

# OVERMEDICALIZATION?

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## ABSTRACT

*As we face a state-sanctioned assault on the lives of so many disadvantaged members of our community, we need to better understand the arguments that are used to harm them. The disability justice movement has emphasized how entities can use specious “overmedicalization” arguments to further these harms. The term “overmedicalization” refers to the tendency of entities to reduce people’s experiences to a purely medical explanation without hearing them share their full understanding of their lived experiences in whatever communicative style best suits them.*

*This Article applies an overmedicalization critique to seemingly distinct areas of the law: gender marking, gender-based participation in sports, access to contraception, and access to abortion. It demonstrates how even progressive arguments challenging injustice in these areas often rely on overly medicalized claims that are not respectful to people’s full personhood.*

*If our goal is to respect one’s full personhood, this Article argues that the solution to overmedicalization is not a complete removal of medical considerations (“demedicalization”). Abortion access is a perfect example. In *Roe v. Wade*, the U.S. Supreme Court defined access to abortion as exclusively a medical right—that of an attending physician to determine whether to terminate a pregnancy. And then, in *Dobbs v. Jackson Women’s Health Organization*, the Court went in the opposite, although demedicalized, direction by treating the pregnant person as merely a uterus that the state could mandate to carry a pregnancy to term. Both discourses left out women’s equality-based interests in respect for their full personhood.*

*As people should not have to demonstrate a life-threatening medical reason to terminate a pregnancy, they should not have to plead gender dysphoria to attain an appropriate gender marker, undergo physical examinations to play a sport that aligns with their gender, or have a medical reason to use contraception or terminate a pregnancy. We should understand these rights as basic to their full personhood as they self-describe them, rather than mediated through an overmedicalized discourse.*

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## INTRODUCTION

The political left often finds itself defending the legitimacy of science to support the reality of climate change<sup>1</sup> or the COVID-19 pandemic.<sup>2</sup> Yet this Article will argue that, paradoxically, the political left has inadequately criticized the overuse of science and medicine by the legal system. The disability justice movement has taken the lead in criticizing overmedicalization through its recognition of the social construction of disability.<sup>3</sup> Rather than

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<sup>1</sup> See generally Mark P. Nevitt, *Is Climate Change a National Emergency?*, 55 U.C. DAVIS L. REV. 591 (2021) (arguing that the President needs to declare a climate emergency to begin to respond to the challenges of climate change because our political system has failed to address the problem sufficiently); Norm Ornstein, *The Eight Causes of Trumpism*, ATLANTIC (Jan. 4, 2016), <https://www.theatlantic.com/politics/archive/2016/01/the-eight-causes-of-trumpism/422427/> [<https://perma.cc/7ZNS-KUEX>] (noting that, when former Speaker of the House Newt Gingrich eliminated the Office of Technology Assessment, it was “the death knell for nonpartisan respect for science in the political arena, both changing the debate and discourse on issues like climate change”); Camilo André De la Cruz Arboleda, *Climate Change in the Era of Post-Truth*, 45 ECOLOGY L.Q. 419 (2018) (reviewing MICHAEL MANN, *THE MADHOUSE EFFECT: HOW CLIMATE CHANGE IS THREATENING OUR PLANET, DESTROYING OUR POLITICS, AND DRIVING US CRAZY* (2016), which describes a “war on climate science”).

<sup>2</sup> See Ruth Colker, *The K-12 Masking Wars*, REGUL. REV. (Aug. 30, 2021), <https://www.thereview.org/2021/08/30/colker-k-12-masking-wars/> [<https://perma.cc/WKW3-AWSC>] (discussing how anti-mask rhetoric has inhibited an effective civil rights response to COVID-19 in the K-12 setting).

<sup>3</sup> See Sean M. Scott, *Contractual Incapacity and the Americans with Disabilities Act*, 124 DICK. L. REV. 253, 269 (2020) (“Most disability rights activists have adopted the social, as opposed to the medical, model of disability. The social model of disability is premised on the idea that identity is largely socially constructed. Thus, social, economic, religious, and political institutions all shape the identity of individuals with impairments[.]”). Some public health scholars have also argued that public health leaders often value medicine and epidemiology over what can be learned from observing people’s lived experiences. See Evan Anderson & Scott Burris, *Imagining a Better Public Health (Law) Response to COVID-19*, 56 U. RICH. L. REV. 955, 1002 (2022) (arguing that a focus on science by public health professionals created the belief that those disciplines “not only

defining people by reference to a fixed, medical category, the disability justice movement understands people's experiences as mediated through "social, economic, religious, and political institutions."<sup>4</sup> Nonetheless, the very existence of the Diagnostic and Statistical Manual (DSM-5),<sup>5</sup> which determines who falls within or outside various mental health disability categories, reflects the entrenched medicalization of the term "disability." Further, this Article will argue that some advocates within the disability justice movement have not gone far enough in documenting the ways that unnecessary medical hurdles have, themselves, been disabling.<sup>6</sup>

By "overmedicalization," this Article refers to the unnecessary reliance on medical categories to determine how people should be treated in society, from the health-care setting to the courtroom. Within the disability arena, overmedicalization is a problem under the Individuals with Disabilities Education Act (IDEA),<sup>7</sup> the Americans with Disabilities Act (ADA),<sup>8</sup> and Supplemental Security Income (SSI).<sup>9</sup> For example, children do not qualify for special education unless they have a medical diagnosis for an impairment, which cannot be the result of "environmental, cultural or economic disadvantages."<sup>10</sup> Students cannot obtain extended time on tests unless they meet a narrow definition of having a learning disability.<sup>11</sup> Similarly, as noted by legal historian Karen Tani, "the SSI program has always embraced medicalized understandings of disability and thereby empowered medical gatekeepers, reinforcing the view that people who claim disability are inexpert and untrustworthy."<sup>12</sup> This Article seeks to extend the critique of overmedicalization to areas of the law outside the disability arena.

Overmedicalization causes us to lose sight of the value of people's lives. Rather than being recognized as humans with a variety of needs, ideas,

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told us what the problem was, but how to solve it, and in so compelling a fashion that anyone with a different idea could be ignored and any consideration of how to implement the solution was entirely superfluous").

<sup>4</sup> Scott, *supra* note 3, at 269.

<sup>5</sup> See AM. PSYCHIATRIC ASS'N, THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION (DSM-5) (2013).

<sup>6</sup> See *infra* Part I. But see LIAT BEN-MOSHE, DEINSTITUTIONALIZATION AND PRISON ABOLITION 108–09 (2020) (discussing "antipsychiatry and mad movements that call for the abolition of psychiatry as a whole" while also recognizing the continued authority that psychiatry holds on determining whether people can live independently).

<sup>7</sup> 20 U.S.C. § 1400(d)(1)(A) (2010) (ensuring all students with disabilities a free, appropriate public education).

<sup>8</sup> 42 U.S.C. §§ 12101–12213 (2008).

<sup>9</sup> 42 U.S.C. §§ 1381–1385 (1972).

<sup>10</sup> See 34 C.F.R. § 300.8(c)(10)(ii) (2018) ("Specific learning disability does not include learning problems that are primarily the result of . . . environmental, cultural, or economic disadvantage.").

<sup>11</sup> See *Black v. Nat'l Bd. of Med. Exam's*, 281 F. Supp. 3d 1247, 1249–50 (M.D. Fla. 2017) ("In this action, Black's history of superlative academic performance refutes the claim that ADHD substantially limits Black's ability to learn, to read, to remember, or to concentrate in comparison to the average person.").

<sup>12</sup> Karen M. Tani, *Disability Benefits as Poverty Law: Revisiting the "Disabled State"*, 170 U. PENN. L. REV. 1687, 1693 (2022).

and capacities, the overmedicalization framework classifies people as “sick”<sup>13</sup> or impaired individuals who require legal intervention to enable them to attend school or work or to receive certain kinds of government assistance. As disability justice activist Marta Russell reminds us, modest benefits are sometimes allocated to disabled people to further capitalist society—to make disabled people into workers rather than to genuinely improve the quality of their lives.<sup>14</sup> But one should not have to rely on cumbersome medical diagnoses of illness or impairment to pursue a life filled with equality, dignity, and respect.<sup>15</sup> Rather than reifying fixed medical categories as the gold standard, this Article urges us to ask whether medical categories are being used in a way that disables individuals through unnecessary administrative hurdles. We should examine whether medical categories are being used as a sloppy shorthand or administrative convenience to avoid claims to equality, dignity, and respect.

While disability scholars have criticized overmedicalization,<sup>16</sup> this problem is not unique to disability law. Rather, overmedicalization is endemic to the legal system’s broader presumption that medical criteria and categories are the best lens to determine who is entitled to various legal rights. This Article will demonstrate that this presumption is as limiting and harmful outside the disability arena as it is within. At a time when both transgender rights and reproductive rights are under daily and sustained attack, this Article will apply the overmedicalization perspective to those important areas and demonstrate how an overreliance on medical categories and criteria for understanding the rights of transgender people and potentially pregnant persons obscures the full breadth of their claims to being treated with equality, dignity, and respect. This Article suggests that overmedicalization has intersectional gender, race, disability, and class dimensions and is part of the larger problem of medical racism.<sup>17</sup>

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<sup>13</sup> See Rabia Belt & Doron Dorfman, *Response: Reweighing Medical Civil Rights*, 72 STAN. L. REV. ONLINE 176, 183 (discussing Talcott Parsons’s work on the “sick role” and the way it “isolate[s] the deviant”) (quoting TALCOTT PARSONS, *THE SOCIAL SYSTEM* 312 (1951)).

<sup>14</sup> See MARTA RUSSELL, *CAPITALISM & DISABILITY* 111 (Keith Rosenthal ed., 2019) (“One reason that Republicans supported the Americans with Disabilities Act in 1990 was to provide protections against employment discrimination so that disabled persons would get off the dole and into jobs.”). Similarly, some public health scholars argue that we medicalize poverty by offering, for example, inhalers rather than treating the symptoms such as poor housing conditions and prenatal care. See Lois Shepherd & Robin Fretwell Wilson, *Introduction: The Medicalization of Poverty*, 46 J.L. MED. & ETHICS 563, 563 (2018).

<sup>15</sup> RUSSELL, *supra* note 14, at 18 (“By placing the focus on curing the so-called abnormality and segregating the incurables into the administrative category of disabled, medicine bolstered the capitalist business interest to shove less exploitable workers with impairments out of the workforce.”).

<sup>16</sup> See, e.g., Katherine A. Macfarlane, *Disability Without Documentation*, 90 FORDHAM L. REV. 59, 63 (2021) (reconceptualizing disability so that “an employee’s representation that they are disabled establishes that they are disabled”).

<sup>17</sup> See generally DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* (1997) (exploring the systemic abuse of Black wo-

Outside the disability arena, some scholars have begun to talk about the problem of overmedicalization, especially in the field of reproductive justice. They focus on how the overreliance of the need for doctors to support women's access to reproductive health care has harmed many pregnant people. Three examples reflect this evolving discussion. Critical race theorist Colleen Campbell has examined Black women's<sup>18</sup> experiences in obstetrics: she concludes that "medical racism and institutional practices expose Black women to unnecessary and riskier surgical interventions" and, "[i]n obstetrics particularly, Black women are simultaneously overmedicalized *and* medically neglected, a paradigm that is an extension of historical medical practices and rooted in the logic of biological race."<sup>19</sup> Meanwhile, lawyer Ivey Best documents the "overmedicalization of childbirth," describing the "transition from women as the primary decision makers in birth to doctors as the primary decision makers in birth [out of] a belief that women are not capable of making the 'right' decision for their unborn babies or fear that women would prioritize their own interest over the interests of their child or the physician."<sup>20</sup> Reproductive justice activist Diane Curtis presents legal arguments in favor of women having the right to self-help gynecological care, including the right to terminate a pregnancy through menstrual extraction without the assistance of a health-care provider.<sup>21</sup> Writing in 1994, before the Court was prepared to overturn *Roe v. Wade*,<sup>22</sup> Curtis's work stressed the importance of this right to self-help, reasoning that "[m]any women have had negative experiences seeking abortions at women's health clinics, facing long delays in crowded waiting rooms, and alienation due to what they perceive to be an overmedicalized procedure."<sup>23</sup>

Campbell, Best, and Curtis document how the presumption that health-care providers are the only experts on the treatment of pregnant persons has often tragic consequences. Campbell explores the alarmingly high rate of C-sections among Black women, which she argues is "partly driven by non-

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men's bodies within reproductive health care settings, and the failures of the feminist and civil rights movements to address those abuses); Matiagnai Sirleaf, *Racial Valuation of Diseases*, 67 UCLA L. REV. 1820 (2021) (discussing how racial valuation within public health influences what actors prioritize or deem worthwhile and leads to the perpetuation of existing racial hierarchies within medicine); Jennifer C. Nash, *Birth Geographies: Race, Reproductive Justice, and the Politics of the Hospital*, 44 HARV. J.L. & GENDER 299 (2021) (focusing on "birth geographies" to help us understand how race, gender, and space influence birth outcomes).

<sup>18</sup> While recognizing that some transgender men and nonbinary persons can become pregnant, this Article uses the term "woman" when that is the term chosen by another author (often writing before there was much recognition of the potential for some transgender men and nonbinary persons to become pregnant).

<sup>19</sup> Colleen Campbell, *Medical Violence, Obstetric Racism, and the Limits of Informed Consent for Black Women*, 26 MICH. J. RACE & L. 47, 50 (2021).

<sup>20</sup> Ivey E. Best, "This Is My [D]joula—[S]he's [A]lso A [L]awyer", 50 CUMBERLAND L. REV. 175, 183 (2020).

<sup>21</sup> See Diane Curtis, *Doctored Rights: Menstrual Extraction, Self-Help Gynecological Care, and the Law*, 20 N.Y.U. REV. L. & SOC. CHANGE 427, 435–42 (1994).

<sup>22</sup> 410 U.S. 113 (1973).

<sup>23</sup> *Id.* at 430.

medical risk factors and a host of other institutional forces.”<sup>24</sup> She contends that the legal system’s understanding of informed consent fails “to protect Black women from overmedicalization and medical violence.”<sup>25</sup> Best explains that many women seek out the assistance of a lawyer, doula combo to avoid trauma during birth.<sup>26</sup> And Curtis reports “that many women who have undergone both pregnant menstrual extractions and clinical abortions have preferred the former.”<sup>27</sup> Although we may consider the process of giving birth as one that necessarily involves the health-care system, these experiences showcase the problematic elements of unnecessary medical intervention that is disrespectful to a person’s full personhood. An overmedicalization perspective can help us see that the need for some medical intervention does not justify additional and unnecessary, disrespectful, and burdensome medical procedures based on rigid medical categories.

This Article will build on the observations of Campbell, Best, and Curtis to demonstrate how overmedicalization plagues the legal fields of transgender and reproductive rights. First, this Article explores the ways in which overmedicalization monopolizes the transgender<sup>28</sup> rights arena. Even states that allow individuals to mark their identities accurately on birth certificates or driver’s licenses often require the individual to identify as having a medical condition called “gender dysphoria,” thus forcing individuals to identify with their “abnormality” instead of positively affirming their gender.<sup>29</sup> Further, the legislature’s rush to ban female transgender athletes (as recently seen in Utah)<sup>30</sup> from participation in girls’ or women’s sports reflects the use of pseudoscience to police female students’ conformity with traditional gender norms.<sup>31</sup> States and athletic entities are using stringent medical categories to further gender conformity in ways that deeply harm both cisgender and transgender women who seek to participate in sports as part of their fuller identities.

Similarly, arguments featuring overmedicalization have dominated reproductive rights jurisprudence. The U.S. Supreme Court’s decision in

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<sup>24</sup> Campbell, *supra* note 19, at 50.

<sup>25</sup> *Id.* at 51.

<sup>26</sup> See Best, *supra* note 20, at 175–76.

<sup>27</sup> Curtis, *supra* note 21, at 430.

<sup>28</sup> This Article uses the term “transgender” rather than “trans” while recognizing that many authors prefer “trans.” As in many areas, this terminology may be evolving but, at this time, both terms seem to be acceptable. See, e.g., NAT’L CTR. FOR TRANSGENDER EQUAL., <https://transequality.org> [<https://perma.cc/TT4S-9QHB>] (using the phrase “transgender” in the organization’s name while having a URL link that uses “trans”).

<sup>29</sup> For an excellent overview of the variety of policies for documenting gender, see Dean Spade, *Documenting Gender*, 8 *DUKEMINIER AWARDS* 137 (2009).

<sup>30</sup> See Eduardo Medina, *Utah Legislature Overrides Governor’s Veto of Transgender Athlete Bill*, N.Y. TIMES (Mar. 25, 2022), <https://www.nytimes.com/2022/03/25/us/utah-transgender-athlete-ban-override.html> (last visited March 9, 2023).

<sup>31</sup> See generally Jessica A. Clarke, *Sex Assigned at Birth*, 122 *COLUM. L. REV.* 1821 (2022) (describing the origins of the terms “biological sex” and “sex assigned at birth” and arguing that the latter term is a critique of the very concept of biological sex).

*Burwell v. Hobby Lobby Stores, Inc.*<sup>32</sup> contains seeds of overmedicalization in considering, although ultimately denying, the right of people who rely on the Affordable Care Act to have full contraceptive access over the objections of their religious employer. In assessing the legality of restrictions on employees' access to contraception, both the majority and dissent unduly emphasized the occasions in which people need access to contraception for medical reasons,<sup>33</sup> with little acknowledgment of people's need to access contraception to control the destiny of their lives, as was previously more fully protected by *Griswold*.<sup>34</sup> We can also see this same trend occurring in abortion rights jurisprudence, where likely the only remaining legally protected reason to terminate a pregnancy will be to save the lives of pregnant people.<sup>35</sup>

Although this Article will consider many examples outside the arena of disability justice to develop this critical perspective on medicalization, a disability example from the COVID-19 pandemic may help foreshadow the discussion. Many employees sought workplace adjustments during the COVID-19 pandemic to help them work in a safe environment. After an initial period of remote work flexibility for all employees, employers began to consider those requests only through the lens of the medical categories recognized by disability law.<sup>36</sup> This Article's overmedicalization lens suggests that employers should consider these requests more broadly as requests to live and work in a humane and safe environment. That right should not be limited to those who fall into certain medical categories.

During COVID-19, most people have tried to find a living environment in which they could feel relatively comfortable, within the socioeconomic and other constraints of their lives. But irrespective of what decisions people made, it was impossible to fully avoid the risk of COVID-19. Some people concluded that they were not comfortable being in a space where others

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<sup>32</sup> 573 U.S. 682 (2014).

<sup>33</sup> *See id.* at 737 ("There are many medical conditions for which pregnancy is contraindicated. It is important to confirm that a premise of the Court's opinion is its assumption that the HHS regulation here at issue furthers a legitimate and controlling interest in the health of female employees.") (citations omitted).

<sup>34</sup> *Griswold v. Connecticut*, 381 U.S. 479 (1965).

<sup>35</sup> The *Dobbs* opinion makes passing reference to the fact that nearly all states protected the right to abortion when the pregnant person's life was threatened by the pregnancy by the end of the 1950s. *Dobbs v. Jackson Women's Health Organization*, No. 19-1392, slip op. at 24 (June 24, 2022).

<sup>36</sup> *See, e.g.*, William P. Nobles III, *Hundreds of DeKalb School Employees Want COVID-19 Work Accommodations*, ATLANTA J.-CONST. (Feb. 10, 2021), <https://www.ajc.com/news/atlanta-news/hundreds-of-dekalb-school-employees-want-covid-19-work-accommodations/DEM6WHWI7ZHNVD6MOAE3GGV55E/> [<https://perma.cc/4BKT-DNTM>] (describing process of moving from remote work to in-person work through a disability lens); Bill Hutchinson, *Judge Puts Brakes on Return to School for COVID-Worried Minneapolis Teachers*, ABC NEWS (Feb. 1, 2021), <https://abcnews.go.com/US/judge-puts-brakes-return-school-covid-worried-minneapolis/story?id=75616231> [<https://perma.cc/9MJY-5PCN>] (discussing teachers' concerns about resuming in-person classes with school district seeking to move ahead despite opposition).

were unvaccinated, unmasked, or even physically present. When people made requests to structure their work life in a way in which they felt comfortable, such as through remote work, most employers responded to those requests based on what they understood to be the ADA's requirements for reasonable accommodations.<sup>37</sup> But the ADA cannot be used to support all the reasons an employee might have for requesting a particular accommodation such as remote work. Because it only provides support for accommodation requests based on the employee's own medical condition, the fact that an employee lives with a high-risk family member would not qualify as sufficient reason to seek a workplace accommodation.<sup>38</sup>

As framed by this Article, the exclusive use of the ADA to consider these COVID-related accommodation requests was insufficient. These requests were fundamentally about how people wanted to live their lives—how much risk they felt comfortable taking on behalf of themselves or others. Evaluating these requests exclusively under the ADA is inadequate because the ADA only provides protection to disabled employees who would themselves be jeopardized by regular workplace rules. The ADA defines which employees are considered disabled by referencing various medical categories involving their physical or mental health. Under this Article's framework, the worker with children at home who are too young to be vaccinated and face a higher COVID-19 risk should be evaluated no differently than the worker with an immunocompromised system. Both are making claims about how they want to live a life of equality, dignity, and respect, and we should treat them accordingly, rather than placing them into medical categories that dictate or limit their range of choices.

In critically examining instances of overmedicalization, we should ask whether employees could use the ADA in a way that does not require them to come forward and demonstrate that they fit certain medical categories to be treated with dignity and respect. In another article, I argue that the ADA could be strengthened through stronger application of universal design principles that ask whether accommodations can be made for the entire workforce rather than merely for those who qualify through the medical categories of disability.<sup>39</sup> To apply this principle in the COVID-19 context, an employer could have a general policy, which I call a universal design policy,

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<sup>37</sup> The variety of arguable legal responses to employee requests for remote work is discussed by EEOC Guidance. *See What You Should Know about COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws*, U.S. EQUAL EMP. OPPORTUNITY COMM'N, <https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws> [https://perma.cc/W24V-75CF] (providing, for example, that the ADA does not protect any employee who wants an accommodation to avoid exposing a family member who is at a higher risk of severe illness from COVID-19 due to an underlying medical condition).

<sup>38</sup> *Id.*

<sup>39</sup> *See generally* Ruth Colker, *The Americans with Disabilities Act's Unreasonable Focus on the Individual*, 170 U. PENN. L. REV. 1813 (2022) (arguing that post hoc universal design should be the default principle rather than ex ante individualized requests for accommodations).



that allows all workers to seek accommodations such as an option to telecommute. No medical tests. No explanations. Just treatment with equality, dignity, and respect, because we would assume there are no bad reasons for requesting remote work. Whether the ADA can, in fact, be used to achieve this result is beyond the scope of this Article. The point is a “should” argument. Employers *should* seek workplace solutions that do not require individual employees to come forward and make requests for reasonable accommodations under rigid medical categories. A more universal policy of requesting remote work could protect many employees and avoid the stigma of needlessly disclosing one’s disability status.

This critical examination of unnecessary medicalization under the ADA also benefits workers who already meet the ADA’s definition of disability. This approach would allow these individuals to seek a workplace accommodation without the medical expense of a diagnosis or the possible stigma of outing themselves as disabled. As we will see, these costs of overmedicalization are not limited to the disability justice field. They also exist in the fields of transgender and reproductive justice.

In Part I, this Article will summarize the discussion of overmedicalization within the disability justice literature. This Part seeks to build on those insights while offering additional critical tools. This Article seeks to show how we can recognize the medical categories that sometimes help explain the lived experiences of some disabled people while also avoiding needless overmedicalization. Overmedicalization can create unnecessary and burdensome barriers to full participation in society. If we listen to voices within the disability community and adopt a person-centered vision,<sup>40</sup> we can better enhance disability justice.

Part II will explore this issue in the realm of transgender justice, an area that has already received some discussion as to whether it belongs in the

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<sup>40</sup> Embedded in the disability justice movement is the precept “[n]othing [a]bout [u]s [w]ithout [u]s.” See, e.g., *What We Believe*, AUTISTIC SELF ADVOC. NETWORK, <https://autisticadvocacy.org/about-asan/what-we-believe/> [https://perma.cc/926M-UKBN] (the motto of this autism advocacy organization). This methodology can be further attributed to the important work of Mari Matsuda, who encouraged us to consider “looking to the bottom” in conceptualizing justice. See, e.g., Mari J. Matsuda, *Looking to the Bottom: Critical Legal Studies and Reparations*, 22 HARV. C.R.-C.L. L. REV. 323, 324 (1987) (“This article suggests that those who have experienced discrimination speak with a special voice to which we should listen. Looking to the bottom—adopting the perspective of those who have seen and felt the falsity of the liberal promise—can assist critical scholars in the task of fathoming the phenomenology of law and defining the elements of justice.”). While I consider myself to be a member of the disability community by virtue of various disabilities, I also recognize that my perspective is limited by my own personal experience with disability. I have benefitted from Katie Eyer’s observation that, “[u]ltimately, one can choose to claim disability identity for some purposes (such as stigma disruption and community building), but not for others (such as affirmative action or claiming to represent all disabled experiences).” Katie Eyer (@katie\_eyer), TWITTER (May 3, 2021, 11:08 AM), [https://twitter.com/katie\\_eyer/status/1389235452587220993](https://twitter.com/katie_eyer/status/1389235452587220993) [https://perma.cc/634W-6T6U]. Thus, I have tried to read and hear the voices of others to enhance my understanding and awareness while being comfortable claiming a disability identity.

disability frame. Rather than considering whether the transgender community should use the ADA to advance their rights, this Part will seek to demonstrate that efforts to attain more justice for transgender people have often been overmedicalized and have failed to fully consider arguments related to the nonmedical aspects of their self-identities. However, this Part, in acknowledgement of the fact that transgender people sometimes wish to use medical categories to explain their experience, also recognizes that we should not seek complete demedicalization.

Part III will take the overmedicalization discussion into a new arena—that of reproductive justice. It will show how overmedicalization has started to infuse discussions about access to contraception and abortion. This Part argues that we need to be more mindful of this overmedicalization so that full access to contraception and abortion is not only available to a subset of the population who can construct medical claims with the assistance of a physician. We can recognize that access to contraception and abortion is health care without suggesting that it only be viewed through a physician-defined medical lens.

Finally, Part IV will identify overarching themes that emerge from consideration of overmedicalization across different areas of the law. This Part considers how listening to the voices of those affected by medicalized discourse may help us avoid overmedicalization without falling into the trap of demedicalization.

## I. DISABILITY MEDICAL FRAMING

The role of medical categories within the field of disability justice is complicated and contested. This Article considers a thorny issue that has caused disagreement among disability scholars and activists. How can one use a critical examination of medical categories, which emphasizes the social construction of disability, while also recognizing that medical categories sometimes help explain the lived experiences of some disabled people? In other words, how can we embrace the social model of disability while not discounting lived experiences, such as pain, for some disabled people? This Article attempts to illustrate how a critical examination of medicalization in the disability context does not require us to abandon medical categories entirely. Demedicalization is not the solution to overmedicalization.

The social model of disability teaches us that the experience of disability is mediated through one's social environment, such as the construction of stairs rather than a ramp. However, more recent accounts of the social model also emphasize that disabled people can have physical or mental impairments that might cause them pain which, in turn, requires medical intervention. Scholars have updated the social model to describe disability as “formulated through a complex interaction between the impairment and the

social environment.”<sup>41</sup> The updated social model does not consider disability to be only a socially created experience. This Article seeks to examine the balance between social experiences and medical categories in determining how we frame the concept of disability.

This Part will argue that the important work of health law and civil rights scholar Craig Konnoth that seeks to apply the social model of disability to other areas like race, as well as the response to his article by Professors Rabia Belt and Doron Dorfman, are insufficiently attentive to the problem of overmedicalization. In considering their claims, this Article seeks to find an appropriate balance between demedicalization and overmedicalization.

A recent article by Craig Konnoth helps bring the disability framing issue to the forefront by arguing that individuals and groups should increasingly turn to a medical frame “as a vehicle for civil rights claims both inside and outside courts.”<sup>42</sup> He embraces the medical frame found in disability law even though the disability community has often been critical of the role of medicine in policing disability categories. He argues that the medical frame has numerous benefits while also acknowledging that “medical entities and institutions have surveilled and exerted control over poor pregnant women,”<sup>43</sup> that “medical institutions continue to pathologize homosexuality to this day,”<sup>44</sup> that “trans individuals have to navigate gatekeeping by medical professionals in order to get gender-affirming care,”<sup>45</sup> and that disability scholars “have long explained how medical institutions have controlled and coerced people with disabilities.”<sup>46</sup> Konnoth’s critique of the medical profession’s abuse of its power and authority captures part of the overmedicalization problem discussed in this Article. He describes the medical profession’s disrespectful control of pregnant women and transgender people as well as its “pathologiz[ation of] homosexuals” as stemming from an overuse or overreach of their power.

Given Konnoth’s partial critique of overmedicalization, one might wonder why he supports a new concept of “medical civil rights,” described as “civil rights claims for which invoking a medical status plays a legitimating role.”<sup>47</sup> He seeks to expand who can benefit from such civil rights claims by recognizing the medical aspects of some conditions such as homelessness or poverty.<sup>48</sup>

Konnoth contends that critics of medicalization have overemphasized the harms and insufficiently considered the benefits of the new medical civil

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<sup>41</sup> Belt & Dorfman, *supra* note 13, at 187.

<sup>42</sup> Craig Konnoth, *Medicalization and the New Civil Rights*, 72 STAN. L. REV. 1165, 1168 (2020).

<sup>43</sup> *Id.* at 1170.

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> *Id.* at 1170–71.

<sup>47</sup> *Id.* at 1172.

<sup>48</sup> *Id.* at 1173.

rights claims.<sup>49</sup> He argues that this use of medical categories provides three benefits: it will (1) provide access to a new set of legal rights, (2) help claims generate greater sympathy, and (3) give claims more legitimacy under the veneer of medical expertise.<sup>50</sup> But he also seems to recognize that his project is aspirational, based on his belief that “ongoing efforts inside medical institutions seek to engage patients in shaping medical discourse in order to enhance their autonomy.”<sup>51</sup> In other words, he seeks to embrace an increased use of medical categories while avoiding the harms of overmedicalization.

Not surprisingly, Konnoth’s article generated a lively response. Disability justice activists and scholars Rabia Belt and Doron Dorfman offer several criticisms of Konnoth’s perspective. They express concern that allowing more people to claim medical rights “causes gatekeeping, surveillance, and parsimoniousness”<sup>52</sup> and causes medical-based benefits and rights to “wither rather than increase.”<sup>53</sup> Thus, they note that “[p]overty rates are higher among Americans with disabilities than among their nondisabled peers.”<sup>54</sup>

Most importantly, Belt and Dorfman caution that non-disabled people need to be careful not to appropriate disability discourse in ways that echo the older, charity model of disability advocacy that often aligned with ableism and an individually-based framework.<sup>55</sup> By contrast, they argue that the more modern disability justice movement “has been pushing toward a more transformative approach that addresses ableism on the group level.”<sup>56</sup> Belt and Dorfman suggest that, rather than advancing self-affirming care, “[m]edicalizing civil rights” would “tak[e] the expertise and decisionmaking capacity away from patients and disabled individuals and hand[ ] it over to other experts to make decisions for them.”<sup>57</sup> They contend that Konnoth’s proposed framework would focus too much on the diagnosis of the medical impairment by a medical professional rather than on the “function of the job or the service that is denied from the plaintiff because of their disability.”<sup>58</sup> In other words, Konnoth’s proposal to expand medical civil rights would move us away from the tenets of the modern disability justice movement.

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> *Id.* at 1174.

<sup>52</sup> Belt & Dorfman, *supra* note 13, at 179.

<sup>53</sup> *Id.* at 180–81 (“Because the ‘unworthy’ poor and people of color are imagined as the people who do not use medical claiming [or disability claiming], if they become more visible and more vocal about medical claiming, what is more likely is that medical-based benefits and rights will wither rather than increase.”).

<sup>54</sup> *Id.* at 182.

<sup>55</sup> *Id.* at 177–78 (noting that disability advocacy historically was “primarily conducted on behalf of people with disabilities, often by non-disabled people,” whose rehabilitation work often “perpetuate[d] dependency and charity views of disability closely aligned with ableism”).

<sup>56</sup> *Id.*

<sup>57</sup> *Id.* at 184.

<sup>58</sup> *Id.* at 187.

While Belt and Dorfman rightfully criticize the ways in which Konnoth's work is overly individualized and excessively reliant on medical categories, greater reference to early work on the social model of disability could strengthen their critique. They contend that Konnoth's reference to the social model of disability is insufficiently "updated and nuanced."<sup>59</sup> As this Article will discuss below, what Belt and Dorfman call the "updated and nuanced" social model of disability bears strong resemblance to the work of what they consider to be classic social disability theorists. In other words, this Article contends that the social model of disability has always been nuanced, especially in the way it considers medical experiences.

Belt and Dorman consider the model of disability developed by Michael Oliver in 1996<sup>60</sup> to exemplify the "classic" social model that contrasts with their "updated and nuanced" model.<sup>61</sup> Oliver's social model distinguishes between the term "impairment," which is the biological term that distinguishes disabled people from non-disabled people, and the term "disability," which refers to the way impairments are viewed and experienced by others.<sup>62</sup> Belt and Dorfman consider Oliver's model to be too narrowly social because it "undermin[es] the myriad personal experiences of disabled people, and hamper[s] a nuanced understanding of the complexity of disability."<sup>63</sup> In other words, they critique his model for moving toward demedicalization, reasoning that it does not appreciate the ways in which medical descriptors such as pain can be important to understanding one's lived experience as a disabled person.<sup>64</sup> The classical social model, in their view, is therefore inadequate; they argue that we need a more "updated and nuanced social model" to understand the category of "disability."<sup>65</sup>

A closer examination of Oliver's work, however, demonstrates that he has developed a more nuanced version of the social model than Belt and Dorfman suggest.<sup>66</sup> Oliver appreciates the role that medical descriptors can play in better understanding the disability experience within the social model framework:

The social model does not deny that some illnesses may have disabling consequences and many disabled people have illnesses at various points in their lives. Further, it may be entirely appropriate for doctors to treat illnesses of all kinds . . . . The problem arises

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<sup>59</sup> *Id.*

<sup>60</sup> See generally MICHAEL OLIVER, UNDERSTANDING DISABILITY: FROM THEORY TO PRACTICE (1996) (establishing a social model of disability that focuses on society's lack of services to account for the needs of disabled people rather than on individual limitations).

<sup>61</sup> See *id.* at 186.

<sup>62</sup> *Id.* at 37–38.

<sup>63</sup> Belt & Dorfman, *supra* note 13, at 186.

<sup>64</sup> See OLIVER, *supra* note 60, at 38.

<sup>65</sup> Belt & Dorfman, *supra* note 13, at 187.

<sup>66</sup> *Id.* at 186.

when doctors try to use their knowledge and skills to treat disability rather than illness.<sup>67</sup>

Oliver acknowledges the problem of overmedicalization without also moving in the direction of demedicalization.

Oliver's deep discussion of the social model is especially illuminating because it reflects the kind of nuanced discussion that Belt and Dorfman seek. He notes the argument that the social model denies the "pain of impairment."<sup>68</sup> Further, he acknowledges the argument that the social model needs to identify a causal relationship between impairment and disability.<sup>69</sup> He rejects those arguments. Instead, Oliver advances the social model of disability as "a pragmatic attempt to identify and address issues that can be changed through collective action rather than medical or other professional treatment."<sup>70</sup> Quoting disability activist Tom Shakespeare, he says, "To mention biology, to admit pain, to confront our impairments, has been to risk the oppressors seizing on evidence that disability is 'really' about physical limitation after all."<sup>71</sup> Thus, Oliver's social model criticizes overmedicalization while recognizing the usefulness of categories such as pain.

Belt and Dorfman also cite Susan Wendell<sup>72</sup> as an example of the classical, social model of disability that they perceive as in need of reform.<sup>73</sup> Also writing in 1996, Wendell connects her work in feminist theory to disabilities studies:

The more I learned about other people's experiences of disability and reflected upon my own, the more connections I saw between feminist analyses of gender as socially constructed from biological differences between females and males, and my emerging understanding of disability as socially constructed from biological differences between the disabled and the non-disabled. In addition, I was increasingly impressed by the knowledge people with disabilities have about living with bodily suffering and limitation and about how their cultures treat rejected aspects of bodily life. It was clear to me that this knowledge did not inform theorizing about the body by non-disabled feminists and that feminist theory of the body was consequently both incomplete and skewed toward healthy, non-disabled experience.<sup>74</sup>

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<sup>67</sup> See OLIVER, *supra* note 60, at 35–36.

<sup>68</sup> *Id.* at 38.

<sup>69</sup> *Id.* at 39.

<sup>70</sup> *Id.* at 38.

<sup>71</sup> *Id.* at 39 (quoting Tom Shakespeare, *A Response to Liz Crow*, COALITION (Sept. 1992)).

<sup>72</sup> See generally SUSAN WENDELL, *THE REJECTED BODY: FEMINIST REFLECTIONS ON DISABILITY* (1996).

<sup>73</sup> Belt & Dorfman, *supra* note 13, at 186 n.60.

<sup>74</sup> WENDELL, *supra* note 72, at 5.

Wendell's work is an important statement of methodology in disability studies. Not only does she emphasize the importance of understanding how disability, like gender, is socially constructed, but she embraces the importance of a people-first approach to thinking about disability justice that affirms people's self-descriptions of their life experiences without mediating that description through medical professionals. This Article seeks to use her people-first approach in discussing not only disability justice issues but also transgender and reproductive justice issues. Belt and Dorfman also recognize the importance of this people-first approach.<sup>75</sup>

Belt and Dorfman claim that Wendell's work needs to be updated to reflect "the interplay between individuals and the physical, biological, and sociocultural environments that characterize their society."<sup>76</sup> But Wendell's work *does* reflect that interplay. She mentions the reality of living with "bodily suffering and limitation" as part of a social experience,<sup>77</sup> and, like Oliver, she uses the social model to understand how one's physical and mental experiences can be mediated through social conditions. This Article considers that view to be "nuanced" in ways that do not require significant updating and thus rejects Belt and Dorfman's distinction between the classic social model and a more modern social model.

Moreover, this Article argues that Belt and Dorfman have gone too far in developing their updated social model. By relying too heavily on the medical category of "impairment" under the ADA to determine who is disabled and entitled to statutory protection, their approach suffers from overmedicalization. Belt and Dorfman reject Konnoth's attempt to broaden the application of the term "impairment" to include the experiences of other marginalized communities, claiming that his approach would make medical-based benefits and rights "wither," not increase, due to the backlash that would ensue from such an expansion.<sup>78</sup> Similarly, in other work, Dorfman has stated: "When the concept of disability gets stretched too far beyond the concept of impairment, it dilutes the meaning of what it means to live with disabilities, causing the lived experiences of disabled people [to] seem trivial and commonplace."<sup>79</sup> "Impairment" is a term that Belt and Dorfman want to firmly maintain under the ADA and limit to individuals with physical or mental impairments.

Belt and Dorfman's disagreement with Konnoth is complicated and nuanced. Belt, Dorfman, and Konnoth each make valid points about the

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<sup>75</sup> Belt & Dorfman, *supra* note 13, at 183–84 (mentioning that various disability movements "have been fighting . . . to get a seat at the table," "to include activist and patient perspectives at different stages in the scientific/medical enterprise," and "to emphasize the benefits of participatory knowledge over the exclusive regime of medical experts").

<sup>76</sup> *Id.* at 187 n.66 (quoting GARY L. ALBRECHT, *THE DISABILITY BUSINESS: REHABILITATION IN AMERICA* 60 (1992)).

<sup>77</sup> WENDELL, *supra* note 72, at 5.

<sup>78</sup> *Id.* at 179–81.

<sup>79</sup> Doron Dorfman, *Disability as Metaphor*, 170 U. PENN. L. REV. 1757, 1758 (2022).

ways in which the medical system has disserved the disability community as well as poor people and people of color. None of them valorizes that system. But Konnoth is satisfied with the aspirational potential of modern medicine, while Belt and Dorfman are comfortable with using a rigorous understanding of impairment to avoid more disability backlash.

This Article contends that none of these three contemporary authors take a sufficiently critical stance on the use of medical categories or the term “impairment” itself. These authors do not examine whether “impairment” can be defined without creating additional hurdles in the lives of disabled people. They fail to assess whether this term could be used in ways that do not promote overmedicalization or demedicalization. As Wendell suggests, there is potential to recognize bodily suffering and limitations while also recognizing how society treats “rejected aspects of bodily life.”<sup>80</sup>

Let us consider, for example, so-called neurological impairments like autism. Autism is classified as an “impairment” because a person with autism does not interact with others within the ableist norms that have been set by society.<sup>81</sup> Under the ADA<sup>82</sup> and special education law,<sup>83</sup> autism is treated like an on/off switch, where one must meet the medically accepted definition in order to obtain certain legal protections. Reflecting the difference between the historical charity model of disability and the disability justice centered view, the Autistic Self Advocacy Network (ASAN) counters this threshold-setting view of autism.<sup>84</sup> Although ASAN recognizes that people are different from each other, it avoids terms like “impairment” which suggest that there is a “normal” brain from which “impairment” is measured.<sup>85</sup> Instead of trying to cure autism, ASAN argues that “[a]utistic people should be allowed to exist, and we should work to make sure that everyone gets the accommodations we need to reach our full potential.”<sup>86</sup>

ASAN also shares some of the medical skepticism that serves as the basis of this Article. It claims that doctors have insufficient training about what autism is and how to work with autistic patients. Relatedly, it believes

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<sup>80</sup> WENDELL, *supra* note 72, at 5.

<sup>81</sup> The Centers for Disease Control (CDC) states: “People with ASD [autism spectrum disorder] often have problems with social communication and interaction, and restricted or repetitive behaviors or interests. People with ASD may also have different ways of learning, moving, or paying attention.” *What is ASD?*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/ncbddd/autism/facts.html> [https://perma.cc/R7PF-9T2J]. The CDC’s use of the word “problems” and “different” are subtle ways of offering a comparison to those people considered “normal.”

<sup>82</sup> See Americans with Disabilities Act, 42 U.S.C. § 12102(1) (2008) (defining disability as a physical or mental impairment that substantially limits one or more major life activities of an individual, a record of such an impairment, or being regarded as having such an impairment).

<sup>83</sup> See Individuals with Disabilities Education Act, 20 U.S.C. § 1401(3)(A)(i) (2015) (listing “autism” as a covered disability for a child who, by reason thereof, needs special education and related services).

<sup>84</sup> See *What We Believe*, AUTISTIC SELF ADVOC. NETWORK, *supra* note 40.

<sup>85</sup> *Id.*

<sup>86</sup> *Id.*



that autistic people should be the ones who determine whether they are autistic, irrespective of whether they went to the trouble and expense of getting an official diagnosis. ASAN argues that doctors should do a better job of listening to the experiences of autistic people rather than being concerned about a formal diagnosis.<sup>87</sup> By emphasizing the ignorance of some medical professionals and the expense of getting a diagnosis, ASAN reveals the way medicine serves as a barrier or hurdle for many people with autism rather than a tool to access needed services. Although ASAN has more confidence in people's self-reports rather than official diagnoses, it acknowledges that official diagnoses are often central to obtaining various kinds of legal protections or services.

ASAN's work also raises the difficult question of the role that "impairment"<sup>88</sup>—a term which federal law relies on heavily and we often think of as central to the idea of disability—should have in determining who is considered disabled. While ASAN recognizes that autistic people may act differently than the norms set by ableist society, it does not conclude that those differences should be called "impairments."

Wendell's social model approach offers a critique of the term impairment—what she refers to as "physical condition"—that is consistent with ASAN's approach. She states:

I do not want to claim or imply that social factors alone cause all disabilities. I do want to claim that the social response to and treatment of biological difference constructs disability from biological reality, determining both the nature and the severity of disability. I recognize that many disabled people's relationships to their bodies involve elements of struggle that perhaps cannot be eliminated, perhaps not even mitigated, by social arrangements. But many of the struggles of people with disabilities and much of what is disabling, are the consequences of having those physical conditions under social arrangements that could, but do not, either compensate for their physical conditions, or accommodate them so that they can participate fully, or support their struggles and integrate those struggles into the cultural concept of life as it is ordinarily lived.<sup>89</sup>

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<sup>87</sup> *Id.*

<sup>88</sup> The ADA defines a disability as a "physical or mental impairment that substantially limits one or more major life activities of such individual." 42 U.S.C. § 12102(1)(A) (2008). The IDEA provides a list of covered impairments. *See* IDEA Regulations, 34 C.F.R. § 300.8(a)(1) (2017) (listing the covered disabilities as autism, deaf-blindness, developmental delay, emotional disturbance, hearing impairment, intellectual disability, multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, speech or language impairment, and traumatic brain injury). These rules serve as gatekeepers to determine who can benefit from the protections offered by the statutes.

<sup>89</sup> WENDELL, *supra* note 72, at 42 (citations omitted).

Wendell provides a full chapter on the “cognitive and social authority of medicine.”<sup>90</sup> She offers a helpful perspective on the role of medicine in making a disability diagnosis: “Acknowledge the possible ignorance of individual practitioners and the incompleteness of medical science, and assume the reality of patients’ symptoms unless there is overwhelming *positive* evidence that they are imagined or pretended.”<sup>91</sup> While Belt and Dorfman do not enumerate what they mean exactly by a social construction of disability that is “multidimensional, dynamic, bio-psycho-social, and interactive in nature,”<sup>92</sup> they likely agree that Wendell offers a helpful perspective on how to think about medicine’s role in defining disability. Rather than being concerned about the over-claiming of disability because it might cause disability backlash, this Article suggests that we first evaluate what we can learn from a people-first approach that listens to those who claim a particular medical-social experience. These voices do not necessarily claim a disability status defined by impairment. How can law listen to and try to respect these voices?

This Article offers these views not to develop a grand theory of overmedicalization. Rather, its critique of overmedicalization is borne out of a pragmatic or utilitarian concern for the aspects of full personhood that an overmedicalized perspective often denies. While medical categories can be helpful in determining who should receive certain kinds of benefits or assistance, they should not be overused in ways that demean people rather than treating each person with equality, dignity, and respect. People should not have to obtain an expensive diagnosis of autism from under-trained medical professionals to be treated with dignity and respect in the workplace. This Article embraces a people-first approach that promotes dignity and respect for people’s understandings of their own lived experiences that do not need to be mediated through a medical stamp of approval. Even if society were transformed to reflect Konnoth’s description of aspirational medicine, it would still be appropriate and necessary to ask if medical categories—defined by medical professionals rather than people’s lived experiences—are being overused.<sup>93</sup> The classic social model of disability provided important insights on that issue, and its emphasis on people’s first-hand accounts of their pain and suffering within an often hostile social environment can continue to inform us today.

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<sup>90</sup> *Id.* at 117–38.

<sup>91</sup> *Id.* at 128.

<sup>92</sup> Belt & Dorfman, *supra* note 13, at 186–87.

<sup>93</sup> See Allison K. Hoffman, *How Medicalization of Civil Rights Could Disappoint*, 72 STAN. L. REV. ONLINE 165, 173 (2020) (questioning whether medicalization would be a useful tool for civil rights advocacy).

## II. TRANSGENDER OVERMEDICALIZATION

This Article proceeds from the premise that we should be skeptical of medical arguments used to determine who is inside and outside a category. This Part examines the use of such arguments in the transgender justice realm. First, it examines relevant legal scholarship on transgender medical framing. This Part then explores how gender marker changes force individuals to overmedicalize their transgender status. Then, it examines how athletic organizations and legislatures have deployed pseudo-scientific arguments to exclude transgender athletes from the many positive aspects of athletic participation. Finally, it considers how the adverse treatment of transgender athletes is similar to the historical adverse treatment of disabled athletes, although disabled athletes are beginning to receive more athletic opportunities. It shows how an overmedicalization perspective can help remove some of the comparable barriers to athletic participation for transgender and disabled athletes.

### A. *Transgender Medical Framing*

Within the progressive legal community, not everyone questions the legitimacy of medical science as having a role to play in promoting transgender justice. Instead, some commentators make pragmatic arguments that rely on medical categories or disability law to enhance the rights of transgender people. Like Konnoth, these individuals seem to believe that medical categories can be used while remaining respectful to the experiences of transgender people. However, other commentators argue that medical categories should play no role in determining legal protections for transgender people. This Section notes that medical categories have been crucial to legal victories in the area of transgender justice, which further raises the question of whether demedicalization is the solution to overmedicalization. Is Konnoth correct that medicine can be transformed to be more respectful to the lives of transgender people?

In a 2008 note published in the *Harvard Journal of Law and Gender*,<sup>94</sup> Alvin Lee acknowledges the criticism of a medicalized conception of gender identity but suggests that employing such a medicalized conception is uniquely justified in the prison context.<sup>95</sup> Lee recognizes that those “who criticize the medical model have articulated a ‘self-determinative model’ of trans identity that rejects the medical model’s perceived pathologization and

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<sup>94</sup> Alvin Lee, Note, *Trans Models in Prison: The Medicalization of Gender Identity and the Eighth Amendment Right to Sex Reassignment Therapy*, 31 HARV. J.L. & GENDER 447 (2008).

<sup>95</sup> *Id.* at 450.

instead adopts a flexible, inclusive, and non-binary view of gender identity.”<sup>96</sup>

Commentators who oppose the use of a medical model to define the right to access transgender care argue that such a model is under-inclusive and disrespectful. Specifically, they find it problematic to limit access to legal protections to only transgender people who meet a narrow medical definition of gender identity disorder or gender dysphoria and suggest that such an approach disrespects their right to self-determination. Lee disagrees, reasoning that “trans-specific health care specialists have noted that such self-determinative principles are to be honored and respected in the responsible administration of sex reassignment therapy.”<sup>97</sup> Like Craig Konnoth,<sup>98</sup> Lee expresses confidence in the ability of the medical system to respect people’s asserted gender identity. However, Lee fails to address the fact that the individual’s right to assert a gender identity must nonetheless be mediated through a medical professional. The transgender person must persuade a medical professional to respect their claim to self-determination to receive legal protection.

Additionally, Lee downplays the significance of the requirement that a person describe themselves as having a “disorder.” While recognizing that disability categorization can be “pathologizing and stigmatizing,” he deflects that criticism by noting that the stigma occurs for social reasons, since it is not the label itself, but “the negative association that society imposes upon disabilities that is stigmatizing.”<sup>99</sup> While it is certainly true that society creates stigma, it is also true that the over-pathologization of transgender status is an aspect of that societal stigma. Transgender people seek *gender-affirming* care. They do not seek to be “cured” from a “disorder.”

Thus, Lee is insufficiently critical of the time and expense incurred by transgender people seeking medical professionals to affirm their own understanding of their gender identity. While some health care professionals are respectful of a self-determination model, it is, by definition, not self-determination if someone requires a health-care professional to affirm their expression of gender identity. Self-determination is at odds with the need for a health-care diagnosis grounded in medically-defined categories.

Similarly, Ali Szemanski’s 2020 note in the *Harvard Journal of Law and Gender* offers pragmatic, medicalized arguments in favor of using the ADA to further the protections of transgender people while also recognizing the opposition of many members of the transgender community to that argument.<sup>100</sup> By the time the article was published, the DSM-5 had been updated

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<sup>96</sup> *Id.* at 451.

<sup>97</sup> *Id.* at 466.

<sup>98</sup> See *supra* text accompanying notes 42–51.

<sup>99</sup> Lee, *supra* note 94, at 465.

<sup>100</sup> See Ali Szemanski, Note, *When Trans Rights Are Disability Rights: The Promises and Perils of Seeking Gender Dysphoria Coverage under the Americans with Disabilities Act*, 43 HARV. J.L. & GENDER 137 (2020).

to refer to “gender dysphoria” rather than “gender identity disorder.”<sup>101</sup> As noted by Szemanski, the decision to change the term was also intended “to move away from treating gender nonconformity itself as a mental disorder.”<sup>102</sup>

Nonetheless, as Szemanski acknowledges, many feminist and queer theorists have rejected the new DSM-5 category because it overemphasizes biology as the determinative factor in creating the gendered body. She recognizes that “such critiques line up with critiques of the medical model of disability, which focuses on ‘curing’ disabled people, views ‘disability as an infirmity of the individual to be responded to with treatment and pity,’ and perpetuates stigma and social prejudice by viewing disabled people as inherently inferior.”<sup>103</sup>

Szemanski dismisses those concerns: “[T]his side of the pathologization critique ignores the lived realities and needs of many trans people, specifically the need for strong, immediate legal protections against the pernicious discrimination faced daily by the community. A world without pathologization may indeed be ideal, but fighting for trans rights using the provisions of the ADA may provide necessary relief to individuals who live in the current world and not an idealized future world.”<sup>104</sup> However, without any citation to statutory or legal authority, Szemanski denies that the ADA requires a formal diagnosis for protection.<sup>105</sup> Despite her concern for the “lived reality” of transgender people, she fails to note that a medical diagnosis was a part of each case that had proceeded under a gender dysphoria theory.<sup>106</sup> That is not surprising, given that gender dysphoria is defined by the DSM-5 and not all people who identify as transgender are presumed to have the diagnosis, as Szemanski acknowledges.

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<sup>101</sup> *Id.* at 146–47.

<sup>102</sup> *Id.* at 147 (“Simply put, being trans alone cannot sustain a diagnosis of gender dysphoria under the DSM-V, as it could for a diagnosis of gender identity disorder under the DSM-IV.”).

<sup>103</sup> *Id.* at 161 (citing Jennifer L. Levi & Bennett H. Klein, *Pursuing Protection for Transgender People through Disability Laws*, in *TRANSGENDER RIGHTS* 74, 79 (Paisley Currah, Richard M. Juang & Shannon Price Minter eds., 2006); Alison Kafer, *Introduction: Imagined Futures*, in *FEMINIST QUEER CRIP* 1, 5 (2013)).

<sup>104</sup> Szemanski, *supra* note 100, at 161.

<sup>105</sup> *Id.*

<sup>106</sup> *See, e.g.*, *Edmo v. Corizon*, 935 F.3d 757, 767 (9th Cir. 2019) (“Both sides and their medical experts agree: Edmo suffers from gender dysphoria, a serious medical condition.”); *Hicklin v. Precynthe*, No. 4:16-cv-01357-NCC, 2018 WL 806764, at \*5 (E.D. Mo. 2018) (relying on declaration from a “clinical and forensic psychologist” to determine that Hicklin has gender dysphoria). The arguable counterexample might be the recent Fourth Circuit decision that cites Szemanski’s article in concluding that a claim under the ADA is cognizable for someone who alleges gender dysphoria. *See Williams v. Kincaid*, 45 F.4th 759, 782 n.3 (4th Cir. 2022) (Ouattlebaum, J., concurring). This case only involved the legal issue of whether ADA coverage was possible; presumably, on remand, the medical evidence in support of that diagnosis would be offered.

By contrast, transgender legal scholar and activist Dean Spade has consistently criticized the medicalization of transgender status.<sup>107</sup> His 2003 article highlights the pernicious role that medicine plays in nearly all areas related to transgender rights:

In almost every trans-related case, whether it be about the legitimacy of a trans person's marriage, the custody of hir children, hir right not to be discriminated against in employment, hir right to wear gender appropriate clothing in school or foster care, hir rights in prison, or whatever other context brings hir to court, medical evidence will be the cornerstone of the determination of hir rights.<sup>108</sup>

Spade notes that medical evidence is required in a context “where medical care associated with sex reassignment is still doled out through gender-regulating processes that reinforce oppressive and sexist gender binaries, and where, because of these circumstances and others, many gender transgressive people will choose not to or be unable to access medical care associated with their gender identity.”<sup>109</sup> In other words, many people who identify as transgender may not have access to a health-care system that is willing to acknowledge their identity. Nonetheless, he notes that legal activists often have to present medical documentation to expand transgender rights because “the reliance on medical evidence and the medical assessment of gender identity is so deeply entrenched.”<sup>110</sup>

Spade then describes his own journey in seeking gender-affirming medical care. He found that the medical community denied his request for chest reconstruction surgery, concluding that he was not sufficiently transgender to qualify for the surgery because he refused to conform to a specific transgender narrative: that he was unwilling to “make the commitment to ‘full-time’ maleness.”<sup>111</sup>

The fact that I don't want to change my first name, that I haven't sought out the use of the pronoun ‘he,’<sup>112</sup> that I don't think that ‘lesbian’ is the wrong word for me, or, worse yet, that I recognize

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<sup>107</sup> See, e.g., Spade, *supra* note 29; Dean Spade, *Resisting Medicine, Re/modeling Gender*, 18 BERKELEY WOMEN'S L.J. 15, 17–18 (2003); see also Dean Spade, *Other Writing*, DEAN SPADE, <http://www.deanspade.net/writing/> [<https://perma.cc/XA73-F4T7>] (listing his articles).

<sup>108</sup> Spade, *Resisting Medicine, Re/modeling Gender, supra* note 107, at 17–18 (footnotes omitted).

<sup>109</sup> *Id.* at 18.

<sup>110</sup> *Id.*

<sup>111</sup> *Id.* at 21.

<sup>112</sup> Although Spade initially retained the pronoun “she” while seeking chest reconstruction surgery, he has subsequently chosen to use the pronoun “he.” Thus, I use the pronoun “he” when referring to Spade. See DEAN SPADE, <http://www.deanspade.net> [<https://perma.cc/AC77-6U4L>] (using the pronoun “he” in self-identification on his website).

that the use of any word for myself—lesbian, transperson, transgender, butch boy, mister, FTM fag, butch—has always been/will always be strategic, is my undoing in their eyes. They are waiting for a better justification of my desire for surgery, something less intellectual, more real.<sup>113</sup>

Because he refused to conform to those expectations, the health-care worker advised Spade to get breast reduction surgery rather than chest reconstruction surgery—even though these are two very different procedures.<sup>114</sup> By contrast, Spade found that the transgender community was accepting of the variety of ways that one might identify as transgender. He described:

The trans people I've met have, shockingly, believed what I say about my gender. Some have a self-narrative resembling the medical model of transsexuality, some do not. However, the people I've met share with me what my counselors do not: a commitment to gender self-determination and respect for all expressions of gender.<sup>115</sup>

Spade's experience leads him to argue that advocates of transgender law and policy should seek "demedicalization."<sup>116</sup> He contends that the current approach "coerce[s] people into expressing gender identity through a narrowly defined binary."<sup>117</sup> Konnoth acknowledges this problem in his article, noting that "transgender individuals have often successfully agitated for more autonomy over medical categories that are relevant to their community, in some cases successfully countering the need to assimilate into the rigid gender binaries that concern Dean Spade."<sup>118</sup> However, Konnoth maintains his aspirational view that medicine can be changed so that it no longer works to reinforce rigid gender binaries.<sup>119</sup> But he fails to recognize that the need to identify with a medical category, by harnessing the approval of medical professionals, is problematic even if those professionals are respectful of transgender people. Konnoth's affirmation of the search for "autonomy"<sup>120</sup> is meaningless if the person seeking recognition must define their personhood in medical terms.

This Article seeks to suggest a framework that does not have to deny that some people may consider transgender status to have a medical component without also requiring medical professionals to valorize that self-affir-

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<sup>113</sup> Spade, *Resisting Medicine/Remodeling Gender*, *supra* note 107, at 21.

<sup>114</sup> *Id.* at 22.

<sup>115</sup> *Id.*

<sup>116</sup> *Id.* at 29.

<sup>117</sup> *Id.*

<sup>118</sup> Konnoth, *supra* note 42, at 1259.

<sup>119</sup> *Id.* at 1249–62.

<sup>120</sup> *Id.* at 1174.

mation. Transgender activist and English Professor Jennifer Finney Boylan endorses such an approach in a 2022 op-ed:

Being trans is many things, but one thing it is not is a Hula-Hoop. It is a medical condition, requiring dependable and affordable treatment, but it is not only a medical condition. It is about rejecting the binary—but it is not only about that either. In the end, the one thing our diverse community might share is a desire for the right to make our own decisions about our bodies, and to get the care we need.<sup>121</sup>

Boylan seeks to allow transgender people to make their own decisions about their bodies and care without having to conform to a rigid definition of a medical condition. Being transgender is not a Hula-Hoop, just as it is not a DSM-5 category.

As we will see in the next two Sections, Konnoth's aspirational vision has not transformed this area of the law. Transgender people continue to have to conform to a narrow understanding of their self-identity to gain any kind of legal protection. Further, the anti-transgender community continues to overuse medicine to exclude them from participation in certain areas, like competitive sports.

### B. Gender Marker Changes

The field of gender marker changes is an excellent example of this Article's overmedicalization thesis. As we will see, the pragmatic legal arguments presented in this area rarely question why gender should matter at all or insist that gender-marker decisions be made solely based on a person's gender self-affirmation. Legal victories maintain the medicalized status quo even if individual plaintiffs attain some relief.

Attorney Megan Brodie Maier has documented the problematic ways that states require people to medicalize their transgender status to receive accurate representations on birth certificates and other government documents.<sup>122</sup> Her article supports the non-medicalized, self-affirming thesis of this Article and would likely be embraced by transgender activists like Dean Spade. These theoretical arguments, however, are inconsistent with the way lawyers have framed cases challenging state gender marker laws.

An example from Montana exemplifies the way that legal arguments can reify the medicalization of gender identity. On July 16, 2021, Amelia

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<sup>121</sup> Jennifer Finney Boylan, Opinion, *Is Being Transgender A Medical Condition?*, WASH. POST (Sept. 13, 2022), <https://www.washingtonpost.com/opinions/2022/09/13/trans-health-care-medicaid-jenny-boylan/> [<https://perma.cc/M6F4-HMVE>].

<sup>122</sup> For an excellent overview of state policies, see Megan Brodie Maier, *Altering Gender Markers on Government Identity Documents: Unpredictable, Burdensome, and Oppressive*, 23 U. PA. J.L. & SOC. CHANGE 203 (2020) (supporting appearance-based policies, self-affirmation policies or removal of gender markers).



Marquez and John Doe filed a case against the state of Montana to challenge its rules for correcting one's gender identity on one's birth certificate.<sup>123</sup> Their lawsuit challenged a state law that requires "any transgender person who seeks to amend their sex designation to undergo gender-affirming surgery and initiate a legal proceeding to prove that they have completed the surgery."<sup>124</sup>

While recognizing that not all transgender people have gender dysphoria, the complaint also emphasizes gender dysphoria, suggesting that the plaintiffs accept that clinical diagnosis. The complaint states: "Gender dysphoria is a medically recognized condition defined by a marked incongruence between a person's gender identity and the sex they were assigned at birth. It is a serious medical condition. Some, but not all, transgender people have gender dysphoria."<sup>125</sup> The following paragraphs of the complaint recognize "treatment" for gender dysphoria and emphasize how the Montana statute is inconsistent with the views of organizations like the American Medical Association that urge "states to eliminate any requirement that transgender people have gender-affirming surgery to amend their birth certificates."<sup>126</sup> The complaint's final statement criticizing the statute emphasizes its inconsistency with medical treatment: "By embracing the Act, the State of Montana has imposed a draconian medical requirement on transgender people that has no medical or other rational justification. It reinstates an archaic understanding of transgender people and ignores modern medical treatment guidelines."<sup>127</sup> Nonetheless, the complaint never argues that one should be able to establish one's gender by simply stating one's preferred gender designation. In fact, its reference to the medical treatment of the plaintiffs<sup>128</sup> suggests that transgender status needs to be mediated through the medical system. While the complaint makes passing reference<sup>129</sup> to a proposed U.S. State Department policy that requires no medical documentation

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<sup>123</sup> Complaint, Marquez v. State of Montana, No. 21-873 (Mont. 13th Jud. Dist. Ct., Yellowstone Cnty. July 16, 2021).

<sup>124</sup> *Id.* at 2.

<sup>125</sup> *Id.* at 6.

<sup>126</sup> *Id.* at 7.

<sup>127</sup> *Id.* at 8.

<sup>128</sup> The complaint states that Marquez "has taken hormone replacement therapy with the aid and support of her treating healthcare professional." *Id.* at 11. The complaint also states that Doe, "with the support and assistance of his treating health professionals, has taken certain steps to bring his body into conformity with his male gender identity. He has taken hormone therapy for approximately two years. In spring 2021, Mr. Doe underwent masculinizing chest reconstruction surgery, commonly known as 'top surgery.'" *Id.* at 12.

<sup>129</sup> *Id.* at 7 ("Additionally, the United States Department of State has proposed changes to the passport and Consular Reports of Birth Abroad application process to allow applicants to self-select their gender, without medical certification.").

to choose or change one's gender marker,<sup>130</sup> it does not emphasize how that policy change acknowledges self-affirmation without medical intervention.

Not surprisingly, the trial court decision in favor of the plaintiffs emphasizes the medicalized story. Ignoring the complaint's assertion that not all transgender people have gender dysphoria, the court quotes a statement from the plaintiffs' expert's declaration that, "for transgender people, the sex assigned at birth does not align with the individual's genuine, experienced sex, resulting in the distressing condition of gender dysphoria."<sup>131</sup> The result was a victory for the plaintiffs. Montana returned to its prior policy that "permitted a transgender person to amend his or her original birth certificate by submitting to DPHHS a completed gender-designation form attesting to gender transition *or* providing government-issued identification displaying the correct sex designation *or* providing a certified court order indicating a gender change."<sup>132</sup> But the court's reasoning focuses only on the needless surgery requirement, rather than concluding that medical documentation is *per se* inappropriate.

One problem with the medicalization approach to gender marker changes is that it presumes the appropriateness of the government recording sex on the government document itself. In his expansive article on documenting gender, Dean Spade argues:

Gender, then, is not just unstable on the documents of transgender people . . . but is unstable and unreliable as an indicator of any particular "truth" across the entire system. Is it, then, a useful tool of identity verification? Do its benefits to various systems of governmental recordkeeping outweigh its costs? Does it do the work that "common sense" tells us it is doing? Looking at each agency and institutional use and observing the history of how the use of identity documents in institutions shifts over time and how gender operates in these contexts over time, we can see the limited value of gender in these recordkeeping schemes.<sup>133</sup>

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<sup>130</sup> See *Selecting Your Gender Marker*, BUREAU CONSULAR AFF., U.S. DEPT. OF STATE, <https://travel.state.gov/content/travel/en/passports/need-passport/selecting-your-gender-marker.html> [<https://perma.cc/FUD5-9C4N>].

<sup>131</sup> Findings of Fact, Conclusions of Law, and Order Granting in Part and Denying in Part Defendants' Motion to Dismiss and Granting Plaintiffs' Motion for a Preliminary Injunction at 8, *Marquez v. State of Montana*, No. 21-873 (Mont. 13th Jud. Dist. Ct., Yellowstone Cnty. Apr. 21, 2022).

<sup>132</sup> Complaint, *supra* note 124, at 8. I have not been able to find a copy of the gender-designation form on Montana's website to determine whether the first option requires any medical statements. Megan Brodie Maier's overview of state policies, written before the Montana judge struck down the new Montana law, notes that Montana's policy about what kind of affirmation to require from the applicant is unclear. See Maier, *supra* note 122, at 225 n.150 (suggesting that Montana may have only required a person to "bring a letter from a doctor stating the person is in the process or has completed the process of changing their gender").

<sup>133</sup> Spade, *supra* note 29, at 209.

Spade's argument pushes us to question the use of medical categories at all in challenging the government's use of gender markers in many areas of life. While it might be helpful to emphasize that one should be allowed to self-affirm one's gender (without any reliance on medical professionals), it is arguably even more progressive to ask why gender is being policed at all. We must recognize that government insistence on gender recordkeeping on birth certificates, passports, and driver's licenses is obsolete and ineffective and leads to potential harassment for those who do not fit certain gender norms or merely do not want to identify their gender. Unfortunately, gender marker case law does not raise the question of why gender is required at all.

In his article supporting the use of medical-framing, Konnoth recognizes the work of Dean Spade in "describ[ing] how trans individuals have to navigate gatekeeping by medical professionals to get gender-affirming care."<sup>134</sup> However, Konnoth dismisses gatekeeping concerns by pointing out what he considers to be the "pragmatic" benefits of medical-framing.<sup>135</sup> Konnoth's pragmatic example is *Blatt v. Cabela's Retail, Inc.*, a case in which a transgender employee brought an ADA claim to require her employer to correctly identify her name on her nametag and to allow her to use a restroom that conformed to her gender identity.<sup>136</sup> The district court considered whether the ADA should be interpreted to allow people who are transgender to qualify as "disabled" and accordingly receive statutory protection from discrimination.<sup>137</sup> This case was brought before the Supreme Court interpreted Title VII to provide protection against transgender discrimination,<sup>138</sup> at a time when there was no national statute protecting employees from discrimination based on their gender identity and, thus, in a period when coverage under the ADA could have far-reaching implications. This argument, however, was difficult to make because the ADA excludes coverage for people who have "transvestism" or "transsexualism."<sup>139</sup> As a matter of statutory interpretation, the court had to determine whether those exclusions meant that Congress intended to exclude all disability-based claims by people who identify as transgender, including people who identify as having gender dysphoria.<sup>140</sup>

Despite the ADA's exclusionary statutory language, the district court ruled that the ADA should be interpreted to cover transgender people who have gender dysphoria by reasoning that the term was distinct from the ex-

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<sup>134</sup> Konnoth, *supra* note 42, at 1170.

<sup>135</sup> *Id.* at 1171.

<sup>136</sup> *See id.* at 1169; *Blatt v. Cabela's Retail, Inc.*, No. 5:14-cv-04822, 2017 WL 2178123 (E.D. Pa. May 18, 2017).

<sup>137</sup> *Blatt*, 2017 WL 2178123, at \*2.

<sup>138</sup> *See Bostock v. Clayton County*, 140 S. Ct. 1731, 1754 (2020) (holding that "[a]n employer who fires an individual merely for being gay or transgender defies [Title VII]").

<sup>139</sup> 42 U.S.C. § 12211(b)(1) (2008).

<sup>140</sup> *Blatt*, 2017 WL 2178123, at \*2.

cluded categories of transvestism and transsexualism.<sup>141</sup> The district court's decision could have wide-ranging implications for people who identify as transgender and are comfortable with claiming to have "gender dysphoria" if it were broadly adopted by other courts. One can imagine many transgender people saying that they do not consider themselves to be "transvestites" or to be "transsexual" but do consider themselves to have the DSM-5 impairment known as "gender dysphoria." If they are willing to make those arguments, they would be able to benefit from the ADA's full range of legal protections, including the right to reasonable accommodation.<sup>142</sup>

Konnoth applauds the district court's ruling in *Blatt* because it expands the availability of ADA protection to a new medical category—gender dysphoria. The *Blatt* decision is consistent with his project of expanding the number of individuals who can be placed into medical categories and receive civil rights protections. Thus, he favors allowing transgender people to receive greater protection through the medicalization of their status under the ADA.

But what are the benefits and costs of such a victory that is achieved by an approach that this Article would describe as overmedicalization?

One benefit would be the coverage of nearly all transgender people under the ADA. Using the social model of disability, one might argue that all transgender people have gender dysphoria because of society's mistreatment of transgender people. Being transgender is not inherently disabling, but society disables that status through its many acts of disrespect to transgender people. Further, one might argue that the DSM-5 has embraced that view by permitting people to merely self-affirm they have gender dysphoria without a formal medical diagnosis.<sup>143</sup> In other words, the social model of disability could suggest there is no daylight between being transgender and having gender dysphoria.

But this victory comes at the cost of the medicalization of transgender status. Blatt merely wanted a name tag that correctly identified her and the ability to use an appropriate restroom. While her employer's conduct was clearly disabling her, it was because of her status as a transgender person. She had to claim she had "gender dysphoria" to distinguish herself from the

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<sup>141</sup> *Id.* at \*3–4.

<sup>142</sup> For protection against other forms of discrimination, they can likely use Title VII of the Civil Rights Act of 1964. See *Bostock*, 140 S. Ct. at 1754 (holding that Title VII provides protection against sexual orientation and transgender discrimination). But Title VII does not provide for the possibility of reasonable accommodations based on sex or gender. It only provides for reasonable accommodation in the context of alleged religious discrimination. See Title VII, 42 U.S.C. §§ 2000e(j), 2000e-2(a)(1). The ADA provides that protection. See ADA, 42 U.S.C. § 12112(b)(5)(A)–(B).

<sup>143</sup> See AM. PSYCHIATRIC ASS'N, *supra* note 5, at 451–59 (referring to the "strong desire" or "strong conviction" of the person seeking a diagnosis of gender dysphoria while also requiring a diagnosis of "clinically significant distress or impairment" without specifying how that determination is to be made).

excluded “transsexual” category. This victory does nothing to move us away from unnecessary medical categories.

And while not a case about government identity documents, Blatt’s case shares some similarities with those cases. If the name tags and restrooms were not based on a sex classification system, then she may not have faced as much (or the same) discrimination. The requirement that she fit a medical category to receive statutory protection makes it harder to challenge the needless sex classification system. As I have argued elsewhere, cases about access to public restrooms should ask the fundamental question of why restrooms are gender-segregated at all.<sup>144</sup>

In sum, it may be helpful in some cases for transgender people to seek ADA protection to attain reasonable accommodations. The social model of disability could allow them to enter that covered category through the label of gender dysphoria, especially because the DSM-5 arguably allows people to be recognized as having gender dysphoria based solely on their self-affirmation. To avoid overmedicalization, transgender people who are comfortable claiming they have gender dysphoria should not be required to present medical documentation to earn that protection. The State Department’s recent step to allow self-identification as the sole step for gender identification<sup>145</sup> should be the model in this area, as it both minimizes needless medicalization and offers important federal protection. Transgender people should not have to conform to a medical category to question the needless reification of gender-based rules in our society, and they should also be able to use medical categories and criteria to describe their experiences when they so choose.

### C. *Participation in Athletics*

#### 1. *Transgender Athletes*

This Section connects two seemingly disparate areas of the law to provide further examples of the problem of overmedicalization. In the transgender context today, states and athletic entities seek to exclude transgender women from athletic participation as women<sup>146</sup> through pseudoscientific ar-

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<sup>144</sup> See generally Ruth Colker, *Public Restrooms: Flipping the Default Rules*, 78 OHIO ST. L.J. 145 (2017) (arguing that the default rule should be for all public restrooms to be gender-neutral).

<sup>145</sup> See *Selecting Your Gender Marker*, BUREAU CONSULAR AFF., *supra* note 130.

<sup>146</sup> See Christopher M. Pardo & Katherine P. Sandberg, *Transgender Students and Sports: Title IX Compliance*, 39 GPSOLO 66, 66 (Mar./Apr. 2022), [https://www.americanbar.org/groups/gpsolo/publications/gp\\_solo/2022/march-april/transgender-students-and-sports-title-ix-compliance/](https://www.americanbar.org/groups/gpsolo/publications/gp_solo/2022/march-april/transgender-students-and-sports-title-ix-compliance/) [<https://perma.cc/ZL3Y-T7AL>] (reporting that thirty states had introduced related legislation, while Arkansas, Florida, Idaho, Mississippi, and Tennessee had enacted those bans, as of March 2022).

guments that rely on gender stereotypes related to women's appearance.<sup>147</sup> Similarly, states and athletic entities have historically tried to exclude disabled athletes' participation in ways that would have allowed them to be fully competitive with their peers.

This Section argues that transgender athletes and disabled athletes should be allowed to excel, not merely participate. Pseudoscience should not serve to exclude them from the many positive aspects of athletic participation. If we hear their stories, we will understand how they are using athletics to grow as people. We should affirm that aspect of their identities. They should not have to undergo invasive medical testing to be able to fully participate in athletics consistent with their self-identity.

The Lia Thomas controversy exemplifies how the overuse of science obscures athletes' voices in public discourse. The Thomas controversy began when Thomas sought to participate in college swimming as a highly competitive female athlete. The well-known women's tennis player Martina Navratilova, who has publicly objected to transgender women participating in women's competitive athletics since 2018,<sup>148</sup> relied on "biology" to object to Thomas' participation as a woman, stating: "I played against taller women, I played against stronger women, and I beat them all. But if I faced the male equivalent of Lia in tennis, that's biology. I would have had no shot."<sup>149</sup> Even commentary in favor of transgender athletes' participation in sports often rests on medical claims about the effects of various hormones on people's bodies.<sup>150</sup> Proponents disagree with Navratilova's argument that trans-

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<sup>147</sup> See, e.g., Michael J. Lenzi, *The Trans Athlete Dilemma: A Constitutional Analysis of High School Transgender Student-Athlete Policies*, 67 AM. U. L. REV. 841, 842, 855 (2018) (contending that "high school athletic associations should pursue fully inclusive models that validate the dignity of trans students" and especially noting that these exclusions are especially unfair for male to female trans girls "who were placed on hormone blockers before they reached puberty and never developed male secondary sex characteristics"); Erin E. Buzuvis, *Transgender Student-Athletes and Sex-Segregated Sport: Developing Policies of Inclusion for Intercollegiate and Interscholastic Athletics*, 21 SETON HALL J. SPORTS & ENT. L. 1, 35 (2011) (arguing that "[s]cience also makes it easier to reject assumptions about sex-based competitive advantage by failing to substantiate a conclusive relationship between competitive advantage and the physical features associated with sex" while acknowledging there are "generalized physiological differences between men and women").

<sup>148</sup> See James Masters, *Martina Navratilova Criticized for Comments About Trans Women in Sport*, CNN (Feb. 18, 2019), <https://www.cnn.com/2019/02/18/tennis/martina-navratilova-trans-women-comments-spt-scli-intl/index.html> [<https://perma.cc/B7SE-KCMR>] (describing a February 2019 op-ed in *The London Sunday Times* and a December 2018 tweet in which Navratilova criticized trans women competing as women in sports).

<sup>149</sup> David Walter Banks, *What Lia Thomas Could Mean for Women's Elite Sports*, N.Y. TIMES (May 29, 2022), <https://www.nytimes.com/2022/05/29/us/lia-thomas-women-sports.html> [<https://perma.cc/X4DD-RK9N>].

<sup>150</sup> See Kathleen Comerford, *Put Me In, Coach!: How Title IX Should Regulate Transgender Female Athletes*, 52 SETON HALL L. REV. 869, 870–71 (2022) (arguing that the U.S. Department of Education's Office for Civil Rights, the agency charged with enforcing Title IX, should impose regulations requiring transgender female athletes to complete one year of hormone suppression therapy before competing in women's sports).

gender women retain inherent biological advantages rather than challenge the underlying assumption that biology must play a major role in determining athletic participation.

The arguments against Thomas's competitive participation in swimming reached such a fever pitch that World Aquatics (formerly called "FINA," Fédération Internationale de Natation), the international governing body for swimming, adopted a policy "that prohibits male-to-female transgender athletes who transitioned after beginning male puberty" to compete in women's events.<sup>151</sup> Athlete Ally, a nonprofit LGBTQ athletic advocacy group, sharply criticized this policy change, arguing that it is "deeply discriminatory, harmful, unscientific and not in line with the 2021 International Olympic Committee framework on Fairness, Inclusion and Non-Discrimination on the Basis of Gender Identity and Sex Variations."<sup>152</sup> Athlete Ally also stated that the new criteria "police the bodies of all women, and will not be enforceable without seriously violating the privacy and human rights of any athlete looking to compete in the women's category."<sup>153</sup> The privacy fears that Athlete Ally raised have begun to materialize in other arenas that have established similar rules. For example, Utah parents accused a female athlete of being transgender when she won first place in her sport by a wide margin; the school traced her records back to kindergarten to prove she had always been female.<sup>154</sup>

We must seek to better understand the claims being made by transgender people. Transgender athletes are not transitioning to achieve an athletic advantage; they are transitioning to achieve a life consistent with their self-identification. Thomas has explained: "Trans people don't transition for athletics. We transition to be happy and authentic and our true selves. Transitioning to get an advantage is not something that ever factors into our decisions."<sup>155</sup> Thomas has indicated that she transitioned when "her gender

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to ensure a competitive athletic opportunity for both transgender women and cisgender women); Joanna Harper, *Transgender Athletes and International Sports Policy*, 85 J.L. & CONTEMPORARY PROBLEMS 151, 154 (2022) (favoring athletic participation rules that require gender-affirming hormone therapy but also suggesting that rules should be sport-specific and athlete-centric); Kendra M. Vosler, *The Struggle for Equality: The Goal is to Maintain Meaningful Competition for all Athletes—Male, Female, and Those Transitioning—But How?*, 55 CREIGHTON L. REV. 113, 135 (2021) (proposing that "if future studies are able to show *conclusively* that post-puberty hormone therapy can eliminate the masculine effects of puberty, then these athletes should be considered for eligibility on a case-by-case basis").

<sup>151</sup> See Olympic Talk, *Swimming Body Announces New Policy on Gender Inclusion*, NBC SPORTS (June 19, 2022), <https://olympics.nbcports.com/2022/06/19/fina-transgender-swimmers-policy/> [<https://perma.cc/8UMR-RPPT>].

<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

<sup>154</sup> Courtney Tanner, *Utah Parents Complained a High School Athlete Might Be Transgender After She Beat Their Daughters*, SALT LAKE TRIB. (Aug. 18, 2022), <https://www.sltrib.com/news/education/2022/08/18/utah-parents-complained-high/> [<https://perma.cc/9LBJ-P3NL>].

<sup>155</sup> Amanda McMaster et al., *Transgender Swimmer Lia Thomas Speaks Out About Backlash, Future Plans to Compete*, ABC NEWS (May 31, 2022), <https://>

dysphoria plunged her into a deep depression, and she struggled with suicidal thoughts.”<sup>156</sup> Competitive swimming, which had been central to her life for decades, is part of who she is. In some ways, swimming is as central to her identity as her gender. The World Aquatics rules, and others like them on the state level, would require Thomas to discard her athletic identity to embrace her gender identity.

But unsurprisingly, Thomas embraced the overmedicalization messaging when she talked publicly about her situation. Thomas did not merely rest her claim to participate as a woman on the fact that it would make her feel “happy and authentic.”<sup>157</sup> Rather, she used the term “gender dysphoria” and identified significant mental health challenges to explain the legitimacy of her transitioning to a female self-identity. The overmedicalization mindset may have caused Thomas to describe her situation based on medical documentation. Even so, it is helpful to distinguish between her decision to identify with a medical category—gender dysphoria—and her decision to disclose significant mental health challenges. In arguing that the solution to overmedicalization is not demedicalization, this Article affirms the importance of Thomas being able to describe her mental health challenges as part of her life experience.

While some of Lia Thomas’s critics may have truly believed that she presented an unfair biological advantage in competing as a woman, the far-reaching Republican response in state legislatures to the transgender athlete issue shows that the medical argument is often a façade for deeply rooted anti-transgender sentiments. In Ohio, for example, the state House of Representatives voted after 11:00 p.m. to attach an unrelated, anti-transgender athlete amendment to a bill that provided resources and mentorship opportunities for new teachers.<sup>158</sup> The bill would allow anyone to question whether a player is transgender and deny players the ability to participate unless they allow a doctor to evaluate their external and internal genitalia, testosterone levels, and genetic makeup.<sup>159</sup> Presumably, this rule would allow a parent or other competitor to challenge a female competitor at the state championship for a sport. Because there would not be enough time for the

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abcnews.go.com/GMA/News/transgender-swimmer-lia-thomas-speaks-backlash-future-plans/story?id=85068951 [https://perma.cc/6KHA-4L5V].

<sup>156</sup> *Id.*

<sup>157</sup> *Id.*

<sup>158</sup> See Jo Ingles, *In Late-Night, Last-Minute Move, Ohio House Passes Ban on Transgender Athletes in Girls Sports*, STATE HOUSE NEWS BUREAU (June 2, 2022), <https://www.stateneews.org/government-politics/2022-06-02/bill-to-step-transgender-athletes-from-participating-in-girls-sports-passes-the-ohio-house> [https://perma.cc/QY42-A7LQ].

<sup>159</sup> *Id.*; see also Jared Gans, *Ohio Republicans Pass Bill Enabling ‘Verification’ Process to Enforce Transgender Sports Ban*, HILL (June 3, 2022), <https://thehill.com/news/state-watch/3510823-ohio-republicans-pass-bill-enabling-verification-process-to-enforce-transgender-sports-ban/> [https://perma.cc/JTU3-4YRX] (“The bill states that if an athlete’s ‘sex is disputed,’ they are required to show a doctor’s statement ‘indicating the participant’s sex’ based on their ‘internal and external reproductive anatomy,’ ‘normal endogenously produced levels of testosterone’ and an ‘analysis of the participant’s genetic makeup.’”).



athlete to meet the medical testing requirements, the female athlete could be deemed ineligible to compete at the highest level of state competition, and thus, this rule could become another weapon used against any masculine-looking female athletes.<sup>160</sup> Such legislation demonstrates how anti-transgender policymakers can wield overmedicalization to reinforce historical patterns of gender discrimination and ignore the voices of transgender athletes.

## 2. *Disabled Athletes*

A disability perspective makes it even more apparent how biological arguments are deployed in athletics for pretextual reasons.<sup>161</sup> While others have written extensively about the ADA's coverage or lack of coverage of disabled athletes,<sup>162</sup> this Article's perspective is different. This Article is concerned with the political and cultural phenomena of excluding some athletes from participation purportedly because of their disability. Like the current arguments for excluding transgender athletes from sports participation, these cases should be understood within the problem of overmedicalization. And, in contrast to the transgender context, the rules have evolved to being more permissive of disabled students' athletic participation.

Let us revisit these disability cases to hear the historical stories of exclusion from an overmedicalization perspective. This survey of cases will demonstrate that, whether the disabled athlete is a young child or a professional athlete, the courts' overarching focus is on whether the requested accommodation would give them a competitive advantage or present a heightened risk of injury. This Article argues, as in the transgender sports examples, that courts should focus on athletes' self-affirmation of the positive role that sports play in their lives, rather than on biological arguments. We should value athletic participation by both the transgender athlete and the disabled athlete irrespective of whether they might be champions.

The first reported disabled athlete case<sup>163</sup> involved Mark Elitt, who was a ten-year-old boy with significant speech impairments as well as Attention

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<sup>160</sup> Of course, this is nothing new. In 1978, as a twenty-two-year-old, I was running in a ten-kilometer race and placed third in the women's division. I did not get my award because they claimed that I had been identified as a "man" when I crossed the finish line. They refused to change the results when I challenged the decision because I was running without a women's running bra (I am a cisgender female with small breasts). After that experience, I was careful to wear a running bra when I competed even though it just made me warmer and less comfortable.

<sup>161</sup> I would like to thank Jasmine Harris for assisting me with this argument.

<sup>162</sup> See generally Maureen A. Weston, *The Intersection of Sports and Disability: Analyzing Reasonable Accommodations for Athletes with Disabilities*, 50 ST. LOUIS UNIV. L.J. 137 (2005); Jonathan R. Cook, *The Americans with Disabilities Act and Its Application to High School, Collegiate and Professional Athletics*, 6 VILL. SPORTS & ENT. L.J. 243 (1999).

<sup>163</sup> *Elitt v. U.S.A. Hockey*, 922 F. Supp. 217 (E.D. Mo. 1996).

Deficit Disorder (ADD).<sup>164</sup> Rather than have Elitt participate in an ice hockey program for disabled children, his parents wanted him to participate in the recreational community program in which players are assigned to teams based on age and ability.<sup>165</sup> Elitt's neurologist testified that he could not communicate beyond the five or six-year-old level. In chambers, the judge found that Elitt's "communication skills in the absence of coaching were practically non-existent" and that he "experienced difficulty in answering very simple questions without assistance from his parents."<sup>166</sup> Further, an evaluation of Elitt's participation in ice hockey revealed that he "cannot fully participate in the game without assistance."<sup>167</sup> Nonetheless, Elitt enjoyed participating in ice hockey with his non-disabled peers. Thus, his parents sought an accommodation that would allow him to play in an integrated environment.

Elitt's parents came up with a two-part solution, in which he would play down to a lower age level, and his brother would be on the ice to assist him.<sup>168</sup> Unlike with Lia Thomas, the primary argument advanced to justify Elitt's exclusion was not that his participation would be a competitive advantage, but rather, that he would pose a danger to himself or others due to his greater height and communication problems. Diane Schaefering, a self-employed power skating instructor, conducted an evaluation of Elitt's participation for U.S.A. Hockey.<sup>169</sup> While she did not observe Elitt or others being hurt by his presence on the ice, she testified "that there was a potential for him being harmed or harming someone else"<sup>170</sup> when his brother was assisting him. As for his participation in a lower age group, Schaefering testified that she had "never heard of anyone playing down to a lower age level," although she had "heard of players moving up to a higher age level when their exceptional skills permitted such a move."<sup>171</sup> She believed it would be more appropriate for Elitt to compete in the special program for children with disabilities,<sup>172</sup> but she offered no evidence that she had ever visited the program, or that she was truly aware of how this type of program worked. Rather, in representing U.S.A. Hockey's interests, Schaefering advised against Elitt's participation in a disability-integrated environment with the accommodations proposed by his parents.

Philip Lovicchio, a representative of the Creve Coeur Hockey Club, also disagreed with Elitt's participation in the lower age group, but for different reasons. Lovicchio suggested that Elitt would have some biological ad-

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<sup>164</sup> *Id.* at 218.

<sup>165</sup> *Id.*

<sup>166</sup> *Id.*

<sup>167</sup> *Id.* at 220.

<sup>168</sup> *Id.*

<sup>169</sup> *Elitt*, 922 F. Supp. at 221.

<sup>170</sup> *Id.*

<sup>171</sup> *Id.*

<sup>172</sup> *See id.* (suggesting that he would be given "proper attention at the Gateway Program").

vantages due to his greater height and assistance from his brother: he reasoned that, because Elitt was a “head taller” than the other skaters, it “would be impossible to play other clubs” if he were on the ice with his brother.<sup>173</sup> He also emphasized the medical nature of the age guidelines, again implying that Elitt might have some kind of competitive advantage due to his “different motor skills.”<sup>174</sup>

These medical arguments seem pretextual on closer examination. Schaefering seemed concerned that Elitt would be harmed by playing down, even though the record showed that he would have great difficulty playing safely among his same-age peers. Although Elitt was technically allowed to play unaccommodated with same-age peers, Schaefering assumed he would accept the segregated disability-only hockey program if denied accommodations. Meanwhile, Lovicchio implied that it would be acceptable to allow Elitt to play with his same-age peers who would be the same size, despite the strong evidence that he could get injured in such an environment. Like Schaefering, Lovicchio probably assumed that Elitt would choose the disability-only league when his requested accommodation was denied.

On closer examination, Mark Elitt and Lia Thomas’ cases have fascinating similarities. By excluding Thomas from the women’s league, World Aquatics presumably would have allowed her to compete on the men’s team. Similarly, by excluding Elitt from the lower-age team, the league would presumably have allowed him to play with his same-age peers. Yet both of those options were only theoretical, not realistic. With Thomas’ breasts, it is hard to imagine she would be allowed to compete in the men’s division in men’s swimming trunks, due to both the likely public reaction and decency law violations. Thus, the World Aquatics rule functioned to exclude Thomas from competitive swimming altogether. Similarly, by excluding Elitt from the lower-age group team, the club would presumably have allowed him to play with his same-age peers, but his lower skill level likely would have caused complaints from others both on and off the team and placed Elitt at risk of physical harm. Therefore, by mandating adherence to the age rules, the ice hockey league effectively removed Elitt from participating altogether.

In these instances, both Elitt and Thomas were overmedicalized in the service of discrimination. Superficial references to Elitt’s height kept him out of the group that best served his interest in fully competing with non-disabled peers, while Thomas’ post-puberty gender transition kept her out of an international swimming competition in a way that would have otherwise served her strong identity as a competitive athlete. For these athletes, medical categories were not used to place them in a setting where they could compete successfully; rather, the categories were used to exclude Elitt from competition with non-disabled peers and exclude Thomas from competitive

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<sup>173</sup> *Id.* at 221–22.

<sup>174</sup> *See id.* at 222.

swimming altogether. This Article suggests that we must critically examine the use of medical categories and rules to see whether they have an underlying pretextual purpose. These two cases supply examples of situations in which biological arguments were employed for the crass purpose of exclusion.

Mark Elitt's experience as a K-12 athlete who was denied an accommodation that would allow him to play in a sport is not unique. In 1995, the Sixth Circuit ruled that the Michigan High School Athletic Association did not need to waive its age restriction to allow nineteen-year-old disabled students to participate in interscholastic athletics,<sup>175</sup> even though the waiver would have allowed students who turned nineteen during their last year of high school to continue to compete in sports.<sup>176</sup> The nineteen-year-old students ran track and cross-country, so an injury prevention-argument (like the one advanced in Elitt's case) was not available to the athletic association. The students were also not "star" players, so the athletic association could not make a competitive unfairness argument to justify these specific instances of exclusion.<sup>177</sup> Because a student would typically have to be retained twice in school to be nineteen years old before the beginning of their senior year of high school, a parent would be very unlikely to make that request merely to help their student gain a competitive advantage.

Despite uncontested evidence that the plaintiffs posed no injury problem to other players and did not possess an unfair competitive advantage, the Sixth Circuit rejected the reasonable accommodation request by determining that the age restriction was "necessary" and could not be waived in individual cases.<sup>178</sup> The possibility that other athletes *might* create those problems, merely because of their age, was sufficient to deny any consideration of a waiver as a reasonable accommodation.

Much like the decision-makers in Elitt's and Thomas's cases, the court was also dismissive of what this rule meant to the individual plaintiffs. Specifically, the Sixth Circuit stated: "In this case, although playing high school sports undoubtedly helped the plaintiffs progress through high school, the waiver of the age restriction is not directed at helping them overcome learning disabilities; the waiver merely removed the age ceiling as an obstacle."<sup>179</sup> This sentence is deeply problematic because it fails to recognize the full scope of what athletic participation can mean to a student. The requested accommodation *does* help students achieve the full benefits of a high school

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<sup>175</sup> See *Sandison v. Michigan High School Athletic Ass'n*, 64 F.3d 1026, 1037 (6th Cir. 1995) (overturning preliminary injunction granted by lower court).

<sup>176</sup> *Id.* at 1028.

<sup>177</sup> *Id.* at 1034 ("Specifically, after finding that the plaintiffs are not 'star' players and are not an injury risk to other competitors, the district court found that the MHSAA must waive Regulation I § 2 as to Sandison and Stanley in order to reasonably accommodate the plaintiffs.").

<sup>178</sup> *Id.* at 1035.

<sup>179</sup> *Id.* (emphasis omitted).

education, even if some of those benefits are achieved on the athletic field, because the mental health effects of sports benefit all aspects of their lives, including in the classroom. By stubbornly sticking to a biological age rule that existed in a school setting, the court failed to consider the full range of both academic and non-academic benefits. It also failed to consider the harm from exclusion from an activity that was likely central to that person's conception of themselves. Instead, biological age—a medical category—became an inflexible barrier to students with learning disabilities who sought to gain a full academic experience through athletics.

Reifying medical categories and failing to consider the impact of athletic exclusion on the disabled student is even more apparent in a 1996 case involving Nick Knapp.<sup>180</sup> Knapp brought his case after Northwestern University used a medical argument to exclude him from participation in their NCAA Division I basketball program.<sup>181</sup> Northwestern University had recruited Knapp in high school when he was considered to be one of the best high school players in Illinois.<sup>182</sup> During September of his senior year, Knapp suffered cardiac arrest during a pick-up game in his high school gym and had to be revived by paramedics.<sup>183</sup> That October, his doctors implanted a cardiac defibrillator in his abdomen that would detect heart arrhythmia and restart his heart in the event of a recurrence.<sup>184</sup> Although Northwestern was aware of Knapp's heart condition when he signed a letter of intent to attend the school in November of his senior year, the university subsequently decided he could not participate on the team.<sup>185</sup> Despite the willingness of Knapp and his parents to sign a release and the opinions of his experts that the level of risk was acceptable, Northwestern agreed to honor his scholarship but did not allow him to participate in the fall of his first year of college by playing in practice or in a game setting.<sup>186</sup>

Knapp sued Northwestern University under the Rehabilitation Act. The district court granted him a permanent injunction to be able to participate,<sup>187</sup> but the Seventh Circuit reversed.<sup>188</sup> The Seventh Circuit deferred to the university's right to determine a student's medical ineligibility, so long as the determination was supported by "reason and rationality and with full regard to possible and reasonable accommodations."<sup>189</sup> It also concluded that Knapp was not disabled under the Rehabilitation Act because he was not

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<sup>180</sup> Knapp v. Northwestern Univ., 101 F.3d 473 (7th Cir. 1996) (reversing district court decision in favor of plaintiff).

<sup>181</sup> *Id.* at 477.

<sup>182</sup> *Id.* at 476.

<sup>183</sup> *Id.*

<sup>184</sup> *Id.*

<sup>185</sup> Knapp v. Northwestern Univ., 942 F. Supp. 1191, 1194 (N.D. Ill. 1996).

<sup>186</sup> Knapp, 101 F.3d at 476–78.

<sup>187</sup> Knapp, 942 F. Supp. at 1199.

<sup>188</sup> Knapp, 101 F.3d at 473.

<sup>189</sup> *Id.* at 484.

substantially limited in a major life activity.<sup>190</sup> As with the previous examples, the Seventh Circuit minimized the impact that not being able to play basketball would have on Knapp's ability to engage in the major life activity of "learning." Instead, because he could learn without participating in intercollegiate athletics, the court reasoned that he did not meet that threshold requirement for being disabled.<sup>191</sup> Northwestern was given carte blanche to construct medical arguments to keep Knapp off the basketball court, despite evidence that he could play safely and was willing to personally accept the risks to himself that came with that decision. Ultimately, the court deferred entirely to these arguments, while also concluding that Knapp could not even allege he was disabled and therefore receive Rehabilitation Act protection.

The Seventh Circuit's determination that playing basketball in college was not an integral part of Knapp's educational experience disregarded his testimony about the relationship between sports and education for him. Through an overmedicalization lens, the court reduced Knapp to his medical condition which had no impact on his learning environment, rather than seeing him as an individual who benefitted broadly from athletic participation in school. Knapp explained in his affidavit:

[C]ompetitive basketball has helped to instill in me the following character traits: confidence, dedication, leadership, teamwork, discipline, perseverance, patience, the ability to set priorities, the ability to compete, goal-setting and the ability to take coaching, direction and criticism . . . . Competitive basketball has also given me recognition in the community, and provided me with the opportunity to meet new people . . . . Competitive basketball has also supplied me with a meaningful outlet for intense physical exercise and an enjoyment and happiness that cannot be duplicated in an open gym or intramural setting.<sup>192</sup>

Consistent with this Article's argument, it is important to read and understand Knapp's self-affirmation to respect his full personhood and to see that his exclusion from athletics would have a profound impact on his "learning," broadly defined. By deferring to Northwestern's use of medical categories, the Seventh Circuit effectively assigned no weight to Knapp's fuller description of his self-identity, mental health, leadership development, and overall "enjoyment and happiness."<sup>193</sup>

The district court, by contrast, viewed Knapp as a full person. While the court noted that intercollegiate athletics may not constitute a major life activity for everyone, it found, "without doubt, that it is for Nicholas Knapp."<sup>194</sup>

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<sup>190</sup> *Id.* at 482.

<sup>191</sup> *Id.* at 480–81.

<sup>192</sup> *Knapp*, 942 F. Supp. at 1195.

<sup>193</sup> *Id.*

<sup>194</sup> *Id.*

In evaluating the risk of athletic activity for Knapp, it weighed the scientific evidence carefully, noting that Knapp had experienced no further episodes despite two years of athletic activity since the first episode and that the likelihood of a second episode was “either low or unknown.”<sup>195</sup> The district court resisted the overmedicalization of Knapp’s situation and condition without disputing the fact that he had faced some medical challenges.

This case is a classic example of overmedicalization. The Seventh Circuit bent over backwards to defer to Northwestern University’s determination, even though the school’s determination had to do with a risk that Knapp was willing to impose on himself. For two years, following the heart incident, Knapp had continued to engage in competitive athletics. Northwestern was willing to allow Knapp to keep his scholarship and have a role with the team but could not play.<sup>196</sup> But Knapp did not want the easy way out: he wanted to be both a student and highly competitive athlete because athletics was integral to his educational experience.<sup>197</sup> And, unfortunately, Northwestern did not make that decision until after Knapp had begun his first year in college. Given his athletic talent, one could imagine that other universities would have been willing to give him an athletic scholarship to attend their university. But those scholarship decisions would have been made before Knapp learned that Northwestern would not permit him to play.

Ironically, Knapp had his first heart incident while playing a pick-up game in high school, before the official interscholastic period of play would have begun. Northwestern has an active intramural league that requires no medical clearances to participate.<sup>198</sup> As Elitt was “othered” by being pushed to the disability league, Knapp was othered by being pushed to the intramural league. But his student-athlete identity at the highest level of participation could not be retained, despite his self-evaluation of the risk, due to his medical status. Thus, in the cases of Thomas, Elitt, and Knapp, institutions were allowed to deploy arguments about rigid medical categories to exclude individuals from activities that were central to their identities and aspirations. Thomas and Knapp could presumably participate in their sports at a recreational level, and Elitt could play hockey in a segregated disability-only league, but ultimately, overmedicalization arguments placed a ceiling on their levels of participation and enjoyment. Each athlete’s self-affirmation of their needs and aspirations was largely ignored.

Surprisingly, entities have been required to reassess rules that preclude disabled athletes from competing, following the Supreme Court’s decision in

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<sup>195</sup> *Id.* at 1197.

<sup>196</sup> *Id.* at 1196.

<sup>197</sup> *Id.* at 1195.

<sup>198</sup> Northwestern’s page to register for intramural sports emphasizes that it is for “all skill levels” and does not mention any medical requirements. See *Intramural Sports*, N RECREATION, <https://nurecreation.com/sports/2020/9/23/intramural-sports.aspx?path=IMs> [<https://perma.cc/7PBC-QMDZ>].

*PGA Tour, Inc. v. Martin*.<sup>199</sup> Casey Martin, a professional golfer, sought permission to use a cart during a Professional Golfers' Association of America (PGA) tournament as a reasonable accommodation. Because of a degenerative circulatory disorder that obstructed the flow of blood from Martin's right leg to his heart, walking the golf course during a tournament, as required by PGA rules, would create "a significant risk of hemorrhaging, developing blood clots, and fracturing his tibia so badly that an amputation might be required."<sup>200</sup> To accommodate his disability, Martin requested the use of a golf cart. Focusing on the importance of an individualized inquiry, the Supreme Court concluded that requiring Martin to walk the course would likely cause him to experience greater fatigue than his competitors, due to the strain caused by his impairment.<sup>201</sup> Thus, the Court rejected the PGA's argument that modifying the rule for Martin would be "outcome-affecting."<sup>202</sup>

While the *Martin* case properly looked at the medical evidence regarding Martin's actual impairment, it did not engage in overmedicalization. As suggested in Part I, such a decision allows us to hear Martin's personal story—how his impairment impacted him and what kinds of minor accommodations could allow him to safely participate at a very high level of athletic competition. The *Elitt* and *Knapp* cases stand in sharp contrast. Although it was apparent that the young athlete posed no unfair competitive advantage and no safety risk, the *Elitt* court refused to permit any exceptions to the age rules. Similarly, the *Knapp* court ignored the athlete's actual medical records in permitting the university to impose an unduly high safety threshold on his ability to play basketball. In the *Martin* case, adhering to the PGA's no-golf-cart rule would have been dangerous for Martin, but the PGA seemingly would have permitted him to walk the course. This irrational outcome is similar to the ice hockey league seemingly allowing Elitt to play (dangerously) with his same-age peers. Genuine concern for the well-being of disabled athletes sometimes leads to a court's acceptance of a requested accommodation, but all too often, courts embrace pretextual medical arguments that paradoxically pose greater health risks.

The *Martin* decision has caused some courts to rethink their rigid adherence to age restrictions in K-12 athletics, in a way that critically examines overmedicalization. For example, in light of *Martin*, a Pennsylvania district court required the state high school athletic association to waive its maximum-age rule for a disabled student so that he could participate in football and track.<sup>203</sup> The student, Luis Cruz, had an intellectual disability, and his Individualized Education Program (IEP) concluded that athletic participation was an essential part of his educational experience, in that it allowed him to

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<sup>199</sup> *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 663 (2001).

<sup>200</sup> *Id.* at 668.

<sup>201</sup> *Id.* at 690.

<sup>202</sup> *Id.* at 663.

<sup>203</sup> See *Cruz ex rel. Cruz v. Pennsylvania Interscholastic Athletic Ass'n*, 157 F. Supp. 2d 485, 500 (E.D. Pa. 2001).



interact and converse with peers and adults, develop job-related interpersonal skills, and familiarize himself with demands and responsibilities that were “absolutely important to his self-esteem and self-confidence.”<sup>204</sup> The head football coach testified “that it was important for Luis Cruz actually to participate in games, if possible, as part of the team, rather than being absolutely limited to practice” and described Cruz’s joy when he “actually scored a touchdown in a football game and hugged the official as he was raising his arms.”<sup>205</sup> As required by *Martin*, the district court completed an individualized assessment to determine that Cruz posed no unfair competitive advantage, holding that his stature and role on the field made him a “marginal player” and “by no means greater than the average height and weight of other, even younger, participants.”<sup>206</sup> The district court did not engage in full demedicalization; instead, it reviewed the actual medical evidence to see if it served exclusion.

The *Cruz* decision seems consistent with the way many states currently handle age limitations for disabled athletes. For example, Ohio has an age cap of twenty but permits an exception for a disabled student, so long as the student does not pose a safety risk or undue competitive advantage.<sup>207</sup> The decision is made on an individualized basis.

The *Cruz* decision and the Ohio approach are not perfect. They seem to serve the exclusion of seniors from competitive high school swimming if they had been retained in school because of their ADHD, due to their supposed age-based competitive advantage. These rules do not require courts to consider the many benefits to the person through their full athletic participation. Instead, these rules primarily consider whether someone has an “unfair competitive advantage.” This Article proposes a more balanced approach that, while not disregarding medical categories and their potential relevance to a person’s participation, does not allow these medical categories to replace consideration of the importance of athletics to the individual. Such an approach understands that disabled athletes should be able to fully participate and achieve the joys of success.

The evolving, more accepting, approach to disabled students’ athletic participation is in sharp contrast to many states’ efforts to flatly ban all transgender athletes from sports participation. The Indiana legislature, for example, passed a law requiring that a birth certificate be used as the exclusive way to determine if someone can participate in the female category for sports.<sup>208</sup> After the Republican Governor vetoed the bill, the state legislature

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<sup>204</sup> *Id.* at 491.

<sup>205</sup> *Id.*

<sup>206</sup> *Id.* at 493.

<sup>207</sup> See *Bylaw 4-2-1 (High School Age Limitation)*, OHIO HIGH SCH. ATHLETIC ASS’N, <https://www.ohsaa.org/Eligibility/Age> [<https://perma.cc/MPE3-86RG>].

<sup>208</sup> See H.B. 1041, 122nd Gen. Assemb., 2d Reg. Sess. (Ind. 2022) (“A male, based on a student’s biological sex at birth in accordance with the student’s genetics and reproductive biology, may not participate on an athletic team or sport designated under this section as being a female, women’s, or girls’ athletic team or sport.”).

overrode that veto.<sup>209</sup> In his veto message, the Governor stated that he saw no evidence of an athletic unfairness issue that needed to be corrected, but the Republican-controlled legislature rushed to join the ten or more states that had already adopted such bans.<sup>210</sup>

The Indiana legislature's support for this bill is a perfect example of pretextual overmedicalization used to exclude people from full participation in athletics. One of the bill sponsors, Michelle Davis, said: "Despite being equal, biological males and biological females both possess different genetic strengths and weaknesses. Because of these differences, biological girls should compete with girls and biological boys should compete with boys."<sup>211</sup> Notice the absolutist nature of this argument rooted in medicalization. In contrast, as we saw above, some states have moved to an individualized assessment in the disability context, an approach that allows for skepticism of absolutist medical arguments that fail to consider the stories of the affected individuals.

Because the athletic transgender exclusion bills focus primarily on K-12 students, they affect children still undergoing significant physical development. Girls who undergo early puberty will likely experience their puberty growth spurt at a younger age, which might put them at a competitive advantage in sports, such as swimming, where additional height could be beneficial.<sup>212</sup> Similarly, girls who undergo late puberty might be at a competitive advantage in a sport like gymnastics where a smaller physique can be beneficial.<sup>213</sup> Yet, no one argues that we have "puberty rules" for participation in swimming or gymnastics for cisgender girls. The obsession with medical categories only occurs when it serves a discriminatory purpose—in this case,

<sup>209</sup> See Delphine Luneau, *Indiana Lawmakers Override Republican Governors' Veto, Pursuing Their Fixation on Discriminating Against Transgender Schoolchildren*, HUM. RTS. CAMPAIGN (May 24, 2022), <https://www.hrc.org/press-releases/indiana-lawmakers-override-republican-governors-veto-pursuing-their-fixation-on-discriminating-against-transgender-schoolchildren> [https://perma.cc/BQG3-KTMN].

<sup>210</sup> See *Holcomb Vetoes Trans Girls Sports Ban, Says The Bill 'Falls Short'*, WTHR (Mar. 21, 2022), <https://www.wthr.com/article/news/local/indiana-governor-eric-holcomb-vetoes-trans-girls-sports-ban-house-bill-1041/531-cf9181fb-e641-4cba-a33d-48f7c75fca17> [https://perma.cc/Y7LC-MRX4].

<sup>211</sup> See Andrew Smith et al., *Indiana Legislatures Override Governor's Veto of Bill Banning Transgender Girls from Sports*, WRTV (May 24, 2022), <https://www.wrtv.com/news/politics/indiana-legislatures-override-governors-veto-of-bill-banning-transgender-girls-from-sports> [https://perma.cc/5KF4-CEFV].

<sup>212</sup> *What is a Growth Spurt During Puberty?*, JOHNS HOPKINS MED. NEWSROOM (Nov. 16, 2020), <https://www.hopkinsallchildrens.org/ACH-News/General-News/What-is-a-Growth-Spurt-During-Puberty> (last visited Mar. 9, 2023); Adam Hadhazy, *What Makes Michael Phelps So Good?*, SCI. AM. (Aug. 18, 2008), <https://www.scientificamerican.com/article/what-makes-michael-phelps-so-good1/> [https://perma.cc/4PDD-CW5A].

<sup>213</sup> See David Epstein, *Female Gymnasts Have Always Been Short. For 30 Years, They've Been Getting Shorter. Why?*, SLATE (Aug. 10, 2016), <https://slate.com/culture/2016/08/why-female-gymnasts-are-so-short.html> [https://perma.cc/VB28-3EQD] (noting that a smaller female gymnast has a better power-to-weight ratio and a lower moment of inertia than a taller gymnast).

the exclusion of transgender girls and women from athletic participation. These rules are not about leveling the playing field for biological reasons because they only emerge when another interest, such as transgender exclusion, occurs. This is overmedicalization in the service of anti-transgender animus.

Will society evolve, as it has in the disability context, to unmask this overmedicalization in the transgender context? Currently, the courts are the only backstop as state legislatures rush to outdo themselves on harming transgender youth. In his veto message, Utah Governor Spencer J. Cox tried to see these student athletes as people rather than pawns in a fight that has nothing to do with actual fairness and competition:

Four kids and only one of them playing girls sports. That's what all of this is about. Four kids who aren't dominating or winning trophies or taking scholarships. Four kids who are just trying to find some friends and feel like they are a part of something. Four kids trying to get through each day. Rarely has so much fear and anger been directed at so few. I don't understand what they are going through or why they feel the way they do. But I want them to live. And all the research shows that even a little acceptance and connection can reduce suicidality significantly. For that reason, as much as any other, I have taken this action [a veto] in the hope that we can continue to work together and find a better way.<sup>214</sup>

His compassionate argument had no effect on the Utah legislature. They overrode his veto.<sup>215</sup>

However, another aspect of the Utah legislation that is worthy of consideration is its fallback position if the absolute ban is overridden by the courts. In that event, the “measure would trigger a commission of experts who would determine eligibility in individual cases and evaluate students’ physical characteristics such as height, weight and wingspan.”<sup>216</sup> On the one hand, one might consider that rule similar to the current age limits for disabled athletes. As long as their additional year of growth does not provide them an unfair competitive advantage or inappropriate risk to other athletes, they are allowed to participate. But what does that mean in the transgender context? According to the Centers for Disease Control and Prevention (CDC), only five percent of girls ages twelve to twenty are over five feet and nine inches.<sup>217</sup> Yet, Katie Ledecky, who has won seven Olympic gold medals

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<sup>214</sup> *Here's Utah Gov. Cox's Statement on Vetoing the Transgender Sports Bill*, SALT LAKE TRIB. (Mar. 22, 2022), <https://www.sltrib.com/news/politics/2022/03/22/gov-spencer-coxs/> [<https://perma.cc/GVT9-X44H>].

<sup>215</sup> See Medina, *supra* note 30.

<sup>216</sup> *Id.*

<sup>217</sup> *2 to 20 Years: Girls Stature-For-Age and Weight-For-Age Percentiles*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 21, 2000) <https://www.cdc.gov/growthcharts/data/set1clinical/cj411022.pdf> [<https://perma.cc/JR5T-FX57>].

and fifteen world championship medals, and is the most decorated female swimmer in history, is six feet tall.<sup>218</sup> One would surmise that she has a wingspan advantage over most of her female competitors. Similarly, Michael Phelps, who is six feet and four inches, is the most decorated male swimmer in history.<sup>219</sup> According to the CDC, only five percent of boys ages twelve to twenty are over six feet and two inches.<sup>220</sup> Further, it has been reported that Phelps has an unusually long wingspan of eighty inches,<sup>221</sup> which may have helped him win an Olympic hundred-meter butterfly event by one-hundredth of a second.<sup>222</sup>

How will this Utah commission, if it is ever established, determine what is fair? Will they use Katie Ledecky or Michael Phelps as the standard? Or will they insist that transgender girls cannot be taller than five feet and nine inches, but cisgender girls can? By making pretextual medical arguments, the Utah legislature is selectively deploying their understanding of what it means to be “female” to exclude transgender girls and women from athletic participation. These medical arguments fail to recognize the full range of physical sizes and musculature in girls and women. They seek to exclude from participation any girls or women who have what they consider to be “atypical” height, weight, and wingspan. If Katie Ledecky were competing in Utah as a teenager, one can imagine that she would have to demonstrate her right to compete in the female category by producing medical records.

Instead of exclusion, or inspecting transgender athletes’ anatomy under a microscope, this Article suggests that we listen to their stories. Lia Thomas, for example, who is likely about the same height as Ledecky, explained the changes in her body because of transitioning. She said: “The mental and emotional changes actually happened very quickly . . . I was feeling a lot better mentally. I was less depressed . . . And I lost muscle mass and I became a lot weaker and a lot, a lot slower in the water.”<sup>223</sup> The overmedicalization arguments for exclusion ignore the actual medical experiences of people like Thomas. Reducing her to some anatomical measurements, under the guise of fairness, misunderstands the range of anatomy already present in sports, and it exemplifies the disingenuous and arbitrary selection of medical criteria on which to base her exclusion.

To end this Section, we should revisit the disability cases. In each case, the courts emphasize that the disabled athlete is not a star on the team; their

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<sup>218</sup> See *Katie Ledecky*, TEAM USA, <https://www.teamusa.org/usa-swimming/athletes/katie-ledecky> [<https://perma.cc/DV5T-FNWL>].

<sup>219</sup> See *Michael Phelps*, TEAM USA, <https://www.teamusa.org/usa-swimming/athletes/Michael-Phelps> [<https://perma.cc/DA5F-JK34>].

<sup>220</sup> *2 to 20 Years: Boys Stature-For-Age and Weight-For-Age Percentiles*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 21, 2000), <https://www.cdc.gov/growthcharts/data/set1clinical/cj41c021.pdf> [<https://perma.cc/7ZGJ-QHEX>].

<sup>221</sup> See Hadhazy, *supra* note 212.

<sup>222</sup> *Id.*

<sup>223</sup> McMaster et al., *supra* note 155.

participation is not likely to make a team more competitive. But why should disabled athletes not be allowed to excel? Casey Martin was a golf pro who earned money by being a competitive player.<sup>224</sup> Michael Phelps reportedly has ADHD.<sup>225</sup> What if Phelps' parents had decided to hold him back a year in kindergarten? Should he then not have been allowed to compete in high school as a nineteen-year-old because he would have been too competitive? As in the transgender context, one needs to ask, what is the comparator? Phelps was already setting world records in high school; that fact should not have been allowed to exclude him from participation against his peers if he had been retained for one grade. Such a rule would have taken one facet of him—his ADHD—and allowed it to dominate the determination of what was appropriate. Disabled athletes and transgender athletes should be allowed to excel, not merely participate. Pseudoscience should not be deployed so that they miss out on the many ways that full athletic participation supports their basic aspirations and attempts to attain full personhood. If we hear their stories, we will understand how they are using athletics to grow as people, not to achieve an unfair competitive advantage. Overmedicalization erases their journey to full personhood.

### III. REPRODUCTIVE RIGHTS OVERMEDICALIZATION

Part III examines the role of medicalization in the area of reproductive justice. First, it illustrates the danger of overmedicalization arguments in cases regarding access to contraception. Next, it demonstrates how the U.S. Supreme Court's abortion jurisprudence—from its overmedicalization approach in *Roe* to its shift to complete demedicalization in *Dobbs*—have undermined their equality interest in respect for their full personhood.

#### A. Contraception

Following the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*,<sup>226</sup> many people have worried that the Court's protection of contraception in *Griswold v. Connecticut* would soon fall because of Justice Thomas's concurrence in *Dobbs*.<sup>227</sup> While that concern is valid, this

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<sup>224</sup> *Casey Martin*, POPULAR BIO (Jan. 29, 2023), <https://popularbio.com/casey-martin/> [<https://perma.cc/5TQH-M3KY>].

<sup>225</sup> *Celebrity Spotlight: How Michael Phelps' ADHD Helped Him Make Olympic History*, UNDERSTOOD, <https://www.understood.org/en/articles/celebrity-spotlight-how-michael-phelps-adhd-helped-him-make-olympic-history> [<https://perma.cc/95EK-8NY4>].

<sup>226</sup> *Dobbs v. Jackson Women's Health Organization*, No. 19-1392, slip op. at 24 (June 24, 2022).

<sup>227</sup> Thomas's concurrence argues that the Court should "eliminate [substantive due process jurisprudence] from our jurisprudence at the earliest opportunity." *Id.* at 7 (Thomas, J., concurring). In their joint dissent, Justices Breyer, Sotomayor, and Kagan argue that the public should not believe the claim that the *Dobbs* abortion decision is unique and does not implicate other constitutional rights like access to contraception.

Article presents a different kind of argument. This Article suggests that we should be concerned that contraception will only be protected when a person needs access to it for medical reasons, rather than to preserve their right to make decisions about bearing children. Overmedicalization can result in relying too heavily on the medical dimensions of issues at the expense of addressing harms to full personhood. This Section will highlight that risk so progressive lawyers can seek to frame arguments to avoid that trap. Further, as we will see, Black women are especially harmed by overmedicalization because they have historically had limited access to health-care professionals,<sup>228</sup> making it especially difficult for them to make burdensome and unnecessary medical arguments.

The majority's insistence that its decision in *Dobbs* to overturn *Roe v. Wade* and uphold Mississippi's fifteen-week abortion ban "concerns the constitutional right to abortion and no other right"<sup>229</sup> is hard to take seriously. The Court attempted to distinguish *Griswold* as not posing the issue of destroying a "potential life."<sup>230</sup> By preventing fertilization or implantation of a zygote, it is hard to understand how contraception has nothing to do with destroying a potential life. And, as has been reported in the news, some states have already taken steps to limit women's access to various forms of contraception.<sup>231</sup>

We can therefore anticipate that lawyers will need to make arguments in the future to justify the constitutional protection of full contraceptive access. The political left must prepare to argue against restrictions on access to contraception. A pre-*Dobbs* case—*Burwell v. Hobby Lobby Stores, Inc.*—gives us a preview into how some of those arguments may be made and, in particular, how *liberals* might use an overmedicalized discourse to protect contraceptive access.<sup>232</sup> In their attempts to prevent newly restrictive rules, the liberal dissenting justices in *Hobby Lobby* adopted an overmedicalization approach that would disparately impact Black women, as this Section describes below.

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Citing Roberts's dissent, they say: "So the majority depicts today's decision as a 'restricted railroad ticket, good for this day and train only.' Should the audience for these too-much-repeated protestations be duly satisfied? We think not." *Id.* at 25 (Breyer, Sotomayor, Kagan, JJ., dissenting) (citations omitted).

<sup>228</sup> See Fabiola Cineas, *Black Women Will Suffer the Most Without Roe*, VOX (June 29, 2022), <https://www.vox.com/2022/6/29/23187002/black-women-abortion-access-roe> [<https://perma.cc/3TL9-GFFE>].

<sup>229</sup> *Dobbs*, slip op. at 66.

<sup>230</sup> *Id.* at 38. Justice Thomas is more explicit. He urges the Court in future cases to "reconsider all of this Court's substantive due process precedents, including *Griswold*." *Id.* at 2301 (Thomas, J., concurring).

<sup>231</sup> See Andrea Michelson, *Contraception is Already Restricted in Many States, and It Could Be the Next Battleground. Here's What You Need to Know*, INSIDER (June 28, 2022), <https://www.insider.com/will-contraception-be-banned-plan-b-iuds-roe-v-wade-overturn-2022-6> [<https://perma.cc/9UFJ-N83L?type=standard>].

<sup>232</sup> See *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682 (2014).

Access to contraception should exist as a right to make fundamental decisions about one's life, not merely to protect oneself from adverse medical consequences that are verified by a medical professional. Any time we insist on the involvement of medical professionals to reaffirm women's right to access contraception, we exclude those with less access to medical providers. Thus, as this Article suggests, we need to be wary of overmedicalization arguments from any point on the political spectrum.

*Hobby Lobby* is a complicated case that is usually discussed as an example of the Supreme Court's deference to religious arguments.<sup>233</sup> But *Hobby Lobby* is also an important example of overmedicalization—by both the majority and dissent—because it only understands women's access to contraception being justified in medical terms. It therefore deserves our close attention.

The *Hobby Lobby* case stemmed from the interaction of two different statutes: the Affordable Care Act (ACA)<sup>234</sup> and the Religious Freedom Restoration Act of 1993 (RFRA).<sup>235</sup> When Congress was considering the ACA, a draft of the bill specified that health plans must cover three categories of preventive care.<sup>236</sup> Concerned that women of childbearing age would bear much higher medical expenses than other groups for what should be considered preventive services, Congress enacted the Women's Health Amendment.<sup>237</sup> Pursuant to the Women's Health Amendment, preventive coverage "include[d] the 'full range' of FDA-approved contraceptive methods."<sup>238</sup> Further, the Senate rejected "the so-called 'conscience amendment,' which would have enabled any employer or insurance provider to deny coverage based on its asserted 'religious beliefs or moral convictions.'"<sup>239</sup> These rules mandated that, beginning in 2011, all ACA plans make all forms of contraception free to women.<sup>240</sup>

Despite the language of the Women's Health Amendment, religious entities began to use the RFRA to challenge the right of employees to receive all forms of contraception, such as intrauterine devices (IUDs), through ACA health-care plans. Under RFRA, a government action that imposes a substantial burden on religious exercise must serve a compelling government interest.<sup>241</sup> If the compelling interest test is met, then the regulation must constitute "the least restrictive means of furthering that compelling govern-

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<sup>233</sup> See, e.g., Leah Rutman, *The Hobby Lobby Decision: Imposing Religious Beliefs on Employees*, ACLU WASH. (Aug. 11, 2014), <https://www.aclu-wa.org/blog/hobby-lobby-decision-imposing-religious-beliefs-employees> [<https://perma.cc/PJU5-2VMV>]; see generally Ira Lupu, *Moving Targets: Obergefell, Hobby Lobby, and the Future of LGBT Rights*, 7 ALA. C.R. & C.L. L. REV. 1 (2015).

<sup>234</sup> Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>235</sup> 42 U.S.C. §§ 2000bb–2000bb-4 (2012).

<sup>236</sup> *Hobby Lobby*, 573 U.S. at 741 (Ginsburg, J., dissenting).

<sup>237</sup> See *id.* at 741–42.

<sup>238</sup> *Id.* at 743.

<sup>239</sup> *Id.* at 744.

<sup>240</sup> See *id.* at 697 (Alito, J., majority).

<sup>241</sup> 42 U.S.C. § 2000bb-1(b)(1).

mental interest.”<sup>242</sup> The “least restrictive means test” inquires whether the government could provide an exemption for religious entities while still meeting its compelling state interest. From a “least restrictive means” perspective, banning a religious entity from qualifying for ACA benefits is more restrictive than allowing them to maintain ACA coverage while being exempt from one requirement—making all forms of contraception available to their employees. But this exemption must still allow the government to meet its compelling state interest. In this context, the exclusion of certain contraceptives from the religious entity’s health-care plan must not result in employees losing access to those certain kinds of contraceptives. If employees would lose access to some contraceptives, then the government’s compelling interest in providing broad contraception coverage would not be met. In that event, RFRA would not mandate an exemption from full contraception coverage for religious entities with ACA plans.

How could the U.S. Department of Health and Human Services ensure that all employees received the full range of contraceptives while still exempting some religious entities from providing that coverage? The Obama administration came up with a plan that would allow a religious employer to not directly provide certain contraceptive care to their employees but, instead, have it “provided by the organization’s insurance company or arranged through its third-party administrator.”<sup>243</sup> In *Hobby Lobby*, the Supreme Court insisted that that exemption—originally only available to nonprofit religious organizations—be available to closely-held for-profit employers with religious objections.<sup>244</sup> The Court assumed that the government could figure out a way to provide contraceptives to any women who were unable to obtain these contraceptives through their employer-provided health insurance policy.<sup>245</sup> Women would be expected to navigate a contraceptive benefit by “requiring them to take steps to learn about, and to sign up for, a new [government funded and administered] health benefit.”<sup>246</sup> This religious exemption became even broader over time, as religious entities objected to even the notice requirement for refusing to provide contraceptive coverage.<sup>247</sup> This broad religious exemption is important and problematic because it reflects the current political appetite of some conservatives to limit

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<sup>242</sup> *Id.* at § 2000bb-1(b)(2); see also *Hobby Lobby*, 573 U.S. at 691 (holding that RFRA “prohibits the Federal Government from taking any action that substantially burdens the exercise of religion unless that action constitutes the least restrictive means of serving a compelling government interest”).

<sup>243</sup> See Adam Sonfield, *Religious Exemptions in Insurance Coverage and the Patient-Clinician Relationship*, 16 AM. MED. ASS’N J. ETHICS 864, 865 (Nov. 2014), <https://journalofethics.ama-assn.org/article/religious-exemptions-insurance-coverage-and-patient-clinician-relationship/2014-11> [<https://perma.cc/4585-DUPR>].

<sup>244</sup> *Hobby Lobby*, 573 U.S. at 719.

<sup>245</sup> *Id.* at 728.

<sup>246</sup> *Id.* at 765 (Ginsburg, J., dissenting).

<sup>247</sup> See *Zubik v. Burwell*, 578 U.S. 403, 407 (2016) (requesting supplemental briefing on whether contraceptive coverage could be provided to employees without notice from employers).



women's access to contraceptives in a post-*Dobbs* world, in which *Griswold v. Connecticut*<sup>248</sup> may no longer be good law.

While the majority's decision is deeply troubling as an incursion into women's access to a full range of contraceptives, the dissent's response is disappointing because of its overmedicalized approach. The dissent in *Hobby Lobby* was authored by Justice Ginsburg and joined by Justice Sotomayor and, in part, by Justices Breyer and Kagan.<sup>249</sup> Justice Ginsburg started her dissent by quoting *Casey*'s emphasis on the importance of women's ability to control their reproductive lives to "participate equally in the economic and social life of the Nation,"<sup>250</sup> before quickly pivoting to an overmedicalized justification for contraception access. In defending ACA coverage for the full range of contraceptives, she emphasized the medical complications associated with a lack of access to a full range of contraceptives. Justice Ginsburg noted that while some women use contraceptives because pregnancy is medically dangerous, others do so to reduce the risk of some serious medical conditions or avoid unintended pregnancies that can increase the possibility of mental health problems for the pregnant woman.<sup>251</sup>

Later in the opinion, in summarizing the importance of the contraception mandate, Justice Ginsburg focused again on the medical benefits:

To recapitulate, the mandated contraception coverage enables women to avoid the health problems unintended pregnancies may visit on them and their children. The coverage helps safeguard the health of women for whom pregnancy may be hazardous, even life threatening. And the mandate secures benefits wholly unrelated to pregnancy, preventing certain cancers, menstrual disorders, and pelvic pain.<sup>252</sup>

Although she claimed to "recapitulate" the earlier discussion, reference to women's basic right to control their reproductive decisions was absent from this discussion. It is an overmedicalized justification.

Of course, Justice Ginsburg's overmedicalization analysis had no impact on the justices in the majority, who cavalierly thought that an alternative mechanism could easily be created, with no burden on women, for the government to directly provide coverage of contraception.<sup>253</sup> And, not surprisingly, the majority's assumptions about easy access to all forms of contraception have proven to be mistaken.<sup>254</sup>

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<sup>248</sup> *Griswold v. Connecticut*, 381 U.S. 479 (1965).

<sup>249</sup> *Hobby Lobby*, 573 U.S. at 739.

<sup>250</sup> *Id.* at 741 (quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 856 (1992)).

<sup>251</sup> *Id.* at 743.

<sup>252</sup> *Id.* at 761 (citations omitted).

<sup>253</sup> *Id.* at 728 (Alito, J., majority).

<sup>254</sup> See Shefali Luthra, *Women Shouldn't Get a Bill for an IUD . . . But Sometimes They Do*, KHN (Feb. 7, 2020), <https://khn.org/news/contraceptives-birth-control-surprise-bills-women-shouldnt-get-a-bill-for-an-iud-but-sometimes-they-do/> [https://perma.cc/

But Justice Ginsburg's overmedicalization analysis is consequential to the *political left* because it is an important example of a liberal justice overusing medical arguments in a way that could be harmful to many women, even if those arguments are successful. From a racial justice perspective, it is important that we argue for access for all women, not merely those who have medical reasons for using certain forms of contraception. We already live in a society where Black women and girls are more likely than white women to live in "contraception deserts," where there are high barriers to contraception access.<sup>255</sup> Medicalizing access to contraception enshrines the right for women with more privileged access to medical professionals who can validate their reasons for seeking contraception. Ironically, *Roe* started us down this path by emphasizing an attending physician's right to determine whether to terminate a woman's pregnancy.<sup>256</sup> It is time for us to reimagine reproductive justice without doctors being a central player in the decision-making process.

Under the methodology suggested by this Article, we should adopt an approach that de-centers medical categories and criteria in determining access to the full range of contraception and focuses instead on the full personhood of those seeking access to contraceptives. Listening to the voices of all women can help us see the limited and even destructive nature of an overmedicalized approach. In a writing about the reproductive experiences of Black women,<sup>257</sup> reporter Fabiola Cineas connects their contemporary stories with the history of Black women's lack of access to reproductive health care:

Overall, Black women have less access to quality health care, and less trust in medical professionals who might recommend birth control. The medical profession has a history of pressuring Black women and other women of color to limit their family sizes and consider tubal sterilization. After all, the American "father of modern gynecology" experimented on enslaved Black women in the 19th century without anesthesia. More than one-third of Black women in a 2005 survey believed that "medical and public health institutions use poor and minority people as guinea pigs to try out new birth control methods."<sup>258</sup>

Further, she notes that Black women are more likely to live in states that have failed to expand Medicaid to broaden access to contraception and

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Q8D7-7W8Z] (reporting difficulties that women have had getting birth control coverage when they worked for a religious entity).

<sup>255</sup> See Cineas, *supra* note 228.

<sup>256</sup> *Roe v. Wade*, 410 U.S. 113, 164 (1973).

<sup>257</sup> See Cineas, *supra* note 228.

<sup>258</sup> *Id.* The practice of forced sterilization is not limited to the nineteenth or twentieth centuries. See generally Mariam Fofana, *Time and Time Again: The Reincarnations of Coerced Sterilization*, 48 J. MED. ETHICS 805 (2022) (discussing forced sterilization at privately operated immigration facilities in the United States).

other forms of health care.<sup>259</sup> They are also more likely to live in states that she describes as contraceptive deserts, where pharmacies are likely to have “limited hours, fewer female pharmacists, fewer patient brochures on contraception, condoms that are difficult to access, and fewer self-checkout options.”<sup>260</sup> And, even when Black women gain access to contraceptives, she notes that they are more likely than white women to choose less effective forms of contraception.<sup>261</sup> Given this lack of access to contraception, she reports that “63 percent of all pregnancies for Black women were unintended, compared to 42 percent for white women.”<sup>262</sup>

Even before *Griswold* goes on the chopping block, Black women already have inadequate access to contraception and would be distrustful of having to further involve health-care providers in their lives to access contraception. Thus, if *Griswold* is reconceptualized to help women gain access to contraceptives *only in consultation with their doctors*, Black women’s access to contraception will become even more limited. Similarly, when the government allows so-called religious employers to dictate the types of contraception available to employees, including Black women, it enlarges the contraception desert by creating one more barrier to contraception access. A person’s right to access contraception should not be filtered through personal or religious proclivities of medical professionals.<sup>263</sup> These overmedicalized filters can become barriers for various people in society, disparately impacting Black women.

In sum, we must be wary of access to contraception being discussed in overmedicalized terms. Contraception should be available to all people, irrespective of their access to medical professionals.<sup>264</sup> We should be fighting for

<sup>259</sup> Cineas, *supra* note 228.

<sup>260</sup> *Id.*

<sup>261</sup> *Id.*

<sup>262</sup> *Id.*

<sup>263</sup> For example, Ohio enacted a medical conscience clause in 2021 under which “a medical practitioner, health care institution, or health care payer has the freedom to decline to perform, participate in, or pay for any health care service which violates the practitioner’s, institution’s, or payer’s conscience as informed by the moral, ethical, or religious beliefs or principles held by the practitioner, institution of payer.” OHIO REV. CODE ANN. § 4743.10 (2021). While there is an exemption for emergency treatment, that exemption would have little effect on medical professionals, like pharmacists, who decline to prescribe a range of contraceptives during non-emergency care. See Jennifer M. Nelson Carney et al., *Ohio’s Medical Practitioner Conscience Clause Becomes Effective*, EPSTEIN BECKER GREEN (Oct. 5, 2021), <https://www.ebglaw.com/insights/ohios-medical-practitioner-conscience-clause-becomes-effective/> [<https://perma.cc/DE34-5S57>]. As Elizabeth Sepper has noted, these religious exemptions can survive even when a medical entity no longer has any ties to a religious entity. See Elizabeth Sepper, *Zombie Religious Institutions*, 112 Nw. U. L. REV. 929, 932 (2018) (arguing that facilities can be governed by religious precepts “sometimes in perpetuity—in facilities that are not, or never have been, religious and by providers who do not share the institution’s religious precepts”).

<sup>264</sup> A simple example to demonstrate overmedicalization is the availability of emergency contraception that can prevent pregnancy when taken within seventy-two hours after unprotected sex, often called Plan B. Only eight states allow pharmacists to dispense emergency contraception without a physician’s prescription. See *Emergency Contraception*, GUTTMACHER INST. (Sept. 1, 2022), <https://www.guttmacher.org/state-policy/ex->

all forms of contraception to be available for free without unnecessary medical hurdles, which was the purpose of the Women's Health Amendment. By relying on an overly medicalized discourse, we are moving away from, rather than towards, that goal.

### B. *Abortion*

While many of us mourn the overturning of *Roe* in the *Dobbs* decision, it is helpful to remember the highly medicalized nature of the right that *Roe* once protected. This overmedicalized framework may not have been the best way to justify abortion access, because it focuses on medical professionals, rather than the significance of abortion access for recognizing the full personhood of pregnant women. Although the *Roe* plaintiff was a woman who had been pregnant and wanted an abortion,<sup>265</sup> the *Roe* Court framed the substantive rules in purely medical terms, focusing on the rights of *doctors*, not the patient. Absent from the discussion was consideration of what access to abortion meant for a woman's conceptualization of her own life and well-being outside of the health-care context.

The *Roe* Court set forth the rules that would control whether a state could restrict abortion in overmedicalized terms:

- (a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
- (b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.
- (c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.<sup>266</sup>

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plore/emergency-contraception [https://perma.cc/MK5V-EJPR]. These eight states have determined that there is no medical reason to require a prescription. They are an example of a positive outcome that this Article argues can result from critically examining medical requirements to see if they constitute an unwarranted hurdle.

<sup>265</sup> *Roe v. Wade*, 140 U.S. 113, 120 (1973) ("Roe alleged that she was unmarried and pregnant; that she wished to terminate her pregnancy by an abortion 'performed by a competent, licensed physician, under safe, clinical conditions'; that she was unable to get a 'legal' abortion in Texas because her life did not appear to be threatened by continuation of her pregnancy; and that she could not afford to travel to another jurisdiction in order to secure a legal abortion under safe conditions . . . . By an amendment to her complaint Roe purported to sue 'on behalf of herself and all other women' similarly situated.").

<sup>266</sup> *Id.* at 164.

Taking a closer look at these rules, the first rule gives the abortion right to the pregnant woman's attending physician. It refers to a decision by the "pregnant woman's attending physician" without any mention of the role of the pregnant person in shaping her own destiny. While the *Roe* decision does mention the importance of the abortion decision being made "in consultation"<sup>267</sup> between the physician and pregnant woman, the consultation requirement never appears in the rule itself.

The second rule is phrased as promoting the interest of the health of the pregnant woman (stereotypically referred to as a "mother"), but it does not concern the pregnant person's ability to determine her own medical needs. This allows the state to make arguments about how a pregnant person's health would be advanced by restricting abortion. Even further, the Court gives great deference to the state's medical assertions through the low-bar "reasonableness" review. Thus, this rule gives the state a monopoly on an overmedicalized discourse with few judicial limitations.

The third rule further validates justifications a state could use to ban abortion in the third trimester of pregnancy. Decision-making is placed in the hands of a medical professional who determines whether the life or health of the pregnant woman (again, stereotypically called a "mother") is in danger. There is no room in this rule for the pregnant woman to explain how terminating a pregnancy may be essential for her life goals and aspirations.

Thus, the *Roe* decision conceptualizes the rights-holders as doctors and states. Overmedicalization erased women's voices even when the Court was thought to have advanced women's reproductive rights.

While the *Roe* majority decision suffers from overmedicalization, the *Dobbs* decision suffers from demedicalization. Although health-care providers are the named plaintiffs in the *Dobbs* lawsuit and the only entities directly subjected to the law's reach, the Court never explores how this statute, and the overturning of *Roe*, implicates health care services in states that banned abortion. In other words, the Court demedicalizes the abortion jurisprudence, acting as if any adverse health consequences to pregnant women are beyond the realm of relevant judicial considerations. This Article does not seek to reject all discussion about the medical implications of contraception or abortion bans. But we need to be careful not to describe those issues *exclusively* in medical terms and needlessly deny women the agency to make determinations about their reproductive lives.

In response to the Court's demedicalization of the abortion issue, critics of *Dobbs* have started to elevate the message "abortion is health care."<sup>268</sup>

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<sup>267</sup> *Id.* at 153.

<sup>268</sup> See *Facts are Important: Abortion is Health Care*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, <https://www.acog.org/advocacy/facts-are-important/abortion-is-healthcare> [<https://perma.cc/ZAZY-4CVS>]; *Abortion is Health Care*, NAT'L HEALTH L. PROGRAM, <https://healthlaw.org/abortion-is-health-care/> [<https://perma.cc/TX84-CVVQ>].

While abortion *can* certainly be an aspect of a comprehensive health-care practice, it is important to not overuse this mantra in a way that risks reducing the right to only those situations where an abortion is medically necessary. In an amicus brief in *Dobbs*, two dozen medical groups emphasized that “abortion is a key part of reproductive health care, that it is safe, and that doctors need to be able to treat patients without government interference.”<sup>269</sup> Instead of thinking of abortion as a way to “treat patients,” this Article emphasizes the importance of thinking of abortion as a way for pregnant people to affirm the life decisions they choose to make. One of the most commonly cited examples of an egregious result of the *Dobbs* opinion is a physician’s reluctance to perform a life-saving abortion during an ectopic pregnancy, which occurs in two percent of pregnancies and is fifty percent more likely for women of color than white women.<sup>270</sup> While this example is certainly important and its disparate impact on women of color should be emphasized, this example should not dominate discussions of why *Dobbs* was wrongly decided. *Dobbs* was wrongly decided because the Constitution’s equal protection and due process clauses should protect pregnant people’s rights to shape their destiny by making the decision whether to terminate a pregnancy. The overmedicalization of the decision-making process harms all people, especially those who have historically had less access to health care.

The *Dobbs* dissenters waver between trying to define the underlying right broadly and overmedicalizing it. First, defining the right broadly, they argue that *Roe* and *Casey* “have protected the liberty and equality of women. *Roe* held and *Casey* reaffirmed that the Constitution safeguards a woman’s right to decide for herself whether to bear a child . . . . Respecting a woman as an autonomous being, and granting her full equality, meant giving her substantial choice over this most personal and most consequential of all life decisions.”<sup>271</sup> While that claim is important to a broad understanding of the rights of pregnant women, it is absent from the *Roe* decision itself.

Second, the dissenting justices define the right in medical terms. They note that pregnancy and childbirth “involve all manner of physical changes, medical treatments (including the possibility of a cesarean section), and medical risk. For example, an American woman is 14 times more likely to die by carrying a pregnancy to term than by having an abortion.”<sup>272</sup> They

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<sup>269</sup> Selena Simmons-Duffin, *Doctors Weren’t Considered in Dobbs, but Now They’re on Abortion’s Legal Front Lines*, NAT’L PUB. RADIO (July 3, 2022), <https://www.npr.org/sections/health-shots/2022/07/03/1109483662/doctors-werent-considered-in-dobbs-but-now-theyre-on-abortions-legal-front-lines> [https://perma.cc/YT4P-TVVH].

<sup>270</sup> See Katharine O’Connell White, *POV: Overturning Roe v. Wade Will Worsen Health Inequities in All Reproductive Care*, BU TODAY (June 24, 2022), <https://www.bu.edu/articles/2022/07/03/1109483662/doctors-werent-considered-in-dobbs-but-now-theyre-on-abortions-legal-front-lines> [https://perma.cc/28RQ-JEK7].

<sup>271</sup> *Dobbs v. Jackson Women’s Health Organization*, No. 19-1392, slip op. at 22 (June 24, 2022) (Breyer, Sotomayor, and Kagan, JJ., dissenting).

<sup>272</sup> *Id.*

then emphasize that “for some women as *Roe* recognized, abortions are medically necessary to prevent harm.”<sup>273</sup> Despite these known medical risks from pregnancy and childbirth, they observe that the *Dobbs* “majority does not say—which is itself ominous—whether a State may prevent a woman from obtaining an abortion when she and her doctor have determined it is a needed medical treatment.”<sup>274</sup>

Thus, the abortion issue is at a crossroads. Will we describe the right to an abortion broadly in personhood and equality terms, or describe it more narrowly in medical terms? It will be a hollow victory if the Court only reconsiders *Dobbs* to acknowledge the abortion right when a patient “and her doctor have determined it is a needed medical treatment.”<sup>275</sup>

We must ensure that overturning *Dobbs* does not only provide us with a medicalized version of abortion access. To make this point more clearly, it is helpful to reexamine the companion case to *Roe* from Georgia: *Doe v. Bolton*.<sup>276</sup> *Bolton* can remind us of the disparate impact faced by poor women when the right to abortion was more medicalized. In Georgia, a woman could only obtain an abortion if two physicians approved the doctor’s decision to perform the abortion “to preserve the life of such mother.”<sup>277</sup> The doctor had to frame the request in narrow medical terms. During the *Doe v. Bolton* era, middle-class women with ample financial resources could find a private hospital that would approve their decision, while poor women who were reliant on public hospitals were denied that opportunity.<sup>278</sup> An overly medicalized right to access abortion has had, and will continue to have, a disparate impact on poor women.

Both overmedicalization and demedicalization suffer from the same problem: leaving pregnant people out of the analysis. Demedicalization causes the courts and legislatures to see pregnant people merely as incubators for fetuses that they can raise or relinquish to the broken foster care and adoption systems. Both overmedicalization and demedicalization render invisible their nine months of forced labor, as well as the immediate and long-term life consequences of giving birth to a child. This Article’s demedicaliza-

<sup>273</sup> *Id.*

<sup>274</sup> *Id.*

<sup>275</sup> *Id.* (emphasis added).

<sup>276</sup> *Doe v. Bolton*, 410 U.S. 179 (1973).

<sup>277</sup> *Id.* at 182–83 n.4 (forbidding a person to perform an abortion “unless the same shall have been necessary to preserve the life of such mother, or shall have been advised by two physicians to be necessary for such purpose”).

<sup>278</sup> See Cary Franklin, *The New Class Blindness*, 128 *YALE L.J.* 2, 57 (2018) (lawyers arguing that the Georgia statute “operates in such a way that (1) white women of means get an overwhelmingly disproportionate share of the legal hospital abortions as compared to poor, non-white women; and (2) women of means are able to obtain illegal but medically safe abortions while poorer women are forced to choose between bearing children they do not want and cannot afford to feed, or risking death or maiming at the hands of an inexpensive abortionist”) (quoting Brief as Amici Curiae & Appendix for State Communities Aid Ass’n at 10–11, *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973), Nos. 70-18, 70-40).

tion perspective seeks to center the pregnant person's lived experiences and right to respect for their full personhood.

As I have argued for decades, the right to choose to terminate a pregnancy should be understood as a fundamental gender-based equality interest, because an equality perspective can help place women's full personhood in the analysis of the impact of banning abortion.<sup>279</sup> She becomes more than merely an incubator for a fetus. The *Dobbs* dissenters supported this way of understanding the right to an abortion, writing: "Respecting a woman as an autonomous being, and granting her full equality, meant giving her substantial choice over this most personal and most consequential of all life decisions."<sup>280</sup>

By contrast, the *Dobbs* majority's one-paragraph consideration of the gender-based equality issue reflects its lack of concern for women's full personhood.<sup>281</sup> This is the Court's *entire* discussion of women's equality interest in being able to obtain a legal abortion:

Neither *Roe* nor *Casey* saw fit to invoke this theory, and it is squarely foreclosed by our precedents, which establish that a State's regulation of abortion is not a sex-based classification and is thus not subject to the "heightened scrutiny" that applies to such classifications. The regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a "mere pretext[t] designed to effect an invidious discrimination against members of one sex or the other." And, as the Court has stated, the "goal of preventing abortion" does not constitute "invidiously discriminatory animus" against women. Accordingly, laws regulating or prohibiting abortion are not subjected to heightened scrutiny. Rather, they are governed by the same standard of review as other health and safety measures.<sup>282</sup>

This cursory analysis of women's equality rights to be able to decide whether to terminate a pregnancy depends on the correctness of the Supreme Court's 1974 decision in *Geduldig v. Aiello*,<sup>283</sup> that discrimination based on pregnancy does not trigger heightened gender-based scrutiny. The *Geduldig* case was decided before the Court held in 1976 that gender-based classifications must meet a heightened scrutiny standard.<sup>284</sup> *Geduldig*'s thin reasoning has

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<sup>279</sup> See, e.g., RUTH COLKER, PREGNANT MEN: PRACTICE, THEORY, AND THE LAW (1994) (centering the discussion of abortion in an equality-based framework).

<sup>280</sup> *Dobbs*, slip op. at 1 (Breyer, Sotomayor, and Kagan, JJ., dissenting).

<sup>281</sup> *Id.* at 10–11 (Alito, J. majority).

<sup>282</sup> *Id.* (citations omitted).

<sup>283</sup> *Geduldig v. Aiello*, 417 U.S. 484, 496–97 n.20 (1974).

<sup>284</sup> See *Craig v. Boren*, 429 U.S. 190, 197 (1976) (finding that gender-based classifications "must serve important governmental interests and must be substantially related to achievement of those objectives").



been the subject of enormous critical commentary,<sup>285</sup> yet the Court relied on that precedent as inflexible *stare decisis* while wreaking havoc on fifty years of reliance on *Roe* as precedent.

While others will certainly craft a strong equality understanding of a woman's right to terminate a pregnancy, this Article quotes that paragraph to make a somewhat different point. That paragraph is the *entirety* of what the Court considers needs to be said about women's equality interests. We hear nothing about pregnancy, childbirth, or raising children. We hear nothing about the financial impact of pregnancy in a society in which paid family leave is not even mandatory. The pregnant person is reduced to a uterus whose treatment can be entirely controlled by the state as a "health and safety measure."<sup>286</sup> To whose health and safety are they referring? Certainly not the person being forced to carry the fetus to term. Additionally, the impact of forced birth is far more than a health or safety concern. Terminating a pregnancy is not merely a medical procedure: it is a profound decision about how one wants to live one's life.

The abortion example brings us full circle to the initial disability examples. As discussed in Part I, the lesson from the disability justice movement is not that medicine should play no role in understanding the lives of disabled people. The important point is to craft rules, including those with a medical component, to consider the full range of people's needs and aspirations in ways that do not create unnecessary medical hurdles. While pregnant people with health emergencies should absolutely receive immediate health-care treatment (which may include an abortion), we should also not require pregnant people to jump through unnecessary hoops that have become all too common in the abortion space—waiting periods,<sup>287</sup> so-called informed consent,<sup>288</sup> and unnecessary medical treatment—to effectuate their decision to terminate a pregnancy. At the other extreme, complete demedi-

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<sup>285</sup> See Maya Manian & Lucinda M. Finley, *Geduldig v. Aiello*, 417 U.S. 484 (1974), in *THE FEMINIST JUDGMENTS (PART II): REWRITTEN OPINIONS OF THE UNITED STATES SUPREME COURT* 185, 185 (Kathryn M. Stanchi, Linda L. Berger & Bridget J. Crawford eds., 2016), ("The legal community and the public reacted with ridicule and rejection . . . Despite sustained criticism, the *Geduldig* decision has never been explicitly overruled and continues to constrain women's access to substantive equality and reproductive liberty"). See generally Reva Siegel, Serena Mayeri & Melissa Murray, *Equal Protection in Dobbs and Beyond: How States Protect Life Inside and Outside of the Abortion Context*, 43 *COLUM. J. GENDER & L.* (forthcoming 2023) (discussing the equality-based amicus brief they filed in *Dobbs*).

<sup>286</sup> *Dobbs*, slip op. at 11 (Alito majority opinion).

<sup>287</sup> The Supreme Court's decision in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), which upheld various abortion restrictions in Pennsylvania, including a twenty-four-hour waiting period rule and a so-called informed consent provision, opened up the floodgates to states passing many burdensome restrictions on access to abortions. See Linda J. Wharton & Kathryn Kolbert, *Preserving Roe v. Wade . . . When You Win Only Half the Loaf*, 24 *STAN. L. & POLICY REV.* 143, 144 (2013) (describing a "plethora of burdensome abortion restrictions that increasingly threaten to make abortion services unavailable to America's most vulnerable women").

<sup>288</sup> See generally Ruth Colker, *Uninformed Consent*, 101 *B.U. L. REV.* 431 (2021) (discussing so-called informed consent laws in abortion context).

calization (as seen in the *Dobbs* majority opinion) can render pregnant people invisible, just as overmedicalization can impose enormous and unnecessary barriers in the way of a pregnant person's decision-making process. We need to unmask both demedicalization and overmedicalization to see how they fail to consider someone's full personhood.

#### IV. OVERMEDICALIZATION JUSTICE?

The cure for overmedicalization is not demedicalization.

The disability justice movement has taught us to listen closely to the voices of our community. These voices can share experiences of physical or mental pain or limitation while also expressing frustration at the ways in which society reduces disabled people to their impairment and fails to see them in their full humanity. To reduce a person's experience of a disability to the ADA's definition of "physical or mental impairment,"<sup>289</sup> which must be confirmed by a medical practitioner, is both a barrier and tool of silencing. The Association on Higher Education and Disability has long emphasized that the primary documentation in an educational institution's determination of whether a student is disabled should be the student's self-report, since "[a] student's narrative of his or her experience of disability, barriers, and effective and ineffective accommodations is an important tool which, when structured by interview or questionnaire and interpreted, may be sufficient for establishing disability and need for accommodation."<sup>290</sup> Under this model, students may self-report a physical impairment such as migraines in their request for accommodation. Or they may self-report that they have been blind since birth, or since a particular age, and that certain kinds of accommodations have been particularly effective for them. The fact that we respect the student by presumptively accepting the self-report does not mean that medical conditions are irrelevant to the disability diagnosis. But we need to ask ourselves whether institutions are creating medical barriers by, for example, insisting on a recent medical confirmation of these conditions.

This perspective can inform other areas of the law, such as gender marking, transgender athletic participation, access to contraception, and access to abortion. The individual's self-report will likely be the most useful piece of information in triggering access to these arenas of life and should be treated as such. While an individual may report a diagnosis of gender dysphoria as part of a request for accurate gender identity documents, that requirement should not be mandatory and should not require confirmation by a medical professional. In athletics, we must stop treating female transgender athletes as if they present unique and unfair biological advantages.

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<sup>289</sup> See 42 U.S.C. § 12102(1) (2008).

<sup>290</sup> *Supporting Accommodation Requests: Guidance on Documentation Practices*, ASS'N ON HIGHER EDUC. & DISABILITY (Oct. 2012), <https://www.ahead.org/professional-resources/accommodations/documentation> [<https://perma.cc/38RL-9BDJ>].

We need to understand the contemporary bans on transgender women's participation in sports as consistent with longstanding attempts to force female athletes to maintain exterior presentations of femininity while playing their sports.<sup>291</sup> These bans preserve patriarchy through claims of artificial medical categories under the guise of biology. They also impose grave harm on many people for whom athletic activity has been central to their emotional and mental health. We can describe these significant harms without reifying false claims about human biology.

We need to ensure that the emerging reconception of reproductive rights does not fall into the overmedicalization trap. Contraception access should not depend on the person having any particular medical condition; it should only depend on the person's right to define their future. In *Dobbs*, the Supreme Court has attempted to take women's health out of the abortion controversy through demedicalization. We should not defend abortion in overmedicalized terms by focusing too closely on the cases of medical necessity with the slogan, "abortion is health care." While abortion may be health care that many people seek in consultation with their medical providers, it should also be an area where the pregnant person's self-report is presumptively the beginning and end of the discussion. The political right has long engaged in practices that are disrespectful of a pregnant person's right to decide to terminate their pregnancies by imposing waiting period rules, bogus informed consent rules, and unnecessary medical treatment requirements. We need to reformulate the right from the narrow way it was conceived in *Roe v. Wade*—as a right that an attending physician made on a behalf of a "mother." We need to conceptualize reproductive justice as the right to affirm one's own understanding of their needs and aspirations, freed from gender-based, disability-based, or race-based norms for appropriate behavior.

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<sup>291</sup> Thus, men and women have different dress codes at the Olympics for the same sports to maintain these rules for gender conforming behavior. See Michael Hincks, *Olympic Kit Rules: Why Beach Volleyball Bikinis Are So Small and Other Tokyo 2020 Restrictions*, INEWS (Aug. 4, 2021), <https://inews.co.uk/sport/olympics/olympics-kit-rules-explained-beach-volleyball-bikinis-size-tokyo-2020-restrictions-1114025> [https://perma.cc/KEU9-7PQU] (reporting that Norwegian women's beach handball team was fined for wearing shorts instead of bikini bottoms by the European Handball Federation).

