WRITTEN STATEMENT OF SHANNON MINTER

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Chair and Members of the Committee, thank you for the opportunity to appear before you today.

My name is Shannon Minter. I have served as the Legal Director of the National Center for LGBTQ Rights for nearly 30 years.

I have worked extensively with transgender young people, their families, and medical experts on health care issues. That work has included reviewing medical research and consulting with policy and medical experts. It has meant hearing directly from doctors, patients, and parents about the impact of this care on young people's lives. And it has involved litigating cases to preserve access to this care—most recently, a class action challenging the administration's subpoenas of families' private medical records from children's hospitals across the country.

The principle that parents are entitled to make medical decisions for their own children is one of the most settled in American law. Parents make those decisions every day, in consultation with their doctors, for every other condition their children face. The government will never know a child better than that child's parents. Parents should not be robbed of the right to make decisions about their child's health just because that child is diagnosed with gender dysphoria.

Gender dysphoria is a recognized clinical diagnosis, and only a small number of young people are diagnosed with it. Fewer still receive any medical treatment: nationwide data show that well under one tenth of one percent of adolescents in the United States are prescribed any medications for gender dysphoria.[1] For many Americans and many legislators, this can feel like a new issue. But medical care for transgender adolescents has been available for more than two decades. The same medications used to treat transgender young people have been prescribed safely to other young people for more than forty years.

[1] *See* Landon D. Hughes et al., *Gender-Affirming Medications Among Transgender Adolescents in the US, 2018–2022*, 179 JAMA Pediatrics 342 (2025), doi:10.1001/jamapediatrics.2024.6081.

A substantial body of research, including multiple longitudinal studies, has found that these treatments are associated with improved mental health, quality of life, and psychosocial functioning, including reductions in depression, anxiety, and suicidality. These findings have been consistent across multiple longitudinal studies.[2]

In 2023, the Utah Legislature commissioned the University of Utah College of Pharmacy's Drug Regimen Review Center to conduct a comprehensive review on the safety and efficacy of medical care for transgender youth. The Drug Regimen Review Center has spent more than two decades evaluating prescription drug therapies for the State of Utah's Medicaid program. It had no prior involvement in the policy debate over this care.

The resulting review, published in May 2025, is more than 1,000 pages and involved tens of thousands of transgender young people. It is the most comprehensive review of this care to date. The review found that hormone therapy is effective in improving mental health and health care outcomes for transgender adolescents. It found the treatments to be safe across categories of risk that critics have raised, including bone density, cardiovascular health, metabolic changes, and cancer. And, in the review's own words, the authors found "virtually no regret associated with receiving the treatments, even in the very small percentages of patients who ultimately discontinued them."[3]

The Utah review is not the only study or review that finds this treatment to be safe and effective. But it is the most recent, largest, and most institutionally independent systematic review of this care available to American policymakers. Its findings warrant this Committee's careful attention.

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[2] *See, e.g.,* Diane Chen et al., *Psychosocial Functioning in Transgender Youth After 2 Years of Hormones*, 388 New England Journal of Medicine 240 (2023); Diana M. Tordoff et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 JAMA Network Open e220978 (2022); Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014). *See also* Joanne LaFleur et al., *Gender-Affirming Medical Treatments for Pediatric Patients with Gender Dysphoria*, University of Utah College of Pharmacy Drug Regimen Review Center (May 2025) (systematic review of nearly 300 studies concluding that these treatments are effective in improving mental health and psychosocial outcomes).

[3] Joanne LaFleur et al., *Gender-Affirming Medical Treatments for Pediatric Patients with Gender Dysphoria*, University of Utah College of Pharmacy Drug Regimen Review Center, prepared for the Utah Department of Health and Human Services (May 2025). The two-part report, totaling approximately 1,051 pages, was commissioned by the Utah Legislature pursuant to S.B. 16 and submitted to the Utah Department of Health and Human Services. The quoted finding regarding regret appears in the review's conclusions. The full report is available through the Utah Department of Health and Human Services.

The clinical standards for this care are supported by our country's leading medical associations, including the American Medical Association, the American Academy of Pediatrics, the American Psychological Association, the American Academy of Child and Adolescent Psychiatry, the American Academy of Family Physicians, the Endocrine Society, and the American College of Obstetricians and Gynecologists. These standards require rigorous, multidisciplinary clinical assessment. They take a conservative approach to treatment, with interventions reserved for adolescents who have demonstrated persistent and well-documented gender dysphoria. They have been in place for many years and are not new.

Critics often suggest that European countries have moved away from this care. That is a mischaracterization. Medical care for transgender young people remains legal and available in Canada, Spain, France, Germany, the Netherlands, Belgium, Australia, New Zealand, and many other countries. Sweden, Finland, and the United Kingdom have adopted protocols that emphasize comprehensive mental health assessment and require careful individualized evaluations, which are already part of the standard of care in the United States. None of those countries has banned this care. The American debate has too often conflated more cautious clinical protocols with categorical bans, and they are not the same.

Critics also invoke the UK's Cass Review as raising questions about this care.[4] In reality, the Cass Review's critique was largely specific to the British health system and problems associated with care provided by a single, overwhelmed national clinic at Tavistock. The U.S. healthcare system, where care is delivered by hospital-based multidisciplinary teams under established guidelines, does not raise those concerns. The Cass Review also recommended that medical treatment continue to be available for adolescents for whom it is clinically indicated, following multidisciplinary assessment. It did not call for a ban. Dr. Cass herself has stated publicly that her findings have been misrepresented and that the review was not intended to restrict access for young people who benefit from a medical pathway.[5]

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[4] Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report* (Apr. 2024) (commissioned by NHS England), https://cass.independent-review.uk/home/publications/final-report/.

[5] *See* Hilary Cass, *Editorial: The Cass Review – Implications and Reassurance for Practitioners*, 29 Child & Adolescent Mental Health 311 (2024) (emphasizing that the Review was not intended to roll back care for these young people).

Dr. Cass is not alone. Dr. Gordon Guyatt, the physician who coined the term "evidence-based medicine" and who developed the GRADE system that has become a widely used framework for rating the certainty of medical evidence, co-authored several systematic reviews of this care. He has objected in the strongest possible terms to the use of that work to justify bans. Dr. Guyatt has called reliance on these systematic reviews to justify prohibiting healthcare for transgender youth an "unconscionable" misuse of his work, and he and his co-authors have stated plainly that "it is unconscionable to forbid clinicians from delivering gender-affirming care." As Dr. Guyatt has explained, a finding of low-certainty evidence does not mean that a treatment does not work, and much of what physicians do across all of medicine rests on evidence of similarly low or very low certainty. To single out this one area of care for prohibition on that basis, he and his colleagues warn, "is a clear violation of the principles of evidence-based shared decision-making."[6]

Categorical bans on medical care for transgender young people prevent doctors from exercising clinical judgment. They prevent parents from obtaining medical care that their children's doctors have recommended. They override the framework of informed parental consent and careful clinical assessment that governs every other area of pediatric medicine in this country.

While the Supreme Court in *United States v. Skrmetti* held that one form of state ban did not warrant heightened scrutiny under the Equal Protection Clause, the Court did not adjudicate the underlying medical evidence and expressly left the policy question to the states. The Court did not address the question of whether these laws violate parents' constitutional rights.

The Committee should be especially cautious about any federal proposal that would replicate the state ban approach. A federal ban would impose a single political judgment on every family in the country, override the standards of care developed by medical associations, and remove from parents the ability to make medical decisions for their own children in consultation with their doctors. It would also undermine the principles of federalism by intruding on the established authority of states, not the federal government, to regulate the practice of medicine. The harm any such ban would cause to transgender young people and their families is profound and unjustified.

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[6] *Systematic Reviews Related to Gender-Affirming Care*, McMaster University Department of Health Research Methods, Evidence, and Impact (Aug. 14, 2025), https://hei.healthsci.mcmaster.ca/systematic-reviews-related-to-gender-affirming-care/.

Parents, their children, and their providers are under threat in other ways. In the past year, the Department of Justice has issued more than twenty subpoenas to children's hospitals across the country, demanding the protected medical records of minors who received transgender health care. The unprecedented subpoenas have sought extraordinarily sensitive information, including patients' names, dates of birth, home addresses, Social Security numbers, diagnoses, and treatment records. NCLR represents families challenging these subpoenas, including in a class action filed in federal court in Maryland on behalf of families whose transgender children received care at children's hospitals across the country.

Federal courts have repeatedly rejected the Department's demands. At least seven federal courts have moved to quash or limit these subpoenas. Judges across the country have found that the subpoenas serve no legitimate investigative purpose and were designed instead to intimidate hospitals, frighten families, and pressure clinicians to stop providing lawful medical care. One federal judge wrote that the government's demand for deeply private patient information carried "more than a whiff of ill-intent." Another wrote that "no clearer evidence of improper purpose could exist than the Government's own repeated declarations that it seeks to end the very practice it claims to be merely investigating." In a related set of rulings concerning the Federal Trade Commission's investigation of medical organizations that support this care, the Chief Judge of the United States District Court for the District of Columbia found "extensive evidence of animus" and "wafer-thin justifications lacking evidentiary support," concluding that the agency's investigation was rooted in "viewpoint-based animus" toward the organizations' advocacy for transgender health care.

This pattern of judicial rejection should give this Committee pause. Federal courts across the country, with judges appointed by presidents of both parties, have consistently found that these executive actions have no legitimate basis and are being conducted to harass and intimidate American families. The families involved have done nothing wrong. They have sought medical care recommended by their children's doctors, in jurisdictions where that care is lawful, under a standard endorsed by our nation's leading medical and mental health associations. They deserve the protection of the law, not federal investigation.

The right of parents to direct the upbringing and medical care of their children is among the oldest constitutional liberties recognized by the Supreme Court, described by Justice O'Connor

in *Troxel v. Granville* as "perhaps the oldest of the fundamental liberty interests." That right does not disappear simply because a legislator disapproves of parents' choices. It exists precisely because parents, not politicians, are the ones who know their children best and bear the responsibility for raising them. When the government displaces parents to dictate medical decisions for their children, it substitutes political values for family values. A federal ban would mark a profound step away from the American tradition of parental authority and toward political indoctrination of children by the state. The state bans, the federal proposals before this body, and the executive-branch enforcement campaign that federal courts have repeatedly rebuked all share a common feature: they substitute political judgment for the considered medical decisions of parents and the doctors who treat their children.

I urge the Committee to reject any federal measure that would extend this approach, whether by prohibition, funding restrictions, or investigative pressure on families and the institutions that serve them. As a transgender person myself who has benefited from a supportive family and church and from access to medical care—and as a parent and grandparent—I know firsthand what is at stake for these families. They deserve what every other American family deserves: the freedom to make medical decisions in consultation with their doctors, under the standards of the medical profession, without political interference.

I thank the Committee for the opportunity to provide this testimony and welcome the Committee's questions.

Respectfully submitted,

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