

UNCERTAIN SCIENCE, CERTAIN HARM: *Skrametti's* Misguided Deference

Kit Beyer¹

ABSTRACT

In *United States v. Skrametti*, the Supreme Court relied on the “medical context” and “medical and scientific uncertainties” surrounding youth gender-affirming care to uphold Tennessee’s ban on the procedures. This Note argues that this deferential posture is misguided. First, it examines a series of historical episodes in which medical arguments legitimized or justified anti-LGBTQ+ government actions, undermining the assumption that medical regulations are presumptively benign. Further, the Note contends that reflexive deference to medical uncertainty creates inconsistencies in the Court’s jurisprudence that are difficult to defend: the Court does not treat either “medical context” or the existence of epistemic uncertainty as reasons for deference in other areas of constitutional law. Based on these analyses, the Note argues against extending *Skrametti*’s deferential approach. Judicial review under the Equal Protection Clause should be no weaker simply because a medical law is at issue.

1. J.D. expected 2028, Yale Law School; B.A. 2024, University of California at Berkeley. I am grateful to Professor Reva Siegel for conversations within and outside of her course that inspired this Note. I also thank Jeffrey S. Haber for his generosity and the editors of the *Dukeminier Awards Journal* for their thorough and thoughtful feedback. All remaining errors are my own.

© 2026 Kit Beyer. All rights reserved.

TABLE OF CONTENTS

INTRODUCTION287

I. DEFERENCE AND DISAGREEMENT IN SKRMETTI.....291

II. SUBORDINATION THROUGH MEDICALIZATION297

 A. *Lavender Scare*297

 B. *Anti-Sodomy Legislation*299

 C. *Americans with Disabilities Act*301

 D. *Lessons of History*303

III. SELECTIVE DEFERENCE303

 E. *Religion and Medical Uncertainty*303

 F. *Originalism and Historical Ambiguity*307

IV. REJECTING SKRMETTI’S MISSTEPS.....311

 G. *Doctrinal Distortions*.....311

 H. *Alternative Paths*314

CONCLUSION.....316

INTRODUCTION

A publication emerges amidst fierce cultural controversy over a social issue. It makes claims that contradict prevailing views within its discipline and attracts intense media coverage. Politicians on one side of the spectrum denounce it. Those on the other side endorse it. The principal author faces targeted harassment and threats from critics. The publication's conclusions spur public contestation, online discourse, legislative proposals, open letters, and scholarly investigation. To this day, the debate continues. Definitive resolution seems a long way off.

This description captures, at a high level of generality, the release of both the 1619 Project in 2019² and the Cass Review's final report in 2024.³ The former originated as a series of essays in the *New York Times Magazine* that challenged dominant historiographical narratives by foregrounding the role of slavery in American history.⁴ The latter was an independent review commissioned by England's National Health Service to offer recommendations for the treatment of transgender and gender-dysphoric youth.⁵ These publications and the criticism they generated exemplify how uncertainty is a core feature of knowledge production.⁶ In history as in medicine, the process of discovery and advancement is dynamic, dialogic, and unsettled.

2. *The 1619 Project*, N.Y. TIMES MAG. (Aug. 18, 2019), <https://www.nytimes.com/interactive/2019/08/14/magazine/1619-america-slavery.html?smid=pl-share> [<https://perma.cc/VWM4-KMMV>]; see also Lauren Michele Jackson, *The 1619 Project and the Demands of Public History*, NEW YORKER (Dec. 8, 2021), <https://www.newyorker.com/books/under-review/the-1619-project-and-the-demands-of-public-history> [<https://perma.cc/6G67-7MUN>] (describing the academic and political backlash to the 1619 Project's claims); Clyde W. Ford, Opinion, *I never Imagined that Being a Black Author Could Put Me in Harm's Way*, L.A. TIMES: VOICES (Apr. 5, 2022, at 03:05 PT), <https://www.latimes.com/opinion/story/2022-04-05/black-authors-targeted-threats-book-banning> [<https://perma.cc/ST5W-PSVC>] (reporting on threats and harassment directed at author Nikole Hannah-Jones).

3. HILARY CASS, INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE: FINAL REPORT (2024), https://cass.independent-review.uk/wp-content/uploads/2024/04/CassReview_Final.pdf [<https://perma.cc/92N4-58F7>]; see also Meredith McNamara et al., *An Evidence-Based Critique of "The Cass Review" on Gender-Affirming Care for Adolescent Gender Dysphoria*, YALE L. SCH. INTEGRITY PROJECT (July 1, 2024), https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf [<https://perma.cc/SX6J-BH8B>] (critiquing the Cass Review's conclusions); Sammy Gecsoyler, *Hilary Cass Warned of Threats to Safety After 'Vile' Abuse Over NHS Gender Services Review*, GUARDIAN (Apr. 20, 2024, at 12:30 ET), <https://www.theguardian.com/society/2024/apr/20/doctor-hilary-cass-warned-of-threats-to-safety-after-vile-abuse-over-nhs-gender-services-review> [<https://perma.cc/LNJ4-T5KC>] (describing online abuse toward Dr. Cass).

4. Jake Silverstein, *The 1619 Project and the Long Battle Over U.S. History*, N.Y. TIMES (Nov. 12, 2021), <https://www.nytimes.com/2021/11/09/magazine/1619-project-us-history.html> [<https://perma.cc/2F3L-KQEK>].

5. Thomas Mackintosh, *Cass Review: Gender Care Report Author Attacks 'Misinformation'*, BBC (Apr. 20, 2024), <https://www.bbc.com/news/health-68863594> [<https://perma.cc/2DWY-G4YC>].

6. See RAJAN GURUKAL, HISTORY AND THEORY OF KNOWLEDGE PRODUCTION: AN INTRODUCTORY OUTLINE 3 (2019) (explaining that "[t]here is synthesis and aggregation, besides the problem of elusive circulation, dialectical expansion, and mutual nullification").

The contemporary Supreme Court, however, has taken remarkably different approaches to uncertainty in each of these fields. With its self-proclaimed, though selective, turn toward originalist methodology,⁷ the Court increasingly relies on historical narratives to justify its constitutional decisions.⁸ Interested parties have taken note of this pattern, as demonstrated by the rise of the “historians’ brief,” an *amicus curiae* submission by “honest-to-goodness historians,” to borrow a phrase from Chief Judge Jeffrey Sutton.⁹ Many cases see historians’ briefs submitted on both sides, illustrating the ubiquity of disagreement over historical claims.¹⁰ Nonetheless, Justices of diverse ideologies cite historians’ briefs at high rates relative to other briefs¹¹ and often deny or downplay the presence of any ambiguity in the historical record.¹² Historical arguments enjoy broad legitimacy in the Roberts Court.¹³

By contrast, the response of the Court’s conservatives to medical expert evidence—at least in the contexts of reproductive and gender-affirming health-care—has ranged from cautious to hostile. Rather than invoking briefs by medical professionals as authority, the Court has underscored the extent of indeterminacy in medical knowledge.¹⁴ According to the Court, ongoing disagreement among medical researchers and practitioners and the existence of open questions in the field warrant deference to elected officials when they regulate medical practice. The Court’s ruling in *United States v. Skrmetti*,¹⁵ which approved Tennessee’s prohibition of puberty blockers and hormone therapy for transgender minors, exemplifies this deferential posture. Writing for

7. Richard H. Fallon, Jr., *Selective Originalism and Judicial Role Morality*, 102 TEX. L. REV. 221, 236–37 (2023) (identifying originalist self-identification on the Court); *id.* at 247–63 (supplying examples of selective originalism in practice).

8. Karen M. Tani, *Foreword: Curation, Narration, Erasure: Power and Possibility at the U.S. Supreme Court*, 138 HARV. L. REV. 1, 43–46 (2024).

9. Jeffrey S. Sutton, *The Role of History in Judging Disputes About the Meaning of the Constitution*, 41 TEX. TECH. L. REV. 1173, 1176 (2009).

10. See Maryjane Johnson & Samuel Breidbart, *Historians’ Friend-of-the-Court Briefs from the Supreme Court’s 2023 Term*, BRENNAN CTR. FOR JUST. (July 1, 2024), <https://www.brennancenter.org/our-work/research-reports/historians-friend-court-briefs-supreme-courts-2023-term> [<https://perma.cc/7B6J-SP3C>].

11. M. Henry Ishitani, *Today’s Brandeis Brief? The Fate of the Historians’ Brief Amidst the Rise of an Originalist Court*, 2 J. AM. CON. HIST. 1, 34 (2024).

12. See, e.g., *Alexander v. S.C. State Conf. of the NAACP*, 602 U.S. 1, 12 (2024) (Thomas, J., concurring) (“The historical record compels this interpretation of the Elections Clause’s text.”); *Dobbs v. Jackson Women’s Health Org.*, 597 U.S. 215, 240 (2022) (insisting that the “clear answer” of history is that the Fourteenth Amendment does not protect a right to abortion); *Timbs v. Indiana*, 586 U.S. 146, 154 (2019) (calling the “historical . . . case” for incorporation of the Excessive Fines Clause “overwhelming”).

13. This phenomenon in the Roberts Court can be seen as a continuation of a trend that began much earlier. Thus in 1993, Erwin Chemerinsky could already write that “[i]n virtually every area of constitutional law, the Supreme Court increasingly is relying on tradition as its guide in decisionmaking.” Erwin Chemerinsky, *History, Tradition, the Supreme Court, and the First Amendment*, 44 HASTINGS L.J. 901, 901 (1993).

14. See *infra* notes 44–70 and accompanying text.

15. 605 U.S. 495 (2025).

the conservative majority, Chief Justice Roberts invoked “medical and scientific uncertainties” as grounds for upholding Tennessee statute, SB1, over a challenge by transgender minors who sought access to gender-affirming care.¹⁶ Despite SB1’s references to sex, typically a disfavored classification under the Equal Protection Clause,¹⁷ the law’s “medical context” made the Court reluctant to scrutinize it closely.¹⁸

Judicial emphasis on the need to defer to health-related legislative judgments is nothing new. Even in the heyday of the *Lochner* era, the Court recognized matters related to health and medicine as proper objects of governmental regulation and core areas falling within the “police powers” of state and local governments.¹⁹ As the Court repudiated the *Lochner* line of cases, its reluctance to second-guess legislators’ choices about medical matters deepened. The once-exalted “right to do business” and its underlying laissez-faire “school of thought,” Justice Douglas wrote for the Court in *Williamson v. Lee Optical*, had fallen from grace.²⁰ The *Lochner* tradition gave way to the cost-benefit balancing of “the legislature, not the courts”²¹—and not, the Justices in *Skrmetti* added, the American medical establishment.²² In this sense, the Court’s conservatives are self-consciously carrying the mantle of the post-1937 Court’s anti-*Lochnerian* judicial restraint into the present.²³ The Court made the same move in *Dobbs v. Jackson Women’s Health Organization*, criticizing “the freewheeling judicial policymaking that characterized discredited decisions such as *Lochner*” as an “unprincipled approach”²⁴ and faulting *Roe v. Wade*,²⁵ the case establishing the constitutional right to terminate a pregnancy,

16. *Id.* at 524 (quoting *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007)).

17. *United States v. Virginia*, 518 U.S. 515, 532–33 (1996).

18. *Skrmetti*, 605 U.S. at 496.

19. *See, e.g.*, *Jacobson v. Massachusetts*, 197 U.S. 11, 39 (1905) (upholding compulsory vaccination); *Zucht v. King*, 260 U.S. 174, 176–77 (1922) (upholding the exclusion of unvaccinated students from public schools); *Adams v. Milwaukee*, 228 U.S. 572, 581 (1913) (upholding an ordinance preventing the importation of out-of-city milk unless the cows’ owner filed a certificate with the Commissioner of Health certifying their freedom from disease); *Muller v. Oregon*, 208 U.S. 412, 421 (1908) (invoking the need for “healthy mothers” to uphold limitations on the workday length for women).

20. 348 U.S. 483, 486, 488 (1955).

21. *Id.* at 487.

22. *See* 605 U.S. at 524–25 (calling for “legislative flexibility” and declining to intervene in “open questions . . . before medical authorities”); *see also id.* at 530 (Thomas, J., concurring) (“There are several problems with appealing and deferring to the authority of the expert class. First, so-called experts have no license to countermand the ‘wisdom, fairness, or logic of legislative choices.’” (quoting *FCC v. Beach Commc’ns, Inc.*, 508 U.S. 307, 313 (1993))).

23. *See* Douglas NeJaime & Reva B. Siegel, *Not Lochner!: Substantive Due Process as Democracy-Promoting Judicial Review*, 113 CALIF. L. REV. 2199, 2199 (2026) (“In modern substantive due process cases, judges invoke *Lochner* to . . . warn judges against protecting unenumerated rights and second-guessing the decisions of democratic bodies”).

24. 597 U.S. 215, 240 (2022).

25. 410 U.S. 113 (1973).

for its “depart[ure] from the normal rule that courts defer to the judgments of legislatures ‘in areas fraught with medical and scientific uncertainties.’”²⁶

On the one hand, the Court’s withdrawal from the medical thicket may yield democratic benefits by creating greater space for majoritarian decision-making. In *Skrmetti*, Chief Justice Roberts advanced this claim, declaring that access to gender-affirming medical care was best left to “elected representatives” of “the people” acting through “the democratic process.”²⁷ On the other hand, though, this argument overlooks the subordinating potential of medical regulations: the ways in which they can construct and embed social status hierarchies that ultimately degrade democracy rather than reinforce it. *Skrmetti* devotes insufficient attention to this risk. A closer look at *Skrmetti* suggests the need for a less deferential judicial attitude toward legislative interventions in medicine. The Court’s treatment of medical uncertainty in *Skrmetti* went beyond due deference to the legislature. It functioned as an off-ramp that prevented true equal protection analysis from ever beginning.

This Note analyzes the Court’s deferential posture in *Skrmetti*, examining the problems with the majority’s passive acceptance of the medical regulations at issue. To start, the history of medicine as a vehicle of anti-LGBTQ+ subordination illuminates the perils of the Court’s acquiescence.²⁸ Opponents of LGBTQ+ equality have long advanced pathologizing medical arguments as grounds for excluding and marginalizing LGBTQ+ individuals.²⁹ This history belies the *Skrmetti* majority’s implicit assumption that medical classifications are distinctively noninvidious. Undermining that premise, in turn, dismantles the argument for reflexive differences to the political branches’ medical regulations, whether predicated on claims of medical uncertainty or consensus. Such deference, moreover, becomes all the more difficult to justify given its tension with both precedent and current practice in other areas of constitutional law.³⁰ The Court should not step further down *Skrmetti*’s deferential path. Judicial review under the Equal Protection Clause should be no weaker simply because a medical law is at issue.

This Note proceeds in four parts. In Part I, I examine the rhetoric of deference in *Skrmetti*, highlighting how alleged medical uncertainty is central to the opinion’s reasoning and linking this to similar contentions in the Court’s abortion jurisprudence. Part II situates these decisions against the historical background of political actors weaponizing medical discourse to subordinate LGBTQ+ persons. This discredited past, I contend, warrants judicial skepticism toward health-based arguments behind restrictive or exclusionary medical policies. Part III further critiques the Court’s reasoning in *Skrmetti* by identifying inconsistencies in, first, how the Justices address medical regulations and, second, how they handle expert opinion in cases outside the medical context.

26. 597 U.S. at 274 (quoting *Marshall v. United States*, 414 U.S. 417, 427 (1974)).

27. *Skrmetti*, 605 U.S. at 499.

28. See *infra* Part II.

29. See *infra* Part II.

30. See *infra* Part III.

Based on the criticisms that Parts II and III outline, Part IV proposes an alternative to *Skrmetti*'s approach. Courts should not refuse the possibility of searching review in cases dealing with medical regulations. When a gender or sexual minority challenges a medical policy that impedes personal health choices, strict or intermediate-level scrutiny is appropriate. To be sure, epistemic uncertainty remains relevant under this model. In assessing the strength of the governmental interest in regulation and the fit between means and end, courts should give due regard to genuine, good-faith disagreements among professionals, while also considering the potential for bias within the medical establishment.³¹ These factors do not warrant a refusal to engage in heightened review altogether, but they may diminish the persuasive force of expert opinion and widen the scope of policymakers' discretion. Conversely, when professional consensus runs wide and deep, politicians' medical judgment to the contrary, while still relevant, merits less weight.

I. DEFERENCE AND DISAGREEMENT IN SKRMETTI

On March 22, 2023, Tennessee passed SB1,³² banning gender-affirming care for minors. The state legislature included factual findings that some procedures used to treat gender dysphoria "can lead to the minor becoming irreversibly sterile, having increased risk of disease and illness, or suffering adverse and sometimes fatal psychological consequences."³³ In addition to these findings, SB1 announced Tennessee's purported interests in "encouraging minors to appreciate their sex" and preventing "medical procedures . . . that might encourage minors to become disdainful of their sex."³⁴ SB1 accordingly bars healthcare providers from administering medical procedures "for the purpose of: (1) Enabling minors to identify with, or live as, a purported identity inconsistent with the minor's sex; or (2) Treating purported discomfort or distress from a discordance between the minor's sex and asserted identity."³⁵

Arguments based on health and medical science featured prominently in the litigation leading up to the Court's decision in *Skrmetti*. The appendix to the petition for certiorari filed by the Department of Justice on behalf of the transgender minor plaintiffs, asserted that "every major American medical organization with a position on the issue, including the American Academy of Pediatrics and the American Medical Association, agrees that puberty blockers and hormone therapy 'are appropriate and medically necessary treatments for adolescents when clinically indicated.'"³⁶ This argument had previously

31. See Chloë FitzGerald & Samia Hurst, *Implicit Bias in Healthcare Professionals: A Systematic Review*, BMC MED. ETHICS, Mar. 2017, at 13 ("Based on the available evidence, physicians and nurses manifest implicit biases to a similar degree as the general population.").

32. TENN. CODE ANN. § 68–33–103 (2023).

33. *Id.* § 68–33–101(b).

34. *Id.* § 68–33–101(m).

35. *Id.* § 68–33–103(n)(1), (n)(2).

36. Petition for Writ of Certiorari at 7–8, *Skrmetti*, 605 U.S. 495 (2025) (No. 23–477) (quoting the District Court's opinion in *L.W. ex rel. Williams v. Skrmetti*, 679 F. Supp. 3d

been dismissed by the Sixth Circuit, which had reversed the District Court's ruling in favor of the plaintiffs and reasoned that "the Constitution does not require [Tennessee] to view [gender dysphoria] treatments in the same way as the majority of experts or to allow drugs for all uses simply because the [Food and Drug Administration] approved them for others."³⁷

After the Supreme Court granted certiorari on the question of whether SB1 violated the Equal Protection Clause,³⁸ numerous medical associations signed on to amicus briefs on both sides of the case. The American Academy of Pediatrics summarized a wide range of studies to support its conclusion that puberty blockers and hormone therapy "can alleviate clinically significant distress and lead to significant improvements in the mental health and overall wellbeing of adolescents with gender dysphoria."³⁹ In opposition, a group of fifty-six physicians stressed that gender-affirming medications "present concerning risks" of "enduring negative side effects that should be avoided in adolescent patients at all costs."⁴⁰ The briefs sparred over questions of evidence and expertise such as the significance of the term "low quality"⁴¹ and the medical authority of the World Professional Association of Transgender Health (WPATH).⁴²

The Court, therefore, faced a tangle of conflicting claims. Some threads of the medical evidence tugged in one direction; others pulled another way. The majority in *Skrmetti* attempted to cut the Gordian knot.⁴³

Chief Justice Roberts opened his equal protection analysis by asserting that SB1 "incorporates two classifications": first, age, since only minors' access to gender-affirming medications was restricted, and second, "medical use," since children could access the treatments for purposes other than treating gender dysphoria.⁴⁴ These classifications, the Court explained, are subject to rational basis review,⁴⁵ as opposed to the more searching intermediate scrutiny

668, 709 (M.D. Tenn.) (2023)).

37. *L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 478 (6th Cir. 2023).

38. *United States v. Skrmetti*, 83 F.4th 460 (6th Cir. 2023), *cert. granted*, 92 U.S.L.W. 3340 (U.S. June 24, 2024) (No. 23–477).

39. Brief of American Academy of Pediatrics, et al. as Amici Curiae Supporting Petitioner at 5, *Skrmetti*, 605 U.S. 495 (2025) (No. 23–477) [hereinafter AAP's Brief].

40. Brief of Fifty-Six Physicians as Amici Curiae Supporting Respondents at 3, *Skrmetti*, 605 U.S. 495 (2025) (No. 23–477) [hereinafter Fifty-Six Physicians' Brief].

41. Compare AAP's Brief at 22 (explaining that "low quality" is a medical "[term] of art" that refers to "studies that were not randomized controlled clinical trials"), with Fifty-Six Physicians' Brief at 15–16 (concluding that the "low quality" status of several studies suggests that the treatments' "purported benefits . . . are not outweighed by the known risks").

42. Compare American Psychological Ass'n and Other Leading Mental Health Organizations as Amici Curiae Supporting Petitioner (describing WPATH as "the leading association of medical professionals treating transgender individuals"), with America's Frontline Doctors et al. as Amici Curiae Supporting Respondents at 13, *Skrmetti*, 605 U.S. 495 (2025) (No. 23–477) (deeming WPATH "essentially a scam").

43. See *Gordian knot*, MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/Gordian%20knot> [<https://perma.cc/W53P-MCTL>] (last visited Feb. 21, 2026).

44. *Skrmetti*, 605 U.S. at 511.

45. *Id.* Rational basis review requires the challenged classification to be "rationally

that would have applied had the Court interpreted the statute as classifying on the basis of sex.⁴⁶ Remarkably, the Court called upon SB1's "medical context" as supporting the application of rational basis review without explaining how this carve-out fit into the Court's traditional equal protection framework,⁴⁷ which emphasizes suspect classifications and political participation.⁴⁸

Yet even when performing rational basis review, the Court does not recognize pure animus as a permissible legislative motive. In *Romer v. Evans*,⁴⁹ the Court invalidated a Colorado voter initiative that aimed to ban local legislatures from enacting civil rights protections for LGBTQ+ individuals. Writing for the majority, Justice Kennedy reasoned that a law "inexplicable by anything but animus toward the class it affects . . . lacks a rational relationship to legitimate state interests."⁵⁰ *Romer* exhibits that even under a highly deferential standard of review, courts decline to defer when the democratic process encodes status hierarchies based on hostility to disfavored groups.

While the Sixth Circuit had explicitly found that animus was absent from legislators' motives, the *Skrmetti* majority declined to do so. Instead, the Court argued that SB1 cleared *Romer*'s "inexplicable but for animus" test given Tennessee's determination that "debate among medical experts" was "ongoing."⁵¹ Since SB1 "responds directly to that uncertainty," the Court found that it had a rational explanation separate from animus.⁵²

Crediting the legislature's findings that gender-affirming puberty blockers or hormones could have "harmful effects . . . [not] yet fully known" due to the "experimental" nature of the treatment and a lack of "high-quality, long-term medical studies,"⁵³ the Court concluded that SB1's classifications were "plainly rationally related to these findings and the State's objective of protecting minors' health and welfare."⁵⁴ It stressed the "wide discretion" that States wield "to pass legislation in areas where there is medical and scientific uncertainty."⁵⁵ For this proposition, the Court cited *Gonzales v. Carhart*.⁵⁶

The reference to *Gonzales*, in which a fractured Court upheld the Partial-Birth Abortion Ban Act of 2003,⁵⁷ demonstrates how the Court's jurisprudence around medical uncertainty is inextricably bound up with its abortion juris-

related to furthering a legitimate state interest." *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 312 (1976).

46. *United States v. Virginia*, 518 U.S. 515, 524 (1996).

47. *Skrmetti*, 605 U.S. at 512 (claiming that applying heightened scrutiny based on "mere reference to sex . . . would be especially inappropriate in the medical context").

48. Guido Calabresi, *The Proper Role of Equality in Constitutional Adjudication: The Cathedral's Missing Buttress*, 134 *YALE L.J.* 2848, 2856 n.15 (2025).

49. 517 U.S. 620 (1996).

50. *Id.* at 632.

51. *Skrmetti*, 605 U.S. at 523.

52. *Id.*

53. *Id.* at 522–23 (citing TENN. CODE ANN. § 68–33–101(b)).

54. *Id.* at 523.

55. *Id.* at 524 (citing *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007)).

56. 550 U.S. 124 (2007).

57. 18 U.S.C. § 1531.

prudence, as Mary Ziegler has documented.⁵⁸ The history she traces is worth recounting in part here, as the core themes recur in *Skrimetti*.

In the litigation leading up to *Roe*, supporters of abortion rights pressed arguments resting on the uncertainty of when life begins.⁵⁹ Even the basic nature of this question—whether it inquires into a matter of objective scientific fact or instead invites religious or philosophical judgment—admits of no easy answer. The Court declined to resolve it in *Roe*,⁶⁰ despite its reliance on medical evidence in assessing the weight of the state interest in regulating abortion to ensure patients' safety.⁶¹

The problem of medical uncertainty recurred soon after *Roe* in *Colautti v. Franklin*, which addressed the constitutionality of a Pennsylvania law that required abortion providers "to preserve the life and health" of a viable fetus.⁶² In its briefing to the Supreme Court, Pennsylvania insisted that uncertainty about the viability line was a reason to let the legislature set the standard, criticizing the "elitist view that physicians and hospitals should regulate abortion practice as opposed to the federal government or state legislatures."⁶³ Meanwhile, opponents of the law argued that uncertainty supported deference to physicians, not to legislators.⁶⁴ The Court in *Colautti* ultimately voided Pennsylvania's statute for vagueness, observing that physicians' definitions of viability differed, and uncertainty rising from this disagreement would impose an intolerable "chilling effect" on the exercise of their "best medical judgments" in determining whether to perform an abortion.⁶⁵ Confronted with uncertainty rooted in an absence of medical consensus, the Court in *Colautti* elected to limit the reach of restrictive legislation so that physicians would retain greater freedom to reach sound medical conclusions.

Although the Court's later interventions on medical uncertainty plaguing abortion legislation were anything but consistent, *Colautti* was far from the final word on the matter. As the anti-abortion movement gained traction, the Court shifted away from curtailing regulatory control over physician and patient decisions, instead invoking uncertainty to restrain judicial scrutiny of abortion regulations. In *Webster v. Reproductive Health Services*, Chief Justice Rehnquist argued that the "essentially indeterminate" medical lines

58. See generally Mary Ziegler, *The Jurisprudence of Uncertainty: Knowledge, Science, and Abortion*, 2018 Wis. L. Rev. 317 (2018).

59. *Id.* at 319–20.

60. *Roe v. Wade*, 410 U.S. 113, 159 (1973).

61. *Id.* at 149–50 (discussing how "[m]odern medical techniques" have rendered abortion safer but acknowledging the state interest "in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient").

62. 439 U.S. 379, 380 n.1 (1979).

63. Brief for Appellants at 26–28, *Colautti*, 439 U.S. 379 (1979) (No. 77–891).

64. Brief for the American Public Health Ass'n et al. as Amici Curiae at 29–31, *Colautti*, 439 U.S. 379 (1979) (No. 77–891).

65. 439 U.S. at 396.

of trimesters and viability could not translate into a workable judicial framework.⁶⁶ The Court later returned to a *Colautti*-type analysis in *Stenberg v. Carhart*, relying on the “division of medical opinion” and “an absence of controlled medical studies” to invalidate Nebraska’s ban on so-called “partial-birth abortion.”⁶⁷ The tides turned once more after Justice Alito replaced Justice O’Connor and the Court upheld a similar federal ban in *Gonzales*.⁶⁸ “The evidence presented in the trial courts and before Congress demonstrates both sides have medical support for their position,” and given this “documented medical disagreement,” the Court determined that lawmakers deserve “wide discretion.”⁶⁹ This language, as noted *supra*, reappears in *Skrmetti*.⁷⁰

Despite this deferential turn, *Gonzales* also emphasized that the “Court retains an independent constitutional duty to review factual findings where constitutional rights are at stake.”⁷¹ The Court later reaffirmed this point when, switching its stance yet again in *Whole Woman’s Health v. Hellerstedt*, it denied “that legislatures, and not courts, must resolve questions of medical uncertainty.”⁷² That proposition, Justice Breyer wrote for the majority, was “inconsistent with this Court’s case law,” which “placed considerable weight upon evidence and argument presented in judicial proceedings.”⁷³

Finally, in spurning *Roe* and its progeny, *Dobbs* returned to a presumption of deference—to legislators, not experts—when “medical and scientific uncertainties” abound.⁷⁴ As Aziza Ahmed observes, “[u]nlike *Roe*, which started us down the path of an expert-driven discussion of abortion access (i.e., listen to the doctors), the *Dobbs* decision . . . threw the core question of [abortion access] back into the political arena.”⁷⁵ Post-*Dobbs*, legislators can come down on either side of medical debates around abortion without being subjected to close judicial scrutiny.

The Court’s repeated about-faces are dizzying. They reveal that medical uncertainty has rationalized both deference and skepticism toward legislative outputs, both judicial abstinence and intervention. Despite this pattern, *Skrmetti* leaves little doubt where the current Court lands in the context of transgender minors. The majority repeats the Cass Review’s claim that “people on all

66. 492 U.S. 490, 492 (1989).

67. 530 U.S. 914, 936–37 (2000).

68. *Gonzales v. Carhart*, 550 U.S. 124, 168 (2007).

69. *Id.* at 161–63.

70. *United States v. Skrmetti*, 605 U.S. 495, 124 (2025).

71. 550 U.S. at 165.

72. 579 U.S. 582, 609 (2016).

73. *Id.*

74. *Dobbs v. Jackson Women’s Health Org.*, 597 U.S. 215, 274 (2022) (quoting *Marshall v. United States*, 414 U.S. 417, 427 (1974)). I say “presumption” because *Dobbs* leaves open the possibility that a court may decline to defer to legislative judgment provided that it sufficiently explains its departure from the “normal rule.” *Id.*; see also Siena Hohne, *The Courts’ Role in Evaluating Medical Evidence in Gender-Affirming Care Ban Litigation: Lessons from L.W. v. Skrmetti*, 34 *TUL. J.L. & SEXUALITY* 119, 134 (2025).

75. Aziza Ahmed, *Feminist Legal Theory and Practice After Dobbs: Science, Politics, and Expertise*, 34 *YALE J.L. & FEMINISM* 48, 50–51 (2023).

sides of the debate” distort studies “to support their viewpoint” and reference the Review’s conclusion that the long-term evidence supporting gender-affirming care for transgender youth is insufficient.⁷⁶ “We cite this report,” the Court hastened to add, “not for the guidance [it] might provide on . . . United States law . . . but to demonstrate the open questions regarding basic factual issues before medical authorities and other regulatory bodies. Such uncertainty ‘afford[s] little basis for judicial responses in absolute terms.’”⁷⁷ As in *Gonzales* and *Dobbs*, and unlike in *Colautti* and *Stenberg*, the Court in *Skrmetti* deployed medical uncertainty to approve legislative imposition at the expense of bodily autonomy.

But the Court’s abortion precedents show that *Skrmetti*’s result was not foreordained. The Justices have recognized, albeit inconsistently, their capacity to weigh the medical “evidence and argument” that parties put forth in adversarial adjudication.⁷⁸ In *Skrmetti*, by relying instead on *Gonzales*’ reasoning—and specifically on the part giving “wide discretion” to legislatures rather than the emphasis on courts’ “independent constitutional duty”—the Court gave short shrift to the equality values at stake. Yet in Chief Justice Roberts’ view, while both sides of the debate over gender-affirming care raised “sincere concerns,” it was the role of elected representatives, not judges, to address them.⁷⁹ A majority vote in the legislature, not an individualized medical determination by a physician, would and should govern transgender minors’ access to care.

There is an undeniable allure to the Court’s democratic rhetoric. Legislators are not subject-matter experts in every field into which they intervene—but then again, neither are the Justices. If nothing else, reflexive judicial deference to legislatures allocates greater decision-making discretion to politically accountable bodies than to federal judges, whose tenure is not regularly subject to voter approval.⁸⁰ If the people’s representatives make poor policy choices, their constituents can eject them from office come election day, whereas removing a federal judge poses far more formidable hurdles.⁸¹

Yet, for all its surface appeal, this logic fails to grapple with the substantial risks of avoiding careful judicial review simply because the state asserts a medical justification. Medical explanations have long rationalized classificatory and subordinating legislation targeted at gender and sexual minorities.⁸²

76. *United States v. Skrmetti*, 605 U.S. 495, 524 (2025) (citing *Cass*, *supra* note 3, at 13).

77. *Id.* at 525 (quoting *Marshall v. United States*, 414 U.S. 417, 427 (1974)).

78. *Hellerstedt*, 579 U.S. at 609.

79. 605 U.S. at 525.

80. U.S. CONST. art. III, § 1 (providing that federal judges hold their offices “during good Behaviour”).

81. Frank Thompson Jr. & Daniel H. Pollitt, *Impeachment of Federal Judges: An Historical Overview*, 49 N.C. L. REV. 87, 88 (1970) (observing that “the Framers deliberately created a complicated and cumbersome process for the removal of federal judges”).

82. Other groups, such as racial minorities, have also been targets. *See generally* Ayah Nuriddin, Graham Mooney & Alexandre R. White, *Reckoning with Histories of Medical Racism and Violence in the USA*, 396 LANCET 949 (2020). Addressing this history is beyond

This history, partially examined in Part II, suggests the danger of entrenching deference to medical regulations as a rule of constitutional doctrine.

II. SUBORDINATION THROUGH MEDICALIZATION

Medicine crosscuts the history of gender and sexuality law. Medical arguments have served both reformatory and regulatory purposes, sometimes aiming to eliminate arbitrary discrimination and other times merely rationalizing oppressive restrictions. Further complicating matters, moral assumptions often tangle with medical claims. The following historical episodes illustrate these points and highlight that courts' hands-off approach when legislatures point to medical conclusions, categories, or contestation risks allowing subordinating policies to survive legal challenges unscathed.

A. *Lavender Scare*

The seeds of Cold War-era anti-homosexual hysteria were sown long ago. Prosecutions and trials for sodomy originally occurred through ecclesiastical courts; only after Henry VIII broke from the Catholic Church did Parliament enact a law in 1533 secularizing the offense as a civil crime.⁸³ The New England legal codes "substantially copied" England's statute.⁸⁴ Even so, the legal disapproval of same-sex relations remained "fundamentally a Christian, religious judgment" for most of U.S. history.⁸⁵ Yet, since the emergence of early sexology in the nineteenth century, the law has also intersected with a medicalizing discourse that understands homosexuality in psychiatric or biological terms.⁸⁶ This discourse proved a versatile weapon in Senator Joseph McCarthy's paranoid crusade to locate and repress subversive actors.⁸⁷

On February 20, 1950, McCarthy gave a six-hour speech on the Senate floor identifying eighty-one cases of "unsafe risks" in the State Department.⁸⁸ The fourteenth case McCarthy identified, he alleged, was a "flagrantly homosexual" translator with communist affiliations.⁸⁹ McCarthy added that a top intelligence official told him that "practically every active Communist is twisted mentally or physically in some way."⁹⁰ He described the sixty-second case

the scope of this Note, but it further supports the dangers of a wide-reaching rule of deference to medical regulations.

83. BYRNE FONE, *HOMOPHOBIA: A HISTORY* 215–17 (2000).

84. Roger Thompson, *Attitudes towards Homosexuality in the Seventeenth-Century New England Colonies*, 23 J. AM. STUD. 1, 32 (1989).

85. WILLIAM N. ESKRIDGE JR., *DISHONORABLE PASSIONS: SODOMY LAWS IN AMERICA, 1861–2003*, at 1 (2008).

86. MICHEL FOUCAULT, *THE HISTORY OF SEXUALITY* 39 (Robert Hurley trans., 1978); Nancy J. Knauer, *Homosexuality as Contagion: From the Well of Loneliness to the Boy Scouts*, 29 HOFSTRA L. REV. 403, 410 (2000).

87. See generally ALEX GOODALL, *LOYALTY AND LIBERTY: AMERICAN COUNTERSUBVERSION FROM WORLD WAR I TO THE MCCARTHY ERA* (2013) (providing an account of McCarthy's anti-subversive efforts).

88. 96 CONG. REC. 1957 (1950).

89. *Id.* at 1961.

90. *Id.*

more obliquely, attempting to “handle this matter delicately,” yet connected the case to number fourteen and asserted that “[t]here is certainly something wrong with this group,” regardless of whether they were communists or not, due to their “unusual mental aberrations.”⁹¹

McCarthy’s association of homosexuality and mental illness reflected a widely held belief, including within medical circles.⁹² The first edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published in 1952, classified homosexuality as a “sociopathic personality disturbance.”⁹³ Yet medical experts disagreed over how to address the “problem” they identified. Theorists such as Edmund Bergler condemned homosexuality as a “neurotic condition,” arguing that homosexuals belonged in “a special psychiatric category” and constructing psychoanalytic arguments from the foundations of conservative beliefs about sexuality and gender roles.⁹⁴ But more liberal notes were also in the air, as exemplified by famed sexologist Alfred Kinsey’s 1948 study, *Sexual Behavior in the Human Male*.⁹⁵ While seeking to “strictly avoid[] social or moral interpretations of the fact,”⁹⁶ Kinsey nevertheless contested traditional assumptions about the supposed abnormality of homosexuality by documenting its prevalence.⁹⁷ Kinsey’s report proved influential in shaping arguments for the liberalization of sexuality law.⁹⁸ By 1957, the U.K. Government’s Committee on Homosexual Offences and Prostitution published the Wolfenden Report, which, relying on medical evidence and witnesses, recommended the decriminalization of private homosexual behavior between consenting adults.⁹⁹

91. *Id.* at 1978–79.

92. Michael Bronski summarizes the state of affairs at the close of World War II:

As medicine’s power to define homosexuality grew, so did the implications of what it meant to be homosexual. Psychiatry, which had once defined homosexuality simply as a sexual act, now defined it as a psychological state, present with or without physical acts. Many psychiatrists believed that homosexuality should not be punished, but as a profession, they believed it could be cured.

MICHAEL BRONSKI, *A QUEER HISTORY OF THE UNITED STATES* 166–67 (2011).

93. AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 38–39 (1st ed. 1952).

94. EDMUND BERGLER, *HOMOSEXUALITY: DISEASE OR WAY OF LIFE?* 13 (1956). In addition to his opposition to homosexual conduct, Bergler was a proponent of traditional gender arrangements and considered reproduction and motherhood as essential to female sexuality. BRONSKI, *supra* note 92, at 186.

95. *See generally* ALFRED C. KINSEY, WARDELL R. POMEROY & CLYDE E. MARTIN, *SEXUAL BEHAVIOR IN THE HUMAN MALE* (1948).

96. *Id.* at 5.

97. BRONSKI, *supra* note 92, at 178 (explaining how, in the wake of the Kinsey Report, “Americans now understood that homosexuals were everywhere, even if you could not see them”).

98. Michael D. Kirby, *Sexuality and Global Forces: Dr. Alfred Kinsey and the Supreme Court of the United States* (Branigin Lecture), 14 IND. J. GLOB. LEGAL STUD. 485, 497 (2007).

99. *See generally* WOLFENDEN COMMITTEE, HOME OFFICE & SCOTTISH HOME DEPARTMENT, *REPORT OF THE COMMITTEE ON HOMOSEXUAL OFFENCES AND PROSTITUTION*, 1957, Cmnd. 247 (UK). *But see* NICHOLAS C. EDSALL, *TOWARD STONEWALL: HOMOSEXUALITY AND SOCIETY IN*

Congressional hearings under the Hoey Committee, a bipartisan Senate subcommittee charged with investigating the employment of homosexuals in the federal government, brought expert disagreement to the surface.¹⁰⁰ The Eisenhower Administration, seeking to foreground the medical dimension of homosexuality over its supposed risk to national security, gave the committee a list of medical witnesses who could testify.¹⁰¹ The Committee ultimately heard testimony from a series of medical experts, who offered a more tolerant perspective than the national security officials who had testified before them.¹⁰²

Lawmakers were unpersuaded. The Hoey Committee's interim report announced that "eminent physicians and psychiatrists, who are recognized authorities on this subject, were consulted" and claimed that "physicians generally agree that indulgence in sexually perverted practices indicates a personality which has failed to reach sexual maturity."¹⁰³ The report made no mention of the medical testimony that controverted its narrative, such as one witness's point that much of the evidence was based only on the "sick" subpopulation seeking treatment rather than the general gay population.¹⁰⁴ The report recommended that "sex deviants" be "considered as proper cases for medical and psychiatric treatment," and concluded that they also "must be treated as transgressors and dealt with accordingly"—that is, investigated and dismissed from government employment.¹⁰⁵ Selective though it was, the Hoey Committee's report marked a shift in the history of the Lavender Scare, distilling McCarthy's inflated rhetoric into a statement of government policy.¹⁰⁶

B. *Anti-Sodomy Legislation*

Anti-sodomy laws are another area where stigmatic and subordinating public health arguments surface to rationalize anti-LGBTQ+ discrimination. The twentieth century witnessed the rise of new health-based arguments in favor of criminalizing sodomy. These contentions differed from the longstanding idea that homosexuality itself was a disease.¹⁰⁷ Rather, the claim was that

THE MODERN WESTERN WORLD 315–16 (2003) (noting the Report's careful hedging, limited scope, and failure to provide "expert cover for subsequent legislation" given the controversy surrounding the issue of homosexual law reform).

100. DAVID K. JOHNSON, *THE LAVENDER SCARE: THE COLD WAR PROSECUTION OF GAYS AND LESBIANS IN THE FEDERAL GOVERNMENT* 101–03, 113–15 (2004).

101. *Id.* at 106.

102. *Id.* at 113.

103. S. REP. NO. 81–241, at 2–3 (1950).

104. *Executive Session Hearing of the Subcomm. on Investigations of the S. Comm. on Expenditures in the Exec. Dep'ts*, 81st Cong. 2281 (July 26, 1950) (statement of George Raines) ("[Y]our committee would be well advised to ask all witnesses the background of their experience . . . because the homosexual in the drawing room is quite a different individual than the homosexual the psychiatrist sees in his office. Only sick people go to a doctor").

105. S. REP. NO. 81–241 at 3.

106. JOHNSON, *supra* note 100, at 117.

107. For an account of this history, see *generally* JENNIFER TERRY, *AN AMERICAN OBSESSION: SCIENCE, MEDICINE, AND HOMOSEXUALITY IN MODERN SOCIETY* (1999).

homosexual relations posed some unique health risk, principally the spread of HIV, that justified restricting gay intimacy or singling it out for more severe punishment than comparable heterosexual conduct.¹⁰⁸

An early case arose in the 1970s, when a schoolteacher contested Texas' Homosexual Conduct Law, § 21.06,¹⁰⁹ in *Baker v. Wade*.¹¹⁰ Texas passed § 21.06 in 1973, the same year that the American Psychological Association board voted to remove homosexuality from the DSM¹¹¹ and nearly two decades after the American Law Institute voted to remove consensual sodomy from the Model Penal Code (MPC).¹¹² Texas and a handful of other States declined to follow the MPC, decriminalizing only heterosexual sodomy, while leaving the prohibition of homosexual sodomy on the books.¹¹³ Whatever the original grounds for this unequal treatment, with the advent of the AIDS crisis and the ensuing level of public hysteria and uncertainty,¹¹⁴ medical arguments provided a convenient means to legitimate this discriminatory legislation.

In response to the plaintiff's challenge, Dallas Doctors Against AIDS (DDAA) organized to defend the statute on medical terms, claiming that homosexual conduct posed a unique medical risk.¹¹⁵ In 1985, in motions to intervene after the court had entered final judgment for the plaintiff, DDAA declared that "newly discovered evidence" established the lethality of AIDS and its connection to homosexuality.¹¹⁶ The group cited statistics and articles purporting to "show that homosexuals have accounted for a vastly disproportionate share of the AIDS cases" and included affidavits by medical professionals.¹¹⁷

The judge in *Baker* rejected DDAA's effort, expressing concern that there was "no supporting affidavit filed to establish that these articles [attached to the motions] appeared in periodicals considered authoritative and reliable in the medical profession."¹¹⁸ The court noted that it did not need to "resolve the differences between the 'expert opinions' expressed in the affidavits," since medical questions were "initially for the Texas Legislature, not this Court," to decide, but it added that DDAA's medical arguments contained "problems" and

108. David W. Purcell, *Forty Years of HIV: The Intersection of Laws, Stigma, and Sexual Behavior and Identity*, 111 AM. J. PUB. HEALTH 1231, 1231 (2021).

109. TEX. PENAL CODE § 21.06 (2024), *invalidated by* *Lawrence v. Texas*, 539 U.S. 558 (2003).

110. 563 F. Supp. 1121 (N.D. Tex. 1982), *rev'd* 769 F.2d 289 (5th Cir. 1985). For an account of Section 21.06 and the *Baker* case, see Scott De Orio, *The Invention of Bad Gay Sex: Texas and the Creation of a Criminal Underclass of Gay People*, 26 J. HIST. SEXUALITY 53, 72–77 (2017).

111. BRONSKI, *supra* note 92, at 218.

112. Marie-Amélie George, *The Harmless Psychopath: Legal Debates Promoting the Decriminalization of Sodomy in the United States*, 24 J. HIST. SEXUALITY 225, 227 (2015).

113. ESKRIDGE, *supra* note 85, at 184.

114. BRONSKI, *supra* note 92, at 224–27.

115. ESKRIDGE, *supra* note 85, at 307.

116. Brief in Support of Motion to Set Aside Final Judgment and Reopen the Evidence at 4, *Baker v. Wade*, 106 F.R.D. 526 (N.D. Tex. 1985) (No. CA 3–79–1434–R).

117. *Id.* at 4–11.

118. 106 F.R.D. 526, 532 (N.D. Tex. 1985).

were “certainly not sufficient to require a different result.”¹¹⁹ This thoughtful treatment of the evidence, questioning the articles’ reliability and noting deficiencies, illustrates how courts can engage independently with medical claims even while respecting the legislature’s first-mover status.

Similar arguments recurred at the United States Supreme Court. As the State of Georgia sought to defend its anti-sodomy statute in *Bowers v. Hardwick*,¹²⁰ it submitted a brief arguing that “the legislature should be permitted to draw conclusions concerning the relationship of homosexual sodomy in the transmission of [AIDS] and other diseases such as anorectal gonorrhea, Hepatitis A, Hepatitis B, enteric protozoal diseases, and Cytomegalovirus, and the concomitant effects of this relationship on the general public health and welfare.”¹²¹

The *Bowers* Court did not address the public health argument in its opinion sustaining the statute, but this medicalized discourse gained popularity in state courts. Challengers and supporters of anti-sodomy laws tracked down expert testimony favoring their side; judges in Michigan, Tennessee, and Montana proved willing to review the detailed records developed by pro-LGBT legal advocates and their medical allies and invalidate the laws under state constitutions.¹²² In *Gryczan v. State*, for example, the Montana Supreme Court shot down the State’s HIV-based medical rationale as “grossly inaccurate,” citing a report and amicus briefing by a state association of public health officials.¹²³ Far from performing uncritical deference, the court probed the State’s claims for correctness and found them lacking.

The medical arguments in favor of anti-sodomy laws eventually lost. Yet they only failed because courts did not blindly defer to the activists and States that advanced them.¹²⁴ Repression wore the guise of medical authority and capitalized on the fear and uncertainty of the AIDS crisis, but courts’ insistence on rigorous review brought these arguments to defeat.

C. *Americans with Disabilities Act*

Medical classifications have also shaped legal inclusion and exclusion under disability rights law. In 1990, Congress passed the Americans with Disabilities Act (ADA), providing a regime of disability-based civil rights protections.¹²⁵ Despite its breadth, the ADA was not all-encompassing. Excluded from coverage was a set of conditions including “transsexualism” and “gender

119. *Id.* at 535.

120. 478 U.S. 186 (1986).

121. Brief of Petitioner Michael J. Bowers, Attorney General of Georgia at 37, *Bowers v. Hardwick*, 478 U.S. 186 (1986) (No. 85–140).

122. ESKRIDGE, *supra* note 85, at 275.

123. 942 P.2d 112, 123–24 (Mont. 1997).

124. ESKRIDGE, *supra* note 85, at 276 (“Not a single judge in any of these states accepted public health or AIDS prevention as a basis for the state to make consensual (homosexual) sodomy a crime. These cases effectively ended the AIDS argument for sodomy laws.”).

125. Americans with Disabilities Act of 1990, Pub. L. No. 101–336, 104 Stat. 327 (codified as amended at 42 U.S.C. §§ 12101–12213 (2012)).

identity disorders not resulting from physical impairments” along with pedophilia, compulsive gambling, and kleptomania.¹²⁶ “This list,” Kevin M. Barry explains, “was a slapdash collection of mental impairments drawn from the DSM-III-R,”¹²⁷ the version in effect at the time of the ADA’s passage. Yet, as Barry documents, the ADA’s exclusions were also drawn from Senators’ moral disapproval of the enumerated conditions, which they considered “socially unacceptable” and thus unworthy of legal protection.¹²⁸ Consequentially, while most “physical or mental impairment[s] that substantially limit[] one of more major life activities” received protected status,¹²⁹ the ADA offered no protection for what is now termed “gender dysphoria.” The ADA, in Barry’s words, “became a moral code separating the deserving disabled from the subjects of scorn”¹³⁰

The ADA exclusion, like the Lavender Scare and the campaign to defend anti-sodomy arguments, shows medical categorizations can supply a resource for discriminatory legal regimes. There is another layer of complexity here: the conditions then labeled “transsexualism” and “gender identity disorders” could only qualify for ADA coverage in the first place because the medical community considered them “disorders.” This pathologization of trans identity itself embodies a moral judgment, leading many advocates and academics to criticize the medical framing of transness as harmful and stigmatizing.¹³¹ Further, medical definitions have been summoned to support anti-trans legal arguments in other contexts, such as debates over conversion therapy or job discrimination.¹³² In the context of the ADA, medical classification, but for transgender status’ “moral content,”¹³³ could have opened the door for anti-discrimination claims by transgender individuals. Instead, medical framing pairs with transgender status’ “moral content” such that trans identity is simul-

126. *Id.* § 12211.

127. Kevin M. Barry, *Disabilityqueer: Federal Disability. Rights Protection for Transgender People*, 16 YALE HUM. RTS. & DEV. L.J. 1, 11 (2013).

128. *Id.* at 13.

129. 42 U.S.C. § 12102.

130. Barry, *supra* note 127, at 4.

131. Ali Szemanski, *When Trans Rights Are Disability Rights: The Promises and Perils of Seeking Gender Dysphoria Coverage Under the Americans with Disabilities Act*, 43 HARV. J.L. & GENDER 137, 140 n.7, 159–68 (2020); see also Huma Khursheed, *Medical Care vs. Medicalization: The Implications of the Fourth Circuit’s Decision in Williams v. Kincaid*, 101 N.C. L. REV. 1839, 1843 (2023) (noting that there exists “concern among advocates for transgender rights that treating gender dysphoria under the lens of disability rights invites medicalization and stigma against the transgender community”).

132. See, e.g., Brief of Foundation for Moral Law as Amicus Curiae Supporting Petitioner at 13, *Chiles v. Salazar*, No. 24–539 (U.S. Dec. 13, 2024) (arguing that discordance between physical anatomy and gender identity “is a medical condition” requiring “treatment” and analogizing gender-affirming care to “agreeing with a person suffering from Anorexia Nervosa when they assert that they are overweight”); *Bostock v. Clayton Cnty.*, 590 U.S. 644, 709 (2020) (Alito, J., dissenting) (suggesting that the fact that “in 1964 homosexuality was thought to be a mental disorder” means that Title VII does not protect employees from employment discrimination based on sexual orientation).

133. 135 CONG. REC. 19853 (1989) (statement of Sen. William Armstrong).

taneously made legible to lawmakers and rendered excludable from the new benefits established by the law.

D. *Lessons of History*

These episodes share a common structure: political actors sought to embed contested anti-LGBTQ+ moral judgments into the law, relying on medical frameworks to lend legitimacy to their sentiments. The Hoey Committee treated curated psychiatric opinion as proof that exclusion of gay employees was necessary for national security. Defenders of anti-sodomy laws urged courts to sustain patent discrimination based on supposed epidemiological evidence. The ADA borrowed diagnostic categories to mark certain identities as unworthy of protection while disclaiming responsibility for the value choices embedded in those categories. Considering the historic role of medical determinations in upholding the second-class status of LGBTQ+ Americans, a strict rule of judicial deference in the medical sphere risks closing courts' eyes to unequal and unjust legislation.

No doubt, the science will often be uncertain, making deference easier than careful analysis.¹³⁴ But the complexity of the task cannot absolve courts of their constitutional obligation. Prejudice, history tells us, can operate through and alongside medical rationales. Judges' duty to enforce the Equal Protection Clause requires them to independently evaluate the evidence before them, not assume the validity of the legislature's view, when gender and sexual minorities challenge medical regulations.

III. SELECTIVE DEFERENCE

An additional problem with *Skrametti's* deferential approach is the inconsistency it generates regarding the Court's review of medical policies and its handling of evidence. Multiple irregularities emerge between this and other constitutional contexts. First, the Court does not defer to medical policies when religious claimants bring free-exercise challenges.¹³⁵ Second, the Court does not treat disagreement between experts as a reason for deference in its Second Amendment cases.¹³⁶ I address each incongruity in turn.

E. *Religion and Medical Uncertainty*

The modern Court has rejected States' efforts to validate burdens on religious exercise with medical or health concerns. *Church of the Lukumi Babalu*

134. Ari Ezra Waldman even argues that "in fact-intensive constitutional litigation," judges "manufactur[e] factual uncertainty" even where it does not actually exist, giving them "the opportunity to dismiss scientific claims they do not like and decide factual questions as they see fit." Ari Ezra Waldman, *Manufacturing Uncertainty in Constitutional Law*, 91 *FORDHAM L. REV.* 2249, 2252, 2291 (2023). Whether this pattern constitutes conscious opportunism or unconscious results orientation, it weakens the Court's claims to consistency and impartiality—foundations of the rule of law.

135. See *infra* Section III.A.

136. See *infra* Section III.B.

*Aye, Inc. v. City of Hialeah*¹³⁷ exemplifies this skepticism. When practitioners of religious animal sacrifice challenged the City of Hialeah's ordinances restricting animal slaughter, Hialeah, in its brief, framed "the fundamental question" of the case as "whether a municipality may, consistent with the First Amendment, enact regulations to prevent . . . animals from being uncleanly held, inhumanely killed, and unsafely discarded."¹³⁸ Hialeah asserted that sacrificed animal remains created a "health hazard," serving as "vectors of serious disease."¹³⁹

The Court accepted the legitimacy of Hialeah's interest "in protecting the public health."¹⁴⁰ However, the majority reasoned that the ordinances not only burdened Santeria religious sacrifice but appeared "target[ed]," since animal sacrifice was prohibited even in "licensed, inspected, and zoned slaughterhouses" that could control health risks.¹⁴¹ Bolstering the inference of improper "targeting" was a city council resolution expressing "concern that certain religions may propose to engage in practices which are inconsistent with public morals, peace, or safety."¹⁴²

None of these facts compelled the conclusion that Hialeah had targeted Santeria. The circumstantial evidence of targeting that the Court noted was present, but it was not overwhelming. The public health concerns had evidentiary support in uncontested factual findings by the district court.¹⁴³ The Court could easily have deferred to Hialeah's purported health judgment, especially since it had a free-exercise precedent in hand that bowed to legislative choice.¹⁴⁴ Instead, the Court found the ordinances to be targeted and subjected them to fatal strict scrutiny.¹⁴⁵

The *Skrmetti* Court should have pursued a similar route. Just as the Court scrutinized Hialeah's resolution expressing "concern" about ritual sacrifice, it should have cast a critical look at Tennessee's stated interest in influencing children to adopt a state-approved attitude of "appreciat[ion]," and not "disdain[.]" toward their sex.¹⁴⁶ Instead, Chief Justice Roberts strained to fold the State's ideological aim into its medical one, asserting that the interests "simply reflect the State's concerns regarding the use of puberty blockers and hormones to treat gender dysphoria."¹⁴⁷ He made this claim although SB1 lists the interest

137. 508 U.S. 520 (1993).

138. Brief of Respondent at *3, *Church of Lukumi Babalu Aye*, 508 U.S. 520 (No. 91-948), 1992 WL 541282.

139. *Id.* at 5-7.

140. *Church of Lukumi Babalu Aye*, 508 U.S. at 538.

141. *Id.*

142. *Id.* at 535.

143. Brief of Respondent at *7, *Church of Lukumi Babalu Aye*, 508 U.S. 520 (No. 91-948), 1992 WL 541282.

144. *Emp. Div. v. Smith*, 494 U.S. 872, 890 (1990) (upholding Oregon's ban on consumption of peyote even as applied to ritual use).

145. *Church of Lukumi Babalu Aye*, 508 U.S. at 546.

146. TENN. CODE ANN. § 68-33-101(m).

147. *United States v. Skrmetti*, 605 U.S. 495, 517 (2025).

in “encouraging minors to appreciate their sex” separately from the interests in “protecting minors from physical and emotional harm” and “protecting the integrity of the medical profession,” implying that Tennessee saw its promotion of a state-approved concept of sex as a distinct goal. The Chief Justice cited the Tennessee Attorney General’s brief for his reformulation of SBI’s stated interests—even though the Court has previously insisted that a State’s “justification must be genuine, not hypothesized or invented *post hoc* in response to litigation.”¹⁴⁸

Had the Court not been so reluctant to see a sex classification in the statute, it could have followed a smooth doctrinal path to assess the fit between Tennessee’s interests and the chosen means of the treatment ban. Instead, this task fell to the dissenters alone. Though both *Skrmetti* and *Church of the Lukumi Babalu Aye* involved constitutional challenges to laws framed as health regulations, the Court took a highly deferential approach in the former and a skeptical view in the latter. Such inconsistency risks demoting the Equal Protection Clause to second-class constitutional status.

Skepticism toward medical regulations resurged during the COVID-19 pandemic. In *Roman Catholic Diocese of Brooklyn v. Cuomo*, a synagogue and a church sought to enjoin enforcement of COVID-19 capacity restrictions while they litigated Free Exercise Clause challenges in the lower courts.¹⁴⁹ Again, in a *per curiam* opinion, the Court—before determining that strict scrutiny applied—cast a critical eye on the lines drawn by an elected branch of government, in this case the Governor of New York.¹⁵⁰ The Court first pointed to comments made by the Governor at a press conference¹⁵¹ as raising targeting concerns,¹⁵² then turned to the substance of the regulations. The Court noted that “[i]n a red zone . . . businesses categorized as ‘essential’ may admit as many people as they wish” and added that “[t]he disparate treatment is even more striking in the orange zone.”¹⁵³ The results, the Court worried, were “troubling,” with religious entities treated more “harshly” than comparable secular establishments; therefore, the regulations would have to meet strict scrutiny.¹⁵⁴ The Court acknowledged that Justices “should respect the judgment of those with special expertise and responsibility” in the field of public health.¹⁵⁵ Still, it enjoined the policies because they struck at a core constitutional guarantee,

148. *United States v. Virginia*, 518 U.S. 515, 533 (1996).

149. 592 U.S. 14, 15–16 (2020) (*per curiam*).

150. *Id.* at 17–18.

151. The remarks, raised by the Diocese in its reply brief, consisted of the Governor’s acknowledgment that the disputed executive order was “most impactful on houses of worship.” Reply Brief in Support of Emergency Application for Writ of Injunction at 9, *Roman Catholic Diocese*, 592 U.S. 14 (2020) (*per curiam*) (No. 20-A87).

152. *Roman Catholic Diocese*, 592 U.S. at 16.

153. *Id.* at 17.

154. *Id.* at 17–18.

155. *Id.* at 19.

implicating the Court's "duty to conduct a serious examination of the need for such a drastic measure."¹⁵⁶

The dissenters in *Roman Catholic Diocese* took issue with the Court's non-deferential approach. Justice Breyer, in dissent, invoked "medical and scientific uncertainties" and "the disease-related circumstances rapidly changing" as reasons to "grant elected officials 'broad' discretion."¹⁵⁷ Justice Sotomayor, in her separate dissent, emphasized medical experts' conclusions and cited the American Medical Association's brief.¹⁵⁸

In one sense, there is an ideological throughline between *Roman Catholic Diocese* and *Skrametti*: the liberal Justices' stances' alignment with the position of the medical establishment. In another respect, *Roman Catholic Diocese* inverts the *Skrametti* outcome. The conservative Justices in the *Roman Catholic Diocese* majority declined to defer to political judgment on a fast-moving medical matter, instead closely reviewing the regulations even before settling on the proper level of constitutional scrutiny, while the liberal Justices in dissent called for deference to elected officials due to the uncertainty surrounding the health situation.

Had *Skrametti* followed this skeptical path, the Court might have looked to the charged language in SB1's title, introduced as the "Protecting Children from Gender Mutilation Act."¹⁵⁹ It could have taken notice of remarks by Tennessee legislators such as Representative Gino Bulso, who equated trans identity with a "fiction" and "fantasy,"¹⁶⁰ or Representative William Lambert, the bill's House sponsor, who described trans identification as "a growing social contagion."¹⁶¹ It might have considered the sponsors' acknowledgments that the treatments were only banned for reasons relevant to trans patients¹⁶² as on par with Governor Cuomo's admission regarding the impact of his COVID-19 policies on houses of worship.¹⁶³ But in *Skrametti*, deference won the day.

156. *Id.* at 20.

157. *Id.* at 37–38 (Breyer, J. dissenting) (quoting S. Bay United Pentecostal Church v. Newsom, 590 U.S. 965, 967 (2020) (Roberts, C.J., concurring)).

158. *Id.* at 40 (Sotomayor, J., dissenting).

159. Brooke Migdon, *Tennessee Lawmakers Introduce Bill to Ban Gender-Affirming Care for Transgender Youth*, HILL (Nov. 9, 2022), <https://thehill.com/homenews/state-watch/3727880-tennessee-lawmakers-introduce-bill-to-ban-gender-affirming-care-for-transgender-youth/> [<https://perma.cc/XL77-XYRS>].

160. *Hearing on HB1 Before the House Civ. Just. Comm.*, 113th Sess. (Tenn. 2023) (statement of Rep. Gino Bulso).

161. *Hearing on HB1 Before the House Health Subcomm.*, 113th Sess. (Tenn. 2023) (statement of Rep. William Lambert).

162. *Id.* (statement of Rep. William Lambert) ("Many of these medications are needed for some children"); *Hearing on SB1 Before the S. Health & Welfare Comm.*, 113th Sess. (Tenn. 2023) (statement of Sen. Jack Johnson) (confirming that a cisgender boy could undergo breast tissue removal surgery under SB1).

163. Chief Justice Roberts and the conservative Justices who signed on to his *Skrametti* opinion have minimized reliance on legislative history as an interpretive tool. See, e.g., *Trump v. Hawaii*, 585 U.S. 667, 691 (2018) (asserting that the Court "need not consider such extra-textual evidence" as "statutory background and legislative history"); *Azar v. Allina Health Servs.*, 587 U.S. 566, 579 (2019) ("[L]egislative history is not the law." (quoting

Comparing *Church of Lukumi Babalu Aye, Roman Catholic Diocese*, and *Skrmetti* exposes a pattern of selective skepticism. In its religious exercise cases, the Court has not hesitated to identify inconsistencies and overbreadth in health regulations, even amid genuine scientific uncertainty. It has done so with attention to the nuances of the elected officials' avowed purpose, whether expressed in a formal resolution, as in *Church of Lukumi Babalu Aye*, or official remarks to the press, as in *Roman Catholic Diocese*.¹⁶⁴ In *Skrmetti*, conversely, the Court seized upon medical uncertainty as a reason to give legislators considerable free rein despite the risks of unequal treatment, bias, and animus operating in this sensitive political area.¹⁶⁵ The upshot is a patchwork jurisprudence, with medical regulations sometimes enjoying the benefit of wide judicial deference and other times receiving no favored treatment.

F. *Originalism and Historical Ambiguity*

A majority of the sitting Justices,¹⁶⁶ along with many of their colleagues on the lower courts,¹⁶⁷ espouse originalism, an interpretive methodology that considers the meaning of the Constitution at the time of ratification binding on the present generation.¹⁶⁸ Unearthing this meaning—whether in terms of

Epic Sys. Corp. v. Lewis, 584 U.S. 497, 523 (2018)); *Medina v. Planned Parenthood S. Atl.*, 606 U.S. 357, 381 (2025) (“When it comes to interpreting the law, speculation about what Congress may have intended matters far less than what Congress actually enacted”); *Martin v. United States*, 605 U.S. 395, 408 (2025) (rebutting an argument based on legislators’ purpose as “guesswork” that failed to account for the possibility of multiple purposes). But in practice, all these Justices have continued to utilize unenacted statutory history to interpret legal texts. Anita S. Krishnakumar, *Statutory History*, 108 VA. L. REV. 263, 273 (2022). In religious liberty cases in particular, the Court, in opinions that the Chief Justice has joined or authored, has conducted what one scholar calls a “worried search for anti-Christian animus” in the decision-making procedures of multi-member bodies, including legislatures and commissions. Stephen M. Feldman, *The Roberts Court’s Transformative Religious Freedom Cases: The Doctrine and the Politics of Grievance*, 28 CARDOZO J. EQUAL RTS. & SOC. JUST. 507, 543 (2022) (discussing *Masterpiece Cakeshop v. Colo. Civ. Rts. Comm’n*, 584 U.S. 617 (2018)); *Espinoza v. Mont. Dep’t of Revenue*, 591 U.S. 464, 482 (rejecting reliance on legislative enactments that were “born of [anti-Catholic] bigotry”); *Mahmoud v. Taylor*, 606 U.S. 522, 539 (2025) (detailing the background of a school board policy alleged to violate religious liberty, including references to specific remarks by Board members).

164. *Church of Lukumi Babalu Aye Inc. v. City of Hialeah*, 508 U.S. 520, 542 (1993); *Roman Catholic Diocese of Brooklyn v. Cuomo*, 592 U.S. 14, 16 (2020).

165. Neil S. Siegel, *Legalist Versus Realist Accounts of United States v. Skrmetti*, 2026 U. ILL. L. REV. (forthcoming 2026) (manuscript at 19) (“Trump and the Republican Party saw the wave of anti-trans statutes that had been enacted by conservative state legislatures over the prior several years and decided to ride it during the 2024 presidential election campaign”).

166. For recent assessments, see William Baude & Michael Stokes Paulsen, *Sweeping Section Three Under the Rug: A Comment on Trump v. Anderson*, 138 HARV. L. REV. 676, 711 n.171 (2025); Ryan C. Williams, *Lower Court Originalism*, 45 HARV. J.L. & PUB. POL’Y 257, 262–63 n.15 (2022); Meghan J. Ryan, *The Death of the Evolving Standards of Decency*, 51 FLA. ST. U. L. REV. 255, 259 (2024) (“For the first time ever, a majority of the Justices are originalists, and their decisions clearly reflect this.”).

167. See, e.g., Diarmuid F. O’Sconnlain, *The Role of the Federal Judge in the Constitutional Structure: An Originalist Perspective*, 50 SAN DIEGO L. REV. 517 (2013).

168. Lawrence B. Solum, *Originalism Versus Living Constitutionalism: The Conceptual*

the Framers' and ratifiers' intentions¹⁶⁹ or the now-dominant approach¹⁷⁰ that searches for the "original public meaning" of the text—requires historical research, an enterprise in which few judges have formal schooling.¹⁷¹ Judges are not historians¹⁷² any more than they are public health experts. A disconnect thus arises between judges' professional training and the demands of originalist interpretation. In response, judges take different paths: some judges reject originalism altogether,¹⁷³ while others attend seminars.¹⁷⁴ Increasingly, judges rely on briefing from professional historians.¹⁷⁵

The problem that a history-centered methodology creates is that historical evidence often gives rise to competing interpretations, not clear consensus. Although this parallels the medical uncertainty the Court grapples with in *Skrmetti* and its abortion jurisprudence, historical uncertainty garners drastically different treatment, as recent Second Amendment decisions demonstrate.

In *District of Columbia v. Heller*, the Court divided over the constitutionality of D.C.'s prohibition on handguns.¹⁷⁶ Justice Scalia, writing for the majority to invalidate the law, conducted a survey of the historical

Structure of the Great Debate, 113 NW. U. L. REV. 1243, 1244 (2019).

169. See generally H. Jefferson Powell, *The Original Understanding of Original Intent*, 98 HARV. L. REV. 885 (1984) (identifying and criticizing this approach).

170. William Baude, *Originalism as a Constraint on Judges*, 84 U. CHI. L. REV. 2213, 2221 (2018); Keith E. Whittington, *Originalism: A Critical Introduction*, 82 FORDHAM L. REV. 375, 380 (2013).

171. But see Stephen E. Sachs, *Originalism as a Theory of Legal Change*, 38 HARV. J.L. & PUB. POL'Y 817, 822 (2015) (conceding that "[d]oing originalist research requires some specialized techniques" but comparing this enterprise to "ordinary lawyer's work," such "chasing down an old chain of title").

172. See N.Y. State Rifle & Pistol Ass'n, Inc. v. Bruen, 597 U.S. 1, 107 (Breyer, J., dissenting) (arguing that judges are unaccustomed "to resolving difficult historical questions," since courts are "staffed by lawyers, not historians," and "[l]egal experts typically have little experience answering contested historical questions or applying those answers to resolve contemporary problems"); United States v. Bullock, 679 F. Supp. 3d 501, 507 (S.D. Miss. 2023), *rev'd*, 123 F.4th 183 (5th Cir. 2024) ("Judges are not historians. We were not trained as historians. We practiced law, not history").

173. Chihiro Isozaki, *State Justices Speak Out Against Originalism*, STATE CT. REP. (Oct. 7, 2024), <https://statecourtreport.org/our-work/analysis-opinion/state-justices-speak-out-against-originalism> [<https://perma.cc/Y7LX-BHUY>].

174. Reva B. Siegel, *Memory Games: Dobbs's Originalism as Anti-Democratic Living Constitutionalism—and Some Pathways for Resistance*, 101 TEX. L. REV. 1127, 1144–46 (2023). As Siegel documents, Georgetown's Center for the Constitution has regularly hosted seminars on originalism; in 2022, over 20 federal judges, all Republican appointees, disclosed their attendance there. See also Letter from Fix the Court to Judge Roslynn R. Mauskopf (Aug. 10, 2023), <https://fixthecourt.com/wp-content/uploads/2023/08/Letter-on-luxury-judicial-seminars.pdf> [<https://perma.cc/4WQY-S53H>] (questioning whether the "Originalism for Judges" seminar "comports with ethical norms and the goals of legal education").

175. Adam Liptak, *As the Supreme Court Focuses on the Past, Historians Turn to Advocacy*, N.Y. TIMES (Aug. 4, 2025), <https://www.nytimes.com/2025/08/04/us/politics/supreme-court-historians-advocacy.html> [<https://perma.cc/5PJ2-S8CN>].

176. 554 U.S. 570, 572–74 (2008).

understanding of the Second Amendment.¹⁷⁷ In dissent, Justice Stevens conducted his own historical analysis to reach the opposite conclusion.¹⁷⁸

Over a decade later, writing in dissent in *New York State Rifle & Pistol Association, Inc. v. Bruen*, Justice Breyer reflected on *Heller*'s treatment of history "to show the difficulties inherent in answering historical questions and to suggest that judges do not have the expertise needed to answer those questions accurately."¹⁷⁹ The Court in *Heller*, Justice Breyer charged, "not an expert in history, had misread Blackstone and other sources explaining the English Bill of Rights," prompting "21 English and early American historians (including experts at top universities)" to alert the Court to its mistake¹⁸⁰ in a brief in the follow-up case *McDonald v. Chicago*.¹⁸¹ This lack of expertise counseled against relying "solely on history to interpret the Constitution."¹⁸²

For the *Bruen* majority, however, Justice Thomas announced that restrictions on the Second Amendment right were permissible only if consistent with the country's historical regulation of firearms.¹⁸³ Advocates had already absorbed *Heller*'s lesson that historical evidence would be dispositive: the *Bruen* amici defended their interpretation of the Second Amendment on historical terms.¹⁸⁴ Justice Thomas fliespecked each purported historical analogue for the challenged law, deeming each one insufficient,¹⁸⁵ while Justice Breyer, like Justice Stevens in *Heller*, disputed the majority's historical conclusions in his dissent.¹⁸⁶

The significant point is that the Court has not treated conflicting historical accounts as a reason to defer to legislative judgments. Historical ambiguity, that is, has not operated as a reason to review gun control regulations more generously and afford less protection to the Second Amendment right. In *Heller* and *Bruen* both, the Court, aided by amici, assessed the available evidence and determined which sources and findings it considered most persuasive. Such close judicial scrutiny is not always easy—on the contrary, in

177. *Id.* at 577–619.

178. *Id.* at 652–77 (Stevens, J., dissenting).

179. 597 U.S. 1, 108 (2022) (Breyer, J., dissenting).

180. *Id.* at 108–09 (Breyer, J., dissenting).

181. 561 U.S. 742 (2010).

182. *Bruen*, 597 U.S. at 110 (Breyer, J., dissenting).

183. *Id.* at 17.

184. See, e.g., Brief of Americans Against Gun Violence as Amici Curiae Supporting Respondents at 13–15, *Bruen*, 597 U.S. 1 (2022) (No. 20–843) (making an argument based on "empirical methods for studying founding-era English usage"); Brief of Giffords Law Center to Prevent Gun Violence as Amicus Curiae Supporting Respondents at 3, *Bruen*, 597 U.S. 1 (2022) (No. 20–843) (invoking "the history of self-defense principles" in favor of New York's law); Brief of Madison Society Foundation, Inc. as Amicus Curiae Supporting Petitioners at 6, *Bruen*, 597 U.S. 1 (2022) (No. 20–843) (urging the Court to look "to the public understanding and tradition of the colonies"). For an overview of all briefs in the case, see generally Ilya Shapiro, *Friends of the Second Amendment: A Walk Through the Amicus Briefs* in *D.C. v. Heller*, 20 J. FIREARMS & PUB. POL'Y 15 (2008).

185. *Bruen*, 597 U.S. at 39–70.

186. *Id.* at 115–30 (Breyer, J., dissenting).

the years following *Bruen*, the history-and-tradition inquiry strained judicial capabilities and pulled courts to “conflicting conclusions.”¹⁸⁷ Yet the Court has vindicated the constitutional right at stake even in the face of considerable evidentiary contestation.

Set alongside the Second Amendment cases, *Skrmetti*’s presumption of deference, ostensibly based at least in part on the uncertainties in the field of medicine, thus becomes even more aberrational. The Court’s handling of epistemic uncertainty and expert dissensus apparently differs by discipline. In *Skrmetti*, the medical focus of SB1 seems to have informed the Court’s *ex ante* choice to apply rational basis review over intermediate scrutiny, rather than entering into the analysis in the actual application of the standard.¹⁸⁸ By contrast, in the Second Amendment cases, the Court imposed a demanding history-based test despite ambiguities in the historical record.¹⁸⁹ This asymmetrical response undermines principled adjudication. If “areas fraught with medical and scientific uncertainties” deserve judicial deference,¹⁹⁰ it is unclear why areas fraught with historical uncertainties should be so different.

It may be that historical scholarship lies closer to the judicial ken, such that judges feel comparatively more at home handling historical issues than medical issues.¹⁹¹ But we often call upon judges to evaluate complex medical evidence in the course of performing their judicial function,¹⁹² conversely, *Bruen*’s aftermath illustrates that attempting to settle contested historical matters is no mean feat even for seasoned jurists.¹⁹³ Further, if this is, in fact, the justification for the differential treatment across subject matters, the Court has yet to articulate it. As with the disparity in treatment of medical regulations across constitutional domains, we have inconsistency without explanation.

187. *United States v. Rahimi*, 602 U.S. 680, 743 (2024) (Jackson, J., concurring).

188. See Jessica A. Clarke, *Skrmetti*’s Shell Game 30–31 (Aug. 16, 2025) (unpublished manuscript), <https://ssrn.com/abstract=5394647> [<https://perma.cc/K3DT-HZMP>] (connecting the Court’s “commitment to avoiding heightened scrutiny” to its “invent[ion]” of “a new legal concept, ‘medical treatment’ . . . that it construes as a nondiscriminatory object of state regulation”); Craig Konnoth, *The Use and Misuse of Medicine in Skrmetti*, SCOTUSBLOG (July 3, 2025, at 13:23 ET), <https://www.scotusblog.com/2025/07/the-use-and-misuse-of-medicine-in-skrmetti/> [<https://perma.cc/BRT4-9PPV>] (arguing that “*Skrmetti* invoked biological differences, not to satisfy heightened scrutiny . . . but to justify a new ‘medical context’ exception to the application of such scrutiny”).

189. The Court’s choice, Reva Siegel has argued, emerged from present-day political contestation over gun rights, which “transformed the ‘natural’ meaning of the Constitution’s text so that, for increasing numbers of Americans, a law-and-order Second Amendment simply appeared there as the founders’ Constitution.” Reva Siegel, *Dead or Alive: Originalism as Popular Constitutionalism in Heller*, 122 HARV. L. REV. 191, 239 (2008).

190. *Dobbs v. Jackson Women’s Health Org.*, 597 U.S. 215, 274 (2022) (quoting *Marshall v. United States*, 414 U.S. 417, 427 (1974)).

191. See William Baude & Stephen E. Sachs, *Originalism and the Law of the Past*, 37 LAW & HIST. REV. 809, 818 (2019) (arguing that “ordinary legal reasoning” requires inquiring into facts about the past).

192. See *infra* notes 208–09 and accompanying text.

193. *United States v. Rahimi*, 602 U.S. 680, 743 (2024) (Jackson, J., concurring) (noting that “confusion plagu[es] the lower courts” in *Bruen*’s wake).

This inconsistency matters because it converts uncertainty into a one-way ratchet. Deference appears where legislatures regulate sexual and gender minorities through medicine, allowing rational basis review to displace the ordinary inquiry into fit, purpose, and potential animus. The result is a rule that shields medical restrictions from the scrutiny that comparable uncertainties in other fields do not prevent.

IV. REJECTING SKRMETTI'S MISSTEPS

The Court should not extend *Skrmetti*'s misguided deference. I acknowledge that the mere existence of the doctrinal inconsistency does not, by itself, require course correction. Complete doctrinal consistency may not be desirable: one unstated rationale for *Skrmetti*'s "medical context" reasoning would be that *judicial* error in the medical field is more likely than *legislative* error. Under this view, leaving medical decisions to legislators, without meaningful judicial review, would minimize social costs. But this justification poses problems.

First, the judicial error rationale would not explain the Court's willingness to displace health policy judgments when they burden religious exercise.¹⁹⁴ More fundamentally, the Court does not ordinarily choose a level of scrutiny based on perceived error risks. If the Constitution assures that individuals will not be denigrated based on immutable birth characteristics,¹⁹⁵ the law can brook no departure from that command, at least not absent some legislative showing that surpasses bare rationality. Building on this premise, this Part first elaborates the nature of *Skrmetti*'s error, then argues for a different approach.

G. Doctrinal Distortions

In *Skrmetti*, by repeatedly emphasizing the "medical context" of SB1 and the concomitant need for deference, the Court seems to assume that medical regulations are less likely to be unconstitutionally invidious in the same way that other sex-based classifications are, hence why even the explicit reference to sex will not trigger heightened scrutiny. As the historical account in Part II indicates, the reality is more complicated. LGBTQ+ persons have faced a history of subordination and discrimination channeled through medicalized discourses and restrictions. As incremental progress unfolded, opponents of LGBTQ+ rights relied on unsound medical accounts that, if credited, would have impeded the gay community's success in making civil rights advancements. In short, medical regulations can reflect and entrench sex stereotypes just as severely as, for instance, legislation regulating the administration of

194. See *supra* Section III.A.

195. For a survey of the features that Court has deemed relevant in establishing a suspect class, see *Frontiero v. Richardson*, 411 U.S. 677, 685–88 (Brennan, J.). For a comprehensive originalist account of the meaning of the Fourteenth Amendment's equality commitments, see generally AKHIL REED AMAR, *BORN EQUAL: REMAKING AMERICA'S CONSTITUTION, 1840–1920* (2025).

estates,¹⁹⁶ the sale of alcohol,¹⁹⁷ or the distribution of social security benefits.¹⁹⁸ In enacting SB1, Tennessee's legislators may have been actuated by genuine medical concerns, support for stereotypical sex conformity, or, most likely, some confluence of both. Judicial scrutiny should account for these interlocking motivations, but the equal protection analysis should begin by determining whether the law classifies based on sex. *Skrmetti* short-circuited that threshold step by treating the statute's medical framing as evidence that no sex classification existed at all.

To be sure, *Skrmetti* professed adherence to the standard equal protection paradigm of identifying a classification and then applying the corresponding level of scrutiny. Because he construed SB1 not to classify by sex, Chief Justice Roberts did not directly exempt medical regulations from heightened scrutiny. He did, however, point to SB1's "medical context" as a reason to avoid across-the-board application of heightened scrutiny to all sex-classificatory laws: even explicit textual "reference to sex," he stated, could fail to qualify as a sex classification "especially . . . in the medical context."¹⁹⁹ In Kate Redburn's words, *Skrmetti* "mov[ed] the locus for considering medical or biological justifications for sex classifications from heightened scrutiny to the threshold question of whether a classification exists," effectively "pull[ing] [SB1] out of the normal process of constitutional evaluation under the guise of deferring to medical authority."²⁰⁰ In carving out the "medical context" as meriting minimal scrutiny, the Court appears to proceed on the assumption that there is something uniquely objective about medical regulation, and that it can be presumed to rest on physical realities rather than such constitutionally problematic bases as stereotypes, animus, or invidious intent.

Without the "medical context" animating its deferential reading of the law, the Court likely would have recognized SB1's manifest sex classification. Application of SB1, as the decision's dissenters and critics note turns on a minor's transgender status, which in turn depends on identifying their sex

196. *Reed v. Reed*, 404 U.S. 71, 77 (1971) (invalidating the Idaho Code's male priority in the appointment of an estate's administrator).

197. *Craig v. Boren*, 429 U.S. 190, 192 (1976) (invalidating Oklahoma's statute prohibiting the sale of low-alcohol beer to males between ages 18 and 21 but allowing such sales to females within that range).

198. *Weinberger v. Wiesenfeld*, 420 U.S. 636, 638–39 (1975) (invalidating a provision of the Social Security Act that let widows but not widowers collect certain benefits).

199. *Skrmetti*, 605 U.S.495, 496 (2025).

200. Kate Redburn, *Skrmetti Beyond Scrutiny*, 139 HARV. L. REV. 167, 184, 193 (2025). This deviation from the norm seems tied to a recurring pattern in the Court's jurisprudence that Reva Siegel labels "physiological naturalism": the Court's tendency to treat reproductive processes as exclusively physiological, such that their regulation reflects objective, natural differences rather than social assumptions and norms. Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 265 (1992). Adopting the physiological naturalist lens clouds the Court's perception, preventing it from seeing constitutionally impermissible stereotypes because it assumes that the legal distinctions layered atop physiological ones cannot perpetuate gendered social norms.

assigned at birth.²⁰¹ By SB1's terms, a doctor can prescribe a cisgender male gender-affirming treatment to support him in living and identifying as male but cannot provide that same care to a cisgender female. SB1 singles out gender dysphoria, gender identity disorder, gender incongruence, and mental conditions as impermissible reasons to prescribe gender-affirming care, a feature of the law that the majority opinion heavily relied on.²⁰²

Of course, these conditions are all sex-dependent. As Justice Sotomayor stressed in her dissent, sex becomes a "but-for" cause of the deprivation of medical treatment.²⁰³ For trans minors who seek affirming care to alleviate dysphoria or "incongruence," changing their sex would change the purpose of the medical treatment.²⁰⁴ The purpose would shift from one that SB1 prohibits, such as treating gender dysphoria, to one that SB1 permits, such as treating body dysphoria. Even trans patients *without* gender dysphoria, gender identity disorder, or gender incongruence cannot access medications that would be available to them if they were of the opposite sex. So long as the treatment "[e]nabl[es]" a minor "to identify with, or live as, a purported identity inconsistent with the [their] sex," the minor cannot access it.²⁰⁵ Since any affirmative medication will enable a minor to identify as their chosen gender, no transgender minor can access the covered treatments modify their bodies in line with their preferred gendered conventions, whereas all cisgender minors can.²⁰⁶

It cannot be true, then, that SB1's application "does not turn on sex."²⁰⁷ SB1 is textbook sex discrimination. Under a generous reading of *Skrametti*, SB1's "medical context" blinded the Court's judgment, preventing it from seeing that SB1 treats transgender minors as lesser than their cisgender peers. Less charitably, the Justices seized upon "medical context" as a distorting lens that obscured a sex-classificatory line and facilitated their evasion of heightened review.

201. *Skrametti*, 605 U.S. at 588 (Sotomayor, J., dissenting) ("The doctor's next step depends on the adolescent's sex [assigned at birth]."); Noa Ben-Asher, *Gender Trouble in the Court: Recentring "Sex" in Transgender Rights*, 67 WM. & MARY L. REV. (forthcoming 2026) (manuscript at 7), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5417694 [<https://perma.cc/9TBW-554V>] ("SB1 . . . conditions access to medical treatment on the patient's sex.").

202. *Skrametti*, 605 U.S. at 497 (majority opinion) ("SB1 does not exclude any individual from medical treatments on the basis of transgender status. Rather, it removes one set of diagnoses—gender dysphoria, gender identity disorder, and gender incongruence—from the range of treatable conditions.").

203. *Id.* at 596–97 (Sotomayor, J., dissenting).

204. *Id.*

205. TENN. CODE ANN. § 68–33–103(a)(1)(A).

206. As Naomi Schoenbaum observes, SB1 would allow, for example, a natal boy with breast tissue to remove it, thereby conforming with his preference to appear more masculine, but it would not allow a natal girl to undergo the exact same procedure—even though "both cases involve a medical intervention to align a minor's physiological traits with their gender identity. In other words, *both* cases involve gender-affirming care." Naomi Schoenbaum, *Sex Equality After Skrametti*, 67 B.C. L. REV. (forthcoming 2026) (manuscript at 4), <https://dx.doi.org/10.2139/ssrn.5649170> [<https://perma.cc/AHM7-VJXX>].

207. *Skrametti*, 605 U.S. at 496.

H. *Alternative Paths*

Skrmetti's blunder was not inevitable. Our legal system routinely calls upon judges to make evaluations of credibility, evidentiary sufficiency, and persuasive force in highly complicated matters, including medicine.²⁰⁸ They can, and do, consider professional standards in assessing the reasonability of medical actors' decisions.²⁰⁹ The adversarial system relies on parties and interested outsiders' incentives to furnish judges with the strongest facts supporting each side. Thus, as Justice Breyer explained in *Hellerstedt*, the Court's pre-*Dobbs* abortion cases, such as *Gonzales* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*,²¹⁰ "relied heavily on the District Court's factual findings and the research-based submissions of amici."²¹¹ *Dobbs* rejected the law these cases gave us, but they illustrate the viability of a judicial posture toward medical uncertainty that, like the approach the Court is attempting to work out in its history-reliant cases, reviews expert input and reaches an evidence-based conclusion. The Court in *Roman Catholic Diocese* and *Gonzales* was correct that it has a "duty to conduct a serious examination"²¹² and "review factual findings"²¹³ in ruling on the merits of constitutional challenges.

This is not to say that legislative judgment would ever be irrelevant. The fact that lawmakers democratically enacted a medical policy undoubtedly deserves judicial notice and respect. This deference, however, should not extend nearly as far as *Skrmetti* took it, with the majority essentially rewriting

208. See *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 592 (1993) (requiring trial judges "[f]aced with a proffer of expert scientific testimony" to conduct "a preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid and of whether that reasoning or methodology properly can be applied to the facts in issue"). In establishing this rule, the Court expressed its "confiden[ce] that federal judges possess the capacity to undertake this review." *Id.* at 593. See also Daniel W. Shuman, *Expertise in Law, Medicine, and Health Care*, 26 J. HEALTH POL. POL'Y & L. 267, 267–68 (observing that "[p]hysicians offer expert testimony in a wide variety of civil and criminal proceedings" that may or may not relate to health care, including personal injury cases and homicide prosecutions, and "it falls to the courts to fashion mechanisms to address these purported experts' qualifications and their methodologies").

209. The law of medical malpractice is the most obvious example. The defendant's liability "is a function of negligence and causation"; "[n]egligence," in turn, is a function of standard of care"; and "[t]he standard of care expected of physicians is usually described in terms of 'custom': what is the accepted practice among other physicians practicing in the same specialty?" Ralph Peeples, Catherine T. Harris & Thomas B. Metzloff, *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37 WAKE FOREST L. REV. 877, 878 (2002). Consideration of medical standards has also surfaced in litigation over abortion rights. See *Johnson v. State*, No. 2023-CV-18853, 2024 WL 5456519, at *16 (Dist. Ct. Wyo. Nov. 18, 2024) (rejecting amici's argument that abortions undermine the "two-patient paradigm" because "[u]nlike the facts presented by the Plaintiffs, Amici does not support their position that there is a 'two-patient' paradigm in medicine with any medical literature"), *aff'd*, *State v. Johnson*, 582 P.3d 380 (Wyo. 2026).

210. 505 U.S. 833 (1992).

211. *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, 608 (2016).

212. *Roman Catholic Diocese of Brooklyn v. Cuomo*, 592 U.S. 14, 20 (2020).

213. *Gonzales v. Carhart*, 550 U.S. 124, 165 (2007).

the State's asserted interests and downplaying the significance of overt statutory reference to sex as a classificatory boundary governing access to treatment. A lack of medical consensus, while unfairly treated as a reason for maximal deference in *Skrametti*, could justify affording some degree of greater latitude to legislators. But it does not call for wholesale judicial withdrawal and departure from entrenched doctrinal analysis, especially given the heightened potential for animus or targeting lurking behind a medical regulation as applied to LGBTQ+ persons.

My claim is not for a new equal-protection framework, but for ordinary equal-protection analysis applied without a medical carveout.²¹⁴ After resolving whether a classification exists, a court would apply the appropriate level of scrutiny. At this point, ongoing expert disagreement could enter the analysis. When experts have not reached a consensus, or when an existing consensus appears unstable, a legislative majority can more easily connect its intervention to a legitimate health-protective purpose. In contrast, a legislature that defies professional practices and protocols bears a heavier burden in explicating the relationship between its chosen means and asserted medical interest.

Within this framework, medical judgment, too, would not be entitled to unqualified and uncritical acceptance. History, once again, proves informative. The medical establishment is not free from the biases of the society it inhabits. All too often, it has been a complicit and even eager partner in legitimizing inequality and oppression, not only through the slanted writings of individual conservative theorists such as Berger but also in its leadership of entire oppressive projects, including the anti-abortion²¹⁵ and eugenics movements.²¹⁶ These sordid histories supply yet another argument against wholesale deference and in favor of calibrated judicial scrutiny. Courts should consider and weigh

214. Although the “medical context” seems to have been doing much of the work in *Skrametti*, I repeat that the Court does not explicitly purport to be carving out a medical exception to its ordinary equal protection jurisprudence. The case’s core claim, flawed though it may be, is that SB1 does not classify on the basis of sex. Therefore, *Skrametti* need not pose an obstacle to heightened review of future legislation even in the medical area. A greater hurdle would likely be the Court’s much-criticized case *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974), which licensed discrimination on the basis of pregnancy on the grounds that pregnancy is “an objectively identifiable physical condition.” This logic implies that “objective” biological differences can immunize sex classifications from heightened scrutiny, an exception within the Court’s sex equality case law that threatens to swallow the heightened scrutiny default. For decades, the Court declined to rely on *Geduldig*. Reva Siegel, *The Pregnant Citizen, From Suffrage to the Present*, 108 GEO. L.J. (19TH AMEND. SPECIAL ED.) 167, 172–73 (2020). However, it has recently revived the decision in both *Skrametti*, 605 U.S. 495, 496 (2025), and *Dobbs*, 597 U.S. 215, 236 (2022). It remains to be seen how far this resurrection will extend.

215. Siegel, *supra* note 200, at 280–319 (tracing this history).

216. Paul A. Lombardo, *Medicine, Eugenics, and the Supreme Court: From Coercive Sterilization to Reproductive Freedom*, 13 J. CONTEMP. HEALTH L. & POL’Y 1, 2 (1996) (identifying physicians as “the most influential advocates in the eugenics movement”); Philip Reilly, *The Surgical Solution: The Writings of Activist Physicians in the Early Days of Eugenical Sterilization*, 26 PERSPS. BIOLOGY & MED. 637, 643–47 (1983) (highlighting physicians’ role in generating pro-eugenics literature).

medical evidence as one piece in a broader inquiry and remain alert to the possibility that seemingly neutral medical policies can mask invidious hostility.

CONCLUSION

The Court's approach in *Skrmetti* illustrates the risks of uncritical deference to legislators' medical judgments. By elevating alleged medical uncertainty above constitutional principles, the majority sidestepped rigorous review of a law that facially discriminates on the basis of sex, invoking "medical context" to circumvent the Court's ordinary regime of matching classifications with tiers of scrutiny. The historical record, from the Lavender Scare to anti-sodomy legislation, underscores the ways in which medicalized reasoning has long been harnessed to subordinate LGBTQ+ individuals. Far from a neutral domain, medicine has repeatedly served as a vehicle for embedding social hierarchies.

These concerns remain live today. As state legislators²¹⁷ and the federal government²¹⁸ move to criminalize gender-affirming care, as the Trump Administration bans trans people from serving in the military,²¹⁹ and as the Supreme Court considers whether states can separate the sexes in school sports,²²⁰ medical judgments shoulder much of the weight in supporting these policies. At the oral arguments in the sports separation cases, Justice Kagan posed the question directly: "And how do you think the question of scientific uncertainty should play out in an analysis like this?"²²¹ "I think," the advocate representing the challengers to Idaho's law responded, "the Court has not fully grappled with what does scientific uncertainty mean and how does it come into conflict with heightened equal protection scrutiny."²²² Just so—and it will

217. Amy Harmon, *Republicans Are 'Running Out of States' to Pass New Transgender Restrictions*, N.Y. TIMES (June 7, 2024), <https://www.nytimes.com/2024/06/07/us/state-legislatures-transgender-bills.html> [<https://perma.cc/CP2D-GFJH>].

218. Azeen Ghorayshi, Amy Harmon & Reed Abelson, *Trump Moves to End Gender-Related Care for Minors, Threatening Hospitals That Offer It*, N.Y. TIMES (Dec. 18, 2025), <https://www.nytimes.com/2025/12/18/health/trump-gender-affirming-care-funding.html> [<https://perma.cc/DU6E-MJFA>]; Annie Karni & Aishvarya Kavi, *House Passes Bill to Ban Gender Transition Treatments for Minors*, N.Y. TIMES (Dec. 17, 2025), <https://www.nytimes.com/2025/12/17/us/politics/bill-gender-transition-treatments-minors.html> [<https://perma.cc/6K33-Z8NU>].

219. Exec. Order No. 14183, *Prioritizing Military Excellence and Readiness*, 90 Fed. Reg. 8757 (Jan. 27, 2025).

220. *Little v. Hecox*, 104 F.4th 1061 (9th Cir. 2024), *cert. granted*, 93 U.S.L.W. 3378 (U.S. July 3, 2025) (No. 24–38); *West Virginia v. B.P.J.*, 98 F.4th 542 (4th Cir. 2024), *cert. granted*, 93 U.S.L.W. 3378 (U.S. July 3, 2025) (No. 24–43).

221. Transcript of Oral Argument at 121–22, *Hecox*, No. 24–38 (U.S. argued Jan. 13, 2026). Justices Barrett, Gorsuch, and Kavanaugh also all inquired about scientific uncertainty in the *Hecox* argument. *Id.* at 41, 124, 129. Justice Kavanaugh pressed the question again in the *B.P.J.* argument, Transcript of Oral Argument at 81, *B.P.J.*, No. 24–43 (U.S. argued Jan. 13, 2026), and Justice Sotomayor asked about it as well. *Id.* at 99 (asking about "the quantum of certainty or uncertainty that would have to exist in the science").

222. Transcript of Oral Argument at 122, *Hecox*, No. 24–38 (U.S. argued Jan. 13, 2026).

likely take more time and more cases for the Court to “fully grapple” with what scientific uncertainty entails.

For now, as *Skrametti* illustrates, reflexive deference to elected officials risks perpetuating injustice by licensing efforts by the political majority to single out a disfavored class and denigrate its individual members as inferior. It would allow claims of medical rationalization to hollow out the central aims of the Equal Protection Clause.

A more principled judicial approach would recognize that medical uncertainty does not automatically justify abdication of constitutional review. Courts can, and should, apply heightened scrutiny when legislative majorities impose burdens based on immutable or socially stigmatized characteristics, even when state actors marshal medical authority or appeal to scientific debate to prop up their policies. Such a standard better preserves the Court’s equal protection doctrine and aligns with its patterns of judicial review in other domains. The lessons of history and the Court’s jurisprudential inconsistencies call for a recalibration—one that would restore some measure of harmony both to the case law and to the lives of transgender Americans.