

*SYMPOSIUM:
GENDER, HEALTH & THE CONSTITUTION*

GENDER-AFFIRMING CARE AND CHILDREN’S LIBERTY

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INTRODUCTION

Over the last three years, a wave of statutes banning gender-affirming care for transgender and gender-diverse minors passed in states across the country. All of the bans have been challenged in court under a number of legal claims, but with a void that may seem surprising. Attorneys representing families affected by the bans typically write with great empathy about the children involved and the impact such bans have on their lives, but the legal arguments circle around the children rather than bringing claims squarely on their behalf. Instead, the legal claims tend to focus on violations of equal protection that treat transgender children categorically differently than cisgender children or violations of the fundamental due process rights of the parents. This is not a mistake by the attorneys involved; there is not a robust understanding of a child’s liberty interest in directing their own medical care.

It is the contention of this essay that our underdeveloped understanding of children’s rights makes it more difficult to explain how harmful gender-affirming care bans are and to challenge them in court. Part I explains the nature of gender-affirming care, outlining its medical standards and context, while also exploring the recent surge of legislation seeking to restrict its access. Part II discusses the grounds underlying existing challenges to gender-affirming care bans, highlighting the emphasis on equal protection and parental rights. The essay concludes by exploring what seeds of such a children’s liberty argument exist and what the broader consequences of courts recognizing such a right would be. Such a claim is no silver bullet that guarantees courtroom victory, but it

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provides crucial reframing that both supports current litigation and plants seeds for a broader reevaluation of children's rights.

I. GENDER-AFFIRMING CARE AND BANS

If a child expresses to their parents that they believe their gender is different than the sex they were assigned at birth, and those parents are supportive of their child, the parents could choose one of many paths forward. The first, which is likely followed by virtually all parents initially, is essentially to do nothing, to wait and see how strongly and consistently the child expresses their gender. Another action that doesn't require any external advice or services is to allow some level of social expression or transition, such as allowing the child to choose clothing, hairstyles, pronouns, and a name more consistent with their gender identity. Should parents and the child look into medical treatment, any medical gender-affirming care would be likely be guided by the World Professional Association for Transgender Health's (WPATH) Standards of Care, accepted by most as "the authoritative medical consensus" guiding appropriate healthcare,¹ and the Endocrine Society's guide regarding use of medical hormones.² Treatment is based on an individualized plan as determined by the child, their parents, and their medical providers.³ Both policies recommend that medical interventions be considered only after a child has received a formal diagnosis of gender dysphoria and after other measures such as counseling and social transition are explored.⁴

For many trans children, the first potential medical intervention would be medication known as puberty blockers, which delay the onset of puberty.⁵ Use of puberty blockers can help in two important ways. First, it is immensely distressing for a trans child or teenager to go through the physical changes of puberty.⁶ The changes to their body can magnify the emotional and mental stress caused by a difference between their gender

1. Developments in the Law, *Outlawing Trans Youth: State Legislatures and the Battle over Gender-Affirming Healthcare for Minors*, 134 HARV. L. REV. 2163, 2166 (2021).

2. Jessica Matsuda, *Leave Them Kids Alone: State Constitutional Protections for Gender-Affirming Healthcare*, 79 WASH. & LEE L. REV. 1597, 1605 (2022).

3. *Id.* at 1605. It is perhaps obvious, but still worth noting, that some trans children as well as trans adults choose not to receive any gender-affirming medical care.

4. *Id.* at 1606.

5. Nicole Scott, *Trans Rights Are Human Rights: Protecting Trans Minors' Right to Gender-Affirming Care*, 14 DREXEL L. REV. 685, 696 (2022).

6. 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. INTERDISC. L.J. 179, 212 (2016).

identity and their body.⁷ Trans youth typically know that these changes to their bodies will be permanent and will affect their ability to present an appearance consistent with their gender identity.⁸ For example, a sixteen-year-old girl who died by suicide posted a letter online explaining that her parents “would never come around,” she would only be able to seek gender-affirming care after the age of eighteen, and that she “felt hopeless, that I was just going to look like a man in drag for the rest of my life.”⁹ Multiple studies have shown that transgender people who received puberty blockers and other hormonal treatment have dramatically better outcomes than those were unable to access such treatment.¹⁰

A second impact of puberty blockers is to give time for the trans child and their parents to decide whether to seek any other medical treatment. The Endocrine Society's guidelines recommend that puberty blockers begin at the start of a measure of puberty known as the Tanner scale, specifically Tanner stage two.¹¹ That scale was developed by pediatric endocrinologist James Tanner, who studied photographs of children living in a British orphanage beginning in the late 1940s.¹² Based on these photographs, he developed five stages of development, as well as an estimate of when most children began puberty, around eleven years old.¹³ Later researchers who tried to replicate Tanner's work, however, have found that puberty began for most of their subjects two years earlier than Tanner had found, around ages nine to ten.¹⁴

If puberty blockers are step one of medical care for trans children, step two is typically use of hormone therapy. The Endocrine Society and WPATH guidelines recommend that hormone therapy be considered only once a child is old enough to understand and make the decision for themselves.¹⁵ The WPATH standards, for example, recommend that an adolescent should receive an intervention only if they “demonstrate[] the emotional and cognitive maturity required to provide informed

7. See Anne Alstott, Melisa Olgun, Henry Robinson, & Meredith McNamara, “*Demons and Imps*”: Misinformation and Religious Pseudoscience in State Anti-Transgender Laws, 35 *YALE J.L. & FEMINISM* 223, 243 (2024).

8. See Ikuta, *supra* note 6, at 212-13.

9. Ashley Fantz, *An Ohio Transgender Teen's Suicide, a Mother's Anguish*, CNN (Jan. 4, 2015, 9:53 AM), <https://www.cnn.com/2014/12/31/us/ohio-transgender-teen-suicide/index.html>.

10. See Alstott et al., *supra* note 7, at 244.

11. Matsuda, *supra* note 2, at 1607-08.

12. CARA NATTERSON & VANESSA KROLL BENNETT, *THIS IS SO AWKWARD: MODERN PUBERTY EXPLAINED I* (2023).

13. *Id.* at 2.

14. *Id.* at 4-6. The data also varied by race, as Black boys and girls typically entered puberty slightly earlier than White children. *Id.* at 6.

15. See Matsuda, *supra* note 2, at 1608-09; *Outlawing Trans Youth*, *supra* note 1, at 2166-67.

consent/assent for the treatment.”¹⁶ In order to help decide whether a trans youth has this level of maturity, the standards lay out some specific questions to consider, including the following:

Can the young person think carefully into the future and consider the implications of a partially or fully irreversible intervention?

Is the young person able to understand and manage the day-to-day short- and long-term aspects of a specific medical treatment (e.g., medication adherence, administration, and necessary medical follow-ups)?¹⁷

The Endocrine Society’s guidelines similarly refer to “sufficient mental capacity to give informed consent,” but more specifically state that most adolescents have sufficient capacity “by age 16 years.”¹⁸ There is a gap, obviously, between the onset of puberty, beginning as early as nine years old, and capacity to give informed consent to further treatment. Puberty blockers give the trans youth the ability to pause irreversible physical changes of puberty that would likely cause mental and emotional harm until they are capable of deciding for themselves whether to seek further interventions. (Surgical intervention, which much of the more sensational rhetoric around gender-affirming care focuses on, is extremely rare for people under the age of eighteen.¹⁹)

Despite the medical consensus in favor of gender-affirming care, in recent years there has been a confluence of publicity and activism resulting in a wave of state laws banning gender-affirming care. Although resistance to affirming the identity of transgender people is obviously not a modern phenomenon, political action around gender-affirming care received a push in 2019 when conservative thinktank The Heritage Foundation organized a series of events discussing the supposed medical risks of gender-affirming care.²⁰ Another spark of publicity arose out of a divorce in Texas. In the course of arguing over custody, Jeffrey Younger asserted that his pediatrician ex-wife had improperly manipulated one of their two children into what Younger called a “false gender self-identity”

16. E. Coleman, et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT’L J. TRANSGENDER HEALTH S1, S61 (2022), <https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644>.

17. *Id.* at S62.

18. Wylie C. Hembree, Peggy T. Cohen-Kettenis, Louis Gooren, Sabine E. Hannema, Walter J. Meyer, M. Hassan Murad, Stephen M. Rosenthal, Joshua D. Safer, Vin Tangpricha & Guy G. T’Sjoen, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3871 (2017).

19. *Outlawing Trans Youth*, *supra* note 1, at 2167.

20. *See id.* at 2172-73.

as a trans girl, and asked that he be given sole custody in order to raise the child as a boy. After his claims received some media coverage,²¹ the Texas Attorney General's office sent a letter to the Texas Department of Family and Protective Services urging the agency to investigate possible child abuse. The letter described the child as in "immediate and irrevocable danger" from "permanent and potentially irreversible harm" based solely on the mother's intent to "forc[e]" the child to transition.²² Younger turned his custody battle into a cause célèbre and ran for the Texas State House of Representatives.²³ After an unsuccessful attempt in 2021 to amend the Texas Family Code to add gender-affirming healthcare to the statutory definition of child abuse,²⁴ in February 2022 Texas Attorney General Ken Paxton issued a letter stating that providing gender-affirming healthcare to minors "can legally constitute child abuse" under existing Texas state law.²⁵ Shortly afterwards, Texas Governor Greg Abbott sent a letter to the

21. Younger, in the words of the *New York Times*, "sought attention" with a website describing his family, including his daughter's deadname. J. David Goodman, *How Medical Care for Transgender Youth Became "Child Abuse" in Texas*, N.Y. TIMES (Mar. 11, 2022), <https://www.nytimes.com/2022/03/11/us/texas-transgender-youth-medical-care-abuse.html>. For more information on the term "deadname" and why using someone's deadname is harmful, see Chase Strangio, *A Transgender Person's Deadname is Nobody's Business. Not Even a Reporter's*, NBC (May 14, 2020), <https://www.nbcnews.com/think/opinion/transgender-person-s-deadname-nobody-s-business-not-even-reporter-ncna1206721>.

22. Letter from Ken Paxton, Att'y Gen., Tex., to Trevor Woodruff, Acting Comm'r, Tex. Dep't Fam. Protective Servs. (Oct. 24, 2019), https://www.texasattorneygeneral.gov/sites/default/files/images/admin/2019/Press/Acting%20Commissioner%20Woodruff_DF-15-09887-S_10242019.pdf; see also Emma Platoff & Stacy Fernandez, *Top Texas Republicans Order Investigation Into Mother Who Supports Child's Gender Transition*, TEX. TRIBUNE (Oct. 24, 2019 7:00 PM), <https://www.texastribune.org/2019/10/24/top-texas-republicans-order-investigation-mother-who-supports-childs-g/>.

23. Karen Brooks Harper, *His Public Custody Battle Helped Ignite a Movement Against Transgender Health Care for Kids. Will it Carry Him to the Texas House?*, TEX. TRIBUNE (Mar. 14, 2022 5:00 AM), <https://www.texastribune.org/2022/03/14/jeff-younger-transgender-care-house/> ("His fight became a rallying cry for the hard right. On conservative websites and GOP politicians' social media, Younger was held up as a victim, a tragic example of allowing the so-called leftist transgender agenda to continue unabated. His child's birth name became a popular hashtag on Twitter.")

24. See Megan Munce, *Gender-Affirming Medical Treatment for Transgender Kids Would Be Considered Child Abuse Under Texas Senate Bill*, TEX. TRIBUNE (Apr. 28, 2021), <https://www.texastribune.org/2021/04/27/texas-senate-transgender-child-abuse/>.

25. TEX. OP. ATT'Y GEN. NO. KP-0401, *Whether Certain Medical Procedures Performed on Children Constitute Child Abuse* (Feb. 18, 2022), <https://texasattomevgeneral.gov/sites/default/files/global/KP-0401.pdf>. Arthur Leonard has outlined the political pressures weighing on both Attorney General Paxton and Governor Abbott from the right at the time, concluding that publicly targeting trans children and their families was a political choice aimed at winning their primaries. See Arthur S. Leonard, *Texas Court Blocks Investigation or Prosecution of Parents and Doctors for Providing Gender-Affirming Treatment for Transgender Youths*, 2022 LGBT L. NOTES 2, 3-4 (2022).

Commissioner of the Texas Department of Family and Protective Services directing them to investigate “any reported instances” of gender-affirming care and bring child abuse proceedings as necessary.²⁶

On a nationwide level, the Texas state actions coincided with an explosion in state legislative actions attempting to ban gender-affirming care for minors. As the Movement Advancement Project has chronicled, bills aiming to ban gender-affirming care were almost unheard-of until 2020, when seventeen states considered such bills, although no states actually passed a bill into law.²⁷ The numbers of bills again rose in 2021,²⁸ and Arkansas became the first state to actually pass a gender-affirming care ban for minors into law over the Governor’s veto.²⁹ As of the writing of this article, over twenty states ban such care for minors,³⁰ and tracking proposed state legislation affecting trans people is a monumental task. For example, as of February the American Civil Liberties Union (ACLU) had identified over 450 bills that it labeled as anti-LGBTQ,³¹ and other publications by the Movement Advancement Project³² and journalists such as Erin Reed³³ devote considerable time and effort simply to identifying and tracking bills banning gender-affirming care.

Most of the legislative bans threaten health care providers with professional sanctions such as loss of a medical license or even criminal prosecution if they treat a minor patient with gender-affirming care.³⁴ The Texas approach, as described above, targets parents as perpetrators of

26. Letter from Greg Abbott, Governor, Tex., to Jaime Masters, Comm’r, Tex. Dep’t of Fam. Protective Servs. (Feb. 22, 2022), <https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf>.

27. Movement Advancement Project, *LGBTQ Policy Spotlight: Bans on Medical Care for Transgender People* (2023) at i, 8, <https://www.mapresearch.org/file/MAP-2023-Spotlight-Medical-Bans-report.pdf>.

28. *Id.* at 8.

29. Devan Cole, *Arkansas Becomes First State to Outlaw Gender-Affirming Treatment for Trans Youth*, CNN (Apr. 6, 2021, 6:56 PM), <https://www.cnn.com/2021/04/06/politics/arkansas-transgender-health-care-veto-override/index.html>.

30. Anumita Kaur, *Ohio Lawmakers Ban Gender-Affirming Care for Minors, Overriding Governor’s Veto*, WASH. POST (Jan. 24, 2024, 3:19 PM), <https://www.washingtonpost.com/nation/2024/01/24/transcare-veto-override/>.

31. *Mapping Attacks on LGBTQ Rights in U.S. State Legislatures in 2024*, ACLU, <https://www.aclu.org/legislative-attacks-on-lgbtq-rights-2024/> (last visited Feb. 25, 2024).

32. Movement Advancement Project, *Bans on Best Practice Medical Care for Transgender Youth*, https://www.lgbtmap.org/equality-maps/healthcare/youth_medical_care_bans/ (last visited Feb. 25, 2024).

33. Erin Reed, *Anti-Trans Legislative Risk Assessment Map—February Update*, ERIN IN THE MORNING (Feb. 19, 2024), <https://www.erininthemorning.com/p/anti-trans-legislative-risk-assessment-96f>.

34. See Megan Medlicott, *A Parent’s Right to Obtain Puberty Blockers for Their Child*, 56 CONN. L. REV. 301, 312 (2023).

child abuse. Florida also treats gender-affirming care as potential parental abuse by giving Florida courts temporary emergency jurisdiction over custody disputes.³⁵ Such bans have immediate and dramatic impacts on families with transgender children, who face urgent questions of whether they can and should flee the state in order to provide continuity of care for their child and avoid legal liability for the parents that could see the state taking their child away.³⁶

Given the stakes of the legislation, attorneys and advocacy organizations leapt into action in response to bans of gender-affirming care, filing challenges in states across the country. The next part turns to these legal challenges and their bases.

II. EXISTING CHALLENGES

Legal challenges to state legislative bans of gender-affirming care for minors have had considerable success in securing temporary or permanent injunctions preventing the laws from going into effect.³⁷ The Sixth³⁸ and Eleventh³⁹ Circuits, however, reversed injunctions previously entered by lower courts, at least partially substantiating fears that appellate courts or even the Supreme Court might erase the hard-won victories.

Notably, the challenges to gender-affirming care bans make a variety of legal arguments, but none focus upon a freestanding right of *the child* to access medical care. This is not a failing of the attorneys involved—the case law simply does not provide clear precedent for such an argument. Instead, challengers muster a variety of other claims that circle around the child's rights.

For example, one thread of arguments focuses on the group of children denied care on the basis of their gender identity and their sex. Challenges framed under the Equal Protection Clause focus on the classifications made by gender-affirming care bans both upon sex and

35. Brandon Girod, *Florida's Transgender-affirming Care Ban is Now Law. Here's What SB 254 Does*, PENSACOLA NEWS J. (May 18, 2023, 1:25 PM), <https://www.pnj.com/story/news/politics/2023/05/17/florida-sb-254-florida-abduction-transgender-bill-now-law-what-it-does/70206291007/>.

36. See Ernesto Londoño & Azeen Ghorayshi, *Fight or Flight: Transgender Care Bans Leave Families and Doctors Scrambling*, N.Y. TIMES (July 6, 2023), <https://www.nytimes.com/2023/07/06/us/transgender-health-care-bans.html>.

37. See Alstott et al., *supra* note 7, at 229.

38. *L. W. by & through Williams v. Skrmetti*, 83 F.4th 460 (6th Cir. 2023).

39. *Eknes-Tucker v. Governor of Alabama*, 80 F.4th 1205 (11th Cir. 2023).

status as a transgender person.⁴⁰ Such arguments highlight that medical treatments are banned depending on the gender identity of the minor receiving them—treatments remain legal if provided to a cisgender person but are banned if they are given to a transgender person.⁴¹ Briefs also argue that discrimination on the basis of gender identity is inherently discrimination on the basis of sex, often citing the analysis in *Bostock v. Clayton County* applying the word “sex” in Title VII to gender identity.⁴² Advocates also argue that the availability of specific types of care turn on the sex someone was assigned at birth: for example, someone assigned male at birth can still be prescribed testosterone-based hormonal treatment, but not someone who was assigned female at birth.⁴³ Gender care bans are also described as hinging medical care on stereotypes about sex.⁴⁴ In addition to arguments for heightened scrutiny, equal protection challenges argue that gender-affirming care bans fail even rational basis review, describing the laws as “arbitrary [and] irrational”⁴⁵ and motivated only by “generalized fears, negative attitudes, and disapproval of transgender people” which cannot be a legitimate basis for legislation.⁴⁶

These arguments directly identify some of the real harm of such laws—that they specifically target transgender youth—and are obviously worth arguing in court. And such challenges have garnered some success. Notably, Katie Eyer found “extraordinarily high levels of substantive success in contemporary constitutional litigation” when specifically examining claims that transgender people are a suspect or quasi-suspect class, although her research focuses on a set of cases ending slightly before the explosion in gender-affirming care bans.⁴⁷

Professor Eyer’s work examines cases from 2017 to 2021 and captures what felt like an inflection point in equal protection analysis. In

40. Complaint at 49, *Poe v. Drummond*, No. 23-cv-00177 (N. Dist. Ok. May 2, 2023); Complaint at 40, *Walker v. Marshall*, No. 2:22-cv-167 (M.D. Ala. April 11, 2022).

41. Brief of Plaintiffs-Appellees at 30, *Brandt v. Rutledge*, No. 21-2875 (8th Cir. Jan. 13, 2022); Complaint at 35, *L.W. v. Skrmetti*, No. 23CV00376 (M.D. Tenn. April 20, 2023); Complaint at 28, *Poe v. Labrador*, No. 1:23-cv-00269 (S.D. Idaho May 31, 2023); see also Complaint at 43, *K.C. v. Indiana*, No. 1:23-cv-595 (S.D. Ind. April 5, 2023); Complaint in *Poe v. Drummond*, *supra* note 40, at 51.

42. Brief of Plaintiffs-Appellees in *Brandt*, *supra* note 41, at 31.

43. *Id.* at 31; Complaint at 21, *Doe v. Thornbury*, No. 3:23CV-230 (W.D. Ky. May 3, 2023); First Amended Complaint at 39, *Van Garderen v. Montana*, No. 23-541 (Mont. 4th Dist. July 17, 2023).

44. Brief of Plaintiffs-Appellees in *Brandt*, *supra* note 41, at 31, see also Complaint in *Poe v. Labrador*, *supra* note 41, at 27-28; Complaint in *Walker v. Marshall*, *supra* note 40, at 41.

45. Brief of Plaintiffs-Appellees in *Brandt*, *supra* note 41, at 29 (citing *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 446 (1985)).

46. Complaint in *Poe v. Labrador*, *supra* note 41, at 29.

47. Katie Eyer, *Transgender Constitutional Law*, 171 U. PA. L. REV. 1405, 1424-30 (2023).

all twenty-four cases that assessed whether gender identity should trigger heightened scrutiny under the Equal Protection Clause, the transgender parties were successful.⁴⁸ This included the first two appellate decisions to apply heightened scrutiny to classifications on the basis of gender identity, an important milestone in equal protection analysis.⁴⁹

As Professor Eyer acknowledges, however, before 2014, courts had uniformly rejected such equal protection claims.⁵⁰ Moreover, the legal ground has shifted since the cases included in her study. The Fourth⁵¹ and Ninth⁵² Circuits have held that classifications on the basis of gender identity should receive heightened scrutiny, but the Sixth⁵³ and Eleventh⁵⁴ Circuits have held the opposite. Additionally, both the Sixth and Eleventh Circuits link their rejection of equal protection claims to another recent Supreme Court case, *Dobbs v. Jackson Women's Health Organization*.⁵⁵ In an analysis of the Sixth Circuit's ruling on an emergency motion that allowed Tennessee's gender-affirming care ban to go into effect, Marc Spindelman explained the link between the two cases: "Now that *Dobbs* allows women's reproductive biology once again to be legally transformed into their social destinies without violating constitutional sex equality rules, those same rules can't possibly block the government from locking transgender people, or at least transgender youth, into . . . their 'biological birth' fate."⁵⁶ Professor Spindelman acknowledges that the *Skrmetti* opinion was preliminary and ran against the previous "emerging judicial consensus" that gender-affirming care bans were constitutionally problematic.⁵⁷ Yet it is also significant that both cases reference a sharply conservative decision from recent years—one that was issued after Justice Amy Coney Barrett replaced Justice Ruth Bader Ginsburg and shifted the balance of the Court even further to the right.

The equal protection claims brought on behalf of transgender children may prove successful in lower courts, bring rhetorical power to the argument in the longer term, and have significant practical effects for thousands of children even if victories are temporary. But few believe that

48. *Id.* at 1425.

49. *Id.* at 1426.

50. *Id.*

51. *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 610 (2020).

52. *Karnoski v. Trump*, 926 F.3d 1180, 1200-01 (2019).

53. *L. W. by & through Williams v. Skrmetti*, 83 F.4th 460, 486 (6th Cir. 2023).

54. *Eknes-Tucker v. Governor of Alabama*, 80 F.4th 1205, 1230 (11th Cir. 2023).

55. *L. W.*, 83 F.4th at 481; *Eknes-Tucker*, 80 F.4th at 1229.

56. Marc Spindelman, *Trans Sex Equality Rights After Dobbs*, 172 U. PA. L. REV. ONLINE 1, 3-4 (2023).

57. *Id.* at 1, 11.

the Supreme Court would find that classifications on the basis of gender identity should receive heightened scrutiny, should the Court feel inclined to address the current circuit split.

This doctrinal uncertainty helps to explain why arguments that gender-affirming care bans discriminate on the basis of sex are also included, as sex-based classifications at least receive intermediate scrutiny. But as Katie Eyer has also outlined (and criticized), supporters of gender-affirming care bans have successfully argued before some courts that the Supreme Court has already held that regulating medical treatment on the basis of sex does not violate the Equal Protection Clause.⁵⁸ While the equal protection arguments are significant, therefore, they have serious doctrinal weaknesses that may prove fatal in the short and medium term.

A second strand in challenges to the gender-affirming care bans addresses the substance of the bans, but as a violation of the rights of the child's *parents*. In this framing, bans infringe on the right of parents to make decisions regarding the "care, custody, and control" of their children, including the parents' right to "seek and follow medical advice" for their children.⁵⁹ This right is not derived from the children's right to medical advice or care; it is an independent claim arising out of the parent/child relationship.⁶⁰

This framing has considerable doctrinal support. The right of parents to control the upbringing of their children grew from seeds planted over a century ago in *Meyer v. Nebraska*, holding that a state law that forbade teaching children in any language other than English violated the Fourteenth Amendment. The Court's fundamental rights analysis was in its infancy, but the Court began to define the idea of liberty as "generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men."⁶¹ The Court believed that one such privilege was the "natural duty of a parent to give his children education suitable to their station in life," so even though the State also had an interest in promoting civic development and promoting American

58. See generally Katie Eyer, *Transgender Equality and Geduldig 2.0*, 55 ARIZ. ST. L.J. 475 (2023).

59. Brief of Plaintiffs-Appellees in *Brandt*, *supra* note 41, at 47; see also Complaint in *L.W. v. Skrmetti*, *supra* note 41, at 37; Complaint in *Poe v. Labrador*, *supra* note 41, at 30; Complaint in *K.C. v. Indiana*, *supra* note 41, at 44; Complaint in *Doe v. Thornbury*, *supra* note 43, at 19-20; Complaint in *Walker v. Marshall*, *supra* note 40, at 43; Complaint in *Poe v. Drummond*, *supra* note 40, at 56; First Amended Complaint in *Van Garderen v. Montana*, *supra* note 43, at 41-42 (making an analogous claim under Montana Constitution).

60. See Brief of Plaintiffs-Appellees in *Brandt*, *supra* note 41, at 47.

61. *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923).

ideals, it could not promote those American ideals among children by violating the rights of the parents to raise their child according to their own more pluralistic values.⁶² This conclusion was underscored two years later in *Pierce v. Society of Sisters*, in which the Court similarly found that an Oregon statute requiring children to attend public school rather than private Catholic schools also violated the liberty interest of parents to direct the upbringing of their children. Again, although the Court acknowledged the State's interest in the healthy development of children, the Court held that a child is "not the mere creature of the state," and parents have the right and "high duty" to direct their child's destiny.⁶³

In 2000, the Supreme Court described the "interest of parents in the care, custody, and control of their children"⁶⁴ as "perhaps the oldest of the fundamental liberty interests recognized by this Court."⁶⁵ The case challenged a Washington state statute allowing any person to ask for visitation rights with children; in the facts before the Court it was grandparents petitioning for visitation with grandchildren they had previously seen in regular weekend visitation.⁶⁶ The Court held that such a broad statute was unconstitutional, and that as long as a parent was fit, the state should not "inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children."⁶⁷

Such arguments based in the fundamental rights of parents, however, depend upon what Anne Dailey and Laura Rosenbury have called the "veil of parent-child unity," concealing and weakening children's interests and their own agency.⁶⁸ In other circumstances, this veil can work to harm transgender children, such as the example they give of a trans child who wants to access gender-affirming care but whose parents refuse to consent.⁶⁹

Another danger is that by not including the child's decision-making and instead accepting characterization of medical care as something that parents and doctors control, the claim fails to combat a powerful rhetorical argument made by anti-trans activists that children don't really want

62. *Id.* at 400.

63. *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925).

64. *Troxel v. Granville*, 530 U.S. 57, 66 (2000).

65. *Id.* at 65.

66. *Id.* at 60.

67. *Id.* at 68-69.

68. Anne C. Dailey & Laura A. Rosenbury, *The New Parental Rights*, 71 *DUKE L.J.* 75, 97 (2021); see also Anne C. Dailey, Laura A. Rosenbury, *The New Law of the Child*, 127 *YALE L.J.* 1448, 1467-70 (2018).

69. Dailey & Rosenbury, *The New Parental Rights*, *supra* note 68, at 135.

gender-affirming care. In a recent article, Anne Alstott, Melisa Olgun, Henry Robinson, and Meredith McNamara identify several specific claims about trans children that have been supported by misinformation and “religious pseudoscience.”⁷⁰ Two of these claims undermine the agency of trans children. First, the “victimization claim” views doctors and other health care providers as pressuring children into unnecessary and harmful medical treatment that they don’t really want.⁷¹ Second, the “social contagion claim” argues that trans children have been “recruited or hoodwinked by social media and peers.”⁷²

This characterization of parents as allowing or even directing victimization of their children by “encouraging” their children to be trans is the criticism described above as part of the custody fight that sparked arguments around gender-affirming care in Texas and ultimately led to the state treating consent to gender-affirming care as child abuse. It also helps to explain a paradox in current political discourse, which is to reject parental decision-making in the context of gender-affirming care but protect it in other circumstances. For example, in forty states, even older teenagers who want to be vaccinated against Covid-19 cannot do so if their parents refuse to consent.⁷³ Arguing against vaccine mandates, Senator Rand Paul claimed, “The state doesn’t own your children. Parents own the children.”⁷⁴ Forty states allow children under the age of eighteen to marry as long as they have their parent’s consent.⁷⁵ During committee debate over an Idaho bill that would have set a minimum marriage age of sixteen years old, after one state representative expressed concern that a parent might be involved in coercing a child into marriage, another representative responded, “Hopefully parents have the best interests. We know occasionally that doesn’t happen, but I have more faith in the family than I do in government.”⁷⁶ In recent years, Florida has famously

70. Alstott et al., *supra* note 7, at 244.

71. *Id.* at 255.

72. *Id.* at 259.

73. Jan Hoffman, *As Parents Forbid Covid Shots, Defiant Teenagers Seek Ways to Get Them*, N.Y. TIMES (June 26, 2021), <https://www.nytimes.com/2021/06/26/health/covid-vaccine-teens-consent.html>.

74. Felicia Sonmez, *Sen. Rand Paul Says Government Should Not Force People to Receive Vaccinations*, WASH. POST (Mar. 5, 2019 3:38 PM), https://www.washingtonpost.com/politics/sen-rand-paul-says-government-should-not-force-people-to-receive-vaccinations/2019/03/05/bfae6534-3f6e-11e9-9361-301ffb5bd5e6_story.html.

75. Unchained At Last, *About Child Marriage in the U.S.*, <https://www.unchainedatlast.org/laws-to-end-child-marriage/> (last visited Feb. 25, 2024).

76. Nathan Brown, *House Panel Weighs Child Marriage Bill*, POST REGISTER (Feb. 21, 2020), https://www.postregister.com/news/government/house-panel-weighs-child-marriage-bill/article_89538f0e-8a5a-5bbe-85e9-78819dc54b81.html.

restricted discussion of LGBTQ+ topics in classrooms, but the statutory restrictions are operationalized through individual parent complaints.⁷⁷ Activist judge Matthew Kaczmaryk even found that providing family planning services to teenagers violated a father's rights to raise his children to practice abstinence until marriage.⁷⁸

Parents' rights to direct the upbringing of their children have, as Naomi Cahn put it, been used as a "Trojan horse" for ideological and political goals.⁷⁹ Challenging this selective weaponization of parents' rights is a valuable function of the legal challenges to gender-affirming care bans, reminding courts and the public that if parents' rights protect anti-trans parents they should equally protect the decisions of more accepting parents. The shifting usage of parents' rights, however, and particularly characterizations of gender-affirming care as parents as abusing or otherwise harming their trans children, are significant vulnerabilities for legal challenges rooted in fundamental parental rights.

Lawyers representing families that include trans children have added a number of other challenges arising from other constitutional and statutory provisions. Several arise under the First Amendment, such as arguing that medical care is itself speech⁸⁰ or at least that referring patients to other providers in other jurisdictions should be understood as speech rather than medical care.⁸¹ Several briefs argue that gender-affirming care bans also violate the Affordable Care Act's prohibition of discrimination on the basis of sex.⁸² Some argue that the bans are unconstitutionally vague.⁸³ And a few try to articulate some claims made more directly by the children affected, both under federal⁸⁴ and state constitutions.⁸⁵

Again, the absence of a right asserted squarely on behalf of trans children is not a failure or mistake by the lawyers bringing challenges to

77. See Clifford Rosky, *Don't Say Gay: The Government's Silence and the Equal Protection Clause*, 2022 U. ILL. L. REV. 1845, 1853 (2022).

78. *Deanda v. Becerra*, 645 F. Supp. 3d 600, 607, 627-28 (N.D. Tex. 2022).

79. Naomi Cahn, *The Political Language of Parental Rights: Abortion, Gender-Affirming Care, and Critical Race Theory*, 53 SETON HALL L. REV. 1443, 1446 (2023).

80. Complaint in *K.C. v. Indiana*, *supra* note 41, at 44.

81. Brief of Plaintiffs-Appellees in *Brandt*, *supra* note 42, at 49.

82. Complaint in *L.W. v. Skremetti*, *supra* note 41, at 38; Complaint in *K.C. v. Indiana*, *supra* note 41, at 45; Complaint in *Poe v. Drummond*, *supra* note 40, at 58.

83. Complaint in *Walker v. Marshall*, *supra* note 40, at 45.

84. Complaint in *K.C. v. Indiana*, *supra* note 41, at 43 (arguing that the ban "improperly and inappropriately invades bodily autonomy and prohibits the delivery of medically necessary health care").

85. First Amended Complaint in *Van Garderen v. Montana*, *supra* note 43, at 43-48 (challenging a ban under the Montana State constitutional rights to individual privacy and dignity as well as the right to receive information).

gender-affirming care bans. They are working within existing doctrine and correctly identifying claims with a chance of success. It is worth asking, however, how the arguments might change with a more robust understanding of a child's right to medical care, and how such claims might be framed. The last Part turns to this question.

III. A CHILDREN'S RIGHTS CLAIM

The context in which children have had some success in arguing they should be allowed to access medical care is a specific one; the mature minor doctrine as applied to abortion. In the wake of *Roe v. Wade*,⁸⁶ the Supreme Court held that constitutional rights such as the then-recognized right to abortion “do not mature and come into being magically only when one attains the state-defined age of majority.”⁸⁷ In cases successfully challenging state laws requiring that a minor seeking an abortion obtain the consent of their parents, the Court held that states had to provide an alternative to parental consent.⁸⁸ This alternative meant that a pregnant minor had to be given an opportunity to show either that they were mature enough to make the decision to terminate their pregnancy themselves or that the abortion was in their best interests in the eyes of a court.⁸⁹

To be clear, this alternative was not presented as necessary because minors seeking abortions had the same rights or decision-making capacities as adults seeking abortions. In *Planned Parenthood v. Danforth*, the first case addressing the question of parental consent, the Court noted that it has “long . . . recognized that the State has somewhat broader authority to regulate the activities of children than adults.”⁹⁰ In *Bellotti v. Baird*, the Court explained that it was appropriate for states to limit the decision-making authority of minors because they “often lack the experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them.”⁹¹ The existence of a judicial bypass procedure was meant to allow only the minor who could convince a court that “she is mature and well enough informed to make intelligently the

86. 410 U.S. 113 (1973).

87. *Planned Parenthood of Cent. Missouri v. Danforth*, 428 U.S. 52, 74 (1976).

88. *Bellotti v. Baird*, 443 U.S. 622, 643 (1979).

89. *Id.* at 643-44.

90. *Danforth*, 428 U.S. at 74 (citations omitted).

91. *Bellotti*, 443 U.S. at 635. The Court also highlighted the peculiar vulnerability of children and parents' rights as reasons justifying why children's constitutional rights are not the same as adult's rights. *Id.* at 634.

abortion decision on her own” to actually make the decision to terminate a pregnancy on her own behalf.⁹²

The idea of allowing or facilitating some minors to direct their own care, however, may have continued vitality. A recent Note in the *Yale Law Journal* argued that even in the wake of *Dobbs v. Jackson Women's Health Organization*,⁹³ minors' rights to judicial bypass procedures “remain[] on solid ground even without a federal constitutional abortion right.”⁹⁴ One reason, the two student authors argue, is that the mature minor doctrine existed under the common law and recognized the rights of adolescents to make decisions about their own medical care.⁹⁵

Language from the *Bellotti* decision describing the significance and urgency of the abortion decision also could be easily applied to gender-affirming care. The Court emphasizes that the options facing a pregnant minor are different than other decisions. Comparing the decision to terminate a pregnancy to the decision to marry—another choice that requires parental consent—the Court explains that if a minor wants to marry and cannot because her parents refuse to consent, she can simply wait until her eighteenth birthday and then get married.⁹⁶ A pregnant minor could not similarly wait until they became a legal adult—and a transgender minor facing the irreversible physical changes of puberty cannot simply wait until they turn eighteen to go on puberty blockers. Just as an unwanted pregnancy is “exceptionally burdensome,” so is denying a transgender minor on the cusp of puberty the medication that puts puberty on pause.⁹⁷

Another bolster for a right to direct medical care held by the child comes from Professor Jessie Hill, who in 2007 undertook a comprehensive analysis of court decisions dealing with a claimed right to make decisions about medical treatment. She identified two freestanding and conflicting lines of doctrine: “the ‘public-health’ line of cases, which emphasizes the police power of the state over individual rights, and the ‘autonomy’ line of cases, which emphasizes individual bodily integrity and dignity interests.”⁹⁸ The public health line began in the context of

92. *Id.* at 647.

93. 597 U.S. 215 (2022).

94. Jessica Quinter & Caroline Markowitz, *Judicial Bypass and Parental Rights After Dobbs*, 132 *YALE L.J.* 1908, 1940 (2023).

95. *Id.* at 1941.

96. *Bellotti*, 443 U.S. at 642.

97. *Id.*

98. B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 *TEX. L. REV.* 277, 278 (2007).

mandatory vaccination laws,⁹⁹ but also included other claims to care outside of the mainstream—as Hill put it, “quacks, snake-oil salesmen, and unsafe and untested drugs.”¹⁰⁰ In such cases, courts deferred to legislatures that had limited medical treatment in the service of protecting public health—indeed, the people seeking untested care or wanting to decline care such as vaccines were seen as “potential threats to the health of the body politic.”¹⁰¹ By contrast, cases falling under the autonomy line acknowledged the constitutional significance of directing one’s own care, including but not limited to in the context of pregnancy and abortion.¹⁰² Hill concludes that the distinction between the two categories is artificial,¹⁰³ and that the Supreme Court “has already recognized a substantive-due-process right to make medical treatment decisions without unwarranted government interference.”¹⁰⁴

None of the preceding arguments establish as clear doctrine that a child asserting that a gender-affirming care ban violated a substantive due process right to direct their own medical treatment would win. But the division between public health and autonomy lines of medical decision-making cases highlights why at least articulating the argument would be helpful. When gender-affirming care is characterized as the product of peer pressure and profit-hungry doctors seeking to make a buck rather than do no harm, gender-affirming care is placed squarely in the public health line of cases, in which gender-affirming care becomes quackery and a threat to the health of vulnerable citizens. In such circumstances, courts defer to legislatures. Existing legal challenges that discuss equal protection or the violation of parental rights are relevant, but a right to direct medical treatment would push analysis toward the autonomy line of cases. Gender-affirming care is supported by every major medical organization.¹⁰⁵ And while the children who might receive puberty blockers are likely not themselves “mature minors,” the same life-changing consequences faced by a pregnant minor are faced by a transgender minor. They cannot simply wait until the age of eighteen to access that care—in the meantime, their body will have gone through irreversible and significant changes. Just as in the context of abortion,

99. *Id.* at 296.

100. *Id.* at 304.

101. *Id.*

102. *Id.* at 306.

103. *Id.* at 313.

104. *Id.* at 329.

105. Alstott et al., *supra* note 7, at 243.

“there are few situations in which denying a minor the right to make an important decision will have consequences so grave and indelible.”¹⁰⁶

Asking what a freestanding right of a child to direct their own medical care would look like and making that claim in the context of gender-affirming care bans thus has three strong arguments in its favor. First, it develops a nascent and viable argument that minors hold *some* ability to direct their own care that could support both challenges to gender-affirming care bans and other contexts, such as if a transgender teenager wants gender-affirming care but their parents refuse to consent. Second, the argument directly counters characterizations of transgender minors as confused, pressured, or exploited. This argument has both political and legal significance, and arguing that gender-affirming care bans violate only the fundamental rights of the parents at least fails to challenge that phrasing. Finally, placing the people most affected by gender-affirming care bans at the heart of an argument appropriately centers them, bringing the focus squarely onto the children being harmed. This may not immediately or fundamentally change the threats faced by transgender children or the lawsuits brought on their behalf, but it may be worth adding to the quiver of lawyers fighting for them.

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