LET THEM BE CHILDREN: HOW THE LAW SHOULD SUPPORT PARENTS IN PROTECTING THEIR CHILDREN FROM THE HARMFUL EFFECTS OF GENDER-AFFIRMING TREATMENT

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INTRODUCTION

As of July 2022, twenty-one states have introduced thirty bills restricting minors from accessing transgender-related treatment, while thirty-one bills were introduced in 2021 alone.[1] These bills have become law in only three states, with Arizona only banning *surgical* procedures for minors and Arkansas and Alabama remaining temporarily blocked by federal judges.[2] While these outright bans are being hotly contested and are receiving a large amount of attention,[3] a similar issue has been left mostly undisturbed: What happens when parents and minors disagree on whether the child should undergo gender-affirming treatment?[4]

Several states, including Minnesota, Washington, Oregon, and California, have laws allowing minors as young as thirteen to direct their

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1. *See* Priya Krishnakumar & Devan Cole, *2022 Is Already a Record Year for State Bills Seeking to Curtail LGBTQ Rights, ACLU Data Shows*, CNN (July 17, 2022, 5:57 PM), https://www.cnn.com/2022/07/17/politics/state-legislation-lgbtq-rights/.

2. *Id.*

3. Only Arkansas was able to successfully pass a ban in 2021 and multiple cases are being filed across the country to oppose such laws. *See id.*

4. Gender-affirming treatment, as defined by the World Health Organization, encompasses social, psychological, behavioral, and medical interventions "designed to support and affirm an individual's gender identity" when it conflicts with their biological sex. It includes the use of puberty blockers, hormone therapy, and sex reassignment surgery. *Gender Incongruence and Transgender Health in the ICD*, WORLD HEALTH ORG., https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd (last visited July 19, 2022).

own mental health care—including gender-affirming care—and leaving parents powerless to intervene.[5] In Washington, a thirteen-year-old child is entitled to receive mental health and gender-affirming care under a parent's insurance without parental consent or even knowledge.[6] Oregon passed a law in 2015 permitting minors fifteen and older to obtain puberty blockers, cross-sex hormones, and surgeries at taxpayers' expense all without parental permission.[7] In 2018, a similar bill giving all children in foster care, aged twelve and older, the right to access gender-affirming treatment was passed in California.[8] And in September of 2021, California signed a bill sponsored by Planned Parenthood which bars health insurers from disclosing to parents any "sensitive services"—now including gender-affirming care—received by their minor dependents.[9]

One of the reasons why the issue of medical treatment for transgender minors is attracting so much attention is the public's realization that there have been no laws restricting the use of puberty blockers, cross-sex hormones, or even a standard minimum age for such treatment.[10] This raises serious questions of what the harmful effects of hormonal treatment on children are, whether they are based on sound scientific research, what treatment best serves the interests of a child suffering from gender dysphoria, and what is the role of the legislatures and courts in protecting children from unwarranted diagnoses and harmful therapy.[11] Because children cannot fully understand the permanent consequences of their decisions, the rights of parents to make medical decisions in the best interest of their child should be protected.[12]

This Note will begin by introducing the general background of what gender dysphoria is, how gender-affirming medical treatments—such as

5. Abigail Shrier, *When the State Comes for Your Kids*, CITY J. (June 8, 2021), https://www.city-journal.org/transgender-identifying-adolescents-threats-to-parental-rights.

6. *Id.*

7. *Id.*

8. *Id.*; *see* Assemb. B. 2119, 2017-18 Reg. Sess. (Cal. 2018).

9. *2021 Legislative Priorities,* NARAL PRO-CHOICE CAL., https://prochoicecalifornia.org/laws-policy/2021-legislative-priorities/ (last visited Mar. 24, 2022).

10. Madeleine Jacob, *Jury Rules Against Dad Trying to Save His 7-Year-Old from Gender 'Transition'*, LIFESITENEWS (Oct. 21, 2019, 5:33 PM), https://www.lifesitenews.com/news/breaking-jury-rules-against-dad-trying-to-save-his-7-year-old-from-gender-transition.

11. *See, e.g.*, Walt Heyer, *Mom Dresses Six-Year-Old Son as Girl, Threatens Dad with Losing His Son for Disagreeing*, FEDERALIST (Nov. 26, 2018), https://thefederalist.com/2018/11/26/mom-dresses-six-year-old-son-girl-threatens-dad-losing-son-disagreeing/.

12. *See* Jacob, *supra* note 10.

puberty blockers, cross-sex hormones, and sex reassignment surgery—are used to treat gender dysphoria in children, and what physical and psychological risks are involved. Next, the Note will discuss the history of parents' substantive due process rights to direct their children's upbringing, its natural extension to children's medical treatment, and its existing limits in the medical context and in other contexts where parental consent is circumvented. Third, this Note will look at the case law and argue how these existing methods should not be extended to minors seeking gender-affirming care and how any law that arbitrarily takes away parents' rights to direct their children's medical care is unconstitutional under the Fourteenth Amendment.

I. AN OVERVIEW OF THE MEDICAL TREATMENT FOR GENDER DYSPHORIA AND THE RISKS IT POSES

Gender dysphoria refers to the "psychological distress" that results from an individual's biological sex not matching their gender identity, that is, the individual's "psychological sense of their gender."[13] Rather than being based on sound, scientific proof, the causes of gender dysphoria are still being researched[14] and proper treatment of patients who suffer from it is highly experimental.[15] There is serious disagreement within the medical community that the benefits of physical intervention on the bodies of children to "reassign" their sex is supported by research.[16] In fact, research shows a heightened risk of serious, adverse side effects for recipients of sex reassignment procedures as opposed to those who are reaffirmed in their

13. *What is Gender Dysphoria?*, AM. PSYCHIATRY ASS'N, https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria (last visited July 19, 2022).

14. *See* Lawrence S. Mayer & Paul R. McHugh, *Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences*, NEW ATLANTIS, Sept.-Nov. 2016, at 86, 102, 105; Garima Garg et al., *Gender Dysphoria*, TREASURE ISLAND (FL): STATPEARLS PUBL'G (May 5, 2022), https://www.ncbi.nlm.nih.gov/books/NBK532313/.

15. Mayer & McHugh, *supra* note 14, at 106-08; *see also* Ryan T. Anderson, *Sex Reassignment Doesn't Work. Here Is the Evidence.*, THE HERITAGE FOUND. (Mar. 9, 2018), https://www.heritage.org/gender/commentary/sex-reassignment-doesnt-work-here-the-evidence.

16. *See* Mayer & McHugh, *supra* note 14, at 106-08; Ryan T. Anderson & Robert P. George, *Physical Interventions on the Bodies of Children to "Affirm" Their "Gender Identity" Violate Sound Medical Ethics and Should Be Prohibited*, PUB. DISCOURSE (Dec. 8, 2019), https://www.thepublicdiscourse.com/2019/12/58839/.

biological sex.[17] Especially when dealing with minors, parents should be wary about the unethical nature of interfering with their children's natural, healthy development at a time when they are most vulnerable.[18]

A. *Science Does Not Support Invasive Physical Intervention to Treat Gender Dysphoria*

Dr. Paul McHugh, former chief of psychiatry at John Hopkins Hospital, co-authored a peer-researched report on the mental issues faced by the LGBTQIA+ community.[19] In his report, Dr. McHugh explains that the underlying basis of what makes a person male or female is his or her distinct roles in the reproductive system, rather than the atypical behaviors exhibited by members of a sex.[20] Gender is not "entirely detached from the binary of biological sex," because a person's entire physiology is defined by his or her sexual chromosomes, hormones, brain function, and anatomy of their reproductive role.[21] Defining a person based on the "unique combination of characteristics" that person has would encompass a plethora of attributes and traits, causing gender to be defined too broadly and rendering the distinctions meaningless.[22]

Basing an individual's identity on binary sex roles allows for a stable, reliable definition of gender rooted in biology and makes them easily identifiable, even when these individuals behave in ways that are atypical of males and females.[23] Hence, "the only variable that serves as the fundamental and reliable basis"[24] to determine an individual's sex is the

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17. *See* Mayer & McHugh, *supra* note 14, at 73-75; *see also* Doug Mainwaring, *Experts Reveal Stunning Truths About How Transgenderism Harms Children*, LIFESITENEWS (Sept. 25, 2018, 2:44 PM), https://www.lifesitenews.com/news/experts-reveal-stunning-truths-about-how-transgenderism-harms-children.

18. *See* Anderson & George, *supra* note 16.

19. Mayer & McHugh *supra* note 14, at 4-6. Dr. Paul McHugh is University Distinguished Service Professor of Psychiatry and currently teaches psychiatry and behavioral sciences at the Johns Hopkins University School of Medicine. He was the chief of psychiatry for twenty-six years at the Johns Hopkins Hospital. *Id.*

20. *Id.* at 87-88.

21. *Id.* Dr. McHugh explains that "human sexual identity is mostly built into our constitution by the genes we inherit and the embryogenesis we undergo. Male hormones sexualize the brain and the mind." Paul R. McHugh, *Surgical Sex: Why We Stopped Doing Sex Change Operations*, FIRST THINGS (Nov. 2004), http://www.firstthings.com/article/2004/11/surgical-sex.

22. Mayer & McHugh, *supra* note 14, at 88.

23. *Id.* at 89.

24. *Id.* at 90.

individual's biological reproductive role—otherwise, all that is left are stereotypes.[25] The fact that some individuals experience incongruence between their biological sex and their gender identity does not change their biological nature.[26] Thus, a person struggling to line up his or her gender identity, "a more subjective attribute," [27] with his or her biological sex is understood to have a mental disorder rather than a physical one.

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), in code 302.85, defines gender dysphoria as "[a] marked incongruence between one's experienced/expressed gender and assigned gender" that "is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning."[28] This definition differs significantly from the earlier DSM-4 version—which used the term gender identity disorder—because it added the requirement that the patient experience "clinically significant distress or impairment."[29] The main difference between the two versions is that the DSM-4 definition was used as a psychiatric diagnosis, recognizing gender identity confusion as a mental disorder requiring clinical treatment, while the new DSM-5 definition of gender dysphoria instead diagnoses only the *distress* caused by gender identity confusion and thus frames treatment in light of gender-affirming conduct based on subjective experiences.[30] This shift in diagnosis weakens the medical requirements for a mental health disorder because it is no longer based on a consistent reliable diagnosis.[31]

Because the definition of gender dysphoria is vague and confusing, it leads to many inconsistent diagnoses.[32] For example, there may be people who are transgender but who do not suffer from gender dysphoria because

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25. *Id.* at 93. "Sex as a status—male or female—is a recognition of the organization of a body that can engage in sex as an act. That organization isn't just the best way to figure out which sex you are. It's the only way to make sense of the concepts of male and female at all." Anderson, *supra* note 15.

26. Mayer & McHugh, *supra* note 14, at 93-94.

27. *Id.* at 93.

28. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 452-53 (5th ed. 2013) [hereinafter DSM-5].

29. Mayer & McHugh, *supra* note 14, at 94-95.

30. *Id.* at 95-96. The original term in DSM-4 for "gender identity disorder" involved a stronger, more persistent diagnosis based on symptoms of "clinically significant distress" whereas DSM-5 "gender dysphoria" is centered on a less significant medical issue based on "a state of feeling." Rena M. Lindevaldsen, *An Ethically Appropriate Response to Individuals with Gender Dysphoria*, 13 LIBERTY U.L. REV. 295, 298-99 (2019).

31. Lindevaldsen, *supra* note 30, at 300.

32. Mayer & McHugh, *supra* note 14, at 95-96.

the incongruence does not cause them to experience significant psychosocial distress.[33] Conversely, some individuals who do not identify with a gender that opposes their biological sex may still struggle with gender identity based on accepted social norms.[34] A major concern is that individuals who express incongruence between their gender identity and biological sex, are often misdiagnosed and given clinical interventions, which previously were reserved only for psychiatric disorders.[35] Moreover, such diagnoses and treatments do not account for individuals who express a desire to identify as members of the opposite sex due to anxiety, depression, or other mental health issues unrelated to gender dysphoria.[36] Alarmingly, there is an increasing amount of clinical research showing evidence of an association between children and adolescents with gender dysphoria and autism spectrum disorder; possibly because, as one such study notes, a symptom of autism can be "intense, obsessive interests on a gender-specific theme."[37]

In the context of children, the DSM-5 criteria for gender dysphoria are even more troublesome.[38] Although the "clinically significant distress" is still part of the diagnosis, other criteria for gender dysphoria include "a strong preference for toys, games or activities stereotypically used or engaged in by the other gender."[39] This additional criteria is scientifically unsound and simply fails to account for the fact that a child can display a preference towards a gender that is incongruent with that child's biological sex without ever identifying with that opposite gender.[40] The diagnosis of gender dysphoria is unreliable even for children who do identify as a gender

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33. *Id.* at 95.

34. *Id.* For example, some girls behave like "tomboys" without ever identifying themselves as boys. *See* Dennis E. Reidy et al., *Feminine Discrepancy Stress and Psychosocial Maladjustment Among Adolescent Girls*, 49 CHILD PSYCHIATRY HUM. DEV. 176, 176 (2018) (discussing "discrepancy stress," a form of gender role stress that "stems from fear of the consequences for not conforming to traditional gender roles").

35. Mayer & McHugh, *supra* note 14, at 95-96.

36. *Id.*

37. Sanja Zupanic et al., *Case Report: Adolescent With Autism and Gender Dysphoria*, 12 FRONTIERS IN PSYCHIATRY 1, 2 (May 26, 2021) (citing multiple other studies finding a correlation between autism and gender dysphoria); *see also* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE (7th version 2012), https://www.wpath.org/publications/soc [hereinafter WPATH] ("The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population.").

38. DSM-5, *supra* note 28, at 452.

39. *Id.*

40. Mayer & McHugh, *supra* note 14, at 96.

opposite to their biological sex.[41] Children simply lack the ability to rationalize socially acceptable gender roles, which may lead to psychological difficulties in identifying with their biological sex.[42]

Incongruence between gender identity and biological sex has also been linked to traumatic childhood experiences, which have caused children to disassociate with members of a sex.[43] Unfortunately, there has been little development of alternative treatments to address the possibility that these children are suffering from trauma, rather than true gender incongruence,[44] since transgender healthcare does not focus on exploring the cause of gender dysphoria but rather the best way to affirm the child's preferred gender identity.[45] Thus, the immediate response to children exhibiting gender-dysphoric symptoms is to have them begin some form of gender-affirming treatment,[46] which demonstrates the urgency for legal protections for similarly situated minors and parents who want to explore other treatment options.

Ultimately, gender-affirming treatment is any treatment that seeks to affirm the desired gender of the patient, regardless of their biological makeup.[47] There is virtually no scientific evidence that transgender identity is based on biological reality.[48] Thus, the idea that people are born in the wrong body is ideologically flawed.[49] Human beings are not ghosts that live inside non-personal bodies which can be reconstructed to conform to their

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41. *Id.*

42. *Id.*

43. *Id.* For example, a transsexual woman who de-transitioned back to a man explained that he had a traumatic experience during childhood with his abusive father, causing him to disassociate himself with the male sex. *See* Stephen B. Levine, *Transitioning Back to Maleness*, 47 ARCHIVES SEXUAL BEHAV. 1295, 1296-97 (2018). *See also* Garg et al., *supra* note 14 ("There is also growing evidence the childhood abuse, neglect, maltreatment, and physical or sexual abuse may be associated with [gender dysphoria].").

44. Although recommended treatment includes psychotherapy, it is performed with the goal of affirming whatever gender identity the child prefers. *See* WPATH, *supra* note 37, at 10, 16. Any psychological attempts to guide a transgender person to accept the reality of their biological gender are labelled "gender identity conversion therapy" and are condemned as unethical. AM. PSYCHIATRY ASS'N, *supra* note 13.

45. The most widespread protocol used by professionals working with gender non-conforming individuals, the WPATH Standards of Care, states that treatment should affirm a person's choice of gender identity. *See* WPATH, *supra* note 37, at 1-3 (The WPATH Standards of Care is an international, clinical guideline standardizing the recommended assessment and treatment for gender non-conforming individuals).

46. *Id.*

47. *See id.* at 3; WORLD HEALTH ORG., *supra* note 4.

48. Mayer & McHugh, *supra* note 14, at 106.

49. *See* Anderson & George, *supra* note 16.

internal sense of being.[50] Rather, the body is an essential part of who and what a person is, organized into two distinct reproductive systems: male and female.[51] The fact that a person struggles with intersex conditions, identity crises, or acts in a way that is gender non-conforming to society's expectations does not change this scientific reality.[52]

Sexual development disorders and gender dysphoria do not scientifically create a third reproductive system or a spectrum of sexes.[53] Neither does sexual reassignment surgery change someone into his or her desired sex, because it is a "biological impossibility."[54] As Dr. McHugh states, "no degree of supporting a little boy in converting to be considered, by himself and others, to be a little girl makes him biologically a little girl."[55] The most this type of treatment can do is feminize men and masculinize women, creating "counterfeits or impersonators of the sex with which they 'identify,'" leading to a problematic and distressing future.[56]

This type of treatment is especially concerning when performed on children because a vast majority later come to accept their biological sex.[57] According to DSM-5, as many as seventy to ninety-eight percent of gender dysphoric boys and fifty to eighty-eight percent of gender dysphoric girls eventually align their gender identity with their biological sex.[58] When medical professionals interfere with the natural, healthy development of children in an attempt to "reassign" their sex, they are not only affirming false assumptions but are mutilating healthy bodies in the process.[59] "The purpose of medicine is to bring about human health and wholeness, human flourishing in the physical and psychological domains."[60] Removing

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50. *Id.*

51. *Id.* For a full discourse on this point with scientific research and analysis, s*ee generally* Mayer & McHugh, *supra* note 14.

52. Anderson & George, *supra* note 16.

53. *Id.*

54. Anderson, *supra* note 15 (quoting Princeton philosopher Robert P. George); *see also* Mayer & McHugh, *supra* note 14, at 92-93.

55. Mayer & McHugh, *supra* note 14, at 93.

56. Anderson, *supra* note 15.

57. Laura A. Haynes, *The American Psychological Association Says Born-That-Way-And-Can't-Change Is Not True of Sexual Orientation and Gender Identity*, THERAPY EQUAL., www.therapyequality .org/american-psychological-association-says-born-way-cant-change-not-true-sexual-orientation-gender-identity (last visited Mar. 25, 2021).

58. DSM-5, *supra* note 28, at 455.

59. *See* Anderson & George, *supra* note 16.

60. *Id.*

perfectly healthy organs to reaffirm an inherently misguided belief violates the medical ethic of "do no harm."[61]

B. *Sex Reassignment Surgery, Cross-Sex Hormones and Puberty Blockers Are Still Highly Experimental*

Gender dysphoria is a complex disorder involving many subjective and hard-to-identify factors that cannot be easily cured with gender-affirming treatment.[62] There is much controversy as to whether gender-affirming treatment actually benefits the patient.[63] Scientific data on why gender dysphoria persists or desists specifically in children is scant, particularly due to the large uncertainties in how adults should interpret the conflicting behavior of these children.[64]

The DSM-5 notes that there is no substantial evidence that children who are encouraged or supported in their desired gender have higher rates of persistence because there have been no systematic long-term follow-ups on these children.[65] The high rates of lost follow-ups with gender reassignment patients[66] are especially alarming because medical professionals have no real data, but instead "are left with opinions based on theory, anecdotal clinical contacts, and the blog postings of those who have de-transitioned."[67] Further studies on such individuals need to be conducted before medical professionals can propose treatments that benefit gender dysphoric patients long-term.[68]

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61. *Id.*

62. *See* Haynes, *supra* note 57 (noting that the APA Handbook of Sexuality and Psychology states the origins of transgender identity are "most likely the result of a complex interaction between biological and environmental factors" including the "influence of family of origin dynamics"). *See generally* Mayer & McHugh, *supra* note 14, at 95-97.

63. *See*, *e.g.*, Mayer & McHugh *supra* note 14, at 112; Haynes, *supra* note 57.

64. Mayer & McHugh, *supra* note 14, at 106-07.

65. DSM-5, *supra* note 28, at 455.

66. "[T]he results of many gender reassignment studies are unsound because researchers lost track of more than half of the participants." Anderson, *supra* note 15 (quoting David Batty, *Sex Changes Are Not Effective, Say Researchers*, GUARDIAN (July 30, 2004, 12:49PM), https://www.theguardian.com/society/2004/jul/30/health.mentalhealth).

67. Levine, *supra* note 43, at 1298; "[L]oss to follow-up can severely compromise a study's validity" because "even small proportions of patients lost to follow-up can cause significant bias." Joseph R. Dettori, *Loss to Follow-Up*, 2 EVIDENCE-BASED SPINE-CARE J. 7, 7, 9 (2011).

68. *See* Levine, *supra* note 43, at 1300; Mayer & McHugh, *supra* note 14, at 108.

Even the few follow-up studies that exist on post-operative transsexuals are unreliable because they were either poorly designed,[69] did not extend beyond the first five years,[70] or failed to show improvements that reached statistical significance.[71] For example, a study of psychological outcomes of puberty suppression and sex-reassignment surgery on children was published in 2014 in the journal *Pediatrics*.[72] This study was performed on a relatively small sample size—fifty-five transgender adolescents and young adults—who were assessed three times during the study: before the start of medical intervention, during the introduction of cross-sex hormones, and one year after sex-reassignment surgery.[73]

Notably, the study did not provide a matched control group of transgender adolescents who did not receive gender-affirming medical intervention.[74] The study suggested that gender dysphoria, body image, and overall functioning improved over time.[75] However, without the matched control group, it is difficult to tell if these improvements were actually attributed to the interventions or would have occurred anyways.[76] The small sample size and missing matched control group suggest that there is much about this area that needs to be researched, especially regarding harmful long-term effects on children.[77]

In 2016, the Obama administration conducted an exhaustive review of all existing peer-reviewed research on surgical treatment for gender dysphoria to

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69. Anderson, *supra* note 15.

70. Levine, *supra* note 43, at 1299.

71. Mayer & McHugh, *supra* note 14, at 108. "Hayes, Inc., a research and consulting firm that evaluates the safety and health outcomes of medical technologies," gave the lowest quality ratings to studies of sex reassignment treatment, finding the long-term follow-up to be "too sparse." Anderson, *supra* note 15.

72. *See generally* Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 4 PEDIATRICS 134 (2014).

73. *Id.* at 2; Mayer & McHugh, *supra* note 14, at 108.

74. Mayer & McHugh, *supra* note 14, at 108. *See generally* De Vries et al., *supra* note 72 (no mention of a control group).

75. *See* Mayer & McHugh, *supra* note 14, at 108; De Vries et al., *supra* note 72, at 6-7.

76. Mayer & McHugh, *supra* note 14, at 108. In a clinical trial, a control group "does not receive the new treatment being studied. This group is compared to the group that receives the new treatment, to see if the new treatment works." *Control Group*, NAT'L CANCER INST., https://www.cancer.gov/publications/dictionaries/cancer-terms/def/control-group (last visited Oct. 11, 2022). In other words, without a control group, researchers cannot determine whether the treatment under investigation truly has a significant effect on the experimental group.

77. *See* Mayer & McHugh, *supra* note 14, at 108.

decide whether those procedures should be covered by Medicare.[78] After reviewing the evidence, the Centers for Medicare and Medicaid Services refused to issue a National Coverage Determination because the clinical evidence for the efficacy of gender-affirming treatments remained inconclusive due to the low quality and strength of the studies.[79] It observed that the study results were inconsistent: of the best designed studies, some reported benefits while others reported harms.[80]

As seen by the lack of proper studies, there is relatively little evidence that gender-affirming treatments are beneficial to children suffering from gender dysphoria.[81] Despite the lack of data on the outcomes of such puberty-delaying treatments, there is a push among many advocates to proceed with puberty blockers and sex reassignment surgery at younger ages.[82] There has been a significant increase in children and teens being referred to gender dysphoria clinics, "with the median age now seeking assessment and treatment estimated to be 8 years old."[83] Four to five-fold increases in trans-identifying youth have been reported in gender clinics across the United States and in other countries.[84] Importantly, even supporters have voiced concern over whether the teenagers coming out as transgender today are different from the adults who transitioned in previous

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78. Tamara Syrek Jensen et al., *Gender Dysphoria and Gender Reassignment Surgery*, CMS (Aug. 30, 2016), https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed =N&NCAId=282&bc=ACAAAAAAQAAA&.

79. Identified issues included: "mostly observational study designs with no comparison groups, subjective endpoints, potential confounding (a situation where the association between the intervention and outcome is influenced by another factor such as a co-intervention), small sample sizes, lack of validated assessment tools, and considerable lost to follow-up." *Id.*

80. *Id.*

81. *See id.* ("All studies reviewed had potential methodological flaws. . . ."); Mayer & McHugh, *supra* note 14, at 107.

82. *See* Mayer & McHugh, *supra* note 14, at 107.

83. Tabitha Frew et al., *Gender Dysphoria and Psychiatric Comorbidities in Childhood: A Systematic Review*, 73 AUSTL. J. PSYCH. 255, 256 (May 5, 2021) ("A range of studies finds gender dysphoria is becoming increasingly prevalent and this trend is particularly highlighted in child populations."). *See also* Luda Berdnyk, *Study Shows Teenage Gender Dysphoria Diagnosis in Sweden Soar by More Than 1,500% in Recent Years*, SWEDES STATES (Feb. 27, 2020), https://swedesinthestates. com/study-shows-teenage-gender-dysphoria-diagnosis-in-sweden-soar-by-more-than-1500-in-recent-years/.

84. *See* Lisa Marchiano, *Outbreak: On Transgender Teens and Psychic Epidemics*, 60 PSYCH. PERSP. 345, 348 (2017); Emily Bazelon, *The Battle Over Gender Therapy*, N.Y. TIMES (June 15, 2022), https://www.nytimes.com/2022/06/15/magazine/gender-therapy.html ("In countries that collect national data, like the Netherlands and Britain, the number of 13-to-17-year-olds seeking treatment for gender-identity issues has also increased, from dozens to hundreds or thousands a year.").

generations and who were the subjects of the studies that found gender-affirming treatment beneficial.[85]

Since the first transgender youth clinic in the United States opened in Boston in 2007, over sixty "gender clinics" have opened that cater exclusively to children.[86] Many of these children are given non-FDA approved puberty blockers,[87] the results of which can take years to manifest.[88] By prescribing treatment that is seriously lacking in scientific data, physicians simply have no way of knowing what the physical and psychological consequences are without testing them on the bodies of children.[89] Even if minors consent to such treatment despite being made aware of the many risks, their age and immaturity renders informed consent[90] pointless and highlights the necessity of parental consent and guidance in such situations.[91] The current use of puberty blockers and sex-reassignment

85. Bazelon, *supra* note 84 ("[T]he rise in trans identification among teenagers could be a result of what they called 'social influence,' absorbed online or peer to peer.").

86. *Id.*

87. Lupron Depot-PED and other GnRH agonists are prescribed to treat children with central precocious puberty. Any other usage is not approved by the FDA and is considered "off-label." *See* Craig Monger, *FDA Adds New Warning for Commonly Used Puberty Blockers*, 1819 NEWS (Aug. 6, 2022), https://1819news.com/news/item/fda-adds-new-warning-to-commonly-used-puberty-blockers; *Drugs@FDA: FDA Approved Drugs*, FDA, https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=020263 (search "Lupron") (The most recently issued Label states that Lupron is indicated for central precocious puberty only).

88. Because the FDA has not approved the use of Lupron or similar puberty blockers to stop the normal development of puberty, there have been no controlled studies to determine the consequences of this use. Michael K. Laidlaw, *The Pediatric Endocrine Society's Statement on Puberty Blockers Isn't Just Deceptive. It's Dangerous.*, PUB. DISCOURSE (Jan. 13, 2020), https://www.thepublicdiscourse.com/2020/01/59422/.

89. Anderson & George, *supra* note 16.

90. Informed consent is defined as "[a] person's agreement to allow something to happen, made with full knowledge of the risks involved and the alternatives. . . . A patient's knowing choice about a medical treatment or procedure, made after a physician or other healthcare provider discloses whatever information a reasonably prudent provider in the medical community would give to a patient regarding the risks involved in the proposed treatment or procedure." *Informed Consent*, BLACK'S LAW DICTIONARY (11th ed. 2019).

91. *Id. See also* Kathryn Hickey, *Minor's Rights in Medical Decision Making*, 9 JONA'S HEALTHCARE L., ETHICS & REGUL. 101, 101-02 (2007) ("[T]he inability of minors to give full, informed consent to participation creates true ethical and legal dilemmas . . . .").

surgery is an unethical human experimentation[92] on our most vulnerable members of society.[93]

C. *There Are Permanent Physical and Psychological Impacts of Sex Transition Therapy on Children*

Children who are referred to clinics for demonstrating symptoms of gender dysphoria are placed on some form of the Dutch protocol,[94] which begins at a young age: social transitioning, puberty blockers, cross-sex hormones, and surgery.[95] Not only is there a low quality of evidence that gender transition procedures work,[96] there are serious harmful effects that begin at the very first stage of the protocol. Social transitioning involves dressing a child in clothing of the opposite sex, changing a child's name and pronouns, and having parents, therapists, teachers, and other adults reinforce a child's misguided gender identity.[97]

This treatment has lasting effects on children by creating gender confusion that children cannot comprehend and putting them on track for

92. Children cannot give informed consent to participate in clinical trials or research on human subjects and must receive parental consent according to subpart D of the HHS regulations at 45 CFR 46. Allowing children to consent to experimental gender-affirming treatment, especially against their parents' wishes, is no different and should not be treated as an exception. *See Research with Children FAQs,* U.S. DEP'T HEALTH & HUM. SERV., https://www.hhs.gov/ohrp/regulations-and-policy/guidance/faq/children-research/index.html#:~:text=By%20definition%2C%20children%20are%20unable,or%20legal%20guardian(s) (last visited July 19, 2022).

93. *See* Erin Brewer, *Detransitioners: Stories of Medical Abuse, Part 2*, YOUTUBE (Feb. 5, 2020), https://www.youtube.com/watch?v=NSR1oEEyack.

94. The Dutch protocol is based on the studies performed in 2014 by de Vires et al. in a Dutch clinic discussed in note 72; *see "Gender-Affirming" Hormones and Surgeries for Gender-Dysphoric US Youth*, SOC'Y FOR EVIDENCE BASED GENDER MED. (May 28, 2021), https://segm.org/ease_of_obtaining_hormones_surgeries_GD_US (noting that while the Dutch protocol discouraged early transitioning in minors, North America "sharply reduced [the] role of psychotherapy" and preferred affirmation while discouraging exploratory therapy); *see generally* De Vries et al., *supra* note 72.

95. *See, e.g.*, Anderson & George, *supra* note 16.

96. An evaluation of the Endocrine Society's influential guidelines demonstrates low to very low ratings for their quality of evidence supporting gender transition therapy. Peter Sprigg, *The Evidence Suggests Gender Transition Procedures for Minors are Experimental*, FAMILY RSCH. COUNCIL (Feb. 13, 2020), https://frcblog.com/2020/02/evidence-suggests-gender-transition-procedures-minors-are-experimental/. For the official Endocrine Society's guidelines see Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. ENDOCRINOLOGY & METABOLISM 3869 (2017).

97. *See* Laidlaw, *supra* note 88. Laidlaw described social transitioning as a "mind manipulation" to affirm the child's false belief that he or she is trapped in the wrong body. *Id.*

medical sterility.[98] For example, Walt Heyer, an outspoken de-transitioned transsexual, described how his grandmother dressed him as a girl when he was four, five, and six years old, conditioning him to identify as a female which negatively affected his entire life and led him to undergo unnecessary sex-reassignment surgery.[99] International expert in childhood gender dysphoria, Kenneth Zucker, calls social transitioning, iatrogenic—an illness caused by a physician—and notes that it is unsurprising that the rate of gender dysphoria persistence in such children is much higher than those who are allowed to become comfortable in their biological bodies.[100]

The next step in gender-affirming treatment, puberty blockers, follows soon afterward. Contradictory to the claim that puberty blockers buy time for the child to figure out his or her gender identity,[101] a majority of children placed on this treatment end up receiving cross-sex hormones or sex-reassignment surgery.[102] Once medical personnel intervene with the child's natural, pubertal development, there is a high risk that the child is locked into a sex change, long before the child can truly understand what is happening.[103] Puberty blockers themselves have serious, permanent effects on a child's body.[104] The way puberty blockers work is that they drastically reduce the amount of signals the pituitary gland sends to the body, lowering sex hormones and "freez[ing] pubertal development."[105]

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98. *See, e.g.*, Philip J. Cheng et al., *Fertility Concerns of the Transgender Patient*, 8 TRANSLATIONAL ANDROLOGY & UROLOGY 209, 210 (2019) ("Both transgender men and women are at risk of losing their reproductive potential during the process of medical or surgical transition with [gender-affirming hormone therapy]," while most bottom surgery renders patients "permanently sterile."); WPATH, *supra* note 37, at 100, 103 (listing impaired fertility as risk factors).

99. *See* Brief for Walt Heyer as Amicus Curiae Supporting Petitioners, Doe v. Boyertown Area Sch. Dist., 897 F.3d 518, 523 (3d Cir. 2018) (No. 18-658), 2018 WL 6788556.

100. Laidlaw, *supra* note 88.

101. Also called the "watchful waiting model," this method calls for physical intervention in children's bodies to suppress puberty. *See* Reidar Schei Jessen & Katrina Roen, *Balancing in the Margins of Gender: Exploring Psychologists' Meaning-Making in Their Work with Gender Non-Conforming Youth Seeking Puberty Suppression*, 10 PSYCH. & SEXUALITY 119, 119-20 (2019).

102. According to a Dutch study, all seventy participants who were put on puberty blockers continued on to receiving cross-sex hormones and sex-reassignment surgery. Laidlaw, *supra* note 88.

103. *See* Heyer, *supra* note 11.

104. *See, e.g.*, Nigel A. Spry et al., *Long-Term Effects of Intermittent Androgen Suppression on Testosterone Recovery and Bone Mineral Density: Results of a 33-Month Observational Study*, 104 BJU INT'L 806, 806 (2009); *see also* WPATH, *supra* note 37, at 97-104 (listing the medical risks of hormone therapy); Cheng et al., *supra* note 98, at 215 ("[T]he risks of long-term exposure to hormones by transgender individuals is not understood, and thus, any potential risks to the patient or future offspring is unknown.").

105. *See* Laidlaw, *supra* note 88.

Pubertal development not only affects the development of male and female genitalia, but is also a very important stage for bone density, brain, and psychological development.[106] Thus, by stopping the pituitary gland from sending necessary functional signals to the body, puberty blockers freeze the development of the bone, brain, and other organs in whatever stage they were when the injections began.[107] For short-term use, the theory is that once the injections stop, the pituitary gland will start sending signals at normal levels over time.[108]

However, because puberty blockers, such as Lupron, are being used off-label,[109] there is no way of knowing if blocking normal puberty is reversible.[110] Studies have shown that puberty blockers prevent children's bones from meeting their full adult potential, putting them at serious risk of osteoporosis and fractures.[111] Puberty blockers can also lead to memory impairment, slow reaction times, reduced IQ, and increased behavioral and emotional problems, including anxiety and depression.[112] Finally, Lupron, the most prescribed off-label treatment, has numerous reports of patients developing disabling side effects and even death.[113] These reports have risen in the past few years,[114] despite there being a long history of lawsuits against Lupron manufacturers.[115]

Cross-sex hormones and sex-reassignment surgery are the last steps in the gender-affirming treatment process. As discussed above, data on the

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106. *Id.*

107. *Id.* This treatment creates a "disease state known as hypogonadotropic hypogonadism by means of medication." *Id.*

108. *Id.*

109. *See* Monger, *supra* note 87.

110. Pediatric endocrinologist Paul Hruz states: "Rather than claiming that puberty suppression is reversible, researchers and clinicians should focus on the question of whether the physiological and psychosocial development that occurs during puberty can resume in something resembling a normal way after puberty-suppressing treatments are withdrawn." Laidlaw, *supra* note 88.

111. *See* Spry et al., *supra* note 104, at 806.

112. Laidlaw, *supra* note 88.

113. *Id.*; *see* Christina Jewett, *Women Fear Drug They Used to Halt Puberty Led to Health Problems*, KAISER FAMILY FOUND. (Feb. 2, 2017), https://khn.org/news/women-fear-drug-they-used-to-halt-puberty-led-to-health-problems/.

114. *FDA Adverse Events Reporting System (FAERS) Public Dashboard*, FDA (Mar. 31, 2022), https://fis.fda.gov/sense/app/95239e26-e0be-42d9-a960-9a5f7f1c25ee/sheet/45beeb74-30ab-46be-8267-5756582633b4/state/analysis (search "Lupron").

115. *See generally* LUPRON VICTIMS HUB, http://lupronvictimshub.com/index.html (last visited Jan. 11, 2022). For details about the adverse risks and claims against Lupron see Brief for Karin Klein as Amicus Curiae Supporting Petitioners, Klein v. Tap Pharm. Prods., 571 U.S. 1104 (2013) (No. 13-542).

long-term effects of sex reassignment procedures is scarce since quality research is lacking and key participants are often missing from follow-up studies.[116] The most thorough follow-up of patients who underwent sex-reassignment surgery was conducted in Sweden and extended over thirty years.[117] Even though Sweden has a society that strongly supports transgender lifestyles, the study revealed serious mental health concerns: the suicide rate for those who underwent surgical reassignment was "strikingly high" compared to those who did not have sex reassignment surgery, and the suicide risk worsened years after obtaining the sex reassignment.[118] Additionally, studies have consistently found that transgender people have a higher mortality risk than the general population, and those using hormone treatment, regardless of treatment type, are more likely to die from lung cancer and cardiovascular disease.[119]

After conducting his own studies, psychiatrist-in-chief at John Hopkins Hospital, Dr. McHugh, concluded that sex reassignment surgery was hurting his patients more than it was helping them.[120] In an article explaining his reasons for terminating sex-reassignment surgery, Dr. McHugh explained that the hospital was "cooperating with a mental illness" and that the physicians would better help the patients by treating the mental disorder rather than reconstructing healthy genitalia.[121] For those that survive, many regret their sex-reassignment surgery and suffer life-long harm including irreversible changes to their bodies, sterility, and years of their life lost to an alternative identity.[122]

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116. *See* Jensen et al., *supra* note 78; Anderson, *supra* note 15; Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLOS ONE 1, 6 (Feb. 22, 2011) ("Previous clinical studies might have been biased since people who regard their sex reassignment as a failure are more likely to be lost to follow-up.").

117. Dhejne et al., *supra* note 116, at 7.

118. *Id.*, at 5-6. *See* Anderson, *supra* note 15 ("Ten to 15 years after surgical reassignment, the suicide rate of those who had undergone sex-reassignment surgery rose to 20 times that of comparable peers.")

119. *See* CHRISTEL JM DE BLOK ET AL., MORTALITY TRENDS OVER FIVE DECADES IN ADULT TRANSGENDER PEOPLE RECEIVING HORMONE TREATMENT: A REPORT FROM THE AMSTERDAM COHORT OF GENDER DYSPHORIA 7 (2021); Dhejne et al., *supra* note 116, at 6.

120. *See* McHugh, *supra* note 21.

121. *Id.*

122. *See* Brief for Walt Heyer as Amicus Curiae Supporting Petitioners, Doe v. Boyertown Area Sch. Dist., 897 F.3d 518, 523 (3d Cir. 2018) (No. 18-658), 2018 WL 6788556.

II. Due Process and Parental Rights

The Supreme Court has long declared that one of the liberties specially protected by the Due Process Clause of the Fourteenth Amendment is the right of parents to direct their children's upbringing:[123] "[T]he interest of parents in the care, custody, and control of their children — is perhaps the oldest of the fundamental liberty interests recognized by this Court."[124] Recognizing that parents have a natural duty to nurture their children from which flows their fundamental rights of parental control, the Court has "respected the private realm of family life which the state cannot enter."[125] A century of jurisprudence upholding the primary right of "parents in the upbringing of their children is now established beyond debate as an enduring American tradition."[126]

Inherent in parents' rights to direct their children's upbringing is the right to choose or refuse medical procedures for their children.[127] While the Supreme Court has not explicitly held that the parental rights afforded by the Due Process Clause include choosing the child's medical care, it has implied as much by acknowledging "parents' authority to decide what is best for the child" in the medical context.[128] This recognition of parents' power is the reason why parental consent is normally required before a child can make important medical decisions.[129] Particularly relevant in this context, "[t]he fact that a child may balk at hospitalization or complain about a parental refusal to provide cosmetic surgery does not diminish the parents' authority

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123. *See, e.g.*, Meyer v. Nebraska, 262 U.S. 390, 399 (1923); Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 639 (1974); Wash. v. Glucksberg, 521 U.S. 702, 720 (1997).

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

125. Prince v. Massachusetts, 321 U.S. 158, 166 (1944) ("It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder. . . . It is in recognition of this that these decisions have respected the private realm of family life which the state cannot enter."); Pierce v. Soc'y of Sisters, 268 U.S. 510, 535 (1925) ("The child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations.").

126. Wisconsin v. Yoder, 406 U.S. 205, 232 (1972). *Accord* Moore v. East Cleveland, 431 U.S. 494, 503 (1977) ("Our decisions establish that the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and tradition.").

127. *See* Parham v. J.R., 442 U.S. 584, 604 (1979).

128. *Id.*

129. Dubbs v. Head Start, Inc., 336 F.3d 1194, 1203 (10th Cir. 2003) (holding that parental consent was required for their children's medical procedures because Supreme Court precedent implies that parental consent is a fundamental right).

to decide what is best for the child."[130] Furthermore, even where the child, state officials, or the court believes that a specific medical intervention would benefit the child, this assessment does not transfer away the decision-making authority parents are endowed with.[131]

Great deference is afforded to familial privacy and parental authority because the law presumes that parents generally act in the best interest of their children.[132] The "special importance and primacy of the familial relationship . . . militate[s] against governmental intrusion."[133] Absent a finding of neglect or abuse by a court, parents are the appropriate decision-makers for their children.[134] The Court is appropriately reluctant to disrupt the integrity of the family because it recognizes that it is not best situated to evaluate all the intricacies of family life and review every parental decision.[135]

Although children also have constitutionally protected rights, these rights are limited because the Supreme Court recognizes that minors do not possess "the capacity to take care of themselves"[136] and that "during the formative years of childhood and adolescence, minors often lack the experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them."[137] In addition to subjecting children to the control of their parents, the Supreme Court further acknowledges the vulnerability of children by allowing the government to "limit the freedom of children to choose for themselves in the making of important, affirmative choices with

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130. *Parham*, 442 U.S. at 604.

131. *See id.*

132. *See id.* at 602 ("[H]istorically [the law] has recognized that natural bonds of affection lead parents to act in the best interests of their children."); Troxel v. Granville, 530 U.S. 57, 68 (2000) ("[T]here is a presumption that fit parents act in the best interests of their children.").

133. Newmark v. Williams, 588 A.2d 1108, 1115 (Del. 1991).

134. *Parham*, 442 U.S. at 604.

135. Of the guiding principles that shape a state court's best interests determination, the importance of family integrity was the most frequently referenced in state statutes, even over the health, safety, and protection of the child. Additionally, of the state statutes that list factors for courts to consider in best interests determinations, the parent-child relationship was specifically mentioned in nearly twice as many statutes as the child's mental and physical health. *See* CHILD WELFARE INFO. GATEWAY, DETERMINING THE BEST INTERESTS OF THE CHILD 2 (2020), https://www.childwelfare.gov/pubPDFs/best_interest.pdf.

136. Schall v. Martin, 467 U.S. 253, 265 (1984).

137. Bellotti v. Baird, 443 U.S. 622, 635 (1979); *accord Parham*, 442 U.S. at 602 ("The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions.").

potentially serious consequences."[138] Because such choices that will greatly impact minors' fundamental rights are closely guarded, children cannot exercise some of these rights until they reach the age of majority.[139] Hence, parents are entrusted with the responsibility of holding these rights "in-trust" for their children until they reach the proper age to exercise them without harming themselves.[140] This safeguarding role is particularly significant when a decision that will impact a child's entire future, such as sterilization, can be deferred until the child becomes old enough to make that judgment both aptly and independently.[141] Prohibiting parents from fulfilling their role of directing such consequential treatment for their children, when they believe it is in their children's best interests, is the kind of intrusive government conduct that parental due process rights guard against.[142]

A. *Existing Limits on Parental Rights in the Medical Context*

While the traditional deference awarded to parental rights is well recognized, there are several situations where parental authority over a child's medical decisions is limited when it seriously jeopardizes a child's health or public safety.[143] These exceptions include vaccines, medically

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138. *Bellotti*, 443 U.S. at 634-35 (recognizing three reasons why children's constitutional rights "cannot be equated with those of adults: [1] the peculiar vulnerability of children; [2] their inability to make critical decisions in an informed, mature manner; and [3] the importance of the parental role in child rearing").

139. *See Parham*, 442 U.S. at 626-29; Skylar Curtis, *Reproductive Organs and Differences of Sex Development: The Constitutional Issues Created by the Surgical Treatment of Intersex Children*, 42 MCGEORGE L. REV. 841, 859 (2011) (explaining that children have latent rights, such as voting, marriage, and procreation).

140. *See* Joseph Millum, *The Foundation of the Child's Right to an Open Future*, 45 J. SOC. PHIL. 522, 523-24 (discussing Feinberg's recognition of "rights-in-trust," which must be "*saved* for the child until he is an adult") (quoting Joel Feinberg, *The Child's Right to Open Future*, *in* WHOSE CHILD?: CHILDREN'S RIGHTS, PARENTAL AUTHORITY, AND STATE POWER 125-26 (William Aiken & Hugh Lafollette eds., 1980)).

141. *See generally* Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law's Failure to Protect Intersex Infants*, 21 BERKELEY J. GENDER L. & JUST. 59 (Sep. 2013) (arguing against genital surgery on intersex children, even where parents and physicians believe it is medically necessary for the child, because it permanently impacts children's ability to make this profoundly personal decision for their own future).

142. *See Parham*, 442 U.S. at 602-03; Brief for Petitioners at 26, Smith v. Bell, No. 16-1513 (13th Cir. Petition for cert. filed Feb. 17, 2020) (No. 14-0123) ("Parents have the primary duty to act on behalf of their children in a way consistent with their family values.").

143. *See* Elizabeth S. Scott & Clare Huntington, *Conceptualizing Legal Childhood in the Twenty-First Century*, 118 MICH. L. REV. 1371, 1426 (2020).

necessary or lifesaving treatment, sterilization, and abortion.[144] The rationale underlying the medically necessary and abortion limitations will be analyzed and compared to the context of gender-affirming treatment of minors.

1. Abortion

In the past fifty years, a substantial limitation on parental medical decision-making authority has developed in the context of minors' reproductive rights. The Supreme Court held that, while the State has a duty to safeguard the family unit and parental authority, it cannot impose an absolute parental veto over a minor's decision to get an abortion since it would not strengthen the family unit.[145] The landmark case is *Bellotti v. Baird* where the Supreme Court, despite acknowledging the presumption that parents act in the best interests of their children,[146] held that if a state requires a pregnant minor to obtain parental consent for an abortion, then the state must also "provide an alternative procedure whereby authorization for the abortion can be obtained," or in other words, a judicial bypass procedure.[147] The Court held, "A pregnant minor is entitled in such a proceeding to show either: (1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests."[148] Thus, a minor must have an opportunity to seek judicial permission for an abortion without first consulting or notifying her parents.[149]

The holding in *Bellotti* supported the development of the "mature minor doctrine" first recognized in common-law.[150] Under this doctrine, adolescents who are deemed mature can consent to or refuse their own medical treatment.[151] Mature minors are commonly defined as "minors who are able to understand the nature and consequences of the medical treatment

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144. *See id.* at 1427-28, 1444; *infra* Part III.A.1-2.
145. *See* Planned Parenthood v. Danforth, 428 U.S. 52, 74-75 (1976).
146. Bellotti v. Baird, 443 U.S. 622, 638-39 (1979).
147. *Id.* at 643.
148. *Id.* at 643-44.
149. *See id.*
150. Hickey, *supra* note 91, at 102.
151. *Id.*

offered . . . ."[152] This doctrine allows an adolescent to validly consent to a proposed treatment if the minor can understand its nature and risks, if the physician believes the minor is capable of giving the same degree of informed consent as an adult patient, and if the treatment does not involve very serious risks.[153]

Legal recognition of this doctrine is both "limited and patchwork."[154] Only fourteen states permit mature minors to consent to general medical treatment while thirty-four states have no legal exceptions for mature minors.[155] However, there must normally be clear and convincing evidence that the minor fully understands the consequences of his actions, and courts make this determination by weighing several factors including age, degree of maturity and judgment, ability, experience, education, training, and conduct/demeanor at the time of the incident.[156]

Although the Supreme Court has never ruled on the applicability of the mature minor doctrine to medical procedures outside of reproductive rights,[157] advocates strongly promote this doctrine as a means for minors to receive gender-affirming treatment without parental consent.[158] The argument is that the Supreme Court's rationale for permitting a parental consent exception to minors seeking abortion is equally applicable to minors

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152. Garry S. Sigman & Carolyn O'Connor, *Exploration for Physicians of the Mature Minor Doctrine*, 119 J. PEDIATRICS 520, 521 (1991). *See* Hickey, *supra* note 91, at 102 ("A minor who is deemed able to understand short- and long-term consequences is considered to be 'mature' and thus able to provide informed consent/refusal for medical treatment.").

153. *See* Samuel Dubin et al., *Medically Assisted Gender Affirmation: When Children and Parents Disagree*, 46 J. MED. ETHICS 295, 297 (2020).

154. *Id.* A majority of states have not adopted the mature minor doctrine. States that have adopted it, expressly or impliedly through statute or court decisions, vary in how the doctrine is applied and how maturity is determined. *See* Jonathan F. Will, *My God My Choice: The Mature Minor Doctrine and Adolescent Refusal of Life-Saving or Sustaining Medical Treatment Based Upon Religious Beliefs*, 22 J. CONTEMP. HEALTH L. & POL'Y 233, 255 (2006).

155. Dubin et al., *supra* note 153, at 297 (noting that the mature minor doctrine is primarily an ethical principle, and it "does not necessarily grant legality to a decision-making process").

156. *See* Commonwealth v. Nixon, 761 A.2d 1151, 1153-54 (Penn. 2000); Cardwell v. Bechtol, 724 S.W.2d 739, 744-45 (Tenn. 1987); *In re* E.G., 549 N.E.2d 322, 326-27 (Ill. 1989); Belcher v. Charleston Area Med. Ctr., 422 S.E.2d 827, 838 (W. Va. 1992); *see also* Sigman & O'Connor, *supra* note 152, at 522-24 (listing factors that have influenced court decisions in mature minor cases).

157. *The Mature Minor Doctrine*, USLEGAL, http://healthcare.uslegal.com/treatment-of-minors/ the-mature-minor-doctrine/ (last visited Mar. 3, 2022).

158. *See* Emily Ikuta, *Overcoming the Parental Veto: How Transgender Adolescents Can Access Puberty-Suppressing Hormone Treatment in the Absence of Parental Consent Under the Mature Minor Doctrine*, 25 S. CAL. INTERDIS. L.J. 179, 203 (2016); Dubin et al., *supra* note 153, at 297.

seeking gender-affirming treatment.[159] In *Bellotti*, the Court noted that a minor's abortion decision is unique in that the minor cannot simply postpone her decision until she reaches the age of majority because the possibility of aborting has an expiration date.[160] Moreover, unwanted motherhood may be exceptionally burdensome for a minor such that "there are few situations in which denying a minor the right to make an important decision will have consequences so grave and indelible."[161] Put another way, "the urgency of obtaining treatment (an abortion) in that case, and the enduring consequences of withholding that treatment from the minor, convinced the Court that the Constitution did not allow the government to require pregnant adolescents to obtain parental consent to get an abortion."[162]

By focusing on this urgency reasoning, the justification is that the Court's rationale equally applies to transgender adolescents entering puberty because, once secondary sex characteristics have formed and pubertal development is complete, the changes are irreversible and hormone treatment becomes less effective.[163] Additionally, minors who cannot access puberty blockers will be burdened by their unwanted development into a gender they do not identify with and the lasting effects of the physical change.[164] Thus, the argument is that the judicial bypass allowed in the abortion context should be allowed for minors with gender dysphoria seeking puberty suppression treatment since it is substantially similar given the limited time minors have before pubertal changes begin.[165]

The premise of that argument is illogical, however, because the situation faced by a pregnant minor and a minor with gender dysphoria are inherently different. This argument creates a false sense of urgency. Once a pregnant mother gives birth, there is nothing that can be done to reverse this. However, once an adolescent goes through puberty, there are still multiple options left available if they later wish to transition; in fact, the same gender-affirming treatment plan is followed regardless of at what point in life someone transitions.[166] While hormone treatments and even surgery may

159. *See* Ikuta, *supra* note 158, at 219.

160. Bellotti v. Baird, 443 U.S. 622, 642 (1979).

161. *Id.*

162. Ikuta, *supra* note 158, at 219.

163. *Id.* at 219-20.

164. *Id.* at 220.

165. *Id.*

166. "A person who is transitioning later in life has access to the same medical and nonmedical gender affirming procedures as people who begin transitioning earlier." Veronica Zambon, *Tips on*

become less effective after pubertal development, these are still viable possibilities and most people who transition do in fact take this route post-puberty.[167] One of the biggest concerns with post-puberty transitioning is that attaining a satisfactory appearance becomes more difficult—in other words, people who have transitioned will have a harder time looking the way they want to.[168] Simply because transitioning as a minor is an easier process than transitioning post-puberty does not make this situation akin to the predicament faced by a minor with an unwanted pregnancy. More importantly, the health risks minors are exposed to when undergoing gender-affirming treatment, such as impaired psychological development and infertility, are much more substantial than those faced in an abortion procedure.[169]

Likewise, the applicability of the mature minor doctrine is also inappropriate in this context. One of the doctrine's requirements for a mature minor's consent to be valid is that the treatment does not involve very serious risks.[170] This is not the case in gender-affirming treatment. Recognizing that "mature minors" have the ability to understand the long-term consequences of an abortion[171]—a choice eliminating their fertility in that period of their lives—is not analogous to an ability to understand the long-term consequences of irreversible hormone therapy or surgery[172]—a choice eliminating their fertility for the rest of their lives. While minors might be mature enough to recognize that they do not currently want a child of their own, it is highly unlikely that they can comprehend whether or not they will want a child in thirty years.[173] "There is a widespread assumption

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Transitioning and Presenting as More Feminine Later in Life, MED. NEWS TODAY (Apr. 9, 2021), https://www.medicalnewstoday.com/articles/male-to-female-transition-later-in-life.

167. Jaclyn M. White Hughto & Sari L. Reisner, *A Systematic Review of the Effects of Hormone Therapy on Psychological Functioning and Quality of Life in Transgender Individuals*, 1 TRANSGENDER HEALTH 21, 21, 24 (2016).

168. S. Giordano, *Lives in a Chiaroscuro. Should We Suspend the Puberty of Children with Gender Identity Disorder?*, 34 J. MED. ETHICS 580, 580 (2008).

169. "The total abortion-related complication rate is estimated to be about 2%." Karima R. Sajadi-Ernazarova & Christopher L. Martinez, *Abortion Complications*, TREASURE ISLAND (FL): STATPEARLS PUBL'G (May 24, 2021), https://www.ncbi.nlm.nih.gov/books/NBK430793/.

170. Dubin et al., *supra* note 153, at 297. Concerningly, the "legal standard for what is high-risk treatment is based on medical opinion," which, as discussed above, is highly contradictory and disputed regarding gender-affirming treatment for adolescents. Sigman & O'Connor, *supra* note 152, at 523.

171. Hickey, *supra* note 91, at 101-02.

172. *See supra* Part II.

173. *See* Sarah R. Holley & Lauri A. Pasch, *Counseling Lesbian, Gay, Bisexual and Transgender Patients*, *in* FERTILITY COUNSELING: CLINICAL GUIDE AND CASE STUDIES 190 (Sharon N. Covington ed.,

that transgender people do not want to have biological children" but, in fact, several studies have shown the opposite to be true.[174] With the sharp rise in minors being diagnosed with gender dysphoria, more patients are seeking treatment at a younger age—a time "when reproductive wishes may not yet be clearly defined" and many may not realize that they will want to have children after transitioning.[175] Disturbingly, many adolescents are not adequately informed about family planning issues, with one study finding that only twenty percent had discussed fertility with a healthcare provider and only thirteen percent had discussed the effects of hormones on fertility.[176] Of those adolescents that had been given formal consultations, few took advantage of any future family-planning methods, raising concern that their decision was motivated by a childish and short-sighted attempt to avoid any delay in medical transitioning.[177] Because of the high possibility that transgender youth might change their perspectives about having children later in life, it is even more important that adolescents are protected from "initiating treatment that could have potentially irreversible effects on fertility."[178]

Even beyond infertility, the other consequences of gender-affirming treatment, like permanent deformities and psychological harm, make this a situation where a minor cannot be found to give informed consent.[179] This is more in line with the rationale behind the holding in *Bellotti*—under the best-interests-of-the-child test, the primary purpose underlying this parental authority exception is to protect minors from entering a serious, life-altering situation (parenthood) which they are not prepared to handle due to their peculiar vulnerability.[180] Such a rationale hardly seems applicable as

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2015) ("Discussions regarding fertility preservation may be needed as research has demonstrated that there are cases of people who have received [transgender] treatments who later regretted their inability to produce genetically related children.").

174. Cheng et al., *supra* note 98, at 210 ("One study of 50 transmen showed that 54% desired children.").

175. *Id.*

176. *Id.* at 211.

177. *Id.*

178. *Id.*

179. *See* Hickey, *supra* note 91, at 101, 104.

180. Bellotti v. Baird, 443 U.S. 622, 634, 642 (1979) ("[T]he constitutional rights of children cannot be equated with those of adults [due to] the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing.").

justification for allowing minors to enter a serious, life-altering situation (medical transitioning) that they are not prepared to handle.[181]

In order to supersede a parent's child-rearing decisions, the State must rebut the presumption that a parent is acting in the best interest of their child.[182] Despite repeated claims that there is a medical consensus on this topic, gender-affirming treatment is still highly experimental and there is no substantial evidence that providing such irreversible treatment is effective or safe, let alone in a child's best interest.[183] This is a high burden because both courts and physician ethicists agree that parents generally act in the best interest of their children:

> [Parents] know their child best, are best suited to weigh competing interests, and make decisions based on specific values and priorities. Cursory professional assessments from the state examining children's medical interests alone are insufficient to replace the judgment of a loving and nurturing parent, but instead must be weighed in the context of interwoven interests.[184]

Therefore, the state has no grounds to intervene in parents' decisions on this matter because choosing non-emergency gender-affirming treatment cannot be in the child's best interest when weighed against the potential risks. The mature minor doctrine and judicial bypass procedures are inapplicable in this context and should not be construed as providing legal precedent for allowing minors to receive gender-affirming care without parental knowledge or consent.

2. *Medically Necessary and Lifesaving Treatment*

The recent influx of attention devoted to the cause of encouraging young children to begin transitioning, even without parental consent, looks to the

181. One of the main rationales for parental consent requirements is the need to protect minors "from their own improvident decisionmaking." OFF. OF TECH. ASSESSMENT, ADOLESCENT HEALTH, VOL. III: CROSSCUTTING ISSUES IN THE DELIVERY OF HEALTH AND RELATED SERVICES 123 (1991). *See* Bellotti v. Baird, 443 U.S. at 638-39 ("Legal restrictions on minors, especially those supportive of the parental role, may be important to the child's chances for the full growth and maturity that make eventual participation in a free society meaningful and rewarding.").

182. *See Parham* v. J.R., 442 U.S. 584, 602 (1979); Troxel v. Granville, 530 U.S. 57, 68 (2000).

183. *See supra* Part II.

184. Katherine Drabiak, *Resolving Physician-Parent Disputes Involving Pediatric Patients*, 20 HOUS. J. HEALTH L. & POL'Y 353, 368-69 (2021).

existing limits on parental rights as a guideline.[185] Thus, advocates of minors receiving gender-affirming treatment focus heavily on attempting to prove that transitioning should be considered a medical necessity.[186] Two routes are typically proposed as a way to invoke state intervention to bypass parental disagreement: labeling a child's gender dysphoria as an "emergency"[187] or labeling a parent's refusal of gender-affirming treatment as child abuse.[188]

Parents have a duty to seek medical treatment when their child has a life-threatening illness.[189] This affirmative duty was established in *People v. Pierson*, one of the earliest cases involving judicial intervention over parents' denial of medical treatment.[190] Under the doctrine of *parens patriae*, the state has a duty to intervene in circumstances where the child suffers harm, exploitation, and neglect.[191] Although the State has "an independent interest in the well-being of its youth,"[192] it can only intervene in family affairs if parents are not acting in the best interests of their children.[193] Because parental authority is grounded in the principle of the child's well-being, a parent's medical decision will not receive deference if it poses a substantial risk of serious harm to the child's health.[194] This is true even when the

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185. *See* Ikuta, *supra* note 158, at 195.

186. *See, e.g.*, Molly Nunn, *Transgender Healthcare Is Medically Necessary*, 47 MITCHELL HAMLINE L. REV. 605 (2021). In the insurance industry context, health care is medically necessary when "a prudent physician" selects it "for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standard of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily . . . for the convenience of the patient, treating physician, or other health care provider." *Definitions of "Screening" and "Medical Necessity" H-320.953*, AMA, https://policysearch.ama-assn.org/policyfinder/detail/H-320.953?uri=%2FAMADoc%2FHOD.xml-0-2625.xml (last visited Mar. 13, 2022).

187. *See* Nunn, *supra* note 186, at 622 & n.94 ("[T]he absence of gender-affirming care presents dire consequences: patients may resort to self-harm and suicide.").

188. *See* Heyer, *supra* note 11; Douglas S. Diekema, *Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention*, 25 THEORETICAL MED. & BIOETHICS 243, 244-45 (2004).

189. People v. Pierson, 68 N.E. 243, 247 (N.Y. 1903).

190. *Id.*

191. Prince v. Massachusetts, 321 U.S. 158, 166-67 (1944).

192. Ginsberg v. New York, 390 U.S. 629, 640 (1968).

193. *See* Parham v. J.R., 442 U.S. 584, 602-03 (1979); Troxel v. Granville, 530 U.S. 57, 68-69 (2000).

194. Parham v. J.R., 442 U.S. 584, 602-03 (1979) (recognizing parents' broad authority over children's medical decisions but also noting that the "state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized.").

parent's decision is based on religious beliefs such as in the event of a parent's refusal to allow their child to receive a lifesaving blood transfusion.[195] However, the law is still attentive to the religious beliefs that impact parents' medical decisions for their child, as is demonstrated by the numerous religious exemptions that have been upheld.[196] Still, in a true medical emergency where a child's life is imminently at risk, parental rights almost always give way to the interests of the child and the state.[197]

Invoking *parens patriae* and state intervention to override parental medical decision-making requires specific factors beyond the state's intention to act in the best interest of the child.[198] Since *People v. Pierson*, cases that uphold judicial intervention compelling medical treatment for minors generally require that (1) the child has a life-threatening disease or medical condition that will cause substantial bodily harm; (2) the proposed treatment has a high chance of success; and (3) the benefits of the proposed intervention far outweigh the risks.[199] These cases also require the State to overcome a high burden of demonstrating that parents' medical decisions run contrary to their child's best interest.[200] To safeguard the important role and constitutional rights of parents, each of the three factors must be satisfied for judicial intervention to be appropriate, especially that the child is currently suffering from a serious, life-threatening ailment.[201] While some courts permit states to petition for intervention where the child has an ongoing substantial medical condition, the courts must still evaluate the nature of the condition and would likely not be permitted to order treatments that are

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195. *See, e.g.*, *Prince*, 321 U.S. at 170 ("Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion, when they can make that choice for themselves."); *In re* McCauley, 565 N.E.2d 411, 414 (1991) (ordering a blood transfusion over parental religious objections after deciding it was in the dangerously ill child's best interests); Muhlenberg Hosp. v. Patterson, 320 A.2d 518, 521 (N.J. Super. Ct. Law Div. 1974) (same); *In re* Guardianship of L.S. & H.S., 87 P.3d 521, 527 (Nev. 2004) (same).

196. Most states have enacted spiritual treatment exemptions from the obligation of a parent to seek medical care for a child. *See, e.g.*, ARIZ. REV. STAT. ANN. § 8-201.01(A)(1) (2016); CAL. WELF. & INST. CODE § 300.5 (West 2016); N.J. STAT. ANN. § 9:6-1.1 (West 2016).

197. *See* Lee Black, *Limiting Parents' Rights in Medical Decision Making*, 8 AM. MED. ASS'N J. ETHICS 676, 676 (2006).

198. *See id.* at 676-77, 679; Diekema, *supra* note 188, at 250.

199. Diekema, *supra* note 188, at 248-49; *see generally* Black, *supra* note 197.

200. *See* Black, *supra* note 197, at 676.

201. *Id.* at 677.

"risky, extremely invasive, toxic with many side effects, and/or offers a low chance of success."[202]

Accordingly, there is no basis to extend decisions to override parental medical decision-making in circumstances where the child is not presently sick and does not have an existing, life-threatening medical condition.[203] Thus, the medically necessary exception is not applicable to the context of gender dysphoria because, on its own, it is not a life-threatening condition and cannot cause substantial bodily harm. As previously discussed, identifying as the sex opposite one's biology is no longer classified as a mental illness by the DSM-5; gender dysphoria only warrants psychological intervention when the gender incongruence causes mental distress.[204] Even if this mental distress was so serious that a court chose to classify it as an ongoing substantial medical condition, courts should not order gender-affirming medical treatment because it is toxic, risky, and invasive[205]—especially since there are other, safer treatment options available.[206]

i. Life-Threatening "Emergency"

Nevertheless, those in favor of gender-affirming medical treatment for minors believe it is a medical necessity and even an "emergency" requiring state intervention when a gender dysphoric child has non-affirming parents.[207] Arguments centering on mental health and suicide are at the forefront of this movement.[208]

For example, one study reported that transgender students were four times more likely to seriously consider, make plans for, and attempt suicide

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202. *Id.* (quoting *In re* D.R., 20 P.3d 166, 169 (Okla. Civ. App. 2001)).

203. *See id.*

204. DSM-5, *supra* note 28, at 453.

205. *See supra* Part II.

206. *Id.* These include psychotherapy and counseling, deferring medical treatment until the age of majority, or even limiting treatment to non-medical interventions such as social transitioning.

207. *See* Nunn, *supra* note 186, at 622 & n.94 ("In some--even many--cases the specter of suicidality and other forms of self-harm . . . frames mental health justifications for medical necessity of declarations for sex reassignment surgery and hormones therapy.") (quoting DANIEL SKINNER, MEDICAL NECESSITY 108 (2019)).

208. *Id.*; *see* Brief for Walt Heyer as Amicus Curiae Supporting Petitioners, Doe v. Boyertown Area Sch. Dist., 897 F.3d 518, 523 (3d Cir. 2018) (No. 18-658), 2018 WL 6788556 ("The proponents of gender identity theory tell parents and schools that they must support and affirm a child's transgender journey to prevent the child from attempting suicide.").

than their peers.[209] However, another study states that, of the youth who identify themselves as transgender or nonbinary, about half considered suicide in 2021, while about twenty percent actually attempted suicide.[210] In contrast, about thirty percent of cisgender[211] youth considered suicide while about ten percent attempted it.[212] The Trevor Project, the world's largest suicide prevention and crisis intervention organization for LGBTQIA+ youth, prominently displays its "estimates that at least one LGBTQ youth between the ages of 13–24 attempts suicide every 45 seconds in the U.S."[213] Using such alarming and extreme statistics as a basis, many organizations declare that the suicide risk among trans youth is a "public health crisis" and that gender-affirming treatment is medically necessary because, if minors are not affirmed, they will die by suicide.[214] Thus, the argument is that parental authority should be ignored when parents refuse to allow their children to medically transition, because this denial is not in the best interests of the child since it increases suicide risk and will thus substantially harm them.[215]

This argument has several flaws. Primarily, the types of medical emergencies that this parental consent exception was created for are inherently different from the situation of a minor seeking gender-affirming treatment—this situation does not satisfy any of the three traditional requirements for judicial intervention.[216] Unlike the medical emergencies that this exception was created for, the danger faced by the child is neither a substantial bodily harm nor imminently life-threatening, and there is no

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209. *See* Michelle M. Johns et al., *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, 68-69 (2019).

210. THE TREVOR PROJECT, NATIONAL SURVEY ON LGBTQ YOUTH MENTAL HEALTH 2021, at 3 (2021), https://www.thetrevorproject.org/wp-content/uploads/2021/05/The-Trevor-Project-National-Survey-Results-2021.pdf.

211. "Cisgender" is the term given to people whose gender identity matches their sex at birth. *Cisgender*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/cisgender (last visited Mar. 3, 2022).

212. THE TREVOR PROJECT, *supra* note 210, at 3. While transgender youth do have higher rates of suicide attempts, this rate is far from being four times higher than cisgender youth. *Id.*

213. THE TREVOR PROJECT, *Estimate of How Often LGBTQ Youth Attempt Suicide in the U.S.* (Mar. 11, 2021), https://www.thetrevorproject.org/research-briefs/estimate-of-how-often-lgbtq-youth-attempt-suicide-in-the-u-s/#:~:text=Dividing%20the%20number%201%20by,for%20Disease%20Control%20and%20Prevention.

214. *See generally* Lore M. Dickey & Stephanie L. Budge, *Suicide and the Transgender Experience: A Public Health Crisis*, 75 AM. PSYCH. ASS'N 380 (2020).

215. *See* Nunn, *supra* note 186, at 622.

216. *See* Diekema, *supra* note 188, at 248-49; *see generally* Black, *supra* note 197.

medical consensus that gender-affirming procedures are the only way to save the child's life or even the most appropriate option for a child suffering from gender dysphoria.[217] Moreover, it is unlikely that courts will be able to meet their high burden of proving that parents are acting against their child's best interests when protecting them from experimental and disruptive medical interventions.[218]

As to the first requirement for judicial intervention, a court should only order medical treatment over parental objection when required "to save the life or limb of the child."[219] Yet gender dysphoria is neither life-threatening nor able to cause substantial bodily harm to a child.[220] Children are in no physical danger if their healthy bodies are merely allowed to continue developing normally. Ironically, using chemicals and surgery to alter and damage a child's body and natural development is arguably the physical danger that the child is faced with.[221] Additionally, this exception requires that the serious danger be imminent in some way,[222] and an imminent threat is missing from the context of a minor seeking gender-affirming medical treatment because no one can know when a gender dysphoric youth might attempt suicide, or if there will be an attempt at all. The only argument that can make untreated gender dysphoria look like an imminent, life-threatening danger to children is to try and use high suicide statistics to fill this requirement.

Suicide rates cannot be used as a blanket stand-in for the imminent danger requirement because it is neither correlative nor applicable to every minor's situation. While these statistics show that transgender youth are clearly facing significant mental health struggles, they do not establish the

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217. *See* Black, *supra* note 197, at 677; s*ee also supra* Part II.

218. Black, *supra* note 197, at 676; *see also* Troxel v. Granville, 530 U.S. 57, 72-73 (2000).

219. *In re* Carstairs, 115 N.Y.S.2d 314, 316 (Dom. Rel. Ct. 1952).

220. *See* Laidlaw, *supra* note 88.

221. *See supra* Part II. In 2019, the American Journal of Psychiatry published a study reporting that gender-affirming surgeries "are associated with improved mental health outcomes" for gender dysphoric patients. SOC'Y EVIDENCE-BASED GENDER MED., *Correction of a Key Study: No Evidence of "Gender-Affirming" Surgeries Improving Mental Health* (Aug. 30, 2020), https://segm.org/ajp_correction_2020. After many researchers called out the study's methodological problems, the Journal issued a correction and reversed its key finding, stating that "the results [of the reanalysis] demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related healthcare visits or prescriptions or hospitalizations following suicide attempts . . . ." *Id.*

222. *See* Diekema, *supra* note 188, at 248-49.

cause of the higher suicide rates.[223] For this argument to work, there must be substantial causation specifically between denying a minor gender-affirming medical treatment and suicide. However, transgender youth experience a multitude of factors that strongly affect suicide ideation including comorbid mental health issues, rejection by friends and family, bullying and harassment, and generally feeling unsafe.[224] Moreover, when gender identity disorder was reclassified as gender dysphoria, it was no longer considered a mental disorder, so the effects of the incongruity itself are not being adequately considered as a factor.[225] Most notably, research has shown that suicide rates actually increase after surgical reassignment,[226] while other research shows no difference.[227] Thus, causation cannot be established.

Likewise, automatically assuming that all transgender youth are in imminent danger of suicide is inconsistent with the reality that eighty percent do not attempt suicide.[228] In addition, relying on the fear of suicide to legitimize this situation as a medical emergency sets a dangerous precedent: it opens the door for impressionable adolescents to be encouraged to use a devastating mistake as a tool, or even a weapon.[229] This message should be rejected outright.

In a recent Ohio case addressing the custody of a child with gender dysphoria, a juvenile court judge noted that "[t]he threat of suicide and the existence of suicidal ideation can never hold this Court hostage as it searches for proper outcome of litigation revolving around the best interests of that child."[230] She went on to caution that "troubled adolescents" too often

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223. *See* Dickey & Budge, *supra* note 214, at 381 ("[S]uicide is nuanced and complicated."); Johns et al., *supra* note 209, at 71 (admitting that its study cannot be used to infer causation and that transgender highschoolers are more prone to "violence victimization" and "substance use" which all contribute to suicide risk).

224. *See* H. G. Virupaksha et al., *Suicide and Suicidal Behavior Among Transgender Persons*, 38 INDIAN J. PSYCH. MED. 505, 507 (2016).

225. *See* DSM-5, *supra* note 28, at 453.

226. Dhejne et al., *supra* note 116, at 7.

227. *See* Jensen et al., *supra* note 78; SOC'Y EVIDENCE-BASED GENDER MED., *supra* note 221.

228. *See* THE TREVOR PROJECT, *supra* note 213.

229. *See* Mary Hasson, *Judge Who Removed Trans Teen from Parents Highlights What's at Stake*, FEDERALIST (Feb. 21, 2018), https://thefederalist.com/2018/02/21/judge-removed-trans-teen-parents-highlights-whats-stake/ (calling attention to a "troubling" trend exemplified by a case where "the county and the hospital filed papers with the court suggesting the threat of the teen's 'imminent suicide' was reason enough to approve hormone treatments"); *In re* JNS, No. F17-334 X, Hamilton County Juvenile Court (Feb. 16, 2018), https://www.scribd.com/document/371667957/Ruling-from-Judge-Sylvia-Sieve-Hendon-on-transgender-boy#.

230. *In re* JNS, No. F17-334 X, Hamilton County Juvenile Court (Feb. 16, 2018), https://www.scribd

"threaten self-harm" to try to force a particular outcome and that the court cannot "take jurisdiction every time a minor threatens self-harm if he or she is unable to gain parents' consent for some desired procedure, such as a rhinoplasty or similar cosmetic surgery."[231] Prompted by this case, family expert and attorney Mary Hasson pointed out how suicide statistics are being used as "emotional blackmail."[232] Drastic suicide statistics are repeatedly used to create a panic where parents—and even judges and doctors—are told they only have two choices: affirm the child's gender transition or be responsible for the unaffirmed child's suicide.[233]

This false choice does not accurately represent the options that both parent and child have available to them and should not be persuasive in the medical community or the court systems.[234] To be sure, a child struggling with suicide is a genuine concern that should not be minimized. But with the scientific uncertainty surrounding gender dysphoria,[235] gender-affirming medical procedures should not be considered when viable options such as therapy and counseling are available.[236] For example, "48% of LGBTQ youth reported they wanted counseling from a mental health professional but were unable to receive it in the past year."[237] This situation is fundamentally different from cases where a child's life is at risk directly from the illness or where courts have found valid reasons to limit parental authority based on the existence of non-invasive or well-established, lifesaving medical treatment.[238] A parent's refusal to allow their child to receive non-emergency gender-affirming treatment is not the same as a refusal to allow their child a lifesaving blood-transfusion; instead, it is a personal, family decision based on a determination of what is in the best interest of that

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.com/document/371667957/Ruling-from-Judge-Sylvia-Sieve-Hendon-on-transgender-boy#. Even though custody was ultimately awarded to the minor's gender-supportive grandparents due to the complicated facts of the case, the judge noted that "the entire field of gender identity and non-conforming gender treatment" is plagued by "a surprising lack of definitive clinical study available to determine the success of different treatment modalities." *Id.*

231. *Id.*

232. *See* Hasson, *supra* note 229.

233. *Id.*

234. *See* Scott & Huntington, *supra* note 143.

235. *See In re* JNS, No. F17-334 X, Hamilton County Juvenile Court (Feb. 16, 2018), https://www.scribd.com/document/371667957/Ruling-from-Judge-Sylvia-Sieve-Hendon-on-transgender-boy#; *see also supra* Part II.

236. THE TREVOR PROJECT, *supra* note 210, at 5.

237. *Id.* at 2.

238. *See* Black, *supra* note 197, at 676-77.

specific child—a determination which parents are best situated to make, and a determination that courts must presume parents are best situated to make.[239] Therefore, the argument that high suicide rates among unaffirmed transgender youth constitutes a life-threatening condition must fail.

The second requirement for judicial intervention also cannot be satisfied because the proposed treatment for gender dysphoria must have a high chance of success, and this cannot be shown since gender-affirming treatment is experimental.[240] Importantly, this is unlike other situations warranting state intervention because the medical procedures in those cases were standard and well-known in the medical community as the appropriate treatment required for that ailment.[241] Here however, there is no generally accepted knowledge or conclusive medical proof that gender-affirming treatment will remove the suicide risk, alleviate gender dysphoria, or be in the best interest of the child.[242] Even acknowledging that minors with gender dysphoria have a higher suicide rate, there is no concrete evidence that medically transitioning will solve that matter since it may not be causative.[243] The psychological distress and mental health problems experienced by gender dysphoric youth are not solely a product of their inability to medically transition or even from their gender dysphoria.[244] Thus, to assume that gender-affirming treatment is a cure-all would ignore the complex and multi-faceted reality underlying mental health issues. Again, research has shown that surgical reassignment can actually have the opposite effect and increase suicide rates post-surgery.[245] Because causation between the

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239. *Id.*; Parham v. J.R., 442 U.S. 584, 604 (1979).

240. *See* Black, *supra* note 197, at 676; *supra* Part II.

241. The cases discussing the state's power to take a child for medical treatment despite the religious objections of the parents in a nonemergency or a non-life-threatening situation have focused primarily on the nature of the treatment in question, its efficacy in temporarily or permanently solving the medical problem, and similar considerations. For a listing of such cases, see *Power of Court or Other Public Agency to Order Medical Treatment Over Parental Religious Objections for Child Whose Life is Not Immediately Endangered*, 21 A.L.R.5th 248 (1994).

242. *See* Gibson v. Collier, 920 F.3d 212, 223 (5th Cir. 2019). "There is no medical consensus that sex reassignment surgery is a necessary or even effective treatment for gender dysphoria." *Id.* The First Circuit has also concluded that "the WPATH Standards of Care reflect not consensus, but merely one side in a sharply contested medical debate over sex reassignment surgery." *Id.* at 221.

243. *See, e.g.*, Dickey & Budge, *supra* note 214, at 381; SOC'Y EVIDENCE-BASED GENDER MED., *supra* note 221; Jensen et al., *supra* note 78, at 25, 28, 47.

244. "[C]hildren with gender dysphoria often experience a range of psychiatric comorbidities, with a high prevalence of mood and anxiety disorders, trauma, eating disorders and autism spectrum conditions, suicidality and self-harm." Frew et al., *supra* note 83, at 261.

245. Dhejne et al., *supra* note 116, at 5.

treatment and the risk cannot be established, there is no basis for the conclusion that gender-affirming treatment will have a high chance of success.

Likewise, the third requirement cannot be met because the benefits of gender-affirming medical treatment must significantly outweigh the risks.[246] Even assuming that the benefits could potentially include a reduced sense of dissonance from gender dysphoria, better mental health, and a decreased likelihood of suicide, these benefits certainly do not "significantly outweigh" the potential risks.[247] These risks, as discussed in Part II, include the possibility of desistance, irreversible bodily changes, infertility, cardiovascular disease, lung cancer, osteoporosis, impaired brain and psychological development, reduced IQ, memory impairment, slow reaction times, increased behavioral and emotional problems including anxiety, depression, and even death.[248] Such a serious decision should not be construed as a medically necessary procedure for minors, especially in light of the other, less intrusive options available in the interim.[249]

It is critical to recognize that a determination of risks and benefits, especially in this context, is more difficult than most courts realize because it requires value judgments that vary depending on the perspective.[250] To obtain judicial intervention, the state has the burden of proving that the parents' medical decision is contrary to their child's best interests.[251] Yet often, parents are genuinely seeking what is in the child's best interests, but there is disagreement as to what weight to give different interests, risks, and benefits.[252] In this situation, there is an intersection of stakeholders: state, physicians, parents, and minors.[253] This overlap of rights and obligations

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246. *See* Diekema, *supra* note 188, at 252; Black, *supra* note 197, at 676.

247. Diekema, *supra* note 188, at 252; *see* Black, *supra* note 197, at 676-79.

248. *See supra* Part II.

249. *Id.* These include psychotherapy and counseling, deferring medical treatment until the age of majority, or even limiting treatment to non-medical interventions such as social transitioning. *See also* THE TREVOR PROJECT, *supra* note 210, at 5.

250. *See* Diekema, *supra* note 188, at 253.

251. *Id.* at 246-47.

252. *Id.*

253. *See* Drabiak, *supra* note 184, at 400, 410 ("[T]he child's best interest calculation must assess not only the state's interest in protecting potential life through *parens patriae*, but must also integrate competing interests at stake, such as the privacy of the familial relationship, the ability of parents to make medical judgments for their children, the gravity of the illness, the risks and invasiveness of treatment, and the potential for a successful outcome.").

leads to a related issue, the next route promoted by those supporting the medical transition of minors without parental consent.

ii. Medical Neglect and Child Abuse

Under state child abuse law, parents that refuse to provide an effective treatment when their child has a life-threatening condition are guilty of medical neglect.[254] However, the traditional concept of child neglect, which assumes that a parental decision to decline a particular treatment is based on lack of care, fails to consider that parents may instead be "operating from a different set of values, principles, and goals."[255] When parents and physicians disagree, it is often not because parents simply refuse all medical treatment for their child, but rather it is based on which treatment type or plan is best suited for the child's needs.[256] Parental treatment disagreements involve various nuances, "including religious reasons, their desire to seek a second opinion, preference for alternative treatments, divergent opinions on how to manage long-term treatment plans for children, and whether certain procedures offer sufficient benefit compared to risks."[257] Yet it is not uncommon to see the media and even courts oversimplify the factors of a dispute, stating parents caused their child's death by refusing to seek medical care.[258]

Consequently, parents find themselves facing charges of child abuse or legal restrictions simply because others have a different interpretation of their child's needs.[259] When controversial ideas successfully convince judges that gender-affirming treatment is a medical necessity, it becomes much easier for good parents to lose their children to custody battles or emancipation.[260] In at least ten states, parental conflicts over how to support

254. *See* Diekema, *supra* note 188, at 244-45; People v. Pierson, 68 N.E. 243, 247 (N.Y. 1903).

255. Drabiak, *supra* note 184, at 358.

256. *Id.* at 359.

257. *Id.* at 360.

258. *Id.*; *see* Jason Wilson, *Letting Them Die: Parents Refuse Medical Help for Children in the Name of Christ*, GUARDIAN (Apr. 13, 2016, 10:30 AM), https://www.theguardian.com/us-news/2016/apr/13/followers-of-christ-idaho-religious-sect-child-mortality-refusing-medical-help.

259. *See* Diekema, *supra* note 188, at 244-45.

260. *See, e.g.*, Heyer, *supra* note 11; *In re* JNS, No. F17-334 X, Hamilton County Juvenile Court (Feb. 16, 2018), https://www.scribd.com/document/371667957/Ruling-from-Judge-Sylvia-Sieve-Hendon-on-transgender-boy#; Abigail Shrier, *How a Dad Lost Custody of Son After Questioning His Transgender Identity*, NEW YORK POST (Feb. 26, 2022, 7:58 AM), https://nypost.com/2022/02/26/dad-lost-custody-after-questioning-sons-transgender-identity/.

children who are confused about their gender identities have resulted in bitter custody fights.[261] While family courts are sometimes necessary to help resolve treatment disputes between parents, the very structure of a family may be subject to the personal values of the ruling judge,[262] and cases where custody is entirely removed from parents and given to someone else who is willing to authorize gender-affirming care are even more problematic.[263] Even more concerning is the growing trend allowing courts to impose what sort of medical treatment parents must give to their transgender children,[264] despite that treatment is still experimental.[265] In 2019, the Arizona Supreme Court clarified that family court judges can craft custody orders to protect children from harm, including requiring a custodial parent to provide a gender nonconforming child with affirmative counseling, gender exploration therapy, or other expert help approved by the court.[266] On the other hand, in March of 2022, Texas began investigating parents who let their children medically transition genders after recognizing such gender-affirming treatments as child abuse under Texas law.[267] As noted in the introduction, multiple states are considering or already restricting gender-affirming treatment, with some bills carrying severe penalties for families seeking such

261. *See* Maria Polletta, *Judges Can Overrule Parents on Treatment for Transgender Children, Arizona Supreme Court Rules*, AZCENTRAL (Apr. 26, 2019, 11:04 AM), https://www.azcentral.com/story/news/politics/arizona/2019/04/26/supreme-court-judges-can-require-treatment-transgender-kids-arizona/3579403002/.

262. *See* Shrier, *supra* note 260. The Arizona Supreme Court held that a family court exceeded its authority "by appointing specific treatment professionals" for a gender dysphoric child "and limiting the parent's sole legal decision-making authority." It stated that "[t]he court must be mindful not to unnecessarily intrude on the sole legal decision-maker's unshared authority to make major decisions concerning the child's upbringing, even if those decisions conflict with expert opinion *or the court's own views on childrearing*." Paul E. v. Courtney F., 439 P.3d 1169, 1171, 1177 (Ariz. 2019) (emphasis added).

263. *See In re* JNS, No. F17-334 X, Hamilton County Juvenile Court (Feb. 16, 2018), https://www.scribd.com/document/371667957/Ruling-from-Judge-Sylvia-Sieve-Hendon-on-transgender-boy# (granting custody of a transgender teen to grandparents supportive of the teen's transition).

264. *See* Polletta, *supra* note 261.

265. *See supra* Part II.

266. *Paul E.*, 439 P.3d at 1171–78. A family court can impose such specific limits on parental authority when it finds that "the child would be physically endangered or the child's emotional development would be significantly impaired" absent that limitation. *Id.* at 1177. Under such a standard, it is easy to see the opportunity for abuse if judges accept the argument that suicide threats equate to physical endangerment or non-affirming responses cause emotional impairment.

267. Brad Brooks, *Texas Investigating Parents of Transgender Youth for Child Abuse*, REUTERS (Mar. 1, 2022, 7:52 PM), https://www.reuters.com/world/us/texas-investigating-parents-transgender-youth-child-abuse-2022-03-02/.

medical treatment for minors.[268] The only thing that is clear is that the entire country is torn in heated debate as to what constitutes the best interest of these children.[269]

Parents are left in an impossible situation: no matter how they choose to respond, their medical decision-making authority is questioned, judged, undermined, and politicized—they may be subject to allegations of child abuse whether they refuse or allow to let their child transition.[270] The fact that parents, the ones with a fundamental right to direct their child's upbringing and the ones best situated to do so, have no ability to navigate this situation without facing potential legal consequences[271] shows that judicial involvement in this heated issue may not be proper. Courts cannot be the appropriate decision makers, especially if they force parents to start their children on gender affirming treatment plans and experimental hormones[272] instead of being guided by caution and choosing the safest path for adolescents: allowing their bodies to undergo a healthy, normal development. The need for balance between parental and state authority cannot be diminished.

To flourish, families and children must be confident that their homes are free from state intrusion.[273] In *Newmark v. Williams*, the court recognized that "primacy of the familial unit is a bedrock principle of law" because "preservation of the family is 'fundamental to the maintenance of a stable, democratic society. . . .'"[274] When parental autonomy is respected and free from government interference, children's need for continuity is satisfied and

268. Krishnakumar & Cole, *supra* note 1.

269. *See, e.g.*, *id.*; Brooks, *supra* note 267; Shrier, *supra* note 260.

270. Schools and physicians have called CPS on parents who are not supportive of their child's transition. *See* Shrier, *supra* note 5. One mother had CPS called on her by her own therapist after explaining why she chose not to affirm her teen daughter. *Id.* A Canadian father was even jailed for speaking out about his child's court-enforced transition. *See* Bruce Bawer, *A Certain Madness Amok*, CITY J. (Apr. 1, 2021), https://www.city-journal.org/canadian-father-jailed-for-speaking-out-about-trans-identifying-child.

271. *See, e.g.*, Shrier, *supra* note 5; Brooks, *supra* note 267; Bawer, *supra* note 270.

272. *See* Paul E. v. Courtney F., 439 P.3d 1169, 1178 (Ariz. 2019). The Supreme Court of Arizona stated that, if a child "would be physically endangered or suffer significant emotional impairment" from being denied gender affirming treatment, then courts could compel parents to "retain a gender expert," permit their child "to gender explore" and even "select a specific therapist and expert" that parents do not agree with. *Id.*

273. *See* Diekema, *supra* note 188, at 244.

274. Newmark v. Williams, 588 A.2d 1108, 1115 (Del. 1991) ("Courts have also recognized that the essential element of preserving the integrity of the family is maintaining the autonomy of the parent-child relationship.").

their psychological well-being is secured.[275] "The notion of familial privacy involves reciprocal interests encompassing not only a parental right to make decisions for their children, but children's right to be secure in their family structure without state interference."[276] Legal scholar Robert Araujo argues that the stability of the family reflects the stability of society: "undue intrusion, interference, or separation of the family can indicate a concentration of excess power in the state, signaling an unraveling of democratic principles."[277] Thus, the importance of parents' rights in their children's medical decisions is undeniably crucial; the parental role cannot simply be replaced by the State or fluctuating political views.

CONCLUSION

Parental authority has long been recognized as a fundamental right to be protected.[278] But the right of parents to direct their children's upbringing has slowly been whittled away by recent court decisions.[279] When parents are faced with a child who claims to have gender dysphoria and wants to begin gender-affirming procedures, courts should help parents protect their children from this harm and only interfere in dire circumstances to ensure the least invasive approach is taken.[280] Minors questioning their gender identity should wait until adulthood to transition because many children who display gender nonconforming behavior desist upon reaching puberty or adulthood and would then be forced to deal with lifelong consequences made during a developmental period known for its uncertainty.[281] Because of this possibility, where a decision to desist will be child-specific, parents, who know their child better than doctors or courts, are best situated to make this determination based on the best interests of their child.[282]

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275. *Id.*

276. Drabiak, *supra* note 184, at 370.

277. *Id.* at 369; Robert John Araujo, *Natural Law and the Rights of the Family*, 1 INT'L J. JURIS. FAM. 197, 200 (2010).

278. *See, e.g.*, Meyer v. Nebraska, 262 U.S. 390, 399 (1923); Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 639 (1974); Washington v. Glucksberg, 521 U.S. 702, 720 (1997).

279. *See, e.g.*, Scott & Huntington, *supra* note 143.

280. *See* Black, *supra* note 197, at 676-79; Diekema, *supra* note 188, at 252-54.

281. *See supra* Part II.

282. As long recognized by Fourteenth Amendment jurisprudence, the law must presume that parents are acting in the best interest of their child. *See* Parham v. J.R., 442 U.S. 584, 602 (1979); Troxel v. Granville, 530 U.S. 57, 68 (2000) (overturning a ruling where the judge's determination of the child's best interest was held over the parent's determination which should have received special weight).

This is in stark contrast to the scenario portrayed by advocates arguing that gender-affirming treatment is a medical necessity for minors.[283] While the importance of mental health should not be diminished, characterizing gender dysphoria as a life-threatening condition requiring immediate treatment is not an accurate portrayal of the situation.[284] It is not equivalent to medical conditions where the refusal of treatment will result in death, and, even when treatment is necessary, there is no medical consensus that gender-affirming procedures are the most appropriate option in the best interest of all minors.[285] Therefore, the medical necessity exception is not applicable to this situation, and minors seeking gender-affirming treatment should not be allowed to misuse this important exception to override parental consent for such a life-altering decision.[286] Thus, any law allowing minors to circumvent the consent of their parents in seeking gender-affirming treatment violates the right of parents to direct their children's upbringing and thus, violates the Due Process Clause of the Fourteenth Amendment, which protects the rights of parents to direct their children's upbringing.[287]

This fundamental Due Process guarantee is especially infringed upon by laws like the one in Washington, which allows minors to receive gender-affirming treatment under their parents' insurance without parental knowledge or consent.[288] In these instances, parents are not even given the chance to hear about their children's diagnoses, let alone direct subsequent medical treatment.[289] These laws unconstitutionally allow a parent's determination of what is in their child's best interest to be substituted by the determination of another.[290] Even where parental discretion is subject to limitation, the Supreme Court has recognized that parents should still "retain plenary authority to seek [medical] care for their children."[291] Thus, state laws that involve the complete exclusion of parental awareness and consent

283. *See generally* Nunn, *supra* note 186.

284. *See supra* Part III.A.2.

285. *Id.*

286. *Id. See Troxel*, 530 U.S. at 72-73 ("The Due Process Clause does not permit a State to infringe on the fundamental right of parents to make childrearing decisions simply because a state judge believes a 'better' decision could be made.").

287. *See supra* Part III.A.2.

288. *See* Shrier, *supra* note 5.

289. *Id.*

290. *See Troxel*, 530 U.S. at 72-73.

291. Parham v. J.R., 442 U.S. 584, 604 (1979).

in children's medical decisions are in direct violation of this constitutional right.[292]

292. *Id.*