PEDIATRICS PERSPECTIVES

Caught in the Middle: The Care of Transgender Youth in Texas

Catherine M. Gordon, MD, MS, FAAP, FSAHM

In the United States, approximately 0.7% of adolescents identify as transgender or gender fluid.[1] Many pediatric centers now provide multidisciplinary care to assist in the transition from a child's or adolescent's assigned sex at birth (or natal sex) to their affirmed (or preferred) gender. During early puberty, therapy is available that results in the suppression of sex steroid production and secretion, followed later in adolescence by the administration of supraphysiologic doses of sex hormones appropriate for their gender identity.[1–3] The duration of pubertal suppression with gonadotropin hormone releasing hormone agonists varies, but can extend up to 4 years for younger patients who are not able to provide consent until age 16 for receipt of gender-affirming therapy. Puberty blockers represent an invaluable intervention for these children and adolescents, to reduce anxiety and "buy time" until final decisions can be made about gender assignment.

Recent legislation and legal directives in Texas have sought to put a halt on the medical management of transgender youth (ie, minors aged <18 years). On February 21, 2022, Texas Attorney General Ken Paxton issued a legal opinion concluding that treating minors with gender dysphoria with puberty blockers and/or supraphysiologic doses of testosterone to females or estrogen to males can legally constitute child abuse under Texas law. In response, Governor Abbott sent a letter to the Department of Family and Protective Services (DFPS) directing the agency to conduct a prompt and thorough investigation of any reported instances of sex-change procedures, and administration of the above-described treatments for gender dysphoria, without regard to medical necessity. In addition to directing DFPS to investigate reports of procedures, the letter contended "Texas law imposes reporting requirements upon all licensed professionals who have direct contact with children who may be subject to such abuse, including doctors, nurses, and teachers, and provides criminal penalties for failure to report such child abuse." In addition, Abbott stated there are "similar reporting requirements and criminal penalties for members of the general public." Two days later, on February 23, 2022, a DFPS employee asked her supervisor how the Governor's letter would affect

Department of Pediatrics, Texas Children's Hospital and Baylor College of Medicine, Houston, Texas

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Address correspondence to Catherine M. Gordon, MD, MS Texas Children's Hospital, 6621 Fannin St, Pediatrics - WT1980 Houston, TX 77030, E-mail: catherine.gordon@bcm.edu

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DFPS policy; that employee had a transgender child. The DFPS employee was subsequently put on leave from her job and investigated for child abuse. On behalf of the DFPS employee, her minor child, and a licensed psychologist, the American Civil Liberties Union, Lamda Legal Defense and Education Fund, Inc. and other attorneys immediately sued DFPS and the Texas Governor, related to the enforcement of the Paxton Opinion. A court hearing was held on March 11, 2022, and the district court judge issued a statewide injunction against the Governor's order. The judge opined that a state order to consider medically accepted treatments for transgender youth as abuse had been improperly adopted and violated the State Constitution. Governor Abbott appealed, and the injunction is no longer in effect pending further rulings by the appellate court. The US Department of Health and Human Services (HHS) has issued guidance, countering the Paxton Opinion, and numerous professional societies have similarly voiced strong dissent.[4] Finally, the HHS Office for Civil Rights announced on February 22, 2022, that they would be investigating cases "involving discrimination on the basis of sexual orientation and gender identity in accordance with all applicable law."[5]

Throughout all of this, what was the appropriate stance for children's hospitals and other health care facilities in Texas that provide care for transgender youth? As hospital leaders, we care deeply about both the health and welfare of these children and adolescents and at the same time, were faced with the very real concern that our clinicians could be prosecuted. We also had to consider the risk for prosecution of loving parents and other caregivers, who entrust their child's care to an experienced health care professional, yet learn that by doing so, they may also be at risk for prosecution. Additionally, we were reminded of the growing body of evidence showing that for minors with gender dysphoria, when deemed to be medically appropriate and necessary by their health care team, gender-affirming therapy improves their physical and mental health.[1–3,6] As hospital leaders, we had a duty to care for patients and families, but at the same time, the responsibility to protect both them and our physicians, psychologists, and medical staff from criminal liability.

In the forefront of our thinking was the known high risk of suicide in transgender individuals, including both youth and adults.[6] Government action that condemns the care of this population has the potential to exacerbate depression and despair in these individuals, including those who find hope as new patients, and lead to the perception of abandonment if we withdraw care abruptly. My colleagues and I were troubled by the potential negative impact of any threat to care on a population of patients known to be at high risk for depression and self-harm.[6] Pubertal blockade and gender-affirming therapy have the potential to lower this risk, an observation I have witnessed in my clinical work for over two decades. As noted by the HHS Office for Civil Rights, government action that overrides evidence-based medical practices "block parents from making critical health care decisions for their children and create a chilling effect on health care providers who are necessary to provide care for these youth."[5] Our hospital and all health care professionals in Texas have been put in an extremely difficult position. Given the many unknowns, our hospital, like that of others, put a brief and temporary pause on certain elements of our transgender program until we understood the implications of such directives. However, and importantly, we continued to offer as many services as we could, including psychological and medical counseling, and never closed our clinic. We have to make adjustments to ensure we are providing care while understanding the ongoing government actions that evolve on a nearly daily basis, but continued care for our patients has remained our priority. As of this writing, the legal proceedings are continuing, and the end results are unpredictable. There is also ongoing concern about the potential for additional directives and legislation in Texas.

My own connection to the issue of care to transgender children and adolescents stems from my joint training in pediatric endocrinology and adolescent medicine. During my fellowship, I was fortunate to work under Dr. Norman Spack who founded the first pediatric transgender program in the United States in 2007, modeled after a similar multidisciplinary system in the Netherlands.[7] Dr. Spack was dual trained in both subspecialities and encouraged me to pursue a similar path. Working closely with Dr. Spack, I had the opportunity to serve as the primary care physician for several transgender youths, a decade before the formal clinical program opened. I saw the benefits of relieving the distress of a young person with gender dysphoria, discomfort related to a disconnect between an individual's personal gender identity and the gender assigned at birth. Over and over, I worked with young adolescents who were seemingly locked in the "wrong body" and their anxiety was exacerbated by the onset of normal pubertal changes. Early in my career, I saw how pubertal blockade and eventual gender-affirming

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therapy represented a life-changing, and for some, life- saving treatment of these children and adolescents.

Providing evidence-based and comprehensive medical care for transgender and gender diverse children and adolescents is a complex issue. These health care decisions should be left to physicians, patients, and their families. The recent government directives in Texas undermine the physician-patient-family relationship with the potential to erode the trust that our families place in us. Families with transgender children, patient advocates, and those who provide care for them in either the medical or behavioral health realm have reminded us that criminalizing this important care further stigmatizes an already vulnerable group. My colleagues and I appreciate the support of the Texas Pediatric Society, the American Academy of Pediatrics, and numerous other organizations in opposing the criminalization of this life-saving care for transgender youth. Prioritizing both their health and well-being includes the provision of medical treatment. We look forward to the day when these youth will no longer be caught in the middle between politics, and their much-needed medical care. Until that day, we will continue to advocate for them and their families.

ABBREVIATIONS

DFPS: Department of Family and Protective Services
HHS: US Department of Health and Human Services

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