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ARTICLE

AN ETHICALLY APPROPRIATE RESPONSE TO INDIVIDUALS WITH GENDER DYSPHORIA

Rena M. Lindevaldsen †

ABSTRACT

Prior to 2013, the DSM identified individuals whose gender identity did not align with their biological sex as individuals with “gender identity disorder.” In 2013, gender identity disorder was declassified as a mental disorder and referred to as “gender dysphoria.” Since the switch, there has been a significant increase in the number of children and adolescents questioning their gender identity and receiving medical interventions to prevent the onset of puberty or to surgically alter their body. There also is a growing body of literature indicating that adults who have surgically altered their body to align with their gender identity persist in the psychological distress they encountered prior to the medical interventions.

As the medical community is grappling with the appropriate treatment protocols for someone whose gender identity does not align with his or her biological sex, the legal community is struggling with how to balance the interests of the transgender individual and the significant religious, free speech, privacy, and conscience-based interests of those who are asked (or required) to accommodate the person’s preferred gender identity. Some legislatures have even enacted laws to strip medical professionals of tools available to them to help patients by banning counseling for minors who desire to align their gender identity with their biological sex. Courts have issued conflicting rulings on situations that have arisen in schools, prisons, hospitals, and places of employment.

This Article will explore existing medical and legal responses to gender dysphoric individuals, address ethical dilemmas posed by those existing responses, and then propose a path forward.

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I. INTRODUCTION

In the past few decades, we have witnessed drastic changes in the prevalence of those with gender identity disorder and in how the medical and legal communities respond to those individuals. For example, significantly more children are questioning their gender identity and receiving puberty-suppressing hormones than just a few years ago¹, gender identity disorder has been declassified as a mental disorder, some states prohibit counseling to minors that would affirm their biological sex,² and nondiscrimination laws have been interpreted to mandate that people be allowed to use the restroom or locker room of their gender identity rather than their biological sex.³ Unfortunately, the politicization of this mental health issue is depriving people of receiving the help they need.

Despite the dearth of research to demonstrate the efficacy of current medical interventions (which includes puberty-suppressing hormones, cross-sex hormone therapy, and sex-reassignment surgery),⁴ the medical and

1. “Fourfold and fivefold increases of trans-identifying kids and teens are being reported in gender clinics in the United States and other countries. The first transgender youth clinic in the United States opened in Boston in 2007. Since then, 40 other clinics have opened that cater exclusively to children.” Lisa Marchiano, *Outbreak: On Transgender Teens and Psychic Epidemics*, 60 PSYCHOL. PERSP. 345, 348 (2017). Lisa Marchiano referred to the significant number of teens and tweens identifying as transgender as a “psychic epidemic.” *Id.* at 345. *Cf.* Priyanka Boghani, *When Transgender Kids Transition, Medical Risks are Both Known and Unknown*, FRONTLINE (June 30, 2015), www.pbs.org/wgbh/frontline/person/priyanka-boghani (“While the Endocrine Society’s guidelines suggest 16 [for the use of cross-gender hormones], more and more children are starting hormones at 13 or 14 . . .”).

2. The following states prohibit counseling to minors that seeks to change one’s gender identity so that it would align with the patient’s biological sex. *See, e.g.*, CAL. BUS. & PROF. CODE § 865.1 (West 2019); CONN. GEN. STAT. § 19a-907a (2018); DEL. CODE ANN. §§ 3510, 3902 (2018); S.B. 270, 29th Leg. Sess. (Haw. 2018); MD. CODE ANN., HEALTH OCC. § 1-212.1 (LexisNexis 2018); NEV. REV. STAT. § 629.600 (2017); H.B. 587, 2018 Session (N.H. 2018); N.M. STAT. ANN. §61-1-3.3 (LexisNexis 2017); OR. REV. STAT. § 675.850 (2015); R.I. GEN. LAWS § 23-94-3 (2017); VT. STAT. ANN. tit. 26 § 3210(a)(13) (2015); WASH. REV. CODE ANN. § 18.130.180 (LexisNexis 2018).

3. *See* Matt Stevens, *Transgender Student in Bathroom Dispute Wins Court Ruling*, NY TIMES (May 22, 2018), available at <https://www.nytimes.com/2018/05/22/us/gavin-grimm-transgender-bathrooms.html>; *see infra* notes 114-121 and accompanying text (discussing legal decisions dealing with restroom and locker room use).

4. *See, e.g.*, Sara Reardon, *Transgender youth study kicks off*, 531 NATURE 560, 560 (2016) (“some scientists worry that putting off puberty in older children may disrupt bone and brain development”); Paul W. Hruz et al., *Growing Pains: Problems with Puberty Suppression in Treating Gender Dysphoria*, 52 THE NEW ATLANTIS 3, 24 (2017); Ryan T. Anderson, *Sex Reassignment Doesn’t Work. Here is the Evidence*, HERITAGE FOUND. (March 9, 2018), <https://www.heritage.org/gender/commentary/sex-reassignment-doesnt-work-here-the->

legal culture has quickly adopted the notion that the proper response to someone identifying as the opposite sex—of his biological sex—is to affirm the person’s gender identity. In fact, the most recent version of the *American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders* (DSM) removed “gender identity disorder” from its manual and replaced it with “gender dysphoria.”⁵ This shift emphasizes that the incongruity between biological sex and gender identity is no longer considered a mental disorder but, rather, warrants psychological intervention only if that incongruity causes the person mental distress.⁶ And, at that point, the goal of therapy is to affirm the person’s gender identity rather than his biological sex. This is a shift that normalizes identifying as a gender different than one’s biological sex.

This Article will explore the ethically appropriate medical and legal response to those with gender identity disorder (GID).⁷ Significantly, it will challenge the contemporary notion that the medical and legal communities should simply affirm one’s gender identity when it conflicts with that person’s biological sex. This Article will begin with a discussion of how the medical and legal communities have responded to individuals with gender identity disorder, including several recent changes in how the medical community treats GID and how the legal community responds to those with GID. The next section will highlight the ethical dilemmas posed by the existing medical and legal responses to individuals with GID. Finally, the Article will propose ethically appropriate medical and legal responses to those with GID.

evidence (The article discusses a memorandum prepared by the Centers for Medicare and Medicaid Services in 2016 during President Obama’s administration that was entitled “Proposed Decision Memo for Gender Dysphoria and Gender Reassignment Surgery.” The memo stated that “[b]ased on a thorough review of the clinical evidence available at this time, there is not enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria.” The final memo in August 2016 reached a similar conclusion. In the most robust study, from Sweden, researchers found a nineteen times greater likelihood for death by suicide of those who had had sex reassignment surgery).

5. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL MENTAL DISORDERS 451 (5th ed. 2013) [hereinafter DSM-5].

6. See, e.g., Wynne Parry, *Gender Dysphoria: DSM-5 Reflects Shift in Perspective on Gender Identity*, HUFFPOST (June 4, 2013 2:11 PM), available at www.huffpost.com/entry/gender-dysphoria-dsm-5_n_3385287.

7. As this Article discusses, the shift in DSM-5 from “gender identity disorder” to “gender dysphoria” is itself not an ethically appropriate response. Thus, this Article will continue to use the nomenclature of “gender identity disorder” as contained in the DSM-4.

II. THE MEDICAL AND LEGAL RESPONSES TO GENDER IDENTITY DISORDER

A. *The Medical Response to GID*

A medical response to individuals with GID includes, at a minimum, both mental and physical health components. From a mental health perspective, until the most recent changes to the DSM in 2013, “gender identity disorder” was listed as a psychiatric disorder. Before the change in 2013, the diagnostic criteria in the DSM-4 for GID referred to a “strong and persistent cross-gender identity” and that the “disturbance” was manifested in the specific ways identified in the DSM.⁸ For children, some of those manifestations included a repeated stated desire that the child is the other sex; preference in boys for “cross-dressing” or in girls for “wearing stereotypical masculine clothing;” “intense desire to participate in the stereotypical games and pastimes of the other sex;” or “strong preference for playmates of the other sex.”⁹ For adolescents and adults, the disturbance is manifested by symptoms such as “a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.”¹⁰ The DSM-4 also included a criteria for diagnosis that the “disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.”¹¹

A 2008 task force report by the American Psychological Association on Gender Identity and Gender Variance explained that the DSM-4 diagnostic criteria for GID included “(a) a strong or a persistent cross-gender identification, (b) persistent discomfort with one’s sex or a sense of inappropriateness in the gender role associated with one’s sex, and (c) clinically significant distress or impairment in functioning.”¹² One court explained that

[t]he feelings of dysphoria can vary in intensity. Some patients are able to manage the discomfort, while others become unable to function without taking steps to correct the disorder. A person

8. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL MENTAL DISORDERS 493 (4th ed. 1994) [hereinafter DSM-4].

9. *Id.* at 537.

10. *Id.*

11. *Id.* at 538.

12. AM. PSYCHOLOGICAL ASS’N, REPORT OF THE APA TASK FORCE ON GENDER IDENTITY AND GENDER VARIANCE, at 31 (2009), [hereinafter Gender Identity Task Force Report]. The American Psychological Association and American Psychiatric Association are two separate entities.

with GID often experiences severe anxiety, depression, and other psychological disorders. Those with GID may attempt to commit suicide or to mutilate their own genitals.¹³

In 2013, the DSM update omitted “gender identity disorder” and replaced it with “gender dysphoria.”¹⁴ The change in the DSM-4 from “gender identity disorder” to “gender dysphoria” in the DSM-5 involved more than just a change in nomenclature. The diagnostic criteria for GID in the DSM-4 spoke in terms of a “strong and persistent cross-gender identification,” referred to symptoms as a “disturbance,” and acknowledged that it “cause[d] clinically significant distress or impairment in social, occupational, or other important areas of functioning.”¹⁵ Significantly, the DSM-5’s “gender dysphoria” has a normalizing effect by eliminating the word “disorder.” According to Webster’s dictionary, “dysphoria,” is defined as “a state of feeling unwell or unhappy.”¹⁶ Feeling “unwell or unhappy” connotes a less significant mental health issue than “significant distress” or “disturbance.” In fact, the American Psychiatric Association explained gender dysphoria as being “very uncomfortable” with one’s biological sex.¹⁷

This shift from “gender identity disorder” to “gender dysphoria” is significant because the DSM is published by the American Psychiatric Association and is “the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders.”¹⁸ The DSM’s stated purpose is to “provide[] a common language for clinicians to communicate about their patients and establishes consistent and reliable diagnoses that can be used in the research

13. *Fields v. Smith*, 653 F.3d 550, 553 (7th Cir. 2011).

14. DSM-5, *supra* note 5, at 451.

15. DSM-4, *supra* note 8, at 493, 538.

16. WEBSTER’S DICTIONARY 361 (10th ed. 2001).

17. *What is Gender Dysphoria*, AM. PSYCHIATRIC ASS’N, <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria> (last visited Mar. 3, 2019). At least one author has suggested that the change in the DSM-5 for children perhaps is a more conservative approach to diagnosis than in the DSM-4. Kenneth Zucker explains that the criterion that children express a strong desire to be the other gender could prevent diagnosis because previously some children were diagnosed without expressing such a desire. Kenneth J. Zucker, *The DSM-5 Diagnostic Criteria for Gender Dysphoria*, in C. TROMBETTA, ET AL., *MANAGEMENT OF GENDER DYSPHORIA: A MULTIDISCIPLINARY APPROACH* 33, 34 (2015).

18. DSM-5 *Frequently Asked Questions*, AM. PSYCHIATRIC ASS’N, <https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions> (last visited Mar. 3, 2019).

of mental disorders.”¹⁹ The DSM-5’s diagnostic criteria’s declassification of GID as a mental disorder presents challenges to those who believe the proper course of treatment is a mental health approach without medical interventions. The shift in diagnostic criteria also seems to more quickly trigger a diagnosis, which allows people to begin the physical transition through the use of hormones and surgeries. The lower standard for diagnosis suggests that individuals will be referred for medical interventions more quickly than before.²⁰ In fact, the recent literature indicates that medical intervention for children and adolescents in particular is beginning earlier and used more often than previously.²¹

Before getting to the specific medical interventions for those with GID, it is important to highlight the two overarching approaches on how to respond to a patient with GID. One approach relies on certain protocols set forth in the Harry Benjamin International Gender Dysphoria Association’s Standards of Care for Gender Identity Disorders (WPATH Standards of Care). That approach provides GID patients with hormones and, for some, sex reassignment surgery,²² as it seeks to change the patient’s biological sex to align with his beliefs about his gender. The other approach is to treat the

19. *Id.*

20. Conversely, some have expressed concern that removing the label of “disorder” could provide barriers to some seeking medical interventions, including hormone treatment and sex-reassignment surgery. Francine Russo, *Where Transgender Is No Longer a Diagnosis*, SCI. AM. (Jan. 6, 2017), www.scientificamerican.com/article/where-transgender-is-no-longer-a-diagnosis/#googDisableSync.

21. *See supra* note 1.

22. The Harry Benjamin standards have been adopted by the World Professional Association for Transgender Health (WPATH) as the appropriate treatment protocols (WPATH Standards of Care). The standards are available at https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care_V7%20Full%20Book_English.pdf. That the medical profession is relying on the work of Harry Benjamin as established protocols in this area is itself problematic. Dr. Harry Benjamin, an international sexologist, was a colleague of Alfred Kinsey. Among other things that should call into question the validity of his work, Dr. Kinsey admittedly performed sexual experiments on hundreds of infants and children. See JUDITH A. REISMAN, *CRIMES AND CONSEQUENCES THE RED QUEEN AND THE GRAND SCHEME* 132-65 (1998). The Rene Guyon society coined the phrase “sex by eight or else it’s too late.” Michel Marriott, *Child Sexual Abuse: Hidden Crimes Come Out of the Closet*, WASH. POST (June 8, 1984), https://www.washingtonpost.com/archive/politics/1984/06/08/child-sexual-abuse-hidden-crimes-come-out-of-the-closet/8d4f3132-0c9c-4d0f-a4a8-e439ac91410f/?utm_term=.6b50e42a2c70. “It comes probably as a jolt to many, even open-minded people, when they realize that chastity cannot be a virtue because it is not a natural state.” JUDITH A. REISMAN, *CRIMES AND CONSEQUENCES THE RED QUEEN AND THE GRAND SCHEME* 190-91 (2nd Ed. 1998).

underlying causes of GID through psychological counseling or psychotherapy.²³ This approach seeks to align the patient's beliefs about his gender with his biological sex. The different treatment approaches are driven in large part by ideological differences regarding "the origins, meanings, and fixity/malleability of gender identity."²⁴

The American Psychiatric Association, which authors the DSM, is itself not immune from the ideologically driven pressures to GID. In 1980, the American Psychiatric Association first classified GID as a mental disorder.²⁵ Even before that, following the American Psychiatric Association declassification of homosexuality as a mental disorder,²⁶ there had been a growing number of practitioners and advocacy groups who believed that identifying patients as having GID and treating them with the goal of aligning gender identity with the genetic sex "pathologize[s] differences in gender identity or expression."²⁷ These practitioners maintain that the proper approach of treatment is to "provide care that affirms patients' gender identities and reduces the distress of gender dysphoria."²⁸

"Affirmation," in this context, translates as doing whatever is necessary to bring external gender characteristics in line with internal belief of gender.²⁹ For those who seek to affirm the patient's gender identity when it conflicts with his biological sex, GID is *not* considered a disorder. Thus, patients who identify as the opposite gender of their genetic sex are to be encouraged to accept and embrace their inner belief. This can be accomplished by

23. Paul McHugh, *Surgical Sex*, FIRST THINGS (Nov. 2004), <https://www.firstthings.com/article/2004/11/surgical-sex>.

24. William Byne, et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 ARCHIVES OF SEXUAL BEHAV. 759, 769 (2012); see also Reardon, *supra* note 4 (quoting a psychiatrist at the William Alanson White Institute in New York City, "People are making declarations of knowledge that are their belief systems, that aren't also backed up by empirical research.").

25. Heino F. L. Meyer-Bahlburg, *From Mental Disorder to Iatrogenic Hypogonadism: Dilemmas in Conceptualizing Gender Identity Variants as Psychiatric Conditions*, 39 ARCHIVES OF SEXUAL BEHAV. 461, 461-62 (2010), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2844928/>.

26. See generally Paul E. Rondeau, *Selling Homosexuality to America*, 14 REG. U.L. REV. 443, 444 (2001) (discussing how the declassification was influenced by the social and political climate at the time).

27. See WPATH Standards of Care, *supra* note 22, at 3.

28. *Id.* (parenthetical statement omitted).

29. *Id.* at 1, 3. "The overall goal of SOC is . . . to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves." *Id.* at 1. A core principle of the SOC is to "provide care . . . that affirms patients' gender identities and reduces the distress of gender dysphoria." *Id.* at 3.

encouraging patients to live as the opposite gender role, undertaking a hormone regimen to either delay puberty or change their physical appearance to reflect their expressed gender identity, or undergoing sex reassignment surgery to remove and replace sexual organs with those of the person's desired gender.³⁰

The greater a patient's distress over the incongruence between his biological sex and desired gender, the more prone the professional is to recommend changing a person's biological characteristics through hormones and surgery.³¹ The World Professional Association for Transgender Health (WPATH) is among those who support a person's ability to choose to undergo hormone therapy and sex reassignment surgery. WPATH describes itself as an international professional association with a mission to "promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health."³² WPATH believes that pathologizing differences in gender identity expression—including even diagnosing someone with GID—demonstrates a lack of respect for patients.³³ Instead, treatment should affirm a person's choice of gender identity.³⁴

The WPATH Standards of Care set forth protocols for treatment of individuals with GID.³⁵ Those treatment options mirror those identified earlier.³⁶ The treatment protocols also indicate that prior to surgery to change sex characteristics, a person should engage in a twelve-month period of taking hormones and living in a gender role that is consistent with his perceived gender identity.³⁷ However, insofar as the DSM-5 refers to a *six-month* periods rather than *twelve-month* periods before medical intervention should begin, it seems that the WPATH twelve-month minimum period is likely to decrease.³⁸

30. *Id.* at 9-10.

31. *See, e.g., id.* at 5 (the WPATH takes the position that "[t]reatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them.").

32. *Id.* at 1.

33. WPATH Standards of Care, *supra* note 22, at 3.

34. *Id.*

35. *Id.* at 9-10.

36. *Id.*

37. *Id.* at 60.

38. *Id.* at 60; DSM-5, *supra* note 5, at 216. The DSM-4 stated that a patient would have a "strong and persistent cross-gender identification." DSM-4, *supra* note 8, at 493. There was no express minimum time period before medical interventions would be justified. Thus, the DSM-4 diagnostic criteria paired with the WPATH treatment protocols were the industry standard. The DSM-5, however, expressly included a time period, indicating that a patient

For children, the WPATH Standards of Care also provide that hormones should be used to prevent the onset of puberty and that children and adolescents as young as sixteen could be given cross-gender hormones.³⁹ In what appears to be a trend of providing medical interventions at an earlier age, the 2017 changes to the Endocrine Society's clinical practice guidelines state that "gender-affirming hormone treatment may sometimes be appropriate for children under 16 years old"⁴⁰ Some doctors even perform surgical procedures on minors with GID. For example, Dr. Norman Spack at the Gender Management Clinic in Boston, Massachusetts, reports that he has worked with a local plastic surgeon to have breast removal surgery performed on an adolescent female who desired to transition to a male.⁴¹ Since the Clinic opened in 2007, Dr. Spack and others have worked with an average of nineteen adolescents per year to assist them in changing their biological sex characteristics to reflect their client's identity.⁴²

In contrast to the medical interventions approach, the other approach seeks to bring one's gender identity in accord with one's biological sex. The primary justification for this approach is that gender is an immutable trait, is binary in nature, and coincides from birth with an individual's sex.⁴³ At birth, the sex of the child is determined by genes contained in two of the forty-six chromosomes in human cells, referred to as the "sex chromosomes."⁴⁴ Once a child is born, the child's family then develops and fosters a child's identity, including gender identity, by teaching the child gender-appropriate behavior. GID, therefore, is properly viewed as the result of one or more physiological problems, or a result of environmental factors influencing a

would demonstrate a "marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration."

39. WPATH Standards of Care, *supra* note 22, at 18-20.

40. John Otrompke, *Some Children May Now Receive Sex Change Hormone Therapy Before 16: ENDO Guideline*, LANCET (Mar. 26, 2018), <http://usa.thelancet.com/blog/2018-03-26-some-children-may-now-receive-sex-change-hormone-therapy-16-endo-guideline>.

41. ASSOCIATED PRESS, *Sex-Change Treatment for Kids on the Rise*, CBS NEWS (updated Feb. 20, 2012), http://www.cbsnews.com/8301-204_162-57381241/sex-change-treatment-for-kids-on-the-rise/.

42. *Id.*

43. Scripture also affirms the binary nature of sex. See *Genesis* 1:27 (New International Version) ("So God created mankind in his own image, in the image of God he created them; male and female he created them."); *Genesis* 5:2 (New International Version) ("He created them male and female and blessed them."); *Mark* 10:6 (New International Version) ("But at the beginning of creation God 'made them male and female.'").

44. See Teresa A. Zakaria, *By Any Other Name: Defining Male and Female in Marriage Statutes*, 3 AVE MARIA L. REV. 349, 352 (2005) (citing D. PETER SNUSTAD & MICHAEL J. SIMMONS, PRINCIPLES OF GENETICS 126, 137 (3d ed. 2003)).

person's perception of a particular gender.⁴⁵ Biologically, however, nothing is wrong with the person.

Another justification for the psychotherapy approach is that it avoids the medical risks associated with hormone use and sex reassignment surgery. Prolonged use of hormones to chemically change the body to appear more like the targeted gender has serious health risks.⁴⁶ These risks can include, among others, infertility, an increased likelihood of cardiovascular disease, heart attack, stroke, deep vein thrombosis, pulmonary embolism, diabetes, elevated liver enzymes, sleep apnea, hypertension, and the destabilization of psychiatric disorders in patients who are bipolar or schizoaffective.⁴⁷ As with any surgery, sex reassignment surgery carries its own risks, including postoperative bleeding, hematoma, infection, hypertrophic scarring, and other risks associated with the attempt to alter genitalia.⁴⁸ Hormone treatment and sex reassignment surgery also may irrevocably transform the body, causing serious implications for GID patients who later self-report experiencing regret at having chosen this treatment approach and are left with irreversible physical consequences.⁴⁹ Despite these risks, an increasing number of patients are choosing surgical interventions, including genital surgery.⁵⁰ A recent study by researchers at Johns Hopkins Center for Surgical Outcomes Research found that the total number of surgical interventions for individuals with gender identity disorder "increased nearly four-fold from the beginning of the study's time span in 2000 to the end in 2014."⁵¹

45. K.J. Zucker, *Children With Gender Identity Disorder: Is There a Best Practice?*, 56 *NEUROPSYCHIATRIE DE L'ENFANCE ET DE L'ADOLESCENCE* 358, 363 (2008).

46. UNITED KINGDOM DEP'T OF HEALTH, *A Guide to Hormone Therapy for Trans People* 10-12 (2007), www.gires.org.uk/assets/DOH-Assets/pdf/doh-hormone-therapy.pdf.

47. *Id.*; see also WPATH Standards of Care, *supra* note 22, at 40.

48. Cameron Bowman & Joshua Goldberg, *Care of the Patient Undergoing Sex Reassignment Surgery (SRS)* 11-14, 23-26, *AM. MED. STUDENT ASS'N* (Jan. 2006), <https://www.amsa.org/wp-content/uploads/2015/04/CareOfThePatientUndergoingSRS.pdf>.

49. Stig-Eric Olsson & Anders Möller, *Regret After Sex Reassignment Surgery in a Male-to-Female Transsexual: A Long-Term Follow-Up*, 35 *ARCHIVES OF SEXUAL BEHAV.* 501, 501 (2006).

50. Sabrina Barr, *Gender Reassignment Surgeries on the Rise in the US, Study Finds*, *INDEP.* (Mar. 4, 2018), <https://www.independent.co.uk/life-style/health-and-families/gender-reassignment-surgery-transgender-rise-america-study-john-hopkins-university-medicine-a8239476.html>. For example, "[d]uring a five-year period from 2000 to 2005, 72 per cent of the patients who had gender reassignment procedures in the US decided to undergo genital surgery. From 2006 to 2011, this percentage increased to 83.9 per cent of patients." *Id.*

51. Chanapa Tantibanchachai, *Study Suggests Gender-Affirming Surgeries are on the Rise, Along with Insurance Coverage*, *HUB JOHNS HOPKINS HOSP.* (Feb. 28, 2018), <https://hub.jhu.edu/2018/02/28/gender-affirming-reassignment-surgeries-increase/>.

In addition to the known health risks, there are many *unknown* risks that caution against medical interventions, particularly for children and adolescents. It is becoming more common to prescribe puberty-suppressing hormones to pre-pubertal children to “block hormone-induced biological changes, such as vocal chord changes, the development of breast tissue or changes in facial structure, that are irreversible and can be especially distressing to children who are gender-non conforming or transgender.”⁵² “Puberty blockers are prescribed to children as young as nine or ten and are often touted as being a safe and reversible way to ‘buy time’ while the young person sorts out his or her identity.”⁵³ The FDA, however, has not approved these puberty-suppressing drugs (GnRH analog drugs) for the treatment of gender identity disorder.⁵⁴ Some doctors go further, provide cross-sex hormones to adolescents, and perform surgical procedures on teenagers.⁵⁵

Despite the use of medical interventions in children and adolescents, a 2017 study published by the National Center for Biotechnical Information acknowledges that there is a dearth of research on the effectiveness of the medical interventions or on the medical risks.⁵⁶ In fact, while many assume puberty-suppressing hormones are safe and reversible, they are known to

52. Priyanka Boghani, *When Transgender Kids Transition, Medical Risks are Both Known and Unknown*, FRONTLINE PBS (June 30, 2015), <https://www.pbs.org/wgbh/frontline/article/when-transgender-kids-transition-medical-risks-are-both-known-and-unknown/>. See also Bigad Shaban et al., *Transgender Kids Could Get Hormone Therapy at Earlier Ages*, NBC BAY AREA (updated Sep. 13, 2017), www.nbcbayarea.com/news/local/Transgender-Kids-Eligible-for-Earlier-Medical-Intervention-Under-New-Guidelines-423082734.html (“Doctors . . . recommend kids get off the puberty blocker by the time they turn 14 for fear of potential side-effects”).

53. Lisa Marchiano, *Outbreak: On Transgender Teens and Psychic Epidemics*, 60 PSYCHOL. PERSP. 345, 352 (2017), <https://www.tandfonline.com/doi/pdf/10.1080/00332925.2017.1350804?needAccess=true>.

54. Paul W. Hruz et al., *Growing Pains: Problems with Puberty Suppression in Treating Gender Dysphoria*, NEW ATLANTIS, Spring 2017, at 18, https://www.thenewatlantis.com/docLib/20170619_TNA52HruzMayerMcHugh.pdf.

55. Marchiano, *supra* note 53, at 352.

56. W.C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3891 (2017), <https://academic.oup.com/jcem/article/102/11/3869/4157558>; see also Hruz, *supra* note 54, at 24 (“there are virtually no published reports, even case studies, of adolescents withdrawing from puberty-suppressing drugs and then resuming the normal pubertal development typical for their sex.”).

negatively affect bone mass density and final height.⁵⁷ “[T]hey certainly prevent the surge of endogenous hormones at puberty that would normally rewire the brain in ways we don’t fully understand.”⁵⁸

One group of experts in the field point out that while some seek to block the normal surge of hormones at puberty to prevent additional distress on the child, it is possible that such suppression actually interferes with “the natural consolidation of one’s gender identity” with biological sex.⁵⁹ Those doctors suggested that “[r]ather than claiming that puberty suppression is reversible, researchers and clinicians should focus on the question of whether the physiological and psychosocial development that occurs during puberty can resume in something resembling a normal way after puberty-suppressing treatments are withdrawn.”⁶⁰

Finally, the statistics demonstrate that most children, and a small number of adults, diagnosed with GID eventually become “comfortable with their natal gender.”⁶¹ The WPATH Standards of Care states that only six to twenty-three percent of pre-pubertal children who were referred for treatment for gender identity disorder persisted with their beliefs into their adulthood.⁶² Stated otherwise, before they reached adulthood, seventy-seven to ninety-four percent of children with gender identity issues later developed an identity that aligned with their biological sex. For that reason, the WPATH Standards of Care expressly state that it is “important that parents explicitly let the child know that there is a way back.”⁶³ A 2014 Special Report on LGBT Bioethics, which the Hastings Center published, echoed this data in concluding that “only 10 to 20 percent of these children [with gender dysphoria] will still have gender dysphoria by the time they reach

57. Denise Chew et al., *Hormonal Treatment in Young People with Gender Dysphoria: A Systematic Review*, 141 PEDIATRICS 1, 12-13 (2018), <http://pediatrics.aappublications.org/content/pediatrics/141/4/e20173742.full.pdf>.

58. Marchiano, *supra* note 53, at 352.

59. Hruz, *supra* note 54, at 22-23.

60. *Id.* at 23.

61. Byne, *supra* note 24, at 763.

62. WPATH Standards of Care, *supra* note 22, at 11.

63. *Id.* at 17; see also AM. PSYCHOLOGICAL ASS’N, *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People*, 70 AM. PSYCHOL. 832, 843 (2015) (“Emphasizing to parents the importance of allowing their child the freedom to return to a gender identity that aligns with sex assigned at birth or another gender identity at any point cannot be overstated, particularly given the research that suggests that not all young gender nonconforming children will ultimately express a gender identity different from that assigned at birth.”).

adulthood.”⁶⁴ While there is little research into whether successful therapy is the cause for the patient eventually accepting a gender identity that is consistent with his biological sex,⁶⁵ the phenomenon itself implies that GID is a mental disorder in need of psychotherapy rather than a biological condition in need of hormones and surgery to alter one’s physical characteristics. This data stands in direct conflict with the jurisdictions⁶⁶ that prohibit licensed mental health providers from offering counseling that affirms a patient’s biological sex when that patient seeks counseling to align his gender identity with his biological sex.

One prominent physician who advocates against hormonal and surgical interventions is Dr. Paul McHugh. He has received significant public criticism for his opposition to medical interventions for GID.⁶⁷ Dr. McHugh’s statements, however, are particularly relevant given that he previously served for twenty-six years as the psychiatrist-in-chief at the Johns Hopkins Hospital, which was one of the first hospitals to perform sex reassignment surgeries.⁶⁸ When Dr. McHugh became the psychiatrist-in-chief at Johns Hopkins School of Medicine in 1975, he made it a priority to discontinue the surgeries.⁶⁹ After studying patients with GID who sought, or had received, sex reassignment surgery, Johns Hopkins decided to stop performing sex reassignment surgeries.⁷⁰ Through his research, Dr. McHugh

64. Brendan S. Abel, *Hormone Treatment of Children and Adolescents with Gender Dysphoria: An Ethical Analysis*, HASTINGS CTR. REP., Sept.-Oct. 2014, at S23, S24.

65. Byne, *supra* note 24, at 771-72.

66. *See supra* note 2.

67. *See, e.g., McHugh Exposed: HRC Launches Website Debunking the Junk Science of Paul McHugh*, HUM. RTS. CAMPAIGN (Apr. 21, 2017), www.hrc.org/press/mchugh-exposed-hrc-launches-website-debunking-the-junk-science-of-paul-mchu; Samuel Smith, *Johns Hopkins Researcher Responds After Over 500 Experts Condemn His Sexuality*, *Gender Report*, CHRISTIAN POST (Mar. 29, 2017), <https://www.christianpost.com/news/johns-hopkins-researcher-responds-after-over-500-experts-condemn-his-sexuality-gender-report-178836/>.

68. *See* McHugh, *Surgical Sex*, *supra* note 23; Rachel Witkin, *Hopkins Hospital: A History of Sex Reassignment*, JOHN HOPKINS NEWS-LETTER (May 1, 2014), <https://www.jhunewsletter.com/article/2014/05/hopkins-hospital-a-history-of-sex-reassignment-76004/>; Amy Ellis Nutt, *Long Shadow Cast by Psychiatrist on Transgender Hospital Finally Recedes at Johns Hopkins*, WASH. POST (Apr. 5, 2017), https://www.washingtonpost.com/national/health-science/long-shadow-cast-by-psychiatrist-on-transgender-issues-finally-recedes-at-johns-hopkins/2017/04/05/e851e56e-0d85-11e7-ab07-07d9f521f6b5_story.html?utm_term=.8b7a37da4279.

69. *See* McHugh, *Surgical Sex*, *supra* note 23.

70. *Id.* He concluded his article by stating the medical profession had “wasted scientific and technical resources and damaged our professional credibility by collaborating with madness [of changing one’s sex through surgery in order to discover one’s true identity] rather than trying to study, cure, and ultimately prevent it.” *Id.*

found that sex reassignment surgery had not cured the patients because it had not treated the underlying psychological issues that had manifested themselves as GID.⁷¹ Many other hospitals similarly stopped performing the surgeries.⁷² In 2017, however, Johns Hopkins Hospital, under different leadership, announced that it would open a transgender health service and again provide “gender-affirming surgery . . . for transgender individuals.”⁷³

In the same way that the American Psychological Association declassified homosexuality as a mental disorder based on *emerging* (not existing) science and the public pressure to help alleviate discrimination based on sexual orientation,⁷⁴ Dr. McHugh points out that those who advocated for sex reassignment surgery were swept away by prevailing cultural fashion.

The zeal for this sex-change surgery—perhaps, with the exception of frontal lobotomy, the most radical therapy ever encouraged by twentieth-century psychiatrists—did not derive from critical reasoning or thoughtful assessments. These were so faulty that no one holds them up anymore as standards for launching any therapeutic exercise, let alone one so irretrievable as a sex-change operation. The energy came from the fashions of the seventies that invaded the clinic—if you can do it and he wants it, why not do it? It was all tied up with the spirit of doing your thing, following your

71. *Id.* Even the APA Task Force on Gender Identity and Gender Variance pointed out that “[c]oexisting psychiatric conditions occur frequently among children referred for clinical evaluations.” *Supra* note 12, at 47. In other words, there are underlying problems manifesting themselves in a variety of ways, including as GID. The APA, however, did not acknowledge that GID is the manifestation of issues that need resolving. Rather, the APA takes the position that GID itself can be cured by changing one’s sex characteristics.

72. See McHugh, *Surgical Sex*, *supra* note 23. Dr. McHugh’s conclusions are bolstered by a study published in 2011 that followed postoperative transsexuals in Sweden and found many had continued health and psychological issues even after surgery, including higher rates of suicide. See Travis Wright Colopy, *Setting Gender Identity Free: Expanding Treatment for Transsexual Inmates*, 22 HEALTH MATRIX: J.L.-MED. 227, 266 (2012) (discussing study by Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLOS ONE 1 (Feb. 2011), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885>); see also Travis Cox, *Medically Necessary Treatments for Transgender Prisoners and the Misguided Law in Wisconsin*, 24 WIS. J. L., GENDER, & SOC’Y 341, 364-65 (2009) (discussing dissatisfaction of post-operative patients).

73. Kelly Gooch, *Johns Hopkins to Resume Gender-Reassignment Surgeries*, BECKER’S HOSP. REV. (Apr. 6, 2017), <https://www.beckershospitalreview.com/hospital-physician-relationships/johns-hopkins-to-resume-gender-reassignment-surgeries.html>.

74. Paul McHugh, *Psychiatric Misadventures*, 61 AM. SCHOLAR 497, 501-04 (1992); Paul E. Rondeau, *Selling Homosexuality to America*, 14 REG. U. L. REV. 443, 446-47 (2001-2002).

bliss, an aesthetic that sees diversity as everything and can accept any idea, including that of permanent sex change, as interesting and that views resistance to such ideas as uptight if not oppressive.⁷⁵

Rather than performing surgery to remove or alter body parts, Dr. McHugh maintains that licensed mental health professionals should “learn how to manage this condition as a mental disorder when we fail to prevent it.”⁷⁶ For those physicians who refuse to treat the underlying causes of GID and, instead, recommend sex reassignment surgery, he stated that they have “abandon[ed] the role of protecting patients from their symptoms and become little more than technicians working on behalf of a cultural force.”⁷⁷

There is a lack of clarity in the psychiatric community about the immutability of gender, the classification of GID as a mental disorder, and, more importantly, the appropriate course of treatment for GID. These ambiguities prompted the *Psychiatric Times* to publish an article in 2012 immediately after a federal judge issued the first decision ordering a state to pay for a prisoner with gender identity disorder to receive sex-reassignment surgery. The article criticized the decision as “foolish” and based on “psychiatric experts, who may [yet] again have led psychiatry down the slippery slope of diagnostic overreaching.”⁷⁸ The author of that article, Dr. Phillips, highlighted the fact that there is ongoing controversy surrounding the proper diagnosis, label, and treatment of GID.⁷⁹ He explained that the DSM-5 workgroups, who, at the time, had been working on changes to the DSM-4, have been criticized for their decision to change gender identity disorder to gender dysphoria in an alleged effort to remove social stigma attached to those with GID.⁸⁰ He characterized the current understanding about GID as one of “bewilderment over how to treat” it, highlighting that

75. McHugh, *supra* note 74, at 503.

76. *Id.*

77. *Id.* at 504.

78. James Phillips, *Gender Identity Disorder in Prison: Depending on a Diagnosis that is Soon to Disappear?*, *PSYCHIATRIC TIMES* (Sept. 28, 2012), <http://www.psychiatristimes.com/articles/gender-identity-disorder-prison-depending-diagnosis-soon-disappear>. Dr. Phillips is an associate clinical professor of psychiatry at the Yale School of Medicine.

79. *Id.*

80. *Id.*

“as with other value-laden diagnoses, there is no scientific way to decide whether GID or Gender Dysphoria is or is not a psychiatric illness.”⁸¹

B. The Legal Response to GID

It is no surprise that a divided medical approach to GID has produced conflicting legal responses. Similar to the medical responses, the two overarching approaches observed in the case law and legislation are (i) that sex is biologically determined at birth and cannot be changed through medical interventions or (ii) that a person can change his or her gender from the biological sex determined at birth. For example, a 1976 decision by a New Jersey intermediate appellate court concluded that a man who had undergone a male-to-female sex-reassignment surgery should be treated as a woman for purposes of a marriage license.⁸² In the decades that followed, other jurisdictions similarly concluded that a person should be treated as the sex he or she desires to be for purposes of driver’s license name changes,⁸³ birth certificates,⁸⁴ prison assignments,⁸⁵ and bathroom use.⁸⁶

Conversely, in 1999, a Texas Court of Appeals concluded that biology determines one’s sex.⁸⁷ After pointing out its belief that the legislature should determine whether someone who undergoes a sex change surgery should be legally treated as having changed his sex, the court held that because “male chromosomes do not change with either hormonal treatment or sex reassignment surgery. . . . [A] post-operative female transsexual is still a

81. *Id.* Dr. Phillips also questioned the expert testimony offered in favor of Mr. Kosilek, stating that “[w]e can wonder, after psychiatry’s disastrous experiences with homosexuality and the violent sexual predator statutes, why the plaintiff psychiatrists would allow themselves to be sucked into this morass of another dubious, value-driven, sex-related diagnosis? Does psychiatry need to look foolish one more time for its diagnostic overreaching?” *Id.*

82. *M.T. v. J.T.*, 355 A.2d 204, 210-11 (N.J. Super. Ct. App. Div. 1976).

83. National Center for Transgender Equality, *ID Documents Center*, NAT’L CTR. FOR TRANSGENDER EQUALITY (last updated Nov. 2018), <https://transequality.org/documents> (identifying and categorizing state laws as to their friendliness to permitting name changes for transgender individuals).

84. *See Changing Birth Certificate Sex Designations: State-by-State*, LAMBDA LEGAL (last updated Sept. 17, 2018), <https://www.lambdalegal.org/know-your-rights/article/trans-changing-birth-certificate-sex-designations> (listing statutes that permit birth certificate changes to sex designation and identifying all states as permitting a change from transgendered individuals under certain circumstances except Kansas, Ohio, and Tennessee).

85. *See infra* notes 98-102 and accompanying text (identifying various cases on this issue).

86. *See infra* notes 112-125 and accompanying text (identifying cases that have addressed this issue).

87. *Littleton v. Prange*, 9 S.W.3d 223 (Tex. App. 1999).

male.⁸⁸ In reaching its decision, the court relied on an Ohio court decision that had reached a similar decision in determining for probate purposes that a male who became a post-operative female was not validly married to another male.⁸⁹

Adopting that line of reasoning, in 2004, a Florida Court of Appeals declared a marriage void that had been entered into between a biological female and another biological female who had undergone female-to-male sex reassignment.⁹⁰ In the context of a custody dispute, the wife and birth mother claimed the marriage was void because her “husband” was born a female.⁹¹ The court of appeals agreed with her, concluding that sex is determined at birth and, therefore, the marriage between two women was void.⁹² There have been very few other reported cases dealing with how to designate a person’s sex for purposes of a marriage license after the person has undergone sex reassignment surgery. In the wake of *Obergefell v. Hodges*, declaring unconstitutional a law limiting marriage to one man and one woman, it would seem the question of one’s sex for purposes of a marriage license is unlikely to garner much litigation. In fact, some states have moved to gender-neutral designations on their marriage licenses.⁹³

The idea that people can change their sex has led to some strange circumstances, including the headline *Thomas Beatie, The ‘Pregnant Man,’ Wants a Fourth Child*.⁹⁴ Thomas Beatie was born female, underwent *partial* sex-reassignment surgery, married a woman, and eventually became

88. *Id.* at 230.

89. *Id.* at 228 (citing *In re Ladrach*, 513 N.E.2d 828, 832 (Ohio Prob. Ct. 1987) (“[A] person’s sex is determined at birth by an anatomical examination by the birth attendant.”)).

90. *Kantaras v. Kantaras*, 884 So. 2d 155, 161 (Fla. Dist. Ct. App. 2004).

91. *Id.*

92. *Id.*

93. The New York City marriage license application refers to individuals as a bride, groom, spouse A or B. See OFFICE OF THE CITY CLERK, THE CITY OF NEW YORK, *Marriage License Application*, https://www1.nyc.gov/cityclerkformsonline/marriageLicense.htm?PARAM_TARGET=_target0&page=0. The City of San Francisco’s marriage license application simply refers to “first person” and “second person.” See CITY AND COUNTY OF SAN FRANCISCO, OFFICE OF THE COUNTY CLERK, *San Francisco County Clerk Public Marriage License Application*, <https://sfgov.org/countyclerk/sites/default/files/Public%20Marriage%20License%20Application%20-%20MLPA.pdf>.

94. *Thomas Beatie, the ‘Pregnant Man,’ Wants a Fourth Child*, HUFFINGTON POST (updated Sept. 5, 2012), https://www.huffpost.com/entry/thomas-beatie-pregnant-man-fourth-child_n_1855318.

pregnant.⁹⁵ In reality, the “pregnant man” was a biological woman who had undergone some, but not all, surgical procedures to transition to living as a man.⁹⁶ A more recent headline explained how excited a five-year-old boy was that *both* of his transgendered parents were set to undergo sex-reassignment surgery.⁹⁷ After the surgeries, the boy’s dad would look like a woman and the boy’s mom would look like a man.

One area of law that has had extensive litigation involves how prison officials should treat those with gender identity disorder. The two primary issues that arise in the prison context are whether to house a person in male or female facilities⁹⁸ and whether the Eighth Amendment requires prisons to provide hormone and sex-reassignment surgery to inmates.⁹⁹ The Eighth Amendment precedent seems to prohibit absolute bans by prisons on providing cross-gender hormones but leaves prisons the flexibility in some circumstances as to whether sex-reassignment surgery must be provided.¹⁰⁰

95. *Id.* While Beatie was pregnant with her fourth child, she was attempting to divorce her wife. The Arizona court hearing the divorce questioned whether Arizona could divorce the couple insofar as Arizona prohibits same-sex marriage. Other courts have similarly held that a person’s sex is determined at birth and cannot be changed. *Id.*

96. *Id.*

97. Molly Rose Pike, *Transgender Parents Who are BOTH Set to Undergo Sex Changes Insist Their Son, Five, is ‘Excited’ About Their Ops—But This Morning Viewers Claim It’s ‘Unfair’ to Expose Him to Their Plans*, DAILYMAIL.COM (Sept. 11, 2018),

<https://www.dailymail.co.uk/femail/article-6154731/Parents-set-undergo-sex-changes-insist-son-excited-plan.html>.

98. *See, e.g., Richardson v. District of Columbia*, 322 F. Supp. 3d 175 (D.D.C. 2018) (holding that prison officials did not act with deliberate indifference toward the health and safety of a male-to-female transgender inmate who was housed in the male prison population); *Zollicoffer v. Livingston*, 169 F. Supp. 3d 687 (S.D. Tex. 2016) (allegations were sufficient to plead male-to-female transgender inmate housed in the male facilities was incarcerated under conditions posing a substantial risk of harm); *Shaw v. District of Columbia*, 944 F. Supp. 2d 43 (D.D.C. 2013) (alleged a failure to train and supervise claim against prison officials when plaintiff was housed in the male prison, which was consistent with his biological sex, rather than female facilities).

99. *See, e.g., Kosilek v. Spencer*, 774 F.3d 63, 91-92 (1st Cir. 2014) (concluding that the decision of the Department of Corrections not to provide sex reassignment surgery was not deliberately indifferent to plaintiff’s medical condition insofar as the DOC chose one of two alternative courses of treatment—cross-gender hormones and sex-reassignment surgery—both of which alleviated negative effects within the boundaries of modern medicine); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1189-90 (N.D. Cal. 2015) (concluding that inmate was likely to succeed on a claim that prison officials were deliberately indifferent to the prisoner’s medical needs in refusing to provide sex-reassignment surgery); *see also Marjorie A. Shields, Provision of Hormone Therapy or Sexual Reassignment Surgery to State Inmates with Gender Identity Disorder (GID)*, 89 A.L.R. 6th 701 (2013).

100. *See supra* note 99.

The courts have not uniformly decided whether a prison is required to house prisoners in male or female facilities based on their biological sex or on their gender identity.¹⁰¹ The issue of where to house a transgendered prisoner raises obvious security and safety concerns that continue to be debated.¹⁰²

In recent years, the legal controversies have focused more on non-discrimination in the contexts of healthcare and education. In the healthcare context, the Patient Protection and Affordable Care Act of 2010 (ACA) prohibits exclusion, discrimination, and denial of healthcare on the basis of race, color, national origin, age, disability, or sex in healthcare.¹⁰³ The implemented regulations apply, in part, to “every health program or activity, any part of which receives Federal financial assistance [from HHS, as well as HHS administered health programs and activities].”¹⁰⁴ By applying an expansive definition of “sex,” plaintiffs have argued that the ACA also prohibits discrimination based on gender identity.¹⁰⁵ Non-discrimination in

101. See *supra* note 98.

102. The U.S. Federal Bureau of Prisons released new guidelines in 2018 in its Transgender Offender Manual. See U.S. DEP’T OF JUSTICE: FED. BUREAU OF PRISONS, *Transgender Offender Manual* (May 11, 2018), <https://www.bop.gov/policy/progstat/5200-04-cn-1.pdf>. The manual states that inmates will be housed according to biological sex, with rare exceptions made. *Id.* This was a change from the 2017 revisions that encouraged placement of inmates according to gender identity “when appropriate.” See Jenny Gathright, *The Guidelines for Protection of Transgender Prisoners Just Got Rewritten*, NPR (May 12, 2018), <https://www.npr.org/sections/thetwo-way/2018/05/12/610692321/the-guidelines-for-protection-of-transgender-prisoners-just-got-rewritten>. The Transgender Executive Council will make recommendations about placement based on “an inmate’s health and safety, the inmate’s history of behavior and the security of the institution and its inmates.” *Id.*

103. Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116 (2010), incorporates by reference other federal statutes that prohibit discrimination based on race, color, and national origin (42 U.S.C. § 2000d); sex (20 U.S.C. § 1681); disability (29 U.S.C. § 794); and age (42 U.S.C. § 6101).

104. 45 C.F.R. § 92.2(a) (2016).

105. For cases concluding that transgender status is included in sex discrimination, see *Equal Employment Opportunity Comm’n v. R.G. & G.R. Harris Funeral Homes*, 884 F.3d 560, 574-75 (6th Cir. 2018) (concluding that discrimination based on transgender or transitioning status constitutes discrimination based on sex); *Glenn v. Brumby*, 663 F.3d 1312, 1316-19 (11th Cir. 2011) (holding that terminating an employee because she is transgender violates the prohibition on sex-based discrimination under the Equal Protection Clause following the reasoning of *Price Waterhouse*); *Smith v. City of Salem, Ohio*, 378 F.3d 566, 573-75 (6th Cir. 2004) (holding that transgender employee had stated a claim under Title VII based on the reasoning of *Price Waterhouse*); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215-16 (1st Cir. 2000) (holding that a transgender individual could state a claim for sex discrimination under the Equal Credit Opportunity Act based on *Price Waterhouse*); *Schwenk v. Hartford*, 204 F.3d 1187, 1201-03 (9th Cir. 2000) (holding that a transgender individual could state a claim under the Gender Motivated Violence Act under the reasoning of *Price Waterhouse*).

health care services makes sense in the context of ensuring that no one is denied necessary medical treatment, but non-discrimination in the medical context has been argued to require doctors to foster a person's belief about his or her sex, divorced from the realities of the medical efficacy of such treatment.¹⁰⁶ In fact, some argue that it would be a denial of appropriate care if doctors refused to give feminizing hormones to a man transitioning into a woman.¹⁰⁷

The Northern District of Texas refused such an expansive interpretation of "sex" discrimination in the health care context. In *Franciscan Alliance, Inc. v. Burwell*, private health care providers and eight states sued the United States Department of Health and Human Services to, among other things, prevent implementation of an ACA regulation that prohibited discrimination on the basis of "gender identity" and "termination of pregnancy."¹⁰⁸ "Plaintiffs argue[d that] the new regulation [would] require them to perform and provide insurance coverage for gender transitions and abortions, regardless of their contrary religious beliefs or [independent] medical judgment."¹⁰⁹ The court concluded that defendants had exceeded their authority in interpreting "sex" to include gender identity and that the provisions likely violated the Religious Freedom Restoration Act as applied to the plaintiffs.¹¹⁰ The court issued a nationwide injunction against enforcement of the provisions prohibiting discrimination on the basis of "gender identity" and "termination of pregnancy."¹¹¹

In the education context, the legal challenges have focused primarily on curriculum and access to restrooms and locker facilities. The plaintiffs in the restroom and locker facilities cases assert that it violates Title IX and the Fourteenth Amendment Equal Protection guarantee to refuse to permit

For those who have rejected the argument that sex discrimination includes transgender status, see *Texas v. United States*, 201 F. Supp. 3d 810, 836 (N.D. Tex. 2016) (concluding that Title IX does not prohibit discrimination based on gender identity or transgender status); *Johnston v. Univ. of Pittsburgh*, 97 F. Supp. 3d 657, 682-83 (W.D. Pa. 2015) (holding that Title IX does not prohibit discrimination based on gender identity or transgender status).

106. See *Chu*, *infra* note 140 and accompanying text.

107. See, e.g., Wyatt Fore, *Trans/forming Healthcare Law: Litigating Antidiscrimination under the Affordable Care Act*, 28 *YALE J. L. & FEMINISM* 243, 262 (2017).

108. *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 670-71 (N.D. Tex. 2016).

109. *Id.* at 670.

110. *Id.* at 670. The Religious Freedom Restoration Act prohibits the federal government from substantially burdening a person's exercise of religion without demonstrating a compelling government interest that is advanced in the least restrictive means possible. 42 U.S.C.A. § 2000bb-1 (1993).

111. *Burwell*, 227 F. Supp. 3d at 695-96.

transgendered students to use the restroom consistent with their gender identity.¹¹² Often, the school districts involved offer to allow the student to use single-sex teacher restrooms or a gender neutral restroom. The students, however, maintain that it is stigmatizing to be excluded from the student restrooms.¹¹³ Some courts have concluded that Title IX’s prohibition against “sex” discrimination includes transgendered persons because “by definition, [they] do not conform to gender stereotypes,” which the Supreme Court previously held constituted “sex” discrimination under Title VII.¹¹⁴

In a recent case from Gloucester County, Virginia, the district court applied intermediate scrutiny to conclude that plaintiff had sufficiently pled an Equal Protection claim.¹¹⁵ Significantly, the court concluded that transgendered individuals constituted a suspect class because (1) they have historically been “subjected to discrimination,” (2) “transgender status has no bearing on a transgender individual’s ability to contribute to society,” (3) “transgender status is immutable,” and (4) the class is a minority group that is “politically powerless.”¹¹⁶ In applying the intermediate scrutiny standard, the school board asserted that the policy requiring students to use the restroom and locker facilities consistent with their biological gender

112. See *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Board of Educ.*, 858 F.3d 1034, 1054-55 (7th Cir. 2017) (affirming district court granted preliminary injunction against school district on claims that the school’s restroom policy violated Title IX and the Equal Protection clause); *Dodds v. U.S. Dept. of Educ.*, 845 F.3d 217, 220-22 (6th Cir. 2016) (denied school district’s request for stay of preliminary injunction).

113. See, e.g., *Adams v. Sch. Bd. of St. John’s County*, 318 F. Supp. 3d 1293, 1308 (M.D. Fla. 2018) (felt “alienated and humiliated”); *Grimm v. Gloucester County Sch. Bd.*, 302 F. Supp. 3d 730, 737-38 (E.D. Va. 2018).

114. See, e.g., *Grimm*, 302 F. Supp. 3d at 745; *M.A.B. v. Bd. of Educ. of Talbot Co.*, 286 F. Supp. 3d 704 (D. Md. 2018) (holding that plaintiff could state a claim for Title IX sex discrimination based on transgender status); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 301 (W.D. Pa. 2017) (Plaintiff’s request for preliminary injunctive relief denied).

115. *Grimm*, 302 F. Supp. 3d at 750-52. *Grimm*’s initial claims were dismissed in 2015 for failure to state a claim upon which relief could be granted. *Id.* at 741. The Fourth Circuit reversed and remanded, instructing the district court to give deference to a Department of Education guidance letter issued under President Obama’s administration that construed Title IX to require schools to treat transgendered students consistent with their gender identity. *Id.* at 739-40. The United States Supreme Court then granted a stay of the Fourth Circuit’s decisions. *Id.* at 740. After President Trump’s administration rescinded the guidance letter, the Supreme Court vacated the Fourth Circuit decision. *Id.* The plaintiff then filed an amended complaint. *Id.* Based on new facts (the plaintiff had chest reconstruction surgery, obtained an order changing his name, and received an amended birth certificate) since the first dismissal and a number of other decisions that had considered the legal issues, the court denied the school board’s motion to dismiss. *Id.* at 741, 752.

116. *Id.* at 749.

protected the privacy interests of their students.¹¹⁷ The court rejected the privacy concerns of other students as “sheer conjecture.”¹¹⁸ “[A] ‘transgender student’s presence in a restroom provides no more of a risk to other students’ privacy rights than the presence of an overly curious student of the same biological sex who decides to sneak glances at his or her classmates performing their bodily functions.”¹¹⁹

Following *Grimm*, two district courts have similarly rejected privacy concerns.¹²⁰ The Middle District of Florida addressed the issue of whether Drew Adams, who was born a female, was now a male.¹²¹

Drew Adams says he is a boy and has undergone extensive surgery to conform his body to his gender identity; medical science says he is a boy; the State of Florida says so (both Adams’ Florida birth certificate and Florida driver’s license say he is a male); and the Florida High School Athletic Association says so. Other than at his school, Adams uses the mens’ bathroom wherever he goes When confronted with something affecting our children that is new, outside of our experience, and contrary to gender norms we thought we understood, it is natural that parents want to protect their children. But the evidence is that Drew Adams poses no threat to the privacy or safety of any of his fellow students.¹²²

After reviewing prior case law asserting a privacy interest against permitting transgender students the use of locker room or bathroom facilities consistent with their gender identity, the district court in Oregon concluded that “high school students do not have a fundamental privacy right to not share school restrooms, lockers, and showers with transgender students whose biological sex is different than theirs.”¹²³

Interestingly, even Justice Ginsburg understood that bans on sex discrimination would continue to require separate dressing facilities. In 1975, while she was a law professor at Columbia University, she wrote in an op-ed for the *Washington Post* that “[s]eparate places to disrobe, sleep, perform

117. *Id.* at 751.

118. *Id.*

119. *Id.* (quoting *Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034, 1052 (7th Cir. 2017)).

120. *Adams v. Sch. Bd. of St. John’s County*, 318 F. Supp. 3d 1293, 1296-97 (M.D. Fla. 2018); *Parents for Privacy v. Dallas Sch. Dist.*, 326 F. Supp. 3d 1075, 1099, 1101 (D. Or. 2018).

121. *Adams*, 318 F. Supp. 3d at 1296.

122. *Id.* at 1296-97. The factual description of the case indicates that Drew had a double mastectomy as a minor. *Id.* at 1301.

123. *Parents for Privacy*, 326 F. Supp. 3d at 1099.

personal bodily functions are permitted, in some situations required, by regard for individual privacy. Individual privacy, a right of constitutional dimension is appropriately harmonized with this equality principle.”¹²⁴

Of course, if female students who identify as male are permitted to use the boys’ locker room, it raises unique concerns for school employees assigned to monitor locker rooms. For example, in one recent case in Florida, a male teacher was disciplined for refusing to monitor the boys’ locker room because he would have had to oversee a female student in a state of undress.¹²⁵ The catch-22 in today’s “me-too” culture is apparent in that situation: the male teacher risks allegations of inappropriate conduct with respect to watching a girl undress but then faces discipline for refusing to watch the girl undress.

In addition to the restroom and locker room controversies, there also are legal challenges to the curriculum. These legal challenges focus on the authority of parents to opt their children out of curriculum and activities designed to teach children that gender identity is fluid and sex is changeable. In one lawsuit in Minnesota, the “[p]arents of a five-year-old student sued the school because it was not accommodating enough of their ‘gender nonconforming’ child.”¹²⁶ Specifically, the school refused to include a book entitled “I am Jazz” in the classroom.¹²⁷ “I am Jazz” is a children’s book about Jazz Jennings, a girl with a reality television show that chronicles her life as a biological male who came out as transgendered as a toddler.¹²⁸ “Because the school was not willing to” expose kindergarten students to the book “without first notifying parents and allowing them to opt out,” the plaintiffs sued.¹²⁹ As a result of the suit, the school board approved a gender inclusion policy that

124. Ryan T. Anderson, *A Brave New World of Transgender Policy*, 41 HARV. J.L. & PUB. POL’Y 309, 321 (2018) (quoting Ruth Bader Ginsburg, *The Fear of the Equal Rights Amendment*, WASH. POST, Apr. 7, 1975, at A21); see also Eugene Volokh, *Prominent Feminist: Bans on Sex Discrimination ‘Emphatically’ Do Not ‘Require Unisex Restrooms’*, WASH. POST: VOLOKH CONSPIRACY (May 9, 2016), https://www.washingtonpost.com/news/volokh-conspiracy/wp/2016/05/09/prominent-feminist-bans-on-sex-discrimination-emphatically-do-not-require-unisex-restrooms/?utm_term=.51927fb081a2.

125. Joy Pullmann, *School Punishes Male Teacher for Refusing to Watch a Naked Girl in the Boys’ Locker Room*, FEDERALIST (Nov. 14, 2018), <https://thefederalist.com/2018/11/14/florida-school-district-gags-p-e-teachers-telling-parents-girl-watching-naked-sons/>.

126. Ryan T. Anderson, *A Brave New World of Transgender Policy*, 41 HARV. J.L. & PUB. POL’Y 309, 316 (2018).

127. *Id.*

128. *Id.*

129. *Id.*

permits a student to choose his or her gender and to use bathroom and locker rooms consistent with the student's gender identity.¹³⁰

Although arising in the context of sexual orientation or sex education curriculum, rather than gender identity issues, several courts have held that parents do not have a fundamental right to opt their children out of curriculum that violates their beliefs. Those cases have involved an assembly where presenters used sexually explicit language and performed sexually explicit skits with students; schools providing condoms to students without parental notice; a survey for elementary school children that asked several explicit questions about sexual matters; and first-grade story time where teachers read to students a book about a fairy tale with a prince meeting his prince charming.¹³¹ The courts have held, absent a state law providing a right to opt out, parents' substantive due process right to direct the education of their children allows them to choose whether to send their children to public or private school, but does not allow them to dictate curriculum in public schools.¹³²

Finally, there has been a push to legislatively prohibit efforts to counsel individuals who struggle with GID, but who would like to align their gender identity with their biological sex.¹³³ The Ninth Circuit Court of Appeals upheld a ban on providing such counseling.¹³⁴ The opinion rested in part on the assertion that speech engaged in by licensed professionals in the course of their work is somehow exempt from scrutiny under the First Amendment.¹³⁵ This reasoning was expressly rejected in June 2018 by Justice Thomas in his majority opinion in *National Institute of Family and Life Advocates v. Beccerra (NIFLA)*.¹³⁶ The *NIFLA* decision expressly rejected the

130. *Id.* at 316-17.

131. See *Fields v. Palmdale Sch. Dist.*, 427 F.3d 1197, 1200 (9th Cir. 2005), *amended by* 447 F.3d 1187, 1191 (9th Cir. 2006) (student survey); *Brown v. Hot, Sexy & Safer Prod., Inc.*, 68 F.3d 525, 529 (1st Cir. 1995) (school assembly); *Parker v. Hurley*, 474 F. Supp. 2d 261, 262-63, 266 (D. Mass. 2007), *aff'd* 514 F.3d 87, 107 (1st Cir. 2008) (the reading of "King and King"); *Curtis v. Sch. Comm. of Falmouth*, 652 N.E.2d 580, 582 (Mass. 1995) (condom distribution).

132. *Fields*, 427 F.3d at 1205.

133. See *supra* note 2 (listing the statutes).

134. *Pickup v. Brown*, 740 F.3d 1208, 1238 (9th Cir. 2014), *abrogated by* *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018); *cf.* *King v. Governor of the State of New Jersey*, 767 F.3d 216 (3d Cir. 2014) (affirming a ban on counseling to help minors deal with unwanted same-sex attractions), *abrogated by* *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018).

135. *Pickup*, 740 F.3d at 1229 ("Most, if not all, medical and mental health treatments require speech, but that fact does not give rise to a First Amendment claim").

136. *Nat'l Inst.*, 138 S. Ct. at 2371-72.

notion there is a category of “professional speech” afforded lesser First Amendment protection.¹³⁷

As these examples highlight, fostering a person’s belief about gender identity when it conflicts with biological sex has generated conflicting legal and medical responses. It also has created ethical dilemmas for those involved in caring for patients with GID or accommodating the individual’s gender identity.

III. THE ETHICAL DILEMMAS POSED BY THE EXISTING MEDICAL AND LEGAL RESPONSES TO INDIVIDUALS WITH GID

When the medical and legal communities ignore the biological reality that sex is immutable, those needing help are denied that psychological help, while others are deprived of fundamental liberty interests. The approach that fosters a person’s idea that sex can be changed regardless of the efficacy of the medical interventions is consistent with the philosophy that an individual has autonomy to “define one’s own concept of existence”¹³⁸ This notion of autonomy, or individualism, undergirds the argument that a person who is denied something that he desires is being treated unfairly or discriminatorily. As Dr. McHugh explained, the shift to medically accommodating a person’s belief he can change his sex rests on the idea “if you can do it and he wants it, why not do it?”¹³⁹

Thus, in the context of GID, physicians provide cross-gender hormones and surgeries to alter physical appearance to promote the person’s self-identity as a gender different than his or her biological sex. In other words, the person *wants* to be the opposite sex, therefore, the medical profession should help realize that desire. This overlooks the fact that biological sex cannot actually be changed and medical interventions might cause more harm than good. The legal argument rests on the premise that to deny a person’s desire for medical interventions would undermine that person’s individual autonomy. This “want-based” approach raises two primary ethical dilemmas: (1) whether assisting a patient to align his biological sex with his gender identity is consistent with a doctor’s duty to do no harm; and (2) whether the law is treating those who are required by law to accommodate the person’s gender identity “fairly”.

137. *Id.*; see also Peter Sprigg, *Will the Supreme Court Save Sexual Orientation Change Efforts?*, FRC BLOG (July 2, 2018), <http://frcblog.com/2018/07/will-supreme-court-save-sexual-orientation-change-efforts/> (discussing the *Pickup* decision and the implications of *NIFLA* on that decision).

138. *Lawrence v. Texas*, 539 U.S. 558, 574 (2003).

139. See McHugh, *supra* note 74.

In November 2018, a *New York Times* op-ed highlighted the prevalent mindset that the medical profession should ignore medical realities and assist patients with medical interventions to attempt to change their sex.¹⁴⁰ Andrea Long Chu, a biological male about to undergo surgery to complete her physical transformation to become a female, asserts it is irrelevant whether the medical interventions will cause her harm or whether they will make her feel better.¹⁴¹ She said that she was confident they would not help her feel better, however, the only relevant question is whether she *wants* the surgery.¹⁴² Chu explained,

I feel demonstrably worse since I started on hormones. . . . I was not suicidal before hormones. Now I often am. . . . I still want this, all of it. I want the tears; I want the pain. Transition doesn't have to make me happy for me to want it. . . . The medical maxim "First, do no harm" assumes that health care providers possess both the means and the authority to decide what counts as harm. . . . [S]urgery's only prerequisite should be a simple demonstration of want. Beyond this, no amount of pain, anticipated or continuing, justifies its withholding.¹⁴³

Adopting a standard of care that asks only whether a patient *needs* a particular medical intervention raises concerns about utilitarianism when government or insurance companies start limiting procedures based on a cost-benefit analysis. However, medical interventions for GID should involve a needs-based analysis because the medical interventions include irreversible medical interventions with significant health risks including the removal of healthy body parts.¹⁴⁴ This stands in stark contrast with denying patients

140. Andrea Long Chu, *My New Vagina Won't Make Me Happy*, N.Y. TIMES (Nov. 24, 2018), <https://www.nytimes.com/2018/11/24/opinion/sunday/vaginoplasty-transgender-medicine.html>.

141. *Id.*

142. *Id.*

143. *Id.*

144. A utilitarian approach to providing health care ignores the intrinsic value of each human being. As Justice Thomas explained in *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015), "[H]uman dignity has long been understood in this country to be innate. When the Framers proclaimed in the Declaration of Independence that 'all men are created equal' and 'endowed by their Creator with certain unalienable Rights,' they referred to a vision of mankind in which all humans are created in the image of God and therefore of inherent worth. That vision is the foundation upon which this Nation was built." *Id.* at 2639 (Thomas, J., dissenting). A health care system that would deny or significantly delay health care to those deemed unworthy to receive the care—because the decisions are based on a cost-benefit analysis rather than on whether the patient needs the care—ignore the reality of the innate value of each human life.

medically necessary treatment because they are too old or unlikely to survive the procedure.

A. Medical, Rather than Psychological, Interventions Harm the Patient

GID stands alone in treating patients in a manner that fosters the patient's belief about himself or herself when that belief does not align with reality.¹⁴⁵ For example, those with a Compulsive Overeating Disorder are encouraged to reduce their mental dependency on food consumption.¹⁴⁶ Meanwhile, patients with anorexia or bulimia are encouraged to increase their food intake or retain their food, despite mental impulses to the contrary.¹⁴⁷ In other words, the anorexic is not encouraged to believe he or she is overweight and in need of losing weight; he or she is encouraged to attain a proper understanding of the role of food in his or her life and a healthy self-perception. No one would suggest that liposuction is the proper treatment protocol for the malnourished anorexic because he or she believes he or she is overweight. In the same way, mental health professionals should not be encouraging patients with GID to surgically alter their bodies to conform to their perceived gender identity.

Body Integrity Identity Disorder is probably most analogous to GID, yet the course of treatments for each differs drastically. Body Integrity Identity Disorder is a situation where a physically whole person desires to become an amputee.¹⁴⁸ As with GID, the belief is so persistent that some patients have attempted self-amputation.¹⁴⁹ If the American Psychological Association (APA) were to approach Body Integrity Identity Disorder in the same way it approaches the treatment of GID, then the APA and other mental health

145. See, e.g., Zakaria, *By Any Other Name*, *supra* note 44, at 359 ("GID is the only pathology for which 'the patient makes the diagnosis and prescribes the treatment'").

146. Denise E. Wilfley et al., *A Randomized Comparison of Group Cognitive-Behavioral Therapy and Group Interpersonal Psychotherapy for the Treatment of Overweight Individuals with Binge-Eating Disorder*, 59 ARCHIVES GENERAL PSYCHIATRY 713, 717-18 (2002).

147. Cynthia M. Bulik et al., *Anorexia Nervosa*, HANDBOOK OF EVIDENCE-BASED PRACTICE IN CLINICAL PSYCHOLOGY 580 (Peter Sturmey & Michel Hersen eds., 2012); see also Zakaria, *By Any Other Name*, *supra* note 44, at 362; *Bulimia Nervosa: Diagnosis and Conditions*, MAYO CLINIC, <https://www.mayoclinic.org/diseases-conditions/bulimia/diagnosis-treatment/drc-20353621> (last visited Mar. 6, 2019); *Anorexia Nervosa: Diagnosis and Conditions*, MAYO CLINIC, <https://www.mayoclinic.org/diseases-conditions/bulimia/diagnosis-treatment/drc-20353621> (last visited Mar. 6, 2019).

148. Michael First, *Desire for amputation of a limb: paraphilia, psychosis, or a new type of identity disorder*, 34 PSYCHOL. MED. 919, 926-27 (2004), <https://pdfs.semanticscholar.org/8de0/318dda1a5f9175a61c01f827270a91452c2a.pdf>.

149. *Id.* at 926.

professionals would encourage their patients to schedule appointments with surgeons to remove healthy limbs. Yet, given the very few instances where Body Integrity Identity Disorder amputations have been performed,¹⁵⁰ it seems that the medical establishment does not believe it constitutes sound medical judgment to perform an amputation on a physically whole person, even if the patient desires to be an amputee. If, like in cases for the treatment of GID, the standard for surgery asks only whether a doctor can perform the procedure and whether the patient wants the surgery, we would see healthy body parts amputated based on a patient's persistent desire to be an amputee.

Not only does it seem inconsistent with other treatment modalities to foster a client's version of reality that is inconsistent with actual reality (here, the biological facts), but to foster that belief with a hormone regimen or major surgery fails to treat the root issues of the mental. As a result, there are other professionals who take the position that GID patients should be treated with psychotherapy rather than with hormones and surgery.¹⁵¹ Significantly, even some professionals who advocate the use of hormones or surgery believe that psychotherapy is an important part of continuing treatment.¹⁵²

This psychological-based approach is justified for several reasons. First, the perspective that sex is an immutable trait, binary in nature, and coincides from birth with an individual's sex.¹⁵³ The Supreme Court has long held that sex is an immutable characteristic.¹⁵⁴ At birth, the sex of the child is determined by genes contained in two of the forty-six chromosomes in

150. *Id.* at 919 (17% of subjects had an arm or leg amputated with one-third obtaining the amputation through a doctor); see also Mo Costandi, *The Science and Ethics of Voluntary Amputation*, GUARDIAN (May 2012), <http://www.guardian.co.uk/science/neurophilosophy/2012/may/30/1> (doctors characterizing a British doctor's decision to perform voluntary amputations as an "inappropriate" medical procedure).

151. McHugh *supra* note 23, at 3.

152. WPATH Standards of Care, *supra* note 22, at 61 ("it is recommended that these patients also have regular visits with a mental health or other medical professional").

153. Scripture also affirms the binary nature of sex. See *Genesis* 1:27 ("So God created man in his own image, in the image of God he created them; male and female he created them."); *Genesis* 5:2 ("He created them male and female and blessed them."); *Mark* 10:6 ("But at the beginning of creation God 'made them male and female'").

154. See, e.g., *Caban v. Mohammed*, 441 U.S. 380, 398 (1979) ("Gender, like race, is a highly visible and immutable characteristic . . ."); *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 360 (1978) ("Second, race, like gender and illegitimacy is an immutable characteristic which its possessors are powerless to escape or set aside"); *Craig v. Boren*, 429 U.S. 190, 212 n.2 (1976) (Stevens, J., concurring) ("Since sex, like race and national origin, is an immutable characteristic determined solely by the accident of birth." (citing *Weber v. Aetena Casualty & Surety Co.*, 406 U.S. 164, 175)).

human cells, referred to as the “sex chromosomes.”¹⁵⁵ Once a child is born, the child’s family then develops and fosters the child’s identity, including gender identity, by teaching the child gender-appropriate behavior. GID, therefore, is properly viewed as either the result of one or more physiological problems, or a result of environmental factors influencing a person’s perception of a particular gender.¹⁵⁶ Biologically, however, nothing is wrong with the person.

Second, a psychotherapy approach that seeks to align one’s gender identity with one’s biological sex avoids both the medical risks associated with hormone use and sex reassignment surgery. It also addresses the ethical risk of obtaining informed consent from a patient with what, until recently, was considered a mental disorder. In addition, prolonged use of hormones to chemically change the body to appear more like the targeted gender have serious health risks.¹⁵⁷

Third, statistics demonstrate seventy-seven to ninety-four percent of children diagnosed with GID eventually become “comfortable with their natal gender.”¹⁵⁸ There is little research into whether successful therapy is the cause for the overwhelming majority of children eventually accepting a gender identity consistent with their biological sex. Given these numbers, the jurisdictions prohibiting counseling to help minors align their gender identity with biological sex is inconsistent with a medical professional’s duty to help their patients.¹⁵⁹ In a jointly-authored article, three doctors explained that the use of puberty-suppressing hormones rests on the presumption that it gives adolescents more time to explore their gender identity “without the distress of the developing secondary sex characteristics” but

[i]t presumes that natural sex characteristics interfere with the “exploration” of gender identity, when one would expect that the development of the natural sex characteristics might contribute to the natural consolidation of one’s gender identity. It also presumes that interfering with the development of natural sex characteristics can allow for a more accurate diagnosis of the

155. See Zakaria, *By Any Other Name*, *supra* note 44, at 352.

156. See Zucker, *Is There a Best Practice*, *supra* note 45, at 363.

157. *Transgender Identification Position Statement*, CHRISTIAN MED. & DENTAL ASS’NS, <https://cmda.org/wp-content/uploads/2018/04/Transgender.pdf>; cf. Cecile A. Unger, *Hormone Therapy for Transgender Patients*, 5 *TRANSLATIONAL ANDROLOGY & UROLOGY* 877 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5182227/>.

158. *Report*, *supra* note 24, at 763; see also *WPATH Standards of Care*, *supra* note 22, at 11.

159. *Report*, *supra* note 24, at 771.

gender identity of the child. But it seems equally plausible that the interference with normal pubertal development will influence the gender identity of the child by reducing the prospects for developing a gender identity corresponding to his or her biological sex.¹⁶⁰

The fourth rationale for the therapy-only approach is that in the absence of solid medical evidence concerning the causes of, and effective treatment modalities for GID, medical professionals should take the approach consistent with their ethical obligation to do no harm.¹⁶¹ Psychotherapy is the only alternative that does not *harm* an individual who *may actually be* mentally impaired.¹⁶² If GID is a disorder, mental health professionals should attempt to *fix* the psychological by taking an approach that minimizes the health risks of their patients.¹⁶³ Indeed, at least one recent study of 200 women who had transitioned to living as a male and later de-transitioned back to living a life consistent with their biological sex, demonstrated that 92.5% of them “responded said that their dysphoria was the same or better after detransitioning than during transition. Only 8% of respondents felt somewhat or completely positive toward their own transition, whereas 60.2% felt somewhat or completely negative toward it.”¹⁶⁴

B. Individuals are Deprived of their Rights When Laws and Policies Require them to Accommodate a Person’s Incongruent Gender Identity.

When discussions take place on how to accommodate a person’s perceived gender identity, they often ignore the impact those decisions will have on those who are forced to conform their actions to appease the desires of the individual with GID. The asserted interests of the individual with GID are similar in all of the various circumstances; failure to accommodate his or her perceived gender identity causes harm, isolation, discrimination, or stigmatization. Those interests, however, should be weighed against the

160. See Hruz, *Growing Pains*, *supra* note 4, at 22-23.

161. *Id.* at 14 (“... whether blocking puberty is the best way to treat gender dysphoria in children remains far from settled and it should be considered not a prudent option with demonstrated effectiveness but a drastic and experimental measure”); see also Edward J. Furton, *A Critique of ‘Gender Dysphoria’ in DSM-5*, 42 ETHICS & MEDICS 7 (2017), https://www.ncbcenter.org/files/4915/0651/5526/EM_July2017_FINAL.pdf (highlighting the higher prevalence of psychiatric hospitalization, mortality, and suicide attempts among postoperative transsexual individuals as compared to preoperative transgendered individuals).

162. Abel, *supra* note 65, at S25.

163. Cf. McHugh, *supra* note 23.

164. See Marchiano, *supra* note 1, at 353.

significant interests of those who refuse to change their policies or actions in to conform to the individual's perceived gender identity. All too often, those interests are ignored or trivialized. Whether it is a school forced to grant boys access to the girls' locker room, a physician who is forced to perform a double mastectomy on a woman who wants to be a man, prisons required to house men in women's facilities, or businesses forced to compromise their religious beliefs or other business standards, courts often overlook the religious, scientific, medical beliefs, or other significant interests of those required to accommodate a person's perceived gender.

Controversies surrounding accommodations in schools for individuals with GID arise in the context of curriculum decisions, anti-bullying policies, access to restrooms and locker rooms, and counseling services. The three significant interests implicated in these situations are parental rights, the health and safety of children, and privacy interests. Although some courts have refused to acknowledge parents have rights concerning the curriculum once the parents make the choice to place their children in the public school,¹⁶⁵ the fact is that curriculum and anti-bullying policies' goal is to change the way students perceive and understand sex and gender. As a promotional video for a public school in California demonstrates, the curriculum goes beyond trying to dispel certain stereotypes about what toys girls and boys should play with or what jobs they should pursue.¹⁶⁶ The schools encourage students to perceive sex and gender as fluid and, therefore, perhaps they should identify as a gender inconsistent with their biological sex.¹⁶⁷ In the video, the teachers explain the success they have had in getting children to reconsider their views on gender identity.¹⁶⁸ The video shows each young child in the classroom going up to the white board and placing an "x" on a line representing where on the spectrum they would place themselves in terms of identifying as a boy or a girl.¹⁶⁹

These curriculum decisions implicate the rights of parents to direct the education and upbringing of their children on an issue where many people have conflicting opinions.¹⁷⁰ In addition, when schools are introducing

165. See *supra* notes 124-125 and accompanying text.

166. *Creating Gender Inclusive Schools Trailer*, NEW DAY FILMS, <https://www.newday.com/film/creating-gender-inclusive-schools> (last visited Dec. 4, 2018).

167. *Id.*

168. *Id.*

169. *Id.*

170. While there are those who believe one's biological sex should not limit the ability of people to choose a different gender identity and require others in society to accommodate that belief, there are others with sincerely held beliefs who disagree. Some hold religious objections to the notion that a person can change his or her sex. See *supra* note 43 (identifying a few Bible

young, elementary-aged, students to these materials, parents might not be prepared to have their child exposed to some of these issues at such an early age. The curriculum decisions also implicate the health of children. As discussed earlier, seventy-seven to ninety-four percent of all children with gender dysphoria reconcile their gender identity to their biological sex as they progress through puberty into young adulthood.¹⁷¹ When schools use curriculum emphasizing such gender confusion, to children this might mean they have a gender identity that does not match biological sex. Rather than emphasizing that such confusion is a natural part of becoming comfortable with being a male or female, more children opt to label themselves with a gender that is inconsistent with their biological sex and to become entrenched in that belief.¹⁷² One expert explained the impact this way:

It appears likely that being conditioned to believe you are the opposite sex creates ever-greater pressure to continue to present in this way, especially in young children. Once one has made the investment of coming out to friends and family, having teachers refer to you by a new name and pronoun, will it really be so easy to change back? Pediatric transition doctors in the Netherlands who first pioneered the use of puberty blockers in dysphoric children caution against social transition before puberty precisely because of the high desistance rates and the likelihood that social transition will encourage persistence.¹⁷³

Another author referred to the growing incidence of “rapid-onset gender dysphoria” among teen girls as the “new anorexia.”¹⁷⁴ Professor Littman explained that “[p]arents have described clusters of gender dysphoria outbreaks occurring in pre-existing friend groups with multiple or even all members of a friend group becoming gender dysphoric and transgender-identified in a pattern that seems statistically unlikely based on previous

verses that speak to the binary nature of sex); Southern Baptist Convention, *On Transgender Identity*, Resolution 2250 (2014), <http://www.sbc.net/resolutions/2250/on-transgender-identity>; *Transgender Identification Position Statement*, CHRISTIAN MEDICAL & DENTAL ASS'NS (Apr. 21, 2016), <https://cmda.org/wp-content/uploads/2018/04/Transgender.pdf>.

171. WPATH Standards of Care, *supra* note 23, at 11.

172. See Marchiano, *supra* note 1 (referring to the significant number of teens and tweens identifying as transgender as a “psychic epidemic”); see also *Creating Gender Inclusive Schools Trailer*, *supra* note 166.

173. Marchiano, *supra* note 1, at 351.

174. See Robert Tracinski, *Is Transgender the New Anorexia?*, FEDERALIST (Sept. 6, 2018), <http://thefederalist.com/2018/09/06/transgender-new-anorexia/> (reviewing a study published by Brown University Professor Lisa Littman).

research.”¹⁷⁵ The author pondered whether transgenderism is replacing anorexia among young girls as the new “maladaptive coping technique . . .”¹⁷⁶

Steering children toward adopting a gender identity different than their biological sex is, at best, a risky course to pursue. Not only are there many known medical and psychological health risks as they pursue a path that seeks to alter their sexual characteristics to align with their gender identity, but the dearth of research on the long-term consequences of puberty-suppressing and cross-gender hormones¹⁷⁷ should caution against so quickly encouraging children to explore a gender identity different than their biological sex. The locker room and restroom cases implicate privacy rights of those forced to undress in front of someone of the opposite sex.¹⁷⁸

The anti-bullying or anti-discrimination policies similarly seek to change how people perceive gender identity by using punishment for noncompliance with the accepted dogma. One situation arising with some frequency is how people must address someone who identifies as a gender different than his or her biological sex. In an Oregon case, a transgender schoolteacher won a \$60,000 settlement after co-workers allegedly failed to address a biological male teacher as “they.”¹⁷⁹ In the settlement, the school also agreed to build gender-neutral restrooms at all district schools.¹⁸⁰ An Indiana school teacher was forced to resign because he refused to refer to students by their chosen gender identity rather than their biological sex.¹⁸¹ Initially, he reached an agreement with the school where he would refer to all students by their last name rather than a pronoun.¹⁸² He was then told that he would have to use the student’s preferred pronoun.¹⁸³

175. *Id.*

176. *Id.*

177. See *supra* note 57 and accompanying text.

178. See *supra* notes 118-121 and accompanying text (discussing two recent cases and the courts’ rejection of privacy interests).

179. Bradford Richardson, *Transgender teacher wins \$60k settlement for co-workers’ improper gender pronouns*, WASH. POST (May 25, 2016), <https://www.washingtontimes.com/news/2016/may/25/transgender-teacher-awarded-60k-improper-pronouns/>.

180. *Id.*

181. Brianna Heldt, *Indiana Teacher Forced to Resign Over Refusal to Use Transgender Pronouns*, TOWNHALL (June 6, 2018), <https://townhall.com/tipsheet/briannaheldt/2018/06/06/indiana-teacher-forced-to-resign-over-refusal-to-use-transgender-pronouns-n2487919>.

182. *Id.*

183. *Id.*

In a Wisconsin case, a high school girl who identified as a boy sued the school district after the school she attended refused to permit her to use the boys' restroom.¹⁸⁴ The student alleged in her complaint that she would be humiliated if required to use the girls' restroom.¹⁸⁵ The school district reached an \$800,000 settlement for its "discrimination."¹⁸⁶ In a Florida case, a school disciplined a school teacher for refusing to monitor the boys' locker room as the middle school students undressed, because a girl, who identified as a boy, was using the boys' locker room.¹⁸⁷

The anti-bullying and anti-discrimination policies leave no room for disagreement by those who take the position that psychological intervention, rather than medical intervention, is needed for those whose gender identity does not align with their biological sex. In addition to harming the youth involved in the same way the curriculum issues do, this stifles the free speech of students and employees and tramples religious liberties of those who disagree by stamping out statements and actions inconsistent with the notion that people can change their sex.¹⁸⁸

184. Jacey Fortin, *Transgender Student's Discrimination Suit Is Settled for \$800,000*, N.Y. TIMES (Jan. 10, 2018), <https://www.nytimes.com/2018/01/10/us/transgender-wisconsin-school-lawsuit.html>.

185. *Id.*

186. *Id.*

187. *See Adams, supra* note 121.

188. Unfortunately, given Supreme Court precedent on claims arising under the Free Exercise Clause, it is difficult for a plaintiff to succeed on such a claim unless it can be asserted on the state or federal versions of the Religious Freedom Restoration Act (RFRA). *Emp't Div. v. Smith*, 494 U.S. 872, 890 (1990). In *Smith*, the Court held the "right of free exercise does not relieve an individual of the obligation to comply with a 'valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion proscribes (or proscribes).'" *Id.* at 879. After *Smith*, unless a claim falls within an exception to *Smith*, the law will only be subject to rational basis review. In an effort to reverse *Smith* and return to a strict scrutiny standard for Free Exercise claims, Congress enacted the RFRA in 1993. 42 U.S.C. § 2000bb-1. It provides that federal actions infringing the free exercise of religion are subject to strict scrutiny. Several states passed similar laws for claims arising out of state actions. *See State Religious Freedom Restoration Acts*, NAT'L CONFERENCE OF STATE LEGISLATURES (May 4, 2017), <http://www.ncsl.org/research/civil-and-criminal-justice/state-rfra-statutes.aspx> (identifying states with a RFRA). A recent Supreme Court decision offered an example of a situation that triggered strict scrutiny even under *Smith*. The Supreme Court struck down a decision of a Colorado Civil Rights Commission because the Commission's conduct demonstrated it did not give Masterpiece Cakeshop a neutral hearing process. *Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n*, 138 S. Ct. 1719, 1729-31 (2018). In essence, the application of the nondiscrimination was not a law of neutral and general applicability.

Controversies surrounding medical professionals involve two sides of the same coin: (1) prohibiting medical professionals from taking non-hormonal or surgical steps they believe would help a person struggling with gender identity issues, or (2) requiring medical professionals to perform medical procedures they believe violate their duty to “do no harm.” The claims concerning denial of care have included a hospital’s or physician’s refusal to (i) perform a double mastectomy on the healthy breasts of a female college student,¹⁸⁹ (ii) provide female hormones to a male,¹⁹⁰ (iii) perform a hysterectomy on a healthy uterus,¹⁹¹ and (iv) perform chest reconstruction surgery on a female who had her healthy breasts removed as part of her transition to adopting a male identity.¹⁹² Forcing medical professionals to perform these procedures violates the rights of conscience medical professionals hold to help heal their patients. In some situations, the policies also violate the free speech and free exercise rights of medical professionals.

Not only are doctors being sued for their refusal to surgically alter or remove healthy body parts, but licensed mental health professionals are increasingly being prohibited from counseling minors who are struggling with *unwanted* gender confusion.¹⁹³ Eleven states prohibit mental health providers from counseling patients to help them align their gender identity with their biological sex.¹⁹⁴ However, such professionals are permitted to counsel patients in a way that affirms their gender identity. These laws infringe free speech rights through the use of sanctions.¹⁹⁵ In the same way the school policies pose a risk of harm to youth by encouraging them to identify as transgender rather than to align their gender with their biological sex, these laws prohibit mental health providers from helping patients work

189. Amy Littlefield, *Meet the Trans Law Student Suing His Doctor for Canceling His Gender Affirming Surgery*, REWIRE (Jan. 3, 2018), <https://rewire.news/article/2018/01/03/meet-trans-law-student-suing-doctor-canceling-gender-affirmation-surgery/>.

190. *Lambda Legal Sues Doctor and Clinic for Denying Medical Care to Transgender Woman*, LAMBDA LEGAL (Apr. 16, 2014), https://www.lambdalegal.org/news/il_20140416_sues-doctor-clinic.

191. Claudi Buck & Sammy Caiola, *Transgender Patient Sues Dignity Health for Discrimination over Hysterectomy Denial*, SACRAMENTO BEE (Apr. 20, 2017), <https://www.sacbee.com/news/local/health-and-medicine/article145477264.html>.

192. *States Largest Healthcare Network Sued for Refusing to Provide Care to Transgender Man*, ACLU WASH. (Dec. 20, 2017), <https://www.aclu-wa.org/news/states-largest-healthcare-network-sued-refusing-provide-care-transgender-man>.

193. See *supra* note 2.

194. *Id.*

195. See *supra* notes 126-29 and accompanying text for a discussion of the laws prohibiting such counseling and the case law reviewing the bans.

through the unwanted feelings they are having. Instead, the counselors can only affirm existing gender identity, *even if the patient does not desire that gender identity*. Thus, youth who need help working through natural feelings during their formative years are denied that help.

The controversies surrounding business owners forced to accommodate a person's perceived gender identity mirror the legal issues that have arisen in the context of businesses forced to comply with sexual orientation nondiscrimination policies. For example, New York City recently passed an ordinance that requires employers, landlords, and other businesses to use the preferred name and pronoun of the employee, tenant, or client regardless of an individual's biological sex.¹⁹⁶ Noncompliance can be met with fines up to \$250,000.¹⁹⁷ In another case, the Sixth Circuit Court of Appeals held a funeral home discriminated against a funeral director who had been fired after informing the owner that he intended to dress as a woman while at work.¹⁹⁸ The owner of the funeral home explained he had been a Christian for more than sixty-five years, and it conflicted with his sincerely-held, religious beliefs to accommodate the man's request to dress as a woman as part of his gender transition. The owner explained he has always sought to run his business consistent with his religious beliefs, and he believed "a person's sex (whether male or female) is an immutable God-given gift and that people should not deny or attempt to change their sex."¹⁹⁹

A recent Canadian case arose when a man identifying as a female filed a human rights complaint against a local waxing spa that turned him away when he requested a bikini wax.²⁰⁰ The spa explained to the man that it could not perform the service because the spa's only employee who performed the services was a Muslim who held religious beliefs that precluded her from physical contact with males outside her family. Although the spa did have

196. Eugene Volokh, *You Can Be Fined for Not Calling People 'Ze' or 'Hir,' If That's the Pronoun That They Demand You Use*, VOLOKH CONSPIRACY OPINION: WASH. POST (May 17, 2016), https://www.washingtonpost.com/news/volokh-conspiracy/wp/2016/05/17/you-can-be-fined-for-not-calling-people-ze-or-hir-if-thats-the-pronoun-they-demand-that-you-use/?utm_term=.6e876b84a4da.

197. *Id.*

198. *Equal Emp't Opportunity Comm'n v. R.G. & G.R. Harris Funeral Homes*, 884 F.3d 560, 600 (6th Cir. 2018).

199. Robert Pear, *Transgender Workers Gain New Protection Under Court Ruling*, N.Y. TIMES (March 24, 2018), <https://www.nytimes.com/2018/03/24/us/politics/transgender-title-vii.html>.

200. Mary Caton, *Transgender Woman Files Human Rights Complaint Against Windsor Spa*, WINDSOR STAR (May 13, 2018), <https://windsorstar.com/news/local-news/transgender-woman-files-human-rights-complaint-against-windsor-spa>.

one employee who performed waxing services on men, that employee was on sick leave.²⁰¹ In late 2018, a nonprofit, evangelical organization in Austin, Texas filed suit seeking an injunction against a local Austin, Texas ordinance that would require it to hire or retain homosexuals or transgendered individuals.²⁰² The organization explained that those “lifestyles are contrary to the biblical, Judeo-Christian understandings of sexuality and gender.”²⁰³

In another case, a baker, Jack Phillips, refused to make a custom cake to celebrate a person’s gender transition.²⁰⁴ What makes this case unique is that the request to bake the cake came on the same day that Jack Phillips of Masterpiece Cakeshop won his case at the United States Supreme Court for refusing to bake a custom cake for a same-sex wedding ceremony.²⁰⁵ That Supreme Court decision reversed the decisions below, holding he engaged in sexual orientation discrimination when he refused to bake a custom cake for a same-sex wedding reception.²⁰⁶ During the entire litigation, which worked its way to the United States Supreme Court, Jack Phillips asserted that his strong, religious beliefs prevented him from baking a custom cake celebrating a marriage contrary to the Bible.²⁰⁷ Thus, when he was asked to bake the gender transition cake, he again refused based on his religious beliefs.²⁰⁸ In June 2018, the attorney who requested the custom cake filed a complaint with the Colorado Civil Rights Commission against Jack Phillips and Masterpiece Cakeshop.²⁰⁹

These business situations implicate First Amendment free speech and free exercise of religion issues. When businesses are compelled to refer to a person

201. *Id.*

202. Alexia Fernandez Campbell, *Texas Evangelical Groups Are Suing for the Right to Discriminate Against LGBTQ Workers*, VOX (Oct. 11, 2018), <https://www.vox.com/2018/10/11/17961620/texas-evangelical-lgbtq-discrimination-lawsuit>.

203. *Id.*

204. Scott Shackford, *Can a Baker Be Forced to Make a Transgender Celebration Cake?*, REASON.COM (Aug. 15, 2018), <https://reason.com/blog/2018/08/15/can-a-baker-be-forced-to-make-a-transgen>.

205. *Id.*

206. *Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm’n*, 138 S. Ct. 1719, 1723, 1732 (2018).

207. *Id.* at 1723-24.

208. Scott Shackford, *Can a Baker Be Forced to Make a Transgender Celebration Cake?*, REASON.COM (Aug. 15, 2018), <https://reason.com/blog/2018/08/15/can-a-baker-be-forced-to-make-a-transgen>.

209. *Id.*; see also James Doubek, *Colorado Baker Sues State, After Refusing to Make Cake for Transgender Woman* (Aug. 16, 2018), <https://www.npr.org/2018/08/16/639147599/colorado-baker-sues-state-again-after-refusing-to-make-cake-for-transgender-woman>.

by his or her gender identity rather than biological sex, it infringes the free speech rights of the business.²¹⁰ Similarly, forcing business owners to make business decisions that conflict with the sincerely-held religious beliefs of the owners of the entity raises free exercise of religion issues.²¹¹

In recent years, gender identity issues also have arisen in custody disputes. Specifically, the courts have grappled with whether it is in a child's best interests to be with a parent who refuses to accommodate a child's expressed gender identity. If the court accepts the notion that "sex" can be changed, then it views the refusal to accommodate a child's expressed gender as "harmful" to the child. In one case, parents lost custody of their teenage daughter because they refused to accommodate her desire to transition to a male.²¹² The court awarded custody to the grandparents who were willing to help the girl transition.²¹³ In a case that made news in November 2018, a mother asserted that her six-year-old son desired to be a girl and that it was child abuse for the father to refuse to accommodate the son's desires.²¹⁴ Not only is the allegation of child abuse in that context unfounded based on prevailing medical data, but there is a dispute in the case about whether the boy even has gender-identity issues—the father has presented evidence that the boy does not wish to identify as a girl.²¹⁵ How can courts properly decide these questions of harm, abuse, and custody when there is such a disagreement among medical professionals? Yet, they are forced to make decisions as the custody disputes come before them.

210. See Joe Martins, *The One Fixed Star in Higher Education: What Standard of Judicial Scrutiny Should Courts Apply to Compelled Curricular Speech in the Public University Classroom?*, 20 U. PA. J. CONST. L. 85, 89–97 (2017) (explaining the First Amendment compelled speech doctrine).

211. See *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2767, 2785 (2014) (United States Department of Health and Human Services (HHS) mandate required closely held corporations to provide health-insurance coverage for methods of contraception contrary to the sincerely held religious beliefs of the companies' owners is unconstitutional under the Religious Freedom Restoration Act).

212. Nicole Russell, *Ohio Judge Strips Custody from Parents for Not Letting Daughter Take Trans Hormones*, FEDERALIST, (Feb. 20, 2018), <http://thefederalist.com/2018/02/20/ohio-judge-strips-custody-parents-not-letting-daughter-taking-trans-hormones/>.

213. *Id.*

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

215. *Id.*

IV. AN ETHICALLY-APPROPRIATE RESPONSE TO GID

Whenever there are two competing interests at stake, someone is going to feel as though they are treated unfairly or discriminated against. Thus, unfortunately, the goal in the situations discussed above cannot be to find a way to accommodate both sides involved in the controversy in a way that meets all of their expectations.²¹⁶ Rather, the goal should be to properly weigh the interests involved. All too often, the countervailing interests of those who adopt the psychological approach are ignored or given very little weight. Indeed, if Chu's perspective is adopted and the medical and legal communities must always bow to the *desires* of a person to have medical interventions and legal accommodations, irrespective of harm to the patient, then significant rights will be infringed.

There are at least four reasons a person should *not* be forced to violate her speech, religious, scientific, or medical beliefs to accommodate another person's desires to live a life inconsistent with his biological sex. First, it is clear that, despite the lack of medical evidence supporting the efficacy of hormonal and medical interventions for GID, there remain medical professionals willing to provide such intervention. Thus, recognizing the right of medical professionals to refuse to provide hormone or medical interventions when doing so would violate their religious or conscience beliefs would *not* preclude individuals from still receiving those interventions.²¹⁷ The notion that medical interventions should be readily-available at every medical facility places undue burden on the interests of the person with GID.

Second, when minors are involved, the medical and legal professions should proceed cautiously. Even organizations that are at the forefront in advocating for the right of individuals to undergo medical interventions for GID acknowledge that most minors eventually align their gender identity with their biological sex.²¹⁸ As a result, the default approach when dealing with minors should be counseling rather than medical interventions. With respect to transgender students in schools, the schools admittedly have an interest in preventing students from actual harm through bullying, but the schools should not use the anti-bullying policies to teach children that gender

216. Cf. Rena M. Lindevaldsen, *The Fallacy of Neutrality from Beginning to End: The Battle Between Religious Liberties and Rights Based on Homosexual Conduct*, 4 Liberty U. L. Rev. 425 (2010) (explaining why in the clash between religious liberties and rights based on homosexual conduct there is no ability to reach an agreeable compromise).

217. It is beyond the scope of this Article to discuss whether such medical interventions should be prohibited as contrary to appropriate medical standards.

218. See *supra* notes 62-67 and accompanying text.

identity is fluid and to encourage in any way a student to adopt a gender identity inconsistent with his or her biological sex. Similarly, for privacy and safety concerns, students should not be forced to use restrooms or locker rooms with students of the opposite biological sex.

Third, the courts should proceed very cautiously in making custody decisions that weigh in favor of the parent wanting to proceed with medical interventions for a child with GID. Given the statistics, the primary focus for courts should be on whether the parents are willing to secure appropriate psychological counseling for the child to work through what are often natural feelings of gender confusion during the pre-pubertal and adolescent years.

Fourth, in the face of discrimination claims against business owners, courts should recognize that there will be other businesses to perform the services. In the cases that have made news over the past few years, the allegations have not rested on a total deprivation of requested services. Rather, the arguments have rested on the notion that the plaintiff wanted a cake from a specific baker,²¹⁹ a reception at a particular location,²²⁰ flowers from a specific florist,²²¹ or photos from a specific photographer.²²² The plaintiff had the opportunity to readily obtain the services from someone else, but insisted that the law force the business owner to violate his or her religious beliefs. In a nation birthed out of abuses toward the rights of religious freedom and conscience, the courts should be hesitant to so readily disregard or minimize the claims of these business owners.

V. CONCLUSION

In the context of privacy and liberty interests, the United States Supreme Court precedent has recognized an ever-expanding notion of individual autonomy. Lest autonomy trample every other right guaranteed in the Constitution, however, there must be limits. We should proceed cautiously in the interests of truly helping those individuals who believe their biological-

219. See, e.g., *Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n*, 138 S. Ct. 1719, 1724 (2018).

220. Katie Zezima, *Couple Sues a Vermont Inn for Rejecting Gay Wedding*, NEW YORK TIMES (July 19, 2011), <https://www.nytimes.com/2011/07/20/us/20vermont.html>.

221. The Associated Press, *Washington Supreme Court Rules Against Florist in Same-Sex Wedding Case*, CBS NEWS, Feb. 16, 2017, available at <https://www.cbsnews.com/news/washington-supreme-court-florist-same-sex-wedding-case/>.

222. John Fund, *Winnowing Down Religious Liberty*, NATIONAL REVIEW (Aug. 13, 2013), <https://www.nationalreview.com/corner/winnowing-down-religious-liberty-john-fund/>.

sex characteristics are a mistake and desire to remove healthy body parts to align their physical characteristics with their psychological beliefs.

From a legal perspective, the courts must recognize the significant fundamental liberty interests involved in forcing parents, medical professionals, employees, students, and business owners to accommodate a person's gender identity. All too often, courts afford little weight to those who hold religious, scientific, or other conscience-based beliefs that sex is an immutable characteristic.