THE NOT-SO-SILENT EPIDEMIC OF SECRET GENDER-AFFIRMING POLICIES IN THE NATION'S SCHOOLS: PARENTAL RIGHTS AND THE PROMISE OF *PIERCE V. SOCIETY OF SISTERS*

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Does the new epidemic of secret gender-transition policies in the public schools violate the constitutional and common law right of fit parents to direct the care and upbringing of their children? This Article argues that policies hiding from parents the fact that school personnel are helping their children socially transition to the opposite sex while in school violates the historic right of parents to direct their children's medical care.

The Article traces the origins of parental rights in the common law and the broader Western legal tradition and analyzes the current state of the law concerning medical decisionmaking on behalf of minors. It then argues that secret gender-affirming policies constitute a form of medical decisionmaking independent of parents—and even if assisted social transitioning does not constitute medical treatment per se, it so influences children's future choices that it deprives parents of a meaningful opportunity to assist their children in navigating these issues. Thus, the effort of public schools to exclude parents from the decisionmaking process at the outset does contradict historic common law principles and arguably violates parents' constitutional rights.

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INTRODUCTION

The phrase "silent epidemic" may be overused, but the phenomenon can be real. And given the central role of public schools in American society, it is no surprise that many "silent epidemics" impacting those schools have been identified over the years. Limiting ourselves to several examples from the first four years of the current decade, the phrase has been applied to student disengagement,[1] student mental health issues due to COVID-19,[2] and out-of-school suspensions.[3] Examples could be multiplied.

Granted, once the appellation "silent" is ascribed to a given "epidemic," in print or in public debate, it is no longer literally silent. Yet typically, the epidemic continues for a season to be unnoticed by all except experts in the relevant field. At some point, the issue will generally register with the public sufficiently that the appellation must be dropped.

The purpose of this Article is to address a current, until-recently "silent" epidemic raging in America's public schools that has finally attracted much more attention from the media and the public, and which has generated increasing litigation in our courts. This epidemic is one in which public schools are hiding from parents, even by deceptive means, that school personnel are secretly helping their children to socially transition to the opposite sex while in school.[4]

Just how widespread is this epidemic? One vantage point comes from the petition for a writ of certiorari in a case in which a school policy explicitly designed to deceive parents—and defended as such—was challenged as a violation of parental rights. *John and Jane Parents 1 v. Montgomery County Board of Education* is the first case in which this issue was litigated to arrive at the United States Supreme Court, although the parents' petition for a writ of certiorari was denied.[5]

The parents lost their case in the United States District Court for the District of Maryland. The Board of Education filed a motion to

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1 *See* SAMANTHA E. HOLQUIST, JARED CETZ, SANTIAGO D. O'NEIL, DANA SMILEY, LANEY M. TAYLOR & MARISA K. CROWDER, MCREL INT'L, THE "SILENT EPIDEMIC" FINDS ITS VOICE: DEMYSTIFYING HOW STUDENTS VIEW ENGAGEMENT IN THEIR LEARNING 1 (2020).

2 *See* Randi Weingarten, *America's Silent Epidemic*, AM. FED'N OF TCHRS. (May 15, 2022), https://www.aft.org/column/americas-silent-epidemic [https://perma.cc/93EP-89V3].

3 *See* Bryan Goodwin, *Does Restorative Justice Work?*, EDUC. LEADERSHIP, October 2021, https://ascd.org/el/articles/research-matters-does-restorative-justice-work [https://perma.cc/MLV3-LEGE].

4 *See infra* notes 5–12 and accompanying text, Section II.B, Conclusion.

5 John & Jane Parents 1 v. Montgomery Cnty. Bd. of Educ., 78 F.4th 622 (4th Cir. 2023), *cert. denied*, 144 S. Ct. 2560 (2024).

dismiss for failure to state a claim.[6] The court dismissed various federal claims on that basis and dismissed the state law claims on standing grounds.[7] The parents did not appeal the dismissal of the state law claims. On appeal, the federal claims were also dismissed on standing grounds in a 2-1 decision at the United States Court of Appeals for the Fourth Circuit.[8] In their petition, the parents addressed both the standing issue and the merits of the case, i.e., whether the district's policy violated their parental rights.[9]

In the petition, filed on November 13, 2023, the parents documented "over 1,000 such policies affecting over 10,000,000 school children."[10] Eleven months later, on October 30, 2024, the latest update from the source the parents cited now documents that in thirty-seven states and the District of Columbia, such policies have been implemented in 1,215 school districts, which run 21,314 schools attended by 12,360,787 students.[11] In some school districts, including Montgomery County, the policies apply all the way down to the pre-kindergarten level.[12]

The enormity of this epidemic was recognized by Justices Alito and Thomas in their dissent from denial of certiorari in the second case to raise this issue at the Court, *Parents Protecting Our Children, UA v. Eau Claire Area School District*.[13] They acknowledged that in that petition the Court had been "told that more than 1,000 districts have adopted such policies."[14] Justices Alito and Thomas noted—as was also true in *John and Jane Parents 1*—that the Court of Appeals' decision to get rid of the case on standing grounds was concerning:

> I am concerned that some federal courts are succumbing to the temptation to use the doctrine of Article III standing as a way of avoiding some particularly contentious constitutional questions. While it is important that federal courts heed the limits of their constitutional authority, it is equally important that they carry out

6 John & Jane Parents 1 v. Montgomery Cnty. Bd. of Educ., 622 F. Supp. 3d 118, 123 (D. Md. 2022)

7 *Id.* at 139–42, 144–47.

8 *John & Jane Parents 1*, 78 F.4th at 636.

9 Petition for Writ of Certiorari at 11, 25, *John & Jane Parents 1*, 144 S. Ct. 2560 (No. 23-601) (discussing the opinions below).

10 *Id.* at 1.

11 *List of School District Transgender – Gender Nonconforming Student Policies*, DEFENDING EDUC., https://defendinged.org/investigations/list-of-school-district-transgender-gender-nonconforming-student-policies/ [https://perma.cc/RD78-2M8P] (Apr. 21, 2025).

12 Petition for Writ of Certiorari, *supra* note 9, at 3.

13 Parents Protecting Our Child., UA v. Eau Claire Area Sch. Dist., 95 F.4th 501 (7th Cir. 2024), *cert. denied*, 145 S. Ct. 14 (2024).

14 *Parents Protecting Our Child., UA*, 145 S. Ct. at 14 (Alito, J., dissenting from denial of certiorari).

> their "virtually unflagging obligation . . . to exercise the jurisdiction given them."[15]

Presumably, Justices Alito and Thomas were influenced by the arguments in the *Parents Protecting Our Children* cert petition, and they likely were by the arguments in the *John and Jane Parents 1* cert petition also. The former, *Parents Protecting Our Children*, noted that at the time of filing, twenty-eight cases involving this issue existed, and that many of them were disposed of on standing grounds.[16] In the latter, the pseudonymous parents quoted Judge Niemeyer's Fourth Circuit dissent, which asserted that deciding the case on standing grounds was "an 'unfortunate abdication' of the judicial duty."[17]

In the *John and Jane Parents 1* litigation, the parents argued that the policy, which they aptly referred to as the "Parental Preclusion Policy,"[18] violated their fundamental parental rights and "primary responsibilities to determine what is in their minor children's best interests with respect to their support, care, nurture, welfare, safety, and education."[19] In *Parents Protecting Our Children*, the association of parents only argued the standing issue, but left no doubt what right it was trying to vindicate: "parental decision-making authority over a major health-related decision."[20]

These assertions serve as the springboard for this Article. The Article will provide both a general background on parental rights and responsibilities, and specifically address, first, how medical care of minors fits into the larger context, and, second, why secret affirmation of gender transitioning violates the long-standing constitutional and common law rights of parents.

Part I will start with the constitutional framework of parental rights and explain the framework's common law and broader Western legal foundations, including those extending back to Roman and canon law. Part I will end with a review of how the parental rights framework and foundations have played out in the current legal environment governing parental medical decisionmaking. This

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15 *Id.* at 14–15 (quoting Colo. River Water Conservation Dist. v. United States, 424 U.S. 800, 817 (1976)).

16 Petition for Writ of Certiorari at 2, 13 n.12, 15 n.15, *Parents Protecting Our Child., UA*, 145 S. Ct. 14 (No. 23-1280).

17 Petition for Writ of Certiorari, *supra* note 9, at 1 (quoting John & Jane Parents 1 v. Montgomery Cnty. Bd. of Educ., 78 F.4th 622, 637 (4th Cir. 2023) (Niemeyer, J., dissenting)).

18 *Id.* at 3.

19 *Id.* at 7–8 (quoting Complaint at 12, John & Jane Parents 1 v. Montgomery Cnty. Bd. of Educ., 622 F. Supp. 3d 118 (D. Md. 2022) (No. 8:20-cv-03552)).

20 Petition for Writ of Certiorari, *supra* note 16, at i.

examination of caselaw will demonstrate that the scope of parental authority in this area is broad and subject to only limited exceptions.

Part II analyzes policies such as Montgomery County's "Parental Preclusion Policy" in light of the parental rights principles explicated in Part I. To set the stage, Part II begins by surveying the debate over the benefits and risks of so-called gender-affirming care for minors. Part II ends by synthesizing all that precedes it and makes the case that secret affirmation of students' gender transitioning constitutes a form of treatment that violates parental rights.

The Conclusion notes that such secret transitioning policies cannot pass constitutional muster under *Pierce v. Society of Sisters*.[21]

I. THE FUNDAMENTAL RIGHT OF PARENTS TO DIRECT THEIR CHILDREN'S MEDICAL CARE

A. Constitutional Protection of Parental Rights

Beginning with the holdings in *Pierce*[22] and *Meyer v. Nebraska*,[23] the Supreme Court has affirmed for more than a century that the right of parents to direct the care and upbringing of their children is protected by the Constitution.[24] While the Court has never specified the level of deference parental rights are due,[25] it has described those rights as "precious,"[26] "deeply rooted in [our] Nation's history,"[27] "essential to the orderly pursuit of happiness by free men,"[28] and "perhaps the oldest of the fundamental liberty interests recognized by this Court."[29]

Because the Constitution does not expressly address parents' rights, opinions differ as to where such rights are found.[30] The most

21 Pierce v. Soc'y of Sisters, 268 U.S. 510 (1925).

22 *Id.*

23 Meyer v. Nebraska, 262 U.S. 390 (1923).

24 *See, e.g.*, Santosky v. Kramer, 455 U.S. 745, 747–48 (1982); Bellotti v. Baird, 443 U.S. 622, 637–39 (1979). Numerous state courts have reached the same conclusion. *See, e.g.*, Holick v. Smith, 685 S.W.2d 18, 20 (Tex. 1985) ("The natural right existing between parents and their children is of constitutional dimensions.") (first citing *In re* G.M. 596 S.W.2d 846, 846 (Tex. 1980); and then citing Wiley v. Spratlan, 543 S.W.2d 349, 352 (Tex. 1976)); *In re* J.P., 648 P.2d 1364, 1372 (Utah 1982) (noting that the right of parents to direct the upbringing of children under their control is "protected by the Constitution").

25 William G. Ross, *The Contemporary Significance of* Meyer *and* Pierce *for Parental Rights Issues Involving Education*, 34 AKRON L. REV. 177, 183 (2000).

26 May v. Anderson, 345 U.S. 528, 533 (1953).

27 Moore v. City of East Cleveland, 431 U.S. 494, 503 (1977) (plurality opinion).

28 *Meyer*, 262 U.S. at 399.

29 Troxel v. Granville, 530 U.S. 57, 65 (2000) (plurality opinion).

30 *See, e.g.*, Doriane Lambelet Coleman & Philip M. Rosoff, *Adolescent Medical Decisionmaking Rights: Reconciling Medicine and Law*, 47 AM. J.L. & MED. 386, 389 (2021)

commonly cited location is the Fourteenth Amendment's Due Process Clause as supplemented by the legal fiction of substantive due process.[31] Others have suggested that parents' rights are among the unenumerated rights or "rights . . . retained by the people," as referenced in the Ninth Amendment[32] and reflected in the Fourteenth Amendment's Privileges or Immunities Clause.[33] Justice Scalia, writing in dissent in *Troxel v. Granville*, suggested the following:

> In my view, a right of parents to direct the upbringing of their children is among the "unalienable Rights" with which the Declaration of Independence proclaims "all men . . . are endowed by their Creator." And in my view that right is also among the "othe[r] [rights] retained by the people" which the Ninth Amendment says the Constitution's enumeration of rights "shall not be construed to deny or disparage."[34]

(suggesting that "the doctrine of parental autonomy[] is grounded in the First and Fourteenth Amendments, including in the Speech, Religion, Association, and Due Process Clauses").

31 *See, e.g.*, Deanda v. Becerra, 645 F. Supp. 3d 600, 621 (N.D. Tex. 2022); Dubbs v. Head Start, Inc., 336 F.3d 1194, 1203 (10th Cir. 2003); *see also* Lynne Marie Kohm, The Assault on Parental Rights in America 1–2 (July 30, 2020) (unpublished manuscript), https://ssrn.com/abstract=3664216 [https://perma.cc/3W5E-PYQU] (suggesting that due process mandates that parents who have acted consistently with their duties as parents be permitted to exercise their rights in protecting their children's best interests).

32 The Ninth Amendment provides that "[t]he enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people." U.S. CONST. amend. IX.

33 The Fourteenth Amendment's Privileges or Immunities Clause states: "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States . . . ." U.S. CONST. amend. XIV, § 1. Numerous scholars—with the possible concurrence of Justice Thomas—have pointed to this clause as the primary provision protecting fundamental individual rights from state interference. *See, e.g.*, Bradley P. Jacob, *Back to Basics: Constitutional Meaning and "Tradition,"* 39 TEX. TECH L. REV. 261, 276 (2007) (citing Steven G. Calabresi, *Lawrence, the Fourteenth Amendment, and the Supreme Court's Reliance on Foreign Constitutional Law: An Originalist Reappraisal*, 65 OHIO ST. L.J. 1097, 1109 (2004)); *see also* Trisha Olson, *The Natural Law Foundation of the Privileges or Immunities Clause of the Fourteenth Amendment,* 48 ARK. L. REV. 347, 396–438 (1995); David M. Smolin, *Fourteenth Amendment Unenumerated Rights Jurisprudence: An Essay in Response to* Stenberg v. Carhart, 24 HARV. J.L. & PUB. POL'Y 815, 820 (2001) (asserting that "[t]he privileges and immunities of citizenship concept . . . links common law liberties, a natural law tradition of ethically ordered liberties, and unenumerated rights").

In his concurring opinion in *Troxel*, Justice Thomas noted that the posture of the case foreclosed the "opportunity to reevaluate the meaning of [the Privileges or Immunities] Clause," but opined that the Court had long recognized "a fundamental right of parents to direct the upbringing of their children." *Troxel*, 530 U.S. at 80 & n.* (Thomas, J., concurring in judgment).

34 *Troxel*, 530 U.S. at 91 (Scalia, J., dissenting) (first quoting THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776); and then quoting U.S. CONST. amend. IX). The quotation is reproduced as it appears in the U.S. Reports. However, Justice Scalia's alteration

A third basis for constitutional protection of parental rights is the Fourteenth Amendment's guarantee of liberty.[35] Federal courts have found that the Fourteenth Amendment incorporates associational rights which may be asserted by both parents and children against unwelcome intrusion by the state in areas pertaining to children's healthcare.[36] In *Deanda v. Becerra*, for example, the United States District Court for the Northern District of Texas held that a regulation promulgated by the United States Department of Health and Human Services unconstitutionally interfered with parents' rights to control access to family planning services for their minor children.[37] The regulation provided that parental consent was not required by those administering Title X services including contraceptive prescriptions.[38] The court held that the regulation contravened both the constitutional and statutory rights of parents to control their children's access to such services.[39] With respect to the parents' constitutional rights under the Fourteenth Amendment, the court pointed to the Supreme Court's statement in *M.L.B. v. S.L.J.* that "[c]hoices about . . . the upbringing of children are among the associational rights this Court has ranked as 'of basic importance in our society,'" and are "sheltered by the Fourteenth Amendment against the State's unwarranted usurpation, disregard, or disrespect."[40] The court further emphasized that "[t]he principle that parental consent must be secured before medical treatment

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is confusing: "othe[r]" is better rendered "other[]," denoting the elimination of the "s" at the end of "others." Justice Dallin Oaks, of the Supreme Court of Utah, expressed the same view in *In re J.P.*: "The rights inherent in family relationships—husband-wife, parent-child, and sibling—are the most obvious examples of rights retained by the people. They are 'natural,' 'intrinsic,' or 'prior' in the sense that our Constitutions presuppose them . . . ." *In re* J.P., 648 P.2d 1364, 1373 (Utah 1982).

35 The Fourteenth Amendment provides: "[N]or shall any State deprive any person of life, liberty, or property, without due process of law . . . ." U.S. CONST. amend XIV, § 1.

36 *See, e.g.*, Kennedy v. Sch. Dist. of Lebanon, No. 11-cv-00382, 2011 U.S. Dist. LEXIS 157416 at *12, *12–13 (M.D. Pa. Dec. 21, 2011) (noting that "the right of parents to the care, custody, and nurture of their children has long been recognized as a liberty interest protected by the Fourteenth Amendment").

37 Deanda v. Becerra, 645 F. Supp. 3d 600 (N.D. Tex. 2022), *aff'd in part, rev'd in part*, 96 F.4th 750 (5th Cir. 2024).

38 *See id.* at 607–08.

39 *See id.* at 621–29. With respect to the parents' statutory rights, the court cited Texas Family Code § 151.001(a)(6), which provided that "the right to consent to the child's . . . medical and dental care, and psychiatric, psychological, and surgical treatment" resided with the parent. *Id.* at 607–08 (quoting TEX. FAM. CODE ANN. § 151.001(a)(6) (West 2023)).

40 *Id.* at 625 (emphasis omitted) (quoting M.L.B. v. S.L.J., 519 U.S. 102, 116 (1996)).

provided is time honored and has been recognized by both the courts and the legislature."[41]

The United States Court of Appeals for the Ninth Circuit likewise found that parents sufficiently alleged a violation of their constitutional right to family association when they complained of nonconsensual medical examinations of their minor children by social workers while the children were in protective custody.[42] The court found that the Fourteenth Amendment "includes the right of parents to make important medical decisions for their children, and of children to have those decisions made by their parents rather than the state."[43]

B. Historic Recognition of Minority Status and Parental Rights and Responsibilities

1. Common Law Foundation

Whatever the constitutional source of parental rights, those rights are firmly rooted in our nation's legal history and should be treated as fundamental. While the Court has never established a precise formula for determining whether a right not specified in the Constitution deserves heightened scrutiny, it has identified two criteria. First, the asserted right must be "deeply rooted in [the] Nation's history and tradition."[44] Second, the right must be central to the preservation of liberty.[45] The right of parents to direct the upbringing and maintenance of their children meets both criteria. The absence of any explicit reference to parental rights in the Constitution reflects how thoroughly imbedded the concept was in our common law tradition and how self-evident the Founders considered it to be.[46]

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41 *Id.* at 612 (alteration in original) (quoting Parents United for Better Schs., Inc. v. Sch. Dist. of Phila. Bd. of Educ., 646 A.2d 689, 691 (Pa. Commw. Ct. 1994)).

42 *See* Benavidez v. County of San Diego, 993 F.3d 1134, 1141 (9th Cir. 2021).

43 *Id.* at 1149 (quoting Wallis v. Spencer, 202 F.3d 1126, 1141 (9th Cir. 2000)). In *Benavidez* and *Wallis*, the Ninth Circuit recognized a right of family integrity—an associational right belonging to both parents and children for parents to make medical decisions on behalf of their children instead of having those decisions made by the state. For a more extensive discussion of the issue of family integrity and associational rights, see Shanta Trivedi, *My Family Belongs to Me: A Child's Constitutional Right to Family Integrity*, 56 HARV. C.R.-C.L. L. REV. 267 (2021).

44 Moore v. City of East Cleveland, 431 U.S. 494, 503 (1977) (plurality opinion).

45 Bowers v. Hardwick, 478 U.S. 186, 191–92 (1986) (explaining that the category of rights "qualifying for heightened judicial protection" "includes those fundamental liberties that are 'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if [they] were sacrificed'" (alteration in original) (quoting Palko v. Connecticut, 302 U.S. 319, 325, 326 (1937)).

46 *See, e.g.*, RICHARD E. LESSNER, THE CORNERSTONE OF LIBERTY: NATURAL LAW, AMERICA'S UNWRITTEN CONSTITUTION 10–15 (2001); Jennifer H. Gelman, Comment, *Brave*

From an early date, the English common law placed upon parents both the duty and the right to guide their children's development and make important decisions for them. Children were viewed as lacking the knowledge, experience and judgment to make life-changing decisions on their own.[47] Consequently, they were protected from the enforcement of contracts other than those for necessities;[48] they had but limited authority to dispose of their estates;[49] they were sheltered from lawsuits in a variety of contexts;[50] they were forbidden to marry without consent;[51] and they were precluded from holding positions of public trust.[52] Given the disabilities of minors under the common law, it was generally understood that parents were bound to provide what was lacking and ensure their children's protection and maintenance. Seventeenth-century philosopher John Locke reflected that mindset when he wrote as follows:

> [Adam's descendants] are all born infants, weak and helpless, without knowledge or understanding. But to supply the defects of this imperfect state till the improvement of growth and age had removed them, . . . all parents were, by the law of Nature, under an obligation to preserve, nourish, and educate the children they had begotten . . . .[53]

New School: A Constitutional Argument Against State-Mandated Mental Health Assessments in Public Schools, 26 N. ILL. U. L. REV. 213, 215–16 (2005).

47 *See, e.g.*, 3 MATTHEW BACON, A NEW ABRIDGMENT OF THE LAW 136 (London, W. Strahan & M. Woodfall, 4th ed. 1778) (speaking of "the Indulgence the Law has thought fit to give Infants, who are supposed to want Judgment and Discretion in their Contracts and Transactions with others, and the Care [the Law] takes of them in preventing their being imposed upon or over-reached by Persons of more Years and Experience"); *see also* JOHN SHERIDAN, THE PRESENT PRACTICE OF THE COURT OF KING'S BENCH 559 (Dublin, James Moore 1792) (describing the legal disabilities to which minors were subject as "privileges" that were meant "to secure them from hurting themselves by their own improvident acts"); 1 RICHARD HOOKER, OF THE LAWS OF ECCLESIASTICAL POLITY (1593), *reprinted in* 1 RICHARD HOOKER, THE WORKS OF THAT LEARNED AND JUDICIOUS DIVINE, MR. RICHARD HOOKER 168 (Isaac Walton ed., Oxford, Clarendon Press 1875) (opining that young children lack the capacity for right reason and require the guidance of others more mature).

48 *See, e.g.*, 2 KNIGHTLEY D'ANVERS, GENERAL ABRIDGMENT OF THE COMMON LAW 769 (London, E. Nutt, R. Nutt & R. Gosling, 2d ed. 1722); *see also* BACON, *supra* note 47. As further clarified by Bacon, even contracts for "Necessaries" were subject to review for their reasonableness. *Id.* at 133.

49 4 BACON, *supra* note 47, at 336.

50 Minors were sheltered, for example, from prosecution for capital crimes. *See id.* at 341.

51 *Id.* at 336.

52 *See id.* at 345–46.

53 JOHN LOCKE, SECOND TREATISE ON CIVIL GOVERNMENT § 56 (1690), *reprinted in* JOHN LOCKE, ON POLITICS AND EDUCATION 101 (1947) (opining that children lack capacity to understand the law before age twenty-one and must be guided by parent or guardian, *id.* at § 59).

The obligation to provide for their children's maintenance included the exercise of care for their children's bodily health.[54] By the late 1800s, the High Court of Justice in England and Wales was routinely holding that the failure of a parent or guardian to provide proper medical care for a child, if death resulted, constituted grounds for manslaughter.[55]

Further, the English common law recognized a correlative right for parents to make the decisions necessary to fulfill those obligations. "The power . . . that parents have over their children arises from that duty which is incumbent on them, to take care of their offspring during the imperfect state of childhood."[56] Thus, for more than three centuries, the common law has posited in parents the right to provide for their children's nurture and support in the way they consider best—including the right to select appropriate medical care.[57]

These principles were naturally extended to our own nation following the War of Independence,[58] and the same concepts of minority status and parental rights and responsibilities were reflected in our earliest cases.[59] Thus, American law, from the outset, made parents "the

54 *See id.* at § 61 (stressing the duty to provide "[t]he necessities of [the child's] life, the health of his body, and the information of his mind"); *see also* 9 HALSBURY'S LAWS OF ENGLAND 625 (1909) (defining criminal neglect to include the failure to "provide adequate food, clothing, [or] medical aid" for a minor under one's care); JOHN TAYLOR, ELEMENTS OF THE CIVIL LAW 383 (Cambridge, Joseph Bentham 1755) (noting the possibility of civil liability for a parent who failed to provide for his child's "[b]odily [h]ealth and [p]reservation").

55 *See, e.g.*, R v. Downes [1875] 1 QBD 25 (as applied to a child two years of age); R v. Morby [1882] 8 QBD 571 at 574 (with the caveat that liability for manslaughter would require proof that death would not have occurred had medical aid been provided).

56 LOCKE, *supra* note 53, at § 58; *see also* 1 WILLIAM BLACKSTONE, COMMENTARIES *440 ("The *power* of parents over their children is derived from the former consideration, their duty; this authority being given them, partly to enable the parent more effectually to perform his duty, and partly as a recompence for his . . . trouble in the faithful discharge of it."). The duty of parents and their corresponding rights were more than philosophical constructs. They were expressly recognized by the English courts. *See, e.g.*, *In re* Agar-Ellis [1883] 24 Ch 317 at 327 ("The law recognises the rights of the father because it recognises the natural duties of the father."); *see also In re* Hudson, 126 P.2d 765, 771 (Wash. 1942) (discussing parental rights at common law and the holding of *In re Agar-Ellis*).

57 *See* WILLIAM FORSYTH, A TREATISE ON THE LAW RELATING TO THE CUSTODY OF INFANTS 9 (London, William Benning & Co. 1850).

58 *See* Lynne Marie Kohm, *Tracing the Foundations of the Best Interests of the Child Standard in American Jurisprudence*, 10 J.L. & FAM. STUD. 337, 347 (2008).

59 *See, e.g.*, C.C. ANDREWS, DIGEST OF OPINIONS OF THE ATTORNEYS GENERAL OF THE UNITED STATES 134 (Washington, D.C., William M. Morrison & Co. 1857) (discussing the limited enforceability of contractual obligations undertaken by minors); 1 JOHN ANTHON, DIGESTED INDEX TO THE REPORTED DECISIONS OF THE SEVERAL COURTS OF LAW IN THE UNITED STATES 181 (New York, I. Riley 1813) (discussing the law of promissory notes signed by minors); 1 JOHN BOUVIER, INSTITUTES OF AMERICAN LAW 138 (Philadelphia, Robert E. Peterson & Co. 1854) (noting the reliance of infants on the legal protection of parents

guardian[s] of [their] children by nature and by nurture,"[60] and the "[o]bligation[s] and right[s]" invested in the parents were viewed as "correlative."[61] In his *Institutes of American Law*, jurist John Bouvier explained that "[t]o enable the parents to perform their duties toward their children, and for their benefit, the law has invested them with considerable authority."[62] As consistently affirmed by our courts for more than a century, that authority includes both the obligation and the right of parents to direct the medical care of their children subject only to limited exceptions as discussed in Section I.C.2 of this Article.[63]

2. The Broader Western Legal Tradition

The common law's recognition of minority status and parental authority did not arise in a vacuum. It owed much to the broader legal culture that developed throughout Western Europe during the Middle Ages and before.[64] Accordingly, the protections provided children under the common law—and the responsibility of parents to direct their children's development and care—had their genesis before Blackstone, Coke, and even Bracton.[65] The concept of minority status, for example, was present, though nascent, in Roman law as developed during the classical period and later codified by Justinian. As early as the

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"until [they have] attained a sufficient maturity to manage [their] affairs"); WILLIAM MACPHERSON, A TREATISE ON THE LAW RELATING TO INFANTS 60 (Philadelphia, John S. Littell 1843) (stressing the general right of parents to exercise control over their children's affairs "by virtue of their guardianship *for cause of nurture*").

60 MACPHERSON, *supra* note 59, at 61 (noting that the father's right under the law extended until the child was twenty-one).

61 *See* 1 T. RUTHERFORTH, INSTITUTES OF NATURAL LAW 31 (Cambridge, J. Bentham 1754). "[S]ince nature cannot be supposed to prescribe a duty to the parents, without granting them the means, which are necessary for the discharge of such duty; it follows, that nature has given the parents all the authority, which is necessary for bringing up the child in a proper manner." *Id.* at 160.

62 BOUVIER, *supra* note 59, at 135.

63 *See, e.g.*, Mayhew v. Burns, 2 N.E. 793, 794 (Ind. 1885) (holding, in a wrongful death action, that parents had a common law right to recover for "medical attendance, care, and nursing" while the child was alive because the parents "owed the child the corresponding obligation of care, nursing, and medical attention"); Harris v. Crawley, 126 N.W. 421, 421 (Mich. 1910) (reversing a lower court's award of damages for medical expenses to a minor child because the expenses would be chargeable against the father rather than the child).

64 *See* William W. Bassett, *Canon Law and the Common Law*, 29 HASTINGS L.J. 1383, 1386–87 (1978).

65 For a more detailed description of the historic development of parental rights and obligations under the law in the context of education, see Eric A. DeGroff, *Parental Rights and Public School Curricula: Revisiting* Mozert *After 20 Years*, 38 J.L. & EDUC. 83, 108–22 (2009) (tracing the origin of parents' legal rights and responsibilities at common law to the thirteenth century, and their early counterpart under the Church's canon law of the sixteenth and seventeenth centuries).

fourth century, the Emperor Constantine granted protection for children from being sued outside the province where they lived.[66] Children under the age of seven could not be charged with crimes;[67] minors faced restrictions on their right to marry;[68] and the heads of Roman families (the *paterfamilias*) were at least implicitly obliged to provide financial support for their households, including their legitimate children.[69]

The work of the canonists of the Roman Catholic Church[70] had an even more direct influence than that of the Romans in the development of these principles in the common law. Like its Roman counterpart, canon law recognized jurisdictional limitations for suits levied against minors;[71] it offered protection for children against the enforcement of ill-advised contracts;[72] and it was among the canonists that the duty of parents to nurture and support their children acquired a moral dimension.[73] Drawing from relevant New Testament writings,[74] Church Fathers pronounced a curse upon parents who failed to provide for their children. A canon of the fourth-century Council of Gangra asserted that, "[i]f anyone shall forsake his own children and shall not nurture them, . . . but shall neglect them, . . . let him be

66 R.H. Helmholz, *Children's Rights and the Canon Law: Law and Practice in Later Medieval England*, 67 JURIST 39, 42 (2007).

67 *See, e.g.*, W.W. BUCKLAND & ARNOLD D. MCNAIR, ROMAN LAW AND COMMON LAW: A COMPARISON IN OUTLINE 46, 350 (2d ed. 1952).

68 *See, e.g.*, Sarah Hanley, *"The Jurisprudence of Arrêts": Marital Union, Civil Society, and State Formation in France, 1550–1650*, 21 L. & HIST. REV. 1, 6 (2003) (noting that Roman law had adhered to strict parental consent as a condition for valid marriage).

69 R.H. Helmholz, *Support Orders, Church Courts, and the Rule of* Filius Nullius*: A Reassessment of the Common Law*, 63 VA. L. REV. 431, 433–34 (1977).

70 As explained by the late Professor Harold Berman, canon law consisted of rules and decrees drawn from scripture and other authoritative writings of the Roman Catholic Church, pronouncements by popes, Church councils and bishops, laws of Christian kings relating to the Church, and a variety of other sources. *See* Harold J. Berman, *The Religious Foundations of Western Law*, 24 CATH. U. L. REV. 490, 497–98 (1975). Berman often referred to the medieval canon law as "the first modern Western legal system." HAROLD J. BERMAN, LAW AND REVOLUTION: THE FORMATION OF THE WESTERN LEGAL TRADITION 2 (1983). The Church began to collect and systematize this body of law around 1050 to 1250 A.D., facilitated by the work of Gratian in the twelfth century and Pope Gregory IX in the thirteenth century. *See* Bassett, *supra* note 64, at 1388–89; BERMAN, *supra*, at 202–03.

71 Helmholz, *supra* note 66, at 50.

72 *Id.*

73 CHARLES J. REID, JR., POWER OVER THE BODY, EQUALITY IN THE FAMILY: RIGHTS AND DOMESTIC RELATIONS IN MEDIEVAL CANON LAW 83 (2004).

74 *See, e.g.*, *Luke* 11:11–12 ("What father among you, if his son asks for a fish, will instead of a fish give him a serpent; or if he asks for an egg, will give him a scorpion?"); *1 Timothy* 5:8 ("If any one does not provide for his relatives, and especially for his own family, he has disowned the faith and is worse than an unbeliever.").

Anathema."[75] The Council's declaration later became formally embedded in canon law and was foundational to the Church's understanding of family relations.[76] Thus, by the medieval period, the duty to nurture and maintain one's child had become "part and parcel of parenthood"[77] and was being routinely enforced by the English Court of Chancery.[78]

Perhaps no issue better illustrates the medieval Church's respect for the natural rights of parents than the Church's stance on the forced baptism of infants abducted from non-Christian (primarily Jewish) families. By the thirteenth century, Church canons had established an age of "reason" or "discretion" which, for most purposes, was associated with the attainment of puberty or age fourteen, at least for males.[79] Children under that age—whether Christian or "heathen"—were to remain under the rule of their parents.[80] As early as the ninth century, a canon of the Council of Mainz, which was later included in the *Decretals* of Pope Gregory IX, provided that "if a person entered a monastic community before the legal age . . . , without his or her parents' consent, the parents ha[d] up to a year to demand that the child be returned to their custody."[81] The "legal age" of consent for joining a religious order or monastery without a parent's consent was "fourteen for males and twelve for females."[82]

Unfortunately, adherence to the Church's teaching on this matter was inconsistent. The abduction and baptism of Jewish children by zealous Catholics in France, Italy and elsewhere became a "source of

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75 *Canons of Gangra*, *in* John Fulton, INDEX CANONUM 223, 227 (New York, Pott, Young & Co. 1872); *see also* REID, *supra* note 73, at 84 (discussing the Council of Gangra).

76 The fourth-century canon of the Council of Gangra was included essentially verbatim centuries later by Gratian in his landmark summary of Church law, and the same principle was reflected in the writings of St. Thomas Aquinas and the *Decretals* of Pope Gregory a hundred years after Gratian. *See* John Witte, Jr., *The Nature of Family, the Family of Nature: The Surprising Liberal Defense of the Traditional Family in the Enlightenment*, 64 EMORY L.J. 591, 606 (2015) (noting Aquinas's observation of the need for "nurture, protection, food, shelter, and education" by children from their parents); *see also* Jessica Goldberg, *The Legal Persona of the Child in* Gratian's Decretum, 24 BULL. MEDIEVAL CANON L. 10, 19–20 (2000).

77 Adam Hofri-Winogradow, *Parents, Children and Property in Late 18th-Century Chancery*, 32 OXFORD J. LEGAL STUD. 741, 747 (2012).

78 Goldberg and Helmholz cite multiple cases from the Court of Chancery enforcing the obligation of parental support as early as the eleventh century and through the fifteenth. *See* Helmholz, *supra* note 69, at 437–42; Goldberg, *supra* note 76, at 25.

79 Goldberg, *supra* note 76, at 18.

80 *See, e.g.*, ST. THOMAS AQUINAS, SUMMA THEOLOGICA pt. III, q. 68, art. 10 (Fathers of the English Dominican Province trans., Thomas Baker 1914) (1265–1274).

81 Aviad M. Kleinberg, *A Thirteenth-Century Struggle Over Custody: The Case of Catherine of Parc-aux-Dames*, 20 BULL. MEDIEVAL CANON L. 51, 58 (1990).

82 *Id.*

anxiety for Jewish communities."[83] While the seizure and forceable baptism of such children was reportedly "never a widespread phenomenon,"[84] it occurred often enough that Pope Benedict XIV issued two letters in 1747 ruling that, with few exceptions,[85] "minor children should never be baptized without consent of parents."[86] The right of parents to refuse baptism for a nonbelieving child had been defended in the strongest terms by Aquinas hundreds of years earlier, when he asserted:

> [N]o one ought to break the order of the natural law, whereby a child is in the custody of its father, in order to rescue it from the danger of everlasting death.
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> . . . .
>
> . . . Man is directed to God by his reason, whereby he can know Him. Hence a child before coming to the use of reason, in the natural order of things, is directed to God by its parents' reason, under whose care [the child] lies by nature . . . .[87]

The canonists had a profound effect on the development of legal thought throughout the Christian world and particularly in England.[88] Catholic clergy constituted much of the educated class in England during the medieval period and held responsible positions in the common law courts.[89] Interplay between the canonists and the common lawyers was therefore inevitable. Hence, the influence of canon law on the tenor and substance of the common law has been described by scholars as "foundational," "pervasive," "incalculable," and "enduring."[90]

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83 Matthew A. Tapie, Spiritualis Uterus*: The Question of Forced Baptism and Thomas Aquinas's Defense of Jewish Parental Rights*, 35 BULL. MEDIEVAL CANON L. 289, 294 (2018).

84 Kleinberg, *supra* note 81, at 67.

85 Exceptions were made for infants who were in imminent danger of death, abandoned by their parents, or baptized with permission of at least one of their parents or another family member. *See* Tapie, *supra* note 83, at 302.

86 *Id.*

87 AQUINAS, *supra* note 80, at pt. II-II, q. 10, art. 12 (R. & T. Washbourne, Ltd. 1917). In answer to his readers' concern that failure to baptize an unbeliever when possible and thus save his errant soul, Aquinas asserted that the guilt would lie with the child's parents, in whose custody God had placed it. "[T]o provide the sacraments of salvation for the children of unbelievers is the duty of their *parents*. Hence it is *they* whom the danger threatens, if through being deprived of the sacraments their children fail to obtain salvation." *Id.* (emphasis added).

88 *See* CARL GÜTERBOCK, BRACTON AND HIS RELATION TO THE ROMAN LAW: A CONTRIBUTION TO THE HISTORY OF THE ROMAN LAW IN THE MIDDLE AGES 61 n.(o) (Brinton Coxe trans., Philadelphia, J.B. Lippincott & Co. 1866).

89 Berman, *supra* note 70, at 498.

90 Bassett, *supra* note 64, at 1386–87, 1408–11. Professor Helmholz similarly opined that "the development of the common law rules regulating domestic relations cannot be understood without [an examination of the canon law enforced in the ecclesiastical courts]." Helmholz, *supra* note 69, at 433.

Clearly, then, a respect for the family—and for the sanctity of parent-child relationships—has been woven into the fabric of western legal thought from before the Middle Ages. Though only briefly summarized here, this extensive history demonstrates that Justice O'Connor did not exaggerate when she described parental rights as "perhaps the oldest of the fundamental liberty interests recognized by this Court."[91]

C. Current State of the Law Concerning Medical Decisionmaking on Behalf of Minors

Although the Supreme Court affirmed in *Parham v. J.R.* the right of parents to make medical decisions on behalf of their children,[92] it has never fully elaborated what that might look like. Lower federal courts and state courts, however, have considered this issue frequently and have consistently affirmed the historic common law right of parents to make such decisions with limited exceptions. The general contour of parental rights as reflected in these cases is clear. But questions remain about how those principles should apply in the context of gender-transition and public-school policies. This Section of the Article will summarize relevant federal and state caselaw, while Part II will suggest how the principles established by this body of law should apply to secret gender-transition policies and practices in the nation's schools.

1. The Broad Scope of Parental Authority

From the turn of the twentieth century to the present, both federal and state courts have construed broadly the right of parents to direct their children's medical care. The thinking has been that (1) children lack the capacity to consent to medical treatment; (2) nonconsensual treatment constitutes an assault or battery by the provider; therefore (3) consent must be obtained from a parent or guardian with legal authority to act on the child's behalf. A 1920 decision by the Texas Commission of Appeals (Commission) reflects this reasoning.[93] In that case the Commission held for a father who sued doctors for performing a nonemergency tonsillectomy on his eleven-year-old daughter without his permission.[94] The daughter had been visiting an adult sister when the daughter became ill.[95] The sister, who

91 Troxel v. Granville, 530 U.S. 57, 65 (2000) (plurality opinion).

92 Parham v. J.R., 442 U.S. 584 (1979) (holding that the state's process for voluntary institutionalization of mentally ill minor children by their parents was constitutional); *see infra,* notes 239 and 286–87 and accompanying text.

93 Moss v. Rishworth, 222 S.W. 225 (Tex. Comm'n App. 1920).

94 *Id.* at 226–27.

95 *Id.* at 226.

had three years of training as a graduate nurse, took the daughter to a doctor and ultimately gave permission for the surgery when told that it was medically necessary.[96] Through no apparent fault of the surgeon, the young girl died under anesthesia.[97] Despite the sister's extensive medical training, her status as an adult, her close relationship to the decedent, and her temporary lawful custody of the child, the Commission held that the surgery was nonconsensual because the girl's parent "was the only one who could legally give consent to perform it."[98] As the Commission explained, "[t]he law wisely reposes in the parent the care and custody of the minor child, and neither a physician nor those in temporary custody of the child will be permitted . . . to determine those matters touching its welfare."[99]

Fifteen years later, the Supreme Court of Michigan likewise held that parental permission was required before medical treatment could be given to a minor.[100] In September 1927, the teacher of a nine-year-old boy suspected that the boy had infected tonsils.[101] She therefore had the boy taken, during the school day, to the city physician.[102] The physician determined that surgery was needed,[103] and the boy was taken to a hospital where surgery was performed by authority of the city doctor.[104] The boy's parents became aware of the surgery only after it was completed.[105] Despite the fact that school personnel and a trusted physician agreed correctly that the treatment was justified, the court found the surgery unlawful. Citing *Moss v. Rishworth*, the court emphasized that "[e]xcept in the very extreme cases, a surgeon has no legal right to operate upon a child without the consent of its parents or guardian."[106]

Courts have further found that the requirement for parental consent extends beyond surgeries or other physical interventions to less invasive procedures including medical exams. In *Kennedy v. School District of Lebanon*, a school district had a policy requiring all students to

96 *Id.*
97 *Id.*
98 *Id.*
99 *Id.* at 227.
100 Zoski v. Gaines, 260 N.W. 99 (Mich. 1935).
101 *Id.* at 100.
102 *Id.*
103 *Id.*
104 *Id.*
105 *Id.*
106 *Id.* at 102 (citing Moss v. Rishworth, 222 S.W. 225, 226 (Tex. Comm'n App. 1920)); *see also* Mohr v. Williams, 104 N.W. 12 (Minn. 1905), *overruled in part by* Genzel v. Halvorson, 80 N.W.2d 854 (Minn. 1957); *cf.* Browning v. Hoffman, 111 S.E. 492 (W. Va. 1922), *overruled in part by* Belcher v. Charleston Area Med. Ctr., 422 S.E.2d 827 (W. Va. 1992); Rolater v. Strain, 137 P. 96 (Okla. 1913).

receive physical exams administered by a specific provider.[107] The district had informed parents of the time and location of the exams and had promised parents that they could be present.[108] However, some of the physicals were later rescheduled without notice.[109] Operating under the revised schedule, health officials took the plaintiffs' child from his class a month earlier than originally planned and gave him a complete physical.[110] The change of date prevented his parents from attending, and the child went home very upset.[111] Although they had originally consented to the exam, the parents sued the school district for violating their Fourteenth Amendment rights.[112] Holding for the parents, the district court declared:

> [T]he right of parents to the care, custody, and nurture of their children has long been recognized as a liberty interest protected by the Fourteenth Amendment to the Constitution. Specifically, . . . the right to familial association is a right with many subsets, including both the right of parents to make medical decisions for their child, and the right of the child to have those decisions made by their parent rather than the state.[113]

At least three federal circuits have considered this issue, and all have affirmed the rights of parents consistent with historic common law principles. The United States Court of Appeals for the District of Columbia, in *Bonner v. Moran*,[114] considered circumstances similar to those in *Moss*.[115] A fifteen-year-old boy was living in Washington, D.C., with his mother when his aunt brought his cousin (the aunt's niece) to the city to receive treatment for severe burns.[116] Attending physicians told the aunt that a skin graft would help the girl if a suitable donor could be found.[117] The boy's blood matched the girl's, and with his aunt's encouragement the young boy agreed to serve as a donor.[118]

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107 Kennedy v. Sch. Dist. of Lebanon, No. 11-cv-00382, 2011 U.S. Dist. LEXIS 157416 (M.D. Pa. Dec. 21, 2011).

108 *Id.* at *4.

109 *Id.* at *14.

110 *Id.* at *4.

111 *Id.*

112 *Id.* at *8.

113 *Id.* at *12–13 (citing Troxel v. Granville, 530 U.S. 57, 65–66 (2000) (plurality opinion) ("It is cardinal with us that the custody, care and nurture of the child reside first in the parents . . . ." *Id.* at 65.)); *see also* City of Dallas v. Mosely, 286 S.W. 497, 500 (Tex. Civ. App. 1926) (finding state statute creating a Department of Health to be placed in the city's schools constitutional only because the law permitted parents to opt their children out of any proposed examinations).

114 Bonner v. Moran, 126 F.2d 121 (D.C. Cir. 1941).

115 *See supra* notes 93–99 and accompanying text.

116 *Bonner*, 126 F.2d at 121.

117 *Id.*

118 *Id.*

Unfortunately, the donor process turned into a painful, two-month cycle of surgeries and blood transfusions for the boy.[119]

The boy's mother, who claimed she knew nothing about his ordeal until it was over,[120] sued on behalf of herself and her son for assault and battery.[121] The court did not reach the merits of her complaint, but it overruled a key jury instruction which the plaintiffs had challenged.[122] The trial court had instructed the jury that, if they believed the child himself was "capable of appreciating . . . the nature and consequences of the operation and actually . . . or . . . impliedly consented," the jury should rule for the defendant surgeon.[123] Citing both *Zoski*[124] and *Moss*,[125] the court emphasized the common law's infancy exception to the matter of consent.[126] Among other factors, the court noted that the need for the skin graft was not immediate; the boy's mother could have been contacted before the procedure began; and the possible long-term effects of the surgeries on the boy's future life were not self-evident.[127] The court therefore affirmed that the mother's consent was legally required.[128] Neither the consent of the child himself nor that of a related adult with lawful custody sufficed.

More recently, the United States Court of Appeals for the Tenth Circuit addressed a complaint by parents whose children were subjected to unapproved physical exams by a Head Start program in Tulsa, Oklahoma.[129] In reversing the trial court's dismissal of the parents' claim over the nonconsensual exams, the court held that the assertion of a Fourteenth Amendment substantive due process claim was at least plausible, and that the trial court's application of a "shocks the conscience" standard was erroneous.[130]

More recently still, the United States Court of Appeals for the Sixth Circuit considered a Fourteenth Amendment claim by parents whose newborn infants underwent health screenings which involved

119 *Id.* at 121–22.
120 *Id.* at 122.
121 *Id.* at 121.
122 *Id.* at 122–23.
123 *Id.* at 122.
124 *See supra* notes 100–06 and accompanying text.
125 *See supra* notes 93–99 and accompanying text.
126 *Bonner*, 126 F.2d at 122.
127 *Id.* at 122–23. The court referenced the boy's absence from school for two months; the multiple surgeries required, with each involving anesthesia; the removal of skin from his body; bloodletting; and the eventual permanent disfigurement. *Id.* at 123.
128 *Id.* at 122.
129 *See* Dubbs v. Head Start, Inc., 336 F.3d 1194, 1197 (10th Cir. 2003).
130 *Id.* at 1203.

the taking of blood samples.[131] Under the state's Newborn Screening Program, the Michigan Department of Health and Human Services obtained and stored blood samples without the parents' consent.[132] In reversing the trial court's dismissal of the parents' due process claim, the court characterized the rights of the parents as fundamental and subject to strict scrutiny:

> Parents possess a fundamental right to make decisions concerning the medical care of their children. . . .
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> . . . [C]hildren do not possess the right to make medical decisions for themselves because [they] " . . . are not assumed to have the capacity to take care of themselves." . . . [Thus,] [c]hildren "are assumed to be subject to the control of their parents." . . .
>
> The existence of a fundamental right means that "[g]overnment actions that burden the exercise of [the right] are subject to strict scrutiny, and will be upheld only when they are narrowly tailored to a compelling governmental interest."[133]

2. Exceptions to Parental Discretion

The right of parents to direct their children's medical care is not unlimited, but the courts have given substantial deference to parents consistent with the constitutional and common law principles outlined above. In only two circumstances have courts consistently overruled parental decisions. First, they have appropriately stepped in when the life of a child was at stake or the parents' failure to provide recommended treatment was likely to cause serious and irreparable harm to the child.[134] Second, they have overruled parental preferences when those choices were deemed likely to compromise public health.[135]

A substantial number of the cases in which courts have countermanded parental decisions have entailed the need for prompt action

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131 *See* Kanuszewski v. Mich. Dep't of Health & Hum. Servs., 927 F.3d 396 (6th Cir. 2019).

132 *Id.* at 404.

133 *Id.* at 418–19 (fifth and sixth alterations in original) (first quoting Schall v. Martin, 467 U.S. 253, 265 (1984); and then quoting Seal v. Morgan, 229 F.3d 567, 574–75 (6th Cir. 2000)).

134 *See infra* notes 136–42 and accompanying text.

135 *See, e.g.*, Phillips v. City of New York, 775 F.3d 538, 540 (2d Cir. 2015) (holding that the requirement for all children to be vaccinated in order to attend public school was a constitutionally permissible exercise of state police power); Leta v. Hamilton Cnty. Dep't of Job & Fam. Servs., 668 F. Supp. 3d 724, 730 (S.D. Ohio 2023) (holding that children temporarily removed from parents' homes and placed in foster homes could be given vaccinations without parental consent); Kraus v. City of Cleveland, 116 N.E.2d 779, 801–03 (Ohio Ct. Com. Pl. 1953) (holding that fluoridation of local water supplies against the wishes of parents did not violate the parents' right to rear and care for their children).

to provide critical, lifesaving care. In *Morrison v. State*, for example, the Missouri Court of Appeals upheld the judgment of a juvenile court ordering a blood transfusion for a twelve-day-old infant against his parents' wishes.[136] Medical personnel were convinced that without the blood transfusions death would be imminent.[137] Likewise, in *Custody of a Minor*, the Supreme Judicial Court of Massachusetts concluded that multiple stages of chemotherapy offered the only lifesaving alternative for a twenty-month-old infant suffering from an aggressive form of leukemia.[138] Even then—despite clear medical evidence supporting its action—the court felt it necessary to justify its intervention:

> [Courts] uniformly have decided that State intervention is appropriate where the medical treatment sought is necessary to save the child's life.
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> . . . .
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> . . . [C]ourts have shown great reluctance to overturn parental objections to medical treatment where the child's condition is not life-threatening, and where the proposed treatment would expose the child to great risk.[139]

Even when the child's life was not at risk, courts have intervened when necessary to prevent catastrophic physical or mental harm. In *People ex rel. Wallace v. Labrenz*, the Illinois Supreme Court determined that a blood transfusion was essential for a child in order to prevent severe and permanent brain impairment.[140] Likewise, in *In re Jensen*, the Oregon Court of Appeals ordered treatment for a fifteen-month-

136 Morrison v. State, 252 S.W.2d 97 (Mo. Ct. App. 1952).

137 *Id.* at 99. Courts have regularly ordered blood transfusions or other lifesaving care even when parental objections were motivated by religious beliefs. *See, e.g.*, People *ex rel.* Wallace v. Labrenz, 104 N.E.2d 769, 771 (Ill. 1952) (where newborn daughter had a blood condition and doctors unanimously concluded that, without a blood transfusion, she had little hope of surviving); State v. Perricone, 181 A.2d 751, 753 (N.J. 1962) (infant with enlarged heart showed signs of oxygen deprivation and needed blood transfusion); *In re* D.L.E., 645 P.2d 271, 272 (Colo. 1982) (fourteen-year-old's life was in danger due to grand mal epileptic condition but mother refused treatment due to religious objections); *In re* Eric B., 235 Cal. Rptr. 22 (Cal. Ct. App. 1987) (ordering that a three-year-old child undergo chemotherapy and radiation for cancer, followed by two years of observation).

138 Custody of a Minor, 379 N.E.2d 1053 (Mass. 1978).

139 *Id.* at 1062. Likewise, in *In re Willmann*, the Ohio Court of Appeals considered the condition of a seven-year-old boy with an aggressive form of cancer in his left arm. *See In re* Willmann, 493 N.E.2d 1380, 1383 (Ohio Ct. App. 1986). Noting that a combination of surgery and chemotherapy offered only a sixty percent chance of survival, but that death was certain without it, the court approved the recommended treatment over the parents' objection. *See id.* at 1384, 1390; *see also In re* Hamilton, 657 S.W.2d 425 (Tenn. Ct. App. 1983) (ordering chemotherapy and radiation for sarcoma, despite the fact that the child had only a twenty-five to fifty percent likelihood of survival with the treatment, because without the treatment death was likely within six to nine months).

140 *See Wallace*, 104 N.E.2d at 771.

old girl for hydrocephalus over her parents' objections.[141] Though there was no immediate risk to the child's life, the condition was likely to lead to severe brain damage and retardation.[142]

At the opposite end of the spectrum, courts have generally accommodated parents' decisions when a child's life was not at stake and the potential threat to health was less severe even when the judges believed that medical intervention would substantially improve the child's quality of life. In *In re Hudson*, for example, a child's deformed left arm was alarmingly long and heavy, leading to significant adverse health effects including damage to her heart and immune system.[143] Doctors recommended amputation but acknowledged that the surgery would carry significant risk.[144] The child's mother preferred to wait until her daughter was an adult and could decide for herself.[145] The juvenile court had found the child neglected and destitute as defined by state law and had ordered that the surgery be done.[146] On appeal, however, the Washington Supreme Court reversed the ruling, emphasizing the deference due to parents:

> [N]o court is vested with authority to deprive a parent, who is a fit person . . . , of custody and control of the child. . . . [T]he mere fact that the court is convinced of the necessity of subjecting a minor child to a surgical operation will not sustain a court order which deprives a parent of the responsibility and right to decide respecting the welfare of the child.[147]

In a similar case, the New York Court of Appeals held for a father whose fourteen-year-old child was born with a severe cleft palate and harelip.[148] Doctors recommended a series of surgeries to correct the deformity.[149] They were convinced that the treatment would enhance the child's social and emotional welfare, and that further delay would make surgery more difficult.[150] The boy's father, however, had strong reservations about medical treatment in general and the boy had developed a similar distrust for doctors.[151] Noting that there was no

141 *In re* Jensen, 633 P.2d 1302, 1303 (Or. Ct. App. 1981); *see also* Muhlenberg Hosp. v. Patterson, 320 A.2d 518 (N.J. Super. Ct. Law Div. 1974) (ordering blood transfusion for a newborn whose condition created an imminent danger of severe and irreparable brain damage if treatment was withheld).

142 *See In re Jensen*, 633 P.2d at 1303.

143 *In re* Hudson, 126 P.2d 765, 767–68 (Wash. 1942).

144 *Id.* at 768.

145 *Id.*

146 *Id.* at 769.

147 *Id.* at 778.

148 *In re* Seiferth, 127 N.E.2d 820 (N.Y. 1955).

149 *Id.*

150 *See id.* at 821–22.

151 *See id.* at 822.

present emergency and that there was no serious threat to life or health, the court deferred to the family.[152]

Between the two extremes have been many cases in which recommended treatment may have lengthened or enhanced the life of a child, but there was little or no risk of imminent death or catastrophic harm without the treatment. Faced with such value-laden decisions, at least one jurisdiction has adopted a bright-line test and has chosen not to intervene except when a child's life literally is at stake. In *In re Green*, the Supreme Court of Pennsylvania considered the plight of a young patient who had had childhood polio and suffered from ninety-four percent curvature of the spine.[153] Already unable to stand, the boy was likely to become completely bed-ridden without a recommended bone transplant.[154] His mother agreed to the surgery but would not approve the blood transfusions that the surgery could entail.[155] Noting that the disease was debilitating, but not fatal, the court declined to countermand the mother's wishes.[156] Highlighting the difference between its approach and that of the New York Court of Appeals,[157] which has taken a more nuanced approach,[158] the court explained its decision to give maximum deference to the parents:

> [A] fatal/non-fatal distinction . . . steers the courts of this Commonwealth away from a medical and philosophical morass: if spinal surgery can be ordered, what about a hernia or gall bladder operation or a hysterectomy? . . . [A]s between a parent and the state, the state does not have an interest of sufficient magnitude outweighing a parent's religious beliefs when the child's life is *not immediately imperiled* by his physical condition.[159]

Other courts have adopted balancing tests that generally defer to parents when the proposed medical care would entail significant risk or when the relative risks and benefits of the recommended treatments are not entirely clear. As one court has explained:

> Where the proposed treatment is dangerous to life, or there is a difference of medical opinion as to the efficacy of a proposed treatment, or where medical opinion differs as to which of two or more

152 *See id.* at 823.

153 *In re* Green, 292 A.2d 387 (Pa. 1972).

154 *Id.* at 388.

155 *See id.*

156 *See id.*

157 *See id.* at 391–92.

158 *See, e.g.*, *In re* Sampson, 278 N.E.2d 918 (N.Y. 1972); *In re* Sampson, 323 N.Y.S.2d 253 (N.Y. App. Div. 1971). The child's facial deformity was not life-threatening, and the proposed surgery entailed substantial risk. But the New York courts intervened out of concern for the child's quality of life.

159 *In re Green*, 292 A.2d at 392.

> suggested remedies should be followed, requiring the exercise of a sound discretion, the opinion of the parent should not be lightly overridden.[160]

Following that principle, the Delaware Supreme Court held on behalf of the parents in *Newmark v. Williams*.[161] The patient was a three-year-old boy who faced certain and imminent death from an aggressive pediatric cancer if not given chemotherapy.[162] However, his chance of surviving even with the treatment was less than fifty percent.[163] In view of the "primacy of the familial unit," the "autonomy of parental decision making authority over minor children," the "invasiveness of the proposed chemotherapy," and the "considerable likelihood of [the proposed treatment's] failure," the court declined to order the treatment public officials had sought.[164]

Even if a child's life or health is in immediate peril and the need for proposed treatment is indisputable, courts have consistently held that parental consent must be sought absent an emergency that makes timely communication with the parents impossible. This was illustrated in *Wells v. McGehee*, where the Louisiana Court of Appeals considered a suit by the mother of a seven-year-old girl who died under anesthesia when emergency surgery was performed without the mother's permission.[165] The girl broke her forearm on a school playground and was taken to the hospital.[166] The school principal tried

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160 Morrison v. State, 252 S.W.2d 97, 102 (Mo. Ct. App. 1952).

161 Newmark v. Williams, 588 A.2d 1108 (Del. 1991).

162 *See id.* at 1109.

163 *See id.* at 1111.

164 *Id.* at 1115; *see also In re* Phillip B., 156 Cal. Rptr. 48 (Cal. Ct. App. 1979). There, the court held for the parents where a twelve-year-old boy with Downs Syndrome suffered from a heart defect that would ultimately lead to death, but the proposed treatment also entailed significant risk and the treatment was not certain of success. The court reasoned as follows:

> Inherent in the preference for parental autonomy is a commitment to diverse lifestyles, including the right of parents to raise their children as they think best. . . .
>
> . . . .
>
> . . . [S]ince the state should usually defer to the wishes of the parents, it has a serious burden of justification before abridging parental autonomy by substituting its judgment for that of the parents.

Id. at 51. *But see In re* A.E., No. 3-12-0968, 2013 WL 4678227 (Ill. App. Ct. Aug. 26, 2013) (ordering treatment of a newborn infant for a life-threatening infection over the objections of her mother, while noting that without such treatment, the child's death was not certain, but that the mortality rate for untreated infants with that condition was as high as fifteen percent and the proposed treatment carried little risk).

165 Wells v. McGehee, 39 So.2d 196 (La. Ct. App. 1949).

166 *See id.* at 197.

unsuccessfully to contact the mother before surgery.[167] Following the girl's death, the mother sued the doctor for malpractice and for failing to obtain her consent before operating.[168] The court upheld the trial court's dismissal of the claim but specifically noted the effort made to contact the mother before the daughter's surgery:

> The general rule that a surgeon operates at his peril without first obtaining the consent of his patient or someone legally authorized to consent for him is qualified in its application by most courts in cases of emergency or unanticipated conditions where some immediate action is found necessary for the preservation of the life or health of the patient, and it is impracticable to first obtain consent to the operation or treatment which the surgeon deems to be immediately necessary.[169]

The lay of the land, then, is quite clear. Courts have given substantial deference to parents in directing the healthcare of their children subject only to narrow exceptions. We pause, however, to briefly address an issue erroneously seen by some as an additional exception to parental discretion. This "pseudo-exception" is highlighted by *United States v. Skrmetti*.[170] At issue in *Skrmetti* was the constitutionality of a Tennessee statute that "prohibits all medical treatments intended to allow 'a minor to identify with, or live as, a purported identity inconsistent with the minor's sex'"[171] even with parental consent.

The "exception" presented in *Skrmetti* is entirely different from the issue that is this Article's focus. *Skrmetti* was not about a claim of parental rights by individual parents against a medical provider; rather it was about a statute that limited the choices of all parents within a state in the name of public health. This difference is significant and serves to demonstrate a distinction with long roots in our

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167 *See id.* at 198.

168 *See id.* at 197.

169 *Id.* at 202 (quoting 41 AM. JUR. *Physicians and Surgeons* § 110 (1942)); *see also* Jackovach v. Yocom, 237 N.W. 444 (Iowa 1931) (affirming the lower court's decision in favor of a surgeon's lifesaving amputation performed on a seventeen-year-old who shattered his arm when jumping off a train and emphasizing that the parents lived eight miles away, had no phone, and could not be reached prior to surgery); Luka v. Lowrie, 136 N.W. 1106 (Mich. 1912) (affirming a judgment in favor of a physician who amputated a fifteen-year-old boy's foot after he was hit by a train and his parents were not available to give consent). *But cf.* Rogers v. Sells, 61 P.2d 1018 (Okla. 1936) (affirming the trial court in finding that a surgeon was guilty of assault and battery for operating without parental consent where the surgeon and three colleagues all deemed immediate amputation necessary and performed it without waiting for the parents to arrive but expert testimony at trial questioned the need for immediate action).

170 L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460 (6th Cir. 2023), *aff'd sub nom.* United States v. Skrmetti, 145 S. Ct. 1816 (2025).

171 Petition for a Writ of Certiorari at I, *Skrmetti*, 145 S. Ct. 1816 (No. 23-477) (quoting TENN. CODE ANN. § 68-33-103(a)(1)(A) (2025)).

constitutional understanding. Justice Barrett questioned Solicitor General Prelogar about this distinction at oral argument when she asked: "Do you agree with me that the resolution of this case has no impact on the parental rights claim that the Sixth Circuit also addressed?"[172] General Prelogar agreed.[173]

Thus, it is instructive to examine the Sixth Circuit's opinion,[174] because this distinction is often ignored by those who claim that one cannot both oppose parental preclusion policies and support legislation like that at issue in *Skrmetti*. The following statement by the Sixth Circuit about the Due Process and Equal Protection claims set the stage:

> The claimants . . . do not argue that the original fixed meaning of the due process or equal protection guarantees covers these claims. That prompts the question whether the people of this country ever agreed to remove debates of this sort—over the use of innovative, and potentially irreversible, medical treatments for children—from the conventional place for dealing with new norms, new drugs, and new public health concerns: the democratic process.[175]

Next the court addressed the Due Process claim specifically, contrasting the Supreme Court's historic treatment of individual parental rights versus the claim brought by plaintiffs in *Skrmetti*:

> This country does not have a "deeply rooted" tradition of preventing governments from regulating the medical profession in general or certain treatments in particular, whether for adults or their children. Quite to the contrary in fact. State and federal governments have long played a critical role in regulating health and welfare, which explains why their efforts receive "a strong presumption of validity." . . . These interests give States broad power, even broad power to "limit[] parental freedom."[176]

The Sixth Circuit went on to note that these state interests "gain[] strength in areas of 'medical and scientific uncertainty,'" as is the case with gender-affirming care.[177] The court's parental rights analysis was embedded within its Due Process analysis where it noted that "[p]arental rights do not alter this conclusion because parents do not have a constitutional right to obtain reasonably banned treatments for their children."[178] The court then carefully distinguished typical areas of parental substantive due process rights involving the upbringing of

172 Transcript of Oral Argument at 64, *Skrmetti*, 145 S. Ct. 1816 (No. 23-477).

173 *Id.*

174 *Skrmetti*, 83 F.4th at 460.

175 *Id.* at 471.

176 *Id.* at 473 (first quoting Heller v. Doe *ex rel.* Doe, 509 U.S. 312, 319 (1993); and then quoting Prince v. Massachusetts, 321 U.S. 158, 167 (1944)).

177 *Id.* at 473 (quoting Gonzales v. Carhart, 550 U.S. 124, 163 (2007)).

178 *Id.* at 475.

their children with the issue before it: individual parents attempting to control healthcare legislation for the entire state.[179] The court noted that the "[l]evel of generality is everything in constitutional law."[180] Thus, as stated above, the issue in *Skrmetti* is a pseudo-exception to the parental discretion addressed in this Article.

II. ANALYSIS OF SECRET GENDER-AFFIRMING POLICIES AND PRACTICES IN LIGHT OF LONG-STANDING PARENTAL RIGHTS PRINCIPLES

As reflected in Part I above, our legal tradition has always recognized a strong presumption favoring the right of fit parents to direct their children's medical care. The courts have carved out narrow exceptions to that principle, but secret gender-transition policies and practices by public officials do not fall within those exceptions. This Part will address (1) the current debate on the relative benefits and risks of gender-affirming care for minors; and (2) the application of parental rights principles to secret gender-affirming policies in the nation's schools.

A. The Ongoing Debate on the Benefits and Risks of Gender-Affirming Care for Minors

Treatment protocols for transgender youth in the United States generally follow the Endocrine Society Clinical Practice Guidelines (Guidelines) or the Standards of Care (SOC) adopted by the World Professional Association for Transgender Health (WPATH).[181] Consistent with the "Dutch model" published in 1998,[182] under both the Guidelines and the SOC, children asserting a transgender identity are encouraged to consider the possibility of transition and are offered a range of interventions to help pursue their preferred identity.[183] The Dutch model, which now predominates in this country, affirms the use of puberty blocking agents to suppress a patient's physical and

179 *Id.*

180 *Id.*

181 *See* Natalie J. Nokoff, *Medical Interventions for Transgender Youth*, NAT'L INST. HEALTH: NAT'L LIBR. MED. (Jan. 19, 2022), https://www.ncbi.nlm.nih.gov/books/NBK577212/ [https://perma.cc/PQ3S-3YLS].

182 Nokoff notes that Drs. Cohen-Kettenis and van Goozen, of the Netherlands, first published an account of a transgender patient treated with a Gonadotropin-releasing hormone (GnRH) to delay the onset of puberty. *Id.*

183 *Id.* While hormonal treatments and other physical interventions are not a foregone conclusion under this approach, recent research has indicated that more than ninety percent of children and adolescents who engage in supportive social transitioning continue on toward such treatments and, in some cases, surgical interventions as well. *See infra* notes 250 and 305 and accompanying text.

hormonal development at the onset of puberty, typically between ages ten and thirteen.[184] For those who meet selected criteria, the Guidelines further recommend the use of cross-gender hormone therapy as early as age sixteen, with gradually increasing doses over time to induce secondary sex characteristics consistent with the child's perceived gender.[185] Surgical treatment is generally not recommended until at least age eighteen,[186] though the recently released version 8 WPATH Standards (SOC8) cite the approval of mastectomies for some female patients as early as sixteen[187] and insurance company databases have identified girls "as young as [fourteen] years old undergoing [] gender-affirming mastectom[ies]."[188] Both before and during puberty, and throughout adolescence, the protocols also call for social transition with a goal of affirming the child's chosen identity.[189] "Social transition" may include the use of preferred names and pronouns, access to restrooms and other sex-specific facilities and activities corresponding to the student's gender identity, and creation of an environment supportive of gender-appropriate grooming and lifestyle.[190]

Proponents of gender-affirming care for minors have characterized the treatments as "safe, effective and essential."[191] Puberty

184 *Id.* The terms "Dutch model" and "Dutch protocol" are used synonymously and broadly throughout this Article to encompass, not only the specific procedures pioneered by Dutch clinical teams beginning in the late 1990s, but gender-affirming approaches in general. The Dutch model introduced in 1998 and later amended in 2018 features the use of puberty blockers and cross-sex hormones for qualifying children and adolescents as well as recommendations for the creation of gender-affirming environments for young people experiencing gender discomfort. *See* Maria ATC van der Loos et al., *Children and Adolescents in the Amsterdam Cohort of Gender Dysphoria: Trends in Diagnostic- and Treatment Trajectories During the First 20 Years of the Dutch Protocol*, 20 J. SEXUAL MED. 398, 398–99 (2023). Before development of the Dutch model, gender-affirming medical treatment had already been available for adults for more than twenty years. *Id.*; *see also The 2023 Dutch Debate Over Youth Transitions*, SOC'Y FOR EVIDENCE BASED GENDER MED. (Nov. 19, 2023), https://segm.org/Dutch-protocol-debate-Netherlands [https://perma.cc/X7ZA-TN2Y].

185 *See* Nokoff, *supra* note 181.

186 Expert Declaration of Deanna Adkins, MD, in Support of Plaintiffs' Motion for Preliminary Injunction at 10, Hecox v. Little, 479 F. Supp. 3d 930 (D. Idaho 2020) (No. 20-cv-184).

187 E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH S1, S43 (2022).

188 Samuel Dubin, Megan Lane, Shane Morrison, Asa Radix, Uri Belkind, Christian Vercler, David Inwards-Breland, *Medically Assisted Gender Affirmation: When Children and Parents Disagree*, 46 J. MED. ETHICS 295, 296 (2020).

189 *See* Expert Declaration of Deanna Adkins, MD, *supra* note 186, at 7.

190 *Id.*

191 *Id.* at 10.

blockers are described as a mere "pause" in a child's normal development,[192] with "fully reversible" effects[193] that have "no known negative consequences."[194] Cross-gender hormone treatments are also said to be at least "partially reversible."[195] Supporters assert that such treatments help reduce the risk of suicide[196] and enhance mental health.[197] Some even claim that support for the gender-affirming model is virtually unanimous among medical providers,[198] in one case suggesting that "all leading medical professional associations support and promote access to gender-affirming care."[199] Proponents of the Dutch model can point to a long list of studies supporting their assertions.[200] Other evidence, however, suggests that the benefits of these treatments are not as certain, the risks are not as slight, and the opinions of medical professionals are not as unified as the proponents claim.

Evaluating the proper role for parents in their children's development of sexual identity and expression should first acknowledge that well-respected alternatives do exist to the gender-affirming model

192 *See id.* at 8; *see also* Emily Ikuta, Note, *Overcoming the Parental Veto: How Transgender Adolescents Can Access Puberty-Suppressing Hormone Treatment in the Absence of Parental Consent Under the Mature Minor Doctrine*, 25 S. CAL. INTERDISC. L.J. 179, 191 (2016).

193 Coleman et al., *supra* note 187; *see also* Federica Vergani, Comment, *Why Transgender Children Should Have the Right to Block Their Own Puberty with Court Authorization*, 13 FIU L. REV. 903, 922 (2019); Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, PEDIATRICS, Oct. 2018, at 1, 5.

194 Vergani, *supra* note 193, at 922–23. Professional medical associations weighing in on the effects of puberty blockers have been only slightly more modest in suggesting that "serious[ly] adverse" side effects of such therapy "are exceedingly rare." Brief of Amici Curiae American Academy of Pediatrics et al. in Support of Plaintiffs-Appellees and Affirmance at 13, Brandt v. Rutledge, 47 F.4th 661(8th Cir. 2022) (No. 21-2875).

195 Maximiliane Hädicke, Manuel Föcker, Georg Romer & Claudia Wiesemann, *Healthcare Professionals' Conflicts When Treating Transgender Youth: Is It Necessary to Prioritize Protection Over Respect?*, 32 CAMBRIDGE Q. HEALTHCARE ETHICS 193, 193–94 (2023).

196 Vergani, *supra* note 193, at 924–25.

197 Expert Declaration of Deanna Adkins, MD, *supra* note 186, at 6.

198 *See, e.g.*, *What Does the Scholarly Research Say About the Effect of Gender Transition on Transgender Well-Being?*, CORNELL UNIV.: WHAT WE KNOW PROJECT, https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/ [https://perma.cc/WND8-9CCM] (last visited Nov. 12, 2025) (speaking of "a robust international consensus" regarding the benefits of hormone therapy and surgery); Roy Abernathy, Note, *Seeking Remedies for LGBTQ Children from Destructive Parental Authority in the Era of Religious Freedom*, 26 WASH. & LEE J.C.R. & SOC. JUST. 625, 661–62 (2020) (listing an array of medical associations that have "recognized the benefits of gender-affirming treatment and discourage[d] barriers to gender transition treatment," *id.* at 661).

199 Mary Kelly Persyn, *The Quality of Mercy*, L.A. LAW., Feb. 2023, at 28, 30.

200 *See, e.g.*, *What Does the Scholarly Research Say About the Effect of Gender Transition on Transgender Well-Being?*, *supra* note 198.

described above.[201] In fact, the use of a gender-affirming model for children is a relatively recent development.[202] Even for adults, medical and surgical treatment for gender dysphoria did not appear openly until the 1920s, in Germany, and did not reach the United States until after World War II.[203] For children, the use of gender-suppressing hormones and cross-gender therapy was pioneered in the Netherlands only thirty years ago, with the results first published in 1998.[204] It was not until the 2010s that countries in Western Europe, North America and Australia began to actively promote the Dutch model for gender-dysphoric youth.[205] Before that time, practitioners generally followed a more conservative approach. Rather than encourage transition, the traditional approach sought to "treat the underlying causes of [gender dysphoria] through psychological counseling or psychotherapy" with a view toward "align[ing] the patient's beliefs about his gender with his biological sex."[206] Though currently out of favor in some circles, this "watchful waiting" approach still provides an alternative to the more aggressive Dutch model—an alternative that a growing number of European countries are beginning to rediscover.[207]

The relatively recent appearance of the gender-affirming model has likely contributed to the lack of definitive data supporting it. Although proponents of the model can cite an impressive number of studies, the supporting research has been characterized by others as

201 SOC'Y FOR EVIDENCE BASED GENDER MED., https://segm.org/ [https://perma.cc/T46X-3FFL] (last visited Nov. 12, 2025). Sources cite two well-recognized alternatives—the "wait and see approach" and the "therapeutic approach"—which are increasingly endorsed among medical professionals throughout Western Europe. *See, e.g.*, Brief of Amici Curiae Medical & Mental Health Professionals Supporting Defendants-Appellants and Urging Reversal at 34–36, Brandt v. Rutledge, 47 F.4th 661 (8th Cir. 2022) (No. 21-2875); *see also infra* notes 205–06, 226–38 and accompanying text.

202 Jeremi M. Carswell, Ximena Lopez & Stephen M. Rosenthal, *The Evolution of Adolescent Gender-Affirming Care: An Historical Perspective*, 95 HORMONE RSCH. PAEDIATRICS 649, 651–52 (2022).

203 *Id.* at 651.

204 *Id.* at 652.

205 SOC'Y FOR EVIDENCE BASED GENDER MED., *supra* note 201.

206 Rena M. Lindevaldsen, *An Ethically Appropriate Response to Individuals with Gender Dysphoria*, 13 LIBERTY U. L. REV. 295, 300–01 (2019).

207 *See infra* notes 226–38 and accompanying text.

"thin"[208] and "deeply flawed,"[209] and the model it supports has been criticized as "unproven"[210] and "experimental."[211] In 2014, the medical consulting firm, Hayes, Inc., reviewed the existing research supporting hormone therapy for adolescent gender dysphoria. Upon review, Hayes gave that body of research the company's lowest rating and concluded that the "evidence on long-term results of sex reassignment was too sparse to support meaningful conclusions."[212] A more recent, comprehensive review of gender-affirming research was conducted on behalf of the United Kingdom's National Health System by the National Institute for Health and Care Excellence (NICE).[213] NICE reviewers "concluded that the evidence [supporting] both puberty blocking and cross-sex hormones is of very low certainty."[214] Even WPATH has acknowledged, in its most recent version of the SOC, that "the number of studies [tracking the long-term effects of its recommended protocol] is still low," and "a systematic review regarding outcomes of treatment in adolescents is not possible."[215] The lack of

208 Paul W. Hruz, Lawrence S. Mayer & Paul R. McHugh, *Growing Pains: Problems with Puberty Suppression in Treating Gender Dysphoria*, NEW ATLANTIS, Spring 2017, at 3, 6–7. Dr. Hruz is an associate professor of pediatrics, cell biology, and physiology at the Washington University School of Medicine, St. Louis. *Paul W. Hruz, MD, PhD*, WASHU MED., https://pediatrics.wustl.edu/people/paul-w-hruz-md-phd/ [https://perma.cc/3224-PGQM] (last visited Nov. 15, 2025). Dr. Mayer is a research physicist, epidemiologist, and biostatistician affiliated with the Harvard University Institute for Quantitative Social Science. *Lawrence S. Mayer*, HUM. FLOURISH. PROGRAM, https://hfh.fas.harvard.edu/people/lawrence-s-mayer [https://perma.cc/2RHM-W4YF] (last visited Nov. 13, 2025). Dr. McHugh is a Distinguished Service Professor of Psychiatry at Johns Hopkins University. *Paul R. McHugh, MD*, JOHNS HOPKINS MED., https://profiles.hopkinsmedicine.org/provider/paul-r-mchugh/2777430 [https://perma.cc/J4VP-VVYS] (last visited Nov. 15, 2025).

209 E. Abbruzzese, Stephen B. Levine & Julia W. Mason, *The Myth of "Reliable Research" in Pediatric Gender Medicine: A Critical Evaluation of the Dutch Studies—and Research That Has Followed*, 49 J. SEX & MARITAL THERAPY 673, 676 (2023). Dr. Levine is a Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine and a Distinguished Life Fellow of the American Psychiatric Association. *See* Declaration of Stephen B. Levine, MD at 1, B.P.J. vs. W. Va. St. Bd. of Educ., 649 F. Supp. 3d 220 (S.D. W. Va. 2023) (No. 2:21-cv-00316).

210 Stephen B. Levine, E. Abbruzzese & Julia W. Mason, *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, 48 J. SEX & MARITAL THERAPY 706, 707 (2022).

211 Hruz et. al., *supra* note 208, at 14.

212 *See* Ryan T. Anderson, *Sex Reassignment Doesn't Work. Here is the Evidence.*, THE HERITAGE FOUND. (Mar. 9, 2018), https://www.heritage.org/gender/commentary/sex-reassignment-doesnt-work-here-the-evidence [https://perma.cc/BVC8-LFPS]. The Hayes Corporation is a research consulting firm that provides independent evaluations of clinical and scientific evidence on behalf of hospitals, healthcare systems, government agencies and insurers. *Id.*

213 Levine et al., *supra* note 210, at 712.

214 *Id.*

215 Coleman et al., *supra* note 187, at S46.

definitive research on the long-term effects of gender-affirming care has led one physician to dismiss the movement toward that model as "a headlong rush" toward what "can only be seen as off label experimentation."[216]

Recent research further suggests that the benefits of gender-affirming care for children and adolescents may be overstated by its supporters. A study conducted at Johns Hopkins Hospital in the early 2000s showed that most patients who had undergone sex-change surgery years earlier "were little changed in their psychological condition."[217] "They had much the same problems with relationships, work, and emotions as before. The hope that they would emerge now from their emotional difficulties to flourish psychologically had not been fulfilled."[218]

Nor is the staff at Johns Hopkins alone in finding the benefits of gender transition for minors questionable. The World Health Organization (WHO) recently published guidelines on the health of trans and gender-diverse people.[219] The new guidelines explicitly omit any recommendations for treatment of children and adolescents. WHO explains that it has limited its new guidelines to adult patients because "the evidence base for children and adolescents is limited and variable regarding the longer-term outcomes of gender affirming care for children and adolescents."[220] Similarly, in the fall of 2020, the American Journal of Psychiatry was forced to correct findings from a study published a year earlier that erroneously claimed patients having sex reassignment surgery were less likely to need mental health treatment following surgery.[221] Authors of the original article acknowledged that "the results demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related health care."[222] Notably, when asked to cover sex reassignment surgery under Medicare and Medicaid, the Obama administration declined to do so, citing research

216 G. KEVIN DONOVAN, MEDICAL EXPERIMENTATION WITHOUT INFORMED CONSENT: AN ETHICIST'S VIEW OF TRANSGENDER TREATMENT FOR CHILDREN 4 (2022).

217 Paul R. McHugh, *Surgical Sex*, FIRST THINGS (Nov. 1, 2004), https://www.firstthings.com/article/2004/11/surgical-sex [https://perma.cc/6WY2-7WCV].

218 *Id.*

219 WORLD HEALTH ORG., FREQUENTLY ASKED QUESTIONS (FAQ): WHO DEVELOPMENT OF A GUIDELINE ON THE HEALTH OF TRANS AND GENDER DIVERSE PEOPLE (2024).

220 *Id.* at 3.

221 Ryan T. Anderson, *"Transitioning" Procedures Don't Help Mental Health, Largest Dataset Shows*, THE HERITAGE FOUND. (Aug. 3, 2020), https://www.heritage.org/gender/commentary/transitioning-procedures-dont-help-mental-health-largest-dataset-shows [https://perma.cc/3HPR-GPNX].

222 *Id.*

that actually found increased rates of mortality and psychiatric hospitalization for those who had undergone such treatment.[223]

Not only are there questions about the effectiveness of hormonal and surgical treatments, but a growing body of evidence suggests that the procedures may be harmful. Reported side effects include a lack of bone density and a likelihood of sexual dysfunction; an increased risk of cardiovascular disease, stroke, myocardial infarction, deep vein thrombosis, diabetes, elevated liver enzymes, and hypertension; and an increased risk of death—particularly for younger females—due to these illnesses.[224] Even at best, adolescents who persevere in gender transition may well become "patient[s] for life," requiring "regular administration of hormones," and thereby "exposing them to significant physical, mental health, and relational risks," and "being irreversibly sterilized chemically and/or surgically."[225]

Given the risks of childhood and adolescent gender transition, and uncertainty about its long-term effects, a number of Western European countries are beginning to question the gender-affirming approach. Most significantly, in March 2024, the United Kingdom's National Health Service (NHS) temporarily issued a nationwide ban on the routine use of puberty-suppressing hormones for children under eighteen and instead encouraged a focus on "psychosocial and psychological support."[226] Under those guidelines, puberty blockers were still available for "carefully selected cases,"[227] but the NHS concluded that "there is not enough evidence to support the safety or clinical effectiveness of [puberty blockers] to make the treatment routinely available at this time."[228] Then, on December 11, 2024, the United Kingdom's Department of Health and Social Care announced via a press

223 Ryan T. Anderson, *Sex Change: Physically Impossible, Psychosocially Unhelpful, and Philosophically Misguided*, PUB. DISCOURSE (Mar. 5, 2018), https://www.thepublicdiscourse.com/2018/03/21151/ [https://perma.cc/JB46-CD82] (citing research findings by the Obama administration's Centers for Medicare and Medicaid Services). The mortality rate in a Swedish longitudinal study among those who underwent sex-reassignment surgery was almost 20:1 greater than the control population, much of which was due to completed suicides and to an increase in neoplasm and cardiovascular disease of 2 to 2.5-fold. *Id.*

224 *See, e.g.*, Lindevaldsen, *supra* note 206, at 304; Brief of Amicus Curiae Medical & Mental Health Professionals, *supra* note 201, at 27–28; Abigail Shrier, *Top Trans Doctors Blow the Whistle on 'Sloppy' Care*, THE FREE PRESS (Oct. 4, 2021), https://www.thefp.com/p/top-trans-doctors-blow-the-whistle [https://perma.cc/6VJS-MKWT].

225 Declaration of Stephen B. Levine, MD, *supra* note 209, at 45.

226 NAT'L HEALTH SERV. ENG., PUBERTY SUPPRESSING HORMONES (PSH) FOR CHILDREN AND YOUNG PEOPLE WHO HAVE GENDER INCONGRUENCE/GENDER DYSPHORIA 2 (2024).

227 Leor Sapir, *The U.K. Is Backing Off Transgender Mania. The U.S. Should Follow*, NAT'L REV. (Oct. 28, 2022, 1:21 PM), https://www.nationalreview.com/2022/10/the-u-k-is-backing-off-transgender-mania-and-the-u-s-should-follow/ [https://perma.cc/W4KA-MJRK].

228 NAT'L HEALTH SERV. ENG., *supra* note 226, at 3.

release that "[l]egislation will be updated today to make the [puberty blocker ban] indefinite and [the decision] will be reviewed in 2027."[229]

Like their counterparts in the United Kingdom, the governments of Sweden and Finland have recently "placed severe restrictions on access to hormones" outside of carefully controlled clinical settings.[230] Though Finland had adopted the Dutch protocol in 2011, the nation's experts in adolescent gender psychology became concerned about the "lack of research" supporting the protocol and have decided to reverse field.[231] Sweden has also tightened access to puberty-suppressing hormone treatments and adopted a default of "psychosocial support and psychotherapy, with a *focus on accepting and thriving in natal puberty*."[232] The Swedish National Board of Health and Welfare based its reversal on "[u]ncertain science and new knowledge,"[233] concluding that "it is not yet possible to draw firm conclusions about the efficacy and safety of the [hormonal] treatments based on scientific evidence."[234] Other countries including Denmark,[235] Scotland,[236] and France[237] have also determined that ready access to hormones for children and adolescents may not be warranted. There is clearly growing discomfort with the Dutch protocol among leading practitioners throughout Western Europe.[238]

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229 Dep't of Health & Soc. Care, *Press Release: Ban on Puberty Blockers to be Made Indefinite on Experts' Advice*, GOV.UK (Dec. 11, 2024), https://www.gov.uk/government/news/ban-on-puberty-blockers-to-be-made-indefinite-on-experts-advice [https://perma.cc/FY2U-M863].

230 Leor Sapir, *Finland Takes Another Look at Youth Gender Medicine*, TABLET MAG. (Feb. 21, 2023), https://www.tabletmag.com/sections/science/articles/finland-youth-gender-medicine [https://perma.cc/G7N4-3QGY].

231 *Id.*

232 SOC'Y FOR EVIDENCE BASED GENDER MED., *supra* note 201 (emphasis added).

233 *Uppdaterade rekommendationer för hormonbehandling vid könsdysfori hos unga* [*Updated Recommendations for Hormone Therapy for Gender Dysphoria in Young People*], NAT'L BD. OF HEALTH & WELFARE (Feb. 22, 2022), https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/uppdaterade-rekommendationer-for-hormonbehandling-vid-konsdysfori-hos-unga/ [https://perma.cc/Q5A8-KJQW].

234 *Id.*

235 *See Denmark Joins the List of Countries That Have Sharply Restricted Youth Gender Transitions*, SOC'Y FOR EVIDENCE BASED GENDER MED. (Aug. 17, 2023), https://segm.org/Denmark-sharply-restricts-youth-gender-transitions [https://perma.cc/HSR5-TB33].

236 *See* Mary McCool, *Scotland's Under-18s Gender Clinic Pauses Puberty Blockers*, BBC (Apr. 18, 2024), https://www.bbc.com/news/uk-scotland-68844119 [https://perma.cc/U55R-M4JT].

237 *See* Brief of Family Research Council as Amicus Curiae Supporting Rehearing En Banc at 3–4, Brandt v. Rutledge, 47 F.4th 661 (8th Cir. 2022) (No. 21-2875) (noting that France's Académie Nationale de Médecine concluded that caution is warranted due to the lack of available research).

238 *See* J. Cohn, *Some Limitations of "Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View,"* 49 J. SEX & MARITAL THERAPY 599, 600–01 (2023).

B. The Application of Parental Rights Principles to Secret Gender-Affirming Policies

1. Secret Gender-Affirming Policies Contradict Historic Common Law Principles

Recognizing the historic role of parents in navigating questions of healthcare for their children, the Supreme Court opined, in *Parham v. J.R.*, that a parent's "'high duty' to recognize symptoms of illness and to seek and follow medical advice" should be the "starting point" in determining their role in directing their children's healthcare.[239] The only clear exceptions to that principle under modern caselaw have been where parents' refusal to provide needed healthcare (1) has threatened the life of their child[240] or (2) would have resulted in imminent, irreversible, and substantial injury.[241] And even when a child's life has been at stake, courts have held that healthcare providers were liable if they failed to obtain parental consent prior to treatment unless the child was in imminent peril and the physician was unable to contact the parents.[242]

Secret gender-affirming policies as practiced by school districts across the country clearly fall outside these exceptions. First, evidence does not establish that gender incongruity poses a heightened and imminent risk of death. While transgender youth do suffer an elevated level of suicidality, the actual incidence of suicide is reportedly small and a causal link has not been established.[243] In a recent interview, Finland's leading expert on pediatric gender medicine and chief psychiatrist at the Tampere University gender clinic addressed the concern over suicide rates among transgender youth, stating that "[w]hile there *is* evidence that teenagers who identify as transgender have elevated rates of suicide and suicidality, . . . suicide is extremely rare even among transgender-identified youth."[244] She also pointed out that, given their high rate of comorbidities, "there is *no* evidence that their

239 Parham v. J.R., 442 U.S. 584, 602 (1979).

240 *See supra* notes 136–39 and accompanying text.

241 *See supra* notes 140–42 and accompanying text.

242 *See supra* notes 165–69 and accompanying text.

243 *See* Sapir, *supra* note 230. While any degree of self-harm is tragic, the suicide rate among transgender adolescents is 0.03 percent according to a recent study from the United Kingdom. *Id.* Moreover, as many as sixty-eight percent of transgender youths have significant comorbidities such as depression and autism—which independently carry a heightened risk of suicide—thereby making it difficult to ascribe suicidality specifically to gender-related issues. *See id.*

244 *Id.*

elevated risk is *because of* unaffirmed gender identity *or* that social and medical transition will reduce their risk for self-harm.[245]

Second, even if gender-related concerns did create a life-or-death dilemma, gender dysphoria does not create an emergency requiring such prompt intervention that parental notification is impossible. Rather, the school policies at issue intentionally preclude parental notification—sometimes selectively based on school personnel's perception of the parents' likely support for social transition.[246]

As discussed earlier in this Article, circumstances that have not entailed a risk of death or substantial and imminent harm to the child have been decided by courts on a case-by-case basis, with a strong presumption favoring parental rights.[247] Factors influencing whether courts have ordered medical treatment over parents' objections have included: (1) the likelihood that recommended treatments would be successful; (2) the dangers posed by inaction; (3) the degree of risk associated with the treatments; (4) the availability of alternative forms of care; and (5) whether medical authorities agreed about the risks and benefits of the recommended treatment.[248] These factors, as a whole, would counsel against school policies that offer gender-affirming care to minors without parental consent. As reflected in Section II.A above, the gender-affirming model is increasingly controversial among well-credentialed experts. A growing number of providers worldwide view the risks and benefits of that model as uncertain at best.[249] As a result, healthcare providers in other countries are returning to alternative forms of care including that of "watchful waiting." Historically, American courts have deferred to parents where the relative risks and benefits of proposed treatments were unclear, reasonable alternatives existed, and respected medical authorities supported the parents' choices.

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245 *Id.*

246 2022–2023 GUIDELINES FOR STUDENT GENDER IDENTITY IN MONTGOMERY COUNTY PUBLIC SCHOOLS 2–3 (2022) [https://perma.cc/7KRY-RNDL]. The 2022–2023 Guidelines for Student Gender Identity in Montgomery County Public Schools, for example, provide that: (1) development plans for nonconforming students will be developed in collaboration with the student's family *only* "if the family is supportive of the student"; (2) school staff will support "a *student-led* [gender-affirming] plan that *works toward* inclusion of the family, *if possible*"; (3) evidence of transgender status may therefore remain strictly at school; and (4) school staff members may not disclose students' status to parents without the students' permission. *See id.* (emphasis added).

247 *See* Troxel v. Granville, 530 U.S. 57, 68–69 (2000) (plurality opinion) ("[S]o long as a parent . . . is fit[], there will normally be no reason for the State to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children.").

248 *See supra* notes 160–64 and accompanying text.

249 *See supra* notes 208–38 and accompanying text.

2. Secret Affirmation of Students' Gender Transition Constitutes a Form of Treatment in Violation of Parental Rights

The analysis above pertains to gender-affirming care generally, which can include a full range of treatments. To this point, the interventions offered by public schools have largely been confined to social transitioning. The final issue addressed in this Article is whether a primary or secondary school's policy of affirming students' *social* transition without parental consent is a form of *medical* treatment or otherwise violates parents' constitutional or common law rights. For the reasons explained below, this Article suggests that social transition is a form of healthcare. But even if it does not constitute medical treatment per se, it places children on a pathway toward transition that is so determinative of their long-term choices that it effectively removes from parents the opportunity to have input while there is still time to make a meaningful difference in the outcome.[250]

The status of social transition as a form of healthcare has been at least tacitly acknowledged by healthcare agencies and by both advocates and opponents of the gender-affirming model. Indeed, one of the stated objectives of social transition is to enhance "mental health and well-being."[251] In a recent statement on gender-affirming care for young people, the United States Department of Health and Human Services (HHS) characterized "gender-affirming care" as a "form of healthcare" and emphasized that "social transitions" are a "crucial" aspect of healthcare for children exploring gender identity.[252] The American Academy of Pediatrics—which strongly supports gender-affirming care—does not address the question as directly as HHS but acknowledges the vital role social transition plays for children and adolescents who are "explor[ing] their gender identity."[253] Other proponents of gender-affirming care similarly emphasize the key role

250 *See, e.g.*, *Early Social Gender Transition in Children is Associated with High Rates of Transgender Identity in Early Adolescence*, SOC'Y FOR EVIDENCE BASED GENDER MED. (May 6, 2022), https://segm.org/early-social-gender-transition-persistence [https://perma.cc/4ZW6-6R35] (reporting on a recent study showing that over ninety-seven percent of children who underwent early social transition persisted in identifying as transgender five years later and that sixty percent of the children included in the study started hormone treatments—which are clearly medical in nature—during the course of the study).

251 Ruth Hall, Jo Taylor, Catherine Elizabeth Hewitt, Claire Heathcote, Stuart William Jarvis, Trilby Langton & Lorna Fraser, *Impact of Social Transition in Relation to Gender for Children and Adolescents: A Systematic Review*, 109 ARCHIVES DISEASE CHILDHOOD s12, s12 (2024).

252 OFF. OF POPULATION AFFS., DEP'T OF HEALTH & HUM. SERVS., GENDER-AFFIRMING CARE AND YOUNG PEOPLE (2022).

253 *See* Brief of Amici Curiae American Academy of Pediatrics et al., *supra* note 194, at 4.

social transition plays in the process of gender transition. The Trevor Project—a leading suicide prevention and crisis intervention organization for LGBTQ+ youth—has characterized social transition as "the primary affirmative care intervention" for prepubertal youth.[254] And WPATH acknowledges that healthcare professionals can play an important role in social transitioning.[255]

Those who question the gender-affirming protocol characterize social transition as "a major . . . mental health decision"[256] and "a form of psychosocial treatment."[257] The Cass Review, drafted two years ago for the United Kingdom's NHS, described social transition as "an active intervention [which] may have significant effects on the child or young person in terms of their psychological functioning."[258] The report stressed that "[w]hatever position one takes [on the benefits or harms of social transitioning], it is important to acknowledge that *it is not a neutral act.*"[259] In sum, whether social transition is labelled an "intervention," a "treatment," an "exploration," or a form of "healthcare," proponents and opponents alike acknowledge that it *at least* plays a critical role in the process of gender exploration and transition.

This, then, raises two further questions: (1) whether a school's affirmation of students' changed names and pronouns is a component of social transitioning; and (2) if so, whether a school's affirmation of students' early steps toward gender exploration apart from parental knowledge and consent violates the parents' constitutional or common law rights.

These questions are beginning to percolate through the lower federal courts, and the early decisions are split. Courts that have rejected claims of parental rights have reflected a common decisional framework, asserting that school policies either mandating or permitting secrecy by teachers and staff (1) do not implicate constitutional rights because the policies are not coercive; (2) do not constitute a form of treatment because the students involved generally have no diagnosed medical condition; (3) amount to nothing more than showing respect

254 *Gender-Affirming Care for Youth*, THE TREVOR PROJECT (Jan. 29, 2020), https://www.thetrevorproject.org/research-briefs/gender-affirming-care-for-youth/ [https://perma.cc/8PVD-DKJL].

255 Coleman et al., *supra* note 187, at S39–S40.

256 Expert Affidavit of Dr. Erica E. Anderson, PhD at 22, T.F. v. Kettle Moraine Sch. Dist., No. 2021CV1650, 2023 WL 6544917 (Wis. Cir. Ct. Oct. 3, 2023).

257 Declaration of Stephen B. Levine, *supra* note 209, at 47 (quoting Kenneth J. Zucker, *Debate: Different Strokes for Different Folks*, 25 CHILD & ADOLESCENT MENTAL HEALTH 36, 36 (2020)).

258 THE CASS REV., INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE: INTERIM REPORT 62 (2022).

259 *Id.* at 62–63 (emphasis added).

to students by acknowledging their preferred names; and (4) are justified by the authority the courts have invested in the public schools.

A recent decision dismissing claims of parental rights in the United States District Court for the District of New Jersey—*Doe v. Delaware Valley Regional High School Board of Education*[260]—exemplifies this thinking. The court twice denied parents' motions for a temporary restraining order and a preliminary injunction. The second denial has been appealed to the United States Court of Appeals for the Third Circuit.[261] In that case, parents sued to enjoin the school board from pursuing a policy requiring school employees to "recognize[] and respect[]" a student's asserted gender identity and providing that "[t]here is no affirmative duty . . . to notify a student's parent of the student's gender identity or expression."[262] When parents challenged this policy, the court rejected their claim,[263] relying heavily on the Third Circuit's reasoning in *Anspach v. City of Philadelphia, Department of Public Health*.[264]

In *Anspach*, the Third Circuit affirmed dismissal of a claim alleging violation of constitutional rights to family privacy and parental liberty.[265] An unemancipated minor had been given emergency contraceptive treatment by a local health clinic without her parents' knowledge.[266] Her parents learned of the treatment when the child became ill after taking the prescribed pills, and in their suit against the City of Philadelphia they claimed a violation of substantive due process under the Fourteenth Amendment.[267] In rejecting the parents' claim, the court reviewed landmark Supreme Court decisions affirming parental rights.[268] The court determined from its review that claims of parental liberty had been upheld by the Supreme Court "only where the behavior of the state actor compelled interference in the parent-

260 Doe v. Del. Valley Reg'l High Sch. Bd. of Educ., No. 24-00107, 2024 WL 706797 (D.N.J. Feb. 21, 2024) (opinion denying first motion for temporary restraining order and preliminary injunction); Doe v. Del. Valley Reg'l High Sch. Bd. of Educ., No. 24-00107, 2024 WL 3029154 (D.N.J. June 17, 2024) (order denying second motion for temporary restraining order); Doe v. Del. Valley Reg'l High Sch. Bd. of Educ., No. 24-00107, 2024 WL 5006711 (D.N.J. Nov. 27, 2024) (opinion denying second motion for preliminary injunction).

261 Notice of Appeal at 1, Doe v. Del. Valley Reg'l High Sch. Bd. of Educ., No. 24-00107, 2024 WL 5006711 (D.N.J. Dec. 6, 2024).

262 Amended Verified Complaint and Jury Demand at 5–6, Doe v. Del. Valley Reg'l High Sch. Bd. of Educ., No. 24-00107 (D.N.J. Mar. 15, 2024).

263 *Doe*, 2024 WL 5006711, at *10–14.

264 Anspach *ex rel.* Anspach v. City of Phila., Dep't of Pub. Health, 503 F.3d 256 (3d Cir. 2007).

265 *Id.* at 258–59.

266 *Id.* at 259–60.

267 *Id.* at 260.

268 *Id.* at 261.

child relationship."[269] In *Anspach*, the child's decision to visit the health clinic was voluntary, and no specific action had been mandated or prohibited by the state.[270] The court concluded that "recognition [of constitutional rights] does not extend to circumstances where there is no manipulative, coercive, or restraining conduct by the State."[271] Adopting the *Anspach* analysis, the *Doe* court found that the school board had not "engaged in coercive behavior" by affirming the student's name change and thus did not violate the parents' constitutional rights.[272] "[T]here are no allegations that the Board Defendants engaged in 'treatment' by 'actively approach[ing] [Jane] regarding [Jane's] preferred name,' or that they suggested that Jane be referred to by a particular name and pronoun."[273]

The same reasoning prevailed in *Willey v. Sweetwater County School District No. 1 Board of Trustees*, where parents sought a preliminary injunction to block implementation of a policy affirming the use of students' preferred names and pronouns while prohibiting disclosure to parents.[274] Consistent with the rationale in *Doe*, the *Willey* court found that there were "no allegations anyone at the school actively approached the Student regarding the Student's preferred name, nor that anyone at the school suggested the Student be referred to by any particular name or pronoun."[275]

Contrary to the assertions in *Anspach*, *Doe*, and *Willey*, there is no consensus among the federal courts that coercion is the lodestar for constitutional protection of parental rights. In a decision involving a school policy similar to those in *Willey* and *Doe*, the United States District Court for the Southern District of California upheld a First Amendment free-speech claim by teachers who were effectively forced by the school's policy to withhold from parents material information about their children's use of alternative names and pronouns.[276] As in *Willey* and *Doe*, the adoption of alternative names and pronouns in

269 *Id.* at 262.

270 *Id.* at 266, 268.

271 *Id.* at 266.

272 Doe v. Del. Valley Reg'l High Sch. Bd. of Educ., No. 24-00107, 2024 WL 706797, at *11 (D.N.J. Feb. 21, 2024).

273 *Id.* at *11.

274 Willey v. Sweetwater Cnty. Sch. Dist. No. 1 Bd. of Trs., 680 F. Supp. 3d 1250, 1263 (D. Wyo. 2023).

275 *Id.* at 1274. The district court later granted the school board's motion for summary judgment, but stated that, "upon inquiry parents must be given access to information concerning their children's education and, absent reasonable concern for the child's safety, that information *cannot be intentionally withheld or knowingly misrepresented.*" *Willey v. Sweetwater Cnty. Sch. Dist. No. 1*, No. 23-CV-69-SWS at 38 (D.N.J. Apr. 28, 2025) (emphasis added).

276 Mirabelli v. Olson, 691 F. Supp. 3d 1197 (S.D. Cal. 2023).

Mirabelli v. Olson was strictly voluntary on the part of the students.[277] Nevertheless, while no parents had joined the suit as plaintiffs, the court opined that the district's policy "harm[ed] the parents by depriving them of the long recognized Fourteenth Amendment right to care, guide, and make health care decisions for their children."[278]

A number of federal courts have addressed this issue in the context of condom distribution. In *Deanda v. Becerra*, a parent successfully challenged a federal regulation forbidding parental notification requirements for community healthcare facilities that provided Title X services including the distribution of condoms.[279] Plaintiff claimed that the provision of condoms to an unemancipated minor without parental notice or consent violated his Fourteenth Amendment right to direct his child's medical care.[280] The *Deanda* court rejected the assertion in *Anspach* that parental liberty interests are recognized only when state action involves some form of "coercion,"[281] noting that the Supreme Court's decision in *Troxel v. Granville*[282] did "not rely on a heavy distinction between 'voluntary' and 'compulsory' programs."[283] In fact, the court noted, if coercion were necessary for vindicating parents' constitutional rights—as *Anspach* asserts—schools could literally perform surgeries on students without the knowledge or consent of their parents as long as the students were not coerced or enticed to undergo the treatments.[284] The *Deanda* court accurately observed that "[o]ne cannot find the Third and Sixth Circuits' voluntary-compulsory distinction in any controlling precedent or the history of parental rights in this nation or pre-dating it."[285]

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277 *See id.* at 1203 (providing a brief description of the school district's policy).

278 *Id.* at 1222. Parents later joined the lawsuit as plaintiffs, and the district court certified a class for teachers and one for parents. The district court granted summary judgment for all plaintiffs and entered a permanent injunction. The Ninth Circuit stayed the injunction, but the parents and teachers filed an application with the Supreme Court seeking vacatur of the stay, which was granted as to the parents. *Mirabella v. Bonte*, 607 U.S. ___ (2026) (per curiam) (opinion granting application as to parents) (at slip op. 2-3) (Mar. 2, 2026).

279 Deanda v. Becerra, 645 F. Supp. 3d 600 (N.D. Tex. 2022), *aff'd in part, rev'd in part*, 96 F.4th 750 (5th Cir. 2024); *accord In re* Alfonso v. Fernandez, 606 N.Y.S.2d 259 (N.Y. App. Div. 1993); *see supra* notes 37–41 and accompanying text; *see also* Parents United for Better Schs., Inc. v. Sch. Dist. of Phila. Bd. of Educ., 148 F.3d 260 (3d Cir. 1998) (finding voluntary condom distribution program within the schools constitutional by virtue of the parental opt-out provision).

280 *Deanda*, 645 F. Supp. 3d at 611–13.

281 *Id.* at 627.

282 Troxel v. Granville, 530 U.S. 57 (2000).

283 *Deanda*, 645 F. Supp. 3d at 625.

284 *See id.* at 626.

285 *Id.* at 627–28.

The Supreme Court itself spoke to this issue, in dictum, in *Parham v. J.R.*, where the Court affirmed the right of parents to seek institutional mental health for their children against their children's wishes.[286] Emphasizing the centrality of parental rights within the nation's common law heritage, the Court opined that

> We cannot assume that the result in *Meyer v. Nebraska* and *Pierce v. Society of Sisters* would have been different if the children there had announced a preference to learn only English or a preference to go to a public, rather than a church, school.[287]

A second assertion courts have made in denying relief for parents is that the secret use of children's preferred names and pronouns by schools does not constitute medical care because the children have no "*diagnosed* mental health condition."[288] In rejecting parents' motion for a preliminary injunction, the *Willey* court suggested that, "[a]bsent evidence the Student was *suffering or diagnosed* with a mental health condition related to gender identity," the parents were likely to lose their Fourteenth Amendment claim of parental rights on the merits.[289] A similar result was reached in *Foote v. Town of Ludlow*,[290] as will be discussed below.[291] Such holdings, however, are both illogical and inconsistent with common law tradition. Under the court's rationale, a school could offer medical treatment to students without their parents' consent as long as no formal diagnosis had yet been made. Such a policy would clearly conflict with the holding in *Kennedy v. School District of Lebanon*, where the United States District Court for the Middle District of Pennsylvania held unconstitutional the provision of healthcare screening exams without allowing parents the right to be present.[292] Not only did those children have no diagnosed illness, there was no reason to suspect that any illness existed. The exams were strictly diagnostic, yet the court held that they violated the parents' rights. By contrast, social transition as practiced in the public schools is more than merely diagnostic. While affirmation of new names and pronouns may help children explore the possibility of living in another

286 Parham v. J.R., 442 U.S. 584 (1979).

287 *Id.* at 603–04 (internal citations omitted).

288 Willey v. Sweetwater Cnty. Sch. Dist. No. 1 Bd. of Trs., 680 F. Supp. 3d 1250, 1274 (D. Wyo. 2023) (emphasis added).

289 *Id.* (emphasis added).

290 Foote v. Town of Ludlow, No. 22-30041, 2022 WL 18356421, at *5 (D. Mass. Dec. 14, 2022).

291 *See infra* notes 294–303 and accompanying text.

292 Kennedy v. Sch. Dist. of Lebanon, No. 11-cv-00382, 2011 U.S. Dist. LEXIS 157416 (M.D. Pa. Dec. 21, 2011); *see supra* notes 107–13 and accompanying text.

gender role, social transition also facilitates gender transition and renders further medical interventions much more likely.[293]

In the appeal of *Foote*, the United States Court of Appeals for the First Circuit, in a per curiam opinion, concluded that the parents had successfully identified a fundamental right under *Meyer*, *Pierce*, and *Troxel*, including by alleging that the school committee and its personnel had "performed 'medical treatment' on the Student through accepting the Student's social transition without parental consent," relying on *Parham* for this latter point.[294] However, the First Circuit affirmed the district court's dismissal of this count, agreeing with that court that the parents' specific allegations did not establish the school's actions constituted medical treatment.[295]

Similarly, in *Littlejohn v. School Board of Leon County*, the United States Court of Appeals for the Eleventh Circuit, over a dissent, rejected the medical treatment argument.[296] In so doing, despite citing *Troxel* and *Parham*, the court would only assume without deciding that the parents invoked a fundamental right.[297]

The *Foote* and *Littlejohn* courts differed on the threshold substantive due process issue of whether the defendants' action constituted executive or legislative action, and thus which of two different tests applied: the "shocks the conscience" test for executive action or the levels of scrutiny test for legislative action.[298] *Littlejohn* was decided second, and the majority explicitly acknowledged the *Foote* court's opposite conclusion, explaining the differing conclusions on the basis of differing litigation tactics and differing circuit precedents.[299]

While the *Foote* court had applied the levels of scrutiny test, the *Littlejohn* court applied the shocks the conscience test.[300] Because there was no circuit precedent applying the "shocks the conscience" test in a parental rights case, the court turned to qualified immunity cases and school-based cases addressing other issues to decide the school board's actions did not shock the conscience.[301]

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293 *See Early Social Gender Transition in Children is Associated with High Rates of Transgender Identity in Early Adolescence*, *supra* note 250.

294 Foote v. Ludlow Sch. Comm., 128 F.4th 336, 349, 349–50 (1st Cir. 2025).

295 *Id.* at 349–50.

296 Littlejohn v. Sch. Bd. of Leon Cnty., 132 F.4th 1232, 1238–39 (11th Cir. 2025); *id.* at 1287 (Tjoflat, J., dissenting).

297 *Id.* at 1238 n.5 (noting specifically that it "express[ed] no opinion about whether Defendants' actions implicated the Littlejohns' child's medical or mental-health care").

298 *Id.* at 1242; *Foote*, 128 F.4th at 345–47.

299 *Littlejohn*, 132 F.4th at 1243 n.8.

300 *Id.* at 1243–46.

301 *Id.*

Since the parents in both cases have filed cert petitions, the Supreme Court now has before it one petition under each test.[302] And the arguments made in this Article on the central issue—social transition as medical treatment—are relevant in both cases. The same would have been true if only one set of parents filed a cert petition, but more importantly should the Court grant cert in either or both cases.[303]

A third assertion made by courts that have rejected parents' challenges to secret gender-affirming policies is that the schools' use of alternative names and pronouns is merely a matter of "accord[ing] the [student] the basic level of respect expected in a civil society."[304] This statement might be true if students were merely requesting that teachers and staff use preferred nicknames. But if that were all the students were requesting, policies requiring teachers and staff to use the students' new names and to hide the changes from parents would be unnecessary. School boards have adopted these policies because they understand that the new names and pronouns play a key role in the process of social transition.[305] Social transition, in turn, is nothing less than the first phase of a gender-affirming treatment protocol—a healthcare protocol which is subject to growing criticism in other countries and for which well-established medical alternatives exist. For schools to suggest that affirmation of students' new names and pronouns is merely polite accommodation by school personnel is plainly disingenuous.

Finally, the *Doe*, *Willey*, and *Foote* courts appeared to believe that, because the gender issues arose in the context of public schools, the schools were free to do as they wished. The *Willey* court, in particular, asserted that "case law . . . establishes that parents simply do not have a constitutional right to control each and every aspect of their

302 Petition for a Writ of Certiorari, *Foote*, No. 25-77 (U.S. July 18, 2025); Petition for Writ of Certiorari, *Littlejohn*, No. 25-259 (U.S. Sept. 3, 2025).

303 And obviously, the same is true as numerous other cases continue to work their way through the judicial system.

304 Foote v. Town of Ludlow, No. 22-30041, 2022 WL 18356421, at *5 (D. Mass. Dec. 14, 2022).

305 *See, e.g.*, Lily Durwood, Katie A. McLaughlin & Kristina R. Olson, *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 116, 116 (2017); *Study Finds that Early Social Transition for Transgender Youth Results in Good Mental Health Outcomes, but Unaccepting School Environments May Lead to Greater Risk of Suicidality*, FENWAY HEALTH (July 27, 2021), https://fenwayhealth.org/study-finds-that-early-social-transition-for-transgender-youth-results-in-good-mental-health-outcomes-but-unaccepting-school-environments-may-lead-to-greater-risk-of-suicidality/ [https://perma.cc/8QGU-E3JS]; *What Does "Social Transition" Mean?*, RAINBOW HEALTH ONT., https://www.rainbowhealthontario.ca/trans-health-knowledge-base/what-does-social-transition-mean [https://perma.cc/D5YY-QAK9].

children's education and oust the state's authority over that subject."[306] That statement is true as far as it goes. But the fact that an action occurs within a public school does not make the issue strictly educational, nor does it grant a school carte blanche to ignore other parental rights. The courts have invested considerable authority in the public schools to establish curricula and otherwise direct students' education. But it is one thing for a school to determine what it will teach, and a very different matter for a school to insert itself into an area so central to the integrity of the family as the right for parents to make basic healthcare choices for their children.

CONCLUSION

This Article opened with a brief discussion of *John and Jane Parents 1*[307] and *Parents Protecting Our Children*;[308] and Part I opened with a reference to *Pierce v. Society of Sisters*,[309] the case being celebrated in this Symposium and the application of whose holding and teachings drive this Article. Having argued that the principles first articulated in *Pierce* confirm that policies such as Montgomery County's "Parental Preclusion Policy" and the secret transitioning policy at issue in *Parents Protecting Our Children* violate parents' right to control medical decisionmaking for their children, it seems appropriate to end with the same three cases.

We begin with *Pierce*. There, the Court famously wrote that "[t]he child is not the mere creature of the State," and went on to address "the right, coupled with the high duty," of "those who nurture him and direct his destiny."[310]

In his Fourth Circuit dissent in *John and Jane Parents 1*, Judge Niemeyer explained just what an encroachment on parental rights the Parental Preclusion Policy is:

> The issue of whether and how grade school and high school students choose to pursue gender transition is a family matter, not one to be addressed initially and exclusively by public schools without the knowledge and consent of parents. Yet, the Montgomery County Board of Education (the "Board") preempts the issue to

306 Willey v. Sweetwater Cnty. Sch. Dist. No. 1 Bd. Of Trs., 680 F. Supp. 3d 1250, 1275 (D. Wyo. 2023) (quoting Swanson v. Guthrie Indep. Sch. Dist. No. I-L, 135 F.3d 694, 699 (10th Cir. 1998)).

307 John & Jane Parents 1 v. Montgomery Cnty. Bd. of Educ., 78 F.4th 622 (4th Cir. 2023), *cert. denied*, 144 S. Ct. 2560 (2024).

308 Parents Protecting Our Child., UA v. Eau Claire Area Sch. Dist., 95 F.4th 501 (7th Cir. 2024), *cert. denied*, 145 S. Ct. 14 (2024).

309 Pierce v. Soc'y of Sisters, 268 U.S. 510 (1925).

310 *Id.* at 535. Nothing changes when the issue involves medical treatment, as here, rather than education, as in *Pierce*.

> the exclusion of parents with the adoption of its "Guidelines for Student Gender Identity," which invite all students in the Montgomery County public schools to engage in gender transition plans with school Principals without the knowledge and consent of their parents. This policy implicates the heartland of parental protection under the substantive Due Process Clause of the Fourteenth Amendment.[311]

And as noted at the beginning, both Judge Niemeyer, as well as Justices Alito and Thomas, in their dissent from cert denial in *Parents Protecting Our Children*, bemoaned the fact that courts are avoiding the issue by dismissing cases based on standing.[312] This practice cannot continue. Again, looking to Judge Niemeyer and Justices Alito and Thomas, it is clear that the injury suffered by parents subjected to parental preclusion policies are not speculative, but current and ongoing.

As long as some courts continue to dismiss parents' cases on standing, and as long as other courts refuse to find *Pierce* applicable on the merits,[313] the promise of *Pierce* cannot be fulfilled in one of the most urgent parental rights debates of the day. But *Pierce* is applicable, and under its clear teachings such policies cannot pass constitutional muster. Recognizing that these secret transitioning policies conceal healthcare treatments—or at a minimum, represent a first step leading to healthcare treatments—makes that conclusion all the more plain.

311 *John & Jane Parents 1*, 78 F.4th at 636 (Niemeyer, J., dissenting) (emphasis omitted).

312 *See supra* notes 15–17 and accompanying text.

313 *See supra* notes 9, 13–17, 269–84 and accompanying text, Conclusion.