

Is “Gender-Affirming Medical Care” Any of These? Defining Affirmation, Medicine, and Care in Context

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Abstract

This article examines the contested phrase “gender-affirming medical care,” now common in legislation, litigation, and clinical guidance. It analyzes the term’s three components — affirmation, medicine, and care — and asks what each requires in ordinary clinical practice, drawing on classical and contemporary philosophy-of-medicine frameworks. The article argues that the bundled expression often obscures more than it clarifies: “affirmation” is treated as will-realization rather than truth-recognition; “medical” is invoked where interventions compromise rather than restore bodily function; and “care” is reduced to consent-compliance rather than fiduciary beneficence. The analysis is conceptual, not prescriptive. Its aim is to disaggregate a rhetorically powerful composite into concrete clinical acts, monitoring obligations, and claimed benefits so that ethical and policy debates can proceed on clearer terms. By testing the phrase against its own parts, the article shows that it often fails to meet the minimal thresholds of each and calls for greater precision in medical language.

Keywords: Gender-Affirming Care, Legislation, Medical Ethics, Gender Identity, Medical Language

Introduction

Legislation, litigation, and professional guidelines increasingly turn on contested medical terminology, including what is commonly referred to as “gender-affirming medical care,” a term that now appears in state statutes, court opinions, and policy statements from leading medical associations. Yet it carries more than descriptive weight. The term embeds assumptions about truth, medicine, and beneficence that shape the debate from the start.¹ Before law and policy can meaningfully engage the merits of such interventions, the terminology itself warrants examination, both for its legal implications and for the persuasive force it carries in public debate. The point is underscored by *United States v. Skrmetti* (2025), in which the US Supreme Court addressed state restrictions on pediatric gender-transition

¹ Many clinicians and guideline authors have adopted “gender-affirming” terminology to reduce stigma, to align with depathologizing frameworks, and to standardize communications for clinical pathways, reimbursement, and policy. Those aims are intelligible. The present analysis is narrower: terms used in statutes and clinical standards should not, by definition alone, pre-decide the evidentiary and proportionality thresholds that ordinarily govern high-risk, irreversible interventions.

interventions.² While this article does not engage the legal arguments of that case, the ruling illustrates how “gender-affirming medical care” (and similar formulations) has become pivotal not only in professional discourse but in constitutional adjudication.

Beyond its legal salience, this phrase now frames public and professional discussion of medical interventions. It is rhetorically potent: “affirming” suggests truthfulness, “medical” implies scientific legitimacy, and “care” evokes benevolence. Each term carries a weight of meaning that can, and should, be examined. This is not a mere semantic exercise; in bioethics, precise definitions are essential to consistent standards, equitable treatment, and informed policy. Without them, policy and clinical standards drift, at the patient’s expense.

The interventions covered by this expression range from puberty blockers and cross-sex hormones to surgeries that remove healthy organs or construct new anatomy.³ Even their most indisputable consequences are often little known outside clinical circles. Long-term hormone therapy can impair fertility⁴ and typically entails ongoing medical monitoring; after gonad removal, continued sex-steroid replacement is required indefinitely to avoid hypogonadism-related harms.⁵ Surgeries are irreversible and permanently eliminate the capacities of the organs they remove.⁶ In many cases, these interventions disable or alter normal bodily functions and commit the patient to long-term — often lifelong — medical follow-up.⁷

² *United States v. Skrmetti*, No. 23-477, 605 U.S. ____ (June 18, 2025), slip op., https://www.supremecourt.gov/opinions/24pdf/23-477_2cp3.pdf.

³ E. Coleman et al., “Standards of Care for the Health of Transgender and Gender Diverse People, Version 8,” *International Journal of Transgender Health* 23, suppl. 1 (2022): S1–S259, <https://doi.org/10.1080/26895269.2022.2100644>. SOC-8 lists surgical procedures including chest masculinization (mastectomy), hysterectomy with salpingo-oophorectomy, orchiectomy, vaginoplasty/vulvoplasty, metoidioplasty, penectomy, and phalloplasty, which alter primary and/or secondary sex characteristics.

⁴ Katharina Feil et al., “Fertility, Contraception, and Fertility Preservation in Trans Individuals,” *Deutsches Ärzteblatt International* 120, no. 14 (2023): 243–50 (cross-sex hormone therapy can impair fertility; counseling on preservation recommended prior to treatment), <https://doi.org/10.3238/arztebl.m2023.0026>; Wylie C. Hembree et al., “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline,” *Journal of Clinical Endocrinology & Metabolism* 102, no. 11 (2017): 3869–3903 (guideline discussion of fertility effects and pre-treatment fertility-preservation counseling for patients initiating cross-sex hormone therapy), <https://doi.org/10.1210/je.2017-01658>.

⁵ Hembree et al., “Endocrine Treatment.” The guideline recommends regular clinical and laboratory monitoring during sex-steroid therapy. It also states that adult regimens restore physiologic sex-hormone levels using the principles of hormone-replacement therapy for hypogonadal patients; after gonadectomy, ongoing replacement is indicated, and stopping hormones increases bone-loss risk (with bone mineral density monitoring advised if therapy ceases).

⁶ Coleman et al., “Standards of Care, Version 8,” (classifies surgical interventions as irreversible; enumerates among others mastectomy, hysterectomy with salpingo-oophorectomy, and orchiectomy, each entailing permanent loss of the removed organ’s functions); Hembree et al., “Endocrine Treatment,” sec. 4.4; sec. 5.0 (post-gonadectomy, loss of endogenous sex-steroid production and need for replacement; permanent loss of gonadal reproductive function).

⁷ Representative protocols describe regular dilation after vaginoplasty to prevent a surgically created canal from narrowing or closing, with maintenance often advised indefinitely; phalloplasty is commonly staged and may involve additional operations and prolonged recovery. See Joseph J. Pariser and Nicholas Kim, “Transgender Vaginoplasty: Techniques and Outcomes,” *Translational Andrology and Urology* 8, no. 3 (2019): 241–47 (postoperative dilation/maintenance), <https://doi.org/10.21037/tau.2019.06.03>; Devin Coon et al., “Gender-Affirming Vaginoplasty: A Comparison of Algorithms, Surgical Techniques and Management Practices across 17 High-Volume Centers in North America and Europe,” *Plastic and Reconstructive Surgery – Global Open* 11, no. 5 (2023): e5033 (technique variation; management practices),

The analysis treats each element of the term to show that it falters under both widely used, practice-oriented accounts in the contemporary philosophy of medicine and the more comprehensive classical philosophical account of the person as an integrated unity of body and soul. While the clearest ethical concerns involve pediatric care (including questions of consent), the conceptual thresholds implied by the phrase are often unmet even for adults. The three components overlap in practice: affirmation, medicine, and care are not completely separate domains. However, this article approaches them singly, allowing each to be tested against its own criteria before considering their interrelation.

Is It “Gender-Affirming”?

To “affirm” something is to recognize and confirm it as true. In clinical settings, affirmation may take the form of reassurance, validation, or support, but the underlying structure is the same: affirmation aligns with reality, not against it. If a patient with severe protein-calorie malnutrition insists “I am overweight,” treatment that affirms the claim is not an act of truth-telling but of collusion in error.

In the classical philosophical-anthropological tradition, the human person is understood as an integrated psychophysical unity — often described in that tradition as a unity of body and soul — and sex is not an accessory but a fundamental determination of that unity. To affirm someone as the opposite sex is to deny this integral wholeness. Contemporary realist accounts also underscore this point,⁸ arguing that gender is the lived form of a sexed body: the social reality of a body already determined as male or female, not a free-floating psychological construct detachable from the organism to which it belongs.⁹

One recent account observes that our modern technological imagination quietly shifts the meaning of affirmation itself. Once, to affirm was simply to take the world and the body as given. Now the given is treated as raw material for the will, to be reshaped until it matches desire.¹⁰ By this logic, one affirms not by recognizing what is, but by

<https://pmc.ncbi.nlm.nih.gov/articles/PMC10226616/>; Annie M. Q. Wang et al., “Outcomes Following Gender-Affirming Phalloplasty: A Systematic Review and Meta-Analysis,” *Sexual Medicine Reviews* 10, no. 4 (2022): 499–512 (complication and revision rates; staged procedures and recovery profiles), <https://doi.org/10.1016/j.sxmr.2022.03.002>.

⁸ Carrie Hull, *The Ontology of Sex: A Critical Inquiry into the Deconstruction and Reconstruction of Categories* (New York: Routledge, 2006), <https://doi.org/10.4324/9780203007785>. Note that the existence of intersex conditions does not undermine this point. Intersex diagnoses involve atypical chromosomal, gonadal, or anatomical development and are matters of biological variation within human sex dimorphism, not evidence of a third sex or of disembodied gender identity. Leonard Sax’s widely cited analysis, “How Common Is Intersex? A Response to Anne Fausto-Sterling,” *Journal of Sex Research* 39, no. 3 (2002): 174–78, <https://doi.org/10.1080/00224490209552139>, has been critiqued on definitional grounds, but even if one accepts higher prevalence estimates, these conditions remain rare and present distinct clinical management needs. They are qualitatively different from gender dysphoria in otherwise typical male or female bodies, and their existence does not establish that gender can be detached from sexed embodiment, as Hull also observes.

⁹ Alternative anthropological accounts — especially certain social-constructionist frameworks — treat gender as independent from biological sex. While these perspectives fall outside the classical view, they require their own justification for using “affirmation” in a clinical sense, given that the detachment from the body changes what “truth” in affirmation could mean.

¹⁰ Michael Hanby, “Transgender Theory and Post-Political Order,” *Humanum Review*, *U.S. v. Skrametti* Special Issue, May 25, 2025, “From the scientific and biotechnical point of view, ‘nature’ is simply whatever happens or can be made to happen. It measures truth, what things *are*, by our power, what we can *do*.” <https://humanumreview.com/articles/transgender-theory-and-post-political-order>.

bringing what is into conformity with what is wished. The word remains, but its meaning is inverted: what once denoted truth-recognition now denotes will-realization. This plays out in self-help and motivational literature.

Even bracketing these philosophical commitments, *gender-affirming* falters under conceptually minimal analysis and ordinary clinical terms. Affirmation treats its object as true. In medicine, when a truth-apt clinical claim is at stake, warrant ordinarily rests on tests, examinations, and findings that stand apart from the patient's own report. With gender identity, diagnostic standards rely on reported incongruence and associated distress over time rather than on objective tests or biomarkers.¹¹ Yet medicine cannot operate on self-report alone when reality is disputed: "I have a fracture" begins, not ends, inquiry.

The same point becomes evident when we shift from words to procedures. Performing a vaginoplasty on a healthy male body does not make it more like a healthy female body, although postoperatively, the two will superficially share the absence of a penis and testes. Rather, this simply disables the male; it does not confer female-specific reproductive anatomy, physiology, or function.¹² The alteration is merely morphological. Such interventions are not only non-affirming but positively pathological on function-based accounts.

Counterarguments

Proponents may assert that the term affirmation reduces stigma and builds therapeutic alliance; respectful language matters. As noted above, however, in clinical practice, affirm ordinarily denotes truth-recognition rather than a presumption of correctness. Respect and alliance are compatible with assessment; they do not require presuming the truth of contested claims. If affirm is used only to describe an interpersonal demeanor, then it is distinct from the clinical question; by contrast, in policy and protocol contexts, gender-affirming often functions as an outcome-preferring label that tends to make identity-congruent interventions the default, although access is filtered by eligibility criteria.

Some have cited neurobiological studies to argue that transgender identity is grounded in biology, claiming that certain transgender individuals have brain structures more similar, on average, to the opposite sex.¹³ Yet even setting aside the methodological limitations of such studies,¹⁴ these findings concern group averages, not diagnostic markers.

¹¹ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., text rev. (DSM-5-TR) (Washington, DC: American Psychiatric Association, 2022), <https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890425787>; see also APA, "What Is Gender Dysphoria?" (criteria summary for adolescents/adults and children), <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>.

¹² Daniel Kodosi and John Maier, "Philosophical Malpractice," *The Philosophers' Magazine*, July 20, 2025, <https://philosophersmag.com/philosophical-malpractice/>.

¹³ Representative neuroimaging reports include J.-N. Zhou et al., "A Sex Difference in the Human Brain and Its Relation to Transsexuality," *Nature* 378, no. 6552 (1995): 68–70, <https://doi.org/10.1038/378068a0>; F. P. M. Kruijver et al., "Male-to-Female Transsexuals Have Female Neuron Numbers in a Limbic Nucleus," *Journal of Clinical Endocrinology & Metabolism* 85, no. 5 (2000): 2034–41, <https://doi.org/10.1210/jcem.85.5.6564>; Giuseppina Rametti et al., "White Matter Microstructure in Female to Male Transsexuals before Cross-Sex Hormonal Treatment: A Diffusion Tensor Imaging Study," *Journal of Psychiatric Research* 45, no. 2 (2011): 199–204, <https://doi.org/10.1016/j.jpsychires.2010.05.006>.

¹⁴ Alberto Frigerio, Lucia Ballerini, and Maria Valdés Hernández, "Structural, Functional, and Metabolic Brain Differences as a Function of Gender Identity or Sexual Orientation: A Systematic Review of the Human Neuroimaging Literature," *Archives of*

They are equally compatible with a simpler conclusion: male and female brains each span a range, and some individuals cluster toward one end without ceasing to be their biological sex. Because the distributions substantially overlap, average differences do not support individual-level classification or brains to be swapped across bodies; they only show that not all members of a sex are identical. Even if such correlations were consistent, they would not establish that gender can be defined apart from the sexed body.¹⁵

Another counterargument is that in contemporary usage, gender simply means identity, so to affirm gender is to affirm self-identification.¹⁶ But that is a change in usage, not a refutation. If gender is defined to exclude the body, then of course affirmation need not track the body — but only by abandoning the term's embodied referent. That shift is semantic, resolving the dispute by redefinition rather than by argument.

Is It “Medical”?

To call something medical is not merely to note that clinicians perform it or that it uses surgical or pharmaceutical techniques. In both classical and modern accounts, medicine is the art and science of restoring or preserving health. From Hippocrates to Aquinas¹⁷ to contemporary philosophers of medicine, the practice is directed toward diagnosing, preventing, and treating disease or injury to maintain or restore proper bodily functioning. Even accounts that present

Sexual Behavior (advance online publication, May 6, 2021) (noting small samples, cross-sectional designs, analytic heterogeneity, and potential confounding by sexual orientation and prior hormone exposure), <https://doi.org/10.1007/s10508-021-02005-9>.

¹⁵ On why group differences do not by themselves support individual diagnostic classification (especially under broad distributional overlap) and the need for validated predictive biomarkers, see Eva Loth et al., “The Meaning of Significant Mean Group Differences for Biomarker Discovery,” *Molecular Psychiatry* 26 (2021): 1426–34, <https://pmc.ncbi.nlm.nih.gov/articles/PMC8601419/>. For a general statistical caution against inferring individual status from aggregate signals, see S. V. Subramanian, Kelyn Jones, and Carole Brown, “Revisiting Robinson: The Perils of Individualistic and Ecological Fallacy,” *International Journal of Epidemiology* 38, no. 2 (2009): 342–60, <https://pmc.ncbi.nlm.nih.gov/articles/PMC2663721/>.

¹⁶ Some societies have recognized culturally specific categories or roles outside contemporary Western male/female norms (e.g., *hijras* in South Asia; *fa'afafine* in Samoa; various Native American roles often discussed under “Two-Spirit”; and rabbinic categories such as *androgynos* and *tumtum* relating to bodily ambiguity). These examples are diverse and context bound; they do not establish that gender, in a clinical sense, can be defined apart from sexed embodiment. For representative discussions, see Serena Nanda, *Neither Man nor Woman: The Hijras of India*, 2nd ed. (Belmont, CA: Wadsworth Publishing Company, 1999), <https://search.worldcat.org/oclc/39678474>; Johanna Schmidt, *Migrating Genders: Westernisation, Migration, and Samoan Fa'afafine* (London: Routledge, 2016), <https://doi.org/10.4324/9781315595276>; Sue-Ellen Jacobs, Wesley Thomas, and Sabine Lang, eds., *Two-Spirit People: Native American Gender Identity, Sexuality, and Spirituality* (Urbana: University of Illinois Press, 1997), <https://www.press.uillinois.edu/books/?id=p066450>; and *Encyclopaedia Judaica*, 2nd ed., ed. Michael Berenbaum and Fred Skolnik (Detroit: Macmillan Reference USA, 2007), vol. 2, s.v. “Androgynos,” <https://www.encyclopedia.com/religion/encyclopedias-almanacs-transcripts-and-maps/androgynos>.

¹⁷ Hippocrates, “On the Art,” in *Hippocrates*, vol. II, Loeb Classical Library 148, trans. W. H. S. Jones (Cambridge, MA: Harvard University Press, 1923), 191–95, at 193: “to do away with the sufferings of the sick, to lessen the violence of their diseases ...,” <https://archive.org/details/hippocrates02hippuoft>. See also Hippocrates, “Oath,” in *Hippocrates*, vol. I (Loeb 147), trans. W. H. S. Jones (1923), 298–301, <https://archive.org/details/hippocrates01hippuoft>. Thomas Aquinas, *Summa theologiae*, II–II, q. 1, a. 1 (respondeo), trans. Fathers of the English Dominican Province (New York: Benziger Brothers, 1947): “the object of the medical art is health, for it considers nothing save in relation to health” (*obiectum medicinae est sanitas, quia nihil medicina considerat nisi in ordine ad sanitatem*), <https://www.newadvent.org/summa/3001.htm> (English); <https://www.corpusthomicum.org/sth3001.html> (Latin).

themselves as value-neutral rest on some conception of health as an objective good to which interventions must be answerable.¹⁸

One influential biostatistical account defines health in terms of how well an organism's parts function, relative to species-typical norms.¹⁹ Disease, in this framework, is a measurable departure from those norms that lowers the odds of survival or reproduction. On this view, interventions that damage or remove organs in sound working order — such as sterilizing gonads or amputating breasts without pathological cause — *produce* disease.

In contrast, a widely discussed normativist account defines health as the ability to achieve one's vital goals in standard circumstances.²⁰ A desire to occupy the social role of the opposite sex is intelligible as a psychological phenomenon. Lacking the bodily sex-specific characteristics of that role, however, does not constitute a pathology; nor does the normative account require medicine to pursue any self-reported goal that conflicts with actual capacities.²¹

Medicine rightly encompasses not only curative and preventive aims but also palliation and the relief of suffering. Analgesia, hospice care, and psychiatric interventions are part of medicine's vocation, even when they do not restore lost functions. But even here, proportionality and evidentiary standards apply: the greater the irreversibility and loss of baseline functions, the stronger the justification required that benefits are durable and outweigh foreseeable harms.

Gender-transition procedures are generally not aimed at curing or preventing disease. They alter healthy bodies to fit a self-reported identity, often by disabling or removing normally functioning organs. The resulting loss of fertility, sexual function, and other capacities is often integral to the desired phenotype, not an incidental side effect.²² This differs from most accepted interventions, where impairment is an unfortunate trade-off for treating pathology. Given their aims and effects, whether such procedures can rightly be considered medicine in the ordinary sense is doubtful.

¹⁸ Christopher Boorse, "Health as a Theoretical Concept," *Philosophy of Science* 44, no. 4 (1977): 542–73, <https://doi.org/10.1086/288768>; Lennart Nordenfelt, "The Concepts of Health and Illness Revisited," *Medicine, Health Care and Philosophy* 10, no. 1 (2007): 5–10, <https://doi.org/10.1007/s11019-006-9017-3>; and Edmund D. Pellegrino and David C. Thomasma, *A Philosophical Basis of Medical Practice* (New York: Oxford University Press, 1981), 58–118, <https://archive.org/details/philosophicalbas00pell>.

¹⁹ Boorse, "Health as a Theoretical Concept."

²⁰ Nordenfelt, "The Concepts of Health and Illness Revisited."

²¹ Still other contemporary frameworks in the philosophy of medicine, including Jerome Wakefield's harmful-dysfunction analysis and K. W. M. Fulford's account of medicine as essentially evaluative, likewise treat judgments about health and intervention as answerable to more than preference alone — combining empirical warrant with publicly defensible reasons about value. Applied here, such accounts do not confer "medical" status by label: they require, at a minimum, either a demonstrated dysfunction in the relevant internal mechanisms (for Wakefield) or explicit value-reasoning proportionate to the foreseeable loss of function and open to reasonable scrutiny (for Fulford). Jerome C. Wakefield, "The Concept of Mental Disorder: On the Boundary Between Biological Facts and Social Values," *American Psychologist* 47, no. 3 (1992): 373–88, <https://doi.org/10.1037/0003-066x.47.3.373>. K. W. M. Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), <https://search.worldcat.org/oclc/19456328>.

²² Coleman et al., "Standards of Care, Version 8" (hormone therapy targets suppression of endogenous sex steroids and induction of secondary sex characteristics; pre-treatment fertility counseling; sterilizing nature of orchiectomy and hysterectomy with oophorectomy); Hembree et al., "Endocrine Treatment" (treatment goals include suppression/induction; ongoing monitoring; counsel on potential infertility); Feil et al., "Fertility, Contraception, and Fertility Preservation" (summary of fertility impairment across regimens; preservation options).

Medicine typically resists altering or removing healthy organs in conditions such as body dysmorphic disorder or body integrity identity disorder, where the problem lies not in the organ but in perception or identification. The therapeutic aim is to address the discordance, not to make the body match the disordered image. This is not to equate gender dysphoria with either condition; the narrower point is that in all such cases the bodily structure is not diseased, and the mismatch lies between body and self-concept. Historically, medicine has sought to resolve such mismatches by addressing the self-concept, not by impairing healthy anatomy.

These philosophical concerns find a practical counterpart in recent independent evidence reviews. The UK's National Institute for Health and Care Excellence (NICE) has examined puberty blockers and cross-sex hormones,²³ and the Cass Review, incorporating and extending those reviews, has independently evaluated gender identity services for children and young people.²⁴ All concluded that the research base for pediatric gender-transition interventions is of very low quality and insufficient to establish safety or long-term benefit.²⁵ Against that backdrop, a procedure does not become medical by virtue of who performs it or how skillfully; it becomes medical by what it aims at and what it accomplishes. Where the aim is not the restoration of healthy functioning, and the accomplishment is to compromise it, the description as medical does not hold, and the practices fall outside what medicine, in its ordinary sense, is understood to encompass.

Counterarguments

Some treat the recognition and endorsement of gender-affirming medical care terminology by professional associations as dispositive. Once major bodies use the label, the classification of the relevant interventions as medical is deemed settled. For advocates, such endorsements may appear to decisively buttress claims of safety and long-term benefit. But the value of such appeals to authority turns on independence, representativeness, and transparent methods; policy statements, often issued by small committees and subject to advocacy influence, falter under this standard. By conventional criteria, such statements are generally accorded less evidentiary weight than reviews that spell out how they searched, what they included, and how they judged the strength of evidence.²⁶ Policy statements

²³ National Institute for Health and Care Excellence (hereafter NICE), *Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria* (hereafter NICE, *GnRH Review*), March 2021, https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_GnRH-analogues_For-upload_Final.pdf; NICE, *Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria* (hereafter NICE, *Hormones Review*), March 2021, https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_Gender-affirming-hormones_For-upload_Final.pdf.

²⁴ Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report*, April 2024, https://cass.independent-review.uk/wp-content/uploads/2024/04/CassReview_Final.pdf.

²⁵ These reviews lay out clear, publicly available methods and transparent grading of evidence quality. Their low-certainty ratings reflect limits in the underlying studies rather than reviewer bias. The point is not UK-specific: they exemplify methodological safeguards any jurisdiction should expect before authorizing high-stakes, irreversible interventions. While critics dispute aspects of the Cass Review and the NICE appraisals, even critical commentaries typically concede that the current pediatric evidence base is too limited to support confident claims of long-term benefit. My reliance here is limited to that modest point; accordingly, I do not undertake in this article to adjudicate any ongoing disputes over interpretation, scope, or policy implications. NICE, *GnRH Review*; NICE, *Hormones Review*; Cass, *Final Report*.

²⁶ See notes 23–25. For a detailed treatment of the standard criteria for evaluating arguments from expert authority, see Douglas Walton, *Appeal to Expert Opinion: Arguments from Authority* (University Park: Pennsylvania State University Press, 1997), <https://www.psupress.org/books/titles/0-271-01694-9.html>.

can standardize vocabulary, but labels alone do not legitimize the term. Similarly, even where it exists, consensus may follow evidence but does not raise its quality.

Some will point to cosmetic surgery to show we accept non-restorative alterations as medicine. Yet cosmetic surgery already sits somewhat uneasily in the medical tent. Some of it is reconstructive, but much is ornamental, tolerated more as a cultural concession than as part of medicine's central art. Yet cosmetic surgery does not ordinarily ablate sex-specific reproductive structures or impose lifelong medical dependence. Even when medicine sacrifices healthy tissue, the loss is accepted for the sake of preserving health. Gender-transition surgery is different: it effectively treats the sacrifice itself (fertility, sexual function, intact organs) as the remedy. Medicine can accept loss for health's sake; it cannot redefine loss as a cure. If elective cosmetic surgery is near the border of medicine, transition procedures are well past it. In such cases, the Hippocratic imperative to avoid harm remains a vital ethical boundary that preserves the good of the whole human being in the integrity of body and person.²⁷ The point is not to withhold care, but to ensure that interventions genuinely promote patient health and well-being by standards that medicine applies to all patients, regardless of the condition.

Others may argue that experiencing one's sexed body as incongruent can precipitate depression or anxiety, and that relieving suffering is a medical aim; they may contend that psychiatric diagnosis often relies in part on patient reporting. But diagnosis does not dictate proportional treatment. Self-reported distress can warrant psychosocial and psychiatric care. Supportive families, schools, and clinics may ease that distress. But that is distinct from the causal claim that transition-related interventions improve long-term, hard outcomes — and, absent strong evidence of durable benefit, such distress is a weak justification for irreversible procedures that disable healthy function absent strong evidence of durable benefit. Concerns about diagnostic expansion and medicalization only heighten the need not to let a label do the justificatory work.

Is It "Care"?

Even if gender-transition interventions could be classed as medical, a further question remains: do they meet the moral obligations that make medicine an act of care? Medicine, at its best, is not merely a technical service but a fiduciary relationship ordered toward the patient's good. In clinical ethics, care implies technical competence, fidelity to the patient's welfare, prudence amid uncertainty, and a commitment to avoid harm.

The duty of care²⁸ also includes proportionality: the scale and irreversibility of the intervention should bear a reasonable relationship to the certainty and magnitude of the expected benefit. When interventions remove healthy organs, impair fertility, or carry significant lifelong medical burdens, this proportionality threshold rises. In other domains of medicine, life-altering interventions with no return path are reserved for conditions that pose a clear and

²⁷ D. C. Schindler, "Can Transitioning Be Healthcare? A Reflection on Sex as Symbol," *Humanum Review*, U.S. v. Skrmetti Special Issue, May 20, 2025, <https://humanumreview.com/articles/can-transitioning-be-healthcare-a-reflection-on-sex-as-symbol>. Schindler argues that medicine's integrity lies in serving the good of the whole human being, understood as a unity of body and person; when its ends are recast in terms extrinsic to that wholeness, it ceases to be medicine in the proper sense.

²⁸ I use "duty of care" in the clinical-ethical (fiduciary) sense: obligations of beneficence and non-maleficence, balanced by proportionality between expected benefits and foreseeable burdens. See Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 8th ed. (New York: Oxford University Press, 2019), chs. 4–6, <https://global.oup.com/ushe/product/principles-of-biomedical-ethics-9780190640873>; and Pellegrino and Thomasma, *A Philosophical Basis of Medical Practice*, 58–118.

present danger to life or long-term health, anchored in strong evidence of benefit.²⁹ Under low-certainty evidence, best interests favor least-restrictive means first, with irreversible options reserved for clearer indications.

Within the classical tradition, care is a moral orientation toward the patient's good, not merely the execution of a chosen procedure. Modern philosophy of medicine retains this orientation in, for example, an emphasis on beneficence within a covenantal relationship³⁰ and an account of medicine as a moral community.³¹ Both approaches resist reducing care to technical provision or choice.

A further component of care is safeguarding against transient cultural pressures or institutional ideologies that may not align with patient welfare. The fiduciary role obliges clinicians to distinguish the patient's interests from those of third parties and to resist conflating affirmation of a stated identity with the pursuit of the patient's objective good. In gender-transition interventions, this includes recognizing that rapidly shifting cultural narratives, peer influence, or institutional commitments that do not necessarily track long-term clinical benefit may shape demand. Recent increases in referral rates and changing patient demographics in multiple countries underscore this.³² Agreement with a self-description does not, by itself, justify irreversible alterations to intact anatomy.

To provide care is not merely to comply with a request or endorse a belief, but to act in ways proportioned to benefit over a life. Where evidence is weak, risks are high, and alternatives exist, proceeding is better described as service provision than as care in the richer ethical sense.

Counterarguments

Some argue care consists in respecting patient autonomy and that honoring requests is itself care. Informed consent is necessary but not sufficient; agreement alone does not make an act one of care. Valid consent requires understanding benefits and risks, key uncertainties, and available alternatives, including nonmedical options. In the context of gender-transition procedures, especially for minors, these conditions are often contested, and independent reviews have judged the evidence base low-certainty.³³ Where the evidentiary basis is uncertain, proceeding is not automatically an act of care simply because the patient or guardian agrees.

Reducing the essence of care to compliance with patient wishes treats care as though it were commerce, where the transaction is complete when the request is met, regardless of the long-term cost to the buyer. Autonomy, while

²⁹ Some advocates frame the central danger as suicide. The population-level evidence remains unsettled, and current studies have not established that medical transition reduces completed suicides. See NICE, *GnRH Review*; J. Ruuska et al., "All-Cause and Suicide Mortalities among Adolescents and Young Adults Referred to a Gender Identity Service," *BMJ Mental Health* 27, no. 1 (2024): e300940, <https://mentalhealth.bmj.com/content/ebmental/27/1/e300940.full.pdf>; Cass, *Final Report*; cf. J. M. Turban et al., "Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation," *Pediatrics* 145, no. 2 (2020): e20191725 (ideation only), <https://pmc.ncbi.nlm.nih.gov/articles/PMC7073269/>. Prudence requires robust evidence before adopting irreversible interventions as suicide-prevention policy. Nothing here, however, denies the gravity of distress; comprehensive psychosocial and psychiatric care should be offered regardless of the treatment course.

³⁰ H. Tristram Engelhardt, Jr., *The Foundations of Bioethics*, 2nd ed. (New York: Oxford University Press, 1996), 102–34, <https://global.oup.com/academic/product/the-foundations-of-bioethics-9780195057362>.

³¹ Edmund D. Pellegrino, "The Medical Profession as a Moral Community," *Bulletin of the New York Academy of Medicine* 66, no. 3 (1990): 221–32, <https://pmc.ncbi.nlm.nih.gov/articles/PMC1809760>.

³² Cass, *Final Report*.

³³ NICE, *GnRH Review*; NICE, *Hormones Review*; Cass, *Final Report*; see also note 25.

essential, is not the sum of clinical ethics; it is bounded by non-maleficence, beneficence, and professional standards. Patients might request what is not in their interest, and clinicians have no ethical duty to comply simply because of a request. In fact, refusing foreseeably harmful interventions can be an exercise of respect for autonomy rightly understood — in fiduciary terms, the autonomy of the whole person over the course of a life, not the immediate choice of a moment. Respect for autonomy also includes protecting patients from choices that outstrip the evidence base for risks. This is neither refusal of care nor paternalism, but fidelity to the patient's long-term good under uncertainty.

Others will appeal to measures of patient satisfaction, noting that some individuals report relief or happiness after intervention. Yet satisfaction is not identical to welfare; by itself, it cannot establish that the intervention was in the patient's long-term interest. Patient-reported outcomes and lived experience are important for follow-up and for understanding subjective well-being, but they do not replace evidentiary or proportionality standards when risks are substantial or losses are nonrecoverable. In other domains of medicine, satisfaction is weighed against objective outcomes and foreseeable harms.

Conclusion

The label gender-affirming medical care subsumes three claims at once: that the interventions affirm what is true, are medical in aim and effect, and constitute care. Where those claims cannot be shown, the label obscures more than it clarifies and risks confusion in clinical decision-making.

Having tested the phrase by its own terms, the inconsistency that emerges is not merely semantic but practical. In medicine, language is part of practice. Terms shape what clinicians look for and how patients understand themselves. They also narrow which actions seem reasonable or obligatory. Bundling the three terms tends to insulate each part from scrutiny. The result is a narrowing of moral and clinical imagination at precisely the point where medicine most needs openness: in conditions of profound personal distress, contested evidence, and high-stakes intervention.

These are questions of language, ethics, and the goods of medicine. The deeper need is to recover the habit of speaking about clinical acts truthfully, describing what they actually do in the body and in the life, before judging whether they are wise or good. This is not a call for linguistic purity or moralizing diagnosis. It is an appeal to the precision without which neither trust nor care can survive.

In the classical tradition, medicine's authority derived not from fulfilling wishes but from its orientation toward the patient's good as a whole human being — a standard that persists in contemporary philosophy of medicine, which holds that interventions must answer to truth and to good: truth in description, and good in judgment. Language that dodges this twofold test is not just out of step with tradition. It fails the patient.

There should be common ground enough to insist that medicine name its acts accurately, justify them by their ends, and give care the dignity of meaning something more than acquiescence. Where such an agreement holds, disputes over what counts as gender-affirming become less a matter of identity politics and more a question of clinical and moral truth, a shift that can only help the patients and families who have most at stake in the answer.

The argument here has been limited to the conceptual and philosophical analysis of the phrase gender-affirming medical care. The analysis applies beyond this phrase, however. Any composite, putatively medical term that bundles empirical claims with contested moral judgments should be disaggregated and tested in this way, lest language foreclose clinical and ethical reasoning. When words are made to bear what is not true, speaker and patient alike suffer the consequences.