

Other Voices

Values and Evidence in Gender-Affirming Care

by OS KEYES and ELIZABETH A. DIETZ

What,” Moti Gorin asks in an article in this issue of the journal, “is the aim of pediatric ‘gender-affirming’ care?” He offers two answers. It can, following the lead of “major American professional medical associations,” take a biomedical approach by aiming to ameliorate or avoid adverse effects of gender dysphoria like distress, depression, and suicide. Or it can treat achievement of an individual’s embodiment goals and well-being as its clinical end point. The relative merits of each, Gorin argues, “do not reduce to disagreements over the strength of the underlying scientific evidence. Rather, they embody fundamentally different and opposed conceptions of the central aims of transition-related medical interventions.”¹ We agree: these are two different ways of conceiving of gender-affirming care, both of which are operationalized by patients and practitioners alike, and the reasons that they both matter are not explained by competing interpretations of the underlying evidence base. However, we disagree with the assertion that they are fundamentally opposed to one another. Trans people express their needs in terms of both formulations. And the developmental arc of the field of trans health has led to World Professional Association for Transgender Health (WPATH) standards of care that (like the numerous professional practice associations, hospitals, and practitioners who use them as guidance) treat both biomedical aims and embodiment or well-being goals as appropriate warrants for care. Disagreement—where it exists—is not about the strength of the underlying evidence but about how to think about the evidence itself.

Gorin’s argument is a useful source through which to make sense of relationships between underlying values and the evidence that is used to justify and foreclose the permissibility of gender-affirming care. Trans people and their allies see the provision of this care as necessary and warranted. They tend to call for research and evidence that will support process and outcome improvements, rather than questioning whether such care should be provided. Opponents of gender-affirming care tend to hold a different set of starting assumptions, treating its usefulness or permissibility as an open question. Accordingly, they call for evidence to settle whether such care is permissible and, more fundamentally, whether to regard

transgender identity as a legitimate and recognizable way of being. These differences also do not reduce to disagreements about the underlying scientific evidence: they integrate evidence with normative belief structures about sex, gender, power, and the right role of medicine therein. By explicating the inextricability of value judgments from the conduct of evidence-based medicine, we argue that arguments like Gorin’s about evidence-based epistemic formulations (here, what the right aims of gender-affirming care should be) ought to be considered alongside the underlying values that not only animate the philosophical questions at stake but also frame the kinds of and standards for evidence that are used to referee them.

Values and Evidence

In Gorin’s argument, Florence Ashley’s essay “Adolescent Medical Transition Is Ethical: An Analogy with Reproductive Health” represents the “embodiment” argument for gender-affirming care.² Gorin argues that embodiment goals (and the well-being that they are imagined to bring about) are inappropriate clinical end points because they fail to establish gender-affirming care as “conventional health care—in other words, that . . . [which] treats or prevents illness, injury, disease, mortality, or so on.”³ However, his critique fails to engage Ashley’s own evaluation of the evidentiary standards for psychological interventions, which anticipates his argument. The evidentiary standards for evidence-based medicine trace back to a framework called “Grading of Recommendations Assessment, Development and Evaluation,” proposed in 2004 by a group known as the GRADE Working Group. Ashley notes that such studies “are also rated poorly because mental health measures are predominantly self-reported, which the GRADE framework looks unfavourably upon despite it being the norm in psychology.”⁴ In other words, gender-affirming care is indeed like other forms of health care in that outcomes are necessarily self-reported, producing evidence graded as lower quality. The subjective quality of this kind of evidence does not abrogate the necessity of care in other mental health care contexts, however; to exceptionalize gender-affirming care in this way is a value-laden decision. The decision highlights ways that values are entangled with evidence, including vital ways that values shape ideas about what “evidence” in evidence-based medicine (EBM) is or should be.

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To some, this might seem confusing; after all, “EBM has a ring of obviousness to it.”⁵ Who would not want medical treatment to be based on the best available evidence? The issue is that, in practice, the evaluation of “best” is far more disputed than Gorin implies. For example, the understanding of “best” in evidence-based medicine deploys a particular form of rationality in which randomized controlled trials (RCTs) are necessary for evidence to meet the highest quality of the GRADE framework. But there are many kinds of knowledge that this devalues, including clinicians’ experiential evidence of engaging in medical work and patients’ experience of receiving care. There are also many kinds of questions that simply cannot be answered using RCTs, for reasons of ethics (in scenarios where it would be inappropriate to randomize or deny treatment), reasons of viability (in scenarios where it is simply impossible to randomize treatment), or reasons of practicality (when RCTs would be too expensive to undertake at scale). Conversely, there are many situations in which forms of knowledge that evidence-based-medicine approaches discount—from clinical experience to patient knowledge—have been vital to shaping medicine.⁶

Unsurprisingly, then, “normal medicine” looks very different from the world Gorin imagines.⁷ With respect to clinical practice guidelines, for example, Karin Verkerk et al. emphasize that “[c]linical practice guidelines should be based on the best available evidence. However, this evidence is often incomplete, controversial, or lacking. Considerations beyond the evidence are therefore needed to be able to formulate specific and applicable recommendations for clinical practice.”⁸ Entire domains of medicine, from kidney dialysis to gynecological care, have been fundamentally shaped by forms of patient and clinician activism absent from evidence-based medicine, and these domains legitimize and articulate themselves in ways that a strict adherence to evidence-based medicine would render impossible. In the practice guidelines of the Infectious Diseases Society of America, for example, 37 percent of the strong recommendations are based only on expert consensus.⁹ Many surgical procedures are not backed up by RCTs,¹⁰ and the vast majority of pharmaceutical drug evaluations, though often held up as the ur-form of RCTs, cannot answer many questions about side effects.¹¹ All these are instances in which the epistemic and ethicopolitical values of “normal medicine” reflect a pragmatic hybridization of different parties and forms of evidence, including patient advocacy, observational trials, case studies, and more phenomenological knowledge—precisely what we see (and Gorin takes issue with) in the knowledge base around gender-affirming care. Trans medicine, in other words, simply *is* normal medicine.

Normal Evidence

The practice of evidence-based medicine is a value-laden affair. These values relate not only to the inter-

pretation of an existing body of evidence but also to the foundational assumptions upon which interpretation is based—assumptions about what evidence, in what forms, should be taken seriously. In this commentary, we have argued that Gorin’s arguments are based not only on a substantial misreading of the evidentiary base but also on a substantial misreading of what it means for something to count as evidence. Gorin demands that trans medicine adhere to a form of evidence gathering that is not expected of other domains of medicine. This both exceptionalizes trans care and (given the framework he has chosen) demands a standard for evidence that discounts and dismisses the kinds that trans people generate through their testimony about the value and importance of gender-affirming care by treating such accounts as biased or conflicted.

There is an urgency inherent to value questions around empirical or evidence-based claims. But it is particularly heightened at the moment, when U.S. and international legislative bodies are weighing bans on adolescent gender-affirming care like Tennessee’s, in which “the legislature finds it likely that not all harmful effects associated with these types of medical procedures when performed on a minor are yet fully known, as many of these procedures, when performed on a minor for such purposes, are experimental in nature and not supported by high-quality, long-term medical studies.”¹² To make the same argument—an argument that, as we have demonstrated, treats trans medicine as exceptional—is not only to legitimize the legislative bans in place. It is also to frame the evidentiary threshold necessary to overcome that legitimation as one that can be met only by discarding the hard-won successes that trans people have had in ensuring that, just like patients in any other domain of medicine, our voices are present in conversations about our bodies.

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1. M. Gorin, “What Is the Aim of Pediatric ‘Gender-Affirming’ Care?,” *Hastings Center Report* 54, no. 3 (2024): 35-50, at 30.
2. F. Ashley, “Adolescent Medical Transition Is Ethical: An Analogy with Reproductive Health,” *Kennedy Institute of Ethics Journal* 32, no. 2 (2022): 127-71.
3. Gorin, “What Is the Aim of Pediatric ‘Gender-Affirming’ Care?,” 46.
4. Ashley, “Adolescent Medical Transition Is Ethical,” 146.
5. K. Bell, “Cochrane Reviews and the Behavioural Turn in Evidence-Based Medicine,” *Health Sociology Review* 21, no. 3 (2012): 313-21, at 314.
6. D. J. Sheridan and D. G. Julian, “Achievements and Limitations of Evidence-Based Medicine,” *Journal of the American College of Cardiology* 68, no. 2 (2016): 204-13.

7. S. Timmermans and M. Berg, *The Gold Standard: The Challenge of Evidence-Based Medicine* (Philadelphia: Temple University Press, 2010).

8. K. Verkerk et al., “Considered Judgement in Evidence-Based Guideline Development,” *International Journal for Quality in Health Care* 18, no. 5 (2006): 365-69, at 369.

9. D. H. Lee and O. Vielemeyer, “Analysis of Overall Level of Evidence behind Infectious Diseases Society of America Practice Guidelines,” *Archives of Internal Medicine* 171, no. 1 (2011): 18-22.

10. P. L. Ergina et al., “Challenges in Evaluating Surgical Innovation,” *Lancet* 374 (2009): 1097-1104.

11. J. P. Vandenbroucke, “When Are Observational Studies As Credible As Randomised Trials?,” *Lancet* 363 (2004): 1728-31.

12. Tenn. Code Ann. §68-33-101 (2024).

Other Voices

Troubling Trends in Health Misinformation Related to Gender-Affirming Care

by STEF M. SHUSTER and MEREDITH McNAMARA

Amidst the misinformation climate that dominates policy and social discourse about trans people and their health care,¹ Moti Gorin presents an article in this issue of the *Hastings Center Report* disputing autonomy-based rationales regarding gender-affirming care for trans and nonbinary youth.² Trans and nonbinary people experience a gender identity that is distinct from sex assigned at birth. According to the newest guidelines from the World Professional Association for Transgender Health (WPATH), the goal of gender-affirming care is to “[p]artner with [transgender and gender-diverse] people to holistically address their social, mental, and medical health needs and well-being while respectfully affirming their gender identity.”³ Medical aspects of gender-affirming care can help bring one’s body into alignment with identity.⁴ Gorin suggests that the justifications for treating gender dysphoria in youth are illogical and conflict with the medical community’s commitment to the principle of nonmaleficence. From this ethicist’s perspective, the purported failure of the medical community to demonstrate the effectiveness of treatments for gender dysphoria outweighs patient autonomy. To construct his argument, Gorin skirts decades of clinical research, offers a narrow review of contemporary scholarship in trans bioethics, and reanimates several misinformation themes from today’s debate.

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We depart from this conversation to contextualize the virulent ideas circulating in misinformation campaigns. These campaigns have been used to excuse and justify unprecedented legal interference into standard health care. As a consequence of this interference, what has been glossed over is how gender-affirming care meets conventional evidentiary standards, the protocols for accessing such care, and how refusal to offer it is more harmful than centering trans and nonbinary people’s autonomy over their health.

Contextualizing Transgender Medicine amidst Misinformation Campaigns

Trans medicine is not novel. Visibility can be conflated with novelty in the public eye, and novelty can be jarring. Thus, it bears emphasis that hormone therapy for gender-affirming care has been used since the 1930s and that trans medicine developed into a professional medical field in the 1950s. Until only the late twentieth century, medical professionals asserted their authority over trans and nonbinary people with exceptionally stringent diagnostic criteria, with contrived explanations for trans identity, and by withholding access to care.⁵ The medical community has worked with and studied the experiences of transgender people, including youth,⁶ for over seventy-five years.

State of the evidence. Claims about the evidence on gender-affirming care dominate public discourse but are detached from scientific norms. Gorin notes that ran-