

Evidentiary Pragmatism in Transgender Health Care

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In early 2025, the White House issued an executive order prohibiting funding for gender-affirming health care for minors, including puberty blockers and hormone therapy. Calling for the end of “reliance on junk science,” the order echoed claims that the evidence base on gender-affirming health care is of low quality and thus insufficient to justify offering it.^{1,2}

Medicine often proceeds from imperfect evidence. The majority of medical practices, including those recommended in World Health Organization guidelines, are predicated on low- or very low-quality evidence.^{3–6} This is doubly true in the context of child and adolescent medicine.⁷ Gender-affirming health care is often subject to greater scrutiny than equivalent interventions in other populations.⁸ Setting aside the question of whether it is accurate to describe the evidence base of gender-affirming health care as low quality, more evidence is always welcome, and clinicians offering gender-affirming health care have been at the forefront of the quest to expand our knowledge of how to best care for transgender people. However, this does not mean that clinical decision-making and policy should ignore the best available evidence while waiting for better evidence.

Opposition to gender-affirming health care on evidentiary grounds has placed transgender communities in a catch-22. Observational studies that are relatively short are considered too weak to support access to gender-affirming health care, whereas longer-term observational studies are discounted for having significant participant attrition or being “too old” and therefore not representing the current clinical population.⁹ As for randomized controlled trials, they do not offer a reliable alternative because of expected mass withdrawal from the control arm as well as noncompliance, crossover, response bias, and ethical concerns.^{10,11} There is, it seems, no way to satisfy critics of gender-affirming health care.

This catch-22 has only been aggravated by Donald Trump’s presidential administration, which has banned research on gender-affirming health care for minors, removed gender identity from Centers for Disease Control and Prevention data, and slashed National Institutes of Health funding. Even if alternative sources of funding are found, conservative attacks, harassment, and federal- and state-level bans on gender-affirming health care are making it extremely difficult, if not impossible, to study. Studying gender-affirming health care requires funding,

institutional support, and the ability to offer the studied interventions. The Trump administration’s attacks on gender-affirming care will have worldwide repercussions. The United States is the largest funder of research in the world and produces nearly half the publications on transgender health care worldwide.¹² Given the current rise in antitrans bills across the world, the monumental reduction in transgender health research in the United States will have global ramifications and may contribute to the banning of gender-affirming health care in other countries.

Access to interventions should not be predicated on unreasonable evidentiary expectations. It would be a perversion of science if beneficial—or at least harmless—interventions were impossible to ever be offered because the requested strength of evidence could not realistically be achieved. For instance, asking for randomized controlled trials for all interventions would be inappropriate because not all questions can realistically be studied using the methodology.¹³ Similarly, minimal participant attrition may not be realistic in a long-term observational study.

The rights of marginalized groups should not depend on unrealistic, unreasonable, or impossible to meet evidentiary standards. Nor should they depend on evidentiary standards that the group has no reasonable opportunity to meet—which occurs when research is prohibited, funding is severely restricted, or funding is allocated unfairly. This is a matter of health policy, ethics, and human rights. As a matter of health policy, truly beneficial care should never be placed out of reach. As a matter of ethics and human rights, placing unrealistic demands on marginalized groups belies the bioethical

principle of justice as well as the promise of human rights.

Given the foregoing, the principle of evidentiary pragmatism should be recognized as a core component of evidence evaluation, clinical decision-making, and policymaking. Evidentiary pragmatism requires that actionable conclusions be shaped by the levels of evidence that are reasonably achievable. A level of evidence is reasonably achievable when we can realistically design and complete a study that, if the hypothesis is true, can be expected to meet that evidentiary standard. For example, high-quality evidence could not be achieved through a randomized controlled trial if we can reasonably expect such trials to effectively become observational studies because of asymmetrical withdrawal, or if they would be fundamentally flawed by severe systematic bias—whether or not that bias is recognized in the grading scheme.

Authors should carefully explain which levels of evidence are reasonably achievable and characterize their degree of achievability, including any significant barriers to feasibility. Factors that affect achievability include but are not limited to funding constraints, difficulty securing ethical approval, barriers to representative recruitment, likelihood of participant withdrawal, loss to follow-up, unmasking, noncompliance, and crossover, as well as any other factor that may lead to the level of evidence being downgraded or upgraded. To ensure the quality of an analysis, topic experts, such as clinicians, researchers, and members of the studied community, should be involved throughout the process because they can provide invaluable insights into the intervention and population under study as well as probable participant behavior.

When reviewing scientific evidence and generating clinical or policy recommendations, studies should be assessed relative to both the highest reasonably achievable level of evidence and the degree to which that level is attainable. Conclusions and recommendations should follow the principles (1) that evidence quality must be judged in relation to what is reasonably achievable, rather than the highest possible evidentiary level; and (2) that interventions should not depend on evidence standards that cannot realistically be met. Although this should be done in all evidence evaluation, it is especially important when applying frameworks that formalize levels of evidence, such as GRADE (the Grading of Recommendations Assessment, Development and Evaluation framework), which systematizes the appraisal of evidence quality and recommendation strength.

When moderate-quality evidence is the highest reasonably achievable standard, consistent low-quality evidence should be weighed similarly to consistent moderate-quality evidence when high-quality evidence is achievable. When only low- or moderate-quality evidence is reasonably feasible, consistent low-quality evidence should typically be sufficient to ground a clinical recommendation or policy, the content of which should be informed by what the evidence shows. This approach aligns with current practice. Under the GRADE framework, a strong recommendation is one that should generally be followed because the expected benefits clearly outweigh the harms, even when the underlying evidence is of low quality. More than half of World Health Organization strong recommendations are based on low- or very low-quality evidence, and the American Academy of Pediatrics expressly recognizes

cases in which “high-quality studies have not been performed and are unlikely ever to be performed,”^{14(p34)} yet strong or moderate recommendations are warranted.^{3,15} Groups developing clinical recommendations and policies must pay careful attention to the consistency, rigor, and comprehensiveness of reviews applying evidentiary pragmatism to mitigate the risk of biased conclusions drawn from cherry-picked lower-quality evidence.

Given the practical realities of transgender health, for which high-quality evidence is often unattainable and even moderate-quality evidence is difficult to produce, the predominance of low-quality evidence should not, by itself, justify restricting access—especially when that evidence is consistent.

The principles of medical ethics and human rights require us to not lose sight of the big picture when delving into highly technical evidentiary debates in which double standards abound. Respect for autonomy, beneficence, and justice are critical considerations in health care, as are the rights to equality and health. Although I have focused on transgender health care, the approach I have suggested may be beneficial to evidence assessment more generally, especially given the limits and weaknesses of evidence-based medicine in certain areas of research and the risk of double standards when controversial interventions are involved. Nobody's health care needs should be placed beyond proof. An inaccessible right is no right at all. **AJPH**

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CONFLICTS OF INTEREST

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