Trans Experiences in Health Care: Testimonial Injustice in Clinical Practice

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Abstract

Healthcare providers should advocate for human and civil rights. They ought to recognize injustices that unfairly disadvantage certain groups of people and work to improve broader conditions that affect health. Healthcare systems have historically undervalued and even excluded certain voices from the creation of an evidence base for care, furthering health disparities for members of these groups. This is a form of testimonial injustice. Trans people experience a particular form of testimonial injustice in healthcare settings when evidence and expertise related to their lived experience are excluded from consideration, as was the case with the 2024 Cass Review. Such exclusion can lead to mistreatment and harm. Providers must be vigilant in recognizing and addressing testimonial injustice against trans patients and the health disparities it can cause.

Keywords: Health Care, Healthcare Providers, Trans Patients, Gender-affirming Care

Introduction

Trans individuals (people who identify as transgender, transsexual, or whose gender identity is different from the sex they were assigned at birth) face many barriers to health care. The lack of competent, knowledgeable providers poses a significant barrier to gender-affirming care, as well as other forms of everyday health care for trans people.[1] Addressing this challenge requires health professionals to actively oppose structures that perpetuate epistemic injustice, which Miranda Fricker defines as "wrong done to someone specifically in their capacity as a knower."

[1] Safer JD, Coleman E, Feldman J, Garofalo R, Hembree W, Radix A, Sevelius J. Barriers to healthcare for transgender individuals. Curr Opin Endocrinol Diabetes Obes. 2016 Apr;23(2):168-71. doi: 10.1097/MED.0000000000000227. PMID: 26910276; PMCID: PMC4802845.

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Testimonial injustice (a kind of epistemic injustice) undermines collective understanding of marginalized perspectives through systemic misrepresentation or dismissal of marginalized individuals' experiences or contributions.[2] Testimonial injustice contributes to unjust conditions for accessing care and results in poorer health outcomes for transgender individuals. As professionals committed to ethical and equitable patient treatment, we believe it is imperative that healthcare providers recognize and carefully consider the experiences and expertise of trans people in order to address injustices experienced by trans people in healthcare settings. Through an analysis of the Cass Review, we demonstrate how a flawed interpretation of available evidence and the dismissal of trans testimonies generates an injustice that results in significant and unwarranted restrictions on gender-affirming care.

Testimonial Injustice

Trans people regularly experience testimonial injustice in health care. It occurs when providers inappropriately discount their patients' accounts — for example, by refusing to believe patients when they say that they are trans or gender non-conforming. This results in prejudiced assumptions about health behaviors or needs, bias and stereotyping that influence clinical judgment, and harm in the form of worse physical and mental health outcomes.[3]

Testimonial injustice takes several pernicious forms. For example, a Black woman whose reports of high postpartum pain are disregarded by her providers because of her Blackness has suffered testimonial injustice when she receives lower doses of pain medication compared to other postpartum patients at the same hospital.[4] Her attestation of pain, an experience at once personal and universal, has been inappropriately regarded as insufficiently credible, resulting in harmful and unequal postpartum pain management.

Testimonial injustice harms the physical, mental, and social well-being of trans people, worsening health outcomes caused by systemic barriers and discriminatory practices. Negative healthcare experiences, along with mistreatment from providers, lead to disproportionately high rates of depression, psychological distress, and suicidal ideation among trans patients.[5] These harmful interactions lead to lower healthcare utilization and delayed treatment. Trans people are also less likely to receive preventative cancer screenings, including for cervical, breast, and colorectal cancers.[6] These disparities, compounded by the accumulation of daily stress from discrimination, contribute to not

[2] Fricker M. *Epistemic Injustice: Power and the Ethics of Knowing.* New York, NY: Oxford University Press; 2007.

[3] Fact Sheet: Protecting and Advancing Health Care for Transgender Adult Communities. Center for American Progress. https://www.americanprogress.org/article/fact-sheet-protecting-advancing-health-care-transgender-adult-communities/#:~:text=Compared%20with%20the%20general%20population

[4] Greene NH, Kilpatrick SJ. Racial/ethnic disparities in peripartum pain assessment and management. *Joint Commission Journal on Quality and Patient Safety.* 2024. doi:10.1016/j.jcjq.2024.03.009; Badreldin N, Grobman WA, Yee LM. Racial disparities in postpartum pain management. *Obstetrics & Gynecology.* 2019;134(6):1147-1153. doi:10.1097/AOG.0000000000003561

[5] Levine, S., Heiden-Rootes, K., & Salas, J. (2022). Associations Between Healthcare Experiences, Mental Health Outcomes, and Substance Use Among Transgender Adults. *The Journal of the American Board of Family Medicine*, *35*(6), 1092–1102. https://doi.org/10.3122/jabfm.2022.220186r1; Inman, E. M., Juno Obedin-Maliver, Ragosta, S., Hastings, J., Berry, J., Lunn, M. R., Flentje, A., Capriotti, M. R., Lubensky, M. E., Stoeffler, A., Zubin Dastur, & Moseson, H. (2023). *Reports of Negative Interactions with Healthcare Providers among Transgender, Nonbinary, and Gender-Expansive People assigned Female at Birth in the United States: Results from an Online, Cross-Sectional Survey*. *20*(11), 6007–6007. https://doi.org/10.3390/ijerph20116007

[6] Kiran, T., Davie, S., Singh, D., Hranilovic, S., Pinto, A. D., Abramovich, A., & Lofters, A. (2019). *Cancer screening rates among transgender adults: Cross-sectional analysis of primary care data. 65*(1), e30–e37.

only an increased risk of cancer but also to worse cancer outcomes.[7] Trans people are diagnosed at later stages, they are less likely to receive treatment for cancer and also have higher mortality rates for certain cancers.[8] Similar disparities are seen in cardiovascular health;[9] trans people are at greater risk for heart attacks.[10] They are also more likely to have multiple concurrent chronic conditions, including coronary heart disease, asthma, arthritis, diabetes, cancer, stroke, kidney disease, etc.[11]

Clearly, there are significant and life-threatening gaps in care for trans people. These disparities result in worsened health outcomes, increased mistrust, and preventable deaths. A key factor in addressing these disparities is awareness of testimonial injustice: providers must recognize how their personal interactions with trans individuals, in the context of broader systemic barriers to adequate healthcare, can contribute to harmful practices and negligent care. In what follows, we argue that testimonial injustice contributes to trans peoples' well-documented experiences of healthcare discrimination.

The Cass Review

The 2024 Cass Review ("the Review"), an independent review of gender treatment for trans youth commissioned by the National Health Service (NHS) in England, has caused significant harm to young trans people in the UK. The NHS ordered the Review, comprising of six systematic reviews, after concerns arose regarding an increase in referrals for trans care associated with doubts about its scientific rationale. The Review's recommendations stem from a narrow reading of the evidence base for gender-affirming care and have resulted in significant restrictions on puberty-suppressing medication, hormone therapy, and care availability for trans youth in the UK.[12]

Professional organizations and transgender health providers have widely criticized the Review's findings. They assert that it contains many errors that "conflict with well-established norms of clinical research and evidence-based health care" and "raise serious concern about the scientific integrity of critical elements of the report's process and recommendations."[13] For example, the Review claims that referrals for trans care have grown exponentially (even

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[7] Jackson, S. S., & Hammer, A. (2023). Cancer risk among transgender adults: A growing population with unmet needs. *Acta Obstetricia et Gynecologica Scandinavica*, *102*(11), 1428–1430. https://doi.org/10.1111/aogs.14686

[8] Jackson, S. S., & Hammer, A. (2023). Cancer risk among transgender adults: A growing population with unmet needs. *Acta Obstetricia et Gynecologica Scandinavica*, *102*(11), 1428–1430. https://doi.org/10.1111/aogs.14686 ; Jackson, S. S., Han, X., Mao, Z., Nogueira, L., Suneja, G., Jemal, A., & Shiels, M. S. (2021). Cancer Stage, Treatment, and Survival Among Transgender Patients in the United States. *JNCI: Journal of the National Cancer Institute*, *113*(9), 1221–1227. https://doi.org/10.1093/jnci/djab028

[9] *Health disparities and equitable access to health care persist with transgender adults*. (n.d.). American Heart Association. https://newsroom.heart.org/news/health-disparities-and-equitable-access-to-health-care-persist-with-transgender-adults

[10] Alzahrani, T., Nguyen, T., Ryan, A., Dwairy, A., McCaffrey, J., Yunus, R., Forgione, J., Krepp, J., Nagy, C., Mazhari, R., & Reiner, J. (2019). Cardiovascular Disease Risk Factors and Myocardial Infarction in the Transgender Population. *Circulation: Cardiovascular Quality and Outcomes*, *12*(4). https://doi.org/10.1161/circoutcomes.119.005597

[11] Downing, J. M., & Przedworski, J. M. (2018). Health of Transgender Adults in the U.S., 2014–2016. *American Journal of Preventive Medicine*, *55*(3), 336–344. https://doi.org/10.1016/j.amepre.2018.04.045

[12] *WPATH and USPATH COMMENT on the CASS REVIEW*.; 2024. https://www.wpath.org/media/cms/Documents/Public%20Policies/2024/17.05.24%20Response%20Cass%20Review%20FINAL%20with%20ed%20note.pdf?_t=1716075965

[13] McNamara M, Baker K, Connelly K, et al. An evidence-based critique of "The Cass Review" on gender-affirming care for adolescent gender dysphoria. 2024; Rew L, Young CC, Monge M, Bogucka R. [White paper]. 2020.

while most transgender adolescents in the UK are not referred for care, and an expert critique of the Review led by the Integrity Project at Yale University found that the exponential growth is likely the result of double-counting referrals). This critique observes that the Review makes the provision of gender-affirming care appear "rushed, careless, and common,"[14] despite a waiting time of over two years for the assessment. Further, of the patients seen during the Review's period of study, only 27 percent were referred to endocrinology for *consideration* of medical intervention.

The Review includes an unsubstantiated concern that early supportive interventions such as puberty blockers necessarily result in irreversible effects. Puberty blockers, or gonadotropin releasing analogue (GnRHa), cause a temporary downregulation of the production of estrogen or testosterone when used during early puberty.[15] When prescribed for cis (people whose gender identity corresponds to the sex they were assigned at birth) and trans youth alike, they pause puberty (i.e., delaying development of secondary sex characteristics) reversibly. Reproductive function is restored if endogenous puberty resumes.[16] This therapy alone does not typically cause permanent physical changes, and when treatment is stopped, puberty resumes.[17] GnRHa medications are commonly used in treatment for precocious puberty in cisgender youth without impairing reproductive development or function, and research has demonstrated that puberty was continued within one year after GnRHa discontinuation.[18,19] Long-acting GnRHa usage is also routinely seen in fertility *preservation* as the only medical option to preserve ovarian function in patients with cancer.[20] Indeed, after starting GnRHa medications, the collection of sperm or ova for reproductive purposes is a well-established option.[21] Studies have consistently shown that puberty blockers lead to positive outcomes for trans youth, including significant improvements in overall functioning, reductions in depressive symptoms, and lower lifetime rates of suicidal ideation.[22]

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[14] McNamara M, Baker K, Connelly K, et al. An evidence-based critique of "The Cass Review" on gender-affirming care for adolescent gender dysphoria. 2024; Rew L, Young CC, Monge M, Bogucka R. [White paper]. 2020.

[15] Guss, C., & Gordon, C. M. (2022). Pubertal Blockade and Subsequent Gender-Affirming Therapy. *JAMA Network Open*, *5*(11), e2239763. https://doi.org/10.1001/jamanetworkopen.2022.39763

[16] Riggs, D. W., Tollit, M., & Lin, A. (2021). Refusing puberty blockers to trans young people is not justified by the evidence. *The Lancet Child & Adolescent Health*, *5*(9), e35–e36. https://doi.org/10.1016/s2352-4642(21)00233-9

[17] Mayo Clinic Staff. (2023, June 14). *Pubertal blockers for transgender and gender diverse youth*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/in-depth/pubertal-blockers/art-20459075

[18] Heger, S., Müller, M., Ranke, M., Schwarz, H.-P., Waldhauser, F., Partsch, C.-J., & Sippell, W. G. (2006). Long-term GnRH agonist treatment for female central precocious puberty does not impair reproductive function. *Molecular and Cellular Endocrinology*, *254-255*, 217–220. https://doi.org/10.1016/j.mce.2006.04.012

[19] Kim, E. Y. (2015). Long-term effects of gonadotropin-releasing hormone analogs in girls with central precocious puberty. *Korean Journal of Pediatrics*, *58*(1), 1. https://doi.org/10.3345/kjp.2015.58.1.1

[20] Massarotti, C., Stigliani, S., Gazzo, I., Lambertini, M., & Anserini, P. (2023). Long-acting gonadotropin-releasing hormone agonist trigger in fertility preservation cycles before chemotherapy. *ESMO Open*, *8*(4), 101597. https://doi.org/10.1016/j.esmoop.2023.101597

[21] Giordano, S., & Holm, S. (2020). Is puberty delaying treatment "experimental treatment"?. *International Journal of Transgender Health*, *21*(2), 113–121. https://doi.org/10.1080/26895269.2020.1747768

[22] McNamara M, Baker K, Connelly K, et al. An evidence-based critique of "The Cass Review" on gender-affirming care for adolescent gender dysphoria. 2024; Rew L, Young CC, Monge M, Bogucka R. [White paper]. 2020. *;* Rew L, Young CC, Monge M, Bogucka R. Review: Puberty blockers for transgender and gender diverse youth-a critical review of the literature. *Child Adolesc Ment Health.* 2021;26(1):3-14. doi:10.1111/camh.12437; Mayo Clinic Staff. Pubertal blockers for transgender and gender diverse

The Review's approach to the evaluation of evidence led to the exclusion of substantial peer-reviewed evidence in support of puberty blockers and hormones, including evidence regarding the lived experiences of trans youth. For instance, the authors deemed only one of the 50 studies in the systematic review of puberty blockers to be "high quality." This is not a value-neutral or inevitable way to frame these studies. Rather, the research studies excluded from the Review because of "low evidence" were often qualitative or observational investigations that had no control group, while the ones considered "high quality" tended to be randomized controlled trials (RCTs).[23] However, discounting observational studies inappropriately treats transness as exceptional because observational studies constitute much of the evidence that guides clinical care for all fields of medicine.[24] Indeed, the World Health Organization published a series of papers in 2019 on the value of including qualitative studies in the development of clinical guidelines, arguing that "Qualitative evidence is crucial to improve the understanding on how, and whether, people perceive health interventions to be effective and acceptable. It is also essential to understand the factors influencing the implementation of health policies and interventions." In other words, this kind of evidence provides context and reasoning that frame, rather than flattens, the complexity of human experiences that shape and are shaped by gender-affirming care.[25]

Randomized controlled trials are often considered unethical in studying gender-affirming care. One reason for this is the lack of clinical equipoise: the medical community has already accepted gender-affirming care as the clinical standard, so there is dubious value in using limited resources to study resolved research questions.[26] In a randomized clinical trial, the control group would typically receive psychotherapy for gender-incongruent puberty instead of medications, which would necessitate withholding beneficial gender-affirming care from participants when there is evidence that treatment prevents serious harm.[27] On the other hand, observational studies can include more diverse patient populations and offer greater specificity about experiences than randomized controlled studies. Larger

youth. Mayo Clinic. Published June 14, 2023, https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/in-depth/pubertal-blockers/art-20459075, Lee, J. Y., & Rosenthal, S. M. (2022). Gender-Affirming Care of Transgender and Gender-Diverse Youth: Current Concepts. *Annual Review of Medicine*, *74*(1). https://doi.org/10.1146/annurev-med-043021-032007

[23] Cass H. Final Report – Cass Review. cass.independent-review.uk. Published April 2024. https://cass.independent-review.uk/home/publications/final-report/

[24] McNamara M, Baker K, Connelly K, et al. An evidence-based critique of "The Cass Review" on gender-affirming care for adolescent gender dysphoria. 2024; Rew L, Young CC, Monge M, Bogucka R. [White paper]. 2020.

[25] *Using qualitative research to strengthen guideline development*. (n.d.). Www.who.int. https://www.who.int/news/item/08-08-2019-using-qualitative-research-to-strengthen-guideline-development *;* Downe, S., Finlayson, K. W., Lawrie, T. A., Lewin, S. A., Glenton, C., Rosenbaum, S., Barreix, M., & Tunçalp, Ö. (2019). Qualitative Evidence Synthesis (QES) for Guidelines: Paper 1 – Using qualitative evidence synthesis to inform guideline scope and develop qualitative findings statements. *Health Research Policy and Systems*, *17*(1). https://doi.org/10.1186/s12961-019-0467-5 *;* Lewin, S., Glenton, C., Lawrie, T. A., Downe, S., Finlayson, K. W., Rosenbaum, S., Barreix, M., & Tunçalp, Ö. (2019). Qualitative Evidence Synthesis (QES) for Guidelines: Paper 2 – Using qualitative evidence synthesis findings to inform evidence-to-decision frameworks and recommendations. *Health Research Policy and Systems*, *17*(1). https://doi.org/10.1186/s12961-019-0468-4 *;* Glenton, C., Lewin, S., Lawrie, T. A., Barreix, M., Downe, S., Finlayson, K. W., Tamrat, T., Rosenbaum, S., & Tunçalp, Ö. (2019). Qualitative Evidence Synthesis (QES) for Guidelines: Paper 3 – Using qualitative evidence syntheses to develop implementation considerations and inform implementation processes. *Health Research Policy and Systems*, *17*(1). https://doi.org/10.1186/s12961-019-0450-1

[26] Schall TE, Jaffe K, Moses JD. Roles of Randomized Controlled Trials in Establishing Evidence-Based Gender-Affirming Care and Advancing Health Equity. *The AMA Journal of Ethic*. 2024;26(9):E684-689. doi:https://doi.org/10.1001/amajethics.2024.684

[27] Ashley F, Tordoff DM, Olson-Kennedy J, Arjee Restar. Randomized-controlled trials are methodologically inappropriate in adolescent transgender healthcare. *International Journal of Transgender Health*. Published online June 24, 2023:1-12. doi:https://doi.org/10.1080/26895269.2023.2218357

observational studies with extended follow-ups can also identify long-term benefits or harms that are useful for clinical guidelines.[28] Treating this kind of evidence as insufficient to support trans care represents a biased approach that undermines the legitimacy of patient testimony in the development of an evidence base for trans individuals. The selective use of evidence constitutes a form of testimonial injustice, as an entire body of medical knowledge important to, and often generated by, those affected is systematically dismissed.

The Review limited meaningful involvement from trans patients and providers who had experience in the provision of gender-affirming care.[29] The Review's Assurance Group — which was intended to provide "expert advice" on the conduct of the review — explicitly left out trans voices, stating that its "Members are independent of … providers of gender dysphoria services, and of any organisation or association that could reasonably be regarded as having a significant interest in the outcome of the Review."[30] The logic of this exclusion was to ensure that nobody with a "significant interest in the outcome of the review" would bias its results through their personal or professional commitments. This approach is analogous to attempting to eliminate bias from a panel shaping clinical guidelines for heart disease by excluding both cardiologists and heart disease patients. The problem is not merely that trans people and those with expertise in their care were excluded as experts. This approach also flies in the face of contemporary best research practices that treat both lived and professional experience as important forms of expertise. Trans people and the people who provide them with health care should have been actively involved in research that affects their lives and care. The deliberate exclusion of their voices from the review process is a clear example of testimonial injustice.

The Review excludes providers with experience in gender services due to the assumption of bias. In doing so, it implies that those who *are* empowered to lend their expertise are without bias. By treating only *support* for transgender adolescents as a disqualifying bias, the Review reviews its own normativity. The framework of testimonial injustice helps us to understand the links between the discounting of individual testimony about identity and the constitution of medical authority that translates such refusal to believe into refusal to provide care.

In addition to minimizing the input of patients and providers with lived experience in the Assurance Group, the Cass Review also included healthcare workers who explicitly deny trans identity in its "online multi-professional panel to explore issues around gender identity services." When prompted with the statement

> *There is no such thing as a trans child. Gender dysphoria is always an indicator of another underlying problem, and assessment should focus on understanding the causes of their distress.*

21 percent of the panel responded that they strongly agree or agree. The authors of the Review may feel that excluding transgender people and the physicians who care for them preserves objectivity. We argue, however, that it is inappropriate to include as expert advisors individuals who do not acknowledge the existence of the group the Cass

[28] Gershon AS, Lindenauer PK, Wilson KC, et al. Informing Healthcare Decisions with Observational Research Assessing Causal Effect. An Official American Thoracic Society Research Statement. *American Journal of Respiratory and Critical Care Medicine*. 2021;203(1):14-23. doi:https://doi.org/10.1164/rccm.202010-3943st

[29] Maung, D. H. (2024, April 12). *Response to the Cass Review*. GenderGP Transgender Services. https://www.gendergp.com/response-to-the-cass-review/

[30] *Assurance Group – Cass Review*. (2017). Independent-Review.uk. https://cass.independent-review.uk/about-the-review/assurance-group/

Review examines and whose access to care the Review will, in turn, shape.[31] These experts call the existence of transgender youth (not just the kind of care that they need) into question: another decisive case of testimonial injustice. The Review does not make it clear that such a significant proportion of the experts it relies on do not believe in transgender children or that the root cause of distress in this population is gender. It may be unclear to policymakers and the public that people holding such views are shaping practice norms. This insight emerges only when evaluating the Likert response answers provided by the Review's expert consultants via auxiliary reports, not via the main document or any included disclosures, discussions, or reports of the Review's limitations.

The Review has had immediate and significant ramifications for trans NHS patients' access to gender-affirming care.[32] It was also extensively cited as evidence against adolescent gender-affirming care provision in the oral arguments of US v. Skrmetti, a case about the constitutionality of Tennessee's ban on gender-affirming care for minors.[33] Citing its early findings, the British government ordered closures of children's gender services and stopped accepting referrals for gender-affirming care.[34] The Review was also used to justify halting the use of puberty blockers for the treatment of youth gender dysphoria, though the same medications remained available for other pediatric health needs (e.g., precocious puberty).[35]

Systemic Testimonial Injustice

Trans people experience testimonial injustice far beyond what the Cass Review manifests. One such everyday form is how trans individuals must not only articulate the legitimacy of their identities but defend them against accusations of insufficient self-knowledge or the intent to deceive others about their gender.[36] Many have experienced this injustice when required to convince their healthcare providers that they are "trans enough" to receive needed care. In a focus group conducted with trans youth in 2022, participants described having their gender identity questioned by providers:

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[31] *Online Panel with Primary and Secondary Care Professionals Cass Review Engagement Report*.; 2021. https://cass.independent-review.uk/wp-content/uploads/2022/03/REPORT-Cass-Review-professional-panel-FINAL.pdf

[32] Horton C. The Cass Review: Cis-supremacy in the UK's approach to healthcare for trans children. *International Journal of Transgender Health.* 2024;1–25. doi:10.1080/26895269.2024.2328249; *United Nations Independent Expert on Protection against Violence and Discrimination Based on Sexual Orientation and Gender Identity Country Visit to the United Kingdom of Great Britain and Northern Ireland (24 April -5 End of Mission Statement.*; 2023. https://www.ohchr.org/sites/default/files/documents/issues/sexualorientation/statements/eom-statement-UK-IE-SOGI-2023-05-10.pdf

[33] *Search - Supreme Court of the United States*. (2023). Supremecourt.gov. https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/23-477.html

[34] Ali J. Doctors warn "NHS is failing trans people" amid row over Tavistock gender clinic. PinkNews | Latest lesbian, gay, bi and trans news | LGBTQ+ news. Published February 9, 2023. https://www.thepinknews.com/2023/02/09/tavistock-gender-clinic-closure-staff-open-letter-trans-healthcare/; NHS England» NHS England's Response to the Final Report of the Independent Review of Gender Identity Services for Children and Young People. www.england.nhs.uk. https://www.england.nhs.uk/long-read/nhs-englands-response-to-the-final-report-of-the-independent-review-of-gender-identity-services-for-children-and-young-people/

[35] McNamara M, Baker K, Connelly K, et al. An evidence-based critique of "The Cass Review" on gender-affirming care for adolescent gender dysphoria. [White paper]. 2024.

[36] Zimman L. "The other kind of coming out": Transgender people and the coming out narrative genre. Gender and Language. 2009;3(1). doi:https://doi.org/10.1558/genl.v3i1.53

> I think the big question, the question I've come back to over and over again [the doctor] asked me is, what does being a girl mean to you? And I didn't have an answer. He was very skeptical of my lack of an answer for that. He was like, well I just – I feel like you should be able to talk about this. I think you might be moving too fast if you can't talk about this. And I was like, well, no I think it's just a stupid question. But I didn't say that because I was 14 and small and nervous… And then when my parents came back in … he said he wanted to caution us against moving too quickly because he's against permanent changes in children at a young age. He says he doesn't think it's a good idea... He just doesn't think there's enough science behind it to back it up.[37]

Trans youth suffer testimonial injustice when their identities and existence are met with unreasonable skepticism or discounted entirely. This perceived lack of credibility often results in challenges from medical providers who may frame their own skepticism as concerns regarding reversibility and potential for regret. While irreversible interventions may demand special scrutiny and regret is generally to be avoided, the fact of such risks should not automatically preclude the provision of gender-affirming care. The frame of testimonial injustice helps us to see how provider interactions like these exemplify the systemic prejudice that trans people and others who diverge from cisnormative expectations face when their credibility is discounted, and accounts of their own selves are deemed untrustworthy.[38]

Clinicians' skepticism about their adolescent patients' need for gender-affirming care may be rooted in an assessment that there is insufficient evidence to support gender affirmation as a standard of care. While the Cass Review's findings of such evidentiary weakness have been strongly disputed by a number of analyses discussed elsewhere in this piece, we also posit that quibbling over what the evidence reveals is only *part* of the task of evaluating evidence. In the case of gender transition, where the denial of care will be experienced as a significant harm to the trans person, inaction – care refusal – must not be treated as a morally neutral option. Instead, care refusal must itself be regarded as having the potential to harm. Whether someone considering the ethics of gender-affirming care begins with an assumption that care provision or care denial ought to be, the status quo is, particularly in light of the vehemence of contemporary fights over access to gender-affirming care, more a question of values than it is of evidence.

Physicians often treat patients whose symptoms cannot be proven or diagnosed with "objective" data. Myriad forms of routine medical care rely solely or primarily on patient testimony; not only is gender dysphoria unexceptional in this regard as a diagnosis, hormonal and surgical intervention to alleviate distress and bring about patient well-being is similarly standard medical procedure. Psychological and psychiatric care can often *only* be provided on the basis of patients' self-reported experiences of mental illness, as those illnesses may not generate measurable physical effects. For instance, conditions such as the excess breast tissue that indicates gynecomastia in cisgender men are similarly predicated on patient articulations of their own experiences and needs. In all these cases, self-related phenomena are clinically relevant, and although some may dismiss them as empirically intractable, doing so would clearly be a mistake.[39]

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[37] Lucas R. Factors associated with facilitators and barriers to gender-affirming care among transgender and nonbinary youth and young adults in Washington: A mixed-methods approach. University of Washington. Published July 14, 2022. http://hdl.handle.net/1773/49002

[38] While some may argue that other medical diagnoses *privilege particular kinds of quantitative evidence for care efficacy,* and therefore so should gender affirming care, further addressing such counterarguments is beyond the scope of this paper.

[39] Tekin, Ş. (2017). The missing self in scientific psychiatry. *Synthese*, *196*(6), 2197–2215. https://doi.org/10.1007/s11229-017-1324-0

Healthcare systems also pose various significant hurdles to accessing forms of gender-affirming care, including their criteria for insurance coverage approval. Insurers' criteria are unstandardized and often arbitrary. Yet, they profoundly shape the kind of care available, particularly given the economic precarity that prevents many trans people from paying for treatment out-of-pocket.[40] To secure coverage, trans individuals must frame their experience in accordance with insurers' standards rather than medical standards alone.[41] The need to provide persuasive accounts to unlock care forces trans people to conform to specific, deficit-based descriptions of their identities as pathological and the ambiguous definition of medical necessity used by insurance companies.[42] This system reflects a form of testimonial injustice, effectively requiring trans people to present strategic narratives to obtain care and mold their needs to fit the stringent requirements of insurance. The disparate insurance criteria for gender-affirming care undermines existing forms of evidence — which are primarily based on testimonies. It treats the knowledge that trans people possess about their bodies as insufficiently credible to warrant medical autonomy.[43] This is an unjust standard of evidence. In this way, even well-meaning providers sometimes subject trans patients to arbitrary barriers to care purely on the basis of their gender identity.

Conclusion

All providers should understand the risk of testimonial injustice to trans people in healthcare contexts. This is particularly urgent for providers who treat trans patients. Since all providers will treat trans patients regardless of specialty, all healthcare practitioners should address testimonial injustice. Accordingly, they must work to counter the devaluation of trans testimonies, not just in individual patient and provider experiences but across the medical community and system at large. Invalidating trans-patient experiences not only erodes trust in the healthcare system but may lead to inadequate or harmful therapeutic approaches. As a result, testimonial injustice perpetuates a cycle of negative health outcomes, which can include worsened mental health,[44] significantly greater risk of cardiovascular disease,[45] higher rates of chronic illness,[46] higher rates of disability,[47] and more preventable deaths[48] compared to

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[40] Dozier R. How Navigators Influence Insurance Coverage for Gender-Affirming Surgeries: A Qualitative Study. *The Permanente Journal*. 2023;27(1):72-76. doi:https://doi.org/10.7812/tpp/22.115

[41] Dietz E. More Necessary than Medical: Reframing the Insurance Argument for Transition-Related Care. *IJFAB: International Journal of Feminist Approaches to Bioethics*. 2020;13(1):63-88. doi:https://doi.org/10.3138/ijfab.13.1.04

[42] Kirkland A, Talesh S, Perone AK. Health insurance rights and access to health care for trans people: The social construction of medical necessity. *Law & Society Review*. 2021;55(4):539-562. doi:https://doi.org/10.1111/lasr.12575

[43] Keyes O, Dietz EA. Values and Evidence in Gender-Affirming Care. *Hastings Cent Rep*. 2024;54(3):51-53. doi:10.1002/hast.1592

[44] Buyea E. The Impact of Banning Gender-Affirming Care in America: A Step Backward for Equality – Tufts CHSP. Tufts University. Published June 26, 2023. https://sites.tufts.edu/chsp/2023/06/26/the-impact-of-banning-gender-affirming-care-in-america-a-step-backward-for-equality/

[45] Health disparities and equitable access to health care persist with transgender adults. American Heart Association. https://newsroom.heart.org/news/health-disparities-and-equitable-access-to-health-care-persist-with-transgender-adults

[46] Barbee H, Deal C, Gonzales G. Anti-transgender legislation—a public health concern for transgender youth. *JAMA Pediatrics.* 2021;176(2). doi:10.1001/jamapediatrics.2021.4483

[47] Smith-Johnson M. Transgender Adults Have Higher Rates Of Disability Than Their Cisgender Counterparts. *Health Affairs*. 2022;41(10):1470-1476. doi:https://doi.org/10.1377/hlthaff.2022.00500

[48] Barbee H, Deal C, Gonzales G. Anti-transgender legislation—a public health concern for transgender youth. *JAMA Pediatrics.* 2021;176(2). doi:10.1001/jamapediatrics.2021.4483

cisgender individuals. The stakes here are high: testimonial justice is essential to providing good health care for all. Justice demands that we not only take the testimonies of trans people seriously but understand them as fundamental to the provision of needed health care.