5-28-2024

Criminalizing Transgender Care

Lewis Grossman

Criminalizing Transgender Care

Lewis A. Grossman*

ABSTRACT

Since 2021, twenty-four states, in extraordinarily quick succession, have enacted statutes banning physicians from prescribing puberty blockers and cross-sex hormones to minors for treatment of gender dysphoria. Although the Food and Drug Administration has not approved these drugs for this use, off-label prescribing is a common practice, and leading medical organizations all agree that this off-label use of puberty blockers and sex hormones is an essential component of transgender medical care. These state laws thus represent an extreme, and unprecedented, interference with the provision of standard-of-care medicine. This article, after exploring the ongoing litigation challenging these bans, argues that they violate a fundamental right under the Due Process Clause of the Fourteenth Amendment—namely, the right to obtain standard-of-care treatment from a physician. It demonstrates that this right is deeply rooted in America's history and traditions by presenting the first-ever comprehensive review of state policies regarding off-label prescribing practices and showing that the states have virtually never interfered with physicians' prescribing decisions in this manner. Finally, in light of relevant judicial precedents, this article shows why courts should strike down these unparalleled, oppressive state laws as unconstitutional.

* Ann Loeb Bronfman Professor of Law, American University Washington College of Law. The author thanks Susan Carle, Glenn Cohen, Anjali Deshmukh, Michael Dorf, Angi Porter, David Pozen, and Gustavo Ribeiro for their insights and recommendations, He is also grateful to participants in the 2024 Stanford BioLawLapalooza and the UCLA Health Law Scholarship Workshop. American University Washington College of Law students Hallie Hoffman and Liam Sullivan provided invaluable research assistance. Finally, the author thanks WCL Dean Roger Fairfax for his financial support for this project and for his inspiring leadership.

INTRODUCTION

Drugs known as puberty blockers and sex hormones are an essential component of medical care for adolescents experiencing gender dysphoria[1]—that is, "incongruence between experienced

[1] "Gender Dysphoria" (GD) is also sometimes referred to as Gender Incongruence (GI). The former term was included in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders in 2013, and the latter appeared in 2019 in the eleventh revision of the World Health Organization's International Classification of Diseases (ICD-11).

gender identity and the sex assigned at birth."[2] Adolescent gender dysphoria is a serious, increasingly common medical condition associated with suicidal ideation and attempts and other high-risk behaviors.[3] The Clinical Practice Guidelines of the Endocrine Society[4] and Standards of Care promulgated by the World Professional Association for Transgender Health (WPATH)[5] recommend that specially trained, specialist physicians prescribe drugs to treat gender dysphoria in youth, when appropriate, following comprehensive biopsychological evaluations by multidisciplinary teams. Every major American medical association and world health authority recognizes the necessity of such pharmaceutical care.[6]

American lawmakers are not in the habit of interfering with medical practices that medical experts endorse so widely. Yet starting with Arkansas in 2021, an accelerating wave of states has enacted laws that not only ban the provision of gender affirming care to adolescents, but in some instances *criminalize* it.[7] As of today, 23 states have passed laws prohibiting most or all provision

---

Marc-Antoine Crocq, *How Gender Dysphoria and Incongruence Became Medical Diagnoses – a Historical Review*, 23 DIALOGUES CLINICAL NEUROSCIENCE 44, 44. In an effort to "depathologize" GI, the ICD moved the condition from the chapter on Mental and Behavioural Disorders to the chapter on Sexual Health. *Id.* at 49. Although some people prefer the term GI for this reason, this article will predominantly use the "gender dysphoria" to emphasize that many people seeking gender-affirming care are in distress and thus need *medical* treatment.

[2] E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INTERNATIONAL JOURNAL OF TRANSGENDER HEALTH S1, 559 (2022) (hereinafter WPATH Standards of Care). For some people, including some adolescents, gender affirming care culminates in sex-reassignment surgery, but this article focuses solely on drug treatments. Wylie C Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 THE JOURNAL OF CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3872, 3894 (2017) (hereinafter Endocrine Society Clinical Practice Guideline). But see Coleman et al., *supra* at S65-66 (suggesting that although vaginoplasty may be appropriate for some minors, phalloplasty is not).

[3] Derek S Day, John J Saunders & Anu Matorin, *Gender Dysphoria and Suicidal Ideation: Clinical Observations from a Psychiatric Emergency Service*, 11 CUREUS e6132 (2019); Marla E. Eisenberg et al., *Risk and Protective Factors in the Lives of Transgender/Gender Nonconforming Adolescents*, 61 J ADOLESCENT HEALTH 521 (2017); Arnold H. Grossman & Anthony R. D'Augelli, *Transgender Youth and Life-Threatening Behaviors*, 37 SUICIDE & LIFE THREATENING BEHAV. 527 (2007).

[4] Hembree et al., *supra* note 2.

[5] Coleman et al., *supra* note 2.

[6] Medical Association Statements in Support of Health Care for Transgender People and Youth | GLAAD, (2023), https://glaad.org/medical-association-statements-supporting-trans-youth-healthcare-and-against-discriminatory/ (last visited Jan 19, 2024).

[7] The states that criminalize the provision of this care are Alabama, Florida, Idaho, North Dakota, and Oklahoma. *See infra* note [ ].

of medication (and surgery) to youth for gender transition,[8] although courts have blocked four of these statutes from taking effect.[9] Although current state statutes prohibit such care only for minors younger than 18 years old, bills have been introduced prohibiting it for young adults of various ages up to 25 years old,[10] and some advocates for the transgendered community express fear that the current barrage of youth bans presages future attempts to ban it altogether.[11]

Transgender youth and their supporters have filed cases in state and federal court challenging about fifteen of the state bans on the use of puberty blockers and cross-sex hormones to treat gender dysphoria in minors (PB/CSH bans). [12] The federal lawsuits,[13] as well as some of

---

[8] ALA. CODE § 26-26-1 to -9 (2022)), ARK. CODE ANN. § 16–114–401 to -403 (2023), FLA. STAT. ANN. § 456.52 (West 2023), GA. CODE ANN. § 31-7-3.5 (2023) (banning hormone therapy but not puberty blockers), IDAHO CODE § 18-1506C, IND. CODE § 25-1-22-1 to 18 (2023), IOWA CODE ANN. § 147.164 (West 2023), KY. REV. STAT. ANN. § 311.372 (2023), LA. STAT. ANN. § 40:1098.1-1099.1 (2023), MISS. CODE ANN. § 41-141-1 to -9 (2023), MO. ANN. STAT. § 191.1720 (West 2023), MONT. CODE ANN. § 50-4-1001 to -1008 (2023), NEB. REV. ST. § 71–6912 to -6917 (2023), N.C. GEN. STAT. ANN. § 90–21.150 to -154 (2023), N.D. CENT. CODE § 12.1–36.1–01 to –04 (2023), 63 OHIO REV. CODE ANN. § 3129.02 (West 2023), OKLA. STAT. ANN. tit. 63 §2607.1 (2023), S.C. H4624 (to be codified at S.C. CODE ANN. § 44-42-310 (2024), S.D. CODIFIED LAWS § 34-24-33 to -38 (2023), TENN. CODE ANN. § 68–33–101 to –109 (2023), TEX. HEALTH & SAFETY CODE ANN. § 161.701-706 (2023), UTAH CODE ANN. § 58-1-603 & 78B-3-427 (2023), W. VA. CODE § 30-14-17 (2023), Wyo. H. Bill No. HB0156 (2024). Arizona bans only surgery. ARIZ. REV. STAT. § 32-3230 (2021). In two additional states (Kansas and Wisconsin), the governor vetoed legislation banning medical care for transgender youth and the legislature failed to override the veto. [cites]

[9] Brandt v. Rutledge, 551 F. Supp. 3d 882 (E.D. Ark. 2021), *affirmed*, 47 F.4th 661 (2022); Doe v. Ladapo, 2023 WL 3833848 (N.D. Fla. 2023); Poe v. Labrador, 2023 WL 8935065 (D. Idaho 2023); van Garderen v. Montana, No. DV-23-541 (Mont. Dist. Ct. Sept. 27, 2023), https://wp.api.aclu.org/wp-content/uploads/2023/09/131-Order-Granting-Plaintiffs-Motion-for-Preliminary-Injunction.pdf). For current status of all litigation, see Movement Advancement Project | Health Care / Bans on Best Practice Medical Care for Transgender Youth, https://www.lgbtmap.org/equality-maps/healthcare_youth_medical_care_bans (last visited Jan 20, 2024).

[10] Oklahoma lawmaker lowers age limit in proposed gender-affirming care ban | The Hill, https://thehill.com/homenews/state-watch/3849734-oklahoma-lawmaker-lowers-age-limit-in-proposed-gender-affirming-care-ban/ (last visited Jan 20, 2024); Maggie Astor, *G.O.P. State Lawmakers Push a Growing Wave of Anti-Transgender Bills*, N.Y. TIMES, Jan. 25, 2023, https://www.nytimes.com/2023/01/25/us/politics/transgender-laws-republicans.html (last visited Jan 20, 2024).

[11] Orion Rummler, *Transgender Adults Worry States Could Limit Their Health Care Access*, THE 19TH (2022), https://19thnews.org/2022/10/transgender-healthcare-adults-limit-restrict/ (last visited Jan 20, 2024).

[12] Ernesto Londoño & Mitch Smith, *Young People Left in Limbo as Battle Over Transgender Care Shifts to Court*, THE NEW YORK TIMES, Oct. 3, 2023, https://www.nytimes.com/2023/10/03/us/transgender-care-lawsuits-courts.html (last visited Jan 21, 2024) (lawsuits challenging the youth care bans filed in "at least 14 states"); Movement Advancement Project | Health Care / Bans on Best Practice Medical Care for Transgender Youth, *supra* note 9.

[13] Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131 (M.D. Ala. 2022), *overruled*, 80 F.4th 1205 (11th Cir. 2023); Brandt v. Rutledge, 551 F. Supp. 3d 882 (E.D. Ark. 2021), *affirmed*, 47 F.4th 661 (2022); Doe v. Ladapo, 2023 WL 3833848 (N.D. Fla. 2023); Koe v. Noggle, 2023 WL 5339281 (N.D. Ga. 2023); Poe v. Labrador, 2023 WL 8935065 (D. Idaho 2023); K.C. v. Individual Members Med. Licensing Bd., 2023 WL 4054086 (S. D. Ind. 2023), *stayed*, 2024 WL 811523 (7th Cir. 2024); Doe v. Thornbury, 2023 WL 4230481 (W. D. Ky. 2023), *overruled* 83 F.4th 460 (6th Cir. 2023);

the state lawsuits,[14] assert that the bans violate the Equal Protection Clause and Due Process Clause of the United States Constitution. The equal protection claims contend that these bans discriminate on the basis of sex and transgender status and are thus subject to intermediate judicial scrutiny, which the laws cannot survive. The due process argument is that parents have a fundamental right to direct the medical care of their children and thus to obtain PB/CSH treatments for them. Under this theory, because the bans violate a fundamental right, they are subject to strict scrutiny.

These suits were initially successful; at least ten U.S. district courts issued preliminary injunctions blocking the enforcement of these laws.[15] In the summer of 2023, however, transgender rights advocates experienced two major setbacks, when the U.S. Courts of Appeals for the Sixth and Eleventh Circuits (together comprising five of the states with bans) held that U.S. district courts within their purview had abused their discretion in enjoining state bans.[16] The circuit courts denied that these laws discriminated on the basis of sex or transgendered status and that they implicated a fundamental right subject to strict scrutiny under the Due Process Clause. With respect to the due process claims, both circuit courts applied a test regarding the identification of fundamental rights which asks, among other things, whether the right is "deeply rooted in this Nation's history and tradition." The U.S. Supreme Court articulated this test in *Washington v.*

Voe v. Mansfield, Complaint for Declaratory and Injunctive Relief, No. 1:23-cv-000864 (M.D.N.C. Oct. 11, 2023); Poe v. Drummond, 2023 WL 6516449 (N.D. Okla. 2023); L.W. v. Skrmetti, 2023 WL 4232308 (M.D. Tenn. 2023), *overruled*, 83 F.4th 460 (6th Cir. 2023).

[14] Motion for Preliminary Injunction, Noe v. Parson, No. 23AC-CC04530 (Cir. Ct. Mo. July 25, 2023); Van Garderen v. Montana, *supra* note [ ] (Montana). *See also* Soe v. La. Bd. Med. Examiners, Petition for Declaratory and Permanent Injunctive Relief, https://lambdalegal.org/wp-content/uploads/2024/01/LA-Verified-Petition-FINAL-01.08.2024-SIGNED.pdf (La. Civ. Dist. Ct. Jan. 8, 2024) (claims under Louisiana Constitution); Appellants' Opening Brief, Planned Parenthood of the Heartland v. Hilgers, Appeal No. 23-644 (Neb. S. Ct Nov. 17, 2023) (claim under Nebraska Constitution); Loe v. Texas, Temporary Injunction Order, No. D-1-GN-23-003616 (Dist. Ct. Tx. Aug. 25, 2023) (claims under Texas Constitution).

[15] *See supra* note [ ].

[16] L.W. v. Skrmetti, 73 F.4th 408 (6th Cir. 2023) (staying Tennessee injunction), 83 F.4th 460 (6th Cir. 2023) (reversing Tennessee and Kentucky injunctions); Eknes-Tucker v. Gov'r of Alabama, 40 F.4th 1205 (11th Cir. 2023) (vacating Alabama injunction). In addition, on February 28, 2024, the Seventh Circuit issued a stay on the district court's order enjoining enforcement of the Indiana ban, with no explanation but with an announcement that an opinion and judgment will follow. https://wp.api.aclu.org/wp-content/uploads/2024/02/KC-decsiion.pdf

Glucksberg,[17] a 1997 case denying the existence of a fundamental right to obtain physician-assisted suicide, and reaffirmed it in *Dobbs v. Jackson Women's Health Organization*,[18] the 2022 decision rejecting a fundamental right to obtain an abortion.

In the ongoing litigation, states have defended their PB/CSH bans based purely on medical and scientific arguments, not on cultural or moral grounds. While pointing to studies that (they contend) undermine the Endocrine Society and WPATH's recommendations, the states also emphasize that the use of these drugs for transgender care in youth is "experimental" because the Food and Drug Administration (FDA) has not approved them for this use. Consider, for example, the opening of Arkansas's brief justifying its ban:

> Contrary to the story that Plaintiffs tell, there is no scientific consensus that children ought to undergo the irreversible, experimental gender-transition procedures regulated by the ... Act. Indeed, there is no dispute that the procedures at issue here are entirely experimental: They have never been approved—or evaluated—by the Food and Drug Administration as a method of gender transition in children.[19]

When FDA approves a drug, it does not approve the substance for all uses, but only for those adequately supported by clinical studies submitted to and reviewed by the agency. These approved uses are set forth in the "Indications" section of the drug's approved labeling. But federal law, with rare exceptions, does not interfere with physicians' authority to prescribe drugs for additional uses based on their professional judgment. Indeed, off-label prescribing is extremely common. Moreover, off-label uses of drugs are not necessarily "experimental." To the contrary, they are often supported by significant evidence and constitute the standard of care; that is,

[17] 521 U.S. 702, 720 (1997).
[18] 597 U.S. 215, 237 (2022).
[19] Brandt v. Rutledge, Defendants' Combined Brief in Opposition to Plaintiff's Motion for Preliminary Injunction at 1.

physicians would frequently be committing medical malpractice by *not* prescribing a drug off-label.[20]

As a general matter, the federal Food, Drug, and Cosmetic Act (FD&C ACT) implicitly cedes to states the power to restrict the off-label use of drugs as part of their authority over the "practice of medicine" within their borders.[21] As this article will show, however, states almost never exercise this power. Thus, although the states frame their PB/CSH bans as run-of-the-mill health regulations protecting children from "dangerous and unproven treatments,"[22] they are, in fact, extraordinary. Even in those extremely rare instances when states have interfered with off-label prescribing, they have never previously (outside the context of abortion medication) prohibited an off-label use of a drug that orthodox medical experts widely embrace as the standard of care. Nor (outside the abortion context) has a state ever before made off-label prescribing of a drug for a medical use a *crime*.

In defense of their bans, the states point to other western nations that have severely restricted the use of these treatments in minors.[23] But none of these countries *bans* pharmaceutical treatment for gender dysphoria for minors.[24] If American states were truly concerned about the health and safety of transgendered youth, they could limit and regulate the use of puberty blockers and cross-sex hormones in various ways. Instead, they have entirely prohibited this care. It would be absurd to contend that such prescriptions are *never* consistent with the standard of care—even when, for example, a multidisciplinary team of specially trained physicians determines that a 17-year-old is likely to commit suicide without such treatment. The states' total bans on a standard-

[20] *See infra* p. [ ].
[21] *See infra* p. [ ].
[22] *See, e.g.*, L.W. v. Skrmetti, Defendants' Response in Opposition to Plaintiffs' Motion for a Preliminary Injunction at 1.
[23] *See, e.g.*, Skrmetti Response, *supra* note [ ], at 15, Rutledge Combined Brief, *supra* note [ ], at 20-30.
[24] *See infra.* p. [ ].

of-care treatment embraced by the medical profession is an astonishing invasion of people's right to bodily integrity that, I will argue, renders these statutes unconstitutional under the Due Process Clause of the Fourteenth Amendment.

These bans prohibit the off-label use of FDA-approved drugs for transgender care even when adolescent patients, their parents, and their physicians all desire these treatments. They are thus in tension with Americans' broad historical embrace of freedom of therapeutic choice without government interference.[25] More importantly, they conflict with the country's unwavering commitment to freedom of choice among remedies accepted by the orthodox medical profession. Notably, the bans have emerged from states that, in other contexts, have been at the forefront of *noninterference* with physician prescribing practices.[26] The stark inconsistency of these bans with the same states' other policies highlights their arbitrariness and discriminatory motivation.

In short, the state prohibitions on prescribing puberty blockers and hormones to minors suffering from gender dysphoria constitute an indefensible abuse of the states' power to regulate the practice of medicine and violate these patients' fundamental right to obtain standard-of-care medical treatment. These laws constitute the first time that any government of the United States, federal or state, has completely banned a standard-of-care off-label use of a drug—or any standard of care treatment—outside the abortion context. And abortion care is distinguishable; the *Dobbs* court emphasized that abortion raises unique substantive due process questions because of the state's interest in protecting "potential life."[27]

Although the plaintiffs in lawsuits challenging these bans also rely on the Equal Protection Clause, this article focuses on their due process claims and argues that these claims are cogent,

[25] LEWIS A. GROSSMAN, CHOOSE YOUR MEDICINE: FREEDOM OF THERAPEUTIC CHOICE IN AMERICA (2021).
[26] *See infra* p. [ ].
[27] *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 262 (2022) (criticizing the dissenters' stoking of "unfounded fear" that the Court's decision will imperil other substantive due process rights).

even under the constrained approach to substantive due process the Supreme Court manifested most recently in *Dobbs*. This article will proceed as follows. Section I provides the medical background regarding the off-label use of puberty blockers and sex hormones in the treatment of gender dysphoria in adolescents. It also discusses disputes regarding what constitutes the "standard of care" for treatment of gender dysphoria in adolescents and explains why it is not necessary to resolve this dispute to conclude that complete bans on the use of drugs for this indication are unconstitutional. Section II describes the state bans themselves and the substantive due process challenges to them, with special focus on the litigation in Alabama, Tennessee, and Kentucky.

The remainder of the article seeks to undermine the Sixth Circuit's and Eleventh Circuit's reasoning in rejecting the due process claims. Section III examines the true significance of FDA approval of a drug for a particular use, discusses the agency's almost total noninterference with off-label prescribing, and explains why many uses remain off-label even though they are extremely common and backed by extensive scientific evidence. Section IV shows that the states also have a long tradition of noninterference with off-label prescribing—and sometimes with physician prescribing of drugs that FDA has not approved for *any* use. Section V of the article then highlights the hypocritical and arbitrary enactment in some of the very same states that have enacted PB/CSH bans of laws that explicitly protect off-label prescribing of other drugs (and the prescribing of entirely unapproved drugs) even when these practices *violate* the standard of care.

Section VI examines the rare prior instances in which states have, by law or regulation, explicitly prohibited particular off-label uses. It shows that none of these laws (except for restrictions on abortion medication) have restricted off-label prescribing that conformed to the standard of care.

Section VII lays out the argument that patients have a fundamental right to obtain standard-of-care treatment without government interference, including standard-of-care off-label uses of drugs. Finally, Section VIII explains why courts must find the PB/CSH bans unconstitutional if they apply the strict judicial scrutiny required for invasions of fundamental rights—and why the bans might even fail rational basis review.

I. The Use of Drugs for Gender-Affirming Care

A. Puberty Blockers, Sex Hormones, and Treatment of Gender Dysphoria

Puberty blockers, also known as gonadotropin-releasing hormone (GnRH) analogues, inhibit the body's natural production of gonadal hormones: estrogen, progesterone, and testosterone.[28] FDA first approved a GnRH analogue for human use in the 1980s as a prostate cancer treatment.[29] Over the years, these drugs have also obtained FDA approval for various other indications, including endometriosis, uterine fibroids, breast cancer, and central precocious puberty—a condition where a child (more commonly a girl) reaches puberty at an abnormally early age.[30] Puberty blockers are not currently approved by FDA for treatment of gender dysphoria, and their use for this purpose is thus "off-label."

---

[28] Gonadotropin Releasing Hormone (GnRH) Analogues, *in* LiverTox: Clinical and Research Information on Drug-Induced Liver Injury (2012), http://www.ncbi.nlm.nih.gov/books/NBK547863/ (last visited Mar 7, 2024).

[29] FDA Review Package for NDA 19010 (1985), https://www.accessdata.fda.gov/drugsatfda_docs/nda/pre96/019010Orig1s000rev.pdf

[30] *See, e.g.*, Lupron Depot® Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/020011Orig1s046;019943Orig1s039lbl.pdf; Zoladex® Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/019726s059,020578s037lbl.pdf; *New Indication for Lupron Depot-PED*, Pharma Marketletter, May 10, 1993; Lupron Depot-PED Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/020263s050lbl.pdf; Zoladex Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/019726s059,020578s037lbl.pdf; Melinda Chen & Erica A. Eugster, *Central Precocious Puberty: Update on Diagnosis and Treatment*, 17 Paediatric Drugs 273 (2015).

The medical use of estrogens (female sex hormones) has a much longer history.[31] The early twentieth century saw the emergence of a largely unregulated market for poorly characterized ovarian preparations and extracts. In 1933, Ayerst began selling the first modern pharmaceutical version of a sex hormone—a bio-identical estrogen therapy for treatment of menopausal symptoms (Emmenin® tablets).[32] In 1938, Congress began requiring the manufacturers of new drugs to submit new drug applications (NDAs) to FDA, and it gave the agency the power to review the drugs for safety prior to marketing.[33] Soon afterward, the agency let NDAs become effective for two treatments for menopausal symptoms: estrogen diethylstilbestrol (DES) in 1941 and conjugated equine estrogens (Premarin®) in 1942.[34] Over the next half century, FDA approved various formulations of estrogens, progestins, and combinations of them for various other conditions. Today, they are FDA-approved for (among other things) treatment of vasomotor symptoms due to menopause, treatment of vulvar and vaginal atrophy due to menopause, prevention of postmenopausal osteoporosis, treatment of androgen-dependent prostate cancer, pregnancy prevention, and hypoestrogenism (estrogen deficiency) due to "hypogonadism, castration, or primary ovarian failure."[35] FDA has not approved any estrogen or progestin drug product for treatment of gender dysphoria in patients of any age.

---

[31] Grace E. Kohn, Katherine M. Rodriguez & Alexander W. Pastuszak, *The History of Estrogen Therapy*, 7 SEX MED REV 416 (2019).

[32] *Id.* at 3.

[33] Federal Food, Drug, and Cosmetic Act, Pub. L. No. 75-71, 52 Stat. 1040 (1938). The drug application and approval provisions were codified at 21 U.S.C. § 355.

[34] Marcia L. Stefanick, *Estrogens and Progestins: Background and History, Trends in Use, and Guidelines and Regimens Approved by the US Food and Drug Administration*, 118 Suppl 12B AM J MED 64, 65S (2005). Until 1962, FDA did not "approve" NDAs but rather let them become effective if it had no objections, and, as a formal matter, it reviewed the drugs for safety but not for effectiveness. This changed with the 1962 Drug Amendments, Pub. L. No. 87-781, 76 Stat. 780, 781 § 102.

[35] *Id.* at 66S. *See, e.g.,* Premarin® Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/004782s181lbl.pdfhttps://www.accessdata.fda.gov/drugsatfda_docs/label/2024/004782s181lbl.pdf; Yaz® Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/021676s020lbl.pdf. "Hypogonadism" includes delayed puberty in girls. Premarin® Prescribing Information, supra note [ ] at 23, 27.

Testosterone therapy also has a long history. For centuries, doctors prescribed preparations made from animal testes to treat the symptoms of male hypogonadism, including impotence.[36] Some researchers even performed transplants of human testicles.[37] In 1935, European scientists first isolated and extracted a hormone they called "testosterone" from bull testes,[38] and later that year other scientists learned to synthesize testosterone in the laboratory.[39] From that point on, drug companies focused on developing the synthesized version of the hormone, first in the form of subdermal pellets and then in injectable form.[40] Schering started selling injectable synthesized testosterone propionate under the brand name Oreton® in about 1938.[41] In its early years, Oreton's label declared: "Oreton stimulates the development of male sex characteristics and is consequently of value in the treatment of male hypogonadism. In the male climeractic and prostatism, both the physical and mental status is improved."[42] (The "male climeractic" is an obsolete term for what is now sometimes called "male menopause.")

Today, testosterone drugs are available in multiple formulations (including transdermal patches) and are approved for "primary hypogonadism (congenital or acquired)" and "hypogonadotropic hypogonadism (congenital or acquired)."[43] In 2015, FDA began requiring all

---

[36] Eberhard Nieschlag & Susan Nieschlag, *Testosterone Deficiency: A Historical Perspective*, 16 ASIAN J. ANDROLOGY 161, 163 (2014). As late as 1947, the Reed & Carnrick company sold "Ampacoids Testicle," an injectable "purified ... extract ... of desiccated, defatted, whole fresh testicle" for treatment of "sexual neurasthenia," prostatitis, and "the male climeractic" (a condition later commonly referred to as "male menopause"). PHYSICIANS' DESK REFERENCE 321 (1st ed. 1947).

[37] *Id.* at 163–64; Mary Rostom, Ranjith Ramasamy & Taylor P. Kohn, *History of Testosterone Therapy through the Ages*, 34 INT J IMPOT RES 623, 624 (2022).

[38] Nieschlag & Nieschlag, *supra* note 36 at 165.

[39] *Id.*

[40] *Id.*; Rostom, Ramasamy, and Kohn, *supra* note 37 at 625.

[41] B. P. Lewis & R. V. Castle, *Grandfathered Drugs of 1938*, 18 AM PHARM 36, 38 (1978).

[42] PHYSICIANS' DESK REFERENCE 325 (1st ed. 1947). The drug was also indicated for use in "check[ing]" various conditions in women, including "postpartum pains, lactation, breast engorgement, functional uterine bleeding, dysmenorrhea, and endometriosis." *Id.*

[43] *See, e.g.*, Androgel® Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/022309s020lbl.pdf; Delatestryl® Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/009165s034lbl.pdf.

prescription testosterone products to declare that their "safety and efficacy ... in men with age related hypogonadism have not been established." [44] The only pediatric use for which a testosterone product has been approved is delayed puberty.[45] Nevertheless, testosterone is routinely used off-label for treatment of other disorders of sexual development (DSDs) in children, such as micropenis in infants and Klinefelter syndrome.[46] Testosterone is not approved for treatment of gender dysphoria.

Despite the lack of FDA approval, health professionals have been prescribing estrogen and testosterone for gender-affirming care in adults since the middle of the twentieth century.[47] Today, they and puberty blockers are part of standard-of-care treatment for gender dysphoria in adolescents.[48] In accordance with the WPATH Standards of Care and Endocrine Society Clinical Practice Guideline, physicians may—following a comprehensive, multidisciplinary physical and mental health evaluation—commence the use of a puberty blocker in patients showing the first signs of puberty. This drug delays development while patients, parents, and physicians together decide whether to proceed to the use of cross-sex hormones, a step with more permanent implications. If gender dysphoria persists, doctors may (after a comprehensive assessment of the

---

[44] *Id.*; Center for Drug Evaluation and Research, *FDA Drug Safety Communication: FDA Cautions about Using Testosterone Products for Low Testosterone Due to Aging; Requires Labeling Change to Inform of Possible Increased Risk of Heart Attack and Stroke with Use*, FDA (2019), https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-cautions-about-using-testosterone-products-low-testosterone-due (last visited Mar 8, 2024).

[45] Delatestryl® Prescribing Information, *supra* note [ ]. The "Indications" section for testosterone drugs not approved for delayed puberty specifically states that "[s]afety and efficacy ... in males less than 18 years old have not been established." *See, e.g.*, Androgel Prescribing Information, *supra* note [ ].

[46] Clinical Guidelines for the Management of Disorders of Sex Development in Childhood, https://dsdguidelines.org/htdocs/clinical/ (last visited Mar 8, 2024); Ganka Douglas et al., *Consensus in Guidelines for Evaluation of DSD by the Texas Children's Hospital Multidisciplinary Gender Medicine Team*, 2010 INT. J PEDIATRIC ENDOCRINOLOGY 919707 (2010); Simon Chang, Anne Skakkebæk & Claus Højbjerg Gravholt, *Klinefelter Syndrome and Medical Treatment: Hypogonadism and Beyond*, 14 HORMONES (ATHENS) 531, 534 (2015) ("Although studies on the effect of testosterone treatment in KS are few, the general consensus dictates that most men with KS should have testosterone treatment offered to them sometime around puberty ....").

[47] *Eknes-Tucker*, 80 F.4th at 1221 n. 12.

[48] Coleman et al., *supra* note 2 at S110-127, S254.

patient and robust communication about risks and implications) prescribe estrogenic drugs to transgender females or testosterone to transgender males. Physicians ordinarily wait until the patient is sixteen years old before commencing hormone treatments, although occasionally, under compelling circumstances, they will initiate them in younger post-pubertal patients.[49]

An abundance of published research provides evidence of these drugs' safety and effectiveness for treatment of gender dysphoria in minors.[50] A recent report commissioned by the United Kingdom's National Health Service (NHS), the *Cass Review*, recommended that the NHS severely restrict this use of puberty blockers and cross-sex hormones because of the dearth of "high quality" research supporting their effectiveness for improving mental health in transgendered youth.[51] But a primary characteristic of "high quality" studies is the double-blinded use of randomized controls, preferably placebo controls,[52] and this type of research is challenging, if not impossible, for drugs with such obvious physical manifestations, as well as arguably unethical in the context of treatment of gender dysphoria.[53] Thus, pharmaceutical treatment of gender dysphoria will likely remain an area in which the standard of care is determined by the best available evidence, but not necessarily "high quality" evidence.

---

[49] Hembree et al., *supra* note 2; Coleman et al., *supra* note 2 at 543–66.

[50] Brief of *Amici Curiae* American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations, Koe v. Noggle, 2023 WL 5339281 (N.D. Ga. Aug. 20, 2023) at 17-18 nn. 55-56 (citing eighteen studies finding positive mental health outcomes for adolescents receiving puberty blockers or hormone therapy); *id*. at 18 ("These studies find positive mental health outcomes … including statistically significant reductions in anxiety, depression, and suicidal ideation.").

[51] THE CASS REVIEW: INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE 6-7 (2024). For early critiques of the *Cass Review*, see Cal Horton, *The Cass Review: Cis-Supremacy in the UK's Approach to Healthcare for Trans Children*, 0 INTERNATIONAL JOURNAL OF TRANSGENDER HEALTH 1 (2024); Dori Grijseels, *Biological and Psychosocial Evidence in the Cass Review: A Critical Commentary*, (2024), https://osf.io/wjafd (last visited Apr 29, 2024).

[52] Adrian Baker et al., *A Review of Grading Systems for Evidence-Based Guidelines Produced by Medical Specialties*, 10 CLIN. MED. 358 (2010); *Grading Quality of Evidence and Strength of Recommendations*, 328 BRIT. MED. J. 1490 (2004).

[53] Horton, *supra* note 54 at 13–15.

Although the use of sex hormones in the treatment of gender dysphoria is off-label, efforts are underway to gain FDA approval. In 2023, a nonprofit called the Research Institute for Gender Therapeutics (RIGT) was founded expressly for the purpose of pursuing this goal.[54] Its first major action was to propose a Phase 3 (late-stage) clinical trial of the use of estradiol, an estrogenic drug, as a treatment for "gender incongruence."[55] Although RIGT proposed a double-blind placebo-controlled study, FDA responded by suggesting that other designs might be more appropriate, in view of ethical and practical concerns about using a placebo in such a trial. The agency also suggested including individuals as young as thirteen years old in the study. RIGT intends to commence its research following a study re-design. It plans eventually to seek FDA approval of puberty blockers and testosterone in gender-affirming care, as well.[56] If FDA approves these products for treatment of gender dysphoria in minors, a strong argument could then be advanced that federal law preempts the state bans.[57]

Like most pharmaceuticals, these drugs present risks as well as benefits. Puberty blockers pose the risk of loss of bone mineral density.[58] Estrogenic drugs are associated with endometrial

---

[54] Theresa Gaffney, *The Push to Get Estrogen FDA-Approved for Gender-Affirming Care*, STAT (Nov. 28, 2023), https://www.statnews.com/2023/11/28/fda-gender-affirming-care-estrogen-approval/ (last visited Mar 8, 2024).

[55] "This signals support for the categorization of transgender and gender-diverse identities as related to sexual health rather than mental health, as the Diagnostic and Statistical Manual of Mental Disorders term 'gender dysphoria' indicates." *Id.*

[56] *Id.*; Maya Goldman, *How the FDA Could Boost Gender-Affirming Care*, AXIOS (2023), https://www.axios.com/2023/12/15/fda-transgender-hormone-therapy-gender-affirming-care (last visited Mar 8, 2024).

[57] *See* Zogenix, Inc. v. Patrick, No. 14-11689-RWZ, 2014 WL 1454696 (D. Mass. Apr. 15, 2024) (granting preliminary injunction against state ban on FDA-approved drug on obstacle preemption grounds). For analysis of the preemptive force of FDA drug approvals, see Lars Noah, *State Affronts to Federal Primacy in the Licensure of Pharmaceutical Products*, 2016 MICH. ST. L. REV. 1 (2016); Patricia J. Zettler, *Pharmaceutical Federalism*, 92 IND. L. J. 845 861-69, 872-75 (2017).

[58] Lupron Depot® Prescribing Information, *supra* note [ ]; Coleman et al., *supra* note 2 at S114 (observing that the long-term effects on bone mass in adolescent patients "have not been well established"). In September 1, 2023, a group of physicians and organization submitted a citizen petition to FDA requesting that the agency take steps to study and suppress the off-label use of puberty blockers to treat gender dysphoria in minors. Citizen Petition Re: Action Urgently Needed to Address Off-Label Use of Puberty Blockers in Children (Sept. 1, 2023), https://www.regulations.gov/document/FDA-2023-P-3767-0029. The petitioners contended that the drugs pose risks to bone health, fertility, and neurocognitive development and that their benefit to minors with gender dysphoria has not been demonstrated. *Id*. at 3-6.

cancer, cardiovascular disorders, breast cancer, and dementia, among other diseases.[59] Testosterone drugs are associated with various conditions, including benign prostatic hyperplasia, prostate cancer, and thromboembolism.[60]

For adolescents commencing cross-hormone therapy, a particularly concerning risk is permanently diminished fertility. In individuals assigned male at birth, estrogens and progestins impair sperm production, with an unknown effect on long-term fertility if treatment is discontinued.[61] Individuals assigned female at birth who are prescribed testosterone similarly face the risk of diminished future fertility, even following termination of treatment, although little research has been performed on this question, either. [62] The WPATH Standards of Care and the Endocrine Society Clinical Practice Guideline stress the importance of informing and counseling adolescents requesting gender-affirming medical treatments about the potential loss of fertility and advising them about available options to preserve fertility.[63] Fertility preservation techniques, such as cryopreservation of oocytes and ovarian tissue, are available and improving for individuals assigned female at birth.[64] Individuals assigned male at birth can cryopreserve their sperm, although the sperm production of those still in early puberty is insufficient for cryopreservation.[65]

B. The Standard of Care Question

In the ongoing litigation, the parties are clashing over the question of whether the WPATH Standards and Endocrine Society Guidelines constitute the standard of care for treatment of gender dysphoria in adolescents. In Alabama, for example, the plaintiffs challenging the PB/CSH ban

[59] *See, e.g.*, Premarin® Prescribing Information, *supra* note [ ].
[60] *See, e.g.,* Androgel® Prescribing Information, *supra* note [ ].
[61] Coleman et al., *supra* note 2 at S158.
[62] *Id.* at S157.
[63] *Id.* at S48, S57; Hembree et al., *supra* note 2 at 3879–80.
[64] Hembree et al., *supra* note 2 at 3880; Coleman et al., *supra* note 2 at S103.
[65] Hembree et al., *supra* note 2 at 3879; Coleman et al., *supra* note 2 at S102-103. Researchers are currently investigating the possibility of using direct testicular extraction of sperm and cryopreservation of immature testicular tissue to preserve the fertility of such younger adolescents. *Id.* at S103.

emphasized that WPATH "developed the standard of care, which represents an expert consensus based on the best available science, on transgender health."[66] They highlighted the fact that numerous medical associations embrace these standards, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the Endocrine Society.[67] The plaintiffs also stressed that "decades of substantial scientific evidence show that treatment dramatically improves mental health outcomes for transgender youth, including reducing rates of suicidal ideation and suicide attempts …."[68]

Alabama responded: "The evidence is distressingly thin. But contrary to Plaintiffs' claims, the best evidence available does not show that the interventions improve mental health or reduce suicides in the long term."[69] The state pointed to multiple European nations that have recently restricted minors' access to gender affirming care based on reviews of the literature.[70] Alabama asserted: "Though Plaintiffs and their experts rely on the WPATH Standards and the Endocrine Society Guidelines as establishing 'gender affirming care' as the accepted 'standard of care,' in fact these proposed treatment guidelines from various professional societies and interest groups simply reflect increasingly divergent views for how to approach the management of gender dysphoria in youth. They are not 'standards of care' in the traditional sense."[71]

It is unnecessary to resolve disputes about exactly what practices constitute the standard of care to conclude that the state PB/CSH bans prohibit at least some necessary standard-of-care

[66] Memorandum in Support of Plaintiffs' Motion for Temporary Restraining Order & Preliminary Injunction at 16, Eckes-Tucker v. Marshall, 603 F.Supp.3d 1131 (M.D. Ala. 2022) (No. 2:22-cv-00184-184-LCB).
[67] *Id.*at 16.
[68] *Id.* at 27-28.
[69] Defendants' Response in Opposition to Plaintiffs' Motion for Preliminary Injunction at 3, 603 F.Supp.3d 1131 (M.D. Ala. 2022) (No. 2:22-cv-00184-184-LCB).
[70] *Id.* at 3, 58-64.
[71] *Id.* at 26. *See also* Defendants' Combined Brief in Opposition to Plaintiffs' Motion for Preliminary Injunction at 12, Brandt v. Rutledge, 2023 WL 4073727 (E.D. Ark. 2023) (No. 4:21CV00450 JM) ("[T]he WPATH and Endocrine Society documents are merely 'treatment guidelines'—not 'standards of care.'").

treatment.[72] No credible American medical authority asserts that it is *never* appropriate to prescribe puberty blockers and sex hormones to treat gender dysphoria in youth. And the foreign nations Alabama cites in its brief do not prohibit this use of these drugs in all cases. France, for example, urges "great medical caution."[73] Finland's policy allows for hormonal interventions "under certain conditions."[74] Sweden allows it in "strictly controlled research settings or in very 'exceptional cases.'"[75] In March 2024, England's National Health Service (NHS)—in response to an interim version of the *Cass Review*—adopted a new, more conservative policy regarding the use of pharmaceuticals in the treatment of gender-dysphoric youth, but even under this revised policy, puberty blockers may be used in the context of a research protocol and cross-sex hormones may be prescribed if approved by an independent multidisciplinary team of clinicians.[76] In short, the United States is the only western nation with laws that completely ban physicians from using pharmaceutical treatments for gender dysphoria in minors.

Even the lawyers representing the plaintiffs in the recently proliferating "detransitioner" malpractice lawsuits do not allege that PB/CSH treatments for minors always violate the standard

---

[72] The board of medicine of at least one state (Florida) has taken steps to declare the provision of gender-affirming treatments to minors a violation of the standard of care. *See, e.g.*, *Florida Restricts Doctors from Providing Gender Treatments to Minors*, N.Y. TIMES, Nov. 5, 2022, at A20. Christine Jordan Sexton, *Ron DeSantis Is Reshaping Florida's Medical Boards*, FLORIDA POLITICS - CAMPAIGNS & ELECTIONS. LOBBYING & GOVERNMENT. (Dec. 30, 2022), https://floridapolitics.com/archives/578266-gov-desantis-is-reshaping-floridas-medical-boards/ (last visited May 21, 2024). However, when I use the phrase "standard of care" in this article, I am referring to the standards established by the actual practices of reasonably prudent healthcare providers under similar circumstances, not standards that state legislatures or potentially politicized state medical boards establish by fiat. Moreover, standards of care for specialty areas, including pediatrics, are established by practitioners within that specialty, not by state boards of medicine composed of physicians mostly or entirely from outside the specialty area in question.

[73] *Id.* at 63 (quoting Académie Nationale de Médicine, *Medicine and Gender Transidentity in Children and Adolescents* (2022)).

[74] *Id.* at 61 (citing Finland's Council for Choices in Healthcare Policy Statement (2020)).

[75] *Id.* at 59 (quoting Sweden National Board of Health and Welfare Policy Statement (2022)).

[76] NHS England Stops Prescribing Puberty Blockers and Updates its Cross-Sex Hormones Policy for Minors, https://segm.org/England-UK-Puberty-Blockers-Cross-Sex-Hormones-Policy-March-2024 (last visited Apr 17, 2024). Following issuance of the *Cass Review,* Dr. Cass herself clarified: "There are young people who absolutely benefit from a medical pathway, and *we need to make sure that those young people have access*—under a research protocol, because we need to improve the research …." *Growing Divide on Youth Gender Medicine*, N.Y. TIMES, May 21, 2024, at D3 (emphasis added).

of care. In 2023, approximately a dozen people who received gender affirming care in their teenage years and later regretted doing so brought lawsuits against their healthcare providers alleging malpractice and fraud.[77] If their attorneys thought they could credibly contend that the provision of puberty blockers and sex hormones to a minor for gender affirming care constitutes medical malpractice in and of itself, they surely would have done so. They have not, however.

Consider the complaint Kayla Lovdahl filed in California state court. It never asserts that it is a breach of malpractice to administer gender affirming drugs to a teenager. Instead, the complaint alleges:

> Defendants breached the standard of care … by, among other things: (1) failing to properly evaluate, assess, diagnose, discover, and treat Plaintiff's medical and mental health conditions … that presented prior to and concurrent with her gender dysphoria symptoms; (2) failing to recognize and provide or refer Kayla to a qualified mental health care provider who could evaluate and treat her on a regular basis over an extended period of time; (3) grossly overemphasizing Plaintiff's gender dysphoria symptoms ….; (4) failing to provide Plaintiff with competent informed consent regarding the treatment options available and the relevant risks and benefits of treatment; and (5) manipulating Plaintiff and her parents into a false decision-making matrix by deliberately obscuring relevant information, by presenting false and misleading information, and by … grossly exaggerating the suicide risk when no such risk existed for Kayla.[78]

The complaints of other "detransitioner" plaintiffs frame their malpractice claims similarly.[79]

In contending that the administration of puberty blockers and sex hormones to transgender minors violates the standard of care, the states with PB/CSH bans stress the uncertainty regarding the proper treatment protocol for adolescent gender dysphoria. In this respect, it is interesting to contrast how some of these same states addressed the recent question of whether doctors violated

---

[77] Molly Hennessy-Fiske, *'Detransitioners' Wield Influence in Shaping Conservative Transgender Laws*, WASHINGTON POST, Jan. 3, 2024, https://www.washingtonpost.com/nation/2023/12/06/detransitioners-transgender-care-laws/ (last visited Mar 2, 2024).

[78] Complaint at 29, Lovdahl v. Kaiser Found. Hosps., No. STK-CV-UMM-2023-0006100 (Cal. Super. Ct. June 14, 2023).

[79] See, e.g., Petition at 19, Aldaco v. Perry, No. 067-343803 (Tex. Dist. Ct. Jul. 31, 2023) (alleging that the physician breached the standard of care by failing to take specified steps before prescribing the plaintiff cross-sex hormones).

the standard of care when they prescribed the antiparasitic drug ivermectin for COVID treatment—a truly experimental off-label use with almost no significant scientific support. The Indiana Attorney General opined:

> The SARS-CoV-2 virus, and thus COVID-19 and the medical field's knowledge of both, is rapidly evolving. Furthermore, studies on the safety and efficacy of potential treatments and preventative medications conflict in outcomes and results… [M]edical judgments … should be left to the [health care providers] who are trained and skilled in the knowledge to know what is best for their patients. If scientists and public health experts cannot come to a consensus on the safety and efficacy of certain medications, such as ivermectin, then it is reasonable to believe that prescribing them off-label would likely fall within the standard of care.[80]

In the same context, the Nebraska Attorney General advised: "[P]hysicians may utilize reasonable 'investigative or unproven therapies' that reflect a reasonable approach to medicine so long as physicians obtain 'written informed patient consent.'"[81]

These statements are strikingly inconsistent with the states' (almost contemporaneously) expressed reason for passing the PB/CSH bans—to protect children from "experimental" treatments.

II. The Legal Struggle over the State Bans

A. Emergence of the Bans

In March 2021, the Arkansas legislature passed House Bill 1570, titled "To Create the Arkansas Save Adolescents from Experimentation (SAFE) Act."[82] Governor Asa Hutchinson vetoed the bill, but the legislature overrode the veto, and the law took effect on April 6, 2021.[83]

---

[80] Off-Label Prescription of Medications for Treatment and Prevention of COVID-19, 2022 Ind. OAG No. 1, 2022 WL 2812523 at *7 (2022).
[81] Prescription of Ivermectin or Hydroxychloroquine as Off-Label Medicines for Prevention or Treatment of Covid-19, Neb. Op. Att. Gen. No. 21017, 2021 WL 5183144 at *3.
[82] https://www.arkleg.state.ar.us/Home/FTPDocument?path=%2FBills%2F2021R%2FPublic%2FHB1570.pdf [cite to session laws if therein]. The full history of bill is available at HB1570 Bill Information, https://www.arkleg.state.ar.us/Bills/Detail (last visited Feb 26, 2024).
[83] *Id.*

Thus Arkansas became the first state in the nation to ban the provision of gender affirming care for minors.

The SAFE Act prohibits a physician or other health care professional from providing "gender transition procedures" to people under eighteen years of age.[84] The statute defines "gender transition procedures" as:

> [A]ny medical or surgical service, including without limitation physician's services, inpatient and outpatient hospital services, or prescribed drugs related to gender transition that seeks to:
>
> (i) Alter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex; or
>
> (ii) Instill or create physiological or anatomical characteristics that resemble a sex different from the individual's biological sex, including without limitation medical services that provide puberty-blocking drugs, cross-sex hormones, or other mechanisms to promote the development of feminizing or masculinizing features in the opposite biological sex, or genital or nongenital gender reassignment surgery performed for the purpose of assisting an individual with a gender transition.[85]

With respect to pharmaceutical treatments in particular, the Arkansas legislature's findings declare: "The prescribing of puberty-blocking drugs is being done despite the lack of any long-term longitudinal studies evaluating the risks and benefits of using these drugs for the treatment of ... distress [at identifying with one's biological sex] or gender transition."[86] These findings also state:

> Healthcare providers are … prescribing cross-sex hormones for children who experience distress at identifying with their biological sex, despite the fact that no randomized clinical trials have been conducted on the efficacy or safety of the use of cross-sex hormones in adults or children for the purpose of treating such distress or gender transition.[87]

[84] Codified at 20-9-1502(a).
[85] Codified at 20-9-1501(6)(A).
[86] H.B. 1570 §2(6)(B).
[87] *Id.* §2(7).

The findings then identify a list of "serious known risks" associated with the use of "cross-sex hormones."[88]

Finally, the law establishes a variety of mechanisms for enforcing the ban. First, it declares: "Any referral for or provision of gender transition procedures to an individual under eighteen (18) year of age is unprofessional conduct and is subject to discipline by the appropriate licensing entity or disciplinary review board with competent jurisdiction in this state."[89] Second, the law provides: "A person may assert an actual or threatened violation of this subchapter as a claim or defense in a judicial or administrative proceeding and obtain compensatory damages, injunctive relief, [or] declaratory relief …."[90] Third, the law gives the attorney general authority to bring an action to enforce compliance with the law.[91] Finally, HB 1570 prohibits insurers from reimbursing gender transition procedures for minors.[92]

In August 2021, a U.S. district court preliminarily enjoined enforcement of the Arkansas law as likely violative of both the Equal Protection Clause and Due Process Clause of the Fourteenth Amendment of the U.S. Constitution.[93] The Eight Circuit upheld this preliminary injunction in August 2022.[94] In June 2023, the district court made the injunction permanent.[95] Thus, the first state ban on medical treatment for adolescent gender dysphoria is not currently in force. But Arkansas inspired an astonishing surge of similar statutes around the country. Since the enactment of HB 1570, twenty-two additional states have passed similarly broad prohibitions on

[88] *Id.* §2(8).
[89] Codified at 20-9-504(a).
[90] Codified at 20-9-1504(b).
[91] Codified at 20-9-1504(f)(1).
[92] Codified at 20-9-164(b).
[93] Brandt v. Rutledge, 551 F. Supp.3d 882 (E.D. Ark. 2021). The court also based on the injunction on likely violations of the First Amendment. *Id.* at 893-94.
[94] Brandt v. Rutledge, 47 F.4th 661 (9th Cir. 2022).
[95] Brandt v. Rutledge, 2023 WL 4073727 (E.D. Ark. June 20,2023).

gender affirming care for adolescents—twenty-one in 2023 alone.[96] Much of the language of these statutes closely echoes that of the Arkansas statute. Five states, however, go further than Arkansas by making violation of the bans a crime—in three of these states, a *felony*.[97]

Today, 36 percent of American transgender youth live in states that prohibit both medication and surgery for treatment of gender dysphoria in minors.[98]

B. Constitutional Challenges

Transgendered minors and their parents have brought constitutional challenges to most or all these state bans in court, on both equal protection and due process grounds.[99] They have had significant success obtaining preliminary injunctions in U.S. district courts.[100] The results in federal courts of appeals have been mixed, however. As noted above, in August 2022, the Eighth Circuit upheld the Arkansas preliminary injunction, which is now permanent.[101] But in 2023, in *L. W. v. Skrmetti*, the Sixth Circuit reversed the preliminary injunctions issued with respect to the Tennessee ban and the Kentucky ban.[102] The plaintiffs in both states are seeking certiorari in the

[96] *Supra* note [ ] (citations of statutes).
[97] ALA. CODE § 26-26-4(c) (Class C felony); FLA. STAT. ANN. § 456.52(5)(c) (first degree misdemeanor); IDAHO CODE § 18-1506C(5) (felony with mandatory imprisonment); N.D. CENT. CODE § 12.1–36.1–02(2)(b) (class A misdemeanor); OKLA. STAT. ANN. tit. 63 §2607.1(D) (felony).
[98] Movement Advancement Project | Health Care / Bans on Best Practice Medical Care for Transgender Youth, *supra* note 9.
[99] *Supra* note [ ].
[100] Brandt v. Rutledge, 551 F. Supp.3d 882 (E.D. Ark. 2021); Eknes-Tucker v. Marshall, 603 F.Supp.3d 1131 (M.D. Ala. 2022); Doe v. Ladapo, 2023 WL 3833848 (N.D. Fla. June 6, 2023); K.C. v. Individual Members of Licensing Bd. of Ind., 2023 WL 4054086 (S.D. Ind. June 16, 2023) (based on equal protection only); Doe v. Thornbury, 2023 WL 4230481 (W.D. Ky. June 28, 2023); L. W. v. Skrmetti, 2023 WL 4232308 (M.D. Tenn. June 28, 2023); Koe v. Noggle, 2023 WL 5339281 (N.D. Ga. Aug. 20, 2023) (based on equal protection only); Poe v. Labrador, 2023 WL 8935065 (D. Idaho Dec. 26, 2023). *But see* Poe v. Drummond, 2023 WL 6516449 (N.D. Okla. Oct. 5, 2023) (denying request for preliminary injunction). In *van Garderen v. State of Montana*, supra note [ ], the plaintiffs won a preliminary injunction based on the equal protection and privacy clauses of the Montana Constitution.
[101] 47 F.4th 661 (8th Cir. 2022).
[102] L.W. v. Skrmetti, 83 F.4th 460 (6th Cir. 2023) (overturning L. W. v. Skrmetti, 2023 WL 4232308 (M.D. Tenn. June 28, 2023) and Doe v. Thornbury, 2023 WL 4230481 (W.D. Ky. June 28, 2023).

U.S. Supreme Court.[103] Also in 2023, the Eleventh Circuit, in *Eknes-Tucker v. Governor of Alabama*, vacated a district court's preliminary injunction against the enforcement of Alabama's ban.[104] The discussion below will focus on the substantive due process claims in the litigation challenging the Tennessee, Kentucky, and Alabama bans.

In granting preliminary injunctions, the federal district courts in Alabama, Tennessee, and Kentucky all held that the PB/CSH bans under review violated the parents' substantive due process rights to direct the medical care of their children. In *Troxel v. Granville,* a case concerning visitation rights, the U.S. Supreme Court held that parents have the right "to make decisions concerning the care, custody, and control of their children" and described this right as "the oldest of the fundamental liberty interests" recognized by the Court.[105] The three district courts all cited cases from their respective circuits holding that *Troxel* protected parents' right to direct their children's medical care.[106]

To say that parents have the right to direct their children's medical care raises a second question, however: can they demand *any* treatment for their children, regardless of its regulatory status, its scientific support, and its acceptance in the medical community? Such a reading would give minors a greater constitutional right to access medical treatments than adults, because courts have consistently held that people do not have a substantive due process right to obtain

[103] Petition for Writ of Certiorari, L. W. v. Skrmetti, No. 23-466 (Nov. 1, 2023); Petition for Writ of Certiorari, Jane Doe 1 v. Kentucky *ex rel*. Cameron, No. 23-492 (Nov. 3, 2023). In addition, the United States is seeking certiorari in the Tennessee case. Petition for Writ of Certiorari, United States v. Skrmetti, No. 23-477 (Nov. 6, 2023). The United States is seeking certiorari only on the equal protection issues, because it intervened in the case pursuant to 42 U.S.C. § 2000h-2, which authorizes intervention in a private equal-protection suit "if the Attorney General certifies that the case is of general public importance." *Id.* at 11.

[104] 80 F.4th 1205 (11th Cir. 2023).

[105] 530 U.S. 57, 65-66 (2000).

[106] The district court in Alabama cited *Bendiburg v. Dempsey*, 909 F.2d 463, 470 (11th Cir. 1990) (father has right to refuse risky method of administering antibiotics to son) (cited at *Eknes-Tucker*, 603 F. Supp.3d at 1144). The district courts in Kentucky and Tennessee cited *Kanuszewski v. Mich. HHS*, 927 F.3d 396, 419 (6th Cir. 2019) (parents have right to refuse collection of blood sample from newborn to test for diseases and retention of these samples) (cited at *Thornbury*, 2023 WL 4230481 at *5, and *L.W.*, 2023 WL 4232308 at *6-7).

investigational drugs that FDA has not approved for any use.[107] In defending its statute, Kentucky asserted that the plaintiffs were asserting "a fundamental right to obtain whatever drugs they want for their children, without restriction."[108] Alabama suggested that the plaintiffs were claiming a "substantive due process right to experimental medical procedures."[109] Framed as such, the plaintiffs' claims have little support in the case law.

In fact, however, the parent plaintiffs in these cases limited the range of treatments they claimed they were constitutionally entitled to provide to their children. They did so in various ways: "medical treatments that are recognized to be safe, effective, and medically necessary,"[110] "established medical treatments,"[111] "appropriate medical care,"[112] and "well accepted medical treatment."[113] The district court in *Skrmetti* was vague in its pronouncement of the fundamental right, calling it "the right of parents to request certain medical treatments on behalf of their children."[114] The other courts were more careful, however. In *Thornbury* (the Kentucky case), the district court explained:

> [T]he puberty-blockers and hormones barred by [the Kentucky law] are established medical treatments essential to the well-being of many transgender children: every major medical organization in the United States agrees that these treatments are safe, effective, and appropriate when used in accordance with clinical guidelines. This case is therefore distinguishable from those … in which plaintiffs claimed a right to access treatment for themselves that was not already available or accepted.[115]

---

[107] Abigail Alliance v. Eschenbach, 495 F.3d 695 (2007); Rutherford v. United States, 616 F.2d 455 (1980).
[108] *Thornbury*, 2023 WL 4230481 at *6 (quoting Kentucky brief).
[109] Defendant's Response in Opposition to Plaintiffs' Motion for Preliminary Injunction at 102, Eknes-Tucker v. Marshall, 603 F.Supp.3d 1131 (M.D. Ala. 2022) (No. 2:22-cv-00184-184-LCB).
[110] Complaint for Declaratory and Injunctive Relief at 28, Eknes-Tucker v. Marshall, 603 F.Supp.3d 1131 (M.D. Ala. 2022) (No. 2:22-cv-00184-184-LCB).
[111] Complaint at 20, Doe v. Thornbury, 2023 WL 4230481 (W.D. Ky. 2023).
[112] Complaint for Declaratory and Injunctive Relief at 34, L. W. v. Skrmetti, 2023 WL 4232308 (M.D. Tenn. June 28, 2023) (No. 3:23-cv-00376).
[113] *Id.* at 38. *Cf. Poe v. Labrador*, 2023 WL 8935065 *15 (D. Idaho 2023) ("the appropriately precise way to frame the issue is to ask whether parents' fundamental right to care for their children includes the right to choose a particular medical treatment, in consultation with their healthcare provider, that is generally available and accepted in the medical community").
[114] *Skrmetti*, 2023 WL 4232308 at *8.
[115] *Thornbury*, 2023 WL 4230481 at *6.

The *Eknes-Tucker* court (reviewing the Alabama ban) found that the parents had a "fundamental right to treat their children with transitioning medications subject to *medically accepted standards*."[116] It emphasized, "Defendants produce no credible evidence to show that transitioning medications are 'experimental.'"[117]

In reversing the Tennessee and Kentucky injunctions, the Sixth Circuit maintained that the use of puberty blockers and hormones to treat gender dysphoria in minors is, in fact, "experimental." In an initial opinion temporarily staying the preliminary injunction in Tennessee, Chief Judge Sutton observed that no Supreme Court case extends parents' right to make decisions concerning the care of their children "to a general right to receive *new medical or experimental treatments*."[118] In drawing the line between drugs within the substantive due process zone of protection and those without, Sutton placed great emphasis on FDA approval. He remarked: "There is no Constitutional right to use a new drug that the FDA has determined is unsafe or ineffective." Here, Judge Sutton manifested a misunderstanding of the drug approval process. FDA has *not* determined that puberty blockers and sex hormones are "unsafe" or "ineffective" for gender affirming care in adolescents. Because nobody has submitted a supplemental NDA to the agency seeking approval of any of these drugs for this indication, FDA has reached no conclusions at all.

Judge Sutton continued:

> Gender-affirming procedures often employ FDA-approved drugs for non-approved, "off-label" uses… But the Constitution does not require Tennessee to view these treatments the same way as the majority of experts or to allow drugs for all uses simply because the FDA has approved them for some…. It is well within a State's police power to ban off-label uses of certain drugs. At the same time, it is difficult to maintain that the medical community is of one mind about the use of

[116] *Eknes-Tucker*, 603 F.Supp.3d at 1145 (emphasis added).
[117] *Id.*
[118] *L. W.*, 73 F.4th at 417.

> hormone therapy for gender dysphoria when the FDA is not prepared to put its credibility and careful testing protocols behind the use.[119]

This passage evinces a further misconception about the FDA drug approval system. FDA itself does not research drugs for approval; drug manufacturers do. And, as explained below,[120] manufacturers frequently opt not to submit a supplemental NDA for a new indication for reasons totally unrelated to the level of scientific evidence or medical consensus supporting the use.[121]

In his decision finally overturning both the Tennessee and Kentucky injunctions, Judge Sutton continues to impart too much significance to FDA approval and to misapprehend FDA's role. Once again, he asserts: "Neither doctors, adults, nor their children have a constitutional right to use a drug that FDA deems unsafe or ineffective," without recognizing that the agency only makes such a determination when reviewing an NDA.[122] The opinion then wrongly states that it is not "unusual for the FDA to permit drugs to be used for some purposes but not for others, or to allow some drugs to be used by adults but not by children." [123] In fact, as also explained below,[124] FDA almost never restricts off-label uses in this manner; indeed, it lacks the power to do so.[125]

---

[119] *Id.* at 418.
[120] *Infra* p. [ ].
[121] *Infra* p. [ ].
[122] Indeed, even when it denies an NDA, FDA often does not conclude that a drug is ineffective for the relevant use, but merely that the sponsor has not provided sufficient proof ("substantial evidence") that the drug is effective. 21 U.S.C. § 355(d)(5).
[123] *L. W.*, 83 F.4th at 473.
[124] *Infra* p. [ ].
[125] The opinion's citations to regulations requiring pediatric studies for some drugs and mandating labeling information for approved pediatric and geriatric indications are entirely unrelated to the legality of off-label prescribing, as is its citation to a case concerning a manufacturer's *promotion* of an off-label use. *L. W.*, 83 F.4th at 473-74 (citing 21 C.F.R. § 201.23(a), 201.57(c)(9)(iv)-(v); In re Celexa & Lexapro Mktg. & Sales Pracs. Litig., 915 F.3d 1 (1st Cir. 2019)). The only authority FDA may have to influence the indications for which drugs are prescribed is through imposition of Elements to Assure Safe Use (ETASU) as components of Risk Evaluation and Mitigation Strategies (REMS) for particularly risky drugs. 21 U.S.C. § 355-1(f) (2024). However, the REMS provisions of the FDCA envision that ETASU will have an indirect impact—at most—on prescribing drugs for unapproved indications. *See* 21 U.S.C. § 355-1(f)(3) (listing permissible components of ETASU). Patricia J. Zettler, *Toward Coherent Federal Oversight of Medicine*, 52 SAN DIEGO LAW REVIEW 427, 498 n. 410 (2015) ("FDA has not exercised its REMS authority to prohibit off-label prescribing of drugs ….").

By contrast, in *Eknes-Tucker*, the Eleventh Circuit decision reversing the Alabama injunction, Judge Lagoa does not dwell on the fact that FDA has not approved puberty blockers and sex hormones for gender affirming care.[126] This fact is largely irrelevant the court; it intimates that parents might not even have a right to obtain a drug for an FDA-*approved* use.[127] Moreover, the court sees no need to decide whether the use of these drugs to treat gender dysphoria meets the professional standard of care, because there is no "fundamental right to treat one's children with transitioning medications subject to medically accepted standards."[128] *Eknes-Tucker* reaches this conclusion by narrowly applying the *Dobbs* "deeply rooted in our history and tradition" test to puberty blockers and sex hormones in particular, noting that the use of these drugs to treat gender dysphoria did not emerge "until well into the twentieth century."[129] The same, of course, could be said for most uses of modern pharmaceuticals. While acknowledging that parents retain "'plenary authority' in deciding to pursue *lawfully available* treatment for their children,"[130] the Eleventh Circuit denies that parents have "a fundamental right to direct a particular medical treatment for their child that is prohibited by *state law*." The Eleventh Circuit thus seems to grant states the plenary authority to restrict the use of any drugs for any purpose, FDA-approved or not, subject only to rational basis review. [131]

The remainder of this article seeks to undermine the reasoning of both circuit courts and to explain why American parents possess a fundamental right to obtain necessary standard-of-care

[126] When analyzing why the Alabama ban survives rational basis scrutiny, the court observes that "FDA has not approved [the drugs] for this purpose although it has for others." 80 F.4th at 1234.
[127] In this regard, Judge Lagoa may have written the opinion with an eye to current and future disputes regarding federal preemption of state prohibitions on the FDA-approved use of the drug mifepristone for abortion. *See, e.g.*, GenBioPro, Inc. v. Sorsaia, 2023 WL 5490179 (S.D.W.V. 2023).
[128] 80 F.4th at 1225 (internal quotation marks omitted).
[129] *Id.* at 1221.
[130] *Id*. at 1223 (emphasis added) (quoting *Parham v. J. R.*, 442 U.S. 584, 604 (1979).
[131] *Id.* at 1223 (emphasis added).

medical treatment for their children, including when that treatment is an off-label use of an FDA-approved drug.

III. FDA (NON)-REGULATION OFF-LABEL PRESCRIBING AND THE PREVALENCE OF OFF-LABEL USE

A. FDA Power and Policy

As mentioned earlier, in the ongoing litigation, states defending their bans rely heavily on the argument that the use of puberty blockers and hormones for gender affirming care in adolescents is "experimental" because FDA has not approved these drugs for these purposes.[132] This contention misunderstands, or misrepresents, a fundamental aspect of FDA drug regulation: in most instances, the mere fact that the agency has not approved a particular additional use of a drug that it has approved for one or more other indications tells us nothing about the amount of scientific support for that additional use. To equate "off-label" and "experimental" is simply inaccurate.[133]

Since enactment of the 1962 Drug Amendments, FDA has formally reviewed new drugs for effectiveness as well as safety.[134] The agency does not review and approve drug *substances*, but rather drug substances labeled for specific indications. The applicant chooses what uses to study for purposes of preparing an NDA. When FDA approves an NDA, it approves not only the

---

[132] *Supra* p. [ ].

[133] Katrina Furey & Kirsten Wilkins, *Prescribing "Off-Label": What Should a Physician Disclose?* 18 AMA J. ETHICS 587, 588 (2016) ("Contrary to what patients might assume, off-label drug use is not the same as experimental or research use.").

[134] Pub. L. 87-781, 76 Stat. 780, 781 (1962) (codified at 21 U.S.C. § 355). I use the word "formally" because even before 1962, FDA drug reviewers were considering the effectiveness of drugs for the labeled indications in some situations. Most obviously, if a drug under review was labeled as effective for a critical or imminently fatal disease or condition (such as a heart attack), the safety of that product could not be divorced from its effectiveness. *Drug Safety: Hearings Before a Subcomm. of the H. Comm. On Govt. Operations*, 88th Cong. 150 (testimony of George Larrick, FDA Comm'r) ("Of course, [before 1962] the question of benefit was an integral part of the safety question in dealing with a product to be used in a life-threatening disease …."). Moreover, as Daniel Carpenter has shown, FDA reviewers were, without explicit statutory authority to do so, beginning to take account of efficacy data even in other situations before 1962. DANIEL CARPENTER, REPUTATION AND POWER: ORGANIZATIONAL IMAGE AND PHARMACEUTICAL REGULATION AT THE FDA 118-227 (1st ed. 2010).

drug substance, but also the required labeling. This labeling, the specific wording of which is laboriously negotiated between the agency and sponsor, sets forth the particular indication or indications for which the drug is approved (along with much additional information).

If after initial approval, the manufacturer wants to seek approval for an additional indication, it can perform additional studies trying to demonstrate that the product is safe and effective for that indication and, if these studies are successful, it can file a supplemental NDA. The absence of a particular indication from a drug's labeling does not ordinarily mean that the manufacturer has filed a supplemental NDA rejected by FDA because of safety or effectiveness concerns. Rather, in the vast majority of instances, it simply reflects the fact that the sponsor has not sought approval for that indication and thus has not presented FDA with any relevant data. In other words, an unapproved use of a drug is usually not one that FDA has *disapproved*, but rather one that the agency has not *considered*.

FDA has long embraced the view that once a drug is approved for one use, the agency will not interfere with physicians' decisions to prescribe it for other indications.[135] In 1972, the agency issued a proposed rule in which it declared: "Once the new drug is in a local pharmacy after interstate commerce, the physician may, as part of the practice of medicine, lawfully … vary the conditions of use from those approved in the package insert, without informing or obtaining the approval of the Food and Drug Administration."[136] FDA thought this approach was consistent with Congress's intent when it enacted the 1938 Food, Drug, and Cosmetic Act and the 1962 Drug Amendments. "Throughout the debate leading to enactment, there were repeated statements that Congress did not intend [FDA] to interfere with medical practice and references to the

[135] Although states also authorize various other categories of health care providers to prescribe prescription drugs, this article will, for simplicity's sake, refer only to "physicians" or "doctors."
[136] 37 Fed. Reg. 16503, 16503 (Aug. 15, 1972).

understanding that the bill did not purport to regulate the practice of medicine as between the physician and the patient."[137] FDA emphasized: "The labeling is not intended either to preclude the physician from using his best judgment in the interest of the patient, or to impose liability if he does not follow the package insert."[138] Although the agency never finalized this rule, it has referred to it as established policy[139] and has articulated the principle of noninterference in the practice of medicine in additional contexts.[140] FDA's regulations on investigational new drug applications (that is, requests for NDA exemptions for unapproved drugs used in clinical research) incorporate this policy by exempting the off-label use of an approved drug in the practice of medicine from FDA review.[141]

When FDA enunciated this noninterference policy in the 1972 proposed rule, it observed that it nonetheless was "obligated … to take whatever action is warranted to protect the public" when an "unapproved use of an approved new drug becomes widespread or endangers the public health …."[142] Soon thereafter, however, a federal court severely cabined the agency's power to address even such situations. The case, *U.S. v. Evers*, concerned an off-label practice addressed in detail later in this article: the intravenous administration of Calcium EDTA, a "chelation" drug approved only for treatment of lead poisoning, to treat cardiovascular disease—a use with little

---

[137] *Id*.
[138] Id. at 16504.
[139] *E.g.*, "Use of Approved Drugs for Unlabeled Indications," 12 FDA DRUG. BULL. 4 (Apr. 1982); 40 Fed. Reg. 15392, 15393–15394 (Apr. 7, 1975).
[140] FDA, GUIDANCE FOR INSTITUTIONAL REVIEW BOARD AND CLINICAL INVESTIGATORS, "OFF-LABEL" AND INVESTIGATIONAL USE OF MARKETED DRUGS, BIOLOGICS, AND MEDICAL DEVICES (Jan. 1998) ("Good medical practice and the best interests of the patient require that physicians use legally available drugs, biologics and devices according to their best knowledge and judgement. If physicians use a product for an indication not in the approved labeling … when the intent is the 'practice of medicine' [the use] does not require the submission of an Investigational New Drug Application (IND), Investigational Device Exemption (IDE) or review by an Institutional Review Board (IRB).")
[141] 52 Fed. Reg. 8798 (Mar. 19, 1987), codified at 21 C.F.R. § 312.2(d) ("This part does not apply to the use in the practice of medicine for an unlabeled indication of a new drug. . . .").
[142] 37 Fed. Reg. at 16,504.

scientific support.[143] The United States, at FDA's behest, brought a misbranding action against an Alabama doctor who promoted and ran a chelation clinic, seeking to enjoin him from continuing the practice.[144]

The district court ruled in Dr. Evers' favor, explaining, "It is well-recognized that a package insert may not contain the most up-to-date information about a drug and the physician must be free to use the drug for an indication not in the package insert when such usage is part of the practice of medicine and for the benefit of the patient.[145] The district court held that an FDA prohibition of a physician's off-label use of an approved drug would be *unconstitutional*. The court observed that it would "exceed the powers of Congress" to "interfere with medical practice as between the physician and the patient."[146] Furthermore, citing recently decided Supreme Court abortion decisions, the district court observed: "The courts have rather uniformly recognized the patients' rights to receive medical care in accordance with their licensed physician's best judgment and the physician's rights to administer it as may be derived therefrom."[147]

The U.S. Court of Appeals for the 5th Circuit upheld the district court.[148] The reviewing court found it unnecessary to reach the constitutional issues, however, because it held, as a statutory matter, that Evers' conduct did not violate the Food, Drug, and Cosmetic Act.[149] The government contended that the defendant's off-label prescribing violated a provision of the Act that prohibits the performance of any act "done while [a drug] is held for sale (whether or not the

---

[143] *Infra* p. [ ].
[144] U.S. v. Evers, 453 F. Supp. 1141, 1144 (M.D. Ala. 1978).
[145] Id. at 1149.
[146] Id. at 1149-50 (citing *Linder v. U.S.*, 268 U.S. 5 (1925)).
[147] Id. at 1150 (citing *Doe v. Bolton*, 410 U.S. 179 (1973) and *Whalen v. Roe*, 429 U.S. 589 (1977). *See also* State Bd. of Medical Examiners v. Rogers, 387 So. 2d 937, 939 (Fla. 1980) (holding that a state medical board's requirement that a physician discontinue chelation therapy "unreasonably interferes with [his] right to practice medicine by curtailing the exercise of his professional judgment ….").
[148] U.S. v. Evers, 643 F.2d 1043 (5th Cir. 1981).
[149] Id. at 1044.

first sale) after shipment in interstate commerce and results in such article being adulterated or misbranded."[150] The particular misbranding provision the government alleged Dr. Evers had violated deems a drug to misbranded "unless its labeling bears … adequate directions for use."[151] By regulation, FDA defines "adequate directions for use" to mean adequate directions for the "layman."[152] In another rule, however, the agency states that directions for a layman are not required for a prescription drug that, among other requirements, provides "adequate information for use" by a practitioner.[153] Despite the undeniable absence of such "information for use" against cardiovascular disease in the chelation drug's labeling, the court concluded that this requirement could not rationally be applied to Dr. Evers' off-label prescribing:

> The requirement which the FDA seeks to impose is nonsensical. Since Calcium EDTA is a prescription drug, the misbranding provision under which Dr. Evers was charged requires him to provide adequate information for use by prescribing physicians. However, Dr. Evers was the only physician who used the Calcium EDTA in question. The government's application of the statute may therefore be reduced to the following proposition: Dr. Evers did not provide adequate information to himself. It is doubtful at best that this interpretation was intended by the drafters of the statute.[154]

Later decisions have confirmed that FDA does not have authority under the FDCA to prohibit physicians from prescribing approved drugs for off-label uses. The Second Circuit has declared: "Once FDA-approved, prescription drugs can be prescribed by doctors for both FDA-approved and -unapproved uses; the FDA generally does not regulate how physicians use approved drugs."[155] The Third Circuit has observed: "Because the FDCA does not regulate the practice of

[150] Id. at 1047 (quoting 21 U.S.C. § 331(k)).
[151] Id. (quoting 21 U.S.C. § 352(f)(1)).
[152] 21 C.F.R. § 201.5 (2023).
[153] 21 C.F.R. § 201.100(c) (2023).
[154] *Evers*, *supra* note [ ], at 1053.
[155] U.S. v. Caronia, 703 F.2d 149, 153 (2nd Cir. 2012) (analyzing First Amendment protection of the promotion of off-label uses).

medicine, physicians may lawfully prescribe drugs for off-label uses."[156] In the related context of medical device regulation, the United States Supreme Court has asserted that off-label use "is an accepted and necessary corollary of the FDA's mission to regulate in this area without directly interfering with the practice of medicine."[157]

B. The Prevalence of Off-Label Prescribing

In part because FDA has almost no power over off-label prescribing,[158] it is extremely common in American medicine.[159] A study of office-based physicians' prescribing patterns for 160 commonly used drugs found that 21 percent of the prescriptions were off-label.[160] Recent estimates of the percentage of prescriptions overall that are off-label range as high 50 percent.[161] The frequency of off-label prescribing varies significantly by drug type and therapeutic area. For example, psychiatric drugs—especially antipsychotics—are particularly likely to be prescribed

[156] In re. Schering Plough Corp. Intron/Temodar Consumer Class Action, 678 F.3d 235, 240 (3rd Cir. 2012). *See also* Planned Parenthood Ariz. v. Humble, 753 F.3d 905 (FDA "has consistently maintained [the] position" that the FDCA 'does not … limit the manner in which a physician may use an approved drug'" (quoting 12 FDA Drug Bulletin 5 (1982)); Chaney v. Heckler, 718 F.2d 1174, 1180 (D.C. Cir. 1983) ("FDCA's legislative history expresses a specific intent to prohibit FDA from regulating physicians' practice of medicine…. Congress would have created havoc in the practice of medicine had it required physicians to … obtain[ ] FDA approval before putting drugs to new uses.").

[157] Buckman Co. v. Plaintiffs' Legal Comm., 531 U.S. 341, 350 (2001) (analyzing federal preemption of state medical device regulations). The FDCA contains a provision explicitly disclaiming any intention "to interfere with the authority of a health care practitioner to prescribe or administer any legally marketed device to a patient for any condition or disease within a legitimate health care practitioner-patient relationship." 21 U.S.C. § 396. No similar provision exists for drugs.

[158] As noted previously, *supra* note [ ], since 2007 FDA has had power to limit off-label prescribing of some particularly risky drugs by imposing risk evaluation and mitigation strategies (REMS) containing elements to assure safe use (ETASU). 21 U.S.C. § 505-1(f)(3). ETASU may control the distribution and use of a drug in ways that, in practice, inhibit off-label use. For example, ETASU can require that a drug be prescribed only by health care providers with particular training or experience or that it be prescribed only in certain health care settings. Id. at § 505-1(f)(3)(A), (C). See Zettler, *supra* note 117 at [XXX].

[159] Randall S. Stafford, *Regulating Off-Label Drug Use — Rethinking the Role of the FDA*, 358 NEW ENGLAND JOURNAL OF MEDICINE 1427 (2008).

[160] David C. Radley, Stan N. Finkelstein & Randall S. Stafford, *Off-Label Prescribing among Office-Based Physicians*, 166 ARCH INTERN MED 1021 (2006).

[161] James M. Beck, *Off-Label Use in the Twenty-First Century: Most Myths and Misconceptions Mitigated*, 54 UIC L. REV. 1, 25 (2021).

off-label.[162] So are cardiovascular medications.[163] Off-label prescribing of oncology drugs is especially prominent, with one estimate as high as 75 percent of uses.[164]

Notably for purposes of this article, pediatrics is another area in which the prevalence of off-label uses is extremely high.[165] Clinical data regarding the use of drugs in children (and thus FDA approvals for these uses) are relatively sparse for various reasons, including "unfamiliarity with age-related developmental pharmacology in pediatric patients, ethical considerations with conducting pediatric research, and a lack of financial incentive for the pharmaceutical industry."[166] Congressional efforts to incentivize and (in many instances) mandate pediatric research[167] have mitigated but not solved the problem.[168] According to one study, almost 40 percent of pediatric prescriptions are off-label.[169] Moreover, about 80 percent of off-label prescriptions to children in

[162] Radley, Finkelstein, and Stafford, *supra* note 149 at 1427–28.
[163] Gail A. Van Norman, *Off-Label Use vs Off-Label Marketing of Drugs*, 8 JACC BASIC TRANSL. SCI. 224, 225 (2023).
[164] Michael Soares, *"Off-Label" Indications for Oncology Drug Use and Drug Compendia: History and Current Status*, 1 JOURNAL OF ONCOLOGY PRACTICE 102, 104 (2005); Beck, *supra* note 150 at 26 and sources cited in note 113.
[165] Soares, *supra* note 153 at 104.
[166] H. Christine Allen et al., *Off-Label Medication Use in Children, More Common than We Think: A Systematic Review of the Literature*, 111 J OKLA STATE MED ASSOC 776, 2 (2018); See also Aysha Muthanna Shanshal & Saad Abdulrahman Hussain, *Off-Label Prescribing Practice in Pediatric Settings: Pros and Cons*, 12 SYSTEMATIC REVIEWS IN PHARMACY, 1267 (2021) (ascribing the dearth of pediatric data to "the complexity of the clinical trials, lack of attention of the added value, and inconvenient return on financial resources for pediatric medicine development.").
[167] In 1997, Congress incentivized pediatric testing by providing six months of "pediatric exclusivity" for innovator drugs (that is, a half-year delay on generic entry) when the NDA sponsor performs pediatric testing at FDA's request. FDA Modernization Act of 1997, 111 Stat. 2296, 2306-06 (codified at 21 U.S.C. § 355a). In 2003, Congress added another section to the FDCA requiring every NDA for a new active ingredient, new indication, new dosage form, new dosing regimen, or new route of administration to include a "pediatric assessment" (absent an agency waiver or deferral) and authorizing FDA to mandate pediatric testing of approved drugs in some circumstances. Pediatric Research Equity Act of 2003 (PREA), 117 Stat. 1936 (codified at 21 U.S.C. § 355c. Congress and FDA have also taken other steps to encourage pediatric testing. PETER BARTON HUTT ET AL., FOOD AND DRUG LAW: CASES AND MATERIALS 896–99 (5th ed. 2022).
[168] Allen et al., *supra* note 155 at 2; Katelyn Yackey et al., *Off-Label Medication Prescribing Patterns in Pediatrics: An Update*, 9 HOSPITAL PEDIATRICS 186 (2019).
[169] Allen et al., *supra* note 155 at 5. A 2014 study showed that the frequency of pediatric inpatient off-label prescriptions was declining but that they still represented about one quarter of the total. Yackey et al., *supra* note 157.

the outpatient setting are off-label by *indication*, not merely because the drugs have been approved for use in adults but not children.[170]

None of this is to deny that much off-label use lacks robust scientific support. One study of off-label prescriptions of commonly used medications for adults found that 73 percent of them were for indications with little or no scientific support,[171] and another (conducted in the Netherlands) found that only fourteen percent of off-label prescriptions for children were supported by high-quality evidence.[172] Researchers have also found that off-label drug uses lacking strong scientific evidence are associated with a much higher incidence of adverse drug events in both adults and children.[173]

Conversely, however, many off-label drug uses—including the use of puberty-blockers and sex hormones for treatment of gender dysphoria—have significant scientific support. As FDA has explained:

> "[U]napproved" or, more precisely, "unlabeled" uses may be appropriate and rational in certain circumstances, and may, in fact, reflect approaches to drug therapy that have been extensively reported in medical literature.
>
> . . . Valid new uses for drugs already on the market are often . . . confirmed by well-planned and executed clinical investigations. Before such advances can be added to the approved labeling, however, data substantiating the effectiveness of a new use or regimen must be submitted by the manufacturer to [the] FDA for evaluation. This may take time and, without the initiative of the drug manufacturer

[170] Divya Hoon et al., *Trends in Off-Label Drug Use in Ambulatory Settings: 2006-2015*, 144 PEDIATRICS e20190896, 5 (2019) ("74.6 % were off-label by indication, 17.6% were off-label by age, 0.6% were off-label by weight, and 4.7% were off-label based on the combination of age, indication, and [where applicable] weight.").

[171] Radley, Finkelstein, and Stafford, *supra* note 149 at 1021, 1022 (defining "scientific support" of a use as effectiveness shown in controlled trials or observed in clinical settings").

[172] Tjitske M. van der Zanden et al., *Off-Label, but on-Evidence? A Review of the Level of Evidence for Pediatric Pharmacotherapy*, 112 CLINICAL PHARMACOLOGY & THERAPEUTICS 1243 (2022) (defining "high quality evidence" as meta-analysis, systematic reviews, and high-quality randomized controlled trials).

[173] Tewodros Eguale et al., *Association of Off-Label Drug Use and Adverse Drug Events in an Adult Population*, 176 JAMA INTERN MED 55, 55 (2016) (finding an ADE rte of 21.7 per 10,000 person-months for off-label use lacking strong scientific evidence versus 1.54% for on-label drug use); Benjamin Horen, Jean-Louis Montastruc & Maryse Lapeyre-Mestre, *Adverse Drug Reactions and Off-Label Drug Use in Paediatric Outpatients*, 54 BRITISH JOURNAL OF CLINICAL PHARMACOLOGY 665 (2002) (finding higher incidence of adverse drug reactions for off-label uses in pediatric outpatients). Notably, the first study cited above also found that off-label uses with strong evidence were *not* associated with a higher risk of adverse drug events than on-label uses. Eguale et al.

> whose product is involved, may never occur. For that reason, accepted medical practice often includes drug use that is not reflected in approved drug labeling.[174]

In other words, even when strong clinical evidence in support of an off-label use is available, manufacturers may not invest the resources necessary to persuade FDA to make the use "on-label" because they conclude that such an effort, even if successful, would not increase profits enough to offset its costs. After all, when an off-label use of a drug is widely known, a manufacturer can make substantial revenues from sales of the drug for that use without pursuing approval. Although the manufacturer cannot commercially promote an unapproved use, it can—under the protection of the First Amendment—disseminate truthful and non-misleading scientific information about it.[175] Moreover, scientists, physicians, and journalists unassociated with the manufacturer can spread the word about a promising or firmly established off-label use with no limitations whatsoever. Drug manufacturers thus often decide that seeking FDA approval is not a worthwhile investment.[176] This calculation not only inhibits manufacturers from submitting supplemental NDA's; it often dissuades them from funding the costly trials necessary to develop data regarding the off-label use in the first place.

Nevertheless, sometimes—as with puberty blockers and sex hormones for treatment of gender dysphoria in adolescents[177] —the safety and efficacy of an off-label use are so well

---

[174] 12 FDA Bulletin 5 (1982).

[175] Washington Legal Found. v. Friedman, 13 F. Supp. 2d 51 (D.D.C. 1998), 36 F. Supp. 2d 418 (1999), *vacated for lack of controversy sub. nom.* Washington Legal Found. v. Henney, 202 F.3d 331 (D.C. Cir. 2000); FDA, DRAFT GUIDANCE: COMMUNICATIONS FROM FIRMS TO HEALTH CARE PROVIDERS REGARDING SCIENTIFIC INFORMATION ON UNAPPROVED USES OF APPROVED/CLEARED MEDICAL PRODUCTS (rev. 2023); U.S. v. Caronia, 703 F.3d 149 (2d Cir. 2012).

[176] Pearson Bownas & Mark Herrmann, *Keeping the Label Out of the Case*, NULR ONLINE, 484 (2009), https://scholarlycommons.law.northwestern.edu/nulr_online/169. Bownas and Herrmann list some additional reasons why manufacturers do not seek FDA approval for well-supported off-label uses, including the ethical and practical difficulty of performing placebo-controlled studies on an off-label use that is already the standard of care. *Id.* at 484–85.

[177] *See infra* p. [ ].

established that it constitutes the standard of care.[178] FDA itself recognizes this phenomenon.[179] In such situations, a doctor is effectively *obligated* to prescribe the drug off-label to avoid the possibility of medical malpractice liability or board discipline.[180] In pediatrics, off-label use constitutes the standard of care so frequently that the National Institute of Child Health and Human Development (NICHD) is sponsoring an ongoing study of medicines prescribed off-label for about 60 different diseases and conditions entitled "Pharmacokinetics of Understudied Drugs Administered to Children Per Standard of Care" (POPS).[181]

IV. STATE (NON)-REGULATION OF OFF-LABEL PRESCRIBING CONSISTENT WITH THE STANDARD OF CARE

As discussed above, FDA does not prohibit off-label prescribing because it does not have authority to interfere with the "practice of medicine."[182] A corollary to this principle is that the

[178] Beck, *supra* note 150 at 28; Stephanie Greene, *False Claims Act Liability for Off-Label Promotion of Pharmaceutical Products*, 110 PENN ST. L. REV. 41, 46 (2005); George Horvath, *Off-Label Drug Risks: Toward a New FDA Regulatory Approach*, 29 ANNALS HEALTH L. & LIFE SCIS. 101, 102 (2020); David A. Simon, *Off-Label Innovation*, 56 GA. L. REV. 701, 721–22 (2021); Veronica Henry, *Off-Label Prescribing: Legal Implications*, 20 J. LEGAL MED. [i], 380 (1999); Valentina Petkova et al., *Off-Label Prescribing in Pediatric Population—Literature Review for 2012–2022*, 15 PHARMACEUTICS 2652, 2 (2023); Bownas and Herrmann, *supra* note 165 at 486; Philip Rosoff & Doriane Coleman, *The Case for Legal Regulation of Physicians' Off-Label Prescribing*, 86 NOTRE DAME LAW REVIEW 649, 656 (2011) ("many" off-label uses are "evidence-based" and thus "appropriately established as the standard of care").

[179] FDA Draft Guidance, RESPONDING TO UNSOLICITED REQUESTS FOR OFF-LABEL INFORMATION ABOUT PRESCRIPTION DRUGS AND MEDICAL DEVICES 2 (2011) ("FDA recognizes that ... off-label uses ... may be important therapeutic options and may even constitute a medically recognized standard of care."). *See also* Washington Legal Found. v. Friedman, 13 F. Supp. 2d 51, 71 (D.D.C. 1998) ("[E]ven by FDA's own admissions, off-label treatments may constitute the standard of care for some conditions.")

[180] Beck, *supra* note 150 at 28–29; Sandra H. Johnson, *Polluting Medical Judgment? False Assumptions in the Pursuit of False Claims Regarding off-Label Prescribing*, 9 MINN. J.L. SCI. & TECH. 61, 68 (2008); John Berlau, *Dr. Kessler, Remove the Gag*, W. ST. J. Dec. 5, 1995, at A20 (quoting AMA Vice President Roy Schwarz as saying: "In some cases, if you didn't use drugs in the off-label way, you'd be guilty of malpractice."); Physician Risk Management: Off-label prescribing? Know evidence base!, RELIAS MEDIA (2013), https://www.reliasmedia.com/articles/62949-off-label-prescribing-know-evidence-base (last visited Feb 19, 2024) (quoting attorney Samantha L. Prokop as saying "In fact, failure to use a drug or product off-label could also be considered malpractice, if the standard of care required off-label use.").

[181] DANIEL BENJAMIN, *Pharmacokinetics of Understudied Drugs Administered to Children Per Standard of Care*, (2023), https://clinicaltrials.gov/study/NCT01431326 (last visited Dec 31, 2023).

[182] *Supra* p. [ ].

states—which indisputably have regulatory power over the practice of medicine[183]—*can* regulate or prohibit off-label uses of approved drugs.

It is astonishing how rarely they have done so, however. This section examines state limitations on off-label use of drugs and reveals that the states are almost as *laissez-faire* with respect to off-label prescribing as FDA is. As the review below will show, states have, in rare instances, banned specific off-label uses of particular drugs. But an examination of these scarce examples reveals another notable fact: outside the context of gender affirming drugs and abortion medication, no state has *ever* prohibited—let alone criminalized—off-label prescribing of an FDA-approved drug for a use that constituted the medical standard of care.

A. Medical Board Discipline

States *could* regulate off-label prescribing through their disciplinary systems for physicians administered by state medical boards. The most longstanding form of state regulation of the "practice of medicine" is the medical licensing schemes controlling who is permitted to be a physician.[184] The U.S. Supreme Court explicitly confirmed the states' power to exclude unqualified people from the practice of medicine in 1889.[185] Furthermore, as the Court later acknowledged, "a state's legitimate concern for maintaining high standards of professional conduct extends beyond the initial licensing."[186] Thus, legitimate state regulation of the practice of medicine extends to discipline (license suspension or revocation, probation, reprimands,

[183] McNaughton v. Johnson, 242 U.S. 344, 356 (1917) ("It is established that a State may regulate the practice of medicine, using this word in its most general sense."); Lambert v. Yellowly, 272 U.S. 581, 594 ("there is no right to practice medicine which is not subordinate to the police power of the States"); Gonzales v. Oregon, 546 U.S. 243, 270 (2006) (referring to "the States' general regulation of medical practice").
[184] See GROSSMAN, *supra* note 25 at 14–18, 24–74 (discussing state medical licensing in the late-18th century and the 19th century).
[185] Dent v. West Virginia, 129 U.S. 114, 122–23 (1889).
[186] Barsky v. Board of Regens, 347 U.S. 442, 451 (1954).

monetary fines, and censures) imposed by state boards on already-licensed physician for "unprofessional, immoral, dishonorable, or gross misconduct."[187]

Because "unprofessional conduct" and "gross misconduct" both encompass situations in which a physician fails to comply with the standard of care,[188] a board may discipline a doctor for off-label prescribing that violates this standard. Indeed, doctors have occasionally been disciplined for off-label prescriptions below the standard of care. It is important to emphasize, however, that this discipline was based on the violation of the standard of care, not on off-label prescribing in and of itself.

Medical licensing boards rarely intervene in off-label prescribing, however. They do not have the resources or motivation to routinely examine the prescribing practices of individual doctors.

> [T]he medical licensing boards are not well placed either to regulate or even investigate anything other than the most grievous violations of medical standards, generally brought to their attention by disgruntled or poorly served patients, or occasionally by law enforcement authorities.... [T]hey tend to grant great leeway to physicians in the way they care for their patients and prescribe medicines.... [S]crutiny of off-label use is generally off limits.[189]

B. Malpractice Law

State malpractice law is another way states regulate the practice of medicine. State courts do not frequently interfere with physicians' off-label prescribing practices, however. Reported

---

[187] S. Sandy Sanbar, *Chapter 2 Medical Practice: Education and Licensure*, *in* LEGAL MEDICINE 7, [xx] (7th edition ed. 2007).

[188] *Id. See, e.g.*, 22 Tex. Admin. Code § 190.8(1) (in a rule implementing Tex. Occ. Code § 164.052, a Texas statutory provision allowing the Board of Medical Examiners to take disciplinary action against a person who "fails to practice medicine in an acceptable manner consistent with public health and welfare," the board defines "Failure to practice in an acceptable professional manner consistent with public health and welfare" to include "failure to treat a patient according to the generally accepted standard of care."). A state court upheld this interpretation of the code in *Chalifoux v. Tex. State Bd. of Med. Examiners*, 2006 WL 3196461 (Tex. App. 2006).

[189] Rosoff and Coleman, *supra* note 167 at 665.

cases that explicitly hold a doctor accountable for straying from the approved labeling are sparse to nonexistent.[190]

This dearth of decisions reflects the fact that prescribing a drug off-label does *not* automatically—or even presumptively—violate the standard care.[191] As explained earlier,[192] many off-label uses are supported by extensive evidence. Moreover, the sheer frequency of off-label prescribing undermines malpractice claims against doctors for harm allegedly caused by this practice. The traditional standard of care that doctors owe their patients in malpractice cases is measured by the "customary practice among physicians" as shown by expert testimony.[193] As Professor Philip G. Peters explains, "Under a custom-based standard of care, the relevant inquiry is not whether the defendant behaved like a reasonable person or even whether she behaved as a reasonable physician, but instead whether the defendant conformed with customary practices."[194] In 2000, Peters identified a "quiet and persistent shift" away from this standard, as many states—starting with Washington in the seminal case of *Helling v. Cary*[195]—embraced a "reasonable physician" approach and either explicitly or implicitly ceased to defer to physician custom in malpractice cases.[196] A quarter of a century later, however, the customary standard maintains a strong hold on American malpractice law. A recent article observes that although "some

[190] My searches for such cases on Lexis turned up no examples. *Id.* at 666–67 (reporting, based on their own Westlaw search, "the dearth of published cases ... in which off-label use by a medical provider was a focus of the plaintiff's case" and that these cases "evidence strong deference to the professional judgment of individual physicians.").
[191] 124 AM. JUR. TRIALS 487 § 13 (2012); Beck, *supra* note 150 at 12.
[192] Supra p. [ ].
[193] Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV., 1194 (1992); Philip G. Jr. Peters, *The Quiet Demise of Deference to Custom: Malpractice Law at the Millenium*, 57 WASH. & LEE L. REV. 163, 164–70 (2000). *See also* RESTATEMENT (SECOND) OF TORTS § 299A (1965) (physicians are required "to exercise the skill and knowledge *normally* possessed by members of [their] profession ... in good standing in similar communities" (emphasis added)). In many jurisdictions, specialists' standard of care is derived from nationwide standards rather than those of a particular community or type of community. Jay M. Zitter, Annotation, *Standard of Care Owed to Patient by Medical Specialists as Determined by Local, "Like Community," State, National, or Other Standards*, 18 A.L.R. 4th 603 (2024).
[194] Peters, *supra* note 183 at 165.
[195] 519 P.2d 981 (Wash. 1974) (rejecting reliance on custom and instead embracing a reasonableness test).
[196] Peters, *supra* note 183 at 204.

commentators ascertain an overall trend towards replacing the custom standard with that of a 'reasonable physician,' … this continues to remain a minority approach amongst the states."[197]

In states that still use the customary standard of care in malpractice cases, the very prevalence of off-label prescribing compels courts to assign minimal, if any, probative value to the fact that a physician has strayed from the FDA-approved label.[198] Some state courts require physicians merely to "take account" of the information in the FDA-approved physician package insert.[199] In these states, the labeling may serve as evidence of the standard of care, but only if accompanied by expert testimony supporting the assertion.[200] Other states reject the use of FDA-approved labeling as evidence of the standard of care altogether.[201]

In sum, states rarely use malpractice law to rein in off-label prescribing precisely because off-label prescribing is such a common practice in the medical community. With respect to off-label prescribing, state malpractice law thus effectively defers to the expert judgment of the medical profession.[202] Yet some of the very same states whose malpractice law is most deferential to the medical community's judgment (including in the off-label context[203]) are today banning the use of puberty blockers and hormones for gender dysphoria in adolescents, thus outlawing a

---

[197] Edward K. Cheng, Elodie O. Currier & Payton B. Hampton, *Embracing Deference*, 67 VILL. L. REV. 855, 864 (2022).

[198] Rosoff and Coleman, *supra* note 167 (the state judiciaries' deference to physician's off-label prescribing decisions "is not surprising, as medical malpractice law in general reflects the standard of care as set by the medical profession, not by the judiciary or juries."); James R. Bird, *Package Inserts for Prescription Drugs as Evidence in Medical Malpractice Suits Comment*, 44 U. CHI. L. REV. 398, 399 (1976). On the limited probative force of the fact that a prescription was off-label, *see, e.g.,* Richardson v. Miller, 44 S.W.3d 1, 22 (Tenn. App. 2000) ("the fact that terbutaline was put to an off-label use is simply one piece of information along with everything else for the fact-finders to sort out and consider.")

[199] Rosoff and Coleman, *supra* note 167 at 670.

[200] *Id.*

[201] *Id.* at 670–71; *see* Bownas and Herrmann, *supra* note 165 ("in medical malpractice cases involving an off-label use, the product's label should not be admitted as evidence of either the standard of care or the physician's alleged breach of that standard.").

[202] Cheng, Currier, and Hampton, *supra* note 187 at 864.

[203] See, e.g., Arnold v. Lee, 720 N.W.2d 194, 2006 WL 1410161, at *6 (Iowa Ct. App. May 24, 2006) (upholding trial court's refusal to admit the FDA approved drug labeling into evidence because of the "risk for unfair prejudice").

treatment approach widely embraced and used by the same professionals they defer to in other contexts.[204]

C. General State Affirmations of Noninterference with Off-Label Prescribing

Some state legislatures have explicitly articulated their states' policies of not interfering with off-label prescribing. An Arizona statute prohibits any organ of the state from punishing a health care provider "for offering, providing or making available lawful health care services, including the off-label use of health care services for which there is a reasonable basis that is allowed under state law."[205] Montana recently enacted a similar provision.[206]

Such policies have also been articulated by state attorneys general. For example, in 1978, the California Attorney General issued an opinion interpreting that state's Sherman Food, Drug, and Cosmetic Law not to restrict off-label prescribing. As explained by the opinion, although

[204] *See, e.g.*, NEB. REV. STAT. ANN. § 44-2810 (LexisNexis 2023)(defining the general standard of care in medical malpractice cases as "the ordinary and reasonable care, skill, and knowledge ordinarily possessed and used under like circumstances by members of his profession engaged in a similar practice in his or in similar localities"); IDAHO CODE § 6-1012 (2024) (requiring plaintiff in malpractice suit to "affirmatively prove by direct expert testimony ... that [the] defendant ... negligently failed to meet the applicable standard of health care practice of the community in which such care allegedly was or should have been provided, as such standard existed at the time and place of the alleged negligence of such physician"); TENN. CODE ANN. § 29-26-115(a)(1) (2023) (malpractice plaintiff has burden of proving that defendant failed to act in accordance with the "recognized standard of acceptable professional practice in the profession ... in the community in which the defendant practices or in a similar community at the time the alleged injury or wrongful action occurred").

[205] ARIZ. REV. STAT. ANN. § 32-3221(A) (2023). The statute defines "off-label use" to mean: "any use if the intent is the practice of medicine and the use is not specified in the labeling or indications for use for prescription drugs, biologics, approved medical devices and dietary supplements approved by the United States food and drug administration.") Montana recently enacted a similar provision. Medical Practice Protection Act § 3(1)(c), 2023 Mt. Laws 533 (2023) ("A health care provider may ... offer, provide, or make available health care services, including the off-label use of health care services as allowed under state law.")

[206] Medical Practice Protection Act § 3(1)(c), 2023 Mt. Laws 533 (2023) ("A health care provider may ... offer, provide, or make available health care services, including the off-label use of health care services as allowed under state law.") In addition, many states have laws prohibiting insurance companies from denying drug coverage based solely on the fact that the drug was prescribed for an unapproved use. These laws variously apply to specific off-label uses (such as for cancer and AIDS); off-label uses for some combination of "chronic," "serious," "disabling," and "life-threatening" illnesses; or, in numerous jurisdictions, to all off-label uses. *See* statutes cited in Beck, *supra* note 50 at n. 49. The jurisdictions with the most expansive coverage protections for off-label uses include Maryland, New Hampshire, North Dakota, Ohio, Oregon, Puerto Rico, Tennessee, Virginia, and Washington. TENN. CODE ANN. § 56-7-2352(a)(6) (2023). *Id.* Tennessee's code section providing the broadest type of coverage guarantee includes the following legislative finding: "Off-label use of an FDA-approved drug is legal when prescribed in a medically appropriate way and is often necessary to provide needed care."

California "has the power to regulate, through the exercise of its police power, the practice of medicine … and … may regulate the administration of drugs," the Sherman Law nonetheless protects "the right of the practitioner to exercise his professional discretion when providing drugs in a therapeutic setting."[207]

Recent controversies regarding off-label prescribing of the antimalarial drug hydroxychloroquine and the antiparasitic drug ivermectin for treatment COVID-19 (a topic discussed in more detail below[208]) generated a spurt of similar pronouncements by the attorneys general of some of the very same states that would, shortly thereafter, ban off-label uses of puberty blockers and sex hormones. For example, the Nebraska attorney general opined that "governing law allows physicians to use FDA-approved medicines that are unproven for a particular off-label use so long as (1) reasonable medical evidence supports that use and (2) a patient's written informed consent is obtained."[209] The Indiana attorney general stated: "Off-label prescribing of medications is a generally accepted and widespread practice. Therefore, it is often within the standard of care absent other circumstances that would make such action medical malpractice or otherwise negligent in some way."[210]

These attorney general opinions, which authorized the use of hydroxychloroquine and ivermectin against COVID-19 under the principles they laid out, embraced an extremely capacious vision of appropriate prescribing that is markedly inconsistent with the same states' bans on pharmaceutical treatments for adolescent gender dysphoria.

---

[207] Opinion of California Attorney General E.J. Younger, CV 76/212 & 77/236, 61 Ops. Cal. Atty. Gen. 192, 194, 209 (1978).
[208] *Infra* p. [ ].
[209] Prescription of Ivermectin or Hydroxychloroquine as Off-Label Medicines for Prevention or Treatment of Covid-19, Neb. Op. Att. Gen. No. 21017, 2021 WL 5183144 at *4, 2021.
[210] Off-Label Prescription of Medications for Treatment and Prevention of COVID-19, 2022 Ind. OAG No. 1, 2022 WL 2812523 at *7 (2022). *See also* Kan. Atty. Gen. Op. No. 2022-4, 2022 WL 1051357 at *1 (2022) (off-label prescribing is legal under Kansas law "if the physician or other authorized prescriber under the appropriate licensing statute meets the standard of care and conduct [sic] obligations to the patient."

D. State Authorization of Off-Label Use of Puberty Blockers and Hormones for Other Conditions

Notably, the very same state laws that prohibit the use of puberty blockers and sex hormones to treat gender dysphoria in minors explicitly authorize off-label use of these drugs in minors for other conditions. For instance, the West Virginia statute (in language echoed in every other state's law) expressly exempts from the ban the provision of any service (including medication) to a minor "when a physician has … diagnosed a disorder of sexual development and … the physician has determined through genetic or biochemical testing that the individual does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action."[211] As discussed above,[212] although puberty blockers and sex hormones are FDA-approved for some sexual development disorders, they are frequently prescribed off-label for others.

Consider, for example, the typical treatment of Klinefelter syndrome, a condition in which boys are born with an extra X chromosome. Klinefelter syndrome is the most common cause of congenital primary hypogonadism, affecting about one in every 600 males.[213] Doctors routinely prescribe testosterone to minors with Klinefelter syndrome on a long-term basis, starting around puberty, even though is not approved for this use or for any other long-term use in adolescents.[214] Moreover, the only completed studies regarding the long-term use of testosterone for Klinefelter syndrome are observational, not controlled.[215] Nevertheless, all the states that have banned the use of testosterone for gender affirmation care in minors explicitly permit its use for Klinefelter syndrome.

---

[211] W. VA. CODE § 30-14-17(C)(2).
[212] *Supra* p. [ ].
[213] Chang, Skakkebæk, and Gravholt, *supra* note 46 at 532.
[214] *Id.* at 534; Maria Vogiatzi et al., *Testosterone Use in Adolescent Males: Current Practice and Unmet Needs*, 5 J. ENDOCRINE SOC. 2 (2021).
[215] Vogiatzi et al., *supra* note 205 at 7; Chang, Skakkebæk, and Gravholt, *supra* note 46 at 534–35.

Moreover, none of these states have ever intervened in the commonplace long-term off-label prescription of testosterone and estrogen to adults for another type of "gender-affirming" use—the preservation of desired female and male secondary characteristics into middle age and beyond. Estrogen is approved for specific menopausal symptoms (vasomotor symptoms and vulvar and vaginal atrophy) "at the lowest effective dose and for the shortest duration consistent with treatment goals and risks for the individual women."[216] Nevertheless, despite the risks (including endometrial cancer, cardiovascular disorders, dementia, and breast cancer), untold numbers of women take hormone replacement therapy in an effort to remain—in the words of the title of a 1960s bestseller promoting the use—"Feminine Forever."[217] And although the labeling of all testosterone products now states that their "safety and efficacy … in men with 'age-related hypogonadism' has not been established,"[218] American men frequently shrug at the potential heart disease risks and use these drugs as a "fountain of youth" to "recapture their vitality, decrease body fat, and enhance libido."[219] The same states that are banning PB/CSH treatment for adolescents in severe crisis have nothing to say about these risky, nonessential off-label uses of the same drugs in adults.

V. State Authorization of Physician Prescribing *Outside* the Standard of Care

The previous section alone does not fully capture the states' broad acceptance of off-label prescribing. Many of the same states that have enacted PB/CSH bans on the grounds that they are protecting children from "experimental" treatments have also, in other contexts, passed laws

[216] *E.g.*, Premarin® Prescribing Information at 15, 27
[217] Robert A. Wilson, Feminine Forever (2nd Printing edition ed. 1968). On historical usage patterns, see Kohn, Rodriguez, and Pastuszak, *supra* note 31 at 5–7.
[218] *E.g.*, Androgel® Prescribing Information.
[219] Hormone therapy no cure-all for "low T" in aging men, WWW.HEART.ORG, https://www.heart.org/en/news/2020/06/17/hormone-therapy-no-cure-all-for-low-t-in-aging-men (last visited Mar 9, 2024).

explicitly protecting doctors who prescribe unproven treatments that clearly do *not* represent the standard of care. This section reviews these instances, which illustrate not only the depth of these states' commitment to noninterference with physicians' prescribing practices, but also their hypocrisy in banning well-established gender affirming care—an arbitrariness that, as explained later, causes the bans to fail strict scrutiny (and perhaps even rational basis scrutiny).

A. Chelation Therapy for Cardiovascular Disease

The drug Calcium EDTA, also known as disodium edetate and calcium disodium versenate, is FDA-approved for treatment of lead poisoning.[220] The use of this and other drugs that bind to metals in the blood is called "chelation therapy." FDA approved Calcium EDTA in 1953 as an injection for treatment of lead poisoning.[221] Although FDA deemed the drug to be safe at the relevant dose, subsequent studies showed that high doses of the drug could lead to kidney disorders.[222] In 1970 (eight years after Congress required FDA to assess drugs' effectiveness as well as safety) the agency found injectable Calcium EDTA to be effective for lead poisoning and lead encephalopathy.[223]

Since the 1950s, Calcium EDTA has also acquired an alternative, unproven use for treatment of cardiovascular disease (CVD). [224] Early on, some conventional practitioners embraced

---

[220] Calcium Disodium Versenate Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/008922s022lbl.pdf

[221] US EPA National Center for Environmental Assessment, *The Use and Hazards of EDTA as an Alternative Medicine*, (2009), https://hero.epa.gov/hero/index.cfm/reference/details/reference_id/548451 (last visited Feb 4, 2024).

[222] Matteo Paolieri, *Ferdinand Münz: EDTA and 40 Years of Inventions*, 42 BULLETIN FOR THE HISTORY OF CHEMISTRY / DIVISION OF THE HISTORY OF CHEMISTRY OF THE AMERICAN CHEMICAL SOCIETY 133, 6 (2017).

[223] 35 Fed. Reg. 437 (Jan. 13, 1970). The agency also found calcium disodium edetate injection "probably effective in the treatment of other heavy metal poisoning and in the removal of radioactive and nuclear fission products, such as plutonium and yttrium," but reclassified it as lacking substantial effectiveness for these other purposes in 1976, after nobody submitted data in support of them. 41 Fed. Reg. 40206 (Sept. 17, 1976).

[224] Robin Rowbury, *Miracle Molecules of Our Age: Ethylenediaminetetraacetic Acid*, 94 SCIENCE PROGRESS (1933-) 232, 237 (2011); Heidi Braun Grebe & Philip J. Gregory, *Inhibition of Warfarin Anticoagulation Associated with Chelation Therapy*, 22 PHARMACOTHERAPY: J. HUMAN PHARMACOLOGY & DRUG THERAPY 1067, 1067 (2002); Jeanne Drisko, *Chelation Therapy*, *in* INTEGRATIVE MEDICINE: FOURTH EDITION 1004, 1004 (2018).

this use based on published observational studies.[225] During the 1960s, however, as further research yielded uneven results, conventional practitioners largely stopped prescribing Calcium EDTA for treatment of CVD.[226] In the early-1970s, the use of EDTA injections as a treatment for heart disease reemerged among a small group of "integrative" physicians (some with sketchy professional backgrounds[227]) who combined orthodox and alternative therapies in their practices.[228] The rise of chelation therapy as an alternative treatment was part of a broader surge of interest in "holistic" medicine in the 1970s.[229] Chelation therapy differed in an important way from most other alternative medicine modalities, however: it was the off-label use of a drug approved by FDA for another indication.

What chelation therapy for heart disease shared with most other alternative treatments was a lack of scientifically rigorous evidence of effectiveness—namely, well-controlled randomized clinical trials. Although some case reports published in alternative medicine journals in the 1980s and 1990s declared spectacular results, the few, small controlled clinical trials performed during this period failed to show Calcium EDTA to be an effective treatment for CVD.[230] In the mid-1980s, the American Medical Association, the American College of Cardiology, and the American

[225] Filippo Ravalli et al., *Chelation Therapy in Patients With Cardiovascular Disease: A Systematic Review*, 11 J. AM. HEART ASS'N e024648 (2022); Gervasio A. Lamas et al., *Heavy Metals, Cardiovascular Disease, and the Unexpected Benefits of Chelation Therapy*, 67 JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY 2411, 2412 (2016).
[226] Drisko, *supra* note 215 at 1005; EDTA Chelation Therapy as a Treatment for Vascular Disease, INTRAVENOUS DISODIUM EDETATE ("CHELATION"), https://chelation.me/ (last visited Feb 6, 2024); Lamas et al., *supra* note 216 at 2412.
[227] Allan Parachini, *Chelation Advocates Face Legal and Image Problems*, L.A. TIMES, Apr. 14, 1985, at 6:1.
[228] A search of the phrase "chelation therapy" in the Newspapers.com database shows mentions starting to appear in about 1974, climbing throughout the remainder of the decade, peaking in about 1983, settling into a pre-peak level of usage for about ten years, and then surging again starting in about 1994.
[229] U. F. O. Themes, *The Role of Chelation Therapy in Cardiovascular Disease, Diabetes Mellitus, and Heavy Metal Detoxification: The TACT Trials*, THORACIC KEY (Feb. 27, 2020), https://thoracickey.com/the-role-of-chelation-therapy-in-cardiovascular-disease-diabetes-mellitus-and-heavy-metal-detoxification-the-tact-trials/ (last visited Feb 6, 2024); GROSSMAN, *supra* note 25 at 143–44.
[230] Maria v. Villarruz-Sulit, Antonio L. Dans & Flordeliza N. Tan, *Chelation Therapy for Atherosclerotic Cardiovascular Disease*, COCHRANE DATABASE SYST REV CD002785 (2002); Lamas et al., *supra* note 216 at 2412.

Heart Association all issued statements advising against chelation therapy for CVD.[231] In 1994, the AMA issued another position statement on chelation therapy, asserting that "chelation therapy for atherosclerosis is an experimental process without proven efficacy."[232] In 1998, a chelationist organization called the American College for the Advancement in Medicine was forced to acknowledge—in a settlement with the Federal Trade Commission—that science did not support its claims that EDTA chelation therapy was effective in treating atherosclerosis.[233] Today, chelation therapy's effectiveness for treatment of CVD has still not been established.[234]

Earlier, this article discussed how FDA's efforts to shut down Dr. Evers' Alabama chelation clinic in the early 1970s culminated in a court decision that restricts the agency's authority to regulate off-label prescribing in general.[235] Around that time, some state medical boards also took steps to prevent doctors from using chelation therapy for CVD. In 1977, the Florida Board of Medical Examiners disciplined chelationist Dr. Robert Rogers,[236] but in a remarkable 1980 opinion, the Supreme Court of Florida quashed this order, holding that "the Board's action

---

[231] M. R. Lewin, *Chelation Therapy for Cardiovascular Disease. Review and Commentary*, 24 TEX HEART INST J 81, 81, n. * (1997).
[232] AMA, AMA Policy Compendium H–175.994, H–175.997 (1994).
[233] Medical Association Settles False Advertising Charges Over Promotion of "Chelation Therapy," FEDERAL TRADE COMMISSION (1998), https://www.ftc.gov/news-events/news/press-releases/1998/12/medical-association-settles-false-advertising-charges-over-promotion-chelation-therapy (last visited Feb 6, 2024).
[234] In 2012, the results of an NIH-sponsored placebo-controlled trial left open the possibility that chelation might be effective for CVD, but the authors emphasized that the results were "not, by themselves, sufficient to support the routine use of chelation therapy for treatment of post-MI patients." Gervasio A. Lamas et al., *Effect of Disodium EDTA Chelation Regimen on Cardiovascular Events in Patients with Previous Myocardial Infarction: The TACT Randomized Trial*, 309 JAMA 1241 (2013). Following the completion of TACT, a task force of the American Heart Association and American College of Cardiology acknowledged TACTS's modestly positive findings but remained convinced that "the usefulness of chelation therapy in cardiac disease is highly questionable." Stephan D. Fihn et al., *2014 ACC/AHA/AATS/PCNA/SCAI/STS Focused Update of the Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease*, 64 JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY 1929, 1937 (2014). Recent meta-analyses of all evidence to date found insufficient evidence to conclude that chelation therapy is effective for treatment of CVD. Maria Vanessa Villarruz-Sulit et al., *Chelation Therapy for Atherosclerotic Cardiovascular Disease*, 2020 COCHRANE DATABASE SYST REV CD002785, 15 (2020); Ravalli et al., *supra* note 216 at 1, 20.
[235] United States v. Evers, 643 F.2d 1043 (5th Cir. 1981); supra p. [ ].
[236] Howard Wolinsky, *Therapy Decision Delayed*, FLORIDA TODAY, Mar. 5, 1977, at 2B ; Rogers v. State Bd. of Med. Examiners, 371 So.2d 1037, 1038 (Fla. App. 1979).

unreasonably interferes with Dr. Rogers' right to practice medicine by curtailing the exercise of his professional judgment to administer chelation therapy."[237]

Perhaps inspired by this decision, in 1983, the Oklahoma legislature protected chelationists with what seems to have been the very first state law authorizing physicians to prescribe a drug for a specific off-label use. The governor vetoed a provision that would have required insurance companies to cover chelation therapy, but he allowed the following language to become law: "Nothing in the [act defining the standard of for the healing arts] shall be construed to prohibit the use of chelation therapy …."[238] This provision shielding doctors from discipline for prescribing an unproven remedy often dismissed as "quackery"[239] remains in effect today.

Two other states subsequently also passed chelation shield laws. In 1993, after the South Dakota medical board ordered a physician to stop providing chelation therapy to treat blocked arteries, the legislature enacted an amendment to the medical licensing law stating that "the board may not base a finding of unprofessional or dishonorable conduct solely on the basis that a licensee practices chelation therapy."[240] A supporter of the bill in the state legislature explained, "I believe the people should have the freedom of choice on this issue."[241] Louisiana followed suit in 1999, passing a law providing that "it shall be lawful … for a licensed physician to prescribe, dispense, [or] administer … to any person, any chelating agent or chelation therapy for the treatment or

---

[237] State Bd. of Med. Examiners v. Rogers, 387 So.2d 937, 938 (1980). The court did not question the Board's conclusion that "chelation therapy can best be classified as investigational." *Id*. at 939. But after emphasizing the absence of allegations that Dr. Rogers had either harmed his patients or defrauded them, the court opined: "Although the state has the power to regulate the practice of medicine … [t]he regulations imposed must be reasonably related to the public health and welfare and must not amount to an arbitrary or unreasonable interference with the right to practice one's profession …." *Id*. (citing *Doe v. Bolton*, 410 U.S. 179 (173)).

[238] OKLA. STAT. tit. 76, § 20.2 (2024).

[239] For example, the Oklahoma State Medical Association condemned the bill mandating health insurance coverage of chelation therapy as "pure and simple quackery." Prime Target for Nigh Veto (editorial), DAILY OKLAHOMAN, Mar. 19, 1983, at 14.

[240] 1993 S.D. SESS. LAWS Ch. 272 (codified at S.D. CODIFIED LAWS § 36-4-29). *See* House Approves Legislation Allowing Chelation Therapy, ARGUS-LEADER, Feb. 27, 1993, at 3 (describing medical board action).

[241] Chelation Treatment Bill Passes Senate Hurdle 6-1, ARGUS-LEADER, Feb. 11, 1983, at 3 (statement of Rep. Ed Olson, R-Mitchell).

prevention of any medical condition when the physician, in his professional judgment, deems it in the best interest of the patient."[242] Soon afterward, the Tennessee and Missouri medical boards decided to not interfere with chelation therapy in their states.[243]

Every one of these states that has acted to protect doctors who prescribe Calcium EDTA for a truly experimental off-label use are now outlawing scientifically supported, standard-of-care off-label use of puberty blockers and hormones.

B. Hydroxychloroquine and Ivermectin for COVID-19

The chelation statutes discussed above, though now decades old, cannot be dismissed as an artifact of the past. During the past few years, some states have taken similar actions to authorize the off-label, unproven use of drugs to treat COVID-19.

As discussed above,[244] during the pandemic, some state attorneys general authorized the off-label prescription of hydroxychloroquine and ivermectin for COVID-19, even though these were entirely unproven remedies for the virus. The Indiana attorney general concluded his opinion, "Experts disagree and studies conflict on prevention and treatment methods for COVID-19, so it is not unreasonable for HCPs to prescribe medications off-label and it be considered within the

---

[242] 1999 La. Sess. Law Serv. Act 1019 (West). By its terms, this statute sunset on February 1, 2001. *Id*. [From 1980 McDonagh v. Board in Missouri: Respondent has located the following states that have a specific statute permitting chelation therapy for treatment of atherosclerosis: Oklahoma, Title 76, § 20.2; South Dakota, § 36-4-29; Alaska, § 08.64.326(a)(8)(A); Washington, § 18.130 .180(4); Arizona, § 32-1401(21)(q)(gg).]

[243] In 2000, the Tennessee medical board—in response to a public outcry—unanimously rejected proposed regulations that would have restricted chelation therapy for conditions other than heavy metal poisoning to clinical trials in academic institutions. Bill Snyder, *Outcry Stops Vote to Restrict Chelation*, THE TENNESSEAN, Nov. 16, 2000, at 1B. The following year, the Missouri Board of Registration for the Healing Arts adopted a rule that declared EDTA chelation therapy "of no medical or osteopathic value except for those uses approved by the [FDA]" but nonetheless also provided that the board "shall not seek disciplinary action against a licensee based solely upon a non-approved use of EDTA chelation if the licensee has the patient sign the Informed Consent for EDTA Chelation Therapy form, included herein …." MO. CODE STATE REGS. ANN. tit. 4 § 2150-2.165 (2001). In multiple other states, including North Carolina, physicians practicing chelation therapy claimed protection under more general Medical Freedom Acts enacted during the 1990s, which will be described below, *infra* p. [ ]. *See* Cardiovascular Disease: Is the Government Doing More Harm than Good? EDTA Chelation Therapy, 42 (1999) (Chelationist Ted Rozema testifying in Congress that his home state of North Carolina was "one of eight states that have legislation protecting the physician doing alternative medicine, including chelation therapy.").

[244] *Supra* p. [ ].

standard of care."[245] Only an extremely expansive vision of "standard of care" would include this use of either hydroxychloroquine or ivermectin.[246] By authorizing the use of these drugs for COVID-19, these states were protecting off-label treatments that were far more "experimental" than the use of puberty blockers and sex hormones for treatment of adolescent gender dysphoria.

Some state legislatures explicitly protected the off-label use of ivermectin by *statute*. In 2021, North Dakota enacted a law declaring: "The [medical] board may not take disciplinary action against a licensee based solely on the licensee prescribing or dispensing ivermectin for the off-label treatment or prevention of [COVID-19]."[247] Missouri and Tennessee passed similar measures.[248] All three of these states shortly afterward outlawed the prescription of puberty blockers and sex hormones to transgender teens on the grounds of protecting them from "experimental" treatments.

C. State Protections of Doctors Prescribing Drugs Not Approved for Any Use

Numerous states—including many with PB/CSH bans—have enacted two types of statutes that protect doctors' use of entirely unapproved treatments that they deem appropriate for their patients: "right to try" laws designed to give terminally ill patients access to early-stage investigational drugs and "medical freedom" acts that authorize physicians to prescribe alternative and complementary therapies. These laws further demonstrate the states' widespread commitment

[245] 2022 WL 2812523 at *8.
[246] As one author observed in April 2020, early in the pandemic, there was "no evidence-based literature supporting a standard of care for coronavirus infections." Joseph M. Geskey, *Off-Label Prescribing in the Era of COVID-19*, MED. ECON. (2020), https://www.medicaleconomics.com/view/label-prescribing-era-covid-19 (last visited Mar 15, 2024). As time went on, neither remedy developed significant scientific support. *See, e.g.* Demarco v. Christiana Care Health Services, 263 A.3d 423, 425 (Del. Ch. 2021) (ivermectin "is not part of the standard of care for the COVID-19 virus); Ilan S. Schwartz, David R. Boulware & Todd C. Lee, *Hydroxychloroquine for COVID19: The Curtains Close on a Comedy of Errors*, 11 THE LANCET REGIONAL HEALTH – AMERICAS (2022), https://www.thelancet.com/journals/lanam/article/PIIS2667-193X(22)00085-0/fulltext (last visited Feb 25, 2024).
[247] N.D. Cent. Code § 43-17-31.2 (2021).
[248] Mo. Ann. Stat. § 334.100(8) (2023); Tenn. Code Ann. § 63-10-224(e) (2022).

to not interfering with the practice of medicine and to ensuring that patients can exercise freedom of therapeutic choice in consultation with their physicians.[249]

Since 2014, forty-one states (including all but one of the states that has enacted a PB/CSH ban) have passed "right-to-try" laws based on a model bill disseminated by the libertarian Goldwater Institute.[250] These statutes allow patients with terminal diseases to access investigational medical products that have successfully completed Phase One clinical trials—a phase comprising small, uncontrolled safety studies not designed to assess efficacy.[251] The model statute and the state laws based on it apply to minor patients as well as adults.[252]

These statutes all explicitly protect physicians from legal consequences for prescribing unapproved drugs pursuant to the "right to try" schemes. The model statute states that "No medical licensing board shall revoke a license, fail to renew a license, or take any other action against a license solely based on a medical professional's recommendation, prescription, or treatment with an investigational drug, biological product, or device."[253] Some of the parallel state law provisions are relatively modest; they protect physicians only if the prescription is consistent with the standard

[249] GROSSMAN, *supra* note 25 at 197–98, 213–14.
[250] *Id.* at 197. Goldwater's Model Right to Try Act is available at Christina Corieri, *Everyone Deserves the Right to Try: Empowering the Terminally Ill to Take Control of Their Treatment*, GOLDWATER INSTITUTE POLICY REPORT, 2–3 (2014). Kansas is the only state with a ban against pharmaceutical treatment of adolescent gender dysphoria that has not also enacted a right to try statute. See Right to Try In Your State | Right to Try - National Movement, https://righttotry.org/in-your-state/ (last visited Feb 21, 2024).
[251] Corieri, *supra* note 241 at 2. This aspect of the laws is mostly symbolic, for the right to access provisions are almost certainly preempted by the federal Food, Drug, and Cosmetic Act. GROSSMAN, *supra* note 25 at 198. In any event, the FDCA itself was amended in 2018 to include a new section that basically provides the same path to access at a federal level. Trickett Wendler Right to Try Act, Pub. L. No. 115-176, 132 Stat. 1372 (2018) (codified in part at 21 U.S.C. § 360bbb-0a).
[252] *See, e.g.*, Goldwater Model Right to Try Act § 2(B)(4) ("In the case that the patient is a minor or lacks the mental capacity to provide informed consent, a parent or legal guardian may provide informed consent on the patient's behalf); N.C. GEN. STAT. § 90-325.1(d) (defining an eligible patient, in part, as an individual who "has given informed consent in writing," or "if the individual is a minor or is otherwise incapable of providing informed consent, the parent or legal guardian has given informed consent in writing ....).
[253] Corieri, *supra* note 241 at 3.

of care.[254] Others, however, are astonishingly broad. Consider, for example, this provision from the Utah right to try law:

> *Standard of care – Medical practitioners not liable – No private right of action.*
>
> (1) It is not a breach of the applicable standard of care for a physician, other licensed health care provider, or hospital to treat an eligible patient with an investigational drug or investigational device under this chapter.
>
> (2) A physician, other licensed health care provider, or hospital that treats an eligible patient with an investigational drug or investigational device under this chapter may not, for any harm done to the eligible patient by the investigational drug or device, be subject to:
>
> (a) civil liability;
>
> (b) criminal liability; or
>
> (c) licensure sanctions ….[255]

It is important to emphasize that these "right to try" laws protect doctors who prescribe not only approved drugs for unapproved uses but also *entirely unapproved* drugs.

The second common type of state statute protecting doctors who prescribe unapproved drugs are "Medical Freedom Acts." These laws shield physicians from disciplinary action for practicing complementary and alternative medicine (CAM). Alaska passed the first such law in 1990, amending its medical practice act to declare that "the board may not base a finding of professional incompetence solely on the basis that a licensee's practice is unconventional or experimental in the absence of demonstrable physical harm to the patient."[256] Since then, about

---

[254] *See, e.g.*, W. VA. CODE § 16-51-5 (2023) ("Notwithstanding any other law, a licensing board may not revoke, fail to renew, suspend or take any action against a health care provider's license ... based solely on the health care provider's recommendations to an eligible patient regarding access to or treatment with an investigational drug, biological product or device *as long as the recommendations are consistent with medical standards of care* (emphasis added).).

[255] UTAH CODE ANN. § 58-85-104 (West 2023); *cf.* GA. CODE. ANN. § 31-52-10 (2016) (immunizing health care providers using investigational products pursuant to the right to try act from civil liability so long as they obtain written informed consent). Some other states immunize health care providers without any requirement they follow the standard of care or exercise reasonable care, but only with respect to licensing board sanctions. *See, e.g.*, N.C. GEN. STAT. § 90-325.4 (2015).

[256] GROSSMAN, *supra* note 25 at 213; Alaska Stat. § 06.64.326(a)(8)(A) (2017). Eleven states have enacted a different type of statute known as "Safe Harbor Legislation," which exempt CAM providers from the states' medical licensing requirements. *Id.* at 213–16.

sixteen additional states have enacted such measures, including seven of the states that have recently passed bans on pharmaceutical treatment of adolescent gender dysphoria.[257]

Although the Medical Freedom Acts vary in the degree of protection they provide to physicians, they are all motivated by the goal of ensuring (in the words of the Florida law's "legislative intent" statement) "that citizens be able to choose from all health care options, including the prevailing or conventional methods as well as other treatments designed to complement or substitute for the prevailing or conventional treatment methods."[258] Extremely few CAM treatments have been demonstrated to be safe and effective in scientific studies.[259] With these Medical Freedom Acts, states are thus encouraging physicians to administer drugs that have much less scientific support or professional acceptance than pharmaceutical treatments for adolescent gender dysphoria.

VI. Previous State Bans on Specific Off-Label Prescribing

Before now, have states ever *banned* particular off-label uses of drugs? On rare occasions, state legislatures have enacted statutes prohibiting specific off-label uses, and state medical boards have issued policies declaring an off-label use to violate state practice standards. This section contains the first-ever systematic examination of the entire body of state restrictions on off-label prescribing.[260] Most of these restrictions concern one of four off-label uses: chelation therapy for cardiovascular disease, anabolic steroids for enhancing athletic performance, abortion medication for terminating pregnancy beyond a certain gestation period, and hydroxychloroquine for

[257] For lists of the states, *see* Michael Ruggio & Lauren DeSantis-Then, *Complementary and Alternative Medicine: Longstanding Legal Obstacles to Cutting Edge Treatment*, 2 J Health Life Sci Law 137, nn. 119-30 (2009); John Lunstroth, *Voluntary Self-Regulation of Complementary and Alternative Medicine Practitioners*, 70 Albany Law Review 209, 86 (2006). The seven states that have enacted both Medical Freedom Acts and bans on pharmaceutical treatment of adolescent gender dysphoria are Oklahoma, Florida, Georgia, Texas, Indiana, Louisiana, and South Dakota.

[258] Fla. Stat. § 456.41(1) (2001).

[259] Grossman, *supra* note 25 at 204.

[260] Others have provided examples of such prohibitory measures. *See, e.g.*, Beck, *supra* note 150 at nn. 47-48.

treatment of COVID-19. As will be made clear below, all these restrictions vary in significant ways from the current state criminal bans on the off-label use of puberty blockers and sex hormones for treatment of adolescent gender dysphoria.

A. Chelation Therapy for Cardiovascular Disease

Over the years, as some states have enacted laws permitting physicians to prescribe chelation therapy for treatment of cardiovascular disease,[261] the medical boards in a number of other states have declared this practice to be misconduct subject to discipline. For example, in 2001, the Iowa Medical Examiners Board adopted a rule prohibiting physicians from prescribing Calcium EDTA for indications other than heavy metal poisoning except in "carefully controlled clinical investigations of its effectiveness."[262] The next year, Mississippi's board issued a rule allowing off-label use of EDTA only in approved research protocols or if the use is supported by "substantial, high quality research" and the physician provides obtains informed consent.[263]

Though these regulations severely limited an off-label use of an FDA-approved drug, they differed dramatically from the current PB/CSH bans, both because they were directed at an unproven use roundly rejected by the medical establishment and because they continued to allow the use under restricted circumstances.

B. Hydroxychloroquine for COVID

In March and April 2020, as the COVID-19 pandemic ravaged the nation, the internet was replete with assertions that various medicines approved for other uses might be effective against the new virus. The first drug to capture the web by storm was hydroxychloroquine, an off-patent

[261] *Supra* p. [ ].
[262] 23 Iowa Admin. Bull. 1409 (Mar. 8, 2001) (codified at IOWA ADMIN. CODE r. 653-13.5).
[263] 30 MISS. CODE R. § 2635-4.1 (2002) (supportive research must be "peer reviewed and published in recognized journal such as those cited in PubMed or in the National Library of Medicine").

product approved for uncomplicated malaria and for the autoimmune disorders lupus and rheumatoid arthritis.[264] Even though the evidence in support of using hydroxychloroquine as a COVID treatment was anecdotal, President Donald Trump began touting hydroxychloroquine in late March, and Fox News started featuring it regularly.[265] By mid-April 2020, 46 percent of voters supported using hydroxychloroquine for COVID before the completion of full testing.[266] Runs on pharmacies and widespread hoarding led to shortages of the medicine, risking the health of lupus and arthritis patients.[267] Under pressure from Trump, FDA authorized distribution of hydroxychloroquine by the National Strategic Stockpile for use against COVID.[268]

The hydroxychloroquine craze started to die down in late April 2020, after FDA highlighted the risk of abnormal heart rhythms in patients treated with the drug and a Department of Veterans Affairs study showed worse outcomes for COVID patients who used hydroxychloroquine.[269] FDA withdrew the emergency use authorization (EUA) for hydroxychloroquine in June because its "known and potential benefits … no longer outweigh the known and potential risks."[270]

---

[264] Drugs@FDA: FDA-Approved Drugs, https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm (last visited Mar 5, 2023) (hydroxychloroquine sulfate); Philip Bump, *The Rise and Fall of Trump's Obsession with Hydroxychloroquine; Forty Days of Promotion, Hype--and Eventual Retreat*, WASHINGTON POST BLOGS (Apr. 24, 2020), https://www.washingtonpost.com/politics/2020/04/24/rise-fall-trumps-obsession-with-hydroxychloroquine/ (reviewing the emergence of the idea of treating Covid-19 with the drug in mid-March).

[265] Bump, *supra* note 255.

[266] NATIONAL TRACKING POLL #200436, (2020), https://morningconsult.com/wp-content/uploads/2020/04/200436_crosstabs_POLITICO_RVs_v2_JB.pdf.

[267] Denise Grady, *Malaria Drug Helps Virus Patients Improve, in Small Study*, NEW YORK TIMES, Apr. 1, 2020, https://www.nytimes.com/2020/04/01/health/hydroxychloroquine-coronavirus-malaria.html.

[268] Christopher Rowland, *FDA Approves Use of Unproven Treatments, Saying the Risks Are Worthwhile*, WASHINGTON POST, Mar. 31, 2020, at A05.

[269] Denise Grady, *New U.S. Treatment Guidelines for Covid-19 Don't See Much Progress*, N.Y. TIMES, Apr. 22, 2020; Christopher Rowland, *VA Study Links Anti-Malarial Drug Trump Touted to Higher Death Rates*, WASHINGTON POST, Apr. 22, 2020, at A23; FDA Drug Safety Communication: FDA cautions against use of hydroxychloroquine or chloroqine for COVID-19, (2020).

[270] Office of the Commissioner, *Coronavirus (COVID-19) Update: FDA Revokes Emergency Use Authorization for Chloroquine and Hydroxychloroquine*, FDA (2020), https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-revokes-emergency-use-authorization-chloroquine-and (last visited Feb 25, 2024). The hydroxychloroquine craze during COVID and President Trump's role in it is reviewed in Jennifer S. Bard, *The President's Remedy - What the Hydroxychloroquine Story Teaches Us about the Need to Limit off-Label Prescribing Powers*, 71 CATH. U. L. REV. 427, 430–38 (2022).

During the hydroxychloroquine craze, a few states took steps to limit off-label prescribing of the drug to preserve its availability to patients with lupus and arthritis.[271] These restrictions took the form of either executive orders by governors or administrative rules by health agencies. For example, New York governor Andrew Cuomo ordered: "No pharmacist shall dispense hydroxychloroquine or chloroquine except when written as prescribed for an FDA-approved indication; or as part of a state approved clinical trial related to COVID-19 …. No other experimental or prophylactic use shall be permitted."[272] The Georgia Board of Pharmacy issued an emergency rule restricting the dispensing of hydroxychloroquine unless the prescription included a "diagnosis … consistent with the evidence for its use."[273]

These state actions bore no resemblance to the state PB/CSH bans. Firstly, the off-label use of hydroxychloroquine they were designed to suppress—the prevention or treatment of COVID—lacked any significant evidence of effectiveness or safety. In addition, these were time-limited measures designed for the specific purpose of ensuring, during a public health emergency, that the drug would remain available to patients using it for its FDA-approved uses.

C. Anabolic Steroids for Athletic Performance

At the 1988 Seoul Olympics, Canadian sprinter Ben Johnson was stripped of his gold medal for illegal doping.[274] This event occurred during a period in which Americans were becoming aware of an anabolic steroid and human growth hormone "abuse explosion" among not only high-level athletes, but also high school students and younger children trying to boost their strength and

[271] State Action on Hydroxychloroquine and Chloroquine Access | Lupus Foundation of America, https://www.lupus.org/advocate/state-action-on-hydroxychloroquine-and-chloroquine-access (last visited Mar 1, 2024).
[272] 9 N.Y. Comp. Codes R. & Regs. § 8.202.10 (NY Executive Order No. 8.202.10) (2020).
[273] Ga. Comp. R. & Regs. 480-10-0.38-.22 (2020).
[274] Michael Janofsky, *Johnson Loses Gold to Lewis After Drug Test*, N.Y. TIMES, Sep. 27, 1988, at A1.

performance.[275] American lawmakers, concerned about the integrity of sport and the health of youth, turned their attention to the problem of performance-enhancing drugs.[276]

Anabolic steroids are "synthetic substances similar to the male sex hormone testosterone" that "promote the growth of skeletal muscle (anabolic effects) and the development of male sexual characteristics (androgenic effects)."[277] As discussed earlier, FDA has approved these synthetic testosterone products for a variety of medical uses, and doctors prescribe them off-label for others—including gender-affirming care. [278] Human growth hormone (HGH), a different type of synthetic hormone, is FDA-approved for various medical conditions in children and adults.[279]

Between 1988 and 1990, Congress held three hearings on the abuse of anabolic steroids and HGH by athletes.[280] It enacted a law making it a felony to "distribute any anabolic steroid for any use in humans other than the treatment of disease pursuant to the order of a physician.[281] It added anabolic steroids to the list of Schedule III controlled substances under the Controlled Substances Act (CSA), thus effectively barring doctors from prescribing them for nonmedical purposes.[282] Congress also added a provision to the FDCA prohibiting the distribution of human growth hormone (HGH) "for any use in humans other than the treatment of disease or other

---

[275] JON R. MAY, *FDA Compilation: State Laws/Regulations Pertaining to the Control of Anabolic Steroids*, n.p. (Introduction) (1991); Charles E. Yesalis, *Steroid Use Is Not Just an Adult Problem*, N.Y. TIMES, Dec. 4, 1988, at 12.
[276] Yesalis, *supra* note 266 at 323.
[277] National Institute on Drug Abuse, *Anabolic Steroids and Other Appearance and Performance Enhancing Drugs (APEDs) | National Institute on Drug Abuse (NIDA)*, (--), https://nida.nih.gov/research-topics/anabolic-steroids (last visited Mar 17, 2024).
[278] *Supra* p. [ ].
[279] *See, e.g.*, Humatrope® Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/019640s108lbl.pdf.
[280] Maxwell Mehlman, Elizabeth Banger & Matthew Wright, *Doping in Sports and the Use of State Power*, 50 SAINT LOUIS UNIVERSITY LAW JOURNAL, 15 (2005); Ryan J. McGrew, *Raising the Bar: Why the Anabolic Steroid Control Acts Should Be Repealed and Replaced*, 15 HOUS. J. HEALTH L. & POL'Y 233, 236–37 (2015).
[281] Anti-Drug Abuse Act of 1988, Pub. L. No. 100-690 § 2403, 102 Stat. 4181, 4230-31 (1988).
[282] Anabolic Steroids Control Act of 1990, Pub. L. No. 101-647 § 1902, 104 Stat. 4789, 4851-52 (codified at 21 U.S.C. §§ 802(41)(A), 812 Sch. III(e)). (A Drug Enforcement Administration (DEA) criminalizes prescribing any controlled substance unless the prescription is "issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 C.F.R. § 1306.04 (2024).

recognized medical condition, where such use has been [approved by FDA] and pursuant to the order of a physician."[283] This provision remains the FDCA's only explicit restriction of an off-label drug use.

During this period, most state legislatures also took steps to suppress nonmedical uses of anabolic steroids and, in some states, nonmedical uses of HGH.[284] In many states, these steps included making the act of prescribing these drugs for body building or enhancement of athletic performance unprofessional conduct. Colorado law, for example, declares it to be unprofessional conduct for a physician to prescribe an anabolic steroid "for the purpose of the [sic] hormonal manipulation that is intended to increase muscle mass, strength, or weight without a medical necessity to do so or for the intended purpose of improving performance in any form of exercise, sport, or game."[285] Delaware's legislature went further; in that state it is a *felony* to "prescribe … any anabolic steroid … for the purposes of increasing human muscle weight or improving human performance in any form of exercise, sport, or game."[286]

Such laws represent another rare example of state prohibitions on off-label prescribing. Nonetheless, they differ in a critical way from the PB/CSH bans currently being litigated. They prohibit the *nonmedical* use of controlled substances.[287] They have no effect on legitimate medical practice.

[283] Pub. L. No. 100-690 § 1904, 104 Stat. at 4853 (codified at 21 U.S.C. § 333(e)).
[284] JON R. MAY, *State Laws/Regulations Pertaining to the Control of Anabolic Steroids (FDA Compilation)*, (1991); Jeffrey A. Black, *The Anabolic Steroids Control Act of 1990: A Need for Change Comment*, 97 DICK. L. REV. 131, 96–97 (1992).
[285] COL. REV. STAT. § 12-240-121(1)(o) (1987).
[286] DEL. CODE ANN. tit. 16, § 4757(a)(7) (1990).
[287] *Id.*

D. Controlled Substances for Obesity

For many decades, before the recent emergence of Ozempic® and Wagovy®, amphetamines were popular treatments for obesity.[288] But these stimulants are addictive, commonly abused, produce psychosis and violent and erratic behavior in chronic users, and contribute to social ills like crime and unemployment.[289] They are thus "scheduled" substances under the federal Controlled Substances Act. Amphetamines with no currently accepted medical use are in Schedule I. Those with an FDA-approved indication but a high potential for abuse and a high risk of dependence (such as Aderall® for attention-deficit/hyperactivity disorder[290]) are in Schedule II. Others are in Schedule III or Schedule IV, depending on their potential for abuse and risk of dependence.[291] Two Schedule III amphetamines and two Schedule IV amphetamines are currently approved as short-term treatments for obesity. No Schedule II amphetamine is approved for this purpose.[292]

Several states have enacted statutes prohibiting physicians from prescribing Schedule II amphetamines for treatment of obesity. [293] Two state medical boards have done the same by regulation.[294] Ohio's medical board goes further, with a rule providing: "A prescriber may utilize a schedule III or IV controlled substance for the treatment of obesity only if it has an F.D.A.

---

[288] Ann A. Coulter, Candida J. Rebello & Frank L. Greenway, *Centrally Acting Agents for Obesity: Past, Present, and Future*, 78 DRUGS 1113 (2018).

[289] National Institute on Drug Abuse, *Methamphetamine Research Report: Overview | NIDA*, (--), https://nida.nih.gov/publications/research-reports/methamphetamine/overview (last visited Mar 17, 2024); DOJ/DEA, *Drug Fact Sheet: Amphetamines* (2022), https://www.dea.gov/sites/default/files/2023-02/Amphetamines%202022%20Drug%20Fact%20Sheet_0.pdf.

[290] Adderall® XR Capsules Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2001/21303lbl.pdf

[291] 21 U.S.C. § 812 (2024).

[292] Coulter, Rebello, and Greenway, *supra* note 294 at 3. *See, e.g.*, Fendique® ER Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/018074Orig1s037lbl.pdf.

[293] ALA. CODE §§ 20-2-54, 34-24-360(21) (2024); MISS. CODE ANN. § 41-29-139(e) (2024); N.Y. PUB. HEALTH LAW § 3304(b) (2024).

[294] 201 KY. ADMIN. REGS. 9:016, § 3(3) (2024); N.J. ADMIN. CODE § 13:35–7.8(a) (2024).

approved indication for this purpose ….”[295] Finally, the medical boards of Kansas and Louisiana have taken even more restrictive actions, issuing regulations prohibiting the prescription of *any* amphetamines for treatment of obesity (and thus banning on-label as well as off-label uses).[296]

For the most part, these statutes and rules are distinguishable in important ways from the PB/CSH bans. First of all, obesity was not recognized as a disease by the scientific community until 1985 and by the medical community until 2013,[297] so the older provisions were arguably enacted to prohibit *nonmedical* uses of amphetamines. Second, the statutes and rules banning the use of Schedule II amphetamines for treatment of obesity are not prohibiting standard of care treatment; doctors rarely prescribe even Schedule III drugs for weight control, let alone Schedule II drugs.[298]

Finally, it is important to emphasize that these statutes and rules are directed at *controlled substances*. Indeed, many of them appear in the controlled substance portions of their states’ statutory or administrative codes.[299] The prescription of controlled substances for medical purposes raises issues beyond the drug’s effectiveness and safety for the person taking them. That is why, at the federal level, a medical agency (FDA) administers the FDCA, whereas a law

[295] OHIO ADMIN. CODE 4731-11-04 (2024).
[296] KAN. ADMIN. REGS. § 100-23-1(a) (2024); LA. ADMIN. CODE tit. 46, § 6905(A) (prohibiting the prescription “for the purpose of weight control or weight reduction in the treatment of obesity any amphetamine, dextroamphetamine, methamphetamine, or phenmetrazine drug or compound; any Schedule II controlled substance; human chorionic gonadotropin (HCG); thyroid hormones; diuretic medications; or any drug, medication, compound, or substance which is not indicated for use in the treatment of exogenous obesity by express approval of the U.S. Food and Drug Administration (FDA).”) It is an open question whether a state can completely ban an FDA-approved use for an approved drug. *See* Lars Noah, *State Affronts to Federal Primacy in the Licensure of Pharmaceutical Products*, 2016 MICH. ST. L. REV. 1 (2016); Jared C. Huber, *Preemption Exemption: FDA-Approved Abortion Drugs after Dobbs Notes*, 98 NOTRE DAME L. REV. 2217 (2022); Thomas A. Costello, *Quitting Cold Turkey: Federal Preemption Doctrine and State Bans on FDA -Approved Drugs Notes*, 26 WM. & MARY BILL RTS. J. 839 (2017). *Cf.* Zogenix, Inc. v. Patrick, No. 14-116890-RWZ, 2014 WL 4373251 (D. Mass. Aug. 28, 2014) (striking down a state ban on any use of an FDA-approved opioid).
[297] Coulter, Rebello, and Greenway, *supra* note 294 at 1–2.
[298] *Id.* at 3.
[299] For example, the Alabama, Mississippi, and New York provisions all appear in the portions of their respective codes regulating controlled substances.

enforcement agency (DEA) administers the CSA. The latter statute is intended to control the *abuse* of addictive drugs, and thus to protect not only the patients who are prescribed them, but also users to whom they are illegally diverted and society at large.[300]

State controlled substances acts, most of which are modeled on the Uniform Controlled Substances Act drafted by the U.S. Department of Justice, are directed at the same problems.[301] In other words, the state lawmakers passing these prohibitions on off-label prescribing of amphetamines for obesity were not motivated by a particular medical interest in the safety and efficacy of this category of drugs for treatment of obesity; rather, they wanted to limit *abuse* of these drugs. For example, the New Jersey Board of Medical Examiners justified its regulation forbidding physicians to prescribe Schedule II amphetamines for treatment of obesity as follows: "The expected benefits should include a severe reduction in the black-market availability of these Controlled Substances, with fewer people abusing and addicted to these drugs."[302]

Puberty blockers, estrogen, and progesterone are not controlled substances, so the states banning their use in treating gender dysphoria in adolescents cannot have been similarly motivated. And although testosterone is a controlled substance, the legislatures that have banned its use for treatment of gender dysphoria have not justified these prohibitions with reference to the risks of diversion, addiction, or abuse. The PB/CSH bans are, unlike the amphetamine restrictions, direct intrusions into medical practice based merely on clinical disagreement with the medical profession.

---

[300] JOANNA R LAMPE, *The Controlled Substances Act (CSA): A Legal Overview for the 116th Congress*, 2 (2019) ("The CSA simultaneously aims to protect public health from the dangers of controlled substances diverted into the illicit market while also seeking to ensure that patients have access to pharmaceutical controlled substances for legitimate medical purposes.").

[301] Grinspoon v. DEA, 828 F.2d 881, 887 n. 9 (1st Cir. 1987) ("To date, 48 states, the District of Columbia, Guam, and the Virgin Islands have adopted the Uniform CSA."); RUFUS KING, THE DRUG HANG-UP: AMERICA'S FIFTY-YEAR FOLLY 28 (1972), https://www.druglibrary.net/special/king/dhu/dhu28.htm (last visited Mar 17, 2024).

[302] Lemmon Co. v. N.J. State Bd. Of Med. Examiners, 417 A.2d 568, 570 (quoting communication from Board president to Attorney General).

E. Abortion Medication

The abortion context provides the only prior example in which multiple states have completely banned an off-label use that clearly accords with the standard of care.

In 2000, FDA approved an oral regimen of two drugs, mifepristone and misoprostol, for use in medication abortion.[303] The original labeling described the indication as "medical termination of intrauterine pregnancy through 49 days' pregnancy."[304] It set the dose of mifepristone at 600 mg, followed in two days by .4 mg of misoprostol.[305] But within a year of the approval, ninety-six percent of medication abortions did not follow this protocol.[306] Instead, they followed a new protocol based on clinical trials that was embraced by the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA), and other leading authorities.[307] This protocol—deemed to be safer and more effective than the labeled regimen—used 200 mg of mifepristone and .8 mg of misoprostol, the latter administered vaginally instead of orally. It was used through sixty-three days of pregnancy.[308]

Despite the emergence of this new protocol, over the next few years, at least six states enacted bans (in some instances *criminal* bans) on off-label prescribing of mifepristone.[309] Although the legislatures of these states were purportedly motivated by concerns about women's

---

[303] Letter from FDA to Population Council (Sept. 28, 2000), https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2000/20687appltr.pdf.

[304] Mifeprex® Prescribing Information (2000), https://www.accessdata.fda.gov/drugsatfda_docs/label/2000/20687lbl.pdf. The entire two-drug regimen was included in the mifepristone labeling. The labeling for misoprostol, already approved for ulcer prevention in certain patients, was not revised to mention abortion.

[305] *Id*. FDA also imposed a restricted distribution regime requiring, among other things, in-person administration of both drugs and a follow-up visit. *Id*.

[306] Oklahoma Coal. for Reproductive Justice v. Cline, 368 P.3d 1278 (Okla. 2016).

[307] Planned Parenthood Arkansas & Eastern Okla. v. Jegley, 2016 WL 6211310 at *23 (E.D. Ark. 2016); Planned Parenthood of Cincinnati Region v. Taft, 444 F.3d 502, 505–06 (6th Cir. 2005).

[308] *Id.*

[309] OHIO REV. CODE ANN. § 2929.123(A) (2004); 2011 OKLA. SESS. LAWS 821-23 (amended by 2014 Okla. Sess. Law serv. Ch. 121 (West)) (codified at 63 OKLA. STAT. § 1-729a (West 2011); 2011 N.D. SESS. LAWS ch. 109, § 6 (2011); ARIZ. REV. STAT. § 36-449.03(E)(6) (2012); Texas Health & Safety Code Ann. § 171.063 (2013); ARK. CODE ANN. § 20-16-1501-1510 (2015).

safety,[310] this explanation was clearly a pretext for the true goal of limiting abortion beyond 49 days of pregnancy.[311] In a decision striking down that state's law, the Oklahoma Supreme Court emphatically declared it to be "so completely at odds with the standard that governs the practice of medicine that it can serve no purpose other than to prevent women from obtaining abortions and to punish and discriminate against those who do."[312] The court reached this conclusion in part because of the utter inconsistency between the off-label ban for abortion medication and "the deference physicians receive in almost all other areas of medicine." This deference, the court pointed out, was reflected in other Oklahoma laws "recogniz[ing] the importance of allowing physicians to prescribe medications based on science and their medical judgment rather than dogmatic adherence to FDA labeling."[313]

Oklahoma's true motives were exposed after FDA updated the mifepristone label in 2016, largely to reflect the ACOG protocol that most physicians were already following.[314] Following the update, the unrevised Oklahoma statute no longer gave special status to the current FDA labeling; instead it continued to require physicians to comply with the outdated, obsolete 2000 labeling. The Oklahoma Supreme Court declared this mandate to be unconstitutional under the Due Process Clause of the 14th Amendment.[315] This article will consider the importance of that decision and others like it later.[316]

---

[310] 63 OKLA. STAT. at § 1-729a(A) (legislative findings); Planned Parenthood Arizona, Inc. v. Humble, 753 F.3d 905, 910 (9th Cir. 2014).
[311] *Id.* at 915 (plaintiffs introduced evidence that "the law will effectively ban medication abortions outright because many women do not discover they are pregnant before 49 days....").
[312] Cline v. Okla. Coal. for Reprod. Just., 313 P.3d 253, 262 (2013) (endorsing and bolding this language from state district court opinion).
[313] Id. at 261, 262.
[314] Mifeprex® Prescribing Information (2016), https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf.
[315] Okla. Coal. for Reprod. Just. v. Cline, 441 P.3d 1145 (2019).
[316] *Infra* p. [ ].

For now, the main lesson to be drawn from the state laws prohibiting off-label use of mifepristone is that a legislature's stated objective of protecting the health of patients receiving a drug may be a mere pretext for another policy. And as will be addressed further below, whereas the Supreme Court has recognized the true goal of these mifepristone statutes (whether it be described as protecting "potential life" or "the life of an unborn human being") as legitimate,[317] the Court has also stated that "animus" toward a class affected by a law (for example, transgendered individuals) is *not* a legitimate state interest. [318]

VII. A Fundamental Right to Receive Standard-of-Care Off-Label Treatment

A. Review of the Relevant Case Law

This article contends that Americans have a fundamental right to access drugs for off-label uses that meet the standard-of-care, and thus that the state bans on PB/CSH treatment of gender dysphoria in adolescents violates the Due Process Clause of the Fourteenth Amendment.

This section explains why this assertion is consistent with the existing case law.

Under the Supreme Court's decision in *Washington v. Glucksberg*, "the Due Process Clause specially protects those fundamental rights and liberties which are, objectively, 'deeply rooted in this Nation's history and tradition' and 'implicit in the concept of ordered liberty' such that 'neither liberty nor justice would exist if they were sacrificed.'"[319] The second element of the *Glucksberg* test is easily met in this situation; laws that prevent people from obtaining standard-of-care treatment from licensed physicians violate the most basic notions of self-protection and bodily autonomy (especially when it is a treatment for a life-threatening condition.)

---

[317] *Dobbs*, 597 U.S. at 222, 256.
[318] Romer v. Evans, 517 U.S. 620, 632 (1996). *See infra* p. [ ].
[319] *Glucksberg*, 521 U.S. at 720-21 (quoting Snyder v. Massachusetts, 291 U.S. 97, 105 (1934) and Palko v. Connecticut, 302 U.S. 319, 325, 326 (1937). *See also Dobbs*, 142 S. Ct. at 2246 (embracing this standard).

The two courts that have upheld state PB/CSH bans have instead decided that these laws violate no rights that are "deeply rooted in this Nation's history and tradition." The Eleventh Circuit observed, "[T]he use of these medications in general—let alone for children—almost certainly is not 'deeply rooted' in our nation's history and tradition... [T]he earliest-recorded uses of puberty blocking medication and cross-sex hormone treatment for purposes of treating the discordance between an individual's biological sex and sense of gender identity did not occur until well into the twentieth century."[320] This inappropriately narrow approach to framing the asserted right would, in our quickly evolving and highly technological society, entirely immunize many laws from strict scrutiny no matter how severely they violated people's liberties. As observed by the authors of the seminal article on the appropriate level of generality in defining fundamental rights, "Describing a claimed right in very specific terms … disconnects it from previously established rights."[321] A judicial approach requiring such specificity, they argue, would "all but abidcat[e] the judicial responsibility to protect individual rights."[322]

The Sixth Circuit, describing the asserted right more broadly, concluded: "This country does not have a "deeply rooted" tradition of preventing governments from regulating the medical profession in general or certain treatments in particular, whether for adults or their children."[323] This assertion may be true with respect to prohibitions against the administration of never-marketed investigational drugs that FDA has not reviewed at all. But puberty blockers and sex hormones have been thoroughly investigated for other conditions, reviewed by FDA for these uses, prescribed by physicians for many decades, and are part of the standard-of-care treatment regimen

[320] *Eknes-Tucker*, 80 F.4th at 1220-21.
[321] Laurence H. Tribe & Michael C. Dorf, *Levels of Generality in the Definition of Rights*, 57 U. CHI. L. R. 1057, 1066 (1990).
[322] *Id*. at 1086.
[323] *L. W.*, 83 F.4th at

for gender dysphoria, including in minors. *Abigail Alliance v. von Eschenbach* (cited and discussed by the Sixth Circuit[324]) is thus clearly distinguishable. In that case, the D.C. Circuit held that terminally ill patients did not have a fundamental right to access innovative, entirely unapproved drugs that had never been subjected to controlled clinical trials and had never been available for use by physicians.[325] Such drugs *could not* be standard-of-care treatment.[326]

If we define the right as one to access standard-of-care treatment, the "history and tradition" is met. As shown above, the state bans on the use of puberty blockers and sex hormones for treatment of gender dysphoria apparently represent the first instances ever, outside the abortion context, of either the federal government or a state government *banning* the standard-of-care off-label use of a drug—or indeed, any standard of care treatment—based exclusively on a purported disagreement with the medical profession about the treatment's safety and efficacy for patients.

Supporters of the PB/CSH bans try to draw support from the Supreme Court's 1926 decision in *Lambert v. Yellowley*. This case, decided shortly after the 1917 ratification of the Eighteenth Amendment establishing prohibition, upheld provisions of two federal criminal statutes that limited the amount of liquor a physician could prescribe for medical purposes.[327] Two features of *Yellowley* distinguish it from the dispute over PB/CSH bans, however. First, although the medical profession once widely embraced the medicinal use of alcoholic beverages, it was no longer the standard of care by the 1920s.[328] *Yellowley* observed: "[P]hysicians differ about the

---

[324] *Id*. at 474-75.
[325] Abigail Alliance v. Eschenbach, 495 F.3d 695 (2007).
[326] Similarly distinguishable is a case in which the court denied a substantive due process right to obtain a quack remedy never subjected to successful controlled clinical testing and never accepted by the medical profession. *Rutherford v. United State*s, supra note 99 (rejecting due process right to access Laetrile, an alternative cancer remedy derived from apricot pits).
[327] Lambert v. Yellowley, 272 U.S. 581 (1926). These statutes were the Volstead Act, Pub. L. 66-66, 41 Stat. 305 (1919) and the Willis-Campbell Act, 67 Pub. L. 96, 42 Stat. 222 (1921).
[328] In 1917, the American Medical Association passed a resolution stating that alcohol's "use in therapeutics … has no scientific value." American Medical Association and Prohibition, 176 BOSTON MEDICAL AND SURGICAL JOURNAL 884

value of malt, vinous, and spiritous liquors for medicinal purposes, but … the preponderating opinion is against their use for such purpose ….”[329] Moreover, when Congress limited the volume of alcoholic beverages that doctors could prescribe, it was acting not to protect patients from dangerous or ineffective medical treatment, but rather to inhibit liquor’s diversion to beverage use. As the Supreme Court recognized, Congress was thus promoting the purpose of the Eighteenth Amendment itself—the suppression of social and moral evils stemming from the consumption of alcoholic beverages.[330]

Importantly, in the context of medical care in prison, multiple courts have already held that a total ban on the use of drugs to treat gender dysphoria violates inmates’ constitutional rights. Prisoners’ right to access medical treatment is protected, not by the Due Process Clause, but by the “cruel and unusual punishment” clause of the Eight Amendment. Writing for the majority in *Estelle v. Gamble,*[331] Justice Thurgood Marshall opined that the Eight Amendment embodies “broad and idealistic concepts of dignity, civilized standards, humanity, and decency” that “establish the government’s obligation to provide medical care for those whom it is punishing by incarceration.”[332] An incarcerated person advancing a claim of inadequate medical care must show first, a serious medical need, and second, “deliberate indifference” by the prison officials responding to the need.[333] The high burden of “deliberate indifference” reflects inmates’

(1917). For a historical review of the use of medical alcohol and its regulation, see GROSSMAN, *supra* note 25 at 228–31; Jacob M. Appel, *“Physicians Are Not Bootleggers”: The Short, Peculiar Life of the Medicinal Alcohol Movement*, 82 BULLETIN OF THE HISTORY OF MEDICINE 355 (2008).

[329] *Yellowley*, 272 U.S. at 590.

[330] *Id.* at 589-90.

[331] 429 U.S. 97 (1976).

[332] *Id*. at 102-03.

[333] *Id* at 105*;* Jennifer Levi & Kevin M. Barry, *Transgender Rights & the Eighth Amendment*, 95 S. CAL. L. REV. 109, 128–29 (2021).

diminished expectation of a right to care as compared to, for example, people involuntarily confined to mental institutions, who are protected by the Due Process Clause.[334]

Nevertheless, even under the "deliberate indifference" standard, "[n]umerous courts have concluded that categorical bans on hormone therapy, and so-called 'freeze-frame' policies that prohibit hormone therapy for those who were not receiving it prior to incarceration, violate the Eighth Amendment because such policies are deliberately indifferent to the individual medical needs of incarcerated people."[335] For instance, in *Fields v. Smith*,[336] the Seventh Circuit held that a Wisconsin ban on providing hormone therapy to inmates with gender dysphoria (then called "gender identity disorder" or "GID") violated the Eighth Amendment. In their defense, the corrections officials invoked *Gonzalez v. Carhart*, the Supreme Court case upholding a ban on "partial birth abortion."[337] They asserted that *Carhart* stood for proposition that a legislature may "constitutionally limit the discretion of physicians by outlawing a particular medical procedure."[338] The court rejected this argument.

> *Carhart* is not helpful to defendants in this case because they did not present any medical evidence that alternative treatments for GID are effective. As defendants point out, some medical uncertainty remains as to the causes of GID, but there was no evidence of uncertainty about the efficacy of hormone therapy as a treatment. Just as the legislature cannot outlaw all effective cancer treatments for prison inmates, it cannot outlaw the only effective treatment for a serious condition like GID.[339]

---

[334] Youngberg v. Romeo, 457 U.S. 307, 321-22 ("Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish."). *See* Rose Carmen Goldberg, *The Antidotes to the Double Standard: Protecting the Healthcare Rights of Mentally Ill Inmates by Blurring the Line between Estelle and Youngberg Note*, 16 YALE J. HEALTH POL'Y L. & ETHICS [i] (2016) (challenging this differential treatment of mentally ill people in state custody).
[335] Levi and Barry, *supra* note 307 at 130.
[336] 653 F.3d 550 (7th Cir. 2011).
[337] 550 U.S. 124 (2007). *Carhart* is discussed further below, *infra* p. [ ].
[338] *Id*. at 557.
[339] *Id*.

In *Keohane v. Florida Department of Corrections Secretary*, the 11th Circuit similarly struck down, on Eight Amendment grounds, the department's policy of refusing to start inmates on hormone therapy during the first two years of their sentence. The court explained, "It seems to us that responding to an inmate's acknowledged medical need with what amounts to a shoulder-shrugging refusal even to consider whether a particular course of treatment is appropriate is the very definition of 'deliberate indifference'—anti-medicine, if you will."[340] If a ban on hormone treatments for treatment of prisoners with gender dysphoria violates the Eighth Amendment, it certainly also violates the more robust due process rights of people, including adolescents, who are not in state custody.

B. Response to Likely Objections

Finally, it is important to address two likely objections to this article's assertion that people have a fundamental right to access standard-of-care off-label drug treatment. One is that this right cannot be "deeply rooted" in American history and tradition because the very notion of "off-label prescribing" is largely a creation of the authority that FDA received in 1962 to comprehensively regulate the effectiveness claims made in drug labeling. In fact, however, if we pull the lens back a bit from the specific question of "off-label prescription" of drugs, the right to access standard-of-care treatment extends back to the country's origins.

As I show in my book *Choose Your Medicine: Freedom of Therapeutic Choice in America*, efforts to limit people's access to drugs and other treatments—and disputes over those efforts—are as old as the country.[341] In that book, I show that "throughout most of American history, a broad swath of the population has believed that people have a right to choose their preferred

[340] Keohane v. Fla. Dept. Corrections Sec., 952 F.3d 1257, 1266-67 (dictum).
[341] GROSSMAN, *supra* note 25.

medical treatments without government interference."[342] In the book, I concede that the history I relate "does not necessarily demonstrate that a right to try potentially life-saving treatments—let alone treatments for less severe conditions—is so 'rooted' in American history and tradition that it is entitled to special constitutional protection in court."[343] But *none* of the contested restrictions that I examine in *Choose Your Medicine* were prohibitions on what we would now call standard-of-care medicine. To the contrary, the book's episodes concern struggles over government limitations (supported by the medical establishment) on *unorthodox* remedies or, in modern times, on drugs that FDA has not approved for any use.

There is a simple reason why one cannot find declarations from throughout the country's history that people have a fundamental right to access treatments endorsed by the medical profession: outside abortion restrictions and the PB/CSH bans, American lawmakers have virtually never *tried* to prohibit such treatments.[344] The presumption that people have a right to obtain standard-of-care medical treatments is so deeply rooted in America's history and traditions that it has almost never even been tested. Still, it is possible to find compelling evidence that the very notion of prohibiting a physician from prescribing a drug—even a potentially harmful drug—for a use recognized by the medical profession is utterly foreign to Anglo-American jurisprudence.

Most of the "great [English] common law authorities" cited by *Dobbs* to support that holding also made statements suggesting that the law should not second-guess physicians' standard-of-care prescriptions, particularly through the imposition of criminal penalties.[345] In 1644, Sir Edward Coke pronounced: "If one that is in the mystery of a physician, take a man to

---

[342] LEWIS A. GROSSMAN, CHOOSE YOUR MEDICINE: FREEDOM OF THERAPEUTIC CHOICE IN AMERICA 5 (2021).
[343] *Id.* at 7.
[344] The one possible exception to this statement is the state prohibitions on the FDA-approved use of amphetamines to treat obesity. *See supra* p. [ ].
[345] *Dobbs*, 597 at 242-45 (citing Coke, Hale, and Blackstone).

cure, and give him such physic as within three days he die thereof, without any felonious intent, and against his will, it is no homicide."[346] About a century later, Sir Matthew Hale stated: "If a physician, whether licensed or not, gives a person a potion without any intent of doing him any bodily hurt, but with intent to cure or prevent disease, and contrary to the expectation of the physician, it kills him, he is not guilty of murder or manslaughter."[347] Hale's reference to "licensed or not" reflects an apparent disagreement between him and Coke regarding whether *unlicensed* physicians should be criminally liable in such a situation; neither jurist questioned the immunity of licensed doctors.[348] On the eve of the American Revolution, Sir William Blackstone agreed with both of his predecessors that "[i]f a physician or surgeon gives his patient a potion or plaster to cure him, which, contrary to his expectation, kills him, this is neither murder nor manslaughter, but a misadventure, and he should not be punished criminally …."[349]

Before independence, American colonial governments sporadically took steps to defend their citizens from *irregular* medicine, but they never sought to interfere with the provision of care in accordance with orthodox medical professional standards. A 1649 Massachusetts statute—intended to protect the colony's inhabitants from quacks—prohibited people employed as physicians or surgeons from "exercise[ing] or put[ting] forth any act contrary to the known, *approved rules of the art* in each ... occupation ... without the advice and consent of such as are skilful [sic] in the same art ... and consent of the patient or patients."[350] The colonies of New York and New Jersey enacted medical licensing laws in 1760 and 1772, respectively. These largely

[346] EDWARD COKE, 4 INSTITUTES OF THE LAW OF ENGLAND 251 (1644).
[347] MATTHEW HALE, 1 PLEAS OF THE CROWN 429 (1736).
[348] JOHN J. ELWELL, A MEDICO-LEGAL TREATISE ON MALPRACTICE AND MEDICAL EVIDENCE 199–200 (1860).
[349] WILLIAM BLACKSTONE, 4 COMMENTARIES 197 (1769).
[350] *Quoted in* Commonwealth v. Thompson [sic], 6 Mass. (6 Tyng) 134, 140 (1809).

unenforced measures were designed to exclude, through examination, unorthodox practitioners as well as ignorant ones, while leaving the field open to qualified "regulars."[351]

After independence, although state governments did not directly regulate drugs' safety or effectiveness, they increasingly did so indirectly through licensing regimes. Organized medicine advocated for these regimes in part to suppress irregular sects with different armamentariums. These sects included Thomsonianism (a botanical approach based on lobelia and cayenne pepper) and homeopathy (a system based on extremely diluted preparations of substances that, in much greater amounts, produced symptoms like those of the disease being treated). As I observed in *Choose Your Medicine*, "These sects were so firmly identified with the particular types of drugs they administered that state licensing laws were effectively a form of drug regulation."[352] These licensing regimes, though not always effective, were extremely controversial. Indeed, state legislatures revoked almost all of them by the time of the Civil War in response to populist activism.[353]

The important point here, however, is that when licensing was in effect, it invariably privileged orthodox medicine—the type of care provided by practitioners who were members of local and state medical societies and graduates of foreign and domestic medical schools.[354] By putting the state's stamp on regular medicine, these licensing laws implicitly endorsed the types of drugs used by regular physicians. Notably, orthodox drug treatments were potent and potentially dangerous. In the early nineteenth century, regular doctors widely practiced what is now referred to as "heroic" medicine, a methodology centered on copious bleeding and the administration of

[351] GROSSMAN, *supra* note 347 at 15.
[352] *Id.* at 5.
[353] *Id.* at 24–44.
[354] *Id.* at 13, 25.

depleting drugs such as blistering plasters and mineral-based purgatives and emetics.[355] Medical dissidents condemned these drugs as dangerous "poisons."[356] The licensing laws, by limiting the medical field to regular doctors, effectively authorized their use.

Early American medical malpractice law similarly protected the use of orthodox remedies in accordance with regular standards of care. The first American treatise focused on medical malpractice observed: "The standard of ordinary skill, which is required of every physician and surgeon … is that degree and amount of knowledge and science, which the *leading authorities* have pronounced as the result of their researches and experience …."[357] An 1853 Pennsylvania Supreme Court decision articulated the standard of care as "reasonable skill and diligence, by which we mean such as thoroughly educated surgeons ordinarily employ."[358]

Under these principles, a physician was not liable if a drug he prescribed in accordance with professional standards injured a patient. Although there seem to be no reported cases that articulate this precise rule (perhaps because of an absence of relevant claims), it is implicit in the holding of a prominent case involving Samuel Thomson, the famously *unorthodox* founder of the Thomsonian school. One of Thomson's patients died after Thomson repeatedly induced violent "puking" in him with lobelia, a botanical emetic. The Supreme Judicial Court of Massachusetts—citing Lord Hale—acquitted Thomson of criminal malpractice. The court's decision hinged on the fact that the state legislature did not, at the time, restrict the practice of such "itinerant quacks" through licensing or otherwise. The court explained, "[T]here is no law which prohibits any man from prescribing for a sick person with his consent, if he honestly intends to cure him by his prescription. And it is not felony, if, through his ignorance of the quality of the medicine prescribed,

[355] *Id.* at 12–13.
[356] *Id.* at 32–33.
[357] ELWELL, *supra* note 353 at (emphasis added).
[358] McCandless v. McWha, 22 Pa. 261, 268 (1853).

or of the nature of the disease, or of both, the patient, contrary to his expectation, should die."[359] The same principle obviously applied to a licensed regular physician prescribing drugs in accordance with professional standards.

The fact that American law traditionally privileges standard-of-care medicine and protects physicians who provide it does not, in and of itself, demonstrate that *patients* have a fundamental right to access this type of care. As observed earlier, however,[360] judges have rarely had an opportunity to articulate this right precisely because of the dearth of laws prohibiting such care—a dearth itself explained by Americans' deep commitment to bodily autonomy and the right of self-preservation. Nevertheless, a few courts have recognized a right to obtain standard-of-care medical treatment in other contexts. Consider, for example, *State v. Housekeeper*, an 1889 case in which a man brought a malpractice suit against a surgeon who operated on his wife against his wishes.[361] Maryland's highest court ruled that a "husband had no power to withhold from his wife the medical assistance which her case might require."[362] It explained: "The consent of the wife, not that of the husband, was necessary…. The professional men whom she had called in and consulted, being possessed of skill and scientific knowledge, were the proper persons to determine what ought to be done."[363] A contrary result, the court declared, would be "cruel."[364]

Still, the strongest evidence of a fundamental right to obtain standard-of-care medical treatment is the lack of statutes invading this right. The only early examples I can find of American laws banning treatments routinely prescribed by regular physicians are nineteenth-century statutes

[359] Commonwealth v. Thompson [sic], 6 Mass. (6 Tyng) at 140. See also Bowman v. Woods, 1 Greene 441, 442, 444 (Iowa 1848) (in states where the licensing regime did not regard "the regular system" with "partiality or distinguishing favor," irregular practitioners did not commit malpractice if they provided care consistent with the "ordinarily diligence and skill in their respective systems of treating diseases.").
[360] *Supra* p. [ ].
[361] State v. Housekeeper, 16 A. 382 (Md. 1889).
[362] *Id.* at 384.
[363] *Id.*
[364] *Id.* (quoting Carstens v. Hanselman, 28 N.W. 159, 164 (Mich. 1886)).

forbidding all provision of alcoholic beverages, with no exception for medical purposes.[365] (At the time, orthodox doctors commonly prescribed liquor and wine to their patients, and brandy, whisky, sherry, and port appeared in the U.S. Pharmacopoiea.[366]) But these state laws were motivated not by a legislative rejection of liquor's value as a drug, but rather by concerns that "ill-behaved druggists or pretended pharmacists [would] debauch the public morals by dealing out intoxicating liquors and nostrums as beverages."[367] In any event, many state courts read a medical exception into these prohibitory statutes, holding that the measures were otherwise absurd and unjust, or even unconstitutional.[368]

In sum, an examination of the historical record reveals no instances in which a state prohibited physicians from providing a standard-of-care pharmaceutical treatment based on the government's independent assessment of the drug's safety and efficacy. The absence of such laws is powerful evidence of a right deeply rooted in the nation's history and traditions. When the U.S. Supreme Court, in *New York State Rifle & Pistol Association v. Bruen*, performed a "history and tradition" test to determine that a "public carry" firearm licensing law violated New Yorkers' Second Amendment rights, it assigned apparently dispositive importance to the fact that "[a]part from a few late-19th-century outlier jurisdictions, American governments simply have not broadly prohibited the public carry of commonly used firearms for personal defense."[369] Moreover, the

---

[365] GROSSMAN, *supra* note 347 at 229.
[366] *Id.*
[367] Commonwealth v. Fowler, 28 S.W. 786, 787 (Ky. 1894).
[368] GROSSMAN, *supra* note 347 at 229.
[369] 597 U.S. 1, 44 (2022). In *Bruen,* the court was examining the historical record to determine whether there was a tradition of firearms regulation that constituted a limit on the enumerated Second Amendment right to bear arms, rather than to determine whether a fundamental substantive due process right existed in the first place. Nevertheless, the law at issue in *Bruen* was a state law, and the Second Amendment thus applied only because it was incorporated via the Due Process Clause of the Fourteenth Amendment, the same provision at issue here. Moreover, the Supreme Court has not suggested that the history and tradition test should be applied differently in these two different contexts. For a critique of the use of the absence of legislation to demonstrate a Second Amendment right, see Jacob D. Charles, *The Dead Hand of a Silent Past:* Bruen*, Gun Rights, and the Shackles of History*, 73 DUKE L. J. 67 (2023).

absence of inconsistent statutes is not the only evidence of a "deeply rooted" American right to obtain standard-of-care treatments prescribed by one's physician; this lack of regulation must be viewed in light of a long, robust tradition of statements and actions favoring a broader right to therapeutic choice extending even to *unorthodox* therapies.[370]

A second argument likely to be advanced against this article's assertion of a substantive due process right to obtain standard-of-care treatment is that because the medical "standard of care" changes over time and can differ from state to state[371], it is too unstable and variable a concept upon which to base a constitutional right. One simple response to this objection is that American courts already determine people's rights by reference to the standard of care all the time—namely, the rights of plaintiffs to recover damages in medical malpractice cases. Furthermore, even if constitutional law raises unique concerns, there is already a type of constitutional litigation in which courts routinely determine the contours of a fundamental right by reference to evolving and variegated "community standards"—obscenity cases.

In the 1973 case *Miller v. California*, the Supreme Court defined the line between speech protected by the First Amendment and unprotected "obscenity" by asking whether "the average person, applying *contemporary community standards*, would find that the work, taken as a whole, appeals to the prurient interest."[372] The Court specifically rejected the argument that application of a national constitutional right cannot vary with local standards:

> Under a National Constitution, fundamental First Amendment limitations on the powers of the States do not vary from community to community, but this does not mean that there are, or should or can be, fixed, uniform national standards of precisely what appeals to the "prurient interest" or is "patently offensive." These are essentially questions of fact, and our Nation is simply too big and too diverse for this Court to reasonably expect that such standards could be articulated for all

[370] *See generally* GROSSMAN, *supra* note 347.
[371] Some jurisdictions apply a national or nongeographic standard of care for medical specialists. Zitter, *supra* note [ ].
[372] Miller v. California, 413 U.S. 15, 24 (1973) (emphasis added).

> 50 States in a single formulation, even assuming the prerequisite consensus exists.[373]

Although, as the Court has acknowledged, "contemporary community standards … change a great deal between communities and over time,"[374] the *Miller* standard remains the test for obscenity, and many hundreds of federal and state courts have applied it over the years to delineate the scope of parties' fundamental First Amendment rights.[375]

VIII. SCRUTINIZING THE BANS

In the wave of litigation concerning the bans on pharmaceutical treatment of adolescent gender dysphoria, different courts have subjected the bans to different levels of scrutiny. Some have applied strict scrutiny because they, like this article, have deemed the laws to violate a fundamental right.[376] Other courts have determined that the bans are unconstitutional sex-based classifications under the Equal Protection Clause, struck down the bans using the intermediate scrutiny required for such claims, and then deemed it unnecessary to apply the more stringent strict scrutiny applicable to violations of fundamental rights under the Due Process Clause.[377] Finally, some courts—most notably the Sixth and Eleventh Circuits—have held that the bans are not subject to heightened scrutiny under either the Due Process Clause or the Equal Protection Clause

---

[373] *Id*. at 30.

[374] Counterman v Colorado, 143 S. Ct. 2106, 2130 (2023) (Sotomayor, J., concurring). *See also* Sable Communications of Cal. V. FCC, 492 U.S. 115, 124 ("There is no constitutional barrier under *Miller* to prohibiting communications that are obscene in some communities under local standards even though they are not obscene in others.)

[375] A Westlaw search on March 7, 2023, of all federal and state cases for "obscenity" & "contemporary community standards" produced 1,608 results. Even if some of these are cases in which courts do not directly apply the "contemporary community standards" test, "many hundreds" certainly are such cases.

[376] *Doe v. Thornbury*, 2023 WL 4230481 (W.D. Ky. 2023), *rev'd* 83 F.4th 460 (6th Cir. 2023); *Brandt v. Rutledge*, 2023 WL 407327 (E.D. Ark. 2023), *aff'd* 47 F.4th 661 (8th Cir. 2022) (applying intermediate scrutiny); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d (M.D. Ala. 2022), *rev'd* 80 F.th 1205 (11th Cir. 2023).

[377] *Brandt v.* Rutledge, 47 F.4th 61; *L. W. v. Skrmetti*, 2023 WL 4232308 (M.D. Tenn. 2023), *rev'd* 83 F.4th 460 (6th Cir. 2023); *Koe v. Noggle*, 2023 WL 5339281 (N.D. Ga. 2023); *K. C. v. Individual Members Med. Licensing Bd*., 2023 WL 4054086 (S.D. Ind. 2023); *Poe v. Labrador,* 2023 WL 895306 (D. Idaho 2023). Some of these cases also found the bans to be unconstitutional classifications based on *transgender status*.

and have thus applied the rational basis test.[378] This section will show how the bans almost certainly cannot survive any form of heightened scrutiny and may even be vulnerable under a rational basis analysis.

A. Heightened Scrutiny

The strict scrutiny standard requires a court to strike down a law as unconstitutional if it is not "narrowly drawn" (or "the least restrictive means") to advance a "compelling government interest."[379] Predictably, the few U.S. district courts that have performed the exercise of applying strict scrutiny to the state PB/CSH bans have found these laws to be unconstitutional. None of them has questioned whether the state has a compelling interest in protecting the health and safety of children.[380] But they have easily concluded that a total ban on the use of puberty blockers and hormones for treatment of gender dysphoria in minors is not narrowly tailored to advance this interest.[381]

In supporting their conclusion that the bans are more restrictive than necessary, these courts have cogently emphasized that none of the European nations that have restricted PB/CSH treatment for gender dysphoria in adolescents have entirely *prohibited* the use of these drugs for

[378] *Skrmetti*, 83 F.4th 460; *Eknes-Tucker*, 80 F.th 1205; Doe v. Lapado, 2023 WL 3833848 (N. D. Fla. 2023).
[379] *E.g.*, Carey v. Population Servs. Int'l, 431 U.S. 678, 686 (1977) ("regulations imposing a burden on [a fundamental right] may be justified only by compelling state interests, and must be narrowly drawn to express only those interests."); Roman Catholic Diocese v. Cuomo, 141 S. Ct. 63, 69 (2020) (Gorsuch, J., concurring) (government officials' actions subject to strict scrutiny are unconstitutional "unless they are pursuing a compelling interest and using the least restrictive means available.")
[380] *Brandt,* 2023 WL 4073727 at *36 ("The state has a compelling in 'safeguarding the physical and psychological well-being of a minor.'" (quoting Globe Newspaper Co. v. Superior Ct. for Norfolk Cnty., 457 U.S. 596, 607 (1982))). *Eknes-Tucker*, 603 F. Supp. 3d at 1145 ("The state's interest in safeguarding the physical and psychological well-being of a minor is a compelling one."); *Thornbury*, 2023 WL 4230481 at *6 (assuming sub silentio that state has a compelling interest).
[381] *Brandt*, 2023 WL 4073727 at *36; *Eknes-Tucker,* 603 F. Supp. 3d at 1146. *Cf. Thornbury*, 2023 WL 4230481 at *4, *6 (the ban is not designed to serve the state's interest in protecting children because it allows the same treatments for cisgender minors, and the Commonwealth does not "even attempt to show that [it] employs the least restrictive means necessary to achieve its purpose" (citing *Brandt* and *Eknes-Tucker*, *supra*)).

this purpose.[382] As one of these courts pointed out: "The [Alabama] Act, unlike the cited European regulations, does not even permit minors to take transitioning medications for research purposes, even though Defendants adamantly maintain that more research is needed."[383]

In short, because these state laws prohibit the use of puberty blockers and sex hormones for treatment of gender dysphoria in adolescents under any circumstances, they are extremely unlikely to survive strict scrutiny.[384] Indeed, none of the PB/CSH bans has yet survived even intermediate scrutiny, which requires a court to strike down a law unless it serves "important government objectives" and is "substantially related to the achievement of those objectives."[385] The states obviously have an "important" interest in protecting children.[386] Nonetheless, the judges applying intermediate scrutiny have found that the bans are not "substantially related" to that interest, a test the Supreme Court has said requires a "close means-end fit."[387]

[382] *Brandt*, 2023 WL 4073727 at *36; *Eknes-Tucker,* 603 F. Supp. 3d at 1146. For a discussion of these other country's restrictions, see *supra* p. [ ].
[383] *Eknes-Tucker*, 603 F. Supp. 3d at 1146.
[384] Applying strict scrutiny to laws regulating standard-of-care pharmaceutical treatment of gender dysphoria in minors—or laws regulating any other standard-of-care treatment—would not necessarily result in courts overturning narrowly tailored restrictions short of complete bans. As one scholar who performed an empirical analysis of the application of strict scrutiny concluded: "Courts routinely uphold laws when applying strict scrutiny, and they do so in every major area of law in which they use the test. Overall, 30 percent of all applications of strict scrutiny … result in the challenged law being upheld." Adam Winkler, *Fatal in Theory and Strict in Fact: An Empirical Analysis of Strict Scrutiny in the Federal Courts*, 59 VANDERBILT LAW REVIEW 793, 795–96 (2006).
[385] Craig v. Boren, 429 U.S. 190 (1976).
[386] *Noggle*, 2023 WL 5339281 at *18 ("[T]he state's asserted interest in protecting children through regulation of the medical profession is, of course, and important one."); *K. C.*, 2023 WL 4054086 at *1, *9 (concluding that the state's "proffered interest in protecting the wellbeing of minors and regulating the medical profession" are sufficient to survive intermediate scrutiny.) One court confusingly held that the state did *not* demonstrate an important interest; it reached this conclusion by narrowly (and tautologically) identifying that interest as an "interest in banning these treatments.") *Skrmetti*, 2023 WL 4232308 at *29.
[387] Sessions v. Morales-Santana, 582 U.S. 47, 68 (2017).

In denying that such a fit exists, these courts, like the courts that have applied strict scrutiny, have emphasized that the states "opted to ban—rather than otherwise regulate—gender transition procedures for minors."[388] As a U.S. district court observed in striking down the Florida ban:

> [T]he treatments are available in appropriate circumstances in all the countries cited by the defendants, including Finland, Sweden, Norway, Great Britain, France, Australia, and New Zealand. Some or all of these insist on appropriate preconditions and allow care only in approved facilities—just as the Endocrine Society and WPATH standards insist on appropriate preconditions, and just as care in the United States is ordinarily provided through capable facilities. Had Florida truly joined the international consensus—making these treatments available in appropriate circumstances or in approved facilities—these plaintiffs would qualify, and the instant motions would not be necessary.[389]

Courts applying intermediate scrutiny have also found a lack of a substantial relationship between the PB/CSH bans and the states' goal of protecting children's health because the scientific evidence does not support such a relationship. As one court stressed, the available evidence clearly demonstrates that the pharmaceutical treatments for gender dysphoria "are safe, effective, and medically necessary for some adolescents."[390] The U.S. district court in Florida found, in light of the scientific record, that the state's ban would not survive even *rational basis* scrutiny."[391]

B. Precedents from the Abortion Context

Courts have subjected government bans on standard-of-care abortion services to a different form of heightened scrutiny, namely, the "undue burden" test of *Planned Parenthood v. Casey*.[392]

---

[388] *K. C.*, 2023 WL 4054086 at *10. *See also Labrador*, 2023 WL 8935065 at *14 (the ban fails heightened scrutiny "because the means (a total prohibition on gender-affirming medical care) is not closely fitted with the ends (protecting children."); *Noggle*, 2023 WL 5339281 at *22 (stressing that the state's scheme "prohibits clinicians and parents form determining the correct course of treatment on an individualized basis").
[389] *Doe v. Ladapo*, 2023 WL 3833848 at *14.
[390] *Labrador*, 2023 WL 8935065 at *4. *See also Noggle*, 2023 WL 5339281 at *19 ("the preliminary record evidence of the medical risks and benefits of hormone therapy shows that a broad ban on the treatment is not substantially likely to serve the state's interest in protecting children").
[391] *Lapado*, 2023 WL 3833848 at *11 ("There is no rational basis for a state to categorically ban these treatments.")
[392] 505 U.S. 833 (1992).

The mixed results of these cases offer lessons to litigants challenging the state PB/CSH bans. Overall, they suggest that these laws should not survive any form of heightened scrutiny.

In 1992, the U.S. Supreme Court, in *Planned Parenthood v. Casey*, modified the approach to reviewing abortion rights established nineteen years earlier by *Roe v. Wade*.[393] (*Dobbs* overturned both of these decisions in 2022.[394]) *Casey* replaced the strict scrutiny standard of *Roe*[395] with a more forgiving—but still heightened—standard asking whether the challenged regulation imposes an "undue burden" on a woman's ability to obtain an abortion.[396] Subsequently, courts confronted some situations in which they had to decide whether prohibitions against standard-of-care abortion services violated this test. These cases provide insight into whether any law prohibiting standard-of-care treatment could ever survive heightened scrutiny.[397]

In *Gonzalez v. Carhart*,[398] decided in 2007, the Supreme Court upheld the constitutionality of Congress's ban on "partial birth abortion" (intact dilation and evacuation), a method for ending a second-trimester pregnancy. The plaintiffs contended that the Partial Birth Abortion Ban imposed an unconstitutional burden on the abortion right because it prohibited the procedure even when it was "necessary, in appropriate medical judgment, for the preservation of the …. health of the mother."[399] The Court rejected this argument. While acknowledging that some abortion doctors believed intact D&E was sometimes the safest method of abortion, the Court stressed that other

[393] Roe v. Wade, 410 U.S. 113 (1973); *Casey*, 505 U.S. 833.
[394] *Dobbs*, 597 U.S. at 231.
[395] *Roe*, 410 U.S. at 155.
[396] *Casey*, 505 U.S. at 874.
[397] Jonathan H. Adler, *Super Deference and Heightened Scrutiny*, 74 FLA. L. REV. 267, 298 n. 194 (2022) (describing the "undue burden" test as a *sui generis* form of heightened scrutiny, but a form of heightened scrutiny nonetheless."); David L. Faigman, Ashutosh A. Bhagwat & Kathryn M. Davis, *Amicus Brief of Constitutional Law Professors David L. Faigman and Ashutosh A. Bhagwat, et al. in the Case of Gonzales v. Carhart*, 34 HASTINGS CONST. L.Q. 69, 72–73 (2006) ("[T]he level of scrutiny application to abortion regulations, including that inherent in the 'undue burden' test ... is heightened scrutiny.").
[398] 550 U.S. 124 (2007).
[399] *Carhart*, 550 U.S. at 161 (quoting *Ayotte v. Planned Parenthood*, 546 U.S. 320, 327-28 (2005).

physicians disagreed and thus that "[t]here is documented medical disagreement whether the Act's prohibition would ever impose significant health risks on women."[400] The opinion observed, "The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical uncertainty."[401]

Though *Carhart*, on its face, might seem to weigh against an argument that state PB/CSH bans should fall under heightened scrutiny, there are some important distinctions. First, at least the way the Court presented the facts, a "substantial part" of the medical community thought that the intact D&E procedure was never necessary to preserve the mother's health.[402] Implicitly, the Court seemed to be conceding that a total ban on a medical procedure *would* be unconstitutional if almost the entire medical community deemed it to sometimes be necessary. And one could argue that there is no significant disagreement within the medical community regarding whether puberty blockers and sex hormones are sometimes necessary when treating minors for gender dysphoria.

Second, in upholding the ban on intact D&E, *Carhart* emphasized that there was "a commonly used and generally accepted [alternative] method."[403] No such "generally accepted" alternative treatment exists for adolescent gender dysphoria. Finally, and importantly, the *Carhart* court was not applying the strict scrutiny standard of *Roe*, but rather the less stringent "undue burden" test of *Casey*, an opinion that "confirms the State's interest in promoting respect for human life at all states in the pregnancy."[404] This article argues that the PB/CSH bans violate a fundamental right and are thus subject to *strict scrutiny* review.

---

[400] *Id*. at 162.
[401] *Id.* at 163.
[402] *But see* Neil S. Siegel, *The Virtue of Judicial Statesmanship*, 86 TEX. L. REV. 959, 1024 (2007) ("[A]s every lower court had found, the weight of credible evidence heavily favors the position of the American College of Obstetricians and Gynecologists that the banned procedure is safest for women in certain circumstances.").
[403] *Id*. at 163, 164, 167.
[404] *Carhart*, 550 U.S. at 163.

Courts also applied *Casey*'s "undue burden" test to the state bans on off-label use of the abortion drug mifepristone discussed earlier in this article. Notably, a slight majority of these courts concluded that these laws violated the Due Process clause (or were likely to do so).[405] As explained earlier, both the American College of Obstetricians and Gynecologists and the AMA endorsed an off-label protocol for medication abortion. In striking down the Arkansas law, a U.S. district court emphasized:

> Defendants offer no justification for why, in legislation, the State of Arkansas would reject the evidence-based protocols for medication abortion in the light of this evidence regarding the ACOG and the AMA. Further, in determining whether regulations actually further women's health, the Supreme Court has repeatedly looked at the generally accepted standards for medicine set by the nation's major health organizations. *See, e.g*., *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (considering American College of Obstetricians and Gynecologists and other standards).[406]

In these cases, multiple courts thus decided that state prohibitions on off-label medication abortion protocols that constituted the standard of care violated *Casey*'s "undue burden test." The use of puberty blockers and sex hormones for treatment of gender dysphoria in adolescents similarly represents the standard of care embraced by major medical organizations. And because in the gender-affirming care context, the states have no countervailing interest in protecting potential life, courts should subject the PB/CSH bans to less forgiving strict scrutiny and strike them down as unconstitutional.

---

[405] *Okla. Coal. for Reprod. Just. v. Cline*, 292 P.3d 27; *Cline v. Okla. Coal. for Reprod. Just.*, 313 P.3d 253; *Planned Parenthood Arkansas*, 2016 WL 6211310*; Planned Parenthood Arizona, Inc. v. Humble*, 753 F.3d 905. *Contra* Planned Parenthood S.W. Ohio Region v. DeWine, 696 F.3 490, 506-07 (6th Cir. 2012). *Cf.* MKB Management Corp. v. Burdick, 855 N.W.2d 31 (N.D.2014) (three-justice majority finds the prohibition on off-label prescribing of mifepristone unconstitutional, but North Dakota requires concurrence of four justices to declare statute unconstitutional); Planned Parenthood of Greater Texas v. Abbott, 748 F.3d 583, 604 (5th Cir. 2014) (rejecting facial challenge, because as-applied challenge is "proper means of challenging the lack of [a health and life of the mother] exception to the regulations at issue ….").

[406] *Planned Parenthood Ark.*, 2016 WL 6211310 at *23.

C. Arbitrariness

One court that struck down a PB/CSH ban using intermediate scrutiny appropriately called the law "arbitrary" in explaining why it was not substantially related to the state's interest in protecting the health of minors.[407] The utterly arbitrary nature of the state bans is perhaps their greatest constitutional weakness, regardless of what level of scrutiny is applied.

As shown earlier,[408] the states that have enacted PB/CSH bans maintain a commitment to noninterference in physicians' off-label prescribing practices in virtually every other situation that conforms to the standard of care.[409] This is no less true when it comes to pediatrics—an area with a particularly high rate of off-label prescribing.[410] Moreover, as also shown earlier,[411] some of these states explicitly *permit* some off-label prescribing that does *not* conform to the standard of care, thus putting a lie to their assertions that they are trying to protect children from "experimental" treatments. Finally, there is the bans' most arbitrary feature of all: the very same statutes that prohibit the use of puberty blockers and sex hormones for treatment of gender dysphoria in minors explicitly permit off-label prescribing of these same drugs for other conditions in minors.[412]

The states argue that these bans are nonetheless *not* arbitrary because they prohibit a type of care that is supported by particularly low-quality evidence. Lawyers defending the Arkansas ban, for example, stressed that according to the Endocrine Society itself, the evidence supporting the use of puberty blockers and cross-sex hormones in minors is "'*very* low quality' or, at best,

[407] *Skrmetti*, 2023 WL 4232308 at *30
[408] *Infra* p. [ ].
[409] Even more capriciously, a few of these states explicitly authorize off-label uses of some other drugs that violate the standard of care, with no limitations on pediatric use. *Supra* note [ ].
[410] *Supra* p. [ ].
[411] *Supra* p. [ ].
[412] *Supra* p. [ ].

merely 'low quality.'"[413] But this assertion ignores the fact that only a small minority of medical treatments—perhaps as few as ten percent—are supported by high quality evidence.[414] With respect to off-label prescriptions in particular, one study found that only twenty-one percent were backed by strong scientific evidence.[415] Why, then, are state legislatures prohibiting—and even criminalizing—this *one* off-label use while leaving virtually all other off-label prescribing untouched?

Such arbitrariness can sometimes lead courts to declare state laws unconstitutional even under rational basis review. [416] For example, the Supreme Court has held that a zoning requirement not subject to heightened review can be declared unconstitutional under the Due Process Clause if it is "clearly arbitrary and unreasonable, having no substantial relation to the public health, safety, morals, or general welfare."[417] In *Moore v. East Cleveland*, the U.S. Supreme Court applied this standard to strike down an ordinance arbitrarily limiting who counts as a family member for legal occupancy of a single family home.[418] In *City of Cleburne v. Cleburne Living Center*, an equal protection case, the Supreme Court struck down, for lack of a legitimate rational basis, an

[413] Defendants' Combined Brief, supra note [ ], at 86 (quoting Endocrine Society Guidelines).
[414] Mark H Ebell et al., *How Good Is the Evidence to Support Primary Care Practice?*, 22 EVID BASED MED 88 (2017) (only 18% of primary care treatments); Jeremy Howick et al., *The Quality of Evidence for Medical Interventions Does Not Improve or Worsen: A Metaepidemiological Study of Cochrane Reviews*, 126 JOURNAL OF CLINICAL EPIDEMIOLOGY 154 (2020) (9.9% of Cochrane reviews of treatments).
[415] Tewodros Eguale et al., *Drug, Patient, and Physician Characteristics Associated With Off-Label Prescribing in Primary Care*, 172 ARCHIVES OF INTERNAL MEDICINE 781 (2012) (data from primary care physicians).
[416] Carolene Products Co. v. U.S., 323 U.S. 18, 31-32 (1944) (a law subject to rational basis review is unconstitutional if it is an "arbitrary fiat."). For an example of a case in which the Supreme Court struck down an arbitrary state action as unconstitutional under rational basis review, see *Allegheny Pittsburgh Coal Co. v. County Com'n*, 488 U.S. 336 (1989).
[417] Euclid v. Ambler Realty Co. 272 us 365, 395 (1926).
[418] Moore v. East Cleveland, 431 U.S. 494 (1977). For another, more recent example of a case in which the Supreme Court struck down an arbitrary state action as unconstitutional under rational basis review, see *Allegheny Pittsburgh Coal Co. v. County Comm'n*, 488 U.S. 336 (1989).

ordinance that "arbitrarily" required group-care facilities for the mentally disabled to obtain land use permits, but not other facilities with multiple occupants.[419]

Even under the rational basis test, the state must be pursuing a "legitimate" interest by enacting the law under review. In some decisions striking down arbitrary laws under rational basis review, courts have concluded that the state's purported motive for enacting the law was a mere pretext for an illegitimate purpose. The Supreme Court used this reasoning in *Romer v. Evans*, a case of particular relevance to this article. *Romer* considered an equal protection challenge to a Colorado constitutional provision that prohibited any state action designed to protect homosexuals from discrimination.[420] The Court presumed that homosexuality was not a "suspect classification" subject to strict scrutiny,[421] but it nonetheless struck down the amendment under rational basis review. The Court explained that the amendment's "sheer breadth is so discontinuous with the reasons offered for it that the amendment seems inexplicable by anything but animus toward the class it affects; *it lacks a rational relationship to legitimate state interests*."[422]

Some of the decisions that have struck down PB/CSH bans have used similar reasoning. For example, a U.S. district court in Florida dismissed that state's justifications of its ban as "pretextual," maintained that "the state's disapproval of transgender status ... was a substantial motivating factor in enactment of [the ban]," and held that "dissuading a person from conforming

---

[419] 473 U.S. 432, 446 (1985). *See also* United States Dep't of Agric. v. Moreno, 413 U.S. 528 (striking down, for lack of a legitimate rational basis, a statute denying food stamps to members of a household with unrelated members).
[420] Romer v. Evans, 517 U.S. 618 (1996).
[421] *Id*. at 1632.
[422] *Id. See generally* William Araiza, *Animus and Its Discontents*, 71 FLORIDA LAW REVIEW 155 (2020). When discussing the PB/CSH bans' arbitrariness, it is difficult to divorce the substantive due process analysis from the equal protection arguments also advanced in the ongoing litigation. After all, by prohibiting essential medical care to a particular disfavored group (transgendered individuals), the bans raise both liberty and equality concerns. As Justice Anthony Kennedy observed in his opinion protecting the right of same-sex marriage: "The Due Process Clause and the Equal Protection Clause are connected in a profound way, though they set forth independent principles. Rights implicit in liberty and rights secured by equal protection may rest on different precepts and are not always co-extensive, yet in some instances each may be instructive as to the meaning and reach of the other." Obergefell v. Hodges, 576 US. 644, 672 (2014).

to the person's gender identity rather than to the person's natal sex is not a legitimate state interest."[423] The court concluded: "[T]here is no rational basis, let alone a basis that would survive heightened scrutiny, for prohibiting these treatments in appropriate circumstances."[424]

Thus, the arbitrariness of the state PB/CSH bans arguably makes them unconstitutional even under highly deferential rational basis review. As this article has shown, however, the bans should be subject to strict scrutiny because they violate the fundamental rights of adolescent patients and their parents. And if an arbitrary law cannot survive rational basis scrutiny, it stands to reason that it cannot survive strict scrutiny.

Indeed, the Supreme Court has held that a law that infringes on fundamental rights is unconstitutional if it attacks a problem only in one narrow situation while ignoring other manifestations of the same problem. For example, in *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, the Court observed: "All laws are selective to some extent, but categories of selection are of paramount concern when a law has the incidental effect of burdening religious practice."[425] The Court explained: "It is established in our jurisprudence that 'a law cannot be regarded as protecting an interest of the highest order ... when it leaves appreciable damage to that supposedly vital interest unprohibited.'"[426] Or as Justice Alito similarly observed with respect to a state policy limiting large religious services during the COVID-19 pandemic: "Having allowed

[423] *Ladabo*, 2023 WL 3833848 at *11. *See also Labrador*, 2023 WL 8935065 at *14 ("[T]he Court finds that the asserted objective is pretextual, given that [the law] allows the same treatments for cisgender minors that are deemed unsafe and thus banned for transgender minors.")
[424] *Id.*
[425] 508 U.S. 520, 542 (1993).
[426] *Church of Lukumi Babalu Aye*, 508 U.S. 520, 547 (1993) (quoting *Florida Star v. B. J. F.*, 491 U.S. 524, 541-42 (1989) (Scalia, J., concurring)).

thousands to gather in casinos, the State cannot claim to have a compelling interest in limiting religious gatherings to 50 people ....”[427]

How then, can states that allow puberty blockers and sex hormones to be used off-label for any other condition in patients of any age have a compelling interest in prohibiting their use only for treatment of gender dysphoria in minors?

CONCLUSION

Although a majority of the current roster of U.S. Supreme Court justices is unlikely to embrace the arguments set forth in this article, I offer them with the goal of nudging the court back toward a more capacious view of fundamental rights that eventually embraces a right so basic as the right to obtain standard-of-care treatments prescribed by one’s physician. Moreover, the state PB/CSH bans are also subject to *state* constitutional limitations, and state supreme courts need not embrace the U.S. Supreme Court’s currently parsimonious approach to fundamental rights. In any event, throughout American history, the constitutional right of access to medical treatments has been forged much more frequently in legislatures, agencies, popular publications, and street demonstrations than in courthouses.[428] Perhaps this article will assist advocates for transgender medical rights—and medical rights more broadly—in these other forums.

[427] Calvary Chapel Dayton Valley v. Sisolak, 140 S. Ct. 2603, 2608 (2020) (Alito, J., Dissenting). *See also Church of Lukumi*, 508 U.S. at 547 (“It is established in our jurisprudence that a law cannot be regarded as protecting an interest of the highest order … when it leaves appreciable damage to that supposedly vital interest unprohibited.’”)
[428] *See generally* GROSSMAN, *supra* note 347.