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GUEST ESSAY

What Decades of Providing Trans Health Care Have Taught Me

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By Marci L. Bowers

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This year more than 350 anti-transgender bills have been introduced in state legislatures, pushing discussion about treatment for trans and gender-diverse patients further into the national spotlight. It isn't hard to surmise that politically convenient doubts about the validity of trans identities have come to take the form of prohibitions against trans health care.

In states where such anti-treatment bills have passed, families are already in despair. Some fear losing health care for their children or losing their children altogether. Some are simply moving. Doctors and mental health workers in some states would risk losing their licenses for providing medical care to an already chronically underserved population. And if more laws that limit or deny access to care pass, the lives of transgender and gender-diverse teenagers are likely to worsen.

To be sure, worthwhile questions about how best to address gender diversity, adolescent mental health and teens' expectations about gender remain. But answers to them will not be found in legislation that will harm — not protect — children, families and their health care providers. We must ask ourselves: Why are legislators and politicians making medical decisions for patients and families instead of doctors?

Although gender diversity has existed for centuries, medical treatment of gender dysphoria — the diagnosis for those who experience discomfort when their gender identities do not match their sex assigned at birth — developed as transgender people became increasingly visible in the late 20th century. In 1979, a group of trans-knowledgeable professionals, surgeons and mental health experts met to establish standards for the health care needs of transgender patients. The standards provided order, objectivity and science to a process that was then poorly understood by the medical community. The authors of these guidelines founded an organization that would later become known as WPATH, the World Professional Association for Transgender Health, which I now lead.

Decades of medical experience and research since has found that when patients are treated for gender dysphoria, their self-esteem grows and their stress, anxiety, substance use and suicidality decrease. In 2018, Cornell University's Center for the Study of Inequality released a comprehensive literature review finding that gender transition, including hormones and surgery, "improves the well-being of transgender people." Nathaniel Frank, the project's director, said that "a consensus like this is rare in social science."

The Cornell review also found that regret — a decision to either stop treatment or express unhappiness about one's decision to transition socially, medically or surgically — became even less common as surgical quality and social support improved. All procedures in medicine and surgery inspire some percentage of regret. But a study published in 2021 found that fewer than 1 percent of those who have received gender-affirming surgery say they regret their decision to do so, a much lower rate than has been reported for more common medical interventions like plastic surgery and orthopedic care. A separate analysis of a survey of more than 27,000 transgender and gender-diverse adults found that the vast majority of those who detransition from medical affirming treatment said they did so because of external factors (such as family pressure, financial reasons or a loss of access to care), not because they had been misdiagnosed or their gender identities had changed.

When considering the growing body of overwhelmingly positive data about adult transgender treatment, it makes sense that earlier intervention, which can lessen the

permanent effects of puberty, would make gender transition easier for teenagers. Puberty blockers had been used with minimal concern about side effects since the 1980s. They have been approved by the F.D.A. to treat endometriosis, prostate cancer and precocious puberty. When used for adolescents experiencing gender dysphoria, they allow for an additional safeguard as gender-diverse patients become more certain about their identities through ongoing evaluation, family support and review. Offered shortly after puberty begins, blockers are typically used to delay puberty for as long as two years. Decreasing bone density — a side effect of puberty blockers — can return to normal once puberty resumes, either by withdrawing the blockers or administering cross-sex hormones.

While those who express gender nonconformity before puberty only receive supportive care, not medication or surgery, experts who treat gender dysphoria in early puberty consider the benefits of treating teenagers obvious, based on the effectiveness of adult treatments.

The presumption that gender-diverse identities are not real — that young people will eventually come to accept their birth assigned gender as their minds catch up to their maturing bodies — is not supported by the evidence and is likely harmful. There are, after all, more than 40 identified intersex variations representing diversity in the development of genitalia. Gender identity is similarly diverse. In nature, for every rule, there is an exception.

As is the case for any recommended treatment in medicine, set the bar too high and patients are left untreated. Set the bar too low and patients are treated unnecessarily or inaccurately. For transgender and gender-diverse patients, setting the bar too low would equate to allowing hormones or surgery with little evaluation. In those cases, patients could slip past the usual rigors of WPATH standards and evaluation, resulting in a higher percentage of patients who are treated and who might later stop treatment, regret their decisions or detransition altogether. On the other hand, a lowered bar could mean someone who is suicidal as a result of gender dysphoria might be prevented from self-harm. Such is the delicate balance that clinicians routinely negotiate, and why treatment recommendations must remain individualized.

Of late, in response to overwhelming demand, gender clinics are increasingly evaluating patients who must endure long wait lists and see further barriers to care as gatekeeping. It is not surprising, then, that some recently treated patients may have felt rushed or inadequately evaluated. Rising demand, and the complications it brings, suggests a need for more providers, not fewer. The medical community must address gaps in care, not allow for politicians to widen them.

Anti-treatment bills will not protect children, and they will not help the medical community provide better care for patients in need. We should instead take anti-transgender legislation for what it is: thinly veiled cruelty to a specific minority population of the country. These bills are symptoms of a larger problem, where belittlement and bullying are reminders of what many trans people endure as children, teenagers and young adults. In a country where the murder of transgender people

— specifically transgender women of color — is far too frequent, these bills feel as if they are part of a larger aim: to rid the world of transgender people. Confronted with the growing visibility of those who seem to condone such violence, it is difficult not to feel as though our nation has lost its empathy and compassion.

The field of transgender medicine is evolving rapidly, but it is every bit as objective- and outcome-driven as any other specialty in medicine. Allow the remaining scientific questions to be answered by knowledgeable researchers, without the influence of politics and ideology. Leave delicate medical decisions faced by gender-diverse patients to those who truly care about these lives — patients, their families and their providers. Trans and gender-diverse people contribute positively to society and live ordinary lives. They deserve accessible medical care, not judgment and persecution.

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