

# MEDICAL REVOLT AND THE ABANDONMENT OF THE DUTCH PROTOCOL: COMPARATIVE VIEWS ON THE PROVISION OF GENDER-AFFIRMING CARE TO CHILDREN

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## I. INTRODUCTION

Oliver Jones knew something wasn't right but couldn't point to what it was.<sup>1</sup> What he did know was that he was getting in fights with other students, refusing to participate in class, yelling at teachers, and feeling apathy toward everything.<sup>2</sup> A school therapist told Jones that she suspected that Jones might have gender dysphoria, and after hearing the description, Jones agreed.<sup>3</sup> Indeed, as Jones describes it:

I was the textbook trans guy. I refused to wear dresses. I begged my mum to let me have short hair and buy clothes from the boys' section. I only played with the boys at school, and I wanted nothing to do with the girls. I spent my free time playing video games, football, skateboarding and running around outside. When my poor behavior at school was called out by teachers and counsellors, I told them I wished I was a boy. That was the only explanation I could give.<sup>4</sup>

Things suddenly made sense.

The realization that Jones did not have to live life as a female was not an immediately life changing moment,<sup>5</sup> and transitioning had its challenges.<sup>6</sup> Jones faced a delay in starting hormone therapy,<sup>7</sup> as well as bigotry from teachers and students.<sup>8</sup> Still, Jones began transitioning, and despite the challenges was able to experience his first moment of gender euphoria—described as “feeling at ease or happy with the alignment of their gender identity and their gender

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1. Oliver Jones, *Becoming Prom King: How my Classmates Showed Their Support for My Transition*, in GENDER EUPHORIA 7, 7 (Laura Kate Dale ed., 2021).

2. *Id.*

3. *Id.*

4. *Id.* at 8.

5. *Id.* at 9.

6. *Id.* at 10-12.

7. *Id.* at 12.

8. *Id.* at 11-12.

expression”<sup>9</sup>—when his teachers and classmates voted him prom king.<sup>10</sup>

Oliver Jones’ experience with gender dysphoria is not entirely unique. Nor is it unusual that a young person would seek medical treatment after a diagnosis of gender dysphoria. Indeed, medical protocols, like those based on the work of Dutch researchers and referred to as the Dutch Protocol or the Dutch Approach, exist and are widely accepted procedures for the treatment of gender dysphoria in children and adolescents. Recently, however, the Dutch Protocol has been called into question by health care services in several European countries.<sup>11</sup>

Europe is not alone. Transgender individuals have been in the United States since before its inception.<sup>12</sup> In the 1990’s, the transgender rights movement began to coalesce into a social force.<sup>13</sup> But even as trans rights began to increase, the U.S. government sought to exclude trans people from receiving health care.<sup>14</sup> The Americans with Disabilities Act, for example, included a set of exclusions, among them transgender people.<sup>15</sup> This exclusion was the result of animosity from two senators who viewed sexual behavior disorder to be unworthy of legal protection.<sup>16</sup> Today, attempts to bar transgender people from access to health care still exist in other forms. In particular, a number of conservative states have introduced, considered, or passed legislation restricting or denying gender-affirming care to adolescents and children.<sup>17</sup>

Before delving into the content of this article, a note on terminology. For purposes of this article, I use “transgender” to mean “people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth.”<sup>18</sup> This is as opposed to someone who is “cisgender”

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9. Soren Hodshire, *Your Guide to Understanding Gender Euphoria*, HEALTHLINE (Mar. 13, 2023), <https://www.healthline.com/health/transgender/gender-euphoria#definition> [<https://perma.cc/AVR8-GDSH>].

10. Jones, *supra* note 1, at 15.

11. Frieda Klotz, *A Teen Gender-Care Debate Is Spreading Across Europe*, THE ATLANTIC (Apr. 28, 2023), <https://www.theatlantic.com/health/archive/2023/04/gender-affirming-care-debate-europe-dutch-protocol/673890/> [<https://perma.cc/P8NB-GVB5>].

12. In her monumental book, *Transgender History*, Professor Susan Stryker traces the documented presence of transgender individuals in the United States to at least the 1620’s, when a possibly intersex person known as Thomas of Thomasine Hall sometimes presented as both male and female. See SUSAN STRYKER, *TRANSGENER HISTORY: THE ROOTS OF TODAY’S REVOLUTION* 45-46 (rev. ed. 2017).

13. Kevin M. Barry, Brian Farrell, Jennifer Levi & Neelima Vanguri, *A Bare Desire to Harm: Transgender People and the Equal Protection Clause*, 57 B.C. L. REV. 507, 508 (2016).

14. *Id.* at 510.

15. 42 U.S.C. § 12211.

16. Barry et al., *supra* note 13, at 510.

17. ELANA REDFIELD, KERITH J. CONRON, WILL TENTINDO & ERICA BROWNING, *PROHIBITING GENDER-AFFIRMING MEDICAL CARE FOR YOUTH* (March 2023), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Youth-Health-Bans-Mar-2023.pdf> [<https://perma.cc/VM6R-ANTL>].

18. *Glossary of Terms*, HUM. RTS. CAMPAIGN (May 31, 2023), <https://www.hrc.org/>

meaning that their gender identity is in alignment with the sex they were assigned at birth.<sup>19</sup>

Section II provides background information to help readers develop a clear picture of transgender individuals in the United States. It proceeds in two parts. First, it looks at transgender demographics in order to help provide some insight into the number of transgender people in the general population. It then provides a discussion of gender dysphoria to help readers understand why gender-affirming care is necessary for trans individuals.

Section III proceeds in two parts. First, it addresses the current standard for the treatment of transgender children based on what is known as the “Dutch Protocol.” This includes the history of the Dutch Protocol as well as its absorption into current standards of care. Second, it discusses how several European states—Finland, Sweden, France, Norway, and the United Kingdom—have each moved away from, if not outright abandoned, the Dutch Protocol.

Section IV discusses the status of gender-affirming care in the United States. It begins by reviewing the positions of medical professionals both in support of and in opposition to providing gender-affirming care to children. It then looks at how various state legislatures have chosen to address the provision of gender-affirming care for children by looking at examples on both sides of the political spectrum.

Section V examines the question of whether bans on gender-affirming care are based on medical necessity or political animus. First, it argues that animus towards trans individuals is not new. Building upon this argument, it claims that similar animosity exists in Europe, but that resistance to the Dutch Protocol comes from both conservative and liberal leaning countries. Finally, it argues that the approaches of the European nations provide a good argument for questioning the efficacy of gender-affirming care methods for adolescents and children, but that this argument has been lost in the wave anti-LGBTQ bills flooding the state legislatures.

Section VI examines how gender-affirming care bans have fared in the courts. It begins by looking at a court case challenging Florida’s gender-affirming care ban, as well as the court’s treatment of the argument that the ban is consistent with European nations’ position on gender-affirming care. It then examines a case from the Sixth Circuit Court of Appeals which lead to a different result, but without any discussion of the actions of European nations.

## II. WHAT’S THE BIG DEAL ABOUT GENDER?

Before diving into the substantive subject matter of this article, there are two pieces of key background information which should be addressed: what are the demographics of the transgender community, and what is gender dysphoria. The

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resources/glossary-of-terms [https://perma.cc/3T8M-2HB3] (defining “transgender”).

19. *A Guide to Gender Identity Terms*, NPR (June 2, 2021), https://www.npr.org/2021/06/02/996319297/gender-identity-pronouns-expression-guide-lgbtq (defining “cisgender”).

first is important to understand that there are a substantial number of transgender individuals who may decide that they no longer need to hide. The second is key for understanding why someone would choose to transition.

#### *A. Transgender Demographics*

It is unclear exactly how many people in the United States identify as transgender. The Williams Institute estimates that there are roughly 1.6 million people ages 13 and up who are transgender.<sup>20</sup> Of that number, about 1.3 million are aged 18 or older.<sup>21</sup> This means that about 300,000 people who are transgender are aged 13-17.<sup>22</sup> Another way of thinking about those numbers is that roughly 1/5 of transgender Americans are minors.<sup>23</sup>

Within the adult population, about 38.5% are trans women.<sup>24</sup> Another 35.9% are trans men.<sup>25</sup> The remaining 25.6% identify as gender non-conforming.<sup>26</sup> Transgender individuals account for approximate 0.5% of the adult population and 1.4% of minors.<sup>27</sup>

Interestingly, the percentage of transgender individuals in the general population appears to have remained steady.<sup>28</sup> This suggests that claims of increased “epidemiology,” which will be discussed later, are just a clinical reaction to people feeling safer coming out. Indeed, Professor Susan Stryker, a prominent transgender activist, has written that, following a series of transgender/gender non-conformity friendly cases such as *Ulane v. Eastern Airlines*<sup>29</sup> and *Price Waterhouse v. Hopkins*,<sup>30</sup> the 1990s ushered in a new wave of transgender activism.<sup>31</sup> Thus, for a time, and even as recently as the 2020 decision of *Bostock v. Clayton County*,<sup>32</sup> there had been a sense of increased safety for transgender individuals.

#### *B. Gender Dysphoria*

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is a manual published by the American Psychological Association in order to assist

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20. JODY L. HERMAN, ANDREW R. FLORES & KATHRYN K. O'NEILL, HOW MANY ADULTS AND YOUTH IDENTIFY AS TRANSGENDER IN THE UNITED STATES? 1 (2022), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf> [<https://perma.cc/8KS4-GQQE>].

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

28. *Id.*

29. *Ulane v. Eastern Airlines*, 742 F.2d 1081 (7th Cir. 1984).

30. *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989).

31. STRYKER, *supra* note 12, at 151-53.

32. *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020).

with identification and treatment of mental health issues. Although the term “Gender Identity Disorder” had existed in previous editions of the DSM, “gender dysphoria” appeared for the first time in the DSM-5.<sup>33</sup> The change reflected an acknowledgement that “[p]ersons experiencing gender dysphoria need a diagnostic term that protects their access to care and won’t be used against them in social, occupational, or legal areas.”<sup>34</sup>

But what is gender dysphoria? Clinically, it is “psychological distress that results from an incongruence between one’s sex assigned at birth and one’s gender identity.”<sup>35</sup> Usually gender dysphoria begins in childhood, but some people may not experience it until after puberty or much later in adulthood.<sup>36</sup>

Diagnosing gender dysphoria is fairly straight forward. It requires that the diagnosing provider first find that their patient experiences:

[a] marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

- (1) A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.
- (2) A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.
- (3) A strong desire for the primary and/or secondary sex characteristics of the other gender.
- (4) A strong desire to be of the other gender.
- (5) A strong desire to be treated as the other gender.
- (6) A strong conviction that one has the typical feelings and reactions of the other gender.<sup>37</sup>

Next, the patient’s condition must be associated with “clinically significant distress,” which is distress that severely limits or impairs the patient’s ability to meaningfully function to the extent that medical or surgical extension is required.<sup>38</sup> Sometimes, this distress can lead to extreme actions including suicide or self-injury.<sup>39</sup>

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33. See AM. PSYCHIATRIC ASS’N., GENDER DYSPHORIA (2013), [https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA\\_DSM-5-Gender-Dysphoria.pdf](https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Gender-Dysphoria.pdf) [<https://perma.cc/W3QW-WKAN>].

34. *Id.*

35. 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/XRF2-S3YX>].

36. *Id.*

37. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 452 (5th ed. 2013) [hereinafter DSM-5] (parenthetical information in original omitted).

38. *Id.* at 453, 458.

39. See *Edmo v. Corizon, Inc.*, 935 F.3d 757, 772-73 (9th Cir. 2019) (discussing Edmo’s

It bears noting that some transgender individuals will never experience gender dysphoria.<sup>40</sup> Many of these people will feel comfortable in their bodies.<sup>41</sup> Others, like author Maia Kobabe, may feel more comfortable in their bodies with the help of things like androgynous clothing or chest binders.<sup>42</sup> For others, medical treatment or surgical intervention may be necessary. The rest of this article is dedicated to discussion of those types of treatments.

### III. THE DUTCH PROTOCOL, WPATH AND EUROPEAN REVOLT

#### *A. The Dutch Protocol & Standards of Care*

##### *i. The Dutch Protocol*

In 1998, a Dutch gender identity clinic published research identifying a new protocol for gender-affirming care in youth.<sup>43</sup> This protocol has come to be known as the Dutch Approach.<sup>44</sup> A unique feature of this approach was the introduction of puberty blockers earlier as means of buying time for young people to determine their identity.<sup>45</sup>

The Dutch approach identified a number of criteria for determining when it is appropriate to use puberty blockers for children and adolescents experiencing gender dysphoria. These criteria included: (i) a presence of gender dysphoria from early childhood; (ii) an increase of the gender dysphoria after the first pubertal changes; (iii) an absence of psychiatric comorbidity that interferes with the diagnostic work-up or treatment; (iv) adequate psychological and social support during treatment; and (v) a demonstration of knowledge and understanding of the effects of puberty blockers, feminizing/masculinizing hormones, surgery, and the social consequences of sex reassignment.<sup>46</sup> Feminizing/masculinizing hormones could be started at age 16.<sup>47</sup> Surgery became appropriate at age 18.<sup>48</sup> Since the Dutch Approach was introduced, these criteria have become established as part of the standard of care, as discussed below.

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history of gender dysphoria and ultimate attempt to self-castrate).

40. *Gender Dysphoria*, MAYO CLINIC (Feb. 26, 2022), <https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/symptoms-causes/syc-20475255> [<https://perma.cc/E3BZ-WZ5F>].

41. *Id.*

42. MAIA KOBABE, *GENDER QUEER: A MEMOIR* 184, 102, 212 (2019).

43. P.T. Cohen-Kettenis & S.H.M. van Goozen, *Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent*, 7 *EUR. CHILD & ADOLESCENT PSYCHIATRY* 246, 246 (1998).

44. Annalou de Vries & P.T. Cohen-Kettenis, *Clinical Management of Gender Dysphoria in Children and Adolescents: the Dutch Approach*, 59 *J. HOMOSEXUALITY* 301, 301 (2012).

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

*ii. Evolution into Standards of Care*

The World Professional Association for Transgender Health (“WPATH”) publishes standards of care for the health of transgender and gender diverse individuals.<sup>49</sup> Originally published in 1979, the WPATH Standards of Care are on their 8<sup>th</sup> version.<sup>50</sup> The Standards of Care were created to provide “clinical guidance for health professionals to assist transgender and gender diverse people with safe and effective pathways to achieve lasting personal comfort with their gendered selves and to maximize their overall health, psychological well-being, and self-fulfillment.”<sup>51</sup>

After addressing medical and ethical concerns related to the treatment of transgender adolescents, the WPATH Standards of Care offered a number of recommendations. First, they recommended “prescribing menstrual suppression agents for adolescents experiencing gender incongruence who may not desire testosterone therapy.”<sup>52</sup> Next, WPATH recommended surgical care, but only when the patient met certain criteria.<sup>53</sup> These criteria included: (1) The adolescent satisfied the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care;<sup>54</sup> (2) the experience of gender diversity and incongruence was marked and sustained over time;<sup>55</sup> (3) the adolescent demonstrated the emotional and cognitive maturity required to provide informed consent and assent for the treatment;<sup>56</sup> (4) the adolescent’s mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and/or gender-affirming medical treatments have been addressed;<sup>57</sup> (5) the adolescent has been informed of the reproductive effects, including the potential loss of fertility, and available options to preserve fertility, and these have been discussed in the context of the adolescent’s stage of pubertal development;<sup>58</sup> (6) the adolescent has reached Tanner stage two of puberty for pubertal suppression to be initiated;<sup>59</sup> (7) and, the adolescent had at

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49. See E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People*, 23 INT’L J. TRANSGENDER HEALTH, no. S1, 2022, at S1, S48.

50. *History and Purpose*, WORLD PRO. ASS’N TRANSGENDER HEALTH, <https://www.wpath.org/soc8/history> [<https://perma.cc/85PP-RHVV>] (last visited Sept. 4, 2023).

51. *Id.*

52. Coleman et al., *supra* note 49, at S54.

53. *Id.* at S59.

54. *Id.* Furthermore, “[c]riteria for the ICD-11 classification gender incongruence of adolescence or adulthood require a marked and persistent incongruence between an individual’s experienced gender and the assigned sex, which often leads to a need to ‘transition’ to live and be accepted as a person of the experienced gender.” *Id.*

55. *Id.* at S60.

56. *Id.* at S61.

57. *Id.* at S62.

58. *Id.* at S63.

59. *Id.* at S64.

least twelve months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.<sup>60</sup> The age and maturity level of adolescents is also taken into account, with higher ages being deemed necessary for irreversible treatments.<sup>61</sup>

WPATH also includes a number of recommendations for the treatment of children. These recommendations include:

1. We recommend health care professionals working with gender diverse children receive training and have expertise in gender development and gender diversity in children and possess a general knowledge of gender diversity across the life span.
2. We recommend health care professionals working with gender diverse children receive theoretical and evidenced-based training and develop expertise in general child and family mental health across the developmental spectrum.
3. We recommend health care professionals working with gender diverse children receive training and develop expertise in autism spectrum disorders and other neurodiversity or collaborate with an expert with relevant expertise when working with autistic/neurodivergent, gender diverse children.
4. We recommend health care professionals working with gender diverse children engage in continuing education related to gender diverse children and families.
5. We recommend health care professionals conducting an assessment with gender diverse children access and integrate information from multiple sources as part of the assessment.
6. We recommend health care professionals conducting an assessment with gender diverse children consider relevant developmental factors, neurocognitive functioning, and language skills.
7. We recommend health care professionals conducting an assessment with gender diverse children consider factors that may constrain accurate reporting of gender identity/gender expression by the child and/or family/caregiver(s).
8. We recommend health care professionals consider consultation, psychotherapy, or both for a gender diverse child and family/caregivers when families and health care professionals believe this would benefit the well-being and development of a child and/or family.
9. We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and

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60. *Id.*

61. *Id.* at S65.



families/caregivers work with other settings and individuals important to the child to promote the child's resilience and emotional well-being.

10. We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and families/caregivers provide both parties with age-appropriate psychoeducation about gender development.
11. We recommend that health care professionals provide information to gender diverse children and their families/caregivers as the child approaches puberty about potential gender affirming medical interventions, the effects of these treatments on future fertility, and options for fertility preservation.
12. We recommend parents/caregivers and health care professionals respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity.
13. We recommend health care professionals and parents/caregivers support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition.
14. We recommend the health care professionals discuss the potential benefits and risks of a social transition with families who are considering it.
15. We suggest health care professionals consider working collaboratively with other professionals and organizations to promote the well-being of gender diverse children and minimize the adversities they may face.<sup>62</sup>

Conspicuously absent from the list of recommendations for children are any mention of hormone therapy or surgical intervention.

### *B. European Revolt*

Since 2020, there has been disagreement about whether the Dutch Protocol is truly the best method of treatment for adolescents and children with gender dysphoria.<sup>63</sup> Several European Nations like Finland, Sweden, France, Norway, and the United Kingdom, have already broken away and adopted new recommendations for treatment. Here, we examine the reports of Finland, Sweden, and the United Kingdom and their recommendations.

#### *i. Finland*

In 2020, the Council for Choices in Health Care in Finland (“COHERE Finland”) released its report, *Medical Treatment Methods for Dysphoria Related*

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62. *Id.* at S69.

63. Klotz, *supra* note 11.

to Gender Variance in Minors (the “Finland Report”).<sup>64</sup> The Finland Report looked at the scope and climate of treatment for adolescents with gender dysphoria before making several recommendations.<sup>65</sup> It is important to note the centralized nature of treatment in Finland where “the diagnostics of gender identity variation, the assessment of the need for medical treatments, and the planning of their implementation are centralized by law in the multi-professional research clinics of Helsinki University Central Hospital (HUS) and Tampere University Hospital (TAYS).”<sup>66</sup> These recommendations cover a broad range of medical care ranging from psychosocial treatment to surgical intervention.<sup>67</sup>

First, the Finland Report recommends that psychosocial treatment be provided by primary health care, student health care, and in schools.<sup>68</sup> Furthermore, those providing the health care should be competent to do so.<sup>69</sup> Treatment should be coordinated with a child or youth psychiatrist and should be done locally.<sup>70</sup>

The Finland Report recommends that children who have not started puberty and experience “persistent, severe anxiety” related to gender may be sent to TAYS or HUS for consultation.<sup>71</sup> In these circumstances:

[I]f a child is diagnosed prior to the onset of puberty with a persistent experience of identifying as the other sex and shows symptoms of gender-related anxiety, which increases in severity in puberty, the child can be guided at the onset of puberty to the research group on the gender identity of minors at TAYS or HUS for an assessment of the need for treatment to suppress puberty. Based on these assessments, puberty suppression treatment may be initiated on a case-by-case basis after careful consideration and appropriate diagnostic examinations if the medical indications for the treatment are present and there are no contraindications.<sup>72</sup>

On the other hand, children who have already undergone puberty may be referred directly to the research group at TAYS or HUS for intensive gender studies.<sup>73</sup>

Despite the possibility that an adolescent may be prescribed puberty suppressors, there are limits to treatment options. The Finland Report makes it

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64. COUNCIL FOR CHOICES IN HEALTH CARE, FIN. MINISTRY OF SOC. AFFS. AND HEALTH, MEDICAL TREATMENT METHODS FOR DYSPHORIA RELATED TO GENDER VARIANCE IN MINORS (2020), [https://segm.org/sites/default/files/Finnish\\_Guidelines\\_2020\\_Minors\\_Unofficial%20Translation.pdf](https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf) [<https://perma.cc/2PS8-C92D>].

65. *Id.*

66. *Id.* at 4.

67. *Id.* at 8.

68. *Id.* at 9.

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*

73. *Id.*

clear that “the initiation of hormonal interventions that alter sex characteristics may be considered before the person is 18 years of age only if it can be ascertained that their identity as the other sex is of a permanent nature and causes severe dysphoria.”<sup>74</sup> Surgical intervention for individuals under age 18 is not an option.<sup>75</sup>

*ii. Sweden*

In Sweden, the National Board of Health and Welfare (“NBHW”) also looked into the status of care for adolescents with gender dysphoria.<sup>76</sup> In a short report titled *Care of Children and Adolescents with Gender Dysphoria* (hereinafter the “Sweden Report”), the NBHW addressed issues related to the increasing number of adolescents referred for diagnostic assessment of gender dysphoria.<sup>77</sup> The NBHW offered its own recommendations for treatment.<sup>78</sup>

First, the NBHW stated that its position that “the risks of puberty blockers and gender-affirming treatment are likely to outweigh the expected benefits of these treatments.”<sup>79</sup> The reasons for this conclusion, according to the NBHW, are (1) the lack of reliable scientific evidence concerning the safety of treatments; (2) new knowledge that some young adults do detransition; and (3) uncertainty from the increase in the number of care seekers.<sup>80</sup>

While the Sweden Report does argue that criteria for offering gender-affirming hormones in Sweden should be more closely linked to those in the Dutch Protocol, it takes the clear position that, in so far as young people are concerned, such treatment should be provided in a research context.<sup>81</sup> The NBHW rejects the Dutch Protocol’s position that treatment should be based on a cross-gender identity, and instead takes the position that gender dysphoria, rather than gender identity, should determine access to care.<sup>82</sup> As a result, Sweden too has moved away from the Dutch Protocol.

*iii. The United Kingdom*

In February of 2022, the National Health Service (“NHS”) released an interim report titled *Independent Review of Gender Identity Services for Children and*

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74. *Id.*

75. *Id.* at 10.

76. SWED. NATIONAL BOARD OF HEALTH AND WELFARE, CARE OF CHILDREN AND ADOLESCENTS WITH GENDER DYSPHORIA 1 (2022), <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf> [<https://perma.cc/E7RM-G634>].

77. *Id.* at 3.

78. *Id.* at 5.

79. *Id.* at 3.

80. *Id.* at 3-4.

81. *Id.* at 3.

82. *Id.* at 4.

*Young People* (the “Cass Review”).<sup>83</sup> Thus far, the Cass Review has provided the most thorough and transparent look at a country reviewing its treatment standards. While the Cass Review takes a serious look at the state of treatment of transgender adolescents and children, it does so with the following view:

Every gender-questioning child or young person who seeks help from the NHS must receive the support they need to get on the appropriate pathway for them as an individual. Children and young people with gender incongruence or dysphoria must receive the same standards of clinical care, assessment and treatment as every other child or young person accessing health services.<sup>84</sup>

This statement seems to indicate that the work of the Cass Review is truly medical rather than political or ideological. Indeed, the report makes clear that the study was commissioned solely by the NHS, rather than by a political body.<sup>85</sup>

The Cass Review attributes its creation as a response to the increased number of referrals to the Gender Identity Development Service (GIDS), which has resulted in longer waiting lists as well as questions about how the NHS should provide care for young people.<sup>86</sup> As the Cass Review reports, referrals jumped from roughly 50 in 2009 to about 2,500 per year in 2020.<sup>87</sup> This resulted in a waiting list over 4,000 names and two years long.<sup>88</sup>

After thoroughly detailing its research process, which included speaking to practitioners, the Cass Review offered interim advice on how the NHS could proceed with providing gender-affirming care to adolescents and children.<sup>89</sup> This advice includes the provision of informed regional services, rather than the single specialist model currently in use.<sup>90</sup> The Cass Review also responded to reports from a Multi Professional Review Group (MPRG), which found that (1) due to documentary issues, “it is not always easy to determine if the process for referral for endocrine treatment has been fully or safely followed for a child or young person;” (2) there is “limited evidence of systematic, formal mental health or neurodevelopmental assessments being routinely documented, or of a discipline of formal diagnostic formulation in relation to co-occurring mental health difficulties;” and (3) “there is concern that communications to [general practitioners] and parents regarding prescribed treatment with puberty blockers

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83. THE CASS REV., INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE: INTERIM REPORT (2022), <https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf> [<https://perma.cc/NUL5-KFR5>].

84. *Id.* at 15.

85. *Id.*

86. *Id.* at 12.

87. *Id.* at 32.

88. *Id.*

89. *Id.* at 69.

90. *Id.*

sometimes come from non-medical staff.”<sup>91</sup> As a result, advice on hormonal treatment focuses on consent, documentation, and formal diagnosis.<sup>92</sup>

#### IV. THE FRACTURED STATUS OF GENDER-AFFIRMING CARE FOR TRANSGENDER YOUTH IN THE UNITED STATES

##### *A. Views of Medical Professionals*

###### *i. In Favor of Providing Care*

Gender-affirming care is considered safe, effective, and medically necessary by all of the relevant medical communities. This includes the American Medical Association,<sup>93</sup> The American Academy of Pediatrics,<sup>94</sup> the American Academy of Child and Adolescent Psychiatry,<sup>95</sup> the American Psychological Association,<sup>96</sup> the American Psychiatric Association,<sup>97</sup> and the Endocrine Society.<sup>98</sup> Each of these societies includes medical specialties directly involved in providing gender-affirming care for children and adolescents.

Individually, many doctors have shown support for the provision of gender-

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91. *Id.* at 43.

92. *Id.* at 70-71.

93. James L. Madara, *AMA to states: Stop interfering in health care of transgender children*, AMA, (Apr. 26, 2021), <https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children> [https://perma.cc/WU54-KLG9].

94. Press Release, Am. Acad. of Pediatrics, *AAP Policy Statement Urges Support and Care of Transgender and Gender-Diverse Children and Adolescents* (Sept. 17, 2018), <https://www.aap.org/en/news-room/news-releases/aap/2018/aap-policy-statement-urges-support-and-care-of-transgender-and-gender-diverse-children-and-adolescents/> [https://perma.cc/69LR-L9B9].

95. Press Release, Am. Acad. of Child and Adolescent Psychiatry, *AACAP Statement Responding to Efforts to ban Evidence-Based Care for Transgender and Gender Diverse Youth* (Nov. 8, 2019), [https://www.aacap.org/AACAP/Latest\\_News/AACAP\\_Statement\\_Responding\\_to\\_Efforts-to\\_ban\\_Evidence-Based\\_Care\\_for\\_Transgender\\_and\\_Gender\\_Diverse.aspx](https://www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts-to_ban_Evidence-Based_Care_for_Transgender_and_Gender_Diverse.aspx) [https://perma.cc/ER42-RGVV].

96. *Criminalizing Gender Affirmative Care with Minors*, AM. PSYCH. ASS’N, <https://www.apa.org/topics/lgbtq/gender-affirmative-care> [https://perma.cc/4AQC-HTMQ] (last visited Sept. 25, 2023).

97. *Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth*, AM. PSYCHIATRIC ASS’N (July 2020), <https://www.psychiatry.org/getattachment/8665a2f2-0b73-4477-8f60-79015ba9f815/Position-Treatment-of-Transgender-Gender-Diverse-Youth.pdf> [https://perma.cc/U8VW-7U6B].

98. Press Release, The Endocrine Soc’y, *Endocrine Society alarmed at criminalization of transgender medicine* (Feb. 23, 2022), <https://www.endocrine.org/news-and-advocacy/news-room/2022/endocrine-society-alarmed-at-criminalization-of-transgender-medicine> [https://perma.cc/2MEM-F26H].

affirming care to adolescents and children.<sup>99</sup> Others have chosen to leave states due to care bans, creating additional health care problems.<sup>100</sup>

*ii. Against Providing Care*

While the major medical professional organizations have voiced support for gender-affirming care, there are medical voices opposed to the provision of gender-affirming care to adolescents and children. Some do so for religious reasons.<sup>101</sup> Often these individuals are associated with groups such as the Alliance Defending Freedom or the American College of Pediatricians which has been labeled a hate group by the Southern Poverty Law Center.<sup>102</sup>

Many of these physicians practice in fields that are not directly related to the care of individuals with gender dysphoria, and have therefore provided limited, if any, care to transgender individuals.<sup>103</sup> Some, including several doctors acting as expert witnesses, have not engaged in any research on the effects of providing gender-affirming care to adolescents and children.<sup>104</sup>

*B. Conflicting State Laws*

Unsurprisingly, different states have taken different approaches to addressing the treatment of gender dysphoria in adolescents and teens. This section does not provide an exhaustive view of state laws, but instead uses representative states to show different approaches. It begins by discussing states which are protective of trans adolescents and children and then moves onto looking at approaches taken by states which have sought to limit or deny treatment.

*i. Favorable States*

*a. Minnesota*

Minnesota is a sanctuary state for minors receiving gender-affirming care,

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99. Scottie Andrew, *More than 200 medical professionals condemn bills trying to restrict transgender kids from getting gender reassignment treatments*, CABLE NEWS NETWORK (Feb. 7, 2020, 10:27 AM EST), <https://www.cnn.com/2020/02/07/health/doctors-condemn-anti-trans-health-care-trnd/index.html> [<https://perma.cc/M8GB-7VA7>].

100. William Melhado, *Doctors treating trans kids are leaving Texas, exacerbating healthcare crisis*, UNITED PRESS INT'L (Jul. 17, 2023, 8:24 AM), [https://www.upi.com/Top\\_News/US/2023/07/17/doctors-leaving-Texas-transgender-children/6321689595155/](https://www.upi.com/Top_News/US/2023/07/17/doctors-leaving-Texas-transgender-children/6321689595155/) [<https://perma.cc/6PWP-UZRR>].

101. Aviva Stahl, *Four controversial doctors helping Republicans attack trans healthcare*, THE GUARDIAN, <https://www.theguardian.com/society/2023/jun/09/doctor-republican-trans-gender-affirming-minor-healthcare-lgbtq-rights> [<https://perma.cc/H3D7-WK6Q>] (last modified June 9, 2023, 11:18 PM EDT).

102. *Id.*

103. *Id.*

104. *Id.*

meaning that they have proactively enacted legislation aimed at protecting the rights of minors experiencing gender dysphoria or seeking gender-affirming care. The Minnesota legislature has protected gender-affirming care through several steps. First, the legislature made clear that:

A law of another state that authorizes a state agency to remove a child from the child's parent or guardian because the parent or guardian allowed the child to receive gender-affirming health care, as defined in section 543.23, paragraph (b), is against the public policy of this state and must not be enforced or applied in a case pending in a court in this state. A court order for the removal of a child issued in another state because the child's parent or guardian assisted the child in receiving gender-affirming care in this state must not be enforced in this state.<sup>105</sup>

Another legislative protection makes the presence of a child in Minnesota for the purpose of receiving gender-affirming care a sufficient “contact” with the state to satisfy jurisdiction for initial child custody determinations.<sup>106</sup> Similarly, in custody cases where gender-affirming care for a child is at issue, Minnesota courts “shall not determine that this state is an inconvenient forum if the law or policy of the other state that may take jurisdiction limits the ability of a parent to obtain gender-affirming health care.”<sup>107</sup>

Minnesota also forbids both the issuance of subpoenas and the recognition of foreign subpoenas “if the subpoena is related to a violation of another state's laws when the other state's laws are designed to interfere with an individual's right to receive gender-affirming health care.”<sup>108</sup>

*b. California*

Another sanctuary state is California, which recently enacted S.B. 107.<sup>109</sup> Among other provisions, S.B. 107 contains a number of policies to protect gender-affirming care as well as transgender minors and their families.<sup>110</sup> Perhaps the most important of these measures are sections 8 and 9, which read:

SEC. 8. Section 3453.5 is added to the Family Code, to read:

3453.5. (a) A law of another state that authorizes a state agency to remove a child from their parent or guardian based on the parent or guardian allowing their child to receive gender-affirming health care or gender-affirming mental health care is against the public policy of this state and shall not be enforced or applied in a case pending in a court in

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105. H.F. 146, 93d Leg., at 1 (Minn. 2023).

106. *Id.* at 1-2.

107. *Id.* at 4-5.

108. *Id.* at 5.

109. S.B. 107, 2021-22 Leg. (Cal. 2021-22).

110. *Id.*

this state.

...

SEC. 9. Section 819 is added to the Penal Code, to read:

819. (a) It is the public policy of the state that an out-of-state arrest warrant for an individual based on violating another state's law against providing, receiving, or allowing their child to receive gender-affirming health care or gender-affirming mental health care is the lowest law enforcement priority.

(b) California law enforcement agencies shall not knowingly make or participate in the arrest or participate in any extradition of an individual pursuant to an out-of-state arrest warrant for violation of another state's law against providing, receiving, or allowing a child to receive gender-affirming health care and gender-affirming mental health care in this state, if that care is lawful under the laws of this state . . .

(c) No state or local law enforcement agency shall cooperate with or provide information to any individual or out-of-state agency or department regarding the provision of lawful gender-affirming health care or gender-affirming mental health care performed in this state.<sup>111</sup>

....

These sections serve as a direct response to the State of Texas, which criminalized the provision of gender-affirming care.

*ii. Anti-Care States*

By March of 2023, thirty-three states had either introduced legislation to restrict gender-affirming care or had passed laws restricting such care.<sup>112</sup> These laws would affect an estimated 146,000 transgender youth.<sup>113</sup> As of writing, it is unclear how many of these laws will ultimately be enacted.

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111. *Id.* at 9-10.

112. These states include Arizona, Arkansas, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wyoming. *See* REDFIELD ET AL., *supra* note 17.

113. *Id.* at 3, 11.



*a. Texas*

Texas has led the way in using draconian means to attempt to ban gender-affirming care for minors. Senate Bill No. 14 (S.B. No. 14) codified the state's initial foray into regulating queer bodies, which it does through several means.<sup>114</sup> First, it targets children's health care plans, forbidding coverage of gender-affirming care.<sup>115</sup>

Next, it directly targets gender-affirming care for minors through a series of prohibitions on methods of care. In its entirety, the section states:

Sec. 161.702. PROHIBITED PROVISION OF GENDER TRANSITIONING OR GENDER REASSIGNMENT PROCEDURES AND TREATMENTS TO CERTAIN CHILDREN. For the purpose of transitioning a child's biological sex as determined by the sex organs, chromosomes, and endogenous profiles of the child or affirming the child's perception of the child's sex if that perception is inconsistent with the child's biological sex, a physician or health care provider may not knowingly:

- (1) perform a surgery that sterilizes the child, including:
  - (A) castration;
  - (B) vasectomy;
  - (C) hysterectomy;
  - (D) oophorectomy;
  - (E) metoidioplasty;
  - (F) orchiectomy;
  - (G) penectomy;
  - (H) phalloplasty; and
  - (I) vaginoplasty;
- (2) perform a mastectomy;
- (3) provide, prescribe, administer, or dispense any of the following prescription drugs that induce transient or permanent infertility:
  - (A) puberty suppression or blocking prescription drugs to stop or delay normal puberty;
  - (B) supraphysiologic doses of testosterone to females; or
  - (C) supraphysiologic doses of estrogen to males; or
- (4) remove any otherwise healthy or non-diseased body part or tissue.<sup>116</sup>

This prohibition model is one that will see repeated below.

There are exceptions to S.B. No. 14. Drugs prescribed for the treatment of

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114. S.B. 14, 88th Leg., Reg. Sess. (Tex. 2023).

115. *Id.*

116. *Id.* at 2-3.

precocious puberty are not covered by the ban.<sup>117</sup> Also, children who began treatment before June 1, 2023, and completed twelve or more sessions of counseling or therapy are exempt, but are required to wean off of medication and may not switch to a different course of treatment.<sup>118</sup>

Another proposed legislative bill would criminalize the provision of gender-affirming care by medical professionals.<sup>119</sup> In its entirety, the section states:

- (B) subject to Paragraph (C), includes the following acts by a medical professional or mental health professional for the purpose of attempting to change or affirm a child's perception of the child's sex, if that perception is inconsistent with the child's biological sex as determined by the child's sex organs, chromosomes, and endogenous hormone profiles:
  - (i) performing a surgery that sterilizes the child, including castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, and vaginoplasty;
  - (ii) performing a mastectomy;
  - (iii) administering or supplying any of the following medications that induce transient or permanent infertility:
    - (a) puberty-blocking medication to stop or delay normal puberty;
    - (b) supraphysiologic doses of testosterone to females; or
    - (c) supraphysiologic doses of estrogen to males; or
  - (iv) removing any otherwise healthy or non-diseased body part or tissue.<sup>120</sup>

Violating this provision would result in a finding of child abuse.<sup>121</sup>

*b. Florida*

In March of 2023, the Florida Board of Medicine entered a new administrative rule affecting gender-affirming care for minors. The rule states in its entirety:

64B8-9.019 Standards of Practice for the Treatment of Gender Dysphoria in Minors.

- (1) The following therapies and procedures performed for the treatment of gender dysphoria in minors are prohibited.

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117. *Id.* at 3.

118. *Id.*

119. H.B. 42, 88th Leg., Reg. Sess. (Tex. 2023).

120. *Id.*

121. *Id.*

- (a) Sex reassignment surgeries, or any other surgical procedures, that alter primary or secondary sexual characteristics.
- (b) Puberty blocking, hormone, and hormone antagonist therapies.
- (2) Minors being treated with puberty blocking, hormone, or hormone antagonist therapies prior to the effective date of this rule may continue with such therapies.<sup>122</sup>

The Florida legislature then decided to take measures even farther. In the midst of a spree of anti-LGBTQ legislation, the legislature passed a general statute stating that “Sex-reassignment prescriptions and procedures are prohibited for patients younger than 18 years of age.”<sup>123</sup> “Sex-reassignment prescriptions or procedures” is defined as:

1. The prescription or administration of puberty blockers for the purpose of attempting to stop or delay normal puberty in order to affirm a person's perception of his or her sex if that perception is inconsistent with the person's sex as defined in subsection (8).
2. The prescription or administration of hormones or hormone antagonists to affirm a person's perception of his or her sex if that perception is inconsistent with the person's sex as defined in subsection (8).
3. Any medical procedure, including a surgical procedure, to affirm a person's perception of his or her sex if that perception is inconsistent with the person's sex as defined in subsection (8).
- (b) The term does not include:
  1. Treatment provided by a physician who, in his or her good faith clinical judgment, performs procedures upon or provides therapies to a minor born with a medically verifiable genetic disorder of sexual development, including any of the following:
    - a. External biological sex characteristics that are unresolvably ambiguous.
    - b. A disorder of sexual development in which the physician has determined through genetic or biochemical testing that the patient does not have a normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a male or female, as applicable.<sup>124</sup>

A fact sheet provided by the Florida Surgeon General further indicates that social transitioning should not be used as treatment.<sup>125</sup> Florida’s ban has already been

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122. FLA. ADMIN. CODE ANN. r. 64B8-9.019 (2023).

123. FLA. STAT. § 456.52(1) (2023).

124. FLA. STAT. § 456.001(9) (2023).

125. FLA. DEP’T OF HEALTH, TREATMENT OF GENDER DYSPHORIA FOR CHILDREN AND ADOLESCENTS (2022), [https://www.floridahealth.gov/\\_documents/newsroom/press-releases/2022/04/20220420-gender-dysphoria-guidance.pdf](https://www.floridahealth.gov/_documents/newsroom/press-releases/2022/04/20220420-gender-dysphoria-guidance.pdf) [<https://perma.cc/2A47-A396>].

challenged in Federal Court.<sup>126</sup>

*c. Idaho*

Idaho is another state which has sought to ban gender-affirming care for minors through statutory means.<sup>127</sup>

- (2) Except as provided in subsection (4) of this section, any medical practitioner who knowingly engages in any of the following practices upon a child for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex shall be guilty of a felony:
  - (a) Performing surgeries that sterilize or mutilate, or artificially construct tissue with the appearance of genitalia that differs from the child's biological sex, including castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, clitoroplasty, vaginoplasty, vulvoplasty, ovariectomy, or reconstruction of the fixed part of the urethra with or without metoidioplasty, phalloplasty, scrotoplasty, or the implantation of erection or testicular prostheses;
  - (b) Performing a mastectomy;
  - (c) Administering or supplying the following medications that induce profound morphologic changes in the genitals of a child or induce transient or permanent infertility:
    - (i) Puberty-blocking medication to stop or delay normal puberty;
    - (ii) Supraphysiological doses of testosterone to a female; or
    - (iii) Supraphysiological doses of estrogen to a male; or
  - (d) Removing any otherwise healthy or nondiseased body part or tissue.<sup>128</sup>

Like similar bans, the authors of the law seek to justify it as a means to protect children.<sup>129</sup>

There are some exceptions built into the statute.

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126. *See Doe v. Ladapo*, No. 4:23CV114-RH-MAF, 2023 WL 3833848 (N.D. Fla. June 6, 2023).

127. H.B. 71, 67th Leg., Reg. Sess. (Id. 2023).

128. *Id.*

129. *Id.* at § 1. The statute is referred to as the “Vulnerable Child Protection Act.”

## V. IS IT MEDICINE OR POLITICS?

*A. Europe v. United States: The Politics of Gender Identity*

Gender Identity is a hot button topic in the United States. From airline pilots,<sup>130</sup> to school bathrooms,<sup>131</sup> to health care,<sup>132</sup> U.S. courts have repeatedly been called upon to determine whether transgender people deserve the same rights as other human beings. School boards attempt to decide who can use which restrooms,<sup>133</sup> politicians try to determine who can compete in what sports,<sup>134</sup> and parents attempt to remove books from libraries<sup>135</sup> all in the name of protecting children.

While all LGBTQ individuals have been targeted by proposed laws, there has been a particular focus on transgender youth.<sup>136</sup> This has not only included bans on gender-affirming care, but also bans on classroom discussions of gender, forced outing of students to their parents, and removal of library books featuring trans characters.<sup>137</sup> Additional proposed laws would limit or remove avenues for people to change their gender marker on legal documents.<sup>138</sup>

But anti-trans sentiment is not limited to the United States. The rest of the world, including Europe, has seen its share of anti-trans rhetoric. It was only in 2017 that the European Court of Human Rights found that requiring transgender individuals be sterilized before they could transition constituted a human rights violation.<sup>139</sup> Since then, some European nations have sought to limit trans rights, including the consideration of a near-total ban on gender recognition in Slovakia.<sup>140</sup> The United Kingdom has also seen abundant anti-trans rhetoric from both its government and the media.<sup>141</sup>

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130. See *Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081 (7th Cir. 1984).

131. See *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586 (4th Cir. 2020).

132. See *Williams v. Kincaid*, 45 F.4th 759 (4th Cir. 2022).

133. *Gloucester Cnty. Sch. Bd.*, 972 F.3d.

134. See *Hecocx v. Little*, 479 F. Supp. 3d 930 (Dist. Id. 2020).

135. Eesha Pendharkar, *ACLU Texas Files OCR Complaint Over a District's Anti-Trans Book Ban*, EDUC. WEEK (Nov. 30, 2022), <https://www.edweek.org/leadership/aclu-texas-files-ocr-complaint-over-a-districts-anti-trans-book-ban/2022/11> [<https://perma.cc/3QY5-49G6>].

136. *Mapping Attacks on LGBTQ Rights in U.S. State Legislatures*, AM. C.L. UNION (Aug. 25, 2023), <https://www.aclu.org/legislative-attacks-on-lgbtq-rights> [<https://perma.cc/3HRJ-J2TZ>].

137. *Id.*

138. *Id.*

139. *Human Rights Victory! European Court of Human Rights ends Forced Sterilisation*, TRANSGENDER EUR. (Apr. 6, 2017), [https://tgeu.org/echr\\_end-sterilisation/](https://tgeu.org/echr_end-sterilisation/) [<https://perma.cc/UJ69-Z8LH>].

140. Jamie Wareham, *Trans Rights Increased in Europe Despite Growing Backlash in 2022*, FORBES (May 11, 2023), <https://www.forbes.com/sites/jamiewareham/2023/05/11/trans-rights-increased-in-europe-and-asia-in-2022-despite-growing-backlash/> [<https://perma.cc/C9X4-G9SW>].

141. *Id.*; see also Frankie de la Creutz, *A Surge in Transphobia Is Endangering Trans People*

Yet not all political treatment of transgender individuals has been negative.<sup>142</sup> Just as the United States has seen different state governments take different positions- some antagonistic, some friendly- so too has Europe. Europe has seen a division in how different European countries have treated their trans communities. Spain recently enacted laws covering employment, protections for trans migrants, and discrimination based on gender expression.<sup>143</sup> Iceland, and Finland also lead the way in protecting trans rights.<sup>144</sup>

It is clear that there is division between US states and nations in Europe regarding how to treat trans youth seeking gender-affirming care. But are there any other parallels we can draw? It would be easy to say that those countries in Europe offering support to trans youth are politically left-leaning, much like the states acting as safe-havens for trans youth in the U.S., while those seeking to oppress trans youth are far-right leaning. But that is not quite right. The United Kingdom has a conservative government, yet also grants extensive LGBTQ protections.

To be sure, Slovakia is among the most far-right governments in Europe.<sup>145</sup> Italy, however, has lurched to the right, yet it maintains legal protections for LGBTQ individuals.<sup>146</sup> The United Kingdom also has a conservative government, but it too grants extensive LGBTQ protections, including protections for trans youth.<sup>147</sup> Therefore, while there may be some correlation between right-wing conservatism and anti-trans legislation, the correlation is not perfect; some conservative national governments in Europe still provide protections for LGBTQ people.

### *B. Medical Concerns or a Bare Desire to Harm*

Even if there is a political element to bans on gender-affirming care, and even if there are international parallels linking conservatism and anti-trans ideology, the question still remains: are state bans on gender-affirming care legitimate, or merely evidence of a bare desire to harm the LGBTQ community? This may be

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*in the U.K.*, THEM (Feb. 18, 2021), <https://www.them.us/story/transphobia-surge-endangering-trans-people-uk> [<https://perma.cc/CL9F-J9QQ>].

142. *Id.*

143. *Id.*

144. *Id.*

145. Klotz, *supra* note 11.

146. Italy's Prime Minister, Georgia Meloni, leads with incredible animus towards the LGBTQ community, so it is unclear what the future holds. See Maggie Baska, *Who is Italy's new 'fascist' leader Giorgia Meloni and what does she say about LGBTQ+ rights?*, PINK NEWS (Sept. 27, 2022), <https://www.thepinknews.com/2022/09/27/giorgia-meloni-italy-prime-minister-lgbtq-rights-adoption-trans/> [<https://perma.cc/HL2D-GWEB>].

147. *Gender equality and promoting and protecting the rights of LGBT+ people*, GOV.UK (Aug. 26, 2022) <https://www.gov.uk/government/publications/official-development-assistance-oda-fcds-international-programme-spend-objectives-2021-to-2022/gender-equality-and-promoting-and-protecting-the-rights-of-lgbt-people> [<https://perma.cc/2PVT-7NCV>].

a more difficult question than it seems. There are arguments to be made either way.

A number of U.S. states have chosen to argue that their new or proposed bans on gender-affirming care are the result of an attempt to protect children.<sup>148</sup> Some go so far as to claim that their bills are intended to protect children from experimental medical procedures.<sup>149</sup> None address the fact that research has shown that individuals with gender dysphoria are at higher risks for suicide than the general population.<sup>150</sup> None address the reality that removing the standard processes for treatment of gender dysphoria is likely to cost some trans adolescents and children their lives -- the lives of the same children whom the proponents of gender-affirming care bans claim to be protecting. Even though states do have a legitimate interest in protecting the lives of children, their failure to address the prevalence of suicide amongst the trans youth population weakens the argument that bans on gender-affirming care are in the interest of protecting children.

Perhaps a more legitimate argument could have been made by pointing to the growing number of nations questioning reliance on the Dutch Protocol. Trans-friendly nations like Finland are questioning the extent to which the Dutch Protocol should be relied upon. Pointing to the evidence nations like Finland use to question the efficacy of the Dutch Protocol could have strengthened the argument that gender-affirming care bans are not about discrimination, but are instead about providing safe medical care. That multiple nations' health services were investigating the process for treating gender dysphoria in adolescents and children would have provided at least a veneer of legitimacy.

Instead, gender-affirming care bans have been introduced alongside hundreds of other anti-LGBTQ bills.<sup>151</sup> These bills have sought to harass, if not erase, trans children in schools, health care, sports, and their communities.<sup>152</sup> Furthermore, politicians have sought to capitalize on their anti-LGBTQ records as they seek higher offices.<sup>153</sup> The politics of trans-erasure are abundantly clear.

And yet, it is still the case that there is medical backlash against the Dutch

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148. Jo Yurcaba, *Texas AG says transition care for minors is child abuse under state law*, NBC NEWS (Feb. 22, 2022, 5:04 PM EST), <https://www.nbcnews.com/nbc-out/out-politics-and-policy/texas-ag-says-transition-care-minors-child-abuse-state-law-rcna17176> [<https://perma.cc/EG7U-GTXB>].

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

150. Elena Garcia-Vega, Aida Camero, María Fernández, & Ana Villaverde, *Suicidal Ideation and Suicide Attempts in Persons with Gender Dysphoria*, 30 PSICOTHEMA 283, 283 (2018), <https://www.psicothema.com/pi?pii=4483> [<https://perma.cc/GG7X-Q4SU>].

151. AM. C.L. UNION, *supra* note 136.

152. *Id.*

153. Hannah Demissie, *DeSantis campaign touts his 'draconian' LGBTQ record vs. Trump; gay conservatives denounce him*, ABC NEWS (July 5, 2023, 8:51 PM), <https://abcnews.go.com/Politics/desantis-campaign-touts-draconian-lgbtq-record-trump-gay/story?id=100595946> [<https://perma.cc/PML7-VXKV>].

Protocol. It seems that anti-trans activists and their political allies have stumbled onto a legitimate argument for limiting gender-affirming care. And yet, their approach- opportunistically introducing legislation as part of a culture war- has reduced any legitimacy that may have existed.

## VI. IMPACT ON U.S. LAW

### *A. Court Treatment of Gender-Affirming Care Bans*

#### *i. Florida*

Florida was one of the first states to see its ban on gender-affirming care challenged in court.<sup>154</sup> Seven plaintiffs brought suit challenging the law prohibiting the use of puberty blockers by their transgender children.<sup>155</sup> The numerous defendants included the Florida Surgeon General, the Florida Board of Medicine and its members, the Florida Board of Osteopathic Medicine and its members, the Florida Attorney General, and all of Florida's 20 State Attorneys.<sup>156</sup>

Three plaintiffs moved for a preliminary injunction.<sup>157</sup> In reaching its decision, the court made clear that Gender Identity is real,<sup>158</sup> and that even Florida's medical defendants and expert witness had admitted as much.<sup>159</sup> Furthermore, the court rejected the idea that being transgender is a choice.<sup>160</sup> Even the state's medical defendants admitted that such a view is wrong, and that "pushing individuals away from their transgender identity is not a legitimate state interest."<sup>161</sup>

In assessing the plaintiffs' Fourteenth Amendment claims, the court found that intermediate scrutiny should apply.<sup>162</sup> The court reasoned that "If one must know the sex of a person to know whether or how a provision applies to the person, the provision draws a line based on sex."<sup>163</sup> Sex is a quasi-suspect class subject to intermediate scrutiny,<sup>164</sup> and the court found that there could be no doubt that the statute drew a line based on sex.<sup>165</sup> The court also found that Florida's gender-affirming care ban triggered intermediate scrutiny because, "heightened scrutiny might be appropriate for statutes showing 'prejudice against

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154. Doe v. Ladapo, No. 4:23CV114-RH-MAF, 2023 WL 3833848 (N.D. Fla. June 6, 2023).

155. *Id.*

156. *Id.*

157. *Id.* at \*1.

158. *Id.* at \*2.

159. *Id.*

160. *Id.*

161. *Id.*

162. *Id.* at \*8.

163. *Id.* (citing *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1737 (2020); *Adams*, 57 F.4th at 801).

164. *Id.* (citing *United States v. Virginia*, 518 U.S. 515, 533 (1996); *Adams*, 57 F.4th at 801).

165. *Id.*



discrete and insular minorities.”<sup>166</sup>

For a statute to survive intermediate scrutiny, the state must show that its classification is substantially related to a sufficiently important interest.<sup>167</sup> The court found that “[d]issuading a person from conforming to the person’s gender identity rather than to the person’s natal sex is not a legitimate state interest.”<sup>168</sup> In fact, that court implied that the only reason for Florida’s action was an intent to discriminate against transgender individuals.<sup>169</sup>

The plaintiffs also raised a Due Process Clause argument, claiming that the statute violated their right to control their children’s medical treatment.<sup>170</sup> Among the various defense arguments which the court deemed “pretextual” was an argument that Florida’s statute was consistent with how various European countries treat hormones used in gender-affirming care for adolescents and children.<sup>171</sup> This assertion is, as the court duly noted, false.<sup>172</sup> None of the countries cited by Florida- Finland, Sweden, Norway, Great Britain, France, Australia, and New Zealand- have banned the use of hormones in gender-affirming care.<sup>173</sup> Instead, as the court noted, the use of hormones in gender-affirming care is allowed for adolescents and children in certain circumstances which, if Florida were truly aligned with the countries it cited, the plaintiffs’ children would satisfy.<sup>174</sup>

The court granted a preliminary injunction, adopting language which indicated a strong aversion to the statute itself:

Gender identity is real. Those whose gender identity does not match their natal sex often suffer gender dysphoria. The widely accepted standard of care calls for evaluation and treatment by a multidisciplinary team. Proper treatment begins with mental-health therapy and is followed in appropriate cases by GnRH agonists and cross-sex hormones. Florida has adopted a statute and rules that prohibit these treatments even when medically appropriate. The plaintiffs are likely to prevail on their claim that the prohibition is unconstitutional.<sup>175</sup>

Despite this outcome in Florida, and a similar one in the 8<sup>th</sup> Circuit, not all courts have agreed.<sup>176</sup>

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166. *Id.* at \*9.

167. Adams, 57 F.4th at 801.

168. Doe v. Ladapo, No. 4:23CV114-RH-MAF, 2023 WL 3833848, at \*10 (N.D. Fla. June 6, 2023).

169. *Id.*

170. *Id.* at \*11.

171. *Id.* at \*39, 40.

172. *Id.*

173. *Id.*

174. *Id.*

175. *Id.* at \*16.

176. See Brandt v. Rutledge, 47 F.4th 661 (8th Cir. 2022).

*ii. Sixth Circuit*

On July 8, 2023, the Sixth Circuit Court of Appeals issued an opinion in *L.W. by and through Williams v. Skrmetti*.<sup>177</sup> In that case, the state of Tennessee challenged a ruling from the Middle District of Tennessee granting a preliminary injunction against Tennessee's gender-affirming care ban.<sup>178</sup> The Sixth Circuit granted a stay of the injunction.<sup>179</sup>

In addressing the Equal Protection claim, the court found that intermediate scrutiny did not apply, despite the statute's implication of sex.<sup>180</sup> The court also rejected the notion that any pretext existed which would trigger intermediate scrutiny.<sup>181</sup> Indeed, the court went so far as to say that implicating sex was necessary for the statute to serve its purpose.<sup>182</sup>

The court further rejected the argument that transgender individuals constitute a quasi-suspect class.<sup>183</sup> Instead the court argued that the United States Supreme Court has not recognized a quasi-suspect class in many years, and that this makes sense because:

Gender identity and gender dysphoria pose vexing line-drawing dilemmas for legislatures. Plenty of challenges spring to mind. Surgical changes versus hormone treatment. Drugs versus counseling. One drug versus another. One age cutoff for minors versus another. Still more complex, what about sports, access to bathrooms, definitions of disability? And will we constitutionalize the FDA approval rules in the process? Even when accompanied by judicial tiers of scrutiny, the U.S. Constitution does not offer a principled way to judge each of these lines—and still others to boot. All that would happen is that we would remove these trying policy choices from fifty state legislatures to one Supreme Court.<sup>184</sup>

The court's ruling takes no account of the fact that gender dysphoria is not a question for legislatures but rather a medical diagnosis based on facts. Nor does it offer any reason why treatment for gender dysphoria should be a question for legislatures rather than medical professionals. This would have been the perfect place to discuss the Tennessee ban's reliance on the medical community, including European perspectives, rather than political animus, but the court refrained from that depth of analysis.

Equally frustrating is the majority's refusal to engage in deep analysis of any of the other issues presented. We are told that numerous courts have come to

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177. *L.W. v. Skrmetti*, No. 23-5600 (6th Cir. Jul. 8, 2023).

178. *Id.*

179. *Id.*, slip op. at 2.

180. *Id.*, slip op. at 11.

181. *Id.*

182. *Id.*

183. *Id.*, slip op. at 12.

184. *Id.*

different conclusions regarding the status of transgender people as a quasi-suspect class, and indeed that several courts have ruled against bans on gender-affirming care. However, these cases are dismissed with no better explanation than “We appreciate their perspectives, and they give us pause. But they do not eliminate our doubts about the ultimate strength of the challengers’ claims for the reasons just given.”<sup>185</sup> Those reasons—that the court has not recognized transgender people as a protected class regardless of *Bostock v. Clayton Cnty.*,<sup>186</sup> as well as deference to the legislature—lack depth or development.

*B. What Role Should the Revolt Against the Dutch Protocol Play in U.S. Gender-Affirming Care Ban Cases?*

It is easy to get lost in the politics of gender-affirming care and write policies off as merely systemic transphobia. Some certainly fit this description, Florida in particular, as the *Ladapo* case makes clear, is taking a hardline against trans adolescents and children because it can, not because there is a reason to do so.<sup>187</sup> As a result of the politics of trans existence taking a front seat, there is less scrutiny of the fact that there is increasing dissent about the efficacy of the Dutch Protocol.

This oversight is important. That the medical communities have called for a move away from the Dutch Protocol should carry some weight. That these medical communities come from nations across the political spectrum should also provide strength to the argument that pumping the breaks on gender-affirming care is a non-partisan move.

Florida bungled this opportunity. Despite Florida’s claims to the contrary, none of the European nations have banned gender-affirming care for adolescents or children.<sup>188</sup> Therein lies the problem for conservative state leaders. Rather than adopting a sound strategy for regulating access to gender-affirming care based on science, research, and actual concern for the well-being of trans children, they seized their opportunity to restrict or reduce that access as part of large anti-LGBTQ legislative packages.

The fact that European nations have taken a step back from the Dutch Protocol could be a canary in the coal mine moment. Perhaps we do need more research, more assessment of the efficacy of hormone therapy. Europe has shown us that these discussions do not have to be political stunts, but can actually be part of a rigorous inquiry into the state of health care for trans adolescents and children. But the lesson seems to be that, in order to have those discussions, legislatures need to remove themselves from the conversation and let the professionals investigate.

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185. *Id.*, slip op. at 14.

186. *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1737 (2020).

187. *Doe v. Ladapo*, No. 4:23CV114-RH-MAF, 2023 WL 3833848 (N.D. Fla. June 6, 2023).

188. *Id.* at \*14.

## VII. CONCLUSION

Gender dysphoria is a challenge facing many transgender adolescents and children. It is also a treatable condition. Treatment may include social transition as well as medical treatment such as the prescribing of hormones. The standards of care, based on the Dutch Protocol, have been widely accepted by the relevant medical communities, but have recently come into question, with health agencies in European countries pulling away from the Dutch Protocol.

At the same time, conservative law makers have escalated a culture war against LGBTQ Americans. Among the targets in this culture war are transgender adolescents and children. While claiming to protect children, a number of states have passed or are considering legislation restricting access to gender-affirming care. What has been lost in the ensuing struggle over trans, and indeed all LGBTQ rights, is the fact that there may be legitimate questions about the treatment of transgender adolescents and children which only medical professionals can answer.

So, what can these European nations teach the various U.S. state legislatures? Questions about gender-affirming care for adolescents and children should be about methodology, not about access. Each of the European nations above has raised similar questions to those raised by conservative legislatures as a justification for enacting bans. But where U.S. state legislatures have sought to severely restrict or block access, the European nations have sought to investigate the treatment methodology. That is how you protect vulnerable trans children; by honoring their existence while investigating the means by which gender dysphoria is treated.