No. 23-477

IN THE

Supreme Court of the United States

UNITED STATES OF AMERICA,

Petitioner,

—v.—

JONATHAN THOMAS SKRMETTI, ATTORNEY GENERAL AND REPORTER FOR TENNESSEE, ET AL.,

Respondents,

—and—

L.W., BY AND THROUGH HER PARENTS AND NEXT FRIENDS, SAMANTHA WILLIAMS AND BRIAN WILLIAMS, ET AL.,

Respondents in Support of Petitioner.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR *AMICUS CURIAE* interACT: ADVOCATES FOR INTERSEX YOUTH IN SUPPORT OF PETITIONER

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INTEREST OF *AMICUS CURIAE* [1]

Amicus interACT: Advocates for Intersex Youth is a nonprofit organization that employs legal and policy advocacy to protect the rights of children with innate variations in their physical sex characteristics, sometimes called intersex. Founded in 2006 under the name Advocates for Informed Choice, it is the oldest and largest organization in the country dedicated to safeguarding the bodily autonomy and self-determination of youth with intersex variations. Since its inception, interACT has worked to end harmful, non-consensual medical interventions on intersex infants and young children, while also advocating for access to necessary care.

Amicus is compelled to expose the statute at issue here (Tennessee's SB 1, codified at Tenn. Code Ann. § 68-33-101) as irredeemably irrational through a discussion of the statute's "intersex exception." That provision expressly permits unnecessary and irreversible genital surgeries on *non-consenting* infants and young children when performed to make their bodies conform to societal expectations about sex and gender, even as the statute prohibits the very same procedures—and far less invasive ones, like puberty blockers and hormone treatments—when transgender teenagers seek them *consensually* to relieve severe psychological distress. Besides perpetuating severe harm against intersex children in Tennessee, SB 1's intersex exception

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[1] No party's counsel authored this brief in whole or in part. No party, no party's counsel, nor any person other than *amicus*, its members, and/or its counsel, contributed money for the preparation or submission of this brief.

lays bare the irrational double-standard at the statute's heart and exposes its purported nondiscriminatory justifications as pretextual.

SUMMARY OF ARGUMENT

Intersex people have a range of innate variations in physical characteristics—*e.g.*, chromosomes, genitals, internal reproductive organs, and hormone function—that cause their bodies to develop in ways that differ from binary stereotypes associated with male or female bodies. Having an intersex variation is not the same as being transgender: a transgender person has a gender identity that differs from the sex category assigned to them at birth. While a transgender person may happen to have an intersex variation, most transgender people were born with physical sex characteristics that did not depart from binary stereotypes regarding infants' bodies.

Nonetheless, transgender and intersex communities share many similar experiences, struggles, and needs. Both transgender and intersex individuals frequently encounter social and medical scrutiny, skepticism, and discrimination because of the challenge they pose to societal assumptions about sex and gender—such as the understanding of sex as strictly binary, or of gender as synonymous with one's bodily characteristics as they appeared at birth. These notions fuel the pathologization of both groups, resulting in severe harm to their health, autonomy, and well-being.

Although superficially divergent, the typical medical experiences of both communities stem from the same stereotypical beliefs about what it means to be male or female, and who is eligible for membership in

either category. Transgender people face barriers to accessing the gender-affirming care that they want and need, while intersex children are subjected to irreversible medical interventions irrespective of their own wishes and needs. For both communities, the impact is that vulnerable individuals are denied the ability to make the deeply personal medical decisions that are right for them.

These dynamics are on full display in Tennessee's SB 1. The statute outlaws less invasive treatments for *consenting adolescents* when conceptualized as gender-affirming care, but expressly permits a higher-impact tier of intervention (*i.e.*, genital surgery) on *non-consenting infants* when intended to conform their bodies to stereotypes of what male and female bodies should look like. In so doing, SB 1 abrogates self-determination and autonomy for both transgender and intersex minors.

SB 1's intersex exception belies all of Tennessee's claimed justifications for the law and demonstrates its utter irrationality. SB 1 purports to protect minors' fertility and mental health, while approving surgeries on intersex infants that cause sterility and lifelong psychological harm. SB 1 purports to adopt a "wait and see" approach that postpones even *reversible* medical interventions until adulthood, even as it endorses *irreversible* surgeries on intersex minors in infancy. By endorsing nonconsensual and harmful interventions on vulnerable intersex infants, SB 1's intersex exception threatens, rather than protects, the "integrity of the medical profession." SB 1 purports to encourage minors to "appreciate" their natal sex characteristics, but

only if those natal characteristics fit the state's presumptions about what male and female bodies should look like. In the end, the only possible explanation for SB 1's divergent treatment of transgender and intersex minors is that the statute is *specifically intended* to enforce overbroad expectations about how male and female bodies should develop, appear, and function. Enforcing sex stereotypes for its own sake is plainly illegitimate as a state interest, spelling SB 1's doom under any level of Equal Protection scrutiny.

ARGUMENT

I. LIKE TRANSGENDER PEOPLE, INTERSEX PEOPLE DEPART FROM, AND ARE SEVERELY HARMED BY, STEREOTYPICAL EXPECTATIONS ABOUT SEX.

A. Intersex People Have Innate Variations in Physical Sex Characteristics That Differ From Stereotypical Expectations About Male and Female Bodies.

Intersex variations (which SB 1 refers to as "disorder[s] of sex development"[2]) encompass a wide range of physical sex-related traits—pertaining to the external genitals, internal reproductive organs, chromosomes, and/or hormone production and response—that

[2] The phrase "disorder of sex development" is largely considered pathologizing by the intersex community. *Amicus* will occasionally use it due to its appearance in SB 1, but will primarily use "intersex variation" and "variation in sex characteristics." *Amicus* views the three terms as coextensive.

differ from typical binary notions of male and female bodies. Intersex is not usually considered a "third" sex category *per se*, but rather represents the wide range within which innate, physical sex-related characteristics can exist.

Some individuals' intersex variations are visually apparent or otherwise discovered at birth. In other instances—as where the variations are internal rather than external, or genetic with a delayed presentation—intersex variations may not be discovered until later in life (if ever). Estimates suggest that about 2% of babies are born with intersex variations, yet the true figure is likely higher.[3]

Intersex traits originate from variations in the embryonic development process. A fertilized egg, which divides to form an embryo, usually has two sex chromosomes: XX or XY. For the first few weeks of gestation, XX and XY embryos look the same: both possess undifferentiated gonadal tissue, Müllerian and Wolffian ducts, a genital tubercle, and labioscrotal folds. These structures later develop in different ways depending on genetic and hormonal factors. Typically, for an embryo with XY chromosomes, the gonads become testes; the Müllerian ducts regress as the Wolffian ducts develop into the vas deferens, epididymis, and seminal vesicles; the genital tubercle becomes a penis; and the labioscrotal folds fuse and form a scrotum. For an embryo with XX chromosomes, typically the gonads become ovaries; the Wolffian ducts regress

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[3] Melanie Blackless et al., *How Sexually Dimorphic Are We? Review and Synthesis*, 12 A. J. HUM. BIOL. 151, 151 (2000).

as the Müllerian ducts develop into the uterus, fallopian tubes, and upper portion of the vagina; the genital tubercle becomes a clitoris; and the labioscrotal folds develop into the outer labia. At puberty, hormones secreted by the testes or ovaries cause the expression of secondary sex characteristics such as breast development, facial and body hair, and depth of voice.

There are many ways in which this "typical" process can vary, affecting how bodies develop, appear, and function.[4] For example, some intersex variations describe observable differences in one's genitals that may have a range of underlying genetic or hormonal causes:

- **Hypospadias** refers to a urinary opening located somewhere other than the tip of the penis, which may be on the underside and further toward the perineum. Hypospadias can often be a feature of other variations discussed below, including Partial Androgen Insensitivity and 5-alpha Reductase Deficiency.

- **Clitoromegaly**, sometimes described as genital "virilization," refers to a clitoral size that is considered larger than typical. Clitoromegaly can be associated with other variations discussed below, such as Congenital Adrenal Hyperplasia and Aromatase Deficiency.

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[4] *Intersex Variations Glossary*, INTERACT, 2022, at 3, https://tinyurl.com/3zwv3943.

Other variations primarily affect the internal reproductive organs (other than gonads) and are unlikely to be outwardly apparent:

- In **Mayer-Rokitansky-Küster-Hauser Syndrome (MRKH)**, the Müllerian ducts do not develop in the typical way. People with MRKH have XX chromosomes and may be born with no vagina or a vagina that is shallower than typical, and may have a partial uterus or no uterus. They usually have ovaries that produce typical levels of estrogen, and develop typical secondary sex characteristics at puberty.

- **Persistent Müllerian Duct Syndrome (PMDS)** occurs when the Müllerian ducts—which typically break down in a fetus with XY chromosomes—remain and begin to develop as they would in a fetus with XX chromosomes. People with PMDS have XY chromosomes, a penis and testes, and also may have a uterus, fallopian tubes, and/or upper vaginal canal. PMDS is usually not noticed at birth, but may be discovered later due to suspicious abdominal pain or bleeding from the urethra.

Other variations primarily affect hormone production, which in turn can affect genital appearance and/or secondary sex characteristics:

- **Congenital Adrenal Hyperplasia (CAH)** affects the enzymes responsible for the adrenal glands' hormone production. People with CAH and XX chromosomes may naturally produce higher-than-typical levels of testosterone,

which sometimes results in a larger-than-typical clitoris and the fusion of the urethra and vaginal canal to form a single opening. They may also develop body and facial hair or increased muscle mass during childhood or puberty.

- **Swyer Syndrome**, which affects people with XY chromosomes, is a form of "complete gonadal dysgenesis," meaning that a person's gonadal tissue does not develop into testes or ovaries and does not produce hormones. With no testosterone production, their body does not develop a penis, and usually develops a vulva and vagina. They also do not produce anti-Müllerian hormone (AMH), and therefore often develop a uterus and fallopian tubes as well. They usually will not start puberty spontaneously or begin menstruating, but some do menstruate (without ovulating) if they receive estrogen therapy.

- People with **"Ovotesticular DSD"** are born with both ovarian and testicular tissue: either one testis and one ovary, or one or more ovotestes (a single gonad made up of ovarian and testicular cells together). How their genitals and secondary sex characteristics develop will depend partially on the levels of estrogen and testosterone that their bodies make, which can vary. Sometimes a person with an ovary and a testis or with ovotestes can produce both viable sperm and viable eggs.

In other variations, hormone production is typical, but the body responds differently to those hormones or

cannot "sense" or convert them into the typically usable forms:

- People with **Androgen Insensitivity Syndrome (AIS)** have XY chromosomes and testes, and either a diminished or no response to the testosterone their bodies produce. People with *complete* AIS are born with a vulva and vagina, and their testes are undescended. In adolescence, their body naturally converts their testosterone to estrogen (a process known as aromatization), and they develop breasts and other features associated with typical estrogen puberty. People with *partial* AIS have some response to testosterone and may be born with a shallow vaginal opening or a phallus that may be perceived as a large clitoris or a small penis. Their testes may be partially descended. In adolescence, they may develop some features associated with typical testosterone puberty and others associated with typical estrogen puberty.

- In **Aromatase Deficiency**, a person with XX chromosomes does not have the enzyme responsible for converting androgens into estrogen and will accordingly experience "heightened" levels of testosterone and lower levels of estrogen. At birth, they may have a larger-than-typical clitoris and their labia may be fused (resembling the appearance of a scrotum). At puberty, they may not menstruate or develop breasts, and may develop secondary sex characteristics such as facial hair and muscle mass.

- People with **5-alpha Reductase Deficiency (5-ARD)** have XY chromosomes and testes that

> produce typical levels of testosterone, but do not have the enzyme that converts testosterone to the more powerful androgen dihydrotestosterone (DHT). People with 5-ARD often have noticeable genital differences at birth, such as a smaller-than-typical penis, or genitals that do not look like either a typical penis or vulva. Others will have a typical-looking vulva and will be assigned female at birth (possibly without their variation being noticed). In adolescence, people with 5-ARD often develop some features associated with typical testosterone puberty, such as increased muscle mass and depth of voice, and may experience genital growth.

Variations originating in a person's chromosomes (or chromosome-linked genes) can cause differences in how a person's gonads or other internal organs develop, how their hormones function, or how their body looks:

- People with **Klinefelter Syndrome** develop with an extra copy of the X chromosome, resulting in a 47XXY pattern. They may produce lower amounts of testosterone, start puberty later than typical (or require hormone therapy to initiate puberty), or develop breast tissue.

- In **De la Chapelle Syndrome**, also known as "XX Male Syndrome," a particular gene typically seen on Y chromosomes (known as the SRY gene) translocates to an X chromosome, causing a person with XX chromosomes to develop genitals and internal organs as someone with XY chromosomes typically would. They will be born

with a penis and testes (which might be undescended) and are often infertile. In adolescence, they may experience breast growth, and may not develop the characteristics usually associated with typical testosterone puberty.

- In **Turner Syndrome**, a person is born with a 45X chromosome pattern instead of 46XX, or with a mosaic combination of 45X and other chromosome patterns. People with 45X/46XX chromosomes may notice fewer signs as they are more likely to go through a typical estrogen puberty and to start menstruating. People with 45X/46XY chromosomes may be born with testicular tissue (and often go through a typical testosterone puberty), and may have a typical-appearing penis/scrotum or vulva, or may have genital differences such as hypospadias.

- Due to random differences early in embryonic development, people with **mosaicism** or **chimerism** have different chromosome patterns in some cells of their body than in others (*e.g.*, some cells with XX chromosomes and others with XY, or some with XY and some with XXY). Both mosaicism and chimerism can cause variations in one's genitals, gonads and other reproductive structures, hormone function, secondary sex characteristics, and fertility—for example, having combinations of internal structures like a fallopian tube along with a vas deferens, or developing pubertal changes that are not expected for the sex they were assigned.

The vast majority of intersex children receive a social gender assignment of either male or female at

birth. As with non-intersex children, this assignment is typically made based on the appearance of their visible sex characteristics. If a child is born with noticeable genital variation, additional factors—such as chromosomes, internal organs, and hormonal or genetic characteristics—may be investigated and considered.[5] When determining which sex category to assign, experts' opinions may differ as to which factors should be given the most weight, and individual providers could each make opposite recommendations for the most appropriate sex assignment for a given intersex child.[6]

Critically, being intersex (or having intersex variations) is not the same as being transgender or non-binary. "Transgender" describes a person whose gender identity differs from the sex category assigned to them at birth. "Non-binary" describes a person with a gender identity outside the traditional binary categories of male and female. While a transgender or non-binary person may happen to have a physical intersex variation, most transgender and non-binary people are born with physical sex characteristics that do not depart from binary stereotypes regarding infants' bodies. By the same token, people with intersex variations are not necessarily transgender or non-binary. Many (but not all) intersex people have a binary, cisgender identity, meaning that they identify with the male or female sex designation they were given at birth.

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[5] Peter Lee et al., *Consensus Statement on the Management of Intersex Disorders*, 118 PEDIATR. e488 (2006).

[6] *See Zzyym v. Pompeo*, 341 F. Supp. 3d 1248, 1258 (D. Colo. 2018) (noting "a lack of consensus as to how individuals born intersex could be classified as either 'male' or 'female'").

As intersex children grow into adolescence and adulthood, they share the same need as transgender adolescents and adults for competent, affirming medical care that meets their treatment needs. Some intersex adolescents and adults seek and access gender-affirming care to align their body with their own wishes and needs, while others have treatment needs specific to their intersex variation, and still others have no treatment needs at all.

B. Intersex Infants Experience Coercive Sex Assignment and Surgery, Causing Lasting Physical and Psychological Harm.

Intersex children have long faced nonconsensual surgical interventions to enforce conformity with a binary sex assignment of either male or female. These surgeries, which include reshaping or removal of genital tissue and internal reproductive organs, are usually carried out before age two. Such surgeries continue today in hospitals across the United States.[7]

In extremely rare situations, an intersex variation presents a genuine need for emergent surgical intervention—*e.g.*, when a urinary opening is absent at birth.[8] But in the overwhelming majority of cases, these surgeries respond not to an actual medical need,

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[7] N. J. Nokoff et al., *Prospective Assessment of Cosmesis Before and After Genital Surgery*, J. PEDIATR. UROL. E 13(1), No. 13, 28.e1 (2017).

[8] Melissa Gardner & David E. Sandberg, *Navigating Surgical Decision Making in Disorders of Sex Development (DSD)*, FRONTIERS IN PEDIATR. 6, No. 339, Nov. 19, 2018, https://tinyurl.com/3tu6abun.

but rather to parents' and surgeons' discomfort and assumptions regarding the child's future gender identity, gendered behavior, and even sexuality. A systematic review of more than 70 primary studies reporting on childhood intersex surgeries analyzed the rationales offered to justify the practice. In 20% of studies, the rationales included the parents' desire that surgery be performed and/or the prevention of parental distress.[9] In 31% of studies, cosmetic rationales were offered, such as surgeons' or parents' judgment that the infant's genital appearance was unacceptable.[10] In 39% of studies, the rationales for surgery included aligning the infant's body with the sex assignment chosen by parents and doctors[11]—*e.g.*, by performing clitoral "reduction" surgery to create a "phenotypical appearance that resembles the assigned gender [female]."[12] Notably, none of these are medical factors that affect an infant's present health. And, strikingly, 39% of the studies provided *no rationale* for the surgeries performed.[13]

Operating in infancy without the patient's consent violates self-determination and carries unique risks—including the risk that infant surgery will enforce a sex assignment that will not match the individual's gender

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[9] Luke Muschialli et al., *Perspectives on conducting "sex-normalising" intersex surgeries conducted in infancy: A systematic review*, PLOS GLOB. PUBLIC HEALTH 4(8), No. e0003568, Aug. 28, 2024, at 28.

[10] *Id*. at 23. *See also* Martin Kaefer & Richard C. Rink, *Treatment of the Enlarged Clitoris*, FRONT PEDIATR. 5, No. 125, Aug. 27, 2017.

[11] Muschialli et al., *supra* note 9, at 24, 28-29.

[12] Kaefer & Rink, *supra* note 10, at 1-2.

[13] Muschialli et al., *supra* note 9, at 28.

identity. Medical providers recognize that "future gender identity cannot be predicted for any infant with absolute certainty."[14] Indeed, that is an understatement: for infants with many intersex variations, the initial sex assignment will prove incorrect from 10% to more than 60% of the time.[15] Since intersex infants can be raised as boys or as girls without any nonconsensual surgery, there is no reason to risk this outcome.

Often, surgeons have relied upon the size of the phallus/clitoris at birth as wholly determinative of an intersex child's sex assignment.[16] This is not because this trait has any established link to a person's gender identity, but strictly for surgical convenience: it is easier to reduce a phallus/clitoris deemed "too large" to make it look like a "typical" clitoris than it is to surgically enlarge one that is "too small" to make it look like a "typical" penis. For this reason, infants with intersex variations resulting in a larger-than-typical clitoris ($\geq$ 1 cm) or a smaller-than-typical penis ($<$ 2.5 cm) are generally assigned female—and accordingly, subjected to clitoral reduction, often in addition to vaginoplasty (surgical creation or enlargement of a vaginal opening)

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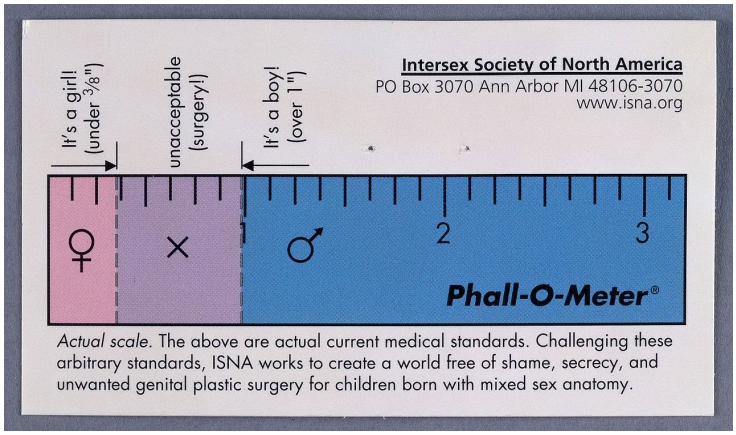
[14] Emilie K. Johnson et al., *Differences of Sex Development: Current Issues and Controversies*, 50 UROL. CLIN. N. AM. 433, 438 (2023).

[15] Paulo Sampaio Furtado et al., *Gender dysphoria associated with disorders of sex development*, NAT. REV. UROL., Oct. 9, 2012, at 2-3 (reporting 10% for Congenital Adrenal Hyperplasia, 20% for Partial Androgen Insensitivity, and 63% for 5-alpha Reductase Deficiency).

[16] *See* William G. Reiner, *Psychosexual development in genetic males assigned female: the cloacal exstrophy experience*, 13 CHILD ADOLESC. PSYCHIATR. CLIN. OF N. AM. 657, 658-59 (2004); Muschialli et al., *supra* note 9, at 37-38.

and/or orchiectomy (removal of testes). The Intersex Society of North America created the below image (satirically dubbed the "Phall-O-Meter")[17] to visualize these crude standards, revealing how infants' bodies falling between these two arbitrary measurements were deemed in need of surgical "correction."



While the sex-assignment guidelines for some intersex variations are shifting away from a purely genital focus, the practice of giving undue weight to phallic size in sex-assignment decisions persists.[18] Sometimes the projected future ability to "achieve penetrative intercourse" factors into the choice of sex assignment;[19] correspondingly, some surgeries on infants preemptively construct "functional genital anatomy"

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[17] *The "Phall-O-Meter,"* INTERSEX HUMAN RIGHTS AUSTRL. (Oct. 26, 2014), https://tinyurl.com/2bjanw5r.

[18] *See* Peter Lee et al., *Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care*, 85 HORM. RES. PAEDIATR. 158, 164-65 (2016).

[19] *See, e.g., id.* at 169.

for penetrative sex "as a male or a female," which is considered gender-conforming behavior.[20] Other times, infant surgery attempts to steer the child's gender identity development in the direction "preferred" by parents or doctors, following the discriminatory (and unproven) belief that engineering an infant's sex characteristics to appear "typical" will promote "acceptance" and "retention" of the initial sex assignment and prevent the child from later identifying a different way.[21] In these cases, stereotypical social preferences for children to develop into cisgender and heterosexual adults lead to "brute force" attempts to engineer these identities through infant surgery. The ultimate goal is gender conformity, and erasing or "correcting" the child's traits through infant surgery advances it.[22]

The consequences of these nonconsensual infant surgeries can include loss of fertility, loss of sexual

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[20] Pierre D.E. Mouriquand et al., *Surgery in disorders of sex development (DSD) with a gender issue: If (why), when, and how?* 12 J. PEDIATR. UROL. 139, 141 (2016); Kaefer & Rink, *supra* note 10, at 2; Muschialli et al., *supra* note 9, at 23.

[21] *See, e.g.*, Muschialli et al., *supra* note 9, at 8 (reviewed study recommending that if "the female gender is proposed…a surgical correction should be performed as early as possible to permit the development of a good gender identity").

[22] *See, e.g.,* Heather M. Byers et al., *Unexpected Ethical Dilemmas in Sex Assignment in 46,XY DSD due to 5-alpha Reductase Type 2 Deficiency*, AM. J. OF MED. GEN. 175(2), May 25, 2017, https://tinyurl.com/2hmacrf4 (intersex infants underwent orchiectomy once given a female sex assignment because parents were "distressed" by "the ambiguity [the gonads] represented"); Mouriquand et al., *supra* note 20, at 144 ("It remains unclear how much harm non-corrected unusual genitalia may cause for an individual and the family.").

sensation and function, and urinary incontinence.[23] A Human Rights Watch report found almost ubiquitous trauma among the intersex people interviewed, frequently described as relating to non-consensual childhood surgery and the surrounding secrecy and shame.[24] Studies of intersex patients have found statistically significant correlations between suicidal ideation and a history of gonadectomy,[25] and between a history of non-consensual surgery and delaying seeking necessary healthcare as an adult due to high levels of "medical mistrust."[26] For all the harm they entail, there is no persuasive evidence that these nonconsensual infant surgeries provide any benefits at all, other than the "benefit" of conforming a child's body to stereotypical expectations.

The harms of these surgeries are vividly illustrated by the case of David Reimer. In 1967, when Da-

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[23] Human Rights Watch, *"I Want to be Like Nature Made Me": Medically Unnecessary Surgeries on Intersex Children in the US* (July 25, 2017), https://tinyurl.com/42z46wur.

[24] *Id.* at 59-63.

[25] Katinka Schweizer et al., *Coping with Diverse Sex Development: Treatment Experiences and Psychosocial Support During Childhood and Adolescence and Adult Well-Being*, 42 J. OF PEDIATR. PSYCH. 504, 513-14 (2017); Karsten Schutzmann et al., *Psychological Distress, Self-Harming Behavior, and Suicidal Tendencies in Adults with Disorders of Sex Development*, 38 ARCH. SEX. BEHAV. 16 (2007).

[26] Jeremy C. Wang et al., *Medical Mistrust Mediates the Relationship Between Nonconsensual Intersex Surgery and Healthcare Avoidance Among Intersex Adults*, 57 ANNALS OF BEHAV. MED. 1024, 1027 (2023).

vid was seven months old, his penis was destroyed during a botched circumcision.[27] David was referred to Dr. John Money of Johns Hopkins Hospital, who believed that he could no longer be raised as a boy without stereotype-conforming genitals. Dr. Money thus made the non-evidence-based decision to change David's gender of rearing to female, and he cemented this reassignment with surgery to remove David's testes and create a vulva before David had any conscious awareness of his own gender identity—let alone the ability to consent. David Reimer's life ended in suicide at the age of 38.[28] While David was not intersex, Dr. Money's choice to enforce an arbitrary sex assignment through irreversible surgery on a patient too young to even speak became the blueprint for the medical management of children with "disorders of sex development" to this day.[29] Countless intersex people have suffered similarly traumatizing and harmful interventions in infancy without their knowledge or consent.

Today, these nonconsensual surgical interventions are widely condemned by the intersex community and have been decried by prominent human rights groups including the United Nations, the World Health Organization, and Amnesty International.[30] They have

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[27] Hazel Glenn Beh & Milton Diamond, *An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants with Ambiguous Genitalia?* 7 MICH. J. GENDER L. 1, 7 (2000).

[28] *See* Human Rights Watch, *supra* note 23, at 21-22 (citing John Colapinto, *As Nature Made Him: The Boy Who Was Raised as a Girl* (New York: Harper Collins, 2000)).

[29] Beh & Diamond, *supra* note 27.

[30] Juan E. Méndez (Special Rapporteur), *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading*

likewise been criticized as inhumane by various federal agencies,[31] the American Bar Association,[32] and a growing number of medical associations.[33] Three former U.S. Surgeons General urged in 2017 that "[t]hose whose oath or conscience says 'do no harm' should heed the simple fact that, to date, research does not support the practice of cosmetic infant genitoplasty."[34] Yet, as *amicus* discusses below, the intersex exception of Tennessee's SB 1 (and other similar, recently enacted laws) goes in precisely the opposite direction, giving these practices official state sanction for the first time.

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treatment or punishment ¶ 77, UN Doc. A/HRC/22/53 (2013), https://tinyurl.com/46j3atm8; WHO, *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement* (OHCHR, UN WOMEN, UNAIDS, UNDP, UNFPA, UNICEF AND WHO) (2014), https://tinyurl.com/24nb462t; Amnesty Int'l, *Amnesty International Policy Statement on the Rights of Intersex Individuals* (2013), https://tinyurl.com/578kp4vj.

[31] *See, e.g.,* U.S. Dep't of State, *On Intersex Awareness Day* (Oct. 26, 2023), https://tinyurl.com/446wu59v (noting intersex people "are subjected to medically unnecessary surgeries…which can cause lifelong negative physical and emotional consequences [and] are a medical form of so-called conversion therapy practices in that they seek to physically 'convert' Intersex children into non-Intersex children").

[32] Am. Bar Ass'n, *Midyear Meeting 2023 - House of Delegates Resolution 511* (2023), https://tinyurl.com/5n9ajbbk.

[33] *See, e.g.*, Am. Acad. of Family Physicians, *Genital Surgeries in Intersex Children* (July 2018), https://tinyurl.com/24e4ue97; GLMA: Health Professionals Advancing LGBTQ Equality, *Medical and Surgical Intervention of Patients with Differences in Sex Development* (Oct. 3, 2016), https://tinyurl.com/ycr84bh2.

[34] M. Joycelyn Elders et al., *Re-Thinking Genital Surgeries on Intersex Infants*, PALM CTR., June 2017, at 3, https://tinyurl.com/4x3ansn2.

II. THE INTERSEX EXCEPTION SHOWS THAT SB 1 LACKS ANY LEGITIMATE JUSTIFICATION, AND THAT ITS SOLE PURPOSE IS ENFORCING CONFORMITY WITH SEX-BASED STEREOTYPES.

SB 1 *prohibits* certain medical procedures when undertaken for the purpose of "enabl[ing] a minor to identify with, or live as, a purported identity inconsistent with the minor's sex" or "treat[ing] purported discomfort or distress from a discordance between the minor's sex and asserted identity."[35] But the very same procedures are expressly *permitted* if the purpose instead "is to treat a physical or chemical abnormality present in a minor that is inconsistent with the normal development of a human being of the minor's sex . . . including abnormalities caused by a medically verifiable disorder of sex development."[36]

The inclusion of an intersex exception in SB 1 (as well as every similar law enacted to date)[37] is an irref-

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[35] Tenn. Code Ann. § 68-33-103(a)(1).

[36] Tenn. Code Ann. § 68-33-102(1).

[37] All of the 20 state laws enacted in 2023 restricting access to gender-affirming care, as well as at least 81% of similar bills introduced between 2020 to April 2023, contained an exception allowing the performance of the targeted procedures on children with "disorders of sex development." These include Arkansas SB 199, Florida SB 254, Georgia SB 140, Idaho HB 71, Indiana SB 480, Iowa SB 538, Kentucky SB 150, Louisiana HB 648, Missouri SB 49, Mississippi HB 1125, Montana SB 99, Nebraska LB 574, North Carolina HB 808, North Dakota HB 1254, Oklahoma SB 613, South Dakota HB 1080, Tennessee SB 1, Texas SB 14, Utah SB 16, and West Virginia HB 2007. *See also LGBTQ Policy Spotlight: Bans on Medical Care for Transgender People*, MOVEMENT

utable "tell" of the statute's irrationality. For each justification that Tennessee could invoke to support SB 1's categorical ban on gender-affirming care, there is no explanation for expressly permitting the same interventions when performed non-consensually on infants with intersex variations. SB 1's intersex exception reveals that the law's *only* purpose is enforcing compliance with stereotypical expectations about male and female bodies *for its own sake*. Such a purpose is illegitimate under any standard of scrutiny.

A. The Intersex Exception Exposes SB 1's Fundamental Irrationality.

As SB 1's intersex exception makes clear, Tennessee has no issue with performing the targeted medical interventions on minors, *per se*. Their legality turns entirely on whether they are being offered to make a minor *conform to* societal expectations about members of their sex assigned at birth, or *depart from* those expectations. Thus, the very same intervention—*e.g.*, testosterone injections to deepen one's voice—is lawful if the minor recipient was assigned male at birth, but not if the minor was assigned female. That is sex discrimination on its face: the legality of the intervention is based entirely on the sex assigned on birth.

But SB 1 is not just discriminatory; it is fundamentally irrational. First, consider the issue of consent. SB 1 categorically *bars* all the targeted interventions for transgender minors, even if they are just days shy of 18 years old, are unquestionably capable of providing informed consent, and share their treating physicians'

ADV. PROJ. (Apr. 2023), https://tinyurl.com/4weus9sr (analyzing bills introduced between 2020 and April 2023).

strong belief that the intervention is critical to their health and well-being. At the same time, SB 1 categorically *permits* the targeted interventions when the patients are intersex minors, even if they are mere infants and incapable of understanding what is happening to them, let alone consenting.

Second, consider the degree of invasiveness and reversibility of the targeted interventions. Gender-affirming surgery is incredibly rare for transgender minors. The most common forms of gender-affirming medical care for transgender minors are puberty blockers, which are readily reversible, and hormone therapy, which is partially reversible.[38] On the other hand, invasive and irreversible genital surgery on infants and very young children with intersex variations *is* current practice at many children's hospitals across the United States. SB 1 categorically prohibits *all* forms of gender-affirming care when offered to transgender minors—even those that are reversible and relatively noninvasive. At the same time, SB 1 categorically permits *all* so-called "normalizing" treatments when performed on intersex minors—even those that are highly invasive and unquestionably irreversible, like phalloplasty and orchiectomy.

In other words, Tennessee endorses a higher-impact tier of intervention (*i.e.*, genital surgery) on a much younger population of minors who are unable to provide consent, while restricting a lower-impact tier of intervention for an older population of minors who can and do provide informed consent. This puts the lie

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[38] Expert Decl. of Deanna Adkins at 12-13, *L.W. v. Skrmetti*, No. 3:23-cv-00376 (M.D. Tenn. Apr. 17, 2023), https://tinyurl.com/mr357xfv.

to any notion that SB 1 is intended to protect minors by deferring supposedly dangerous or unproven medical procedures or postponing irreversible changes to their sex characteristics. Tennessee has no problem exposing even the youngest and most vulnerable minors to those purported risks and consequences if the purpose is to make their bodies look more "sex-typical," rather than less.

B. Tennessee's Stated Bases for SB 1 Are Clearly Pretextual.

Tennessee and its allies have offered a variety of purported nondiscriminatory explanations for SB 1. None holds water: the statute's intersex exception is "so far removed from these particular justifications" that it is "impossible to credit them." *Romer v. Evans*, 517 U.S. 620, 635 (1996).

Fertility. Concerns over minors' fertility feature prominently among the purported justifications for SB 1. However, as Plaintiffs explained below, "[g]ender-affirming medical care is not the only type of medical care that may affect fertility, but it is the only care banned under the law," and Tennessee has utterly "fail[ed] to explain why" this is so.[39] Compounding the inscrutability is the fact that the forms of gender-affirming care most commonly accessed by transgender youth—puberty blockers and hormone therapy—*do not* cause permanent infertility,[40] whereas surgeries

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[39] Brief of Plaintiffs-Appellees at 25, *L.W. v. Skrmetti,* No. 23-5600 (6th Cir. Aug. 11, 2023), https://tinyurl.com/c2464z64

[40] *See* Statement of Interest of the United States at 18, *Poe v. Labrador*, No. 1:23-cv-00269-BLW (D. Idaho Aug. 23, 2023) (quoting Idaho H.B. 71 § 1(3)(c)), https://tinyurl.com/3s9nykv3 (noting that

on intersex infants—which SB 1 expressly permits—unquestionably *do*.[41] Furthermore, when treating adolescents' gender dysphoria, a care plan "can always leave room for fertility preservation," but for "many surgical treatments performed on intersex infants" which "permanently impact fertility,"[42] such mitigation is not routinely offered (nor reliably feasible).[43] Curiously, SB 1 allows the latter practice where the risk to the minor patient's fertility is objectively far greater.

Mental Health. Data clearly show the effects of different approaches and experiences on the mental health of youth who are transgender or intersex. Just as withholding gender-affirming care causes demonstrable harm to transgender patients, intersex people who have experienced the nonconsensual surgeries which SB 1 expressly allows have suffered depression, anxiety, post-traumatic stress disorder, and suicidality later in life, as well as trauma and mistrust so severe that many do not seek medical care when they

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it is "simply untrue that puberty blockers 'induce profound morphologic changes in the genitals of a child' or induce 'permanent infertility'").

[41] *See* Rebuttal Decl. of Armand Antommaria, *L.W. v. Skrmetti*, No. 3:23-cv-00376 (M.D. Tenn. May 29, 2023), https://tinyurl.com/4cbw6h92.

[42] Expert Decl. of Deanna Adkins at 20, *L.W. v. Skrmetti*, No. 3:23-cv-00376 (M.D. Tenn. Apr. 17, 2023), https://tinyurl.com/mr357xfv.

[43] *See* Aisha L. Siebert et al., *Differences in gonadal tissue cryopreservation practices for differences of sex development across regions in the United States*, 13 FRONTIERS IN ENDOCR. 13, No. 990359, Jan. 17, 2022, https://tinyurl.com/3e26f4by.

need it.[44] Courts considering similar laws have concluded that the evidence of harmful mental health impacts from withholding gender-affirming care was sufficient on its own to undermine the purported justification of protecting minors' mental health.[45] The added likelihood of harm to the mental health of intersex minors under SB 1's intersex exception further refutes this stated rationale.

Incredibly, SB 1 invokes David Reimer's suicide and shamelessly distorts it into a cautionary tale about gender-affirming care, *which it was not*. "Finding" that "Dr. John Money . . . abused minors entrusted to his care, resulting in the suicide[]" of David Reimer,[46] the Tennessee legislature mischaracterized Dr. Money's "treatment" of David to imply that these tragic consequences resulted from the type of consensual gender-affirming care in adolescents that the state wanted to justify banning. Not so: in the Reimer case, an infant was involuntarily reassigned as female and subjected to non-consensual "normalizing" surgery to remove his testes and create a vulva. That case has nothing to say about reversible interventions like puberty blockers for consenting adolescents. As discussed above, the Reimer case begat the standard practice of nonconsensual "normalizing" surgery on intersex infants that SB 1 specifically chose to *exempt* from its prohibitions.

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[44] *See supra* notes 23-27 and accompanying text.

[45] *E.g.*, Mem. Decision & Order at 38, *Poe v. Labrador*, No. 1:23-cv-00269-BLW (D. Ohio Dec. 26, 2023), https://tinyurl.com/4a3whkar.

[46] Tenn. Code Ann. § 68-33-101(f).

Autonomy and Self-Determination. In support of SB 1, Tennessee cites the purported concern that "minors lack the maturity to fully understand and appreciate the life-altering consequences"[47] of gender-affirming medical interventions. Georgia justifies its similar SB 140 as necessary to safeguard the opportunity for minors, "whose . . . executive function [is] still developing," to "mature and develop [their] own identity" prior to undergoing treatment for gender dysphoria. Georgia further asserts that "[u]nder the principle of 'do no harm,' taking a wait-and-see approach . . . is preferable" to medical intervention before adulthood.[48]

The intersex exception puts the lie to this purported state interest. That exception *prevents* this "wait-and-see" approach from applying to the one group of minors for whom these concerns are most relevant. As biomedical ethics scholars writing as *amici* to the Sixth Circuit highlighted: "[t]he[se] Health Care Bans expressly allow surgical inventions to be performed on minors with intersex conditions . . . including infants too young to participate in the decision-making process, even though such procedures have irreversible, long-term consequences and raise serious ethical concerns."[49] The state's motivation to wait or not to wait depends solely on whether deferring medi-

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[47] Tenn. Code Ann. § 68-33-101(h).

[48] S.B. 140, 2023-2024 Gen. Assemb., Reg. Sess. (Ga 2023), https://tinyurl.com/46ab8phj.

[49] Brief for Biomedical Ethics and Public Health Scholars as *Amici Curiae* Supporting Plaintiffs-Appellees, *L.W. v. Skrmetti,* No. 23-5600 (6th Cir. Aug. 10, 2023), https://tinyurl.com/bdz2uwhf.

cal intervention would uphold or depart from conformity with traditional expectations about how male and female bodies should look. SB 1 is not grounded in stewarding minors' developing autonomy, and the intersex exception demonstrates this irrefutably.

"Integrity of the Medical Profession." Tennessee claims that SB 1 is necessary to protect the "integrity of the medical profession."[50] Here, too, the intersex exception reveals this purported justification as pretextual. As the *amici* biomedical ethicists stated when SB 1 was before the Sixth Circuit, a provider's duty is to "protect and foster [the] patient's free, uncoerced choices."[51] It does not promote medical integrity to permit and endorse nonconsensual and harmful surgeries on intersex infants that international human rights bodies, federal agencies, and medical organizations have condemned as inhumane, abusive, and tantamount to torture. *Supra* at 19-20. Giving the state's imprimatur to a medical practice that robs patients of their opportunity to exercise autonomy over decisions with such profound impacts on their bodies and lives does not protect the integrity of the medical profession; it degrades it.

"Appreciation" of One's Innate Sex Traits. SB 1 states on its face that it is intended to "encourag[e] minors to appreciate their sex" and prohibit treatments "that might encourage minors to become disdainful of their sex."[52] Assuming *arguendo* that it

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[50] Tenn. Code Ann. § 68-33-101(m).

[51] Brief for Biomedical Ethics and Public Health Scholars, *supra* note 49, at 17-18.

[52] Tenn. Code Ann. § 68-33-101(m).

would be a legitimate state interest to encourage minors to appreciate the particular physical sex traits that their bodies naturally happened to develop, SB 1 plainly does not do that—at least, not unless minors were born with traits that conform to stereotypical notions of how male and female bodies look, develop, and function. When children are born with natural traits that do not conform to those stereotypical notions, SB 1 does not encourage them to "appreciate" those traits—it provides explicitly for their erasure, and sends the harmful message to intersex minors that their bodies are innately defective and something of which they should be ashamed.[53] If SB 1 "encourages" anything, it is a minor's acceptance of the sex assignment that doctors chose for them at birth—which, as discussed above, may be subjective and even arbitrary in some cases. SB 1 also disregards the very real harm that accrues to both transgender and intersex young people under such a policy of coercively "encouraging" acceptance of a self that is not theirs.

C. Enforcing Conventional Notions of How Male and Female Bodies Should Look Is Not a Legitimate State Interest.

Amicus agrees with the United States and Respondents in Support of Petitioner that the Sixth Circuit erred by refusing to apply heightened scrutiny to

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[53] *See* Human Rights Watch, *supra* note 23, at 33 (quoting essay by Bo Laurent, founder of the Intersex Society of North America, describing the harm resulting from the "underlying attitude" communicated through non-consensual surgery "that [being] intersex[] is so shameful that it must be erased before the child can have any say in what will be done to [their] body").

SB 1's facially sex-based classifications. Classifying on the basis of variations in sex characteristics implicates one's sex directly. Far from being an "across-the-board" regulation that prohibits certain medical procedures regardless of sex, as the Sixth Circuit majority mistakenly believed (Pet. App'x at 32a), SB 1 makes the legality of a given procedure turn entirely on a patient's sex characteristics. To determine whether a particular intervention for a minor is prohibited, or instead permissible under SB 1's intersex exception, one must know not only what sex that minor was assigned at birth, but also which external genitals, internal reproductive organs, chromosomes, and hormone function that minor was born with, and whether all of those characteristics align with societal expectations for infants who receive that sex assignment.[54] As this makes clear, Tennessee has written one of the most literal sex-based classifications imaginable.

Nonetheless, SB 1 fails any level of Equal Protection review. Even under the most deferential tier of scrutiny, a statute must have at least one motivating purpose that is "a goal that is legitimate for the government to pursue" in the first place.[55] However, as

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[54] To illustrate, a gonadectomy is legal under SB 1 when performed on minor patients with XY chromosomes so long as they have a vulva (or genitals that otherwise do not look like a typical penis), or lower-than-typical testosterone production, or a difference in their body's response to testosterone (such as patients with androgen insensitivity). However, if a minor's physical sex characteristics all align with what is expected of a "typical male"—XY chromosomes, a penis, testes, and typical production of and responsiveness to androgens—a gonadectomy is illegal.

[55] Erwin Chemerinsky, *The Rational Basis Test Is Constitutional (and Desirable)*, 14 GEO. J. L. PUB. POL'Y 401, 402 (2016) (citing *U.S. R.R. Ret. Bd. v. Fritz*, 449 U.S. 166, 174 (1980)).

discussed above, each proffered motivation for SB 1 evaporates at the first sight of an intersex variation. With each possible justification negated by the statute's intersex exception, the only remaining explanation is Tennessee's desire to enforce stereotypical notions about how male and female bodies should look and function—and who should have which one. In other words, SB 1 perpetuates sex-based stereotypes *for its own sake*. No other rationale could account for the gerrymandered outline of SB 1's prohibitions.

"[I]nterests in promoting and enforcing gender stereotyping . . . simply are not legitimate governmental interests." *Latta v. Otter*, 771 F.3d 456, 490 (9th Cir. 2014) (Berzon, J., concurring). As this Court has noted, the entire point of Equal Protection review in this context is to ensure that laws are not premised on "overbroad generalizations about the way men and women are." *Sessions v. Morales-Santana*, 582 U.S. 47, 57 (2017). "If the constitutional conception of 'equal protection of the laws' means anything, it must at the very least mean that a bare desire" to perpetuate such overbroad generalizations "cannot constitute a *legitimate* governmental interest." *Romer*, 517 U.S. at 634-35 (quoting *Dep't of Agric. v. Moreno*, 413 U.S. 528, 534 (1973)) (cleaned up).

In restricting transgender minors' access to gender-affirming care while endorsing harmful "normalizing" interventions on non-consenting intersex infants, SB 1 elevates the enforcement of sex stereotypes over children's safety and well-being. It is unconstitutional under any standard.

CONCLUSION

For the foregoing reasons, *amicus* respectfully requests that the Court reverse the decision of the Sixth Circuit.

Respectfully submitted.

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