Statement to the Idaho House Committee on Judiciary, Rules, and Administration

in SUPPORT of House Bill 465

by Jennifer C. Chavez, Women's Liberation Front

Thank you for considering my testimony. I serve on the board of directors of a radical feminist organization, the Women's Liberation Front (WoLF). WoLF is an all-woman organization with over 700 members who live across the country and abroad, including in Idaho.

The Idaho legislature should take action to stop unethical surgeons and psychologists – and yes, even parents – who seek to perform acts that deprive children of their reproductive function. We urge every Committee member to VOTE YES to report bill 465 out of this Committee with a "do pass" recommendation, for three reasons:

1. Idaho has the chance to lead the nation in halting the medical scandal that is euphemistically described as "childhood gender transition."

2. The protection of vulnerable children must take priority over profit.

3. The bill is well within this legislature's proper authority, and legal challenges are likely to fail.

Each of these points is discussed in further detail below.

1. Idaho has the chance to lead the nation in halting the medical scandal of "childhood gender transition."

The medical procedures that would be prohibited by House Bill 465 are specifically targeted because they "circumcise, excise, infibulate, or mutilate the reproductive organs and parts of a child." H0465, proposed § 18-1506B(2). The bill also specifically prohibits "medications that induce profound morphologic changes in the genitals of a child or induce transient or permanent infertility." *Id.*, proposed § 18-1506B(2)(c).

Make no mistake, unscrupulous medical professionals are performing these procedures and administering these drugs to vulnerable children and teenagers, today. *See* "Evidence of Childhood Medical Transition," Appx. A.

No one could seriously dispute the fact that the surgeries and drugs prohibited by the bill devastate a young person's reproductive system and sexual organs, including permanent sterilization. But proponents attempt to justify these practices by claiming that they are needed to "affirm" a child's self-diagnosis of "gender dysphoria," or to improve a child's mental state by helping them to "pass"—that is, to alter a child's body so they can imitate the physical appearance of the opposite sex, or hide the child's sex characteristics for a more "gender-

neutral" appearance.[1] Many of these techniques cause long-term complications and turn individuals into lifelong medical patients.

It is critical to understand at the outset that "affirmation" as used by the proponents of childhood "gender transition," does not involve any medical evaluation of a specific condition, but instead involves the affirmation of a patient's self diagnosis of need. It puts the minor patient in the doctor's seat, which is an alarming prospect, especially with children. Moreover, some in the medical profession are so eager to push "gender transition" on children that they claim that children begin to "know" and can start communicating their desire for "transition" before they can even speak. For example, prominent pediatric gender clinician Diane Ehrensaft claims that "children will know. . . by the second year of life…they probably know before that but that's pre-pre verbal."[2] There is no evidence to support this idea, which is preposterous on its face.

Gender clinicians have known for a very long time about the likelihood that treating children early and successfully to alleviate their feelings of discomfort avoids the need for surgery or hormones.[3] In contrast, **recent claims of "high levels of distress among children who were discouraged from 'asserting their identities in childhood' [lack] any empirical documentation."**[4]

Unfortunately, when it comes to the surgeries and drugs prohibited in HB 465, the state of Idaho cannot rely on the hope that parents or gender clinicians will exercise sound judgment when it comes to preserving a child's fertility. The same Diane Ehrensaft who thinks 1 year-olds are capable of diagnosing themselves as "transgender" also thinks parents should be "worked with" to convince them to "forfeit[] their [child's] fertility":

> Another thing that's a show-stopper around [parents] giving consent is the fertility issue. That if the child goes directly from puberty blockers to cross-sex hormones they are pretty much forfeiting their fertility and won't be able to have a genetically related child.
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> There's a lot of parents who have dreams of becoming grandparents. It's very hard for them not to imagine those genetically related grandchildren. So we have to work with parents around, these aren't your dreams. [she laughs]. You have to focus on your child's dreams. What they want.

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[1] Dr. Irene Sills, an endocrinologist who gave one boy access to puberty-blocking drugs and estrogen when he was 16 years old, explained that she did this because the boy would have a harder time "passing" if he waited until adulthood. Anemona Hartocollis, "The New Girl in School: Transgender Surgery at 18," NY Times (June 16, 2015), https://www.nytimes.com/2015/06/17/nyregion/transgender-minors-gender-reassignment-surgery.html.

[2] 4thWaveNow, "Gender-affirmative therapist: Baby who hates barrettes = trans boy; questioning sterilization of 11-year olds same as denying cancer treatment," https://4thwavenow.com/2016/09/29/gender-affirmative-therapist-baby-who-hates-barrettes-trans-boy-questioning-sterilization-of-11-year-olds-same-as-denying-cancer-treatment/.

[3] Meyer-Bahlburg, 2002, p. 362, https://journals.sagepub.com/doi/abs/10.1177/135910450200700300S (noting that early treatment of "gender identity disorder" would avoid the need for later "sex reassignment surgery").

[4] *See* Kenneth J. Zucker (2018): The myth of persistence [], International Journal of Transgenderism, https://doi.org/10.1080/15532739.2018.1468293 (emphasis added).

In other words, this supposed expert thinks parents should be made to feel guilty and selfish for wanting to protect their pre-pubescent children's future ability to engage in healthy sexual activity or have children. Another very prominent gender clinician describes how she views her own function as being to affirm a self-diagnosis made by a child who has divined a "need" for surgical procedures from watching thousands of YouTube videos, and to bring the parents around to it:

> Some present with a prolonged history of gender dysphoria but the absolute hardest are the twelve to fourteen year old trans boys [i.e. girls] coming out to their parents…they came out like two months ago, and what happens? At nine years old "something doesn't feel right. I'm starting puberty, I'm doing all this work, **I'm going online, I found 750,000 YouTube videos** [saying] 'this is me one month on T;' I'm connected to my community; **I know I'm trans; I'm twelve years old** and I absolutely have to tell my parents and now my parents are here and I'm here [points far away]. . . . And because I'm thirteen you need to get on the ball and this needs to have happened yesterday and because I am here and my parents are here [far away]" and the parent desperately wants you, the provider, to close that gap by pushing their kid backwards. But **you as a professional know you have to close that gap by pushing them forward and keeping them**. You want to keep them **because you want them to give consent** and be supportive.

Joanna Olson-Kennedy, speaking at the "Gender Odyssey" conference in 2017 (emphasis added).[5]

Regarding the specific threat that children denied access to surgery or hormones will take their own lives, there is simply no evidence to support this threat.[6] In any event, HB 465 applies to all minors, regardless whether they have received a diagnosis of "gender dysphoria." None of the opponents of this bill can provide valid evidence that minors inevitably will suffer long-term psychological effects (much less commit suicide) if they are treated by counseling and other therapies that leave their reproductive systems untouched.

It is now fashionable for gender activists (including some medical professionals) to mischaracterize the use of counseling to help minors feel comfortable in the only bodies they'll ever have, as "conversion therapy." In truth, multiple studies demonstrate that the majority of children diagnosed with "gender dysphoria" will desist from identifying as the opposite sex and come to accept their natal sex, if allowed to proceed through natural puberty, and that process of acceptance by the child can be sped up through appropriate counseling. *Id*. Yet opponents of this bill will insist that "affirming" a child's self-diagnosis of dysphoria and subjecting them to

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[5] See Brie Jontry, "Does prepubertal medical transition impact adult sexual function?" 4thWaveNow (July 8, 2018), https://4thwavenow.com/2018/07/08/does-prepubertal-medical-transition-impact-adult-sexual-function/?fbclid=IwAR3_sxy5_QQcUxOJ9zfwvEPvVy-oEY2KtpDRc-pzpnJHmYqzov88ZiId56Y.

[6] "Mental health problems, including suicide, are associated with some forms of gender dysphoria. But suicide is rare even among gender dysphoric persons." Bailey, et al., "Suicide or transition: The only options for gender dysphoric kids?" Appx. B. The same paper explains that incidence of completed suicide *increases* in adults after "transition."

surgeries and hormones is the only acceptable path. This is an abdication of responsibility by small but vocal minority of the medical profession.

This bill is especially important because it is likely to protect the very population that opponents claim to support: girls and boys who don't fit traditional sex-stereotypes and have a higher chance of growing up to live as healthy gay or lesbian adults if allowed to experience a normal puberty. According to one set of researchers:

> [T]he prevention of homosexuality remains a significant reason for referral of children with GID [gender identity disorder].[7] It would be naive to believe that prevention of homosexuality is not a motivating factor for at least some of the clinicians who work with children referred for gender-atypicality. Indeed, some researchers and clinicians in the area of GID in children are quite open about such a goal, writing books (e.g., Rekers, 1982, 1991) or belonging to organizations devoted to the prevention of homosexuality (e.g., L. Loeb: see www.narth.com/menus/advisors.html). Thus, although the issue of the risk associated with a homosexual outcome should be moot, it is not. It is crucial that researchers and clinicians in the area of GID in children recognize that the most likely outcome for children with GID, with or without treatment (Green, 1987), is homosexuality, and that homosexuality is a non-disordered outcome. Only a very few children with GID continue to have GID as adolescents or adults.[8]

The bill thus puts restrictions on physicians and parents who would push their patients and children toward "gender transition" surgery or drugs, rather than allow them to grow through healthy puberty into healthy same-sex-attracted adults.

A shameful historical precedent.

Just a few decades years ago, state legislatures were adopting laws that not only allowed but in some cases mandated sterilization of vulnerable individuals, during the pseudo-scientific eugenics movement. The U.S. Supreme Court hardly questioned the general practice; instead it deferred to the state legislatures' judgment on scientific matters – just as the courts tend to do today.

But even when state-sponsored sterilization was widely tolerated in the U.S., the Supreme Court emphasized that permanent sterilization interferes with one of the most fundamental human rights, and therefore the principles of equal protection and due process must be strictly observed. The court said:

> We are dealing here with legislation which involves one of the basic civil rights of [humans]. Marriage and procreation are fundamental to the very existence and survival of [the human species]. . . . There is no redemption

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[7] "Gender identity disorder" was the psychological diagnosis later revised and renamed "gender dysphoria."

[8] Bartlett, N.H., Vasey, P.L. & Bukowski, W.M. "Is Gender Identity Disorder in Children a Mental Disorder?," Sex Roles, a Journal of Research, 43, 753–785 (2000), full copy available at: https://www.researchgate.net/profile/Paul_Vasey/publication/263256121_Is_Gender_Identity_Disorder_in_Children_a_Mental_Disorder/links/0c9605200331fc1698000000.pdf

> for the individual whom the law touches. Any experiment which the State conducts is to his irreparable injury. He is forever deprived of a basic liberty.[9]

We've come a long way since then, and today it is widely recognized that sterilizing healthy individuals is a moral crime against human liberty and dignity—especially when those individuals are vulnerable because of their age or social status, and the sterilization is done either against their will or through social or economic coercion.

The history of this shift is discussed in WoLF's report, "Eugenics: Then and Now," (Jan. 26, 2020), Appx. C. The report provides a historical overview of parallels between the procedures offered to pediatric gender clinic patients today, and procedures used on vulnerable populations in the eugenics era. As explained in this report, the period of time when eugenical sterilization was practiced is surprisingly long, in large part because medical professionals and associations insisted that the removal of sexual function could treat an individual's mental health difficulties, and even solve broader social problems.

The same false claims are today being used to justify life-altering surgeries, puberty-blocking drugs, and cross-sex hormones for children and teens who are uncomfortable with their bodies and the social expectations placed on them. But there is no reliable long-term evidence that these medical procedures actually provide the mental health benefits they promise for most of the children who undergo them. *See, e.g*. Bailey, et al., "Suicide or transition: The only options for gender dysphoric kids?" Appx. B.

Many parents of children like those who would be protected by HB 465 deeply desire alternatives that preserve their children's bodies while supporting their mental health, because they have observed the lack of evidentiary support for claims that "social and medical transition" would produce better results. For example:

> . . . [W]e seek to support—not "eliminate"–our children's "gender discordance" although we resist the idea that gender atypicality is a sign of bodily incongruence. More than anything, [we] parents seek to help our children minimize the discomfort that accompanies their nonconformity to gender norms. Since many of our children only experienced dysphoria upon reaching puberty, we call for (much) more evidence that social and medical transition are better at alleviating dysphoria than psychotherapeutic methods.[10]

Moreover, adults who have undergone "gender transition" are coming out in growing numbers to testify that they've been misled about the serious medical complications associated with their "gender affirmation" surgeries. *See* Scott Newgent, The Wild, Wild West of Transgender

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[9] *Skinner v. State of Okl. ex rel. Williamson*, 316 U.S. 535, 541 (1942). Skinner involved a statute providing for sterilization of individuals convicted of certain crimes. The court struck the statute down, but only because it discriminated between two classes: "those who have thrice committed grand larceny" could be sterilized under the statute, while those thrice convicted of embezzlement were left intact.

[10] 4th Wave Now, "'Intellectual no-platforming': Ken Zucker pushes back on the latest attempt to discredit desistance-persistence research," https://4thwavenow.com/2018/05/30/intellectual-no-platforming-ken-zucker-pushes-back-on-the-latest-attempt-to-discredit-desistance-persistence-research/

Surgery, Appx. D.[11] Regarding a personal experience with phalloplasty, Newgent writes, "[if you research this [surgery] online, you will think you hit the jackpot. . . . the plethora of information that pops up is like Disneyland for [someone seeking 'female-to-male gender transition']. Oh, my God it's too good to be true." Newgent continues: "But things are not always what they seem to be, especially with marketing experts and the capricious powers of the internet, creating smoke and mirrors." In reality, phalloplasty can require "anywhere from 2-22 operations, depending on complications and complications are vast, numerous, and frequent. . . . Recovery is brutal" and lasts months and months if not years, depending on what type of complications you have."

Further, "[i]f you investigate, you will find that the decision to get a Phalloplasty obliterated quite a few people's lives. The complication rate is enormous. Prior patients have been shattered physically, spiritual, and left in financial ruin." *Id.* From personal experience Newgent states:

> My surgeon downplayed using the forearm site to the point I allowed myself to feel silly for being troubled about questioning whether or not I should use the forearm. In fact, as I look back, my surgeon was the pivotal point in my entire decision to get the Phalloplasty. . . . My surgeon had this arrogance and gave me such little time, it pushed me into the belief that I should believe him, and because of that, I did. It reminds me of a cult where the followers start to question things, but they look around, and everyone else is so obedient and faithful that they figure it's just them.
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> The authenticity, for me, is that my arm is handicapped for the rest of my life. It hurts to type on the computer, I can't play sports, and my hand remains swollen years after the surgery and it, well it hurts all the time. Not the pulsing pain that ravages you, the, "Damn my hand hurts and I'm having a hard time holding a fork to eat," type of pain. Pain that gives you a glimpse into what your body might feel like as a 100-year-old man, but just in your arm. It's depressing I can't lie.
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> Another predicament is nerve damage; the surgeon cuts so deep that nerve endings are exposed, and they may never close for the rest of your life. For me, I must wear a brace because a graze on my forearm skin sends me through the roof with shock.

Because of this experience, Scott Newgent recently testified in support of a bill in South Dakota that sought to prohibit the use of "gender transition" surgeries and drugs, similar to the bill now before this Committee. Newgent – the only witness who had actually undergone the types of procedures targeted by the bill – was adamant that no child under the age of 18 should be allowed to decide on these procedures.[12]

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[11] Reposted at Madam Nomad, https://madamnomad.com/2020/01/02/transman-offers-the-poop-on-phalloplasty/ (updated Jan. 2, 2020).

[12] Newgent has since published a video condemning the state's law makers for failing to protect children, and the opponents' use of suicide-scare tactics: https://www.youtube.com/watch?v=cM8I5l6P42Q&feature=youtu.be.

2. Protecting vulnerable children must take priority over profits.

Some of the most vocal opposition to House Bill 465 is coming from two camps who stand to gain financially: pediatric gender clinicians and psychologists paid to provide "gender affirmation" services, and business associations who fear they will lose money if gender activists boycott the state.

For example, two physicians recently published an opinion piece in the Idaho Statesman claiming – falsely and with no supporting evidence - that the surgeries and drugs prohibited by HB 465 "can mean life or death since suicide rates and depression are much higher among transgender and gender-diverse youth that are not accepted by adults and are not offered gender-affirming care."[13] These are unscientific, manipulative, and downright Orwellian attempts to distract and mislead. In truth, claims of suicide in children who experience discomfort in their natal sex are greatly exaggerated and misleading. *See* Appx. B.

This Committee should give *zero weight whatsoever* to the various medical professionals or associations who support the medical practices prohibited by HB 465. The sad fact is that the medical profession has an extremely poor track record for recognizing and stopping human rights violations against vulnerable patients when it comes to sterilization. *See* Appx. C. Indeed, when the U.S. Supreme Court issued rulings that upheld the general practice of eugenical sterilization, it cited a report by the American Neurological Association's Committee for the Investigation of Sterilization, which at that time endorsed the idea that state-sponsored sterilization measures "involve no real cruelty since they are done under modern surgical conditions and with the best surgical technique." *See* Appx. E. Thousands of vulnerable people lost their sexual function and fertility as a result, before victims were finally heard.

Proponents of childhood "transition" are making extraordinary claims, which require extraordinary evidence. Despite grand policy statements on the part of several national associations, they have utterly failed to produce that evidence. According to two experts in the field of "gender identity"-related disorders:

> Research to understand the link between gender dysphoria, various mental problems (including suicidality), and completed suicides will take time. **There is already plenty of reason, however, to doubt the conventional wisdom that all the trouble is caused by delaying gender transition of gender dysphoric persons**. We have already mentioned the fact that transitioned adults who had been gender dysphoric (i.e., "transsexuals") have increased rates of completed suicide. Their transition did not prevent this, evidently. Suicide (and threats to commit suicide) can be socially contagious. Thus, social contagion may play an important role in both suicidality and gender dysphoria itself. . . .

Appx. B at 5.

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[13] *See also* Scottie Andrews, "More than 200 medical professionals condemn bills trying to restrict transgender kids from getting gender reassignment treatments," CNN Health (Feb. 7, 2020) https://www.cnn.com/2020/02/07/health/doctors-condemn-anti-trans-health-care-trnd/index.html.

Idaho legislators must also resist any pressure against HB 465 from business interests speculating about the loss of profits. For example, in South Dakota the state chamber of commerce made clear that the *potential* for "loss of conventions, tournaments, top-level entertainment and business investment from outside industries" in their view outweighed the value of preventing *the certainty* of lifelong physical harm and sterility in children who would be protected by the bill.[14]

Nothing in the chamber's statement addressed the crucial goal of preserving children's fertility against medically-unnecessary and unproven practices, except to acknowledge that the goal is sincere. *Id.* But will the chambers of commerce or various business associations in Idaho volunteer to compensate victims or pay malpractice settlements? Will they be there for children who were encouraged by Idaho physicians to undergo expensive "gender-affirming" surgeries or hormonal regimes that end up costing even more because of medical complications? Will they even acknowledge how they failed vulnerable minors? We can be certain they will not.

We urge you to do the right thing, even in the face of manipulative suicide threats and economic pressure.

3. HB 465 is likely to be upheld against legal challenge.

a. The bill serves two critical and legitimate purposes

HB 465 falls well within Idaho's legitimate interests: (1) the state's interest in protecting vulnerable children from extremely harmful medical practices; and (2) clarifying that these practices fall outside of the exceptions in the state's current genital mutilation law.

The importance of the first interest is discussed throughout this testimony. The second and related interest served by HB 465 is no less important: Idaho's current law prohibiting genital mutilation of minors provides an exception for when a "surgical operation" is "[n]ecessary to the health of the person on whom it is performed." Idaho Code Ann. § 18-1506B(2)(a). Given the misleading rhetoric used by proponents of childhood "gender transition" procedures, this phrase could be misinterpreted to mean that "gender transition" procedures are medically necessary and fit the existing exemption. HB 465 thus serves a valid legislative objective to avoid potentially disastrous misinterpretation of the state's genital mutilation law.

For the reasons more fully detailed below, the Idaho legislature can be confident that this bill will be upheld if it is challenged in a competent court of law.

b. The 14th Amendment right to equal protection

In announcing that its state chapter would file a legal challenge to a similar bill in South Dakota, the ACLU claimed that "it is unconstitutional to single out one group of people and categorically ban all care, no matter how medically necessary."[15] This statement implies that the bill denies

[14] South Dakota Chamber of Commerce, "Chamber: Transgender Bill May Impede Economic Development," Capitol-ism, https://sdchamber.biz/newslettersreports/capitolism/january21capitolism/.

[15] https://www.aclu.org/press-releases/aclu-south-dakota-will-challenge-hb-1057-if-passed-law.

"one group of people" the right of equal protection that is recognized under the 14th Amendment to the U.S. Constitution. A challenge based on that argument is likely to fail.

As an initial matter, HB 465 does not in fact "single out one group of people," except insofar as it singles out persons under the age of 18 for special protection. Indeed, the critical goal of this bill is to protect *all minors* from permanent harm to their fertility or sexual function by medically-unnecessary surgery or hormones. The bill does single out a list of specific *procedures* and *drugs* if they are used "*for the purpose* of attempting to change or affirm the child's perception of the child's sex if that perception is inconsistent with the child's sex." HB 465, proposed § 18-1506B(2), (3) (emphasis added). But the restriction on procedures undertaken for this purpose would apply to any medical personnel who practice in Idaho, and would affect any minor who seeks their services.

Nothing in HB 465 identifies "transgender youth" as the subject of the bill. This is unsurprising, considering that the term "transgender" has no coherent agreed-upon meaning in society, much less in the medical field. According to an expert in clinical epidemiology (who himself underwent "gender transition" procedures as an adult only to later reject the idea of "gender identity"), these terms have no fixed meaning, in popular culture or in medicine:

> Until recently, having [a medical diagnosis of "gender dysphoria"] and "being trans" were considered synonymous. This belief has shifted somewhat, as the phenomenon of "non-binary" people emerged. Also, it's apparently no longer necessary even to have [gender dysphoria] to be considered transgender. In San Francisco, if you want to be "trans," they will "rubber-stamp" you and you'll have your genitals inverted (or your breasts will be gone) in no time.[16]

In other words, there is no specific or innate characteristic in common among minors who seek, or whose parents seek out the services of "gender transition" clinics. *Any minor* can experience discomfort with their sexual characteristics or social expectations based on those characteristics; *any minor* is vulnerable to the mistaken belief that there is something wrong with their body that can be cured or improved with surgical or hormonal "treatments" for the purpose of "gender transition."

Treating all minors as a separate class in legislation is not only commonplace but necessary. The Supreme Court "has consistently recognized that the Fourteenth Amendment does not deny to States the power to treat different classes of persons in different ways." *Reed v. Reed*, 404 U.S. 71, 75-76 (1971). When it comes to protecting minors from sterilization, the Court is likely to give the state *more* leeway, not less.

On one hand, the Court has said that "strict scrutiny" is "essential" when examining differential classifications that "a State makes in a sterilization law. . . lest unwittingly or otherwise invidious discriminations are made against groups or types of individuals in violation of the constitutional guaranty of just and equal laws." *Skinner v. State of Okl. ex rel. Williamson*, 316 U.S. 535, 541 (1942). On the other hand, here the purpose of the law is to *protect* a vulnerable group (all

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[16] Hacsi Horváth, MA, PgCert , "The Theatre of the Body: A detransitioned epidemiologist examines suicidality, affirmation, and transgender identity," 4thWaveNow, https://4thwavenow.com/2018/12/19/the-theatr-of-the-body-a-detransitioned-epidemiologist-examines-suicidality-affirmation-and-transgender-identity/ (Dec. 19, 2018).

minors) from medically-unnecessary sterilization, and therefore the law if passed is very likely to survive strict scrutiny.

The Supreme Court has recognized that states including Idaho have "an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, [] mistakes," and from "coercion." *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997). Such coercion is illustrated in the words of gender clinicians quoted in section 1, above. The Suprem Court has also held that states have an additional and distinct interest in "protecting the vulnerable from. . . prejudice, negative and inaccurate stereotypes, and 'societal indifference.'" *Id*. Thus, the state of Idaho has a valid interest in conveying a strong message that minors who don't easily fit typical expectations for their sex "must be no less valued than the lives of" others, and that their self-destructive "impulses should be interpreted and treated the same way as anyone else's." *Id*. at 732.

In short, children who feel discomfort with their sexed bodies or sex-based societal expectations are particularly vulnerable, and deserve special protection under the law.

c. The 14th Amendment right to liberty, privacy, and due process

Given the ACLU's claim that a similar bill bans "medically necessary care" for "transgender youth," it appears they might argue the bill undermines the interrelated protections established in the 14th Amendment for liberty, privacy, and due process. These arguments are likely to fail, because children have no valid "liberty interest" in obtaining the help of surgeons or physicians to impair or destroy their sexual organs, parts, or functioning, absent some true medical necessity that is completely absent here.

As an initial matter, the ACLU's factual description of the bill is false. Far from "banning care," the bill leaves untouched other forms of treatment like counseling therapies that help children feel comfortable in their bodies and accept their natal sex. And while WoLF disagrees that "gender transition" is ever medically necessary, it must be noted that this bill places no restrictions on the actions of *adults* who seek such procedures.

In any event, a challenge to the bill based on due process is likely to fail. The Supreme Court has noted that its analysis begins in "all due process cases, by examining our Nation's history, legal traditions, and practices." *Washington v. Glucksberg*, 521 U.S. 702, 710 (1997). It is therefore important to recognize the fact that the federal government and most states have come to officially recognize that medicalized sterilization poses a serious danger to vulnerable and marginalized populations:

> [N]umerous reports concerning coercive sterilization of minority and poor women began to emerge, and a public outcry ensued alleging racist and classist applications of the federal family planning programs. In response, the [United States] Department of Health, Education, and Welfare developed protective regulations and a standardized consent form for all publicly funded sterilizations in 1976. These regulations prohibited sterilization of persons younger than 21 years and of mentally incompetent or institutionalized persons.

Borrero, et al., "Federally funded sterilization: time to rethink policy?" American Journal of Public Health, 102(10), 1822–1825. doi:10.2105/AJPH.2012.300850 (2012)

The ACLU might attempt to argue that children have a constitutionally-protected privacy or liberty interest in obtaining a physician's assistance to interfere with their sexual functions or parts. But the Supreme Court has rejected similar arguments in what are commonly referred to as the "right to die" cases. One significant case, *Washington v. Glucksberg*, was brought by several physicians and their terminally-ill patients who sought to perform or undergo physician-assisted suicide. The Court distinguished its prior rulings based on the element of third party assistance: while its prior cases had often been described as "right to die" cases, more precisely what the Court actually recognized was a "constitutionally protected right to *refuse* lifesaving hydration and nutrition." 521 U.S. 702, 722-23. The Court went on to explain that *assisted* suicide claims are different because they claim not only a "right to commit suicide" but also "a right to assistance in doing so." *Id.* The Court found that there exists no constitutionally-protected interest in obtaining assistance to end one's life.

Similarly, minors have no traditional or otherwise worthy interest in getting physician assistance to obtain cosmetic genital surgery, puberty blocking drugs, or cross-sex hormones.

Someone might alternatively argue that there is a generalized privacy or liberty interest in making medical decisions in private with one's doctors, or in refusing to use one's own sexual reproductive system to procreate. But while this general class of decisions "may be just as personal and profound," like physician-assisted suicide, the act of interfering with or destroying a child's reproductive system for essentially cosmetic purposes has "never enjoyed similar legal protection" to the act of simply refraining from sexual activity or sexual reproduction *Id.* at 725.

To be sure, the Supreme Court has recognized that minors have a constitutional right to privacy in obtaining contraception, *Carey v. Population Services International*, 431 U.S. 678 (1977), and abortion, *Bellotti v. Baird*, 443 U.S. 622 (1979). But the rights of minors to receive medical procedures is not absolute. "[T]he "constitutional rights of children cannot be equated with those of adults" for at least three reasons: "the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing." *Bellotti*, 443 U.S. at 633.

These principles weigh strongly in favor of HB 465.

Conclusion

House Bill serves interests that are critical to Idaho children and families, and those interests must take priority over profit. And because the bill is tailored to protect one of the most vulnerable populations among us, it is very likely to be upheld against legal challenges. We therefore urge you to vote YES to report House Bill 465 out of this Committee with a "do pass" recommendation.