Transgender Minors and the Right to Care

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ABSTRACT

Arguments to pause or ban gender-affirming care for transgender minors often rely on concerns around the uncertainty of the evidence for the benefits of intervention. To tie the right of transgender minors to a societal evaluation of the benefits of that care makes an incorrect value judgment about what it means to live life as a transgender person, imposes an impractical standard of evidence, and treats care for transgender minors as somehow exceptional when it has not been demonstrated to be. Transgender minors have an ethical right to continued access to care while research is conducted.

The filing and passage of legislation that bans care for transgender minors has increased significantly in the last few years. Arguments in favor of banning care range from a belief that there is no such state as being transgender, to a concern that gender-affirming care causes harm to minors (either from the intervention itself or because of a fear of regret later in life), to an assertion that we need more evidence before such care can be permitted. The right to care cannot and should not be contingent on any of these variables; rather, if there is enough evidence to justify the care, that evidence is sufficient to continue the care while the research continues. Evaluations of the benefits to the individual child must be assessed by the child, their parents, and their care team. To tie the right of transgender minors to gender-affirming care with an evaluation of the benefits of that care at the societal level makes an incorrect value judgment about what it means to live life as a transgender person, imposes an impractical standard of evidence, and treats care for transgender minors as somehow exceptional when it need not be.

Before I turn specifically to care for minors, I will address the skepticism around the existence of gender incongruence or gender dysphoria as legitimate states of being. Although these terms have gone through many iterations in the Diagnostic and Statistical Manual of Mental Disorders (DSM)[1] (the condition first

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appeared in the DSM-III in 1980 as transsexualism), the current DSM-5 restates the experience of distress one might feel when experiencing gender incongruence as *gender dysphoria,* a focus on the distress, as opposed to the state of being. But one need not feel distress to be eligible for care on the condition of a state of being. Despite recent executive orders to the contrary, gender incongruence has a long history across the world.[2,3] In ancient Rome, the *galli* were eunuchs who dressed in women's clothing;[4] the *hijra* in India are similarly trans women who have been acknowledged for centuries. (Indeed, the Indian Supreme Court has recognized *hijras* as a third gender.)[5] References to transgender people can be found in ancient Greece and ancient Mesopotamia.[3] While it may seem like a recent phenomenon in the United States, transgender people have sought medical treatment for their gender dysphoria here since the early 1900s.[6] In the 1950s, Christine Jorgensen became the first trans woman to be widely known in the United States as having undertaken gender-affirming medication and surgery.[7] While in the early part of the 20th century the United States lagged behind Europe in its care for transgender people, in 1966 Johns Hopkins opened its Gender Identity Clinic.[6] Although treatment of minors was less common than treatment of adults during that century, treatment of minors was not unheard of, and a survey of the history of the treatment of minors with gender incongruence reports multiple case studies.[6]

Given that the existence of gender incongruence or dysphoria is a condition or state of being, adults who seek gender-affirming care have the same autonomy rights to request or refuse the established standard of care as they would any other condition. In this way, gender-affirming care is not exceptional. An adult who experiences gender dysphoria or gender incongruence has a range of options available to them, from social transitioning to hormone therapy to surgery. While there have been movements to restrict the legal rights of transgender adults, such as revoking policies that allow gender marker changes on passports or drivers' licenses, attempts to outright ban gender-affirming care for adults have been more limited. When the bans do occur, they tend to be focused on the financial nature of how the care is funded, rather than a ban on the care itself. In spring 2025, ten states had banned the use of Medicaid funds for gender-affirming care.[8]

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Yet even those who argue strongly in favor of the right of adults to access gender-affirming care sometimes back off from an autonomy-based defense of this right when they consider the right of minors to care, and argue that the uncertainly around its long-term impact overrides concerns about autonomy—the right of an individual to make decisions about their own medical care. To ban care in the face of incertitude is an incorrect conclusion to draw from uncertainty. The right to care is so integral to our healthcare system that we allow parents to pursue treatment for their children in other situations when it is not clear what the optimal intervention is. For example, to cite McNamara and colleagues,[9] we remain unsure if premature infants are better off given donor breast milk or synthetic formula when their mother cannot produce their own milk. Both approaches present advantages and benefits, but also risks and potential harms. But it is widely agreed that the infants' parents have the right to decide, even without the knowledge of what impact that choice will have in the future.[9] This is an extreme example, as no one favors feeding an infant nothing while we compile more information, but it is not extreme to say that pediatric medicine is filled with situations where the data are less clear than might be optimally desired, but the right to some form of care is ethically required. A more benign example is that of GLP-1 medications approved by the US Food and Drug Administration (FDA) for children over the age of 12.[9,10] There is an ongoing ethical debate about the use of such medications for children that stems from a variety of concerns related to unknown long-term effects, as well as potential side-effects.[11] Yet we have not paused the access of children who want to use these medications while we continue to do research and discuss its implications, because it is wrong to deprive individuals of the right to decide while more research is conducted.

The second reason often used to override minors' autonomy rights in this sphere is an argument about benefits. Some who wish to ban or pause access to care while researchers explore the benefits of gender-affirming treatment assert that they want to make sure gender-affirming treatment provides enough benefit to offset any potentially unknown side-effects. Under that analysis, it may not be enough for the treatment to work as expected and align the patient's personhood with their gender identity. The treatment must provide more; otherwise, the benefit standard is met once gender-affirming care takes effect. But how do we evaluate what is enough benefit? That is an inherently subjective standard that requires value judgments around what constitutes a fulfilling life. There is no reason to override personal autonomy to make a decision in this realm, as in any other personal health decision. Transgender minors deserve to receive the same level of care that other patients do. Therefore, if such treatment fulfills its purpose and aligns a patient's personhood with their gender identity, the patient has a right to make the choice to access care.

To do otherwise and treat transgender patients differently than we treat other patients simply because they are transgender is unjust. Normally, as long as a medication works as intended, we allow patients to decide whether to take it, and do not impose external value judgments about whether patients can use it as it is intended. The case *United States vs. Skrmetti,*[12] decided by the US Supreme Court in June 2025, was brought to address this injustice. The case presented a challenge to Tennessee's ban on puberty blockers or hormone therapy for transgender minors. Puberty blockers are prescribed as the standard of care for minors who undergo precocious puberty, and hormone therapy is prescribed to minors who suffer from endometriosis. The Tennessee ban and other state bans are not objections to the medications themselves; if that were true, the law would ban any child from receiving such treatment. Rather, the case objected to the reason for the use of the treatment. A 16-year-old with painful endometriosis may receive estrogen to treat her condition, but that same 16-year-old who requests estrogen to treat feelings of gender dysphoria is not allowed to make the same request. While a majority of the Supreme Court did not agree that such a distinction presented a constitutional violation (although the dissent strongly disagreed), it is certainly an unjust departure from our current system for evaluating medical benefit.

Lessons from cosmetic surgery and similar interventions for minors underscore this point and show how a focus on benefit can lead us down an ethically dubious path. Numerous studies report that tall people are more likely to be perceived as leaders and may earn more in their lifetime.[13,14] Taller people have an advantage in many sports. Parents are allowed to make the choice to ask a doctor to treat their child with idiopathic short stature—that is, significantly below average growth with no known physical cause—with growth hormone therapy, a treatment approved by the FDA.[15] Such treatment has potential side-effects, and a doctor provides a treatment to a child who was not diagnosed with a physical disease. In the same way, cosmetic surgeons perform rhinoplasty on minors to help them align more securely with a cultural ideal of beauty, without seeking proof of future benefit, before they perform the surgery. We allow parents to make the choice that these treatments are in the best interest of their child. We do not use concerns about whether the child might someday regret the choice their parents made as a reason to ban the treatment, and we consider the treatment a success if it helps the child grow, and do not require additional psychological benefit.

Moreover, we do not believe parents are *required* to treat a child with short stature with growth hormone, even if all the available evidence points to a significantly increased chance that the future will be better for the child if they are taller, and we do not require parents to perform cosmetic surgery on their child if their earnings or self-esteem will improve if they are more attractive. Although Julian Savulescu argues that parents who use pre-implantation genetic diagnosis should select embryos with genes that are more likely to have societally beneficial traits,[16] we generally do not believe parents have an ethical obligation to choose parenting options based on what maximizes benefit in a theoretical universe. Children and their parents are allowed to make care choices that are independent of long-term benefit calculations.

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If we require that we fully understand the future benefits of gender-affirming care before we allow such care, the benefit standard asks a question that is almost impossible to answer. While the gold standard for research is the double-blinded placebo study, it would be unethical to conduct a double-blinded placebo study on gender-affirming care. This is because the current standard of care for gender dysphoria is gender-affirming care, which may include puberty blockers, hormones therapy, or surgery. Research studies indicate that transgender teenagers are more likely to report either suicidal ideation or suicide attempts as compared to the general public, a rate that appears to increase when states ban access to care.[17] A study of 220 youths who had accessed puberty blockers or hormones and were followed for a decade reported "very high levels of satisfaction and low levels of regret; the overwhelming majority (97%) continued to access gender-affirming medical care."[18] Several studies by Turban and his team in 2020 and 2022 found a link between puberty suppressants and reduced suicidal ideation in adulthood.[19,20] Thus, if we imposed a placebo on minors with gender dysphoria or gender incongruence, we would deny the standard of care to a patient population with a known risk of possible suicidal ideation or risk of harm to self. It can never be ethical to deliberately deny care to individuals who are more at risk of depressive or suicidal thoughts if such care is withheld. We need to continue to work to develop a robust body of research around the care of transgender minors, but the lack of more evidence does not diminish the evidence that we do have, especially in light of the ethical challenges faced when this care is evaluated. That a study cannot be conducted in a particular way cannot be an argument to refuse to consider the evidence. In the meantime, observational studies, well-crafted qualitative studies, and non-probability sampling are all methods we have used and can continue to use to study the best form of care for transgender minors.[21]

We give enormous deference to the rights of parents to make the choices they believe to be correct for their child and for their family. While this can sometimes be uncomfortable, it is an essential part of respecting parental autonomy, and bans on healthcare that are approved for one purpose but not for another are a violation of that right. Given this rights-based argument for the right to gender-affirming care, the right to this care and to assert an identity exists before a teen's 18th birthday. We recognize this when we allow older teens who are under 18 to access birth control or substance abuse treatment without parental consent, under the legal concept of the mature minor. The concept of the mature minor rests on the idea that adolescents of a certain age and maturity are able to meet the definition of capacity elucidated in the MacArthur Treatment Competence Study[22]: "1) ability to communicate a choice, 2) ability to understand relevant information, 3) ability to reason about treatment options, and 4) ability to appreciate the situation and its likely consequences." Given that an older teen can meet the MacArthur criteria and has the right to assert both their identity and the mechanisms for being in alignment with identity, a fear that the individual may later regret their decision is not a valid reason to ban healthcare for transgender teenagers. We may fear that teenagers cannot fully understand who they are or who they might want to become, and might make a decision to seek gender-affirming care that they may later regret. But if a teenager is able to appreciate their situation and its likely consequences, we must assign to them the right to care that is allowed any person with the cognitive capacity to make an informed decision regarding their own treatment. To focus excessively on regret implies that an experience, if later refuted, must have been a negative one. If we instead view the experience of expressing one's identity as an extension of one's autonomy, which can be changed, or not, our focus on regret becomes less important. As with any medical intervention, a full and informed decision should be made, and we should not be cavalier about the long-term effects of gender-affirming care. But the right to make a decision must not be taken away without strong evidence and rationale for removing that right.

Gender-affirming care for transgender minors is often treated as exceptional in the field of healthcare. This care has been subjected to a higher standard of evidence and cost-benefit analysis than other conditions that affect minors, a distraction from the fundamental right to the care. The uncertainty present in this arena is no different than in other areas of pediatric medicine. The focus on benefit and regret imposes a negative judgment on gender incongruence, rather than recognizing the condition as an identity.

The current standard of care espoused by a broad group of professional medical associations, including the World Professional Association for Transgender Health (WPATH), the Endocrine Society, and the American Academy of Pediatrics, is to treat transgender children with gender-affirming care, including hormones, if appropriate.[23,24,25]

An *informed consent model* best allows us to balance a variety of competing interests[26]: transgender minors and their parents must be fully informed of what we know and what we don't know when it comes to prescribing puberty blockers or hormone therapy. This informed consent perspective allows us to hold space for concerns without letting those concerns eclipse the need for care when it is appropriate. This position allows doctors to be honest about possible side-effects, both immediate and long term, while it gives families the right to make autonomous decisions about what is best for their healthcare. In this manner, we meet our ethical responsibilities to give full information about a medical intervention without withholding needed and ethically required care. At the end of the day, this is what good medicine looks like. Transgender minors aren't seeking special treatment; they assert the right to be provided with the same level of healthcare all patients demand of their healthcare system.

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