UNCONSTITUTIONAL CRUELTY

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ABSTRACT

Despite the long history of transgender people and transgender care, state legislatures suddenly rushed to pass a wave of bans on gender-affirming medical care for trans youth over a three-year period beginning in 2021—an alarming surge within a flurry of legal attacks on the transgender community. In analyzing the constitutionality of these bans, courts and scholars have focused their attention on how to characterize the nature of the rights implicated, and therefore the level of scrutiny warranted. This focus reacts to, and often follows, the current Supreme Court majority's approach to questions about the rights of historically oppressed and marginalized groups: Narrowly define the right, then resort to amateur historical investigation of centuries prior to undermine the right's importance, and finally sanction government action under a rational basis review that is hardly a review at all. This Article shifts the focus from the

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increasingly fraught taxonomic questions about rights to the underexamined nature of state justifications for these bans. Through a detailed inspection of government statements, medical and scientific evidence, and lower court decisions, this Article critiques the dubious state claims of "harm prevention" or "protection." This demonstrates that gender-affirming care bans should have failed under any form of judicial scrutiny, including rational basis review. This examination reveals how overemphasis on a narrow framing of the rights at issue—such as the right to access "experimental" treatments or the right to transition—skews the constitutional analysis and invites the use and misuse of history. Doing so perpetuates social hierarchies and obscures the subordination of marginalized, minoritized, and underrepresented groups. By recentering the analysis on evidence about the health and well-being of the affected group—here, transgender minors—this Article serves as a warning against the risks of judicial evaluation that overly scrutinizes the definition of a right asserted by vulnerable groups, while hardly considering the government's justifications for harming them under the pretext of protecting them. In doing so, the hope is to help restore rationality in constitutional inquiry, where rational basis review often serves as the final impediment to unconstitutional cruelty.

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INTRODUCTION

The current Supreme Court loves to use history,[1] so let us start there. Not only is there a long history for transgender people, but gender-affirming medical care has been around for more than a generation.[2] In fact, medical transition practices have been traced back centuries—if not longer—around the world.[3] History Professor Jules Gill-Peterson—an actual historian, unlike most lawyers, judges, and the entire Supreme Court—has documented sex- and gender-based medical procedures in the U.S. as early as the 1910s.[4] "Sex changes" in children were being performed in hospitals in the 1930s, including the involvement of psychiatrists and psychologists during this time.[5] Evidence of clinicians discussing transgender medicine has been found from the 1950s and 1960s.[6] Thus, Professor Gill-Peterson, along with many others, has emphatically proven one of her most important points: "Today's trans children are *not* the first generation to identify and live openly as trans during childhood. They are not even close to the first generation to transition or to be medicalized during childhood and grow up as publicly trans."[7]

If history is as relevant as the Court continuously claims, these facts should have at least excluded efforts to categorize gender dysphoria and the existence of transgender people as a "dangerous trend."[8] In reality, the sudden onslaught of direct and explicit

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1. *See* Emily Bazelon, *How 'History and Tradition' Rulings Are Changing American Law*, N.Y. TIMES: MAG. (Apr. 29, 2024), https://www.nytimes.com/2024/04/29/magazine/history-tradition-law-conservative-judges.html [https://perma.cc/9KKQ-S75F].

2. *See* JULIAN GILL-PETERSON, HISTORIES OF THE TRANSGENDER CHILD 3 (2018).

3. Henry Carnell, *The Hidden History of Trans Health Care*, MOTHER JONES (Feb. 6, 2025), https://www.motherjones.com/politics/2025/02/hidden-history-transgender-affirming-health-care/ [https://perma.cc/Z42C-P87Y].

4. GILL-PETERSON, *supra* note 2, at 3.

5. *Id.* at 3, 68-70.

6. *See* STEF M. SHUSTER, TRANS MEDICINE: THE EMERGENCE AND PRACTICE OF TREATING GENDER 89 (2021).

7. GILL-PETERSON, *supra* note 2, at 7-8.

8. *See* Exec. Order No. 14187, 90 Fed. Reg. 8771 (Jan. 28, 2025); *see also* United States v. Skrmetti, 145 S. Ct. 1816, 1841 (2025) (Thomas, J., concurring) ("[T]he concept of gender dysphoria as a medical condition is relatively new and the use of drug treatments that change or modify a child's sex characteristics is even more recent." (alteration in original) (quoting

targeting of transgender people specifically for political gain is the recent phenomenon.[9] Legislation to outlaw gender-affirming care specifically is an even newer trend. Not one state had a ban on gender-affirming care until Arkansas's legislature overrode the Governor's veto to pass its law in April of 2021.[10] It was just the first in an alarming trend targeting health care for the transgender community.[11] The Human Rights Campaign declared 2021 the deadliest year for transgender and nonbinary people, witnessing an unprecedented number of anti-trans bills being passed.[12] The

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L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 472 (6th Cir. 2023))).

9. *See* Transcript of Oral Argument at 59-63, *Skrmetti*, 145 S. Ct. 1816 (No. 23-477).

10. *See* Arkansas Save Adolescents from Experimentation (SAFE) Act, No. 626 (2021) (codified at ARK. CODE ANN. §§ 20-9-1501 to -1504 (West 2025)); Lindsay Dawson & Jennifer Kates, *Policy Tracker: Youth Access to Gender Affirming Care and State Policy Restrictions*, KAISER FAM. FOUND. (Aug. 12, 2025), https://www.kff.org/lgbtq/gender-affirming-care-policy-tracker/ [https://perma.cc/KEL4-42JJ].

11. *See* Michael R. Ulrich, *Practicing Medicine in the Culture Wars—Gender-Affirming Care and the Battles Over Clinician Autonomy*, 390 NEJM 779, 779 (2024). This Article uses the term "transgender" to cover people who identify as, or are identified by, not conforming to the gender binary. *See* Susan Stryker, *The Transgender Issue: An Introduction*, 4 GLQ 145, 149 (1998) ("I use *transgender* not to refer to one particular identity or way of being embodied but rather as an umbrella term for a wide variety of bodily effects that disrupt or decentralize heteronormatively constructed linkages between an individual's anatomy at birth, a nonconsensually assigned gender category, psychical identifications with sexed body images and/or gender subject positions, and the performance of specifically gendered social, sexual, or kinship functions."). Some nonbinary people identify as transgender, some do not, and others are indifferent. *See* Helana Darwin, *Challenging the Cisgender/Transgender Binary: Nonbinary People and the Transgender Label*, 34 GENDER & SOC'Y 357, 376-77 (describing "a considerable amount of variance and ambivalence regarding transgender identification"). There are problems with using this as an umbrella term, as it can unify people and create a sense of exclusion. *See* DAVID VALENTINE, IMAGINING TRANSGENDER: AN ETHNOGRAPHY OF A CATEGORY 8-9 (2007). Using the term "transgender" is not meant to exclude nonbinary people, suggest a homogeneity to transgender or nonbinary people, or to ignore the biases and discrimination nonbinary people face. *See generally* Jessica A. Clarke, *They, Them, and Theirs*, 132 HARV. L. REV. 894, 901-04 (2019) (analyzing legal treatment of nonbinary gender identities).

12. Press Release, Laurel Powell, Hum. Rts. Campaign, 2021 Becomes Deadliest Year on Record for Transgender and Non-Binary People (Nov. 9, 2021), https://www.hrc.org/press-releases/2021-becomes-deadliest-year-on-record-for-transgender-and-non-binary-people [https://perma.cc/Q5HP-BEXE]; see also Press Release, Wyatt Ronan, Hum. Rts. Campaign, Breaking: 2021 Becomes Record Year for Anti-Transgender Legislation (Mar. 13, 2021), https://www.hrc.org/press-releases/breaking-2021-becomes-record-year-for-anti-transgender-legislation [https://perma.cc/4B6Z-5WTR]. Forty-seven trans people were murdered in 2021, with the majority being Black or Latine. Orion Rummler & Kate Sosin, *2021 Is Now the Deadliest Year on Record for Transgender People*, THE 19TH (Nov. 20, 2021, at 13:11 CT), https://19thnews.org/2021/11/2021-deadliest-year-record-transgender-people/

following year was record-breaking for laws targeting transgender youth, with seventeen of the twenty-nine bills passed in 2022 focused on this group specifically.[13] In 2023, eighty-seven bills were passed targeting transgender people out of the 615 considered,[14] leading the Human Rights Campaign to declare the organization's first-ever state of emergency.[15] Another fifty-one laws were added in 2024 across seventeen states out of the 701 bills introduced in forty-four states.[16] The exponential increase in legislative attention is radically incongruous with a community that represents less than 1 percent of adults[17] and slightly above 1 percent of thirteen- to seventeen-year-olds.[18] This radical discrepancy is undeniable proof that the transgender community is under attack.

The callous desire to target a small minority group that is already marginalized and underserved is most apparent with state bans on gender-affirming care for transgender minors.[19] Transgender youth already suffer disproportionately higher rates of depression, anxiety, suicidal ideation, and suicide attempts when compared to

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[https://perma.cc/8H8U-PMC7].

13. Press Release, Cullen Peele, Hum. Rts. Campaign, Roundup of Anti-LGBTQ+ Legislation Advancing in States Across the Country (May 23, 2023), https://www.hrc.org/press-releases/roundup-of-anti-lgbtq-legislation-advancing-in-states-across-the-country [https://perma.cc/V93U-A8JW].

14. *2023 Anti-Trans Legislation*, TRANS LEGIS. TRACKER, https://translegislation.com/bills/2023 [https://perma.cc/T7BN-8NCH].

15. Press Release, Hum. Rts. Campaign, For the First Time Ever, Human Rights Campaign Declares State of Emergency for LGBTQ+ Americans; Issues National Warning and Guidebook to Ensure Safety for LGBTQ+ Residents and Travelers (June 6, 2023), https://www.hrc.org/press-releases/for-the-first-time-ever-human-rights-campaign-officially-declares-state-of-emergency-for-lgbtq-americans-issues-national-warning-and-guidebook-to-ensure-safety-for-lgbtq-residents-and-travelers [https://perma.cc/84RL-K9FA].

16. *2024 Anti-Trans Bills Tracker*, TRANS LEGIS. TRACKER, https://translegislation.com/bills/2024 [https://perma.cc/8KSH-SQAU].

17. *See* Jeffrey M. Jones, *LGBTQ+ Identification in U.S. Now at 7.6%*, GALLUP (Mar. 13, 2024), https://news.gallup.com/poll/611864/lgbtq-identification.aspx [https://perma.cc/DQC4-LYGF].

18. JODY L. HERMAN, ANDREW R. FLORES & KATHRYN K. O'NEILL, UCLA SCH. OF L. WILLIAMS INST., HOW MANY ADULTS AND YOUTH IDENTIFY AS TRANSGENDER IN THE UNITED STATES? 1, 5 (2022), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf [https://perma.cc/2TKF-HBRB].

19. *See* Lindsey Dawson & Jennifer Kates, *The Proliferation of State Actions Limiting Youth Access to Gender Affirming Care*, KAISER FAM. FOUND. (Jan. 31, 2024), https://www.kff.org/policy-watch/the-proliferation-of-state-actions-limiting-youth-access-to-gender-affirming-care/ [https://perma.cc/BT8R-69DU].

their cisgender peers.[20] Though health disparities can justify state action, making the case that a complete and total ban on an array of health care treatments is a rational approach to addressing those disparities should be a tall order.[21] This type of excessive government action presumes that there is no person who could benefit from any of the treatments included in these state bans. Evidence, however, supports the positive impact gender-affirming care has on transgender youth. Studies have found reductions in suicidality, self-harm, depression, and improvements in well-being.[22] Unlike state bans, this is not meant to imply any broad application of gender-affirming care. The range of interventions include social and medical approaches and can include therapy and medication, depending on the individual.[23] Like any other form of medical treatment, availability does not equate to its application to any patient presenting with some form of gender dysphoria. The drastic difference between the ban and availability helps to explain why no such measure has been undertaken despite the long history of transgender people, transgender youth, and transgender medical care. The sudden and unabashed assault on such a discrete and insular minority—escalating from zero states with gender-affirming care bans to twenty-seven in three years—raises the question of whether the cruelty is the point.[24]

States appear to recognize that banning access to medical care would be a perplexing response to this population's rate of poor

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20. *See, e.g.*, Sari L. Reisner, Ralph Vetters, M. Leclerc, Shayne Zaslow, Sarah Wolfrum, Daniel Shumer & Matthew J. Mimiaga, *Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study*, 56 J. ADOLESCENT HEALTH 274, 276 (2015); Diana M. Tordoff, Jonathon W. Wanta, Arin Collin, Cesalie Stepney, David J. Inwards-Breland & Kym Ahrens, *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender Affirming Care*, JAMA NETWORK OPEN 8 (Feb. 25, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423 [https://perma.cc/597F-UC4S].

21. *See* Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905).

22. *See infra* Part II.A.

23. *See* T. Zachary Huit, Claire Coyne & Diane Chen, *State of the Science: Gender-Affirming Care for Transgender and Gender Diverse Youth*, 55 BEHAV. THERAPY 1335, 1338 (2024).

24. *See* Dawson & Kates, *supra* note 10. *See generally* ADAM SERWER, THE CRUELTY IS THE POINT: WHY TRUMP'S AMERICA ENDURES (2021) (discussing how transgender people have been dehumanized by the Trump administration and their adherents).

health outcomes,[25] choosing instead to rely on claims that they are protecting minors from theoretical harms caused by gender-affirming care.[26] The evidence emerging in the aftermath of these bans contradicts any notion of harm prevention, with associations between state anti-transgender laws and increasing suicide attempts by transgender youth already found.[27] Ignoring broad medical consensus supporting gender-affirming care—including peer-reviewed research and expertise from clinicians who work with transgender youth[28]—states have leaned heavily on a few hand-picked professionals with no expertise, training, or experience in transgender medical care and a comparatively small set of writings that are questionable in their methodology, results, and conflicts of interest.[29] The timing of this work—miraculously appearing *after* these state restrictions had begun to proliferate—is interesting, but ultimately most do not actually advocate for or support the complete bans states have undertaken.[30] The Cass Review, as but one example, does not actually advocate for an outright ban of gender-affirming care.[31] Nevertheless, after other courts had unanimously struck the bans down, states were ultimately able to find beneficial outcomes in the Sixth and Eleventh Circuit Courts of Appeals, which led to a circuit split and the Supreme Court's grant of certiorari.[32]

This Article assesses the discordance between the various governments' proffered justifications for these attacks with the

25. *See* Tordoff et al., *supra* note 20, at 7, 10.

26. *See, e.g.*, MONT. CODE ANN. §§ 50-4-1001 to -1006 (2025); *see also* Vulnerable Child Protection Act, IDAHO CODE § 18-1506C (2025); Stop Harming our Kids Act, LA. STAT. ANN. § 40:1098 (2025).

27. *See* Wilson Y. Lee, J. Nicholas Hobbs, Steven Hobaica, Jonah P. DeChants, Myeshia N. Price & Ronita Nath, *State-Level Anti-Transgender Laws Increase Past-Year Suicide Attempts Among Transgender and Non-Binary Young People in the USA*, 8 NATURE HUM. BEHAV. 2096, 2101 (2024).

28. *See infra* Part II.A.

29. *See infra* Part III.

30. *See infra* Part III.

31. *See, e.g.*, HILARY CASS, THE CASS REVIEW: INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE 150 (2024), https://cass.independent-review.uk/wp-content/uploads/2024/04/CassReview_Final.pdf [https://perma.cc/8FXC-VJFK]. Solicitor General Prelogar pointed this out during oral argument. *See* Transcript of Oral Argument, *supra* note 9, at 16-17.

32. *See infra* Part I.B; L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460 (6th Cir. 2023), *aff'd sub nom.*, United States v. Skrmetti, 145 S. Ct. 1816 (2025).

medical, historical, and contextual evidence contradicting them —revealing that pretext of "protection" is so flimsy that it should have failed to withstand any level of constitutional scrutiny. The analyses in the judiciary and the academic literature have largely focused on whether heightened scrutiny should apply to gender-affirming care bans under the Fourteenth Amendment's Equal Protection Clause or the Due Process Clause.[33] Yet, a determination of whether heightened scrutiny applies should not be treated as dispositive in constitutional cases. Such a blinkered approach places considerable weight on how the right is framed, empowering judges to determine outcomes covertly through ex ante categorization. Allowing analyses and values to be included in what appears to be the Court merely laying out a threshold question invites manipulation by diminishing transparency.[34]

Lower court decisions on gender-affirming care bans illustrate this point. Most lower courts applied heightened scrutiny because "transgender people constitute at least a quasi-suspect class,"[35] the ban qualifies as sex-based discrimination relying on analysis following the Supreme Court's ruling in *Bostock v. Clayton County*,[36] or the bans interfere with parents' fundamental rights to make medical decisions for their children.[37] The courts upholding the bans, however, framed the issue as a right to access transition treatment, equally applied to all minors,[38] and the parental right to

33. Scott Skinner-Thompson, *Trans Animus*, 65 B.C. L. REV. 965, 989-92, 1018-20 (2024); *Outlawing Trans Youth: State Legislatures and the Battle over Gender-Affirming Care for Minors*, 134 HARV. L. REV. 2163, 2178-85 (2021) (describing how gender- affirming care bans for trans youth likely violate both the Equal Protection Clause and parents' substantive due process rights); Kevin M. Barry, Brian Farrell, Jennifer L. Levi & Neelima Vanguri, *A Bare Desire to Harm: Transgender People and the Equal Protection Clause*, 57 B.C. L. REV. 507, 551-67 (2016) (arguing that transgender people are a suspect class that warrants heightened scrutiny under the Equal Protection Clause); Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1220-31 (11th Cir. 2023); United States v. Skrmetti, 145 S. Ct. 1816, 1829 (2025) ("We are asked to decide whether SB1 is subject to heightened scrutiny under the Equal Protection Clause.").

34. *See* JAMAL GREENE, HOW RIGHTS WENT WRONG 33 (2021).

35. *See* Brandt v. Rutledge, 551 F. Supp. 3d 882, 889 (E.D. Ark. 2021) (quoting Grimm v. Gloucester Cty. Sch. Bd., 972 F.3d. 586, 607 (4th Cir. 2020)), *aff'd*, 47 F.4th 661, 669-71 (8th Cir. 2022), *abrogated by* Brandt *ex rel.* Brandt v. Griffin, 147 F.4th 867 (8th Cir. 2025).

36. *See id.* at 889-92.

37. *See* Doe v. Ladapo, 676 F. Supp. 3d 1205, 1220 (N.D. Fla. 2023); Poe *ex rel.* Poe v. Labrador, 709 F. Supp. 3d 1169, 1195 (D. Idaho 2023).

38. *See* L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 482-83 (6th Cir. 2023), *aff'd sub*

access experimental medical treatments for transitioning.[39] These divergent frames for the rights essentially predetermined the courts' conclusions because neither right, unsurprisingly, was found to be deeply rooted in our nation's history and tradition.[40] The attention paid to the right is somewhat understandable given the Supreme Court's increasingly myopic view of constitutional questions as a matter of the scope of the right and its significance historically.[41] Still, allowing the government to enforce these extreme measures on such a small group without any credible supporting arguments, presumably because rational basis review applied, ought to be a more significant cause for concern.

Indeed, it is difficult to overemphasize the potential magnitude of the Court's decision on gender-affirming care in *United States v. Skrmetti*.[42] The Court continued its rights-centric analytical approach with analysis that amounted to little more than "Tennessee determined" and "Tennessee concluded."[43] This extreme deference, which has proven fatal for transgender minors seeking access to health care,[44] likely serves as a canary in the coal mine for the mounting restraints placed on transgender people. What should cause even more concern is that such a blatant disregard for the harm posed by unnecessary and unsupported government targeting could also represent a bellwether for efforts to limit the rights and protections for other minoritized and underrepresented groups.[45] Court cooperation with the flagrant targeting of transgender people

nom., United States v. Skrmetti, 145 S. Ct. 1816 (2025); Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1229-30 (11th Cir. 2023).

39. *See L.W.*, 83 F.4th at 475; *Eknes-Tucker*, 80 F.4th at 1220-21.

40. *See L.W.*, 83 F.4th at 472-75; *Eknes-Tucker*, 80 F.4th at 1220-21.

41. *See* Jamal Greene, *Foreword: Rights as Trumps?*, 132 HARV. L. REV. 28, 30 (2018).

42. 145 S. Ct. 1816, 1835 (2025).

43. *See id.* at 1835-36.

44. *See* Lee et al., *supra* note 27, at 2101.

45. Discrimination based on sexual orientation has already been constitutionalized in 303 Creative LLC v. Elenis, 143 S. Ct. 2298, 2313-14 (2023). Justice Thomas has also made his desire to reexamine other LGBTQ+ protections well known. *See* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2301 (2022) (Thomas, J., concurring) ("[W]e should reconsider all of this court's substantive due process precedents, including *Griswold*, *Lawrence*, and *Obergefell*."). Readiness to ignore discrimination could also escalate harms to racial and ethnic minorities considering the Court's insistence that the country has reached a postracial era. *See, e.g.*, Students for Fair Admissions, Inc. v. President of Harvard Coll., 143 S. Ct. 2141, 2172 (2023).

for political gain, simply because misleading and disingenuous protective claims were added ex post, portends a future in which culture wars increasingly become justiciable battles to determine who has the freedom to exercise their constitutional rights. This categorical approach tends to raise the stakes of political disputes, putting the public in adversarial positions in which some people's rights matter and some people's rights do not.[46] In such a polarized climate, this message from the highest Court is liable to stoke the partisan flames rather than extinguish them.

Meanwhile, the ease with which states were able to craft the illusion of medical uncertainty will only encourage more politicians, legislatures, and judges to supplant the empirically informed decisions of patients and experts with their own political preferences.[47] Make no mistake, not only are transgender people under attack, but patient autonomy and the practice of medicine are as well.[48] The fact that many standard medical conditions, interventions, and treatments have found themselves within the conspiracy theories promoted by Health and Human Services Secretary Robert F. Kennedy, Jr., should refute any feelings that this description of *Skrmetti* is hyperbolic.[49] With risks affixed to every medical

46. *See* Greene, *supra* note 41, at 79-80.

47. *See* Ulrich, *supra* note 11, at 779; *see also* Michael R. Ulrich, *Politicians as Clinicians:* Skrmetti *and Supreme Court-Sanctioned Intrusion on the Practice of Medicine*, 334 JAMA 855, 855-56 (2025) (describing the Court's disregard for a complete lack of expert support as it blindly accepted Tennessee's justifications). Now *this* is a dangerous trend. In *Dobbs*, the Court exhibited blatant disregard for the clinical impact of eliminating abortion as a constitutional right. 142 S. Ct. at 2276-79. The Court stayed an injunction against an Idaho abortion ban that applied "even when terminating a pregnancy was necessary to prevent grave harm to the woman." Moyle v. United States, 144 S. Ct. 2015, 2016 (2024) (Kagan, J., concurring). And there are examples of judicial activism usurping the Food and Drug Administration's (FDA) authority to analyze the safety and efficacy of medication. All. for Hippocratic Med. v. FDA, 668 F. Supp. 3d 507, 554 (N.D. Tex. 2023), *vacated*, 117 F.4th 336 (5th Cir. 2024) (per curiam). In Judge Kacsmaryk's determination that the "FDA acquiesced on its legitimate safety concerns—in violation of its statutory duty," he cited Sesame Street, Wikipedia, and studies that were retracted due to "fundamental problems with the study design and methodology, unjustified or incorrect factual assumptions, material errors in the authors' analysis of the data, and misleading presentations of the data" that undermine the authors' conclusions and demonstrate a lack of scientific rigor. *Id.* at 545-48, 554; *see Retraction Notice*, 11 HEALTH SERVS. RSCH. & MANAGERIAL EPIDEMIOLOGY 1, 2 (2024) (providing notice of publication retraction for three previously published articles).

48. *See* Ulrich, *supra* note 47, at 855-56.

49. *See* Anjali Huynh & Teddy Rosenbluth, *7 Noteworthy Falsehoods Robert F. Kennedy Jr. Has Promoted*, N.Y. TIMES (Nov. 22, 2024), https://www.nytimes.com/article.rfk-

treatment, *Skrmetti* places nearly every aspect of medical care at risk.[50]

Outcomes for these types of cases, however, should not be so entwined with the framing of the right. This practice grants the government considerable leeway to restrict the peoples' liberties so long as it can find a way to narrow the right in its favor. Had state justifications played any role when evaluating gender-affirming care bans, they would have withered and wilted under even the faintest light. Indeed, any insistence that heightened scrutiny is necessary to invalidate gender-affirming care bans can only stem from a willingness to turn a blind eye to the harms they cause.[51] States' alleged interests are further delegitimized by failing to address any demonstrable harm prevalent in the targeted population,[52] the lack of supporting evidence and experts,[53] and their own contradictory exceptions that undermine each of the reasons they offer.[54] Centering the health and wellbeing of transgender youth —especially the over 120,000 transgender youth covered by gender-affirming care bans as of July 2025[55]—should make it abundantly clear that these extreme prohibitions fail under any form of scrutiny, including under rational basis review.

Despite its reputation as a standard of review that requires no review at all,[56] rational basis review is the people's last line of defense against an oppressive government arbitrarily constraining the lives of those it dislikes and disapproves of. By its own definition, a legitimate end and rational means to achieve that end are required.[57] Not only do gender-affirming care bans fail each prong,

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conspiracy-theories-fact-check.html [https://perma.cc/9TWQ-X5RH].

50. *See* Ulrich, *supra* note 47, at 856.

51. Nothing in this Article should be taken to indicate that arguments for heightened scrutiny do not stand on strong legal footing, or that there are not broader benefits from additional Equal Protection Clause judicial protection.

52. *See infra* Part II.A.

53. *See infra* Part III.A.

54. *See infra* Part III.A.

55. *Map: Attacks on Gender Affirming Care by State*, HUM. RTS. CAMPAIGN FOUND. (July 2025), https://www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map [https://perma.cc/AT8N-WFBM].

56. Katie R. Eyer, *The Canon of Rational Basis Review*, 93 NOTRE DAME L. REV. 1317, 1319 (2018).

57. *See* Reed v. Reed, 404 U.S. 71, 76 (1971); City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432, 440 (1985).

they actively cause harm to the population they are supposedly protecting.[58] Ignoring the relevance of people's lived experiences when assessing constitutionality is advantageous for authoritarian-style governance not simply because it improves the probability of the government winning, but also because it conceals the impact of their actions.[59] This is both bad constitutional analysis and runs the risk that "it will further coarsen society to the humanity" of others.[60] *Skrmetti* makes clear the risks of allowing the government to infringe on individual autonomy with no genuine justification. Rather than partake in the semantic feud over rational basis, animus, and rational basis with bite, this Article aims to restore legitimacy and rationality to rational basis review out of "fear for our democracy"[61] and to provide a shield against the rise in unconstitutional cruelty.[62]

This Article proceeds in three parts. Part I examines the origins of state efforts to target the rights of transgender people, including access to gender-affirming care. Examining the diverging lower court rulings reveals that the framing of the right was essentially dispositive, an outcome that was replicated by the Supreme Court. Part II then contextualizes state justifications within their authority to protect and promote public health, safety, and welfare. Highlighting the health disparities transgender minors face displays how banning health care provides no benefits while increasing harm and thereby undermines assertions of harm prevention. The exceptions that states include in regulating health care for minors reveal an inconsistency that invalidates any legitimate goal they have put forward. Finally, Part III highlights the importance of demonstrating that gender-affirming care bans fail rational basis review not only for transgender youth but also for the protection of medical practice and the validity of constitutional analysis. Though heightened scrutiny may very well be warranted, this Article's analytical approach exposes the brash efforts to exacerbate health disparities for political gain, shines a light on the

58. *See infra* Part II.
59. Greene, *supra* note 41, at 109-10.
60. Gonzales v. Carhart, 550 U.S. 124, 157 (2007).
61. Trump v. United States, 144 S. Ct. 2312, 2372 (2024) (Sotomayor, J., dissenting).
62. *See* SERWER, *supra* note 24, at 183-204.

transgender youth who deserve to be acknowledged and accepted, and joins the growing effort to rescue constitutional analysis from the brink where the only salient endpoint is the centuries-old opinions and approaches of a small group of landowning, white men. In doing so, this Article lays out a path for protecting transgender rights that treats *Skrmetti* as the beginning of the fight, not the end.

I. A SOLUTION IN SEARCH OF A PROBLEM

In a one-day special session in March of 2016, North Carolina passed House Bill 2, often referred to as "the bathroom bill."[63] The law required people to use the bathroom that corresponded to their sex assigned at birth and prohibited localities from enacting their own protective measures.[64] The special session came just days after Charlotte's City Council passed an ordinance allowing transgender people to use the bathroom of their choosing.[65] The lack of public demand for the measure may help to explain the sudden backlash the state faced, which included cancellations from sports leagues, musicians, and corporate projects that would have created an estimated 2,900 jobs.[66] The projected economic losses were $525 million by the end of 2017 and more than $3.76 billion by the end of 2028 if the law had remained in force.[67] Instead, the bathroom restrictions were repealed on March 30, 2017,[68] and state prohibitions on local antidiscrimination laws expired on December 1, 2020.[69]

The contrast between the outcry North Carolina faced and the legislative wrath transgender people have endured just a few years later is striking. Still, the more recent pursuit against transgender

63. *See* Elena Schneider, *The Bathroom Bill that Ate North Carolina*, POLITICO (Mar. 23, 2017), https://www.politico.com/magazine/story/2017/03/the-bathroom-bill-that-ate-north-carolina-214944/ [https://perma.cc/2HUM-UHTN].

64. *See id.*

65. *See id.*

66. *See* Emery P. Dalesio & Jonathan Drew, *'Bathroom Bill' to Cost North Carolina $3.76 Billion*, AP NEWS (Mar. 30, 2017, at 14:03 ET), https://apnews.com/article/e6c7a15d2e16452c8dcbc2756fd67b44 [https://perma.cc/3YQT-BEMW].

67. *See id.*

68. 2017 N.C. Sess. Law 4, § 1 (repealing N.C. GEN. STAT. § 143-760 (2016)).

69. *Id.* § 3-4.

rights was similarly without a demand from constituents.[70] Indeed, this trans attack sequel can hardly be attributed to people's general awareness and understanding of gender-affirming care. But the perplexing path from 2016 to 2021 is more than a curiosity. Given the tie between legislative power and the needs of the people, the origins of this effort to ban transgender youth from accessing medical care is legally relevant. This Part starts with an investigation into the beginnings of this more recent and augmented assault on transgender people to contextualize states' asserted interests and assess the validity of their health-based justifications for banning health care. This underscores the relevance of the conflicting rights framings that occurred in the lower courts.

A. Origins of an Attack

Despite gender-affirming care existing for decades, the number of states passing gender-affirming care bans for minors went from zero to twenty-seven between May 2021 and May 2024, with nineteen passed in 2023 alone.[71] Thanks to the forthrightness of Terry Schilling, the President of the conservative advocacy group American Principles Project, we need not speculate on the derivation of the swift surge.[72] After the Supreme Court declared a constitutionally protected right to same-sex marriage, social conservative organizations and politicians were left searching for a new cause that would galvanize their base, motivate donors, and raise the movement's national profile.[73] Mr. Schilling candidly stated, "we

70. *See* Kim Parker, Juliana Menasce Horowitz & Anna Brown, *Americans' Complex Views on Gender Identity and Transgender Issues*, PEW RSCH. CTR. (June 28, 2022), https://www.pewresearch.org/social-trends/2022/06/28/americans-complex-views-on-gender-identity-and-transgender-issues [https://perma.cc/H9LA-CG2G] (reporting that most American adults were not closely following laws related to transgender people in 2022). *But see Americans Have Grown More Supportive of Restrictions for Trans People in Recent Years*, PEW RSCH. CTR. (Feb. 26, 2025), https://www.pewresearch.org/short-reads/2025/02/26/americans-have-grown-more-supportive-of-restrictions-for-trans-people-in-recent-years/ [https://perma.cc/C6Y6-WWZH].

71. Dawson & Kates, *supra* note 10.

72. *See* Adam Nagourney & Jeremy W. Peters, *How a Campaign Against Transgender Rights Mobilized Conservatives*, N.Y. TIMES (Apr. 17, 2023), https://www.nytimes.com/2023/04/16/us/politics/transgender-conservative-campaign.html [https://perma.cc/V863-XT9W].

73. *Id.*

threw everything at the wall" to find "an issue that the candidates were comfortable talking about" and that would serve as a kindling to ignite an emotional response from their base to buoy their political aims.[74]

After the failed efforts to push a bathroom ban in North Carolina backfired in 2016,[75] Mr. Schilling's organization conducted polling that suggested restricting participation in sports for transgender women and youth access to gender-affirming care would best serve their goals.[76] Careful planning among national conservative organizations—including the Alliance Defending Freedom, the Family Policy Alliance, and the Heritage Foundation[77]—helped to successfully integrate these newly developed causes with their other fights against shifting gender norms,[78] efforts to combat structural racism,[79] and limitations on reproductive health care.[80] The result was a boon for Mr. Schilling's organization, which saw a dramatic increase in donations.[81] Yet, Mr. Schilling's belief that "[t]his is a political winner"[82] does not qualify as a valid basis for limiting people's rights.

Consequently, *Skrmetti* stands for more than the constitutionality of gender-affirming care bans. The case represents the Supreme Court's willingness to allow legislatures to—in the words of West Virginia District Court Judge Joseph Goodwin—"creat[e] a 'solution'

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74. *Id.*

75. *See* Deena Prichep, *Transgender Bathroom Bills Are Back, Gaining Traction After Past Boycotts*, NPR (May 6, 2024, at 17:30 ET), https://www.npr.org/2024/05/06/1249406353/transgender-bathroom-bill-republican-states [https://perma.cc/EP9L-ZEBU].

76. *See* Nagourney & Peters, *supra* note 72.

77. *See* Maggie Astor, *G.O.P. State Lawmakers Push a Growing Wave of Anti-Transgender Bills*, N.Y. TIMES (June 20, 2023), https://www.nytimes.com/2023/01/25/us/politics/transgender-laws-republicans.html [https://perma.cc/S338-8ZEH].

78. *See* Dan Cassino, *Why Are Republicans So Focused on Restricting Trans Lives?*, WASH. POST (Mar. 21, 2022), https://www.washingtonpost.com/politics/2022/03/21/republican-trans-sports-texas-idaho-lgbtq/ [https://perma.cc/64W9-9VNG].

79. *See* Jean Yi, *Why Trans Rights Became the GOP's Latest Classroom Target*, FIVETHIRTYEIGHT (May 12, 2022, at 06:00 ET), https://fivethirtyeight.com/features/why-trans-rights-became-the-gops-latest-classroom-target/ [https://perma.cc/945W-9R93].

80. *See* Ariel Cohen & Sandhya Raman, *With* Roe *Overturned, Trump's GOP Turns to Transgender Health Care*, ROLL CALL (July 16, 2024, at 18:20 ET), https://rollcall.com/2024/07/16/with-roe-overturned-trumps-gop-turns-to-transgender-health-care/ [https://perma.cc/9L99-ZZGB].

81. *See* Nagourney & Peters, *supra* note 72.

82. Astor, *supra* note 77.

in search of a problem."[83] Legislatures are not free to do whatever they wish because any action is inevitably going to impact the freedoms, rights, and liberties of someone.[84] The police powers of the states allow government action that protects or promotes the public's health, safety, or welfare,[85] meaning when states restrict access to gender-affirming care the prohibitions must relate back to these interests in some tangible way.[86]

Though there may be some slight variations, the bans across the country are practically identical because much of the legislation is based off of the same model law that states were provided.[87] As a result, examining the first law passed, and challenged, in Arkansas

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83. B.P.J. v. W. Va. State Bd. of Educ., 649 F. Supp. 3d 220, 227 (S.D. W. Va. 2023).

84. *See* Michael R. Ulrich, *The Second Amendment's Second Sex*, 134 YALE L.J.F. 125, 155 (2024).

85. *See* Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905); *see also* Hill v. Colorado, 530 U.S. 703, 715 (2000) ("It is a traditional exercise of the States' 'police powers to protect the health and safety of their citizens.'" (quoting Medtronic, Inc. v. Lohr, 518 U.S. 470, 475 (1996))); Barsky v. Bd. of Regents of the Univ. of N.Y., 347 U.S. 442, 449 (1954) ("It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power.").

86. *See* Lawton v. Steele, 152 U.S. 133, 136-137 (1894) ("To justify the State in thus interposing its authority in behalf of the public, it must appear, first, that the interests of the public generally, as distinguished from those of a particular class, require such interference; and, second, that the means are reasonably necessary for the accomplishment of the purpose, and not unduly oppressive upon individuals."); *see also Jacobson*, 197 U.S. at 25 ("A local enactment or regulation, even if based on the acknowledged police powers of a [s]tate, must always yield in case of conflict with the exercise by the [g]eneral [g]overnment of any power it possesses under the Constitution, or with any right which that instrument gives or secures.").

87. Since 2023, the Family Policy Alliance's Help Not Harm campaign has lobbied Republican legislators to pass twenty-five instances of Help Not Harm legislation, or the gender-affirming care bans. *See Help Not Harm*, FAM. POL'Y ALL., https://familypolicyalliance.com/help-not-harm/ [https://perma.cc/6DD5-Y2YW]. The Family Policy Alliance describes itself as "Christian ministries that defend faith and protect families by organizing, educating and mobilizing the social conservative movement in America" to, among other things, combat "the transgender agenda." *About Us*, FAM. POL'Y ALL., https://familypolicyalliance.com/about-us/ [https://perma.cc/5UVP-UEVC]. One key difference is how the laws treat minors already undergoing care. Some states, like Louisiana, permitted a minor to continue to receive their medication and be "weaned off" slowly to avoid harm of immediate cessation. *See* Stop Harming our Kids Act, LA. STAT. ANN. § 40:1098.2(D) (2025). That contrasts with Mississippi's law, which was an immediate, complete ban on gender- affirming care, including conduct that "aids or abets the performance or inducement of gender transition procedures." Regulate Experimental Adolescent Procedures (REAP) Act, MISS. CODE ANN. § 41-141-5 (West 2025).

provides a general understanding of what the laws entail.[88] Labelled the "Save Adolescents from Experimentation (SAFE) Act," House Bill 1570 made clear from its title what the arguments were to support its importance and constitutionality.[89] Under this law, health care professionals are explicitly prohibited from providing any "gender transition procedures" to minors or referring them to another provider for those procedures.[90] The Act defines "gender transition procedures" to include, in essence, any treatment that alters, removes, or creates physical or anatomical characteristics that differ from the minor's sex assigned at birth, such as puberty-blocking medication and hormone therapy.[91] The Act also prohibits referrals,[92] bans health coverage, and eliminates any public funding coverage, including through Medicaid and grants to institutions and organizations.[93] Efforts to federalize this approach have now come through executive order as well.[94]

As the statute's name suggests, states banning gender-affirming care maintain that these are noble pursuits aimed at protecting youth from unnecessary harm.[95] Though some states have more

88. Some states did not wait for legislation to pass. Before Texas passed its ban, the Attorney General and Governor declared the ban unnecessary to prosecute anyone that enabled access to such care due to existing child abuse laws. Tex. Off. of the Att'y Gen., Opinion No. KP-0401, Whether Certain Medical Procedures Performed on Children Constitute Child Abuse 2 (Feb. 18, 2022). The state began investigations into parents of transgender youth soon thereafter, which the Texas Supreme Court sanctioned even before allowing the subsequent ban to take effect. *In re* Abbott, 645 S.W.3d 276, 280 (Tex. 2022); Eleanor Klibanoff, *Texas Resumes Investigations into Parents of Trans Children, Families' Lawyers Confirm*, TEX. TRIB. (May 20, 2022, at 13:17 CT), https://www.texastribune.org/2022/05/20/trans-texas-child-abuse-investigations/ [https://perma.cc/R76P-SMWE].

89. H.B. 1570, 93d Gen. Assemb., Reg. Sess. (Ark. 2021) (codified at ARK. CODE ANN. §§ 20-9-1501 to -1504).

90. ARK. CODE ANN. § 20-9-1502(a)-(b) (West 2025).

91. *See id.* § 20-9-1501(6)(A). The Act uses the term "biological sex," though Professor Jessica Clarke explains the problems with this term, including its rise to prominence specifically to deny the validity of transgender identities. *See* Jessica A. Clarke, *Sex Assigned at Birth*, 122 COLUM. L. REV. 1821, 1838-50 (2022).

92. *See* ARK. CODE ANN. § 20-9-1502(b) (West 2025).

93. *See id.* § 20-9-1503(a), (d).

94. *See* Exec. Order No. 14187, 90 Fed. Reg. 8771 (Jan. 28, 2025).

95. Other names include the Vulnerable Child Compassion and Protection Act, ALA. CODE § 26-26-1 (2025); The Stop Harming Our Kids Act, LA. STAT. ANN. § 40:1098 (2025); the Youth Health Protection Act, MONT. CODE ANN. § 50-4-1001 (2025); the Let Them Grow Act, NEB. REV. STAT. § 71-7301 (2025); and South Dakota's law, colloquially known as the "Help Not Harm" bill, *see Noem Signs Bill Prohibiting Certain Care for Transgender Youth*, S.D. PUB. BROAD. (Feb. 13, 2023, at 16:55 CT), https://www.sdpb.org/politics/2023-02-13/noem-signs-bill-

overtly connected restrictions to religious and moral opposition,[96] states have primarily relied on medical and scientific justifications to support banning gender-affirming care. The focus on minors was meant to grant states more legal leeway through protective claims that—even with the informed consent process—youth would still make decisions that are uninformed and impulsive and that do not take into consideration long-term consequences.[97]

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prohibiting-certain-care-for-transgender-youth [https://perma.cc/Y8JF-R7LW]; S.D. CODIFIED LAWS §§ 34-24-33 to -38 (2026).

96. *See* Brendan Farrington, *Florida Gov. DeSantis Signs Bills Targeting Drag Shows, Trans Rights and Care for Transgender Children*, PBS NEWS (May 17, 2023, at 14:09 ET), https://www.pbs.org/newshour/politics/florida-gov-desantis-signs-bills-targeting-drag-shows-trans-rights-and-care-for-transgender-children [https://perma.cc/2G48-LFPQ] (reporting that the sponsor of the ban on gender-affirming care, Representative Randy Fine, defended the legislation by stating "God does not make mistakes with our children"); Devan Cole, *Mississippi Enacts Ban on Gender-Affirming Care for Transgender Minors*, CNN (Feb. 28, 2023, at 18:07 ET), https://www.cnn.com/2023/02/28/politics/mississippi-transgender-health-care-ban [https://perma.cc/4BBS-UV4V] (quoting Governor Reeves, who, while signing the ban, stated: "[T]here are two positions here. One tells children that they're beautiful the way they are. That they can find happiness in their own bodies. The other tells them that they should take drugs and cut themselves up with expensive surgeries in order to find freedom from depression. I know which side I'm on"). While waiting for their ban to pass, South Carolinian legislators enacted the Medical Ethics and Diversity Act, which empowered medical practitioners, health care institutions, and health care payers to deny providing or paying for any health care they opposed based on religious, moral, or ethical beliefs. *See* S.C. CODE. ANN. § 44-139-30(A) (2025). The denial can be based on religious, moral, or ethical beliefs, so the law grants a broad ability to refuse care without concern for the sincerity or medical logic of such a refusal. *See id.* § 44-139-10(D). The refusal can come at any point during the medical process, including examination, testing, and diagnosis, and could include mental health care, such as psychological therapy or counseling. *See id.* § 44-139-20(4). The inclusion of mental health services is particularly confusing because it has no bearing on the minor's physical state, which is the central point of restricting gender-affirming care. Indeed, some opposition around gender-affirming care has relied on emphasizing therapy as a means to deal with gender dysphoria. Threatening, investigating, and criminalizing parents and third parties, using religious and moral justifications, and denying mental health services all cast doubt on suggestions that states were simply motivated by protecting minors from the potential risks and long-term consequences of these treatments.

97. *See, e.g.*, Letter from Douglas A. Ducey, Governor of Ariz., to Katie Hobbs, Sec'y of State of Ariz. (Mar. 30, 2022), https://azgovernor.gov/sites/default/files/sb1138_sb1165_signing_letter.pdf [https://perma.cc/3KQ8-XDJJ] ("The irreversible nature of these procedures underscores why such a decision should be made as an adult, not as a child, and further supports the importance of this legislation."); Megan Henry, *Lawmaker Behind Bill Blocking Gender-Affirming Care Believes Care Is 'Child Abuse'*, OHIO CAP. J. (Nov. 16, 2023, at 04:50 ET), https://ohiocapitaljournal.com/2023/11/16/lawmaker-behind-bill-blocking-gender-affirming-care-believes-that-kind-of-care-is-child-abuse/ [https://perma.cc/TF4C-3FWJ] (quoting Representative Gary Click, a sponsor of Ohio's bill, who stated, "[t]he [Save Adolescents from Experimentation (SAFE)] Act portion of this bill protects the bodily integrity

Using informed consent to limit patient autonomy when the very purpose is to promote autonomy—ensuring patients can make an informed and voluntary decision that aligns with their own personal values—is apparently a contradiction lost on proponents of these bans.[98] Importantly, the purpose of informed consent is not to prevent someone from undergoing any treatment that includes risks or to enable others to determine for the patient whether the risks outweigh the benefits.[99] Informed consent's primacy in medical care is distinctly opposed to the formerly paternalistic practice of medicine that empowered the physician to make all decisions about what was best for the patient.[100] Bans on gender-affirming care then are part of a larger shift in which states are increasingly harkening back to an era of reduced patient autonomy, only with government officials supplanting the totalitarian role formerly occupied by physicians.[101]

States can point to the fact that the law does generally treat minors as unable to make their own medical decisions,[102] though historically decision-making authority has belonged to the parent or legal guardian and typically includes the minor's assent.[103] Yet, gender-affirming care bans make no exceptions for circumstances in which the parents, minor, and clinician agree,[104] demonstrating a lack of trust in all parties involved.[105] This raises questions about

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and mental health of children who are unable to provide informed consent by providing necessary guardrails around the medical industry").

98. *See* RUTH R. FADEN & TOM L. BEAUCHAMP IN COLLABORATION WITH NANCY M.P. KING, A HISTORY AND THEORY OF INFORMED CONSENT 274-80 (1986).

99. Informed consent could be considered, at least in part, an effort to minimize risks, but the general concern is understanding risks and benefits, alternatives, and the consequences of patients' decisions which they are able to clearly communicate. *See* Paul S. Applebaum, *Assessment of Patients' Competence to Consent to Treatment*, 357 NEJM 1834, 1834, 1836 (2007).

100. *See* Cobbs v. Grant, 502 P.2d 1, 9-10 (Cal. 1972).

101. Ulrich, *supra* note 47, at 855.

102. *See, e.g.*, CAL. FAM. CODE § 6910 (West 2026). *See generally Pediatric Decision Making*, AM. MED. ASS'N. CODE OF MED. ETHICS, https://code-medical-ethics.ama-assn.org/ethics-opinions/pediatric-decision-making [https://perma.cc/S8NV-QM2N] (outlining special ethical considerations relevant to providing medical care to minors).

103. *See* Megan S. Wright, Claudia Kraft, Michael R. Ulrich & Joseph J. Fins, *Disorders of Consciousness, Agency, and Health Care Decision Making: Lessons from a Developmental Model*, 9 AM. J. BIOETHICS NEUROSCI. 56, 58-59 (2018).

104. *See, e.g.*, IOWA CODE § 147.164 (2025).

105. *See* Doe v. Ladapo, 737 F. Supp. 3d 1240, 1290 (N.D. Fla. 2024) ("That there are risks

the sincerity of state explanations centered on uninformed decision-making, especially when considering the ability of parents and minors to make other medical decisions.[106] An outright prohibition is better understood as either determining prospectively that the benefits will never outweigh the risks for any minor or that gender-affirming care has no benefits at all. With efforts to expand prohibitions beyond those under eighteen years of age, the latter seems a more accurate description of the ban proponents' intentions.[107]

This type of extreme paternalism is exceedingly rare in medicine, if not utterly singular.[108] To declare that there is no benefit from gender-affirming care—medical care that has existed for decades before efforts to restrict access became in vogue[109]—for any transgender youth should be difficult to justify. To support the proposition that this care is without benefits, or that it is too risky or dangerous, states assert that gender-affirming care is categorically experimental.[110] Much of this allegation centers on the lack of data gathered in randomized controlled trials (RCTs).[111] A double-blind randomized controlled trial, in which neither the participant nor the researcher is aware of which treatment option is given to a participant, is generally considered the gold standard in evaluating

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of the kind presented here is not a rational basis for denying properly screened patients the option to choose this treatment.").

106. *See infra* notes 367-74 and accompanying text.

107. *See* Azeen Ghorayshi, *Many States Are Trying to Restrict Gender Treatments for Adults, Too*, N.Y. TIMES (Apr. 22, 2023), https://www.nytimes.com/2023/04/22/health/transgender-adults-treatment-bans.html [https://perma.cc/7CUC-C948]; Astor, *supra* note 77.

108. Though it is impossible to cite to the absence of such extreme limitations, there are examples provided later of treatments that are less regulated or specifically exempted despite carrying significant risks, lacking definitive data for minors, having irreversible impact on sterility, and serving no medical need. *See infra* notes 302-09 and accompanying text.

109. *See* Jeremi M. Carswell, Ximena Lopez & Stephen M. Rosenthal, *The Evolution of Adolescent Gender-Affirming Care: An Historical Perspective*, 95 HORMONE RSCH. PAEDIATRICS 649, 651-52 (2022).

110. *See* Andy Rose & Jack Forrest, *Iowa's Governor Signs Law Banning Gender-Affirming Care for Minors*, CNN (Mar. 22, 2023, at 22:29 ET), https://www.cnn.com/2023/03/22/politics/iowa-gender-affirming-care-ban [https://perma.cc/G49W-JJ2C] (quoting Republican state Representative Steven Holt, who stated that the treatment is too "experimental" and "that the medical efficacy of these treatments is not proven"); *Doe*, 737 F. Supp. 3d at 1273.

111. *See, e.g.*, Koe v. Noggle, 688 F. Supp. 3d 1321, 1353-56 (N.D. Ga. 2023) (rejecting the argument a total ban is warranted because gender-affirming care is supported with "low-quality" evidence).

efficacy.[112] But this is not the only way to conduct rigorous and credible research concerning safe and effective treatments.[113] Ethical considerations such as clinical equipoise—the requirement that there be genuine uncertainty regarding the treatments that research participants can be randomized to—can also prevent RCTs from gaining approval from institutional review boards (IRBs) for gender-affirming care research given that data already exists demonstrating safety and efficacy.[114] Beyond that, other study methodologies, such as cross-sectional studies and longitudinal studies, are used extensively and considered viable forms of generating valid information on medical treatments.[115]

States rejected existing data gathered using these other forms of research methods, arguing the evidentiary support lacked high-quality, long-term data that left harmful effects for gender-affirming care unknown.[116] As a result, states considered the potential long-term harms, some of which they categorized as irreversible, to outweigh any unsubstantiated benefits.[117] For example, Tennessee cited concerns for "becoming irreversibly sterile," the more ambiguous fear of "increased risk of disease and illness," and "adverse and sometimes fatal psychological consequences."[118] Accordingly, Tennessee outright rejected the notion that gender-affirming care is consistent with medical standards at

112. *See* Eduardo Hariton & Joseph J. Locascio, *Randomised Controlled Trials—The Gold Standard for Effectiveness Research*, 125 BRIT. J. OBSTETRICS & GYNAECOLOGY 1716, 1716 (2018).

113. *See* Angus Deaton & Nancy Cartwright, *Understanding and Misunderstanding Randomized Controlled Trials*, 210 SOC. SCI. & MED. 2, 17 (2018).

114. *See* Florence Ashley, Diana M. Tordoff, Johanna Olson-Kennedy & Arjee J. Restar, *Randomized-Controlled Trials Are Methodologically Inappropriate in Adolescent Transgender Healthcare*, 25 INT'L J. TRANSGENDER HEALTH 407, 408 (2024); Simona Giordano & Søren Holm, *Is Puberty Delaying Treatment 'Experimental Treatment'?*, 21 INT'L J. TRANSGENDER HEALTH 113, 115-16 (2020).

115. *See* Ashley et al., *supra* note 114, at 412-13.

116. *See, e.g.*, TENN. CODE ANN. § 68-33-101(b) (West 2025); Joanna Wuest & Briana S. Last, *Agents of Scientific Uncertainty: Conflicts Over Evidence and Expertise in Gender-Affirming Care Bans for Minors*, 344 SOC. SCI. & MED. 5 (2024), https://www.sciencedirect.com/science/article/pii/S0277953623008900 [https://perma.cc/W3VY-2S7Q].

117. *See* TENN. CODE ANN. § 68-33-101(b). Arkansas's SAFE Act included this legislative finding: "The risks of gender transition procedures far outweigh any benefit at this stage of clinical study on these procedures." *See* H.B. 1570, 93d Gen. Assemb., Reg. Sess. (Ark. 2021).

118. TENN. CODE ANN. § 68-33-101(b).

all.[119] This stance requires either ignoring medical consensus[120] or considering any opposing viewpoint as sufficient to qualify as medical uncertainty.[121]

The FDA also plays a key role in state efforts to categorize gender-affirming care as experimental.[122] States highlight that while the medications used in gender-affirming care have been approved by the FDA as safe and effective, the agency has not granted their explicit approval for the purpose of transitioning.[123] States equate this to the FDA concluding these treatments are not safe and effective when used on transgender minors.[124] This

119. *See id.* § 68-33-101(c).

120. *See Medical Association Statements in Support of Health Care for Transgender People and Youth*, GLAAD (June 26, 2024), https://glaad.org/medical-association-statements-supporting-trans-youth-healthcare-and-against-discriminatory/ [https://perma.cc/U8YQ-M3QJ] (collecting the statements of over thirty major medical organizations that support gender-affirming care); 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 NEJM 240, 245 (2023); Annelou L.C. de Vries & Sabine E. Hannema, *Growing Evidence and Remaining Questions in Adolescent Transgender Care*, 388 NEJM 275, 276-77 (2023) ("Despite uncertainties that call for further study, current information shows that mental health improves with [gender-affirming hormones (GAH)], whereas withholding treatment may lead to increased gender dysphoria and adversely affect psychological functioning."); *Developments in the Law—Intersections in Healthcare and Legal Rights*, 134 HARV. L. REV. 2158, 2165 (2021).

121. *See* Meredithe McNamara, Christina Lepore & Anne Alstott, *Protecting Transgender Health and Challenging Science Denialism in Policy*, 387 NEJM 1919, 1920 (2022); United States v. Skrmetti, 145 S. Ct. 1816, 1836-37 (2025).

122. States banning treatments approved by the FDA raises preemption questions under the Supremacy Clause, but a complete examination of that issue is beyond the scope of this Article. *See* U.S. CONST. art. VI, cl. 2; Zogenix, Inc. v. Patrick, No. 14-11689, 2014 WL 1454696, at *2 (D. Mass. Apr. 15, 2014) (enjoining Massachusetts's ban on Zohydro ER because "[w]hen the Commonwealth interposed its own conclusion about Zohydro ER's safety and effectiveness ... it obstruct[ed] the FDA's Congressionally-given charge"); *see also* Lewis A. Grossman, *Criminalizing Transgender Care*, 110 IOWA L. REV. 281, 293 (2024). In *Wyeth v. Levine*, the Court noted there is a presumption against preemption when states act within the traditional realms of their police power unless it conflicts with a "clear and manifest purpose of Congress." 555 U.S. 555, 565 (2009). This Article's discussion of police powers then may be relevant to a preemption analysis. Though, as Professor Patricia Zettler has demonstrated, whether the state action falls within its traditional role of regulating the practice of medicine—and as a result should be exempt from FDA preemption—is no longer the primary focus as courts examine the underlying intent of the state. *See* Patricia J. Zettler, *Pharmaceutical Federalism*, 92 IND. L.J. 845, 886 (2017).

123. *See, e.g.*, L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 478 (6th Cir. 2023).

124. *See id.* ("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

position, however, distorts the scope of the statutory authorization that the FDA must operate within.[125]

Congress did not task the agency with evaluating a drug or device for any and every type of use, but more precisely with evaluating only the specific treatment for which the manufacturer submits the drug or device.[126] The FDA's approval for one type of use does not speak to the safety and efficacy of other potential applications of the drug or device, known as off-label uses, once approved and on the market.[127] Nevertheless, these off-label uses are commonplace in medicine, legal in every state, and essential for a wide range of health care treatments.[128] Some states still contend that, at the very least, the lack of approval lends credibility to claims of uncertainty for both the safety and efficacy of gender-affirming care, regardless of its reliance on treatments approved by the FDA for other diagnoses.[129]

These arguments provide some understanding of states' typical justifications for banning gender-affirming care for minors, but they likely understate the fervency of the opposition. The experimental label is meant to intimate more than a lack of clarity around safety and efficacy or a hesitancy that merely calls for more data. For example, Idaho's statute restricts the ability of a clinician to

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presents unacceptable dangers.").

125. *See generally* David A. Kessler, *The Regulation of Investigational Drugs*, 320 NEJM 281, 281 (1989) (discussing FDA regulations of investigational drug trials).

126. *See* 21 U.S.C. § 355. The FDA regulates the marketing, sale, promotion, and entry of drugs in the United States. *See* Kessler, *supra* note 125, at 281. To have a drug approved for a specific purpose, the drug sponsor must submit an application to the FDA, undergo rigorous clinical trials, and comply with the FDA's standards for safety and efficacy. *See generally id.* (explaining the FDA's process for regulating new investigational drugs); 21 C.F.R. §§ 300-330 (2025) (implementing the regulatory framework for FDA drug approval).

127. *See* Wendy Teo, *FDA and the Practice of Medicine: Looking at Off-Label Drugs*, 41 SETON HALL LEGIS. J. 305, 311-13 (2017); William L. Christopher, *Off-Label Drug Prescription: Filling the Regulatory Vacuum*, 48 FOOD & DRUG L.J. 247, 248 (1993).

128. *See* Barbara A. Noah, *Just a Spoonful of Sugar: Drug Safety for Pediatric Populations*, 37 J.L. MED. & ETHICS 280, 281 (2009) (noting that drugs are often prescribed "off-label" for children, as drugs are typically tested on and approved by the FDA only for adults); *see also* James M. Beck & Elizabeth D. Azari, *FDA, Off-Label Use, and Informed Consent: Debunking Myths and Misconceptions*, 53 FOOD & DRUG L.J. 71, 76-85 (1998) (positing that off-label use is ubiquitous throughout medical care, ethical, and legal under both common law and state statutory protections).

129. *See L.W.*, 83 F.4th at 478.

"mutilate" a child's genitals.[130] Justice Gorsuch echoed the hyperbolic descriptor in a concurrence allowing Idaho's ban to go into effect, referring to the state's desire to prevent "the surgical removal of children's genitals."[131] This extreme labeling of all gender-affirming care was then reaffirmed in a White House Executive Order entitled "Protecting Children From Chemical and Surgical Mutilation," which alleged that "[a]cross the country ... medical professionals are maiming and sterilizing a growing number of impressionable children."[132] The Order goes on to define "chemical and surgical mutilation" to include hormones and puberty blockers, despite their common use in other treatments for minors.[133] In his *Skrmetti* concurrence, Justice Thomas references castration as he explains why states might "reasonably question whether any of the banned treatments" could ever be medically necessary.[134]

States have put forth witnesses to supplement the goal of extinguishing any legitimacy attached to gender-affirming care. Rather than providing expert medical insight, as one might reasonably expect, this small group of "experts" has instead compared gender-affirming care to the atrocities conducted in the Tuskegee and Nazi experiments,[135] and to eugenics more generally;[136] opined on the influence of the fictitious "Transgender Treatment Industry;"[137] and expressed concern over the impact on sexual function based on a reality television show.[138] These fraudulent descriptions are meant to demonize opponents of gender-affirming care bans and any clinicians who have or would provide any type of gender-affirming care. Other proclamations from state witnesses that youth have merely been conned into confusion because of "Internet involvement with trans websites" and "trans 'influencers' on Internet sources such as video blogs on YouTube,"[139] not only

130. IDAHO CODE § 18-1506C(3)(a) (2024).

131. Labrador v. Poe *ex rel.* Poe, 144 S. Ct. 921, 923 (2024) (mem.) (Gorsuch, J., concurring).

132. Exec. Order No. 14187, 90 Fed. Reg. 8771 (2025).

133. *See id.*

134. United States v. Skrmetti, 145 S. Ct. 1816, 1844 n.5 (2025) (Thomas, J., concurring).

135. *See* Declaration of Stephen B. Levine, M.D., ¶ 112, Brandt v. Rutledge, 677 F. Supp. 3d 877 (E.D. Ark. 2023) (No. 21-cv-00450).

136. *See* Kadel v. Folwell, 620 F. Supp. 3d 339, 370 (M.D.N.C. 2022).

137. *Id.*

138. L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 704 n.48 (M.D. Tenn. 2023).

139. *See* Declaration of Stephen B. Levine, M.D., *supra* note 135, ¶ 10, 20. Dr. Levine

undercut gender-affirming care but deny the very existence of transgender people. This sort of rhetoric—used with no credible studies or sources in support—is meant to detach gender-affirming care from the realm of credible medicine. This framing tries to pull the debate away from health, medicine, and science, and to diminish the legal relevance of the stark discrepancy these bans have with research and expert opinions. The issue instead can be labeled a product of immature youth being duped by trans influencers and educational programs.[140] The extremity of the unsubstantiated claims and conspiracy theories helps to contextualize the radical absolutism in these state bans.[141]

The exceptions in these prohibitions[142]—none of which are related to providing gender-affirming care to transgender minors[143]—also infer a rejection of gender-affirming care as medical care, if not the entire existence of transgender youth. Bans such as the one in Idaho even go so far as to explicitly state that it is never necessary to the health of the child to provide treatment that is meant to affirm "the child's perception of the child's sex if that perception is inconsistent with the child's biological sex."[144] Even efforts to limit abortions to the greatest extent possible typically include exceptions for serious risks to the health and life of the pregnant person.[145] Though there are serious and ongoing questions about the ambiguity and narrow applications of these abortion

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claims he has never seen "a trans adolescent who has not spent countless hours on trans Internet sites" and refers to patients being influenced by "school trans awareness training programs[.]" *Id.* at ¶ 15.

140. *See id.*

141. *See* Poe *ex rel.* Poe v. Labrador, 709 F. Supp. 3d 1169, 1194 (D. Idaho 2023) (contemplating Idaho state ban).

142. Exceptions include surgery on intersex infants. *See* ARK. CODE ANN. § 20-9-1502(c)(1) (West 2025); IDAHO CODE § 18-1506B(4) (2025).

143. *See, e.g.*, TENN. CODE ANN. § 68-33-103(b)(1)(A) (West 2025) (permitting the use of puberty and hormone blockers for precocious puberty); KY. REV. STAT. ANN. § 311.372(3)(c) (West 2025) (allowing care to treat minors who have suffered injuries caused by gender-affirming care).

144. IDAHO CODE § 18-1506C(1)(3) (2025).

145. *See* Mabel Felix, Laurie Sobel & Alina Salganicoff, *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, KAISER FAM. FOUND. (June 6, 2024), https://www.kff.org/womens-health-policy/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/ [https://perma.cc/W4CV-3B2J]. All states banning abortion have an exception to "preserve the life" of or "prevent the death" of the pregnant person. *Id.*

exceptions,[146] at the very least their inclusion acknowledges that abortion is in fact medical care that can be necessary in some circumstances.[147]

The credibility of the claims made both by states and their medical witnesses is certainly pertinent to the constitutional analysis of gender-affirming care bans; yet lower courts used them almost exclusively to determine the right at stake and, as a result, the standard of review the court applied.[148] Whether gender-affirming care was deemed experimental, for instance, carried considerable weight in deciding whether these bans interfered with constitutionally protected parental rights or if they qualified as discrimination warranting heightened scrutiny.[149] This was crucial because in the lower courts, rational basis review resulted in upholding the restrictions and heightened scrutiny resulted in striking them down, rendering the conclusion on the applicable standard dispositive and the application of the standard practically moot. As a result, the medical validity of state justifications can essentially be tied directly to the case outcomes by impacting how the courts frame the right at issue in the first place.

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146. *See* Anisha Kohli, *Doctors Are Still Confused by Abortion Exceptions in Louisiana. It's Limiting Essential Care*, TIME (May 24, 2023, at 15:11 ET), https://time.com/6282288/louisiana-abortion-exceptions-confusion-doctors/ [https://perma.cc/UJH3-M9P6]; Elissa Nadworny & Selena Simmons-Duffin, *Abortion Bans Still Leave a 'Gray Area' for Doctors After Idaho Supreme Court Case*, NPR (June 28, 2024, at 08:11 ET), https://www.npr.org/sections/shots-health-news/2024/06/28/nx-sl-5021863/idaho-abortion-emergency-supreme-court-case-reaction [https://perma.cc/Q6SN-PUBU]; David S. Cohen, Greer Donley & Rachel Rebouché, *The New Abortion Battleground*, 123 COLUM. L. REV. 1, 72-76 (2023) (discussing the vagueness in abortion exceptions and the possibility that the Emergency Medical Treatment and Labor Act (EMTALA) preempts restrictive state laws); Teneille R. Brown, *Abortion and the Extremism of Bright Line Rules*, 119 NW. L. REV. ONLINE 1, 12-15 (2024), https://northwesternlawreview.org/articles/abortion-and-the-extremism-of-bright-line-rules/ [https://perma.cc/26VM-ZBKC].

147. *See* Jane Stoever, *Legally Recognizing Reproductive Coercion While Questioning Sexual Violence Exceptionalism*, 51 J.L., MED. & ETHICS 560, 562-63 (2023).

148. *See, e.g.*, Poe v. Drummond, 697 F. Supp. 3d 1238, 1257 (N.D. Okla. 2023) ("Defendants' framing of the issue is consistent with the approach approved by the Supreme Court. They define the asserted right as 'a fundamental right for parents to choose for their children to use puberty blockers, cross-sex hormones, and surgeries for the purposes of effectuating a gender transition.'").

149. *See, e.g.*, L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 478 (6th Cir. 2023).

B. The Relevance of Framing Rights

Much of the case law and literature on transgender rights have focused on—perhaps understandably—rights.[150] Rights to medical care,[151] parental rights to direct the health care of their children,[152] rights of clinicians to practice medicine,[153] and the right to equal treatment under the law.[154] The discrepancies in the lower courts have centered on the parental right and the right to equal protection, though the Supreme Court granted certiorari only to the equal protection claims.[155] The desire to get courts to apply a heightened level of scrutiny is clear, and given the impact this determination has had in the lower courts, the effort is logical.[156] But when looking at lower court outcomes, it is apparent that framing the right at

150. *See, e.g.*, Katie Eyer, *Transgender Constitutional Law*, 171 U. PA. L. REV. 1405, 1415-53 (2023).

151. *See, e.g.*, Edmo v. Corizon, Inc., 935 F.3d 757, 787-97 (9th Cir. 2019) (per curiam) (upholding the decision that gender-confirming surgery was medically necessary).

152. *See, e.g.*, Poe *ex rel.* Poe v. Labrador, 709 F. Supp. 3d 1169, 1195 (D. Idaho 2023) ("[T]he appropriately precise way to frame the issue is to ask whether parents' fundamental right to care for their children 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. And the Court has no difficulty concluding that such a right is deeply rooted in our nation's history and traditions and implicit in our concept of ordered liberty.").

153. *See, e.g.*, Doe v. Ladapo, 737 F. Supp. 3d 1240, 1285 (N.D. Fla. 2024) ("The provision requiring a physician, not a nurse, to give an injection—or even perhaps precluding a pharmacist from filling a prescription—is either extraordinarily poor statutory craftsmanship or an animus-based roadblock intended to reduce access to care. The provision survives neither rational-basis nor intermediate scrutiny."); K.C. v. Individual Members of Med. Licensing Bd. of Ind., 677 F. Supp. 3d 802, 818-20 (S.D. Ind. 2023) (finding likelihood of success that Indiana's law that prohibits physicians from aiding or abetting another practitioner in the provision of gender-affirming care violates the First Amendment), *rev'd*, 121 F.4th 604 (7th Cir. 2024).

154. *See, e.g.*, Fowler v. Stitt, 104 F.4th 770, 794-97 (10th Cir. 2024) (reversing district court opinion rejecting an equal protection claim), *cert. granted and judgment vacated*, 145 S. Ct. 2840 (2025).

155. The United States' petition only raises the equal protection claim, but the ACLU's petition included this and the parental rights claim. Petition for a Writ of Certiorari at 26, 34, L.W. *ex rel.* Williams v. Skrmetti, 144 S. Ct. 2679 (2024) (No. 23-466). Both arguments are considered here, with *Skrmetti* leaving a parental rights challenge open.

156. *Compare* Koe v. Noggle, 688 F. Supp. 3d 1321, 1344-57 (N.D. Ga. 2023) (holding that Georgia's ban discriminated on the basis of natal sex and gender nonconformity, and failed to satisfy heightened scrutiny), *with* Poe v. Drummond, 697 F. Supp. 3d 1238, 1259-64 (N.D. Okla. 2023) (applying rational basis review to both constitutional questions and upholding the statute).

issue has merged with the court's evaluation of state justifications in an opaque way that practically predetermines the outcome.[157]

This issue of framing is perhaps clearest when considering the parental right to make decisions concerning the "care, custody, and control of [one's] children,"[158] which was not foreclosed by *Skrmetti*.[159] Centering access to gender-affirming care as a parental right comes with some risks,[160] but it is sensible to highlight how the bans infringe on a right that the Supreme Court called "perhaps the oldest of the fundamental liberty interests recognized by this Court."[161] If courts agree, the laws are subject to strict scrutiny and more likely to be struck down.[162] But the two circuit courts that allowed bans to go into effect framed the parental right much more narrowly.

In *L.W. v. Skrmetti*, a significant reason the Sixth Circuit Court of Appeals allowed Tennessee's gender-affirming care ban to go into effect was because the court framed the asserted right as "access to an experimental drug."[163] The Sixth Circuit acknowledged a substantive due process parental right to make decisions for their children, but cabined the right by proposing the Supreme Court has extended it only to specific aspects of parenting.[164] This framed the challenge to Tennessee's ban as an effort to extend constitutional guarantees to "new medical treatments," which is not deeply rooted in this country's history and traditions, rather than merely reaffirming existing parental protections.[165] The Eleventh Circuit Court of

157. *Poe*, 709 F. Supp. 1198 ("The Sixth and Eleventh Circuit's framing of the fundamental right renders the Fourteenth Amendment largely meaningless. If the right is narrowly defined as the right to seek a specific medical treatment, the entirety of modern medicine would fall outside of the scope of a parent's right to control their children's health care. That is so, because no such medical treatment could be shown to be deeply rooted in our nation's history and traditions.").

158. Troxel v. Granville, 530 U.S. 57, 65 (2000).

159. *See* Transcript of Oral Argument, *supra* note 9, at 64.

160. *See* L.W. *ex rel.* Williams v. Skrmetti, 73 F.4th 408, 419 (6th Cir. 2023) ("The challengers pin their main claims for likelihood of success on the assumption that heightened scrutiny applies.").

161. *Troxel*, 530 U.S. at 65.

162. *See id.* at 66.

163. L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 473 (6th Cir. 2023).

164. *See id.* at 475.

165. *See id.* at 471 ("In each instance, they seek to extend the constitutional guarantees to new territory.").

Appeals followed suit in *Eknes-Tucker v. Governor of Alabama*, chiding the district court for recognizing the "right to treat [one's] children with transitioning medications," especially without any discussion of "the history of the use of puberty blockers or cross-sex hormone treatment."[166] The court found it implausible that the Constitution protected a right to access these medications as part of our nation's deeply rooted history because the earliest-recorded uses of treatment for "discordance between an individual's biological sex and sense of gender identity did not occur until well into the twentieth century."[167]

The Tennessee district court, on the other hand, had framed the parental right at a higher level of generality, rejecting the notion that the right to raise and care for one's child includes education and religion but not health care decisions.[168] The district court was not relying solely on the reasoning that the right to raise one's children would include medical decisions. Rather, it was obligated to follow the explicit direction from the Sixth Circuit's own words in *Kanuszewski v. Michigan Department of Health and Human Services*: "Parents possess a fundamental right to make decisions concerning the medical care of their children."[169] We see the same circumstance in the Eleventh Circuit, where the Alabama district court relied on the court of appeals' holding that "[e]ncompassed within this [parental] right is the more specific right to direct a child's medical care," though "subject to medically accepted standards."[170] With the medical profession's overwhelming support of gender-affirming care, the district court rejected Alabama's ban, finding no credible evidence to support its justifications.[171]

As it turns out, the Sixth and Eleventh Circuits were arguing more with themselves than with the district courts. Their attempts to distinguish their own prior case law directs our attention to

166. *See* 80 F.4th 1205, 1220-21 (11th Cir. 2023).

167. *Id.*

168. *See* L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 683-84 (M.D. Tenn 2023).

169. 927 F.3d 396, 418 (6th Cir. 2019). "Otherwise stated, a parent has a 'fundamental right to make decisions concerning the care, custody, and control of her' children, ... which would seem to naturally include the right to direct their children's medical care." *Id.* (quoting Troxel v. Granville, 530 U.S. 57, 72 (2000)) (citing Parham v. J.R., 442 U.S. 584, 604 (1979)).

170. Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131, 1144 (M.D. Ala. 2022) (citing Bendiburg v. Dempsey, 909 F.2d 463, 470 (11th Cir. 1990)).

171. *See id.* at 1145.

rights framing as well. For example, the Sixth Circuit suggested the constitutional difference was that the government was *compelling* the drawing and storage of blood from newborns in *Kanuszewski*, whereas the gender-affirming care ban concerns *restricting* medical care.[172] This version of parental rights hollows out the scope of protection and hardly limits government interference. So construed, the parental right is limited to directing only medical care that the state grants access to, allowing the government to override the right simply by banning medical care. The Eleventh Circuit similarly sought to thread the needle with the Supreme Court's decision in *Parham v. J.R.* by narrowing that case's relevance only to procedural requirements for a child when a parent wants to utilize lawful treatments.[173] It seems the circular reasoning of upholding a state ban on medical care because there cannot be a right to medical care the state has banned went unnoticed by the members of these two courts.

Both courts' invocation of *Parham* is particularly confusing given the broad—though questionable—deference the Supreme Court granted parents in instances of medical decision-making for their children.[174] The Court held that parents could involuntarily commit their children to mental health facilities with minimal procedural protections for the minor, questioning interference in such important family matters when the "natural bonds of affection lead parents to act in the best interests of their children."[175] The Court also expressed skepticism at the judiciary's role for "questions [that] are essentially medical in character" and so best left for medical experts.[176] Considering the Court's words and the severe deprivation of liberty which accompanies involuntary confinement, it seems

172. *See* L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 476 (6th Cir. 2023).

173. *See* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1222-23 (11th Cir. 2023) (citing Parham v. J.R., 442 U.S. 584, 604, 609 (1979)). The Sixth Circuit did the same. *See L.W.*, 83 F.4th at 476-77.

174. *See L.W.*, 83 F.4th at 476; *Eknes-Tucker*, 80 F.4th at 1222-24. The Eleventh Circuit even quoted *Parham*'s declaration that parents have "plenary authority." *See id.* at 1223. The Supreme Court saw the minor's right to avoid involuntary confinement as "inextricably linked with the parents' interest in and obligation for the welfare and health of the child." Parham v. J.R., 442 U.S. 584, 600 (1979).

175. *Parham*, 442 U.S. at 602. The "protections" the Court found to be required included a "neutral factfinder," which could include a staff physician. *Id.* at 606-07.

176. *See id.* at 607-09.

inarguable that *Parham* stands for a far-reaching parental right when it comes to "the welfare and *health* of the child" that should not be so easily avoided with a narrow framing by lower courts.[177]

The medical assessment of the treatment factors into the equal rights framing as well. The right to equal protection was center stage in the Eighth Circuit's decision in *Brandt ex rel. Brandt v. Rutledge*, upholding the district court's injunction against Arkansas's ban.[178] The Eighth Circuit found that the law discriminated on the basis of sex because "the minor's sex at birth determines whether or not the minor can receive certain types of medical care."[179] The law violated the right to equal access to medical treatments because a minor born as a male can access testosterone, whereas a minor born as a female cannot.[180] The circuit courts that allowed gender-affirming care bans to go into effect, however, saw the reference to sex as a necessity to indicate accessing treatment for the purpose of transitioning.[181] This explains why the Sixth and Eleventh Circuits interpreted the bans along the lines of a narrowly defined right to access medical treatments meant to help transition from a person's sex assigned at birth.[182]

Under the latter framing, the limitation is about a right to access transition treatment, which is equally restricted to all minors.[183] The Eighth Circuit explicitly rejected this argument as one that conflates the classifications used in the law with the justifications for the law.[184] The *Brandt* court found it irrational to suggest that an individual was able to access treatment and procedures only if the government approved of the reason for accessing them.[185] More directly to the equal protection claim, the Eighth Circuit made clear that the government's approval rested entirely on the individual's sex assigned at birth.[186]

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177. *See id.* at 600 (emphasis added).

178. *See* 47 F.4th 661, 671 (8th Cir. 2022).

179. *Id.* at 669.

180. *Id.*

181. *See* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1228 (11th Cir. 2023); L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 481-82 (6th Cir. 2023).

182. *See Eknes-Tucker*, 80 F.4th at 1229-30; *L.W.*, 83 F.4th at 482-83.

183. *See Eknes-Tucker*, 80 F.4th at 1231; *L.W.*, 83 F.4th at 482-83.

184. *See Brandt*, 47 F.4th at 669-70.

185. *See id.* at 670.

186. *See id.* ("The biological sex of the minor patient is the basis on which the law

The courts in each case are purporting to simply identify the right and apply the applicable test, and balancing interests through those tests is something that reasonable people will sometimes do differently.[187] But that process has a transparency and forthrightness lacking in these gender-affirming care cases. As Professor Richard Fallon has pointed out, "the framing of applicable triggering and scrutiny rights require[s] controversial judgments about desirable or undesirable consequences."[188] The deviations in the courts' rights framing for gender-affirming care bans reveal the symbiotic relationship between the courts' evaluating the scope and strength of a right and the government's interest in limiting that right.[189] The rights framing already exposes the court's underlying views about gender-affirming care, gender dysphoria, and transgender people generally and, as a result, an appraisal of what the government is doing.[190] A court's view of the right to such care, regardless of the source of the right, is substantially influenced by how significant and accurate they believe the government's claim of protecting the welfare of minors to be.[191]

This was reflected, perhaps subtly, in the Supreme Court's *Skrmetti* oral argument. Some Justices questioned the presence of discrimination because "it prohibits all boys and girls from transitioning using certain medical treatments."[192] But because transgender minors want access to the care and cisgender minors do not, equating the burden for all minors signifies a view that transgender minors are not being burdened at all. The same is true for parallels drawn between two minors with the same sex assigned at birth who

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distinguishes between those who may receive certain types of medical care and those who may not.").

187. RICHARD H. FALLON, JR., THE NATURE OF CONSTITUTIONAL RIGHTS: THE INVENTION AND LOGIC OF STRICT JUDICIAL SCRUTINY 75 (2019).

188. *Id.* at 50.

189. *See id.* at 66 ("[A]lthough the strict scrutiny formula appears to contemplate categorically separate judicial inquiries into whether a [fundamental] right exists and whether a restriction is narrowly tailored to a compelling governmental interest, those elements are likely to be symbiotically interactive in application.").

190. *Cf. id.* at 50. Professor Fallon makes the point that this type of overlap is ubiquitous in constitutional analyses. *See id.* at 51.

191. *See id.* at 56.

192. Transcript of Oral Argument, *supra* note 9, at 43. Justice Jackson compared this reasoning to arguments made in *Loving v. Virginia*, in which the state argued all races were equally disadvantaged by the miscegenation ban. *See id.* at 144.

can both access hormones only for gender-conforming purposes. Justice Kagan got to the heart of the issue, explaining that the state's classification is clearly based on the view "that there's something fundamentally wrong, fundamentally bad, about youth who are ... trying to transition."[193]

Skrmetti further demonstrates a disregard for transgender people in how the constitutional question is framed. Chief Justice Roberts insisted that the law does not discriminate based on transgender status but merely excludes the use of treatments for certain medical conditions.[194] The narrowly focused exclusion of gender dysphoria, gender identity, and gender incongruence—conditions for which only transgender people would seek access to puberty blockers and hormone therapy—was apparently irrelevant.[195] This stance is so egregiously preposterous that Justice Alito declined to join this portion of the majority opinion.[196] Instead he wrote a concurrence, joined by Justice Thomas, making clear that he believes discriminating based on gender identity is constitutional because the Equal Protection Clause is concerned only with differentiations between "the two biological sexes: male and female."[197]

The problem with covertly incorporating viewpoints on state action into framing the right is that it conceals the Court's assessment of the government's means and ends. By framing the right for gender-affirming care as one tied to accessing "experimental" medication,[198] a court is all but deciding the outcome of the analysis in two respects. First, a "right to access experimental medication" indicates a right that either does not exist or is so trivial that it does not warrant any judicial oversight against government intrusion.[199]

193. *Id.* at 139. According to Justice Kagan, the purpose of the ban "sounds to me like we want boys to be boys and we want girls to be girls." *Id.* at 137.

194. United States v. Skrmetti, 145 S. Ct. 1816, 1829 (2025).

195. *See id.*

196. *See id.* at 1855 (Alito, J., concurring).

197. *See id.* at 1856. Justice Barrett also wrote a concurrence that suggested discriminating on the basis of gender identity is constitutional because, according to her, being transgender is not a trait ascertainable at birth, is not an immutable characteristic, does not define a discrete group that is identifiable, and has not been subject to a history of de jure discrimination. *See id.* at 1849-53, 1855 (Barrett, J., concurring).

198. References to the treatments as "experimental" are found in the majority opinion and the concurrences of Justices Thomas and Alito. *See id.* at 1832 (majority opinion); *id.* at 1844 (Thomas, J., concurring); *id.* at 1859 (Alito, J., concurring).

199. *See* L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 488 (6th Cir. 2023).

The Sixth Circuit confirmed this by comparing the right to access gender-affirming care to the right to "use a drug that the FDA deems unsafe or ineffective."[200] Second, the "right to experimental drugs" framing already casts any state restriction in a protective light.[201] The experimental label does a significant amount of work upfront in diminishing the strength of the challengers' rights claim by painting gender-affirming care as dangerous and risky, with at best uncertain benefits, while simultaneously buoying any alleged state justification from the outset. This challenges the view that analysis over what right is at stake is solely to determine the standard of review that must be applied. This stance could only be accurate if the court actually applies the standard by investigating what it is the government is doing and why. Yet labeling the issue as a right to "experimental" treatment incorporates the "why" examination: The government is acting *because* the treatment is experimental.

The Supreme Court has seemed increasingly uninterested in delving into the government's means and ends,[202] so seeing the issue as the state infringing on "the right to experimental treatment" goes a long way to suggest even a shallow examination of the government's claims is unnecessary. But both the asserted interest of the government and the right to access gender-affirming care dovetail into the rights and wellbeing of the transgender minor. Consequently, the actual impact on the minor should take center stage. This next Part will aim to do just that. Rather than evaluating the state justifications in the context of determining the right, the goal is to provide an accurate examination into the credibility and existing support of state claims to validate their gender-affirming care bans. While rights certainly do act as a constraint on government action, so too does reviewing the legitimacy of the state's authority to act in the first instance. Even a cursory appraisal of state justifications for these bans on medical care reveals a serious constitutional

200. *Id.* at 473 (citing Abigail All. for Better Access to Developmental Drugs v. von Eschenbach, 495 F.3d 695, 703, 706 (D.C. Cir. 2007) (en banc)). They added that this category includes experimental drugs the FDA has banned but a doctor believes might save a terminally ill patient's life. *See id.*

201. *See* Poe *ex rel.* Poe v. Labrador, 709 F. Supp. 3d 1169, 1193 (D. Idaho 2023).

202. *See* Greene, *supra* note 41, at 30.

deficiency that is not reliant on questions of parental rights and heightened equal protection scrutiny.

II. AUTHORITY TO ACT

Even though considerations of the right and state interest coalesce around the wellbeing of transgender youth, transgender health plays a relatively minor (pardon the pun) role in the legal analysis. The debate over how to frame the right all but ensures this. Divergences over the scope of the parental right, while intrinsically tied to the minor's wellbeing, have been more focused on history to determine which paternalistic authority is best suited to control the medical options available to the transgender youth.[203] Meanwhile, the equal protection dispute concentrates primarily on technicalities and textual quarrels in assessing whether banning gender-affirming care qualifies as sex discrimination for purposes of the Fourteenth Amendment.[204] As enjoyable as arguing linguistics and semantics may be for lawyers and judges, there are very real and very serious consequences to these questions that should feature more prominently.[205]

This Part situates the justifications for gender-affirming care bans within the state's authority to act. Evidence supporting the benefits of gender-affirming care should raise concern about government intervention that serves as a complete impediment to accessing care for a population already suffering from poor health. Looking at the health disparities suffered by transgender youth, any link between alleged protection claims and reality begins to dissolve.[206] Without a credible connection between banning health care and alleviating health disparities, the states instead attempt to undermine the supportive data for gender-affirming care to assert that prevention and medical ethics favor their bans.[207] Centering the lived experiences of transgender minors and taking note of the

203. *See supra* Part I.B.
204. *See supra* Part I.B.
205. *See infra* Part II.A.
206. *See infra* Part II.A.
207. *See infra* Part II.B.

inconsistency of states' actions, however, reveal the illegitimacy of these claims.[208]

Thus, the deliberation over whether heightened scrutiny applies —be it under fundamental parental rights, sex-based discrimination, or transgender identity as a suspect or quasi-suspect class —should be superfluous. Rational basis review requires a legitimate government interest and a rational connection between that interest and the government's action.[209] Using transgender health as a lens to examine these health care bans, it is apparent that they offer no benefit and are more likely to exacerbate existing health disparities, which can hardly be considered a rational response to the needs of a vulnerable population.

A. Legislative Authority and the Needs of Transgender Youth

The government receives its authority to act from the people.[210] This may seem obvious, but it is a point worth noting before discussing how bans on gender-affirming care—or, frankly, any government action—should be evaluated. The Supreme Court's growing fixation on rights has placed an enormous weight on the framing of those rights in determining the constitutionality of government action.[211] We have seen this approach in significant doctrinal areas such as Second Amendment rights,[212] free exercise challenges,[213] and speech rights.[214] Professor Jamal Greene described

208. *See infra* Part II.B.

209. *See* Reed v. Reed, 404 U.S. 71, 76 (1971); City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432, 440 (1985).

210. *See* THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776).

211. *See supra* Part I.B.

212. *See* New York State Rifle & Pistol Ass'n v. Bruen, 142 S. Ct. 2111, 2127 (2022) ("[T]he government must affirmatively prove that its firearms regulation is part of the historical tradition that delimits the outer bounds of the right to keep and bear arms.").

213. *See* Kennedy v. Bremerton School District, 142 S. Ct. 2407, 2433 (2022) (holding that the football coach's prayers after the game were private speech and protected by the Free Exercise Clause).

214. *See* 303 Creative LLC v. Elenis, 143 S. Ct. 2298, 2313 (2023) (describing the existence of an antidiscrimination statute as a mandate for a web designer who might theoretically create wedding websites in the future to "speak as the State demands or face sanctions for expressing her own beliefs"); Nat'l Inst. of Fam. & Life Advocs. v. Becerra, 138 S. Ct. 2361, 2378 (2018) (determining the California law requiring unlicensed crisis pregnancy centers to give notice they were not a licensed medical center unduly burdened the crisis pregnancy center's speech).

the last fifty years of the Supreme Court's constitutional jurisprudence as "primarily an *interpretive* exercise fixed on identifying the substance and reach of any constitutional rights at issue."[215] One problem with this approach, according to Professor Greene, is the difficulty, if not impossibility, of sorting all individual actions, beliefs, and interests into rights that are protected and those that are not.[216] Attempting to do so can also obscure the impact of government action, especially those actions that reinforce subjugation and entrench social hierarchies.[217]

Every government action will inherently infringe on someone's freedom and liberty to some degree. This truism is reflected in the fact that even the lowest form of judicial review demands at least a legitimate government interest.[218] If the government derives its "powers from the consent of the governed,"[219] a central component of any legal analysis should be the extent to which the government is acting for the benefit of the people. Rights can act as an important barrier to oppressive government authority but interrogating the government's interest and the connection between the alleged benefits to the public and the challenged legislation prevents arbitrarily interfering with people's lives.[220]

The police power is the sovereign, inherent authority of the state to protect its people, which predated the Constitution and remained with the states after they granted the federal government limited, enumerated powers.[221] Part of the reason states retained police powers was the notion that they would be better able to understand the specific health, safety, and welfare needs of their populace,

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215. *See* Greene, *supra* note 41, at 30.

216. *See* GREENE, *supra* note 34, at 4.

217. *See* Greene, *supra* note 41, at 34 (explaining how the rights as trumps framing "requires us to formulate constitutional politics as a battle between those who are of constitutional concern and those who are not").

218. *See* City of New Orleans v. Dukes, 427 U.S. 297, 303 (1976).

219. THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776). The Revolutionary War was about being restricted by a government that did not represent Americans and their interests, not to be free from government action. *See* GREENE, *supra* note 34, at 11.

220. *See* Jacobson v. Massachusetts, 197 U.S. 11, 38 (1905) ("The police power of a State ... may be exerted in such circumstances or by regulation so arbitrary and oppressive in particular cases as to justify the interference of the courts to prevent wrong and oppression.").

221. *See generally* Walter Wheeler Cook, *What is the Police Power?*, 8 COLUM. L. REV. 322 (1907) (discussing the history of the phrase "police power" and the relationship between the state and national government to provide a definition of "police power").

which may vary from state to state.[222] Though protecting health, safety, and welfare undoubtedly casts a wide net, the state's authority to limit rights—just like rights themselves—is not absolute. The potency of the police power is at its zenith when the government is infringing on individual rights to protect others from risk of serious harm, especially those people that are less capable of taking steps to safeguard themselves.[223] But police power is not meant to provide unfettered paternalistic authority for the government to declare what is best for everyone.[224] Police power is at its most vulnerable to constitutional challenge when the government is limiting someone's rights exclusively for that person's benefit.[225] As a result, bans on gender-affirming care—which have no protective effect for others beyond the people seeking care—should be in a precarious constitutional position at the outset.

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222. *See* Mayor of New York v. Miln, 36 U.S. 102, 103 (1837) ("It is not only the right, but the bounden and solemn duty of a state, to advance the safety, happiness, and prosperity of its people, and to provide for its general welfare, by any and every act of legislation which it may deem to be conducive to these ends; where the power over the particular subject, or the manner of its exercise, are not surrendered or restrained by the constitution of the United States.").

223. For example, confining a person infected with a contagious disease that has a high mortality rate, is easily transmissible, and can spread asymptomatically. *See* City of Milwaukee v. Washington, 735 N.W.2d 111, 129 (Wis. 2007) (upholding the confinement of a woman with tuberculosis to jail after she failed to adhere to treatment protocol).

224. Under the social contract inherent in organized society, people forgo unlimited rights and freedoms in exchange for the government undertaking efforts that protect and promote everyone's health, safety, and wellbeing. *See* Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era*, 20 HASTINGS CONST. L.Q. 267, 316-18 (1993). At a conceptual level, then, it is acceptable to limit someone's rights in circumstances that put others at significant risk, so long as the government limits the rights of others when they put that individual at risk. *See id.*

225. *But see* Picou v. Gillum, 874 F.2d 1519, 1521-22 (11th Cir. 1989) (summarizing appellant's challenge to Florida's mandatory helmet law for motorcyclists as the right to be free from paternalistic legislation and reasoning the law was a rational use of the state's police powers). Mandatory helmet laws generated significant litigation and exhibited the tension between a state's use of police power for the public health and individual rights. *See, e.g.*, ABATE of Ga., Inc. v. Georgia, 137 F. Supp. 2d 1349, 1352 (N.D. Ga. 2001) (rejecting challenge to the constitutionality of Georgia's motorcycle helmet law), *aff'd*, 264 F.3d 1315 (11th Cir. 2001); Benning v. State, 641 A.2d 757, 765 (Vt. 1994) (upholding Vermont's helmet laws under the Vermont and Federal Constitutions). Another example of police power legislation subject to constitutional challenge based on infringing personal freedom and choice was mandatory seatbelt laws. *See, e.g.*, Atwater v. City of Lago Vista, 532 U.S. 318, 354 (2001) (finding arrest for failure to wear seatbelt did not violate the Fourth Amendment); State v. Hartog, 440 N.W.2d 852, 860 (Iowa 1989) (upholding Iowa's mandatory seatbelt law as a proper use of its police power).

Transgender health disparities provide a tangible goal the state could point to for action. Their mental health disparities stem from increased rates of depression, anxiety, suicidal ideation, and suicide attempts.[226] Elevated rates of suicidal ideation should be especially concerning. Suicide is already the second leading cause of death for youth fourteen-to-eighteen years of age,[227] yet transgender youth experience episodes of suicidal ideation at rates two to three and a half times those of their cisgender peers.[228] One study found that 86 percent of transgender youth reported considering suicide within the previous six months, while an alarming 56 percent reported previously attempting suicide.[229] It is difficult to comprehend any argument that a complete ban on access to health care is an appropriate solution to suicide or any of the other troubling disparities this population faces.

The ban on health care likewise provides no alleviation of the drivers of transgender mental health disparities. Increased rates of suicidal ideation and suicide attempts stem from a number of sources, including social rejection, lack of parental or family support, and bullying.[230] These bans—along with the unnecessarily cruel rhetoric that surrounds them—are more likely to exacerbate these problems, as well as other drivers of suicidality like internalized

226. Tordoff et al., *supra* note 20, at 1.

227. Asha Z. Ivey-Stephenson, Zewditu Demissie, Alexander E. Crosby, Deborah M. Stone, Elizabeth Gaylor, Natalie Wilkins, Richard Lowry & Margaret Brown, *Suicidal Ideation and Behaviors Among High School Students — Youth Risk Behavior Survey, United States, 2019*, 69 MORBIDITY & MORTALITY WKLY. REP. 47, 47 (2020).

228. Kacie M. Kidd, Gina M. Sequeira, Taylor Paglisotti, Sabra L. Katz-Wise, Traci M. Kazmerski, Amy Hillier, Elizabeth Miller & Nadia Dowshen, *"This Could Mean Death for My Child": Parent Perspectives on Laws Banning Gender-Affirming Care for Transgender Adolescents*, 68 J. ADOLESCENT HEALTH 1082, 1082 (2021).

229. Ashley Austin, Shelley L. Craig, Sandra D'Souza & Lauren B. McInroy, *Suicidality Among Transgender Youth: Elucidating the Role of Interpersonal Risk Factors*, 37 J. INTERPERSONAL VIOLENCE, at NP2696, NP2707 (2022). Another study conducted a survey across ten states and nine large urban school districts and found that approximately 44 percent of transgender youth considered suicide while 35 percent attempted suicide. Michelle M. Johns, Richard Lowry, Jack Andrzejewski, Lisa C. Barrios, Zewditu Demissie, Timothy McManus, Catherine N. Rasberry, Leah Robin & J. Michael Underwood, *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students—19 States and Large Urban School Districts, 2017*, 68 MORBIDITY & MORTALITY WKLY. REP. 67, 69 (2019).

230. Tordoff et al., *supra* note 20, at 2; *see also* Austin et al., *supra* note 229, at NP2706-07. Interpersonal microaggressions have been shown to have a strong association with suicide attempts. *Id.* at NP2708.

self-stigma and school belonging.[231] Data is already bearing this out, with researchers finding evidence of a causal relationship between enacting anti-transgender laws and increased suicide attempts among transgender youth.[232]

Impacts on the educational environment are especially influential because this is the primary means of socialization and, due to truancy laws, transgender youth have less opportunity to self-protect through abstention. Transgender students have reported being threatened or injured at school at a rate approximately four-to-six times higher than their cisgender peers, with a quarter of transgender students reporting experiences of forced sex and sexual violence as well.[233] The high rates of violence and victimization almost certainly contribute to this population's higher rates of substance use, including cigarettes, alcohol, cocaine, heroin, meth-amphetamines, ecstasy, and prescription opioid misuse.[234] The Executive Order targeting transgender students in primary education threatens existing supportive environments and could compound societal struggles already present for transgender youth.[235] The bans on health care will also amplify internal and external stigma and reduce academic performance, which can have its own long-term consequences.

Banning gender-affirming care, including the ability to discuss potential options or refer patients, serves only to drive transgender youth away from the health care system and those who may be able to help.[236] Even within the health care setting, transgender youth suffer disproportionately from the negative consequences of stigmatizing behavior such as refusing to use affirming language, discrimination, psychiatric pathologization, economic marginalization, and refusals of care.[237] The adverse effects of each barrier,

231. *See* Austin et al., *supra* note 229, at NP2708.

232. Lee et al., *supra* note 27, at 2101.

233. Johns et al., *supra* note 229, at 69.

234. *See id.*

235. *See* Exec. Order No. 14187, 90 Fed. Reg. 8771 (Jan. 28, 2025) (labeling gender-affirming care as "surgical mutilation" and directing agencies and medical professionals to restrict access to gender-affirming care).

236. *See* Gray Babbs, Hill Landon Wolfe, Michael R. Ulrich, Julia Raifman & Sarah Ketchen Lipson, *Sexual and Gender Minority University Students Report Distress Due to Discriminatory Health Care Policies*, 9 STIGMA & HEALTH 601, 603 (2024).

237. *See* Stephanie Loo, Anthony N. Almazan, Virginia Vedilago, Brooke Stott, Sari L.

obstacle, and individual and systemic discrimination can be multiplied by their intersection with other forms of discrimination such as racism, sexism, and ableism.[238] It may come as no surprise, then, that transgender women of color, for example, made up 73 percent of transgender murders in 2020.[239]

States issuing bans, as well as the current presidential administration, are further excluding transgender youth from the health care system by targeting insurance coverage to create more financial barriers.[240] Similar to abortion restrictions, gender-affirming care bans may result in more youth seeking replacement treatment options, with one estimate suggesting as many as 63 percent of transgender Americans in certain areas may be receiving hormones from "disreputable sources" even before the spread of state and federal restrictions.[241] Bans on any and all forms of gender-affirming

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Reisner & Alex S. Keuroghlian, *Understanding Community Member and Health Care Professional Perspectives on Gender-Affirming Care—A Qualitative Study*, 16 PLOS ONE 12, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0255568 [https://perma.cc/PJ87-VJ4C]; *see also* Seán Kearns, Thilo Kroll, Donal O'Shea & Karl Neff, *Experiences of Transgender and Non-binary Youth Accessing Gender-Affirming Care: A Systematic Review and Meta-ethnography*, 16 PLOS ONE 11-15, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0257194 [https://perma.cc/E7ME-ZAAG] (describing common barriers to care including the cost, hesitancy to disclose gender identity, geographical limitations, and ill-equipped providers). While many states already had laws in place allowing health care personnel to refuse care based on religious convictions, these refusal laws are increasingly expanding allowable justifications to include moral or ethical objections and targeting transgender people specifically. *See, e.g.*, S.C. CODE ANN. § 44-139-30 (2025) (codifying the right of healthcare practitioners and medical institutions in South Carolina to refuse care that violates their "conscience").

238. *See, e.g.*, Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241, 1242-44 (1991) (arguing that women of color experience violence through intersecting patterns of racism and sexism that are often excluded from identity politics).

239. 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, 643-44 (2022); *see also* Crenshaw, *supra* note 238, at 1242-44.

240. *See* Kearns et al., *supra* note 237, at 16. A common strategy attacking gender-affirming care for both minors and adults is to ban Medicaid coverage or reimbursement for puberty blockers, hormone treatments, and surgery. *See, e.g.*, FLA. ADMIN. CODE ANN. r. 59G-1.050(7) (2022); Dekker v. Weida, 679 F. Supp. 3d 1271, 1299 (N.D. Fla. 2023) (holding Florida's ban on Medicaid coverage for hormones unconstitutional).

241. Kearns et al., *supra* note 237, at 3; *cf.* Kavitha Surana, *Abortion Bans Have Delayed Emergency Medical Care. In Georgia, Experts Say This Mother's Death Was Preventable*, PROPUBLICA (Sep. 16, 2024, at 05:00 ET), https://www.propublica.org/article/georgia-abortion-ban-amber-thurman-death [https://perma.cc/K87E-2RMN] (discussing the negative impacts

care can put transgender youth at increased risk by driving them to search for medication that has not been checked for safety and efficacy.[242] These bans, along with other anti-transgender legislation, have already resulted in increased internet searches related to suicide and depression within those states.[243]

States do not provide any evidence that their restrictive approach could alleviate or mitigate any of these common health concerns transgender youth face. Nor could they, given that diminished access to health care would only further worsen any poor health outcomes and increase unhealthy, destructive behaviors.[244] The evidence demonstrating gender-affirming care's benefits, however, is much more robust than opponents of such care are willing to admit.

For example, a study found gender-affirming interventions —puberty-blocking medication and hormone therapy specifically—were associated with 60 percent lower odds of moderate to severe depressive symptoms and 73 percent lower odds of self-harm or suicidal thoughts in the first year of care.[245] Another study saw consistently sustained improvements from hormone therapy over a two-year period, with increases in positive outcomes such as life satisfaction.[246] Also pertinent was the association between better outcomes and increased appearance congruence, findings that have been replicated in other research.[247] This finding is an important counterweight to assertions that therapy alone is sufficient to address negative health outcomes for all transgender minors.[248]

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of total bans on care in the abortion context).

242. *See* 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, 979 (2021).

243. George B. Cunningham, Nicholas M. Watanabe & Erin Buzuvis, *Anti-Transgender Rights Legislation and Internet Searches Pertaining to Depression and Suicide*, 17 PLOS ONE 10-11, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0279420 [https://perma.cc/B8W5-HR3B].

244. *See* Babbs et al., *supra* note 236, at 602; Cunningham et al., *supra* note 243, at 11.

245. Tordoff et al., *supra* note 20, at 6.

246. Chen et al., *supra* note 120, at 243.

247. *See id.*; *see also* Priya Chelliah, May Lau & Laura E. Kuper, *Changes in Gender Dysphoria, Interpersonal Minority Stress, and Mental Health Among Transgender Youth After One Year of Hormone Therapy*, 74 J. ADOLESCENT HEALTH 1106, 1109 (2024).

248. *See* Chen et al., *supra* note 120, at 245-47; Anna I. R. van der Miesen, Thomas D.

While therapy may indeed be useful, this does not mean therapy in isolation is enough to prevent deleterious effects for everyone. Further, the availability of care beyond therapy does not mean therapy should or would be excluded.

Other studies have found both short- and long-term benefits for those receiving care, especially compared to those who wanted treatment but could not access it,[249] or those who were referred for gender-affirming treatment but did not receive it.[250] More devastating to bans for minors is evidence that long-term benefits are enhanced by earlier access to care.[251] For example, access to hormone therapy in adolescence as compared to accessing the care at eighteen or older was associated with lower odds of suicidal ideation, psychological distress, binge drinking, and lifetime drug abuse.[252] This further indicates that these bans do not just deny benefits, but also actively create their own additional short- and long-term harms.

This explains why parents of transgender youth have been some of the strongest voices opposing these state bans.[253] Far from displaying any sort of gratitude for state "protections," those with transgender children have expressed a profound concern that laws banning gender-affirming care will increase the likelihood that their child will commit suicide, an inarguably irreversible harm this population experiences at devastatingly high rates.[254] Providers, too,

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Steensma, Annelou L. C. de Vries, Henny Bos & Arne Popma, *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers*, 66 J. ADOLESCENT HEALTH 699, 703 (2020) (finding that transgender adolescents receiving gender-affirming care have better mental health outcomes compared to their peers just beginning treatment).

249. *See* Jack L. Turban, Dana King, Julia Kobe, Sari L. Reisner & Alex S. Keuroghlian, *Correction: Access to Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, 18(6) PLOS ONE 1, 1-2 (2023), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0287283 [https://perma.cc/K9F5-CFLE].

250. *See* Sami-Matti Ruuska, Katinka Tuisku, Timo Holttinen & Riittakerttu Kaltiala, *All-Cause and Suicide Mortalities Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services in Finland in 1996-2019: A Register Study*, 27 BMJ MENTAL HEALTH 1, 2 (2024), https://mentalhealth.bmj.com/content/27/1/e300940 [https://perma.cc/PKU5-VJNV].

251. *See* Turban et al., *supra* note 249, at 10-11.

252. *Id.*

253. *See* Kidd et al., *supra* note 228, at 1087-88.

254. *See id.*; *see also* Jack L. Turban, Dana King, Jeremi M. Carswell & Alex S. Keuroghlian, *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145

have conveyed fears that this type of legislation will increase risks of suicide, suicidal ideation, and self-harm.[255] It is perhaps for these many reasons that legislation limiting access to gender-affirming care is opposed by the American Medical Association, the American College of Physicians, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American Psychiatric Association, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the Endocrine Society, and the Pediatric Endocrine Society, among many other medical organizations.[256]

Unable to tie banning health care to alleviating these health disparities, states have relied on undermining the care itself. The goal is to cast all of gender-affirming care as so experimental and dangerous that it could not reasonably be considered beneficial to anyone. States then ignore the poor health outcomes and instead reframe the bans as preventing harm by protecting minors and medical ethics. To be sure, prevention is a classic public health goal, but conclusory statements of prevention are inadequate justifications medically and legally. Police power, properly understood, does not mean indiscriminate validation for any state action beyond what triggers heightened scrutiny. And yet again, it is not clear that banning gender-affirming care prevents any of the harms suffered by transgender youth. Evidence supporting state protective claims is woefully lacking in support, and the legal substance of such claims is dependent on them being taken at face value. Therefore, the validity of these restrictions, even within the breadth of police powers or the deference afforded under rational basis review, is dubious.

PEDIATRICS 1, 5 (2020), https://publications.aap.org/pediatrics/article-abstract/145/2/e20191725/68259/Pubertal-Suppression-for-Transgender-Youth-and [https://perma.cc/J9VY-WW5Y].

255. Hughes et al., *supra* note 242, at 980; *see also* Simona Martin, Elizabeth S. Sandberg & Daniel E. Shumer, *Criminalization of Gender Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, 385 NEJM 579, 581 (2021).

256. Jack L. Turban, Katherine L. Kraschel & I. Glenn Cohen, *Legislation to Criminalize Gender-Affirming Medical Care for Transgender Youth*, 325 JAMA 2251, 2251 (2021).

B. Undermining Care to Rationalize Declarations of Prevention

Prevention is vital as an upstream mechanism for stopping harm before it occurs or, at least, mitigating the harm to come.[257] This is distinguished from much of traditional medical care, which attempts to treat poor or worsening health conditions.[258] Though the justifications states rely on for their prohibitions to gender-affirming care may be defended as prevention, when examining Arkansas's ban the Eighth Circuit could not find any studies showing negative effects of gender-affirming care.[259] Certainly, medical and scientific understanding is constantly evolving, but the overwhelming consensus of data severely undercuts the implication that risks and benefits from gender-affirming care are a great mystery.[260] This is especially true when compared to other common forms of care—or even the same treatments used outside of gender-affirming care—that are not targeted by state restrictions. Even the Sixth and Eleventh Circuit conceded that gender-affirming care has existed for decades.[261]

Nevertheless, states allege that the data on gender-affirming care is untrustworthy because it is not obtained in randomized controlled trials.[262] Any insistence that a randomized controlled trial is necessary or should be required to legitimize gender-affirming care badly misunderstands how medical knowledge is generated and how minors receive treatment. Randomizing participants to

257. *See* LAWRENCE O. GOSTIN & LINDSAY F. WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 3, 14-18 (3d ed. 2016).

258. *See id.*

259. *See* Brandt *ex rel.* Brandt v. Rutledge, 47 F.4th 661, 671 (8th Cir. 2022) ("[S]everal studies have shown statistically significant positive effects of hormone treatment on the mental health, suicidality, and quality of life of adolescents with gender dysphoria. None has shown negative effects.").

260. *See* 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, 4 (2022), https://www.sciencedirect.com/science/article/pii/S2666379122002622 [https://perma.cc/X28R-VMGE].

261. *See* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1220-21 (11th Cir. 2023); L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 466-68 (6th Cir. 2023).

262. *See* Brief of the States of Arkansas, Alaska, Arizona, Georgia, Indiana, Louisiana, Mississippi, Missouri, Montana, Nebraska, Oklahoma, South Carolina, Texas, Utah, and West Virginia as Amici Curiae at 18-23, *Eknes-Tucker*, 80 F.4th 1205 (No. 22-1107) [hereinafter Brief of the States]; Wuest & Last, *supra* note 116, at 5-6.

different treatments is meant to evaluate interventions when there is uncertainty about whether the test treatment is more effective than a control.[263] The longstanding existence of various forms of gender-affirming care and data presenting both the benefits of care and the risks that accompany denying access make it difficult to justify a study randomizing transgender youth to another intervention arm.[264] Any competent ethical review would prevent research that knowingly placed participants at serious and unnecessary risk of harm and denied them a known benefit without the prospect of gathering new information.[265] Randomizing study participants to a placebo would be impossible because the changes, or lack thereof, would easily identify each treatment arm.[266]

Even Dr. Hilary Cass—chair of the Cass Review—has stated that gathering data on gender-affirming care through RCTs is unworkable: "[T]hey're difficult studies to design because you can't blind people."[267] The emphasis on randomized controlled trials also ignores the other methods of gathering credible data on medical interventions.[268] Both observational studies and longitudinal studies are often used to evaluate treatments.[269] There are also randomized clinical trials, as opposed to controlled trials, that compare already

263. *See* ROBERT J. LEVINE, ETHICS AND REGULATION OF CLINICAL RESEARCH 185 (2d ed. 1986).

264. *See* Janet Y. Lee & Stephen M. Rosenthal, *Gender-Affirming Care of Transgender and Gender Diverse Youth: Current Concepts*, 74 ANN. REV. MED. 107, 109 (2023); de Vries & Hannema, *supra* note 120, at 276.

265. *See* Ashley et al., *supra* note 114, at 409-10.

266. CASS, *supra* note 31, at 50-51 (describing one pitfall of treatment trials as "any design where patients are not blinded and know they are getting a particular drug").

267. Archie Bland, *Thursday Briefing: Unpicking the Landmark Cass Report on Gender Identity Services for Children*, THE GUARDIAN (Apr. 11, 2024, at 01:56 ET), https://www.theguardian.com/world/2024/apr/11/thursday-briefing-cass-report-gender-identity-trans-people [https://perma.cc/3TUS- AT3Z].

268. *See* Deaton & Cartwright, *supra* note 113, at 17.

269. Observational studies include cross-sectional research that is based on data collected from a single point in time. *See* Jizzo R. Bosdriesz, Vianda S. Stel, Merel van Diepen, Yvette Meuleman, Friedo W. Dekker, Carmine Zoccali & Kitty J. Jager, *Evidence Based Medicine—When Observational Studies Are Better than Randomized Controlled Trials*, 25 NEPHROLOGY 737, 738-40 (2020). Longitudinal studies are based on data collected from specific individuals over time. *See* Johanna Olson-Kennedy, Yee-Ming Chan, Robert Garofalo, Norman Spack, Diane Chen, Leslie Clark, Diane Ehrensaft, Marco Hidalgo, Amy Tishelman & Stephen Rosenthal, *Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study*, 8(7) JMIR RSCH. PROTOCOLS 1, 4-6 (2019), https://www.researchprotocols.org/2019/7/e14434/ [https://perma.cc/6SLG-49E6].

established interventions against one another.[270] These other forms of studies are preferable or more ethical in certain circumstances, such as when there is a lack of clinical equipoise.[271] Randomized controlled trials are also rarely used for evaluating interventions on children.[272] Endorsing opposition to any treatment that lacks randomized controlled trials would subject a vast array of treatments used on children to potential bans. When considering claims that gender-affirming care is experimental and lacking reliable data, it is important to remember that in many instances, a randomized controlled trial is not ethical, feasible, or reliable to evaluate all medical treatments, including gender-affirming care.

These same factors must be taken into account when considering allegations that the supporting data for gender-affirming care is "low-quality."[273] Quality labels are used for research methodology without any intent to signify the quality of the data generated.[274] Data from randomized controlled trials are typically—but not always—labeled "high quality," while data from observational

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270. *See* Carla Pelusi, Antonietta Costantino, Valentina Martelli, Martina Lambertini, Alberto Bazzocchi, Federico Ponti, Giuseppe Battista, Stefano Venturoli & Maria C. Meriggiola, *Effects of Three Different Testosterone Formulations in Female-to-Male Transsexual Persons*, 11 J. SEXUAL MED. 3002, 3003 (2014).

271. *See* Ashley et al., *supra* note 114, at 408.

272. *See* Denise Thomson, Lisa Hartling, Eyal Cohen, Ben Vandermeer, Lisa Tjosvold & Terry P. Klassen, *Controlled Trials in Children: Quantity, Methodological Quality and Descriptive Characteristics of Pediatric Controlled Trials Published 1948-2006*, 5 PLOS ONE 1,1,https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0013106 [https://perma.cc/RV3Z-BTSQ]. This is true for interventions on people who are pregnant and surgical interventions as well. *See* Rita Rubin, *Addressing Barriers to Inclusion of Pregnant Women in Clinical Trials*, 320 JAMA 742, 742 (2018); *see also* Natalie S. Blencowe, Julia M. Brown, Jonathan A. Cook, Chris Metcalfe, Dion G. Morton, Jon Nicholl, Linda D. Sharples, Shaun Treweek & Jane M. Blazeby, *Intervention in Randomised Controlled Trials in Surgery: Issues to Consider During Trial Design*, TRIALS, Sep. 2015, at 1, 7, https://link.springer.com/article/10.1186/s13063-015-0918-4 [https://perma.cc/QE5L-BE64].

273. *See* Brief of the States, *supra* note 262, at 19-23; Phoebe Petrovic, *Misinformation Flowed at Wisconsin Assembly Transgender Bills Hearing—Here are Facts on Gender-Affirming Care and Trans Athletes*, PBS WIS. (Oct. 11, 2023), https://pbswisconsin.org/news-item/misinformation-flowed-at-wisconsin-assembly-transqender-bills-hearing-here-are-facts-on- gender-affirming-care-and-trans-athletes/ [https://perma.cc/K45B-FEA5].

274. *See* GRADING OF RECOMMENDATIONS, ASSESSMENTS, DEVELOPMENT AND EVALUATION WORKING GROUP, GRADING OF RECOMMENDATIONS, ASSESSMENT, DEVELOPMENT AND EVALUATION (GRADE) HANDBOOK (Holger Schünemann, Jan Brożek, Gordon Guyatt & Andrew Oxman eds., 2013), https://gdt.gradepro.org/app/handbook/handbook.html [https://perma.cc/E49X-UBKT].

research usually gets labeled "low quality."[275] But rather than considering these categories as concrete, it is more accurate to contemplate them as a spectrum. The labels can shift depending on the specificities of the study. For example, randomized trials with relevant limitations, such as inconsistent results, decline in quality, whereas observational studies with large magnitudes of effect increase in quality.[276] The labels, therefore, reflect methodological aspects of a study, and not a simple way to signal what evidence should be accepted or disregarded. Perhaps more important is that these studies are meant to gather data to inform decision-making, not to create mandates of what treatments or procedures must be undertaken.

At its root, the experimental framing inappropriately conflates clinical research with clinical care. In clinical research, the goal is to produce generalizable knowledge.[277] Those conducting the research are under no ethical obligation to do what is best for any participant in the study.[278] In fact, the validity of a study can be undermined by providing treatment that the participant desires.[279] Instead, the ethical requirements of clinical research are meant to protect research participants from being subjected to unnecessary or disproportionate risks and exploitation.[280] By contrast, in clinical care, the provider has an ethical obligation and fiduciary duty to act in the patient's best interest.[281] This does not grant the clinician a dictatorial power to make this determination independent from the

275. *Id.* at 5.

276. *See id.*

277. *See* LEVINE, *supra* note 263, at 209.

278. *See* Robert J. Levine, *The Nature, Scope, and Justification of Clinical Research: What Is Research? Who Is a Subject? in* THE OXFORD TEXTBOOK OF CLINICAL RESEARCH ETHICS 123, 123 (Ezekiel J. Emanuel et al. eds., 2008); *see also* Ezekiel J. Emanuel, David Wendler & Christine Grady, *An Ethical Framework for Biomedical Research, in* THE OXFORD TEXTBOOK OF CLINICAL RESEARCH ETHICS, *supra*, at 211, 217.

279. *See* Steven Joffe & Franklin G. Miller, *Bench to Bedside: Mapping the Moral Terrain of Clinical Research*, HASTINGS CTR. REP., March-April 2008, at 30, 37-39; *see also* Michael R. Ulrich, *Resource Restraints: Rethinking Disclosure of Individual Genomic Findings*, 17 MICH. ST. U. J. MED. & L. 127, 144 (2012).

280. *See* Emanuel, Wendler & Grady, *supra* note 278, at 125, 129; Alan Wertheimer, *Exploitation in Clinical Research, in* THE OXFORD TEXTBOOK OF CLINICAL RESEARCH ETHICS, *supra* note 278, at 201, 201.

281. *See* Cobbs v. Grant, 502 P.2d 1, 9-10 (Cal. 1972).

patient.[282] Instead, the foundation of the informed consent process is to integrate the clinician's expertise into the patient's right to self-determination and bodily autonomy.[283]

The courts in *L.W.* and *Eknes-Tucker*, however, turned to the lack of direct FDA approval for gender-affirming care treatments to perpetuate the experimental framing and mask the damage being done to the transgender patient and their trust in the health care system.[284] The Sixth Circuit cited the lack of explicit FDA approval to counteract the consensus support from medical groups: "It is difficult to maintain that the medical community is of one mind about the use of these hormones for gender dysphoria when the FDA is not prepared to put its credibility and testing protocols behind the use."[285] Conflating pharmaceutical drug development and regulatory evaluation with the perceptions of the medical community is perplexing, to say the least. It signals either a deliberate distortion of the FDA's role and authority, or that these courts need a refresher on administrative law. Despite claims to the contrary, the FDA is not empowered to establish "when new drugs are safe for certain purposes but not others."[286] Agencies can only act within the scope of the authority granted to them by Congress,[287] and the FDA evaluates the safety and efficacy of a drug submitted for a specific intended use, not for *every* potential use.[288] For the FDA to approve the "new uses" without submission would be operating outside of its

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282. *See id.* at 10.

283. *See* FADEN ET AL., *supra* note 98, at 278-83; Jon F. Merz & Baruch Fischhoff, *Informed Consent Does Not Mean Rational Consent: Cognitive Limitations on Decision-Making*, 11 J. LEGAL MED. 321, 322-23 (1990).

284. *See* L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 474 (6th Cir. 2023) (analogizing the effort to access gender-affirming care to a prior case in which terminally ill patients asserted a "constitutional right to use experimental drugs that the FDA had not yet deemed safe and effective"); Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1234 (11th Cir. 2023) (Brasher, J., concurring). This same point was used by these courts when referring to gender-affirming care as "new." *L.W.*, 83 F.4th at 471; *Eknes-Tucker*, 80 F.4th at 1224.

285. *L.W.*, 83 F.4th at 478.

286. *Id.*

287. *See* U.S. CONST. art. I, §§ 1, 8, cl. 18. Agencies can be delegated broad power from Congress, but legislative power cannot be delegated. *See* Whitman v. Am. Trucking Ass'n, 531 U.S. 457, 464-65, 468, 472-73 (2001). Agency action must comport with the intelligible principle delegated by Congress. *See id.*

288. Amy Kapczynski, *Dangerous Times: The FDA's Role in Information Production, Past, and Future*, 102 MINN. L. REV. 2357, 2359-60 (2018) (detailing how the FDA approves new drugs for marketing for a specific use).

congressional mandate. The absence of approval for a specific use does not equate to a determination that it would be unsafe or ineffective.[289]

In truth, FDA approval limits only how a drug can be marketed, not how it can be used.[290] Once a drug is approved by the FDA, clinicians are able to prescribe it for other conditions, for different populations than those in the study, in other doses, and through different administration mechanisms.[291] This is referred to as off-label use, which is extremely common and accepted in circumstances when it is in the patient's best interest.[292] The Sixth Circuit itself made clear that off-label use is "a widely employed practice" that "does not violate federal law or FDA regulations."[293] For the very same court to then consider off-label use of hormones for gender-affirming care unacceptable without explaining the discrepancy is misleading. Off-label use is legal and ethical because knowledge and data on drugs continue to be gathered and analyzed after FDA approval.[294]

Requiring FDA approval for all potential uses would also be counterproductive to patient care. The length of time and cost needed to evaluate a treatment for any possible condition, for all population types, in every potential dosage, and through each mechanism of delivery would drastically reduce the availability of treatments for nearly all ailments through delay and exorbitant pricing. And with so few trials on minors, they would be deeply

289. *Contra L.W.*, 83 F.4th at 478.

290. Planned Parenthood Cincinnati Region v. Taft, 444 F.3d 502, 505 (6th Cir. 2006) ("[T]he FDA regulates the marketing and distribution of drugs in the United States, not the practice of medicine."); *see also* John J. Smith, *Physician Modification of Legally Marketed Medical Devices: Regulatory Implications Under the Federal Food, Drug, & Cosmetic Act*, 55 FOOD & DRUG L.J. 245, 251-52 (2000).

291. *Taft*, 444 F.3d at 505.

292. *Id.* To make informed decisions in the absence of data from clinical trials, health care prescribers rely on articles in peer-reviewed journals, clinical practice guidelines, and policy and consensus statements for disease management. Shamala Balan, Mohamed Azmi Ahmad Hassali & Vivienne S. L. Mak, *Two Decades of Off-Label Prescribing in Children: A Literature Review*, 14 WORLD J. PEDIATRICS 528, 534 (2018).

293. *Taft*, 444 F.3d at 505.

294. *See generally* David A. Simon, *Off-Label Innovation*, 56 GA. L. REV. 701 (2022) (describing the history and meaning of off-label use, and proposing that providers retain information on and study off-label usage to support new drug indications).

impacted by widespread restrictions on off-label use.[295] Some studies have found rates of off-label prescription use as high as 95 percent for minors.[296] The prevalence of off-label use is also higher in some of the most critical medical fields such as oncology, where evidence suggests the rates of off-label treatment have been increasing.[297] Though there have been efforts to expand the number of trials on pediatric treatments, pharmaceutical companies are not going to conduct new studies on medications that have already been approved, given the cost of conducting trials.[298]

This explains why every state banning gender-affirming care allows clinicians to use drugs off-label. Some of these very same states have even passed legislation to further promote and protect off-label uses. Texas enacted a law allowing nurses to prescribe off-label medication,[299] while Arkansas allows minors to consent to care—including surgery—recommended by a physician without any limitation based solely on off-label status.[300] Thus, it appears that none of the states banning gender-affirming care view off-label use as experimental or dangerous, especially considering the same treatments remain available to cisgender minors. Rather, states

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295. *See* Gilbert J. Burckart & Clara Kim, *The Revolution in Pediatric Drug Development and Drug Use: Therapeutic Orphans No More*, 25 J. PEDIATRIC PHARMACOLOGY & THERAPEUTICS 565, 565 (2020) (citing reasons such as ethical concerns, small population size, concerns over permanent damage to developing bodies, and physiological changes that cause variable effects on pharmacological response). The small population size can create problems with study recruitment, but it also provides less financial incentive for pharmaceutical companies. *See* H. Christine Allen, M. Connor Garbe, Julie Lees, Naila Aziz, Hala Chaaban, Jamie L. Miller, Peter Johnson & Stephanie DeLeon, *Off-Label Medication Use in Children, More Common Than We Think: A Systemic Review of the Literature*, 111 J. OKLA. ST. MED. ASS'N 776, 777 (2018).

296. Allen et al., *supra* note 295, at 781. Rates of off-label use can vary, influenced by factors such as age and condition. *See id.* The younger the population, the less likely there are to be research trials conducted for FDA approval. *See id.* at 782-83. For example, some studies have found that nearly 90 percent of newborns in neonatal intensive care units receive off-label therapies. Mir Lim, David S. Shulman, Holly Roberts, Anran Li, Jessica Clymer, Kira Bona, Hasan Al-Sayegh, Clement Ma & Steven G. DuBois, *Off-Label Prescribing of Targeted Anticancer Therapy at a Large Pediatric Cancer Center*, 9 CANCER MED. 6658, 6659 (2020).

297. *See* Lim et al., *supra* note 296, at 6663.

298. *See* Benedetta Guidi, Andrea Parziale, Luca Nocco, Aniello Maiese, Raffaele La Russa, Marco Di Paolo & Emanuela Turillazzi, *Regulating Pediatric Off-Label Uses of Medicines in the EU and USA: Challenges and Potential Solutions*, 44 INT'L J. CLINICAL PHARMACY 264, 267 (2022).

299. *See* 22 TEX. ADMIN. CODE § 222.4(f) (2025).

300. *See* ARK. CODE ANN. § 20-9-602(7) (West 2025).

object to what they are used for. Indeed, the disparate state action based on the outcome of the treatment and the patient's gender identity has played a part in many courts striking down the restrictions.[301] At the very least, the discrepancies and inconsistencies from these states undercut the justifications they offer to satisfy constitutional requirements.

The credibility of these states continues to deteriorate when gender-affirming care bans are juxtaposed to other policies regulating the practice of medicine. A focus on gender-affirming care is underinclusive when other treatments such as pediatric chemotherapy and radiation can have lasting effects on a minor's growth that impact reproductive capabilities,[302] and pediatric surgeries, such as breast reductions, rhinoplasties, and orthopedic surgeries for sports injuries, can all have long-term impacts as well.[303] The exceptions contained within these bans for surgical interventions on intersex youth also objectively contravene each state justification.[304] These states permit an irreversible surgical intervention on intersex infants that are unable to provide informed consent, which is not medically necessary and carries significant risk of negative long-term consequences.[305] Arguing that all gender-affirming care will render any patient infertile, on the other hand, is perhaps strong rhetorically but weak empirically.[306] The evidence indicates that the effects of puberty blockers are reversible.[307] Furthermore, the severe abortion restrictions these same states have implemented—which have already produced irreversible harm, including infertility[308]—undermine the sincerity of alleged concern about

301. *See* Brandt *ex rel.* Brandt v. Rutledge, 47 F.4th 661, 669 (8th Cir. 2022).

302. *See Late and Long-Term Effects of Childhood Cancer Treatment*, AM. CANCER SOC'Y, https://www.cancer.org/cancer/survivorship/children-with-cancer/late-effects-of-cancer-treatment.html [https://perma.cc/XB5U-2G9M].

303. *See, e.g.*, Maria E. Linnaus & Daniel J. Ostlie, *Complications in Common General Pediatric Surgery Procedures*, 25 SEMINARS PEDIATRIC SURGERY 404, 404, 406-08 (2016) (describing four common complications from pediatric surgeries and their occurrence related to the uniqueness of the pediatric population); Kraschel et al., *supra* note 260, at 4.

304. *See, e.g.*, ARK. CODE ANN. § 20-9-1502(c) (West 2025).

305. *See* HUM. RTS. WATCH, "I WANT TO BE LIKE NATURE MADE ME": MEDICALLY UNNECESSARY SURGERIES ON INTERSEX CHILDREN IN THE US 88-93 (2017), https://www.hrw.org/sites/default/files/report_pdf/lgbtintersex0717_web_0.pdf [https://perma.cc/T4XT-GJ28].

306. *See* Labrador v. Poe *ex rel.* Poe, 144 S. Ct. 921, 921 (2024) (Gorsuch, J., concurring).

307. *See* Abreu et al., *supra* note 239, at 644.

308. This includes Tennessee, where the state's abortion restriction had no explicit health

fertility, while also substantiating that these actions are not driven by science and medicine but by politics and ideology propelled by preferences for a strict sex-based binary and gender norms.[309]

Rather than protecting youth and ensuring ethical standards, restrictions on gender-affirming care hinders the ethical practice of medicine.[310] *Beneficence* requires providing care that would benefit the patient by relieving, reducing, or preventing harm.[311] By banning an entire category of care, clinicians are unable to fulfill that obligation for those patients who would benefit. Rather than protecting the practice of medicine and medical ethics, these bans create an unnecessary ethical quandary for clinicians: do what is best for the patient, or do what is best for the clinician. Given the civil and criminal penalties, the potential to lose their license to practice medicine, and the excessive punitive approach taken by states against transgender care, this ethical dilemma is almost certainly going to result in clinicians factoring their own wellbeing into determinations of what medical recommendations they provide.[312] The many health care providers that halted their

exceptions and a penalty of fifteen years in prison, leading health care providers to perform a hysterectomy to treat an ectopic pregnancy instead of performing an abortion that would have saved the woman's uterus. Kavitha Surana, *Doctors Warned Her Pregnancy Could Kill Her. Then Tennessee Outlawed Abortion.*, PROPUBLICA (Mar. 14, 2023, at 05:00 ET), https://www.propublica.org/article/tennessee-abortion-ban-doctors-ectopic-pregnancy [https://perma.cc/4UFT-DANQ].

309. *See* Astor, *supra* note 77.

310. The Sixth Circuit rejected bioethical arguments made in an amicus brief I coauthored because they believed ethical principles "do not offer meaningful guidance in determining whether to invalidate such laws." L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 478 (6th Cir. 2023). Yet, they had already asserted the relevance of the state's "abiding interest 'in protecting the integrity and ethics of the medical profession.'" *Id.* at 473 (quoting Washington v. Glucksberg, 521 U.S. 702, 731 (1997)).

311. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 13 (8th ed. 2019).

312. *See* Hughes et al., *supra* note 242, at 980; *see also* BEAUCHAMP & CHILDRESS, *supra* note 311, at 12-13. In fact, it is the knowledge that gender-affirming care is effective and the dire consequences that come from denial of such care that create a strong ethical justification for professional civil disobedience. *See* Matthew K. Wynia, *Professional Civil Disobedience—Medical-Society Responsibility After* Dobbs, 387 NEJM 959, 960-61 (2022) (arguing for professional civil disobedience from physicians against state abortion bans that are contrary to patient welfare); Melissa Santos, William T. Zempsky & Jim Shmerling, *Moving Beyond Statements to Protect Transgender Youth*, 332 JAMA 529, 529-30 (2024). As the American Medical Association's Code of Medical Ethics states, "[i]n exceptional circumstances of unjust laws, ethical responsibilities should supersede legal duties." *Preface & Preamble*, AM. MED. ASS'N: CODE OF MED. ETHICS, https://code-medical-ethics.ama-assn.org/preface-

gender-affirming care appointments due to executive orders issued early in President Trump's second term proves the point.[313]

L.W. v. Skrmetti represents states declaring the authority to decide what treatments should and should not be available to patients. By ignoring both clinician and patient autonomy these laws interfere with the familial and physician-patient relationships, and effectively supplant the role of parents and clinicians by continuing to assert an authoritarian command over the practice of medicine.[314] With youth feeling such dire stakes, interfering with the trust and cooperation that is built through open and honest communication within the physician-patient relationship can have long-term costs.[315] This is especially true for a population suffering from health disparities and social exclusion, which these bans have only intensified.[316] Loss of trust in the health care system and in medical providers can reduce access to care for a wide range of issues beyond that which supports patients' gender identity.[317]

Despite efforts to cast all gender-affirming care as either unknown or a recently discovered dangerous treatment, there is a strong foundation of evidence demonstrating the benefits. To be

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preamble [https://perma.cc/PZK9-ZX3G].

313. Jenna Portnoy, *After Trump Order, Hospitals Suspend Some Health Care for Trans Youths*, WASH. POST (Jan. 31, 2025), https://www.washingtonpost.com/dc-md-va/2025/01/31/trans- children-trump-hormones-healthcare/ [https://perma.cc/Y4M3- 88UE].

314. For other examples of state interference with the medical profession, see Dobbs v. Jackson Women's Health Organization, 142 S. Ct. 2228, 2283-85 (2022); Wollschlaeger v. Governor Florida, 848 F.3d 1293, 1307-09 (11th Cir. 2017) (determining Florida's Firearms Owners' Privacy Act violated the First Amendment because it prohibited medical professionals from discussing or writing about the ownership of firearms with their patients); Food & Drug Admin. v. All. for Hippocratic Med., 144 S. Ct. 1540, 1552 (2024) ("[T]he plaintiffs want FDA to make mifepristone more difficult for other doctors to prescribe and for pregnant women to obtain. Under Article III of the Constitution, a plaintiff's desire to make a drug less available *for others* does not establish standing to sue.").

315. *See* Babbs et al., *supra* note 236, at 603.

316. *See* Lauren S.H. Chong, Jasmijn Kerklaan, Simon Clarke, Michael Kohn, Amanda Baumgart, Chandana Guha, David J. Tunnicliffe, Camilla S. Hanson, Jonathan C. Craig & Allison Tong, *Experiences and Perspectives of Transgender Youths in Accessing Health Care: A Systematic Review*, 175 JAMA PEDIATRICS 1159, 1161, 1169 (2021) (describing both the pervasive stigma, discrimination, and invalidation trans youth feel in health care systems, and how trans youth successfully partner with their practitioners while receiving gender-affirming care).

317. *See* Shine v. Vega, 709 N.E.2d 58, 59-61 (Mass. 1999); George J. Annas, *The Last Resort—The Use of Physical Restraints in Medical Emergencies*, 341 NEJM 1408, 1408-09 (1999).

clear, even with this evidence it would be medically, ethically, and legally inappropriate to treat all transgender minors the same—the way states do by banning care. Patients receive different treatments and care in every area of medicine and for a variety of reasons, including different values and preferences between patients. It is critical to keep in mind that the availability of gender-affirming care does not mean any aspect of that care will be used for any specific patient, let alone all transgender minors. Clinicians use their expertise with available evidence to inform patients of the risks and benefits of all treatment options, including pursuing no treatment, to empower patients to make autonomous choices that are informed by medical knowledge and empirical research and align with their beliefs and values.[318] Put more simply, availability of gender-affirming care merely allows clinicians to do what is in their patient's best interest by providing such care when it is medically beneficial.[319]

To present this issue as an all or nothing binary—either any minor presenting with gender dysphoria receives every element of gender-affirming care or it must be banned completely—is dishonest. It is a fabricated narrative created by the political operatives who believed they could create a wedge issue that would be beneficial for fundraising and campaigning.[320] The reason that this type of excessive approach is unheard of in medicine, even for treatments that are much riskier, is that it is unnecessary with legal guardrails already in place. Laws and regulations related to medical licensure and malpractice have long-existed to minimize the

318. *See generally* Ezekiel J. Emanuel & Linda L. Emanuel, *Four Models of Physician-Patient Relationship*, 267 JAMA 2221-22 (1992) (describing the potential roles a physician can play in their patient's medical decision making, including the informative and interpretive models which require the patient to be educated to make the final decision).

319. *See* Jason Rafferty, American Academy of Pediatrics, *Policy Statement: Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142(4) PEDIATRICS 1, 4 (2018), https://publications.aap.org/pediatrics/article/ 142/ 4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for [https://perma.cc/7RRL-86X3] (reaffirming the policy statement in August 2023). The Standards of Care for Transgender Healthcare published by the World Professional Association for Transgender Health has required diagnostic criteria that must be met before providing an adolescent with medical or surgical gender-affirming care. *See* 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, S59-66 (2022).

320. *See* Nagourney & Peters, *supra* note 72.

risk of inappropriate medical care.[321] Thus, the alleged protective benefits of banning gender-affirming care—if they exist at all—are devalued in a health care system that already includes deterrents and punishments for clinicians that provide care that is not medically indicated and puts the patient at unnecessary risk. Banning care for *all* patients then is drastically overinclusive even under the states' own arguments.

Upholding bans on gender-affirming care suggests the existing protective measures for medical care are insufficient and, therefore, opens the door for states to ban other types of care that the government deems too risky, regardless of whether the position is empirically and medically supported. Such an approach is anathema to the many states—notably those passing restrictions on transgender rights and their access to health care—that emphasize the importance of protecting liberty and limiting the government's ability to interfere with individuals' autonomy.[322] Even if rational basis review is the proper analysis to apply, it should not be synonymous with a rubber stamp form of deference. Otherwise, the very practice of medicine is put at risk.

III. AGAINST ARBITRARY ACTION

Lochner v. New York is perhaps the most well-known example of the influence of rights framing.[323] In *Lochner*, the Court framed the constitutional question as a conflict between the individual's "right to labor or the right of contract in regard to their means of livelihood" and "the right of the State to prevent the individual from laboring."[324] This framing has been consistently disavowed in the

321. Doctors can be held liable in tort for their malpractice, lose their license and face discipline from the state licensing board, and be subject to state and federal False Claims Act action if medically unnecessary services were improperly billed to Medicare. *See, e.g.*, Nadia N. Sawicki, *Choosing Medical Malpractice*, 93 WASH. L. REV. 891, 958-64 (2018); Joan H. Krause, *Medical Error as False Claim*, 27 AM. J.L. & MED. 181, 182-83 (2001).

322. *See* Earl M. Maltz, *Faint-Hearted Federalism: The Role of State Autonomy in Conservative Constitutional Jurisprudence*, 72 S.C. L. REV. 55, 66-68 (2020).

323. 198 U.S. 45, 53 (1905).

324. *Id.* at 54. Less attention has been paid to *Muller v. Oregon*, in which just a few years later, the Court upheld an hours-limit for women, holding that their right to labor was not identical to that of men because

> [t]he two sexes differ in structure of body, in the functions to be performed by

legal community: "Mainstream lawyers today, from across the political spectrum, see the *Lochner* decision as disastrously wrong. Nearly every member of the Supreme Court over the past half century has publicly repudiated the decision."[325] According to Professor Greene, "[t]he sin of *Lochner* isn't that the Court identified *a right to contract*, protected by judges—a common view of its error—but rather that it didn't also see *a right to labor*, protected through politics."[326]

In other words, the Court was so absorbed by determining whether a right existed that the government was limiting that it failed to consider *why* the government was limiting that right.[327] This Article is not a call for *Lochner*-style determinations of unenumerated rights, but a warning that continued failure to consider why the government is infringing on people's lives, even when a fundamental right or a suspect class is not involved, imperils a return to another *Lochner* era nonetheless.[328] In fact, a strong argument can be made that current judicial trends have already placed this country along that path.

Bans on gender-affirming care are infringing on liberties protected by the Fourteenth Amendment. Blindly accepting asserted state interests as valid so long as a right does not warrant heightened judicial review provides the government with extensive leverage in the courtroom when the broad scope of police power already affords a significant advantage. Moreover, it offers judges an extraordinary ability to influence the outcome of a case by how it frames the right. The discrepancies in the lower courts are proof.

Despite abundant evidence of animus,[329] the focus here on rational basis review is purposeful beyond providing a counter to the Court's analysis in *Skrmetti*. A focus on rational basis review is

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> each, in the amount of physical strength, in the capacity for long-continued labor, particularly when done standing, the influence of vigorous health upon the future well-being of the race, the self-reliance which enables one to assert full rights, and in the capacity to maintain the struggle for subsistence.

208 U.S. 412, 422 (1908).

325. GREENE, *supra* note 34, at 43.

326. *Id.* at 40.

327. *See id.* at 56-57.

328. *See id.*

329. *See generally* Skinner-Thompson, *supra* note 33 ("[A]n anti-transgender agenda rooted in animus.").

important to minimizing the opportunity to narrowly define rights beyond *Skrmetti* in a way that foretells a state victory—as seen with the Sixth and Eleventh Circuits. A genuine examination for rationality would also help to rein in the diametric phenomenon of judicial activism in rights framing that seemingly leads to judicial restraint in analyzing government action. Rational basis review, considered the lowest form of judicial scrutiny, requires a legitimate government interest and a rational connection between the challenged measure and that interest.[330] Yet, there is a persistent view that the inquiry is so extremely deferential to government action as to be rendered essentially meaningless.[331] While strict scrutiny has been referred to as "'strict' in theory and fatal in fact,"[332] rational basis review has been described as more of a conclusive statement than a framework for constitutional evaluation.[333] This helps to explain the concerted effort of those challenging transgender restrictions to push for heightened scrutiny.[334]

The origin story of rational basis's stereotype of futility is beyond the scope of this Article, but Professor Katie Eyer has displayed its pervasive presence in popular constitutional canon.[335] Professor Eyer has also demonstrated through her substantial work on rational basis that this underwhelming account is misleading and factually inaccurate. Rather than acting as an outright sanction of government action, this standard has repeatedly resulted in the invalidation of arbitrary government action and

330. *See* Reed v. Reed, 404 U.S. 71, 76 (1971); *see also* City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432, 440 (1985).

331. Eyer, *supra* note 56, at 1318-19.

332. Gerald Gunther, *The Supreme Court, 1971 Term—Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 8 (1972); *see also* Adam Winkler, *Fatal in Theory and Strict in Fact: An Empirical Analysis of Strict Scrutiny in the Federal Courts*, 59 VAND. L. REV. 793, 805-09 (2006).

333. *See* JEROME A. BARRON, C. THOMAS DIENES, WAYNE MCCORMACK & MARTIN H. REDISH, CONSTITUTIONAL LAW: PRINCIPLES AND POLICY 699-700 (8th ed. 2012).

334. Beyond *L.W.* and *Eknes-Tucker*, lower courts unanimously held gender-affirming care bans were invalid under at least one of these constitutional protections. *See* Doe v. Ladapo, 676 F. Supp. 3d 1205, 1217-19 (N.D. Fla. 2023) (applying intermediate scrutiny); Brandt v. Rutledge, 677 F. Supp. 3d 877, 922 (E.D. Ark. 2023) ("Act 626 violates Plaintiffs' rights to equal protection."); Poe *ex rel.* Poe v. Labrador, 709 F. Supp. 3d 1169, 1195 (D. Idaho 2023) ("The law therefore fails heightened scrutiny."); Koe v. Noggle, 688 F. Supp. 3d 1321, 1356 (N.D. Ga. 2023) (finding that Defendants failed "to show that their asserted interests are substantially related to SB 140's sex-classificatory legislative scheme").

335. Eyer, *supra* note 56, at 1318-19.

played a momentous role in advancing social movements.[336] In fact, as Professor Eyer's work has demonstrated, rational basis review has frequently been the starting point on a pathway toward more meaningful review.[337]

Placing rational basis review under the microscope also serves to reemphasize the baseline protection that resides in the fact that the government is not empowered to act by the people unless its action is indeed for the people. Shirking the duty to deliver any interrogation of the government's actions helps ensconce social hierarchies and inequities to the detriment of the marginalized and underserved. Because states must act within their authority, even the slightest limitation on peoples' rights must have some credible basis for the restriction. Yet, it is a challenge to ascertain a cognizable and consistently coherent interest among those that states have put forward to justify their gender-affirming care bans. From the supposed experts the states offer to the contradictory exceptions they have in place, it is difficult to find any legitimacy to assertions that these bans are protective. Instead, they reveal that the laws are part of a politically motivated strategy in which attempts to provide justifications and support were cobbled together ex post. Having seen this playbook used before,[338] the hope is that centering the lived experiences and health disparities of transgender minors will highlight and hinder the Court's growing tendency to use rights as a defense for retrenchment and a veil for protecting only those people, values, and rights they deem deserving.

A. Reviving Rationality in Constitutional Analysis

Without an intelligible way to explain how banning care will alleviate health disparities, governments have relied on claims of protecting transgender minors from potential harm.[339] Protecting minors in a general sense may be legitimate, but there obviously must be more specificity to a connection between the state's means

336. *Id.* at 1320.

337. *Id.* at 1324.

338. *See infra* notes 386-98 and accompanying text.

339. *See* United States v. Skrmetti, 145 S. Ct. 1816, 1832 (2025) (quoting TENN. CODE ANN. § 68-33-101(m) (2024)).

and ends, especially given the gravity of banning an entire category of health care for this population alone. States must offer more than the presence of "risks" because risks exist for all medical treatment and risks remain for the cisgender minors allowed to access the medications covered by gender-affirming care bans. Similarly, labeling care experimental cannot go unquestioned. Careless acceptance of state proclamations that health care is too risky or experimental jeopardizes any medication, procedure, or outcome a state finds objectionable, regardless of whether the state's opposition is medically sound.[340]

States likely understand this is not meant to be the standard because they have attempted to provide expert witnesses to support these bans despite arguing that rational basis review should apply.[341] Going against every major medical organization's support for gender-affirming care has made it difficult to find experts willing to support these restrictions.[342] This not only makes the rationality of the bans dubious, but it also explains why states across the country have used the same small cadre of clinicians to defend their bans.[343] Credible clinicians with experience and expertise in gender-affirming care were unanimously opposed to these bans, including those who have publicly questioned whether certain aspects of gender-affirming care have been used inappropriately. Dr. Erica Anderson and Dr. Laura Edwards-Leeper perfectly exemplify the distinction between a desire to ensure safe and appropriate use of gender-affirming care and support for a complete ban. In their amicus brief for *Skrmetti*, they made clear that use of their past statements as support for Tennessee's ban was "spurious," meant to

340. Whether credible reasons exist for a state to be concerned about "treatments" is important in distinguishing between bans on gender-affirming care and bans on conversion therapy. *See e.g.*, Brief of Professors of Law, Medicine, and Public Health as Amici Curiae Supporting Respondents at 2-3, Chiles v. Salazar, 145 S. Ct. 1328 (2025) (No. 24-539).

341. *See infra* notes 343-68 and accompanying text.

342. *See* Kadel v. Folwell, 620 F. Supp. 3d 339, 368 (M.D.N.C. 2022).

343. Madison Pauly, *Inside the Secret Working Group That Helped Push Anti-Trans Laws Across the* Country, MOTHER JONES (Mar. 8, 2023), https://www.motherjones.com/politics/2023/03/anti-trans-transgender-health-care-ban-legislation-bill-minors-children- lgbtq/ [https://perma.cc/8NVF-KU5Y]; Molly Redden, *Inside the Cottage Industry of 'Experts' Paid to Defend Anti-Trans Laws*, HUFFPOST (May 13, 2024), https://www.huffpost.com/entry/paid-experts-defending-anti-trans-law_n_65021a7ee4b0ldf7c3b6d5l3 [https://perma.cc/HS5V-NQ8M].

"manufacture debate about the reasonableness of banning care," and created an illusion of uncertainty when "there is no 'ongoing debate' in the medical and mental health communities as to the reasonableness of banning care."[344]

States were forced to find anyone with a connection to the medical field who would be willing to serve as their "experts."[345] Luckily, they found a willing partner in the conservative religious organization Alliance Defending Freedom (ADF),[346] a group that has written several anti-trans model laws adopted by states, including gender-affirming care bans.[347] Owing to a "poverty of [experts] who are willing to testify" against gender-affirming care, ADF held a recruiting conference where attendees were asked "whether they would be willing to participate as expert witnesses."[348] Given the dearth of options, the twenty-six states with gender-affirming care bans were left to rely on only a handful of paid professionals who would fly around the country to testify on states' behalf.[349] Yet, nearly all of them had never worked with transgender patients or conducted research on gender-affirming care.[350] Their lack of relevant experience, expertise, and research had frequently led to their testimony being struck or drastically redacted.[351]

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344. Brief for Dr. Erica E. Anderson, PhD, and Dr. Laura Edwards-Leeper, PhD, as Amici Curiae Supporting Petitioner at 6, 8, *Skrmetti*, 144 S. Ct. 2679 (No. 23-477).

345. *See, e.g.*, Brandt v. Rutledge, 667 F. Supp. 3d 877, 919 (E.D. Ark. 2023) (finding the State's justification unsupported by evidence).

346. The organization has explicitly stated government policy should be based on "God's created order," which includes "that biological differences between men and women matter, that marriage is the union of one man and one woman, and that children are best cared for by their moms and dads." *Marriage & Family*, ALL. DEF. FREEDOM: ISSUES, https://adflegal.org/issues/marriage/ [https://perma.cc/3C7U-Y6XF].

347. David D. Kirkpatrick, *The Next Targets for the Group That Overturned* Roe, NEW YORKER (Oct. 2, 2023), https://www.newyorker.com/magazine/2023/10/09/alliance- defending-freedoms-legal-crusade [https://perma.cc/Q4TY-2U7J]. Kristen Waggoner, ADF's chief executive and general counsel, made clear the organization intends to fight "the radical gender-identity ideology infiltrating the law." *Id.* She has referred to gender-affirming care as "sterilization and chemical castration" that is pushed by schools to deal with adolescent awkwardness. *Id.*

348. Kadel v. Folwell, 620 F. Supp. 3d 339, 368 (M.D.N.C. 2022) (alteration in original).

349. *See, e.g.*, *id.*

350. *See id.*; Dekker v. Weida, 679 F. Supp. 3d 1271, 1279 (N.D. Fla. 2023).

351. *See, e.g.*, Brandt v. Rutledge, 667 F. Supp. 3d 877, 919 (E.D. Ark. 2023); *see also Kadel*, 620 F. Supp. 3d at 368.

Dr. Patrick Lappert, for example, admitted he had never published on gender dysphoria or hormone blockers or served as an expert witness before attending the ADF conference.[352] After the conference, Dr. Lappert began actively lobbying for gender-affirming care bans and criminal prosecution of doctors offering such treatment.[353] Dr. Lappert had no medically-relevant opinions on the issue but had publicly expressed his belief that gender-affirming care was a "'lie,' a 'moral violation,' a 'huge evil,' and 'diabolical'".[354] As a retired plastic surgeon who had never performed a single surgical procedure to treat gender dysphoria,[355] his opinions regarding the efficacy of puberty blockers or hormone treatment, accuracy of research studies, and rates of desistance and detransitioning were struck by a North Carolina district court.[356]

Dr. Paul Hruz had his entire testimony discredited by a Florida district court because the judge found him evasive and his testimony "deeply biased."[357] This may have been due, at least in part, to the brief Dr. Hruz joined asserting that transgender people are maintaining a charade or delusion because gender dysphoria is a false belief.[358] Or his testimony may have been struck because he, too, had never diagnosed or treated a minor with gender dysphoria.[359] The North Carolina district court ruled that Dr. Hruz was "not qualified to offer expert opinions on the diagnosis of gender dysphoria, the DSM, gender dysphoria's potential causes, the likelihood that a patient will 'desist,' or the efficacy of mental health treatments."[360] Even the district court in Tennessee—which preceded *Skrmetti* at the Supreme Court—declared Dr. Hruz's testimony "minimally persuasive," especially when compared with the experts presented by the plaintiffs who had "diagnosed and

352. *Kadel*, 620 F. Supp. 3d at 368.
353. *Id.*
354. *Dekker*, 679 F. Supp. 3d at 1279.
355. *See* Plaintiffs' Memorandum of Law in Support of Motion to Exclude Expert Testimony of Dr. Patrick W. Lappert at 4, *Kadel*, 20 F. Supp. 3d 339 (No. 19CV272).
356. *Kadel*, 620 F. Supp. 3d at 368-69.
357. *Dekker*, 679 F. Supp. 3d at 1279 n.8.
358. *Id.* at 1279.
359. L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 698 (M.D. Tenn. 2023).
360. *Kadel*, 620 F. Supp. 3d at 364.

treated hundreds of individuals with gender dysphoria" instead of zero.[361]

Dr. Stephen Levine is the only witness states have used who has some experience with transgender patients.[362] He is a former committee chair of the Harry Benjamin International Gender Dysphoria Association and created and practiced at a gender identity clinic at Case Western Reserve in 1974.[363] While Dr. Levine may provide perhaps the most realistic chance of qualifying as an expert, his work from half a century ago is disconnected from current research and medical understanding, as evidenced by having no peer-reviewed publications related to relevant fields.[364] It is also unclear whether he actually believes transgender people or gender dysphoria exist, having stated that transgender patients are suffering from underlying causes other than being transgender.[365] Thus, the relevance of even his experience is questionable, which is borne out by his testimony being limited several times and completely dismissed in at least one case.[366]

Still, Dr. Levine, in his official testimony as a state expert, made clear that he opposed what the state was doing because he did not believe that gender-affirming care for minors is categorically inappropriate.[367] Instead, he admitted that he was unaware of how often medical or surgical care helps and agreed that doctors need to decide on a case-by-case basis.[368] Ultimately, Dr. Levine conceded that gender-affirming care can be appropriate, and that safeguards

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361. *L.W.*, 679 F. Supp. 3d at 698.

362. *Dekker*, 679 F. Supp. 3d at 1278.

363. Alejandra Caraballo, *The Anti-Transgender Medical Expert Industry*, 50 J.L., MED. & ETHICS 687, 689 (2022).

364. *Id.*

365. *Id.* He cites social contagion, rapid onset gender dysphoria, and the internet as causes for gender dysphoria. *See* Plaintiffs' Memorandum of Law in Support of Motion to Exclude Expert Testimony of Dr. Stephen B. Levine, M.D. at 8-9, *Kadel*, 620 F. Supp 3d 339 (No. 19CV272). Dr. Levine and Dr. Lappert both reference a "Transgender Treatment Industry[,]" but these references were deemed inadmissible because there was no evidence or basis in science. See *Kadel*, 620 F. Supp. 3d at 373.

366. See Plaintiff's Memorandum of Law in Support of Motion to Exclude Expert Testimony of Dr. Stephen B. Levine, M.D., *supra* note 365, at 8; Hecox v. Little, 479 F. Supp. 3d 930, 977 n.33 (D. Idaho 2020).

367. *See Kadel*, 620 F. Supp. 3d at 371-72; *Dekker*, 679 F. Supp. 3d at 1285-86.

368. *Kadel*, 620 F. Supp. 3d at 371-72.

should be in place to ensure medical utility.[369] Dr. Hruz also diminished state claims of harm prevention by admitting that under any gender-affirming care model, "no medical and surgical interventions are initiated until after the onset of puberty."[370] Tennessee relied on Dr. James Cantor—whose name was mentioned during the *Skrmetti* oral argument—to support its interest in preventing delayed brain development, despite his testimony that there were "no 'substantial studies to identify such impacts' and that the only two existing studies had 'conflicting results.'"[371]

When states depend on medical justifications to legitimize their asserted interests, their inability to find credible medical experts to support the rationality of their bans is quite telling.[372] Given the ease with which half of the states adopted the model legislation they were provided, it should be easier to find more clinicians within each state who could offer their endorsement. Yet, states are relying on a few experts who were recruited by a political organization that has worked to craft and spread these laws, who have no expertise to offer, and who still do not support the bans they are paid to defend.[373] This, too, reveals how excessive these laws are. As a result, the offered testimony is as weak as the empirical support, providing states with little to stand on when maintaining that these broad prohibitions are protective.[374] Under these circumstances, heightened scrutiny should not be required to strike down the law.

The model legislation these states have adopted also undercuts the alleged motivations with the exceptions that are included. The exceptions are notable because the Supreme Court has shown an inclination to account for exceptions when probing the government's means and ends. The Court has expressed skepticism about the authenticity of asserted government interests when it believes the exceptions undermine the goals of the law. In these circumstances, the Court has used exceptions as evidence of an ulterior motive besides what the government claims.[375] In *Tandon v. Newsom*, the

369. *See Dekker*, 679 F. Supp. 3d at 1286.
370. *Kadel*, 620 F. Supp. 3d at 364.
371. L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 702 (M.D. Tenn. 2023).
372. *See Kadel*, 620 F. Supp. 3d at 368.
373. *See, e.g.*, *id.*
374. *Id.* at 364-65.
375. *See* Nat'l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361, 2376 (2018)

Court held that secular exceptions to California's COVID-19 restrictions on private gatherings weakened the state's claim that individual rights were being limited solely in the interest of preventing the spread of disease.[376] The exceptions the state incorporated, therefore, were seen as evidence that religious practice was being targeted.[377] The Court explained that determining whether things are comparable "must be judged against the asserted government interest that justifies the regulation at issue."[378]

Applying this analytical approach to gender-affirming care bans, the exception allowing surgery on intersex infants dilutes the strength of states' interests based on irreversibility, long-term harm, and capacity to consent. Unlike treatments targeted by gender-affirming care bans, surgery on intersex infants is, in fact, irreversible and does substantially risk irreversible infertility.[379] Increased risks of severe, long-term psychological harm accompany this procedure as well, including higher prevalence of depression, anxiety, and suicide.[380] These nonconsensual operations can also create lifelong issues with trust, which is unsurprising considering people tend to discover later in life that they were permanently altered by people they would expect to protect them.[381] Lack of trust in medical professionals can drive intersex people away from the health care system, as seen in the transgender population, thereby compounding existing health disparities.[382]

But unlike the evidence base for the benefits of gender-affirming care, there is no support to show that surgery on intersex infants provides any benefit.[383] The surgeries are mostly cosmetic and do not address any existing medical problem.[384] In reality, these

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(explaining that the exclusion of most clinics from the licensed-notice requirement "raises serious doubts about whether the government is in fact pursuing the interest it invokes").

376. *See* 141 S. Ct. 1294, 1297 (2021).

377. *See id.*

378. *Id.* at 1296.

379. HUM. RTS. WATCH, *supra* note 305, at 9.

380. Jeremy C. Wang, Katarine B. Dalke, Rahul Nachnani, Arlene B. Baratz & Jason D. Flatt, *Medical Mistrust Mediates the Relationship Between Nonconsensual Intersex Surgery and Healthcare Avoidance Among Intersex Adults*, 57 ANNALS BEHAV. MED. 1024, 1025 (2023).

381. *See id.*

382. *See id. See also* Babbs et al., *supra* note 236, at 603.

383. *See* HUM. RTS. WATCH, *supra* note 305, at 9.

384. *Id.*

surgeries, like bans on gender-affirming care, are about maintaining the gender binary and preventing any "normalization" of people who stray from the "natural outcome" of accepting their sex assigned at birth.[385] Yet, intersex people provide unquestionable evidence that this binary simply does not exist, regardless of what states maintain.[386] Professor Jessica Clarke has done yeoman's—or yeoperson's—work in this space to explain how "an infant's male or femaleness is the product of a medical judgment based in professional, social, and cultural standards, not an observation of natural or neutral fact."[387]

State efforts to validate politically driven restrictions to medical care through unsubstantiated accusations of regret may understandably cause a spell of déjà vu. The path from *Roe* to *Dobbs* is replete with examples of government-created impediments to reproductive health care in the interest of "protecting women" from harm and regret.[388] The Court has endorsed a state interest in providing "a reasonable framework for a woman to make a decision that has such profound and lasting meaning,"[389] and found it "unexceptionable to conclude some women come to regret their choice," despite admitting there was "no reliable data."[390] *Gonzales v. Carhart* is a particularly apt comparison to *Skrmetti*, and not solely because questioning women's capacity to make medical decisions was successfully weaponized to limit their right to bodily and medical autonomy. As Justice Ginsburg detailed in her dissent, the *Carhart* majority also ignored the district courts' evaluation of evidence that consensus medical authority maintained medical utility for the banned procedure while the Congressional findings were unreasonable for relying on a handful of clinicians that had no training, experience, or expertise in the matter.[391]

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385. *See* Declaration of Stephen B. Levine, M.D., *supra* note 135, at 16.

386. *See* Clarke, *supra* note 91, at 1833-38 (explaining the sex binary model is a relatively modern medical approach, which was disproven shortly thereafter because none of the biological markers of sex are present in all people labeled male or female).

387. *Id.* at 1836.

388. *See* Michael R. Ulrich & Arpita Khanna, *Policing Gender: The Interest Convergence of Women's and Transgender Rights*, 28 J. GENDER, RACE & JUST. 585, 601 (2025).

389. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 873 (1992), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

390. Gonzales v. Carhart, 550 U.S. 124, 159 (2007).

391. *See id.* at 178-80 (Ginsburg, J., dissenting).

States are once again relying on unsubstantiated claims of regret, and the Supreme Court was content to disregard the findings of district courts throughout the country. According to the North Carolina District Court in *Kadel v. Folwell*, state experts' statements on regret, desistance, or detransitioning were unreliable and inadmissible because they were based on opinions without evidence.[392] With echoes of *Carhart*, the Eleventh Circuit instead found mere speculation of regret or desistance to be a rational conclusion despite evidence to the contrary.[393] What is legally germane is not whether people with regrets exist, but that the rates of regret are so low that they certainly do not support complete bans.[394] The number of people expressing regret for undergoing gender-affirming care is so low that states with these bans had difficulty finding anyone in their borders to serve as a viable witness.[395] And, as one judge put it, "[r]egret over a medical procedure is not unique to gender-affirming medical care and is common in medicine."[396] This includes medically unnecessary surgical procedures with potential reproductive impacts down the line.[397] Breast implants, tubal ligations, and vasectomies are a few examples.[398]

Along with the intersex carve out, other state laws exempting minors from general restrictions on medical decision-making should

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392. 620 F. Supp. 3d 339, 363-73 (M.D.N.C. 2022).

393. Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1225 (11th Cir. 2023). "Dr. Koe reported that she treats transgender adolescents but has never treated a patient with gender dysphoria who later desisted or expressed regret about receiving these types of treatments." *Id.* at 1216.

394. *See* Dekker v. Weida, 679 F. Supp. 3d 1271, 1297 (N.D. Fla. 2023) ("The difficulty diagnosing a patient calls for caution. It does not call for a one-size-fits-all refusal to cover widely accepted medical treatment. It does not call for the State to make a binary decision not to cover the treatment even for a properly diagnosed patient.").

395. *See, e.g.*, *id.* ("the defendants have offered no evidence of any Florida resident who regrets being treated with GnRH agonists or cross-sex hormones."); Brandt v. Rutledge, 677 F. Supp. 3d 877, 905-06 (E.D. Ark. 2023) (describing two witnesses expressing regret as irrelevant to the case because they transitioned as adults, were not treated in Arkansas, detransitioned for religious reasons, and continue to struggle with their sex assigned at birth). "[T]he evidence proved that there is broad consensus in the field that once adolescents reach the early stages of puberty and experience gender dysphoria, it is very unlikely they will subsequently identify as cisgender or desist." *Brandt*, 677 F. Supp. 3d at 921.

396. *Brandt*, 677 F. Supp. 3d at 905.

397. *See infra* notes 436-42 and accompanying text.

398. *See infra* notes 437-42 and accompanying text.

raise questions about alleged concerns regarding risks and the capacity to understand them. Unlike gender-affirming care bans that do not allow for facts and medicine to determine when treatment might be helpful, mature minor doctrine considers the facts and circumstances of the individual, the condition, diagnosis, and treatment options to determine whether a minor may appropriately make their own medical decision.[399] Arkansas, for example, allows minors to consent to any treatment or procedure—including surgery—recommended by a physician if they understand the consequences.[400] This includes the very treatments, such as puberty blockers and hormones, that the state is banning for transgender minors.[401] Evidently, the state believes cisgender minors have the capacity to understand the risks and benefits of their health care decisions but transgender minors do not. Central to protecting autonomy through informed consent is that disagreeing with a clinician is not evidence that a patient lacks capacity.[402]

Contrary to state allegations, many providers have found that transgender minors are actually more reflective and introspective than their peers when it comes to medical decision-making.[403] They have demonstrated a willingness to seek out a variety of information sources rather than relying on one, and can describe in detail the effects of hormone therapy in terms of both desired outcomes and side effects.[404] Perhaps most importantly, they are able to explain why they want gender-affirming treatment and the harmful consequences of being denied such care.[405] Evidence that transgender youth are capable of providing informed consent, especially for treatments that present less risk,[406] weakens state arguments that a complete ban is protective.

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399. Lauren V. Engle, Note, *Faith by Choice: An Argument for Expanding Mature Minor Provisions in North Carolina*, 20 FIRST AMEND. L. REV. 255, 266-67 (2022).

400. *See* ARK. CODE ANN. § 20-9-602(7) (West 2025).

401. *Id.* §§ 20-9-1501(6)(A)(ii), 20-9-1502(a)-(b).

402. *See* Cruzan *ex rel.* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 270 (1990).

403. Drew B.A. Clark & Alice Virani, *This Wasn't a Split-Second Decision: An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy*, 18 BIOETHICAL INQUIRY 151, 155 (2021).

404. *See id.* at 157-58.

405. *See id.* at 159.

406. *See id.* at 155.

Clinging to this argument to explain why an entire category of care must be banned only for transgender minors suggests states believe that it is being transgender or having gender dysphoria that renders a person incapable of having a role in what health care they should receive. This type of exceptionalism not only contravenes accepted medical and ethical norms for evaluating capacity to consent,[407] it also reeks of an era when being gay was considered a mental disorder.[408] Regardless, the inconsistent approach between a specific type of care for transgender minors and practically all other health care for minors should prove that states are not truly concerned with irreversibility, long-term harm, and capacity to consent.

These many points challenge even the most basic requirement of a legitimate state interest. Knowing the origins of this movement to target transgender minors, this is hardly a shock. An effort to retrofit valid state interests once the political benefits were assessed left states scrambling for support. But the exceptions narrow the target of the restrictions so much as to make plain that the states' alleged interests are nothing more than a cloak thrown over politically motivated and medically unnecessary restrictions. Only a willingness to actively ignore the hypocrisy and inconsistency in state action could allow for an interest in protecting minors—at the broadest, most general level—to be accepted. Even still, linking these facts to the failure of bans to address any actual harms and risks faced by transgender minors also defies any sense of rationality.

B. The Risks of a Toothless Review

During the *Skrmetti* oral argument, Justice Kavanaugh rightly noted that "whether we apply rational basis or intermediate scrutiny, either way, you end up looking at the State's justification" and the states were "articulating a health and safety justification."[409]

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407. *See* FADEN ET AL., *supra* note 98, at 274-80.

408. Jack Drescher, *Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the* Diagnostic and Statistical Manual, 39 ARCHIVES SEXUAL BEHAV. 427, 434 (2010).

409. Transcript of Oral Argument, *supra* note 9, at 102-03.

Unfortunately, he also stated—inaccurately—that states have put forth "very forceful arguments against allowing these medical treatments for minors."[410] This conclusory approach is reflected in *Skrmetti*, in which the Court simply accepted Tennessee's determinations.[411] The Court declined to "second-guess" any of the state's assertions because there was medical and scientific uncertainty.[412] Hopefully this Article has revealed that the state's evidentiary record can only be seen as remotely carrying any weight where the Court places its considerably hefty thumb on the scale.

For example, the Cass Review—a report on gender-affirming care for youth commissioned by the United Kingdom's National Health Service[413]—is referenced in support of Tennessee's ban.[414] Not long after the report's release, however, conflicts of interest became public and other researchers and clinicians—including the British Medical Association[415]—questioned the scientific integrity of the report's processes, conclusions, and recommendations.[416] The report had a secret group of unknown authors, an advisory board that deliberately excluded transgender patients and experts in transgender care, and interviewed self-selecting clinicians, a third of whom believed "there is no such thing as a trans child."[417]

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410. *Id.* at 40-41. Here he was reiterating a point made by Chief Justice Roberts insinuating that equally valid medical points were made by each side, including in how developments in Europe should be weighed. *See id.* at 10.

411. *See* United States v. Skrmetti, 145 S. Ct. 1816, 1835-36 (2025).

412. *Id.* at 1836.

413. CASS REVIEW, *supra* note 31, at 22, 32-33.

414. *Skrmetti*, 145 S. Ct. at 1837, 1844-48. Justice Alito also referenced this Review repeatedly during oral argument. Transcript of Oral Argument, *supra* note 9, at 15-16.

415. *See* Nick Triggle, *BMA Calls for Ban on Puberty Blockers to be Lifted*, BBC (Aug. 1, 2024), https://www.bbc.com/news/artic1es/cqe6npgyr5ro [https://perma.cc/575E-GZSV].

416. *See* MEREDITHE MCNAMARA, KELLAN BAKER, KARA CONNELLY, ARON JANSSEN, JOHANNA OLSON-KENNEDY, KEN C. PANG, AYDEN SCHEIM, JACK TURBAN & ANNE ALSTOTT, AN EVIDENCE-BASED CRITIQUE OF "THE CASS REVIEW" ON GENDER-AFFIRMING CARE FOR ADOLESCENT GENDER DYSPHORIA 8 (2024), https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf [https://perma.cc/5FU5-ZSEU]. This is similar to the studies that were funded by an anti-abortion group and relied upon to question the safety and efficacy of mifepristone and were subsequently retracted. *See* Laura Ungar & Matthew Perrone, *Studies Cited in Case over Abortion Pill Are Retracted Due to Flaws and Conflicts of Interest*, AP NEWS (Feb. 7, 2024, at 16:05 ET), https://apnews.com/article/abortion-pill-mifepristone-redacted-studies-supreme-court-ebd60519fd44dc69c5ac213580dlclba [https://perma.cc/Q596-YVRA].

417. Cal Horton, *The Cass Review: Cis-supremacy in the UK's Approach to Healthcare for Trans Children*, INT'L J. TRANSGENDER HEALTH 1, 3, 7 (2024); *see* McNamara et al., *supra* note

Regardless, the report neither advocates for a ban on gender-affirming care nor does it provide evidence for allegations that such care is demonstrably harmful to all recipients[418]—a point Solicitor General Prelogar stressed, but that the Court appeared more than willing to ignore as it went unanswered.[419]

Another study from Finland has been used to create the illusion that gender-affirming care provides no benefits because it purportedly shows gender-affirming care does not reduce suicide[420]—yet another point referenced in *Skrmetti*.[421] The authors claimed psychological comorbidities were the drivers of mortality and suicide risk, not gender dysphoria and a lack of access to gender-affirming care.[422] The study is another example of late-emerging research that is methodologically questionable and concerning due to conflicts of interest.[423]

The study's methodology is confounding because it controls for psychiatric treatment history while investigating mental health outcomes.[424] The prevalence of poor mental health outcomes among transgender minors prior to undergoing any gender-affirming care is neither a surprise nor an explanation that can be isolated from gender dysphoria. Even the title misleadingly indicates the focus was on adolescents when the inclusion criteria allowed people who visited gender identity clinics before twenty-three years of age, resulting in a median study age of eighteen and a half years.[425] More perplexing was the emphasis on comparing those who were referred to gender-affirming care and a control group that matched them based on age and birthplace.[426] More pertinent was examining the difference between those in the gender-referred group that received

416, at 3.

418. *See* CASS, *supra* note 31, at 21-22; *McNamara et al.*, *supra* note 416, at 4.

419. *See, e.g.*, Transcript of Oral Argument, *supra* note 9, at 17-18 ("the Cass implementation plan itself makes clear that if a medical team determines that these medications are necessary for a particular patient, they will be provided.").

420. *See* Ruuska et al., *supra* note 250, at 5.

421. United States v. Skrmetti, 145 S. Ct. 1816, 1845 (2025) (Thomas, J., concurring). Justice Alito made this point during oral argument as well. Transcript of Oral Argument, *supra* note 9, at 88.

422. *See* Ruuska et al., *supra* note 250, at 3-4.

423. *See id.*

424. *See id.*

425. *See id.* at 2-3.

426. *See id.* at 2.

gender-affirming care and those who were referred but did not receive care.[427] The difference is striking, with mortality twice as high for those who did not receive care, and suicide mortality four times as high.[428] Though the sample size is small, leaving these inarguably noteworthy results—which contradict the authors' conclusion—suspiciously tucked away in the last three sentences of the findings[429] is troubling.

It is impossible to know why researchers would bury such a useful finding, but one potential explanation is the conflicting interests: The senior author disclosed funding from the Society for Evidence Based Gender Medicine (SEGM) and served as an advisory board member for the Cass Review.[430] SEGM is a group formed in Idaho in 2020 that proclaims its formation was "in response to a proliferation of treatment guidelines that promote medicalized youth gender transition."[431] The group has worked diligently to hide the members and the organizational structure, but some investigative reporting has found that SEGM shares funders with prominent anti-LGBTQ+ groups, including the Alliance Defending Freedom (ADF) and the Family Research Council, which have each featured prominently in the anti-transgender legislative proliferation.[432] Highlighting the financial conflicts of interest, the methodological and analytical defects, and the organizational secrecy reveals untrustworthy "data" but also an infrastructure that is ready and willing to generate misinformation under a veil of feigned neutrality and scientific curiosity.

Skrmetti strains to frame the issue as a medical debate best left to legislative appraisals.[433] But as much as they would like to rely on constitutional neutrality when they find it convenient, the Constitution is not "neutral on the question" of limiting liberty

427. *See id.* at 3.
428. *See id.*
429. *See id.*
430. *See id.* at 5.
431. *What Does SEGM Do?*, SOC'Y FOR EVIDENCE BASED GENDER MED., https://segm.org/about_us [https://perma.cc/WT7G-6WGU].
432. *See Group Dynamics and Division of Labor Within the Anti-LGBTQ+ Pseudoscience Network*, S. POVERTY L. CTR. (Dec. 12, 2023), https://www.splcenter.org/resources/reports/defining-pseudoscience-network/ [https://perma.cc/DE5C-AFA7].
433. *See* United States v. Skrmetti, 145 S. Ct. 1816, 1836 (2025).

interests without any valid justification.[434] To recap, states are ignoring existing health disparities and medical consensus and instead relying on a comparatively minuscule amount of research and clinicians, none of which advocate for or support a complete ban on gender-affirming care. To profess that "compassion for the child points in both directions" with regard to assessing Tennessee's ban is another example of how underlying views and assessments are surreptitiously incorporated into judicial framing.[435]

Doing so here depends heavily on detransitioners to equate risks and benefits.[436] It also requires ignoring the drastic discrepancy in data on those risks and benefits. Regrets for gender-affirming care are exceedingly rare, with rates for surgery—the most extreme form of gender-affirming care and rarely performed on anyone under the age of eighteen—having been measured at under 1 percent.[437] Meanwhile, much higher rates have been observed in other common treatments. Patients undergoing increasingly popular weight loss surgeries such as gastric bypass and gastric banding have been found to regret their decision 5.1 percent and 19.5 percent of the time, respectively.[438] Nearly a third of respondents had "high regret" after choosing robot-assisted radical prostatectomy to treat prostate cancer, and similar rates were found for patients who had elective colectomy as treatment for diverticulitis.[439] Even decisions related to reproduction come with regrets in both directions: One study reported rates of regret for tubal ligation at 28 percent,[440] another on vasectomy was up to 7.4 percent,[441] and 7 percent regretted having children at all according to a Gallup poll.[442]

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434. *See e.g.*, Transcript of Oral Argument, *supra* note 9, at 10, 41.

435. *Skrmetti*, 145 S. Ct. at 1841 (Thomas, J., concurring) (quoting L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 472 (6th Cir. 2023)); *see supra* notes 173-79 and accompanying text.

436. *Skrmetti*, 145 S. Ct. at 1832; *See also id.* at 1846-47 (Thomas, J., concurring).

437. Sarah M. Thornton, Armin Edalatpour & Katherine M. Gast, *A Systemic Review of Patient Regret After Surgery—A Common Phenomenon in Many Specialties but Rare Within Gender-Affirmation Surgery*, 234 AM. J. SURGERY 68, 72 (2024).

438. *Id.* at 71.

439. *Id.*

440. *Id.*

441. David K. Charles, Danyon J. Anderson, Sydney A. Newton, Peter N. Dietrich & Jay I. Sandlow, *Vasectomy Regret Among Childless Men*, 172 UROLOGY 111, 112 (2023).

442. Thornton et al., *supra* note 437, at 71.

Regret is also extremely contextual and fact-specific and should not be categorized as equivalent. For gender-affirming care surgery, regret can stem from surgical complications, evolution in gender identity, romantic difficulties, and loss of social support, none of which specifically relate to how detransitioning has been framed.[443] Indeed, proper constitutional analysis is significantly hindered if conducted without the cultural and social environments in which these decisions are made. An Arkansas district court illustrated the legal relevance by minimizing the testimonial weight of two "detransitioners" from another state because "they both de-transitioned as a result of a religious experience and ... continued to struggle living consistently with their birth-assigned sex after deciding to detransition."[444] People can both believe they are transgender and that they are not transgender for any number of reasons. The spurious concept of conversion therapy is a tragic example of how religious guilt and stigma can be exploited to convince some they could "detransition" from being gay.[445]

Rates of desistance—children labeled transgender who are no longer transgender once puberty begins—similarly require context. Studies showing high rates of desistance have been criticized as flawed and misinterpreted, with more modern studies contradicting the high levels.[446] However, it is also worth considering youth who have struggled with gender identity who may have been led astray by gender norms and the castigation kids often experience when they do not conform to gender stereotypes.[447] This is especially true

443. *Id.*

444. Brandt v. Rutledge, 677 F. Supp. 3d 877, 906 (E.D. Ark. 2023).

445. *See* Kirkpatrick, *supra* note 347. ADF is also behind efforts to get conversion therapy protected under free speech rights. *See id.* Justice Thomas has shown his support for framing the issue in this manner. *See* Tingley v. Ferguson, 144. S. Ct. 33, 33-34 (2023) (Thomas, J., dissenting from denial of certiorari) ("Because this question has divided the Courts of Appeals and strikes at the heart of the First Amendment, I would grant review."). The Court recently held that Colorado's restriction on conversion therapy had to be evaluated under strict scrutiny because it censored speech based on viewpoint. *See* Chiles v. Salazar, No. 24-539, 2026 WL 872307, at *13 (U.S. Mar. 31, 2026); *see also* Jack L. Turban & Michael R. Ulrich, Chiles v. Salazar—*Conversion Effort Bans and Free Speech*, 179 JAMA PEDIATRICS 1141-42 (2025).

446. *See* Cal Horton, *"I Was Losing That Sense of Her Being Happy"—Trans Children and Delaying Social Transition*, 18 LGBTQ+ FAM. 187, 188 (2022).

447. *See* Elizabeth P. Rahilly, *Re-Interpreting Gender and Sexuality: Parents of Gender-Nonconforming Children*, 22 SEXUALITY & CULTURE 1391, 1393 (2018).

for young males who are given less flexibility at young ages and are made to believe something is wrong with them if they like dresses, are fond of pink, want to practice ballet or play with dolls, or want to paint their nails.[448] There is a long history of parents misidentifying children as gay or transgender due to nonconforming behavior, or pressuring their children to suppress nonconforming behavior, which can drive their children to search for answers for why they are not "normal."[449] Meanwhile, increased rates in gender-affirming care likely stem from the Affordable Care Act expanding insurance coverage that increases access and utilization of medical procedures,[450] and not the fictional "Transgender Treatment Industry" that has been conjured up as part of a gender ideology conspiracy.[451] Tellingly, none of this information appeared in *Skrmetti* despite the direct tie to assessing the legitimacy of Tennessee's justifications.

In *City of Cleburne v. Cleburne Living Center*, another marginalized group was singled out.[452] The City required a special use permit for a group home for those with mental and intellectual disabilities but not for any other care and multihome facilities.[453] The Court ruled that this population did not qualify for heightened scrutiny, but it still went on to invalidate the law because the city relied on vague, unsubstantiated fear and negative attitudes that were insufficient to satisfy rational basis.[454] The Court went through each of the government's offered interests and realized with ease that each was akin to "irrational prejudice."[455]

The targeting of a historically ostracized group makes *Cleburne* an apt comparison. Though the Court's mention of prejudice has led some to label *Cleburne* an animus case[456] and others a case of

448. *See* Emily W. Kane, *"No Way My Boys Are Going to Be Like That!" Parents' Responses to Children's Gender Nonconformity*, 20 GENDER & SOC'Y 149, 160 (2006).

449. Rahilly, *supra* note 447, at 1393.

450. *See* Brandt v. Rutledge, 677 F. Supp. 3d 877, 888 (E.D. Ark. 2025) (noting evidence of a rise in referrals to gender clinics in the United States "is not surprising given the undisputed testimony that there is an increase in awareness of gender dysphoria and an increase in the number of gender clinics and insurance coverage for treatment").

451. *See* Kadel v. Folwell, 620 F. Supp. 3d 339, 373 (M.D.N.C. 2022).

452. *See* 473 U.S. 432, 447 (1985).

453. *See id.*

454. *See id.* at 448.

455. *Id.* at 450.

456. *See, e.g.*, William D. Araiza, *Animus and Its Discontents*, 71 FLA. L. REV. 155, 157 (2019).

"rational basis 'with bite,'"[457] initial stages of legal protections rely on rational basis review because there is a destabilization of norms that courts are loathe to wade into with broad, protective proclamations or accusations of animus for people perhaps clinging to views that may be antiquated but were previously more widely accepted.[458] Just as this Court has continuously gone out of its way to proclaim those opposed to same-sex marriage are "decent and honorable,"[459] the same is almost assuredly true for those opposed to gender transition.[460] Under rational basis review though, the Court could have avoided notions that they are denigrating proponents of the bans and instead might have pointed to the "medical considerations" and the utter lack of support for such interference with patient and provider autonomy.[461]

Calling attention to the manufactured nature of this "crisis" is not meant to imply a certainty that gender-affirming care will alleviate the problems facing any person struggling with their gender identity. But this is not the standard applied to any treatment or medical intervention, nor could it be. At best, the detransitioning testimonials, inexperienced alleged experts, clandestine group reports, and financially and methodologically questionable studies demonstrate some minimal level of uncertainty or risk that still fall far below most medical treatments and procedures. This may even sustain additional evaluation guardrails—though decreases in regret have been attributed to an already improved rigor in assessing patients for gender-affirming care. But it should be incontrovertible that this hodgepodge of sources Tennessee uses falls well short of providing a rational explanation for banning a broad range of treatments from a minority population already suffering health disparities and social persecution.[462] The Court's

457. *See* Kenji Yoshino, *Why the Court Can Strike Down Marriage Restrictions Under Rational-Basis Review*, 37 NYU REV. L. & SOC. CHANGE 331, 333-34 (2013).

458. *See* Eyer, *supra* note 56, at 1358.

459. Obergefell v. Hodges, 576 U.S. 644, 672 (2015).

460. *See e.g.*, United States v. Skrmetti, 145 S. Ct. 1816, 1852-53 (2025) (Barrett, J., concurring) (declaring unnecessarily that other transgender restrictions "ranging from access to restrooms to eligibility for boys' and girls' sports teams" are "legitimate regulatory policy" because there are "many valid reasons to make policy in these areas").

461. *See supra* Part II.A.

462. *Cf.* United States v. Rahimi, 144 S. Ct. 1889, 1936 (2024) (Thomas, J., dissenting) (stating "the Government throws in a hodgepodge of sources from the mid-to-late 1800s" to

ease in ruling otherwise extends the risks to health care access beyond transgender minors.[463]

States have already begun targeting adults,[464] and the Trump administration issued an executive order aimed at restricting access to gender-affirming care throughout the country within a week of taking office, which defined a child as an individual under nineteen years of age.[465] The myth of a desire to protect minors—along with the counterfeited belief in leaving issues to the states—has been laid bare, with Mr. Schilling of the American Principles Project confirming the true desire to eliminate all transition care and that starting with children was simply a strategic decision.[466] Matt Sharp, speaking on behalf of ADF, also made it known that they do not believe in transgender people or transgender care because of "the truth that every person is either male or female."[467] With attacks on transgender people that target bathrooms, sports, gender education, pronouns, forced outing, legal documents, military participation, and many other areas already underway, the Supreme Court's validation of gender-affirming care bans will only encourage more.[468]

The risks extend further into the practice of medicine considering the paucity of credible medical support states have been able to rally for gender-affirming care bans.[469] Consider, for example, the message sent to legislatures by the Supreme Court's blatant

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support its position).

463. Ulrich, *supra* note 47, at 855.

464. Kiara Alfonseca, *States Move to Restrict Transgender Adult Care Amid Gender-Affirming Youth Care Battles*, ABC NEWS (Feb. 14, 2025, at 06:06 ET), https://abcnews.go.com/US/states-move-restrict-transgender-adult-care-amid-gender/story?id=118733720 [https://perma.cc/EE4X-2BQC].

465. Exec. Order No. 14187, 90 Fed. Reg. 8771 (Jan. 28, 2025). As legal challenges proceed, the White House proclaimed, soon after threatening federal funding, that medical appointments for gender-affirming care were cancelled in Colorado, Illinois, New York, Pennsylvania, Virginia, and Washington D.C. *President Trump Is Delivering on His Commitment to Protect Our Kids*, THE WHITE HOUSE (Feb. 3, 2025), https://www.whitehouse.gov/articles/2025/02/president-trump-is-delivering-on-his-commitment-to-protect-our-kids/ [https://perma.cc/P3QR-NV6Y].

466. Astor, *supra* note 77.

467. *Id.*

468. *See e.g.*, Skrmetti, *Title IX Developments, and Gender Policy Updates*, GENDER DEBRIEF NEWSL. (June 28, 2025), https://manhattan.institute/article/skrmetti-title-ix-developments-and-gender-policy-updates [https://perma.cc/W348-YP24].

469. Ulrich, *supra* note 47, at 855-56.

disregard of district court assessments of the states' posse of misfit medical professionals.[470] A handful of people that may have clinical degrees but little in the way of direct knowledge should be considered woefully insufficient to combat the overwhelming consensus of the many organizations that represent thousands of specialists throughout the country.[471] Allowing such a small number of dissidents to establish a judicially acceptable level of uncertainty within the medical field—especially when those limited few lack expertise in the relevant area of practice—is another way to expand the scope of government authority. Under such a low threshold, a state that wants to limit patient and provider autonomy can put out a casting call for any outsiders willing to accept payment to go against the grain.

To make it constitutionally palatable, a court needs only to frame the issue as the Sixth and Eleventh Circuit did: whether there is a right to access that specific treatment.[472] An Idaho District Court explained the broad threat this places on medical practice because "[i]f the right is narrowly defined as the right to seek a specific medical treatment, the entirety of modern medicine would fall outside of the scope."[473] Even if a higher level of generality is used to filter out only treatments that are "experimental" or have medical uncertainty, the gender-affirming care cases display how easily these labels can be obtained through a handful of paid skeptics who possess a doctorate. This makes inspection of the state interest and action as part of a constitutional analysis imperative, even when dealing with nonfundamental rights.

None of this is meant to imply that *Skrmetti* is the end of the fight over gender-affirming care or transgender rights. In fact, it is just the beginning. In 1967, the Supreme Court upheld the deportation of a gay man because his sexual orientation was included in a statute prohibiting those with "psychopathic personality."[474] Five years later, in *Baker v. Nelson*, the Court dismissed an appeal to Minnesota's ban on same-sex marriage "for want of a substantial

470. *See supra* Part III.A.
471. *See supra* Part III.A.
472. *See supra* Part I.B.
473. Poe *ex rel.* Poe v. Labrador, 709 F. Supp. 3d 1169, 1198 (D. Idaho 2023).
474. *See* Boutilier v. INS, 387 U.S. 118, 120-21 (1967).

federal question."[475] In *Bowers v. Hardwick*, the Supreme Court upheld the authority of the state to prosecute gay people for engaging in consensual sex in the privacy of their own home.[476] These losses at the Supreme Court were not the last word on gay rights, and *Skrmetti* will not be the final declaration on the rights and dignity of transgender individuals.

There is a list of other anti-trans laws working through the lower courts, but additional avenues to challenge gender-affirming care bans exist even after *Skrmetti*. This includes the parental rights argument that was successful in most lower court decisions and was not addressed by the Supreme Court.[477] The post-*Dobbs* landscape provides a useful blueprint for other possibilities.[478] For example, eleven state constitutions have been interpreted to protect some form of a right to abortion.[479] State constitutions with strong liberty protections have been especially useful and would again be fruitful pursuits to assert transgender rights after *Skrmetti*.[480] Strides have also been made on protecting abortion rights through state court precedents,[481] state constitutional amendments,[482] and state ballot measures.[483] Anti-trans laws have been vetoed by Republican Governors across the country, suggesting potential to garner bipartisan support at the state level.[484] Support for access to gender-

475. 409 U.S. 810, 810 (1972).

476. *See* 478 U.S. 186, 188-91 (1986).

477. United States v. Skrmetti, 145 S. Ct. 1816, 1847 (2025).

478. *See* Melissa Murray & Katherine Shaw, Dobbs *and Democracy*, 137 HARV. L. REV. 728, 764-65 (2024).

479. *State Constitutions and Abortion Rights*, CTR. FOR REPRODUCTIVE RTS., https://reproductiverights.org/maps/state-constitutions-and-abortion-rights/ [https://perma.cc/7C53-5Z5X].

480. *See e.g.*, Hodes & Nauser v. Schmidt, 440 P.3d 461, 466 (Kan. 2019); Armstrong v. State, 989 P.2d 364, 372-73, 384 (Mont. 1999); Gainesville Woman Care, LLC v. State, 210 So.3d 1243, 1246 (Fla. 2017); Valley Hosp. Ass'n v. Mat-Su Coal. for Choice, 948 P.2d 963, 968 (Alaska 1997).

481. *See e.g.*, Allegheny Reprod. Health Ctr. v. Pa. Dep't of Hum. Servs., 309 A.3d 808, 889-90 (Pa. 2024).

482. *See e.g.*, MICH. CONST. art. I, § 28.

483. *See e.g.*, Dylan Lysen, Laura Ziegler & Blaise Mesa, *Voters in Kansas Decide to Keep Abortion Legal in the State, Rejecting an Amendment*, NPR (Aug. 3, 2022, at 02:18 ET), https://www.npr.org/sections/2022-live-primary-election-race-results/2022/08/02/1115317596/kansas-voters-abortion-legal-reject-constitutional-amendment [https://perma.cc/VX3S-6CVY].

484. Amanda Gokee & Steven Porter, *Governor Ayotte Vetoes 'Bathroom Bill' in N.H., Just as Her Predecessor Chris Sununu Did*, BOS. GLOBE (July 16, 2025, at 12:32 ET),

affirming care could also be expanded by providing a broader audience a greater understanding of existing protective measures for patients and the dangers that could stem from the Supreme Court's indifference to politically motivated restrictions on clinician and patient autonomy.

But perhaps the greatest threat that emanates from gender-affirming care bans is the zeal of many to punch down and the nation's highest Court sanctioning it. People's capacity to "collectively savor attacks on the vulnerable and, through the alchemy of politics, turn this into public policy" is alarming.[485] This contrived crisis should be used to shine a light on the harms suffered by the transgender community.[486] Instead, supporting the mere availability of gender-affirming care spectrum of treatments results in being labeled a gender ideologist.[487] Nevertheless, the health, wellbeing, and dignity of transgender people should take center stage. It is certainly rational to insist that courts view bans on health care through the lens of health outcomes for targeted populations. As an added benefit, it hopefully will help transgender people—especially transgender youth—to feel seen and heard, and that they are not alone in this fight.

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https://www.bostonglobe.com/2025/07/15/metro/nh-bathroom-bill-veto-transgender/ [https://perma.cc/ED7S-SU2M]; Jo Yurcaba, *Ohio's Republican Governor Vetoes Trans Care Restriction and Sports Ban*, NBC NEWS (Dec. 29, 2023, at 11:01 ET), https://www.nbcnews.com/nbc-out/out-politics-and-policy/ohios-republican-governor-vetoes-trans-care-restriction-sports-ban- rcna131579 [https://perma.cc/8V9N-HP4K]; Orion Rummler, *2 Vetoes in 24 Hours: Governors' Decisions on Anti-Transgender Bills Signal Republican Unease*, 19TH NEWS (Mar. 23, 2022, at 15:48 ET), https://19thnews.org/2022/03/indiana-utah-governors-veto-anti- transgender-sports-bills/ [https://perma.cc/TGK7-N583]; Vanessa Romo, *Arkansas Gov. Asa Hutchinson on Transgender Health Care Bill: 'Step Way Too Far'*, NPR (Apr. 6, 2021, at 19:36 ET), https://www.npr.org/2021/04/06/984884294/arkansas-gov-asa-hutchinson-on-transgender-health-care-bill-step-way-too-far [https://perma.cc/P2JD-PPP5].

485. SERWER, *supra* note 24, at 98.

486. *See* Astor, *supra* note 77.

487. *See e.g.*, Nathanael Blake, *Science Keeps Obliterating the Left's Favorite Transgender Narratives*, FEDERALIST (Mar. 6, 2024), https://thefederalist.com/2024/03/06/science-keeps-obliterating- the-lefts-favorite-transgender-narratives/ [https://perma.cc/M95K-PF3A] ("Ulrich and other activists can fulminate about right-wing conspiracies, but it is right and just to ban the surgical and chemical mutilation of children.").

CONCLUSION

As thousands of people suffered from measles, with multiple children dying, Department of Health and Human Services Secretary Robert F. Kennedy, Jr., stated that these measles outbreaks were "not unusual."[488] In reality, measles was declared eliminated from the U.S. in 2000, helping to explain why he was immediately contradicted by every medical and public health professional with any knowledge about measles and infectious diseases.[489] There should be serious concern about the head of the nation's leading health agency appearing to lack some basic facts and principles of public health. But while undermining vaccines is already a consistent element of Secretary Kennedy's Health and Human Services,[490] the possibility of some being banned should not be overlooked either.[491] *Skrmetti* could very well provide a blueprint for such a drastic shift in public health policy. Secretary Kennedy has expressed that vaccines have not been studied enough,[492] similar to claims for gender-affirming care. He has asserted false connections between autism and vaccinations as well as conspiracy theories tying government officials and Bill Gates together in efforts to exploit

488. Neha Mukherjee, *RFK Jr. Said Measles Outbreaks Are 'Not Unusual' in the US. Doctors Say He's Wrong*, CNN (Feb. 27, 2025, at 18:25 ET), https://www.cnn.com/2025/02/27/health/kennedy-measles-outbreaks-us [https://perma.cc/ZP9P-UK4Y].

489. *See id.*

490. *See* Lena H. Sun, Lauren Weber & David Ovalle, *CDC Leaders Who Resigned Said RFK Jr. Undermined Vaccine Science, Risking Lives*, WASH. POST (Aug. 28, 2025), https://www.washingtonpost.com/health/2025/08/28/rfk-cdc-director-susan-monarez-fired/ [https://perma.cc/3R4D-KRMC].

491. Secretary Kennedy has already led his agencies to restrict the public's access to vaccines with thimerosal and mRNA through guidance adoptions and defunding. *See* Will Stone & Pien Huang, *RFK Jr.'s Vaccine Advisers Raise Disproven Fears About the Preservative Thimerosal*, NPR (June 26, 2025, at 14:52 ET), https://www.npr.org/sections/shots-health-news/2025/06/26/nx-sl-5438485/cdc-acip-rfk-thimerosal-vaccines [https://perma.cc/JJ6C-HHLX]; Amanda Seitz, *RFK Jr. Pulls Funding for Vaccines Being Developed to Fight Respiratory Viruses*, PBS (Aug. 5, 2025, at 18:54 ET), https://www.pbs.org/newshour/health/rfk-jr-pulls-funding-for-vaccines-being-developed-to-fight-respiratory-viruses [https://perma.cc/N6BY-U6UK].

492. Rachel Cohrs Zhang & Sarah Owermohle, *RFK Jr.'s Step-by-Step Blueprint to Question the Safety of Vaccines*, STAT NEWS (Jan. 28, 2025), https://www.statnews.com/2025/01/28/rfk-jr-vaccines-kennedy-confirmation-hearing-vaccination-policy-hhs-secretary/ [https://perma.cc/6BT3-CZH8].

vaccines for profit.[493] He has supported and spread the work of pseudoscientists who mask themselves as vaccine skeptics.[494] With a few fringe publications, a gang of vaccine denialists with doctorates, and claims of uncertainty, the parallels are actually uncanny.[495] Yet, vaccines are hardly alone as a potential target, with the Secretary endorsing farm work as a cure for drug addiction and expressing concerns that antidepressants are as addictive as heroin.[496]

We are at a constitutional tipping point,[497] and *Skrmetti* will play a role. Between targeting a marginalized group suffering from discrimination and disparities, the potential to continue a rights-centric focus that empowers this country's historical past, or the blatant paternalism that tells clinicians, patients, and the public what type of treatments are acceptable, the case should be recognized as much more than access to gender-affirming care for minors. Declarations of concern for transgender minors and constitutional neutrality cannot maintain any semblance of sincerity when the architects behind the attack on transgender people have been so transparent about how contrived these efforts are. The Court's willingness to ignore this reality in *Skrmetti* fits with ongoing judicial trends, but, with such an absurdly inept record of support the states have put together, this may be the most blatant constitutionalization of cruelty yet.

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493. *Id.*

494. Keesha Middlemass, *RFK Jr.'s History of Medical Misinformation Raises Concerns over HHS Nomination*, BROOKINGS INST. (Feb. 6, 2025), https://www.brookings.edu/articles/rfk-jr-s-history-of-medical-misinformation-raises-concerns-over-hhs-nomination/ [https://perma.cc/EZ2K-8FS6].

495. *See* Tom Bartlett, *'You Could Throw Out the Results of All These Papers'*, ATLANTIC (July 23, 2025), https://www.theatlantic.com/health/archive/2025/07/david-geier- vaccine-safety-shoddy-research/683630/ [https://perma.cc/9EBF- CDSK]; Jessica Nix, *RFK Jr. Turns to Fringe Medical Journal to Find New Hires*, BLOOMBERG (July 22, 2025, at 07:00 ET), https://www.bloomberg.com/news/articles/2025-07-22/rfk-jr-turns- to-fringe-medical-journal-to-find-new-hires [https://perma.cc/NY3H-28AM].

496. Brian Mann, *RFK Jr. Says He'll Fix the Overdose Crisis. Critics Say His Plan is Risky*, NPR (Jan. 29, 2025, at 07:00 ET), https://www.npr.org/2025/01/29/nx-sl-5276898/rfk-drugs-addiction-overdose-hhs-confirmation-trump [https://perma.cc/84PU-LEN4]; Brian Mann & Katia Riddle, *Antidepressants Harder to Quit than Heroin? Fact-Checking RFK Jr.*, NPR (Jan. 30, 2025, at 17:17 ET), https://www.npr.org/sections/shots-health-news/2025/01/30/ nx-sl-5281164/antidepressants-ssris-rfk-jr-heroin [https://perma.cc/848W-2PA5].

497. *See generally*, Suzanne B. Goldberg, *Constitutional Tipping Points: Civil Rights, Social Change, and Fact-Based Adjudication*, 106 COLUM. L. REV. 1955 (2006) (describing constitutional tipping points).