17-year-old minor was mature enough to choose to reject life-sustaining treatment based on her religious beliefs).

307. Paul E. Sirbaugh, Douglas S. Diekema & Comm. on Pediatric Emergency Medicine & Comm. on Bioethics, *Consent for Emergency Medical Services for Children and Adolescents*, 128 PEDIATRICS, no. 2, Aug. 2011.

308. Weithorn & Reiss, *supra* note 262, at 810–11. For further discussion of the mature minor exception, see Doriane Lambelet Coleman & Philip M. Rosoff, *The Legal Authority of Mature Minors to Consent to General Medical Treatment*, 131 PEDIATRICS, no. 4, Apr. 2013.

309. *See, e.g.*, Prince v. Massachusetts, 321 U.S. 158, 167 (1944).

intervention. Below, in Part II.A.5.a, I review the criteria that states impose prior to overriding parental healthcare decisions for their children on a case by case basis in dependency proceedings. In Part II.A.5.b, I examine two modern instances in which legislatures have restricted parental authority to consent to an entire class of interventions for all children in that jurisdiction.

a. *Child protective intervention*

All fifty states and the District of Columbia authorize state intervention in the family when the state determines that parental conduct or omissions fall below minimum standards of care.[310] The U.S. Constitution requires that any substantive bases for state intervention be delineated clearly in statute, and that certain procedural due process protections be afforded to families.[311] Enforcement of the statutory standard entails individual case-by-case judicial findings of abuse or neglect.[312] In the context of healthcare, if a reviewing court finds that parental decisions place the child at a risk of harm sufficient to justify its assumption of jurisdiction over the child, it can substitute its judgment for that of the parent to the extent it deems necessary to achieve the goal of protecting the child's health.[313]

In the context of child *neglect* allegations, challenges to parental decisions present as a petition alleging that parents are refusing, or are not seeking, necessary healthcare for their minor children.[314] Petitions raising such claims allege "medical neglect," as defined, for example, in the pertinent California statute:

> (b)(1) The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm or illness, as a result of . . . (C) The willful or negligent failure of the parent or guardian to provide the child with adequate . . . medical treatment . . . .[315]

310. DAVIS ET AL., *supra* note 254, at 439–600; Lois A. Weithorn, *Protecting Children from Exposure to Domestic Violence: The Use and Abuse of Child Maltreatment Statutes*, 53 HASTINGS L.J. 1, 54 (2001); Weithorn, *supra* note 252, at 1323–24. *See generally* Child Welfare Info. Gateway, *Definitions of Child Abuse and Neglect*, DEP'T OF HEALTH & HUM. SERVS. (2022), https://www.childwelfare.gov/pubPDFs/define.pdf (describing laws that define child abuse and neglect).

311. Roe v. Conn, 417 F. Supp. 769, 778 (M.D. Ala. 1969); DAVIS ET AL., *supra* note 254, at 522–31; Weithorn, *supra* note 310, at 63–64.

312. DAVIS ET AL., *supra* note 254, at 573–618; Martha Minow, *Beyond State Intervention in the Family: For Baby Jane Doe*, 18 U. MICH. J.L. REFORM 933, 937 (1985); Weithorn, *supra* note 310, at 12–13.

313. *See* DAVIS ET AL., *supra* note 254, at 513–650.

314. *See, e.g.*, Newmark v. Williams, 588 A.2d 1108 (Del. 1991); Custody of a Minor, 379 N.E.2d 1053 (Mass. 1978).

315. CAL. WELF. & INST. CODE § 300(b)(1) (West 2023). One of the fact patterns in which claims of medical neglect sometimes present are circumstances where parents allege that provision of recommended health care would contravene their religious beliefs. Given the complexity of such cases, California requires the courts to apply a test that recognizes the continuing authority of the state to intervene to provide necessary health care to a child to prevent that child from "suffering serious physical harm or illness." *Id.* at § 300(b)(3).

Less frequently, petitions may invoke the abuse provisions, alleging that parents are harming or risking harm of their children by seeking unnecessary medical treatment.[316] The language defining these provisions is similarly narrow in limiting state intervention to circumstances in which the child's welfare is in serious danger. For example, the provision defining "abuse" in California's Welfare and Institutions Code reads: "The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm inflicted nonaccidentally upon the child by the child's parent or guardian."[317]

Constitutional jurisprudence requires restricting intervention in the family to the narrowest degree of intrusion that is necessary to protect the child.[318] Unfortunately, in the context of child welfare system intervention, this goal has at times been elusive.[319]

> Whenever it is alleged that a child comes within the jurisdiction of the court on the basis of the parent's or guardian's willful failure to provide adequate medical treatment or specific decision to provide spiritual treatment through prayer, the court shall give deference to the parent's or guardian's medical treatment, nontreatment, or spiritual treatment through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, by an accredited practitioner thereof, and shall not assume jurisdiction unless necessary to protect the child from suffering serious physical harm or illness. In making its determination, the court shall consider (1) the nature of the treatment proposed by the parent or guardian, (2) the risks to the child posed by the course of treatment or nontreatment proposed by the parent or guardian, (3) the risk, if any, of the course of treatment being proposed by the petitioning agency, and (4) the likely success of the courses of treatment or nontreatment proposed by the parent or guardian and agency. The child shall continue to be a dependent child pursuant to this subdivision only so long as is necessary to protect the child from risk of suffering serious physical harm or illness.

Id.

316. Carole Jenny & James B. Metz, *Medical Child Abuse and Child Neglect*, 41 PEDIATRICS REVIEW 49, 49 (2020). The American Psychiatric Association's Diagnostic and Statistical Manual identifies a mental disorder referred to as "Factitious Disorder Imposed on Another." AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 324–26 (5th ed. 2013). The Manual describes an updated characterization of a pattern of behavior previously referred to as Munchausen Syndrome by Proxy, whereby parents are viewed as feigning their children's need for medical care, leading to unnecessary and sometimes harmful procedures and interventions. *Id.* at 49–53. Maxine Eichner authored a powerful critique and legal response to what some refer to as "medical child abuse," challenging the vague and unscientific standards often applied by the legal system. Maxine Eichner, *Bad Medicine: Parents, the State, and the Charge of "Medical Child Abuse"*, 50 U.C. DAVIS L. REV. 205, 214 (2016).

317. CAL. WELF. & INST. CODE § 300(a) (West 2023). *See also* IND. CODE § 31-34-1-1 (2023) (focusing on whether the "child's physical or mental health is seriously endangered due to . . . the act or omission of the child's parent . . ."; GA. CODE ANN. §19-7-4(b) (West 2023) ("'Child abuse' means . . . . [a]n act or failure to act that presents an imminent risk of serious harm to the child's physical, mental, or emotional health.").

318. *See supra* Part II.A; *see also* RESTATEMENT OF CHILD. & THE LAWS § 2.30 cmt. b, reporter's note (AM. L. INST., Tentative Draft No. 1, 2018) (discussing scope of parental authority); CAL. WELF. & INST. CODE § 300 (West 2023) ("It is the intent of the Legislature that this section not disrupt the family unnecessarily or intrude inappropriately into family life . . . .").

319. For a discussion of criticisms of the child welfare system, see Weithorn, *supra* note 310, at 54–58 (first quoting U.S. ADVISORY BD. ON CHILD ABUSE & NEGLECT, U.S. DEP'T OF HEALTH & HUMAN SERVS., NEIGHBORS HELPING NEIGHBORS: A NEW NATIONAL STRATEGY FOR THE PROTECTION OF CHILDREN 9–10 (1993); then quoting U.S. ADVISORY BD. ON CHILD ABUSE & NEGLECT, U.S. DEP'T OF HEALTH & HUMAN SERVS., CREATING CARING COMMUNITIES: BLUEPRINT FOR AN EFFECTIVE FEDERAL POLICY ON CHILD ABUSE AND NEGLECT xi (1991); and then quoting U.S. ADVISORY BD. ON CHILD ABUSE & NEGLECT, U.S. DEP'T OF

> The mammoth bureaucracy that has become the nation's web of child protective services agencies has been the target of criticisms for its overly-zealous intervention in families as well as its failure to intervene in other instances, for casting its net too broadly as well as for focusing on too limited a segment of children at risk, for its ignorance of and bias against the cultural traditions of non-white segments of our nation's population and its prejudice against racial and ethnic minorities, for the inefficacy of its interventions, and for a host of other problems.[320]

Data reveal disturbing disparities among those segments of the population whose families are the focus of state intervention. For decades, many have recognized that the child protection system disproportionately intervenes in families of color.[321] Huntington and Scott, in their important piece articulating the "child wellbeing framework," emphasize the role of "racial and class bias in state regulation of children," and indicate the necessity of tempering legal responses to the family with awareness of these patterns and protecting families of color from overreaching by state actors.[322]

Courtney Joslin and Catherine Sakimura have recently highlighted that the child welfare system also disproportionately targets LGBTQ families, a factor of particular relevance to the statutes and administrative decisions discussed in this Article.[323] Indeed, I would extend Huntington and Scott's attention to systemic racial and class bias to incorporate social prejudice against families with LGBTQ members when expressed through legal intervention in the family. The reality that the child welfare system has, and continues to, perpetuate

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HEALTH & HUMAN SERVS., CHILD ABUSE AND NEGLECT: CRITICAL FIRST STEPS IN RESPONSE TO A NATIONAL EMERGENCY vii (1990)).

320. *Id.* at 59.

321. For data and analysis on disproportionate levels of intervention in families of color, see, for example, GOV'T ACCOUNTABILITY OFF., GAO-07-816, AFRICAN AMERICAN CHILDREN IN FOSTER CARE 8, 17–20 (2007); Alan J. Detlaff & Reiko Boyd, *Racial Disproportionalities and Disparities in the Child Welfare System: Why Do They Exist and What Can Be Done to Address Them*?, 692 ANNALS OF AM. ACAD. POLITICAL & SOC. SCI. 253, 270 (2020); DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 7–10, 16–25 (2002); DOROTHY ROBERTS, TORN APART: HOW THE CHILD WELFARE SYSTEM DESTROYS BLACK FAMILIES—AND HOW ABOLITION CAN BUILD A SAFER WORLD 39–47 (2022). For data and analysis on disproportionate levels of intervention in Native American families, see Haaland v. Brackeen, 599 U.S. 255, 297–309 (2023) (Gorsuch, J., concurring); B. Atwood, *Flashpoints Under the Indian Child Welfare Act: Toward a New Understanding of State Court Resistance*, 51 EMORY L.J. 587, 621 (2002); Miss. Band of Choctaw Indians v. Holyfield, 490 U.S. 30, 55–65 (1989) (Stevens, J., dissenting).

322. Huntington & Scott, *supra* note 259, at 1375, 1378, 1438–39; *see also* Josh Gupta-Kagan*, Confronting Indeterminacy and Bias in Child Protection Law*, 33 STAN. L. & POL'Y REV. 217, 260–64 (2022) (discussing unequal application of child protection law in the United States).

323. Courtney G. Joslin & Catherine Sakimura, *Fractured Families: LGBTQ People and the Family Regulation System*, 13 CALIF. L. REV. 78, 169–186 (2022); *see also* Jessica N. Fish, Laura Baams, Armeda Stevenson Wojciak & Stephen T. Russel, *Are Sexual Minority Youth Overrepresented in Foster Care, Child Welfare, and Out-of-Home Placement? Findings from Nationally Representative Data*, 89 CHILD ABUSE & NEGL. 203, 203 (2019) (reporting that sexual minority youth are overrepresented in the child welfare system); *LBGTQ Youth in the Child Welfare System*, MOVEMENT ADVANCEMENT PROJECT, https://www.lgbtmap.org/file/LGBTQYouth_ChildWelfare.pdf (reporting statistics regarding prevalence of sexual minority youth in the child welfare system).

inequalities in our society by scrutinizing and intervening in the lives of some families due to social biases requires heightened vigilance, applying a standard and practice of intervention that is appropriately respectful of family integrity.

Adherence to a narrow substantive basis for state intervention in the family provides one limit on the breadth of such intervention. In the 1970s, in a series of influential works, Michael Wald proposed "that neglect statutes be revised to allow intervention only when a child has suffered or is likely to suffer certain *serious* harms."[324] California's statutory language, as quoted above, now aligns with that recommendation.[325] Consistent with the principle that courts must "give great deference to parental decisions involving minor children,"[326] states typically apply a standard that imposes a high bar on the circumstances permitting state intervention in family decisionmaking regarding children's healthcare under child neglect or abuse provisions. For example, the most common standard, adopted explicitly by statute in approximately half of the states, authorize juvenile courts to override parental authority and intervene in healthcare decisions when it determines that the parental decisions subject children's health to serious danger or harm.[327] In some states, this standard is expressed in a manner similar to that found in the California statute, quoted above, requiring a finding that parental conduct creates a "risk" or a "substantial risk of," or is necessary to prevent, "serious harm or death."[328] Other states expressing a similarly high threshold for intervention describe circumstances justifying intervention as "seriously endanger[ing] the physical health of the child"[329] or presenting an "immediate danger of death, disfigurement, or bodily

324. Michael S. Wald, *State Intervention on Behalf of "Neglected" Children: Standards for Removal of Children from Their Homes, Monitoring the Status of Children in Foster Care, and Termination of Parental Rights*, 28 STAN. L. REV. 623, 625–27, 637 (1976). Wald also argued that, in order to justify state intervention, the harm from which the state seeks to protect children must be one "for which, in general, the remedy of coercive intervention will do more good than harm." Michael Wald, *State Intervention on Behalf of "Neglected" Children: A Search for Realistic Standards*, 27 STAN. L. REV. 985, 1005 (1975).

325. *See* CAL. WELF. & INST. CODE § 300(a) (West 2023).

326. Newmark v. Williams, 588 A.2d 1108, 1116 (Del. 1991) (holding that state intervention was not warranted where parents refused consent for chemotherapy treatment for child with low likelihood of success and the possibility of serious risks to child).

327. In summarizing relevant case law, the Restatement Reporters' Note concludes that the "serious harm or . . . substantial risk of serious harm" standard is applied in the "vast majority of cases involving failure to provide necessary medical care." RESTATEMENT OF THE LAW OF CHILDREN AND THE LAW § 3.26 reporters' note cmt. d (Am. L. Inst., Tentative Draft No. 1).

328. *See supra* note 315 and accompanying text. *See, e.g.*, ALA. CODE § 26-14-7.2 (2023) (failure to provide medical care or treatment when "necessary to present or remedy serious harm to the child"); ALASKA STAT. ANN. § 47.10.011 (West 2023) ("the child is in need of medical treatment to cure, alleviate, or prevent substantial physical harm"); ME. REV. STAT. ANN. tit. 22, § 4002(6)(B-1) (2022) (authorizing intervention when parental conduct "places the child in danger of serious harm); S.C. CODE ANN. § 63-7-20 (2023) (failure to provide healthcare "has caused or presents a substantial risk of causing physical or mental injury").

329. *See* IND. CODE ANN. § 31-24.1-1 (West 2023) ("[t]he child's physical or mental condition is seriously impaired or seriously endangered because of the" parental failure to provide adequate medical care, or provide for other basic needs); MINN. STAT. ANN. § 260E.03 (West 2023) ("failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so"); WIS. STAT.

injury."[330] The standard adopted by the *Restatement of Children and the Law* in the context of medical neglect permits state intervention only when parents have failed to "exercise the minimum degree of care necessary to prevent serious harm or a substantial risk of serious harm to the child's physical or mental health."[331]

Another group of statutes defines neglect as failure to provide "necessary" or "needed" care or treatment.[332] In general, states applying this standard require a showing of harm or serious harm prior to intervention in the family.[333] For example, in Illinois, after observing that the statute's medical neglect provision had typically been applied to override parental refusal of life-saving blood transfusions, a state court of appeals authorized intervention where a child was at "substantial risk" of physical and mental impairment due to inter-cerebral bleeding and other effects of a premature birth.[334] The *Restatement*, in Section 2.30(2), implies a strong relationship between the use of the term "necessary" in reference to children's medical care and the "serious harm" standard: "(a) A parent . . . has a duty to provide necessary medical care for the child; (b) medical care is necessary if it is required to prevent serious harm or a substantial risk of

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§ 48.13 (2023); WASH. REV. CODE § 13.34.130 (2023) ("evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the child's health, welfare, or safety").

330. TEX. FAM. CODE ANN. § 261.001 (West 2023); N.J. STAT. ANN. § 9:6-8.21 (West 2023) (the child's "physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of the parent").

331. Section 3.26(b) reads:

> In a civil child-protection proceeding, the failure or refusal of a parent, guardian, or custodian to provide medical care to a child is medical neglect if the parent, guardian, or custodian fails to exercise the minimum degree of care necessary to prevent serious harm or a substantial risk of serious harm to the child's physical or mental health.

RESTATEMENT OF THE LAW OF CHILDREN AND THE LAW (Am. L. Inst., Tentative Draft No. 1); *see also* § 2.30(2)(a) ("A parent, guardian . . . has a duty to provide necessary medical care for the child; (b) medical care is necessary if it is required to prevent serious harm or a substantial risk of serious harm to the child's physical or mental health or to the safety of others.").

332. *See* N.D. CENT. CODE ANN. § 27-20.3-01 (West 2023) (the child "[i]s without proper parental care . . . necessary for the child's physical, mental, or emotional health"); OKLA. STAT. ANN. tit. 10A, § 1-1-105 (West 2023) (failure to provide "special care made necessary for the child's health and safety by the physical or mental condition of the child").

333. *See, e.g.*, People in the Interest of D.L.E., 645 P.2d 271, 272–75 (Colo. 1982) (holding that the term "proper and necessary" as applied to medical neglect did not warrant state intervention when child's life was not "in imminent danger through a lack of medical care," but finding medical neglect and authorizing state intervention when condition worsened, causing a stroke and permanent paralysis of one side of the child's body, affected brain function, and presented a risk to the child's life); Matter of Betty C., 632 P.2d 412, 414 (Okla. 1981) (interpreting and applying OKLA. STAT. ANN. tit. 10A, § 1-1-105 (d) (West 2023) and holding that "'[h]arm'" must be shown in order to warrant governmental interference with a family unit") and *In re* D.R., 20 P.3d 166, 168–70 (Okla. Civ. App. 2001) (holding that parental failure to comply with medically recommended treatment for a child "in danger of suffering further brain damage or dying without medical treatment" satisfied criteria for state intervention where treatment was not invasive, painful, or presented serious risks to the child).

334. *In re* N., 723 N.E.2d 678, 686 (Ill. App. 1999) (applying 705 ILL. COMP. STAT. 405/2-3 (2023) and characterizing a child "who is not receiving the proper or necessary . . . medical or other remedial care" as neglected).

serious harm to the child's physical or mental health or to the safety of others").[335]

The "harm principle" has received substantial attention in pediatric bioethics as well.[336] According to pediatrician Douglas Diekema, the term "best interests," frequently used by pediatricians and other physicians treating children, fails to capture what is, in fact, a "harm-based standard"[337] that requires evidence that "parental choices endanger the child" who "is suffering from a serious and potentially life-threatening illness or injury that can be readily managed with medical treatment."[338] Given the intrusiveness of child protective investigations, proceedings, and interventions in the family, and the evidence that state action may, at times, express society's biases against population subgroups, such as those identified with racial, ethnic, religious, or sexual minorities, state action must be reserved solely for circumstances "when [it is] necessary to protect the child from serious harm, where other, less intrusive legal strategies have not been, or are unlikely to be, effective."[339] A similarly high threshold for state intervention is also necessary for legislative restrictions of parental authority, such as those reviewed in Part III.A, restricting gender-affirming medical care.

b. *Legislative restriction of parental authority with respect to specific interventions to prevent serious harm*

Very infrequently, the government may single out a particular form of treatment and restrict parental choices for their children on the ground that doing so is necessary to protect the children's welfare. If a legislature restricts parental

335. RESTATEMENT OF THE LAW OF CHILDREN AND THE LAW § 2.30(2) (Am. L. Inst., Tentative Draft No. 1). *But see* State *ex rel*. N.K.C., 995 P.2d 1 (Utah App. 1999) (rejecting assertion that the terms "necessary and proper" in the neglect statute should be construed to require that "child's physical, mental, and emotional condition was impaired or in imminent danger of being impaired," where mother delayed for five hours in seeking medical care for children's injury); State *ex rel.* M.S., 533 P.3d 859, 871–74 (Utah App. 2023) (holding that Utah's medical neglect standard defers to parental decisions that are "reasonable").

336. Douglas S. Diekema, *Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention*, 25 THEORETICAL MED. 243, 258 (2004); *see also*, Erica K. Salter et al., *Pediatric Decision Making: Consensus Recommendations*, 152 PEDIATRICS, no. 3, Sept. 2023, at 1, 4 (asserting that "it is appropriate [for healthcare practitioners] to seek intervention from state agents, including child protection services or the courts" if a parental treatment refusal "causes significant risk of serious imminent harm" and the proposed interventions are viewed by healthcare professionals as are "likely to be effective").

337. *See* Diekema, *supra* note 336, at 248–49; *see also* Katherine Drabiak, *Resolving Physician-Parent Disputes Involving Pediatric Patients*, 20 HOUS. J. HEALTH L. & POL'Y 353, 371–72 (2021).

338. *See* Diekema, *supra* note 336, at 248–49. Law professor Joseph Goldstein, in a classic article, set forth an even higher threshold for state intervention in medical decisions made by parents for their children. Joseph Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy*, 86 YALE L.J. 645, 651–52 (1977). Due to the legal "presumption of parental autonomy in health-care matters" concerning their children, he argued that the state can "overcome" that presumption and override parental decisions only if it can establish that: (1) agreement within the medical profession that is contrary to the parental choice; (2) overriding parental choice is necessary to provide the child with "a chance for normal healthy growth toward adulthood or a life worth living;" and (3) "the expected outcome of denial of that treatment would mean death for the child." *Id.* at 652.

339. Weithorn & Reiss, *supra* note 262, at 809.

choice regarding particular forms of healthcare interventions, asserting that such restrictions are necessary to protect children from harm, it is appropriate to apply the "substantial risk of serious harm" standard to review the purpose of those statutes as well. The *Restatement* summarizes the principles that guide parental authority to consent to and refuse intervention for their children. Section 2.30(a) reads: "A parent or guardian has broad authority to make medical decisions for a child."[340] Section 2.30(b) reads: "A parent does not have authority to consent to medical procedures or treatments that provide no health benefit to the child and pose a substantial risk of serious harm to the child's physical or mental health."[341]

A recent example of legislation that restricts parental authority regarding a particular form of intervention are state statutes passed in twenty-one states and the District of Columbia between 2012 and 2020 addressing "conversion therapy."[342] These statutes characterized "conversion therapy" or "sexual orientation change efforts" ("SOCE") by a health or mental health provider as "unprofessional conduct" and grounds for disciplinary action by a state licensing authority.[343] State legislation relied upon the strong positions of the leading national associations of mental health professionals, based on a robust body of empirical research, demonstrating that SOCE provide no therapeutic benefit and creates substantial risk of serious harm to persons who are subjected to it.[344] For example, the California legislature, in passing Senate Bill 1172, made the following findings, among others:

> The American Psychological Association convened a Task Force on Appropriate Therapeutic Responses to Sexual Orientation. The task force conducted a systematic review of peer-reviewed journal literature on sexual orientation change efforts, and issued a report in 2009. The task force concluded that sexual orientation change efforts can pose critical health risks to lesbian, gay, and bisexual people, including confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, suicidality, substance abuse, stress, disappointment, self-blame, decreased self-esteem and authenticity to others, increased self-hatred, hostility and blame toward parents, feelings of anger and betrayal, loss of friends and potential romantic partners, problems in sexual and emotional intimacy, sexual

340. RESTATEMENT OF THE LAW OF CHILDREN AND THE LAW § 2.30(1)(a) (Am. L. Inst., Tentative Draft No. 1).

341. *Id.* § 2.30(1)(b).

342. The first such statute was passed in California in 2012. CAL. BUS. & PROF. CODE §§ 865–65.2 (West 2023); s*ee also* HAW. REV. STAT. § 453J-1 (2023); N.J. STAT. ANN. § 45:1-55 (West 2023). For a full list of states and legislation, see *LGBQT Youth: Conversion "Therapy" Laws*, MOVEMENT ADVANCEMENT PROJECT (Nov. 6, 2023), https://www.lgbtmap.org/img/maps/citations-conversion-therapy.pdf.

343. *See, e.g.*, CAL. BUS. & PROF. CODE §§ 865–65.2 (West 2023).

344. *See, e.g.*, S.B. 1172, 2011-2012 Leg., Reg. Sess. (Cal. 2012) ("California has a compelling interest in protecting the physical and psychological well-being of minors, including lesbian, gay, bisexual, and transgender youth, and in protecting its minors against exposure to serious harms caused by sexual orientation change efforts.").

> dysfunction, high-risk sexual behaviors, a feeling of being dehumanized and untrue to self, a loss of faith, and a sense of having wasted time and resources.[345]

Scientific evidence consistent with the sources cited in the California bill continues to confirm the strength of the database on which the legislation in the twenty-two enacting jurisdictions rely.[346] And, in recent years, research has demonstrated that "conversion therapy" has been employed to try to change the gender identity of children and adolescents,[347] with harmful effects similar to those cited with respect to SOCE.[348] The American Psychological Association's *Resolution on Gender Identity Change Efforts* was promulgated in 2021, citing numerous empirical studies demonstrating the absence of therapeutic benefit and the likelihood of serious harm resulting from youth involvement in these interventions.[349] There have been legal challenges to these statutes in some

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345. *Id.* The legislature continued:

> (c) The American Psychological Association issued a resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts in 2009, which states: "[T]he [American Psychological Association] advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support, and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth."

Id. It further cited positions issued by the American Psychiatric Association, the American Academy of Pediatrics, the American Medical Association, the National Association of Social Workers, the American School Counselor Association, the American Counseling Association, the American Psychoanalytic Association, the American Academy of Child and Adolescent Psychiatry, and the Pan American Health Association. Many of these positions included citations to scientific authority. *Id.*

346. *See, e.g.*, Anna Forsythe, Casey Pick, Gabriel Tremblay, Shreena Malaviya, Amy Green & Karen Sandman, *Humanistic and Economic Burden of Conversion Therapy Among LGBTQ Youths in the United States*, 176 JAMA PEDIATRICS 493, 497 (2022) (concluding, based on an analysis of published studies, that efforts to change sexual orientation and gender identity exact a high economic burden on society, and are associated with serious psychological harms experienced by those subject to these efforts); John R. Blosnich, Emmet R. Henderson, Robert W. S. Coulter, Jeremy T. Goldbach & Ilan H. Meyer, *Sexual Orientation Change Efforts, Adverse Childhood Experiences, and Suicidal Ideation and Attempt Among Sexual Minority Adults, United States, 2016-2018*, 110 AM. J. PUB. HEALTH 1024, 1027 (2020) (observing that individuals exposed to sexual orientation change efforts demonstrated higher morbidity on all mental health variables examined, including those related to suicidality, than did those without such exposure). For copious additional research in this area, see *APA Resolution on Sexual Orientation Change Efforts*, AM. PSYCH. ASS'N 4–5 (Feb. 2021), https://www.apa.org/about/policy/resolution-sexual-orientation-change-efforts.pdf and Gay & Lesbian Med. Ass'n, *Sexual Orientation and Gender Identity Change Efforts (So-Called "Conversion Therapy")*, AM. MED. ASS'N 2, 5 (2022), https://www.ama-assn.org/system/files/conversion-therapy-issue-brief.pdf.

347. *See* Jack L. Turban, Dana King, Sari L. Reisner & Alex S. Keuroghlian, *Psychological Attempts to Change a Person's Gender Identity from Transgender to Cisgender: Estimated Prevalence Across the US States, 2015*, 109 AM. J. PUB. HEALTH 1452, 1452 (2019).

348. See Jack L. Turban, Noor Beckwith, Sari L. Reisner & Alex S. Keuroghlian, *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults,* 77 JAMA PSYCHIATRY 68, 75 (2020); Florence Ashley, Trans*porting the Burden of Justification: The Unethicality of Transgender Conversion Practices*, 50 J.L., MED. & ETHICS 425, 431–32 & 439 nn.48–57 (2022).

349. *APA Resolution on Gender Identity Change Efforts*, AM. PSYCH. ASS'N 1–2 (Feb. 2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.

states, and those cases are now making their way through the courts.[350] Most courts have held that these statutes are constitutional, although a 2020 Eleventh Circuit decision created a split in the circuits.[351] The basis for holding the statute unconstitutional, however, was not a challenge to parental authority. Rather, providers of SOCE prevailed on the claim that the statutes unconstitutionally infringed their First Amendment rights to freedom of expression, at least at the preliminary injunction stage.[352]

Drafters of the legislation restricting gender-affirming care sought to mimic the framework of the statutes prohibiting SOCE by citing "legislative findings," which the drafters assert rely on scientific authority. Yet, there is a critical difference between these two sets of statutes. While the assertions underlying the prohibitions on SOCE *are* grounded on scientific evidence and supported by a consensus of national associations representing the healthcare professions, the contentions cited in legislation prohibiting gender-affirming care are without scientific support and are contrary to the consensus in the field.

Laws prohibiting female genital mutilation ("FGM") provide another example of widespread state prohibition of a procedure. Forty-one states have adopted statutes that prohibit FGM.[353] FGM is performed on prepubescent and pubescent girls, primarily in certain areas of Africa, the Middle East, and Asia,

350. For a summary of litigation challenging "conversion therapy" bans, see, for example, Kathleen Stoughton, *Toxic Therapy: Examining the Constitutionality of Conversion Therapy Bans in Light of* Otto, 30 AM. U. J. GENDER SOC. POL'Y & L. 81, 86–88 (2022) (reviewing states' legislation prohibiting SOCE and contrasting the federal circuits' determinations of constitutionality); Samuel G. Bernstein, *The Not-So-Straight First Amendment: Why Prohibitions on Conversion Therapy for Children Survive Strict Scrutiny*, 63 B.C. L. REV. 1861, 1874–84 (2022) (analyzing the Third and Ninth circuit's decisions regarding the constitutionality of legislation prohibiting SOCE). For an analysis of the expressive functions of conversion therapy bans, see Marie-Amelie George, *Expressive Ends: Understanding Conversion Therapy Bans*, 68 ALA. L. REV. 793, 825–30 (2017).

351. The Eleventh Circuit, in *Otto v. City of Boca Raton*, 981 F.3d 854, 871–72 (11th Cir. 2020), held that the statutes at issue were content-based regulations that discriminated with respect to viewpoint and violated the health care professionals' First Amendment rights to free speech. It relied on the recent U.S. Supreme Court opinion in *National Institute of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2378 (2018) [hereinafter *NIFLA*]. In *NIFLA*, the Court held that professional speech of individuals who perform personalized services that require a professional license from the State is not exempt from the rule that content-based regulations of speech are subject to strict scrutiny. As such, the *Otto* court applied strict scrutiny. It concluded that the evidence of harm to children did not satisfy that high standard. *Otto*, 981 F.3d at 869. For insightful analyses of the Supreme Court's jurisprudence on the constitutional status of professional speech after *NIFLA*, see Cassandra Burke Robertson & Sharona Hoffman, *Professional Speech at Scale*, 55 U.C. DAVIS L. REV. 2063, 2087 (2022); Clay Calvert, *Weaponizing Proof of Harm in First Amendment Cases: When Scientific Evidence and Deference to the Views of Professional Associations Collide in the Battle Against Conversion Therapy*, MICH. ST. L. REV. 765, 766–67 (2021).

352. *Otto*, 981 F.3d at 869.

353. Patricia A. Broussard, *The Importation of Female Genital Mutilation to the West: The Cruelest Cut of All*, 44 U.S.F. L. REV. 787, 800–02 (2010). Broussard cites legislation in eighteen states, including Arkansas, California, Colorado, Delaware, Georgia, Illinois, Maryland, Minnesota, Missouri, Nevada, New York, North Dakota, Oregon, Rhode Island, Tennessee, Texas, West Virginia, and Wisconsin. *Id.* Since the time of her writing, the number of states with prohibitions of FGM has more than doubled, to forty-one. *See US Laws Against FGM – State by State (Table)*, EQUAL. NOW, https://www.equalitynow.org/us_laws_against_fgm_state_by_state [https://web.archive.org/web/20240118212007/https://equalitynow.org/us_laws_against_fgm_state_by_state] (last updated Aug. 2023).

as a cultural or religious rite of passage.[354] The practice has been performed in the United States, as well, leading to the state prohibitions.[355] The World Health Organization describes these practices as follows:

> Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The practice has no health benefits for girls and women and cause severe bleeding and problems urinating, and later cysts, infections, as well as complications in childbirth and increased risk of newborn deaths.[356]

The assessment of the World Health Organization that the practice has no health benefits, and a long list of very serious harms and risks, is shared by other major public and private health organizations and agencies such as the Department of Health and Human Services' Centers for Disease Control and Prevention and the American Medical Association.[357] The World Health Organization further emphasizes that "FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against girls and women."

One need only read through medical sources and related materials reviewing the absence of any health benefits and the long and disturbing list of harms and risks to understand why there is a consensus among healthcare organizations regarding the need to prohibit this practice. The scientific evidence and the professional consensus spawned by the science led the states to take legislative action.[358] There is variation in the legal approaches taken by the states. For example, states may characterize FGM as child abuse, a separate

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354. *Female Genital Mutilation*, WORLD HEALTH ORG. (Jan. 31, 2023), https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation.

355. Broussard, *supra* note 353, 798–802; *Female Genital Mutilation/Cutting (FGM/C)*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 17, 2023), https://www.cdc.gov/reproductivehealth/womensrh/female-genital-mutilation.html (describing a CDC-sponsored study in "four U.S. communities with high concentrations of populations from high FGM/C-prevalence countries" and finding that 55 percent of participants had experienced FGM).

356. *Female Genital Mutilation/Cutting (FGM/C)*, *supra* note 355. While stating unequivocally that there are no health benefits to the procedure, the CDC lists many of the potential short- and long-term harms. *Id.* For example, severe pain, excessive bleeding, swelling, fever, infections (e.g., tetanus), urinary problems, wound healing, problems, injury to surrounding tissue, menstrual problems (e.g., painful menstruations, difficulty in passing menstrual blood), sexual problems (such as pain during intercourse), increased risk of childbirth complications and newborn deaths, need for later surgeries, psychological problems (e.g., depression, anxiety, post-traumatic stress disorder). For more details on the health consequences of FGM, see, for example, Elliot Klein, Elizabeth Helzner, Michelle Shayowitz, Stephan Kohlhoff & Tamar A. Smith-Norowitz, *Female Genital Mutilation: Health Consequences and Complications – A Short Literature Review*, OBSTETRICS & GYNECOLOGY INT'L 2018, at 1, 4–5, https://doi.org/10.1155/2018/7365715.

357. *Female Genital Mutilation/Cutting (FGM/C)*, *supra* note 355; Ronald M. Davis et al., *Female Genital Mutilation*, 274 JAMA 1714, 1714 (1995).

358. Limor Ezioni, *Contemporary Aspects of Female Genital Mutilation Prohibitions in the United States*, 28 AM. U. J. GENDER, SOC. POL'Y & L. 39, 49–61 (2019).

felony offense, or a form of assault.[359] Yet, there is substantial agreement that this procedure presents a substantial risk of serious harm to those subjected to it.[360]

Subpart II.C below discusses the role that science and medical expertise play in determining "substantial risk of serious harm" to children in the context of child protection adjudications and legislative lawmaking.

C. The Role of Medical and Scientific Evidence in Legal Disputes About Parental Authority to Decide

Courts generally look to evidence presented by the parties via expert testimony or to briefs submitted by the parties or amici to determine what is factually true about medical and scientific issues relevant to the disposition of a case.[361] Medical expertise grounded in science is critical to legal decisionmaking in cases in which the courts' adjudication requires determination of certain medical or scientific facts.[362] Such facts may include the potential risks and benefits of various treatments and the consequences of choosing not to treat a disorder or condition. In some cases—as in challenges to statutes restricting provision of gender-affirming medical care to minors—a court may judge the constitutionality of legislation limiting access to a health care intervention that the state asserts poses a risk of harm to children. "When used as intended, medical and scientific experts are able to provide context and expertise to discern difficult issues of fact and to establish a common baseline for the court."[363] Legal standards governing admissibility of testimony by expert witnesses, if applied properly, help ensure that those testifying are qualified to inform the court about the relevant science and professional practices.[364]

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359. For a description and discussion of individual state laws, see *id.*

360. Ironically, an Idaho lawmaker proposed a bill that would have characterized the provision of gender-affirming medical and surgical care as FGM. *See* H.B. 71, 67th Leg., 1st Reg. Sess. (Idaho 2023) (first draft). The final version of the bill, however, eliminated this characterization, creating a separate statutory provision to prohibit gender-affirming medical and surgical care. *See* IDAHO CODE § 18-1506C (2023) (effective Jan. 1, 2024).

361. *See* Alejandra Caraballo, *The Anti-Transgender Medical Expert Industry*, 50 J. L., MED. & ETHICS 687, 687 (2022); Ari Ezra Waldman, *Manufacturing Uncertainty in Constitutional Law*, 91 FORDHAM L. REV. 2249, 2249–57 (2023).

362. *See* Caraballo, *supra* note 361, at 687.

363. *Id.*

364. *Id.* at 688. Legal standards of admissibility in federal versus state courts may differ, depending upon the state. *See, e.g.*, FAIGMAN ET AL., 1 MODERN SCIENTIFIC EVIDENCE, *supra* note 44, at § 1:1. While federal courts and some state courts follow *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), some states are still guided by *Daubert*'s predecessor, *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923). For further discussion of *Daubert* and admissibility standards governing scientific testimony, see FAIGMAN ET AL., 1 MODERN SCIENTIFIC EVIDENCE, *supra* note 44, at § 1:1; David L. Faigman, Christopher Slobogin & John Monahan, *Gatekeeping Science: Using the Structure of Scientific Research to Distinguish Between Admissibility and Weight in Expert Testimony*, 110 NW. U. L. REV. 859, 863 (2016); Laurens Walker & John Monahan, Daubert *and the* Reference Manual*: An Essay on the Future of Science in Law*, 82 VA. L. REV. 837 (1996); *see also* John Monahan & Laurens Walker, *Twenty-Five Years of Social Science in Law*, 35 L. & HUM. BEHAV. 72, 73–80 (2009) (providing a historical and analytical perspective on the uses of social science in various litigation

In 1993, the U.S. Supreme Court announced the current standard for admissibility of scientific evidence in *Daubert v. Merrell Dow Pharmaceuticals*.[365] The Court interpreted the *Federal Rules of Evidence*, and discarded the previously dominant *Frye* test.[366] In short, while the *Frye* test emphasized the general acceptance of the proffered testimony in the relevant profession, the *Daubert* test requires trial courts to evaluate whether that testimony is "based on scientifically valid principles."[367] The *Federal Rules of Evidence* were revised in 2000 to incorporate *Daubert*'s guidance, and again in 2023 to provide additional direction to federal judges.[368] While *Daubert* indicated that a court is to assess the "scientific validity and thus the evidentiary relevance and reliability—of the principles that underlie a proposed submission," focusing "solely on principles and methodology, not on the conclusions that they generate," the 2023 revisions indicate that the conclusions provided by the expert must reflect "*a reliable application of* the principles and methods to the facts of the case."[369] Under *Daubert*, its progeny, and the *Federal Rules of Evidence*, the trial court becomes the gatekeeper, making independent judgments, reviewable on appeal under the abuse-of-discretion standard, whether the proposed testimony meets scientific standards.[370] In making its

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contexts). For expanded treatment of the topic, see generally JOHN MONAHAN & LAURENS WALKER, SOCIAL SCIENCE IN LAW (10th ed. 2021).

365. 509 U.S. 579, 579 (1993).

366. *Id.* at 597–98.

367. *Id.* at 579–80.

368. As of December 1, 2023, FRE 702 reads:

> A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if the proponent demonstrates to the court that it is more likely than not that:
>
> (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;
>
> (b) the testimony is based on sufficient facts or data;
>
> (c) the testimony is the product of reliable principles and methods; and
>
> (d) the expert's opinion reflects a reliable application of the principles and methods to the facts of the case.

FED. R. EVID. 702. For a discussion of the rationales for revisions of FRE 702, see U.S. Code, Federal Rules of Evid. (as amended to Dec. 26, 2023), available at https://uscode.house.gov/view.xhtml?req=granuleid%3AUSC-prelim-title28a-node230&edition=prelim.

369. *Compare Daubert*, 509 U.S. at 594–95 *with* FED. R. EVID 702 (amended 2023) (emphasis added to highlight language of 2023 amendment) *and* FED. R. EVID 702, Committee Notes on Rules – 2023 Amendment, cmt. 2. Several years earlier, David Faigman, Christopher Slobogin, and John Monahan argued that the Court's distinction between methodology and conclusions in *Daubert* "has no principled basis in science and thus should have none in law," suggesting that the distinction "should be explicitly jettisoned." *Gatekeeping Science*, *supra* note 364, at 863. The 2023 amendment to FRE 702 indicates some movement, although perhaps more implicit than explicit, in that direction.

370. 509 U.S. at 593-94. In 1997, the Court decided *General Electric Company v. Joiner*, 522 U.S. 135, 143, holding that appellate courts must apply the abuse of discretion standard to their review of district court

admissibility determinations, the trial court must consider the underlying methodology, and factors such as whether an expert's conclusions were published and peer-reviewed, and whether the "expert's opinion reflects a reliable application of the principles and methods to the facts of the case."[371] The most recent revision of the *Federal Rules* also highlights that satisfaction of all of its criteria of admissibility must be demonstrated by the proponent by a preponderance of evidence (that is, "more likely than not…").[372]

Although the Court rejected *Frye*'s "general acceptance" test in *Daubert*, it indicated that:

> 'General acceptance' can yet have a bearing on the inquiry. A 'reliability assessment does not require, although it does permit, explicit identification of a relevant scientific community and an express determination of a particular degree of acceptance within that community.' Widespread acceptance can be an important factor in ruling particular evidence admissible, and 'a known technique which has been able to attract only minimal support within the community,' . . . may properly be viewed with skepticism.[373]

Thus, consensus judgments of a professional body as to the state of the science on a particular question could inform a court *as long as* these professional judgments are grounded in empirical work that satisfies the scientific standards now required under the *Federal Rules* and the Court's doctrine.

State legislatures are not, of course, bound by *Daubert* in determining what sources upon which to rely in drafting and adopting their legislative findings. Legislatures can rely on non-scientific, pseudo-scientific, or junk scientific sources as justifications for statutes. We might view such reliance as ill-informed and likely to lead to poor policy decisions. However, unless there are constituents of those legislators who can exercise displeasure at the ballot box, there is not much recourse available to those affected by the statutes. Yet, if the legislation enacted in reliance upon those findings is challenged as unconstitutional, *Daubert*'s standards and FRE 702 may provide a method for scrutinizing the scientific basis of those asserted "medical facts," such as whether gender-affirming medical care for minors, consistent with standards of care endorsed by major professional medical societies, present a substantial risk

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decisions to admit or exclude evidence. In applying the standard to the *Joiner* case, the Court held that the Court of Appeals had applied an "overly 'stringent' review" and "failed to give the trial court the deference that is the hallmark of abuse-of-discretion review." *Id.* In *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999), the Court extended *Daubert*, indicating that the trial court's "gatekeeping obligation" applies not only to scientific expert testimony, but to testimony of other experts as well. *Id.* at 147–51. In this decision, the Court further highlighted the "considerable leeway" exercised by the trial court in determining whether an expert's testimony is reliable. *Id.* at 151.

371. *See* discussion *supra* note 368.

372. FED. R. EVID. 702 (as amended Dec. 1, 2023) (emphasis added to highlight language of 2023 amendment); FED. R. EVID. 702, Committee Notes on Rules – 2023 Amendment, cmt. 1.

373. *Id.* at 594 (quoting United States v. Downing, 753 F.2d 1234, 1238 (3d Cir. 1985)).

of serious harm to minors.[374] That said, there exists a substantial body of scholarship, much of it critical, questioning whether FRE 702 and the *Daubert* trilogy, and application of those principles by federal court judges in their "gatekeeper" roles, have led to a reduction in admission of "pseudo-science" or "junk science"[375] and other testimony not grounded in accepted scientific methods.[376]

The existence of a solid scientific basis for conclusions about what constitutes a substantial risk of serious harm to minors distinguishes the legislative findings cited as justifications for "conversion therapy" and FGM bans from those cited to justify the gender-affirming care restrictions. The

374. I use the term "may" to signal that there are uncertainties as to the applicability of the *Federal Rules of Evidence* at different stages of litigation, and to the standard of appellate review in certain cases. Specifically, and of relevance to several cases reviewed in Part III *infra*, there is a lack of clarity as to whether the *Federal Rules* apply to preliminary injunction hearings. *See* Maggie Wittlin, *Meta-Evidence and Preliminary Injunctions*, 10 U.C. IRVINE L. REV. 1331, 1336–47 (2020). A separate unresolved question involves the standard of review applied *on appeal* to trial court scientific evidence admissibility decisions. Although the *Daubert* trilogy indicate that the abuse of discretion standard applies, Dean David Faigman, a leading scholar in this field, observes that the question of how much deference is due trial court admissibility decisions remains unresolved as it relates to different types of *constitutional* facts. DAVID L. FAIGMAN, CONSTITUTIONAL FICTIONS: A UNIFIED THEORY OF CONSTITUTIONAL FACTS 111–17 (2008). Dean Faigman argues that scientific testimony informing *constitutional reviewable facts* should be subject to "a 'hard-look' or *de novo* review" by appellate courts. David L. Faigman, *Appellate Review of Scientific Evidence Under* Daubert *and* Joiner, 48 HASTINGS L.J. 969, 976 (1997). In the context of constitutional cases such as those that are the subject of this Article, the medical and scientific facts relevant to the disposition of the disputes are not case-specific. That is, the factual accuracy of assertions by states that gender-affirming medical treatment consistent with prevailing standards of care presents certain dangers to minors' health is relevant to all of those cases in which such dangers are alleged. As such, courts' findings regarding these medical or scientific facts are a subset of facts referred to as "constitutional reviewable facts" because they "transcend particular disputes and thus can recur in identical form in different cases and varying jurisdictions. FAIGMAN, CONSTITUTIONAL FICTIONS, supra at 43–47. By contrast, in some litigation, such as civil or criminal child abuse cases, some medical or scientific facts are "adjudicative facts" in that their resolution does not transcend the individual case. *Id* at 44. For example, an adjudicative fact is the case-specific answer to the question of whether a particular parent's failure to bring their child to the hospital emergency room on a particular day was a significant factor in causing that child's death. Given that reviewable constitutional facts transcend individual cases, Dean Faigman asserts that more searching appellate review is necessary "to ascertain and balance the policy implications raised by the science, to ensure consistency across jurisdictions, and to evaluate the methods, principles and reasoning of multiple research studies." *Id.* at 979.

375. Multiple definitions of "pseudo-science" or "junk science" abound. *See, e.g.*, Angelo Fasce, *What Do We Mean When We Speak of Pseudoscience? The Development of a Demarcation Criterion Based on the Analysis of Twenty–One Previous Attempts*, 6 DISPUTATIO 459 (2017). Fasce offers the following useful definition of "pseudoscience":

> It pertains to an issue within the domains of science in the broad sense (the criterion of scientific domain)[;] 2) It suffers from such a severe lack of reliability that it cannot at all be trusted (the criterion of unreliability)[;] 3) It is part of a doctrine whose major proponents try to create the impression that it represents the most reliable knowledge on its subject matter (the criterion of deviant doctrine).

Id. at 479.

376. For representative critiques, see, for example, Jim Hilbert, *The Disappointing History of Science in the Courtroom:* Frye, Daubert, *and the Ongoing Crisis of "Junk Science" in Criminal Trials*, 71 OKLA. L. REV. 759 (2019); Brandon L. Garrett & M. Chris Fabricant, *The Myth of the Reliability Test*, 86 FORDHAM L. REV. 1559 (2018); James R. Dillon, *Expertise on Trial*, 19 COLUM. SCI. & TECH. L. REV. 247 (2018); Barbara Pfeffer Billbauer, Daubert *Debunked: A History of Legal Retrogression and the Need to Reassess "Scientific Admissibility*", 21 SUFFOLK J. TRIAL & APP. ADVOC. 1 (2016).

"conversion therapy" and FGM bans are grounded firmly in robust bodies of scientific evidence.[377] The scientific findings and the bans are also endorsed by an overwhelming consensus of health and mental health professional societies.[378] The legislation prohibiting gender-affirming care is not supported by a body of evidence developed through rigorous scientific methods nor is it endorsed by a consensus of scientific and professional experts in the field. To the contrary, the legislation restricting gender-affirming care relies on litanies of misinformation.

In the litigation challenging the statutes restricting gender-affirming care, an extraordinary consensus of national associations of health and mental health care professionals consistently represents that the science does not support assertions that gender-affirming care, provided according to the published guidelines, poses a substantial risk of serious harm to patients.[379] A cadre of highly qualified expert witnesses, grounding their testimony in scientific studies, articulates this position. By contrast, the states defending their gender-affirming care bans offer as experts persons without relevant experience and qualifications and those persons fail to muster scientific evidence that supports their assertions.[380]

Legislative reliance on knowledge acquired through scientific investigation is also good policy. As Huntington and Scott state: "[M]odern law is increasingly based on behavioral and biological research on child and adolescent development, together with growing empirical evidence about the effectiveness of policy interventions."[381] In discussing the important role of developmental science in recent Supreme Court juvenile justice opinions, the authors emphasize that an extensive and rich "body of scientific research on adolescent development . . . enables regulation . . . responsive to the capacities, vulnerabilities, [and] needs of young" persons.[382] This emphasis on empiricism and scientific evidence is equally important in helping us to answer foundational questions about what types of healthcare interventions are necessary to *prevent* substantial risks of serious harm to youth, and which types of healthcare interventions *present* substantial risks of serious harm to youth. This theme must be front-and-center as we review the statutes and litigation relating to restrictions on gender-affirming care in Part III.

III. STATE EFFORTS TO RESTRICT ACCESS TO

377. *See generally supra* Part II.B.5.b.

378. *See supra* Part II.B.5.b.

379. *See infra* Part III.B.

380. *See* Caraballo, *supra* note 361, at 688–91. For illustrations of these experts' testimony in the cases challenging the gender-affirming care prohibitions, see Part III.B.

381. Clare Huntington & Elizabeth Scott, *The New Restatement of Children and the Law: Legal Childhood in the Twenty-First Century*, 43 FAM. L.Q. 91, 92 (2020).

382. *Id.* at 97–98.

GENDER-AFFIRMING CARE FOR MINORS

This Part surveys states' efforts to restrict access to gender-affirming care for minors. Subpart A describes the state measures passed from 2021 through January 2024, categorizing them by the legal mechanisms employed to prohibit or restrict access to gender-affirming care for minors. Subpart B describes the litigation challenging these measures. Part III is primarily descriptive; this Article reserves most analyses and critiques for Part IV.

A. THE MEASURES

On April 6, 2021, the Arkansas legislature overrode then-Governor Asa Hutchinson's veto of House Bill 1570, subsequently referred to as Act 626.[383] The law, titled the "Arkansas Save Adolescents from Experimentation (SAFE) Act,"[384] sought to prohibit any healthcare professional from providing "gender transition procedures."[385] The Act characterized provision of such procedures as "unprofessional conduct . . . subject to discipline by the appropriate licensing entity or disciplinary review board with competent jurisdiction."[386] The legislation treats referrals from one healthcare professional to another for such services in a like manner.[387] In addition, the statute authorizes private parties or the Attorney General to use judicial or administrative remedies to pursue claims of violations of the statute.[388] The Act also prohibits the use of public funds directly or indirectly "to any entity, organization, or individual that provides gender transition procedures to an individual under eighteen (18) years old."[389] Preceding the operative provisions of the statute, the language cites a "compelling government interest in protecting the health and safety of its citizens, especially vulnerable children," and sets forth legislative "findings."[390]

383. H.B. 1570, 93d Gen. Assemb., Reg. Sess. (Ark. 2021).

384. ARK. CODE ANN. §§ 20-9-1501–04, 23-79-166 (West 2023), *held unconstitutional by* Brandt v. Rutledge, 677 F. Supp. 3d 877, 922-25 (E.D. Ark. 2023), *appeal docketed,* No. 23-2681 (8th Cir. July 21, 2023).

385. The term "gender transition procedures" is defined in the statute as:

> [A]ny medical or surgical service, including without limitation physician's services, inpatient and outpatient hospital services, or prescribed drugs related to gender transition that seeks to:
>
> (i) Alter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex; or
>
> (ii) Instill or create physiological or anatomical characteristics that resemble a sex different from the individual's biological sex, including without limitation medical services that provide puberty-blocking drugs, cross-sex hormones, or other mechanisms to promote the development of feminizing or masculinizing features in the opposite biological sex, or genital or nongenital gender reassignment surgery performed for the purpose of assisting an individual with a gender transition.

Id. § 20-9-1501(6)(A).

386. ARK. CODE ANN. §§ 20-9-1502(a), 1504(a) (West 2021).

387. *Id.* §§ 1502(b), 1504(a).

388. *Id.* § 1504(b), (f)(1).

389. *Id.* § 1503(a). By its terms, this provision would prohibit the use of public funds for any service, however unrelated to gender-affirming care, if the "entity" or "organization" provides the prohibited services. *Id.*

390. H.B. 1570, 93d Gen. Assemb., Reg. Sess. (Ark. 2021).

These findings mention, for example, trends in requests for, or provision of, gender-affirming care to minors, and a list of alleged risks, benefits, and outcomes of providing such care—all without citations to scientific sources.[391] As discussed in more detail in Part III.B, minors, parents, and healthcare providers successfully sued the state of Arkansas in federal court, and Act 626 was held to be unconstitutional and was permanently enjoined.[392] The district court also rejected the findings asserted to justify this statute.[393] Furthermore, experts in the scientific community have harshly criticized these and similar assertions articulated as "support" for restrictions on gender-affirming care in other states.[394]

Between the approximately three years since Act 626 was introduced in Arkansas[395] and the time of the writing of this Article, more than half of the states have sought to restrict gender-affirming care for minors through scores of legislative measures and a handful of proposed administrative initiatives.[396] Thus far, twenty-three states have successfully passed restrictive statutes,[397] the

391. *Id.* Among those "findings" cited by the legislature are those that challenge: the need for gender-affirming medical care (*e.g.*, asserting that "scientific studies" indicate that the distress associated with gender incongruence is often associated with comorbidities and underlying psychopathology that should be the focus of treatment in place of provision of gender-affirming medical care); the efficacy of gender-affirming medical care in treating gender dysphoria (*e.g.*, "suicide rates, psychiatric morbidities, and mortality rates remain markedly elevated" despite gender-affirming care); the adequacy of current research examining safety and efficacy of gender-affirming medical care; the acceptability of the possible risks of such treatment; and the acceptability of the risk-benefit ratio (asserting that "risks of the . . . procedures far outweigh any benefit"). *Id.*

392. Brandt v. Rutledge, 677 F. Supp. 3d 877, 922–25 (E.D. Ark. 2023) (holding Arkansas statute unconstitutional and granting permanent injunction).

393. *Id.* at 901–23.

394. *See, e.g.*, Meredithe McNamara, Hussein Abdul-Latif, Susan D. Boulware, Rebecca Kamody, Laura E. Kuper, Christy L. Olezeski, Nathalie Szilagyi & Anne Alstott, *Combatting Scientific Disinformation on Gender-Affirming Care*, 152 PEDIATRICS, no. 3, Aug. 2023, at 1; McNamara et al., *supra* note 220, at 253; Katherine L. Kraschel, Alexander Chen, Jack L. Turban & I. Glenn Cohen, *Legislation Restricting Gender-Affirming Care for Transgender Youth: Politics Eclipse Healthcare*, 3 CELL REPS. MED. 1, 1 (2022). For an extensive review and critique of the bases for prohibitions on gender-affirming care cited by lawmakers in Texas and Alabama, see BOULWARE ET AL., BIASED SCIENCE, *supra* note 18.

395. The bill was first introduced on February 25, 2021. H.B. 1570, 93d Gen. Assemb., Reg. Sess. (Ark. 2021).

396. As noted in the introduction to this Article, legislative and judicial developments in the regulation of gender-affirming care for minors are proceeding at such a rapid pace, our snapshot in time will, no doubt, be superseded by additional developments within days or weeks following publication. *See supra* Introduction.

397. Those states, in addition to Arkansas, are Alabama, ALA. CODE §§ 26-26-1–26-26-9 (2023); Arizona, ARIZ. REV. STAT. ANN. § 32-3230 (2023); Florida, FLA. STAT. §§ 456.001, 456.52, 456.074, 766.318 (2023); Georgia, GA. CODE ANN. §§ 31-7-3.5, 43-34-15 (2023); Idaho, IDAHO CODE §§ 18-1506C, 19-5307 (2023); Indiana, IND. CODE § 25-1-22 (2023); Iowa, IOWA CODE ANN. § 147.164 (West 2023); Kentucky, KY. REV. STAT. ANN. § 311.372 (West 2023); Louisiana, LA. STAT. ANN. § 40:1098.1 to 40.1098.6 (2023); Mississippi, MISS. CODE ANN. §§ 41-141-1 et seq. (West 2023); Missouri, MO. REV. STAT. §§ 191.1720, 208.152 (2023); Montana, S.B. 99, 68th Leg. (Mont. 2023); Nebraska, NEB. REV. STAT. § 38-179 (2023); North Carolina, N.C. GEN. STAT. §§ 90-21.150-154, 143C-6-5.6 (West 2023); North Dakota, N.D. CENT. CODE § 12.1-36.1 (2023); Ohio, OHIO REV. CODE. ANN. §§ 3109.054, 3129.01-3129.06 (2024); Oklahoma, OKLA. STAT. ANN. tit. 63, § 2607.1 (West); South Dakota, S.D. CODIFIED LAWS § 34-24 (2023); Tennessee, TENN. CODE ANN. § 63-1-101, *et seq.* (2023); Texas, TEX. HEALTH & SAFETY CODE ANN. §§ 62.151, 161.701–161.706; TEX. HUM. RES. CODE ANN. § 32.024; TEX. OCC. CODE ANN. §§ 164.052, 164.0552; Utah, UTAH CODE ANN. §§ 26B-1-214, 58-1-603(2), 78B-3-427 (LexisNexis 2023); West Virginia, W. VA. CODE §§ 30-3-20, 30-14-17 (2023).

most recent of which is Ohio on January 24, 2024, and legislation remains under consideration in other states.[398] Some states whose statutes have been enjoined, such as Arkansas, have proposed or passed subsequent measures, employing different legal strategies in an attempt to circumvent the constitutional limitations imposed upon them by the courts.[399]

I discuss here not only enacted statutes, but also two administrative and executive actions.[400] Below, I examine the provisions of these initiatives, including (1) the types of services prohibited or restricted; and (2) enforcement mechanisms and other limitations, as well as who is subject to those mechanisms or limitations.

1. *Services Prohibited or Restricted*

Most of the statutes create blanket prohibitions that proscribe providing the medical and surgical gender-affirming interventions detailed in the Standards of Care (8th) and the Endocrine Society Guidelines.[401] The statutes do not, however, explicitly proscribe gender-affirming nonmedical interventions, such as counseling by pediatricians or other healthcare practitioners or psychotherapeutic interventions by mental health professionals.[402] That said, to the extent that a statute creates civil or criminal liability for *referrals* to other practitioners, or to aiding, abetting, or facilitating the provision of a proscribed service to a minor, the statute could create liability for professionals engaging in such interactions with patients or their parents.[403] Most statutes prohibit or restrict the full gamut of gender-affirming *medical* services, such as prescribing

398. For updates in legislative proposals, see ACLU, *Mapping Attacks*, *supra* note 2. As of February 4, 2024, twenty states are considering a combined total of 63 bills that would restrict gender-affirming medical care for minors. *Id.*

399. *See* ARK. CODE ANN. §§ 16-114-401–16-114-403, 17-80-122 (West 2023). The "Protecting Minors from Medical Malpractice Act of 2023," was enacted March 13, 2023, and creates a private right of action by a minor against health care professionals who provide gender-affirming care "if the minor is injured, including without limitation any physical, psychological, emotional, or physiological injury, by the gender transition procedure, related treatment, or the aftereffects of the gender transition procedure or related treatment." *Id.* § 16-114-402(a). The statute contains a "safe harbor" provision that identifies a "defense" to such lawsuits, allowing practitioners to prove that prior to providing certain services, they used certain evaluative procedures, made certain clinical findings, and the period of time of reported gender incongruence was at least two continuous years. *Id.* § 16-114-403(a). The informed consent provision, elaborated in section 16-114-403(b), details several pages of recitations that must be provided "verbatim" in order to allow the defense. The required language characterizes the interventions quite negatively, focusing almost exclusively on potential harms, and minimizing the potential benefits of the interventions. Thus, although not prohibiting the provision of certain forms of gender-affirming care, this statute, now in effect, will likely chill the provision of such services, will interfere with professional judgment in applying the standards of practice, and professional judgment in communicating with their patients in a manner that they believe will best inform the patient and family about the potential risks and benefits relevant to that patient.

400. Future updates on bills and other proposals can be found at *Healthcare Laws and Policies: Bans on Best Practice Medical Care for Transgender Youth*, MOVEMENT ADVANCEMENT PROJECT, https://www.lgbtmap.org/img/maps/citations-youth-medical-care-bans.pdf (last updated Feb. 4, 2024).

401. *See supra* Part I.B.2.

402. *See, e.g.*, ALA. CODE § 26-26-4.

403. *See infra* Part III.A.2.e.

puberty suppressing medications and gender-affirming hormones when these interventions are used for the purpose of treating gender incongruence by aligning a TGD minor's physiology and anatomy with their gender identity.[404] The statutes also restrict or prohibit *surgical* procedures modifying genitalia or secondary sexual characteristics.[405] The statutes typically identify exclusions, indicating permissible uses of medications or procedures for purposes other than aligning a TGD minor's physiology and anatomy with their gender identity.[406]

While most state prohibitions or restrictions encompass all the aforementioned categories, some states limit fewer interventions. For example, Georgia's statute prohibits provision of "(1) sex reassignment surgeries, or any other surgical procedures, that are performed for the purpose of altering primary or secondary sexual characteristics; or (2) hormone replacement therapies," but does not limit provision of puberty suppressing drugs.[407] Arizona's statute prohibits "irreversible gender reassignment surgery" to persons under the age of eighteen "for the purpose of assisting an individual with a gender transition," and does not limit minors access to puberty suppressing drugs or hormonal treatments.[408]

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404. *See, e.g.*, ALA. CODE § 26-26-4. This section reads:

> a) Except as provided in subsection (b), no person shall engage in or cause any of the following practices to be performed upon a minor if the practice is performed for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex as defined in this act:
>
> (1) Prescribing or administering puberty blocking medication to stop or delay normal puberty.
>
> (2) Prescribing or administering supraphysiologic[1] doses of testosterone or other androgens to females.
>
> (3) Prescribing or administering supraphysiologic doses of estrogen to males.
>
> (4) Performing surgeries that sterilize, including castration, vasectomy, hysterectomy, oophorectomy, orchiectomy, and penectomy.
>
> (5) Performing surgeries that artificially construct tissue with the appearance of genitalia that differs from the individual's sex, including metoidioplasty, phalloplasty, and vaginoplasty.
>
> (6) Removing any healthy or non-diseased body part or tissue, except for a male circumcision.

Id. See also ARK. CODE ANN. § 20-9-1501(6)(A) (2023) (defining gender transition procedures); ARK. CODE ANN. § 16-114-401(1)(A) (2023) (adopting identical definition of gender transition procedures as in § 20-9-1501(6)(A)); FLA. STAT. § 456.001(9)(a) (2023) (defining "sex-reassignment prescriptions or procedures" as including medical interventions involving "administration of puberty blockers for the purpose of attempting to stop or delay normal puberty in order to affirm a person's perception of his or her sex if that perception is inconsistent with the person's sex," "prescription or administration of hormones or hormone antagonists to affirm a person's perception of his or her sex if that perception is inconsistent with the person's sex").

405. *See. e.g.*, FLA. STAT. § 456.001(9)(a) (restricting surgical procedures "to affirm a person's perception of his or her sex if that perception is inconsistent with the person's sex").

406. *See, e.g.*, ARK. CODE ANN. § 20-9-1501(6) (listing procedures that do not fall within the definition of "gender transition procedures"); S.B. 99, 68th Leg. (Mont. 2023) (limiting the statutory prohibitions to circumstances in which they are "knowingly provided to address a female minor's perception that her gender or sex is not female or a male minor's perception that his gender or sex is not male" and listing certain exceptions); TENN. CODE ANN. § 68-33-103 (2023) (exempting medical procedures "to treat a minor's congenital defect, precocious puberty disease, or physical injury").

407. GA. CODE ANN. § 31-7-3.5 (2023). The enforcement of this statute was temporarily enjoined in *Koe v. Noggle*, No. 23-CV-2904, 2023 WL 5339281, at *26 (N.D. Ga. Aug. 20, 2023).

408. ARIZ. REV. STAT. ANN. § 32-3230 (2023).

Utah prohibits gender-affirming *surgical* interventions, while also creating a two-tiered approach for non-surgical gender-affirming medical interventions depending upon whether the minors were or were not diagnosed with gender dysphoria before the effective date of the bill.[409] Minors who were diagnosed before the effective date are not directly affected by the moratorium.[410] A moratorium on provision of these medical treatments precludes access for all other minors[411] until the state can conduct a "systematic medical evidence review of hormonal transgender treatments."[412] Compare this to West Virginia's statute, which creates an exception to its otherwise blanket prohibition of practitioners' prescriptions for "gender altering medication."[413] It allows for the provision of "pubertal modulating and hormonal therapy for severe gender dysphoria" under limited specified circumstances.[414] The statute provides no exceptions to its prohibition of performance of "irreversible gender reassignment surgery."[415] A handful of states also allow practitioners to "systematically reduce," rather than immediately terminate, drug treatment for minors already under care at the time of the statute's effective date, if immediate termination would be harmful to the minor.[416]

2. *Enforcement Mechanisms, Persons or Entities Subject to Enforcement Mechanisms, and Other Obstacles to Service Provision*

a. *"Unprofessional conduct" designation and license revocation*

The most common statutory provisions prohibit healthcare professionals from providing the specified services for the purpose of gender affirmation,

409. UTAH CODE ANN. § 58-1-603 (LexisNexis 2023).

410. *Id.*

411. UTAH CODE ANN. § 58-1-603.1 (LexisNexis 2023).

412. UTAH CODE ANN. § 26B-1-214 (2023). Furthermore, under the statute, beginning January 2024, all professionals providing "hormonal transgender treatment" must obtain a certification from the state. UTAH CODE ANN. § 58-1-603(2) (2023). The statute defines such treatment as:

> administering, prescribing, or supplying for effectuating or facilitating an individual's attempted sex change: (A) to an individual whose biological sex at birth is female, a dose of testosterone or other androgens at levels above those normally found in an individual whose biological sex at birth is female; (B) to an individual whose biological sex at birth is male, a dose of estrogen or synthetic compound with estrogenic activity or effect at levels above those normally found in an individual whose biological sex at birth is male; or (C) a puberty inhibition drug.

Id. § 58-1-603(e)(i).

413. W. VA. CODE §§ 30-3-20, 30-14-17 (2023). The statute defines "gender altering medication" as "prescribing or administering puberty blocking medication" or cross sex hormones "for the purpose of assisting an individual with a gender transition." W. VA. CODE § 30-14-17.

414. W. VA. CODE § 30-14-17(c)(5). Kentucky provides a different type of exception, whereby a provider who has been treating a minor with medications can "systematically reduce" the treatment over a period of time if immediate termination of treatment would "cause harm to the minor." KY. REV. STAT. ANN. § 311.372(6) (2023).

415. W. VA. CODE §§ 30-3-20, 30-14-17.

416. *See, e.g.*, KY. REV. STAT. ANN. § 311.372(6) (West 2023); LA. STAT. ANN. § 40:1098.2(D) (2023); TEX. HEALTH & SAFETY CODE ANN. § 161.703(b).

threatening loss of licensure and the right to practice within the state.[417] Some statutes state that providing such services for the purpose of gender affirmation is inconsistent with the standards of care in the state, and thus constitutes "unprofessional conduct."[418] Most of the statutes creating this enforcement mechanism indicate that revocation is *mandatory* if the reviewing agency or licensing board finds that the practitioner violated the statute.[419] Mississippi extends this restriction to other practitioners as well for "knowingly engag[ing] in conduct that aids or abets the performance or inducement of gender transition procedures to any person under eighteen (18) years of age."[420] The statute provides no guidance as to what types of conduct constitute "aiding and abetting" under the statute. Broadly construed, this language could include referring practitioners or other professionals on the team providing service. "Aiding or abetting" might even reach professionals who educate patients about gender-affirming care treatment options.[421]

b. *Private causes of action or attorney general enforcement*

Also common are statutory provisions creating a private cause of action allowing a third party to sue the practitioner for a violation of the statute and to seek damages.[422] Sometimes these provisions allow a third party to request injunctive, declaratory, or other forms of relief.[423] Many statutes further authorize the state attorney general to pursue action to enforce the statute.[424]

c. *Restriction on use of state funds*

Some statutes restrict use of state funds for gender-affirming care. Several states prohibit coverage of medical or surgical gender-affirming care through the

417. *See, e.g.*, LA. STAT. ANN. § 40:1098.3 (2023); MISS. CODE ANN. §§ 41-141-9(1) (West 2023) (2023); TEX. OCC. CODE ANN. §§ 164.052(a)(24), 164.0552.

418. *See, e.g.*, MISS. CODE ANN. 41-141-9(1) (West 2023)] ("Any violation of Section 41-141-5 by a physician or other health care professionals shall be considered outside the applicable standard of care and is unprofessional conduct."); see also OHIO REV. CODE ANN. § 3129.05(A) (2024) ("Any violation of [enumerated statutory sections] shall be considered unprofessional conduct and subject to discipline by the applicable professional licensing board").

419. *See, e.g.*, KY. REV. STAT. ANN. § 311.372(4) ("If a licensing or certifying agency for health care providers finds, in accordance with each agency's disciplinary and hearing process, that a health care provider . . . has violated [this statute], the agency shall revoke the health care provider's license or certification; MISS. CODE ANN. §41-141-9(1) (2023) ("A physician who violates Section 41-141-5 shall have his or her license to practice medicine in the State of Mississippi revoked pursuant to an action taken by the Mississippi State Board of Medical Licensure.").

420. MISS. CODE ANN. § 41-141-5(2) (2023).

421. *See* IND. CODE § 25-1-22-(13)(b) (2023) ("[A] physician or other practitioner may not aid or abet another physician or practitioner in the provision of gender transition procedures to a minor."); IND. CODE § 25-1-22-15 (2023) ("A physician or practitioner that takes any action that aids or abets another physician or practitioner in the provision of gender transition procedures for a minor violates the standards of practice . . . and is subject to discipline by the board regulating the physician or practitioner").

422. *See, e.g.*, KY. REV. STAT. ANN. § 311.372(5).

423. MISS. CODE ANN. § 41-141-9(2) (2023).

424. *See, e.g.*, IOWA CODE § 147.164.3.d (West 2023) ("The attorney general may bring an action to enforce this section"); OKLA. STAT. tit. 63, § 63-2607.1 F (2023).

state Medicaid program.[425] For example, the North Carolina statute indicates that no public funds may be used, directly or indirectly, to support or further medical or surgical gender-affirming care, including through governmental health plans or insurance policies.[426] Montana's statute includes a similar restriction, but also states that "[a]ny individual or entity that receives state funds to pay for or subsidize the treatment of minors for psychological conditions, including gender dysphoria, may not use state funds to promote or advocate" the gender-affirming medical treatments prohibited by the statute.[427] In a manner analogous to the Mississippi statute,[428] Montana's statute aims to chill discussions about gender-affirming medical care, even by psychologists, primary care pediatricians, and other practitioners who provide other services to TGD youth.[429] While Mississippi threatens loss of professional licensure, Montana threatens loss of state funding.

d. *Defining the provision of gender-affirming medical or surgical care as criminal conduct*

By statute, five states (Alabama, Florida, Idaho, North Dakota, and Oklahoma) threaten to impose criminal penalties on practitioners who provide gender-affirming medical or surgical care.[430] All of the statutes target healthcare professionals and define the proscribed conduct relatively similarly. For example, Idaho's "Vulnerable Child Protection Act" criminalizes a healthcare practitioner's provision of gender-affirming medical or surgical care "for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex."[431] The services listed in the statute include provision of puberty-suppressing drugs, cross-sex hormones, and specified surgical interventions altering primary or secondary sexual characteristics.[432] The statute further specifies that provision of such services constitutes a felony, and that a medical professional convicted of this crime "shall be imprisoned in the state prison for a term of not more than ten (10) years."[433] Applying a similar definition of the prohibited services, Alabama characterizes provision of these services as a Class C felony,[434] which, according to the Alabama Code, subjects the convicted party

425. *See, e.g.*, S.B. 99, 68th Leg. (Mont. 2023); S.B. 254, 2023 Leg., Reg. Sess. (Fla. 2023); N.C. GEN. STAT. § 143C-6-5.6 (2023); TEX. HEALTH & SAFETY CODE ANN. § 161.703.

426. N.C. GEN. STAT. § 143C-6-5.6(b).

427. S.B. 99, 68th Leg., Reg. Sess. (Mont. 2023).

428. *See* MISS. CODE ANN. § 41-141-5 (2023).

429. S.B. 99, 68th Leg., Reg. Sess. (Mont. 2023).

430. ALA. CODE §§ 26-26-4(c) (2023); FLA. STAT. § 456.52(5)(a) (2023); IDAHO CODE §§ 18-1506C(5) (2023); N.D. CENT. CODE §§ 12.1-36.1-02(2) (2023); OKLA. STAT. tit. 63, § 63-2607.1 A, B, and D (2023).

431. IDAHO CODE § 18-1506C(3).

432. *Id.*

433. *Id.* at § 1506C(5).

434. ALA. CODE §§ 26-26-4(c) (2023).

to a possible prison term of up to ten years.[435] Florida's statute classifies statutory violations as felonies in the third degree, punishable up to a five-year prison term and/or a five thousand dollar fine.[436]

North Dakota classifies a "willful violation" of its prohibition against performance of gender-affirming surgical care as a Class B penalty, whereas a "willful violation" of its proscription against providing gender-affirming medical care is a Class A misdemeanor.[437] Oklahoma characterizes the "knowing" provision of puberty-suppressing drugs, gender-affirming hormones, and gender-affirming surgical care, "for the purpose of attempting to affirm the minor's perception of his or her gender or biological sex, if that perception is inconsistent with the minor's biological sex," as a felony,[438] although without further specification of the grade of felony or possible penalties.

e. *Restrictions and penalties targeting parents and third parties*

Although the enacted statutes prohibiting or restricting gender-affirming care overwhelmingly target the conduct of healthcare professionals, some measures target parental and third party conduct. Most notorious among those measures is Texas's attempt to characterize parental decisions to seek or consent to gender-affirming medical care as a form of "child abuse," which quickly garnered national attention.[439]

In February 2022, Ken Paxton, the Texas Attorney General, issued Opinion No. KP-0401 on the question of "[w]hether certain medical procedures performed on children constitute child abuse."[440] Opinion KP-0401 concluded that provision of gender-affirming medical and surgical care could fall within the purview of the state's family code sections defining child abuse.[441] Specifically, Attorney General Paxton opined that gender-affirming medical and surgical care "can legally constitute child abuse under several provisions of the Texas Family Code" involving conduct that causes or permits physical or emotional injury or "material impairments in the child's growth, development,

435. ALA. CODE § 13A-5-6(3) (2023).

436. FLA. STAT. § 456.52(5)(b) (2023) ("Any health practitioner who willfully or actively participates in a violation of subsection (1) commits a felony of the third degree."); FLA. STAT. §§ 775.082(2)(e) (2023) (specifying punishments for felony in the third degree to be "a term of imprisonment not exceeding 5 years").

437. N.D. CENT. CODE § 12.1-36-01 (2023). The maximum penalty for a Class B felony in North Dakota is "ten years' imprisonment, a fine of twenty thousand dollars, or both," whereas the punishment for a Class A misdemeanor is a "maximum penalty of imprisonment for three hundred sixty days, a fine of three thousand dollars, or both." N.D. CENT. CODE § 12.1-32-01 (2023).

438. OKLA. STAT. ANN. tit. 63, § 2607.1(3)(B) & (D) (2023).

439. Azeen Ghorayshi, *Texas Governor Pushes to Investigate Medical Treatments for Trans Youth as 'Child Abuse'*, N.Y. TIMES (Feb. 23, 2022), https://www.nytimes.com/2022/02/23/science/texas-abbott-transgender-child-abuse.html; J. David Goodman & Amanda Morris, *Texas Investigates Parents Over Care for Transgender Youth, Suit Says*, N.Y. TIMES (Mar. 1, 2022), https://www.nytimes.com/2022/03/01/us/texas-child-abuse-trans-youth.html.

440. Whether Certain Medical Procedures Performed on Children Constitute Child Abuse, Tex. Op. Att'y Gen. Op. KP-0401 (2022).

441. *Id.*

and psychological functioning."[442] The Opinion also invoked *Skinner v. Oklahoma* as a basis for state intervention on matters that might affect a minor's future reproductive capacity and in light of a minor's legal inability to consent to sterilization procedures in Texas.[443] The Opinion further analogized parental decisions to authorize gender-affirming medical or surgical care to circumstances in which parents seek and authorize medical care that does not promote their children's welfare.[444]

The Attorney General's Opinion, while focusing primarily on parental liability under the civil child abuse statutes for seeking or authorizing gender-affirming medical or surgical care, articulates other bases of liability. It also cites potential parental liability for "the failure to stop a doctor or another parent from conducting these treatments and procedures" under the doctrine that imposes an affirmative duty on parents to protect their children from dangers posed by the other parent or third parties.[445] The widest expansion of potential liability, however, flows from mandatory reporting obligations. The Opinion cites that obligation, which falls to healthcare professionals, teachers, employees of educational institutions, and a range of other persons who work with the child, noting as well that failure to report can constitute a criminal offense.[446]

Although the Opinion does not focus on the state's criminal child abuse provisions or consider whether the hypothesized violations of the Texas Family Code could also lead to parallel violations of the state's Penal Code, the specter of such a possibility exists. In all states, civil and criminal child abuse provisions are available to the state, and decisions to invoke the state's authority under either or both sets of laws are typically left to the discretion of state attorneys and social workers.[447]

Soon after the Opinion was issued, Texas Governor Greg Abbott instructed the Texas Department of Family and Protective Services (DFPS) to "follow the law as explained in" Opinion No. KP-0401.[448] Governor Abbott's letter to Jaime Masters, the Commissioner of the Texas DFPS, directed DFPS to "conduct a prompt and thorough investigation of any reported instances of" providing

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442. *Id.* at 2, 8–12 (citing to TEX. FAM. CODE §§ 261.001(1)(A), 261.001(1)(B), 261.001(1)(C), 261.001(1)(D)).

443. *Id*. at 6–8 (citing 316 U.S. 535, 541 (1942)).

444. *Id.* at 7–8. The opinion cites the terms "Munchausen by proxy" an "factitious disorder imposed on another" to refer to such circumstances where parents may be found to request unnecessary procedures for reasons other than their children's well-being. *Id.* For a discussion of these concepts, case law, and critiques, *see* DAVIS, SCOTT, WEITHORN & WADLINGTON, *supra* note 244, at 492–94; Eichner, *supra* note 316, at 205. *See also* RESTATEMENT OF THE LAW OF CHILDREN AND THE LAW § 3.20 cmt. k (Am. L. Inst., Tentative Draft No. 1).

445. Whether Certain Medical Procedures Performed on Children Constitute Child Abuse, Tex. Op. Att'y Gen. KP-0401 (2022) (citing TEX. FAM. CODE §§ 261.001(1)(B) & (D)).

446. *Id.* at 12 (citing TEX. FAM. CODE §§ 261.101(a) & (b); TEX. FAM. CODE § 261.109(a)).

447. For a discussion of the overlapping jurisdiction of civil and criminal child abuse and neglect statutes, *see generally* DAVIS, SCOTT, WEITHORN & WADLINGTON, *supra* note 254, at 446–48.

448. *See* Letter from Greg Abbott, Tex. Gov., to Jaime Masters, Tex. Commissioner of Fam. & Protective Servs. (Feb. 22, 2022).

gender-affirming medical or surgical care.[449] The Texas DFPS commenced investigations into families, but was enjoined from proceeding further—although more than one lawsuit was required to secure a sufficiently broad temporary injunction.[450] In addition, the Texas Supreme Court held that neither the Governor's letter nor the Attorney General's Opinion have binding authority on the actions of DPFS.[451]

In its 2023 legislation restricting access to gender-affirming care, Florida added language to its pre-existing statutory provision, section 61.517, that authorizes a state court to take temporary emergency jurisdiction of a child under circumstances when doing so is necessary to protect the child's safety.[452] The new language allows such jurisdiction when "necessary in an emergency to protect the child because the child has been subjected to or is threatened with being subjected to sex-reassignment prescriptions or procedures," as per section 456.001, which defines the prohibitions against such treatment.[453] Presently, there is a temporary injunction preventing enforcement of the statute.[454] Thus, although the court's opinion did not explicitly address the new language in section 61.517, we can infer that section 61.517 cannot be enforced against parents seeking gender-affirming care while the injunction against the prohibitions is in force.[455]

B. The Litigation

As of this writing, multiple lawsuits have been filed on behalf of minor patients, their parents, and healthcare professionals, seeking declarations that statutes prohibiting or restricting gender-affirming care are unconstitutional, and seeking preliminary and permanent injunctions against enforcement.[456] Suits

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449. *Id.*

450. Doe v. Abbott, 2022 WL 831383, *2 (Tex. Dist. Ct. Mar. 11 2022), *aff'd* 2022 WL 837956 (Tex. App. Mar. 21, 2022) (applying injunction statewide), *aff'd in part*, *rev'd in part sub nom. In re* Abbott, 645 S.W.3d 276, 284 (Tex. 2022) (upholding temporary injunction as applied to plaintiffs, but reversing statewide application to nonparties); Masters v. Voe, 2022 WL 4549010 (Tex. Dist. Ct. July 8, 2022) (granting temporary injunctions), *aff'd* 2022 WL 4359561 (Tex. App. Sept. 20 2022); PFLAG v. Abbott, 2022 WL 4549009, at *2 (Tex. Dist. Ct. Sept. 16, 2022), *aff'd* Masters v. PFLAG, Inc., No. 03-22-00587-CV, 2022 WL 4473903, at *1 (Tex. App. Sept. 26, 2022) (upholding a temporary injunction on behalf of wider group of plaintiffs, including the membership of Federation of Parents and Friends of Lesbians and Gays).

451. *In re Abbott,* 645 S.W.3d. at 280–81.

452. FLA. STAT. ANN. § 61.517 (2023).

453. *Id.* (cross-referring to prohibitions on provision of gender-affirming care defined in Florida Statutes section 456.001).

454. Doe v. Ladapo, No. 23CV114, 2023 WL 3833848 (N.D. Fla. June. 6, 2023), at *17, *appeal filed*, No 23-12159 (11th Cir. June 27, 2023).

455. In addition, the court specifically stated that "the preliminarily enjoined parties must not take any steps to enforce [the prohibitions] against [the named child plaintiffs] or their parents or health care providers." *Id.*

456. Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131, 1151 (Ala. 2022) (granting preliminary injunction), *rev'd* Eknes-Tucker v. Gov. of Ala., 80 F.4th 1205, 1220 (11th Cir. 2023), *petition for reh'g en banc* filed Sept. 11, 2023; Brandt v. Rutledge, 551 F. Supp. 3d 882, 894 (E.D. Ark. 2021) (granting temporary injunction), *aff'd.* 47 F.4th 661, 672 (8th Cir. 2022), Brandt v. Rutledge, 677 F. Supp. 3d 877, 885 (E.D. Ark. 2023) (holding

were also filed to enjoin enforcement of Texas Governor Greg Abbott's directive to the Texas DFPS.[457] Separate suits proceeded in several states to challenge administrative or statutory actions denying state Medicaid coverage for gender-affirming medical and surgical care.[458] Decisions on preliminary injunctions have been rendered in the Eighth,[459] Sixth,[460] and Eleventh Circuits.[461] In addition, federal district courts have adjudicated claims challenging state statutes in the Seventh Circuit.[462]

1. *The Eighth Circuit*

The litigation is farthest along in the Eighth Circuit, which considered the claims of plaintiff minors, parents, and healthcare professionals challenging the Arkansas statute. In *Brandt v. Rutledge*, minors, parents, and healthcare

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Arkansas statute unconstitutional and granting permanent injunction), *appeal filed sub nom.* Brandt v. Griffin; Doe v. Ladapo, No. 23CV114, 2023 WL 3833848, at *17 (N.D. Fla. June 6, 2023), *appeal filed* No. 23-12159 (11th Cir. June 27, 2023); K.C. v. Individual Members of Med. Licensing Bd. of Ind., No. 23-CV-00595, 2023 WL 4054086, at *14 (S.D. Ind. 2023) (granting preliminary injunction in part), *appeal filed*, No. 23-2366 (7th Cir. July 12, 2023); Georgia, Koe v. Noggle, No. 23-CV-2904, 2023 WL 5339281, at *31 (N.D. Ga. Aug. 20 2023) (granting preliminary injunction); Pam Poe v. Raúl Labrador, No. 23-CV-00269, 2024 WL 170678 (D. Idaho Jan. 16, 2024), at *4 (upholding preliminary injunction against Idaho H.B. 1); Doe 1 v. Thornbury, 679 F. Supp. 3d 576 (W.D. Ky. 2023) (granting preliminary injunction), *rev'd* Doe v. Thornbury, 75 F.4th 655, 657 (6th Cir. 2023) (ordering stay of preliminary injunction due to controlling effect of Sixth Circuit opinion in *LW v. Skrmetti*); Noe v. Parson, No. 23AC-CC04530 (Cir. Ct., Cole Community, Mo.) (motion for preliminary injunction filed July 25, 2023), https://lambdalegal.org/wp-content/uploads/2023/07/SB-49-PI-Memo-Final-7-25-23.pdf; Van Garderen v. Montana, No. DV-32-2023-541 (Missoula Cnty. Dist. Ct., Mont. Sept. 27, 2023) (granting preliminary injunction against SB 99), https://www.aclu.org/cases/van-garderen-et-al-v-state-of-montana#summary; Planned Parenthood of Heartland v. Hilgers, C1 23-1821 (Lancaster Cnty. Dist. Ct., Neb. 2023) (denying preliminary injunction); T.D. v. Wrigley, (Burleigh Cnt. Dist. Ct., N.D.) (motion for preliminary injunction filed), https://lawyeringproject.org/wp-content/uploads/2023/09/20230918_TD-v.-Wrigley_Complaint.pdf; Peter Poe v. Gentner Drummond, No. 23-CV-177-JFH-SH- (N.D. Okla. 2023) (preliminary injunction denied Oct. 5, 2023) https://www.aclu.org/cases/poe-v-drummond?document=Opinion-and-Order, *appeal filed* in 10th Cir., Oct. 6, 2023, https://www.aclu.org/cases/poe-v-drummond?document=Plaintiffs-Notice-of-Appeal); L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 678–79 (M.D. Tenn. 2023) (granting preliminary injunction), *rev'd*, 83 F.4th 460, 491 (6th Cir. 2023), *petition for cert. filed*, 2023 WL 7327440 (Nov. 6, 2023) (No. 23-477); Loe v. Texas, No. D-1-GN-23-003616, 2023 WL 5519799, at *1 (Tex. Dist. Aug. 25, 2023) (granting preliminary injunction), *appeal filed* (Travis Cnty. Tex. Aug. 25, 2023).

457. *See supra* text accompanying notes 439-451.

458. Dekker v. Weida, No. 22CV325, 2023 WL 4102243, at *20, (N.D. Fla. June 21, 2023) (holding Florida's statutes prohibiting gender affirming treatments, puberty blockers and gender-affirming hormones unconstitutional and in violation of Affordable Care Act and Medicaid Act); IOWA CODE § 147.164 (West 2023); ARIZ. REV. STAT. ANN. § 32-3230 (2023).

459. Brandt v. Rutledge, 551 F. Supp. 3d 882 (E.D. Ark. 2021) (granting preliminary injunction).

460. L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 716–19 (M.D. Tenn. 2023) (granting preliminary injunction), *rev'd*, 83 F.4th 460, 491 (6th Cir. 2023), *petition for cert. filed*, 2023 WL 7327440 (Nov. 6, 2023) (No. 23-477); Doe 1 v. Thornbury, 679 F. Supp. 3d 576, 587 (W.D. Ky. 2023) (granting preliminary injunction), *rev'd* Doe v. Thornbury, 75 F.4th 655, 657 (6th Cir. 2023).

461. Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131, 1151 (M.D. Ala. 2022) (granting preliminary injunction), *rev'd* Eknes-Tucker v. Gov. of Ala., 80 F.4th 1205, 1231 (11th Cir. 2023).

462. K.C. v. Individual Members of Med. Licensing Bd. of Ind., No. 23-CV-00595, 2023 WL 4054086, at *14 (S.D. Ind. June 16, 2023) (granting preliminary injunction in part); 2024 WL 811523 (7th Cir. Feb. 27, 2024) (staying preliminary injunction); motion for reconsideration and en banc review filed, 2024 WL 887379 (7th Cir. Mar. 1, 2024).

professionals argued that Arkansas's Act 626 prohibited transgender adolescents "with gender dysphoria from treatment that the patient, their parents, and their medical providers agree is medically necessary and in the adolescent's best interest."[463] They assert that this prohibition unconstitutionally violates their equal protection rights, discriminating against them on the basis of their sex and because their "gender identity does not conform to their assigned sex at birth."[464] The plaintiffs also claim that the statute violates parents' due process rights to make healthcare decisions regarding gender-affirming medical care in their children's best interests, together with their children and the recommendations of their healthcare practitioners.[465] The practitioners assert a violation of their First Amendment rights.[466]

The State of Arkansas claims that it has "a compelling government interest in protecting the health and safety of its citizens, particularly 'vulnerable' children who are gender nonconforming or who experience distress at identifying with their biological sex" from "experimental medical treatment" and in ensuring the "ethical standards of the healthcare profession."[467] It claims that Act 626's prohibitions on gender-affirming medical care advance that interest because:

> (i) . . . there is a lack of evidence of efficacy of the banned care; (ii) that the banned treatment has risks and side effects; (iii) that many patients will desist in their gender incongruence; (iv) that some patients will later come to regret having received irreversible treatments; and (v) that treatment is being provided without appropriate evaluation and informed consent. The evidence presented at trial does not support these assertions.[468]

In the first phase of this litigation, the plaintiffs sought, and were granted, a preliminary injunction by the U.S. District Court in the Eastern District of Arkansas.[469] The court observed that: "The primary function of a preliminary injunction is to preserve the status quo until, upon final hearing, a court may grant full, effective relief."[470] In adjudicating a request for a preliminary injunction, the court considers the following four factors: "(1) the likelihood of success on the merits; (2) the likelihood of irreparable harm in the absence of an injunction; (3) the balance of equities; and (4) the public interest."[471] The court granted the preliminary injunction after concluding that the plaintiffs were likely

463. Brandt v. Rutledge, 677 F. Supp. 3d 877, 887 (E.D. Ark. 2023).
464. *Id.* at 887.
465. *Id*. at 885.
466. *Id*. at 923–25.
467. *Id*. at 887, 918.
468. *Id*. at 918.
469. Brandt v. Rutledge, 551 F. Supp. 882 (E.D. Ark. 2021) (granting preliminary injunction).
470. *Id.* at 888 (quoting Ferry-Morse Seed Co. v. Food Corn, Inc., 729 F.2d 589, 593 (8th Cir. 1984)).
471. *Id.* at 889.

to succeed on the merits on all constitutional claims and that facts supported the plaintiffs' claims regarding the other three factors.[472]

On August 25, 2022, a unanimous Eighth Circuit panel applied intermediate scrutiny after concluding that Arkansas' statute created a classification based on sex.[473]

> [U]nder the Act, medical procedures that are permitted for a minor of one sex are prohibited for a minor of another sex. A minor born as a male may be prescribed testosterone or have breast tissue surgically removed, for example, but a minor born as a female is not permitted to seek the same medical treatment. Because the minor's sex at birth determines whether or not the minor can receive certain types of medical care under the law, Act 626 discriminates on the basis of sex.
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> . . .
>
> Statutes that discriminate based on sex must be supported by an "exceedingly persuasive justification." The government meets this burden if it can show that the statute is substantially related to a sufficiently important government interest. Arkansas relies on its interest in protecting children from experimental medical treatment and regulating ethics in the medical profession to justify Act 626.[474]

Rejecting the state's claims, the Eighth Circuit panel concluded that there was "substantial evidence" to support the district court's factual findings that the Act "prohibits medical treatment that conforms with 'the recognized standard of care for adolescent gender dysphoria.'"[475] It noted that the scientific support for gender-affirming medical care is consistent with that of "many other medical innovations," and that studies reveal "statistically significant positive effects of hormone treatment on the mental health, suicidality, and quality of life of adolescents with gender dysphoria [without] negative effects."[476] It also observed that while some international groups that view certain of these treatments as "experimental," those groups still recommend treatment availability for minors under appropriate circumstances, consistent with articulated standards of care.[477]

The panel concluded that the district court's findings are supported by "substantial evidence in the record," and held that "Act 626 is not substantially related to Arkansas's interests in protecting children from experimental medical treatment and regulating medical ethics, and Plaintiffs have demonstrated a

472. *Id.* at 889–94.

473. Brandt *ex rel.* Brandt v. Rutledge, 47 F.4th 661, 669–71 (8th Cir. 2022), *reh'g denied*, Brandt *ex rel.* Brandt v. Rutledge, No. 21-2875, 2022 WL 16957734, at *1 (E.D. Ark. Nov. 16, 2022).

474. Brandt *ex rel.* Brandt v. Rutledge, 47 F.4th 661, 670 (8th Cir. 2022) (quoting and citing United States v. Virginia, 518 U.S. 515, 531 (1996)).

475. *Id.* at 671.

476. *Id.*

477. *Id.* (citing a report by the Council for Choices in Health Care in Finland).

likelihood of success on the merits of their equal protection claim."[478] The court did not address the due process claims in this opinion.[479] In determining the balance of equities so as to adjudicate the plaintiffs' request for a preliminary injunction, the panel again affirmed the district court's findings that the plaintiffs "will suffer irreparable harm absent a preliminary injunction."[480] Specifically, the Eighth Circuit panel cited the finding that, "if Act 626 went into effect, Minor Plaintiffs would be denied access to hormone treatment (including needing to stop treatment already underway), undergo endogenous puberty—a process that cannot be reversed—and suffer heightened gender dysphoria."[481]

On June 20, 2023, Judge James M. Moody, the district court judge who had rendered the opinion reviewed by the Eighth Circuit panel, considered the merits of the case.[482] In a lengthy opinion, Judge Moody examined extensive testimony and evidence submitted by the parties. I review this decision in depth because it is the first, and to date, only federal court decision adjudicating the merits of the plaintiffs' constitutional claims rather than a request for a preliminary injunction.

The court heard testimony from four plaintiffs' expert witnesses, all of whom were judged by the court to "have deep knowledge of the subject matter of their testimony and were fully qualified to provide the opinion testimony they offered. They have provided credible and reliable testimony relevant to core issues in this case."[483] By contrast, of the four state's experts, three were deemed to be "unqualified to offer relevant expert testimony," and that they "offered unreliable testimony . . . grounded in ideology rather than science."[484] The findings of fact include:

- "Gender dysphoria is a serious condition that, if left untreated, can result in other psychological conditions including depression, anxiety, self-harm, suicidality, and impairment in functioning;"[485]
- There is widespread recognition in the health and mental health fields that the social and medical interventions recommended by the major professional societies and associations that have drafted and endorsed current standards of care provide the only mechanisms by which "the clinically significant distress caused by [gender dysphoria] can be relieved;"[486]

478. *Id.*

479. *Id.* 669–71.

480. *Id.*

481. *Id.* at 671–72.

482. *See generally* Brandt v. Rutledge, 677 F. Supp. 3d 877 (E.D. Ark. 2023), *appeal filed sub nom.* Brandt v. Griffin, No. 23-2681 (8th Cir. July 23, 2023).

483. *Id.* at 912.

484. *Id.* at 916.

485. *Id.* at 888.

486. *Id.*

- The state's arguments that increases in minor patients' requests for gender-affirming care in recent years are the product of social influence do not provide persuasive support for Act 626, in light of the diagnostic criteria that must be satisfied (including "longstanding incongruent gender identity and clinically significant distress") under the standards of care; [487]
- The WPATH Standards of Care and the Endocrine Society Guidelines are well-accepted by a consensus of health and mental health associations and practitioners;[488]
- Transgender care under these Standards and Guidelines "is not experimental care;"[489]
- The WPATH Standards' and Endocrine Society Guidelines' "treatment decisions for adolescents with gender dysphoria are individualized based on the needs of the patients;"[490]
- "The informed consent process" stipulated by the Standards and Guidelines "is adequate to enable minor patients and their parents to make decisions about gender-affirming medical care for adolescents;"[491]
- The scientific studies indicate that gender-affirming medical interventions "are effective at alleviating gender dysphoria and improving a variety of mental health outcomes including anxiety, depression, and suicidality;"[492]
- "The evidence base supporting gender-affirming medical care for adolescents is comparable to the evidence base supporting other medical treatments for minors;"[493]
- The "risks of gender-affirming medical care are not categorically different than the types of risks that other types of pediatric healthcare pose;"[494]
- "As with other medical treatments, gender-affirming medical treatments can have potential risks and side effects that must be weighed by patients and their parents after being informed of those risks and side effects by their doctors;"[495]
- "For many adolescents the benefits of treatment greatly outweigh the risks;"[496]

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487. *Id.* at 888–89.
488. *Id.* at 889.
489. *Id.* at 890.
490. *Id.*
491. *Id.* at 890–91.
492. *Id.* at 901.
493. *Id.*
494. *Id.*at 902.
495. *Id.*
496. *Id.*

- "Adverse health effects from gender-affirming medical care are rare when treatment is provided under the supervision of a doctor."[497]

In response to the state's claim that gender-affirming medical care is ill-advised because some minors may later regret their decision to transition, the court acknowledged that this phenomenon occurs.[498] It found, however, that research often cited on this question focused on younger children, that it did not inform questions about the likelihood of "desistance" among adolescents who satisfy the criteria required under the Standards of Care (8th), and that the Standards provide appropriate guidelines for assessment and informed consent relevant to this possibility.[499]

The court held that Act 626 violates the Equal Protection and Due Process Clauses of the U.S. Constitution.[500] It applied intermediate scrutiny in holding that the statute discriminates on the basis of sex and an individual's identity as transgender.[501] It considered the state's asserted interest of "protecting children from experimental medical treatment and safeguarding medical ethics," as well as the claims it alleged to support its argument that Act 626 promotes that interest.[502] The court examined the evidence and concluded that "the State has failed to meet its demanding burden of proving the Act advances its articulated interests."[503] In its due process analysis, the court, applying strict scrutiny, emphasized fundamental liberty interests of parents to "seek medical care for their children, and in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary."[504] While the state's interest in protecting the physical and psychological welfare of minors within the state was compelling, the court concluded that the state had failed to provide evidence that the services banned under Act 626 jeopardize the well-being of children, or that the legislation was narrowly tailored to achieve its aims.[505] The court found no basis on which the Arkansas legislature could constitutionally substitute its judgment for that of the parents.[506] Finally, the court also held that the Act's prohibitions on referrals made by healthcare professionals for gender-affirming care violate those practitioners' First

497. *Id.*
498. *Id.* at 905–06, 921.
499. *Id.*
500. *Id.* at 917–23.
501. *Id.* at 917–18.
502. *Id.* at 918.
503. *Id.* at 922.
504. *Id.* at 922–23.
505. *Id.*
506. *Id.*

Amendment rights.[507] The court permanently enjoined the enforcement of Act 626.[508] The State has since filed an appeal to the Eighth Circuit.[509]

2. *The Sixth Circuit*

In the Sixth Circuit, the federal district courts in *Doe v. Thornbury*[510] and L.*W. v. Skrmetti*[511] decided challenges to the Kentucky and Tennessee statutes, respectively. In both cases, minor plaintiffs and parents challenged the states' bans on gender-affirming medical care, claiming violations of their equal protection and due process rights under the U.S. Constitution.[512] In *Doe*, the court issued a preliminary injunction after concluding that the plaintiffs had demonstrated a likelihood of success on the merits and were likely to suffer irreparable harm in the absence of an injunction.[513] The court applied intermediate scrutiny to the equal protection claim and strict scrutiny to the parents' due process claim.[514] Although more cursory in its analysis of the factual claims and the scientific basis underlying the treatments proscribed by the Kentucky statute, the district court's opinion in *Doe* is in accord with that issued in *Brand v. Rutledge*.

District Court Judge Richardson issued a somewhat narrower ruling in *L.W. v. Skrmetti*. None of the minor plaintiffs had alleged that they would have sought to receive gender-affirming *surgical* care had the Tennessee statute not prevented them from doing so.[515] Therefore, Judge Richardson held that they did not have standing to challenge the provisions in the Tennessee statute that proscribe provision of surgical care.[516] In addition, the court held that the plaintiff physician did not have standing.[517] In the court's analysis of the merits, however, Judge Richardson issued a strong opinion as to the plaintiffs likelihood of success on the due process and equal protection claims—applying strict scrutiny to the due process claim and intermediate scrutiny to the question of whether Senate Bill 1 ("SB1") discriminates on the basis of transgender status

507. *Id.* at 923–26.

508. *Id.* at 925.

509. An appeal was filed July 23, 2023, in Eighth Circuit *sub nom. Brandt v. Griffin*.

510. Doe 1 v. Thornbury, 679 F. Supp. 3d 576, 587 (W.D. Ky. 2023) (granting preliminary injunction), *rev'd* Doe v. Thornbury, 75 F.4th 655, 657 (6th Cir. 2023) (staying preliminary injunction due to controlling effect of Sixth Circuit opinion in L.W. *ex rel.* Williams *v.* Skrmetti, 83 F.4th 460 (6th Cir. 2023)). .

511. L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668 (M.D. Tenn. 2023) (granting preliminary injunction), *rev'd* 83 F.4th 460, 491 (6th Cir. 2023), *petition for cert. filed*, 2023 WL 7327440 (Nov. 6, 2023) (No. 23-477).

512. *Skrmetti*, 679 F. Supp. 3d at 718 (granting preliminary injunction). In *Skrmetti*, the minors and parents were joined by a healthcare practitioner who provided gender-affirming medical care. *Id.* at 681. The state challenged the practitioner's standing as a plaintiff. The court concluded it did not need to decide that question for the purposes of adjudicating the petition for a preliminary injunction given its decision regarding the claims of the other plaintiffs. *Id.*

513. *Thornbury*, 679 F. Supp. 3d at 586–87 (granting preliminary injunction).

514. *Id.*

515. *Skrmetti*, 679 F. Supp. 3d at 681–82 (granting preliminary injunction).

516. *Id.*

517. *Id.* at 682.

or on the basis of sex.[518] The court held that the state failed to muster sufficient evidence to support its claim of an "important interest in protecting minors from the risks associated with the medical procedures banned by SB1 [on the basis that] the risks outweigh the benefits," or that the statute was substantially related to that interest.[519] In reviewing the evidentiary record, as it relates to the purported harms of the treatments, the court concluded:

> [T]he record suggests that either 1) the risks identified by Defendants are not more prevalent in transgender individuals receiving the procedures banned by SB1 than in individuals not receiving these procedures; 2) to the extent that individuals receiving these procedures experience the negative side effects raised by Defendants, that the prevalence of these effects is low, or 3) the risk of negative side effects resulting from the use of such medical procedures banned by SB1 can be mitigated. And the fact that some pediatric treatments may pose certain risks is not sufficient, in the Court's view, to support a finding that the state has an important interest in banning these treatments . . . . Indeed, a conclusion to the contrary would leave several pediatric treatments targeting something other than gender dysphoria vulnerable to severe limitations on access.[520]

It further found that there was sufficient evidence of the benefits of clinically appropriate gender-affirming medical care.[521] In evaluating the evidence that had been presented to the court, it found the state's experts either lacked experience working with transgender youth or failed to provide adequate support for assertions made in their testimony, and were therefore less persuasive than experts testifying on behalf of plaintiffs.[522] While recognizing that deprivation of constitutional rights can, in itself, be the basis for a finding that irreparable harm is likely to follow if a preliminary injunction is not issued, the court found that it was likely that the minor plaintiffs in this case "will suffer actual and imminent injury in the form of emotional and psychological harm as well as unwanted physical changes if they are deprived access to treatment of their gender dysphoria under SB1."[523]

In July 2023, a divided panel of the Sixth Circuit stayed Judge Richardson's preliminary injunction, pending its further consideration on the district court's decision.[524] On September 28, 2023, the Sixth Circuit reversed the preliminary injunctions issued by the district courts in Tennessee and Kentucky and provided a more extensive opinion.[525] In analyzing the plaintiffs' due process claims, the Sixth Circuit relied heavily on *Washington v.*

518. *Id.* at 682–98.
519. *Id.* at 708–10.
520. *Id.* at 708–09.
521. *Id*. at 707–08.
522. *Id.* at 698–701, 706–07.
523. *Id.* at 56–57.
524. L.W. *ex rel.* Williams v. Skrmetti, 73 F.4th 408, 422 (6th Cir. 2023).
525. L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 491 (6th Cir. 2023).

Glucksberg's approach to describing the asserted right and its "history and traditions" methodology.[526] The panel opined that the plaintiffs were claiming constitutional protection for a "new" right that does not fall within the scope of parental authority to make healthcare decisions for their minor children. While the plaintiffs claimed, and the district court held, that the due process right at issue was parents' fundamental right to direct the medical care of their children,[527] the Sixth Circuit recharacterized the asserted right as one of "preventing governments from regulating the medical profession in general or certain treatments in particular."[528] It further redefined the right as a parental right to "obtain banned medical treatments for their children and to override contrary legislative policy judgments in the process."[529] The Sixth Circuit concluded that "[t]his country does not have a 'deeply rooted' tradition of preventing governments from regulating the medical profession, or specific treatments, whether for adults or their children,"[530] nor does it "have a custom of permitting parents to obtain banned medical treatments for their children and to override contrary legislative policy judgments in the process."[531] Therefore, it held that parental decisional authority regarding gender-affirming medical care for their children is not sufficiently rooted in our history and traditions to shield it from the state's regulation.[532]

The panel determined that substantial deference was due to the state in its regulatory policies, particularly where "medical and scientific uncertainty" exist.[533] The court explicitly rejected plaintiffs' "[i]nvocation of medical associations and other experts in the medical community," asserting that there is an "absence of judicially manageable standards for ascertaining whether a treatment is "established" or "necessary."[534] The panel applied a rational basis test to the plaintiffs' due process and equal protection claims, rejecting the district court's analyses related to the need for heightened scrutiny.[535]

Judge Helene White authored a lengthy dissent, concluding that the statutes "discriminate based on sex and gender conformity and intrude on the well-established province of parents to make medical decisions for their minor children."[536] She rejected the majority's reframing of the due process right, and concluded that there is no basis to distinguish the parental decisions at issue in these cases from the healthcare decisions traditionally relegated to parents and

526. *Id*. at 472–73.
527. *Id.* at 469.
528. *Id.* at 473.
529. *Id.* at 475.
530. *Id.* at 473.
531. *Id.* at 475.
532. *Id.*
533. *Id.* at 510. For further discussion of *Glucksberg* and its methodology, *see infra* Part IV.A.
534. *Id.* at 478.
535. *Id.* at 486.
536. *Id.* at 491–92 (White, J., dissenting).

protected as fundamental under the Due Process Clause.[537] While acknowledging the majority's point that parental authority to make healthcare decisions for their children can be limited by the state in some instances, she asserted that "a state cannot simply deem a treatment harmful to children without support in reality and thereby deprive parents of the right to make medical decisions on their children's behalf. Allowing the state to do so is tantamount to saying there is no fundamental right."[538]

In November 2023, the plaintiffs in *Skrmetti* petitioned the U.S. Supreme Court to review the Sixth Circuit's opinion and to consider the following questions:

> Whether Tennessee's SB1, which categorically bans gender-affirming healthcare for transgender adolescents, triggers heightened scrutiny and likely violates the Fourteenth Amendment's Equal Protection Clause.
>
> Whether Tennessee's SB1 likely violates the fundamental right of parents to make decisions concerning the medical care of their children guaranteed by the Fourteenth Amendment's Due Process Clause.[539]

A petition for certiorari seeking review of the Sixth Circuit decision was also filed in November 2023 by the plaintiffs in *Doe*, the challenge to the Kentucky statute, raising generally similar questions.[540]

3. *The Eleventh Circuit*

In *Eknes-Tucker v. Marshall*,[541] plaintiff minors, parents, and healthcare providers challenged Alabama's "Vulnerable Child Compassion and Protection Act," raising claims similar to those raised by plaintiffs in the Eighth and Sixth Circuits, with one notable exception. In *Eknes-Tucker*, the plaintiffs challenged only those sections of the Alabama statute that proscribed gender-affirming medical care (that is, puberty-suppressing medications and gender-affirming hormonal treatment).[542] They did not challenge the provisions that proscribe gender-affirming surgical care.[543] In *Eknes-Tucker*, the U.S. Department of Justice intervened on behalf of the plaintiffs, filing its own motion to enjoin enforcement and participating in the hearing for a preliminary injunction.[544]

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537. *Id.*

538. *Id.* at 511.

539. L.W. *ex rel.* Williams v. Skrmetti, 2023 WL 7327440 (Nov. 6, 2023) (petition for writ of certiorari).

540. Doe v. Kentucky *ex rel.* Cameron, 2023 WL 7327440 (Nov. 6, 2023) (petition for writ of certiorari).

541. *See* Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131, 1137–38 (M.D. Ala. 2022) (enjoining temporarily enforcement of the Alabama statute), *vacated sub nom.* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205 (11th Cir. Aug. 21, 2023), *petition for reh'g en banc filed* Sept. 11, 2023, https://www.glad.org/wp-content/uploads/2023/09/2023-09-11-eknes-tucker-petition-for-rehearing.pdf.

542. *Id.* at 1137–38.

543. *Id.*

544. *Id.* at 1141.

In the District Court for the Middle District of Alabama, the plaintiffs and the United States as intervenor introduced multiple witnesses and substantial documentation in support of the safety and efficacy of gender-affirming medical care.[545] They challenged the legislative findings, some of which alleged that the treatments were "unproven [and] poorly studied," could lead to "numerous harmful effects" and that "[m]inors and often their parents . . . are unable to comprehend and fully appreciate the risk and life implications."[546] In addition, the court received, and referenced in the opinion, amicus briefs submitted by twenty-two healthcare organizations in support of plaintiffs, and fifteen states in support of defendants.[547] The state produced only one expert witness at trial who, by his own admission, had no clinical experience with TGD youth.[548]

The District Court indicated that it gave the testimony of that witness, Dr. Cantor, "very little weight" due to his lack of experience and knowledge related to gender-affirming medical care with minors.[549] Furthermore, it noted that the defendant's 23-year-old witness, who reported having taken hormone therapies for a year beginning at age 19, had been treated in a state other than Alabama.[550] After articulating the standards that must be met in order for the court to issue a preliminary injunction,[551] the court concluded that the parent plaintiffs were substantially likely to demonstrate that they have a fundamental right under the Due Process Clause of the Fourteenth Amendment to direct their children's medical care.[552] That right, the court stated, includes decisions to obtain treatment for gender dysphoria with gender-affirming medications in a manner consistent with accepted medical standards of care.[553]

The court concluded that the defendants produced "no credible evidence to show that transitioning medications are "experimental" or "jeopardize the health

545. *Id.* at 1141–42.

546. *Id.* at 1140 (citing S.B. 184, 2022 Reg. Sess. § 2 (Ala. 2022)).

547. Id. at 1141.

548. *Id.* at 1141. The state also called a twenty-three-year-old who took hormone therapies for gender dysphoria in another state as an adult at age nineteen, and who testified that she regrets that decision. *Id.*

549. *Id.* at 1142–43. Specifically, the court stated:

> On cross examination, however, Dr. Cantor admitted that: (1) his patients are, on average, thirty years old; (2) he had never provided care to a transgender minor under the age of sixteen; (3) he had never diagnosed a child or adolescent with gender dysphoria; (4) he had never treated a child or adolescent for gender dysphoria; (5) he had no personal experience monitoring patients receiving transitioning medications; and (6) he had no personal knowledge of the assessments or treatment methodologies used at any Alabama gender clinic. Accordingly, the Court gave his testimony regarding the treatment of gender dysphoria in minors very little weight.

Id.

550. *Id.* at 1143. It is noteworthy as well that this individual was an adult, not a minor, when she received her treatment.

551. To receive a preliminary injunction, a movant must show that: (1) he or she has a substantial likelihood of success on the merits; (2) he or she will suffer irreparable injury absent injunctive relief; (3) the threatened injury to him or her "outweighs whatever damage the proposed injunction may cause the opposing party; and (4) if issued, the injunction would not be adverse to the public interest." *Id.* at 1143.

552. *Id.* at 1144–45.

553. *Id.* at 1144–46.

and safety of minors suffering from gender dysphoria."[554] It referenced the positions of twenty-two major medical associations for support that the transitioning medications are "well-established, evidence-based treatments for gender dysphoria in minors," and observed that screening and consent processes are required of families prior to commencement of treatment.[555] While the court recognized the limits to parental authority, it was unpersuaded by the state's arguments that parental consent to gender-affirming medical treatment would exceed that authority, in that the treatment was not "experimental," and did not present risks beyond those attendant to many forms of treatment.[556] It observed: "Certainly, the science is quickly evolving and will likely continue to do so. But this is true of almost every medical treatment regimen. Risk alone does not make a medication experimental."[557]

Applying strict scrutiny, the court concluded that the state failed to demonstrate that the it had "genuinely compelling justifications" related to the health and safety of minors with gender dysphoria that would justify restricting these parental rights.[558] It also observed that the Alabama statute was not narrowly tailored to achieve that interest.[559] The court also concluded that the plaintiffs were substantially likely to succeed on the merits of their equal protection claim of discrimination on the basis of sex.[560] The court granted the preliminary injunction after determining that the threat of irreparable harm to plaintiffs was substantial and outweighed any adverse impact on the public interest if the preliminary injunction was granted.[561]

In August 2023, on appeal to the Eleventh Circuit, a three-judge panel vacated the lower court's decision and order.[562] The Eleventh Circuit panel held that plaintiffs had not succeeded in demonstrating "the existence of a constitutional right to 'treat [one's]children with transitioning medications subject to medically accepted standards.'"[563] Relying heavily on the Supreme Court's opinion in *Dobbs v. Jackson Women's Health Organization*, the panel applied a "history and traditions" analysis to the plaintiffs' claims that narrowly circumscribed the definition of the underlying right at issue.[564] It reviewed the relevant precedents that establish parental authority to make health care and other important decisions affecting their children's welfare.[565] Yet, because none

554 *Id.* at 1145.

555. *Id.* at 1145–46.

556. *Id.* at 1144–45.

557. *Id.* at 1144.

558. *Id.* at 1145–46.

559. *Id.*

560. *Id.* at 1146–48.

561. *Id.* at 1148–50.

562. Eknes-Tucker v. Governor of Alabama, 80 F.4th 1205, 1211 (11th Cir. Aug. 21, 2023), *petition filed for reh'g en banc filed* Sept. 11, 2023, https://www.glad.org/wp-content/uploads/2023/09/2023-09-11-eknes-tucker-petition-for-rehearing.pdf.

563. *Id.* at 1210.

564. *Id.* at 1219–26.

565. *Id.*

of those cases dealt with gender-affirming care, the Eleventh Circuit panel held that plaintiffs had failed to cite authority that parental decisions regarding gender-affirming care were protected under this line of cases.[566] After determining that parental choices about their minor children's gender-affirming health care were not protected as fundamental, it applied rational basis review to the statutory challenges.[567]

The Eleventh Circuit summarized the testimony of the expert witnesses below when recounting the procedural history of the case.[568] The court did not reference the evidence presented by the plaintiffs' witnesses, nor the trial court's concerns about the lack of qualification of the defendants' witnesses. Rather, the court appeared to defer to the state's factual assertions about gender-affirming medical care when concluding that the state has a compelling interest in protecting minors' health and safety in the context of such treatment, and that the state's restrictions are rationally related to that interest:

> It is well established that states have a compelling interest in "safeguarding the physical and psychological well-being of . . . minor[s]." . . . . In the same vein, states have a compelling interest in protecting children from drugs, particularly those for which there is uncertainty regarding benefits, recent surges in use, and irreversible effects. Although rational speculation is itself sufficient to survive rational basis review, here Alabama relies on both record evidence and rational speculation to establish that section 4(a)(1)–(3) is rationally related to that compelling state interest. First, the record evidence is undisputed that the medications at issue present *some* risks. As the district court recognized, these medications can cause "loss of fertility and sexual function." The district court also acknowledged testimony that "several European countries have restricted treating minors with transitioning medications due to growing concern about the medications' risks." Second, there is at least rational speculation that some families will not fully appreciate those risks and that some minors experiencing gender dysphoria ultimately will desist and identify with their biological sex. Section 4(a)(1)–(3) addresses these risks by prohibiting the prescription and administration of puberty blockers and cross-sex hormone treatment to a patient under the age of nineteen for purposes of treating discordance between biological sex and sense of gender identity so that children will have more time to develop their identities and to consider all of the potential consequences before moving forward with such treatments. That connection would be sufficient under rational basis review.[569]

The Eleventh Circuit panel's conclusion relied on a narrow construction of the right at issue in the case:

566. *Id.* at 1220–21.
567. *Id.* at 1225.
568. *Id.* at 1213–18.
569. *Id.* at 1225.

> In sum, Plaintiffs' assertion that the Constitution protects the right to treat one's children with puberty blockers and cross-sex hormone therapy is precisely the sort of claim that asks courts to "break new ground in [the] field [of Substantive Due Process]" and therefore ought to elicit the "utmost care" from the judiciary. The district court held that there is a specific right under the Constitution "to treat [one's] children with transitioning medications subject to medically accepted standards," but did so without performing any analysis of whether that specific right is deeply rooted in our nation's history and tradition. Instead, the district court grounded its ruling in an unprecedented interpretation of parents' fundamental right to make decisions concerning the "upbringing" and "care, custody, and control" of one's children. That was error. Neither the record nor any binding authority establishes that the "right to treat [one's] children with transitioning medications subject to medically accepted standards" is a fundamental right protected by the Constitution. And, assuming it is not, then section 4(a)(1)–(3) is subject only to rational basis review—a lenient standard that the law seems to undoubtedly clear. Because the district court erroneously reviewed section 4(a)(1)–(3) with heightened scrutiny, its determination regarding the Parent Plaintiffs' likelihood of success does not justify the preliminary injunction.[570]

These analyses are examined in light of constitutional precedent in Part IV, below.

In 2023, prior to the Eleventh Circuit panel's decision in *Eknes-Tucker*, two federal district courts in Georgia and Florida, respectively, also issued temporary injunctions against the statutes in those states.[571] Although no orders limiting these injunctions have been issued at the time of this writing, it is likely that the Eleventh Circuit will apply *Eknes-Tucker* when considering any appeals to the district court decisions by Florida and Georgia.[572]

4. *Other Litigation*

The U.S. District Court for the Southern District of Indiana, which sits in the Seventh Circuit, enjoined the Indiana statute's prohibition on providing gender-affirming medical care, but permitted enforcement of the prohibition of gender-affirming surgical care in *K.C. v. Medical Licensing Board of Indiana*.[573] On December 26, 2023, the U.S. District Court for the District of Idaho, which sits in the Ninth Circuit, ruled on plaintiffs' motion for a preliminary injunction

570. *Id.* at 1225–26.

571. Doe v. Ladapo, 2023 WL 3833848, at *1 (U.S. Dist. Ct, N.D. Fla. 2023), *appeal filed*, No. 23-12159 (11th Cir. June 27, 2023); Koe v. Noggle, 2023 WL 5339281, at *1 (N.D. Ga. 2023) (granting preliminary injunction).

572. Florida filed an appeal of the district court decision to the Eleventh Circuit in June 2023. The Georgia case, *Koe v. Noggle*, was decided only one day before the Eleventh Circuit issued its opinion in *Eknes-Tucker*. At the time of this writing, no appeal has yet been filed in *Koe v. Noggle*.

573. K.C. v. Med. Licensing Bd. of Ind., No. 1:23-CV-00595, 2023 WL 4054086, at *1 (S.D. Ind. 2023) (granting preliminary injunction in part), *appeal filed*, No. 23-2366 (7th Cir. July 12, 2023).

on enforcement of Idaho's statute.[574] The court held that parents have a "fundamental right to care for their children" that "includes the right to choose a particular medical treatment, in consultation with their healthcare provider, that is generally available and accepted in the medical community."[575] At the time of this writing, no litigation challenging Arizona's (also in the Ninth Circuit) restriction on gender-affirming surgical care for minors has been filed. In the Tenth Circuit, on October 5, 2023, the federal district court in the Northern District of Oklahoma denied plaintiffs petition for a preliminary injunction in *Poe v. Drummond*.[576] In the Fourth Circuit, on October 11, 2023, plaintiffs filed suit against the North Carolina Medical Board, seeking declaratory and injunctive relief, in *Voe v. Mansfield*.[577] There do not appear to be active federal challenges to the statute in West Virginia, the other state within the Fourth Circuit, or in Mississippi, which sits in the Fifth Circuit.

Plaintiffs have challenged several of the statutes in state court, claiming violations of state Constitutions.[578] Although plaintiff minors, parents, and healthcare providers were successful in *Loe v. Texas* in their motion for a preliminary injunction to pause enforcement of the Texas statute that prohibits gender-affirming medical and surgical care, the injunction was stayed after the Texas attorney general filed an appeal to the Texas Supreme Court.[579] Claims have been filed in the state courts in Louisiana, Missouri, North Dakota, and Montana challenging state prohibitions of gender-affirming care under state Equal Protection and Due Process Clauses, as well as additional state constitutional provisions.[580] Claims have also been filed in Nebraska

574. Pam Poe v. Raúl Labrador, Case 1:23-CV-00269, 2023 WL 8935065 (D. Idaho Dec. 26, 2023) (granting preliminary injunction against section 18-1506C), *aff'd* Poe *ex rel.* Labrador, No. 1:23-CV-00269, 2024 WL 170678 (D. Idaho Jan. 16, 2024) (denying stay of preliminary injunction pending appeal).

575. Poe v. Labrador, 2023 WL 8935065, at *15-16.

576. Poe v. Drummond, Case No. 23-CV-00177, 2023 WL 6516449 (N.D. Okla. Oct. 5, 2023), *appeal filed* Oct. 10, 2023, 2023 WL 6516449 (10th Cir. 2023)

577. Complaint for Declaratory and Injunctive Relief at 2, Voe v. Mansfield, 1:23-CV-00864, (M.D.N.C.,) (complaint filed Oct. 11, 2023).

578. For discussion of the potential role of state constitutions in the protection of rights to access gender-affirming care, *see* Jessica Matsuda, *Leave Them Kids Alone: State Constitutional Protections for Gender-Affirming Healthcare*, 79 WASH. & LEE L. REV. 1597 (2022).

579. Loe v. Texas, D-1-GN-23-003616, 2023 WL 5519799 (Tex. Dist.) (granting preliminary injunction), *appeal filed* (Travis Cnty. Dist. Ct., Texas Aug. 28, 2023).

580. Soe v. Louisiana State Bd. of Med. Examiners, petition for declaratory and filed Jan. 8, 2024, https://lambdalegal.org/wp-content/uploads/2024/01/LA-Verified-Petition-FINAL-01.08.2024-SIGNED.pdf; Motion for Preliminary Injunction, Noe v. Parson, 23AC-CC04530 (Cir. Ct., Cole Cnty., Mo., July 25, 2023), https://lambdalegal.org/wp-content/uploads/2023/07/SB-49-PI-Memo-Final-7-25-23.pdf; Complaint, Van Garderen v. Montana, DV-32-2023-0000541-CR (Mont. Dist. Ct., July 17, 2023) (challenging Montana Senate Bill 99 as unconstitutional under the Montana Constitution, requesting declarative and injunctive relief), https://www.aclu.org/cases/van-garderen-et-al-v-state-of-montana; Complaint, T.D. v. Wrigley (N.D. Dist. Ct., Sept. 14, 2023) (challenging North Dakota Century Code § 12.1-36.1 as unconstitutional under North Dakota Constitution and requesting declarative and injunctive relief), https://www.genderjustice.us/work/td-v-wrigley.

challenging the state constitution's single subject requirement because the statute sought to regulate both gender-affirming care and abortion.[581]

IV. THE CONSTITUTIONALITY OF MEASURES RESTRICTING ACCESS TO GENDER-AFFIRMING CARE FOR MINORS

In Subpart IV.A, I examine constitutional doctrine cited by the courts that have considered federal challenges to the statutes described in Part II. In Subpart IV.B, I analyze these courts' application of that doctrine. I focus specifically on the whether the challenged measures unconstitutionally limit parental authority to make health care decisions for their children. I consider the willingness of some courts to give weight to unsubstantiated assertions by the states and their "experts" regarding the alleged dangers to children presented by gender-affirming care. Most trial courts adjudicating requests for preliminary injunctions, while not explicitly referencing *Daubert* or the *Federal Rules of Evidence*, give little weight to testimony by persons without expertise on the relevant subject matter and who do not provide credible scientific support for their assertions.[582] Those courts detail, and weigh more heavily, the testimony of plaintiffs' experts, whose testimony is grounded in appropriate professional qualifications and the research literature published in scientific journals and relied upon by major professional healthcare organizations. By contrast, of the three federal circuit courts considering appeals of the decisions to grant preliminary injunctions, only the Eighth Circuit based its findings of medical and scientific facts on evidence that would likely have satisfied the *Daubert* and FRE 702 requirements.[583]

581. Planned Parenthood of Heartland v. Hilgers, D02 CI 230001820 (Lancaster Cnty. Dist. Ct., Neb. 2023) (denying preliminary injunction).

582. *See supra* Part III.B.

583. In these cases, neither the trial or appellate court explicitly reference *Daubert* or FRE 702. As noted earlier, *supra* note 374, there is a lack of clarity as to whether the *Federal Rules of Evidence* must be followed in adjudicating motions for preliminary injunctions. See Wittlin, *supra* note 374, at 1336–47. Wittlin's review indicated variable application of the *Federal Rules of Evidence* in the federal district courts in such cases, with variance as to whether the courts have explicitly considered whether specific rules apply. *Id.* at 1340–47. These findings extended to application of *Daubert* and Rule 702 when adjudicating requests for preliminary injunctions. Wittlin found that some courts have declined to apply them, but "often consider the parties' *Daubert* arguments when weighing the testimony [or determining if] the evidence should receive any weight." *Id.* at 1345 & nn.101–102. She also found that "[a] substantial number of courts . . . have applied *Daubert* at the preliminary injunction phase. On occasion, judges have even deemed experts unqualified to testify at this stage and excluded their testimony." *Id.* at 1346. Wittlin notes:

> In none of the cited cases did the court consider whether the Rule should *not* apply at the preliminary injunction phase. From all appearances, it seems that one party moved to exclude the witness's testimony, the other party responded with its own *Daubert* arguments, and the court resolved the evidentiary dispute under Rule 702.

Id.

In other words, absent a formal *Daubert* challenge by one side to testimony offered by the other side, some federal courts bring a somewhat more relaxed or informal approach to the "gatekeeper" role required by the

A. THE SPECTER OF *DOBBS*, "HISTORY AND TRADITION," AND NARROW CIRCUMSCRIPTION OF THE UNDERLYING RIGHT

As reviewed in Subparts III.B.2 and III.B.3 above, the Sixth and Eleventh Circuit decisions relied heavily on *Dobbs v. Jacksonville Women's Health Organization*,[584] and other cases cited with approval in *Dobbs*.[585] *Dobbs* left many questions unanswered about the future of substantive due process analysis as applied to legal questions not involving abortion. In *Dobbs*, reversing fifty years of established constitutional jurisprudence, the U.S. Supreme Court held that the right of individuals to access abortion was not protected as a fundamental liberty interest by the Fourteenth Amendment of the U.S. Constitution.[586] In excoriating its own decisions in *Roe v. Wade*[587] and *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[588] the Court rejected its prior holdings that the right to choose an abortion, subject to the Court's framework recognizing certain competing state interests, was protected under the Fourteenth Amendment. In doing so, however, the Court implicitly raised questions about the substantive due process methodology. Substantive due process doctrine has, over the past one hundred years, served as the basis for a range of protections, including parental authority to make decisions regarding the upbringing of their children,[589] rights to marry the partner of one's choice,[590] rights to engage in private consensual intimate sexual relations free from government interference,[591] rights to access contraception,[592] and rights to refuse unwanted healthcare interventions.[593] Although some of the cases establishing protection for these rights also incorporated equal protection considerations,[594] while others veered from application of tiered scrutiny,[595] the Court grounded

Rules and *Daubert*. Yet, in the face of an evidentiary challenge by one of the parties, Wittlin's review indicates that the courts will apply FRE 702 and *Daubert*.

584. 142 S. Ct. 2228 (2022).

585. *See supra* Parts III.B.2–3.

586. *Id.* at 2242–85.

587. 410 U.S. 113 (1973).

588. 505 U.S. 833 (1992).

589. *See supra* Part II.A.

590. Loving v. Virginia, 388 U.S. 1 (1967); Obergefell v. Hodges, 567 U.S. 644 (2015).

591. Lawrence v. Texas, 539 U.S. 558 (2003).

592. Griswold v. Connecticut, 381 U.S. 479 (1965); Eisenstadt v. Baird, 405 U.S. 438 (1972).

593. *See, e.g.*, Cruzan v. Dir. Missouri Dep't of Health, 497 U.S. 261 (1990); Washington v. Harper, 494 U.S. 410 (1990); Vitek v. Jones, 445 U.S. 480 (1980). The Court has at times qualified its decisions when applying the principle that the right to refuse unwanted health care interventions is protected under the Due Process Clause. For example, it states in *Cruzan*, that it has "assumed" and "inferred" the existence of this right. 497 U.S. at 279.

594. *Loving*, 388 U.S. at 1; *Obergefell*, 567 U.S. at 644.

595. *See, e.g.*, *Lawrence*, 539 U.S. at 558 (examining the meaning of liberty under the Due Process Clause without applying or explicitly rejecting tiered scrutiny review); *Cruzan*, 497 U.S. at 279 (applying a balancing test: "determining that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry; 'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests'").

its decisions in each of these areas in the Fourteenth Amendment's protection of liberty, loyally applying substantive due process doctrine.

In reaching its revised conclusion in *Dobbs*, the Court relied on a methodology that has been far more controversial and contested than the discussion in *Dobbs* reveals.[596] The Court stated that the Due Process Clause "has been held to guarantee some rights that are not mentioned in the Constitution, but any such right must be 'deeply rooted in this Nation's history and tradition' and 'implicit in the concept of ordered liberty.'"[597] In support of the "history and tradition" methodology in substantive due process analysis, the Court cited *Washington v. Glucksberg*, the 1997 case in which the Court held the Due Process Clause does not preclude state criminalization of physician assisted suicide (referred today as physician or medical aid in dying).[598] *Glucksberg* had relied on several other cases for this doctrinal requirement.[599] Yet, the *Glucksberg* methodology has not been as consistently followed in the Court's substantive due process jurisprudence as the *Dobbs* opinion implies.[600]

596. Referring to the "history-and-traditions standard" employed by the Court in *Dobbs* as "remarkably broad and polarizing," Reva Siegel observes that "the Court transformed doctrinal standards for determining the scope of the Fourteenth Amendment's liberty guarantee, without acknowledging that it had just changed the scope of constitutionally protected liberties, or why." Reva B. Siegel, *Memory Games:* Dobbs*'s Originalism as Anti-Democratic Living Constitutionalism-and Some Pathways for Resistance*, 101 TEX. L. REV. 1127, 1181 (2023). For additional commentaries on the Court's reinvigoration of the "history and traditions" methodology in *Dobbs*, and analyses as to its possible extensions, see, for example, Reva B. Siegal, *The History of History and Tradition: The Roots of Dobb's Method (and Originalism) in Defense of Segregation*, 133 YALE L.J. 99 (2023), https://www.yalelawjournal.org/forum/the-history-of-history-and-tradition-the-roots-of-dobbss-method-and-originalism-in-the-defense-of-segregation; Randy E. Barnett & Lawrence B. Solum, *Originalism after* Dobbs*,* Bruen*, and* Kennedy*: The Role of History and Tradition*, 118 NW. U. L. REV. 433 (2023); Cass R. Sunstein, Dobbs *and the Travails of Due Process Traditionalism* (Harvard Pub. L., Working Paper No. 22-14, 2023).

597. Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 238 (2022).

598. 521 U.S. 702 (1997). At the time of *Glucksberg*, the medical intervention plaintiffs sought to decriminalize was referred to as "physician assisted suicide." Since that time, the terminology has changed. States legalizing the procedure and proponents refer to it as "death with dignity," "physician/medical aid in dying," or "physician/medically assisted death." Those who support its availability view it not as suicide, but as the right of individuals to control the timing and manner of a death that will occur inevitably within six months from a terminal illness. For a discussion of this shift in terminology and a broader examination of statutory adoption of such statutes in the United States, see Lois A. Weithorn, *Psychological Distress, Mental Disorder, and Assessment of Decisionmaking Capacity Under U.S. Medical Aid in Dying Statutes*, 71 HASTINGS L.J. 637, Part I & n.5 (2020).

599. The *Glucksberg* court cited *Snyder v. Massachusetts* for the proposition that a right must be "so rooted in the traditions and conscience of our people as to be ranked as fundamental," 291 U.S. 97, 105 (1934), and *Palko v. Connecticut* for the proposition that the right must be "implicit in the concept of ordered liberty," 302 U.S. 319, 325, (1937), such that "neither liberty nor justice would exist if they were sacrificed." Washington v. Glucksberg, 521 U.S. 702, 720–21 (1997).

600. Arguably, the Court's approach has been inconsistent, at best. *See, e.g.*, Yale Kamisar, *Foreword: Can* Glucksberg *Survive* Lawrence*? Another Look at the End of Life and Personal Autonomy*, 106 MICH. L. REV. 1453, 1455, 1466–67 (2008) (recognizing *Lawrence's* implicit rebuke of the *Glucksberg* methodology in its critique of *Bowers v. Hardwick*, 478 U.S. 186 (1986), while citing other reasons why the Court is not likely to hold that the Constitution protects the right of individuals to receive physician aid in dying); Ronald Turner, *W(h)ither* Glucksberg*?*, 15 DUKE J. CONST. L. & PUB. POL'Y 183 (2020). *But see*, MacDonald v. Chicago, 561 U.S. 742, 767–70 (2010) (applying *Glucksberg*'s "history and traditions" approach to determine that the

Bowers v. Hardwick,[601] a key predecessor to *Glucksberg*, applied the same rigid form of this methodology used in *Dobbs*, but the decision ultimately met an ignominious demise in 2003 when the Court in *Lawrence v. Texas* emphatically reversed it.[602] In so doing, the Court explicitly rejected its own prior rigid application of the "history and tradition" methodology as applied in *Hardwick*.[603]

Specifically, in *Glucksberg*, the Court concluded that criminalization of assisting a suicide has been a tradition under Anglo-American law for over 700 years, and that it remained virtually universally prohibited in the States and Western democracies.[604] Such an analysis, according to the *Glucksberg* Court, informed the question of whether the liberty interest claimed by the plaintiffs in that case was one protected as fundamental under the U.S. Constitution.[605] In 1986, a decade earlier, the Court in *Bowers v. Hardwick* relied on its "history and tradition" analysis to hold that same-sex partner intimate conduct fell outside the purview of due process protections, concluding that laws proscribing the rights of "homosexuals to engage in acts of consensual sodomy" "have ancient roots," and that "[s]odomy was a criminal offense at common law and was forbidden by the laws of the original thirteen States when they ratified the Bill of Rights."[606] In *Lawrence*, however, Justice Kennedy stated that "history and tradition are the starting point but not in all cases the ending point of the substantive due process inquiry."[607] In addition, he implied that "history and tradition," when relevant, need not look back for reference solely to "ancient" times, or to the point at which the relevant constitutional provision was adopted.[608] Rather, he concluded: "In all events we think that our laws and traditions in the past half century are of most relevance here. These references show an emerging awareness that liberty gives substantial protection to adult persons in deciding how to conduct their private lives in matters pertaining to sex."[609] Justice Kennedy reinforced this perspective of the role of the history and traditions methodology in the Court's substantive due process jurisprudence in *Obergefell v. Hodges*, where the Court held that state laws excluding same-sex partners from entering legally-recognized marriage were unconstitutional.[610] In

Second Amendment's protections are applicable to the states under the Fourteenth Amendment's incorporation doctrine, citing *District of Columbia v. Heller*, 554 U.S. 570 (2008) for the conclusion that individual rights to self-defense through handgun ownership and use is "deeply rooted in this Nation's history and traditions").

601. *Hardwick*, 478 U.S. at 186.

602. 539 U.S. 558 (2003).

603. *Id.*

604. *Id.* at 710–11.

605. *Id.* at 719–22.

606. 478 U.S. at 191-2.

607. 539 U.S. at 572 (quoting Sacramento v. Lewis, 523 U.S. 833, 857 (1998) (Kennedy, J., concurring)).

608. *Id.* at 570–72. *See also* Darren Lenard Hutchinson, *Thinly Rooted:* Dobbs*, Tradition and Reproductive Justice*, 65 ARIZ. L. REV. 385, 396–405 (2023) (arguing that the notion that a tradition is "deeply-rooted" in American values and concepts of liberty does not necessarily require a narrow and backward-looking approach).

609. *Lawrence,* 539 U.S. at 571–72.

610. *Obergefell*, 576 U.S. at 664.

this context, he stated that "history and tradition guide and discipline this inquiry but do not set its outer boundaries. That method respects our history and learns from it without allowing the past alone to rule the present."[611] Recognizing the restrictive impact that a backwards-looking methodology could have on the protection of liberties, he opined: "The nature of injustice is that we may not always see it in our own times."[612]

In contrast to the *Hardwick*, *Glucksberg*, and *Dobbs*' majorities' reliance on some version of an originalist application of the "history and tradition" methodology for discovering which rights are protected under the Due Process Clause, *Lawrence* and *Obergefell* reflect a more dynamic approach to constitutional interpretation, which views the Constitution as a "living" document that can evolve over the centuries through interpretation.[613] This approach, arguably dominant in substantive due process jurisprudence over the past one hundred years, was articulated explicitly in *Lawrence*'s penultimate paragraph:

> Had those who drew and ratified the Due Process Clauses of the Fifth Amendment or the Fourteenth Amendment known the components of liberty in its manifold possibilities, they might have been more specific. They did not presume to have this insight. They knew times can blind us to certain truths and later generations can see that laws once thought necessary and proper in fact serve only to oppress. As the Constitution endures, persons in every generation can invoke its principles in their own search for greater freedom.[614]

Hardwick, *Glucksberg*, and *Dobbs* were also plagued with definitions of the rights at issue in the cases in a manner that all but guaranteed that the right would not be found to be deeply rooted in our Nation's history and traditions.[615] *Hardwick* asked the question of whether our nation had historically and traditionally valued and protected the rights of "homosexuals to engage in acts of consensual sodomy," and whether the claimed liberty to engage in such conduct is "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [they] were sacrificed."[616] Of course, framing the definition of the underlying right in this way dooms any attempt to recognize the right as constitutionally protected under the Due Process Clause. By contrast, *Lawrence* framed the right in a manner that illustrated the evolution and

611. *Id.*

612. *Id.*

613. *See, e.g.*, Reva Siegel, *The History of History and Tradition: The Roots of* Dobbs*'s Method (and Originalism) in the Defense of Segregation*, 133 YALE L.J. FORUM 99, 139 (2023). For further discussion of the notion of a living Constitution, see, for example, DAVID A. STRAUSS, THE LIVING CONSTITUTION (2010).

614. *Id.* at 578–79.

615. Kenji Yoshino, *A New Birth of Freedom?:* Obergefell v. Hodges, 129 HARV. L. REV. 147, 154 (2015) (describing Justice Scalia's "careful description of the right" methodology, as elaborated in the plurality opinion in *Michael H. v. Gerald D.*, 491 U.S. 110 (1989), and *Glucksberg*).

616. Bowers v. Hardwick, 478 U.S. 186, 191–92 (1986), *overruled by* Lawrence v. Texas, 539 U.S. 558 (2003).

historical continuity of the broader right of individuals to make personal choices about intimate aspects of their lives, as in the case of one's choice of intimate sexual partner.[617] It further emphasized that the views about the morality of such conduct, held by some segments of society, had no place guiding constitutional decisions when the underlying conduct did not present harm to others.[618]

The right at issue in *Glucksberg* was characterized by the majority as a right to receive medical assistance in committing suicide.[619] By contrast, the Ninth Circuit en banc panel construed the statute "as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians."[620] Likewise in *Dobbs*, the Court's dual methodological choices—rigidly applying a "history and traditions" analysis that focuses on a point in time 150 years ago, and narrowly characterizing the right as a right to abortion rather than a right to make important decisions about one's health, or a right to bodily integrity—predetermined the Court's ultimate conclusion.

Justice Breyer, in his *Dobbs* dissent, elaborates about how the Court, in recent decades, had rejected the *Glucksberg*, *Hardwick*, and *Dobbs* interpretive approach:

> [I]n the words of the great Chief Justice John Marshall, our Constitution is "intended to endure for ages to come," and must adapt itself to a future "seen dimly," if at all. That is indeed why our Constitution is written as it is. The Framers (both in 1788 and 1868) understood that the world changes. So they did not define rights by reference to the specific practices existing at the time. Instead, the Framers defined rights in general terms, to permit future evolution in their scope and meaning. And over the course of our history, this Court has taken up the Framers' invitation. It has kept true to the Framers' principles by applying them in new ways, responsive to new societal understandings and conditions.
>
> Nowhere has that approach been more prevalent than in construing the majestic but open-ended words of the Fourteenth Amendment—the guarantees of "liberty" and "equality" for all. And nowhere has that approach produced prouder moments, for this country and the Court. Consider an example *Obergefell* used a few years ago. The Court there confronted a claim, based on *Washington v. Glucksberg*, that the Fourteenth Amendment "must be defined in a most circumscribed manner, with central reference to specific historical practices"—exactly the view today's majority follows. And the Court specifically rejected that view. In doing so, the Court reflected on what the proposed, historically circumscribed approach would have meant for interracial marriage. The Fourteenth Amendment's ratifiers did not think it gave black and white people a right to marry each other. To the

617. 539 U.S. 558, 573–74 (2003).
618. *Id.* at 571–78.
619. Washington v. Glucksberg, 521 U.S. 702, 710–20 (1997).
620. *Id.* at 709.

> contrary, contemporaneous practice deemed that act quite as unprotected as abortion. Yet the Court in *Loving v. Virginia*, read the Fourteenth Amendment to embrace the Lovings' union. If, *Obergefell* explained, "rights were defined by who exercised them in the past, then received practices could serve as their own continued justification"—even when they conflict with "liberty" and "equality" as later and more broadly understood. The Constitution does not freeze for all time the original view of what those rights guarantee, or how they apply.[621]

B. THE CONSTITUTIONALITY OF MEASURES RESTRICTING GENDER-AFFIRMING MEDICAL CARE: THE SPLIT IN THE CIRCUITS AND OPINIONS WHOLLY UNTETHERED FROM THE EVIDENTIARY RECORD

Most federal district courts reviewing state statutory bans or restrictions on gender-affirming care that considered due process claims by parents concluded that decisions regarding gender-affirming care fall within constitutionally protected parental authority to make health care decisions for their minor children and that therefore state measures must be reviewed with strict scrutiny.[622] Furthermore, the courts concluded that, in light of the record of scientific evidence, including expert opinions presented by both sides, and consensus positions by scientific and medical professional groups, the state failed to demonstrate a sufficient factual basis for its alleged need to protect children from gender-affirming medical care consented to by parents (and their children) provided in a manner consistent with the standards of care adopted by the healthcare community and its professional associations.[623] In addition, the district courts concluded that states had failed to demonstrate that the highly restrictive means they had adopted were necessary to achieve those ends.[624]

As noted above, a unanimous panel in the Eighth Circuit Court of Appeals affirmed the District Court decision to enjoin enforcement of the Arkansas statute, although it focused its decision on equal protection grounds.[625] By contrast, the Sixth and Eleventh Circuit panels, in reviewing the district court opinions in Tennessee and Kentucky (Sixth Circuit) and Alabama (Eighth Circuit), reversed the lower court decisions, and stayed the preliminary

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621. Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 372–73 (2022) (Breyer, J., dissenting) (citations and footnotes omitted). Charles A. Reich, in a discussion of former Justice Hugo Black's philosophy, addressed the relationship between a dynamic interpretation of the Constitution and its original meaning:

> [I]n a dynamic society the Bill of Rights must keep changing in its application or lose even its original meaning. There is no such thing as a constitutional provision with a static meaning. If it stays the same while other provisions of the Constitution change and society itself changes, the provision will atrophy. That, indeed, is what has happened to some of the safeguards of the Bill of Rights. A constitutional provision can maintain its integrity only by moving in the same direction and at the same rate as the rest of society. In constitutions, constancy requires change.

Charles A. Reich, *Mr. Justice Black and the Living Constitution*, 76 HARV. L. REV. 673, 735–36 (1963).

622. *See generally supra* Part III.B.

623. *See generally supra* Part IIII.B.

624. *See generally* supra Part III.B.

625. *See supra* Part B.1.

injunctions issued by the district courts. These circuit court decisions have created a split in the circuits.[626]

As discussed in Parts III.B. and IV.A., in determining whether the rights asserted by plaintiff minors and parents warrant protection under the Due Process Clause of the Fourteenth Amendment, the Sixth and Eleventh Circuit panels relied heavily upon *Dobbs* and *Glucksberg*. They applied a version of the "history and tradition" methodology and constructed overly narrow definitions of the underlying right. For example, in *Eknes-Tucker*, the Eleventh Circuit panel characterized the right at issue as the "right to treat [one's] children with transitioning medications subject to medically accepted standards" rather than a right of parents to make healthcare decisions for their children.[627] It asserted that this "specific right" is not "deeply rooted in our nation's history and tradition," and that the district court erred in viewing the plaintiffs' claims as encompassed within "parents' fundamental right to make decisions concerning the 'upbringing' and 'care, custody, and control' of one's children."[628]

Parental authority to make healthcare decisions for their minor children is well-established by the U.S. Supreme Court and is not a new or novel right.[629] There is no precedent for the Eleventh Circuit's proposed methodology to use the history or tradition of *the specific healthcare procedure* itself for the purpose of determining the standard of review to be applied to a law that restricts parental authority. Furthermore, the right of parents to exercise their judgment in making healthcare decisions for their children is arguably the narrower or more specific right within the broader category of parental authority to guide the upbringing of their minor children.[630] The illogic of the Eleventh Circuit's approach is stunning. The history of medical science is one of constant evolution and continuing advances. The implication that the Constitution only protects older, more "traditional" forms of medical intervention *would rob parents of the constitutional authority to make health care decisions for their children in areas in which there has been substantial and rapid medical progress*.

As demonstrated in Part II of this Article, parental authority to make healthcare decisions for their minor children can be limited by a state on the grounds that such limitation *is necessary to protect children from substantial risk of serious harm*. Yet, determinations of that risk, as well as assessments of countervailing benefits, must be grounded in scientific evidence and medical expertise.[631] In the context of healthcare decisionmaking for minor children, the state's interests and those of parents do not stand in equipoise. The constitutionally protected presumption of, and deference to, parental decisions

626. *See supra* Part III.B.
627. Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1224 (11th Cir. 2023).
628. *Id.* at 1225–26.
629. *See supra* Part II.A.
630. *See supra* Parts II.A–B.
631. *See supra* Part II.C.

about what type of treatment is best for their children limits the authority of the state to restrict such parental choices when the evidence does not clearly demonstrate that parental actions present substantial risk of serious harm.[632] The existence of some level of *uncertainty* about potential harms and benefits of a treatment—a circumstance that frequently accompanies new and important developments in medical science—is not a sufficient basis for blanket state rejection of parental authority. When parental judgment is aligned with a robust—albeit virtually unanimous—consensus of mainstream medical experts as to the safety of the proposed interventions, it is difficult to muster any reasonable basis for disturbing the traditionally respected default to parental discretion.

The Sixth Circuit envisioned the application of the "history and tradition" methodology differently than the Eleventh Circuit. In *L.W. v. Skrmetti*, the Sixth Circuit panel asserted that "[t]his country does not have a 'deeply rooted' tradition of preventing governments from regulating the medical profession in general or certain treatments in particular, whether for adults or their children."[633] The parents in *L.W.*, of course, did not seek to interfere with the normal regulatory process. Rather, they claimed that as parents, they were entitled to protection against state interference in their exercise of their parental responsibilities unless the state's purpose and means satisfy the appropriate level of constitutional scrutiny.[634] The Sixth Circuit analogized plaintiffs' claims to asserting a constitutional right to eschew all federal and state regulation of medical procedures, including drugs "that the FDA deems unsafe or ineffective."[635] Yet, the FDA has not deemed any of the drugs at issue in these

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632. *See supra* Parts II.A–B.

633. L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 473 (6th Cir. 2023), *appeal docketed*, No. 23-477 (Nov. 6, 2023).

634. The court, in *Skrmetti*, continues:

> Plaintiffs counter that, as parents, they have a substantive due process right "to make decisions concerning the care, custody, and control of their children." At one level of generality, they are right. Parents usually do know what's best for their children and in most matters (where to live, how to live, what to eat, how to learn, when to be exposed to mature subject matter) their decisions govern until the child reaches 18. But becoming a parent does not create a right to reject democratically enacted laws. The key problem is that the claimants overstate the parental right by climbing up the ladder of generality to a perch—in which parents control all drug and other medical treatments for their children—that the case law and our traditions simply do not support. Level of generality is everything in constitutional law, which is why the Court requires "a 'careful description' of the asserted fundamental liberty interest."

Id. at 475 (first quoting Troxel v. Granville, 530 U.S. 57, 66 (2000); and then citing Washington v. Glucksberg, 521 U.S. 702, 721 (1997) (quotation omitted in original)).

635. *Skrmetti*, 83 F.4th at 473. The court also noted:

> So described, no such tradition exists. The government has the power to reasonably limit the use of drugs, as just shown. If that's true for adults, it's assuredly true for their children, as also just shown. 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. Any other

cases to be unsafe or ineffective. The court highlights that the use of some of these medications for gender-affirming care is "off-label."[636] Yet, use of FDA-approved medications for purposes other than those listed in the package inserts is routine within standard medical practice.[637] In a 2014 policy statement, the American Academy of Pediatrics reaffirmed that "the term 'off-label' does not imply an improper, illegal, contraindicated, or investigational use."[638] Given the requirements necessary for FDA approval of a drug for each particular use, healthcare practitioners often ground prescribing decisions for drugs in the scientific literature, accepted standards of care, and treatment guidelines, even when there has not yet been an FDA determination regarding that use.[639] The need for off-label uses of drugs is often greater in pediatrics than in adult medicine, given that most initial drug approvals focus on adult populations.[640] Many federal and state courts, including the U.S. Supreme Court, have explicitly or implicitly recognized that off-label use of drugs and devices is a legal and acceptable aspect of medical practice.[641]

The Sixth Circuit panel stated that "[*i*]*nvocation of medical associations and other experts in the medical community does not alter*" its conclusion as to whether states have authority to prohibit parents from accessing gender-affirming care for their children.[642] The Sixth Circuit's disdain for medical expertise is palpable in its claim "that expert consensus, whether in the medical profession or elsewhere," if given weight in the fact-finding of the court, would

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> approach would not work. If 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 that point, either the parent would take charge of the regulation or the courts would. And all of this in an arena—the care of our children—where sound medical policies are indispensable and most in need of responsiveness to the democratic process.

Id. at 475.

636. *Id.* at 478 ("Gender-transitioning procedures often employ FDA-approved drugs for non-approved, 'off label' uses. Kentucky and Tennessee decided that such off-label use in this area presents unacceptable dangers.").

637. Christopher M. Wittich, Christopher M. Burkle & William L. Lanier, Ten Common Questions (and Their Answers) About Off-Label Drug Use, 87 Mayo Clin. Proc. 982, 983 (2012) (citing studies indicating rates of off-label prescribing, depending upon the area of medicine and population, to be between 21% to 47%).

638. Comm. on Drugs, Am. Acad. Pediatrics, *Policy Statement: Off-Label Use of Drugs*, 133 PEDIATRICS, no. 3, Mar. 2014, at 563.

639. *Id.* at 563–66. Wittich et al., *supra* note 637, at 982–85.

640. Comm. on Drugs, supra note 638, at 563–66. *See also* Wittich et al., *supra* note 637, at 983 (citing a study in which 78.9% of children discharged from pediatric hospitals were prescribed at least one off-label medication).

641. *See* James M. Beck, *Off-Label Use in the Twenty-First Century: Most Myths and Misconceptions Mitigated*, 54 UIC JOHN MARSHALL L. REV. 1, 14–18 (2021) (reviewing case law and citing Buckman Co. v. Plaintiffs Legal Committee, 531 U.S. 341, 349-51 (2001) as support the conclusion that the Court recognized the "legality and propriety" of off-label drug prescribing).

642. L.W. *ex rel* Williams v. Skrmetti, 83 F.4th 460, 477 (6th Cir. 2023) (emphasis in original).

turn judges into "spectators rather than referees in construing our Constitution."[643]

The Sixth Circuit asserted that there is an "absence of judicially manageable standards for ascertaining whether a treatment is 'established' or 'necessary.'"[644] Yet, there are "judicially manageable standards" for a court to inform itself as to the state of the science that is relevant to such determinations. The standards governing admissibility of scientific expert testimony, under the *Federal Rules of Evidence* as interpreted by the U.S. Supreme Court in *Daubert* and its progeny equip courts to exclude, or accord minimal weight to, proffered evidence by witnesses who are not qualified to opine on a particular matter, whose testimony is not the "product of reliable principles and methods," and whose conclusions do not reflect "a reliable application of the principles and methods to the facts of the case."[645]

The trial court judges in *L.W. v. Skrmetti* and *Doe v. Thornbury* in the Sixth Circuit, and in *Eknes-Tucker v. Marshall* in the Eleventh Circuit, engaged in careful evaluation of the evidence presented by both sides. They concluded that the testimony of the states' experts should be accorded minimal weight, and they relied heavily on the plaintiffs' experts. Neither the Sixth or Eleventh Circuit panels directly acknowledged the inconsistency of their own and the trial courts' evidentiary judgments.

The *Skrmetti* court focused repeatedly on what it referred to as "medical and scientific uncertainty"[646] as a basis for deference to state regulation. The concept of "medical and scientific uncertainty" prominently figured into the Supreme Court's decision in *Gonzales v. Carhart*, in which the Court considered the constitutionality of the federal Partial-Birth Abortion Act of 2003.[647] The Court indicated that the "prohibition in the Act would be unconstitutional . . . if it subject[ed women] to significant health risks."[648] It considered the question a factual one, and observed that contradictory evidence had been presented at the trial court concluding that "[t]here is documented medical disagreement whether the Act's prohibition would ever impose significant health risks on women."[649] It then interpreted its precedents as supporting the following principle: "The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty."[650]

643. *Id.* at 479 (citing Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 272–73 (2022) (criticizing use of "the 'position of the American Medical Association'" to indicate "the meaning of the Constitution")).

644. *Skrmetti*, 83 F.4th at 478.

645. *See* FED. R. EVID. 702.

646. *Skrmetti*, 83 F.4th at 473 (quoting Gonzales v. Carhart, 550 U.S. 124, 163 (2007)).

647. 550 U.S. 124, 163 (2007).

648. *Id.* at 161.

649. *Id.* at 161–62.

650. *Id.* at 163. In 2016, in *Whole Women's Health v. Hellerstedt*, the Court reframed the standard in *Gonzales*. 136 S. Ct. 2292 (2016). While acknowledging *Gonzales*' deferential standard for review of legislative fact-finding, it observed that the Court had also indicated that it "must not 'place dispositive weight' on those 'findings.'" *Id.* at 2310 (quoting *Gonzales*, 550 U.S. at 165).

Yet, as scholars emphasize, in many politically contested arenas, the "uncertainty" cited by those courts is *manufactured*.[651] As Ezra Waldman observes:

> A controversy about social facts is manufactured in law when a litigant or a judge claims that there is an ongoing empirical debate about a matter "for which there is actually an overwhelming scientific consensus." Faced with a consensus in favor of legal outcomes that expand the rights of the marginalized, judges with ideological commitments to the contrary engage in tactics reminiscent of the industry-funded pushback to the scientific consensus about the dangers of smoking, using chlorofluorocarbons, and burning fossil fuels. They manufacture doubt when there is none by forbidding any equivocation, misrepresenting scholarship, and claiming that more research is needed. Together, these tactics reflect a broader strategy--namely, to unfairly move the goalposts on the standards of judicial scrutiny such that the only way to protect the rights of marginalized populations is for the science to be infallible, unassailable, and not subject to the slightest doubt or uncertainty.[652]

Waldman points out that in litigation on state prohibitions of gender-affirming care, there is no genuine scientific controversy: "The scientific community generally agrees that gender-affirming hormone therapies are safe [and] necessary."[653] He observes that biased presentations of data arm "partisan legislatures that rationalize restricting the rights of marginalized populations with manipulated or false factual claims . . . ."[654] As a result, some "appellate judges may be inundated with uninterrogated factual claims and incapable of distinguishing between good and bad data or held hostage by legislative fact-finding to which they must often defer."[655] After analyzing cases extending across multiple areas of constitutional law, Waldman observes that some judges, consistent with an ideological agenda, impose unrealistic requirements on scientists, "plead ignorance [as to what is and is not known] and validate the

651. FAIGMAN, CONSTITUTIONAL FICTIONS, *supra* note 374, at 60–61; David Michaels, *Scientific Evidence and Public Policy* (Editorial), 95 AM. J. PUB. HEALTH S5 (2005); David Michaels & Celeste Monforton, *Manufacturing Uncertainty: Contested Science and the Protection of the Public's Health and Environment*, 95 AM. J. PUB. HEALTH S39 (2005); Waldman, *supra* note 361, at 2263–85.

651. Waldman, *supra* note 361, at 2253 (quoting Leah Ceccarelli, *Manufactured Scientific Controversy: Science, Rhetoric, and Public Debate*, 14 RHETORIC & PUB. AFFS. 195, 196 (2011); NAOMI ORESKES & ERIK M. CONWAY, MERCHANTS OF DOUBT (2010)).

652. Waldman, *supra* note 361, at 2253 (first quoting Leah Ceccarelli, *Manufactured Scientific Controversy: Science, Rhetoric, and Public Debate*, 14 RHETORIC & PUB. AFFS. 195, 196 (2011); and then NAOMI ORESKES & ERIK M. CONWAY, MERCHANTS OF DOUBT (2010)).

653. *Id.* at 2251.

654. *Id.* at 2252 (first citing Allison Orr Larsen, *Constitutional Law in an Age of Alternative Facts*, 93 N.Y.U. L. REV. 175 (2018); then Joseph Landau, *Broken Records: Reconceptualizing Rational Basis Review to Address "Alternative Facts" in the Legislative Process*, 73 VAND. L. REV. 425 (2020); and then Harper Jean Tobin, *Confronting Misinformation on Abortion: Informed Consent, Deference, and Fetal Pain Laws*, 17 COLUM. J. GENDER & L. 111 (2008)).

655. Waldman, *supra* note 361, at 2252.

dubious claims of those trying to restrict rights as just as plausible as the scientific consensus . . . ."[656]

In discussing the Court's opinion in in *Gonzales v. Carhart*, Dean David Faigman concludes that: "[t]he 'scientific debate' cited by Justice Kennedy [on the question of whether the challenged federal statute subjects women to serious health risks] was largely manufactured by Congress, which had held highly partisan hearings on the subject and then concluded that a health exception was not necessary."[657] He notes that the three lower courts were in accord as to the "significant body of medical opinion" indicating concerning health risks that women may face in the absence of a health exception.[658] Despite this, Justice Kennedy characterized the matter as "a contested factual question" subject to "documented medical disagreement,"[659] and "relied on this 'uncertainty' to support his conclusion that 'the Act can survive this facial attack.'"[660] Dean Faigman asserts that this "so-called medical disagreement was on the level of such scientific disagreements as evolution v. intelligent design and the reality of global warming."[661]

Aziza Ahmed arrives at a similar conclusion when examining the Court's abortion jurisprudence.[662] She observes that, in the context of abortion, the Court characterizes the opinions of experts on the underlying science as divided, giving "undue weight . . . to discredited experts," while underweighting the contradictory and overwhelming body of evidence" presented by those opposing state restrictions.[663] In *Carhart* specifically, she asserts that Justice Kennedy "side-stepped the public health literature altogether and instead relied on affidavits generated by anti-choice organizations."[664] She critiques the Court's legitimization of such positions as "science" that can compete on an equal footing to knowledge acquired through the scientific method.[665] Mary Ziegler also critiques the Court's "uncertainty" jurisprudence, asserting that the Court does not distinguish between "objective uncertainty, involving gaps in knowledge that can theoretically be closed through research, and subjective uncertainty, involving moral, ethical, or philosophical questions."[666] She argues

656. *Id.* at 2286 ("[J]udges . . . have required some litigants to prove counterfactuals, conduct impossible studies, demonstrate perfection, and eliminate all possible limitations from [scientific studies].").

657. FAIGMAN, CONSTITUTIONAL FICTIONS, *supra* note 374, at 60.

658. *Id.*

659. Gonzales v. Carhart, 550 U.S. 124, 162 (2007).

660. FAIGMAN, CONSTITUTIONAL FICTIONS, *supra* note 374, at 60 (quoting *Gonzales*, 550 U.S. at 163).

661 FAIGMAN, CONSTITUTIONAL FICTIONS, *supra* note 374, at 60.

662. Aziza Ahmed, *The Future of Facts: The Politics of Public Health and Medicine in Abortion Law*, 92 U. COLO. L. REV. 1151, 1152 (2021).

663. *Id.* at 1153.

664. *Id.* at 1155.

665. *Id.*

666. Mary Ziegler, *The Jurisprudence of Uncertainty; Knowledge, Science, and Abortion*, 2018 WIS. L. REV. 317, 318 (2018).

that the conflating of these two categories of uncertainty has allowed the Court to infuse "moral disapproval and disgust into what theoretically are questions of fact."[667] Dean Faigman coined the term "normative constitutional fact-finding" to characterize the Court's tendency to "manipulat[e] empirical research" findings as it approaches "factual questions as a matter of normative legal judgment rather than as a separate inquiry aimed at information gathering."[668] Indeed, the Sixth Circuit's concern that incorporating the consensus opinions of professional and scientific medical bodies undercuts the court's role in construing the Constitution reflects precisely the sort of conflation described by Ziegler and Faigman.

The intentional creation and dissemination of misinformation for political and ideological purposes is, of course, occurring in many spheres in our society at present. Jevin West and Carl Bergstrom, two biologists who have authored numerous publications on misinformation about science, identify some of the strategies used to distort data and scientific findings.[669] They refer to "purveyors of propaganda" who "go out of their way to create doubt even where it is unmerited."[670] The goal of these individuals is to "induce sufficient doubt to 'keep the controversy alive.'"[671] In the context of state-imposed restrictions on gender-affirming care for minors (as with respect to other matters about which there is substantial polarization within our society), there is a handful of poorly-qualified "experts," some of whom have published reports in non-peer-reviewed outlets.[672] They and other opponents of gender-affirming care have established "pseudo-scientific organizations."[673] Policymakers take substantial advantage of what Alejandra Caraballo refers to as the "anti-transgender medical expert industry" in constructing an interpretation of the scientific landscape that is thoroughly inconsistent with that developed through application of well-established scientific methods, including the scrutiny of peer-review.[674] Ahmed notes a similar phenomenon related to abortion litigation.[675] She observes that "anti-abortion advocates sought to change the science and redefine who [are] the

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667. *Id.* at 318–19.

668. David L. Faigman, "*Normative Constitutional Fact-Finding": Exploring the Empirical Component of Constitutional Interpretation,* 139 U. PA. L. REV. 541, 549–50 (1991).

669. West & Bergstrom, *supra* note 45, at 4–5.

670. *Id.* at 5.

671. *Id.*

672. Caraballo, *supra* note 362, at 688–89.

673. *Id.* at 689 (identifying the Society for Evidence-Based Gender Medicine as one such organization, and the American College of Pediatricians, which was established in 2002 to counter the American Academy of Pediatrics' acceptance of LBGQT families).

674. *Id.* at 687.

675. *See* Aziza Ahmed, *Abortion Experts*, 2022 U. CHI. LEG. 1, 2; Aziza Ahmed, *Feminist Legal Theory and Praxis after* Dobbs*: Science, Politics, and Expertise*, 34 YALE J.L. & FEMINISM 48, 49 (2023).

experts,"[676] and that the courts have, at times, given the platform to "physicians and scientists who would try to change the very facts known to be true."[677]

One obvious response to the problems of disinformation and manufactured uncertainty is to call for judicial rigor in the application of *Daubert* and Rule 702 of the *Federal Rules of Evidence*.[678] Federal District Court Judge Vaughn Walker's scrutiny of the qualifications of the proffered expert witnesses and their testimony in *Perry v. Schwarzenegger*—the challenge to the constitutionality of California's initiative-based bar to marriages between partners of the same sex—is exemplary.[679] Judge Walker waded through the qualifications and testimony of witnesses proffered by the defendant-intervenors,[680] and scrupulously applied the requirements of Federal Rule 702, as interpreted by *Daubert* and its progeny.[681] He then clearly and decisively disallowed unqualified "experts" and unsubstantiated testimony about alleged harms to children and society of marriage between partners of the same sex.[682] Many of the federal district court judges hearing challenges to state statutes restricting gender-affirming care, such as Judge Richardson in *L.W. v. Skrmetti*, applied this type of rigor in evaluating the scientific testimony offered in their cases.[683]

Yet, the derision with which some courts, such as the Sixth Circuit panel, regard science, scientific expertise and mainstream positions of professional medical societies suggests that such a call may fall on deaf ears. These judges reject the scientific method, empirical findings, and the training and experience that enables those we have traditionally regarded as "experts" to interpret the state of knowledge on a particular question. These attitudes reflect broader trends in society. For example, Tom Nichols, Professor of National Security Affairs at the U.S. Naval War College, observes that increasing segments of society reveal a "rejection of authority . . . coupled to an insistence that strongly held opinions are indistinguishable from facts." [684] He bemoans this "rejection

676. Ahmed, *Feminist Legal Theory*, *supra* note 675.

677. *Id.*

678. For a summary of the standard and the language of Rule 702, see *supra* notes 365-369 and accompanying text. Edward Cheng, in his critique of the *Daubert* standard, suggests that inherent flaws in the standard and the ways in which it has been applied "invite . . . politicization." Edward K. Cheng, *The Consensus Rule: A New Approach to Scientific Evidence*, 75 VAND. L. REV. 407, 425 (2022) (citing research suggesting that ideology how judges scrutinize expert evidence under *Daubert*).

679. 704 F. Supp. 2d 921, 938–53 (N.D. Cal. 2010).

680. In this case, the named defendants, officials of the state of California, declined to defend the law, which had been adopted through the electorate's endorsement of a ballot proposition. The law was defended instead by the ballot initiate's proponents, whom the court permitted to intervene in the lawsuit for that purpose. *Id.* at 928–30.

681. *Id.* at 946–56.

682. *Id.*

683. L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 698–708 (granting preliminary injunction), *rev'd by* L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 491(6th Cir. 2023), *petition for cert. filed*, 2023 WL 7327440 (Nov. 6, 2023) (No. 23-477).

684. NICHOLS, *supra* note 45, at 28.

of science and dispassionate rationality."[685] To the extent we are located at a point in time when science and expertise are increasingly devalued in some sectors of our society, ideology and politics seek to fill the void.

The "history and traditions" methodology employed by the Court in *Dobbs*, and the Sixth and Eleventh Circuits reviewing state restrictions on gender-affirming medical care, lends itself well to a judicial affinity for values-infused result-oriented reasoning. In critiquing Justice Alito's claim in *Dobbs* that "the purpose of a history-and-traditions standard was not to ascertain the original meaning of the Fourteenth Amendment's liberty guarantee, but to constrain judicial discretion," Reva Siegel states:

> This strains credulity. The history-and-traditions framework is a claim on constitutional memory, a memory game that rationalizes the exercise of power. It functions to conceal rather than to constrain discretion. On this view, Justices who disdain living constitutionalism and values-based constitutional interpretation turn to the past *to vindicate values that they do not wish openly to endorse*. On this view, originalism employs constitutional memory games to justify normative ends the Justices refuse to own as their own.[686]

That ideological and political forces at work in the context of gender-affirming care are unmistakable.[687] Clare Huntington observed: "Family law stands at the center of America's culture wars," tracking "familiar political divisions," infusing a "hyper-politicization [that] poses serious risks to children and families, making them pawns in fights for political power . . ." [688] Naomi Cahn has recently argued that the parent-child-state triad has a fourth participant—political partisanship—serving to distort legal and constitutional analysis.[689] This phenomenon, on point with the subject of this Article, "means that state action becomes not a means for protecting minors but a smokescreen for values that may having nothing to do with the actual interests of minors."[690] When jurists become willing partners with the state in ideological and political

685. *Id.* at 5.

686. Reva B. Siegel, *Memory Games:* Dobbs*'s Originalism as Anti-Democratic Living Constitutionalism-and Some Pathways for Resistance*, 101 TEX. L. REV. 1127, 1175 (2023) (emphasis in original).

687. Reports indicate that these state efforts may be motivated, at least in part, by politics. Terry Schilling, president of the American Principles Project states: "We knew we needed to find an issue that the candidates were comfortable talking about . . . [a]nd we threw everything at the wall." Adam Nagourney & Jeremy W. Peters, *How a Campaign Against Transgender Rights Mobilized Conservatives*, N.Y. TIMES (Apr. 16, 2023), https://www.nytimes.com/2023/04/16/us/politics/transgender-conservative-campaign.html. Schilling characterized the restrictions on gender-affirming care for minors to be "a political winner." Maggie Astor, *G.O.P. State Lawmakers Push a Growing Wave of Anti-Transgender Bills*, N.Y. TIMES (Jan. 25, 2023), https://www.nytimes.com/2023/01/25/us/politics/transgender-laws-republicans.html. For a scholarly discussion of these themes more broadly, see NAOMI CHAN & JUNE CARBONE, RED FAMILIES V. BLUE FAMILIES: LEGAL POLARIZATION AND THE CREATION OF CULTURE (2011).

688. Clare Huntington, *Pragmatic Family Law*, 136 HARV. L. REV. 1501, 1503 (2023).

689. Naomi Cahn, *The Political Language of Parental Rights: Abortion, Gender-Affirming Care, and Critical Race Theory*, 53 SETON HALL L. REV. 1443, 1444, 1474–75 (2023).

690. *Id.* at 1475. Huntington is in accord: "Polarization tends to sacrifice family law's longstanding commitment to child well-being in favor of ideology and political gain." Huntington, *supra* note 688, at 1560.

crusades, our reliance on judicial review for protection of constitutional rights through appropriate scrutiny of unsubstantiated claims of harm to children is on shaky ground.

CONCLUSION

Between 2021 and January 2024, twenty-three states adopted measures restricting or prohibiting parents from accessing gender-affirming care for their minor children. These measures permit brazen and highly aggressive intrusions into the family's traditional authority to make decisions about their minor children's healthcare. Decades of case and constitutional law establish the allocation of decisional authority for healthcare decisions for minor children. These statutes defy these well-settled principles that parents retain legal authority to make most health care decisions for their minor children.[691] Exceptions to the prevailing doctrine of parental consent exist, such as those that authorize minors to make certain health care decisions independently, and those that allow the state to override parental decisions when failure to do so subjects children to substantial risk of serious harm.[692] Yet these state restrictions on gender-affirming care do not fall within the scope of any of these exceptions.

The drafters of these measures seek to characterize the restrictions on gender-affirming care as necessary to protect children from a substantial risk of serious harm. Yet, the drafters reject science and expertise, the guideposts traditionally used to determine whether such risk of harm exists. Most courts reviewing legal challenges to these measures for the purpose of granting or denying motions for preliminary injunctions have concluded that the plaintiffs are likely to prevail at trial in proving that these state statutes unconstitutionally infringe on parental authority to make health care decisions for their children. In the two federal circuits that reversed, the appellate courts ignored the evidentiary record, were littered with endorsement of misinformation, and were derisive of the broad scientifically grounded consensus in this field. In a highly polarized political environment, where ideology and political agendas[693] lead states to engage in a type of "doublespeak"[694] in drafting state statutes asserted to protect

691. *See supra* Part II.A.

692. *See supra* Part II.B.

693. Nagourney & Peters, *supra* note 687 (discussing how conservative strategists focused on a range of rights of transgender persons as target for their movement, after losing in the courts on same-sex marriage, to promote fundraising and energize their movement, and to provide a platform for political candidates). *See also* Faith Pinho, *GOP Candidates Outlined Sweeping Anti-Trans Agenda at Presidential Debate*, L.A. TIMES (Sept. 28, 2023, 7:55 PM), https://www.latimes.com/politics/story/2023-09-28/trans-youth-gop-republicans-transgender-people-ban-debate ("[S]ocial conservatives have whipped up outrage and concern about gender-affirming care for trans kids.").

694. "Doublespeak" may be defined as "language used to deceive usually through concealment or misrepresentation of truth." *Doublespeak*, MERRIAM-WEBSTER DICTIONARY, https://www.merriam-webster.com/dictionary/doublespeak (last visited Mar. 27, 2024). The term evolved from "Newspeak" and "Doublethink," concepts in George Orwell's book, 1984. WILLIAM LUTZ, DOUBLESPEAK 9 (2015). According to linguist William Lutz, doublespeak is euphemism that "is used to mislead or deceive." *Id.* at 3. "It is language designed to alter our perception of reality." *Id.*

children, the willingness of some jurists to relinquish their obligation to serve as gatekeepers of scientific testimony and to accept unsubstantiated claims masquerading as science is troubling indeed.

The cases challenging these state statutes continue to make their way through the courts. Some plaintiffs now turn to state constitutional protections and seek relief in state courts. As these cases move forward, ideally, the principles articulated by Huntington and Scott, which underlie the new *Restatement of the Law of Children*, can focus decisionmakers on what is truly at stake in these cases: *child wellbeing*.[695] In effectuating the goal of promoting children's wellbeing, Huntington and Scott emphasize the importance of grounding our legal regulation of children's lives in "psychological and biological research on child and adolescent development."[696] While state legislatures may be too mired in politics and ideological crusades to abide by this principle, our judiciary has the authority and, arguably, the standards[697] by which to evaluate legal regulation of gender-affirming care against the best available science.

The outcomes of these cases have real-world consequences for many children and their families. Some families, so worried about the welfare of their children without gender-affirming healthcare, have left their homes and moved out-of-state to retain these treatment options.[698] Yet, the outcomes of these cases have broader impacts as well. Public opinion polls reveal that Americans' confidence in the U.S. Supreme Court and many other public institutions is at an historic low point.[699] At a time when public respect for the highest court in the nation is at an all-time low, federal courts' rejection of time-honored constitutional traditions governing the relationship between the family and the state, including well-established and historically protected dimensions of parental authority, and its failure to protect parents' liberty to choose medically recommended and scientifically supported healthcare interventions for their children, will not help rebuild the public trust. These cases offer an opportunity for the judiciary to rise above the ideologically motivated misinformation and distortions that provide pretexts for these state policies. As cases challenging the measures that restrict gender-affirming care for minors continue to work their

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695. Huntington & Scott, *supra* note 259, at 1414–18 (discussing the bias in state regulation of children affecting certain racial, ethnic, and social class minority groups).

696. *Id.* at 1375.

697. *See* Part II.C.

698. Annie Connell-Bryan, Joanne Kenen & Jael Holzman, *Conservative States are Blocking Trans Medical Care. Families are Fleeing.*, POLITICO (Nov. 27, 2022, 7:00 AM), https://www.politico.com/news/2022/11/27/trans-medical-care-red-states-families-00064394; Trip Gabriel, *Two Families Got Fed Up with Their States' Politics. So They Moved Out.*, N.Y. TIMES (Oct. 7, 2023), https://www.nytimes.com/2023/10/07/us/politics/politics-states-moving.html.

699. Lydia Saad, *Historically Low Faith in U.S. Institutions Continues*, GALLUP (July 6, 2023), https://news.gallup.com/poll/508169/historically-low-faith-institutions-continues.aspx. The survey reveals that only 27% of surveyed Americans expressed confidence in the Court. *Id.* This survey has been conducted since 1979. *Id.* Public confidence in the Court was at its lowest in 2022 (at 25%). *Id.*

way through the courts, and two petitions for certiorari sit with the Court to resolve the split in the circuits discussed in Subpart III.B, many opportunities remain for the federal courts to arrive at an honest adjudication of scientific facts and to apply constitutional doctrine faithfully as they scrutinize the challenged state policies.

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