EVIDENCE AND EXPERTISE IN TRANS HEALTH LAW

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INTRODUCTION

According to state officials and antitrans advocacy groups, gender-affirming care bans for minors are a necessary defense against trans medicine's dangerously uncertain and experimental nature.[1] The Supreme Court's pending decision in *United States v. Skrmetti*[2] will likely rest on a doctrinal consideration about whether such bans violate the Fourteenth Amendment's Equal Protection Clause as it pertains to sex discrimination. However, debates over gender-affirming care's expert practitioners and evidence base have remained central to the case and fundamentally shaped the way that legal advocates frame matters of trans health.[3]

The conservative governors and antitrans advocacy groups behind the bans have cast doubt on gender-affirming care's safety and efficacy in a way that parallels the work of antiabortion organizations and jurists. As Aziza Ahmed and Mary Ziegler have expounded in their writings on this "jurisprudence of uncertainty," antiabortion interest groups and attorneys have, for the past two decades, effectively deployed deceptive narratives about the supposed risks and paltry evidence base for many routine abortion practices.[4] Oftentimes, antiabortion groups' work have been buttressed by fringe medical associations, such as the American Association of Pro-Life Obstetricians and Gynecologists, that speak of "randomized control trials," "empirical evidence," and the risks of patient regret to oppose abortion procedures that have been deemed safe and effective by qualified surgeons and professional medical associations.[5] In the context of gender-affirming care bans, fringe medical groups[6] have worked with

[1] Joanna Wuest & Briana S. Last, *Agents of Scientific Uncertainty: Conflicts over Evidence and Expertise in Gender-Affirming Care Bans for Minors*, SOC. SCI. & MED. (Dec. 24, 2023), https://www.sciencedirect.com/science/article/abs/pii/S0277953623008900.

[2] U.S. Supreme Court Docket No. 23-477.

[3] Aziza Ahmed & Joanna Wuest, *Banning Trans Health Care Puts Young People at Risk of Harm*, NATION (Dec. 13, 2024), https://www.thenation.com/article/society/banning-trans-health-care-puts-young-people-at-risk/ [https://perma.cc/C4CR-A9DE] (describing gravity of bans and Equal Protection arguments before court); *see* TENN. CODE ANN. §§ 68-33-101 to -103 (2025).

[4] *See* Aziza Ahmed, *Medical Evidence and Expertise in Abortion Jurisprudence*, 41 AM. J.L. & MED. 85, 86, 103 (2015); Mary Ziegler, *The Jurisprudence of Uncertainty: Knowledge, Science, and Abortion*, 2018 WIS. L. REV. 317, 327; *see also* Ari Ezra Waldman, *Manufacturing Uncertainty in Constitutional Law*, 91 FORDHAM L. REV. 2249, 2252 (2023) (detailing litigants have used misinformation to cast doubt on politicized medical care).

[5] *See* Ahmed, *supra* note 4, at 104-05 (providing examples of litigants' use of American Association of Pro-Life Obstetricians and Gynecologists); *see also* Gonzales v. Carhart, 550 U.S. 124, 159 (2007) ("While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained."). *See generally* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

[6] Such as the American College of Pediatricians ("ACPeds"), not to be confused with the more esteemed and representative group, the American Academy of Pediatrics.

conservative legal movement organizations[7] and conservative state officials in declaring that best practices for children and adolescents experiencing gender dysphoria fail to meet legitimate healthcare evidentiary standards.[8] And although gender-affirming care bans do not face the exact kind of constitutional scrutiny that made uncertainty so doctrinally important to those defending pre-*Dobbs* legislative abortion restrictions, the language of uncertainty has been central to *United States v. Skrmetti*.[9] At the very beginning of oral argument, Chief Justice John Roberts framed the case as a dispute over whether medical professionals are becoming increasingly uncertain about the best practices for gender-dysphoric youth, a debate he argued is best resolved in the legislative branch.[10]

As obfuscating, erroneous, and outright manufactured as many of these medical claims can be, they often draw from very real, expanding fissures and conflicts in the fields of gender identity care and health care more broadly.[11] Therefore, understanding arguments about gender-affirming care's allegedly uncertain evidence base requires attending to the sources of those fractures, not least because they help to explain the discursive force of ban supporters' arguments. The first conflict is one between older, more conservative clinical approaches to treating child and adolescent gender dysphoria and newer, more affirming ones that are targeted by recent state bans.[12] Sensing an opening to reassert their views, some formerly dominant clinician-researchers have sought to reaffirm their own fading epistemological renderings of dysphoria and the

[7] Such as the Alliance Defending Freedom.

[8] Wuest & Last, *supra* note 1; *see, e.g.*, L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 473 (6th Cir. 2023) (holding courts should defer to legislatures on matters of "medical and scientific uncertainty" (quoting *Carhart*, 550 U.S. at 163)).

[9] *Compare* Brief of Equal Protection Constitutional Law Scholars Serena Mayeri et al. as Amici Curiae in Support of Respondents at 7-11, *Dobbs*, 597 U.S. 215 (No. 19-1392) (arguing pregnancy regulations are sex-based classifications subject to heightened scrutiny), *with* Transcript of Oral Argument at 12-14, United States v. Skrmetti, No. 23-477 (U.S. Dec. 4, 2024) (arguing for intermediate scrutiny).

[10] Transcript of Oral Argument, *supra* note 9, at 10 (stating that Supreme Court is "not the best situated to address issues . . . intensely affected by medical considerations" and that it may be better "to leave those determinations to the legislative bodies").

[11] *See generally* Moti Gorin, *Letters to the Editor*, 51 J.L. MED. & ETHICS 717 (2023); Alejandra Caraballo, *The Author Responds*, 51 J.L. MED. & ETHICS 721 (2023).

[12] For an account of the varied and conflicting approaches that gender identity clinicians have used historically and continue to use today, see Diane Ehrensaft, *Gender Nonconforming Youth: Current Perspectives*, 8 ADOLESCENT HEALTH MED. & THERAPEUTICS 57, 60-64 (2017), https://www.dovepress.com/article/download/33024 [https://perma.cc/YH77-FN2Z]; and Wuest & Last, *supra* note 1.

nature of gender identity.[13] *Skrmetti*[14] has thus provided a legal arena for champions of that older, increasingly discredited paradigm to roar back to life.[15]

The second conflict concerns "evidence-based medicine" ("EBM"), a deceptively straight-forward sounding term that describes a contested means by which many leading medical researchers, health bureaucrats, and clinicians evaluate the quality of a given healthcare practice's evidence base.[16] Curiously, both sides in *Skrmetti* rely on the language of "evidence-based" although with different emphases. Ban defenders point to the lack of randomized controlled studies and other "high quality" data for many routine gender-affirming care practices while simultaneously promoting untested practices, some of which are associated with real harms.[17] As bioethicists and legal scholars have noted, some of these alternative proposals for care bear a striking resemblance to discredited sexual-orientation- and gender-identity-change efforts, otherwise known as "conversion therapy" practices.[18] But by targeting gender-affirming care's evidence base and insisting that its practices are rife with dangerous uncertainties, Tennessee has done its best to target that specific form of care rather than consider what the *best available* evidence suggests is appropriate for gender-dysphoric and trans-identified youth, a position frequently espoused by trans medicine's defenders. This approach also characterizes the Trump Administration's Department of Health and Human Services comprehensive report on "Treatment for Pediatric Gender Dysphoria: Review of Evidence and

[13] *See* Wuest & Last, *supra* note 1.

[14] This Essay uses Skrmetti to refer to United States v. Skrmetti collectively with Sixth Circuit decision L.W. ex rel. Williams v. Skrmetti, 83 F.4th 460, 473 (6th Cir. 2023), and lower court case L.W. ex rel. Williams v. Skrmetti, 679 F. Supp. 3d 668 (M.D. Tenn. 2023).

[15] This Essay further explores the arguments presented in Joanna Wuest & Briana S. Last, *The Bad Science Behind Trans Medicine Bans*, DISSENT, Winter 2025, at 116 (2025). This struggle to maintain a paradigm as it crumbles was keenly observed by Thomas Kuhn. *See generally* THOMAS KUHN, THE STRUCTURE OF SCIENTIFIC REVOLUTIONS (1962).

[16] *See* Catherine Pope, *Resisting Evidence: The Study of Evidence-Based Medicine as a Contemporary Social Movement*, 7 HEALTH: INTERDISCIPLINARY J. SOC. STUDY HEALTH ILLNESS & MED. 267, 269-70 (2003) (describing development of EBM movement).

[17] *See* Corrected Brief of Amici Curiae The American College of Pediatricians et al. in Support of Respondents at 19, 37-40, United States v. Skrmetti, No. 23-477 (U.S. Oct. 18, 2024) (arguing there are no randomized, controlled studies documenting long-term effects of puberty blockers and that mental health counseling is the only effective treatment for minors with dysphoria); *see also* Anna Forsythe et al., *Humanistic and Economic Burden of Conversion Therapy Among LGBTQ Youths in the United States*, 176 JAMA PEDIATRICS 493, 498-99 (2022).

[18] Florence Ashley, *Interrogating Gender-Exploratory Therapy*, 18 PERSPS. ON PSYCH. SCI. 472, 474 (2023) (noting "how much gender-exploratory therapy and conversion practices resemble one another from a conceptual and narrative standpoint"); *see* Wuest & Last, *supra* note 15, at 123.

Best Practices," which similarly leverages an EBM framework against gender-affirming care practices and encourages fraught talk therapy alternatives.[19]

This Essay situates *Skrmetti* within the context of these two conflicts over the nature of evidence and expertise. In doing so, it demonstrates how perspectives from the history and sociology of science and medicine can enrich our understanding of gender-affirming-care ban litigation as well as how the law shapes or *coproduces* medical knowledge and authority.[20] Part I provides a short history of the gender identity clinic that details one influential gender identity care expert from a previous generation who has participated directly in *Skrmetti* as well as those gender-affirmative experts who have opposed the Tennessee law at issue in *Skrmetti*. Part II tracks the emergence of the EBM paradigm in healthcare, noting its defining qualities and shortcomings as well as how gender-affirming care ban opponents and proponents have both relied upon the language of EBM. The conclusion briefly observes the consequences that *Skrmetti* and these arguments concerning medical knowledge and authority might have for trans youth and other gender minorities.

I. POWER AND PARADIGM SHIFTS IN THE CLINIC AND COURTROOM

Trans healthcare has changed in radical ways since Johns Hopkins University psychologist John Money opened the nation's first gender identity clinic in 1966.[21] Far from being affirming, early university-based clinics were concerned with understanding gender nonconformity so that they might arrest or change it.[22] Tellingly, the Hopkins clinic's focus on gender-nonconforming children emerged from Money and other researchers' work that began decades earlier with young intersex patients who were subjected to coercive and invasive

[19] *See generally* DEP'T OF HEALTH & HUM. SERVS., TREATMENT FOR PEDIATRIC GENDER DYSPHORIA: REVIEW OF EVIDENCE AND BEST PRACTICES (2025), https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf [https://perma.cc/8CK6-6YWV].

[20] *See* Sheila Jasanoff, *The Idiom of Co-Production*, *in* STATES OF KNOWLEDGE: THE CO-PRODUCTION OF SCIENCE AND SOCIAL ORDER 1, 2-3 (Sheila Jasanoff ed., 2004) (explaining coproduction as the idea "that the ways in which we know and represent the world . . . are inseparable from the ways in which we choose to live in it"). *See generally* Libby Adler, *Just the Facts: The Perils of Expert Testimony and Findings of Fact in Gay Rights Litigation*, 7 UNBOUND: HARV. J. LEGAL LEFT 1 (2011), https://journals.law.harvard.edu/legalleft/wp-content/uploads/sites/81/2015/09/Adler_Just-the-Facts.pdf [https://perma.cc/VKF8-B3M3]; Janet E. Halley, *Sexual Orientation and the Politics of Biology: A Critique of the Argument from Immutability*, 46 STAN. L. REV. 503 (1994); JOANNA WUEST, BORN THIS WAY: SCIENCE, CITIZENSHIP, AND INEQUALITY IN THE AMERICAN LGBTQ+ MOVEMENT (2023).

[21] JOANNE MEYEROWITZ, HOW SEX CHANGED: A HISTORY OF TRANSSEXUALITY IN THE UNITED STATES 167 (2002).

[22] *See* JULES GILL-PETERSON, HISTORIES OF THE TRANSGENDER CHILD 136-38 (2018) (detailing Money's actions and inability to "restrain his desire to study trans life even when he simultaneously refused to consider the situated perspective of a trans person").

medical interventions.[23] Only later did Money and others—such as psychiatrists Richard Green, who was Money's mentee, and Robert Stoller of the UCLA Gender Identity Clinic—become more concerned with "sissy" or feminine children who were assigned male at birth ("AMAB").[24]

These early clinicians endeavored to lure their patients away from their cross-gendered desires and expressions, encouraging those feminine AMAB children, for instance, to stop playing with "girly" toys and to spend more time socializing with and idolizing their male peers and guardians.[25] To explain why gender-nonconforming youth could be successfully made to embrace their assigned sex, those like Money theorized that a young child's gender role or identity was malleable up to a certain age, meaning that clinicians needed to act quickly before the "wrong" sense of gendered self took root.[26] Such practices have been condemned by later researchers and clinicians as coercive gender-identity-change efforts.[27] The research from this era produced collections of misleading statistics, purportedly showing which patients were likely to be successful candidates for such reorientation efforts.[28] For example, in his 1987 book, *The "Sissy Boy Syndrome" and the Development of Homosexuality*, Green found that young feminine AMAB patients were overwhelmingly likely to adopt gay identities in their adulthood rather than transsexual ones (the preferred nomenclature at the time).[29] This approach to gender identity care was informed by the American Psychiatric Association's 1980 diagnostic criteria for what was called "Gender Identity Disorder of Childhood" ("GIDC"), the original draft of

[23] *See* SANDRA EDER, HOW THE CLINIC MADE GENDER: THE MEDICAL HISTORY OF A TRANSFORMATIVE IDEA 16 (2022) (noting "new concept of gender" stemming from intersex research).

[24] *See* GILL-PETERSON, *supra* note 22, at 144-45. *See generally* RICHARD GREEN, THE "SISSY BOY SYNDROME" AND THE DEVELOPMENT OF HOMOSEXUALITY (1987). For complex social and historical reasons, those assigned female at birth ("AFAB") were a rarer phenomenon in both the clinical and in research populations). *See* GILL-PETERSON, *supra* note 18, at 166.

[25] GILL-PETERSON, *supra* note 22, at 145.

[26] *Id.* at 180 (describing puberty as threshold between childhood malleability and "futility of anti-trans intervention in adulthood"). Notably, Money did not entirely reject biological factors. *See* JOHN MONEY & ANKE A. EHRHARDT, MAN & WOMAN, BOY & GIRL: THE DIFFERENTIATION AND DIMORPHISM OF GENDER IDENTITY FROM CONCEPTION TO MATURITY 1, 22 (1972); MEYEROWITZ, *supra* note 21, at 117-18.

[27] *The Lies and Dangers of Efforts to Change Sexual Orientation or Gender Identity*, HUM. RTS. CAMPAIGN, https://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy [https://perma.cc/T2UR-3DVY] (last visited May 14, 2025) ("So-called 'conversion therapy,' sometimes known as 'reparative therapy,' is a range of dangerous and discredited practices that falsely claim to change a person's sexual orientation or gender identity or expression. Such practices have been rejected by every mainstream medical and mental health organization for decades . . . .").

[28] *See generally* Wuest & Last, *supra* note 15, at 120.

[29] GREEN, *supra* note 24.

which was penned by Money and Green.[30] While these clinicians publicly attempted to reorient their patients' gendered senses of self, more recent historical work has shown that they provided transition-related medical interventions to some patients when reorientation was deemed impossible (that is, after the moment a young person's plastic gender had solidified).[31]

While the gender identity clinic's pioneers are almost all deceased, a few clinicians from the subsequent generation of gender identity care have been influential in litigation over gender-affirming care.[32] The late-twentieth-century gender identity clinic became gradually more accepting of the fact that some gender-dysphoric and trans-identified patients were incapable of reorientation, although many practitioners remained wedded to the notion that most of their patients were not predestined to be trans.[33] One example is psychiatrist Stephen Levine, who founded Case Western Reserve University School of Medicine's Gender Identity Clinic in 1974 and who once held some of the highest positions of authority in professional trans health medical associations and working groups, including the Harry Benjamin International Gender Dysphoria Association (now known as "WPATH") and the American Psychiatric Association.[34]

Levine's theories of gender identity have remained largely wedded to pathological notions of gender nonconformity. While he believes that a small portion of that population might have unmalleable trans identities, he thinks that many would benefit from treatment of mental disorders that might be at the root of a person's gender dysphoria, like narcissism.[35] For adolescents in particular, Levine has endorsed the highly discredited "rapid onset gender dysphoria" ("ROGD") thesis, which posits that peer contagion effects (mediated via social

[30] Karl Bryant, *Making Gender Identity Disorder of Childhood: Historical Lessons for Contemporary Debates*, SEXUALITY RSCH. & SOC. POL'Y, Sept. 2006, at 23, 24-26.

[31] GILL-PETERSON, *supra* note 22, at 164-66.

[32] For detailed accounts of the expert witnesses in *Skrmetti* and other litigation over gender-affirming care bans for minors, see Wuest & Last, *supra* note 1; and Wuest & Last, *supra* note 15.

[33] *See* Sahar Sadjadi, *The Vulnerable Child Protection Act and Transgender Children's Health*, 7 TRANSGENDER STUD. Q. 508, 512 (2020). For Zucker's influence on gender-affirming care ban litigation, see Wuest & Last, *supra* note 1, at 2 ("Zucker and other vestigial clinicians have encouraged child and adolescent patients to accept their assigned sex status and have opted for puberty suppressants when acceptance appears infeasible."); and Wuest & Last, *supra* note 15, at 119 (noting same).

[34] Wuest & Last, *supra* note 15, at 121-22.

[35] *See* Leslie M. Lothstein & Stephen B. Levine, *Expressive Psychotherapy with Gender Dysphoric Patients*, 38 ARCHIVES GEN. PSYCHIATRY 924, 925 (1981) ("While this phenomenon is well recognized as one factor in the treatment of patients with borderline and narcissistic disorders, it was revealed methodically as the crux of treatment with [gender dysphoria] patients." (citations omitted)); *see also* Stephen B. Levine & Leslie Lothstein, *Transsexualism or the Gender Dysphoria Syndromes*, 7 J. SEX & MARITAL THERAPY 85, 98 tbl.1 (1981) (listing individual cases of gender dysphoria with other clinical diagnoses).

media) can explain the sudden emergence of a clinical population of gender-dysphoric assigned-female-at-birth ("AFAB") adolescents that appears quite different than the clinic's historical population of AMAB children.[36] Many of those adolescents, Levine has surmised, may be redirecting their teenage anguish toward their gendered senses of self, which clinicians then respond to with psychological treatments that "range from ineffective to harmful."[37] In other words, clinicians today are less certain than necessary whether a given patient will persist in their gender dysphoria and trans-identification, making medical interventions perilous, presumably because transition regret is the worst patient outcome possible.

Unsurprisingly, those clinicians who support an affirmative model of care have been the most vocal opponents of gender-affirming care bans.[38] The affirmative model's undergirding philosophy is that there is no single preferred gendered outcome—trans, cis, or otherwise—for gender-dysphoric children and adolescents.[39] For that reason, many practitioners of gender-affirming care let the child lead their own exploration of gender, allowing them to adopt social markers like new pronouns, names, and garb as they self-determine their gendered lives (although there is more clinical discretion exercised when prescribing pharmaceutical interventions).[40] In contrast to ban supporters' fears of detransition regret, affirmative clinicians do not consider a return to one's assigned gender to be tragic, especially given that data show how risky it can be to prohibit young people from socially transitioning in the first place.[41] Although this clinical approach allows for a young person to vacillate between various

[36] *See* Stephen B. Levine & E. Abbruzzese, *Current Concerns About Gender-Affirming Therapy in Adolescents*, 15 CURRENT SEX HEALTH REPS. 113, 122 n.70 (2023) (noting support for ROGD by AFAB adolescents who detransitioned). For the original paper on ROGD, see Lisa Littman, *Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, PLOS ONE 8-10 (Aug. 16, 2018). https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0202330&type=printable [https://perma.cc/72X2-EC6U] (showing ROGD theory was authored by Littman, who spoke only to parents of gender dysphoric adolescents whom she met on gender-critical web forums).

[37] Levine & Abbruzzese, *supra* note 36, at 114.

[38] For examples of this, see Brief for Amici Curiae Expert Researchers and Physicians in Support of Petitioner, United States v. Skrmetti, No. 23-477 (U.S. Sept. 3, 2024); and Brief of Amici Curiae Clinical Practice Guideline Experts in Support of Petitioner and Respondents in Support of Petitioner, United States v. Skrmetti, No. 23-477 (U.S. Sept. 3, 2024).

[39] Jack L. Turban & Diane Ehrensaft, *Research Review: Gender Identity in Youth: Treatment Paradigms and Controversies*, 59 J. CHILD PSYCH. & PSYCHIATRY 1228, 1236 (2018) ("The affirmative approach for prepubertal transgender children considers no gender identity outcome: transgender, cisgender, or otherwise, to be preferable.").

[40] Joshua Franklin, *The Social Context of Adolescents' Right to Transition*, AM. J. BIOETHICS, Feb. 2019, at 65, 66 (counseling consideration of "limitations of puberty-blocking treatment").

[41] *See* Turban & Ehrensaft, *supra* note 39, at 1236; *cf.* Wuest & Last, *supra* note 1.

gendered feelings and identities, its most renowned researchers adopt a bioessentialist conception of gender identity's etiology.[42] Rather than theorizing that young people's gendered senses of self are highly contingent in a sort of postmodern fashion, following the child's lead rests on the assumption that the patient is an expert in determining what their gender identity truly is deep down.[43] For at least a decade, the affirmative model's founder, Diane Ehrensaft, has served as an expert witness in litigation over trans rights, offering courts a theory of trans identity that is rooted in an immutable biological quality—a strategy that has been central to contemporary trans-rights litigation.[44]

Looking to the expert witness line-up in *Skrmetti*, each side of the debate was represented. Of the four experts supporting the ACLU's initial challenge to the Tennessee ban, three were affirmative care practitioners and researchers, and the fourth was a pediatric bioethicist who has published on decision-making in the context of gender dysphoria diagnoses.[45] The three clinician-researchers included: physician Jack Turban, an Ehrensaft collaborator and director of the University of California-San Francisco's Gender Psychiatry Program in the Division of Child & Adolescent Psychiatry; Aron Janssen, an adolescent psychiatrist and founder and clinical director of the Gender and Sexuality Service at New York University; and Deanna Adkins, founder of the Duke Center for Child and Adolescent Gender Care.[46] All three clinicians were members of leading professional medical associations that specialize in gender-affirming care, including the World Professional Association for Transgender Health ("WPATH"), the Endocrine Society, the American Academy of Pediatrics, and the American Academy of Child and Adolescent Psychiatry. Accordingly, these physicians echoed these associations' warnings about the health risks of gender-affirming care bans for minors.[47] In explaining the

[42] *See generally* JACK TURBAN, FREE TO BE: UNDERSTANDING KIDS & GENDER IDENTITY (2024).

[43] *Id.* at 47 ("[T]he patient is always going to have a better understanding of themselves than the outside observer.").

[44] WUEST, *supra* note 20, at 160-89.

[45] For an example of the fourth expert's research, see Armand H. Matheny Antommaria, *Decision-Making for Adolescents with Gender Dysphoria*, 67 PERSPS. BIOLOGY & MED. 244 (2024). For Antommaria's expert declaration, see Expert Declaration of Armand H. Matheny Antommaria, MD, PhD, FAAP, HEC-C, L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668 (M.D. Tenn. 2023) (No. 3:23-cv-00376).

[46] For the three affirmative clinicians' declarations, see Expert Declaration of Jack Turban, M.D., *Williams*, 679 F. Supp. 3d 668 (No. 3:23-cv-00376); Expert Declaration of Aron Janssen, M.D., *Williams*, 679 F. Supp. 3d 668 (No. 3:23-cv-00376); and Expert Declaration of Deanna Adkins, MD, *Williams*, 679 F. Supp. 3d 668 (No. 3:23-cv-00376).

[47] Expert Declaration of Jack Turban, M.D., *supra* note 46, at ¶ 22; Expert Declaration of Aron Janssen, M.D., *supra* note 46, at ¶¶ 51-54; Expert Declaration of Dr. Deanna Adkins, MD, *supra* note 46, at ¶¶ 66-70. For a list of these associations' statements on bans, see Jack L. Turban, Katherine L. Kraschel & I. Glenn Cohen, Opinion, *Legislation to Criminalize Gender-Affirming Medical Care for Transgender Youth*, 325 JAMA 2251, 2251 tbl. (2021).

etiology of trans identity, both Adkins and Turban respectively referenced the "significant" and "strong innate" biological basis of that identity.[48] Such emphasis on biology is most apparent in the ACLU's original writ of certiorari to the Court, which stated that "[g]ender identity has biological roots and cannot be changed voluntarily, by external forces, or through medical or mental health intervention."[49]

Of Tennessee's six expert witnesses, the older generation of gender identity care was represented by Levine as well as five other researchers and clinicians who lacked significant experience in the treatment of gender dysphoria, none of whom have held the kind of positions of authority that Levine has.[50] Having lost his position of influence in the realm of gender identity care as both a researcher and a leader of professional medical associations, Levine has turned to the law to impose this form of care that today's leading researchers, clinicians, and professional medical associations oppose. In fact, Levine has spent much time recently serving as an expert witness in various cases concerning trans rights, such as those involving states which denied gender-affirming care to incarcerated adults.[51] In *Skrmetti*, Levine's testimony was rife with references to his generation's research record—which many practitioners today view as slim and unfounded—as well as assumptions about the dangers of social transition, citations to the ROGD phenomenon supposedly afflicting AFAB adolescents, and criticisms of the biological theory of gender identity's nature and origins.[52] Tennessee has echoed many of Levine's sentiments, arguing that we are living through an "epidemic [that] is particularly affecting adolescent girls" and that,

[48] Expert Declaration of Deanna Adkins, MD, *supra* note 46, at ¶ 16; Expert Rebuttal Declaration of Jack Turban, MD, MHS at ¶ 24, *Williams*, No. 3:23-cv-00376 (M.D. Tenn. June 1, 2023).

[49] Petition for a Writ of Certiorari at 4-5, L.W. *ex rel* Williams v. Skrmetti, No. 23-466 (U.S. Nov. 1, 2023) ("Gender identity has biological roots and cannot be changed voluntarily, by external forces, or through medical or mental health intervention.").

[50] *See* Expert Declaration of Stephen B. Levine at Exhibit A, *Williams*, No. 23-cv-00376 (May 18, 2023) (Levine's curriculum vitae). For a longer discussion of these expert witnesses, see Wuest & Last, *supra* note 1; and Sam Levin, *Revealed: Trans Rights Case at US Supreme Court Features Doctors Previously Discredited by Judges*, GUARDIAN (Nov. 21, 2024, 7:00 AM), https://www.theguardian.com/world/2024/nov/21/supreme-court-trans-rights-doctors-testimonies-bias [https://perma.cc/7ZPN-8TYD].

[51] Aviva Stahl, *Prisoners, Doctors, and the Battle over Trans Medical Care*, WIRED (July 8, 2021, 8:00 AM), https://www.wired.com/story/inmates-doctors-battle-over-transgender-medical-care/ [https://perma.cc/4PAY-YNDD]. Levine mainly publishes short commentaries now, mostly in the rare medical journal that remains favorable to his perspective. *See generally* Stephen B. Levine, E. Abbruzzese & Julia W. Mason, *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, 48 J. SEX & MARITAL THERAPY 706 (2022); Stephen B. Levine, *What Is the Purpose of the Initial Psychiatric Evaluation of Minors with Gender Dysphoria*, 50 J. SEX & MARITAL THERAPY 773 (2024).

[52] Expert Rebuttal Declaration of Jack Turban, MD, MHS, *supra* note 48, at ¶¶ 15-18, 24; Wuest & Last, *supra* note 15.

"[i]n the face of this unexplained surge of cases, [the state has] acted reasonably to protect its children from potentially irreversible and lifelong harms."[53]

II. TRANS MEDICINE AS EVIDENCE-BASED MEDICINE

According to both the Biden administration and Tennessee, evidence-based medicine ("EBM") is on their side.[54] Understanding these competing claims over the term EBM requires a consideration of another paradigm shift: the shift toward a particular means of evaluating and rank ordering different modes of medical knowledge production. This paradigm shift affords certain forms of statistical knowledge more epistemological authority than the authority of both experiential clinical knowledge and medical professional associations' consensus-based guidelines for care. This Part delineates this broader shift toward an EBM epistemological and healthcare policy framework before delving into these competing claims over the designation "evidence-based" in *Skrmetti*. Together, these two Sections show how ongoing debates within psychology and medicine over the EBM paradigm itself have been transported into the legal and policy realm of trans medicine.

A. *Evidence-Based Medicine: Origins, Epistemology, & Political Economy*

Given the EBM paradigm's dominance in contemporary medical school curricula, research networks, and health bureaucracies today, it is unsurprising that gender-affirming care ban proponents and opponents would both try to seize its language and authority. Although discussions of EBM often prompt the rhetorical question "what could one mean by non-evidence-based medicine?" the term's coinage is relatively new on the scene of U.S. healthcare. Most scholarly accounts of EBM's history begin with Scottish physician A.L. Cochrane's short 1972 treatise on the U.K. National Health Service's ("NHS") inefficiencies which he saw as stemming from poorly devised therapeutic regimens.[55] In *Effectiveness and Efficiency*, Cochrane made the case for medical practices based on evidence from randomized controlled trials ("RCTs"), which generate knowledge from randomly assigning treatment to one group (the treatment group) and a placebo to another group (the control group).[56] Although RCTs are now celebrated as the "gold standard" of medical research, Cochrane was considered one of several maverick therapeutic reformers who championed RCTs over the dominant ways of generating and assessing medical evidence,

[53] Respondents' Brief in Opposition at 34, L.W. *ex rel* Williams v. Skrmetti, Nos. 23-466, 23-477 (U.S. Feb. 2, 2024).

[54] *Id.*; Petition for a Writ of Certiorari, United States v. Skrmetti, No. 23-477 (U.S. Nov. 6, 2023).

[55] *See generally* A.L. COCHRANE, EFFECTIVENESS AND EFFICIENCY: RANDOM REFLECTIONS ON HEALTH SERVICES (1972); Pope, *supra* note 16, at 269-70.

[56] COCHRANE, *supra* note 55, at 23-25 (discussing RCTs and its benefits or snags).

which included clinical judgment and experience as well as knowledge of the basic cellular and molecular elements of pathogens and disease.[57]

It was not until the late 1980s and early 1990s that researchers in the nascent field of clinical epidemiology at McMaster University, including David Sackett and Gordon Guyatt, coined the term "evidence-based medicine."[58] In 1992, their Evidence-Based Medicine Working Group claimed to have inaugurated a paradigm shift in medicine, in part through its engagement with long-standing trends in pharmaceutical regulatory developments and other realms in healthcare where statistical knowledge had become increasingly valorized.[59] The basic EBM approach places special emphasis on population-level data derived from RCTs, which were deemed essential to a scientifically sound approach to patient health.[60] Seeing their framework as erecting a new hierarchy of evidence, Sackett and Guyatt developed the now famous EBM Pyramid that places meta-analyses of RCTs at the top, individual RCTs in the middle, and observational studies, case studies, and expert opinion at the bottom.[61] The EBM Pyramid enjoyed a rapid uptake by health bureaucracies and medical school curricula in the United States, Canada, and the United Kingdom.[62] This included the "Cochrane Centre" (also known as the Cochrane Collaboration), which facilitated the production of systematic reviews of RCTs that might inform health policy, and another version of the EBM epistemological pyramid known as the Grades of Recommendation, Assessment, Development and Evaluation ("GRADE") system.[63]

In the vein of Cochrane's original concerns over the NHS's alleged role in inflationary healthcare costs, many EBM initiatives were spearheaded by neoliberal policymakers in search of cost-cutting measures to reckon with

[57] Pope, *supra* note 16, at 269. For a history of RCTs, see HARRY M. MARKS, THE PROGRESS OF EXPERIMENT: SCIENCE AND THERAPEUTIC REFORM IN THE UNITED STATES, 1900-1990 (1997). For more on this shift away from Flexnerian medicine, see Howard Brody, Franklin G. Miller & Elizabeth Bogdan-Lovis, *Evidence-Based Medicine: Watching Out for Its Friends*, 48 PERSPS. BIOLOGY & MED. 570, 572-73 (2005).

[58] *See generally* Gordon Guyatt et al., *Evidence-Based Medicine: A New Approach to Teaching the Practice of Medicine*, 268 JAMA 2420, 2420 (1992) (introducing "NEW paradigm for medical practice").

[59] *Id*. at 2420-21 (1992). *See generally* MARKS, *supra* note 57, at 129.

[60] *See* Pope, *supra* note 16, at 269-70.

[61] Gordon H. Guyatt et al., *Users' Guides to the Medical Literature: IX. A Method for Grading Health Care Recommendations*, 274 JAMA 1800, 1801 tbl.1 (1995).

[62] Pope, *supra* note 16, at 271 ("[N]otably in Canada and North America, the ideas of these 'clinical epidemiologists' and medical academics began to converge on EBM."); Helen Lambert, *Accounting for EBM: Notions of Evidence in Medicine*, 62 SOC. SCI. & MED. 2633, 2638 (2006); Cornelius Borck, *Negotiating Epistemic Hierarchies in Biomedicine: The Rise of Evidence-Based Medicine*, *in* WEAK KNOWLEDGE: FORMS, FUNCTIONS, AND DYNAMICS 449, 462 (Moritz Epple, Annette Imhausen & Falk Müller eds., 2020).

[63] *See* COCHRANE HANDBOOK FOR SYSTEMATIC REVIEWS OF INTERVENTIONS 389 (Julian P. T. Higgins & James Thomas eds., 2d ed. 2019).

ballooning healthcare expenditures.[64] However, the reasons for that spike in healthcare costs are far more diverse, ranging from long-standing problems associated with the fee-for-service payment model to the unintended consequences of Medicare and Medicaid reforms and other funding features of the United States' public-private healthcare landscape.[65] Accordingly, many EBM critics have accused healthcare bureaucrats, corporate healthcare companies, insurance payers, and independent "risk analysts" of using evidence-based protocols to impose Taylorist managerial restrictions on physician judgment and autonomy in order to lower healthcare costs, rather than addressing the deeper political and economic problems with the funding and provision of care.[66] In the United States, this austerity-induced rationalization has included the establishment of managed care systems, deskilling reforms like task-shifting, and the proliferation of new occupational categories that promise to produce an assembly-line structure of EBM interventions within hospitals and clinics.[67]

The EBM paradigm not only legitimated the neoliberal movement's narrowly economistic approach to good governance, but it also offered a solution for healthcare's trust problems by replacing the authority of "the expert" with a disembodied concept of "expertise."[68] Throughout the late-twentieth century, the public became increasingly aware of pharmaceutical scandals like the thalidomide crisis in Europe and the Tuskegee Syphilis Study's horrific

[64] *See* Borck, *supra* note 62, at 466-68 (explaining EBM both participated in and contributed to sociopolitical agenda marked by catchphrases of "efficiency," "choice," and "value for money"); STEFAN TIMMERMANS & MARC BERG, THE GOLD STANDARD: THE CHALLENGE OF EVIDENCE-BASED MEDICINE AND STANDARDIZATION IN HEALTH CARE 16-17 (2003).

[65] *See* JILL QUADAGNO, ONE NATION, UNINSURED: WHY THE U.S. HAS NO NATIONAL HEALTH INSURANCE 9-10 (2005); COLLEEN M. GROGAN, GROW AND HIDE: THE HISTORY OF AMERICA'S HEALTH CARE STATE 283, 286-87 (2023).

[66] *See* Marc Berg, *Problems and Promises of the Protocol*, 44 SOC. SCI. & MED. 1081, 1085 (1997); GIL EYAL, THE CRISIS OF EXPERTISE 71 (2019) (stating EBM reforms, among others, "sought to subordinate the decisions" of doctors to calculations of risk managers); MARKS, *supra* note 57, at 236 (describing developments in healthcare rationing that further politicized long-standing trend toward standardization of healthcare practices). *But see* David L. Sackett, William M. C. Rosenberg, J.A. Muir Gray, R. Brian Haynes & W. Scott Richardson, *Evidence Based Medicine: What It Is and What It Isn't*, 312 BMJ 71, 72 (1996) (explaining David Sackett's insistence that RCTs and meta analyses do not replace clinical expertise, a view in tension with this application of EBM).

[67] *See* Briana Last, *Therapy Without Therapists*, DAMAGE (Dec. 15, 2020), https://damagemag.com/2020/12/15/therapy-without-therapists/ [https://perma.cc/2K9J-78PS] (discussing methods and effects of rationalization in mental healthcare); TIMMERMANS & BERG, *supra* note 64, at 114-16 (describing shifts of clinical practice, which critics view as "deprofessionalism, corporatization, or even proletarization").

[68] TIMMERMANS & BERG, *supra* note 64, at 107-08 (discussing "how standards and procedures were made and executed by *other physicians*" rather than by outsiders, boosting overall professionalism of medical profession).

violations of patient autonomy.[69] It is no surprise then why many opponents of gender-affirming care draw parallels between trans medicine and these horrors in the history of healthcare, even at times comparing best practices for trans youth, which they frame as inherently coercive and harmful, with Nazi medical experiments.[70] In this sense, some have conceived EBM as an antiauthoritarian, egalitarian, and democratic development in the healthcare industry, one which wrested the ultimate authority in matters of medicine from all-knowing, corruptible experts to disembodied, objective, and fair statistical evidence and systematic reviews of that evidence.[71]

While a strict adherence to EBM guidelines has never fully taken in clinical settings, it has undeniably shifted the epistemology of what constitutes best medical practices.[72] That shift has been lamented by those who perceive EBM's ascent to hegemony as denigrating clinical expertise forged through experience as well as best practices guidelines issued by major professional medical associations, which offer a diversity of evidence including RCTs, observational studies, singular case studies, and other forms of knowledge that depart from population-level statistics.[73] In the clinic, patients often present with far more comorbidities than those in RCT study samples, making clinical translation fraught.[74] These and related shortcomings have led EBM proponents to retroactively include clinical expertise in their paradigm, although critics note that this is oftentimes a rhetorical and defensive maneuver that obfuscates the premium that is still afforded to statistical population-level knowledge.[75] There is also the problem of industry-led RCTs that are often marred by corruption, a great irony considering that the major 1962 amendments to the FDA, which institutionalized the use of RCTs for new drug approvals, was a means of

[69] EYAL, *supra* note 66, at 116-17; *see* Henry K. Beecher, *Ethics and Clinical Research*, 274 NEW ENG. J. MED. 1354, 1355 (1966); Mark Nichter, *The Rise and Transformation of Evidence-Based Medicine*, 115 AM. ANTHROPOLOGIST 647, 647 (2013); *see also* Cecilia Nardini, *The Ethics of Clinical Trials*, *ECANCERMEDICALSCIENCE* 2-3 (Jan. 16, 2014), https://ecancer.org/en/journal/article/387-review-the-ethics-of-clinical-trials/pdf [https://perma.cc/THA2-ZBVT] (surveying important ethical issues surrounding RCTs).

[70] *See* Wuest & Last, *supra* note 1, at 6.

[71] *See* Lambert, *supra* note 62, at 2636-38 (portraying EBM as flexible and "assimilationist" when responding to critiques and limitations); BORCK, *supra* note 62, at 476; EYAL, *supra* note 66, at 39.

[72] *See* Lambert, *supra* note 62, at 2636.

[73] *Id.* at 2641-43; Ross C. Brownson, Rachel C. Shelton, Elvin H. Geng & Russell E. Glasgow, *Revisiting Concepts of Evidence in Implementation Science*, IMPLEMENTATION SCI. 2 (2022), https://implementationscience.biomedcentral.com/articles/10.1186/s13012-022-01201-y.

[74] *See* Angus Deaton & Nancy Cartwright, *Understanding and Misunderstanding Randomized Controlled Trials*, 210 SOC. SCI. & MED. 2, 13 (2018).

[75] *See id.* at 2, 16; BORCK, *supra* note 62, at 449; Lambert, *supra* note 62, at 2636.

combatting industry corruption.[76] In the case of pediatric pharmaceuticals and gender-affirming care for children and adolescents specifically, bioethicists have warned against conducting RCTs, which typically withhold best practices in care from some portion of the population in order to generate new evidence and which are methodologically inappropriate and likely ineffective for care practices that can so immediately affect the physiology of a patient.[77] Such criticisms reveal just how much disagreement currently exists over the EBM paradigm and the definition of "evidence-based" itself, even as knowledge from RCTs and systematic reviews continue to enjoy an epistemological superiority in many realms of healthcare research, practice, and policy.[78]

B. *Evidence-Based Medicine as Terrain of Epistemological Conflict in* United States v. Skrmetti

As the arguments in *Skrmetti* detail, both sides have sparred over the evidence base of gender-affirming care and the means by which medical professionals and political officials might interpret and apply that evidence base in their decision-making. We can look first to how trans medicine's opponents have undermined the statements and protocols issued by domestic and international professional medical associations by weaponizing and occasionally distorting EBM language. In defense of its ban, Tennessee has repeatedly cited the "low or very-low quality" nature of the evidence base for WPATH and the Endocrine Society's trans health protocols as well as the evidence base for the mental health benefits of gender-affirming care.[79] Those designations came straight from the GRADE system, which affords lower quality scores to clinical practices and

[76] Jon Jureidini & Leemon B. McHenry, *The Illusion of Evidence Based Medicine*, 376 BMJ 702, 702 (2022) (lamenting that industry "suppresses negative trial results [and] fails to report adverse events," which thwarts scientific progress); Leonardo M. Siena, Lazaros Papamanolis, Maximilian J. Siebert, Rosa Katia Bellomo & John P.A. Ioannidis, *Industry Involvement and Transparency in the Most Cited Clinical Trials, 2019-2022*, JAMA NETWORK OPEN 8 (Nov. 14, 2023), https://jamanetwork.com/journals/jamanetworkopen/articlepdf/2811814/siena_2023_oi_231263_1699303085.84457.pdf (discussing industry involvement in influential studies at many levels); DANIEL CARPENTER, REPUTATION AND POWER: ORGANIZATIONAL IMAGE AND PHARMACEUTICAL REGULATION AT THE FDA 229-32 (2010); EYAL, *supra* note 66, at 99.

[77] Florence Ashley, Diana M. Tordoff, Johanna Olson-Kennedy & Arjee J. Restar, *Randomized-Controlled Trials Are Methodologically Inappropriate in Adolescent Transgender Healthcare*, 25 INT'L J. TRANSGENDER HEALTH 407, 414 (2024).

[78] *See* STEVEN EPSTEIN, IMPURE SCIENCE: AIDS, ACTIVISM, AND THE POLITICS OF KNOWLEDGE 268-69, 346 (1996) (chronicling HIV/AIDS activists who questioned "black box" of clinical research and successfully advocated for participatory clinical research practices, thereby revealing contextual and ethical considerations that are always present in design of RCTs).

[79] Respondents' Brief in Opposition, *supra* note 53, at 9-10 (stating European countries who pioneered these treatments agree there is lack of reliable evidence).

published research that are not, among other things, informed by RCTs.[80] This characterization of the evidence base for gender-affirming care had been previously affirmed by Guyatt himself, who criticized the American Academy of Pediatrics' 2023 statement supporting gender-affirming care practices for youth while also calling for systematic reviews of these practices, because he argued the statement puts "the cart before the horse."[81]

Tennessee has buttressed these arguments by citing similar findings in the final report for the Independent Review of Gender Identity Services for Children and Young People, colloquially known as the "Cass Review" with namesake British pediatrician Hilary Cass.[82] That report, which itself was spurred by litigation filed by former patients against the United Kingdom's Gender Identity Development Service ("GIDS"), was purportedly based on the GRADE system criteria as well and was conducted to provide an evidence-based evaluation of NHS gender-affirming care practices for children and adolescents.[83] Notably, a team of prominent gender identity clinicians and researchers recently published a Yale School of Medicine report titled "An Evidence-Based Critique of 'the Cass Review' on Gender-Affirming Care for Adolescent Gender Dysphoria," assailing the review for misusing the very EBM language and logic upon which it—and those ban supporters who cite it frequently—rests.[84] Rhetorically

[80] L.W. *ex rel* Williams v. Skrmetti, 83 F.4th 460, 506 (6th Cir. 2023) (White, J., dissenting) (noting Tennessee drew from GRADE system in making its claims); *see* Gordon H. Guyatt, Andrew D. Oxman, Holger J. Schünemann, Peter Tugwell & Andre Knottnerus, *GRADE Guidelines: A New Series of Articles in the* Journal of Clinical Epidemiology, 64 J. CLINICAL EPIDEMIOLOGY 380, 380 (2011) (stating GRADE began developing in 2000 to develop system of rating quality of evidence).

[81] Azeen Ghorayshi, *Medical Group Backs Youth Gender Treatments, but Calls for Research Review*, N.Y. TIMES (Aug. 3, 2023), https://www.nytimes.com/2023/08/03/health/aap-gender-affirming-care-evidence-review.html; *see* Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, AM. ACAD. OF PEDIATRICS: PEDIATRICS 10 (Oct. 1, 2018), http://publications.aap.org/pediatrics/article-pdf/142/4/e20182162/1529435/peds_20182162.pdf (providing suggestions for pediatric providers to promote health and positive development of transgender and gender diverse youth, including "that the medical field and federal government prioritize research").

[82] Brief for Respondents at 8-9, United States v. Skrmetti, No. 23-477 (U.S. Oct. 8, 2024), No. 23-477, at *8-9; *see* HILARY CASS, CASS REV., INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE 20 (2024).

[83] *See* Sheena Meredith, *1000 Families to Sue Tavistock Gender Service*, MEDSCAPE (Aug. 11, 2022), https://www.medscape.co.uk/viewarticle/1000-families-sue-tavistock-gender-service-2022a10021ac [https://perma.cc/EN3M-U89D] (describing suits against GIDS).

[84] MEREDITHE MCNAMARA ET AL., AN EVIDENCE-BASED CRITIQUE OF "THE CASS REVIEW" ON GENDER-AFFIRMING CARE FOR ADOLESCENT GENDER DYSPHORIA 16-19 (2024), https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf [https://perma.cc/9UJC-ZM93] (examining Cass Review's interpretation and representation of data and explaining how it is misleading); *see also* Daniel G. Aaron & Craig Konnoth, *The Future of Gender-Affirming Care — A Law and Policy Perspective on the Cass Review*, 392

inflating the case against gender-affirming care and leading the Yale team to deem its conclusions "pseudoscientific," the Cass Review cited the GRADE system but used nonscientific language such as "weak" and "poor" a total of thirty-one times rather than standard distinctions like "low-quality."[85] In oral arguments, Justice Samuel Alito referenced the Cass Review's view that gender-affirming care protocols feature a "complete lack of high-quality evidence showing that the benefits of the treatments in question here outweigh the risks" as he questioned the Biden administration's claim that such care can be medically necessary for some youth.[86]

Tennessee's arguments here were echoed by the American College of Pediatricians ("ACPeds"), which had previously coordinated with Christian conservative organization the Alliance Defending Freedom to "refute[]" the WPATH Standards of Care.[87] The ACPeds amicus brief supporting Tennessee was based largely on the Cass Review, which it cited repeatedly to argue that the "lack of an evidence-based foundation" for professional medical associations' standards of care "not only renders their guidelines useless, but it reveals that they are actually dangerous."[88] The brief also cited the American Principles Project, an organization helmed by anti-marriage-equality leader Robert P. George, to question whether the Endocrine Society and other expert associations had financial conflicts of interest because many of its members are paid in their professional roles to prescribe and administer gender-affirming

NEW ENG. J. MED. 526, 526 (2025); Thomas Mackintosh, *Cass Review: Gender Care Report Author Attacks 'Misinformation*,*'* BBC (Apr. 20, 2024), https://www.bbc.com/news/health-68863594 [https://perma.cc/QK6E-2UEV] (describing criticism of the Cass review).

[85] MCNAMARA ET AL., *supra* note 84, at 9.

[86] Transcript of Oral Argument, *supra* note 9, at 15.

[87] R.G. Cravens, *Documents Reveal ADF Requested Anti-Trans Research from American College of Pediatricians*, S. POVERTY L. CTR. (June 5, 2023), https://www.splcenter.org/hatewatch/2023/06/05/documents-reveal-adf-requested-anti-trans-research-american-college-pediatricians [https://perma.cc/P27X-9PFQ] (describing coordination between ACPeds and ADF and arguing they "manufactured legislative, legal and public relations challenges to medical science and public policy").

[88] Corrected Brief of Amici Curiae The American College of Pediatricians et al. in Support of Respondents, *supra* note 17 (arguing "Tennessee, by contrast, followed sound science" by banning these practices). The brief states:

> [T]here is not a single large, randomized, controlled study that documents the alleged benefits and potential harms to gender-dysphoric children from pubertal suppression and decades of cross-sex hormone use. Nor is there a single long-term, large, randomized, controlled study that compares the outcomes of various psychotherapeutic interventions for childhood [gender dysphoria] with those of pubertal suppression followed by decades of toxic synthetic steroids.

Id. at 19 (quoting AM. COLL. OF PEDIATRICIANS, GENDER DYSPHORIA IN CHILDREN 10 (2018), https://acpeds.org/assets/imported/corrected-REVISED-NOV-2018-Gender-Dysphoria-in-Children-1.pdf [https://perma.cc/2JJP-SNXW]).

care.[89] ACPeds also cited the "WPATH Files," a self-touted exposé that furthered this financial conspiracy argument. The WPATH Files, ironically, were authored by a nonexpert researcher and published by Environmental Progress, a nonprofit founded by public relations expert Michael Shellenberger, who has worked with Republican officials in Congress to reduce the country's reliance on renewable energy sources.[90]

Like ACPeds, Tennessee has also relied upon what legal scholar Frank Pasquale called "meta-expertise," a technique by which skeptics of professional expertise pit their own—or another nonexpert's—interpretation of quantitative data against the authority of experienced experts and expert associations in a given field.[91] In support of its argument that gender-affirming care bans "protect children from unproven medical interventions," Tennessee cited a *Wall Street Journal* opinion piece signed by "21 medical professionals from nine countries" who had "found the evidence for mental-health benefits of hormonal interventions for minors to be of low or very low certainty" and thus argued that there is "no reliable evidence to suggest that hormonal transition is an effective suicide-prevention measure," despite much evidence to the contrary.[92]

Although a range of medical professionals, including pediatricians and endocrinologists, signed the op-ed, only a few of them had practiced gender identity medicine in the past; many lacked clinical and research experience

[89] *Id.* at 44-45; *see* Joanna Wuest, *Exposing the Gender Identity Industry: Anti-Gender and the Paranoid Critique of Trans Medicine*, SIGNS: J. WOMEN CULTURE & SOC'Y (forthcoming 2025) (showing how the American Principles Project and other conservative think tanks, media outlets, and elected officials have promoted conspiratorial perspective on healthcare industry's interest in gender-affirming care).

[90] Corrected Brief of Amici Curiae The American College of Pediatricians et al. in Support of Respondents, *supra* note 17; MIA HUGHES, ENV'T PROGRESS, THE WPATH FILES: PSEUDOSCIENTIFIC SURGICAL AND HORMONAL EXPERIMENTS ON CHILDREN, ADOLESCENTS, AND VULNERABLE ADULTS 3-4 (2024), https://static1.squarespace.com/static/56a45d683b0be33df885def6/t/65e6d9bea9969715fba29e6f/1709627904275/U_WPATH+Report+and+Files.pdf [https://perma.cc/9Q99-BWVD]; *see* Dana Drugmand, *Long-Time Contrarian Michael Shellenberger Is a Republican Star Witness in Climate Hearings*, DESMOG (Aug. 6, 2020, 5:14 PM PDT), https://www.desmog.com/2020/08/06/michael-shellenberger-republican-star-witness-climate-hearings/ [https://perma.cc/A5N5-K4LK].

[91] *See* Frank Pasquale, *Battle of the Experts: The Strange Career of Meta-Expertise*, *in* THE OXFORD HANDBOOK OF EXPERTISE AND DEMOCRATIC POLITICS 345, 346 (Gil Eyal & Thomas Medvetz eds., 2023).

[92] Respondents' Brief in Opposition, *supra* note 53, at 5, 10; *Youth Gender Transition Is Pushed Without Evidence*, WALL ST. J. (July 13, 2023, 4:51 PM), https://www.wsj.com/articles/trans-gender-affirming-care-transition-hormone-surgery-evidence-c1961e27 (asserting that "systematic review of evidence" does not support gender-affirming care for youths as a method of suicide prevention). *But see* Johanna Olson-Kennedy et al., *Emotional Health of Transgender Youth 24 Months After Initiating Gender-Affirming Hormone Therapy*, J. ADOLESCENT HEALTH 2 (Jan. 16, 2025), https://www.jahonline.org/article/S1054-139X(24)00566-4/pdf (demonstrating significant improvement in psychological well-being of transgender youth after two years of gender-affirming hormone therapy).

treating gender-dysphoric youth.[93] Representing the United States, the list of signatories included the old guard's Levine as well as two other members of the Society for Evidence-Based Gender Medicine ("SEGM"), an anti-gender-affirming advocacy organization. According to a Yale School of Medicine report, the SEGM spreads biased information, has no significant relationships to relevant mainstream professional medical associations treating trans people, and publishes many letters to the editor of scientific journals rather than original scientific studies or even peer-reviewed commentaries on trans healthcare.[94] Of the two Swedish signatories, Sven Román is a SEGM member, and his cosignatory, Angela Sämfjor, is a child and adolescent psychiatrist who founded the Lundstrom Gender Clinic in 2016 before resigning in 2018 and turning against gender-affirming care practices.[95] While the top signatory from Finland, Riittakerttu Kaltiala, is a child and adolescent psychiatrist who once briefly led a pediatric gender identity clinic, she has not spent much of her career in trans healthcare. In fact, when Kaltiala's department at Tampere University Hospital was tasked by the Finnish Ministry of Social Affairs and Health with opening such a clinic, she reluctantly undertook her leadership position before turning against gender-affirming care and collaborating with SEGM.[96] One of the three South African signatories included Reitze Rodseth, a professor of anesthesiology who describes himself as a "Christian apologetic" and has compared gender dysphoria and homosexuality to pedophilia.[97] The other two

[93] *Youth Gender Transition Is Pushed Without Evidence*, *supra* note 92 (listing as signatories Riittakerttu Kaltiala, Laura Takala, Richard Byng, Anna Hutchinson, Anastassis Spiliadis, Angela Sämfjord, Sven Román, Anne Wæhre, Patrik Vankrunkelsven, Sophie Dechêne, Beryl Koener, Celine Masson, Caroline Eliacheff, Maurice Berger, Daniel Halpérin, Reitze Rodseth, Janet Giddy, Allan Donkin, Stephen B. Levine, William Malone, and Patrick K. Hunter).

[94] SUSAN D. BOULWARE ET AL., BIASED SCIENCE: THE TEXAS AND ALABAMA MEASURES CRIMINALIZING MEDICAL TREATMENT FOR TRANSGENDER CHILDREN AND ADOLESCENTS RELY ON INACCURATE AND MISLEADING SCIENTIFIC CLAIMS 28 (2022), https://files-profile.medicine.yale.edu/documents/98a6e83f-d1ac-4098-b67a-25be370aec2b [https://perma.cc/LK3T-TNDM] (characterizing SEGM as ideological organization without ties to mainstream science or its own journal publications—only letters to the editor).

[95] Wuest & Last, *supra* note 1, at 3-4.

[96] Riittakerttu Kaltiala, *'Gender-Affirming Care Is Dangerous. I Know Because I Helped Pioneer It.,'* FREE PRESS (Oct. 30, 2023), https://www.thefp.com/p/gender-affirming-care-dangerous-finland-doctor [https://perma.cc/ZM9B-RGUY] (describing author's hesitation with creating national pediatric gender program at request of Finnish Ministry of Social Affairs and Health); *see* Frieda Klotz, *Pediatric Transgender Care and the Contentious Rise of SEGM*, UNDARK (May 20, 2024), https://undark.org/2024/05/20/pediatric-transgender-care-contentious-segm/ [https://perma.cc/C5S2-XKA8] (describing part of SEGM's policy strategy as involving insertion of their views into European policy through opinion of experts such as Riittakerttu Kaltiala).

[97] Melkbos Fellowship, *TALK 5: Gender Dysphoria - Prof Reitze Rodseth*, YOUTUBE, at 27:05 (Sept. 14, 2022), https://www.youtube.com/watch?v=YCpW7amFWHs; Allan Donkin, Reitze Rodseth & Janet Giddy, *Examining the Cass Review: Impacts on Gender Dysphoria*

South African signatories were Janet Giddy, a renowned HIV specialist researcher and public health advocate, and Allan Dorkin, a pediatrician, neither of whom appear to have much research expertise with gender dysphoria or gender-affirming care.[98]

Beyond the specific arguments in *Skrmetti*, the EBM paradigm and meta-expertise has been used by powerful conservatives to oppose both gender-affirming care and COVID-19 public health measures, like mask mandates, despite the advice of professional medical associations and health officials.[99] Such convergences are instructive as they point toward other conservative campaigns to undermine public health via the politicization of medical uncertainty.[100] In 2023, the Cochrane Collaboration published a review of physical interventions to prevent the spread of respiratory viruses based on seventy-eight studies on the efficacy of masking with surgical masks and N95 respirators, handwashing, and similar efforts.[101] Due to the relative lack of RCTs on masking in general as well as the small or null findings in those few existing RCTs, the Cochrane review ultimately published a report with what the Cochrane Library's editor-in-chief later admitted was obfuscating language taken up by anti-mask-mandate political forces.[102] Moreover, the review's lead author Tom Jefferson gave an interview declaring that "there is just no evidence that [masks] make any difference," contradicting major public health agencies and medical associations' messaging on the importance of masking, bolstered by a greater diversity of evidence beyond the limited RCT data.[103] Notably,

Treatment in South Africa, MAIL & GUARDIAN (July 21, 2024), https://mg.co.za/thought-leader/2024-07-21-examining-the-cass-review-impacts-on-gender-dysphoria-treatment-in-south-africa/ [https://perma.cc/LBA3-TAT4] (arguing that hormone treatment therapy does not reduce suicide risk in gender dysphoric youth).

[98] Donkin et al., *supra* note 97.

[99] Gregg Gonsalves, *The Self-Appointed Covid Experts Are at It Again*, NATION (Mar. 16, 2023), https://www.thenation.com/article/society/covid-masks-lab-leak-pundits/ [https://perma.cc/78VT-GTU3] (explaining how high-profile commentators use their positions to misread COVID-19 evidence in favor of their preferred policies).

[100] Joanna Wuest & Briana S. Last, *Church Against State: How Industry Groups Lead the Religious Liberty Assault on Civil Rights, Healthcare Policy, and the Administrative State*, 52 J.L. MED. & ETHICS 151, 151 (2024); Elizabeth Sepper & Lindsay F. Wiley, *Religious Resistance and the Public's Health*, 50 AM. J.L. & MED. 43, 44 (2024) (arguing that religious challenges to state healthcare policies have generated religious liberty doctrine that threatens public health).

[101] TOM JEFFERSON ET AL., PHYSICAL INTERVENTIONS TO INTERRUPT OR REDUCE THE SPREAD OF RESPIRATORY VIRUSES 3-4 (2023), https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006207.pub6/full [https://perma.cc/XV8F-FUMX] (noting studies took place across different backgrounds, countries, and time periods).

[102] Zeynep Tufekci, *Here's Why the Science Is Clear that Masks Work*, N.Y. TIMES (Mar. 10, 2023), https://www.nytimes.com/2023/03/10/opinion/masks-work-cochrane-study.html.

[103] David Gorski, *The Cochrane Mask Fiasco: How the Evidence-Based Medicine Paradigm Can Produce Misleading Results*, SCI.-BASED MED. (Mar. 13, 2023),

Jefferson has published with the Brownstone Institute, a think tank founded by libertarian Jeffrey Tucker, who helped organize the Great Barrington Declaration.[104] The Brownstone Institute also includes among its senior scholars Jay Bhattacharya—who was recently nominated by Trump to serve as director of the National Institutes of Health.[105] Jefferson is also a gender-affirming-care skeptic, having coauthored a 2019 *BMJ* opinion piece stating that the evidence base is too scant to deem such care safe and effective.[106] That piece has been cited frequently by expert witnesses defending gender-affirming-care bans for minors, including Levine and Mark Regnerus, who was scandalously funded by conservative think tanks to generate evidence defending "traditional marriage" in the litigation that became *Obergefell v. Hodges*.[107]

Those on the side of the gender-affirming-care fight have also leveraged the language of EBM and cognate terms like evidence-based care practices ("EBCP") and evidence-based healthcare ("EBHC").[108] Such advocates have

https://sciencebasedmedicine.org/the-cochrane-mask-fiasco-how-the-evidence-based-medicine-paradigm-can-produce-misleading-results/ [https://perma.cc/LUR8-6EPP]; Lawrence O. Gostin, I. Glenn Cohen & Jeffrey P. Koplan, *Universal Masking in the United States: The Role of Mandates, Health Education, and the CDC*, 324 JAMA 837, 837 (2020); *AMA, AHA, ANA: Open Letter on Mask Use, Stopping Spread of COVID-19*, AM. MED. ASS'N (2020), https://www.ama-assn.org/delivering-care/public-health/ama-aha-ana-open-letter-mask-use-stopping-spread-covid-19 [https://perma.cc/2L94-KBFE]; *see also* Andrew Beers, Sarah Ngyuễn, Kate Starbird, Jevin D. West & Emma S. Spiro, *Selective and Deceptive Citation in the Construction of Dueling Consensuses*, SCI. ADVANCES 1 (Sept. 2, 2023), https://www.science.org/doi/epdf/10.1126/sciadv.adh1933.

[104] *Tom Jefferson*, BROWNSTONE INST., https://brownstone.org/author/tom-jefferson/ [https://perma.cc/C9KT-MD4B] (last visited May 14, 2025); Amanda D'Ambrosio, *New Institute Has Ties to the Great Barrington Declaration*, MEDPAGE TODAY, https://www.medpagetoday.com/special-reports/exclusives/95601 (last updated Nov. 11, 2021).

[105] Jayanta Bhattacharya, BROWNSTONE INST., https://brownstone.org/author/jayb/ (last visited May 14, 2025); Sheryl Gay Stolberg, *Trump Picks Stanford Doctor Who Opposed Lockdowns to Head N.I.H.*, N.Y. TIMES (Nov. 26, 2024), https://www.nytimes.com/2024/11/26/us/politics/jay-bhattacharya-nih-trump.html.

[106] Carl Heneghan & Tom Jefferson, *Gender-Affirming Hormone in Children and Adolescents*, BMJ EBM SPOTLIGHT: BLOG (Feb. 25, 2019), https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/ [https://perma.cc/N7LT-T4PP].

[107] 576 U.S. 644 (2015); Wuest & Last, *supra* note 1 (recording use of Heneghan & Jefferson *BMJ* article in litigation over bans on gender-affirming care for minors); CARLOS A. BALL, SAME-SEX MARRIAGE AND CHILDREN: A TALE OF HISTORY, SOCIAL SCIENCE, AND LAW 94-96 (2014) (assessing flawed findings of Regnerus study on individuals raised by same-sex parents).

[108] *See generally* Livia Puljak, Letter to the Editor, *The Difference Between Evidence-Based Medicine, Evidence-Based (Clinical) Practice, and Evidence-Based Health Care*, 142 J. CLINICAL EPIDEMIOLOGY 311 (2022) (reviewing differing definitions of each term using adjective "evidence-based" and noting lack of a common consensus).

often reached for professional medical associations and researchers' criticisms of classical EBM's rigidity, arguing instead that clinicians should be guided by a plurality of evidence and should not be restricted by the lack of RCTs when other evidence and experienced clinical judgment exist.[109] Emphasizing the WPATH's status as the leading international medical association for trans healthcare and the Endocrine Society's membership base of 18,000, the Biden administration referenced those organizations' "evidence-based practice guidelines for the treatment of gender dysphoria" and the support that those guidelines have garnered from every major medical and mental health association in the United States.[110] The Biden administration also argued that "[a] substantial body of evidence . . . has shown that [gender-affirming treatments] greatly improve the mental health of adolescents with gender dysphoria," a claim which is supported by observational studies of youth and large-scale studies of adults based on self-report.[111] The ACLU similarly discussed the WPATH and Endocrine Society guidelines as evidence-based, noting also that they constituted "the only evidence-based treatments available."[112] The word "only" is key here given that gender-affirming care's opponents often reference "gender exploratory" alternatives to care, which have not themselves been subjected to the same scientific scrutiny as gender-affirming care practices have been; moreover, critics of exploratory treatments have observed disturbing parallels between these practices and discredited sexual orientation and gender identity change efforts.[113]

In their own amicus briefs, professional medical and mental health associations emphasized the language of "evidence-based," seeking to take back authority from Tennessee and its fringe supporters like ACPeds. In one brief, a group of twenty-five organizations, including WPATH, the Endocrine Society, the American Medical Association, and the American Academy of Pediatrics, repeatedly invoked the term "evidence-based" and characterized the GRADE system's language on "low-quality" and "high-quality" evidence as mere "terms

[109] *Policy Statement on Evidence-Based Practice in Psychology*, AM. PSYCH. ASS'N, https://www.apa.org/practice/guidelines/evidence-based-statement (last updated Apr. 2021); Ashley et al., *supra* note 77, at 407.

[110] Petition for a Writ of Certiorari, *supra* note 49, at 4.

[111] *Id.* at 7; Jack L. Turban, Dana King, Jeremi M. Carswell & Alex S. Keuroghlian, *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, PEDIATRICS, Feb. 2020, at 1, 7 ("Among transgender adults in the United States who have wanted pubertal suppression, access to this treatment is associated with lower odds of lifetime suicidal ideation."); 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, S20, S41, S47 (2022) (citing five additional studies by Turban).

[112] Petition for a Writ of Certiorari, *supra* note 49, at 2, 5-6.

[113] Wuest & Last, *supra* note 15, at 123 (connecting opponents of gender-affirming care to "gender-exploratory therapy" and noting that practice's tendency to push individuals away from transition); Ashley, *supra* note 18, at 472-74.

of art."[114] It would be "simply false," the medical associations maintained, to suggest that sound clinical care is always—or even usually—based on RCT data.[115] In a footnote, the brief referenced the fact that of the American Heart Association's 130 recommendations for pediatric care, only one is based on A-level grade data according to the GRADE system.[116] Similarly, the brief contextualized the Sixth Circuit's obfuscating framing of puberty-suppressing medications' "off-label" use in gender-affirming care (meaning the FDA has not approved the drug for this specific use) as a sign of its potential "unacceptable dangers."[117] As the brief noted, off-label prescriptions are very common for all patients, especially for those in pediatric care given the relative lack of clinical trials for that population.[118] Moreover, there actually *is* data from randomized clinical trials (albeit nonblinded ones) on the effect of Lupron (the puberty-suppressing medication) on children with precocious puberty, such that clinicians do not have to extrapolate from data concerning adults, which itself is a very common practice.[119] Finally, the FDA does not at all require RCTs in its

[114] Brief of Amici Curiae American Academy of Pediatrics et al. in Support of Petitioner at 3, 21-22, United States v. Skrmetti, No. 23-477 (U.S. Sept. 3, 2024).

[115] *Id.* at 22 ("To suggest that clinical practice predicated on anything but 'high' quality evidence is unsafe or uncommon in the medical profession is simply false").

[116] *Id.* at 22 n.70 ("[T]he American Heart Association's guideline for Pediatric Basic and Advanced Life Support includes 130 recommendations for pediatric care, only 1 of which is predicated on Level A . . . evidence.").

[117] *Id.* at 23-24 (criticizing Sixth Circuit's conflation of FDA-approved medications prescribed off-label with non-FDA approved medications as "incorrect" and contradictory to "common medical practices"); *see also* L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 478 (6th Cir. 2023).

[118] Brief of Amici Curiae American Academy of Pediatrics et al. in Support of Petitioner , *supra* note 114, at 23-24 (describing how "off-label drug use is common, particularly in disciplines such as pediatrics, where patients are less likely to be included in clinical trials"). Ironically, vocal fringe medical groups that have opposed gender-affirming care—including the fringe Association of American Physicians and Surgeons—sued to block a 1998 FDA rule that encouraged companies to conduct more research on pediatric pharmaceuticals. *See* Ass'n of Am., Physicians & Surgeons, Inc. v. FDA, 226 F. Supp. 2d 204, 205 (D.D.C. 2002) (stating plaintiffs claimed 1998 FDA rule transcended FDA's statutory authority and "the Rule's promulgation was arbitrary and capricious"). For more on the development of the 1998 rule, see CYNTHIA A. CONNOLLY, CHILDREN AND DRUG SAFETY: BALANCING RISK AND PROTECTION IN TWENTIETH-CENTURY AMERICA 151 (2018). *See also* L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th at 509 n.8 (White, J., dissenting) (noting majority ignored and distorted features of off-label drug prescriptions for pediatric patients).

[119] Peter A. Lee et al., *Efficacy and Safety of Leuprolide Acetate 3-Month Depot 11.25 Milligrams or 30 Milligrams for the Treatment of Central Precocious Puberty*, 97 J. CLINICAL ENDOCRINOLOGY & METABOLISM 1572, 1573-77 (2012); Christopher M. Wittich, Christopher M. Burkle & William L. Lanier, *Ten Common Questions (and Their Answers) About Off-Label Drug Use*, 87 MAYO CLINIC PROC. 982, 987 (2012).

approval process, and it has increasingly moved toward an early access model of drug provision.[120]

Both the medical professional associations' brief and the American Psychological Association's separate filing note that RCTs for many pediatric care practices, including certain gender-affirming care practices like puberty suppression, are methodologically fraught and likely unethical.[121] The American Psychological Association cited its own 2021 statement on evidence-based practices, which defines such treatments as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."[122] Still, in a follow-up passage one can see how the "gold standard" logic prevails. As the American Psychological Association's brief explained, "[i]n the absence of larger, randomized-controlled trials, medical providers may appropriately rely on complementary and well-designed observational studies, of which there are many, as cited herein, that support the safety and effectiveness of gender-affirming care in improving the mental health and quality of life for transgender youth."[123] In contesting Tennessee's claim to the EBM paradigm, gender-affirming advocates have often reaffirmed the validity of the EBM epistemological pyramid, reserving its tip for the RCTs of the future and thus ensuring that the debate over access to transition care remains on this terrain.

CONCLUSION

This Essay has demonstrated how historical developments and ongoing conflicts in gender-identity care and healthcare have shaped legal fights over gender-affirming care for minors. In doing so, it has detailed some of the most powerful ways in which the antitrans legal movement has fashioned its medical case against the safety and efficacy of what major domestic and international professional medical associations regard as best practices for gender-dysphoric children and adolescents. By conjuring fears over the dangerous uncertainty and "experimental" nature of these practices, states like Tennessee have defended their bans in the same way that antiabortion state governments have successfully

[120] Daniel G. Aaron, *The Fall of FDA Review*, 22 YALE J. HEALTH POL'Y L. & ETHICS 95, 132, 134 (2023) (highlighting legislative action that eliminated requirement for FDA to conduct two randomized controlled trials during the evaluation of some drugs' efficacy).

[121] Brief of Amici Curiae American Academy of Pediatrics et al. in Support of Petitioner, *supra* note 114, at 22-23 ("[W]ith respect to randomized controlled trials, such trials are often impossible or unethical, especially in the pediatric context."); Brief of the American Psychological Association et al. as Amici Curiae in Support of Petitioner at 22, United States v. Skrmetti, No. 23-477 (U.S. Sept. 3, 2024) (noting that pediatric care medical treatments entail "necessarily limited research," including research conducted through randomized controlled trials, because of time constraints).

[122] Brief of the American Psychological Association et al. as Amici Curiae in Support of Petitioner, *supra* note 121, at 20.

[123] *Id.* at 23.

justified policies that slowly chipped away at *Roe v. Wade*'s foundation,[124] despite protests from the American Medical Association and other leading authorities in reproductive healthcare.[125]

These challenges to experienced and well-credentialed experts and the valorization of a very constrained notion of medical knowledge that undervalues and even excludes highly relevant information about gender-affirming care's life-saving potential will likely have enormous consequences for sexual and gender minority health specifically and for public health generally. As *Skrmetti* revealed, some trans health advocates' arguments and positions have even taken a conservative turn. In oral argument, the Biden Administration expressed support for West Virginia's unique approach to gender-affirming care for minors, a policy that requires two different doctors to diagnose a minor with gender dysphoria severe enough to outweigh what it considers to be the risks of gender-affirming care and to rule out any "confounding" diagnoses.[126] This is a clear capitulation to both Levine's insistence that many instances of gender dysphoria have nothing to do with gender itself as well as Tennessee's unfounded fear that clinicians tend to rapidly place young people onto an "on-ramp" toward gender transition.[127] It is also an invitation for states to adopt West Virginia-style laws that would likely create additional unwarranted medical hoops that minors must jump through to access care.[128] Moreover, scholars of intersex legal rights have cautioned against trans advocates' strong appeals to medical authority and the tendency to revere the "sanctity" of the patient-healthcare provider relationship.[129] Such reverence is an obstacle for those seeking to challenge coercive surgical procedures that promise to "normalize" a child's sex.[130] So, while we should be mindful of the defensive posture that trans advocates have been forced to take as half the country rapidly passed gender-

[124] 410 U.S. 113 (1973).

[125] *See* sources cited *supra* notes 4-5.

[126] Transcript of Oral Argument, *supra* note 9, at 39-40 (describing development of West Virginia's "set of guardrails that are far more precisely tailored to concerns surrounding the delivery of [gender-affirming] care," emphasizing legislature's reliance on studies).

[127] Respondents' Brief in Opposition, *supra* note 53, at 6.

[128] *See* Beans Velocci, *Standards of Care: Uncertainty and Risk in Harry Benjamin's Transsexual Classifications*, 8 TSQ: TRANSGENDER STUD. Q. 462, 462-63 (2021) (detailing different hoops in "proving" that one was suitable candidate for transition). The first generation of gender identity clinicians who treated adults insisted on rigorous psychological evaluations not primarily for medical reasons but rather because they feared physical or legal retribution from those patients who might come to regret their medical transitions. *Id.* at 463.

[129] *See, e.g.*, Ahmed, *supra* note 4, at 114 (noting that abortion rights advocates rely on "the sanctity of the space between women and their physicians" as support for criticism of "abortion 'scripts'").

[130] Ido Katri & Maayan Sudai, *Intersex, Trans, and the Irrationality of Gender-Affirming-Care Bans*, 134 YALE L.J. 1521, 1574, 1579-81 (2025) (describing ways in which intersex advocates have contested coercive medical procedures and argued that intersex conditions are "within the realm of natural human variation," lacking need for medical intervention).

affirming care bans for minors, such defensive maneuvers should avoid succumbing to the dead hand of an older gender identity medicine paradigm as well as the more vulgar interpretations of EBM that threaten sensible, well-studied forms of healthcare and public health policy.[131]

[131] *See generally* ANNA KIRKLAND, HEALTH CARE CIVIL RIGHTS: HOW DISCRIMINATION LAW FAILS PATIENTS (2025) (detailing drawbacks of civil rights strategy that draws its power and authority from healthcare sector); STEF M. SHUSTER, TRANS MEDICINE: THE EMERGENCE AND PRACTICE OF TREATING GENDER (2021) (detailing clinical perils of relying on EBM approaches to trans medicine).