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Intersex, Trans, and the Irrationality of Gender-Affirming-Care Bans

ABSTRACT. The U.S. Supreme Court is poised to address the constitutionality of state laws banning gender-affirming care for transgender youth. This Article provides a comprehensive legal analysis of these bans, uncovering a disturbing normative paradox: despite claiming to protect minors by banning gender-affirming care, these laws simultaneously endorse coercive medical interventions through clauses that permit such procedures for intersex infants. This internal contradiction turns the Court's search for the bans' rational basis into an exercise in irrationality, demonstrating their failure to meet even the most basic standard of constitutional scrutiny.

The Article first challenges prevailing legal narratives by considering the legal interests of trans and intersex minors as distinct yet interconnected. It then argues that the internal incoherence of gender-affirming-care bans amounts to legislative irrationality. This analysis reveals that the statutes' only rational aim is an illegitimate one: an intent to enforce binary understandings of sex and gender on minors' bodies, jeopardizing their health and well-being in contravention of core constitutional safeguards. Finally, the Article extends its doctrinal argument by offering a complementary normative vision, grounded in reproductive justice and critical disability studies, for minors' bodily self-determination.

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INTRODUCTION

Across the United States, a grave injustice persists: the routine and nonconsensual sterilization of children. In response to this crisis, state legislators have, over the past three years, enacted laws that claim to protect minors' bodily integrity. The laws expressly ban minors' access to gender-affirming care.[1] Ironically, while the laws prohibit certain medical procedures, including genital-related surgeries for some minors, they simultaneously permit coercive — and often sterilizing — interventions on the sex characteristics of other minors.[2]

Each ban, while limiting gender-affirming care for trans minors,[3] effectively enables coerced sex assignments for intersex minors by excluding such practices

1. Gender-affirming care refers to a comprehensive range of medical, mental-health, and sociolegal services aimed at helping individuals achieve lasting personal comfort with their gender identity. *See* E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH S1, S5 (2022) [hereinafter *SOC8*]. Interventions may include endocrinological and surgical treatments, voice and communication therapy, primary health care, hair removal, reproductive and sexual-health services, psychological counseling, and social support, all designed to alleviate acute distress and promote overall physical health, psychological well-being, and self-fulfillment. *Id.* Individualized and based on informed consent, gender-affirming care recognizes that each person's needs are unique and that a given individual may not require all available interventions. *See* 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, 3872 (2017) [hereinafter *Endocrine Clinical Practice Guideline*]. While gender-affirming care encompasses a broad spectrum of services, bans on such care typically target specific interventions for minors, such as puberty blockers, hormone therapies, and surgeries. For further discussion, see *infra* Section I.A.1.

2. *See, e.g.*, ALA. CODE § 26-26-4 (2025); ARK. CODE ANN. § 20-9-1502(a) (2025), *invalidated by* Brandt v. Rutledge, 677 F. Supp. 3d 877 (E.D. Ark. 2023); FLA. STAT. § 456.52(1) (2024), *invalidated by* Doe v. Ladapo, 737 F. Supp. 3d 1240 (N.D. Fla. 2024); FLA. ADMIN. CODE ANN. r. 64B8-9.019 (2025); GA. CODE ANN. § 31-7-3.5 (2024); IDAHO CODE § 18-1506C (2025); IND. CODE § 25-1-22-13 (2024); IOWA CODE § 147.164 (2024); KY. REV. STAT. ANN. § 311.372 (West 2024); LA. STAT. ANN. § 40:1098.2 (2024); MISS. CODE ANN. § 41-141-5 (2024); MO. REV. STAT. § 191.1720 (2024); MONT. CODE ANN. § 50-4-1004 (2023); NEB. REV. STAT. § 71-7304 (2024); N.H. REV. STAT. ANN. § 332-M:3 (2024); N.C. GEN. STAT. § 90-21.151 (2024); N.D. CENT. CODE § 12.1-36.1-02 (2023); OHIO REV. CODE ANN. § 3129.04 (LexisNexis 2024); OKLA. STAT. tit. 63, § 2607.1 (2024); S.C. CODE ANN. § 44-42-330 (2024); S.D. CODIFIED LAWS § 34-24-33 (2025); TENN. CODE ANN. § 68-33-103 (2025); TEX. HEALTH & SAFETY CODE ANN. § 161.702 (West 2023); UTAH CODE ANN. § 58-1-603.1 (LexisNexis 2024); W. VA. CODE § 30-3-20 (2024); WYO. STAT. ANN. § 35-4-1001 (2024).

3. This Article employs "trans" to encompass various identities and expressions that diverge from normative expectations linked to birth-assigned sex, including transgender, transsexual, trans nonbinary, and other gender-variant identities and experiences. For previous uses of the

from their scope.[4] These children, whose physical realities challenge binary sex classifications, are often subjected to invasive "sex-normalizing" procedures before their second birthdays, with no effective legal oversight or meaningful protections.[5]

That gender-affirming-care bans exclude sex-normalizing interventions for children with intersex variations is not simply a legislative oversight. Instead, it starkly highlights these statutes' irrationality. Enacted with the stated goal of protecting children's health, safety, and well-being, these laws necessarily produce the opposite effect. As this Article explores, gender-affirming-care bans consistently exclude intersex interventions — exclusions enacted with little to no legislative debate and attracting almost no judicial scrutiny. Yet for every criticism leveled at gender-affirming care, intersex interventions emerge as the true offenders: they are imposed on infants who cannot consent, often cause infertility, lack medical necessity, and are far less supported by research. The disparate treatment of intersex and trans minors highlights a contradiction at the heart of these laws, setting the stage for their constitutional unraveling. Their stark inconsistency exposes a fundamental flaw that renders these bans unconstitutional: they lack any rational basis because they rest on an irreconcilable contradiction. This inconsistency is fatal to such bans' constitutionality, irrespective of whether they discriminate based on a constitutionally suspect classification.

The legal debate over gender-affirming-care bans is rapidly evolving, indicating that the landscape of American civil rights might seismically shift. In 2023 and 2024 alone, state legislators introduced over a thousand bills affecting trans

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term in legal scholarship, see, for example, D Dangaran, *Bending Gender: Disability Justice, Abolitionist Queer Theory, and ADA Claims for Gender Dysphoria*, 137 HARV. L. REV. F. 237, 242 (2024); and Jessica A. Clarke, *They, Them, and Theirs*, 132 HARV. L. REV. 894, 897-98 (2019).

4. "Intersex" is employed here as an umbrella term for people whose sex characteristics vary from the male/female binary. Other terms — notably, Disorders/Differences of Sex Development (DSD) — have been criticized for their pejorative connotations and for seemingly pathologizing benign conditions. *See* Morgan Carpenter, *Intersex Variations, Human Rights, and the International Classification of Diseases*, 20 HEALTH & HUM. RTS. J. 205, 207-08 (2018); Elizabeth Reis, *Divergence or Disorder?: The Politics of Naming Intersex*, 50 PERSPS. BIOLOGY & MED. 535, 536-37 (2007). We thus use "intersex" instead, as the term is prevalent in social, advocacy, and legal spheres and aims to facilitate collective action and center human rights. *See* Carpenter, *supra*, at 207-08; Reis, *supra*, at 536-37.

5. For detailed explorations of standard medical care for intersex minors, see generally discussion *infra* Section I.A.2; and Iain Morland, *Intersex*, 1 TRANSGENDER STUD. Q. 111 (2014), which notes that intersex-related diagnoses often medicalize bodies solely because they do not conform to traditional sex classifications, thus driving physicians to initiate treatments in infancy — often without apparent medical necessity.

rights, almost a third of which sought to ban gender-affirming care.[6] To date, twenty-six such bans have already been enacted.[7] Legal challenges have emerged across the country,[8] accelerating a growing federal circuit split.[9]

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6. Minami Funakoshi & Disha Raychaudhuri, *The Rise of Anti-Trans Bills in the US*, REUTERS (Aug. 19, 2023), https://www.reuters.com/graphics/USA-HEALTHCARE/TRANS-BILLS/zgvorreyapd [https://perma.cc/TW5Q-TPZ4] (providing a comprehensive review of laws and bills limiting gender-affirming care); *Tracking the Rise of Anti-Trans Bills in the U.S.*, TRANS LEGIS. TRACKER, https://translegislation.com/learn [https://perma.cc/BA96-9BXA] (providing a breakdown of total anti-trans bills by category from 2015-2024); *see also* Christy Mallory & Elana Redfield, *The Impact of 2023 Legislation on Transgender Youth*, WILLIAMS INST. 1 (2023), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Legislation-Summary-Oct-2023.pdf [https://perma.cc/Y99C-LL38] (providing an overview of five hundred bills related to gender-affirming care); Annys Shinn, N. Kirkpatrick & Anne Branigin, *Anti-Trans Bills Have Doubled Since 2022. Our Map Shows Where States Stand.*, WASH. POST (May 19, 2023, 7:01 AM EDT), https://www.washingtonpost.com/dc-md-va/2023/04/17/anti-trans-bills-map [https://perma.cc/RHY7-59LX] (documenting over four hundred bills); Susan Jaffe, *More US States Ban Teenagers' Gender-Affirming Care*, 402 LANCET 839, 839-40 (2023) (discussing the implications of state-level bills for public health and human rights).

7. *See supra* note 2.

8. *See, e.g.*, Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131 (M.D. Ala. 2022), *vacated sub nom.* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205 (11th Cir. 2023); Brandt v. Rutledge, 551 F. Supp. 3d 882 (E.D. Ark. 2021), *aff'd sub nom.* Brandt *ex rel.* Brandt v. Rutledge, 47 F.4th 661 (8th Cir. 2022); Doe v. Ladapo, 737 F. Supp. 3d 1240 (N.D. Fla. 2024), *stayed sub nom.* Doe v. Surgeon Gen., No. 24-11996, 2024 WL 4132455 (11th Cir. Aug. 26, 2024); Koe v. Noggle, 688 F. Supp. 3d 1321 (N.D. Ga. 2023); Poe *ex rel.* Poe v. Labrador, 709 F. Supp. 3d 1169 (D. Idaho 2023), *stayed in part*, 144 S. Ct. 921 (2024); K.C. v. Individual Members of Med. Licensing Bd., 677 F. Supp. 3d 802 (S.D. Ind. 2023), *rev'd*, 121 F.4th 604 (7th Cir. 2024); Doe v. Thornbury, 679 F. Supp. 3d 576 (W.D. Ky. 2023), *rev'd sub nom.* L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460 (6th Cir. 2023); Order and Entry Granting Plaintiffs' Motion for Temporary Restraining Order, Moe v. Yost, No. 24CVH03-2481 (Ohio Ct. Com. Pl. Apr. 16, 2024); Verified Petition for Declaratory and Permanent Injunctive Relief, Soe *ex rel.* Soe v. La. State Bd. of Med. Exam'rs, No. 2024-172 (La. Civ. Dist. Ct. Jan. 8, 2024); Petition for a Temporary Restraining Order, Injunctive Relief, and Declaratory Relief, Southampton Cmty. Healthcare v. Bailey, No. 23SL-CC01673 (Mo. Cir. Ct. Apr. 24, 2023); Order, Noe v. Parson, No. 23AC-CC04530 (Mo. Cir. Ct. Aug. 25, 2023); First Amended Complaint, Van Garderen v. State, No. DV-23-541 (Mont. Jud. Dist. July 17, 2023); Planned Parenthood of the Heartland, Inc. v. Hilgers, 9 N.W.3d 604 (Neb. Dist. Ct. 2024); Voe v. Mansfield, No. 23CV864, 2024 WL 5120258 (M.D.N.C. Dec. 16, 2024); Complaint, Dolney *ex rel.* T.D. v. Wrigley, No. 08-2023-CV-02189 (N.D. Dist. Ct. Sept. 14, 2023); Poe v. Drummond, 697 F. Supp. 3d 1238 (N.D. Okla. 2023), *appeal docketed*, No. 23-5110 (10th Cir. Oct. 10, 2023); L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668 (M.D. Tenn. 2023), *rev'd*, 83 F.4th 460 (6th Cir. 2023), *cert. granted sub nom.* United States v. Skrmetti, 144 S. Ct. 2679 (2024); Loe v. State, No. 23-0697, 2023 WL 5519799 (Tex. Dist. Ct. Aug. 25, 2023), *rev'd*, 692 S.W.3d 215 (Tex. 2024); *In re* Abbott, 645 S.W.3d 276 (Tex. 2022).

9. *Eknes-Tucker*, 80 F.4th at 1210-11 (vacating the district court's preliminary injunction enjoining the enforcement of the Alabama ban); *Brandt*, 47 F.4th at 667 (affirming a preliminary

In June 2024, the Supreme Court granted the Department of Justice's petition for certiorari, agreeing to review a Sixth Circuit decision upholding the constitutionality of Tennessee's ban on gender-affirming care.[10] The outcomes of this case and other legal battles over the bans are poised to reshape how American law understands and protects minors and possibly other historically marginalized groups.[11] With a national ban on gender-affirming care looming as a real

injunction against the enforcement of the Arkansas ban); Doe v. Surgeon Gen., 2024 WL 4132455, at *3 (staying a preliminary injunction against the Florida ban); Order at 1, Poe v. Labrador, No. 24-142 (9th Cir. Jan. 30, 2024) [hereinafter *Labrador* Denial of Stay] (denying a motion to stay a preliminary injunction against the enforcement of the Idaho ban); *Skrmetti*, 83 F.4th at 491 (reversing a preliminary injunction against the enforcement of the Tennessee and Kentucky bans).

10. United States v. Skrmetti, 144 S. Ct. 2679, 2679 (2024) (mem.); *see* Petition for a Writ of Certiorari at 1-3, *Skrmetti*, 144 S. Ct. 2679 (No. 23-477).

11. Gender-affirming-care bans and the constitutional questions they raise have attracted scholars' attention. *See, e.g.*, *Developments in the Law — Outlawing Trans Youth: State Legislatures and the Battle over Gender-Affirming Healthcare for Minors*, 134 HARV. L. REV. 2163, 2178-85 (2021) [hereinafter *Outlawing Trans Youth*] (analyzing from a constitutional perspective the onset of the legislative trend against gender-affirming care and noting the intersex exclusion); Marc Spindelman, *Trans Sex Equality Rights After* Dobbs, 172 U. PA. L. REV. ONLINE 1, 2 (2023) (observing that federal adjudication on the constitutionality of the bans may impact public faith in the rule of law); Jessica Matsuda, Note, *Leave Them Kids Alone: State Constitutional Protections for Gender-Affirming Healthcare*, 79 WASH. & LEE L. REV. 1597, 1601 (2022) (arguing that state constitutional challenges are best suited to block the bans); Greg Mercer, Note, *First, Do No Harm: Prioritizing Patients over Politics in the Battle over Gender-Affirming Care*, 39 GA. ST. U. L. REV. 479, 495-96 (2022) (exploring the constitutional entanglements created by the bans); Dominic Bayer, *Child Gender Transition Bans and the Constitution: The Equal Protection Clause and* Bostock, 3 REGENT U. L. REV. PRO TEMPORE 1, 4 (2022) (arguing that prohibitions on gender-affirming care are appropriate uses of state power under the Equal Protection Clause). *See generally* Anne Alstott, Melisa Olgun, Henry Robinson & Meredithe McNamara, *"Demons and Imps": Misinformation and Religious Pseudoscience in State Anti-Transgender Laws*, 35 YALE J.L. & FEMINISM 223 (2024) (analyzing the role of misinformation and religious pseudoscience in the development of anti-transgender laws, offering critical insights into their flawed ideological foundations); Erik Fredericksen, Note, *Protecting Transgender Youth After* Bostock*: Sex Classification, Sex Stereotypes, and the Future of Equal Protection*, 132 YALE L.J. 1149 (2023) (exploring the application of equal-protection principles to anti-transgender policies and providing a constitutional framework for analysis); Ali Libertella, *State Actors to Ban Gender-Affirming Care for Minors and the Ways Forward*, 44 COLUM. J. GENDER & L. 404 (2024) (discussing the actions of state actors in implementing gender-affirming-care bans and proposing strategies for legal and policy responses); John Mejia, *Examining the Constitutionality of Legislative Medical Care Bans for Transgender Youth*, 2024 UTAH L. REV. 861 (evaluating the constitutionality of bans and addressing key legal arguments and judicial decisions relevant to ongoing challenges); Lindsay Sergi, *The Networks: The Coordinated Mobilization of Doctors for Bans on Gender-Affirming Healthcare for Minors*, 25 GEO. J. GENDER & L. 1263 (2024) (investigating the coordinated efforts of medical professionals in advocating for gender-affirming-care bans); Lois A. Weithorn, *The Intrusive State: Restrictions on Gender-Affirming Healthcare for Minors, Exceptions to the Doctrine of Parental Consent, and*

possibility, the stakes of these legal challenges—and the constitutional issues they address—have never been higher.[12]

In the lower courts, these debates have coalesced around key constitutional claims: equal-protection challenges brought by minors based on their sex or transgender status, parental due-process claims asserting rights to consent to their children's health care, and challenges based on doctors' First Amendment rights to provide such care.[13] While federal circuit courts are divided on each of these questions,[14] the Supreme Court has granted certiorari to address only the equal-protection issue.[15]

Reliance on Science and Medical Expertise, 75 UC L.J. 713 (2024) (examining the constitutional implications of gender-affirming-care bans, focusing on their intrusion into family decision-making and the misuse of scientific evidence).

Notably, the bans are part of wider legislative efforts targeting trans minors and adults not only in health care but also in education, athletics, parental rights, and more. Further, our analysis of trans and intersex interests raises broader issues, including access to public goods, discrimination, and reproductive rights. These wider legislative trends and broader issues exceed this Article's scope, suggesting areas for future research. *See, e.g.*, Noa Ben-Asher & Margot J. Pollans, *Gender Regrets: Banning Abortion and Gender-Affirming Care*, 2024 UTAH L. REV. 763, 790 (arguing that conservative ideas about abortion are interrelated with restrictions on gender-affirming care); Grace Worcester, Note, *States' Obligation to Provide for Trans Youth: How Medicaid Requires (Most) States to Provide Access to Puberty Blockers*, 108 MINN. L. REV. 2755, 2769-96 (2024) (examining state obligations under Medicaid to provide puberty blockers for transgender youth, highlighting the legal tensions between healthcare access and state restrictions).

12. *See* Donald J. Trump, *President Trump's Plan to Protect Children from Left-Wing Gender Insanity*, DONALDJTRUMP.COM (Feb. 1, 2023), https://www.donaldjtrump.com/agenda47/president-trumps-plan-to-protect-children-from-left-wing-gender-insanity [https://perma.cc/3R7E-3SAU] (proposing "a law prohibiting child sexual mutilation in all 50 states"). The Trump Administration recently issued an executive order directly targeting gender-affirming care for minors and adolescents. *See* Protecting Children from Chemical and Surgical Mutilation, Exec. Order No. 14,187, 90 Fed. Reg. 8771 (Feb. 3, 2025). If implemented, the order would significantly restrict access to such care across both healthcare providers and payers. This order has already been challenged in court, and the U.S. District Court for the District of Maryland issued a preliminary injunction blocking its enforcement. Complaint for Declaratory and Injunctive Relief at 1-3, PFLAG, Inc. v. Trump, No. 25-cv-00337 (D. Md. Feb. 4, 2025); Order at 1, *PFLAG, Inc.*, No. 25-cv-00337 (D. Md. Mar. 4, 2025) (granting plaintiffs' motion for a preliminary injunction).

13. Claims about parental authority take the form of substantive-due-process claims. *See generally* Weithorn, *supra* note 11 (discussing parental-authority challenges to the bans). Claims on medical authority have been instantiated through free-speech arguments. Although these claims are important aspects of current litigation concerning gender-affirming-care bans, an in-depth descriptive or doctrinal analysis of the bans' substantive-due-process and free-speech implications is beyond the scope of the Article.

14. See *infra* Section I.C for a detailed exploration of the developing circuit split.

15. *See* Petition for a Writ of Certiorari, *supra* note 10, at I (including only the equal-protection issue in the question presented).

The bans' proponents argue that they serve an acute state interest in children's health and welfare, protecting minors from ostensibly "experimental" treatments[16] that could result in sterilization or other irreversible outcomes.[17] Conversely, opponents of the bans emphasize that gender-affirming care is not just a medical intervention; it is a well-established, holistic medical approach that supports the mental health and well-being of gender-variant minors.[18]

This Article provides a doctrinal analysis rooted in a comprehensive descriptive account of the emerging body of law shaping intersex and trans minors' care.[19] We have compiled all bills and enacted legislation that limit gender-affirming care, reviewed their exclusionary clauses, and analyzed the many court filings and judicial opinions stemming from related litigation. Our review reveals a systematic pattern with key normative implications: this entire body of law not only targets gender-affirming care but also allows sex-normalizing interventions to continue.

Commentators, scholars, legislators, and courts have largely overlooked these bans' exclusions of normalizing interventions for intersex minors.[20] These

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16. *See infra* Section I.A.2 (describing standards of care for intersex minors); Section I.B.1 (identifying the bans' exclusions for sex-normalizing intersex procedures).

17. *See, e.g.*, L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 488 (6th Cir. 2023) (concluding that a lack of scientific consensus serves as persuasive evidence that states may formulate their own, possibly divergent, child-welfare strategies with respect to gender-affirming care), *cert. granted sub nom.* United States v. Skrmetti, 144 S. Ct. 2679 (2024).

18. *See, e.g.*, Brandt *ex rel.* Brandt v. Rutledge, 47 F.4th 661, 671 (8th Cir. 2022) (exploring the goals of gender-affirming care and finding the ban unjustifiably unrelated to protecting children).

19. The Article focuses on bans in the United States, which reflect the country's unique sociopolitical and legal context and the related implications for medical interventions for trans and intersex minors. Although our doctrinal analysis centers on U.S. legislation and cases, our normative framework may have global relevance. Despite this potential, a comparative legal analysis with other regions is beyond the scope of this Article. Future research would greatly benefit from a more expansive comparative approach that offers a deeper global perspective on the challenges faced by trans and intersex communities.

20. Among law-review publications, only this Article and a forthcoming article by Holning Lau and Barbara Fedders have focused extensively on intersex exceptions. *See generally* Holning Lau & Barbara Fedders, *Scrutinizing Transgender Healthcare Bans Through Intersex Exceptions*, 36 YALE J.L. & FEMINISM (forthcoming 2025), https://ssrn.com/abstract=4935674 [https://perma.cc/SMK5-7HBZ] (highlighting intersex exceptions in gender-affirming-care bans and arguing that these laws violate equal protection and undermine parents' constitutional right to make informed, individualized decisions about their children's health). For more peripheral discussions of intersex carve-outs in gender-affirming-care bans, see Kathleen Kassa & Alexander J. Merritt, *Health—Regulation and Construction of Hospitals and Other Health Care Facilities*, 40 GA. ST. U. L. REV. 127, 142 n.85 (2023), which focuses on legislative intent and its constitutional implications, with a footnote critiquing intersex carve-outs as a revealing

procedures are framed as necessary to "cure" differences in sex development and make these children's bodies "normal."[21] Such reasoning is reinforced by the fact that cisgender minors receiving gender-related endocrinological or surgical interventions are also excluded from the bans.[22] Under this reasoning, medical care for trans minors is tied to their gender identity and therefore prohibited, while care for intersex and cisgender minors is tied to their physical bodies and permitted. This logic treats societal ideas of "normal" bodies as medical requirements.[23] It assumes that intersex bodies are "wrong" and need to be corrected to fit binary categories of male or female, while considering pretransition trans bodies "healthy" simply because they fit these same categories, even when the

inconsistency; and Zee Scout, *Trans Erasure, Intersex Manipulation: The First Amendment and Other Reflections from Women in* Struggle v. Bain, 47 HARV. J.L. & GENDER 111, 114-17, 164 (2024), which argues that intersex exceptions reinforce binary norms and harm intersex individuals while erasing nonbinary identities. For additional discussions of gender-affirming-care bans that, though they do not address intersex carve-outs, contribute to understanding the broader legal and policy landscape, see generally sources cited *supra* note 11.

Courts have also largely ignored intersex exceptions. For instance, despite describing gender identity in its decision blocking the Florida ban, the district court in *Doe v. Ladapo* noted that it does not concern itself with intersex issues: "With extraordinarily rare exceptions not at issue here, every person is born with external sex characteristics, male or female, and chromosomes that match." 737 F. Supp. 3d 1240, 1255 (N.D. Fla. 2024), *stayed sub nom.* Doe v. Surgeon Gen., No. 24-11996, 2024 WL 4132455 (11th Cir. Aug. 26, 2024). However, some expert declarations on behalf of the plaintiffs in *Skrmetti* did indicate concerns about intersex minors' well-being. *See, e.g.*, Expert Declaration of Armand H. Matheny Antommaria at 23-24, L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668 (M.D. Tenn. 2023) (No. 23-CV-00376).

21. For example, in its brief to the Supreme Court, Tennessee used the allowance of procedures for congenital defects to suggest that its ban was narrowly tailored to prohibit only harmful interventions. *See* Brief for Respondents at 5-7, United States v. Skrmetti, No. 23-477 (U.S. Sept. 3, 2024). This distinction implicitly reinforces the logic that treatments aligning bodies with binary norms are necessary and beneficial. This distinction underpins the "cure logic" by treating normalization as a medical imperative while framing gender-affirming care as dangerous and illegitimate.

22. For example, cisgender minors might undergo endocrinological interventions to avoid early onset of puberty. *See* Erica A. Eugster, *Treatment of Central Precocious Puberty*, 3 J. ENDOCRINE SOC'Y 965, 967-68 (2019). They might also undergo gender-related surgical interventions, such as those to remove excessive breast tissue for males or increase breast size for females. *See* G.A. Kanakis, L. Nordkap, A.K. Bang, A.E. Calogero, G. Bàrtfai, G. Corona, G. Forti, J. Toppari, D.G. Goulis & N. Jørgenson, *EAA Clinical Practice Guidelines—Gynecomastia Evaluation and Management*, 7 ANDROLOGY 778, 779-80 (2019). *See generally* Sebastian Winocour & Valerie Lemaine, *Hypoplastic Breast Anomalies in the Female Adolescent Breast*, 27 SEMINARS PLASTIC SURGERY 42 (2013) (discussing surgeries to increase breast size in adolescent girls). For examples of diagnoses for which cisgender youth receive these treatments, see Brief of Experts on Gender Affirming Care as Amici Curiae in Support of Petitioner and Respondents in Support of Petitioner at 12-15, *Skrmetti*, No. 23-477 (U.S. Sept. 3, 2024).

23. Eli Clare, *Body Shame, Body Pride: Lessons from the Disability Rights Movement*, *in* 2 TRANSGENDER STUDIES READER 261, 264-65 (Susan Stryker & Aren Z. Aizura eds., 2013).

minors living in these bodies experience acute distress. This approach reflects social biases, not medical facts, and fails to address the specific needs and interests of trans and intersex minors.

By permitting coercive procedures for intersex minors and barring affirming care for trans minors while exempting cisgender minors from similar regulations, these bans reveal a deeper legislative agenda: enforcing sex and gender conformity. These restrictions, imposed without constitutional justification, undermine the rights of all minors and entrench societal control over their bodies.

Considering the overall regulatory framework of the bans brings into focus the tensions and challenges trans and intersex minors face. At first, these tensions might seem to reflect conflicting interests: trans minors seek medical interventions that alter their sex characteristics, while intersex advocates frequently call for restrictions on such interventions.[24] Advocacy efforts further illustrate these complexities. Trans litigants have sought to protect the rights of intersex minors[25]—and intersex advocates have sought to support trans litigants[26]—yet some litigation strategies pursued by trans plaintiffs risk undermining intersex minors' interests, and vice versa.[27]

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24. Noa Ben-Asher was among the first to discuss the legal aspects of this tension. *See* Noa Ben-Asher, *The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties*, 29 HARV. J.L. & GENDER 51, 55 (2006); *see also* Marie-Amélie George, *Expanding LGBT*, 73 FLA. L. REV. 243, 319 (2021) ("National LGBT rights groups' strategies have tended to marginalize nonbinary interests, while overwhelmingly ignoring intersex and asexual rights."). Intersex scholarship has long discussed intersex history and medical care in conjunction with trans history and medical care, noting the similarities and differences in their interests. *See, e.g.*, GEORGIANN DAVIS, CONTESTING INTERSEX: THE DUBIOUS DIAGNOSIS 31 (2015); KATRINA KARKAZIS, FIXING SEX: INTERSEX, MEDICAL AUTHORITY, AND LIVED EXPERIENCE 242-43 (2008); Ulrike Klöppel, *Who Has the Right to Change Gender Status? Drawing Boundaries Between Inter- and Transsexuality*, *in* CRITICAL INTERSEX 171, 171 (Morgan Holmes ed., 2016); Cary Gabriel Costello, *Intersex and Trans* Communities: Commonalities and Tensions*, *in* TRANSGENDER AND INTERSEX: THEORETICAL, PRACTICAL, AND ARTISTIC PERSPECTIVES 83, 83-84 (Stefan Horlacher ed., 2016); HIDA VILORIA, BORN BOTH: AN INTERSEX LIFE 310-12 (2017).

25. *See, e.g.*, Brief of Plaintiffs-Appellees at 26, L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460 (6th Cir. 2023) (No. 23-5600) (arguing that S.B. 1 permits sterilizing procedures for intersex minors, implicitly highlighting the law's failure to protect the rights of intersex minors).

26. *See, e.g.*, Brief for Amicus Curiae interACT: Advocates for Intersex Youth in Support of Petitioner at 31, *Skrmetti*, No. 23-477 (U.S. Sept. 3, 2024) [hereinafter Amicus Brief for interACT] ("In restricting transgender minors' access to gender-affirming care while endorsing harmful 'normalizing' interventions on non-consenting intersex infants, SB 1 elevates the enforcement of sex stereotypes over children's safety and well-being.").

27. For example, trans plaintiffs may advocate for parental rights to secure minors' decision-making capacity and support medical professionals' ability to provide gender-affirming care. While emphasizing the minor's agency, they do not explicitly advocate granting parents or

Plaintiffs opposing the bans navigate limited legal frameworks in an increasingly contentious cultural climate. Their strategies are shaped by current constitutional jurisprudence and develop in response to narratives advanced by state actors. Yet there is no necessary conflict between the interests of trans and intersex minors. Rather, the perceived opposition arises from entrenched legal and cultural presumptions about sex and gender as fixed and unchanging, hindering the law's ability to identify minors' actual needs and protect their health and well-being.

Through our analysis of the bans' internal inconsistencies, we demonstrate how these presumptions underpin both the prohibition of gender-affirming care for trans minors and the exclusion of nonconsensual, sex-normalizing procedures for intersex minors.[28] This Article reexamines these fundamental assumptions and their influence on both litigation strategies and constitutional frameworks.[29] Rather than debating the nature of sex and gender, we focus on the tangible realities of minors' bodies, independent of legal definitions and medical classifications. Ultimately, these bans pit one group's interests against the other's, creating a false conflict that obscures the shared harm these restrictive policies cause to minors, adults, and the broader public interest in health and well-being. The key doctrinal question is whether it is logically coherent simultaneously to ban (for trans minors) and permit (for intersex minors) medical interventions that alter the sexed bodies into which minors are born.

The question of coherence highlights a core element uniting the interests of both groups: their consent. Both trans and intersex minors are often denied meaningful age-appropriate participation in these decisions—trans minors through bans on gender-affirming care and intersex minors through medically unnecessary, nonconsensual procedures. Thus, in addition to offering a doctrinal argument for the legislative irrationality of gender-affirming-care bans, we explore alternative normative perspectives on these laws, focusing on bodily self-

doctors overriding authority. Still, this approach differs fundamentally from intersex advocacy. Intersex litigation often challenges early interventions performed on those too young to participate in decisions and thus would likely oppose strengthening parental and medical authority over such procedures. For further discussion, see *infra* Sections II.A-B.

28. *See* Amicus Brief for interACT, *supra* note 26, at 2-3 ("Although superficially divergent, the typical medical experiences of both communities stem from the same stereotypical beliefs about what it means to be male or female, and who is eligible for membership in either category.").

29. *Cf.* Ben-Asher & Pollans, *supra* note 11, at 766 (arguing that conservative ideas about abortion are interrelated with restrictions on gender-affirming care); JULES GILL-PETERSON, A SHORT HISTORY OF TRANS MISOGYNY 10-13 (2024) (illustrating historical change in social ideas regarding the fungibility of gender); Noa Ben-Asher, *Transforming Legal Sex*, 102 N.C. L. REV. 335, 392 (2024) (arguing that the rationale of laws "against transgender children and youth" is that gender-variant "children and adults are *not* desirable social outcomes").

determination. Drawing on reproductive-justice scholarship about pro-choice and pro-life logics and on concepts of access and assisted decision-making from disability studies, we identify three necessary conditions for bodily self-determination: freedom for gender exploration, protection against sex normalization, and safe and supportive environments. We aim to provide tools to safeguard the health and well-being of cis, trans, and intersex minors.

This Article does not attempt to merge intersex and trans issues. Instead, it explores pathways for aligning their legal demands while respecting their distinct challenges, their organizing strategies, the opposition they face, and the public perceptions of their identities and experiences. Although intersex issues are at times overshadowed by trans narratives, both groups share common legal interests. Addressing their unique needs across a variety of lived experiences is essential for ensuring fairness and justice in legal and policy frameworks.

Our analysis acknowledges the diversity within and between the trans and intersex communities, recognizing that individuals and groups under these labels have varied perspectives and experiences.[30] To understand current debates on gender-affirming-care bans, we look to the stances taken by these major legal-advocacy organizations, as articulated in court filings, amicus briefs, and other formal legal documents. These sources offer insight into prevailing legal arguments and can illustrate significant points of contention and policy debate.

However, these sources are limited in that they predominantly represent formalized legal narratives and do not fully capture the heterogeneity of lived experiences or the full spectrum of community voices and experiences. Thus, while we rely on these sources alongside legal decisions, proceedings, and other court

30. The U.S. trans and intersex legal movements encompass a wide array of stakeholders, including advocacy groups engaged in litigation, such as interACT, Lambda Legal, the National Center for Lesbian Rights, and the American Civil Liberties Union. Although this Article focuses on the U.S. context, it is important to note that intersex and trans advocacy is global. *See OII Intersex Network*, Org. Intersex Int'l, https://oiiinternational.com [https://perma.cc/8CRY-2EBV] (listing organizations that advocate for intersex rights internationally); *Services*, InterAction Health & Hum. Rts., https://interaction.org.au/category/articles/services [https://perma.cc/RUN3-CVDL] (describing an Australian intersex advocacy organization's focus on law reform and policy); *Programs*, Org. Intersex Int'l Eur., https://www.oiieurope.org/programs [https://perma.cc/5YG9-LUBJ] (advocating for intersex rights in Europe). *See generally* Tomás Javier Ánzola Rodriguez et al., *Joining Forces: Local Activists and Allies Advancing Trans Rights Worldwide*, Int'l Network of C.L. Orgs. (May 2022), https://inclo.net/wp-content/uploads/2024/02/Joining-Forces.pdf [https://perma.cc/VJ5U-EEYJ] (describing transnational trans advocacy by transgender activists and human-rights lawyers); Zhan Chiam, Sandra Duffy, Matilda González Gil, Lara Goodwin & Nigel Timothy Mpemba Patel, *Trans Legal Mapping Report: Recognition Before the Law*, ILGA World (3d ed. 2019), https://ilga.org/wp-content/uploads/2023/11/ILGA_World_Trans_Legal_Mapping_Report_2019_EN.pdf [https://perma.cc/P5FU-VCGT] (describing global laws recognizing trans people's right to change identity markers and highlighting trans voices and their experience of criminalization worldwide).

filings to outline "what the law says about itself,"[31] we remain cautious of the law's limitations, particularly its capacity to address and transform the underlying conditions of disparity and violence experienced by these communities.

Part I of this Article provides a timely descriptive account of the emerging body of law on trans and intersex medical care. We do so through an in-depth exploration of contemporary medical protocols, as well as a comprehensive legal analysis of the bans and relevant constitutional debates. Part II examines the interplay of intersex and trans legal interests. By contrasting key positions in trans and intersex advocacy, we analyze the tensions in intersex and trans legal debates and identify common ground. Part III considers the legal interests of trans and intersex minors from a collaborative perspective rather than an oppositional one. First, it evaluates the constitutionality of gender-affirming-care bans under rational-basis review, arguing that their internal incoherence amounts to legislative irrationality. It then explores a novel normative vision for bodily self-determination for both trans and intersex minors.

Rather than remaining silent on intersex interests, gender-affirming-care bans expressly exempt the same medical interventions that they deny to transgender minors when they are imposed on intersex minors. In the ensuing litigation, the pursuit of a rational basis becomes an exercise in irrationality. By prohibiting gender-affirming care while permitting sex-normalizing procedures, these bans reveal internal inconsistencies that render them unable to serve the states' asserted interests—or any other legitimate interest. As such, these bans not only jeopardize the health and well-being of trans and intersex minors but also erode the very constitutional safeguards that should protect them.

I. THE LAW OF MEDICAL CARE FOR INTERSEX AND TRANS MINORS

The Supreme Court has long been a significant theater of operations in American culture wars.[32] In 2015, *Obergefell v. Hodges* ended, though perhaps only temporarily,[33] the battle over same-sex marriage.[34] In its wake,

31. *See* DEAN SPADE, NORMAL LIFE: ADMINISTRATIVE VIOLENCE, CRITICAL TRANS POLITICS, AND THE LIMITS OF LAW 7-8 (Duke Univ. Press rev. ed. 2015) (2011) (adopting a cautious approach to "believ[ing] what the law says about itself since time and again the law has changed, been declared newly neutral or fair or protective, and then once more failed to transform the conditions of disparity and violence that people were resisting").

32. *See* Ben-Asher & Pollans, *supra* note 11, at 789-90.

33. *See* Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 332 (2022) (Thomas, J., concurring) (arguing for a reevaluation of substantive-due-process precedents, including Griswold v. Connecticut, 381 U.S. 479 (1965), Lawrence v. Texas, 539 U.S. 558 (2003), and *Obergefell*, 576 U.S. 644).

34. 576 U.S. 644, 681 (2015).

conservatives strategically chose trans issues as focal points of partisan disputes[35] and related legal battles.[36] Perhaps unexpectedly,[37] the 2020 *Bostock v. Clayton County* decision recognized workplace gender-identity discrimination as sex discrimination, although it relied on a formalist textual interpretation of Title VII of the Civil Rights Act of 1964.[38] Then, in 2022, the Court in *Dobbs v. Jackson Women's Health Organization* held that there is no federal constitutional right to abortion in the Due Process Clause.[39] The Court also rejected in dicta arguments by legal scholars that such a right might be grounded in the Equal Protection Clause.[40]

Many bans on gender-affirming care for minors were introduced prior to *Dobbs*. Litigation concerning these bans, however, has taken place largely in the post-*Dobbs* era, putting trans health care, particularly gender-affirming care for minors, in an increasingly precarious constitutional position.[41] The ensuing legal debates have featured reinvigorated child-protection tropes, which were previously wielded by conservatives against same-sex marriage and are now being repurposed to challenge trans rights.[42] Responses to the bans have been constrained by both the current constitutional landscape and the strategic positioning of trans minors at the center of the culture wars. Together, these trends divert attention from broader challenges to the foundational legal structures of sex and

35. *See* Paisley Currah, Sex Is as Sex Does: Governing Transgender Identity 23-24 (2022); *Outlawing Trans Youth*, *supra* note 11, at 2164.

36. *See* Katie Eyer, *Transgender Constitutional Law*, 171 U. Pa. L. Rev. 1405, 1415-59 (2023) (analyzing constitutional-law cases related to trans rights post-*Obergefell*).

37. *See* Paisley Currah, *How a Conservative Legal Perspective Just Saved LGBT Rights*, Bos. Rev. (June 19, 2020), https://bostonreview.net/gender-sexuality/paisley-currah-how-conservative-legal-perspective-just-saved-lgbt-rights [https://perma.cc/YRY8-UFSM].

38. 590 U.S. 644, 656, 683 (2020).

39. *See Dobbs*, 597 U.S. at 237 (setting out to address the "bold assertion that the abortion right is an aspect of the 'liberty' protected by the Due Process Clause of the Fourteenth Amendment"); *id.* at 237-59 (discussing, and ultimately rejecting, the right to abortion as protected by the Due Process Clause).

40. *Id.* at 236; Reva B. Siegel, Serena Mayeri & Melissa Murray, *Equal Protection in* Dobbs *and Beyond: How States Protect Life Inside and Outside of the Abortion Context*, 43 Colum. J. Gender & L. 67, 68-69, 68 n.3 (2023).

41. *See* Ben-Asher & Pollans, *supra* note 11, at 792-94 (exploring how the bans adopt the *Dobbs*-ian claim that the state has an interest in protecting patients from future regret, which justifies restrictions on providing medical care).

42. *See* Mikey Elster, *Insidious Concern: Trans Panic and the Limits of Care*, 9 Transgender Stud. Q. 407, 409 (2022).

gender, framing these disputes as narrow legal questions while masking their underlying ideological battles at the expense of vulnerable groups.[43]

This Article seeks to complicate the current legal debates by foregrounding, distinguishing, and reconciling the interests of the trans and intersex minors impacted by the bans. This Part reviews and analyzes bills, enacted legislation, legislative history, court decisions, litigation documents, expert testimonies, and amicus briefs. It describes the bans' approaches to both intersex and trans care and identifies the repeated exclusion of intersex interventions without legislative discussion. As this Article shows, the bans are thus as much an unprecedented authorization of intersex interventions as they are a regulation of gender-affirming care.

This Part is divided into three Sections. The first situates the bans within historical and contemporary medical standards for trans and intersex care. The second surveys and maps the bans' legislative provisions. The third identifies the key constitutional debates that the bans have ignited. We aim to dissect the complex legal dynamics at play and shed light on the intricacies of intersex and trans minors' rights.

A. Standards of Care for Trans and Intersex Minors

This Section investigates the diagnostic criteria and medical protocols that underpin our analysis of how the bans affect healthcare access for trans minors and enforce normalizing interventions on intersex minors. These guidelines significantly influence trans and intersex experiences, determining both the accessibility and effects of medical interventions. We lay the foundation for understanding these laws' mechanisms by detailing treatment types, timing, and reversibility. While we aim to provide essential context for our subsequent legal analysis, we note that this review cannot address fully the evolving cross-disciplinary discussions around these medical practices and diagnoses.

43. *See* GILL-PETERSON, *supra* note 29, at 20 ("Gender as a system coerces and maintains radical interdependence, regardless of anyone's identity or politics. Trans misogyny is one particularly harsh reaction to the obligations of that system—obligations guaranteed by state as much as by civil society.").

1. Trans Minors: Gender-Affirming Care

Dr. Magnus Hirschfeld began facilitating early medical interventions for gender affirmation in Germany by 1906.[44] European fascism halted Hirschfeld's pioneering development of trans health care and the emerging social efforts for trans inclusion bubbling around his Berlin Institute for Sexual Science.[45] Although the post-World War II period saw advancements in medicine and technology, medical and legal institutional actors in the United States largely framed trans identity as a mental disorder.[46] The year 1966 saw both the publication of diagnostic criteria by Hirschfeld's protégé Dr. Harry Benjamin[47] and the opening of the first Gender Identity Clinic at Johns Hopkins Hospital, which was spearheaded by Dr. John Money and built on Money's ongoing experiments on intersex children.[48] Neither the Benjamin diagnostic criteria nor the Johns Hopkins clinic sought to affirm gender; instead, they treated patients as mentally ill.

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44. *See* Adi Savran & Iris Rachamimov, *In the Folds of a Skirt: The Many Lives of Karl M. Baer*, 131 ZMANIM 22, 22 (2015); *see also* Jordan D. Frey, Grace Poudrier, Jennifer E. Thomson & Alexes Hazen, *A Historical Review of Gender-Affirming Medicine: Focus on General Reconstruction Surgery*, 14 J. SEXUAL MED. 991, 992 (2017) (tracing "the first-ever full-length book to focus exclusively on what is currently referred to as the [transgender and gender nonconforming] population" to Magnus Hirschfeld's *Transvestites*, published in 1910).

45. *See* HEIKE BAUER, THE HIRSCHFELD ARCHIVES: VIOLENCE, DEATH, AND MODERN QUEER CULTURE 25, 84-87, 92 (2017); *see also* Matt Fuller & Leah Owen, *Nazi Gender Ideology, Memoricide, and the Attack on the Berlin Institute for Sexual Research*, 34 PEACE REV. 529, 535-36 (2022) (describing the psychological and societal forces behind the 1933 attack on the Institute for Sexual Science).

46. *See* Frey et al., *supra* note 44, at 992 (noting that trans medical interventions did not receive attention by the American medical community until the 1950s); GILL-PETERSON, *supra* note 29, at 108 (explaining that "homosexuality" was categorized as a mental illness in the *Diagnostic and Statistical Manual* until activists successfully mobilized for its removal in 1973); JOANNE MEYEROWITZ, HOW SEX CHANGED: A HISTORY OF TRANSSEXUALITY IN THE UNITED STATES 120-21 (2002) (explaining how some doctors believed trans health care was prohibited under "local mayhem" laws); Susan Stryker & Nikki Sullivan, *King's Member, Queen's Body: Transsexual Surgery, Self-Demand Amputation and the Somatechnics of Sovereign Power*, *in* SOMATECHNICS: QUEERING THE TECHNOLOGISATION OF BODIES 49, 54 (Nikki Sullivan & Samantha Murray eds., Routledge 2016) (2009) (describing how, between 1949-1966, U.S. doctors ethically opposed performing "sex change" operations).

47. HARRY BENJAMIN, THE TRANSSEXUAL PHENOMENON 11-28 (Symposium Publ'g 1999) (1966).

48. *See* JULIAN GILL-PETERSON, HISTORIES OF THE TRANSGENDER CHILD 129 (2018) (noting Dr. John Money's role in the clinic's opening and how Dr. Harry Benjamin referred patients to the clinic); Zagria Cowan, A Critical Rereading of Harry Benjamin's *The Transsexual Phenomenon* 4 (2016) (unpublished manuscript), https://doryanblu.altervista.org/wp-content/uploads/2022/04/A_critical_rereading_of_Harry_Benjamins.pdf [https://perma.cc/QMT2-JBFV] (noting how Dr. Benjamin referred patients to Johns Hopkins through Dr. Money).

The 1980 edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) introduced Gender Identity Disorder, for the first time providing a diagnosis that allowed trans youth to access gender-related medical technologies.[49] To obtain a diagnosis (and, relatedly, to access care), patients were required to undergo rigorous evaluations and adhere to traditional gender and sexuality norms through an evaluation practice called the "real life test."[50] The "real life test," later renamed "real life experience," required those seeking access to gender-affirming medical interventions to live full-time in their identified gender before accessing surgeries or hormones.[51]

Over the years, the DSM diagnostic criteria related to gender variance have changed.[52] The DSM-5-TR of 2022 includes gender dysphoria, the most recent diagnosis applied to trans minors and adults.[53] This diagnosis appears to adopt

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49. Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders: DSM-III 261-66 (3d ed. 1980).

50. This evaluation practice aimed to assess one's ability to integrate into society in their desired gender role. These expectations reinforced binary understandings of gender and imposed a standard of conformity that pathologized gender-nonconforming expressions and identities. For scholarship on the real-life test (RLT), see generally Stephen B. Levine, *Real-Life Test Experience: Recommendations for Revisions to the* Standards of Care *of the World Professional Association for Transgender Health*, 11 Int'l J. Transgenderism 186 (2009), which found that despite widespread references to RLT in medical literature and practice, there were no scholarly journal articles about RLT or real-life experience (RLE); Helen Barker & Kevan Wylie, *Are the Criteria for the 'Real-Life Experience' (RLE) Stage of Assessment for GID Useful to Patients and Clinicians?*, 10 Int'l J. Transgenderism 121 (2008), which discusses the use of RLE in a study of nineteen patients undergoing gender-role transition; Allison Bischoff, Passing the Test: The Transgender Self, Society and Femininity (2011) (unpublished manuscript), https://digitalcollections.sit.edu/cgi/viewcontent.cgi?article=2158&context=isp_collection [https://perma.cc/B7P8-XPZU], which reviews the history and literature on trans issues in the Netherlands and analyzes five interviews of female-identifying transgender people; and Dean Spade, *Resisting Medicine, Re/Modeling Gender*, 18 Berkeley Women's L.J. 15 (2003), which discusses the law's "heavy reliance on medical evidence to establish gender identity" and advocates for more fluid and nonbinary norms for gender in society, rather than the rigid and binary norms that heavily burden trans people.

51. Levine, *supra* note 50, at 187-88.

52. *See generally* Dangaran, *supra* note 3 (offering a detailed exploration of the history of these criteria in terms of diagnosis, litigation, disability justice, and incarceration).

53. Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR 511 (5th ed. 2022). Gender dysphoria as a diagnosis and social concept has been widely interrogated in trans studies. *See, e.g.*, Florence Ashley, *Gatekeeping Hormone Replacement Therapy for Transgender Patients Is Dehumanising*, 45 J. Med. Ethics 480, 481 (2019); Ido Katri, *Trans Bodies, Gay Sexuality, Dysphoria: Sexual Freedom in the Bathhouse and Beyond*, *in* Enticements: Queer Legal Studies 254, 269 (Joseph J. Fischel & Brenda Cossman eds., 2024).

the gender-affirming approach,[54] which recognizes gender variance as an immutable variation, not a disorder.[55] Rather than pathologizing gender variance, this diagnosis focuses on the distress that can arise for gender-variant people, either because they do not fit into societal gender expectations or as a result of societal attitudes toward their and others' gender experiences.[56] This diagnosis better aligns with the World Professional Association for Transgender Health (WPATH) *Standards of Care*, the prominent and only global guidelines for trans care,[57] which are grounded in research and clinical experience.[58]

Unlike earlier diagnostic criteria and care protocols, gender-affirming care is a patient-centered approach that, rather than pathologizing one's gender identity, focuses on informed consent and understands gender identity through myriad biological, psychological, and social dimensions. This affirming model seeks to offer comprehensive support across medical, social, and legal dimensions.[59] Gender affirmation significantly changed the approach to minors' care, moving away from earlier behavioral therapies aimed at normalizing identities with birth-assigned sex—practices that often worsened gender dysphoria.[60] In the late 1980s and 1990s, endocrinological and certain surgical interventions gradually became available to minors.[61] In 1998, WPATH issued its first clinical guidelines

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54. Some trans advocates and scholars disagree that the new articulation of gender-dysphoria diagnosis is truly trans-affirming. For critiques of the diagnosis, see Florence Ashley, *The Misuse of Gender Dysphoria: Toward Greater Conceptual Clarity in Transgender Health*, 16 PERSPS. ON PSYCH. SCI. 1159, 1159-60 (2019); and Zowie Davy & Michael Toze, *What Is Gender Dysphoria? A Critical Systematic Narrative Review*, 3 TRANSGENDER HEALTH 159, 164-65 (2018).

55. *See* Marco A. Hidalgo, Diane Ehrensaft, Amy C. Tishelman, Leslie F. Clark, Robert Garofalo, Stephen M. Rosenthal, Norman P. Spack & Johanna Olson, *The Gender Affirmative Model: What We Know and What We Aim to Learn*, 56 HUM. DEV. 285, 285-87 (2013) (describing the major premises informing gender-affirming care for youth).

56. *Id.* at 286.

57. John Parsi, *The Eighth Amendment and Medical Consensus on Gender Affirming Care: Reexamining the Dissentals in* Edmo v. Corizon, 101 DENV. L. REV. 127, 169-70 (2023).

58. *See generally SOC8*, *supra* note 1 (providing clinical guidance for healthcare professionals on safe and effective gender-affirmation procedures; emphasizing physical health, psychological well-being, and self-fulfillment; and adopting an evidence-based methodology combining published literature and expert consensus).

59. Jack Turban, *What Is Gender Dysphoria?*, AM. PSYCHIATRIC ASS'N (Aug. 2022), https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria [https://perma.cc/PXC6-RS9Y] (explaining the new diagnosis of "gender dysphoria" and describing the various domains of gender affirmation).

60. *See* Simone Mahfouda, Julia K. Moore, Aris Siafarikas, Timothy Hewitt, Uma Ganti, Ashleigh Lin & Florian Daniel Zepf, *Gender-Affirming Hormones and Surgery in Transgender Children and Adolescents*, 7 LANCET DIABETES & ENDOCRINOLOGY 484, 484-85 (2019).

61. *Id.* at 484.

for adolescents.[62] The American Endocrine Society followed with its own guidelines on minor care in 2009.[63] Current guidelines, as detailed in the 2017 American Endocrine Society clinical-practice guide and the WPATH *Standards of Care*, require comprehensive assessments of the minor's gender incongruence and mandate an extensive process of informed consent before any intervention.[64]

The primary emphasis in affirming care for minors is not on medical interventions but rather on fostering an environment conducive to gender *exploration*.[65] This approach respects the minor's experience of their gender while encouraging an open-minded, comprehensive exploration of their identity, including social, medical, and physical aspects of gender affirmation.[66] It recognizes the minor's current gender identity while also seeking to accommodate any future changes in their identity, expression, or needs. Minors are not expected to adhere continuously to any specific gender identity or expression.[67]

But what, specifically, does such care entail? In practice, affirming care can take several paths, most of which are nonoperative. These paths do not follow a linear-progress protocol; they are dependent not on one another but on the individual patient's needs and desires. The dimensions of gender affirmation include the following:

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62. *See* Stephen B. Levine, George Brown, Eli Coleman, Peggy Cohen-Kettenis, J. Joris Hage, Judy Van Maasdam, Maxine Petersen, Friedemann Pfaefflin & Leah C. Schaefer, *The Standards of Care for Gender Identity Disorders*, 2 INT'L J. TRANSGENDERISM, no. 2, 1998.

63. *See* Wylie C. Hembree, Peggy Cohen-Kettenis, Henriette A. Delemarre-van de Waal, Louis J. Gooren, Walter J. Meyer III, Norman P. Spack, Vin Tangpricha & Victor M. Montori, *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3132 (2009).

64. *See SOC8*, *supra* note 1, at S50 (recommending a "comprehensive biopsychosocial assessment of adolescents"); *Endocrine Clinical Practice Guideline*, *supra* note 1, at 3871 (recommending that before medical intervention, "a multidisciplinary team of medical and [mental health professionals] . . . confirm[] the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent").

65. *See SOC8*, *supra* note 1, at S52 (recommending that healthcare professionals facilitate gender exploration); Florence Ashley, *Thinking an Ethics of Gender Exploration: Against Delaying Transition for Transgender and Gender Creative Youth*, 24 CLINICAL CHILD PSYCH. & PSYCHIATRY 223, 223 (2019) [hereinafter Ashley, *Thinking an Ethics of Gender Exploration*]; Jake Pyne, *Gender Independent Kids: A Paradigm Shift in Approaches to Gender Non-Conforming Children*, 23 CANADIAN J. HUM. SEXUALITY 1, 3 (2014) (discussing the significance of an open-minded approach as contrasted with a diagnostic approach); Florence Ashley, *Interrogating Gender-Exploratory Therapy*, 18 PERSPS. ON PSYCH. SCI. 472, 476-78 (2023) (distinguishing trans-supportive gender exploration from the so-called "gender exploratory therapy" that is akin to conversion therapy).

66. *SOC8*, *supra* note 1, at S50.

67. *See Endocrine Clinical Practice Guideline*, *supra* note 1, at 3871.

Social affirmation. This approach might entail adopting a new gender presentation through new attire, a new haircut, the use of chosen names and pronouns, and the use of gender-specific facilities.[68] This transition requires the active support of families and schools and can occur at any stage of life at which it would be beneficial.[69] Social affirmation is fully reversible.

Puberty blockers. These hormonal medicines temporarily halt the physical developments in sex characteristics linked with puberty.[70] For those experiencing persistent gender incongruence, blockers—which are ordinarily offered only at the onset of puberty[71]—offer more space for gender exploration. Blockers are fully reversible.[72] However, a decision to go from puberty blockers directly to hormone-replacement therapy (described below) can affect the potential for fertility preservation.[73]

Hormone-replacement therapy (HRT). During advanced stages of puberty, testosterone or estrogen can be used to affect secondary sex characteristics (such as hair and fat distribution) with the goal of aligning one's body with one's gender identity. Medical professionals currently recommend that HRT be offered only to those experiencing persistent gender incongruence.[74] The reversibility of these treatments varies: some effects can be fully reversible, while others (such

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68. Ashley, *Thinking an Ethics of Gender Exploration*, *supra* note 65, at 228.

69. *SOC8*, *supra* note 1, at S51-52 (detailing methods for social affirmation in supportive environments).

70. Ashley, *Thinking an Ethics of Gender Exploration*, *supra* note 65, at 229.

71. *Endocrine Clinical Practice Guideline*, *supra* note 1, at 3879.

72. *Id.*

73. Caroline Davidge-Pitts & Christine Burt Solorzano, *Transgender and Gender Diverse Children and Adolescents*, ENDOCRINE SOC'Y (Jan. 24, 2022), https://www.endocrine.org/patient-engagement/endocrine-library/transgender-and-gender-diverse-children-and-adolescents [https://perma.cc/BT9U-RJUL]. Blockers prevent the maturation of gametes during treatment and therefore may impair future fertility, particularly in patients who proceed to taking cross-sex gender-affirming hormones. *SOC8*, *supra* note 1, at S118 (recommending that healthcare professionals inform youth about blockers' potential adverse impacts on fertility). For pre- and early pubertal youth, the primary fertility-preservation options are ovarian or testicular tissue cryopreservation. Rebecca M. Harris, Michelle Bayefsky, Gwendolyn P. Quinn & Leena Nahata, *Fertility Preservation in Transgender and Non-Binary Youth*, *in* REPRODUCTION IN TRANSGENDER AND NONBINARY INDIVIDUALS: A CLINICAL GUIDE 97, 98 (Molly B. Moravek & Gene de Haan eds., 2023). Testicular tissue cryopreservation remains experimental. *Id.* Although ovarian tissue cryopreservation is no longer experimental, few live births after ovarian tissue cryopreservation have been reported. *Id.*

74. *See Endocrine Clinical Practice Guideline*, *supra* note 1, at 3871. Others argue for broad use of hormone-replacement therapy as part of gender exploration even in the absence of persistent gender incongruence. *See, e.g.*, Ashley, *Thinking an Ethics of Gender Exploration*, *supra* note 65, at 229-31.

as hair distribution) cannot.[75] Reversibility also depends on factors such as the duration of administration.[76]

Because HRT impacts the reproductive system and can have a temporary or lasting effect on fertility, the protocols require that adolescents be informed of available fertility-preservation methods, including sperm, oocyte, or embryo cryopreservation.[77] As mentioned, these options might be limited for those transitioning from puberty blockers directly to hormone therapy, although the majority of youth do not access blockers prior to HRT.[78]

Gender-affirming surgery. The surgical path is offered only to adolescents in the last stages of puberty who demonstrate the necessary emotional and cognitive maturity to understand fully these medical procedures, their risks, and their impacts.[79] There are various types of gender-affirming surgeries.[80] For youth, the most common surgical interventions are "top surgeries" (for example, creating a chest or breasts),[81] for which positive outcomes have been reported.[82]

Medical guidelines in the United States explicitly direct clinicians to postpone gender-affirming genital surgeries ("bottom surgeries"), such as gonadectomy or hysterectomy, until patients reach at least eighteen years of age or the legal age of majority.[83] However, there is evidence that some genital-related procedures have been performed on adolescents in contradiction to professional

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75. *See* Helene Frances Hedian, *Gender-Affirming Hormone Therapy (GAHT)*, Johns Hopkins Med., https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/gender-affirming-hormone-therapy-gaht [https://perma.cc/QJS9-CJZZ]; Cécile A. Unger, *Hormone Therapy for Transgender Patients*, 5 Translational Andrology & Urology 877, 880 (2016).

76. *See* Davidge-Pitts & Burt Solorzano, *supra* note 73.

77. Philip J. Cheng, Alexander W. Pastuszak, Jeremy B. Myers, Isak A. Goodwin & James M. Hotaling, *Fertility Concerns of the Transgender Patient*, 8 Translational Andrology & Urology 209, 210 (2019).

78. Michael F. Neblett II & Heather S. Hipp, *Fertility Considerations in Transgender Persons*, 48 Endocrinology Metabolism Clinics N. Am. 391, 394-96 (2019).

79. *SOC8*, *supra* note 1, at S64-66 (detailing conditions and considerations for surgical interventions).

80. Frances Grimstad, Elizabeth R. Boskey, Amir Taghinia & Oren Ganor, *Gender-Affirming Surgeries in Transgender and Gender Diverse Adolescent and Young Adults: A Pediatric and Adolescent Gynecology Primer*, 34 J. Pediatric & Adolescent Gynecology 442, 442-44 (2021).

81. *Id.* at 444.

82. Mahfouda et al., *supra* note 60, at 495.

83. *Endocrine Clinical Practice Guideline*, *supra* note 1, at 3872 ("We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country.").

standards of care, possibly in response to acute mental-health needs.[84] Limited evidence is available about the outcomes of vaginoplasty for youth, although small studies have found positive mental-health outcomes and reductions in gender dysphoria for adolescents who have undergone the surgery.[85]

There is no evidence to suggest that genital or other surgical intervention is regularly—or ever—performed on prepubescent or early-pubescent children.[86] Insurance data from 2019 to 2021 show that among forty million covered Americans, there were fifty-six insurance claims for bottom surgery and 776 claims for top surgery among patients ages thirteen to seventeen who had previously been diagnosed with gender dysphoria.[87] These claims represent 0.06% and 0.88%, respectively, of the total number of patients ages six to seventeen who were newly diagnosed with gender dysphoria during the same period.[88]

Access to gender-affirming care. Minors seeking gender-affirming care in the United States face significant obstacles. High costs, complex assessments, the need for insurance, and parental engagement limit some youths' access.[89] Economic challenges disproportionately affect trans youth of color, and current research suggests that most beneficiaries of gender-affirming care are white and middle class.[90] This demographic pattern thus implies racial disparities in access

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84. A 2017 survey of twenty surgeons affiliated with the World Professional Association for Transgender Health (WPATH) found that eleven had performed at least one vaginoplasty on minors during their entire careers; the youngest minor was fifteen years old. Christine Milrod & Dan H. Karasic, *Age Is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States*, 14 J. Sexual Med. 624, 626 (2017).

85. *Id.* at 625; *SOC8*, *supra* note 1, at S66.

86. *See* Robin Respaut & Chad Terhune, *Putting Numbers on the Rise in Children Seeking Gender Care*, Reuters (Oct. 6, 2022, 11:00 AM GMT), https://www.reuters.com/investigates/special-report/usa-transyouth-data [https://perma.cc/89WE-49J5]. This report analyzed the annual data of roughly forty million patients aged six to seventeen covered by private health plans and public insurance like Medicaid and found that, from 2019 to 2021, 88,389 of the surveyed patients were newly diagnosed with gender dysphoria. *Id.*

87. *Id.*

88. *See id.*

89. *See* Diana M. Tordoff, Jonathon W. Wanta, Arin Collin, Cesalie Stepney, David J. Inwards-Breland & Kym Ahrens, *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 JAMA Network Open art. no. e220978, at 2 (2022) (listing lack of insurance and travel time as barriers to care).

90. Jake Pyne, Thinkable Futures, Permissible Forms of Life: Listening to Talk About Trans Youth and Early Gender Transition 192, 204, 210 (2018) (Ph.D. dissertation, MacMaster University), https://macsphere.mcmaster.ca/bitstream/11375/23651/2/Pyne_Jake_M_finalsubmission2018September_PhD.pdf [https://perma.cc/4YUM-G5PY] (finding that the majority of youth in gender-identity clinics in the United States, Canada, and Europe are white).

to care.[91] Moreover, neurodiverse trans youth often face delays in treatment as clinicians question their cognitive maturity when their experiences do not align with the neurotypical narrative.[92]

To conclude, gender-affirming care for trans youth has evolved from efforts at psychological normalization to interventions aimed at supporting self-identified genders and encouraging gender exploration. The affirming approach emphasizes the importance of wide support networks, informed consent, and ongoing assessment. Our review demonstrates that, contrary to some media portrayals, gender-affirming surgeries are not commonly performed on minors or in violation of professional standards in the United States.[93] The far more prevalent treatments are nonsurgical social-affirmation and endocrinological interventions, such as using blockers and cross-sex hormones. Despite the accessibility obstacles and the lack of systemic review, empirical evidence underscores that gender-affirming care for trans youth supports minors' mental health and overall well-being.[94]

However, recent years have witnessed increasing debate over whether gender-affirming care protocols for minors effectively promote their health and well-being. For example, the *Cass Review*, a report on gender-affirming care for minors in England commissioned by the National Health Service, has featured concerns regarding the quality of the evidence on gender-affirming care.[95] The report claims to have reviewed all available research to conclude that the long-term outcomes of gender-affirming medical interventions for minors lack "good" evidence.[96] On the other hand, the *Cass Review* has been criticized for applying lower standards to the quality of evidence in support of nonaffirming approaches. Critics have noted, for instance, that the report excluded multiple studies demonstrating the benefits of early interventions and failed to

91. *Id.* at 192-93.

92. *Id.* at 66 (describing some clinicians' refusal to recommend transition for neurodiverse youth); *see also* John Parkinson, *Gender Dysphoria in Asperger's Syndrome: A Caution*, 22 Australasian Psychiatry 84, 85 (2014) (cautioning against approving gender-affirming care for young men with Asperger's syndrome).

93. *See, e.g.*, Mahfouda et al., *supra* note 60, at 496 (describing a gap between news reports about minors receiving gender-affirming surgeries and published data on the topic).

94. *Id.* (noting that available evidence indicates that gender-affirming care has positive mental-health benefits); *see also SOC8*, *supra* note 1, at S45-47 (providing a narrative review of the available evidence and noting its limitations).

95. Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report*, Cass Rev. 131-32 (Apr. 2024), https://cass.independent-review.uk/wp-content/uploads/2024/04/CassReview_Final.pdf [https://perma.cc/7NKE-XLPM].

96. *Id.* at 13.

substantiate its claims that certain treatments are controversial, ineffective, unsafe, or harmful.[97]

This is not to suggest that gender-affirming care for minors is exempt from the ongoing need for rigorous research and thoughtful refinement, just as is the case with any evolving field of medical practice or mental-health treatment. Continued study and assessment are essential to ensure that protocols remain grounded in the best available evidence and are effectively tailored to meet the diverse and changing needs of trans and gender-variant youth.[98] In any case, as this Article shows, "sex-normalizing" procedures for intersex minors lack evidence that they promote health and well-being. Yet legislators and the public fail to raise the same concerns about intersex interventions that they raise about gender-affirming care.[99]

2. *Intersex Minors: Sex and Gender Assignment*

Different conditions under the "intersex umbrella" are medically termed "Disorders of Sex Development" or the less pathologizing "Differences of Sex Development" (DSD). The latest consensus on DSD, from 2016, outlines a protocol for managing atypical genital development in infants, children, and youth. The protocol requires thorough clinical and biochemical assessments, including examinations of physical and genital attributes, analysis of hormones, and genetic tests.[100] A multidisciplinary team then uses these findings—considering factors such as potential adult gender identity, anticipated sexual function, fertility, gonadal malignancy risk, and more—to advise on sex assignment and the timing of any surgeries or hormone therapy.[101] In short, the consensus statement provides guidelines for physicians recommending (or not) sex-characteristic alterations to fit binary classifications. There are a number of possible interventions under this umbrella.

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97. *See* Cal Horton, *The Cass Review: Cis-Supremacy in the UK's Approach to Healthcare for Trans Children*, 2024 INT'L J. TRANSGENDER HEALTH art. no. 2328249, at 13-18; *see also* Daniel G. Aaron & Craig Konnoth, *The Future of Gender-Affirming Care—A Law and Policy Perspective on the Cass Review*, 392 NEW ENG. J. MED. 526, 526 (2025) (detailing how the *Cass Review* "transgresses medical law, policy, and practice").

98. For a discussion of evidence and expertise in trans youth care, see generally Joanna Wuest & Brianna S. Last, *Agents of Scientific Uncertainty: Conflicts over Evidence and Expertise in Gender-Affirming Care Bans for Minors*, 344 SOC. SCI. & MED. art. no. 116533 (2024).

99. *See infra* Section I.A.2 (describing standards of care for intersex minors); Section I.B.1 (identifying the bans' exclusions for sex-normalizing intersex procedures).

100. Peter A. Lee et al., *Global Disorders of Sex Development Update Since 2006: Perceptions, Approach and Care*, 85 HORMONE RSCH. PAEDIATRICS 158, 158-59 (2016).

101. *See id.* at 168-71.

Hormonal treatment primarily involves pubertal induction, hormone-replacement therapy at various ages, and, in some instances, pubertal suppression.[102] When relevant, surgery may include genital reconstruction or reduction (such as clitoroplasty, hypospadias repair, or phalloplasty), management of Müllerian structures (including the vagina and uterus), gonadal surgery (on the testes and ovaries), or refashioning of the perineum (perineoplasty).[103]

Unlike in gender-affirming care, surgical and endourological interventions for intersex minors typically begin at a very young age, usually before the age of two.[104] The 2016 consensus recognizes the controversy around the early timing of these procedures, given their irreversibility and patients' lack of choice.[105] Yet despite scholarly recognition that these practices lack an evidentiary basis, these procedures persist and have been difficult to change.[106]

This modern protocol grew out of a troubling medical history. A decade before opening the first gender-identity clinic in the United States, psychologist John Money and his colleagues at the Johns Hopkins Hospital co-founded the country's first institutional clinic for surgical sex reassignments—that is, sex-normalizing interventions.[107] Money and his team experimented on intersex, trans, and even cisgender minors to offer a new theory of gender neutrality.[108]

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102. *Id.* at 172.

103. *Id.* at 173-74.

104. Sarah Creighton, *Surgery for Intersex*, 94 J. Royal Soc'y Med. 218, 218 (2001); Ieuan A. Hughes, C. Houk, S.F. Ahmed & P.A. Lee, *Consensus Statement on Management of Intersex Disorders*, 91 Archives Disease Childhood 554, 557 (2006) (noting "[t]he generalisation that the age of 18 months is the upper limit of imposed gender reassignment").

105. Lee et al., *supra* note 100, at 176.

106. Nat Mulkey, Carl G. Streed, Jr. & Barbara M. Chubak, *A Call to Update Standard of Care for Children with Differences in Sex Development*, 23 AMA J. Ethics 550, 550, 552 (2021); *see* Fae Garland, Michael Thomson, Mitchell Travis & Joshua Warburton, *Management of 'Disorders of Sex Development'/Intersex Variations in Children: Results from a Freedom of Information Exercise*, 21 Med. L. Int'l 116, 145-46 (2021) (studying intersex interventions in England and criticizing their lack of evidence and the related ethical concerns they pose). *See generally* Peter Hegarty & Annette Smith, *Public Understanding of Intersex: An Update on Recent Findings*, 35 Int'l J. Impotence Rsch. 72 (2023) (studying public understandings of intersex characteristics); Emilie K. Johnson, Jax Whitehead & Earl Y. Cheng, *Differences of Sex Development: Current Issues and Controversies*, 50 Urology Clinics N. Am. 433 (2023) (providing an overview of nomenclature, diagnosis, and surgery related to differences of sex development).

107. Walker J. Magrath, *The Fall of the Nation's First Gender-Affirming Surgery Clinic*, 175 Annals Internal Med. 1462, 1462 (2022).

108. Maayan Sudai, *Revisiting the Limits of Professional Autonomy: The Intersex Rights Movement's Path to De-Medicalization*, 41 Harv. J.L. & Gender 1, 35 (2018); Gill-Peterson, *supra* note 29, at 99, 126, 130 (describing how John Money's experiments on intersex minors at Johns Hopkins formed the basis of transsexual medical practices, with children serving as "living laboratories" for gender theory, and including the case of a seventeen-year-old incarcerated individual subjected to early trans-related intervention).

According to Money's theory, a person's gender is malleable until eighteen months.[109] Therefore, infants born with an indeterminate sex ("hermaphrodites," as they were described at the time) should be assigned to a certain sex through surgery, hormones, and gender rearing.[110] "[D]oubts and perplexities" were an obstacle to developing a "healthy personality"; thus, Money thought, a thorough surgery should be done as soon as possible.[111] Money and other leading doctors at Johns Hopkins published several articles containing treatment recommendations for "hermaphrodites."[112]

One of Money's most infamous cases involved the alleged transformation of a seventeen-month-old baby boy into a baby girl using surgical, hormonal, and psychological methods of sex assignment.[113] David and Brian Reimer were identical twins who were neither trans nor intersex.[114] The twins were born with phimosis,[115] a foreskin condition that can affect urination in infants and result in pain during erection later in life.[116] To address this condition, David's parents sent him for medical circumcision at eight months of age; the procedure resulted

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109. *See* Joan G. Hampson, John Money & John L. Hampson, *Hermaphrodism: Recommendations Concerning Case Management*, 16 J. Clinical Endocrinology & Metabolism 547, 550 (1956).

110. Catherine L. Minto, Lih-Mei Liao, Christopher R.J. Woodhouse, Phillip G. Ransley & Sarah M. Creighton, *The Effect of Clitoral Surgery on Sexual Outcome in Individuals Who Have Intersex Conditions with Ambiguous Genitalia: A Cross-Sectional Study*, 361 Lancet 1252, 1252 (2003).

111. Hampson et al., *supra* note 109, at 551.

112. *See, e.g.*, John Money, Joan G. Hampson & John L. Hampson, *An Examination of Some Basic Sexual Concepts: The Evidence of Human Hermaphroditism*, 97 Bull. Johns Hopkins Hosp. 301, 319 (1955); Joan G. Hampson, *Hermaphroditic Genital Appearance, Rearing, and Eroticism in Hyperadrenocorticism*, 96 Bull. Johns Hopkins Hosp. 265, 273 (1955); John Money, Joan G. Hampson & John L. Hampson, *Sexual Incongruities and Psychopathology: The Evidence of Human Hermaphroditism*, 98 Bull. Johns Hopkins Hosp. 43, 55-56 (1955); John L. Hampson, Joan G. Hampson & John Money, *The Syndrome of Gonadal Agenesis (Ovarian Agenesis) and Male Chromosomal Pattern in Girls and Women: Psychologic Studies*, 97 Bull. Johns Hopkins Hosp. 207, 208 (1955); John Money, Joan G. Hampson & John L. Hampson, *Hermaphroditism: Recommendations Concerning Assignment of Sex, Change of Sex, and Psychologic Management*, 97 Bull. Johns Hopkins Hosp. 284, 299-300 (1955); Hampson et al., *supra* note 109, at 551.

113. John Money & Anke A. Ehrhardt, Man & Woman, Boy & Girl: The Differentiation and Dimorphism of Gender Identity from Conception to Maturity 118-19 (1972).

114. Alice D. Dreger & April M. Herndon, *Progress and Politics in the Intersex Rights Movement: Feminist Theory in Action*, 15 GLQ 199, 205 (2009).

115. Milton Diamond & Hazel Glenn Beh, *The Right to Be Wrong: Sex and Gender Decisions*, *in* Ethics and Intersex 103, 104 (Sharon E. Sytsma ed., 2006).

116. *Overview: Phimosis*, InformedHealth.org (May 12, 2023), https://www.ncbi.nlm.nih.gov/books/NBK326437 [https://perma.cc/CY3A-P5BX].

in harm beyond repair to David's penis.[117] In 1967, Money advised the parents to subject David to the sex-normalizing treatment protocol.[118] He directed the infant to genital surgery, ordered the parents to raise him as a girl, and later prescribed the use of hormonal therapy.[119] Over years of recurrent, intrusive, and at times abusive visits to his clinic, Money closely followed and encouraged both twins' gender-identity development: David as a girl (named Brenda) and Brian as a boy.[120]

The case was widely cited in lay media and medical textbooks to support the view that gender identity is open after birth for at least a year, as well as the practice of medically assigning babies to a certain sex.[121] Three decades later, the study was proven erroneous when it was revealed that David had realized very early that he was not a girl but felt obligated to satisfy his parents and doctors.[122] At some point, David refused further treatment, including further genital surgeries, and began identifying as a boy.[123] The case ended tragically for both twins: Brian died of a drug overdose at age thirty-six, and David died by suicide two years later, in 2004.[124] By that time, however, Money's recommendations had evolved into standard practice in U.S. hospitals and medical associations. Money and his experimental sex-normalizing treatments for infants were

117. JOHN COLAPINTO, AS NATURE MADE HIM: THE BOY WHO WAS RAISED AS A GIRL 11 (2000); Peggy T. Cohen-Kettenis, *As Nature Made Him: The Boy Who Was Raised as a Girl*, 342 NEW ENG. J. MED. 1457, 1457 (2000) (reviewing COLAPINTO, *supra*); Hazel Glenn Beh & Milton Diamond, *David Reimer's Legacy: Limiting Parental Discretion*, 12 CARDOZO J.L. & GENDER 5, 11 (2005).

118. John Money, *Ablatio Penis: Normal Male Infant Sex-Reassigned as a Girl*, 4 ARCHIVES SEXUAL BEHAV. 65, 67 (1975).

119. *Id.*

120. COLAPINTO, *supra* note 117, at 79-99.

121. *See, e.g.*, Rachel Witkin, *Hopkins Hospital: A History of Sex Reassignment*, JOHNS HOPKINS NEWS-LETTER (May 1, 2014), https://www.jhunewsletter.com/article/2014/05/hopkins-hospital-a-history-of-sex-reassignment-76004 [https://perma.cc/D9NZ-B7B7]; Money, *supra* note 118, at 66.

122. Milton Diamond & H. Keith Sigmundson, *Sex Reassignment at Birth: Long-Term Review and Clinical Implications*, 151 ARCHIVES PEDIATRICS & ADOLESCENT MED. 298, 299 (1997) (using the pseudonyms John and Joan in place of David's actual name).

123. COLAPINTO, *supra* note 117, at 141-43.

124. Associated Press, *David Reimer, 38, Subject of the John/Joan Case*, N.Y. TIMES (May 12, 2004), https://www.nytimes.com/2004/05/12/us/david-reimer-38-subject-of-the-john-joan-case.html [https://perma.cc/Y5FV-M9LR]; Elaine Woo, *David Reimer, 38; After Botched Surgery, He Was Raised as a Girl in Gender Experiment*, L.A. TIMES (May 13, 2004, 12:00 AM PT), https://www.latimes.com/archives/la-xpm-2004-may-13-me-reimer13-story.html [https://perma.cc/8KNE-P63V].

fundamental to developing modern protocols for both intersex and trans health care.[125]

As we have explained, current standards of trans health care have moved away from early assumptions that gender and sex are binary and must be normalized. Contemporary trans health care recognizes the complexity of gender identity as highly individual and unable to be imposed through early manipulation. Current standards of care focus on affirming an individual's self-identified gender through a patient-centered, informed-consent approach. This shift reflects a more nuanced perspective on gender identity as deeply rooted in one's sense of self, rather than as something that can be externally imposed. Such change is evident, for example, in the removal of requirements for sterilizing genital-related surgeries as a precondition for accessing medical interventions and, often, legal recognition.[126]

For intersex people, "normalization" of the kind described above often meant sterilization. Physicians' indifference to the possibility of infertility was commonplace. As Julie Greenberg notes, customary medical treatment of intersex bodies "renders them sterile or incapable of 'normal' sexual intercourse."[127] In 1993, intersex activists founded the Intersex Society of North America, a major patient-advocacy movement for intersex rights created to fight harmful medical practices for intersex people, particularly the practice of nonconsensual genital surgeries made for cosmetic reasons of "fixing" sex and gender.[128]

Intersex Society of North America and their followers advocated deferring medically unnecessary procedures to a time at which the patient can directly consent.[129] Although change was not immediate, the last decade has seen progress within and outside of international medical associations and institutions, as the standards of care for intersex children and those with DSD have gradually evolved to reflect these concerns.[130] Leading international institutions have denounced part—or all—of what was until recently the standard practice for

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125. GILL-PETERSON, *supra* note 29, at 16; Julie Greenberg, *Legal Aspects of Gender Assignment*, 13 ENDOCRINOLOGIST 277, 277 (2003).

126. *See* CURRAH, *supra* note 35, at 31-35; Ben-Asher, *supra* note 29, at 362; Ido Katri, *Sex Reclassification for Trans and Gender-Nonconforming People: From the Medicalized Body to the Privatized Self*, OXFORD RSCH. ENCYC. POL. 9-10 (July 29, 2019), https://oxfordre.com/politics/display/10.1093/acrefore/9780190228637.001.0001/acrefore-9780190228637-e-1229?print=pdf [https://perma.cc/K2NZ-L3TB].

127. Greenberg, *supra* note 125, at 280.

128. *Our Mission*, INTERSEX SOC'Y N. AM., https://isna.org [https://perma.cc/3PYG-EDE2].

129. *Id.*

130. *See* Maayan Sudai, *Changing Ethical and Legal Norms in the Management of Differences of Sex Development*, 5 LANCET DIABETES & ENDOCRINOLOGY 764, 766 (2017).

intersex babies and youth.[131] The United Nations and the European Union have made similar statements in their reports and campaigns.[132] Within the United States, proposed bills to protect intersex children from nonconsensual normalizing interventions have not materialized into enacted legislation.[133] However, significant voices within the U.S. medical community have called for a reexamination of and changes to existing standards,[134] and two prominent children's hospitals recently stated that they are dramatically revising their protocols.[135]

While there is still a long way to go, the ethical-legal baseline is slowly changing for intersex/DSD care, moving toward a standard of delaying medically unnecessary treatments until a later age. Still, by inscribing the logic of existing protocols into the law, the intersex exclusions in state-law bans on gender-affirming care for trans youth may hinder this already-slow change.

Our review shows that trans and intersex diagnoses and medical protocols share similar origins but are evolving along distinct paths. The intersex/trans dichotomy traces back to Dr. Money's work, which established criteria that differentiate between physical (intersex) and nonphysical (trans) conditions. Money's influence laid the groundwork for practices that are both invasive and life-altering, involving surgical and endocrinological interventions in sex characteristics.

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131. *See, e.g.*, *A Good First Step: Germany Adopts Law Banning IGM. But There Is Still Room for Improvement*, OII Europe (Mar. 30, 2021), https://www.oiieurope.org/a-good-first-step-germany-adopts-law-banning-igm [https://perma.cc/AJ4D-XKAS]; Tanya Ní Mhuirthile, *Malta*, *in* The Legal Status of Intersex Persons 357, 363-67 (Jens M. Scherpe, Anatol Dutta & Tobias Helms eds., 2018); Morgan Carpenter, *Protecting Intersex People from Harmful Practices in Medical Settings: A New Benchmark in the Australian Capital Territory*, 29 Australian J. Hum. Rts. 409, 409-10, 412-14 (2023).

132. *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement*, World Health Org. 1, 7-8 (2014), https://iris.who.int/bitstream/handle/10665/112848/9789241507325_eng.pdf?sequence=1&isAllowed=y [https://perma.cc/9A4H-WX2K]; *The Fundamental Rights Situation of Intersex People*, Eur. Union Agency for Fundamental Rts. 5-7 (Apr. 2015), https://fra.europa.eu/sites/default/files/fra_uploads/fra-2015-focus-04-intersex_en.pdf [https://perma.cc/LJC4-8V54].

133. *Intersex Legislation and Regulation*, interACT, https://interactadvocates.org/intersex-legislation-regulation [https://perma.cc/LW2T-YVKX] (listing national, state, and local bills impacting intersex rights).

134. *See, e.g.*, M. Joycelyn Elders, David Satcher & Richard Carmona, *Re-Thinking Genital Surgeries on Intersex Infants*, Palm Ctr.: Blueprints for Sound Pub. Pol'y 2 (June 2017), https://www.palmcenter.org/wp-content/uploads/2017/06/Re-Thinking-Genital-Surgeries-1.pdf [https://perma.cc/Y5WZ-YDHJ]; Mulkey et al., *supra* note 106, at 550.

135. *Intersex Care at Lurie Children's and Our Supportive Program for a Range of Urogenital Traits (SPROUT)*, Ann & Robert H. Lurie Child.'s Hosp. Chi. (July 28, 2020), https://www.luriechildrens.org/en/blog/intersex-care-at-lurie-childrens-and-our-sex-development-clinic [https://perma.cc/Y6CK-5EUR].

The modern approach to gender-affirming care prioritizes informed consent and reserves medical interventions for trans adolescents and adults. This approach, which recognizes the subjectivity of gender identity, is both evidence based and supported by advocates. In contrast, commonly used intersex care protocols, which often involve coercive sex assignments on infants too young to consent, still lack robust scientific evidence and remain highly contested among advocates.

This duality underscores both the shared foundation and the divergent evolution of care — affirming for trans individuals and coercive for intersex individuals. That trans and intersex interests are nonetheless intertwined is evidenced by the gender-affirming-care bans. Though the bans treat trans and intersex minors differently, they arise from the same belief in the naturalness of binary sex and from a legal and political landscape hostile to gender variance. Ultimately, these laws and the forces behind them bind trans and intersex legal struggles together.

B. Bans on Gender-Affirming Care

Gender-affirming-care bans generally prohibit any medical process of trans affirmation (which some lawmakers call sex or gender reassignment), including mental-health support, hormonal support, and most surgical procedures. The bans do not explicitly say that they target trans people. However, their underlying design prohibits trans access to affirming care: they define "sex" in terms of biologically dimorphic bodily characteristics,[136] and they define affirming care as including interventions that enable one to live or identify in a way "inconsistent with [one's] sex."[137] This approach constrains the ability of trans minors to access and consent to care that affirms their gender identities, which are marked by their incongruence with their birth-assigned sexes.

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136. *See, e.g.*, ARK. CODE ANN. § 20-9-1501(1) (2025) ("'Biological sex' means the biological indication of male and female in the context of reproductive potential or capacity, such as sex chromosomes, naturally occurring sex hormones, gonads, and nonambiguous internal and external genitalia present at birth, without regard to an individual's psychological, chosen, or subjective experience of gender . . . ."), *invalidated by* Brandt v. Rutledge, 677 F. Supp. 3d 877 (E.D. Ark. 2023); KY. REV. STAT. ANN. § 311.372(1)(b) (West 2024); TENN. CODE ANN. § 68-33-102(9) (2025); ALA. CODE § 26-26-3(3) (2025).

137. ALA. CODE § 26-26-4(a) (2025); TENN. CODE ANN. § 68-33-103(a)(1)(B) (2025); *see also* ARK. CODE ANN. § 20-9-1501(4) (2025) ("'Gender reassignment surgery' means any medical or surgical service that seeks to surgically alter or remove healthy physical or anatomical characteristics or features that are typical for the individual's biological sex, *in order to instill or create physiological or anatomical characteristics that resemble a sex different from the individual's biological sex*, including without limitation, genital or nongenital gender reassignment surgery performed for the purpose of assisting an individual with a gender transition." (emphasis added)), *invalidated by* Brandt v. Rutledge, 677 F. Supp. 3d 877 (E.D. Ark. 2023).

The bans prohibit a broad spectrum of medical interventions. They emphasize surgical interventions that are rarely performed and not recommended for treating trans minors—such as anatomical, genital-related,[138] or gonadal- or reproductive-related surgeries.[139] But they also include other treatments, such as cross-sex hormones and puberty-blocking drugs.[140]

Some laws also inhibit social transitioning. Some, for instance, require parental consent before doctors may provide sexual-health-related consultations, health services, or referrals.[141] And some prohibit schools from requiring their personnel to use pronouns that do not conform with a student's "unedited birth certificate."[142] These barriers to social transitioning further complicate trans minors' access to affirming care and support.

Consistent with their focus on trans minors, the bans do not apply to interventions unless they are done for the purpose of transgender affirmation. This means that cisgender minors, who are often the primary recipients of endocrinological treatments, are exempted from the bans.[143] The bans even explicitly exclude cosmetic surgery for cisgender minors, such as breast augmentations for females.[144] The bans' exclusion of intersex minors is even more troubling. Intersex minors are regularly subjected—without their consent—to the same surgical interventions that the bans imply are inappropriate for trans minors, especially surgeries related to genital modification.

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138. *See, e.g.*, ALA. CODE § 26-26-4(a)(4) to (5) (2025) (proscribing penectomy, metoidioplasty, phalloplasty, and vaginoplasty); ARK. CODE ANN. § 20-9-1502(a) (2025), *invalidated by* Brandt v. Rutledge, 677 F. Supp. 3d 877 (E.D. Ark. 2023); MO. REV. STAT. (2024) § 191.1720.2(5)(b) (prohibiting "[s]urgical procedures that artificially construct tissue with the appearance of genitalia that differs from the individual's biological sex").

139. *See, e.g.*, ALA. CODE § 26-26-4(a)(4) to (5) (2025) (proscribing orchiectomy and hysterectomy); MO. REV. STAT. § 191.1720.2(5) (2024).

140. *See, e.g.*, OKLA. STAT. tit. 63, § 2607.1(A)(2)(a)(2) (2024).

141. *See, e.g.*, FLA. STAT. § 456.52 (2024), *invalidated by* Doe v. Ladapo, 737 F. Supp. 3d 1240 (N.D. Fla. 2024).

142. *See, e.g.*, KY. REV. STAT. ANN. § 158.191(5)(b) (West 2024).

143. Susan D. Boulware, Rebecca Kamody, Laura Kuper, Meredithe McNamara, Christy Olezeski, Nathalie Szilagyi & Anne Alstott, *Biased Science in Texas & Alabama*, YALE SCH. MED. (2022), https://medicine.yale.edu/lgbtqi/clinicalcare/gender-affirming-care/biased-science [https://perma.cc/3RA4-SNRL] ("[S]imilar doses of exogenous sex hormones are commonly administered to cisgender individuals for a host of reasons and are well tolerated.").

144. *See, e.g.*, MO. REV. STAT. § 191.1720.2(5)(c) (2024) (specifying that the prohibition on "[a]ugmentation mammoplasty or subcutaneous mastectomy" applies only when done "for the purpose of assisting an individual with a gender transition").

1. Exclusions for Intersex Conditions

The bans, we argue, are not only anti-trans but also anti-intersex, as they effectively write into the law, for the first time, controversial sex-normalizing medical procedures for intersex minors.[145] While these laws do not *require* normalizing interventions for intersex minors, they enable doctors and parents to engage in nonconsensual procedures early in a child's life. Despite purporting to protect trans minors from interventions that might cause sterility or other harm, the bans expressly permit similar procedures for even younger children who cannot participate in the decision-making process. These intersex exclusions thus reveal the bans' internal incoherence — and their sex-normalizing purposes.

All enacted gender-affirming-care bans explicitly exclude intersex/DSD variations from their scope.[146] They mostly do so through generic exceptions, such as those for minors born with "a medically verifiable genetic disorder of sex development,"[147] biological sex characteristics that are "irresolvably ambiguous,"[148] or a "congenital defect."[149] The limitations these bans impose on parents and doctors in the trans-affirming-care context thus do not apply to intersex minors. As a result, it is imperative to understand the similarities and differences between gender-affirming care for trans minors and coercive medical interventions for intersex minors.

First, gender-affirming medical interventions are provided once a trans minor has begun puberty, and nongenital surgical interventions are not offered until the later stages of puberty. In contrast, medical sex assignment for intersex

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145. Medical interventions on intersex infants and minors have been performed for decades without explicit legal authorization or specific regulatory oversight, relying primarily on medical discretion and parental consent. *See* Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law's Failure to Protect Intersex Infants*, 21 BERKELEY J. GENDER L. & JUST. 59, 62-67 (2006); KATRINA KARKAZIS, FIXING SEX: INTERSEX, MEDICAL AUTHORITY, AND LIVED EXPERIENCE 45-46 (2008); ELIZABETH REIS, BODIES IN DOUBT: AN AMERICAN HISTORY OF INTERSEX 85-87 (2009) (discussing the history of medical interventions on intersex individuals without reference to formal legal oversight). Despite advocacy for legal protections, there has been a notable absence of formal statutory mandates governing these interventions.

146. *Mapping the Intersex Exceptions: Anti-Trans Legislation Across the United States Permits Rights Violations Against Intersex Children*, HUM. RTS. WATCH (Oct. 26, 2022), https://www.hrw.org/feature/2022/10/26/mapping-the-intersex-exceptions [https://perma.cc/9SEH-HK9K].

147. IDAHO CODE § 18-1506C(4)(c) (2025); KY. REV. STAT. ANN. § 311.372(3)(a) (West 2024); GA. CODE ANN. § 43-34-15(b)(2) (2024); OKLA. STAT. tit. 63, § 2607.1(A)(2)(b)(4) (2024).

148. ARIZ. REV. STAT. ANN. § 32-3230(B)(1) (2024); KY. REV. STAT. ANN. § 311.372(3)(a) (West 2024); MO. REV. STAT. § 191.1720(8)(1) (2024).

149. TENN. CODE ANN. § 68-33-103(b)(1)(A) (2025).

minors typically occurs before the age of two,[150] including highly intrusive and irreversible procedures.[151] These procedures include creating a vaginal opening, reducing the size of the clitoris, and removing hormone-producing gonads.[152]

While some intersex conditions result in infertility, for others, it is the normalizing surgeries—which often remove or damage reproductive organs—that destroy fertility.[153] In many cases, these surgeries are conducted for nonurgent reasons and are therefore highly controversial.[154] Coercive sex normalization has been challenged in courts[155] and by legislators.[156] Many intersex adults are also critical of performing these procedures at an early age and instead recommend postponing them.[157]

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150. *See* Creighton, *supra* note 104, at 218; Brief of interACT: Advocates for Intersex Youth et al. as Amici Curiae in Support of Respondent at 24-25, Gloucester Cnty. Sch. Bd. v. G.G. *ex rel.* Grimm, 580 U.S. 1168 (2017) (No. 16-273); KARKAZIS, *supra* note 145, at 57-58; *"I Want to Be Like Nature Made Me": Medically Unnecessary Surgeries on Intersex Children in the US*, HUM. RTS. WATCH AND INTERACT 48 (July 2017), https://www.hrw.org/sites/default/files/report_pdf/lgbtintersex0717_web_0.pdf [https://perma.cc/93UJ-6DBV].

151. *See* Sudai, *supra* note 108, at 8.

152. *See* Hughes et al., *supra* note 104, at 556-58.

153. *See What Is Intersex?*, INTERACT (Jan. 26, 2021), https://interactadvocates.org/faq [https://perma.cc/5CQ5-XVHP]; Rashi Kalra, Melissa Cameron & Catharyn Stern, *Female Fertility Preservation in DSD*, 33 BEST PRAC. & RSCH. CLINICAL ENDOCRINOLOGY & METABOLISM art. no. 101289, at 1-2 (2019); Nathalia Lisboa Gomes, Tarini Chetty, Anne Jorgensen & Rod T. Mitchell, *Disorders of Sex Development—Novel Regulators, Impacts on Fertility, and Options for Fertility Preservation*, 21 INT'L J. MOLECULAR SCIS. art. no. 2282, at 12 (2020).

154. Members of Congress have recognized that "babies and children with variations in their sex characteristics are often subjected, without their own informed consent or assent, to irreversible surgeries and other interventions to make their bodies conform to stereotypical expectations of what it means to appear, behave as, or be male or female." H.R. Res. 815, 118th Cong. (2023). Additionally, the resolution noted that "instances in which variations in sex characteristics necessitate surgery on an urgent basis in infancy or early childhood are exceedingly rare." *Id.*; *see also supra* note 106 and accompanying text (citing scholarly recognition that the benefits of many intersex procedures lack an evidentiary basis).

155. *See* Sudai, *supra* note 130, at 765 (citing M.C. *ex rel.* Crawford v. Amrhein, 598 F. App'x 143 (4th Cir. 2015)).

156. *See Intersex Legislation and Regulation*, *supra* note 133. For a comparative review of legal reforms from around the world, see Fae Garland & Mitchell Travis, *Legislating Intersex Equality: Building the Resilience of Intersex People Through Law*, 38 LEGAL STUD. 587, 588 (2018).

157. The extent to which intersex people support early surgeries varies based on the condition at issue and the framing of the question. One survey of 459 individuals with DSD conditions found great support for early surgical interventions among those with a diagnosis of congenital adrenal hyperplasia, as well as strong support for performing some surgeries at the age of legal consent, or during adolescence and adulthood. *See* Elena Bennecke, Stephanie Bernstein, Peter Lee, Tim C. van de Grift, Agneta Nordenskjöld, Marion Rapp, Margaret Simmonds, Jürg C. Streuli, Ute Thyen & Claudia Wiesemann, *Early Genital Surgery in*

Second, unlike trans youth, who often seek gender-affirming care, intersex patients themselves do not typically seek sex-normalizing surgeries. Instead, parents and doctors authorize interventions well before children are able to participate meaningfully in the decision. Parents and doctors justify performing these surgeries on intersex infants based on assumptions about the child's future preferences and the idea that sex normalization will secure the child's parental attachment.[158]

The bans thus demonstrate an inherent incoherence. Gender-affirming care aims to respect trans minors' preferences and lived experiences, but the bans prohibit this care where young people can — and do — consent to it. In contrast, sex-assignment surgeries for intersex babies deny them the option to participate in decision-making around their bodies and identities, yet the bans explicitly exclude such interventions. Juxtaposing the bans' approaches to trans and intersex minors reveals that these laws are not in fact structured to shield children from harmful bodily interventions or to protect their reproductive capacities. Instead, the bans target populations they identify as a threat to traditional gender norms and to the political infrastructure that supports those norms.

2. Regulating Doctors

The bans mostly enforce compliance by penalizing medical practitioners and healthcare providers.[159] Many bans begin by prohibiting any person from

Disorders/Differences of Sex Development: Patients' Perspectives, 50 ARCHIVES SEXUAL BEHAV. 913, 913, 917 figs.2-3, 919 fig.6(a) (2021).

158. Parents and doctors often justify performing sex-normalizing surgeries on intersex infants by asserting that early intervention promotes parental attachment. *See* Hughes et al., *supra* note 104, at 557. By surgically aligning the child's physical characteristics with societal expectations, they believe parents may experience less anxiety and form a stronger attachment to the child. *See id.* The rationale is that atypical genitalia can cause parental distress and uncertainty, potentially hindering the bonding process. ELLEN K. FEDER, MAKING SENSE OF INTERSEX: CHANGING ETHICAL PERSPECTIVES IN BIOMEDICINE 88 (2014) (explaining how medical professionals argue that early surgery can alleviate parental distress and promote attachment). However, these justifications have been challenged, suggesting that parents are coerced to consent in ways that in fact harm their attachment to their child. *Id.* at 88-93; KARKAZIS, *supra* note 145, at 96 (describing how parents, lacking context on these procedures, often rely on doctors and thus become unwilling agents of harm to their children).

159. *See, e.g.*, FLA. STAT. § 456.52(5)(b) (2024) ("Any health care practitioner who willfully or actively participates in a violation . . . commits a felony of the third degree [for performing prohibited gender-transition procedures on minors]."), *invalidated by* Doe v. Ladapo, 737 F. Supp. 3d 1240 (N.D. Fla. 2024); KY. REV. STAT. ANN. § 311.372(4) (West 2024) ("If a licensing or certifying agency for health care providers finds . . . that a health care provider who is licensed or certified by the agency has [performed a gender-transition procedure on a minor], the agency shall revoke the health care provider's licensure or certification."); MO. REV. STAT.

administering hormonal or surgical treatment for the purpose of gender reassignment for a "child"[160] or "minor"[161] (i.e., someone under eighteen).[162] The bans prohibit not only administering such treatments but also referring minors to any other healthcare provider to receive such care.[163]

The prohibitions are enforced via professional, criminal, and civil penalties. Medical practitioners who provide or facilitate gender-affirming procedures risk investigation and discipline by the examining board for "unprofessional conduct,"[164] and they may have their licenses or authority to practice revoked.[165] Civil penalties include withholding public funds, tax deductions, and reimbursements from entities, organizations, and individuals that "aid[] or abet[]" gender transition.[166] Some bans even expose doctors to criminal liability for practices intended to affirm a minor's gender; penalties for these violations may include imprisonment for up to five years.[167]

Bans on gender-affirming care also expose practitioners to liability for compensatory or special damages by making gender-transition procedures actionable in a civil suit.[168] In October 2024, Texas Attorney General Ken Paxton filed a civil lawsuit against Dr. May Chi Lau, accusing her of violating the state's ban by providing hormone treatments to minors.[169] The lawsuit seeks temporary and

§ 191.1720(5) (2024) ("The performance of gender transition surgery . . . shall be considered unprofessional conduct and . . . any health care provider doing so shall have his or her license to practice revoked . . . ."); TEX. HEALTH & SAFETY CODE ANN. § 161.702 (West 2023) ("[A] physician or health care provider may not knowingly . . . perform a surgery that sterilizes the child [or else they may face an enforcement action by the Attorney General]."). Some bans penalize other entities, such as insurance companies. *See, e.g.*, ARK. CODE ANN. § 23-79-166 (2025) (prohibiting insurance companies from reimbursing "gender transition procedures for a person under eighteen (18) years of age"), *invalidated by* Brandt v. Rutledge, 677 F. Supp. 3d 877 (E.D. Ark. 2023).

160. *See, e.g.*, OKLA. STAT. tit. 63, § 2607.1(A)(1) (2024).

161. *See, e.g.*, IOWA CODE § 147.164(1)(c) (2024).

162. *See, e.g.*, MO. REV. STAT. § 191.1720 (2024); FLA. ADMIN. CODE ANN. r. 64B8-9.019(1)(a) (2025); IND. CODE § 25-1-22-6 (2024).

163. *See, e.g.*, ARK. CODE ANN. § 20-9-1502(a) to (b) (2025), *invalidated by Brandt*, 677 F. Supp. 3d 877; *see also* IOWA CODE § 147.164(2) (2024) (prohibiting healthcare professionals from "knowingly engag[ing] in or caus[ing]" gender-transition procedures, and also from "knowingly engag[ing] in conduct that aids or abets" such procedures).

164. *See, e.g.*, MONT. CODE ANN. § 50-4-1004(2)(a) (2023).

165. *See, e.g.*, S.D. CODIFIED LAWS § 34-24-36 (2025).

166. MISS. CODE ANN. § 41-141-5(2) (2024); *see id.* § 41-141-7.

167. *See, e.g.*, FLA. STAT. § 456.52(5)(b) (2024), *invalidated by* Doe v. Ladapo, 737 F. Supp. 3d 1240 (N.D. Fla. 2024).

168. *See, e.g.*, OKLA. STAT. tit. 63 § 2607.1(E)(1) (2024); MISS. CODE ANN. § 41-149-9 (2024).

169. Petition and Request for an Application for Temporary and Permanent Injunctions at 12-26, State v. Lau, No. 493-07676-2024 (Tex. Dist. Ct. Oct. 17, 2024).

permanent injunctions against Dr. Lau's practice, as well as civil penalties totaling $210,000.[170] Through the suit, Texas aims to signal strict enforcement of its ban.[171]

3. Regulating Parents

Although the bans primarily regulate medical practitioners, they also directly and indirectly regulate the conduct of parents who consent to or otherwise facilitate gender-affirming care for their children. By prohibiting affirming care, the bans limit parents' ability to participate in their children's medical decisions. In fact, the bans make it unlawful for *any individual* to facilitate minors' gender-affirming procedures, applying not only to parents but also to any teachers, guardians, or other caretakers who seek to affirm a minor's gender identity.[172] Several statutes, moreover, explicitly state that parental consent is not a defense to liability for providing prohibited care.[173] While some laws do explicitly affirm parental rights, the relevant provisions support only parents who refuse gender-affirming procedures or seek disclosure of information about their children's gender nonconformity.[174]

At its most extreme, enforcement of these laws may involve threatening to disrupt parental custody. The most notorious example is Texas Governor Greg Abbott's instruction to investigate and report parental facilitation of gender-affirming care as child abuse.[175] Abbott's directive relied on an opinion by the state's attorney general that gender-affirming care fit the definition of "abuse" in

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170. *Id.* at 33 (seeking $10,000 per violation, with a total of twenty-one violations).

171. Press Release, Att'y Gen. of Tex., Attorney General Ken Paxton Sues Doctor for Illegally Providing Harmful "Gender Transition" Treatments to Nearly Two Dozen Texas Children (Oct. 17, 2024), https://www.texasattorneygeneral.gov/news/releases/attorney-general-ken-paxton-sues-doctor-illegally-providing-harmful-gender-transition-treatments [https://perma.cc/8ZQF-7SCP].

172. *See, e.g.*, ALA. CODE § 26-26-4(a) (2025) ("[N]o person shall engage in or cause [gender-transition] practices to be performed upon a minor . . . ."); MISS. CODE ANN. § 41-141-5(2) (2024) ("A person shall not knowingly engage in conduct that aids or abets the performance or inducement of gender transition procedures to any person under eighteen (18) years of age.").

173. *See, e.g.*, TENN. CODE ANN. § 68-33-103(c)(1) (2025) ("It is not a defense to any legal liability incurred as the result of a violation of this section that the minor, or a parent of the minor, consented to the conduct that constituted the violation.").

174. *See, e.g.*, ALA. CODE § 26-26-5 (2025) (barring school officials from withholding information about students' gender nonconformity and from encouraging children to withhold this information).

175. Letter from Greg Abbott, Governor of Tex., to Jaime Masters, Comm'r, Tex. Dep't of Fam. & Protective Servs. 1 (Feb. 22, 2022), https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf [https://perma.cc/BT7K-REPW].

the Texas Family Code.[176] By August 2022, eleven investigations were initiated against Texas families with trans children, though none resulted in child removal.[177] Legal challenges eventually led to a Texas Supreme Court ruling, which upheld an injunction preventing child-welfare agencies from investigating individual plaintiffs but allowed investigations to continue statewide.[178] In March 2024, the intermediate court of appeals further blocked investigations into families with trans children.[179]

C. The Pillars of Constitutional Debates

As in Texas, prominent civil-rights organizations — including Lambda Legal, the American Civil Liberties Union, and GLBTQ Legal Advocates & Defenders — and the U.S. government under the Biden Administration have swiftly responded to the bans by challenging their constitutionality in federal and state courts across the country.[180] The plaintiffs in these cases are trans minors, their supportive parents, and doctors offering gender-affirming care. These challenges raise three constitutional arguments: (1) that the bans violate the Equal Protection Clause by discriminating against trans minors in health care,[181] (2) that they violate parents' substantive-due-process rights to make decisions for

176. Tex. Op. Att'y Gen. No. KP-0401, at 1-2 (Feb. 18, 2022), https://texasattorneygeneral.gov/sites/default/files/global/KP-0401.pdf [https://perma.cc/E95B-5H6R].

177. Will DuPree, *8 Child Abuse Investigations Involving Texas Families with Trans Children Closed, No Kids Removed*, KXAN (Aug. 23, 2022), https://www.kxan.com/news/texas/8-child-abuse-investigations-involving-texas-families-with-trans-children-closed-no-kids-removed [https://perma.cc/SK5F-4H2C].

178. *In re* Abbott, 645 S.W.3d 276, 283-84 (Tex. 2022).

179. Abbott v. Doe, 691 S.W.3d 55, 93 (Tex. App. 2023).

180. *Bans on Best Practice Medical Care for Transgender Youth*, Movement Advancement Project (Feb. 2, 2025), https://www.mapresearch.org/equality-maps/healthcare/youth_medical_care_bans [https://perma.cc/D6TS-M895] (detailing all enacted bans and litigation). This data is current as of publication, but the Movement Advancement Project regularly updates its data.

181. Complaint at 20, Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131 (M.D. Ala. 2022) (No. 22-CV-184) [hereinafter *Eknes-Tucker* Complaint]; Complaint at 27, Poe v. Drummond, 697 F. Supp. 3d 1238 (N.D. Okla. 2023) (No. 23-CV-177) [hereinafter *Drummond* Complaint]; Complaint at 41, Brandt v. Rutledge, 677 F. Supp. 3d 877 (E.D. Ark. 2023) (No. 21-CV-450) [hereinafter *Brandt* Complaint]; Complaint at 24, Doe v. Thornbury, 679 F. Supp. 3d 576 (W.D. Ky. 2023) (No. 23-CV-230) [hereinafter *Thornbury* Complaint]; Complaint at 42, Koe v. Noggle, 688 F. Supp. 3d 1321 (N.D. Ga. 2023) (No. 23-CV-2904) [hereinafter *Noggle* Complaint].

their children,[182] and (3) that they infringe on the free-speech rights of medical professionals by limiting their ability to offer medical advice and care.[183]

Although trans minors are often the plaintiffs at the forefront of this litigation, the rights and interests of parents and doctors remain crucially involved. As the petition for certiorari in *Skrmetti* explains, the bans "inflict profound harms on transgender adolescents and their families by denying medical treatments that the affected adolescents, their parents, and their doctors have all concluded are appropriate and necessary to treat a serious medical condition."[184] Because the Supreme Court will decide only the question of equal protection, however, this Section focuses primarily on how lower courts have responded to litigants' equal-protection challenges.

Equal protection requires that the law treat similarly situated people the same. The plaintiffs thus argue that the bans violate trans minors' equal-protection rights by withholding from them health care available to other similarly situated minors.[185] Plaintiffs argue that the bans accomplish this by classifying minors based on their sex or trans status. The type of classification imposed determines the degree of scrutiny that courts apply in reviewing laws challenged under the Equal Protection Clause. Courts typically apply one of three levels of scrutiny: strict scrutiny (the highest level of review) for cases involving suspect classifications such as race or national origin; intermediate scrutiny for cases involving quasi-suspect classifications; or rational-basis review for all other challenges. To satisfy intermediate scrutiny, the government must show that the law is substantially related to an important governmental interest.[186] Under rational-basis review, the most deferential level of review, laws might fail if they arise from group-based animus or are not rationally related to the interests they purportedly further.[187] Courts have thus far applied either rational-basis review or intermediate scrutiny to the bans, depending on whether they find that the bans classify based on sex and whether they recognize trans status as a quasi-suspect classification.

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182. *Eknes-Tucker* Complaint, *supra* note 181, at 4; *Drummond* Complaint, *supra* note 181, at 29; *Brandt* Complaint, *supra* note 181, at 43; *Thornbury* Complaint, *supra* note 181, at 23; *Noggle* Complaint, *supra* note 181, at 29.

183. Complaint at 33, L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668 (M.D. Tenn. 2023) (No. 23-cv-00376) [hereinafter *Skrmetti* Complaint]; *Brandt* Complaint, *supra* note 181, at 44.

184. Petition for a Writ of Certiorari, *supra* note 10, at 16.

185. *Eknes-Tucker* Complaint, *supra* note 181, at 31-32; *Drummond* Complaint, *supra* note 181, at 7; *Brandt* Complaint, *supra* note 181, at 41; *Thornbury* Complaint, *supra* note 181, at 21; *Noggle* Complaint, *supra* note 181, at 42.

186. Kenji Yoshino, *The New Equal Protection*, 124 HARV. L. REV. 747, 755-56 (2011).

187. *Id.* at 760.

In this Section, we identify courts' two predominant approaches to these equal-protection challenges: the trans-affirming approach and the state-centered approach. We use federal district courts' decisions from Tennessee, Arkansas, Alabama, Kentucky, Idaho, and Florida to illustrate the trans-affirming judicial approach. In contrast, we examine the state-centered approach through decisions from the Sixth and Eleventh Circuits.

1. The Trans-Affirming Approach

We consider a court's analysis to be trans-affirming insofar as it recognizes and respects the experiences and identities of trans minors, declines to validate harmful stereotypes about gender-affirming care, and upholds trans people's equality interests. A trans-affirming approach emphasizes the reality of trans experiences rather than relying on assumptions that gender nonconformity harms third parties or warrants moral disapproval. Crucially, trans-affirming legal analysis acknowledges that legal and social understandings of sex and gender are intertwined, complex, and socially implicated and that binary classifications can be exclusionary and harmful. While we do not suggest that these courts have fully incorporated the perspective of trans advocacy, we do identify a consistent trans-affirming analysis in the ways their decisions reflect certain principles.

Decisions by federal district courts in Tennessee,[188] Arkansas,[189] Alabama,[190] Kentucky,[191] Idaho,[192] and Florida[193] exemplify this trans-affirming approach. These courts have adopted the plaintiffs' equal-protection position and have held that their state bans fail intermediate scrutiny. Some have found the states' asserted interests to be pretextual, and others have gone so far as to conclude that the bans are motivated by animus toward trans people.[194] Notably, the district courts have nearly unanimously held the bans unconstitutional.

The Eighth Circuit has similarly adopted the trans-affirming approach and affirmed the Arkansas district court's equal-protection analysis in its ruling on a

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188. L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 677 (M.D. Tenn. 2023), *rev'd*, 83 F.4th 460 (6th Cir. 2023), *cert. granted sub nom.* United States v. Skrmetti, 144 S. Ct. 2679 (2024).

189. Brandt v. Rutledge, 677 F. Supp. 3d 877, 922 (E.D. Ark. 2023).

190. Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131, 1146-48 (M.D. Ala. 2022), *vacated sub nom.* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205 (11th Cir. 2023).

191. Doe v. Thornbury, 679 F. Supp. 3d 576, 582-86 (W.D. Ky. 2023), *rev'd sub nom.* L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460 (6th Cir. 2023).

192. Poe *ex rel.* Poe v. Labrador, 709 F. Supp. 3d 1169, 1191-99 (D. Idaho 2023), *stayed in part*, 144 S. Ct. 921 (2024).

193. Doe v. Ladapo, 737 F. Supp. 3d 1240, 1282-84 (N.D. Fla. 2024), *stayed sub nom.* Doe v. Surgeon Gen., No. 24-11996, 2024 WL 4132455 (11th Cir. Aug. 26, 2024).

194. *Id.* at 1273-75.

preliminary injunction.[195] The Ninth Circuit's denial of a motion to stay the preliminary injunction issued by the Idaho district court further suggests support for the goals of the trans-affirming approach, even if the Ninth Circuit has not expressly adopted a trans-affirming analysis.[196]

These district courts and the Eighth Circuit held that the bans violate trans minors' equal-protection rights. In doing so, their opinions recognized trans plaintiffs' gender identities and rejected the discriminatory assumptions underlying the legislation. This evidence-based focus and rejection of harmful stereotypes underscores these courts' respect for trans minors' lived experiences and their equality interests.

The Arkansas district court rejected harmful stereotypes by holding that the ban's sex-based classifications constitute sex discrimination.[197] The Tennessee district court also recognized that the state's ban reflects facial sex discrimination: it defines the prohibited procedures based on the patient's sex assigned at birth, and it does so explicitly by including in its language a distinction based on sex.[198] For instance, Tennessee's ban prohibits hormonal interventions only when provided "for the purpose" of "[e]nabling" an adolescent to identify with a gender "inconsistent with the minor's sex" or treating distress "from a discordance between the minor's sex and asserted identity."[199]

In vindicating trans individuals' equality interests, some district courts adopted the reasoning of *Bostock v. Clayton County*, applying its logic to the equal-protection context and concluding that the bans discriminate on the basis of sex because they restrict care only for trans minors seeking to affirm their gender identity.[200] In *Bostock*, the Court held that anti-trans discrimination is discrimination based on sex under Title VII, reasoning that treating people differently because they are trans necessarily requires treating them differently because of their sex.[201] That is, when a trans woman is discriminated against for being trans, she is treated differently than other women because she, unlike them, was

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195. Brandt *ex rel.* Brandt v. Rutledge, 47 F.4th 661, 671-72 (8th Cir. 2022).

196. *See Labrador* Denial of Stay, *supra* note 9, at 1.

197. Brandt v. Rutledge, 677 F. Supp. 3d 877, 917-18 (E.D. Ark. 2023); *see also Brandt*, 47 F.4th at 669-70 (affirming the district court's analysis on the level of equal-protection scrutiny).

198. L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 687 (M.D. Tenn. 2023), *rev'd*, 83 F.4th 460 (6th Cir. 2023), *cert. granted sub nom.* United States v. Skrmetti, 144 S. Ct. 2679 (2024).

199. Tenn. Code Ann. § 68-33-103(a)(1)(A) to (B) (2025).

200. *Skrmetti*, 679 F. Supp. 3d at 695. Referencing the Eighth Circuit's affirmation of the Arkansas district court's decision, the Georgia district court explained that the state's ban unlawfully differentiates minors based on "sex at birth," despite there being no explicit sex-based classification in the legislation. *See* Koe v. Noggle, 688 F. Supp. 3d 1321, 1344 (N.D. Ga. 2023) (citing *Brandt*, 47 F.4th at 670).

201. Bostock v. Clayton County, 590 U.S. 644, 660 (2020).

assigned male at birth.[202] Although the Supreme Court has not formally extended *Bostock* to the equal-protection context, the underlying logic is the same. Under the bans, a transmasculine adolescent assigned female at birth cannot receive puberty blockers or testosterone, but an adolescent assigned male at birth can.[203]

Emphasizing the medical consensus, district courts have acknowledged that gender-affirming care is evidence based and medically necessary.[204] These findings further supported these courts' treatment of transgender status as a quasi-suspect class.[205] The Fourth Circuit had previously held that transgender status is a quasi-suspect classification in a case involving trans students' ability to use school bathrooms corresponding with their gender identities.[206] As the Fourth Circuit explained, transgender status satisfies the four factors required to recognize a suspect or quasi-suspect class: (1) trans people have faced discrimination in employment, housing, health care, and education;[207] (2) being trans does not affect one's ability to contribute to society;[208] (3) the incongruence between gender identity and assigned sex at birth is an immutable or distinguishing characteristic;[209] and (4) trans people lack political power.[210]

District courts have accordingly held that the bans warrant intermediate scrutiny, either because they classify based on sex or because they "explicitly target" the quasi-suspect class of transgender persons.[211] In rejecting sex-based classification and unmasking the differential treatment of gender-affirming care, some courts have avoided grounding their analyses in the belief that sex is an immutable biological binary. The Tennessee district court's findings support the position that such essentialist views fail to account for the medical and social realities

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202. *Id.*

203. *See* Petition for a Writ of Certiorari, *supra* note 10, at 19.

204. Brandt v. Rutledge, 677 F. Supp. 3d 877, 889-90, 917-25 (E.D. Ark. 2023); Poe *ex rel.* Poe v. Labrador, 709 F. Supp. 3d 1169, 1181-82 (D. Idaho 2023), *stayed in part*, 144 S. Ct. 921 (2024); Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131, 1139 (M.D. Ala. 2022), *vacated sub nom.* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205 (11th Cir. 2023).

205. *Brandt*, 677 F. Supp. 3d at 889-90, 917-18, 922; *Poe*, 709 F. Supp. 3d at 1191; *Eknes-Tucker*, 603 F. Supp. 3d at 1145, 1147.

206. Grimm v. Gloucester Cnty. Sch. Bd., 972 F.3d 586, 613 (4th Cir. 2020).

207. *Id.* at 611-12.

208. *Id.* at 612.

209. *Id.*

210. *Id.* at 613.

211. *See, e.g.*, Doe v. Ladapo, 737 F. Supp. 3d 1240, 1269 (N.D. Fla. 2024), *stayed sub nom.* Doe v. Surgeon Gen., No. 24-11996, 2024 WL 4132455 (11th Cir. Aug. 26, 2024).

experienced by trans individuals.[212] The Florida district court went the furthest by invoking footnote four of *Carolene Products*,[213] finding that the bans are subject to intermediate scrutiny because trans people are a discrete and insular minority suffering from governmental discrimination.[214] Each federal court that applied intermediate scrutiny under the trans-affirming approach held that the state law it considered failed constitutional review.[215]

Further, the Florida district court in a subsequent decision in the same case held that the ban was motivated by animus against transgender individuals and so invalidated the law under rational-basis review, in addition to concluding that it should fail intermediate scrutiny.[216] It held that even if the ban purportedly sought to safeguard minors' health, it also aimed to protect others from those receiving affirming care and enforced a moral view, neither of which were legitimate state interests.[217] And the Tennessee district court similarly held that the bans were not substantially related to a state interest in protecting minors' welfare.[218] Because the evidence indicated that gender-affirming care posed little risk to trans minors, the court concluded that restricting this health care did not promote trans minors' health and well-being.[219]

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212. *See* L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 689, 691 (M.D. Tenn. 2023), *rev'd*, 83 F.4th 460 (6th Cir. 2023), *cert. granted sub nom.* United States v. Skrmetti, 144 S. Ct. 2679 (2024).

213. United States v. Carolene Prods. Co., 304 U.S. 144, 152 n.4 (1938).

214. Doe v. Ladapo, 676 F. Supp. 3d 1205, 1218-19 (N.D. Fla. 2023), *appeal dismissed sub nom.* Doe v. Surgeon Gen., No. 23-12159, 2024 WL 5274658 (11th Cir. July 8, 2024); *see also Ladapo*, 737 F. Supp. 3d at 1267-68 (invoking footnote four of *Carolene Products* in a subsequent decision in the same case).

215. *See Ladapo*, 737 F. Supp. 3d at 1283; Poe *ex rel.* Poe v. Labrador, 709 F. Supp. 3d 1169, 1193-95 (D. Idaho 2023), *stayed in part*, 144 S. Ct. 921 (2024); Koe v. Noggle, 688 F. Supp. 3d 1321, 1349, 1356 (N.D. Ga. 2023).

216. *Ladapo*, 737 F. Supp. 3d at 1282-84. The district court adopted this analysis after the Eleventh Circuit held in a separate case that gender-affirming-care bans are not subject to intermediate scrutiny. *See* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1231 (11th Cir. 2023); *see also Ladapo*, 737 F. Supp. 3d at 1266-68 (indicating that the district court would have applied intermediate scrutiny absent *Eknes-Tucker*).

217. *Ladapo*, 737 F. Supp. 3d at 1283 (stating that "gender-affirming care causes no harm to others" and that enforcing the view that "transgenderism—and thus gender-affirming care—is morally wrong" is "not . . . a legitimate state interest that can sustain this statute").

218. L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 710 (M.D. Tenn. 2023), *rev'd*, 83 F.4th 460 (6th Cir. 2023), *cert. granted sub nom.* United States v. Skrmetti, 144 S. Ct. 2679 (2024).

219. *Id.* at 709.

States justified their bans by arguing that gender-affirming care's effectiveness is unproven,[220] that the treatment carries risks,[221] that gender dysphoria may resolve itself naturally,[222] that minors may later regret irreversible treatments,[223] and that patients might receive care absent informed consent.[224] The Florida district court rejected these justifications, concluding that gender-affirming care is supported by persuasive research and leading medical organizations and noting that its risks are comparable to those of other medical interventions excluded from the ban's prohibition.[225] These courts' refusals to entertain harmful stereotypes about gender-affirming care — such as the notion that it is inherently risky or experimental — underscore their trans-affirming approach.

Notably, however, none of these courts considered whether the exclusion of intersex interventions from the bans constituted discrimination. While they recognized that allowing only cisgender youth to access gender-related medical interventions discriminates against trans minors, the courts overlooked the distinct harms that intersex minors face as a result of the bans' exclusionary provisions. By focusing solely on the cis/trans binary, the courts — and the trans-affirming approach — neglect the coerced medical interventions imposed on intersex individuals, thus failing to address the broader complexities of sex, gender, and intersectional discrimination.

2. *The State-Centered Approach*

We consider a court's analysis to be state-centered insofar as it focuses primarily on the state's asserted interests, often accepting claims about protecting minors and medical ethics without critically examining whether the asserted state interests are legitimate, pretextual, or rooted in animus. A state-centered approach tends to prioritize governmental authority and discretion in regulating health and welfare and thus risks neglecting the lived experiences of trans minors and the broader harmful impacts of the bans.

Crucially, a state-centered legal analysis often presumes that sex is a fixed, natural, and neutral category. It relies on the belief that sex is a biological binary, disregarding the complexities of gender identity in ways that can reinforce

220. *See, e.g.*, *Poe*, 709 F. Supp. 3d at 1193.

221. *See, e.g.*, *id.* at 1193-94.

222. *See, e.g.*, Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131, 1142-43 (M.D. Ala. 2022), *vacated sub nom.* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205 (11th Cir. 2023).

223. *See, e.g.*, Doe v. Ladapo, 737 F. Supp. 3d 1240, 1291-92 (N.D. Fla. 2024), *stayed sub nom.* Doe v. Surgeon Gen., No. 24-11996, 2024 WL 4132455 (11th Cir. Aug. 26, 2024).

224. *See, e.g.*, *id.* at 1287.

225. *Id.* at 1258-59.

legislative policies that discriminate against transgender individuals. While we do not suggest that these courts intend to discriminate, we identify a state-centered analysis in the ways their decisions reflect these assumptions.

The Sixth and Eleventh Circuits' opinions lifting preliminary injunctions against the bans in Tennessee,[226] Kentucky,[227] and Alabama[228] reflect this state-centered approach. These courts rejected claims that the bans merit heightened scrutiny, instead subjecting them only to rational-basis review.[229] Invoking the Supreme Court's decision in *Dobbs*, they emphasized that states are entitled to broad discretion and a strong presumption of validity for health and welfare regulations.[230] Under this approach, the courts dismissed the plaintiffs' equal-protection challenges to the bans.

These courts, applying a state-centered analysis, held that the bans do not discriminate based on sex or transgender status and therefore do not warrant heightened scrutiny. By relying on fixed notions of sex as a natural binary, the courts accepted the states' justifications without carefully examining whether they were pretextual or rooted in animus. The courts thus upheld the bans under rational-basis review, deferring to the states' asserted interests in protecting minors and regulating medical practices.

The courts first responded to the argument that the bans rely on sex-based classifications that warrant intermediate scrutiny. The Sixth Circuit reasoned that if the *Dobbs* majority declined to apply heightened scrutiny to a state's restriction of a medical treatment applicable to only one sex (i.e., abortion), so, too, should a court evaluating a prohibition on gender-affirming care.[231] A ban that applies to "all minors, regardless of sex," the Sixth Circuit explained, does not trigger such scrutiny.[232]

Judge White dissented, arguing that the bans, unlike facially neutral anti-abortion laws, clearly classify by sex and thus warrant intermediate scrutiny.[233] The majority, however, held that sex-based classifications trigger heightened

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226. L.W. *ex rel.* Williams v. Skrmetti, 73 F.4th 408, 413 (6th Cir. 2023) (granting a stay of the Tennessee district court's preliminary injunction).

227. Doe v. Thornbury, 75 F.4th 655, 657 (6th Cir. 2023) (denying a motion to lift a stay of the Kentucky district court's preliminary injunction).

228. Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1231 (11th Cir. 2023) (vacating the Alabama district court's preliminary injunction).

229. *See id.* at 1227-28; L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 486 (6th Cir. 2023), *cert. granted sub nom.* United States v. Skrmetti, 144 S. Ct. 2679 (2024).

230. *See Skrmetti*, 83 F.4th at 473; *Eknes-Tucker*, 80 F.4th at 1224.

231. *Skrmetti*, 83 F.4th at 481.

232. *Id.* at 480.

233. *Id.* at 505 (White, J., dissenting).

scrutiny only when they "perpetuate[] invidious stereotypes or unfairly allocate[] benefits and burdens."[234] The majority explained that the bans' sex-based classification reflects "enduring" differences between males and females that require different treatment courses.[235] In other words, they viewed sex as a natural and neutral binary.[236] Moreover, the court reasoned that by defining sex based on immutable, dimorphic reproductive characteristics, the bans distinguished based on the nature of the prohibited intervention rather than discriminating against trans individuals.[237]

The Sixth Circuit majority also rejected *Bostock*'s applicability — an argument raised by the dissent[238] — and held that *Bostock*'s analysis applies only in the Title VII context.[239] Thus, the court concluded, the bans do not discriminate based on trans minors' birth-assigned sex. The Sixth Circuit further declined to recognize transgender status as a quasi-suspect classification subject to intermediate scrutiny in its own right. In addition to relying on detransitioners' stories as evidence that transgender identities are not immutable, the majority also explained that transgender individuals are not a discrete group given the diversity of gender identities and experiences and that transgender people do not lack political power.[240] The Eleventh Circuit relied on similar reasoning to reach the same conclusions.[241]

Both circuits held that the bans survive rational-basis review, reasoning that the laws serve legitimate state interests and appropriately draw distinctions based on age, medical diagnosis, and care protocols.[242] The Eleventh Circuit concluded that Alabama has a clear interest in "safeguarding the physical and psychological well-being" of minors, making it "exceedingly likely" that the

234. *Id.* at 484 (majority opinion) (citing J.E.B. v. Alabama *ex rel.* T.B., 511 U.S. 127, 131, 137 (1994)).

235. *Id.* (quoting United States v. Virginia, 518 U.S. 515, 533 (1996)).

236. *See id.*

237. *Id.* at 480-82.

238. Drawing on *Bostock*, Judge White concluded that discrimination based on the difference between gender identity and sex assigned at birth is essentially discrimination against transgender individuals, which is, by definition, discrimination "because of" sex. *Id.* at 502 (White, J., dissenting) (quoting Bostock v. Clayton County, 590 U.S. 644, 655 (2020)).

239. *Id.* at 485 (majority opinion).

240. *Id.* at 487.

241. The Eleventh Circuit deployed a similar state-centered analysis. While acknowledging that the ban draws sex-based distinctions, the court relied on *Dobbs* to find that the ban does not trigger heightened scrutiny because its regulation of gender-affirming care is not pretext for invidious discrimination against members of any sex. *See* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1229-30 (11th Cir. 2023). It also concluded that *Bostock* pertains only to Title VII discrimination. *Id.* at 1228-29. Further, the court expressed "doubt" that transgender status is a quasi-suspect classification. *Id.* at 1230.

242. *See Skrmetti*, 83 F.4th at 480; *Eknes-Tucker*, 80 F.4th at 1225.

state's ban satisfies rational-basis review.[243] Similarly, the Sixth Circuit contended that Tennessee's ban serves a legitimate state interest in exercising caution with respect to irreversible medical treatments for minors.[244] The bans, the panel majorities explained, reasonably distinguish between minors and adults because adults have a significantly greater capacity for decision-making.[245] Thus, the Eleventh Circuit explained that the bans' distinctions based on age ensure that minors have more time to develop their identities before making these potentially permanent decisions about transitioning.[246]

With respect to diagnosis, both circuits suggested that the bans do not target trans identities or classify based on sex assigned at birth but rather ban medical interventions that treat gender dysphoria (a specific diagnosis) in minors. The Sixth Circuit explained that, unlike other medical interventions in minors' sex characteristics, gender-dysphoria treatment addresses a "physical mismatch between the child's perceived gender and biological sex."[247] The Eleventh Circuit came to a similar conclusion, finding that the treatment is allowed for both sexes and only prohibited "for the purpose of attempting to alter the appearance of or affirm the minor's perception of [their] gender or sex, if that appearance or perception is inconsistent with [their] sex."[248]

This difference, the Sixth Circuit held, justifies delaying interventions for trans individuals until adulthood, even if these procedures are permitted for minors not diagnosed with gender dysphoria.[249] This is because the state can "reasonably conclude that a treatment is safe when used for one purpose but risky when used for another."[250] For the Eleventh Circuit, this difference justified applying rational-basis review.[251]

The Sixth Circuit also identified a rational distinction between different care protocols. The majority explained that the bans target the particular effects of (endocrinological) treatment when applied cross sex (i.e., for the purpose of transitioning), as gender-affirming-care protocols authorize.[252] Here, the majority contrasted gender-affirming-care protocols with intersex interventions,

243. *Eknes-Tucker*, 80 F.4th at 1230 (quoting Otto v. City of Boca Raton, 981 F.3d 854, 868 (11th Cir. 2020)).

244. *Skrmetti*, 83 F.4th at 485-86.

245. *Eknes-Tucker*, 80 F.4th at 1230; *Skrmetti*, 83 F.4th at 488.

246. *Eknes-Tucker*, 80 F.4th at 1230.

247. *Skrmetti*, 83 F.4th at 480.

248. *Eknes-Tucker*, 80 F.4th at 1213 (quoting ALA. CODE § 26-26-4(a) (2022)).

249. *See Skrmetti*, 83 F.4th at 480.

250. *Id.*

251. *Eknes-Tucker*, 80 F.4th at 1230.

252. *Skrmetti*, 83 F.4th at 481.

explaining that using testosterone and estrogen to treat a "genetic or congenital condition that occurs exclusively in one sex" differs from gender-affirming care in both the diagnosis and the desired results.[253]

Ultimately, the Sixth and Eleventh Circuits found a rational basis for laws that permit medical interventions aimed at coercing intersex bodies into binary sex assignments—while prohibiting trans minors from accessing care precisely because their gender identities do not align with their binary assigned sex. In doing so, the courts overlooked inherent contradictions in the legislation that exposed its fundamental irrationality.

The Sixth Circuit, for example, in considering "the possibility of a rational classification,"[254] assessed only superficially whether these laws' means bear a rational relationship to their intended ends.[255] As this Article argues, laws such as these that contain contradictory provisions are fundamentally irrational because they simultaneously authorize and prohibit the same actions.[256] Such contradictions prevent the laws from serving their intended purpose, rendering them irrational in the constitutional sense and indicating the possible presence of illegitimate state interests, such as animus or prejudice.

In its excessive deference to states' asserted interests, the state-centered analysis assumes these laws' classifications are rationally connected to their asserted goals without ever fully examining the link. This omission reflects the failure of the state-centered approach not only to acknowledge the complexities of gender identities and experiences but also to apply meaningfully the rational-basis standard of judicial review.

3. Potential Outcomes of Supreme Court Review

The two previous Sections described the developing divide within the lower courts over the bans' constitutionality, which has culminated in the Supreme Court's grant of certiorari in *Skrmetti*.[257] The Court's decision will carry profound consequences for minors and adults across the sex and gender-identity spectrums.

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253. *Id.*

254. *Id.* at 489.

255. *Id.* (finding that "disagree[ment] with the States' assessment of the risks and the right response to those risks . . . does not suffice to invalidate a democratically enacted law on rational-basis grounds"). *But cf.* Romer v. Evans, 517 U.S. 620, 631-32 (1996) (invalidating a state constitutional amendment banning protections against sexual-orientation discrimination under rational-basis review).

256. *See infra* Section III.A.

257. United States v. Skrmetti, 144 S. Ct. 2679, 2679 (2024) (mem.) (granting certiorari).

Finding the bans constitutional would immediately obstruct trans minors' access to gender-affirming care while allowing the contentious practice of coercive intervention in intersex minors' bodies. Enforcing the bans would inflict immediate and acute harm on trans youths' mental health, preserve a status quo that infringes upon intersex children's bodily integrity, and likely subject more trans and intersex minors to "normalizing" conversion practices. And such a ruling could embolden legislatures to pass similar laws targeting trans adults across the United States.[258]

A decision upholding the bans would not necessarily rely on *Dobbs*, as the Court could reach this decision independently. However, circuit courts have repeatedly cited *Dobbs* in their decisions upholding the bans.[259] These decisions are thus part of a broader trend in American constitutional law that employs *Dobbs*'s methodology and reasoning to undermine rights claims by historically marginalized groups.[260] Expanding *Dobbs*'s principles to the gender-affirming-care context would not only target trans and intersex experiences but would also reinforce broader constitutional trends associated with *Dobbs*.

Yet a mandate to uphold the bans does not follow inexorably from *Dobbs*. The plaintiffs in *Skrmetti* do not seek to uncover a new fundamental right in the Constitution but rather to enforce a right to which they are already constitutionally entitled: the right to equal protection under the law. Striking down the bans would safeguard trans minors' access to gender-affirming care and could potentially provide useful precedent for future intersex litigation. At the same time, doing so runs the risk of once again relegating intersex issues to the shadows of trans narratives and ignoring the specific challenges faced by intersex people.[261] A doctrinal outcome that vindicates equal-protection rights only for trans minors is unlikely to provide an effective response to the specific needs of both intersex and trans people, both of whose interests are implicated by the bans.

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258. *See* Funakoshi & Raychaudhuri, *supra* note 6 (estimating that one in five bills introduced in state legislatures that target gender-affirming care applies to adults).

259. Both the Sixth and Eleventh Circuits used *Dobbs* to reject the argument that gender-affirming care involves a fundamental right "deeply rooted in this Nation's history and tradition." *Skrmetti*, 83 F.4th at 472-73 (citing Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 289 (2022)); Eknes-Tucker v. Governor of Ala., 80 F.4th 1205, 1220 (11th Cir. 2023) (quoting *Dobbs*, 597 U.S. at 231). This history-and-tradition approach was limited to the courts' due-process analyses. *See Skrmetti*, 83 F.4th at 472; *Eknes-Tucker*, 80 F.4th at 1219-20. *Dobbs* was cited to underscore legislative discretion and support the application of rational-basis review. *Skrmetti*, 83 F.4th at 484; *Eknes-Tucker*, 80 F.4th at 1224.

260. *See* Reva B. Siegel, *Memory Games:* Dobbs*'s Originalism as Anti-Democratic Living Constitutionalism—And Some Pathways for Resistance*, 101 TEX. L. REV. 1127, 1161-69 (2023).

261. *See, e.g.*, Ido Katri, *Transitions in Sex Reclassification Law*, 70 UCLA L. REV. 636, 694 (2023) (discussing the overshadowing of intersex interests in trans advocacy for reform in sex-reclassification policies).

Regardless of how the Supreme Court decides *Skrmetti*, states' continued authorization of coercive medical practices performed on intersex people will remain an obstacle to aligning trans and intersex interests in litigation and politics. As long as legal frameworks continue to provide for state and medical control over gender-variant people's bodies, access to gender-affirming care will remain precarious. The body of law created by and around the bans has the potential to drive a wedge between trans and intersex legal interests. While this case specifically challenges the ban on gender-affirming care for trans people, it does not necessarily follow that the broader legal framework inherently conflicts with intersex interests. However, the selective regulation of medical interventions raises concerns about how these laws might affect advocacy strategies and alignments in future litigation.

In this way, the law would continue to pit trans interests against intersex interests, creating a false dichotomy that suggests expanding trans access to gender-affirming care is somehow in tension with intersex protections against nonconsensual sex-normalizing procedures. This Article argues that this dichotomy need not exist. Rather, we offer a normative perspective on the alignment of trans and intersex demands that rethinks the interplay of these communities' legal interests—finding areas of intersection while recognizing axes of divergence.[262]

Before we catalog these interests in the next Part, we must note the tension between legal scholarship and real-world practice. As legal scholars, we are afforded the privilege, and perhaps bear the responsibility, of engaging with the law in terms of ideals, norms, and doctrines. But those navigating the legal system in practice face tougher decisions and are often compelled to frame their rights claims within the confines of established legal discourse. The choices made in impact litigation and political advocacy on behalf of minors and marginalized groups who are systemically excluded from traditional avenues of legal power must often be significantly more pragmatic than critical scholarship. Therefore, we do not intend for our examination and critique of various arguments and litigation strategies to be a critique of the people and groups who made such decisions in the tangible context of legal proceedings and advocacy work.

II. THE INTERPLAY OF LEGAL INTERESTS

At first glance, gender-affirming-care bans seem to regulate medical intervention in the sex characteristics of minors whose gender identity is incongruent with their birth-assigned sex. To that end, the bans limit the authority of parents and medical practitioners over the bodies of trans minors and limit trans minors'

262. *See infra* Section III.B.

ability to take an active part in decisions regarding gender-affirming care. At the same time, however, the bans preserve the authority of doctors and parents to subject intersex minors to coercive sex-normalizing interventions. This structural difference in the regulation of trans and intersex care reflects a broader interplay of trans and intersex legal interests, which this Part explores.

Although the academic literature on the tensions between the trans and intersex legal movements remains nascent,[263] the existence of such tensions is well known within the field, primarily due to the work of intersex advocates. This tension is also evident in the courtroom debates over gender-affirming-care bans. While plaintiffs and their attorneys might be committed to intersex interests and frame their arguments around minors' wishes, needs, and consent, they often find themselves compelled to advocate for adherence to accepted medical protocols and for parents' ability to obtain care on behalf of their children — both of which might advance trans interests but harm intersex interests. As we explain, intersex advocates typically resist current medical protocols that allow parents to make permanent decisions about minors' bodies at a time when minors cannot consent.

Examining the bans' contrasting approaches to intersex and trans experiences underscores their role in generating conflict between trans and intersex interests in three domains: medical authority, parental rights, and sex equality. This Part investigates these tensions, juxtaposing legal and advocacy perspectives on access to medical interventions for intersex and trans minors, with the goal of identifying points of potential alignment.

A. Positions on Medical Authority

Medicalization generates both positive and negative outcomes. Within the current U.S. healthcare scheme, access to gender-affirming care, which supports both mental and physical well-being, depends heavily on the medical classification of gender-nonconforming identities.[264] This medicalization can reduce

263. *See supra* note 24 (citing some of the first literature to address the tensions between the trans and intersex legal movements).

264. *See, e.g.*, *Endocrine Clinical Practice Guideline*, *supra* note 1, at 3871 (requiring that a multidisciplinary team of medical and mental-health professionals expressly confirm the existence of persistent gender dysphoria prior to undertaking medical interventions). For a critique of the pathologization of trans health care, see, for example, Spade, *supra* note 50, at 35.

stigma by framing gender-variant identities as conditions rather than choices,[265] thereby enhancing social acceptance and legal protections.[266]

But medicalizing the variance of identities and anatomies can also contribute to stigma and justify coercive medical interventions.[267] Further, medicalization increases state and market control, giving doctors gatekeeping authority.[268] Although some in the intersex and trans communities identify with medical definitions of their conditions (e.g., gender dysphoria for trans people and DSD for intersex people), others wholly reject or only partly accept these definitions.[269]

The leading position in the U.S. medical profession supports intervention for both trans and intersex youth, albeit under significantly different standards of care.[270] Currently, the trans legal movement strategically and carefully embraces medical authority, while the intersex legal movement challenges it.

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265. *See* JOANNA WUEST, BORN THIS WAY: SCIENCE, CITIZENSHIP, AND INEQUALITY IN THE AMERICAN LGBTQ+ MOVEMENT 170-75 (2023).

266. *See* Rabia Belt & Doron Dorfman, *Reweighing Medical Civil Rights*, 72 STAN. L. REV. ONLINE 176, 178 (2020) ("Disability scholars recognize that the history of offering comparatively enhanced recognition and benefits to people designated as medically worthy is a long one."); Craig Konnoth, *Medicalization and the New Civil Rights*, 72 STAN. L. REV. 1165, 1237 (2020) ("[T]he perceived objectivity that medicine brings to the law, especially as opposed to contemporary constitutional analysis, renders it attractive to those who invoke it to seek rights.").

267. Amets Suess, Karine Espineira & Pau Crego Walters, *Depathologization*, 1 TRANSGENDER STUD. Q. 73, 75-76 (2014) (arguing that the pathologization of transgender transition is part of the structural violence inherent to gender as a social order and thus that depathologization is beneficial also for intersex and body-diverse people, antipsychiatry discourses, and activism); Morland, *supra* note 5, at 114 (arguing that intersexuality and transsexuality have been constructed as complementary, with the latter considered an alteration of gender by free will, in contrast to the former demonstrating "gender's assemblage by force"); Michelle Wolff, David A. Rubin & Amanda Lock Swarr, *The Intersex Issue: An Introduction*, 9 TRANSGENDER STUD. Q. 143, 144 (2022) (arguing that the shift in terminology from intersex to DSD further "threaten[s] to repathologize people with anatomical sex variations").

268. Wolff et al., *supra* note 267, at 144 (arguing that "patient-centered" reform to intersex care "largely failed to deliver substantial change, at least in part due to its complicity with neoliberal individualization"); Justus Eisfeld, *International Statistical Classification of Diseases and Related Health Problems*, 1 TRANSGENDER STUD. Q. 107, 107 (2014) (arguing that the very existence of medical-classification systems acts as a gatekeeper to healthcare access for trans and gender-diverse people).

269. *See* Costello, *supra* note 24, at 85 (discussing how "some intermediately-sexed people reframe [the DSD acronym] as standing for 'diversity of sex development'").

270. Wolff et al., *supra* note 267, at 144 (noting that while clinicians, parents, and patient advocates have worked together to develop gender-affirming-care models for trans individuals over several decades, there remains a lack of similar models for intersex-affirming care, underscoring the disparity in medical and advocacy positionalities).

1. Trans Advocacy: Navigating Medical Authority

Trans advocacy has been instrumental in gradually improving and reforming medical protocols, driving the development of and increasing access to gender-affirming medical care.[271] As a result, many trans adults and minors who had previously been barred from certain medical procedures gained access to gender-affirming treatments. The trans legal movement has relied on and embraced medicalized versions of gender transition to secure legal recognition and protection while also fighting for depathologized access to those medical technologies.[272] As explained in its latest edition, the DSM-5-TR of 2022 "focuses on dysphoria as the clinical problem, not identity per se."[273] That is, it pathologizes distress rather than gender incongruence and allows for greater recognition of variation in experiences and identities, including nonbinary and other gender-variant identities, in medico-legal discourse.[274]

To advocate for minors' access to gender-affirming care, litigants rely on contemporary medical protocols and consensus statements. They emphasize that this care, which can include interventions in sex characteristics, is grounded in the gender-dysphoria diagnosis and the goal of reducing its associated risk to mental health, including suicidality.[275] To concretize their legal arguments, litigants draw on trans youths' stories about the harm of being denied care, yet they also affirm medical professionals' authority and parents' rights to follow medically accepted standards, provided that the minors participate in the decision-making and provide consent.[276]

Courts discussing gender-affirming-care bans, both those employing a trans-affirming analysis and those adhering to a state-centered analysis, have also focused far more on medical perspectives than on minors' capacities to make

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271. See generally GILL-PETERSON, *supra* note 29, which provides an extensive historical account of the role of trans and intersex advocates in developing medical technologies and protocols; and STEF M. SHUSTER, TRANS MEDICINE: THE EMERGENCE AND PRACTICE OF TREATING GENDER (2021), which describes the role of trans patients in advocating for the use of medical technologies for gender affirmation.

272. See generally Dangaran, *supra* note 3, for a detailed exploration of these dynamics in historical and current contexts, in terms of diagnosis, litigation, disability justice, and incarceration.

273. AM. PSYCHIATRIC ASS'N, *supra* note 53, at 512.

274. *See* Dangaran, *supra* note 3, at 251 (discussing the shift from DSM-IV-TR to DSM-5-TR).

275. *See, e.g.*, *Drummond* Complaint, *supra* note 181, at 18; Third Amended Complaint for Class-wide Declaratory and Injunctive Relief at 11-12, Doe v. Ladapo, 676 F. Supp. 3d 1205 (N.D. Fla. 2023) (No. 23-cv-00114) [hereinafter *Ladapo* Complaint]; *Brandt* Complaint, *supra* note 181, at 11.

276. *Noggle* Complaint, *supra* note 181, at 19.

decisions about their bodies.[277] The voices and experiences of trans youth thus become secondary to expert opinions emphasizing that gender-affirming care is the only scientifically proven approach to reducing gender dysphoria. Courts also discuss data suggesting that limiting access to gender-affirming care will negatively impact trans youths' mental health and could even cost lives.[278]

The connection between medical and judicial authority highlights trans advocacy's conflicted relationship with predominant medico-legal frameworks. The shift from disorder to distress has, in many cases, provided trans individuals with legal recognition and access to gender-affirming care, legitimizing trans identities and experiences.[279] However, relying on medical paradigms perpetuates the pathologization of trans identities and enhances the role of medical professionals in securing legal protection and recognition.[280] This duality illustrates the tension between expanding access to affirming care and rejecting pathologization. While greater access to care empowers many trans minors and adults by granting them greater autonomy over their bodies and the ability to tell their own stories, it also requires the trans legal movement to negotiate continuously with medical institutions, thereby reinforcing medico-legal power over trans lives.

2. *Intersex Advocacy: Undermining Medical Authority*

Intersex advocacy has a different relationship with medical authority: it generally focuses on ending coercive medical practices aimed at normalizing sex characteristics. Usually, intersex minors are legally assigned a sex on their birth certificate and medically assigned a sex via surgical and hormonal interventions.[281] But the intersex movement argues that most intersex conditions do not necessitate medical intervention and are instead within the realm of natural human variation.[282] Indeed, intersex communities often *challenge* the medical

277. *See, e.g.*, Brandt v. Rutledge, 677 F. Supp. 3d 877, 888-95 (E.D. Ark. 2023); Doe v. Ladapo, 737 F. Supp. 3d 1240, 1257-59 (N.D. Fla. 2024), *stayed sub nom.* Doe v. Surgeon Gen., No. 24-11996, 2024 WL 4132455 (11th Cir. Aug. 26, 2024); L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 482-83 (6th Cir. 2023), *cert. granted sub nom.* United States v. Skrmetti, 144 S. Ct. 2679 (2024).

278. *See, e.g.*, *Brandt*, 677 F. Supp. 3d at 918-19, 921-22.

279. *See* CURRAH, *supra* note 35, at 34.

280. Spade, *supra* note 50, at 23-24.

281. *See The Fundamental Rights Situation of Intersex People*, *supra* note 132, at 4-7; *"I Want to Be Like Nature Made Me": Medically Unnecessary Surgeries on Intersex Children in the US*, *supra* note 150, at 48.

282. *See, e.g.*, *What Is Intersex?*, INTERSEX SOC'Y N. AM., https://isna.org/faq/what_is_intersex [https://perma.cc/TLQ9-DQQH]; *What Is Intersex?*, *supra* note 153 ("Intersex traits are

protocols that treat intersex variations as bodily disorders requiring immediate intervention.[283]

Thus, the intersex legal movement contests these normalizing medico-legal practices. Looking at procedures performed on intersex minors makes clear the harms of early medical interventions on sex characteristics: sterilization, pain, and scarring; loss of genital sensation; continuous surgical maintenance; and irreversibility in cases of incompatible gender assignment.[284] Furthermore, intersex interventions demonstrate the dangers of overreliance on the parent-doctor decision-making framework. Intersex advocates argue that existing medical standards for intersex care encourage parents to consent to medically unnecessary treatments and violate principles of informed consent by failing to disclose the material risks associated with these treatments.[285] Even voices within intersex communities that endorse some use of early medical interventions still advocate for a reformed-care model—one that, like the gender-affirming-care model, is evidence based and patient centered, focuses on minors' informed consent, and respects the unique needs and circumstances of each individual.[286]

Intersex advocacy is thus frequently at odds with medical institutions in litigation over intersex interventions. For example, an intersex individual, M.C., brought a federal lawsuit against a hospital and doctors who performed surgical sex (mis)assignment on him as an infant.[287] M.C. later rejected the assigned sex.[288] In his lawsuit, he argued that by performing medically unnecessary sex-assignment surgery and depriving him of the opportunity "to make his own deeply intimate decisions about whether to undergo genital surgery, if any, when he reached maturity," the doctors and the hospital violated his Fourteenth

natural human variations, *not* disorders."); Dan Christian Ghattas, *Protecting Intersex People in Europe: A Toolkit for Law and Policymakers*, OII EUR. 10-14 (2019), https://www.oiieurope.org/wp-content/uploads/2019/05/Protecting_intersex_in_Europe_toolkit.pdf [https://perma.cc/MK72-8RK8].

283. Sudai, *supra* note 108, at 7.

284. Brief of Amici Curiae interACT: Advocates for Intersex Youth et al. in Support of Employees at 23, Bostock v. Clayton County, 590 U.S. 644 (2020) (Nos. 17-1618, 17-1623, 18-107) [hereinafter *Bostock* Amicus Brief] ("The child may be rendered sterile; may suffer a lifelong diminution or loss of sexual sensation and function; and may experience scarring and incontinence.").

285. Complaint at 13-17, Crawford v. Med. Univ. of S.C., No. 2013CP4002877 (S.C. Ct. Com. Pl. May 14, 2013); Morgan Carpenter, *Fixing Bodies and Shaping Narratives: Epistemic Injustice and the Responses of Medicine and Bioethics to Intersex Human Rights Demands*, 19 CLINICAL ETHICS 3, 9 (2024).

286. *See, e.g.*, *SOC8*, *supra* note 1, at S95-103; Sudai, *supra* note 108, at 16-20.

287. M.C. *ex rel.* Crawford v. Aaronson, No. 13-cv-01303, 2013 WL 11521881, at *1-2 (D.S.C. Aug. 29, 2013), *rev'd sub nom.* M.C. *ex rel.* Crawford v. Amrhein, 598 F. App'x 143 (4th Cir. 2015).

288. *Id.*

Amendment right to substantive and procedural due process.[289] The Fourth Circuit, however, held that both the doctors and the hospital were entitled to qualified immunity because, at the time of the surgery, intersex infants did not have a clearly established right to delay or refuse sex-assignment surgery.[290]

In a malpractice lawsuit filed in the same case, the defendants argued that "[g]enital surgery on infants with DSDs" is "the predominant practice" and is considered the "standard of care."[291] The case ultimately settled and thus failed again to establish legal protection against nonconsensual medical intervention for intersex children.[292] For the intersex-rights movement, claims that affirm medically accepted practices solely because they are medically accepted standards are part of the problem. Further, it is likely in the interests of both the trans and intersex movements to promote a more nuanced approach to medical authority—one that supports standard medical protocols only when they are evidence based and when patients undertaking the risks of irreversible treatment have given informed consent.

B. Positions on Parental Rights

The law presumes that parents are the best decision makers for their children and defers to parental choice unless parents abuse or neglect their children.[293] With respect to medical decision-making, the law assumes that, in most cases, parents act in their child's best interest; therefore, the law protects their status as

289. Complaint at 21, *Crawford*, No. 13-cv-01303 (D.S.C. Aug. 29, 2013).

290. *Crawford*, 598 F. App'x at 149.

291. Medical University of South Carolina's Amended Memorandum in Support of Motion for Summary Judgment at 5, Crawford v. Med. Univ. of S.C., No. 2013-CP-40-02877 (S.C. Ct. Com. Pl. Dec. 15, 2015).

292. Azeen Ghorayshi, *A Landmark Lawsuit About an Intersex Baby's Genital Surgery Just Settled for $440,000*, BuzzFeed News (July 27, 2017, 12:46 PM), https://www.buzzfeednews.com/article/azeenghorayshi/intersex-surgery-lawsuit-settles [https://perma.cc/SL2R-GHBR].

293. *See* Naomi R. Cahn, *The New Kinship*, 100 Geo. L.J. 367, 396 (2012).

the "dominant" decision makers, absent neglect or abuse.[294] In cases of neglect or abuse, the state has the power to interfere with parental autonomy.[295]

Minors' independent rights may also limit parental rights to make medical decisions on behalf of their children. Classic examples include judicial bypass, which allows a minor to end an unwanted pregnancy without parental consent,[296] and the "mature minor" doctrine, which allows minors to make medical decisions without parental consent depending on the particular minor's "age, intelligence, maturity, training, experience, economic independence," and other factors.[297] In recent years, scholars have stressed the need to free children from the ideals of child-parent unity and family privacy, restrain parental rights, and give minors more decision-making power over their health care, especially in life-altering situations.[298] But other scholars still emphasize the "enduring importance" of parental rights—particularly in controversial areas of decision-making—and the harms of state intrusion into families.[299]

The tripartite relationship between child, parent, and state is a fundamental concept in family law.[300] But the regulation of parents' rights vis-à-vis the state and their children is also affected by "partisan divide[s]" on a range of topics, such as education, abortion, and gender-affirming care.[301] In the context of gender-affirming care, conservative state actors use parental rights to restrict minors from independently accessing gender-affirming care—and, conversely, interfere

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294. *See* Parham v. J.R., 442 U.S. 584, 604 (1979) ("In defining the respective rights and prerogatives of the child and parent in the voluntary commitment setting, we conclude that our precedents permit the parents to retain a substantial, if not the dominant, role in the decision, absent a finding of neglect or abuse, and that the traditional presumption that the parents act in the best interests of their child should apply."). Parents still maintain the right to make these decisions even when the benefits are uncertain or risks are high. *See* Naomi Cahn, *CRISPR Parents and Informed Consent*, 23 SMU SCI. & TECH. L. REV. 3, 16-17 (2020) (citing Elana Bengualid, *The Futility of Futility: An Analysis of the Charlie Gard Case Within the Framework of U.S. Law*, 40 CARDOZO L. REV. 463, 469 (2018)).

295. *See* Cahn, *supra* note 293, at 397-98; *see also* Stanley v. Illinois, 405 U.S. 645, 649 (1972) ("The State's right—indeed, duty—to protect minor children through a judicial determination of their interests in a neglect proceeding is not challenged here.").

296. *See* Bellotti v. Baird, 443 U.S. 622, 651 (1979); Jessica Quinter & Caroline Markowitz, Note, *Judicial Bypass and Parental Rights After* Dobbs, 132 YALE L.J. 1908, 1917-18 (2023).

297. Smith v. Seibly, 431 P.2d 719, 723 (Wash. 1967); Michael Hayes, Note, *The Mature Minor Doctrine: Can Minors Unilaterally Refuse Medical Treatment?*, 66 KAN. L. REV. 685, 706-09 (2018).

298. *See* Anne C. Dailey & Laura A. Rosenbury, *The New Parental Rights*, 71 DUKE L.J. 75, 140-42 (2021) (discussing this principle in the context of gender-affirming care).

299. *See* Clare Huntington & Elizabeth Scott, *The Enduring Importance of Parental Rights*, 90 FORDHAM L. REV. 2529, 2529, 2538-39 (2022).

300. Naomi Cahn, *The Political Language of Parental Rights: Abortion, Gender-Affirming Care, and Critical Race Theory*, 53 SETON HALL L. REV. 1443, 1445 (2023).

301. *Id.* at 1444-46.

with parental autonomy when parents *do* consent to gender-affirming care for their minor children.[302] In this way, the legal battle over gender-affirming care again produces contradictory arguments about parents' capacity to consent to medical interventions affecting their minor children's sex characteristics, including interventions that can impact fertility.

1. *Trans Advocacy: Parental Support*

Litigation concerning parents' due-process rights to support their children's access to gender-affirming care exemplifies trans advocates' complicated relationship with parental rights. Parents who support their children's access to gender-affirming care comprise one group of impact litigants challenging the bans. They argue that these laws infringe on their fundamental right to support their children's decisions about their bodies and to provide them with medical care.[303] Yet litigants seem to remain acutely aware that parental rights have, in other contexts (such as abortion access and privacy for LGBTQ students), impeded minors' autonomy. In gender-affirming-care litigation, litigants thus sometimes characterize parents' rights as their ability to support their children's decisions about their bodies. In doing so, these litigants highlight parents' roles in providing for their children's well-being[304] rather than making unilateral healthcare decisions.[305]

Skrmetti, the Supreme Court case reviewing Tennessee's gender-affirming-care ban, will not address the parental due-process claims, as the United States's intervention focused solely on equal-protection issues.[306] Yet parents' interest in providing care may still serve as a proxy for their children's equal-protection

302. *See, e.g.*, *In re* Abbott, 645 S.W.3d 276, 279-81 (Tex. 2022).

303. *Brandt* Complaint, *supra* note 181, at 43; *Eknes-Tucker* Complaint, *supra* note 181, at 28; *Ladapo* Complaint, *supra* note 275, at 50; *Drummond* Complaint, *supra* note 181, at 19-20.

304. *See, e.g.*, Amici Curiae Brief of Families with Transgender Children in Support of Petitioner and Respondents in Support of Petitioner at 3, United States v. Skrmetti, No. 23-477 (U.S. Sept. 3, 2024) (arguing that the bans prohibit parents from providing children with the medical care they need and force them to move states).

305. *See, e.g.*, Petition for a Writ of Certiorari, *supra* note 10, at 16, 31-32 (arguing in the context of parental due-process rights that it is unreasonable categorically to ban treatment that is aligned with the judgment of adolescents, parents, and doctors).

306. *Id.* at 12 n.4 (explaining that while private petitioners' substantive-due-process claims regarding parental rights were recognized by a lower court, the United States, intervening under 42 U.S.C. § 2000h-2 — which applies to equal-protection claims — did not address those due-process claims).

rights.[307] This framing remains unsatisfactory not just from an intersex perspective (as we will explain) but also for trans minors who do not enjoy parental support.[308] Many trans minors do not have parents who affirm their gender and are thus barred from accessing *any* form of gender-affirming care, medical or otherwise.[309] States are already legislating "parents' rights" laws that compel teachers and others to inform parents about their child's gender-nonconforming behaviors or inclinations.[310] By centering the parental role in access to gender-affirming care, trans litigants may unintentionally strengthen parental authority in ways that are less beneficial to other trans minors. At the same time, parents remain crucial insofar as they facilitate minors' own ability to make decisions about their bodies and identities.

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307. Parents play a crucial role in ensuring access to gender-affirming care for their children. When laws ban treatments for gender dysphoria, they not only harm transgender adolescents by denying necessary care but also place an enormous burden on parents, forcing them to choose between relocating or forgoing essential care—both with significant consequences. *See id.* at 31-32. Parents' interest in making medical decisions overlaps with their children's right to equal protection because denying parental authority in this area effectively denies transgender adolescents access to care. In this way, parental decisions serve as a key mechanism for safeguarding children's equal-protection rights and access to health care. *See id.* (underscoring that these laws jeopardize adolescent health care by restricting parents from obtaining that care). Holning Lau and Barbara Fedders argue that transgender-healthcare bans undermine parents' constitutional rights to make informed, individualized decisions for their children's health. *See* Lau & Fedders, *supra* note 20 (manuscript at 54-55). By contrasting these bans with the law's permissive treatment of irreversible surgeries on intersex infants, they contend that the bans aim less to protect children and more to enforce rigid sex norms. *Id.* This approach, they suggest, violates equal protection and infringes upon substantive due process by unduly limiting parental autonomy. *Id.*

308. Gina M. Sequeira, Nicole F. Kahn, Moira A. Kyweluk, Kacie M. Kidd, Peter G. Asante, Baer Karrington, Kevin Bocek, Ruby Lucas, Dimitri Christakis, Wanda Pratt & Laura P. Richardson, *Desire for Gender-Affirming Medical Care Before Age 18 in Transgender and Nonbinary Young Adults*, 12 LGBT HEALTH 29, 33 (2025) (noting that 77.1% of transgender and nonbinary minors who asked for parental consent for gender-affirming care did not receive permission).

309. *See* Dailey & Rosenbury, *supra* note 298, at 137.

310. *E.g.*, Act of Mar. 28, 2022, ch. 2022-22, § 1, 2022 Fla. Laws 248, 249-51 (codified as amended at FLA. STAT. § 1001.42(8)) (requiring district school boards to adopt procedures for notifying parents about students' "mental, emotional, or physical health or well-being" that "reinforce the fundamental right of parents to make decisions regarding the upbringing and control of their children"); *see also* Bella DiMarco, *Legislative Tracker: 2023 Parent-Rights Bills in the States*, FUTUREED (Mar. 16. 2023), https://www.future-ed.org/legislative-tracker-2023-parent-rights-bills-in-the-states [https://perma.cc/UMY3-7P9L] (tracking parental-rights bills in U.S. states).

2. *Intersex Advocacy: Parental Overreach*

Intersex advocacy claims that irreversible interventions in sex characteristics should not be performed on minors before they can provide informed consent. Accordingly, intersex advocates argue that parents should not be allowed to provide consent on a minor's behalf for interventions that are not immediately medically necessary. The movement emphasizes that "those procedures both carry a meaningful risk of harm and can be safely deferred."[311] Scholars argue that under current medical frameworks, medical professionals advise parents to normalize their children—through procedures intended to make them cisgender—rather than affirm their biological variance.[312] Intersex scholarship has long criticized the pressure that new parents experience from doctors to provide "proxy consent" to such procedures.[313]

Due to potential parental conflicts of interest and sex-normalizing surgeries' lack of clear medical benefit, some in the legal intersex movement have advocated for judicial review as a precondition for authorizing early medical interventions on intersex minors.[314] The intersex movement has also asked legislators to limit normalizing medical interventions on intersex minors, but efforts to enact intersex-protective laws have yet to limit medical practice.[315]

Recognizing these distinctions between trans and intersex interests is crucial. If courts recognized and addressed the interplay of trans and intersex legal interests, their decisions concerning the bans could empower intersex-affirming parents to reject interventions that are medically unnecessary yet recommended by doctors. But because courts have yet to account adequately for these concerns, the trans-affirming approach risks complicating future efforts to restrain parental authority to consent to coercive intersex-normalizing interventions.

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311. *"I Want to Be Like Nature Made Me": Medically Unnecessary Surgeries on Intersex Children in the US*, *supra* note 150, at 6, 14-15, 154-57.

312. *See* FEDER, *supra* note 158, at 48; Catherine Clune-Taylor, *Securing Cisgendered Futures: Intersex Management Under the "Disorders of Sex Development" Treatment Model*, 34 HYPATIA 690, 705-06 (2019).

313. *See* Kishka-Kamari Ford, Note, *"First, Do No Harm"—The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants*, 19 YALE L. & POL'Y REV. 469, 478 (2001); Alyssa Connell Lareau, Note, *Who Decides? Genital-Normalizing Surgery on Intersexed Infants*, 92 GEO. L.J. 129, 130-31 (2003); Tamar-Mattis, *supra* note 145, at 65; *see also "I Want to Be Like Nature Made Me": Medically Unnecessary Surgeries on Intersex Children in the US*, *supra* note 150, at 90-91 (discussing the pressure parents face to consent to surgery on their intersex children at the expense of informed consent).

314. Tamar-Mattis, *supra* note 145, at 99-100.

315. *See, e.g.*, H. 6171, 2021 Gen. Assemb., Jan. Sess. (R.I. 2021); S.B. 201, 2019-2020 Leg., Reg. Sess. (Cal. 2019).

C. Positions on Sex Equality

Contemporary American legal theory routinely recognizes the distinction between sex and gender.[316] And the relationship between sex and gender has shaped the trans and intersex movements' legal strategies as well. Litigants challenging the bans argue that blocking access to gender-affirming care for minors is a form of sex discrimination because the bans discriminate against trans minors based on their sex, trans status,[317] or sex stereotypes.[318] While both trans and intersex advocates challenge binary definitions of sex, intersex legal strategies diverge from those of the trans movement. Intersex litigants focus on challenging a different aspect of sex in the law: its characterization as biologically dimorphic. Many legal definitions of "sex," particularly those in anti-trans laws, treat sex as a natural binary.[319] The intersex legal movement argues that dimorphic legal definitions of sex discriminate against people with intersex traits by refusing to recognize their biological variance. In this Section, we explore how both the trans and intersex movements rely on and challenge doctrinal understandings of sex equality.

1. Trans Advocacy: Gender-Identity Immutability

Intersex and trans advocates share many beliefs about sex and gender identity. In legal advocacy, both groups have argued that the law should recognize gender identity as the most "reliable predictor" of "sex."[320] Trans litigation is also concerned with legal reliance on the concept of immutability: trans litigants

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316. *See, e.g.*, Mari Mikkola, *Feminist Perspectives on Sex and Gender*, STAN. ENCYC. PHIL. (Jan. 18, 2022), https://plato.stanford.edu/archives/fall2023/entries/feminism-gender [https://perma.cc/5X95-PNBQ]; Legal Info. Inst., *Gender Identity*, CORNELL L. SCH., https://www.law.cornell.edu/wex/gender_identity [https://perma.cc/SW2M-E54G].

317. *See, e.g.*, *Brandt* Complaint, *supra* note 181, at 41; *Eknes-Tucker* Complaint, *supra* note 181, at 29; *Thornbury* Complaint, *supra* note 181, at 20.

318. *See, e.g.*, *Brandt* Complaint, *supra* note 181, at 42; *Drummond* Complaint, *supra* note 181, at 49; *Skrmetti* Complaint, *supra* note 183, at 35-36.

319. *See, e.g.*, ARK. CODE ANN. § 20-9-1501(1) (2025) ("'Biological sex' means the biological indication of male and female in the context of reproductive potential or capacity, such as sex chromosomes, naturally occurring sex hormones, gonads, and nonambiguous internal and external genitalia present at birth, without regard to an individual's psychological, chosen, or subjective experience of gender . . . ."), *invalidated by* Brandt v. Rutledge, 677 F. Supp. 3d 877 (E.D. Ark. 2023).

320. Brief of Amicus Curiae Transgender Law Center et al. at 15, *In re* Hollister, 470 P.3d 436 (Or. Ct. App. 2020) (No. 171609).

often reject claims that sex is immutable while arguing for legal recognition of gender identity's immutability.[321]

Traditionally, courts have applied heightened scrutiny in the equal-protection context primarily to discrimination based on traits one did not choose but rather was born with. Immutability is one factor relevant to determining the level of scrutiny—though not a universally required one.[322] Some courts, such as the Fourth Circuit, have reformulated this criterion—which comes from footnote four of *Carolene Products*[323]—as requiring "obvious, immutable, or distinguishing characteristics."[324] Although immutability does not necessarily require a biological basis, it is often understood to overlap with biological elements and involve biological methods of proof.[325] Accordingly, courts may be more likely to protect traits understood as biologically immutable.

A similar dynamic exists in statutory antidiscrimination law, where litigants sometimes describe their protected-class membership in essentialist ways.[326] Jessica A. Clarke has criticized this phenomenon as "protected class gatekeeping," arguing that it often yields "ugly 'identity adjudication'" based on "biological standards and cultural stereotypes."[327]

To obtain sex-discrimination protections, trans litigants and their lawyers have at times argued that trans characteristics—namely variant gender identities—are immutable, biological, innate, unchangeable, or a combination thereof.[328] Advocates who hold this position do not negate the importance of gender exploration but rather claim that providing nonjudgmental spaces for

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321. Gay-rights advocates in the 1990s made similar arguments regarding immutability in the context of sexual orientation. *See* Janet E. Halley, *Sexual Orientation and the Politics of Biology: A Critique of the Argument from Immutability*, 46 STAN. L. REV. 503, 516-17 (1994).

322. Jessica A. Clarke, *Against Immutability*, 125 YALE L.J. 2, 13-14 (2015).

323. United States v. Carolene Prods. Co., 304 U.S. 144, 152 n.4 (1938).

324. Grimm v. Gloucester Cnty. Sch. Bd., 972 F.3d 586, 611 (4th Cir. 2020).

325. *See* Clarke, *supra* note 322, at 13-15. Janet E. Halley's pioneering work on this topic argues that gay-rights advocates needed to show biological causation to argue that sexual orientation is immutable, driving them to rely on biological theories about the "gay gene." *See* Halley, *supra* note 321, at 519-21, 524.

326. *See, e.g.*, McDonnell Douglas Corp. v. Green, 411 U.S. 792, 800-07 (1973) (establishing the test for Title VII disparate-treatment claims).

327. Jessica A. Clarke, *Protected Class Gatekeeping*, 92 N.Y.U. L. REV. 101, 147 (2017); *see also* Lihi Yona, *Identity at Work*, 43 BERKELEY J. EMP. & LAB. L. 139, 183 (2022) ("One major drawback of this biological turn is the immense power it affords scientists and doctors over group boundaries and interests.").

328. *Cf.* Courtney Megan Cahill, *Sex Equality's Irreconcilable Differences*, 132 YALE L.J. 1065, 1072 (2023) (identifying how sex-discrimination law typically accepts arguments based in biology and "physical differences").

such exploration allows minors to understand their *innate* gender identities.[329] Many litigants strategically deploy the bioessentialist idea that gender identity is "innate," "biological," and linked to a dimorphic sex characteristic (such as external genitals or gonads).[330] Trans-rights litigation continues implicitly and explicitly to deploy this "born in the wrong body" narrative—like the "born this way" narrative—likely due to the effectiveness of that approach.[331]

Trans litigants challenging the bans similarly argue that gender identity is fixed or unchangeable,[332] that it is "not a choice," and that it is "natural and immutable."[333] This strategic conceptualization of gender identity as immutable rejects the notion that trans people are not "real" men or women, supports trans

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329. *See* Florence Ashley, *"Trans" Is My Gender Modality: A Modest Terminological Proposal*, *in* TRANS BODIES, TRANS SELVES: A RESOURCE BY AND FOR TRANSGENDER COMMUNITIES 22, 22 (Laura Erickson-Schroth ed., 2d ed. 2022) (advocating for "the adoption of a new term: *gender modality*," which "refers to how a person's gender identity stands in relation to their gender assigned at birth").

330. *See, e.g.*, *Drummond* Complaint, *supra* note 181, at 16 ("[A] person's gender identity is durable and cannot be altered voluntarily or changed through medical intervention."); *Ladapo* Complaint, *supra* note 275, at 13 ("Research has shown that an individual's gender identity is innate and cannot be changed."); *see also* Maayan Sudai, *Toward a Functional Analysis of "Sex" in Federal Antidiscrimination Law*, 42 HARV. J.L. & GENDER 421, 424 (2019) (calling this strategy the "bio-essentialist turn"); Clarke, *supra* note 33, at 918 ("[C]ritics charge that feminists deny biological facts about sexual dimorphism in the human species or deny biology altogether."); Clarke, *supra* note 322, at 32 (proceeding to "sketch out . . . objections" to the new immutability); Silver Flight, *Gender: The Issue of Immutability*, U. CIN. L. REV. BLOG (Nov. 12, 2021), https://uclawreview.org/2021/11/12/gender-the-issue-of-immutability [https://perma.cc/PU5D-MEN5] (discussing "the role of immutability in anti-discrimination law regarding transgender, nonbinary, and other gender-nonconforming individuals" (footnotes omitted)).

331. *Cf.* Flight, *supra* note 330 (noting this is "one narrative of transgender experience"); Katri, *supra* note 261, at 642, 655 (identifying this as "a standard counter-narrative of trans and nonbinary identities and treatment as fraudulent").

332. *See, e.g.*, Plaintiffs' Verified Original Petition for Declaratory Judgment and Application for Temporary and Permanent Injunctive Relief at 12, Loe v. Texas, No. D-1-GN-23-003616 (Tex. Dist. Ct. 2023) ("[A] person's gender identity is durable and cannot be altered voluntarily or changed through medical intervention."); *Drummond* Complaint, *supra* note 181, at 16; *Ladapo* Complaint, *supra* note 275, at 13; *see also* Sudai, *supra* note 330, at 436-42 ("Biological gender arguments are becoming more common even among seemingly neutral actors."); Clarke, *supra* note 33, at 906-07 (arguing that gender as an identity is subjective and can thus only be known through individuals' accounts of their own experiences and that gender identity can be further rediscovered, given that gender-variant people live in societies ruled by binary conceptions of association between sex and gender).

333. Grimm v. Gloucester Cnty. Sch. Bd., 972 F.3d 586, 612 (4th Cir. 2020).

litigants' claims for equal protection, and promotes access to necessary health care, sex reclassification, and other gender-affirming practices.[334]

But within the intersex movement, "born this way" narratives, which can suggest that gender identity is a prenatal fact discovered early in life, can have harmful implications. Such narratives might justify medical interventions to make irreversible "correct" classifications at birth.[335] Intersex advocacy largely supports the rights to self-identification of gender identity and gender expression, including in ways that defy the traditional biological binary and the authority of sex assignment at birth.[336] While the intersex community's primary focus is on physical nonbinary sex characteristics, many in the community also support the recognition of gender as a spectrum.[337]

Pushing for new legal definitions of sex and gender from a trans perspective alone may lead advocates to overemphasize gender immutability. To show that

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334. *See, e.g.*, *Drummond* Complaint, *supra* note 181, at 9; Paisley Currah & Shannon Minter, *Unprincipled Exclusions: The Struggle to Achieve Judicial and Legislative Equality for Transgender People*, 7 WM. & MARY J. WOMEN & L. 37, 50-51 (2000); Florence Ashley, *The Constitutive In/Visibility of the Trans Legal Subject: A Case Study*, 28 UCLA WOMEN'S L.J. 423, 450-51 (2021); Rachel Slepoi, Bostock*'s Inclusive Queer Frame*, 107 VA. L. REV. ONLINE 67, 71-72 (2021); Katri, *supra* note 261, at 696.

335. ALICE DOMURAT DREGER, HERMAPHRODITES AND THE MEDICAL INVENTION OF SEX 188-89 (1998); *see also* ANNE FAUSTO-STERLING, SEXING THE BODY: GENDER POLITICS AND THE CONSTRUCTION OF SEXUALITY 1-5 (2000) (describing the implications of identifying someone as "female" when she had a Y chromosome); REIS, *supra* note 145, at 86 (recounting a doctor's "motivations for surgery [as] social rather than strictly medical" in children born with "hypospadias"); Maayan Sudai, *Sex Ambiguity in Early Modern Common Law (1629–1787)*, 47 LAW & SOC. INQUIRY 478, 479 (2022) ("Nevertheless, in some cases, not terribly common but also not so rare, sex did not declare itself at birth but, rather, puzzled viewers such as family members, neighbors, employers, midwives, and doctors."); Maayan Sudai, *'A Woman and Now a Man': The Legitimation of Sex-Assignment Surgery in the United States (1849–1886)*, 52 SOC. STUD. SCI. 79, 80 (2022) (relating the story of a girl whose "parents were eager to follow through" with a surgery); Katri, *supra* note 261, at 640-41 (noting "the pervasive harm caused by the initial act of assigning sex at birth").

336. Ironically, Dr. Money's understanding of gender was not simplistic but rather complex and multilayered: it recognized that gender does not emerge automatically at birth, is not determined by the gonads or chromosomes, and is developed gradually through one's life experiences. Money's concept of gender neutrality, however, was limited to the first year of life and did not further intersex interests. Rather than encouraging children to explore their gender identity, Dr. Money's conception of gender neutrality empowered medical practitioners to impose a gender identity on intersex people in infancy. *See supra* Section I.A.2.

337. *Intersex Is Not a Gender Identity, and the Implications for Legislation*, INTERACTION FOR HEALTH & HUM. RTS. (Dec. 2, 2019), https://ihra.org.au/17680/intersex-characteristics-not-gender-identity [https://perma.cc/5627-4RUW]; *Understanding the Intersex Community*, HUM. RTS. CAMPAIGN, https://www.hrc.org/resources/understanding-the-intersex-community [https://perma.cc/2KW6-ZDQH]; *FAQ: Intersex, Gender, and LGBTQIA+*, INTERACT: ADVOCATES FOR INTERSEX YOUTH (May 18, 2020), https://interactadvocates.org/faq/intersex-lgbtqia [https://perma.cc/65BT-4Y7M].

the bans discriminate against trans adolescents, a minority of litigants even demonstrated that doctors can and do prescribe puberty blockers, estrogen, and testosterone to cisgender minors to suspend or accelerate their puberty and for sex-normalization reasons.[338] Most trans litigants avoid arguments that harm intersex minors, focusing instead on how the bans enforce gender conformity rather than protect children. However, by emphasizing what the bans prohibit (affirmative care) while overlooking what they permit (sex normalization), these arguments risk reinforcing the idea that trans children should receive medical interventions because cis and intersex children do.[339]

2. *Intersex Advocacy: Nondimorphic Sex*

Intersex advocacy takes a different approach to legal definitions of sex and gender. Rather than arguing that gender identity is immutable, intersex advocates emphasize the inherent variability of sex characteristics and the need to recognize a spectrum of intersex variations.

From an intersex perspective, discrimination and humiliation under the law are a result of "natural differences in sex anatomy and physiology."[340] In response to laws that treat sex as biologically dimorphic[341] and binary (that is, laws that assume one's internal and external sex organs are either female or male),[342] intersex advocates critique these definitions as "incoherent and scientifically inaccurate" for failing to represent the "broad spectrum of natural intersex variations."[343] For intersex plaintiffs, a physiologically dimorphic definition of sex excludes many from antidiscrimination protections.[344]

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338. *See, e.g.*, Petition for a Writ of Certiorari, *supra* note 10, at 7.

339. *See Brandt* Complaint, *supra* note 181, at 32, 36 (arguing that the state's ban prohibits gender-affirming care but permits medical interventions for intersex minors, despite the fact that such interventions lack sufficient evidentiary support).

340. Brief for Amicus Curiae interACT: Advocates for Intersex Youth in Support of Plaintiffs-Appellees and Affirmance at 2, Hecox v. Little, 79 F.4th 1009 (9th Cir. 2023) (Nos. 20-35813, 20-35815) [hereinafter *Hecox* interACT Brief].

341. *See* Sudai, *supra* note 330, at 456.

342. *See Hecox* interACT Brief, *supra* note 340, at 4; Melanie Blackless, Anthony Charuvastra, Amanda Derryck, Anne Fausto-Sterling, Karl Lauzanne & Ellen Lee, *How Sexually Dimorphic Are We? Review and Synthesis*, 12 Am. J. Hum. Biology 151, 153 (2000).

343. *Hecox* interACT Brief, *supra* note 340, at 2-3.

344. *See id.* at 2; *Bostock* Amicus Brief, *supra* note 284, at 26-29; Free & Equal: United Nations for LGBTI Equality, *Intersex*, United Nations Hum. Rts. Off. of the High Comm'r [1], [2], https://www.unfe.org/sites/default/files/download/Intersex-English.pdf [https://perma.cc/YCH7-JEN8].

In practice, many dimorphic sex-classification statutes are not explicitly directed at intersex conditions but rather at trans identities and experiences. In addition to gender-affirming-care bans, states have passed anti-trans laws and policies related to bathrooms,[345] public-school facilities,[346] sports,[347] and dimorphic definitions of sex.[348] Trans advocacy and scholarship also argue that dimorphic definitions of sex are discriminatory because they presume a natural and neutral alignment of body attributes, social roles, and individual identities.[349]

Undoubtedly, both movements have an interest in problematizing the practice of doctors assigning newborns to a sex category, and both support the ability to change that categorization based on one's self-identification.[350] However, litigation concerning gender-affirming-care bans demonstrates that the legal framing of gender identity as immutable carries high stakes for trans and intersex people — and possibly for other gender-variant people as well.

Although intersex and trans advocates construct their demands in different ways, these groups share many positions on the variance of bodies, identities, and experiences. They both accept that assigned sex and gender identities are not complementary parts of a coherent, predetermined order of bodies and identities; they hold that gender may be nonbinary; and they reject the idea that sex is dimorphic.[351] Both movements highlight how legislation that defines sex as

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345. *See, e.g.*, FLA. STAT. § 553.865(2), (3)(*l*) (2024) (providing that "females and males should be provided restrooms and changing facilities for their exclusive use, respective to their sex," which the statute defines as "the classification of a person as either female or male based on the organization of the body of such person for a specific reproductive role, as indicated by the person's sex chromosomes . . . and internal and external genitalia present at birth").

346. *See, e.g.*, IOWA CODE § 280.33(2) (2024) (making it illegal to enter restrooms or changing areas in schools "that do[] not correspond with the person's sex").

347. *See, e.g.*, OKLA. STAT. tit. 70, § 27-106(E)(1) (2024) (prohibiting participation in women's and girls' sports by those whose biological sex was male at birth).

348. *See, e.g.*, MONT. CODE ANN. § 1-1-201(1) (2023) (defining individuals as "male" and "female" for the purposes of state statutes by the types of chromosomes and reproductive systems they possess). For an exploration of the impact of such legislation on intersex interests, see Alesdair H. Ittelson, *Attacks on Trans Athletes Are Also an Attack on Intersex People*, ACLU (Oct. 23, 2020), https://www.aclu.org/news/lgbtq-rights/attacks-on-trans-athletes-are-also-an-attack-on-intersex-people [https://perma.cc/R9JL-YJLW].

349. For an early identification of the growing legislative trend in relation to binary classification, see CURRAH, *supra* note 35, at 150-51. For further reading, see M. Dru Levasseur, *Gender Identity Defines Sex: Updating the Law to Reflect Modern Medical Science Is Key to Transgender Rights*, 39 VT. L. REV. 943, 946-47 (2015).

350. *See* Brief of Amicus Curiae Intersex & Genderqueer Recognition Project in Support of Plaintiff-Appellee at 24, Zzyym v. Pompeo, 958 F.3d 1014 (10th. Cir. 2020) (No. 18-1453).

351. *See FAQ: Intersex, Gender, and LGBTQIA+*, *supra* note 337; *About Transgender People*, ADVOCS. FOR TRANS EQUAL. (2024), https://transequality.org/trans-101/about-transgender-people [https://perma.cc/T28X-BYJL].

binary or as purely biological — as the gender-affirming-care bans do — has broad discriminatory effects.[352] Thus, the most frequent causes of conflict between trans and intersex legal interests are not trans or intersex advocates themselves but rather legal presumptions about sex and gender.

III. TOWARD AN INTERSECTIONAL NORMATIVE VISION

Legal recognition of the diversity of bodies and variance of identities would further both trans and intersex legal interests. Yet traditional legal assumptions about sex characteristics and gender identity force these groups to construct their demands in different and sometimes conflicting ways.

This Part offers a normative vision for trans and intersex political and legal alignment around shared principles. In doing so, however, we do not wish to conflate trans and intersex issues. The Article thus adopts an alternative approach: rather than presuming trans and intersex positions are either inherently contradictory or essentially identical, we translate their shared positions into doctrinal prescriptions and normative principles that can ground legal reasoning.

We first offer a doctrinal analysis of gender-affirming-care bans. We argue that the bans' contradictory treatment of trans and intersex minors fails even the lowest standard of constitutional scrutiny: rational-basis review. We then turn from the present litigation to the broader relationship between trans and intersex legal interests. In doing so, we offer a normative perspective on bodily self-determination that legal and political actors might apply in any of the various contexts — legal or otherwise — in which the interests of the intersex and trans communities intersect.

A. Legislative Irrationality

Examining gender-affirming-care bans through the lens of trans and intersex interests, both where they intersect and where they differ, exposes a deep inconsistency: these statutes prohibit trans-affirming care without restricting similar care for cisgender minors, and they effectively authorize nonconsensual intersex-normalizing interventions by excluding such interventions from their prohibitions. Scrutinizing the care protocols that the bans prohibit, permit, and approve alongside states' asserted interests clarifies why these statutes cannot withstand even rational-basis review.

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352. *Hecox* interACT Brief, *supra* note 340, at 18-23; *Bostock* Amicus Brief, *supra* note 284, at 22-26.

1. Rational-Basis Review

Rational-basis review is the most lenient form of judicial scrutiny under the Equal Protection Clause of the Fourteenth Amendment. Courts apply this standard of review in cases that do not involve either suspect classifications (such as race or religion) or fundamental rights. To survive rational-basis review, a law must rationally further a legitimate state interest.[353] A law might fail this test in certain circumstances, such as if its purported legitimate governmental purpose is pretextual—that is, if the law serves a legitimate interest but was enacted with an illegitimate aim, such as animus toward a particular group.[354] However, rational-basis review is widely regarded as highly deferential;[355] it presumes the constitutionality of a law, places the burden of proof on the challengers, and allows states to defend legislation with minimal justification.[356] Under this standard, courts uphold legislation as long as it is plausibly related to a legitimate governmental interest, which traditionally includes public health, safety, morals, and general welfare.[357] Over time, the scope of what constitutes a legitimate interest has evolved, sometimes resulting in inconsistent and perplexing applications.[358]

Key cases illustrate the Court's deferential approach to rational-basis review. In *United States v. Carolene Products Co.*, the Court upheld a prohibition on "filled milk" based on a plausible public-health interest, even without clear legislative intent.[359] Similarly, in *Williamson v. Lee Optical of Oklahoma, Inc.*, the Court

353. Nordlinger v. Hahn, 505 U.S. 1, 11 (1992).

354. Thomas B. Nachbar, *The Rationality of Rational Basis Review*, 102 VA. L. REV. 1627, 1659-60 (2016); Katie R. Eyer, *The Canon of Rational Basis Review*, 93 NOTRE DAME L. REV. 1317, 1319 (2017).

355. *See, e.g.*, Cass R. Sunstein, *Naked Preferences and the Constitution*, 84 COLUM. L. REV. 1689, 1713 (1984); James M. McGoldrick Jr., *The Rational Basis Test and Why It Is So Irrational: An Eighty-Year Retrospective*, 55 SAN DIEGO L. REV. 751, 756 (2018); Todd W. Shaw, *Rationalizing Rational Basis Review*, 112 NW. U. L. REV. 487, 491 (2017); Joseph Landau, *Broken Records: Reconceptualizing Rational Basis Review to Address "Alternative Facts" in the Legislative Process*, 73 VAND. L. REV. 425, 445 (2020).

356. *See* Raphael Holoszyc-Pimentel, Note, *Reconciling Rational-Basis Review: When Does Rational Basis Bite?*, 90 N.Y.U. L. REV. 2070, 2074-75 (2015); Erwin Chemerinsky, *The Rational Basis Test Is Constitutional (and Desirable)*, 14 GEO. J.L. & PUB. POL'Y 401, 410 (2016).

357. *See, e.g.*, Jacobson v. Massachusetts, 197 U.S. 11, 25-27 (1905).

358. *See* Nachbar, *supra* note 354, at 1656; Eyer, *supra* note 354, at 1366.

359. 304 U.S. 144, 148-49 (1937). Notably, footnote four of the opinion hinted at a tiered-scrutiny system, suggesting that more exacting judicial review might be warranted in cases involving discrete and insular minorities. *See id.* at 152 n.4; *see also* Shaw, *supra* note 355, at 494 (arguing that *Carolene Products* marked a divergence in how courts review standard economic regulations as opposed to laws involving "suspect" classifications or fundamental rights).

emphasized that legislation need only be plausibly justified, not empirically supported or optimal.[360] The principle that even underinclusive or imperfect laws can pass rational-basis review was affirmed in *Railway Express Agency, Inc. v. New York*, where the Court upheld an ordinance targeting certain vehicle advertisements, finding it rationally related to a legitimate interest in traffic safety despite its limited scope.[361] The Court further emphasized in *FCC v. Beach Communications, Inc.* that statutory classifications will be upheld if "there is any reasonably conceivable state of facts that could provide a rational basis."[362] Together, these cases — albeit all concerning economic regulation — underscore the broad latitude courts afford legislatures under rational-basis review, demonstrating why this standard is often considered "ultradeferential."[363] Courts applying this standard tend to defer to virtually any plausible rationale,[364] and, in some cases, the fact that a statute does not logically align with its proffered objectives is insufficient to render it unconstitutional.[365] As a result, scholars commonly describe rational-basis review as an empty or meaningless standard.[366]

Yet it is also widely accepted that rational-basis legal precedents are inconsistent and lack clear doctrinal guidelines.[367] In numerous cases, courts have invalidated laws without resorting to higher standards of scrutiny.[368] Indeed, despite general deference with respect to legitimate interests and rational

360. 348 U.S. 483, 487-88 (1955); *see also* Nachbar, *supra* note 354, at 1648-49 (pointing out that *Lee Optical* represents the Court's focus on the rationality of the means rather than on the rationality of the ends in rational-basis review); McGoldrick, *supra* note 355, at 775 (suggesting that the Court's rational-basis review in *Lee Optical* bypassed the legislature's obvious goal of suppressing competition among opticians in favor of letting the statute stand); Shaw, *supra* note 355, at 496-97 (arguing that the reasoning in *Lee Optical* illustrates the deferential nature of traditional rational-basis review).

361. 336 U.S. 106, 109-10 (1949). For a more recent example showing that the means chosen need only be conceivably related to the objective, see *Trump v. Hawaii*, 585 U.S. 667, 704-05 (2018).

362. 508 U.S. 307, 313 (1993).

363. Eyer, *supra* note 354, at 1321.

364. Landau, *supra* note 355, at 445.

365. *See* McGoldrick, *supra* note 355, at 772-74.

366. Eyer, *supra* note 354, at 1318-19 (describing the conventional view of rational-basis review); Richard E. Levy, *Escaping* Lochner*'s Shadow: Toward a Coherent Jurisprudence of Economic Rights*, 73 N.C. L. Rev. 329, 426-27 (1995).

367. *See* Eyer, *supra* note 354, at 1366 & n.231 (citing Thomas B. Nachbar, *Rational Basis "Plus,"* 32 Const. Comment. 449, 475-77 (2017)); Nicholas Walter, *The Utility of Rational Basis Review*, 63 Vill. L. Rev. 79, 89-90 (2018) (exploring deviations from deferential rational-basis review in some economic legislation); McGoldrick, *supra* note 355, at 786-88; Holoszyc-Pimentel, *supra* note 356, at 2072-73, 2106-17 (reviewing eighteen Supreme Court cases between 1971 and 2014 where laws were found to violate the Equal Protection Clause under scrutiny akin to rational-basis review).

368. *See* Eyer, *supra* note 354, at 1319.

relationships, the Court has applied the rational-basis standard in a more searching way when a law appears motivated by animus or irrational prejudice. Judicial review in such cases has sometimes been characterized by scholars as "rational basis with a bite."[369] In these cases, the court can shift the burden of proving a law's "rationality" to the state, examine the legitimacy of legislative objectives, "weigh the benefits and harms" of statutes, "demand persuasive evidence," and invalidate laws that "burden[] one group while ignoring other[s]."[370] These cases are also sometimes classified under the "animus" doctrine.[371] Here, laws targeting subordinated groups or displaying animus are invalidated even without the recognition of a "suspect classification" necessitating higher scrutiny.[372]

For example, in *United States Department of Agriculture v. Moreno*, the Court struck down a federal statute excluding households with unrelated individuals from food-stamp eligibility.[373] While the government claimed the law aimed to prevent fraud, the Court found that its actual purpose was to target "hippie" communities — an illegitimate governmental interest under the Equal Protection Clause.[374]

Similarly, in *Romer v. Evans*, the Court struck down a Colorado constitutional amendment that prohibited state or local protections for LGBTQ+ individuals.[375] The state argued that the law promoted legal uniformity, but the Court rejected this justification, recognizing that the amendment was rooted in animus toward a specific group.[376] The decision reinforced that laws motivated by prejudice do not pass the rational-basis test.

Beyond animus, the Court has been inclined to apply more meaningful review to legislation that discriminates based on immutable characteristics or burdens significant rights.[377] A strict application of rational-basis review is more likely when a law significantly impacts an important interest, even if it is not a formally recognized fundamental right.[378] These cases often involve laws that

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369. Holoszyc-Pimentel, *supra* note 356, at 2072 n.4 (discussing the term's derivation from Gerald Gunther, *The Supreme Court, 1971 Term — Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 18-19 (1972), Gerald Gunther's seminal work on equal protection).

370. *Id.* at 2075.

371. Eyer, *supra* note 354, at 1319.

372. *See id.*

373. 413 U.S. 528, 532-33, 534 (1973).

374. *Id.*

375. 517 U.S. 620, 635 (1996).

376. *Id.* at 626, 632.

377. Holoszyc-Pimentel, *supra* note 356, at 2085-86, 2089-91.

378. *Id.* at 2089-92.

burden interests nearing fundamental status or that have a substantial but indirect impact on a fundamental right. Rational-basis review in this context allows the Court to examine the law's justification carefully without triggering the broader implications of recognizing new fundamental rights.[379]

City of Cleburne v. Cleburne Living Center, Inc.[380] provides an example of a strict application of rational-basis review not directly connected to animus. In *Cleburne*, the Court struck down a zoning ordinance requiring a special permit for a group home for individuals with intellectual disabilities.[381] The Court recognized that the ordinance imposed unique burdens on a vulnerable group without a rational connection to legitimate safety concerns,[382] exemplifying the Court's willingness to scrutinize laws that disproportionately affect groups based on characteristics they cannot change.

Courts have also invalidated legislation when the means seem arbitrary and disconnected from the ends. For example, in *Reed v. Reed*, the Court struck down a statute that preferred men over women in estate administration, concluding that the arbitrary gender classification lacked any rational link to the state's objectives.[383] This and other Supreme Court cases striking down sex-discriminatory laws on rational-basis review signaled a shift toward more rigorous scrutiny of gender-based classifications and paved the way for intermediate scrutiny in gender-discrimination cases.[384]

Similarly, in *Plyler v. Doe*, the Court invalidated a Texas law denying public-education funding for undocumented children.[385] The state argued that the law was rationally related to preserving resources for citizens, but the Court found that the law's impact on vulnerable children outweighed the minimal savings to the state.[386] The Court's finding demonstrated that, even under rational-basis review, laws lacking a genuine, rational link to a legitimate governmental interest may be struck down.

Finally, in *United States v. Windsor*, the Court invalidated Section 3 of the Defense of Marriage Act (DOMA), which defined marriage for federal purposes

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379. *See id.*; Eyer, *supra* note 354, at 1357-59.

380. 473 U.S. 432 (1985).

381. *Id.* at 447-50.

382. Holoszyc-Pimentel, *supra* note 356, at 2087 & n.84; Eyer, *supra* note 354, at 1338; Shaw, *supra* note 355, at 512 & n.174.

383. 404 U.S. 71, 74, 76-77 (1971).

384. Katie R. Eyer, *Constitutional Crossroads and the Canon of Rational Basis Review*, 48 U.C. DAVIS L. REV. 527, 533 n.21, 540-41 (2014) (addressing the historical trajectory of this development in depth).

385. 457 U.S. 202, 223-30 (1982).

386. *Id.* at 227-30.

as a union between one man and one woman.[387] While the Court did not explicitly specify the level of scrutiny applied, it employed reasoning consistent with a heightened rational-basis review.[388] The Court concluded that DOMA's principal purpose was to impose inequality and disadvantage upon same-sex couples, which no legitimate federal interest could justify.[389] The Court's emphasis on federalism concerns and the potential harm to same-sex couples suggests a meaningful application of rational-basis review.[390]

Katie R. Eyer has critiqued the conventional portrayal of rational-basis review as ineffectual or "ultradeferential."[391] Eyer emphasizes that state and federal courts, including the Supreme Court, have often applied rational-basis review rigorously, if inconsistently, even outside of cases classified as "rational basis with a bite" or involving animus.[392] Eyer argues "there are strong reasons to believe" that it is exactly because rational-basis legal precedents are inconsistent and lack "clear, consistent doctrine" that litigants can plausibly make a wide range of arguments in any given case.[393] Although this lack of clarity poses challenges for social movements, it also makes rational-basis review a powerful "disruptive technology" that has been instrumental in advancing constitutional change.[394]

For example, in *Goodridge v. Department of Public Health*, the Massachusetts Supreme Judicial Court meticulously scrutinized the state's justifications for prohibiting same-sex marriage and found them lacking a rational basis.[395] Regarding two of the state's proffered rationales—providing a "favorable setting for procreation" and ensuring the "optimal setting for child rearing"—the court observed that the capacity to procreate has never been a prerequisite for marriage and that no evidence substantiated the claims that same-sex couples are inferior parents.[396] By exposing the irrationality of the state's arguments, the *Goodridge* decision demonstrated the potent capacity of rational-basis review to dismantle discriminatory laws.[397] This judicial approach not only afforded immediate relief to same-sex couples in Massachusetts, but also contributed to a broader

387. 570 U.S. 744, 749-52 (2013); *see* Shaw, *supra* note 355, at 500.

388. Holoszyc-Pimentel, *supra* note 356, at 2116.

389. *Windsor*, 570 U.S. at 769-74.

390. *See* Holoszyc-Pimentel, *supra* note 356, at 2096, 2116-17.

391. Eyer, *supra* note 354, at 1365-66.

392. *Id.*

393. *Id.* at 1366.

394. *Id.* at 1355-56.

395. 798 N.E.2d 941, 961-64 (Mass. 2003).

396. *Id.*

397. Eyer, *supra* note 354, at 1344-45.

nationwide shift,[398] laying the groundwork for subsequent legal developments, including the Supreme Court's recognition of a constitutional right to same-sex marriage in *Obergefell*.[399]

Despite all this, the view that invoking rational-basis review virtually ensures constitutional litigants will fail in their challenges remains widely held.[400] As a result, much of the current jurisprudence,[401] litigation,[402] and scholarship[403] on gender-affirming-care bans focuses on the applicability of higher levels of judicial scrutiny. However, as Eyer shows, cases pertaining to trans issues are particularly illustrative of the potential rational-basis review holds and have already demonstrated a substantial success rate for challenges brought in the pre-*Dobbs* era.[404] Even within the most deferential framework for judicial review, then, courts have the tools to invalidate laws that discriminate against trans people.[405]

2. Deferential Review of Tennessee's S.B. 1

Courts that have upheld gender-affirming-care bans have found that they withstand rational-basis review.[406] This Section examines how the Sixth Circuit applied a deferential form of rational-basis review to Tennessee's S.B. 1 and considers the implications for equal-protection jurisprudence.

Under rational-basis review, a court may recognize any conceivable governmental objective as a legitimate state interest, provided it is neither arbitrary nor

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398. Eyer, *supra* note 36, at 1493.

399. Eyer, *supra* note 354, at 1344-46, 1360-62.

400. *See* Eyer, *supra* note 36, at 1410.

401. The Sixth Circuit's decision in *Skrmetti* illustrates the difficulty of succeeding under rational-basis review. *See* L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 488 (6th Cir. 2023) ("Rational basis review applies, and it requires deference to legislatures, not to medical experts or trial court findings."), *cert. granted sub nom.* United States v. Skrmetti, 144 S. Ct. 2679 (2024). The dissent argued for heightened scrutiny, demonstrating the understanding that rational-basis review would likely lead to an unfavorable outcome. *See id.* at 498 (White, J., dissenting). In contrast to the Sixth Circuit, several district courts applied heightened scrutiny to similar bans on gender-affirming care. *See, e.g.*, Brandt v. Rutledge, 677 F. Supp. 3d 877, 917-18 (E.D. Ark. 2023); Doe v. Thornbury, 679 F. Supp. 3d 576, 582-86 (W.D. Ky. 2023), *rev'd sub nom.* L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460 (6th Cir. 2023). These decisions demonstrate the ongoing legal debate regarding the appropriate level of scrutiny for these types of laws.

402. *See, e.g.*, Brief for Petitioner at 19, United States v. Skrmetti, No. 23-477 (U.S. Aug. 27, 2024); Brief for American Bar Association as Amicus Curiae Supporting Petitioner at 13, *Skrmetti*, No. 23-477 (U.S. Sept. 3, 2024).

403. *See, e.g.*, Jessica A. Clarke, *Scrutinizing Sex*, 92 U. CHI. L. REV. 1, 7 (2025).

404. Eyer, *supra* note 36, at 1410.

405. *See* Holoszyc-Pimentel, *supra* note 356, at 2104 & n.196.

406. *See supra* Section I.C.2.

irrational.[407] The state's interest need not be explicitly articulated in the legislation, as courts may hypothesize plausible justifications during rational-basis review. Still, Tennessee's S.B. 1, the ban at the heart of the Supreme Court's review, does include extensive legislative findings that explicitly outline several governmental goals:

1. *Protecting Minors' Health and Welfare.* The state expresses a concern that minors may suffer physical and emotional harm as a result of gender-affirming care, emphasizing risks such as infertility, psychological distress, and irreversible physical changes.[408]

2. *Ensuring Informed Decision-Making.* S.B. 1 seeks to protect minors from making medical decisions they may later regret, raising concerns about their developmental capacity to grasp the long-term consequences of such treatments.[409]

3. *Regulating Experimental Treatments.* The legislature characterizes gender-affirming care as scientifically experimental, citing a lack of long-term studies and the absence of medical consensus.[410]

4. *Safeguarding Medical Ethics*. The law aims to uphold the ethical integrity of the medical profession, prevent healthcare providers' financial exploitation of minors, and control the influence of pharmaceutical companies.[411]

5. *Aligning with International Standards.* S.B. 1 references developing international health standards, noting some European nations' growing caution toward gender-affirming care for minors.[412]

6. *Encouraging Acceptance of Birth-Assigned Sex.* S.B. 1 asserts an interest in "encouraging minors to appreciate their sex" and prohibiting procedures that "might encourage minors to become disdainful of their sex."[413]

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407. *See* FCC v. Beach Commc'ns, Inc., 508 U.S. 307, 313-16 (1993).

408. TENN. CODE ANN. § 68-33-101(b) (2025).

409. *Id.* § 68-33-101(h).

410. *Id.* § 68-33-101(b).

411. *Id.* § 68-33-101(i) to (k).

412. *Id.* § 68-33-101(e).

413. *Id.* § 68-33-101(m).

The Sixth Circuit's opinion was highly deferential to these legislative objectives. The panel majority explicitly found several of these state interests legitimate and rejected none. The court ratified the state's authority to protect the health and safety of children,[414] including its interest in protecting minors from potentially harmful medical procedures, particularly those with uncertain long-term effects.[415] It further acknowledged the state's longstanding power to regulate the medical profession and limit access to specific treatments.[416]

The panel majority reached these conclusions over Judge White's dissent, which reflected an alternative application of rational-basis review. Judge White concluded that certain state interests articulated in S.B. 1 are illegitimate.[417] For example, she criticized the interest in encouraging minors to appreciate their birth-assigned sex as based on gender stereotypes and thus furthering the impermissible statutory objective of reinforcing gender norms.[418] That is, the emphasis on reinforcing traditional gender norms suggests that the purported health concerns are pretext for impermissible discrimination.

Regarding the means-ends test, the Sixth Circuit found a rational relationship between Tennessee's ban and the state's interest in protecting minors,[419] although it acknowledged that some jurisdictions might rationally adopt a different approach.[420] The court emphasized the principle of judicial deference to legislative decisions, particularly in areas of scientific and medical uncertainty.[421] It stressed the importance of democratic processes in addressing complex and evolving societal issues, cautioning against judicial intervention that could "impose a constitutional straightjacket on legislative choices."[422] This approach reflects a conventional understanding of how rational-basis review should be applied, predicated on the idea that courts should exercise restraint when reviewing the decisions of elected officials.[423]

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414. L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 473 (6th Cir. 2023), *cert. granted sub nom.* United States v. Skrmetti, 144 S. Ct. 2679 (2024).

415. *Id.*

416. *Id.* at 475.

417. *Id.* at 498 (White, J., dissenting).

418. Judge White explained that the statute's text "effectively reveal[s] that [its] purpose is to force boys and girls to *look* and *live* like boys and girls." *Id.* at 505 (citing TENN. CODE ANN. § 68-33-101(m) (2023)).

419. *Id.* at 489 (majority opinion).

420. *Id.* at 488.

421. *Id.*

422. *Id.* at 473.

423. *See* Holoszyc-Pimentel, *supra* note 356, at 2074.

The Sixth Circuit also selectively used empirical data in assessing the ban's rationality. The court pointed to evidence presented by Tennessee regarding potential risks associated with puberty blockers, cross-sex hormones, and gender-affirming surgeries.[424] And it emphasized that these risks, coupled with "flaws in existing research," provided a rational basis for the state's decision to prohibit these interventions for minors.[425] Yet in doing so, the court overlooked the strong body of evidence presented showing that gender-affirming care is safe and effective.[426]

The court noted that rational-basis review does not require courts to resolve scientific disputes or defer to trial-court findings based on conflicting expert testimonies.[427] Yet it paid almost no attention to empirical data provided by the plaintiffs, despite being highly receptive to data provided by Tennessee. Its analysis treated the requirement of a rational means-end relationship as satisfied by harms that are merely possible, even when contested.

Critically, the Sixth Circuit's analysis hinges on its rejection of heightened scrutiny. The court found that the ban did not involve suspect classifications warranting a more stringent level of review.[428] It concluded that S.B. 1 applied equally to all minors, regardless of sex, and did not perpetuate invidious stereotypes or unfairly allocate benefits and burdens based on sex.[429] This rejection of heightened scrutiny is a central point of disagreement with plaintiffs challenging the ban and other courts that have evaluated similar bans, including the district court in *Skrmetti* itself.[430]

This Article proposes an alternative to the pursuit of heightened scrutiny. Rational-basis review can provide a path to striking down these bans. Moving beyond arguments about animus and sex stereotyping, we examine the bans' differential treatment of two groups whose gender identity is incongruent with their sexed bodies—trans and intersex minors—to reveal the bans' internal

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424. *Skrmetti*, 83 F.4th at 489 (highlighting alleged concerns about bone-density loss, infertility, sexual dysfunction, and increased risks of various types of cancer).

425. *Id.*

426. *See, e.g.*, Brief for Biomedical Ethics and Public Health Scholars as Amici Curiae in Support of Plaintiffs-Appellees at 3-10, *Skrmetti*, 83 F.4th 460 (Nos. 23-5600, 23-5609); Brief of Amici Curiae American Academy of Pediatrics et al. in Support of Plaintiffs-Appellees and Affirmance at 15-21, *Skrmetti*, 83 F.4th 460 (Nos. 23-5600, 23-5609); *see also supra* Section I.A.1. (reviewing the development of trans-affirming care and the evidence supporting its availability to minors).

427. *Skrmetti*, 83 F.4th at 488 ("Rational basis review applies, and it requires deference to legislatures, not to medical experts or trial court findings.").

428. *Id.* at 483.

429. *Id.* at 486-87.

430. *See supra* Section I.C.1.

inconsistency. We highlight how this internal inconsistency makes it impossible for these bans to achieve *any* legitimate goal, thus rendering them so irrational that they must be struck down under even rational-basis review.

3. The Bans' Internal Irrationality

The concept of "rationality" is central to both everyday discourse and legal analysis, but its meaning may differ significantly between these contexts.[431] In colloquial terms, rationality implies decisions that are coherent, effective, and consistent with common sense.[432] Rational decisions are those made after reasoned deliberation and designed to achieve desirable outcomes efficiently.[433] By contrast, in the legal sphere—particularly in rational-basis review—the concept of rationality is narrower.[434]

Legal scholars have examined this divergence, arguing that rational-basis review's deferential approach can obscure significant flaws in legislative decision-making.[435] This standard nominally invokes "rationality" but narrowly interprets it as means-ends rationality,[436] evaluating only whether a conceivable connection exists between a law's provisions and its objectives, without requiring effectiveness.[437] Consequently, courts may uphold laws that meet this minimal threshold, even if they appear irrational in the colloquial sense.[438]

In cases where means do not serve the stated ends, rational-basis review *would* require a court to strike down the law.[439] In general, however, courts employ this standard of review to identify ends rather than to evaluate the means-ends relationship.[440] This is because courts infer the ends of legislation from the means; that is, they ask whether the means chosen by the legislature imply a legitimate purpose, even if unstated.[441] Furthermore, courts' focus on ends over the means-ends relationship seems to stem from assumptions that legislators are unlikely to be "so oblivious as to the consequences of [their] actions" that they

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431. Nachbar, *supra* note 354, at 1663-64.

432. *Id.* at 1664.

433. *Id.*

434. McGoldrick, *supra* note 355, at 757-58, 792.

435. *See, e.g.*, *id.* at 753-54; Landau, *supra* note 355, at 429.

436. Nachbar, *supra* note 354, at 1660-61, 1664.

437. *Id.*

438. *Id.* at 1669-71.

439. *Id.* at 1656.

440. *Id.* at 1687.

441. *Id.*

would adopt ineffective means,[442] that such mistakes would be corrected by the political process,[443] and that a court, under a deferential standard, could impute rationality to the legislature's choices.[444]

Even so, laws containing internal contradictions — where provisions work at cross-purposes — should fail rational-basis review. Contradictory provisions prevent courts from finding any consistent, conceivable justification for the law, even when they seek to invent one. After all, a law cannot rationally relate to a governmental interest if its provisions both support and negate that objective. Such legislative flaws will likely be irrational both with respect to the fit between the statute's means and its ends and with respect to the internal coherence of the statutory framework.[445] Simply put, meaningful scrutiny of contradictory legislative provisions can bring notions of colloquial rationality into rational-basis review.

Building on Eyer's argument about the transformative potential of rational-basis review, we argue that evidence of internal contradictions in a law raises serious constitutional questions that require meaningful judicial scrutiny. While we argue that the tools for this analysis exist already under the established rational-basis framework, this doctrinal understanding might be especially powerful for advancing constitutional claims in cases that involve deeply polarizing conflicts over values, beliefs, and social norms.

Internally inconsistent legislative provisions are constitutionally suspect. When courts have invalidated policies targeting trans and intersex individuals under rational-basis review, they have invoked principles including illegitimate purpose[446] and lack of logical alignment between means and ends.[447] Internal

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442. *Id.* at 1656.

443. *Id.* at 1657.

444. *Id.*

445. Thomas B. Nachbar refers to these concepts as instrumental and intrinsic rationality. Nachbar defines instrumental rationality as the logic that evaluates whether an action effectively achieves a desired outcome, focusing on the utility of means to reach specific ends. *See id.* at 1664-66. Courts use this in rational-basis review to assess whether laws reasonably advance legitimate government purposes. *See id.* at 1660-61. By contrast, intrinsic rationality pertains to the internal coherence of a system, judging an action's consistency within a broader framework regardless of outcomes. *See id.* at 1666-67. For instance, assigning two senators per state is intrinsically rational as it aligns with the Constitution's structural logic, reflecting deeper social values rather than mere practical utility. *See id.*

446. *See, e.g.*, Carcaño v. Cooper, 350 F. Supp. 3d 388, 421-22 (M.D.N.C. 2018) (finding that a law prohibiting trans people from entering public bathrooms could fail rational-basis review because plaintiffs plausibly pled discriminatory intent).

447. *See, e.g.*, Ray v. McCloud, 507 F. Supp. 3d 925, 939-40 (S.D. Ohio 2020) (finding that "there is no logical connection between" prohibiting transgender individuals from changing their

contradictions can reveal discriminatory motives, indicate a fundamental disconnect between a law's goals and its means, and create unpredictability and injustice in enforcement.

Recognizing the constitutional irrationality of internally inconsistent provisions can provide a strong basis for challenging the constitutionality of gender-affirming-care bans. The contradictory nature of the bans' simultaneous prohibitions on treatments for trans minors and permissive exclusions for interventions on intersex minors undermines the laws' constitutionality. Unlike other legislation that may be over- or underinclusive yet still survive rational-basis review, gender-affirming-care bans' internal inconsistencies render these laws self-defeating. Central to this inconsistency is the deliberate exclusion of intersex interventions. This is not merely an oversight, but a legislative choice aimed at ensuring that sex-normalizing procedures continue while gender-affirming care for trans minors comes to a halt.

The bans' exceptions for intersex interventions effectively bless these procedures. Yet normalizing interventions pose significant risks of infertility, psychological distress, and irreversible physical changes; negate the minor's and often the parents' ability to provide informed consent; lack long-term studies and medical consensus; are ethically questionable; and contradict evolving international standards.[448] That is, they are problematic on every ground upon which proponents of the bans criticize gender-affirming care.

But are these provisions truly contradictory? The answer lies in the "cure logic"[449] embedded within the bans. This logic operates under the assumption that medical interventions can "normalize" intersex bodies by "curing" intersexuality, thereby rendering these bodies "normal." This view is further reinforced by the fact that cisgender minors are excluded from the bans. According to this framework, the key distinction lies in the notion that medical intervention for trans minors is associated with affirming their *gender identity*, whereas, for intersex and cisgender minors, it is associated with altering or aligning their *sexed bodies* to a normative standard.

The "cure logic" presumes that natal intersex bodies are defective, that cisgender bodies are "healthy," and that gender-affirming care thus renders bodies

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sex markers on a birth certificate and any legitimate government purpose). Courts have also invalidated similar governmental discrimination through arbitrary-and-capricious review under the Administrative Procedure Act. *See, e.g.*, Zzyym v. Pompeo, 958 F.3d 1014, 1018 (10th Cir. 2020) (holding that three of the five reasons given by the State Department for refusing to issue an intersex individual a passport with an "X" designation, as opposed to male or female, were not supported by the administrative record and, thus, were arbitrary and capricious).

448. *See supra* Section I.A.2.

449. *See supra* Section I.A.2.

"unhealthy." However, these presumptions not only lack evidence but also construct trans and intersex bodies as analogous and trans and cisgender identities as binary classifications.

The bans' actual discrimination does not lie in simply allowing medical interventions for cisgender and intersex minors while prohibiting them for trans minors. Rather, it lies in the bans' distinct methods of enforcing sex-gender congruence. The goal of medical intervention differs by group. For trans and intersex minors, interventions address an *incongruence* between sex and gender; for cisgender minors, they affirm a *congruence* between the two. This distinction creates vastly different impacts: trans minors are denied affirmative care, intersex minors are often subjected to coercive interventions, and cisgender minors can voluntarily access similar endocrinological or surgical procedures — even absent medical necessity. These contradictory regulatory frameworks — prohibitive, permissive, and approving — must not be scrutinized separately but rather considered in combination to determine whether they are rationally related to the same state interests.[450]

But the bans' challengers have focused less on questioning the relationship between the states' asserted interests and the bans' actual provisions. Instead, they have provided evidence supporting the safety and effectiveness of gender-affirming care and have argued that the bans discriminate against trans youth based on their sex and transgender status. The challengers' core claim is that cisgender and intersex minors are allowed access to the same medical treatments that are denied to trans minors and that this unequal access demonstrates that the law unfairly targets trans minors for disadvantage.

Yet the bans' regulation through exclusion demands just as much scrutiny. The bans' contradictory regulatory frameworks contrast sharply with other cases where a law's contradictory effect exists only with respect to an issue on which the statute is silent. Ordinarily, statutory silence suggests a lack of regulatory intent (and perhaps a lack of consideration of the issue), which may not necessarily undermine its rationality in the constitutional sense. Yet gender-affirming-care bans are not silent on intersex and cisgender care. Instead, their explicit authorization of sex normalization and their permissive approach to interventions for cisgender minors demonstrate that the legislatures enacting these laws had affirmative intent regarding intervention in the sex characteristics of all minors.

These distinctions show that the bans go beyond targeting gender-affirming care for trans minors. They enforce the traditional alignment of sexed bodies and gender identities by differently regulating access to certain medical interventions

450. *See, e.g.*, L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 479-81 (6th Cir. 2023) (asserting that the bans "treat similarly situated individuals evenhandedly" and thus rejecting the argument that "skeptical, rigorous, or any other form of heightened review" should apply), *cert. granted sub nom.* United States v. Skrmetti, 144 S. Ct. 2679 (2024).

for all minors. While this reality might belie the claim that the bans reflect distinct, anti-trans animus, it reveals that the regulated medical interventions are not only a privilege denied to trans minors but also a coercive intervention imposed on intersex minors.[451] As a single regulatory framework, the bans' own contradictory provisions are simply irrational.

Before the Sixth Circuit, Tennessee justified its ban under rational-basis review as classifying based on age, diagnosis, or medical intervention.[452] That is, the state argued that the ban differentiates between trans minors and trans adults, between those diagnosed with gender dysphoria and those diagnosed with an intersex- or cisgender-related condition, and between those seeking a certain kind of intervention — what the court called "sex-transition"[453] — and those seeking other kinds of interventions. Yet the ban's contradictory provisions call all three of these assertions into question.

The first nonsuspect classification states and circuit courts identify is age. They argue that the bans allow trans adults to access the same care from which they bar trans minors.[454] Yet a critical inconsistency emerges upon review of the bans' complete statutory schemes. These laws impose restrictions on trans *adolescents*' access to care while simultaneously permitting invasive procedures for intersex *infants*. Thus, the true axis of distinction lies not between minors and adults but between trans adolescents and intersex infants and toddlers. In this way, the age justification collapses. Even if adolescents are less mature than legal adults, they certainly possess decision-making capacity superior to that of a newborn or toddler. If the bans aim to delay irreversible medical interventions until adulthood, then their intersex exclusions contradict their own stated objectives.

By prohibiting gender-affirming care for trans adolescents and permitting sex-normalizing interventions on intersex infants, the bans annul both groups' abilities to make decisions about their bodies. But the bans do so in contradictory ways — denying trans minors the ability to consent to treatment and denying intersex minors the ability to withhold such consent. If gender-affirming-care prohibitions are meant to ensure that minors do not make decisions they may later regret, how can the bans simultaneously permit irreversible interventions on intersex infants who cannot consent?

States also claim that the bans impose rational classifications based on minors' medical diagnoses. According to this argument, gender dysphoria is a unique diagnosis that has distinct results: whereas intervention in cisgender and intersex minors' sex characteristics restores "normal" function, medical

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451. *See supra* Part II.

452. *See Skrmetti*, 83 F.4th at 480-81.

453. *See, e.g.*, *id.* at 466.

454. *Id.* at 480.

intervention for gender dysphoria leads to "diseased states," such as high testosterone in female-assigned bodies.[455]

This diagnosis-related rationale lacks a logical connection to the bans' structure because it is undermined by scientific evidence about both gender-affirming care and intersex-normalizing interventions. Despite claiming to ban gender-affirming care because of scientific uncertainty, the bans authorize intersex interventions that are based on outdated and disputed care protocols — and they do so in the absence of long-term studies and with a less-substantial evidence base than that supporting gender-affirming care.[456]

The bans' proponents claim that they do not discriminate based on sex because they prohibit all minors, regardless of their sex, from engaging in "sex transition." But, as this Article reveals, this is simply untrue. The "sex transition" distinction overlooks a crucial fact: both gender-affirming care and sex-normalizing intervention address sex and gender incongruence. Intersex interventions are as much "sex transitions" as trans care. That is, the bans both prohibit *and permit* "sex transition."

Contrasting the bans' treatment of these interventions further uncovers the flawed assumptions underpinning the bans' differential treatment of trans and intersex minors: they presume that sex is naturally binary and possibly assume that intersex bodies are infertile. Unraveling these assumptions underscores the bans' dual impact, and thus their irrationality: they preserve the reproductive potential of trans minors' bodies (by prohibiting intervention) while designating intersex minors' bodies for possible sterilization (through sex normalization).[457] In other words, if the bans are supposed to protect minors from harm such as infertility, psychological distress, and irreversible changes, how can they permit sex-normalizing interventions?

Intersex interventions often produce the very outcomes the bans claim to prevent, including loss of sexual function, reduced fertility, and psychological distress. The claim that these procedures "normalize" bodies is misleading; they often alter natural anatomy without medical necessity and prioritize societal norms over individual well-being, just as the bans do. These outdated, ethically contentious protocols that lack comprehensive evidence undermine the laws' stated goal of protecting minors from harm. In contrast, gender-affirming care — which might, like any other field of science and medicine, benefit from additional research and development in response to patients' changing needs — is an evidence-based approach focused on enhancing psychological and physical well-being.

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455. *See, e.g.*, Reply Brief of Defendants-Appellants at 16, *Skrmetti*, 83 F.4th 460 (No. 23-5600).

456. *See supra* Section I.A.

457. On the question of intersex fertility, see *supra* note 153 and accompanying text.

Debates about intersex and trans care in the international arena have further crystallized these contradictions. While trans-affirming care has been subject to debates and reform rather than outright prohibition in some European states, sex-normalizing interventions have been banned in certain European countries and criticized all over the world.[458] For example, in 2021, the German parliament passed a law comprehensively prohibiting medical interventions on children and teenagers diagnosed with sex-development variations.[459] The law thus protects these minors' self-determination and decision-making capacity in the face of potential health risks.[460]

Given this medical evidence and international response, can the bans be said rationally to serve the state's asserted interests in avoiding medical harm resulting from gender-affirming care, maintaining the standards of the medical profession, or aligning with international caution regarding such treatments? They cannot. The bans' exclusion of intersex interventions indicates that either the laws' provisions are not rationally related to their objectives or the objectives themselves are illegitimate. Even taking the states' asserted interests at face value, prohibiting gender-affirming care while at the same time permitting sex-normalizing interventions is not a rational means of achieving those interests. Instead, these laws endorse outdated notions of sex and gender, ultimately risking the health and well-being of both trans and intersex minors.

The bans' internal contradictions expose their failure to meet the requirements of equal protection. If the state's true intent were to protect minors from medical harm, it would scrutinize all comparable interventions, regardless of gender identity or sex characteristics. By banning gender-affirming care for trans minors while allowing sex-normalizing surgeries for intersex minors, however, the state enforces conformity with birth-assigned sex rather than offering any genuine protection.

To understand why the bans' internal inconsistencies require that they fail rational-basis review, we return to the Massachusetts Supreme Judicial Court's analysis of the state's same-sex-marriage ban in *Goodridge*. There, the court struck down Massachusetts's law because the state's asserted interest in promoting procreation could not justify the ban's choice to isolate same-sex marriage for prohibition while permitting marriage between heterosexual couples who, for various reasons, could not procreate.[461] Similarly, gender-affirming-care

458. For a discussion of critiques related to genital surgery, see Elders et al., *supra* note 134, at 2.

459. Gesetz zum Schutz von Kindern mit Varianten der Geschlechtsentwicklung [Act to Protect Children with Variants of Sex Development], May 12, 2021, BUNDESGESETZBLATT, Teil I [BGBL I] at 1082 (Ger.).

460. *Id.* at 1082-83.

461. Goodridge v. Dep't of Pub. Health, 798 N.E.2d 941, 961-62, 969 (Mass. 2003).

bans claim to protect trans minors from the purported harms of gender-affirming interventions, yet they permit — and even bless — equally risky procedures for intersex minors. As in *Goodridge*, gender-affirming-care bans' internal inconsistencies cannot withstand rational-basis review because they lack a coherent approach to medical intervention in sex characteristics. The distinctions based on age, diagnosis, and medical intervention themselves undermine the purported aim of protecting minors and are simultaneously underinclusive and overinclusive.

States might defend the bans by arguing that the provisions rationally serve another state interest: enforcing societal norms of binary gender conformity. From this perspective, the provisions are consistent with the broader ideological goal of maintaining traditional gender roles. Yet a law must serve a legitimate state interest to survive rational-basis review. If the state's true motive is enforcing gender conformity — a goal that perpetuates social bias rather than serving a legitimate governmental function — the resulting legislation reflects unconstitutional discrimination. Courts have rejected such motives as illegitimate, scrutinizing laws rooted in societal bias under rigorous rational-basis review.[462]

Cleburne provides further insight into how contradictory provisions reveal irrational discrimination. In *Cleburne*, the Court struck down a zoning ordinance that imposed special restrictions on group homes for individuals with intellectual disabilities while exempting similar facilities like boarding houses or fraternities.[463] The Court determined that this selective application revealed prejudice, not a legitimate governmental interest, and thus failed rational-basis review.[464] Gender-affirming-care bans similarly claim to protect minors from the harms of gender-transition-related interventions but permit comparable or riskier procedures for other minors, such as intersex minors undergoing normalizing interventions or cisgender minors undergoing cosmetic surgeries. As in *Cleburne*, these bans fail rational-basis review because their contradictions reveal an illegitimate state interest rooted in societal bias, undermining their stated objective of protecting minors' health.

The deep incoherence created by the bans' contradictory treatment of gender-affirming care and intersex-normalizing interventions reveals their true aim: enforcing binary sex and gender norms rooted in sex stereotypes. This revelation might be grounds for applying more rigorous scrutiny to these laws, either because they discriminate against a quasi-suspect group based on their sex or

462. Eyer, *supra* note 384, at 578 n.202 (reviewing cases where courts scrutinize classifications rooted in group stigma or stereotypes and emphasizing meaningful scrutiny of bias and irrationality under rational-basis review).

463. City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432, 448-50 (1985).

464. *Id.*

transgender status or because they reflect animus against trans people.[465] But, more importantly, the juxtaposition of the bans' treatment of trans and intersex minors reveals an even simpler truth: these laws cannot survive even rational-basis review. This failure alone is sufficient to render them unconstitutional.

B. A Vision of Bodily Self-Determination

As we have demonstrated, the bans are only coherent to the extent that they adopt a fundamentally flawed approach to intersex and trans issues: the erroneous belief that sex is a necessarily binary alignment of biological characteristics and social identity at birth. This misconception drives discrimination against trans adolescents and justifies unnecessary medical procedures on intersex infants. However, uncovering this incoherence for the purposes of rational-basis review in litigation is insufficient. These problematic assumptions about sex and gender create tensions between intersex and trans legal interests and can motivate legal strategies that operate in opposition rather than in alliance.

To help mitigate these tensions, we offer a normative perspective on bodily self-determination to complement our doctrinal argument about the bans' irrationality. While we hope this theoretical intervention informs current debates, it also offers a broader strategy for aligning trans and intersex interests in mutual recognition and protection. This approach respects differences in advocacy methods, acknowledges opposition, and considers evolving public views, particularly regarding future efforts that could divide these groups.

Bodily self-determination is a core value that both the trans and intersex movements share.[466] In the context of a minor's health, we identify three relevant and intersecting dimensions of bodily self-determination: (1) gender exploration, (2) resistance to sex and gender normalization, and (3) access to a safe and supportive environment.

This articulation of a right to bodily self-determination builds upon and recontextualizes the framework developed by reproductive-justice scholars, as antiabortion legislation and gender-affirming-care bans both reflect antiquated legal presumptions about sex and gender.[467] Reproductive-justice scholarship also provides a model for meeting the needs of distinct communities with seemingly conflicting interests. We adapt this approach to address the shared yet divergent

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465. *See* Clarke, *supra* note 403, at 75-76.

466. *See, e.g.*, Dara E. Purvis, *Gender-Affirming Care and Children's Liberty*, 15 CONLAWNOW 155, 155 (2024) (considering self-determination, or "children's liberty," as a possible foundation for challenges to bans on gender-affirming care).

467. *See* Ben-Asher & Pollans, *supra* note 11, at 766-67 (describing courts' use of "history and tradition" tests from the abortion context in gender-affirming-care cases).

interests of trans and intersex minors, aiming to foster alignment while preventing one group's priorities from overshadowing the other's.[468] By building on the theoretical work of reproductive-justice scholars, we offer our own normative intervention to counter the legal and political landscape that pits trans and intersex interests against each other.

Reproductive-justice theory articulates its normative project as encompassing "(1) the right *not* to have a child; (2) the right to *have* a child; and (3) the right to *parent* children in safe and healthy environments."[469] Loretta J. Ross and Rickie Solinger document how this framework was developed in response to pro-choice advocacy's failure to address the broader reproductive-health needs of racialized and other historically marginalized communities.[470] Reproductive-justice scholars criticized grounding the abortion right in the right to privacy as inadequate to account for socioeconomic factors that limit access to reproductive choices, such as forced sterilization and the lack of sufficient child-support services.[471]

The three-dimensional approach developed by reproductive-justice scholars is particularly helpful in its ability to move beyond ensuring the *existence* of choice to ensuring that people can effectively *exercise* it.[472] These dimensions address the complexities of reproductive rights — primarily those affecting access to health care — and underscore the broader systemic challenges facing those who seek to vindicate these rights. Though mainstream movements initially rejected this approach, the majority of reproductive-rights advocates and litigants today have embraced reproductive-justice principles.[473]

We further draw from disability studies on reproductive health, which identify and scrutinize the harmful cultural biases, eugenic tendencies, and reductive medical paradigms that shape the discourse on pregnancy for those with

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468. We are not the first to draw connections between the reproductive-justice framework and access to affirming care. *See, e.g.*, Florence Ashley, *Adolescent Medical Transition Is Ethical: An Analogy with Reproductive Health*, 32 KENNEDY INST. ETHICS J. 127, 127-30 (2022); Blas Radi, *Reproductive Injustice, Trans Rights, and Eugenics*, 28 SEXUAL & REPROD. HEALTH MATTERS 396, 396 (2020).

469. LORETTA J. ROSS & RICKIE SOLINGER, REPRODUCTIVE JUSTICE: AN INTRODUCTION 9 (2017).

470. *See generally id.* (documenting the history and development of the reproductive-justice framework).

471. *See, e.g.*, Melissa Murray, *Race-ing* Roe*: Reproductive Justice, Racial Justice, and the Battle for* Roe v. Wade, 134 HARV. L. REV. 2025, 2091-93 (2020); Erwin Chemerinsky & Michele Goodwin, *Abortion: A Woman's Private Choice*, 95 TEX. L. REV. 1189, 1210-13 (2016) (describing the limits of *Roe v. Wade*'s protections). In the context of disability, see Robyn M. Powell, *Forced to Bear, Denied to Rear: The Cruelty of* Dobbs *for Disabled People*, 112 GEO. L.J. 1095, 1098-99 (2024).

472. *See* ROSS & SOLINGER, *supra* note 469, at 9, 266.

473. Murray, *supra* note 471, at 2056-57.

disabilities.[474] For example, the portrayal of life with a disability as inherently negative limits access to parenthood for people with disabilities.[475] Disability scholarship underscores that both access and choice involve a complex interplay of environmental, architectural, juridical, social, and cultural factors.[476]

Disability scholars have long shown that disability is produced and perpetuated by inaccessible and exclusionary structures, and they have challenged the medical model that views disability solely as an individual condition.[477] Alison Kafer has emphasized the role of relational decision-making in creating a world in which disability is desired rather than disavowed.[478] According to Kafer, choices are not purely autonomous and individualistic but rather shaped by kinship and community relationships, material conditions, broader societal factors, and historical legacies of oppression or privilege.[479] This perspective underscores the importance of care practices that can accommodate decision-making across a spectrum of abilities.[480]

Reproductive justice and disability studies intersect at a pivotal site for the alignment of trans and intersex legal interests: the body. Reproductive justice, which is rooted in advocating for meaningful choice in reproductive health, is expanded by disability scholars' focus on dismantling ableist structures and supporting relational decision-making. These frameworks for understanding the

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474. *See, e.g.*, Michelle Jarman, *Relations of Abortion: Crip Approaches to Reproductive Justice*, 27 Feminist Formations, no. 1, 2015, at 46, 49-50.

475. *Cf.* Mary Ziegler, *The Disability Politics of Abortion*, 2017 Utah L. Rev. 587, 625 (discussing the disconnect between disability-based justifications for abortion and the reproductive-justice movement's focus on autonomy).

476. *See, e.g.*, Doron Dorfman, *The Inaccessible Road to Motherhood—The Tragic Consequence of Not Having Reproductive Policies for Israelis with Disabilities*, 30 Colum. J. Gender & L. 49, 49, 63-64, 67 (2015); Robyn M. Powell, *Safeguarding the Rights of Parents with Intellectual Disabilities in Child Welfare Cases: The Convergence of Social Science and Law*, 20 CUNY L. Rev. 127, 130-34 (2016); Sarah H. Lorr, *Unaccommodated: How the ADA Fails Parents*, 110 Calif. L. Rev. 1315, 1326-30 (2022); Sarah H. Lorr, *Disabling Families*, 76 Stan. L. Rev. 1255, 1275-78 (2024); Robyn M. Powell, *Legal Ableism: A Systematic Review of State Termination of Parental Rights Laws*, 101 Wash. U. L. Rev. 423, 429-31 (2023).

477. Jarman, *supra* note 474, at 61. According to the social model, people are disabled by societal barriers, not by their conditions or differences. *See* Doron Dorfman, *Disability as Metaphor in American Law*, 170 U. Pa. L. Rev. 1757, 1789-91 (2022). In other words, society disables people by failing to remove barriers to full participation. Note that the social model of disability has evolved throughout the years to have more complex meanings and interplays. *See id.* at 1792-97; Belt & Dorfman, *supra* note 266, at 185-88.

478. Alison Kafer, Feminist, Queer, Crip 3, 4, 24, 60-61 (2013).

479. *Id.* at 2-9, 91.

480. *Cf.* Samuel R. Bagenstos, *Disability and Reproductive Justice*, 14 Harv. L. & Pol'y Rev. 273, 289 (2020) (describing widespread informal sterilization of intellectually disabled people, who often play no role in the decision-making process before an operation).

relationship between agency, the body, and society can help address the diverse yet intersecting needs and interests of trans and intersex people.

We build on existing scholarship in intersex and trans studies to conceptualize bodily self-determination in ways that encourage normative alignment of intersex and trans interests. To articulate the three dimensions, we use gender modality as a descriptive framework.[481] This approach not only transcends traditional male/female binaries but also challenges the binary categories of "cisgender" and "transgender," offering a more nuanced understanding of gendered experiences.[482] As Florence Ashley, Shari Brightly-Brown, and G. Nic Rider explain, while gender identity reflects an individual's internal sense of self, gender modality examines how that identity aligns – or diverges – from one's gender assigned at birth.[483]

Equally important, we draw on *A Framework for Intersex Justice* and works by Sean Saifa Wall, which deeply integrate intersex perspectives into the broader concept of bodily self-determination.[484] Wall's contributions expand the scope of this framework by centering the lived realities of intersex individuals and highlighting the structural inequities they face. By incorporating both gender modality and the intersex-justice framework, we gain a deeper understanding of the spectrum of experiences that shape the needs and rights of trans and intersex minors.

Building on this understanding, we center the right to bodily self-determination as an alternative to antidiscrimination arguments. Scholars like Dean Spade[485] and Libby Adler,[486] who critique limited ideas of "choice" and "privacy" within the law, show how these concepts often fail to protect trans rights fully.

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481. *See* Florence Ashley, Shari Brightly-Brown & G. Nic Rider, *Beyond the Trans/Cis Binary*, 630 NATURE 293, 293-95 (2024).

482. *See id.* (noting that while "cisgender" and "transgender" are widely recognized terms, gender modality captures agender, detransitioned, intersex, and other gender-expansive identities).

483. *Id.*

484. *A Framework for Intersex Justice*, INTERSEX JUST. PROJECT, https://www.intersexjusticeproject.org/intersex-justice-framework.html [https://perma.cc/X3TH-USSY]; *e.g.*, Sean Saifa Wall, *Reconceptualising Intersex Embodiment*, *in* INTERSEX STUDIES: A MULTIDISCIPLINARY EXPLORATION 12, 12 (Marisela Montenegro, Joan Pujol, Lucas Platero, Amets Suess Schwend & Surya Monro eds., 2024) [hereinafter Wall, *Reconceptualising Intersex Embodiment*]; Sean Saifa Wall & Bianca I. Laureano, *Intersex Activism, Movement, and Joy: In Conversation with Sean Saifa Wall*, *in* THE PEOPLE'S BOOK OF HUMAN SEXUALITY: EXPANDING THE SEXOLOGY ARCHIVE 175, 177 (Bianca I. Laureano ed., 2023); Sean Saifa Wall, *Standing at the Intersections: Navigating Life as a Black Intersex Man*, 5 NARRATIVE INQUIRY BIOETHICS 117, 117 (2015).

485. SPADE, *supra* note 31, at 22, 90.

486. LIBBY ADLER, GAY PRIORI: A QUEER CRITICAL LEGAL STUDIES APPROACH TO LAW REFORM 22, 29, 55 (2018).

Their work supports a vision of equality rooted in interdependence, challenging individualistic legal frameworks and advancing collective notions of self-determination.

This approach to self-determination resonates with the idea of a "collective self,"[487] an understanding of agency grounded in the mutual vulnerability and interdependence that shapes lived experiences.[488] This contrasts with what some call "gender self-determination" in sex-classification policies, which emphasizes an individual's right to define and express their gender without social or community influence.[489] The collective perspective recognizes that bodies and identities, particularly young ones, exist in dependence and independence. They rely "upon parents or kinship relations, or upon social institutions, to survive and grow and (presumably) learn."[490] Here, the right to self-determination is not isolated but inherently bound to the networks of connections and shared responsibility that make life itself possible and meaningful.

These three dimensions of bodily self-determination represent a normative vision, crafted as a collage of existing doctrines, frameworks, ideas, and principles. This vision aims to lay the groundwork for normative allyship in the pursuit of trans and intersex health and well-being, to transcend existing constitutional constraints and state narratives, and to offer alternative perspectives on supporting minors' health, well-being, and capacity for effective decision-making.[491]

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487. Eric A. Stanley, *Gender Self-Determination*, 1 Transgender Stud. Q. 89, 90 (2014).

488. Judith Butler, Precarious Life: The Powers of Mourning and Violence 49 (2004).

489. Katri, *supra* note 261, at 644, 695-700. Although a right to self-identification is slowly becoming available in sex assignment at birth, it is framed as a negative right geared toward inclusion within a binary legal system and is therefore limited in its ability to address the intersecting systemic harms faced by trans and intersex minors. *See id.* at 696-97. Notably, there are other further articulations of gender self-determination that go beyond reclassification policies. *See, e.g.*, Florence Ashley, *Gender Self-Determination as a Medical Right*, 196 Canadian Med. Ass'n J. E833-34 (2024).

490. Judith Butler, The Force of Nonviolence: An Ethico-Political Bind 37 (2020). As Judith Butler explains, the classic social-contract theories of Locke, Rousseau, and Hobbes assume an original human who is, from the outset, an independent adult male. *Id.* at 38. This original man emerges fully capable, without ever having relied on others for support, nourishment, or warmth, as if he was never a child or dependent on another body for survival. *Id.* at 36. Butler challenges this narrative by suggesting that human vulnerability, not self-sufficiency, is foundational to our experience, emphasizing that dependency and care are inherent aspects of being human. *Id.* at 45-48.

491. *Cf.* Kafer, *supra* note 478, at 3 (arguing that her theory of disability-rights politics serves "as a framework for thinking through how to get 'elsewhere,' to other ways of being that might be more just and sustainable").

1. *Gender Exploration*

Gender exploration emphasizes minors' essential need to explore and express their gender identities and bodies. It necessitates the creation of conditions that not only respect but enable gender variance and bodily diversity. This involves guaranteeing universal access to gender-affirming care and support services that encourage environments where gender exploration is prioritized over enforcing binary gender roles. Applying affirming-care standards to all medical interventions in sex characteristics would not only serve trans minors but would also enable intersex minors to choose whether, when, and how to access medical treatments. For both groups, this approach would ensure that minors can access medical interventions through a supported decision-making process in which they receive guidance from trusted adults who help them understand their options and make informed choices based on their needs and circumstances.[492]

For trans minors, facilitating gender exploration might involve removing barriers to expressing variance of gender identity in social settings, such as schools and community centers.[493] It could also include ensuring access to age-appropriate gender-related healthcare services, such as hormone blockers and gender-affirming surgeries. This need is even more acute for nonbinary minors who are further burdened by the expectation that they adopt a binary identity.

For intersex minors, gender exploration can support navigation and understanding of gender identity outside the binary norms often imposed at birth. This means providing space for intersex minors to explore their identities

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492. Supported decision-making is an approach that shifts the focus from solely assessing capacity to providing support in decision-making according to one's abilities. Nina A. Kohn, Jeremy A. Blumenthal & Amy T. Campbell, *Supported Decision-Making: A Viable Alternative to Guardianship?*, 117 PENN ST. L. REV. 1111, 1120-21 (2013). Originating in disability studies, it helps individuals, particularly those with cognitive or intellectual disabilities, make informed decisions with guidance from trusted people. *See* Peter Blanck, *Supported Decision-Making: Emerging Paradigm in Research, Law, and Policy*, 34 J. DISABILITY POL'Y STUD. 3, 3 (2023); Andrew Peterson, Jason Karlawish & Emily Largent, *Supported Decision Making with People at the Margins of Autonomy*, 21 AM. J. BIOETHICS, no. 11, 2020, at 4, 4-12. For trans minors, supported decision-making could enable age-appropriate gender-related healthcare decisions by ensuring they have the resources and support needed to fully understand and engage in their choices. For a similar discussion on scaffolding trans youth decision-making in medical contexts, see Florence Ashley, *Youth Should Decide: The Principle of Subsidiarity in Pediatric Transgender Healthcare*, 49 J. MED. ETHICS 110, 113 (2023).

493. Like national policies, local-level policy changes, such as shifting rules at schools, might be able to affect identity-shaping norms. *Cf.* SPADE, *supra* note 31, at 57-59 (arguing that gender is not merely a matter of personal choice but is policed and regulated through law and policy). Law and policy can produce destabilizing outcomes for trans and intersex people. For example, programs using birth-assigned sex for categorization often provide security for "normal" minors while creating insecurity for trans and intersex minors. *Id.* at 66-69.

without premature and nonconsensual medical interventions aimed at conforming their bodies to traditional male or female categories.[494]

For all other minors, gender exploration allows young people to experience a range of gender expressions without rigid adherence to gender expectations. Bodily self-determination requires providing all minors with the conditions in which they can explore their gender without stigma or pathologization.

2. Protection Against Sex Normalization

As a dimension of bodily self-determination, protection against sex normalization emphasizes the need to protect children from coercive social and medical normalizing procedures. It grants everyone, but especially minors, the ability to refuse medical or societal attempts to "normalize" their gender expression or sex characteristics. Creating these protections involves addressing structural obstacles that undermine trans minors' relational and supported decision-making and ensuring that choices about sex characteristics and gender expression are assisted by familial, medical, and communal guidance. It emphasizes minors' active involvement in these decisions and opposes nonconsensual medical interventions and practices that resemble conversion therapy.

For intersex minors, protection from normalization is the most fundamental aspect of bodily self-determination. Intersex groups strongly oppose nonconsensual normalizing interventions on intersex bodies at any age but particularly at the ages—such as infancy—when the child cannot participate in decision-making in any way.[495] Normalizing interventions often lack medical necessity and result in significant physical and psychological harm.[496] Protection against normalization would preserve intersex minors' bodily integrity and allow them to develop with less pressure to conform to gender norms.[497]

For trans minors, this dimension highlights the need to resist practices that enforce binary gender roles or other forms of coerced care. Trans minors are vulnerable to coercive social-normalization practices, including conversion

494. *Cf.* Wall, *Reconceptualising Intersex Embodiment*, *supra* note 484, at 15-17, 21 (critiquing societal and medical norms' erasure of intersex identity and supporting the right to gender exploration beyond traditional categories).

495. Nonconsensual interventions on intersex infants can produce long-term harm. *See* Adeline W. Berry & Surya Monro, *Ageing in Obscurity: A Critical Literature Review Regarding Older Intersex People*, 30 Sexual & Reprod. Health Matters 44, 45-47 (2022) (reviewing literature on the experiences of older intersex individuals, highlighting how medical interventions in infancy often lead to lifelong challenges, and reinforcing the need to resist early normalization practices).

496. *Id.* at 44, 45-47.

497. *See* Wall, *Reconceptualising Intersex Embodiment*, *supra* note 484, at 17, 21.

attempts.[498] Like intersex minors, trans minors thus also suffer acute challenges in resisting normalization.[499]

For all minors, protection from normalization ensures that they are not subjected to coercive practices that seek to enforce traditional gender norms. And it affirms the importance of sovereignty over the body.

As we have explored, empirical evidence demonstrates the long-term harm caused by nonconsensual normalizing interventions, revealing the importance of protecting minors and adults from such practices.[500] Studies show that these procedures often result in significant adverse outcomes, both physically and psychologically, underscoring the need to support people's ability to make informed decisions about their sex characteristics and gender expression.[501]

Sex and gender normalization is structured by law and policy that enforce the presumption of sex as dimorphic and gender as binary. Protection from normalization is practically annulled when minors are excluded from decision-making around their own bodies. Parents are also limited in their ability to resist.[502]

The current constitutional debates over gender-affirming-care bans lack any meaningful attention to protecting minors from social and medical normalization. Instead, litigants predominantly frame the issue within the context of trans minors' interests in accessing care. In doing so, they neglect the structural obstacles, such as the intersex exclusions in the bans, that perpetuate coercive normalization practices.

3. Safe and Supportive Environments

Safe and supportive environments are those that enable bodily self-determination and support minors' diversity of gender identities and bodies without judgment or discrimination. Constructing such environments requires ensuring that parents, healthcare providers, educators, and society at large create conditions that enable gender exploration and protect against the harms of

498. *See* Christy Mallory, Taylor N.T. Brown & Kerith J. Conron, *Conversion Therapy and LGBT Youth: Update*, WILLIAMS INST. 7 (June 2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Update-Jun-2019.pdf [https://perma.cc/KXV7-9UQM].

499. SPADE, *supra* note 31, at 82-83, 91-92 (critiquing coercive medical practices that enforce normative gender roles and emphasizing the importance of being able not just to access affirming care but also to resist normalization).

500. *See supra* Section I.A.2.

501. Berry & Monro, *supra* note 495, at 45, 48.

502. Jake Pyne, *"Parenting Is Not a Job . . . It's a Relationship": Recognition and Relational Knowledge Among Parents of Gender Non-Conforming Children*, 27 J. PROGRESSIVE HUM. SERVS. 21, 31-33 (2016).

normalization. This paradigm shift calls for addressing the deep-seated structural barriers and systemic forces that perpetuate coercive social and medical normalization practices, particularly against trans, intersex, and other gender-variant and bodily diverse minors.

All minors would benefit from their parents having the knowledge and resources to advocate for their needs. Healthcare providers should prioritize minors' well-being and agency by prohibiting nonconsensual interventions and promoting gender-affirming care.[503] Schools should train educators to disrupt discrimination and provide gender-affirming facilities and mental-health resources.[504] Public policy must prioritize trans and intersex voices and consider the lived experiences of people marginalized for their sex and gender, as well as the intersection of sex and gender with race, class, and disability.

Framing the bans as an issue of individual autonomy ignores the social structures that uphold certain norms regarding bodies, identities, and experiences. Centering advocacy on safe and supportive environments can shift the focus from merely protecting individual rights to addressing the systemic forces that

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503. *See, e.g.*, Vanessa Bailon & Elsie Duff, *Supporting Transgender Adolescents: Best Practices*, 19 J. FOR NURSE PRACS. art. no. 104741, at 1, 2 (2023); Claire A. Coyne, Briahna T. Yuodsnukis & Diane Chen, *Gender Dysphoria: Optimizing Healthcare for Transgender and Gender Diverse Youth with a Multidisciplinary Approach*, 19 NEUROPSYCHIATRIC DISEASE & TREATMENT 479, 490-91 (2023); Samantha J. Gridley, Julia M. Crouch, Yolanda Evans, Whitney Eng, Emily Antoon, Melissa Lyapustina, Allison Schimmel-Bristow, Jake Woodward, Kelly Dundon, RaNette Schaff, Carolyn McCarty, Kym Ahrens & David J. Breland, *Youth and Caregiver Perspectives on Barriers to Gender-Affirming Health Care for Transgender Youth*, 59 J. ADOLESCENT HEALTH 254, 260 (2016); Beth A. Clark, Jaimie F. Veale, Marria Townsend, Hélène Frohard-Dourlent & Elizabeth Saewyc, *Non-Binary Youth: Access to Gender-Affirming Primary Health Care*, *in* TODAY'S TRANSGENDER YOUTH: HEALTH, WELL-BEING, AND OPPORTUNITIES FOR RESISTANCE 44, 44-55 (Ryan J. Watson & Jaimie F. Veale eds., 2020); Marijke Naezer, Anke Oerlemans, Gijs Hablous, Hedi Claahsen-van der Grinten, Anna van der Vleuten & Chris Verhaak, *'We Just Want the Best for This Child': Contestations of Intersex/DSD and Transgender Healthcare Interventions*, 30 J. GENDER STUD. 830, 834-43 (2021); Amy C. Tishelman, Randi Kaufman, Laura Edwards-Leeper, Francie H. Mandel, Daniel E. Shumer & Norman P. Spack, *Serving Transgender Youth: Challenges, Dilemmas, and Clinical Examples*, 46 PRO. PSYCH. 37, 41-43 (2015).

504. *See, e.g.*, Michelle M. Johns, Alithia Zamantakis, Jack Andrzejewski, Lorin Boyce, Catherine N. Rasberry & Paula E. Jayne, *Minority Stress, Coping, and Transgender Youth in Schools—Results from the Resilience and Transgender Youth Study*, 91 J. SCH. HEALTH 883, 891-92 (2021); Julia Sinclair-Palm & Jen Gilbert, *Naming New Realities: Supporting Trans Youth in Education*, 18 SEX EDUC. 321, 323-26 (2018); Patrick Mulkern, August Wei & Maggi Price, *Best Practices for Supporting Transgender Youth in Schools*, ENCYC. SOC. WORK 2, 8-11 (Oct. 23, 2024), https://oxfordre.com/socialwork/display/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1657?print=pdf [https://perma.cc/P3P4-7QZB].

enforce binary gender norms.[505] And foregrounding broader socioeconomic conditions such as housing, poverty, and healthcare access is crucial for creating such environments.[506] This approach recognizes the interconnected interests of trans and intersex minors, whose experiences of discrimination and lack of support reveal broader implications for bodily self-determination.

4. Applicability

Federal courts have yet to recognize formally a right to bodily self-determination.[507] The law is a limited avenue for social change, particularly in the

505. Consider, for instance, the relationship between the carceral geography of gender-binary segregation and its effects on transgender and gender-nonconforming individuals. *See* Lihi Yona & Ido Katri, *The Limits of Transgender Incarceration Reform*, 31 YALE J.L. & FEMINISM 201, 242 (2020).

506. For further reading on transgender people and homelessness, see Jama Shelton & Lynden Bond, *"It Just Never Worked Out": How Transgender and Gender Expansive Youth Understand Their Pathways into Homelessness*, 98 FAMS. SOC'Y 284, 286-90 (2017); Jama Shelton, *Transgender Youth Homelessness: Understanding Programmatic Barriers Through the Lens of Cisgenderism*, 59 CHILD. & YOUTH SERVS. REV. 10, 12-16 (2015); Jen Reck, *Homeless Gay and Transgender Youth of Color in San Francisco: "No One Likes Street Kids"—Even in the Castro*, 6 J. LGBT YOUTH 223, 224-40 (2009); Jennifer L. Glick, Alex Lopez, Miranda Pollock & Katherine P. Theall, *Housing Insecurity and Intersecting Social Determinants of Health Among Transgender People in the USA: A Targeted Ethnography*, 21 INT'L J. TRANSGENDERISM 337, 339-46 (2020); and Dilara Yarbrough, *The Carceral Production of Transgender Poverty: How Racialized Gender Policing Deprives Transgender Women of Housing and Safety*, 25 PUNISHMENT & SOC'Y 141, 146-56 (2023).

507. Chemerinsky & Goodwin, *supra* note 471, at 1200. However, aspects of a right to bodily self-determination have been recognized in various decisions. *See, e.g.*, Skinner v. Oklahoma, 316 U.S. 535, 541 (1942) (recognizing procreation as a fundamental right, stating that such drastic procedures could not be imposed without significant justification, and establishing protections for bodily autonomy); Rochin v. California, 342 U.S. 165, 172 (1952) (holding that the practice of forced stomach pumping by police to obtain evidence of drug possession violates the Due Process Clause because it "shocks the conscience" and violates principles of justice and decency); Griswold v. Connecticut, 381 U.S. 479, 485-86 (1965) (recognizing a right to privacy that prohibits the state from regulating married couples' contraceptive use); Winston v. Lee, 470 U.S. 753, 755 (1985) (holding that a state-ordered surgery to retrieve a bullet from a suspect's body was unconstitutional because such a surgery would violate the suspect's right to privacy and bodily integrity under the Fourteenth Amendment); Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 271 (1990) (acknowledging the right to refuse life-sustaining medical treatment under certain circumstances). *But see* Sell v. United States, 539 U.S. 166, 171 (2003) (underscoring the importance of respecting bodily integrity in a case concerning the forcible medication of a criminal defendant suffering from "Delusional Disorder" to make them competent for trial, but holding that such forcible medication was allowable under certain circumstances); Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 231 (2022) (holding that the Constitution does not confer a right to abortion and leaving the question to the states).

human-rights context and at the federal level.[508] While we would welcome federal courts' adoption of our normative vision in litigation challenging the bans, we believe our perspective on bodily self-determination will remain valuable even if no federal court formally recognizes it. For example, there is significant potential to advance trans and intersex bodily self-determination in state courts under state constitutions. Litigants in several state constitutional cases have successfully argued substantive-due-process claims in state courts, effectively establishing fundamental rights to "gender autonomy" or "gender self-determination" and rights related to "bodily integrity" or the refusal of "unwanted medical treatment."[509] Although these cases were decided before *Dobbs*, they nevertheless demonstrate the potential for judicial recognition of bodily self-determination in lower courts and reflect a notable record of success when such claims are raised.[510] Our perspective on bodily self-determination can also be useful in political organizing and legal advocacy that aims to shape future litigation, legislation, and regulation.

Opportunities for bodily self-determination are notably absent from the current child-welfare system. Empirical data demonstrate that LGBTQ minors,[511] including gender-variant and intersex minors, are more likely to find themselves in out-of-home placements,[512] in which they face inadequate health and social services,[513] harassment,[514] and attempts at conversion.[515] State custody in this context is disproportionately prevalent among minors of color,[516] and it is evocative of the historical subjugation of other marginalized groups through

508. Samuel Singer, *Trans Rights Are Not Just Human Rights: Legal Strategies for Trans Justice*, 35 CANADIAN J.L. & SOC'Y 293, 298-300 (2020).

509. Eyer, *supra* note 36, at 1445-48.

510. *Id.* at 1445-48, 1464-65.

511. We use the term "LGBTQ" here as it is used in relevant scholarship. *See generally, e.g.*, Laura Baams, Bianca D.M. Wilson & Stephen T. Russell, *LGBTQ Youth in Unstable Housing and Foster Care*, 143 PEDIATRICS art. no. e20174211 (2019) (using the term throughout).

512. *Id.* at 1-4.

513. Adam McCormick, Kathryn Schmidt & Samuel Terrazas, *LGBTQ Youth in the Child Welfare System: An Overview of Research, Practice, and Policy*, 11 J. PUB. CHILD WELFARE 27, 27 (2017).

514. *Id.* at 29-30.

515. *Id.* at 30, 35.

516. *LGBTQ Youth of Color Impacted by the Child Welfare and Juvenile Justice Systems: A Research Agenda*, WILLIAMS INST. 4 (Kerith J. Conron & Bianca D.M. Wilson eds., June 2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBTQ-YOC-Social-Services-Jul-2019.pdf [https://perma.cc/U26N-MDDE].

practices such as Native American and Black family separations.[517] Given the American social-welfare system's racialized history, nonwhite parents of intersex minors may be more likely to have their children taken away if they resist medical interventions.[518]

Nevertheless, various legal challenges to gender-affirming-care bans, including some of those currently before circuit courts and the Supreme Court, have included visual representations of plaintiffs and their families, uniformly portraying them as white, binary, and normative.[519] This otherwise-uncommon inclusion of images, especially of minor plaintiffs, aims to garner sympathy and humanize the plaintiffs—but it also uses whiteness as social capital to strengthen the argument for trans-affirming care. Practically speaking, white parents might be more likely to secure alternative healthcare options for their children and are less susceptible to the influence of medical institutions and discourse that either reject affirming care or impose coercive interventions.[520]

The constitutional challenges to the bans seemingly offer autonomy for all, but in practice, they privilege certain trans minors—those with supportive, resourceful parents who can access care. Trans minors who lack this narrow set of privileges are absent, as are intersex minors. Trans minors are made invisible by advocates' focus on private choice, while intersex minors are ignored by arguments that fail to recognize that accessing medical interventions to alter sex characteristics is not universally a privilege. By centering the normative concept of bodily self-determination, we can move beyond merely seeking autonomy and choice and instead toward challenging systemic obstacles and creating the

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517. *Cf.* ROSS & SOLINGER, *supra* note 469, at 90 ("[T]he foster care system . . . has targeted African Americans, constituting another practice akin to genocide as it destroys the basic social units of a people."); DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 248 (2002) ("Human rights law supports the claim that transracial adoption may constitute cultural genocide."); Maggie Blackhawk, *The Supreme Court, 2022 Term—Foreword: The Constitution of American Colonialism*, 137 HARV. L. REV. 1, 3 (2023) ("Mere decades ago, the United States forcefully sterilized citizens of these nations and removed a quarter or more of Native children from their families." (footnote omitted)).

518. This possibility is supported by the anecdotal experiences of grassroots advocates for intersex minors. *See* Email from Sean Safia Wall, Co-Founder and Strategist, Intersex Just. Project, to author (Jan. 5, 2023, 1:25 PM) (on file with author) (sharing the story of a young mother of color who refused to subject her newborn to coercive intervention and was subsequently threatened with Child Protective Services intervention).

519. *See, e.g.*, *Skrmetti* Complaint, *supra* note 183, at 23; *Brandt* Complaint, *supra* note 181, at 5-7; *cf. Eknes-Tucker* Complaint, *supra* note 181, at 3-4 (describing families impacted by gender-affirming-care bans).

520. *Cf.* Pyne, *supra* note 502, at 27, 34-35 (discussing interviews with mostly white parents of gender-nonconforming children who sought alternative mental-healthcare providers for their children).

conditions in which gender variance and bodily diversity are not just accepted but encouraged.

We do not subscribe to an idealistic vision in which bodily self-determination compels the law to account for the complexities of sexed bodies and gender identities. If bodily self-determination were to be recognized as an independent right, it would likely be a negative one.[521] Still, we offer this normative perspective as a counterpart to our doctrinal prescription that the bans should fail the most basic constitutional review. Our normative vision aims to undermine the bans' embedded legal presumption of sex as immutable and dimorphic by asserting a legal obligation on the part of state actors to recognize and mitigate the harms that such beliefs inflict on minors' bodies, identities, and experiences. And it seeks to move toward the broader goal of trans and intersex allyship while recognizing differences within and between these communities.

CONCLUSION

> "Dr. John Money, one of the earliest advocates for performing or administering such medical procedures on minors and a founder of the Johns Hopkins Gender Identity Clinic, abused minors entrusted to his care, resulting in the suicides of David and Brian Reimer."[522]
>
> — TENN. CODE ANN. § 68-33-101(f)

The Tennessee legislature's invocation of Dr. John Money's controversial practices is less a reflection of child-protective intent and more an indictment of a system grappling with its own contradictions. The Reimer brothers, thrust into a world of unwarranted medical and psychological experimentation at Dr. Money's hands, were neither trans nor intersex. Their story spotlights the realities of institutional dehumanization. It is a warning against the perils of sex-normalizing medical practices and a reminder of the need to affirm — rather than impose — children's gender identities.

A rational legislator genuinely concerned about minors' health and welfare would prohibit medically unnecessary sex-normalizing interventions and require a gender-affirming approach to any procedures affecting minors' sex characteristics — not the other way around. Our analysis exposes the core assumption

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521. The characterization of this right as negative derives from its fundamental nature. Respecting bodily self-determination primarily entails noninterference with an individual's decisions about their own body, rather than the active provision of goods or services. *See* Leif Wenar, *Rights*, STAN. ENCYC. PHIL. (Feb. 24, 2020), https://plato.stanford.edu/archives/spr2023/entries/rights [https://perma.cc/ZXA9-PFAT].

522. Prohibition on Medical Procedures Performed on Minors Related to Sexual Identity, TENN. CODE ANN. § 68-33-101(f) (2025).

that underpins these bans: that sex is a fixed binary status determined at birth, fusing biological traits with social identity. But even if one holds this belief, one still has to justify why it should be legally enforced. In practice, this presumption of enforcement leads to discrimination in health care, unnecessary medical interventions, and conflict between intersex and trans interests.

This Article has traced the historically intertwined medical protocols for trans and intersex care in the United States, rooted in Dr. Money's legacy. While trans health care has evolved toward a gender-affirming, evidence-based model, intersex health care remains mired in nonconsensual practices with minimal scientific support. These divergent standards underscore the profound legal and ethical dilemmas embedded in the bans. Although they claim to preserve trans minors' reproductive potential, these bans target intersex minors for sterilization, revealing the laws not as tools for promoting reproductive health, but as mechanisms for enforcing sex and gender conformity. The stark contrast between what these laws claim to do and what they actually do underscores their contradictory and irrational nature.

Our critique of the bans uncovers how the constitutional conversation on trans rights connects to a parallel shadow legal discourse on intersex rights and creates tensions that need not exist. Overlooking the bans' harm to intersex minors not only ignores critical implications for bodily integrity but also highlights a broader doctrinal inconsistency: laws that claim to protect vulnerable people from coercive medical intervention fail to shield or even address the needs of some of those most at risk of such harms. This finding underscores the urgent need for a more effective legal analysis of the intersecting yet distinct interests of trans and intersex individuals. The risk of these state-level bans evolving into federal policy further magnifies this need, as such a policy could institutionalize these inconsistencies nationwide, entrenching systemic harm under the guise of protection.

We address this need by proposing a normative vision that centers on bodily self-determination, drawing from reproductive justice, disability studies, and trans- and intersex-led research. Examining self-determination from both trans and intersex perspectives offers a path for accommodating minors' varied needs in a supportive environment that facilitates gender exploration while protecting against coerced normalization.

A legal regime that recognized the right to bodily self-determination could have given the Reimer brothers real safeguards against harm—unlike the Tennessee legislature's contradictory provisions. These provisions fail even a deferential means-end test, making the identification of any legitimate state interest practically impossible. Instead, the bans' asserted objectives serve as a smokescreen, obscuring the legislature's deeper intent to enforce sex and gender conformity. This suggests that these laws rely less on rational, evidence-based

grounds and more on societal beliefs about sex and gender—a foundation that cannot serve as a constitutional basis for legislation. Our perspective on bodily self-determination supports our prescription for principled judicial review that would recognize the internal incoherence of S.B. 1 and similar bans as a constitutional flaw.

Adopting a normative perspective that unifies the varied interests of trans and intersex minors recognizes the broad spectrum of needs, perspectives, and experiences within and across these groups. This approach calls for elevating the voices of those most impacted by anti-trans prohibitions and anti-intersex exclusions, establishing their presence in the legal debates surrounding these bans. Our perspective orients the conversation about such bans toward the experiences of those most affected by them.[523]

We close with a challenge to those who shape the legal landscape: look beyond the binary frameworks that often guide debates about minors' and adults' sexes and genders. In place of binaries, we invite you to recognize and affirm the variance of identities and diversity of bodies that have always been here.

523. For an earlier application of this methodology in legal studies, see Singer, *supra* note 508, at 302.