No. 23-477

IN THE

Supreme Court of the United States

UNITED STATES,

Petitioner,

v.

JONATHAN SKRMETTI, ATTORNEY GENERAL AND REPORTER FOR TENNESSEE, *et al.*,

Respondents.

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

BRIEF OF PROFESSOR JAMES F. BLUMSTEIN AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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BRIEF OF PROFESSOR JAMES F. BLUMSTEIN AS *AMICUS CURIAE*

INTEREST OF *AMICUS*[1]

James F. Blumstein serves as University Distinguished Professor of Constitutional Law and Health Law and Policy at Vanderbilt University. That is the highest title that Vanderbilt confers; Professor Blumstein is tenured in the law school and the medical school. He is Director of the Health Policy Center at Vanderbilt and has a courtesy appointment as Professor of Management at the Owen Graduate School of Management. He is an elected member of the National Academy of Medicine (formerly Institute of Medicine) of the National Academies of Sciences. He has received the Sutherland Prize, Vanderbilt's preeminent university-wide award for lifetime achievement in research, and the Hall-Hartman Award, for excellence in teaching at the law school. Professor Blumstein works in the areas of constitutional law and health law and policy and at the intersections of those disciplines. He offers this Brief because of his belief that its analysis would be of benefit to the Court in its deliberations in this matter. He offers this Brief in his individual professional capacity, not on behalf of any of his institutional affiliations.

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1. Pursuant to Supreme Court Rule 37.6, *amicus curiae* states that no counsel for any party authored this brief in whole or in part and that no entity or person, aside from *amicus curiae*, made any monetary contribution toward the preparation or submission of this brief. Reimbursement for printing expenses will be sought from funds made available by Vanderbilt Law School to support faculty work related to faculty research and public interest activity. Such financial support does not signify a position by the University on the merits of the positions advanced in this Brief.

SUMMARY OF ARGUMENT

This case involves a challenge to Tennessee legislation that controls access to and availability of certain medical procedures to persons under eighteen (18) years of age. Those procedures involve the administration to minors of (i) medications that block or impede the onset of puberty (puberty blockers) and (ii) hormones that are used so as to enable a minor to identify with or live with an identity inconsistent with the minor's biological sex at birth. As relevant here, these challenged procedures, which are restricted for minors under Tennessee law, target and treat minors who are diagnosed with a medical condition—gender dysphoria.

The case, in sum, addresses the scope of governmental authority to regulate and control access by minors to certain medical treatments for gender dysphoria. Since there is some degree of medical uncertainty about the wisdom, benefits, and risks of these medical treatments, especially for minors, a further issue is the scope of governmental authority to regulate and control access by minors to medical treatments more generally in the face of medical uncertainty.

In order for medications or treatments to be administered to a patient, consent is required. As a general matter, minors are not able to give consent to medical treatments or procedures. When a patient cannot legally give consent, a substitute (surrogate) decisionmaker is typically authorized to make a decision on behalf of the patient. State law normally determines who can provide consent and under what circumstances.

Some deferential constitutional standards constrain state determinations regarding the parameters of consent. But this Court has refrained from adopting "any general statement" that would "cover every possible phase" of the matter." *Cruzan v. Missouri Department of Health*, 497 U.S. 261, 278 (1990). States may wish to defer to surrogate decisionmaking by parents or others, but, absent special circumstances, such deferral or delegation of decisionmaking to others, such as family members or medical professionals, is not constitutionally required. *Id*. at 286 (states need not "accept the 'substituted judgment' of close family members"; there is no "constitutional requirement that the State recognize that decisonmaking").

In the challenged legislation, Tennessee has determined to protect minor patients and safeguard their ability to form a mature judgment—allowing them to form mature consent to certain treatments when they reach adulthood and are capable of deciding for themselves—thereby precluding the use of surrogate decisionmakers. States may "guard against potential abuses" by surrogate decisionmakers, *id*. at 281, and, also, protect independent state interests such as paternalistically protecting human life and health, even if parents approve of the conduct in question and even if adults are permitted to engage in that conduct.

Age is often used as a proxy for maturity; states have great leeway in drawing age-based lines. That line-drawing flexibility regarding age applies to such fundamental interests as marriage and voting. Such age qualifications can be viewed and approved either as age-based eligibility criteria or as a state's decision about lack

of maturity or wisdom of an under-age person to engage in certain, even fundamental, activity.

Establishing age-based criteria for access to certain medical treatments or procedures or establishing age-based criteria to the ability to provide consent is what Tennessee has done with regard to the challenged legislation. This is a form of paternalism that has long been part of the government's role in protecting minors—from themselves, others (*e.g.*, medical providers), and even their parents. The challenged legislation retains the norm that minors cannot give consent to medical treatment; it protects minors from the risk of relying on surrogate decisionmakers with regard to a particular medical diagnosis—gender dysphoria.

Claims under Equal Protection are unavailing. The challenged law targets minors. Distinguishing between adults and minors is quite routine and surely rational. The challenged law focuses on a medical condition and treatments for that condition by two medical procedures. See Complaint in Intervention, at para. 4 (Doc. No. 38-1, Jt. App. at 56) (The challenged Tennessee law "prohibits certain forms of medically necessary care for transgender minors with a diagnosis of gender dysphoria"). For decades, this Court has allowed states to distinguish between medical conditions—*e.g.,*, even under the regime of *Roe v. Wade*, 410 U.S. 413 (1973), permitting that childbirth be funded under Medicaid even when Medicaid does not fund either therapeutic or nontherapeutic abortions. *Harris v. McCrae*, 448 U.S. 297 (1980); *Maher v. Roe*, 412 U.S. 464 (1977).

(1) Targeting the medical condition of dysphoria, (2) creating age-based classifications regarding access to certain treatments for dysphoria, nor (3) restricting the ability of minors (or surrogates on their behalf) to provide consent to those treatments are not classifications based on sex. All persons with the targeted medical condition are treated similarly; the targeted treatments are based on the medical condition, not based on sex. Under the circumstances, a challenge must meet the requirements of *Personnel Administrator v. Feeney*, 442 U.S., 256, 278-80 (1979): it must establish that ostensibly sex-neutral legislation that targets a medical condition is a sham, a cover-up for an intentional harm adopted "because of " a sex-based outcome, not in spite of that outcome. No such showing can be made here.

Accordingly, the challenged Tennessee legislation should be upheld as not in violation of Equal Protection—– as a rational and traditional form of paternalistic child protection.

ARGUMENT

I. Introduction

This case involves a challenge to Tennessee legislation that controls access to and availability of certain medical procedures to persons under eighteen (18) years of age. The procedures to which this Brief is addressed involve the administration to minors of medications that block or impede the onset of puberty (puberty blockers) and hormones that are "performed for the purpose of enabling a minor to identify with or live with an identity inconsistent with the minor's sex as assigned at birth, or treating

discomfort or distress from discordance between the minor's sex assigned at birth and their asserted identity." These challenged procedures may be prescribed in some circumstances by medical professionals for persons—in this case minors—with "a diagnosis of gender dysphoria." Complaint in Intervention, at para 4 (Doc. 38-1, Jt. App. at 56). This Brief does not address "treatments that do not include any medications," *id.* at para. 29, Jt. App. at 62, which are either not covered by the challenged legislation or are subject to different legal analysis.

Amicus is prompted to prepare and file this Brief because of his belief that the rhetoric and analysis surrounding the prescribing of puberty blockers and hormones, as described, have become polarized so as to distract from the critical analytical issues surrounding this litigation.

At the outset, *Amicus* disassociates himself from any animus targeted at parents or their children who seek out these treatments; likewise, while respecting the religious beliefs of some opponents of these therapies, *Amicus* believes that ultimate policy must reflect and implement secular, not religious commitments, even as religious beliefs can legitimately undergird values that can lead to non-religious policy objectives. See *Epperson v. Arkansas*, 393 U.S. 97 (1968).

The goal of *Amicus* in filing this Brief is to lower the temperature on these issues—to lessen the heat and brighten the light in focusing on the legal issues. In the judgment of *Amicus*, the critical analytical questions have been deemphasized (and key cases/concepts often ignored), and the polarizing issues of the merits or

demerits of transgenderism or gender-affirming care have taken center stage. *Amicus* will seek to redirect the analysis to what, in his judgment, are the core legal issues that need to be addressed in the context of a challenge to the Tennessee legislation.

In broad stroke, the case involves the scope of governmental authority to regulate access to medical treatments by minors. The subject matter of the regulation, of course, is what has triggered the polarizing discourse, but from a legal or constitutional perspective, the subject matter of the regulation is not the main issue. As *Amicus* will contend, these issues arise in any number of contexts, and the principles derived from those contexts control the analysis in this one.

II. In General

In order for medications or treatments to be administered to a patient, consent is required. "At common law, even the touching of one person by another without consent was a battery." *Cruzan v. Missouri Department of Health*, 497 U.S. 261, 269 (1990). In the modern context, consent means "informed consent," which is "generally required for medical treatment." The doctrine of informed consent "has become firmly entrenched in American tort law." *Id.*

If a person cannot legally give consent or informed consent to a medical procedure, then a substitute (surrogate) decisionmaker is typically authorized to make a decision on behalf of a patient who cannot legally provide consent. Within very narrow federal constitutional limitations, decisions about who can provide consent

and under what criteria are left to state law—"state constitutions, statutes, and common law." *Id.* at 277. That is, state law typically controls the determination of consent when a patient is not legally able to make the consent decision. The role of states in regulating who can grant consent and under what circumstances is paramount, subject to highly deferential constitutional review in some situations. *Id.* at 280-81.

This Court has refrained from adopting "any general statement" that would "cover every possible phase" of the matter. *Id.* at 278. In determining the parameters of consent, states are not "required to remain neutral," *id.* at 280; they may advance their own interests, such as "guard[ing] against potential abuses," of those not legally capable of providing consent or informed consent. *Id.* at 281. States may wish to defer to surrogate decisionmaking by parents or others, but, absent special circumstances, such deferral or delegation of decisionmaking to others (*e.g.*, family members or medical professionals) is not constitutionally required. *Id.* at 286. This Court has expressly rejected the position that states "must accept the 'substituted judgment' of close family members." *Id.* States may choose to "rely on family decisionmaking," but this Court has rejected the position that there is "a constitutional requirement that the State recognize that decisionmaking." *Id.* As *Cruzan* states, "we do not think the Due Process Clause requires the State to repose judgment on these matters," involving consent by those not legally able to provide consent, "with anyone but the patient herself."

Family members have close ties and "strong feelings" on matters of consent, "[b]ut there is no automatic assurance that the view of close family members [parents

in *Cruzan*] will necessarily be the same as the patient's." In sum, *Cruzan* stated that a state may choose to "repose judgment," on matters of consent for those unable to grant consent on their own, in a surrogate; that surrogate will be driven by the judgment of the "patient herself." *Id.* In the case of a minor, that person may not have the maturity or judgment to express a judgment on matters of such import and long-term effect as treatment for gender dysphoria.

Tennessee has determined, in the challenged legislation, to protect minor patients and safeguard their ability to form a mature judgment—allowing them to form "informed consent" to treatment when they reach adulthood and are capable of deciding for themselves. Tennessee has implemented that determination by precluding the use of surrogate decisionmakers until the patients can make these important choices as adults, deferring critical and potentially risky medical interventions until the minor reaches adulthood and is in a position to serve as his or her own decisionmaker without reliance on a parent or other surrogate decisionmaker.

In the context of adults, these issues of consent arise when a person is or becomes, for example, comatose and therefore unable to decide on his or her own. Surrogate decisionmakers must step in, and state law has lots of flexibility in determining how a surrogate decisionmaker should decide. "[E]ven where family members are present, 'there will, of course, be some unfortunate situations in which family members will not act to protect a patient.'" *Id.* at 281(internal cite omitted). In "such situations," a state "is entitled to guard against potential abuses" and, also, to protect independent state interests such as protection of risks to human life. *Id.* at 282.

In *Cruzan*, this Court upheld a Missouri state decision to require that the interests of the comatose patient, Nancy Beth Cruzan, to discontinue medical treatment be established by "clear and convincing" evidence, a higher-than-normal standard. *Id.* That is, the state had an interest in vindicating the patient's putative interest in terminating life support but also in vindicating the state's own, independent interest in protecting against error that could be damaging to an interest of the state itself in the preservation of human life.[2] The higher evidentiary standard was a permissible method or procedure through which the state assured that its interests—in protecting human life, in guarding against risks to that interest, and in minimizing other potential risks such as a mistake in determining Nancy Beth's true desires—were recognized and safeguarded.

As a general rule, minors are legally incapable of giving consent to medical treatment. See Ann McNary, *Consent to Treatment of Minors*, Innov. Clin.

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2. That the state can have an independent interest in the preservation of life distinct from the interest of a comatose patient was a pivotal point of disagreement between the *Cruzan* majority and Justice Brennan's dissent. See 497 U.S. at 313-16 (Brennan, J., dissenting). For Justice Brennan, "the only state interest that may be asserted is an interest in safeguarding the accuracy" of the determination. of the patient's wishes regarding the termination of life support. *Id.* at 316. The majority concluded that the state had an independent interest, separate and distinct from that of the patient herself, in the preservation of life. *Id.* at 282 (a state may "simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual"). Likewise, Tennessee has a distinct and legitimate interest in preserving or reserving for a minor the autonomy to make a decision about her or his treatment of dysphoria until that minor reaches adulthood.

Neuroscience, 2014 Mar-Apr; 11 (3-4); 43-45. The analogy is to legally incompetent adult patients. As in the case of legally incompetent adults, minors need to have surrogate decisionmakers in order to grant consent or informed consent; these are typically parents, but not always. As with Nancy Beth Cruzan, government has an independent interest in protecting minors from certain types of errors in judgment and potentially harmful conduct, even if parents approve and even if adults are permitted to engage in that conduct.

For example, adults are constitutionally protected when they engage in sexual activity. *Lawrence v. Texas*, 539 U.S. 558 (2003) (protecting same-sex partners who engage in certain intimate sexual conduct). But minors may not be deemed sufficiently mature to consent to those same activities. Thus, we have laws against "statutory rape," for conduct by minors that would be constitutionally protected if engaged in by adults; that conduct can be punished by the criminal law. *See*, *e.g.*, *Michael M. v. Superior Court*, 450 U.S. 464 (1981) (upholding a statutory rape law, even when only a male is punished for behavior also engaged in by an under-age female partner). Similar dissimilarities between adults and minors occur in the context of marriage. States may not discriminate in marriage against same-sex couples, *Obergefell v. Hodges*, 576 U.S. 644 (2015), or against inter-racial couples, *Loving v. Virginia*, 388 U.S. 1 (1987); yet states routinely and variedly set age requirements for marriage because of different state-based judgments about maturity and ability to consent or preconditions for consent.

Age is often used as a proxy for maturity, and states have great leeway in drawing age-based lines, not only for

marriage but also for voting[3]. Both marriage (*Obergefell* and *Loving*) and access to the vote (*Dunn v. Blumstein*, 405 U.S. 330 (1972)), are fundamental interests subject to strict scrutiny, but states can (and do) set age criteria for marriage or access to the vote. And age qualifications and classifications, which are widespread and include requirements for consent in making a contract or eligibility for a benefit, receive highly deferential review. See *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307 (1976). To reiterate, such age qualifications can be viewed and approved as either age-based eligibility criteria or as a state's decision about the lack of maturity/wisdom of an under-age person to engage in certain (even fundamental) activity.

So, to review things, minors are generally not able to make decisions about medical treatment on their own; they cannot legally provide consent or informed consent. Some form of surrogate decisionmaker is required to provide that consent. And the state may establish criteria, based on age, for granting the ability for minors to give consent—or to use age as a criterion for eligibility to receive a benefit such as medical care. In making a decision regarding consent for a minor, the state may take into account its interests in protecting minors from risk, guarding against minors' immaturity, and protecting minors from potentially improvident decisions—their own or those of surrogate decisionmakers. This is a form of paternalistic protectionism that has long been part of the government's role in protecting minors, from themselves, others (*e.g.*, medical providers), and even their parents.

3. An age ceiling is set at 18 for participating in elections by the 26th Amendment to the federal constitution.

This seems to be what Tennessee has done regarding the medical procedures and treatments at issue in this litigation.

Tennessee has determined that the decisionmaking on behalf of minors regarding certain medical procedures is best deferred until the minors can (are legally authorized to) decide for themselves, without the need for a surrogate decisionmaker. Since minors are not legally authorized to decide on their own—*i.e.*, they cannot provide consent—the state has determined that, all things considered, the interests of minors in making their own medical decisions on the medical procedures at issue are best served by deferring the decisions until minors reach maturity and can legally decide for themselves what to do as adults—*i.e.*, provide legally authorized informed consent.

This is precisely the kind of procedural protection that states can employ under *Cruzan*—deferring decisions until minors reach adulthood and minimizing the risk of error that any surrogate decisionmaker could make, especially regarding a minor, who does not have legal capacity to consent to a procedure or become adequately informed so as to provide a sound basis for informed consent. That decision can be viewed as one limiting minors to engage in consent or informed consent; alternatively, it might be viewed as an age-based eligibility requirement for access to certain types of medical treatments that may have potential benefits but also potentially harmful risks. Tennessee's legislation retains the conventional norm—that minors cannot on their own provide consent to medical procedures—and protects minors from the risk of relying on surrogate decisionmakers (including parents or medical professionals) until the minors reach the age of

consent. In short, if this were not a matter of controversy regarding the particular procedures or treatments in question, the Tennessee statute in question would be easily valid—pretty much a ho-hum matter.

III. On the Other Hand

(1)

At the same time, the general principles described above must and do allow for exceptions. But, interestingly, neither the private parties nor the federal government appear to rely heavily on those types of exceptions. The challengers' claims in this Court are rooted in Equal Protection, not Due Process as in *Cruzan*, perhaps out of a recognition that the traditional grounds for an exception would not fit the circumstances well.

Sometimes, minors have legally protected interests that can be successfully asserted against governmental action. That is not the case in this situation.

Such circumstances can arise when parents and their children assert claims that are protected under the religious exercise provision of the First Amendment. In *Wisconsin v. Yoder*, 40 U.S. 205 (1972), this Court upheld the right of an Amish family not to send a daughter to school after the eighth grade, as required by state law. Compulsory school attendance laws are generally valid, as examples of state protection of the interests of children against possible exploitation by adults (including by family members). But the constitutionally-protected Free Exercise claim allowed the Amish family's religious-exercise claim under the First Amendment to supersede the state's interest in that context.

Similarly, a child has a First Amendment (expression) interest in learning a foreign language (German) that overrides a state's ban on teaching German to children. *Meyer v. Nebraska*, 262 U.S. 390 (1923). In *Pierce v. Society of Sisters*, 268 U.S. 510 (1925), the liberty interests of parents and children to have students attend a non-public school overcame an Oregon requirement that all children attend a public school. In *Carey v. Population Services, International*, 431 U.S. 678 (1977), this Court struck down a New York ban on the sale or distribution of contraceptives to minors under the age of sixteen. At the time, *Roe v. Wade*, 410 U.S. 413 (1973), controlled; a plurality held that a fundamental liberty interest in access to contraceptives applied to minors and that that interest was unconstitutionally burdened by the New York ban.

What these cases all involved is a separate, independent constitutional right that applies to and protects minors. No comparable rights are at issue in this litigation. This Court has rejected the claim, even under the regime of *Roe*, that access to medical care (abortion services) is a constitutionally protected liberty interest, neither for adults nor children. *Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464 (1977).

It is conceivable that challengers could establish some claim under substantive due process to access to medical treatment; but there is no such generalized claim, so any such claim would have to be case-specific and pursued in an as-applied setting. See *Washington v. Glucksberg*, 521 U.S. 702, 735, n.24 (1997). Such a claim would have to be proven in special circumstances and would not form the basis of a facial challenge or the type of overall injunction that the challengers seek. See *Ayotte*

v. Planned Parenthood, 546 U.S. 320 (2006); *Gonzales v. Carhart*, 550 U.S. 124, 167-68 (2007) (requiring as-applied challenges for exceptions to generally valid legislation); *Jacobson v. Massachusetts*, 197 U.S. 11, 38-39 (1905).

(2)

At this point, challengers (the United States) do not pursue a claim based on the traditional exceptions to governmentally-imposed limitations on consent by minors. For the reasons discussed above, this appears to be a reasonable strategic approach. Instead, the challengers in this Court attire their claim in different constitutional clothing—– Equal Protection. This approach does not appear to have merit either, however.

The Tennessee law in question targets minors and limits their ability to provide the necessary consent to the medical procedures in question. Distinguishing between adults and minors is quite routine and surely rational. Looking at the classes for comparison in that way is a dry hole for the challengers.

The Tennessee law in question also focuses on an illness and treatment for that illness by two medical procedures. Can the state draw distinctions based on an illness or on the basis of treatments for illness?

The Court for years has allowed differential treatment, under deferential review, of related medical conditions. Even under the regime of *Roe*, the Court in the abortion-funding cases has permitted government to regard the termination of pregnancy through abortion less favorably—not covered under Medicaid—than

medical treatment designed to facilitate and promote carrying a pregnancy to term (covered). See *Maher v. Roe*, *supra*; *Harris v. McRae*, *supra*. So, in the context of age-based qualification for medical treatment or age-based constraints on consent, any challenge to such a classification is subject to highly deferential review and should be approved. Tennessee may focus its age-based standards, however characterized, as legitimate even as they apply to a certain medical condition and not to other medical conditions.

As for limiting certain (controversial and challenged) procedures but not others, Tennessee likewise seems to be on firm footing.

Under the regime of *Roe*, there are examples of where certain restrictive medical protocols or procedures were invalidated. For example, in a companion case to *Roe*, *Doe v. Bolton*, 410 U.S. 179 (1973), the Court invalidated a state requirement that abortions be performed in an accredited hospital. In *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976), the Court held invalid a state prohibition on the use of saline amniocentesis, a mainstream method of abortion, on the ground that it was insufficiently justified under the *Roe* analytical framework. So, a challenge to limiting a certain set of medical treatments, as involved in this challenge, might have been subject to non-deferential review when the underlying procedure (analogous to a liberty interest like abortion) was constitutionally protected under the *Roe* analytical framework.

But *Roe* has been overruled, *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022). There is, accordingly, no fundamental liberty interest at stake regarding any patient's access to medical treatments or specific types of medical procedures; the government now has much greater freedom to legislate regarding specific medical procedures. *See, e.g., Gonzales v. Carhart*, 550 U.S 124 (2007) (allowing restrictions on use of an abortion procedure, commonly referred to as "partial-birth" abortion, under post-*Roe* "undue burden" analysis).

In addition, the government has strong interests, in general, in regulating access to medical treatments and procedures. Approval of drugs by the federal government is an illustration. There is no right of access to a particular method of treatment, even when such a treatment is the only hope for a terminally ill cancer patient. See *Abigail Alliance for Better Access to Developmental Drugs v. Von Eschenbach*, 495 F.3d 711 (D.C. Cir. 2007)(en banc). The "selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting the public." *Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir. 1980). And where some degree of "medical uncertainty" exists, as in the instant litigation, states are not obligated to give effect to the medical judgment of doctors exercising their preferred medical judgment. *Gonzales v. Carhart*, 550 U.S. at 164 ("The law need not give . . . doctors unfettered choice in the course of their medical practice"). The question is what standard applies to legislation, such as the Tennessee legislation, in the face of "medical uncertainty."

In the face of medical uncertainty, "state and federal legislatures" have "wide discretion to pass legislation in

areas where there is medical and scientific uncertainty." Id. at 163. The existence of medical uncertainty "does not foreclose the exercise of legislative power," *id*. at 164, when the government is pursuing legitimate objectives such as (i) child protection, (ii) guarding against the risk of decisionmaking errors and (iii) vesting ultimate decisionmaking authority in actual adult patient decisionmakers not minors or surrogates. Clearly, there is a considerable degree of medical uncertainty, given the unknowns about risks and benefits.[4] In such situations, the

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4. *Amicus* would point the Court to a recent op ed in the New York Times by Pamela Paul. She recounts, as one of many examples, the case of misguided medical guidance regarding peanut allergies in American children. The medical guidance was that "pregnant and lactating women" should "avoid eating peanuts," and parents should "avoid" feeding them "to children under three." The guidance was based on "guidance issued by the American Academy of Pediatrics in 2000." But that guidance "turned out to be entirely wrong and, in fact avoiding peanuts caused many of those allergies in the first place." The peanut experience was an "avoidable tragedy," one of "several episodes of medical authorities sticking to erroneous positions despite countervailing evidence." This phenomenon arises from the medical profession's intellectual quest for consensus, which results in "dogma" when "the profession has become wed to an idea." The medical profession often does not "remain[ ] open to dissent," but "closes ranks, leaning toward established practice, consensus and groupthink." Under these circumstances, it is not inappropriate for government to act to protect minors from surrogate decisionmakers, reserving the choice to a minor himself or herself when that minor becomes an adult. See Pamela Paul, "Why Medicine Still Has Such Blind Spots," *New York Times*, September 20, 2024, at A22. Ms. Paul cites the work of Dr. Marty Makary, a physician at Johns Hopkins, as providing many examples comparable to the peanut experience. See Blind Spots: When Medicine Gets It Wrong, and What It Means for Our Health (2024).

state legislature may act to protect minors and preserve their ability to control their own healthcare choices once they become adults—even when the protection is targeted at patients as minors themselves, their parents as surrogates, or medical professionals.

(3)

The claims under Equal Protection seem almost to be a makeweight, given all the above. The Tennessee legislation under challenge distinguishes one treatment from another and guards against medical uncertainty associated with certain types of medical treatments by limiting access based on age. The Tennessee legislation also targets one type of illness by establishing an age-based restriction on access to certain treatments for it. Arguably, there are also distinctions based on age-drawn classifications. For the reasons already discussed, these classifications are analyzed under restrained, deferential review.

It seems quite wide of the mark to attempt to fit these categorizations into a sex-based discrimination context. The protections apply to all persons with a particular medical condition and to certain treatments for that condition; there is no sex basis to the coverage. That the disease targets a sex-related medical condition does not change things. Targeting abortion, for example, is not a sex-based classification, as *Dobbs* states. And, as a constitutional matter, a facially neutral law can only be categorized as sex-based if there is an intent to classify or disadvantage based on sex. That intent must be more than foreseeable, as in tort law; it must be adopted "because

of" the sex-based outcome, not in spite of that outcome. *Personnel Administrator v. Feeney*, 442 U.S. 256, 278-80 (1979). The focus of the legislation is on preserving decisionmaking authority for minors regarding treatment for gender dysphoria. Medications that are used for other purposes are beyond the point and not comparable. The target is on drugs that deal with gender dysphoria; that the same drugs are permitted for other purposes, where the minor's interests are quite different and the state's interests are quite different, does not alter the nature of the classifications. This legislation is not a sex-based classification under the *Feeney* standard.

It is arguable that the Tennessee legislation targets a particular health condition, gender dysphoria; but there is no basis for more than deferential review when the ground for classification is a particular illness. Government is able to target prostate cancer or uterine cancer, without having to face more than deferential review, unless the rigorous standards of *Feeney* are satisfied (which they are not for the reasons already set forth). A Court must keep its eye on the ball—– namely, that the legislation under challenge is based on an appropriate legislative judgment that important medical judgments about minors should be made by minors themselves (not surrogate decisionmakers), but only once they reach the maturity of adulthood. A particular medical condition, gender dysphoria, can be targeted by government out of reasonable concerns about risks and balancing risks and benefits—matters that mature, adult individuals themselves should make on their own behalf.

Whenever surrogate decisionmakers are involved—parents or medical professionals—there is always a genuine risk that the balancing of risks and benefits will not reflect the will and preferences of a now-minor who later becomes a mature adult. This is a form of child protection that is contemplated in the law that disallows minors to decide such issues for themselves and that also confers on government the authority to disallow, based on age, consent by minors to the challenged forms of medical treatment—whether through restraints on consent or informed consent or through age-based restraints on eligibility for certain medical interventions.

CONCLUSION

Amicus has chosen to share his views of the appropriate legal and constitutional analysis in this litigation. *Amicus* takes no position on the wisdom or lack of wisdom of allowing minors, with parental consent, to undergo the treatments deferred by the Tennessee legislation. However, the legislature has acted and, in my judgment, within the legitimate, constitutional scope of its authority—to protect the ability of now-minors to make decisions concerning important matters of healthcare for themselves upon attaining adulthood. If, in specific situations, a case can be made that deferral of treatment until adulthood is so essential in defined and time-critical circumstances for individual patients, then a court should be open to such a case and such a showing on an as-applied basis. *Cf. Gonzales v. Carhart*, 550 U.S. at 167-68; *Washington v. Glucksberg*, 521 U.S. at 735, n.24; *Jacobson v. Massachusetts*, 197 U.S. 11, 38-39 (1905). But

such a theory would not support a broad injunction against application of the Tennessee legislation on its face.

Respectfully submitted,

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