May 15, 2025

Robert F. Kennedy Jr. Secretary
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Re: Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices

Dear Secretary Kennedy,

We, the physicians of the Alliance for Hippocratic Medicine, commend the U.S. Department of Health and Human Services (HHS) for its recently released *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices*, published May 1, 2025.

We care deeply for gender-dysphoric youth and their families. We walk alongside them in their distress. We listen. We support. And precisely because we care, we cannot ignore the growing evidence that the risks of medicalized gender transition—especially in minors—outweigh the potential benefits. The HHS report confirms what health authorities in the UK, Sweden, Finland, Germany, Norway, Italy and Florida have already concluded: the current model of care which uses puberty blockers, cross-sex hormones, and surgeries lacks high-quality evidence and carries significant risks.

This review calls attention to the fact that there is very low certainty of benefit in current gender-affirming interventions. It also outlines the potentially serious and often irreversible harms, including infertility or sterility, sexual dysfunction, impaired bone density accrual, adverse cognitive impacts, cardiovascular and metabolic disorders, psychiatric disorders, surgical complications, and regret. Most importantly, the HHS review highlights the urgent need to prioritize psychotherapeutic exploration – not affirmation-only protocols – as the first-line approach to gender-related distress.

We advocate for a model of care that is evidence-based, developmentally informed, ethically grounded, and centered on the whole person. As affirmed by systematic reviews conducted in Sweden, England, Florida, and now the HHS, the most responsible first-line approach to pediatric gender distress is comprehensive psychotherapy, not fast-tracked hormonal or surgical

interventions. These independent reviews—across political and cultural lines—converge on a shared conclusion: the evidence for medical benefit is weak, the risks are significant, and psychosocial support must come first.

We are especially grateful that the HHS report addresses two of the most emotionally charged and frequently misrepresented claims in this field: first, that gender-affirming interventions are necessary to prevent suicide; and second, that they constitute "medically necessary" care. In both cases, the report makes clear that these claims are not supported by the preponderance of evidence.

Framing gender-affirming care as suicide prevention introduces an ethically troubling dynamic in which families and clinicians feel pressured to pursue irreversible interventions under threat of death—even though the data does not show that these treatments reliably reduce suicide risk. This framing can distort the therapeutic relationship, discourage comprehensive mental health care, and create a false sense of urgency that overrides careful clinical discernment.

Likewise, calling these interventions "medically necessary" masks legitimate scientific and ethical uncertainty. It risks shielding gender-affirming care from scrutiny, bypassing individualized medical judgment, and foreclosing alternative approaches—such as psychotherapy, watchful waiting, or developmental exploration—now endorsed by public health systems in Europe. In truth, as the HHS review demonstrates, the evidence for affirmation remains very low quality, especially for children and adolescents, and does not justify such definitive claims.

We believe medicine must be rooted not simply in fulfilling requests, but in guiding patients—especially vulnerable young people—toward flourishing and authentic well-being. Autonomy matters. But autonomy alone is not sufficient reason to offer interventions that lack strong evidence and carry permanent consequences. In times of distress, any option may appear to offer light—but not all light is beneficial. False hope, even when offered with compassion, can cause great harm.

We want to be clear: our concerns are with interventions—not individuals. Gender-dysphoric youth are persons of profound worth and dignity. They deserve to be seen, heard, and cared for with compassion, honesty, and respect. Clinical disagreement about treatment approaches must never be mistaken for disregard of those we serve. On the contrary, our call for caution arises precisely because we care deeply about their long-term well-being.

We do not abandon these youth. We do not dismiss their pain. But we cannot support interventions that are, at best, unproven—and at worst, permanently damaging. We reaffirm our

commitment to a model of care that places the true good of the patient at its center and upholds the integrity of medical practice. We promote compassionate and responsible healthcare that serves not just autonomy but authentic human flourishing.

We are grateful that the HHS is casting light on the fact that the affirmation-based protocols for gender-dysphoric youth rest on uncertain evidence. The stakes are too high. We have a duty to avoid harm and promote the true good for our patients. In light of what we are seeing from Europe – and now with the HHS review – we urge restraint, prudence, and critical scrutiny of the dominant affirmation-first approach shaping the care of these youth in the United States.

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