# FALSE EQUIVALENCY: SHOTS ARE SPEECH AND SPEECH IS CONDUCT?

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## ABSTRACT

This Response addresses Professor Skinner-Thompson's Article, Gender Therapy False Equivalency, which distinguishes between bans on gender-affirming medical treatment for minors and bans on conversion therapy. While Skinner-Thompson persuasively argues that the laws differ on policy grounds, I disagree that they differ in relevant ways as to scientific evidence or constitutionally protected liberty interests. Instead, the key distinction is that Tennessee's ban on gender-affirming care does not implicate a constitutional right, whereas Colorado's Minor Conversion Therapy Law (MCTL) restricts speech qua speech, directly implicating the First Amendment. Accordingly, the two laws cannot be treated as equivalent in constitutional analysis. Courts must scrutinize the MCTL under heightened First Amendment review, regardless of its policy merits.†

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## INTRODUCTION

This coming term, the Supreme Court will decide *Chiles v. Salazar*,[1] in which a Christian therapist challenges Colorado's ban on so-called conversion therapy as violating the First Amendment. *Chiles* is highly anticipated, in part due to the political salience of the case and in part due to the need for clarity in the realm of professional speech. In another recent case, *United States v. Skrmetti*,[2] the Supreme Court upheld Tennessee's ban on gender-affirming medical treatments for minors.

*. Thanks to my colleagues at Pacific Legal Foundation for their helpful comments and revisions.

† This Article was written before the Supreme Court issued its opinion in *Chiles v. Salazar* in 2026. No. 24-539, slip op. (U.S. March 31, 2026).

1. 116 F.4th 1178 (10th Cir. 2024).

2. 605 U.S. 495 (2025).

Some argue that the Court must, or should, extend this precedent to uphold the ban on conversion therapy for minors as well. In this Article, I argue that because *Skrmetti* was not a First Amendment case, the Court will not be bound by it in *Chiles*.

In his Article *Gender Therapy False Equivalency*, Professor Skinner-Thompson correctly states that conversion therapy[3] and gender-affirming medical treatment are not equivalent.[4] He argues that they are not equivalent on two main dimensions: scientific backing and relationship to liberty.[5]

Professor Skinner-Thompson makes compelling policy arguments about the distinction between the two therapies;[6] those arguments are not within the scope of this Response. To the extent *Gender Therapy False Equivalency* is meant to assist "lawmaking" and guide legislators about the subjective experience of each therapy, this Response cannot and does not take issue with that guidance. However, to the extent the Article is meant to guide courts in "constitutional evaluation,"[7] I will argue that it (1) misplaces reliance on policy statements to determine scientific truth, (2) improperly defines the relevant liberty interest, and (3) misses the most relevant factor differentiating the two laws: the presence of a protected constitutional right.

In this Response, I argue that the two policies have similar levels of scientific support and the same relationship to constitutionally protected liberty interests. While the two policies are thus similar on scientific and liberty-depriving dimensions, they have one legally relevant and important distinction: One policy restricts a protected constitutional right, while the other does not.

## I. GENDER THERAPY FALSE EQUIVALENCY

In a country divided on LGBT issues, some states wish to restrict therapeutic attempts to change, discourage, or suppress gay or transgender identity (conversion therapy) in minors.[8] Other states wish to restrict the practices of administering puberty-blocking medications, administering cross-sex hormones, and performing either mastectomy or

3. Scott Skinner-Thompson, *Gender Therapy False Equivalency*, 103 DENV. L. REV. (forthcoming 2026) (manuscript at 2) (on file with authors). As Professor Skinner-Thompson notes, neither proponents nor detractors of "conversion therapy"—formally named Sexual Orientation Change Efforts (SOCE) or Gender Identity Change Efforts (GICE)—approve of the term. Nonetheless, it is the most frequently used and most identifiable name for the practices. Because it is used in Professor Skinner-Thompson's article, I will also use it here.

4. *Id.* (manuscript at 3).

5. *Id.* (manuscript at 1, 3).

6. *Id.* (manuscript at 10).

7. *Id.* (manuscript at 1).

8. *See* Amy Harmon, *More Than 20 States Have Banned Conversion Therapy for L.G.B.T.Q. Minors*, N.Y TIMES (Oct. 7, 2025), https://www.nytimes.com/2025/10/07/us/politics/conversion-therapy-state-bans.html.

genital surgery (collectively "gender-affirming medical treatment") on minors for the purpose of complying with their transgender identity.[9]

Earlier this year, in *United States v. Skrmetti*, the Supreme Court addressed the latter issue. It found that a Tennessee law banning gender-affirming medical treatment for minors did not discriminate based on sex or transgender status.[10] Instead, it regulated the approved uses for a set of drugs and procedures.[11] Thus, the ban neither discriminated against any suspect class under the Equal Protection Clause nor burdened any protected constitutional right.[12]

Evaluating the ban under rational basis review, the Court found it was rationally related to a state interest in protecting minors' health and wellbeing.[13] Specifically, Tennessee stated that gender-affirming treatments can "lead to the minor becoming irreversibly sterile, having increased risk of disease and illness, or suffering from adverse and sometimes fatal psychological consequences," sometimes stemming from regret for procedures consented to as a minor.[14] The Court noted that there is no scientific consensus on whether the benefits of gender-affirming medical treatments outweigh these costs.[15] Thus, the Tennessee ban had a rational relationship to its interest in children's health.

In an upcoming case, *Chiles v. Salazar*, the Supreme Court will have the opportunity to review another state restriction: Colorado's Minor Conversion Therapy Law (MCTL), a ban on conversion therapy. The Tenth Circuit upheld the ban in a divided opinion, finding that the ban—on talk therapy—regulated "professional conduct that 'incidentally involves speech.'"[16] In the First Amendment context, speech by professionals is afforded no less protection than speech by any other group.[17] However, states may regulate professional conduct in a way that incidentally affects speech. The Tenth Circuit found that the MCTL is in this category. It relied on cases upholding informed consent laws that require doctors to inform patients of the risks of abortion.[18] However, those laws did regulate speech (the warning about the effects of the abortion) that

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9. *See* Lindsey Dawson & Jennifer Kates, *Policy Tracker: Youth Access to Gender Affirming Care and State Policy Restrictions*, KFF (Aug. 12, 2025), https://www.kff.org/lgbtq/gender-affirming-care-policy-tracker/; *"They're Ruining People's Lives*,*"* HUM. RTS. WATCH (June 3, 2025), https://www.hrw.org/node/391427/printable/print.

10. United States v. Skrmetti, 605 U.S. 495, 496 (2025).

11. *Id.* For example, a child can be prescribed puberty blockers for precocious puberty, regardless of his or her transgender status. But that same child could be denied puberty blockers to treat gender dysphoria. Thus, the ban restricts the usage of the drugs based on condition, not based on the identity of the child.

12. *Id.*

13. *Id.* at 522.

14. *Id.*

15. *Id.* at 523–24.

16. Chiles v. Salazar, 116 F.4th 1178, 1204 (10th Cir. 2024).

17. *See* Nat'l Inst. of Fam. and Life Advocs. v. Becerra, 585 U.S. 755, 756 (2018).

18. *Id.* at 769–70.

was truly incidental to conduct (the actual abortion).[19] No person would go to a doctor just to hear an informed consent warning. Rather, the primary purpose of the visit is the conduct: the medical procedure of abortion.

The Tenth Circuit erred in its First Amendment analysis in *Chiles* because it found that speech is incidental to conduct in talk therapy, comparing it to a medical procedure like surgery. But Colorado's ban restricts speech *qua* speech, not speech incidental to medical conduct.

In doing so, it ignored the Supreme Court's warning in *National Institute of Family and Life Advocates v. Becerra*[20] that regulations on professional speech should be valid whether the speaker was a professional or not (e.g., anyone advertising a service must include certain truthful information, like price per hour).[21] If the MCTL was applied to non-professionals, it could bar anyone from expressing a non-affirming opinion to a minor and would thus be patently unconstitutional. It is well established that there is no lower tier of First Amendment scrutiny for professional speech—thus, the MCTL also implicates providers' First Amendment rights.[22]

Therefore, the Supreme Court is likely to reverse at least the First Amendment holdings, if not the outcome, of the Tenth Circuit's decision.[23]

### *A. Science*

The data supporting gender-affirming medical treatments for minors is weak.[24] These treatments are the subject of major controversy, with some claiming withholding treatments from transgender youth is unethical and may cause mental harm or even suicide, and others decrying the treatments as experimental medicine performed on those too young to understand the long-term consequences.[25]

The *Cass Review*, commissioned by the United Kingdom's National Health Service and published in 2024, was the "largest review ever undertaken in the field of transgender health care."[26] The review examined

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19. *Id.*
20. 585 U.S. 755 (2018).
21. *Id.* at 768.
22. *Chiles*, 116 F.4th at 1202.
23. *See id.* at 1237 (Hartz, J., dissenting) (noting that, even under strict scrutiny, courts could uphold regulations on professional speech).
24. *See* Kathleen McDeavitt, J. Cohn, & Chan Kulatunga-Moruzi, *Pediatric Gender Affirming Care is Not Evidence-Based*, 17 CURRENT SEXUAL HEALTH REPS. (May 10, 2025), https://link.springer.com/article/10.1007/s11930-025-00404-w.
25. *Id.*
26. *Chiles*, 116 F.4th at 1240 (Hartz, J., dissenting) (citing THE CASS REVIEW, INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE: FINAL REPORT 13 (2024) [hereinafter THE CASS REVIEW],

the evidence base and outcomes related to gender identity services for minors in the United Kingdom, focusing on the use of puberty blockers, cross-sex hormones, and surgical interventions. It "says that youth transgender medicine is 'an area of remarkably weak evidence,' and that 'we have no good evidence on the long-term outcomes of interventions to manage gender-related distress.'"[27] Similarly, "the evidence does not adequately support the claim that gender-affirming treatment reduces suicide risk."[28]

The results of the report led Britain's healthcare authority, the National Health Service, to restrict gender-affirming medical treatments.[29] Finland, Sweden, Denmark, and Norway followed suit.[30]

Similarly, there is not high-quality evidence to support the efficacy of conversion therapy—here, I agree with Professor Skinner-Thompson.[31] As a matter of policy, Professor Skinner-Thompson also convincingly argues that sexual orientation and gender identity are part of human diversity, and thus, there is no moral or health imperative to change them.[32]

To be sure, there is also a lack of high-quality evidence proving the dangers of talk-only conversion therapy. The American Psychological Association (APA)[33] itself stated "there is a dearth of scientifically sound research" on the harms of conversion therapy, and "recent research studies provide no clear indication of the prevalence of harmful outcomes."[34] The studies that do exist on the topic are not scientifically sound, because they are conducted with the highly critiqued method of retrospective social surveys. The APA "point[s] out the flaws in studies in which people who had been exposed to conversion therapy 'are asked to recall and report on their feelings, beliefs, and behaviors at an earlier age or time and are then asked to report on these same issues at present.'"[35] It noted that "'[a]n extensive body of research demonstrates the unreliability of

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https://webarchive.nationalarchives.gov.uk/ukgwa/20250310143933/https://cass.independent-review.uk/home/publications/final-report/).

27. *Id.* (citing THE CASS REVIEW, *supra* note 26, at 13).

28. *Id.* (citing THE CASS REVIEW, *supra* note 26, at 187).

29. John Stewart & James Palmer, *NHS England's Response to the Final Report of the Independent Review of Gender Identity Services for Children and Young People*, NHS ENG. (Aug. 6, 2024), https://www.england.nhs.uk/long-read/nhs-englands-response-to-the-final-report-of-the-independent-review-of-gender-identity-services-for-children-and-young-people/.

30. *See* Joshua P. Cohen, *Increasing Number of European Nations Adopt a More Cautious Approach to Gender-Affirming Care Among Minors*, FORBES (June 6, 2023), https://www.forbes.com/sites/joshuacohen/2023/06/06/increasing-number-of-european-nations-adopt-a-more-cautious-approach-to-gender-affirming-care-among-minors/.

31. Skinner-Thompson, *supra* note 3 (manuscript at 10).

32. *Id.* (manuscript at 8).

33. *Id.* (manuscript at 4–6.)

34. Chiles v. Salazar, 116 F.4th 1178, 1242 (10th Cir. 2024). (Hartz, J., dissenting) (citing AM. PSYCH. ASS'N TASK FORCE, AM. PSYCH. ASS'N, APPROPRIATE THERAPEUTIC RESPONSES TO SEXUAL ORIENTATION 42 (2009)).

35. *Id.* at 1241.

retrospective' studies of this type."[36] This report came out in 2009, but the 2021 report cited by Professor Skinner-Thompson both (1) relies on the 2009 report that found no scientific certainty and (2) does not introduce any new scientifically sound evidence that suggests different outcomes from non-aversive (talk-only) therapy.[37]

Thus, neither treatment is supported nor contradicted by rigorous scientific studies or data. This is not to say that both treatments are equally desirable as a matter of policy—again, Professor Skinner-Thompson makes a convincing policy argument as to their relative merits.[38] But it is not true that one policy is backed by a comprehensive and reliable base of evidence and the other is not. Instead, both practices are based on dubious social science, with few credible studies.[39] And those that exist often bear out conflicting results.[40]

Even if it were advisable for courts to rely on recent scientific advancements, here there is not a large enough difference in the bodies of evidence for each policy to independently support separate constitutional outcomes.

### *B. Liberty*

Both policies implicate parents' constitutional liberty interest in directing the medical care of their children. Professor Skinner-Thompson argues that conversion therapy reduces liberty while gender-affirming medical treatments further liberty.[41] His argument may be correct from the perspective of the average minor subjected to such treatments.[42]

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36. *Id.*

37. *Id.* at 1243–44 (citing AM. PSYCH. ASS'N, RESOLUTION ON SEXUAL ORIENTATION CHANGE EFFORTS 8 (2021)). Judge Hartz does a thorough analysis of the 2021 Resolution's evidence of harm in his *Chiles* dissent. He finds only one study that separates aversive from non-aversive methods: Kate Bradshaw, John P. Dehlin, Katherine A. Crowell, Renee V. Galliher, & William S. Bradshaw, *Sexual Orientation Change Efforts Through Psychotherapy for LGBQ Individuals Affiliated With the Church of Jesus Christ of Latter-Day Saints*, 41 J. SEX & MARITAL THERAPY 391 (2015). In that study, SOCE psychotherapy specifically was coded between 3 (not effective) and 4 (moderately effective), on a scale of 1 (severely harmful) to 5 (highly effective). Aversive methods performed much worse. *Id.* at 398. Seventy-five percent of participants in SOCE psychotherapy did not classify it as harmful. Again, this is not to refute the possibility that this therapy is harmful, only to say the high-quality evidence on talk-only SOCE by professional therapists implied by Professor Skinner-Thompson's article does not exist.

38. *See generally* Skinner-Thompson, *supra* note 3 (manuscript at 1, 4, 7–8).

39. THE CASS REVIEW, *supra* note 26, at 13; *Chiles*, 116 F. 4th at 1243–44 (Hartz, J., dissenting).

40. Meredithe McNamara, Kellan Baker, Kara Connelly, Aron Janssen, Johanna Olson-Kennedy, Ken C. Pang, Ayden Scheim, Jack Turban, & Anne Alstott, *An Evidence-Based Critique of "The Cass Review" on Gender-affirming Care for Adolescent Gender Dysphoria*, INTEGRITY PROJECT 4 (Apr. 2024), https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf.

41. Skinner-Thompson, *supra* note 3 (manuscript at 3, 8).

42. *See* Chiles v. Salazar, 116 F.4th 1178 (10th Cir. 2024). Though it should be noted that the counselor in *Chiles*, for example, states that she only works with "minors who are internally motivated to seek counseling" and "does not try to help minors change their attractions, behavior, or identity, when her minor clients tell her they are not seeking such change." *Id.* at 1193.

But in the context of constitutional law, a liberty interest in a minor's medical care refers to the liberty of *parents* to raise their children according to their own beliefs.[43] As the Sixth Circuit has stated:

> [C]hildren do not possess the right to make medical decisions for themselves because "[c]hildren, by definition, are not assumed to have the capacity to take care of themselves." However, this does not imply that *no one* has a fundamental right to direct the medical care of children. Rather, "[t]he law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions." Children "are assumed to be subject to the control of their parents." Thus, it is logically the parents who possess a fundamental right to direct the medical care of their children.[44]

Thus, any ban by the state on medical care for children implicates the parents', rather than the children's, liberty interests. For example, the Colorado law restricts the types of therapy or provider that parents can choose for their child's treatment. Under the law, parents may send their child to a pastor for non-affirming talk therapy, but they may not send that child to a licensed psychotherapist for the same treatment. And so, any ban on a medical procedure for minors restricts the liberty interest of parents.[45]

Both bans are similarly restrictive of liberty. But implicating a constitutional interest is different from violating a constitutional right. "[A] patient does not have a constitutional right to obtain a particular type of treatment . . . if the government has reasonably prohibited that type of treatment."[46] And "[a] parent's right to demand care for his child could not be stronger than the child's right to access it."[47] Thus, neither ban violates parents' constitutional right to direct the care of their children, because there is no right to access a particular medical procedure.

## II. LEGAL DISTINCTIONS

If the two practices deprive parents of the liberty to make certain medical decisions for their children, and both are backed by dubious and mixed social science—is there a legally relevant distinction between banning the two? If not, the Supreme Court would surely be bound by its decision in *Skrmetti* and required to uphold the MCTL.

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43. *See* K.D. v. Cnty. of Crow Wing, 434 F.3d 1051, 1055 (8th Cir. 2006) ("Parents have a liberty interest 'in the care, custody, and management of their children.'" (quoting Manzano v. S.D. Dep't of Soc. Servs., 60 F.3d 505, 509 (8th Cir. 1995))).

44. Kanuszewski v. Mich. Dep't of Health & Hum. Servs., 927 F.3d 396, 418–19 (6th Cir. 2019).

45. *See* K.C. v. Individual Members of Med. Licensing Bd. of Ind., 121 F.4th 604 (7th Cir. 2024). But even there, "a patient does not have a constitutional right to obtain a particular type of treatment . . . if the government has reasonably prohibited that type of treatment." *Id.* at 627.

46. Mitchell v. Clayton, 995 F.2d 772, 775 (7th Cir. 1993).

47. *K.C.*, 121 F.4th at 627.

I argue that the legally relevant difference between the two laws is that the MCTL infringes on a protected constitutional right—the right to free speech[48]—while the treatment ban does not. Professor Skinner-Thompson addresses this issue briefly: on the First Amendment argument, he says only that some argue "the provider's expressive rights that are at issue. But when it comes to regulating medicine, . . . the liberty and welfare of the patients, not the provider, takes precedence."[49] In his brief dismissal of the argument, he does not discuss *why* courts may protect the right of the provider.[50] Courts must do so because it is their duty to protect those rights enshrined in the Constitution from government interference.[51]

Professor Skinner-Thompson also argues that because *Skrmetti* left a healthcare ban to the political process rather than interfering, "the Supreme Court in *Chiles* should, at the very least, be consistent in its deference to the democratic process. That equivalency should decide the case."[52] But again, in *Skrmetti*, Tennessee's ban on gender-affirming care did not implicate a constitutionally protected right.[53] The ban did not draw distinctions based on suspect or quasi-suspect classifications.[54] In *Chiles*, the government wishes to ban pure speech based on its viewpoint, clearly implicating the First Amendment.[55] The general principle that courts should leave matters of policy to the state political processes only applies where the states do *not* interfere with protected constitutional rights.[56]

Importantly, this distinction is not necessarily outcome determinative. Professor Skinner-Thompson may be right that both bans should, or will, be ruled unconstitutional. But there is good reason to treat them differently: One ban implicates a constitutional right, so it should be evaluated under a higher tier of scrutiny. Even under strict scrutiny, the Court may find Colorado's reason for its ban compelling, and its means narrowly tailored. But it is absolutely reasonable—even required—to subject the MCTL to a higher standard because it endangers an enumerated constitutional right.

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48. Note that this applies purely to talk therapy and not to any aversive or conduct-based methods. The same logic would apply equally to a law that banned gender-*affirming* therapy.

49. Skinner-Thompson, *supra* note 3 (manuscript at 7).

50. *See id.*

51. Chiles v. Salazar, 116 F.4th 1178, 1201–02 (10th Cir. 2024).

52. Skinner-Thompson, *supra* note 3 (manuscript at 3).

53. *See* United States v. Skrmetti, 605 U.S. 495, 520–22, 525 (2025).

54. *Id.*

55. *See Chiles*, 116 F.4th at 1216.

56. *Judicial Restraint*, BRITTANICA, https://www.britannica.com/topic/judicial-restraint (last visited Oct. 22, 2025).

## CONCLUSION

The Supreme Court's analysis of each law should be rooted in the Constitution. Both laws have similarly weak scientific backing. Both laws restrict the liberty of parents to make certain healthcare decisions for their children. But there is one major difference between them that Professor Skinner-Thompson overlooks: one limits a constitutional right and the other does not.