IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

AMERICAN ACADEMY OF HIV MEDICINE; et al., *Plaintiffs*, v. HEALTH RESOURCES AND SERVICES ADMINISTRATION; et al., *Defendants*.	Case No. 1:26-cv-12638-WGY

MOTION FOR LEAVE TO PERMIT ASSOCIATIONAL PLAINTIFFS' MEMBERS TO PROCEED PSEUDONYMOUSLY AND FOR A PROTECTIVE ORDER

Plaintiffs, the American Academy of HIV Medicine, the HIV Medicine Association, a division of the Infectious Diseases Society of America, the International Association of Providers of AIDS Care, Dr. Jennifer K. Brody, and Nurse Practitioner Christopher B. Fox respectfully submit this motion for entry of an order allowing certain non-party declarants Dr. Danielle Doe and Dr. Rachel Roe ("Doe Declarants") to proceed pseudonymously and for a protective order, permitting them to file pseudonymous declarations in support of Plaintiffs' Motion for Preliminary Relief under 5 U.S.C. § 705 and for a Preliminary Injunction under pseudonyms. As grounds therefore, Plaintiffs respectfully refer the Court to their memorandum of law, and attachments hereto, filed alongside this motion.

A proposed order is enclosed hereto.

WHEREFORE, the Plaintiffs respectfully request that this Court grant Plaintiffs' Motion for Leave to Permit Associational Plaintiffs' Members to Proceed Pseudonymously and for a Protective Order and enter their proposed order, in the form attached hereto.

Dated: June 10, 2026

Respectfully submitted,

/s/ Omar Gonzalez-Pagan

José I. Abrigo*
Omar Gonzalez-Pagan (BBO No. 678517)
Jessica Polansky*
Charlie Ferguson*
Lambda Legal Defense and Education Fund, Inc.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: 212-809-8585
Facsimile: 855-535-2236
jabrigo@lambdalegal.org
ogonzalez-pagan@lambdalegal.org
jpolansky@lambdalegal.org
cferguson@lambdalegal.org

Kenneth D. Upton, Jr.*
Lambda Legal Defense and Education Fund, Inc.
3656 North Halsted Street
Chicago, Illinois 60613
Telephone: 312-663-4413
Facsimile: 855-535-2236
kupton@lambdalegal.org

Pelecanos*
Lambda Legal Defense and Education Fund, Inc.
800 South Figueroa St., Suite 1260[†]
Los Angeles, California 90017
Telephone: 213-382-7600
Facsimile: 855-535-2236
pelecanos@lambdalegal.org

[†] Mailing address only

Jeffrey S. Trachtman*
Jason M. Moff*
Stephen P. Ferguson*
Hannah Kanter*
Herbert Smith Freehills Kramer (US) LLP
1177 Avenue of the Americas
New York, New York 10036
Telephone: 212-715-9100
Jeffrey.Trachtman@hsfkramer.com
Jason.Moff@hsfkramer.com
Stephen.Ferguson@hsfkramer.com
Hannah.Kanter@hsfkramer.com

Ryan P. Trumbauer*
Herbert Smith Freehills Kramer (US) LLP
2000 K Street NW 4th Floor
Washington, DC 20006
Telephone: 202-775-4500
Ryan.Trumbauer@hsfkramer.com

* Motions for admission *pro hac vice* pending

Attorneys for Plaintiffs

Rule 7.1 Certificate of Compliance

I certify that, on June 10, 2026, counsel for Plaintiffs provided notice of this motion, seeking to ascertain defendants' position as to the relief requested herein, to the following attorneys at the U.S. Department of Justice by electronic mail:

Abraham George
Chief, Civil Division
U.S. Attorney's Office for the District of Massachusetts
abraham.george@usdoj.gov

Rayford Farquhar
Chief, Defensive Litigation, Civil Division
U.S. Attorney's Office for the District of Massachusetts
rayford.farquhar@usdoj.gov

As of the time of filing, the aforementioned counsel at the U.S. Department of Justice acknowledged receipt of the request but were unable to provide defendants' position by June 10, 2026.

/s/ Omar Gonzalez-Pagan
Omar Gonzalez-Pagan (BBO No. 678517)
Lambda Legal Defense
and Education Fund, Inc.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: 212-809-8585
Facsimile: 855-535-2236
ogonzalez-pagan@lambdalegal.org

CERTIFICATE OF SERVICE

I certify that, on June 10, 2026, counsel for Plaintiffs provided a copy of the forgoing motion and any attachments thereto to the following attorneys at the U.S. Department of Justice by electronic mail:

Abraham George
Chief, Civil Division
U.S. Attorney's Office for the District of Massachusetts
abraham.george@usdoj.gov

Rayford Farquhar
Chief, Defensive Litigation, Civil Division
U.S. Attorney's Office for the District of Massachusetts
rayford.farquhar@usdoj.gov

/s/ Omar Gonzalez-Pagan
Omar Gonzalez-Pagan (BBO No. 678517)
Lambda Legal Defense
and Education Fund, Inc.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: 212-809-8585
Facsimile: 855-535-2236
ogonzalez-pagan@lambdalegal.org

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

AMERICAN ACADEMY OF HIV MEDICINE; et al., *Plaintiffs*, v. HEALTH RESOURCES AND SERVICES ADMINISTRATION; et al., *Defendants*.	Case No. 1:26-cv-12638-WGY

[PROPOSED] ORDER GRANTING PLAINTIFFS' MOTION FOR LEAVE TO PERMIT ASSOCIATIONAL PLAINTIFFS' MEMBERS TO PROCEED PSEUDONYMOUSLY AND FOR A PROTECTIVE ORDER

This matter is before the Court on Plaintiffs' motion for leave to allow non-party declarant members of Plaintiffs the American Academy of HIV Medicine, the HIV Medicine Association, and the International Association of Providers of AIDS Care ("the Associational Plaintiffs") to proceed under pseudonyms and for a protective order.

After consideration of the Plaintiffs' motion, the memorandum in support, and the record in this case, and having otherwise been fully advised, the Court finds there is good cause to grant Plaintiffs' motion and the motion is **GRANTED**. The Court finds that limiting disclosure of the individual identities of the non-party declarant members of the Associational Plaintiffs is necessary to protect their privacy and safety and to ensure that the fact of any of these individuals' participation in this litigation cannot be used in a retaliatory manner. The Court further finds that the non-party declarant members of the Associational Plaintiffs will likely experience a significant

risk of harm absent the requested relief, and that absent such an order, future declarants are likely to be chilled in providing important percipient accounts of federal conduct.

Accordingly, the Court hereby **ORDERS** as follows:

1. Nurse Practitioner Danielle Doe and Dr. Rachel Roe, who are members of Associational Plaintiffs, may proceed under the pseudonyms "Danielle Doe" and "Rachel Roe";

2. Members of the American Academy of HIV Medicine, the HIV Medicine Association, and the International Association of Providers of AIDS Care who wish to submit a declaration in this case and have concerns about their privacy, safety, and retaliation in connection with their participation in this litigation may similarly proceed under pseudonyms; and

3. No part of the restrictions imposed by this Protective Order may be terminated except by written stipulation of the parties or by other order of this Court for good cause shown.

IT IS SO ORDERED.

Dated this _____ day of _________, 2026

BY THE COURT:

____

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

AMERICAN ACADEMY OF HIV MEDICINE; et al., *Plaintiffs*, v. HEALTH RESOURCES AND SERVICES ADMINISTRATION; et al., *Defendants*.	Case No. 1:26-cv-12638-WGY

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR LEAVE TO PERMIT ASSOCIATIONAL PLAINTIFFS' MEMBERS TO PROCEED PSEUDONYMOUSLY AND FOR A PROTECTIVE ORDER

Plaintiffs, the American Academy of HIV Medicine ("the Academy"); the HIV Medicine Association ("HIVMA"), a division of the Infectious Diseases Society of America; the International Association of Providers of AIDS Care ("IAPAC"); Jennifer K. Brody, MD; and Christopher Fox, NP, respectfully submit this memorandum of law in support of their motion for entry of an order allowing Nurse Practitioner Danielle Doe and Dr. Rachel Roe ("Pseudonymous Member Declarants"), who are members of the Associational Plaintiffs, to proceed pseudonymously and for a protective order permitting them to file declarations in support of Plaintiffs' Motion for Preliminary Relief under 5 U.S.C. § 705 and for a Preliminary Injunction under pseudonyms.

INTRODUCTION

Plaintiffs are healthcare providers and associations whose members are healthcare providers who participate in the Ryan White Program and care for people living with HIV, including transgender persons living with HIV, who rely on the Ryan White Program for access

to their medical care. These patients obtain HIV care as well as their primary care, including gender-affirming medical care, through the Ryan White Program.

Plaintiffs are challenging the adoption and imposition of discriminatory conditions ("the Challenged Conditions") on the Ryan White Program that impact people living with HIV and their healthcare providers. The Challenged Conditions, which are being implemented through the FY2026 HRSA General Terms and Conditions and Notices of Funding Opportunity for the Ryan White Program, including those pertaining to the Ryan White Program's Part B Supplemental, Part C, and Part F, prohibit Ryan White funding recipients from acknowledging, affirming, or respecting the identities of transgender people, including transgender patients living with HIV, or from using federal funding in a way that promotes so-called "gender ideology," including through the provision of gender-affirming medical care.

The Pseudonymous Member Declarants—NP Doe and Dr. Roe—are two healthcare providers who are not parties in this case but are members of the Associational Plaintiffs who are impacted by the Challenged Conditions. They seek to provide testimony to support Plaintiffs' Motion for Preliminary Relief under 5 U.S.C. § 705 and for a Preliminary Injunction. However, they fear doing so publicly will place them, their families, their colleagues, their clinics, and their patients at a substantial risk of violence, harassment, and retaliation.

Because the fears and concerns of the Pseudonymous Member Declarants are well-founded, Plaintiffs request permission for the Pseudonymous Member Declarants to proceed under pseudonym.[1] These protections are warranted to protect the Pseudonymous Member Declarants and enable them to participate in this case to vindicate their rights and the rights of their transgender patients.

[1] To protect their privacy pending consideration of this motion, Plaintiffs use in their Complaint and this motion the pseudonyms for Pseudonymous Member Declarants that they seek permission to use.

LEGAL STANDARD

District courts "enjoy[] broad discretion to quantify the need for anonymity in the case before it." *Doe v. Town of Lisbon*, 78 F.4th 38, 45 (1st Cir. 2023) (quoting *Doe v. Massachusetts Inst. of Tech.*, 46 F.4th 61, 72 (1st Cir. 2022) ("*MIT*")). The First Circuit has explained that "the appropriate test" in deciding when a pseudonym may be warranted in civil litigation "must center on the totality of the circumstances." *MIT*, 46 F.4th at 70. In doing so, it explained that it is "unnecessary to festoon the easily understood 'totality of the circumstances' standard with any multi-factor trappings," noting that "district courts enjoy broad discretion to identify the relevant circumstances in each case and to strike the appropriate balance between the public and private interests." *Id.*

While the First Circuit has not specifically weighed in on when anonymity is appropriate for non-parties, it has "sketch[ed] four general categories … in which party anonymity ordinarily will be warranted." *Id.* at 71. These "paradigms" provide guidance to district courts in "balanc[ing] the interests asserted by the movant in favor of privacy against the public interest in transparency, taking all relevant circumstances into account." *Id.* at 72. Courts in this district have granted pseudonymous status to both parties and nonparties under the *MIT* paradigms. *See, e.g.*, *New York v. McMahon*, No. 1:25-CV-10601-MJJ, 2025 WL 1478387 at *1 (D. Mass. Mar. 21, 2025).

At a minimum, pseudonym use is warranted when the person seeking anonymity falls into one or more of the following categories: (1) a "would-be Doe who reasonably fears that coming out of shadows will cause him unusually severe harm (either physical or psychological)"; (2) "identifying the would-be Doe would harm innocent non-parties"; (3) "anonymity is necessary to forestall a chilling effect on future litigants who may be similarly situated"; or (4) a suit is bound up with a "prior proceeding made confidential by law." *MIT*, 46 F.4th at 71-72 (quotations omitted).

Still, "[c]ivil actions come in a wide variety of shapes and sizes, and we are not so sanguine as to believe that these four paradigms capture the entire universe of cases in which pseudonymity may be appropriate." *Id.* at 72. Other courts have looked to other factors such as "whether the justification asserted by the requesting party . . . is to preserve privacy in a matter of sensitive and highly personal nature; . . . whether the action is against a governmental or private party; and, relatedly, the risk of unfairness to the opposing party from allowing an action against it to proceed anonymously." *James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 1993); *see also Foster v. Andersen*, No. 18-cv-02552-DDC-KGG, 2019 WL 329548 (D. Kan. Jan. 25, 2019).

ARGUMENT

Permitting the Pseudonymous Member Declarants to proceed under pseudonym is warranted in this case under *MIT*'s paradigms and the Court's discretion. The Pseudonymous Member Declarants reasonably fear physical and psychological harm, as well as retribution from government actors, should their identities become public based on their provision of medical care to transgender patients and the filing of this lawsuit.

I. NP Doe and Dr. Roe Are Members of Associational Plaintiffs, and Associational Plaintiffs Do Not Need to Identify Members by Name.

At the outset, it is important to note that neither NP Doe nor Dr. Roe are parties to this litigation. They are participating in this case as members of Associational Plaintiffs, namely, the Academy and HIVMA. *See* Doe Decl. ¶ 3; Roe Decl. ¶ 3.[2] Of course, while "an organization must demonstrate that . . . its members would otherwise have standing to sue in their own right," organizations can bring claims on their members' behalf when "neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Students for Fair*

---

[2] References to "Doe Decl." and "Roe Decl." are to the declarations of NP Danielle Doe and Dr. Rachel Roe being filed in support of Plaintiffs' Motion for Preliminary Injunction.

Admissions, Inc. v. President & Fellows of Harvard Coll., 600 U.S. 181, 199 (2023) (citation modified). Importantly, "when it is clear and not speculative that a member of a group will be adversely affected by a challenged action and a defendant does not need to know the identity of a particular member to defend against an organization's claims, the organization does not have to identify particular injured members by name." *Mi Familia Vota v. Fontes*, 129 F.4th 691, 708 (9th Cir. 2025); *see also Am. All. for Equal Rts. v. Fearless Fund Mgmt., LLC*, 103 F.4th 765, 773 (11th Cir. 2024) ("[W]e [have] specifically declined to require an organizational plaintiff to identify by name the members on whose behalf it was suing. . . . And more generally, we have routinely permitted organizations to sue on behalf of pseudonymously identified members." (citations omitted)); *cf. Virginia Coal. for Immigrant Rts. v. Beals*, 803 F. Supp. 3d 454, 468 (E.D. Va. 2025).

This makes sense given that the First Amendment protects associations like the Academy and HIVMA from having to disclose the identities of their members. *See First Choice Women's Res. Ctrs., Inc. v. Davenport*, 146 S. Ct. 1114, 1123-24 (2026) (citing *NAACP v. Alabama ex rel. Patterson*, 357 U.S. 449 (1958)). As the Supreme Court has noted, "associational rights carry special significance for political, social, religious, and other minorities." *First Choice*, 146 S. Ct. at 1122. This is a case in which the Pseudonymous Member Declarants provide care for a vulnerable minority population—transgender people living with HIV. At this time, the medical care they provide is politically fraught given the Trump's Administration's rhetoric and attacks. *See Endocrine Soc'y v. Fed. Trade Comm'n*, No. CV 26-512 (JEB), 2026 WL 1257289, at *1 (D.D.C. May 7, 2026) ("Members of the Executive Branch, including the President, have expressed vehement disagreement with, criticism of, and vitriol toward th[e] message" that "individuals can experience gender incongruence between their biological sex and their gender identity and that gender-affirming care can treat that incongruence."); *In re 2025 UPMC Subpoena*,

No. 2:25-MC-01069-CB, 2026 WL 570419, at *2 (W.D. Pa. Mar. 2, 2026) (noting that the administration's "rhetoric regarding gender-affirming care reflects callous indifference, if not abject cruelty"); *see also Arroyo González v. Rosselló Nevares*, 305 F.Supp.3d 327, 333 (D.P.R. 2018) (disclosing a person's transgender status, particularly now, "exposes transgender individuals to a substantial risk of stigma, discrimination, intimidation, violence, and danger").

In any event, because NP Doe and Dr. Roe are not parties, their request falls arguably under *MIT*'s paradigm regarding cases "in which identifying the would-be Doe would harm innocent non-parties." *MIT*, 46 F.4th at 71 (citation modified). As the First Circuit observed, a "nonparty 'has a stronger case for anonymity' than [a] party." *Id.* (quoting *Doe v. Trs. of Dartmouth Coll.*, No. 18-CV-040-LM, 2018 WL 2048385, at *6 (D.N.H. May 2, 2018)); *see also Smith v. Bentley Univ.*, No. 25-CV-12317-AK, 2026 WL 194339, at *2 (D. Mass. Jan. 26, 2026) ("Nonparties often have a strong claim to privacy, and courts should weigh the likelihood and severity of harm to identifiable nonparties when considering pseudonymity.") (citing *Doe v. Trs. of Bos. Coll.*, 892 F.3d 67, 78–79 (1st Cir. 2018)).

Indeed, for these reasons, courts in this district have permitted members of associational plaintiffs to participate under pseudonym. *See*, *e.g.*, Protective Order, *Am. Pub. Health Ass'n v. Nat'l Institutes of Health*, No. 25-cv-10787-WGY (D. Mass. May 5, 2025) (ECF No. 63) (granting pseudonymity "non-plaintiff organizational members" who "have privacy concerns and fears of retaliation" who by "organizational nature of Plaintiffs" would be "involved in the litigation . . . [by] providing declarations in support of Plaintiffs' Motion for Preliminary Injunction").

II. The Pseudonymous Member Declarants' Justifications Go Beyond Avoiding Annoyance and Are Necessary to Preserve Their Privacy and Sensitive Personal Information.

The fact that the Pseudonymous Member Declarants are members of Associational Plaintiffs should end the inquiry. However, should the Court require additional support for Plaintiffs' motion, additional considerations counsel in favor of Plaintiffs' request. In evaluating a request for anonymity, courts have considered whether a movant "has identified 'a specific sensitive and personal privacy interest.'" *Doe v. Pittsylvania Cnty.*, 844 F.Supp.2d 724, 729 (W.D. Va. 2012).

Here, the Pseudonymous Member Declarants' desire to proceed pseudonymously reflects the sensitive nature of their work, as well as the close relationship they have with their patients. While their identities themselves are not ordinarily highly sensitive information, the nature of their work and the subject matter of this case makes them so. Their work is intertwined with matters touching upon transgender patients' identities and care pertaining to the health and wellbeing of transgender people living with HIV. These are matters that courts, for decades, have found to be sufficiently "highly sensitive" to warrant protection. *See* Protective Order, *Am. Ass'n of Physicians for Hum. Rts., Inc. v. Nat'l Institutes of Health*, No. 25-cv-01620-LKG (D. Md. June 30, 2025) (ECF No. 81) (granting pseudonymity to LGBTQI+ healthcare researchers and providers, including members of associational plaintiffs "who wish to submit a declaration in this case and have concerns about their privacy, safety, and retaliation in connection with their participation in this litigation"); *PFLAG, Inc. v. Trump*, 766 F. Supp. 3d 535, 549 n.14 (D. Md. 2025) (granting motion to proceed under pseudonym when movants asserted that it was necessary to protect them "from undue harassment, discrimination, and violence because of the Minor and Adult Plaintiffs' transgender status"); *Doe v. Cath. Relief Servs.*, No. 1:20-CV-01815-JRR, 2024 WL 4335643, at *3 (D. Md. Sept. 26, 2024) ("Individuals in the LGBTQ+ community face hate, ridicule, violence

and all manner of loathsome, discriminatory, and, at times, criminal treatment.");[3] *Hersom v. Crouch*, No. 2:21-CV-00450, 2022 WL 908503, at *1 (S.D.W. Va. Mar. 28, 2022) (granting motion to proceed under pseudonym when "revealing [movant's] transgender status will subject him to substantial risk of mental and physical harm"); *Doe v. Genesis HealthCare*, 535 F. Supp. 3d 335, 339 (E.D. Pa. 2021) (stating that courts "have allowed anonymity due to the private and intimate nature of being transgender"); *Foster*, 2019 WL 329548, at *2 ("[T]he disclosure of [plaintiff]'s identity would reveal matters of a highly sensitive and personal nature, specifically [plaintiff]'s transgender status and his diagnosed medical condition—gender dysphoria."); *Doe v. Blue Cross & Blue Shield of Rhode Island*, 794 F. Supp. 72, 73 (D.R.I. 1992) ("Particularly in this era of seemingly increased societal intolerance toward 'unconventional' sexual behavior, I will not strip plaintiff of the cloak of privacy which shields him from the stigmatization he might otherwise endure."); *S. Methodist Univ. Ass'n of Women L. Students v. Wynne & Jaffe*, 599 F.2d 707, 712–13 (5th Cir. 1979) ("Where the issues involved are matters of a sensitive and highly personal nature, such as birth control, abortion, homosexuality or the welfare rights of illegitimate children or abandoned families, the normal practice of disclosing the parties' identities yields to a policy of protecting privacy in a very private matter." (citation modified)).

In sum, legitimate privacy concerns motivate Pseudonymous Member Declarants' request for anonymity, not mere annoyance.

---

[3] The court in *Doe v. Catholic Relief Services* granted the plaintiff's motion to proceed pseudonymously. *See* Order, *Doe v. Cath. Relief Servs.*, No. 1:20-CV-01815-JRR (D. Md. Aug. 20, 2020) (ECF No. 12).

III. The Risk of Severe and Substantial Physical and Psychological Harm Justifies the Use of Pseudonyms.

NP Doe and Dr. Roe should be permitted to participate in this case under pseudonyms because doing so publicly would place them at risk of severe and substantial physical and psychological harm.

Under the first paradigm identified by the *MIT* court, parties who reasonably fear severe harm may be granted anonymity. 46 F.4th at 71. This paradigm is satisfied where disclosure would expose a party to particular risks, including physical danger or psychological injury, distinct from ordinary litigation stress. *Id.*

Courts have regularly granted anonymity where "exceptional circumstances" threaten would-be Does, including in cases involving providers of gender-affirming medical care. *See id; In re Subpoena Duces Tecum No. 25-1431-016*, No. 2:25-MC-00041-JHC, 2025 WL 3562151, at *15 (W.D. Wash. Sept. 3, 2025) (allowing for an order to seal in part due to gender-affirming medical care providers' safety concerns); *QueerDoc, PLLC v. U.S. Dep't of Just.*, 807 F.Supp.3d 1295, 1301 (W.D. Wash. 2025) (permitting the redaction of specific gender-affirming medical care provider identifying information).

As providers of gender-affirming medical care, Pseudonymous Member Declarants reasonably fear harm to themselves, their families, and their patients. Doe Decl. ¶¶ 4, 14, 17; Roe Decl. ¶¶ 4, 12, 15. The Pseudonymous Member Declarants' fears are well-founded. Physical violence against providers of gender-affirming medical care and their clinics has sharply risen as anti-transgender legislation and social media campaigns increase their visibility. *See* Abbie E. Goldberg & Elana Redfield, The Williams Institute, *The Experiences of Gender-affirming Care Providers in States Without Laws Restricting Access to Care* (April 2025) (attached as **Exhibit A** to Ferguson Decl.) (reporting that because they provide gender-affirming medical care, 26% of

providers had been personally threatened online, 13% had been threatened in person, and 16% threatened by phone, while 29% of clinics received threats related to the provision of gender-affirming medical care); Landon D. Hughes, et al., *Adolescent Providers' Experiences of Harassment Related to Delivering Gender-Affirming Care*, 73 J. Adolescent Health 672, 674 (2023) (attached as **Exhibit B** of Ferguson Decl.) (finding that 70% of providers of youth gender-affirming care or their clinics experienced targeted harassment). In response, in 2022 the American Academy of Pediatrics, the American Medical Association, and the Children's Hospital Association requested the Attorney General and the Department of Justice to investigate the rising threats of violence against physicians and their practices. *See* Letter from the American Academy of Pediatrics, American Medical Association & Children's Hospital Association to Merrick Garland, U.S. Att'y Gen. (Oct. 3, 2022) (attached as **Exhibit C** to Ferguson Decl.).

Threats of violence hit close to home for Pseudonymous Member Declarants. For example, while Massachusetts, where NP practices, "generally supports access to HIV care and gender-affirming medical care, people in Massachusetts are not immune from the current national climate surrounding these issues, which is highly contentious." Doe Decl. ¶ 15. NP Doe is "aware of people making death threats against healthcare providers who provide gender-affirming medical care in Massachusetts." *Id*. Indeed, in 2022, Boston Children's Hospital experienced weeks of online, email, and phone harassment over their provision of gender-affirming care. *See* Hum. Rts. Campaign Found., *Online Harassment, Offline Violence: Unchecked Harassment of Gender-affirming Care Providers and Children's Hospitals on Social Media, and its Offline Violent Consequences* 13-15 (2022) (attached as **Exhibit D** to Ferguson Decl.). Social media accounts called for doctors to be "put in camps" or subjected to "Nuremberg type trials and punishments," referred to providers as pedophiles, and issued threats that a "day of reckoning is coming" for

doctors. *Id.* at 2. The harassment culminated with the hospital experiencing three different bomb threats, forcing lockdowns and evacuations. *Id.* at 1. Bomb threats were also made to provider's homes. *Id.*

Similarly, Dr. Roe "practice[s] in Tennessee, where there is significant hostility toward transgender people as well as providers who offer affirming care to transgender individuals." Roe Decl. ¶ 13. As Dr. Roe notes, "there has been a significant rise in harassment against those who care for and support transgender people, including in Tennessee," such that she is "aware of targeted online harassment, doxxing, and even bomb threats targeting gender-affirming care providers." *Id.* In Tennessee, health providers reported in 2022 receiving death threats after a far-right ideologue tweeted about a clinic providing gender-affirming care. *Id.* at 6. Posts called for the death and imprisonment of physicians, including calling for doctors having "their families slaughtered while they're forced to watch." Ex. D – Hum. Rts. Campaign Found., *supra*, at 9. Other hospitals and medical facilities providing gender-affirming medical care in Dr. Roe's region, such as St. Louis Children's Hospital and Wake Forest University School of Medicine, have also received threatening messages. *Id.* at 7-8.

In addition to threats of violence, targeted harassment causes physiological harm to providers. *See* Ex. B – Hughes et al., *supra*, at 676. In a study on gender-affirming medical providers for youth, respondents shared that threats of violence caused mental and emotional distress. *Id.* Providers reported feeling of fear of safety, stress, disrupted sleep, and panic attacks. *Id.* Many said that they started psychiatric care and therapy because of harassment. *Id.*; *see also* Ex. A – Williams Inst. (reporting that 80% of gender-affirming medical care providers have heightened levels of stress related to the rise in legislation around gender-affirming care, 77% of

providers experienced increased anxiety, 53% had elevated depression, and 36% had more difficulty sleeping).

Put simply, the Pseudonymous Member Declarants have a reasonable and serious fear that goes beyond mere reputational harm or embarrassment. Threats of harassment and violence because of lawsuit participation would subject them to potential physical and certain psychological harm, as well as disrupt their clinical practice and their patients' ability to receive care. As such, the use of pseudonyms is not only justified but falls squarely within *MIT*'s first paradigm.

IV. Risk of Government Retribution and Chilled Speech Warrants the Use of Pseudonyms.

Plaintiffs also seek pseudonymity for the Pseudonymous Member Declarants because these members fear retribution or stigmatization by becoming the subject of a Department of Justice investigation. They are "concerned that public identification could expose [them] to retaliation that would disrupt [their] ability to provide care, including potential scrutiny from federal and state officials, loss of institutional support, or interference with [their] clinical practice." Roe Decl. ¶ 16; *see also* Doe Decl. ¶ 18.

It is no secret that the Trump administration has been targeting providers of gender-affirming medical care. *See*, *e.g.*, Exec. Order No. 14187, *Protecting Children From Chemical and Surgical Mutilation*, 90 FR 8773 (2025) (directing the Department of Justice to "prioritize investigations and take appropriate action" against providers of gender-affirming medical care for youth); Press Release, Off. of Pub. Affs., U.S. Dept. of Just., *Department of Justice Subpoenas Doctors and Clinics Involved in Performing Transgender Medical Procedures on Children* (July 9, 2025), https://tinyurl.com/3ecxh94d [https://perma.cc/H66N-9QY8] (announcing the sending of more than twenty subpoenas to doctors and clinics providing gender-affirming medical care to children, and stating that "[m]edical professionals and organizations that mutilated children in the

service of a warped ideology will be held accountable by this Department of Justice"). Pseudonymous Member Declarants are aware of this. Doe Decl. ¶ 18; Roe Decl. ¶ 16.

These actions seek to "fulfill the Executive's well-publicized policy objective to terminate and block gender affirming healthcare." *In Re 2025 Subpoena to Children's Nat'l Hosp.*, No. 1:25-CV-03780-JRR, 2026 WL 160792 at *8 (D. Md. Jan. 21, 2026); *see also In re Dep't of Just. Admin. Subpoena No. 25-1431-030*, No. 25-MC-00063-SKC-CYC, 2026 WL 33398, at *7 (D. Colo. Jan. 5, 2026) ("[The] government's . . . true objective [is] pressuring pediatric hospitals into ending gender-affirming care through commencing vague, suspicionless 'investigations.'"); *In re Admin. Subpoena No. 25-1431-019*, 800 F.Supp.3d 229, 237, 239 (D. Mass. 2025) (stating that the subpoena's "true purpose" is to interfere with "Massachusetts's right to protect GAC within its borders, to harass and intimidate [hospitals] to stop providing such care, and to dissuade patients from seeking such care"), *appeal docketed*, No. 25-2092 (1st Cir. Nov. 14, 2025).

The administration has also frequently targeted perceived enemies, including those who litigated against them. *See, e.g.*, Ryan Lucas, *Experts Say Trump's Targeting of Law Firms is Unprecedented*, NPR (Mar. 19, 2025), https://tinyurl.com/5n8y3s32 [https://perma.cc/7LP6-ZNML] (detailing how the Trump administration has repeatedly threatened or prosecuted law firms that represented people or causes unpopular with President Trump). Pseudonymous Member Declarants are aware of this and fear such retribution. Doe Decl. ¶ 18; Roe Decl. ¶ 16.

Moreover, if the Pseudonymous Member Declarants were forced to identify themselves, it would risk a chilling effect, which by itself warrants anonymity, per *MIT*'s third paradigm. *See MIT*, 46 F.4th at 71 (involving cases where anonymity would "forestall a chilling effect on future litigants who may be similarly situated"). Other providers are already frightened to speak about gender-affirming medical care due to the same fears the Pseudonymous Member Declarants share

here. *See* Doe Decl. ¶ 56 ("[P]roviders may be hesitant to speak openly about gender-affirming medical care due to possible political or legal implications."); *id.* at ¶ 57 (noting that "at a conference panel focused on HIV care and related to the Ryan White Program, panelists refused to answer a question about drug interactions with gender-affirming hormone therapy due to fear of backlash"). If the Pseudonymous Member Declarants are denied pseudonymity, providers and the associations they are members of may be discouraged from bringing legal challenges on behalf of themselves, their practices, and their clients when doing so could force them to step into the spotlight and risk both government retribution and their own safety.

V. Pseudonymity is Appropriate Because Defendants are Government Agencies and Officials and Pseudonymity Does Not Undermine the Public's Interest in Open Judicial Proceedings.

Furthermore, the fact that Defendants are government agencies and officials "favors anonymity where a plaintiff is suing a government entity." *Hersom*, 2022 WL 908503, at *2. Here, the only defendants are two federal government agencies—HRSA and HHS—and two government officials sued in their official, not individual, capacities.

Courts are much more likely to permit pseudonymous suits against the government because "there is both 'arguably a public interest in a vindication of . . . rights' and a risk of stigmatization of the plaintiff, who often represents a minority interest." *Int'l Refugee Assistance Project v. Trump*, No. CV TDC-17-0361, 2017 WL 818255 at *3 (D. Md. Mar. 1, 2017) (citing *EW v. N.Y. Blood Ctr.*, 213 F.R.D. 108, 111 (E.D.N.Y. Feb. 19, 2003)). "[T]he public's interest in open proceedings must inform a district court's pseudonymity calculus." *Doe v. Pub. Citizen*, 749 F.3d 246, 274 (4th Cir. 2014); *see also MIT*, 46 F.4th at 72 ("A district court adjudicating a motion to proceed under a pseudonym should balance the interests asserted by the movant in favor of privacy against the public interest in transparency, taking all relevant circumstances into account.").

But of course, here all Plaintiffs are proceeding under their own names. This request to proceed under pseudonym solely concerns non-party declarants who are members of Associational Plaintiffs. Allowing these Pseudonymous Member Declarants to proceed under pseudonyms does not deny the public its right to attend the proceedings or inspect the court's opinions and orders resolving the underlying constitutional issue, or even to know the identity of the parties themselves. *See Doe v. Alger*, 317 F.R.D. 37, 39 (W.D. Va. 2026); *see also Cath. Relief Servs.*, 2024 WL 4335643, at *4 ("Allowing a party to proceed by pseudonym does not deprive the public from knowledge of the case or many of its facts; instead, it deprives the public only of identifying information of a party."). As many courts have held, public interest pertains to the outcome of the litigation, not the individual participants. *See*, *e.g.*, *Doe ex rel. Doe v. Harris*, No. CIV.A. 14-0802, 2014 WL 4207599, at *2 (W.D. La. Aug. 25, 2014) ("[M]any of the cases allowing plaintiffs to proceed anonymously involve challenges to the constitutional, statutory, or regulatory validity of governmental activity."), *aff'd,* No. CIV.A. 14-0802, 2015 WL 5664255 (W.D. La. Sept. 24, 2015).

VI. There Is No Risk of Unfairness to Defendants.

Finally, there is no risk of prejudice or unfairness to Defendants if the Court grants Plaintiffs' request for a protective order allowing the Pseudonymous Member Declarants to proceed under pseudonyms. First, the government does "not need to know the identity of a particular member to respond to" Associational Plaintiffs' claims regarding the Challenged Conditions; this case is a paradigmatic example of associational standing. *League of United Latin Am. Citizens v. Exec. Office of President*, 808 F. Supp. 3d 29, 59 (D.D.C. 2025) (internal quotation marks omitted) (citation omitted) (holding plaintiffs' declarations from several named organizational leaders and pseudonymous declarations were sufficient to demonstrate associational standing); *see also Hunt v. Wash. State Apple Advert. Comm'n*, 432 U.S. 333, 343 (1977). However, should Defendants somehow demonstrate to the Court that such information is

necessary, NP Doe and Dr. Roe have averred that, should the Court require it, they are willing to disclose their identities under a sufficiently protective order. Doe Decl. ¶ 20; Roe Decl. ¶ 18. In such circumstances, Defendants suffer no unfairness or prejudice. *See*, *e.g.*, *Doe v. Univ. of Maryland Med. Sys. Corp.*, No. SAG-23-1572, 2023 WL 3949737, at *3 (D. Md. June 12, 2023) ("[T]here is no risk of prejudice to Defendants by allowing this action to proceed anonymously, given that Defendants are aware of Plaintiff's identity."); *Doe v. Virginia Polytechnic Inst. & State Univ.*, No. 7:19-CV-00249, 2020 WL 1287960, at *5 (W.D. Va. Mar. 18, 2020) ("[T]here is no risk [of unfairness to defendants] because the defendants are aware of Doe's and Roe's identities.").

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court grant Plaintiffs' Motion for Leave to Permit Associational Plaintiffs' Members to Proceed Pseudonymously and for a Protective Order.

Dated this 10th day of June 2026.

Respectfully submitted,

/s/ Omar Gonzalez-Pagan

Jeffrey S. Trachtman*
Jason M. Moff*
Hannah Kanter*
Stephen P. Ferguson*
HERBERT SMITH FREEHILLS KRAMER (US) LLP
1177 Avenue of the Americas
New York, NY 10036
Telephone: 212-715-9100
Facsimile: 212-715-8000
jeffrey.trachtman@hsfkramer.com
jason.moff@hsfkramer.com
hannah.kanter@hsfkramer.com
stephen.ferguson@hsfkramer.com

José I. Abrigo*
Omar Gonzalez-Pagan (BBO No. 678517)
Jessica Polansky*
Charlie Ferguson*
Lambda Legal Defense and Education Fund, Inc.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: 212-809-8585
Facsimile: 855-535-2236
jabrigo@lambdalegal.org
ogonzalez-pagan@ lambdalegal.org
jpolansky@lambdalegal.org
cferguson@lambdalegal.org

Ryan P. Trumbauer*
HERBERT SMITH FREEHILLS KRAMER (US) LLP
2000 K Street NW, 4th Floor
Washington, DC 20006
Telephone: 202-775-4500
Facsimile: 202-775-4510
ryan.trumbauer@hsfkramer.com

* Motion for admission *pro hac vice* pending.

Kenneth D. Upton, Jr.*
Lambda Legal Defense and Education Fund, Inc.
3656 North Halsted Street
Chicago, Illinois 60613
Telephone: 312-663-4413
Facsimile: 855-535-2236
kupton@lambdalegal.org

Pelecanos*
Lambda Legal Defense and Education Fund, Inc.
800 South Figueroa St., Suite 1260[†]
Los Angeles, California 90017
Telephone: 213-382-7600
Facsimile: 855-535-2236
pelecanos@lambdalegal.org

[†] Mailing address only

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I certify that, on June 10, 2026, counsel for Plaintiffs provided a copy of the forgoing document to the following attorneys at the U.S. Department of Justice by electronic mail:

Abraham George
Chief, Civil Division
U.S. Attorney's Office for the District of Massachusetts
abraham.george@usdoj.gov

Rayford Farquhar
Chief, Defensive Litigation, Civil Division
U.S. Attorney's Office for the District of Massachusetts
rayford.farquhar@usdoj.gov

/s/ Omar Gonzalez-Pagan
Omar Gonzalez-Pagan (BBO No. 678517)
Lambda Legal Defense
and Education Fund, Inc.
120 Wall Street, 19th Floor
New York, New York 10005
Telephone: 212-809-8585
Facsimile: 855-535-2236
ogonzalez-pagan@lambdalegal.org

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

AMERICAN ACADEMY OF HIV MEDICINE; et al., *Plaintiffs*, v. HEALTH RESOURCES AND SERVICES ADMINISTRATION; et al., *Defendants*.	Case No. 1:26-cv-12638-WGY

DECLARATION OF CHARLIE FERGUSON

I, Charlie Ferguson, hereby declare and state as follows:

1. I am the Daniel H. Renberg Law Fellow at Lambda Legal Defense and Education Fund and counsel for Plaintiffs in the above-referenced litigation. I am admitted to practice in the State of New York and have applied for admission pro hac vice in this matter, which remains pending.

2. I have personal knowledge of the matters stated herein and am competent to testify thereto.

3. I submit this Declaration in support of Plaintiffs' Motion for Leave to Permit Associational Plaintiffs' Members to Proceed Pseudonymously and for a Protective Order.

4. Attached hereto as **Exhibit A** is a true and correct copy of the William Institute's research report titled *The Experiences of Gender-affirming Care Providers in States Without Laws Restricting Access to Care* (2025), available at https://tinyurl.com/46xtxmmc [https://perma.cc/8H95-8YS4].

5. Attached hereto as **Exhibit B** is a true and correct copy of the article titled *Adolescent Providers' Experiences of Harassment Related to Delivering Gender-Affirming Care* (2023).

6. Attached hereto as **Exhibit C** is a true and correct copy of the letter from the American Academy of Pediatrics, American Medical Association, and Children's Hospital Association to U.S. Attorney General Merrick Garland, dated October 3, 2022.

7. Attached hereto as **Exhibit D** is a true and correct copy of the Human Rights Campaign Foundation's research report titled *Online Harassment, Offline Violence: Unchecked Harassment of Gender-affirming Care Providers and Children's Hospitals on Social Media, and its Offline Violent Consequences* (2022), available at https://tinyurl.com/4s5e2d3n [https://perma.cc/PFX2-ETQP].

Pursuant to 28 U.S.C. § 1746, I declare under the penalty of perjury that the foregoing is true and correct.

Executed on June 10, 2026.

/s/Charlie Ferguson
Charlie Ferguson

EXHIBIT A

UCLA School of Law Williams Institute

RESEARCH THAT MATTERS

THE EXPERIENCES OF GENDER-AFFIRMING CARE PROVIDERS in States Without Laws Restricting Access to Care

April 2025

Abbie E. Goldberg
Elana Redfield

CONTENTS

EXECUTIVE SUMMARY 2
BACKGROUND 7
GENDER-AFFIRMING CARE 7
LEGAL LANDSCAPE OF GENDER-AFFIRMING CARE 7
PRIOR RESEARCH 10
FINDINGS 11
CHARACTERISTICS OF SURVEY RESPONDENTS 11
TYPES OF GENDER-AFFIRMING CARE OFFERED AND PROFESSIONAL RESPONSIBILITIES 12
IMPACTS OF RECENT LEGISLATION 13
ACTIONS TAKEN IN RESPONSE TO RECENT LEGISLATION 28
THINKING ABOUT THE FUTURE 36
CONCLUSION 42
AUTHORS 43
ACKNOWLEDGMENTS 43
SUGGESTED CITATION 43
METHODS 44

EXECUTIVE SUMMARY

Gender-affirming care (GAC) refers to a wide range of treatments sought by transgender youth, adults, and their families. In recent years, many states have moved to restrict access to this care, particularly for transgender minors, while other states have increased their legal protections to protect access to this care. This study aimed to understand the experiences and challenges facing GAC providers in states that, at the time of data collection, had not passed any legislation limiting or banning the provision of GAC to youth or adults. We specifically sought to engage providers who were less vulnerable to legal action but also potentially more burdened as they continue to provide GAC to a wide range of individuals, including those coming from out of state because of new barriers to access in their home states.

Using a mixed-methods, anonymous survey that was partially informed by focus groups with GAC providers, we examined how GAC providers in states without laws restricting access to care were being impacted both professionally and personally by bans in other states and corresponding declines in GAC provision in various states and communities. We focused on multiple impacts, including impacts on medical practices and institutions, clients, providers themselves, and the profession more broadly. We also assessed responses to these impacts taken by providers and their institutions.

Our non-representative sample of 133 GAC providers included those who worked at least partly with youth (82%) and those who worked with adults only (18%). It included mental health providers (e.g., social workers, psychologists; 55%) and medical providers (e.g., physicians, nurses, physician assistants; 45%). Most participants (80%) were LGBQ, and 44% were transgender.

KEY FINDINGS

Characteristics of Survey Respondents

Demographics

- Most (80%) participants were LGBQ, and 20% were heterosexual. Just over half of participants were cisgender, and 44% were transgender or nonbinary.
- In terms of race and ethnicity, most participants were white (87%). About five percent identified as Asian (4.5%), 2.3% Hispanic, 2.3% Latino/a/x, 1.5% Black, 0.8% American Indian/ Alaska Native, and 3.8% as something else (e.g., Middle Eastern, multiracial).
- The largest number of participants worked in Massachusetts (29%), Minnesota (15%), California (15%), New York (11%), Illinois (7%), and Oregon (5%), with smaller numbers (1-3%) in Colorado, Connecticut, Delaware, Maryland, Michigan, New Hampshire, New Jersey, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, Wisconsin, and Washington, D.C.

Types of GAC Offered and Professional Responsibilities

Client Population

- Almost all participants (97%) provided care for adults, and the majority of participants (82%) served at least some youth. Three percent served youth only.

Provider Responsibilities

- All but one provider in the study participated in direct patient care (99%), and the average amount of time spent in patient care was 66%.
- Most respondents (84%) did at least some administrative duties.

Workplace Setting and Focus of Practice

- Approximately 60% worked in a clinical care setting (e.g., medical school, clinic, health center), and 40% worked in a therapy/counseling center (e.g., individual or group therapy practice, college counseling center).
- Almost three-quarters (72%) said that their practice/clinic was LGBTQ or transgender-focused, with 8% saying it was not and 20% indicating that their answer was complicated.

Impacts of Recent Legislation

Impact on Practices and Institutions

Burden on Workload and Demand for Services

- Some providers reported very long waitlists, with 4% saying that over 300 people were on their waitlists and 2% saying 101-300 were on their waitlists. Most (81%) said 0-20 people were waiting, and 12% said they had between 21-100 people.
- Many providers were seeing out-of-state clients, with some reporting that they saw hundreds of people from other states.
- Nearly one-third (31%) of providers said that their out-of-state clients were seeking care because of restrictive laws in their states.

Demand for GAC

- Over half of providers reported that the demand for GAC among adults (54%) and youth (55%) at their practice had increased as a result of recent legislation limiting access to care.
- Only 1% said that demand for GAC had decreased among youth, and no providers reported that demand had decreased among adults.

Health Insurance Coverage for GAC

- Over half (53%) of participants said that they had encountered issues or changes with regard to insurance coverage of GAC over the past few years.

Impact on Clients

Personal Impacts and Access to Care

- Nearly half of providers (48%) reported growing waitlists for youth, and 38% reported increasing waitlists for adult clients.
- Forty-one percent of providers said that their youth clients expressed hesitancy around accessing GAC. Forty-two percent said the same about their adult clients. About three-quarters of participants said their youth clients (72%) and adult clients (77%) were more worried about their continued ability to access care.

- Many also said that their youth (43%) and adult (61%) clients expressed concerns over the privacy and security of their personal information related to accessing GAC.
- Two-thirds (67%) of youth clients and their families were paying more attention to where they chose to live or were considering moving.

Impact on the Profession of GAC

- Almost three-quarters (72%) of providers said that the rise in legislation around GAC had increased visibility and focus on GAC providers and services.
- Around two-thirds of participants said that they perceived a recent increase in burnout among providers (66%) and increased worry about criminal liability and penalties (62%).
- At the same time, over three-quarters of participants believed that providers experienced an increased commitment to providing such care (79%) and increased solidarity among care providers (77%) due to the recent rise in legislation related to GAC.

Impact on Providers

Victimization and Safety

- About one-quarter (26%) of providers had been personally threatened online, and more than one in 10 had been threatened in person (13%) or via phone (16%).
- Over one-quarter said that their place of employment had received threats related to their provision of GAC (29%).

Health and Well-Being

- About 80% of respondents reported increases in stress related to the rise in legislation around GAC, more than three-quarters reported increases in anxiety (77%), and more than half reported increases in depression (53%).
- More than one-third reported more difficulty sleeping (36%), and more than one-quarter reported increased physical challenges (26%) as a result of the increase in legislation.

Professional and Personal Life

- Participants reported increased worry about others due to the increase in anti-transgender legislation. For example, 79% of respondents have spent more time worrying about the health and well-being of their patients as a result of increased legislation related to GAC, and 65% have spent more time worrying about the health and well-being of their more vulnerable colleagues, such as transgender colleagues.
- Nearly 40% of providers spent more time worrying about their financial stability (38%), and 6% had lost professional opportunities due to their visibility as a provider of GAC. About 20% questioned whether they had made the right professional choice to enter the field of GAC (19%).

Stress, Burnout, and Job Satisfaction

- Regarding burnout, on average, participants felt personally burned out or experienced work burnout approximately half of the time (55% and 49%, respectively).
- Lower levels of burnout were experienced in their actual interactions with clients. On average, participants experienced client burnout 29% of the time.

- Participants were, on average, somewhat satisfied with their jobs.

Support from Coworkers and Institutions as a GAC Provider

- Although most participants felt very supported (62%) or somewhat supported (20%) by their employers as a gender-affirming care provider, 12% did not feel this way. More specifically, 7% said they received ambivalent/mixed support, 4% said they felt not very supported, and 1% said they felt not at all supported. Six percent did not answer the question because it was not applicable to them (e.g., because they were self-employed and/or their own "boss").

Additional Challenges as a Transgender or Nonbinary Provider

- 100% of transgender and nonbinary participants said that being transgender or nonbinary made providing GAC more complicated.

Actions Taken in Response to Recent Legislation

Changes in Employer Actions Related to Provision of GAC

- Many providers reported changes in employer practices, such as changes related to the visibility of GAC services. Overall, 65% reported one or more actions that enhanced the visibility and feasibility of GAC provision, including increasing staff who provide GAC and increasing visibility around the provision of GAC. Another 47% reported actions aimed at supporting the well-being and safety of GAC providers.
  - This includes over a quarter (28%) of providers who reported that their employer had increased security in their building to manage existing or possible threats.
- By contrast, 27% of participants reported that their employer had taken one or more actions to reduce their visibility around the provision of GAC.

Changes to Scope of Services

- Thirteen percent of respondents indicated that they have had to apply to new funding streams and grants to provide GAC; 4% have had budget cuts affecting their ability to provide GAC.
- Similar percentages of providers said that they increased the types or scope of GAC they provided (12%) or reduced the types or scope of GAC they provided (9%) as a result of recent legislation.
- Eight percent (8%) said their job responsibilities had changed, and 23% said they were now working with external organizations to coordinate access to GAC.

Changes in Approach to Care

- Over half (57%) said their approach to counseling youth, adults, and families had changed due to recent legislation.
- GAC providers described spending more time discussing risks, protections, and safety, including potential moves out of the state or country and how to protect their personal information, obtain legal documentation, be safe in public, and maintain access to gender-affirming care.
- GAC providers also spent much more time discussing community support and resources.

Changes to Visibility as a Provider

- Nearly half (47%) of participants had sought to become more visible as a GAC provider as a result of the recent rise in legislation around GAC. Just 14% had sought to become less visible as a provider over the past few years.
- Several providers reported seeking to increase professional visibility while minimizing personal and family visibility.

Actions Taken by Providers Personally

- Participants reported taking various actions to help deal with the rise in recent legislation over the past few years. Close to or more than half of the participants were spending time with and seeking support from family and friends (59%), setting boundaries between work and home (51%), exercising/meditating (48%), and engaging in advocacy work on behalf of transgender youth or adults (51%).
- One in five (20%) were considering leaving their current job.
- Many also reported taking actions to protect their safety. Over one-third (39%) were trying to decrease their visibility online, and 30% removed private information about themselves or their family on the internet.
- Some types of providers were more likely to take protective actions. For example, providers who served youth were more likely than those who served adults only to take steps to remove their personal information online (34% versus 12%). They were also more likely to install security systems than those who served adults only (14% versus 0%). Transgender providers were more likely than cisgender providers to take steps to remove their personal information online (38% versus 24%).

Thinking About the Future

Thinking about the future of GAC, providers reported many concerns, including:

- Further restrictions on care
- Funding or resource challenges
- Difficulties facing their state, community, or clinic in managing a continued influx of out-of-state patients
- Concerns about their own personal safety
- Escalation of mental health challenges and suicidality among transgender people

Some providers also spoke about concerns over their own personal capacity to provide GAC in the future.

- At the time of the study, 44% of respondents were not at all worried, and 29% were not very worried about job security. Cisgender providers were less likely to be concerned about their jobs than transgender providers (78% vs. 67%).
- When asked what advice they would give to future health professions students interested in GAC, most emphasized the rewards of providing such care. However, some also emphasized challenges alongside such rewards.

BACKGROUND

GENDER-AFFIRMING CARE

Gender-affirming care commonly refers to health services that support a person in living in alignment with their gender identity when their gender identity differs from their sex assigned at birth.[1] This care may include talk therapy, the use of hormones to delay puberty in adolescents and to promote the development of secondary sex characteristics that are consistent with a person's gender identity, or, in some cases, various surgical interventions.[2] Such treatments are considered evidence-based and typically follow standardized practice protocols. [3] Access to gender-affirming care is supported by a consensus of major medical associations in the U.S.[4]

LEGAL LANDSCAPE OF GENDER-AFFIRMING CARE

Over the past five years, there has been a dramatic rise in anti-transgender legislation across the U.S. In 2024, 672 anti-transgender bills were introduced, making it the fifth consecutive year of record-breaking anti-trans bills introduced. By comparison, 615 bills were introduced in 2023—more than triple the record set in 2022.[5] Of the 672 anti-transgender bills introduced in 2024, 585 were state-level bills filed in 49 states, and 87 were federal bills.[6] A total of 186 of these bills involved health care, typically gender-affirming care (GAC).[7]

---

[1] *See generally,* E. Coleman, et al., Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, 23 Int. J. Transgend. Health S1 (2022) (also known as the "World Professional Association for Transgender Health Standards of Care").

[2] Id.

[3] *See e.g.* Wylie C. Hembree, et. al, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. of Clinical Endocrinology & Metabolism 3869-903 (2017); *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* American Psychiatric Association *(2022)*; E. Coleman, et al., Standards of Care for the Health of Transgender and Gender Diverse People, E. Coleman, et al., Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, 23 Int. J. Transgend. Health S1 (2022) (also known as the "World Professional Association for Transgender Health Standards of Care"); Jason Rafferty, et. al*.,* Am. Acad. of Pediatrics Comm. on Psychosocial Aspects of Child & Fam. Health, AAP Comm. On Adolescence, AAP Section On Lesbian, Gay, Bisexual, And Transgender Health And Wellness, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics 1-14 (2018); *See e.g.* Stephanie L. Budge, et al., *Gender Affirming Care Is Evidence Based for Transgender and Gender-Diverse Youth, 75* J. Adolesc Health 851 (2024); Meredithe McNamara et al., An Evidence-Based Critique of "The Cass Review" on Gender-Affirming Care for Adolescent Gender Dysphoria (2024), https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf; *c.f.* The Cass Review, Final Report: Independent Review of Gender Identity Services for Children and Young People (2024)*,* https://cass.independent-review.uk/wp- content/uploads/2024/04/CassReview_Final.pdf.

[4] GLAAD, Medical Association Statements in Support of Health Care for Transgender People and Youth (June 26, 2024), https://glaad.org/medical-association-statements-supporting-trans-youth-healthcare-and-against-discriminatory/; *See also* Press Release, Am. Med. Ass'n., AMA to States: Stop Interfering in the Health Care of Transgender Children (April 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children.

[5] 2025 Anti-Trans Bills Tracker, Trans Legislation Tracker, https://translegislation.com/ (last visited Apr. 11, 2025).

[6] Id.

[7] Id.

By the end of the 2024 legislative sessions, 26 states had banned some form of GAC for transgender youth. One state passed a ban in 2021, two states in 2022, 19 states in 2023, and two states in 2024.[8] Before 2021, no states banned GAC for transgender youth.[9] None of these laws prohibit the use of these treatments for cisgender youth.

Figure 1. Number of US states with bans on GAC for transgender youth, 2020-2024

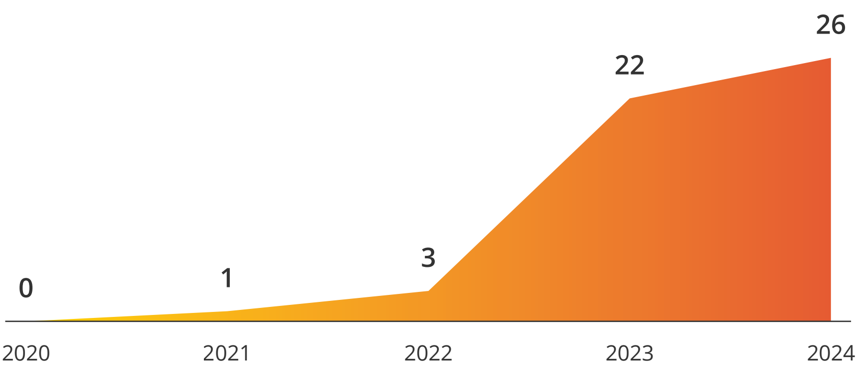
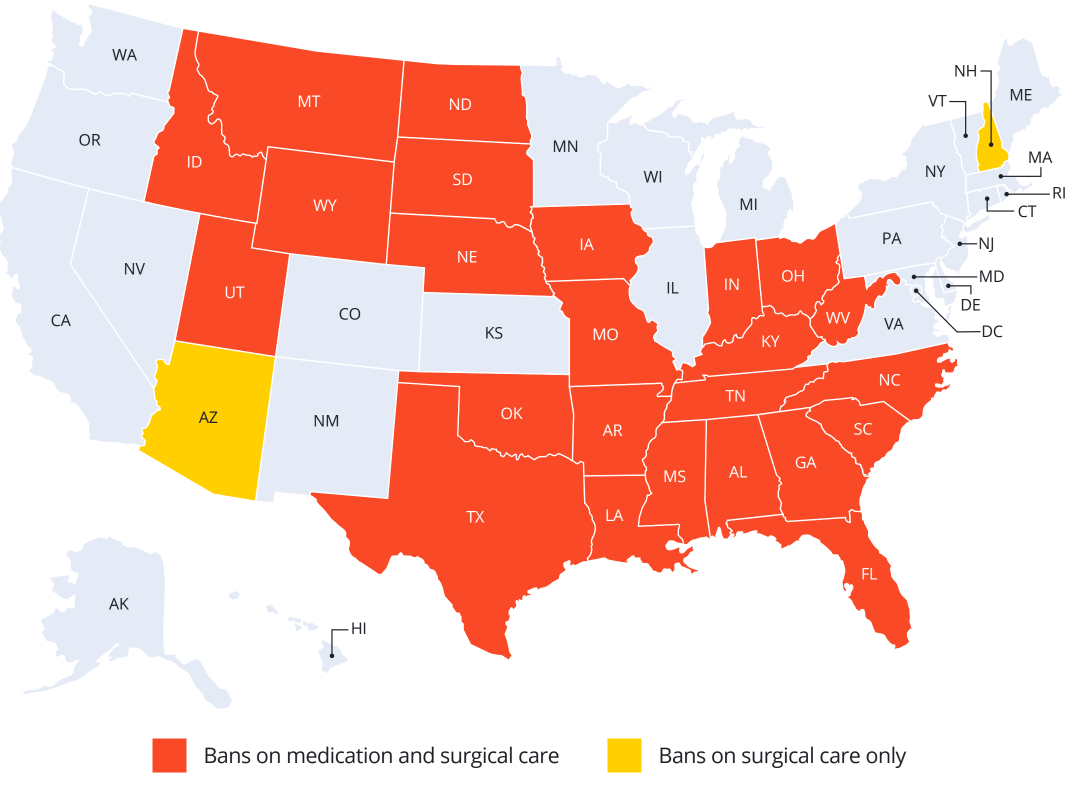


Figure 2. US states with bans on GAC for transgender youth at end of 2024 legislative sessions



[8] Annette Choi, *26 States Have Passed Laws Restricting Gender-Affirming Care for Trans Youth*, CNN.com, Dec. 3, 2024, https://www.cnn.com/politics/state-ban-gender-affirming-care-transgender-dg/index.html.

[9] Movement Advancement Project, LGBTQ Policy Spotlight: Bans on Medical Care for Transgender People (2023), https://www.mapresearch.org/file/MAP-2023-Spotlight-Medical-Bans-report.pdf.

In addition to state bans, mounting political pressures and threats (e.g., of violence, from community members, or loss of funding from state officials) have led several gender clinics, including those situated at major hospitals and medical schools, to close their doors at least to youth patients.[10] These threats to care have only escalated under the current presidential administration, which, after the completion of this study, issued multiple executive orders designed to restrict all federal funding to institutions offering gender-affirming care to youth as well as potentially allowing for criminal prosecution against individual providers.[11] This has led to temporary and ongoing shutdowns of care in states where it is otherwise legal due to concerns about the impact of federal enforcement.[12]

Existing state-level restrictions on GAC vary widely but often criminalize health care workers and sometimes parents, prohibit insurance coverage of GAC, and prohibit state funding to facilities that provide GAC.[13] Some states have also extended the timeframe to sue GAC providers for dissatisfaction with outcomes from the treatments they receive, leaving providers liable for decades.[14] As Kim et al. (2024) note, "proposed policies have a chilling effect on GAC provision via more stringent restrictions on gender affirmation set by clinics such as arbitrary age restrictions or increased mental health clearance requirements), targeted harassment of HCW [health care workers] and facilities, and organizational divestment from services due to risk concerns."[15] In turn, many providers in affected states have had to refer patients to nearby states that do not have such legislative restrictions. Even for patients who are able to travel for care, continuity of care can be undermined by the costs associated with travel and time, inadequate insurance coverage, and growing waitlists at facilities in states without restrictive legislation.[16] Providers in these states have been warned to prepare their institutions and clinical teams for potential increases in patients, prioritize care for those low on medication and those experiencing high distress, use telehealth to facilitate equitable distribution of care, and collaborate and form coalitions with clinics in the same geographic area to further reduce barriers for families.[17]

---

[10] Orion Rummler, *Political Pressure Led to Shutdown of Texas' Largest Gender-Affirming Care Program*, texastribune.org, Mar. 11, 2022, https://www.texastribune.org/2022/03/11/texas-genecis-closure-transgender/; Ron Southwick, *Threats and Harassment: 24 Hospitals Targeted for Providing Gender-Affirming Care*, chiefhealthcareexecutive.com, Dec. 19, 2022, https://www.chiefhealthcareexecutive.com/view/two-dozen-hospitals-targeted-for-providing-gender-affirming-care-report.

[11] Elana Redfield, Williams Institute, Impact of Ban on Gender-Affirming Care on Transgender Minors (2025), https://williamsinstitute.law.ucla.edu/publications/impact-gac-ban-eo/.

[12] Selena Simmons-Duffin, *Trump's Ban on Gender-Affirming Care for Young People Puts Hospitals in a Bind*, NPR.org, Feb. 10, 2025, https://www.npr.org/sections/shots-health-news/2025/02/10/nx-s1-5292390/trump-transgender-gender-affirming-care-hospital.

[13] Hyun-Hee Kim et al., *On the Frontlines of Gender-Affirming Care in a Hostile Sociopolitical Environment*, 40 J. Gen. Int. Med. 458 (2024).

[14] Christy Mallory, Madeline G. Chin & Justine C. Lee, *Legal Penalties for Physicians Providing Gender-Affirming Care*, 326 JAMA 1821 (2023).

[15] Kim et al., *supra* note 13 at 458.

[16] Id.; Emma Davis, *Death Threats, Legal Risk and Backlogs Weigh on Clincians Treating Trans Minors*, NBCnews.com, Aug. 28, 2024, https://www.nbcnews.com/nbc-out/out-news/trans-minors-treatment-clinicians-laws-bans-rcna164515; Meredithe McNamara et al., *Bans on Gender-Affirming Healthcare: The Adolescent Medicine Provider's Dilemma*, 73 J. Adolesc. Health 406 (2023).

[17] McNamara et al., *supra* note 16.

PRIOR RESEARCH

Prior research has identified challenges facing GAC providers in states that have introduced or passed legislation related to the provision of GAC, including institutional pressures, concerns about legal action, career worries, and safety concerns.[18] This work has found that GAC providers who serve children and adolescents (i.e., youth) face the challenge of providing quality care amid the politicization of such care.[19]

Other studies have examined the experiences of GAC providers in states without restrictive legislation. This research has found that providers in these states, at some of the country's most established hospitals, have been attacked, particularly online, as a result of the visibility of these facilities combined with the current national sociopolitical landscape vis-à-vis GAC.[20] Such online harassment has led employers and individuals to safeguard their privacy and safety by removing online resources, websites, and provider descriptions, installing security systems at work and home, and hiring attorneys.[21] For example, a 2023 study of 117 providers of GAC to adolescents found that 70% reported that they or their clinic had experienced threats related to their provision of GAC—most commonly social media posts (44%) or phone calls (38%), with almost one-quarter reporting threatening emails and 21% reporting that protesters had come to their clinic.[22] These threats contributed to a heavier workload (e.g., it took time to respond to such threats and develop system changes to improve security) and poorer psychological well-being.[23] Other research indicates that GAC providers experience additional stresses related to remaining compliant with institution and state regulations, retaliation from local or state authorities, and legal consequences[24]

Research indicates that some providers in states regarded as safe havens for GAC have seen increased patient demand and intensifying scrutiny due to the current politicization of GAC, particularly for youth.[25] In turn, such providers may face high levels of stress due to the complexity of accommodating an influx of new patients and the demands of dealing with heightened levels of national scrutiny and increased intrusions on their privacy (e.g., attacks on social media). Transgender providers, in particular, may be exposed to additional scrutiny for their engagement in GAC.[26]

---

[18] Pranav Gupta et al., *Exploring the Impact of Legislation Aiming to Ban Gender-Affirming Care on Pediatric Endocrine Providers: A Mixed-Methods Analysis*, 7 J. Endocrine Soc. 1 (2023); Ari S. Gzesh et al., *"Death Threats and Dispair": A Conceptual Model Delineating Moral Distress Experienced by Pediatric Gender-Affirming Care Provideers*, 9 Soc. Sci. & Hum. Open 100867 (2024).

[19] Gzesh et al., *supra* note 18; Ahona Shirin, Maya Daniello & Laura Stamm, *Providers' Beliefs and Values: Understanding Their Approach to Gender-Affirming Care*, 16 J. Primary Care & Comm. Health 1 (2025).

[20] Davis, *supra* note 16; Human Rights Campaign Foundation, Online Harassment, Offline Violence: Unchecked Harassment of Gender-Affirming Care Providers and Children's Hospitals on Social Media, and Its Offline Violent Consequences (2022), https://hrc-prod-requests.s3-us-west-2.amazonaws.com/HRCF-OnlineHarassmentOfflineViolence.pdf.

[21] Davis, *supra* note 16; Landon D. Hughes et al., *Adolescent Providers' Experiences of Harassment Related to Delivering Gender-Affirming Care*, 73 J. Adolesc. Health 672 (2023).

[22] Hughes et al., *supra* note 21.

[23] Id.

[24] Jessie Melina Garcia Gutiérrez, *A Narrative Synthesis Review of Legislation Banning Gender-Affirming Care*, 12 Current Pediatrics Report 44 (2024).

[25] Davis, *supra* note 16; Elana Redfield et al. Williams Institute, Prohibiting Gender-Affirming Medical Care for Youth (2023), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Youth-Health-Bans-Mar-2023.pdf.

[26] Daran Shipman & Tristan Martin, *Clinical and Supervisory Considerations for Transgender Therapists: Implications for Working*

FINDINGS

CHARACTERISTICS OF SURVEY RESPONDENTS

Demographics

Participants were 43 years old on average (range 24-77). Just over half of our participants were cisgender (56%); 44% were transgender or nonbinary. Most participants were LGBQ (80%); 20% were heterosexual.

In terms of race and ethnicity, most participants were white (87%). About five percent identified as Asian (4.5%), 2.3% Hispanic, 2.3% Latino/a/x, 1.5% Black, 0.8% American Indian/Alaska Native, and 3.8% as something else (e.g., Middle Eastern; multiracial).

Almost half (48%) were parents. About one-third (32%) had children under 18 only, 4% had children under 18 and over 18, and 12% had children over 18 only.

Asked what states they worked in, the largest number of participants worked in Massachusetts (29%), Minnesota (15%), California (15%), New York (11%), Illinois (7%), and Oregon (5%), with smaller numbers (1-3%) in Colorado, Connecticut, Delaware, Maryland, Michigan, New Hampshire, New Jersey, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, Wisconsin, and Washington DC. Most worked in urban (53%) or suburban (20%) settings, with 6% in rural areas and 20% specifying "something else"—most commonly "college town" or "multiple areas" (e.g., due to telehealth or having multiple offices). Most described the communities where they worked as very (63%) or somewhat (23%) LGBTQ friendly, with 12% saying neutral/mixed, 2% saying not very LGBTQ+ friendly, and 0% saying not at all LGBTQ friendly.

Regarding the overall climate-related to GAC in the place where they lived (e.g., the city/town), no participants described it as very hostile; 8% said somewhat hostile, 11% said neutral, 43% said somewhat affirming, and 38% said very affirming. Asked to elaborate on their response and/or describe any changes in community climate over the past few years, participants offered some thoughts, largely highlighting conflicting support within their community (e.g., liberal area, but some conservative folks are unsupportive; city is supportive, rest of state is not), but some noting conflicting support within their workplace (e.g., higher level administrators were "cautious and/or wary" about the services they provided).

With respect to religion, one-third (33%) said that they were "nothing in particular," 20% were atheist, 13% were agnostic, 13% were Jewish, 6% were Protestant, 4% were Catholic, 2% were Buddhist, and 11% described themselves as something else (e.g., Pagan, Atheist Jewish, Progressive Christian, Spiritual, Unitarian Universalist). Nearly three-quarters (72%) identified their political affiliation as Democrat, 20% as Independent, 1% as Republican, and 17% as something else.

Unsurprisingly, participants were highly educated: 42% had a Ph.D. or an M.D., 55% had a master's degree as their highest level of education, 2% had a college degree, and 2% had an associate's degree/some college. All participants were employed at least part-time, but most were employed full-time

---

with Clients, 45 J. of Marital and Family Therapy 92 (2019); Lauren M. Westafer, et al., *Experiences of Transgender and Gender Expansive Physicians*, 5 JAMA Network Open e2219791 (2022).

(75%); some were self-employed (17%). Just under 10% of participants made $50,000 or less annually (10%); 38% made $51K-$100K, 24% made $101K-$150K, and the remainder (28%) made over $150K, with one missing.

TYPES OF GENDER-AFFIRMING CARE OFFERED AND PROFESSIONAL RESPONSIBILITIES

Provider type. Participants were asked about the type of health care they provided. Just over half (55%) were mental health practitioners, of whom 53% were social workers, 27% were psychologists, and the remaining 20% held other mental health roles, such as licensed marriage and family therapists and licensed mental health counselors. Just less than half (45%) were medical practitioners, of whom 44% were physicians/medical doctors, whose sub-specialties included family medicine, internal medicine, adolescent medicine, pediatrics, and OB/GYN; 31% were nurse practitioners; 9% were registered nurses; and the remaining 16% were other provider types, such as physician assistants and physical therapists.

The vast majority of participants (95%) said that part of their job involved telehealth; just 5% said it did not.

Client population and services offered. Almost all participants (97%) provided care for adults, and the majority of participants (82%) served at least some youth. More specifically, over three-quarters (78%) served youth and adults, 3% served youth only, and just under one-fifth (18%) served adults only. Most had colleagues; just 4% were completely solo practitioners.

Asked what type of GAC their place of employment offered, over three-quarters (80%) said therapy/counseling, almost two-thirds (63%) said hormone therapy, and 23% said at least one type of surgical intervention/procedure. See Table 1.

Table 1. Gender-affirming care services offered

SERVICES OFFERED	PERCENT WHO SAID THEIR OFFICE/ WORKPLACE OFFERED THIS SERVICE
Therapy/counseling	80%
Hormone therapy/cross-sex hormones and/or puberty blockers	63%
Surgical procedures (e.g., masculinizing chest surgery, vaginoplasty, hysterectomy)	23%
Other services, including: • Support with binding/tucking • Assessments/evaluations for referral for gender-affirming medical procedures • Case management, coordination of care/facilitation to specialty services • Medication management • Group therapy, peer support groups	37%

Provider responsibilities. Participants were asked whether they participated in a variety of activities and what percentage of time they spent in each activity. All but one participant participated in at least some direct patient/client care (99%), and most (84%) did at least some administrative duties.

Participants' time was largely spent in patient care. The average percentage of time spent in direct client care was 66%; the percentage of time participants spent on all other activities was 17% or less, with wide ranges (e.g., although participants spent just 5% of their time, on average, in research, the range was 0-90%). See Table 2.

Table 2. Provider responsibilities

TYPE OF ACTIVITY	PARTICIPANTS WHO ENGAGED	AVERAGE PERCENT OF TOTAL TIME IN THIS ACTIVITY			
	%	%	MDN	SD	RANGE
Direct patient/client care	99%	66%	70%	23.7	0-100
Administrative duties	84%	17%	10%	15.3	0-95
Supervision	44%	6%	6%	11.2	0-60
Teaching	32%	3%	0%	7.9	0-50
Research	24%	5%	0%	15.3	0-90
Public education (e.g., giving talks, training health professionals, providing outreach to clients)	22%	2%	0%	6.3	0-50
Something else (e.g., care coordination, patient consultation, program development	5%	0.5%	0%	2.8	0-25

Workplace setting and focus of practice. Approximately 60% worked in a clinical care setting (e.g., medical school, clinic, health center), and 40% worked in a therapy/counseling center (e.g., individual or group therapy practice, college counseling center). Almost three-quarters (72%) said that their practice/clinic was LGBTQ or transgender-focused, with 8% saying it was not and 20% indicating that their answer was complicated. Most clarified that their practice saw multiple types of issues/concerns, but gender care was a focus (e.g., they were in adolescent medicine, which included a large gender program, or that while their practice/clinic was not gender-focused, they personally saw a disproportionate number of transgender clients. For instance, "We are family medicine, but I am LGBTQ/trans focused."). Some noted that their practice was not advertised as LGBTQ-focused but nevertheless attracted a larger number of LGBTQ clients.

IMPACTS OF RECENT LEGISLATION

Impact on Practice and Institutions

Burden on Workload and Demand for Services

Waitlists. Participants were asked how many people were currently on their waitlist for gender-affirming care. Some reported very long waitlists, with 3% saying over 300 and 4% saying 100-300. Most (81%) said 0-20, 5% said 21-40, 5% said 41-60, and 2% said 61-100. Some participants described feeling stress related to long waitlists caused by constraints on timely caregiving and also how much was at stake.

Said one focus group participant[27]:

> *Because of my work and where I am, I've consistently had a waitlist that's lasting about 12-18 months, and I have clients that are waiting on the waitlist, and I'm managing it in the most ethical possible way that I possibly can and getting consultation around the waitlist in and of itself. There's definitely a higher urgency of providing gender-affirming care … and other providers also have insane waitlists. Anxiety is up, depression is up, suicidality is up, and just the overall intensity of the work [is up], in addition to the clients coming in being really quite terrified about our country and what's happening and what has happened. The stress as a provider, even though I'm in a really safe spot, mostly, has become very intense. I do have clients and families that have come from other states, like some of those really unsafe Southern states. They're reaching out, they're getting added to the waitlist … There is an intense demand for providing really exceptional care.*

Out-of-state caseload. Many providers were seeing out-of-state clients, with some reporting that they saw hundreds of people from other states. Three percent said they were seeing over 300 out-of-state clients, 2% were seeing 101-300, 2% were seeing 61-100, 6% were seeing 41-60, 9% were seeing 21-40, and 78% were seeing 0-20 out of state clients. See Table 3.

Figure 3. Waitlists and out-of-state caseload

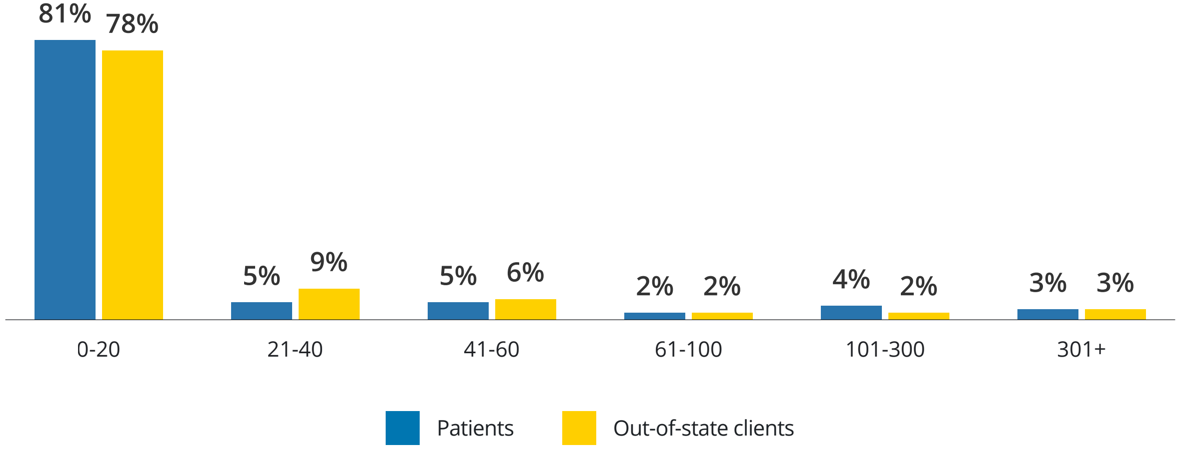


Table 3. Waitlists and out-of-state caseload

WAITLIST (# OF PATIENTS)	%		# OF OUT-OF-STATE CLIENTS	%
0-20	81%		0-20	78%
21-40	5%		21-40	9%
41-60	5%		41-60	6%
61-100	2%		61-100	2%
101-300	4%		101-300	2%
301+	3%		301+	3%

[27] All quotes are from survey respondents unless otherwise specified as from a focus group participant.

Of the participants who indicated that the question about out-of-state clients applied to them, 31% of providers said that their out-of-state clients were seeking care because of restrictive laws in their states; 21% said that their out-of-state clients were seeking care in another state for reasons other than restrictive legislation; 40% indicated that it was not easy to say specifically that the restrictive laws were the sole or primary reason for seeking care ("it's complicated"); and 8% said they were unsure of whether clients were seeking care for that reason.

Some participants provided more detail about their provision of care to out-of-state clients and clients who had relocated in order to access care. Some specifically said they were licensed in multiple states, enabling them to provide care to clients in other states (e.g., via telehealth). Others explained that their status as providers at university counseling or medical centers meant that they saw people from hostile states but who resided transiently in "safe states." Said one, "I work on a college campus. Many of the students I see came here for education and care because of restricted access at home." Others said that they saw people who had fled hostile states and relocated to their area. For example, one participant explained, "We have had an influx of patients moving from ban-states (namely in the Southeast) to get care and escape hostile policies." Another provider detailed, "We have many patients who travel to see us for [GAC] (e.g., youth from [state] who flies in for appointments, supported by community funds). We have also seen a large number of patients who have recently moved to [my state] because of [GAC] restrictions in their former home state."

Some participants said that some of their influx of new patients was not due to restrictive laws alone but also limited access to GAC in patients' home states (e.g., due to few providers or long waitlists). One provider said, "Some out-of-state clients are coming from neighboring states in which there are not bans, but there are also not competent providers closer to their homes. We are getting increasing numbers of people coming from ban/red states, and these clients are traveling farther, and typically, it is due to bans on care." Another shared, "Some patients come from restricted states, but many are experiencing waitlists that are too long in their home state due to limited access to care."

Some providers explained that, because of licensing laws, they could not provide services to individuals outside of the state where they practiced, even if they were providing telehealth services. Some of these providers noted that they had been contacted by individuals in other states but had to decline to treat them, saying, for example, "I am only licensed to practice in [my state]; I have had clients reach out looking for gender-affirming care from out-of-state but am not able to accommodate them due to these licensing restrictions." Another provider said:

> *Some are former clients who wanted to stay with me but moved out of state during the pandemic. Since I am only licensed to provide psychotherapy in [state], new people have to reside in the state where I am licensed. However, I get many requests from folks out of state, and I work to refer them to my network of licensed providers who can "legally" see them. I can't always find people in their states, however, who are available, knowledgeable, or affordable.*

Demand for GAC. The majority of providers reported an increase in demand for GAC, and many reported that the scope of their practice had expanded as a result of recent legislation. Over half of providers reported that the demand for GAC among both adults (54%) and youth (55%) at their practice had increased. Only 1% said that demand for GAC had decreased among youth, and no providers reported that demand had decreased among adults. See Table 4.

Figure 4. Changes in patient demand

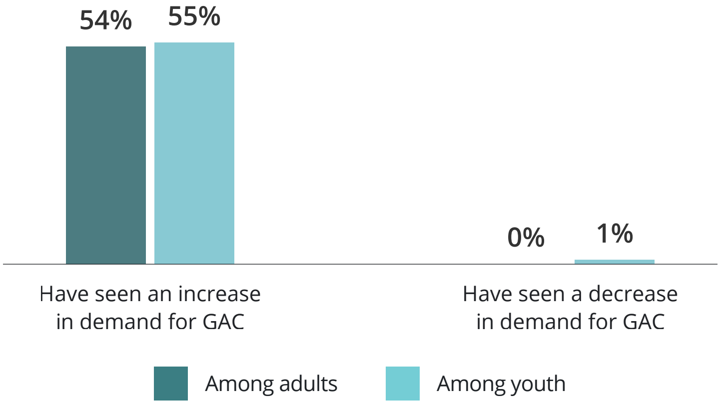


Table 4. Changes in patient demand

PATIENT DEMAND	%
We have had an **increase** in the demand for gender-affirming care among **adults**	54%
In the past few years, I have seen an increase in demand for gender-affirming care, particularly for adults who are moving from states that were imposing bans on medical interventions for gender dysphoria	
Many of my clients and people I work with have relocated from out of state due to hostility.	
The therapy practice where I work is explicitly trans and queer affirming in its name and branding. We have had continuous increase in demand for services in the last several years.	
We have found people are feeling more urgent for care, due to fear that access to interventions will be removed and people who want to get to a place of "passing" so that they are less at risk of safety concerns.	
We're flooded with refugee patients from other states who move to NYC for the gender-affirming care services.	
We have had an **increase** in the demand for gender-affirming care among **youth**	55%
More parents seek me out to see their young children who are socially transitioning	
There has been an increased need for services for trans youth due to social policy stigma and distress related to anti-trans rhetoric and harassment from others while out in public.	
We have seen an increase in adults and youth needing and seeking out gender-affirming mental health care due to the nationwide political rhetoric against gender-diverse people	
We have had a **decrease** in the demand for gender-affirming care among **adults**	0%
We have had a **decrease** in the demand for gender-affirming care among **youth**	1%

Health insurance coverage for GAC. Over half (53%) of participants said that they had encountered issues or changes with regard to insurance coverage of GAC over the past few years. Many elaborated on these changes. The most common changes were the following:

- Increases in denial of coverage (e.g., hair removal, voice therapy, and surgery)
- Increases in denial of coverage for youth in particular (e.g., hormones, surgery)
- Increased requirements for letters of support for surgery
- Increased requests for prior authorizations (previously not required)
- Generally, more "hoops" to jump through

For examples of each, see Table 5.

Table 5. Changes related to health insurance of gender-affirming care

THEME	QUOTES
Denial of coverage, youth-specific	*There are now several insurance providers we work with that restrict access to any gender-affirming surgery until age 18, where before, it was on a case-by-case basis.*
Denial of coverage, adults	*Denials on voice therapy from non-state backed PPOs [preferred provider organizations; a type of health insurance policy]*
Letter requirements	*Letters of support for surgery increasingly get denied or sent back for more information*
	It is always hard to write a letter of support that meets the changing requirements of insurance companies to get prior authorization. I often have to redraft and resubmit letters with small changes in wording to satisfy insurance.
Prior authorizations (PAs)	*PAs will newly be required when previously they weren't*
	We are facing more restrictive prior authorization processes with in-state insurance, and out-of-state patients sometimes have no coverage at all for gender-affirming care.
	Coverage is mandated for insurance plans sold in the state. We get rejections from out-of-state insurance.
Many "hoops" and bureaucracy	*Most of the insurance companies eventually pay but make the providers and patients jump through multiple hoops to obtain approval. Some programs also attach copays or deductibles, which make the care unaffordable for patients. Pharmacies engage in similar behavior.*
	A lot of hoops to have students access gender-affirming surgeries—for example, needing letters of support to even make an appointment for hair removal, etc.

Impact on Clients

Personal impacts and access to care. Participants were asked how the recent rise in legislation around GAC impacted their clients (see Table 6). Nearly half of providers (48%) reported increasing waitlists for youth, and 38% reported increasing waitlists for adult clients. About three-quarters of participants said their youth clients (72%) and adult clients (77%) were more worried about their continued ability to access care. Around 40% of providers said that youth (41%) and adults (42%) expressed increased hesitancy around accessing GAC. Many also said that their youth (43%) and adult (61%) clients

expressed concerns over the privacy and security of their personal information related to accessing GAC. Two-thirds (67%) of youth clients and their families were paying more attention to where they chose to live or were considering moving.

Some participants provided additional detail about the impact of recent legislation on their clients in response to open-ended questions. One theme that emerged in these responses related to parents' increased hesitancy to access care for their children. For example, one provider observed, "Parents of patients have more concerns and are less ready to support their child." Another provider said, "I now notice a big increase in parents of teenage therapy clients wanting to be affirming but also not wanting to allow their children to go on blockers or access HRT because of anti-trans 'information' that they are reading online, etc."

Figure 5. Impact on clients

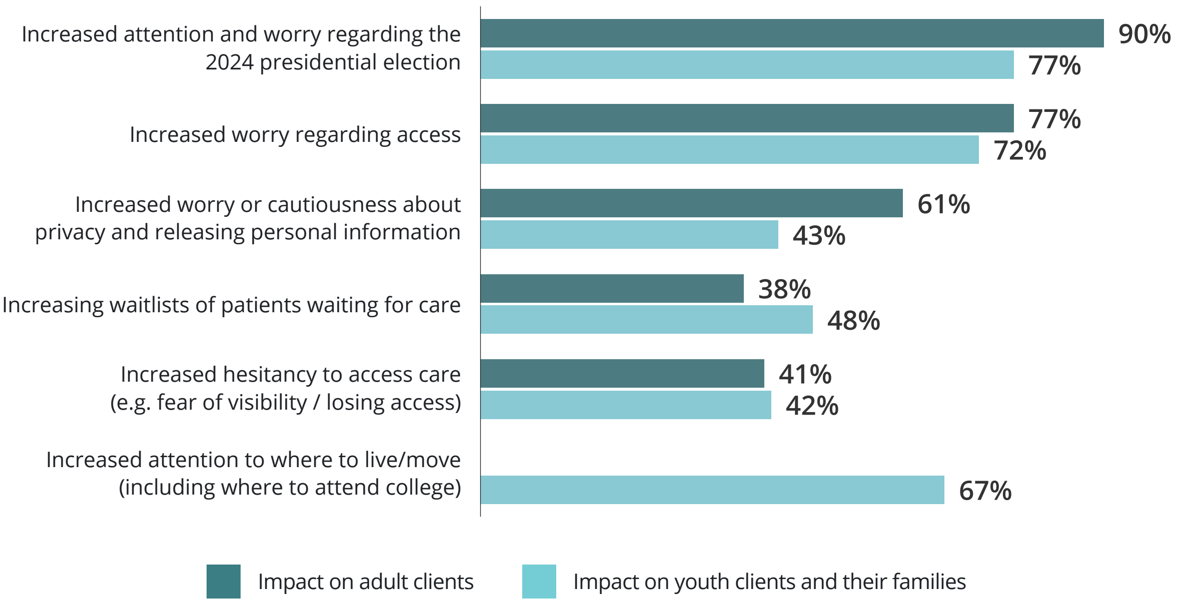


Table 6. Impact on clients

IMPACT	%
ON YOUTH CLIENTS AND THEIR FAMILIES	
Increasing waitlists of youth waiting for care	48%
Increased worry regarding access to gender-affirming care	72%
Increased hesitancy to access care (e.g., because of fear of visibility and/or losing access to care)	42%
Increased worry or cautiousness about privacy and releasing personal information	43%
Increased attention and worry regarding the 2024 presidential election	77%
Increased attention to where to live/move (including where youth are considering going to college)	67%
ON ADULT CLIENTS	
Increasing waitlists of adults waiting for care	38%
Increased worry regarding access to gender-affirming care	77%
Increased hesitancy to access care (e.g., because of fear of visibility and/or losing access to care)	41%
Increased worry or cautiousness about privacy and releasing personal information	61%
Increased attention and worry regarding the 2024 Presidential election	90%

Impact on the Profession of GAC

Participants were asked whether they perceived the increased legislation and politicization of GAC as impacting the profession of providing such care. Specifically, they were asked whether, in their experience, it had affected the visibility of GAC; the viability and attractiveness of the subspecialty to current and potential providers; experiences of burnout, worry, and solidarity among providers; and commitment to care among providers. See Table 7.

Significantly, almost three-quarters (72%) said that the rise in legislation around GAC had increased visibility and focus on GAC providers and services. Around two-thirds of participants said that they perceived a recent increase in burnout among providers (66%) and increased worry about criminal liability and penalties (62%). At the same time, over three-quarters of participants believed that providers experienced an increased commitment to providing such care (79%) and increased solidarity among care providers (77%) due to the recent rise in legislation related to GAC.

Figure 6. Impacts on profession

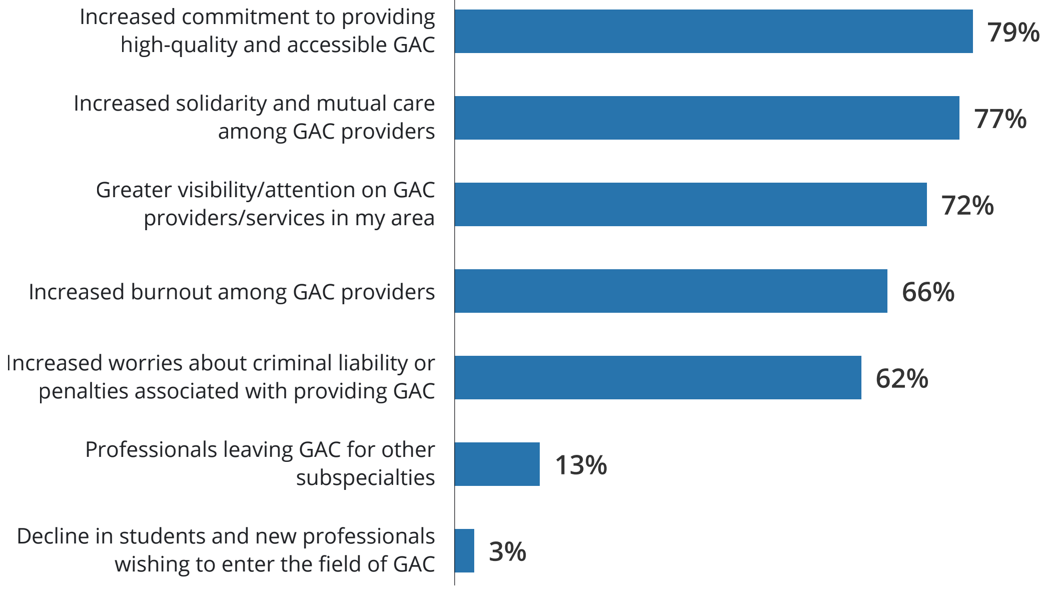


Table 7. Impacts on profession

IMPACT	%
Greater visibility of/attention focused on GAC providers/services within my community	72%
Our hospital has felt the pressure of being one of the only children's hospitals continuing to do gender-affirming surgeries on minors.	
Professionals leaving gender-affirming care for other subspecialties	13%
Decline in students and new professionals wishing to enter the field of GAC	3%
Increased burnout among GAC providers	66%
Increased worries about criminal liability or penalties associated with providing GAC	62%

IMPACT	%
Other therapists /non-specialists (particularly those working with youth) seem more reluctant to even touch gender-affirming care with a 10-foot pole for fear of liability. Recently, half of my trans children/youth caseload was referred by and still sees another therapist for anxiety/depression, etc., but see me for gender-affirming care as if that can be somehow separated from the issues the other therapist is seeking to treat.	
Our legal team has been more cautious about offering gender-affirming care for minors. They now require that I get written consent from all parents/guardians, whereas before, I typically only needed one parent to consent. I had also previously done a verbal informed consent for hormone therapy, and now my organization requires this be documented in writing prior to starting any new patients on hormones.	
There is a lot more talk and fear about transition regrets, and many providers I know have sought out legal counsel and are trying to legally protect themselves in offering trans-affirming mental health care.	
Increased solidarity and mutual care among GAC providers	77%
We have a lot of resources and advocacy groups that have been increasingly vocal since the anti-trans political climate got so intense.	
Increased commitment to providing high-quality and accessible GAC	79%

Impact on Providers

Victimization and safety. Participants were asked whether they had been victimized in a number of different ways by clients, families, or community members because of their work as a gender-affirming care provider. Notably, about one-quarter (26%) had been personally threatened online, and more than one in 10 had been threatened in person (13%) or via phone (16%). See Table 8. Relatedly, over one-quarter said that their place of employment had received threats related to their provision of GAC (29%).

Figure 7. Victimization experiences as a gender-affirming care provider

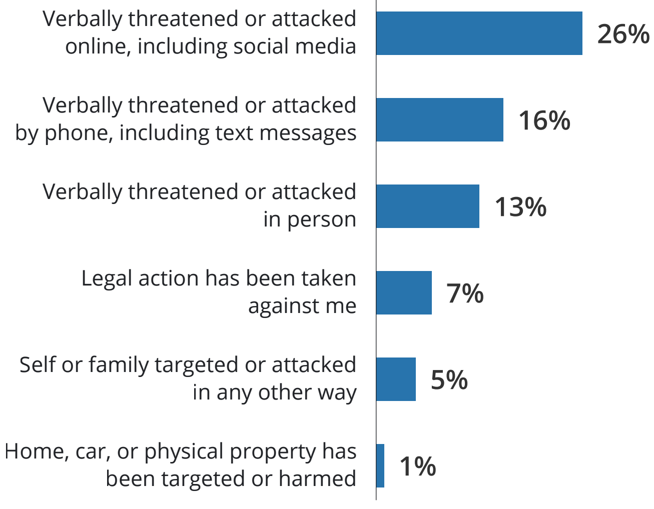


Table 8. Victimization experiences as a gender-affirming care provider

TYPE OF VICTIMIZATION	%	EXAMPLES (FROM OPEN-ENDED SURVEY RESPONSES)
Verbally threatened or attacked **online,** including social media	26%	**Harassment via Twitter, Reddit**
		Some calls for my death online
		I've been accused of horrible things, threatened with physical violence, and been the recipient of harmful rhetoric online
		trolls on social media [have threatened me]
		Harassment via email
		I have had a few emails through my website from folks calling me a child predator because I provide gender-affirming care to youth
		I have received threatening e-mails from some conservative parents in the past few months.
		Negative reviews posted online
		People have posted on my social media and left reviews of me that are negative and target my gender identity
		Anti-trans "journalists" and commentators
		Publishing articles about research presentations, handouts
Verbally threatened or attacked **by phone,** including text messages	16%	*Hate messages in my work voicemail*
		We have received threatening phone calls to our front desk regarding 'doctors who help trans people'
Verbally threatened or attacked **in person**	13%	*Harassed in workplace bathrooms*
		Harassed in large city functions
		Verbally attacked when walking outside the clinic
		Yells, jeering, threatening signs [when I] provided advocacy at the capitol
		[Was] disrupted and verbally harassed while giving a talk
Legal action has been taken against me	7%	*An allegation was made against me to my licensing board; fortunately, the allegation was dropped by the board*
		Allegation was ... thrown out by the board that reviewed it; Lawsuit by a former client ... who now travels around the country advocating for affirming care bans.
Self or family targeted or attacked in any other way	5%	Comments online about self and family
		Self and family harassed by others
		Anonymous letter from a non-trans patient
Home, car, or physical property has been targeted or harmed	1%	*My car has been visibly damaged (keyed and cracked windshield.*

Health and well-being. Participants were asked about whether they had personally experienced changes in their physical, mental, and emotional well-being due to the increase in anti-transgender legislation.

About 80% reported increases in stress, more than three-quarters reported increases in anxiety (77%), and more than half reported increases in depression (53%). Further, more than one-third reported more difficulty sleeping (36%), and more than one-quarter reported increased physical challenges (26%).

Many also reported increased strain on their personal relationships. About one-fifth reported more parenting stress (22%) and/or more stress in their intimate relationships (19%). See Table 9.

Figure 8. Changes in well-being due to increased legislation

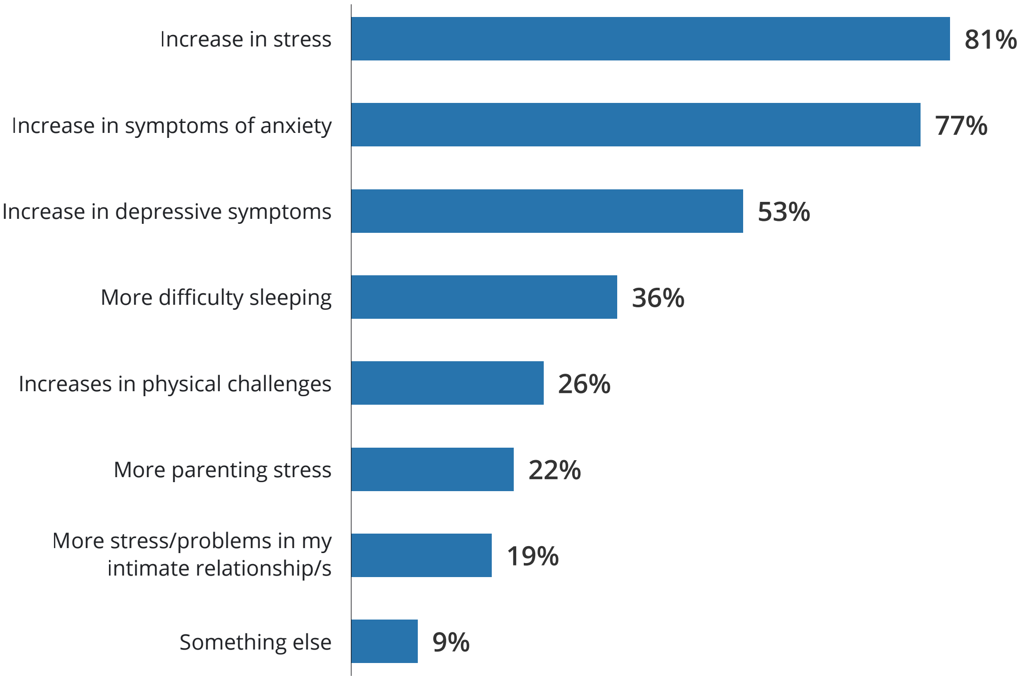


Table 9. Changes in well-being due to increased legislation

ITEM	%
Increases in stress	81%
Increases in symptoms of anxiety (e.g., worry, fear, agitation)	77%
Increases in depressive symptoms (e.g., feelings of helplessness, hopelessness, sadness)	53%
More difficulty sleeping	36%
Increases in physical challenges (e.g., blood pressure, digestive issues, headaches)	26%
More parenting stress	22%
More stress/problems in my intimate relationship/s	19%
Something else • Fear of litigation and harassment • Anger • Grief • Suicidality • Decreased ability to concentrate and focus • Considering change in career focus (leaving clinical work for academia) • Exacerbation of chronic health issues • Decreased socialization/increased isolation	9%

Professional and personal life. Many participants reported that the recent rise in legislation around GAC had an impact on their professional lives, personal lives, and job satisfaction. See Table 10. Over three-quarters (79%) reported that they spent more time worrying about the health and well-being of their patients, and 65% said that they spent more time worrying about the health and well-being of their more vulnerable colleagues, for example, their transgender coworkers.

Nearly 40% of providers spent more time worrying about their financial stability (38%), and 6% had lost professional opportunities due to their visibility as a provider of GAC. About one in five questioned whether they had made the right professional choice to enter the field of GAC (19%).

Figure 9. Impact on professional and personal lives

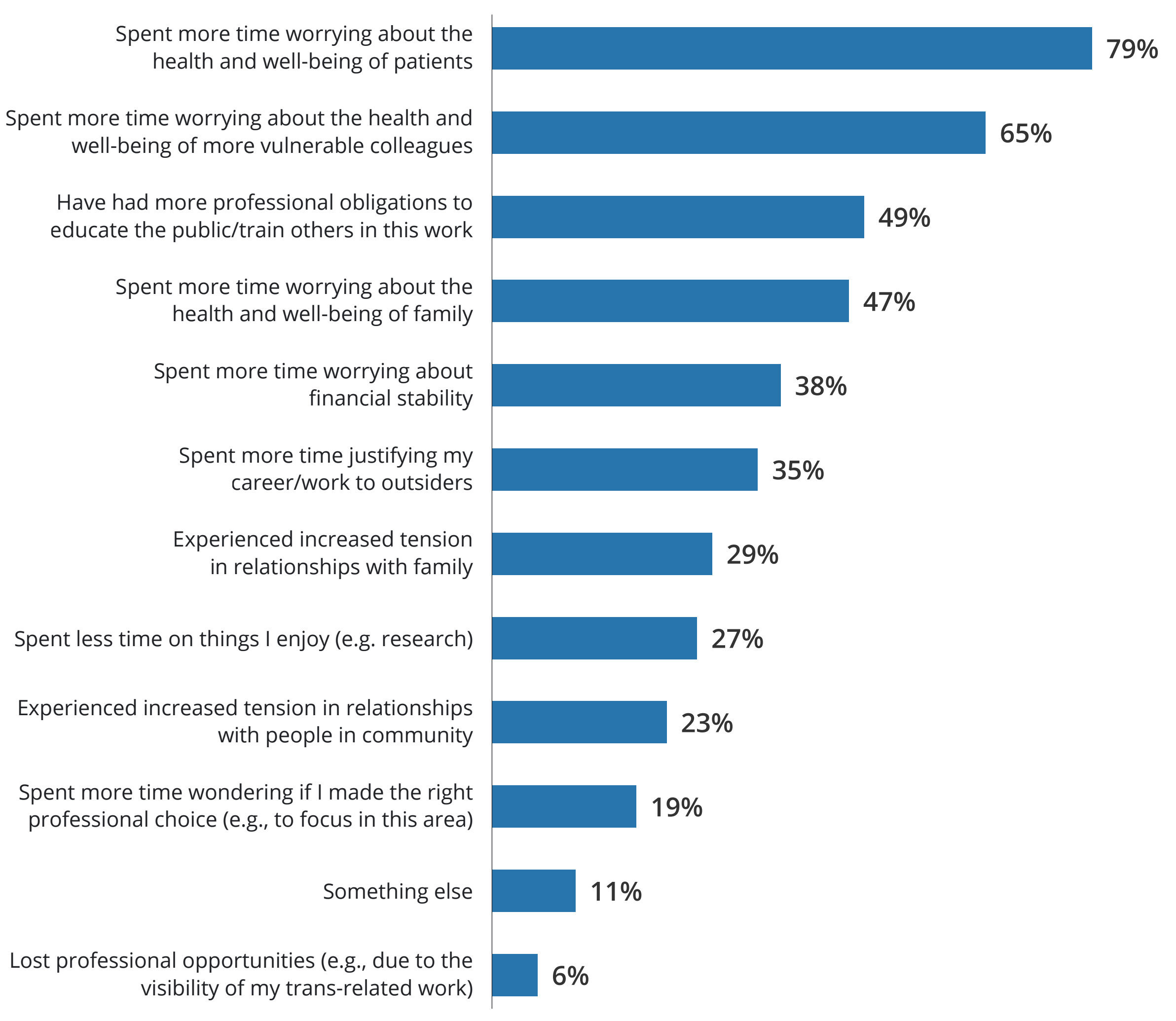


Table 10. Impact on professional and personal lives

ITEM	%
I have spent more time worrying about the health and well-being of my patients/clients	79%
I have spent more time worrying about the health and well-being of my more vulnerable colleagues (e.g., trans colleagues)	65%
I have spent more time worrying about the health and well-being of my family	47%
I have spent more time worrying about financial stability (e.g., should I lose my job or take a new job)	38%
I have experienced increased tension in my relationships with my family (e.g., extended family)	29%
I have experienced increased tension in my relationships with people in my community (e.g., neighbors, the parent community)	23%
I have spent more time justifying my career/work to outsiders (e.g., trans care is health care)	35%
I have had more professional requests/obligations because of the need for providers like myself to educate the public and/or train others in this work	49%
I have spent less time on things I enjoy (e.g., research)	27%
I have spent more time wondering if I made the right professional choice (e.g., to focus in this area)	19%
I have lost professional opportunities (e.g., due to the visibility of my trans-related work)	6%
Something else, such as: **Increased fears about personal safety** ("I had to wear a bulletproof vest for the first time last year; I never thought this would be my life as a pediatrician." "My organization was doxed … we set up a flee plan.") **Increased scrutiny as a trans provider** ("I worry much more about my job stability due to increased stigmatization of the work and of me as a trans provider.")	11%

Stress, burnout, and job satisfaction. Participants were asked about burnout and stress related to their jobs and clients and its impact on them personally and professionally, using the Copenhagen Stress and Burnout Questionnaire. Items were answered on a 5-point scale from 1 = never/to a very low degree; 2 = seldom/to a low degree; 3 = sometimes; 4 = often/to a high degree; and 5 = very often/to a very high degree. A score of 1, in turn, is treated as corresponding to 0% of the time, 2 = 25% of the time, 3 = 50% of the time, 4 = 75% of the time, and 5 = 100% of the time. See Table 11.

Figure 10. Personal, work, and client related burnout and stress among providers

Question	Average percentage of time felt this way
How often do you feel tired?	69%
How often are you emotionally exhausted?	66%
Do you feel worn out at the end of the working day?	63%
How often do you feel worn out?	62%
Is your work emotionally exhausting?	62%
How often are you physically exhausted?	57%
Do you feel burnt out because of your work?	53%
Do you have enough energy for family and friends during leisure time?	52%
Does your work frustrate you?	45%
Are you exhausted in the morning at the thought of another day at work?	42%
How often do you feel weak and susceptible to illness?	37%
How often do you think: "I can't take it anymore"?	36%
Does it drain your energy to work with clients/patients?	34%
Do you feel that you give more than you get back when you work with clients/patients?	34%
Do you sometimes wonder how long you will be able to continue working with clients/patients?	34%
Do you feel that every working hour is tiring you?	30%
Do you find it hard to work with clients/patients?	25%
Do you find it frustrating to work with clients/patients?	24%
Are you tired of working with clients/patients?	23%

Personal burnout | Work-related burnout | Patient/client burnout

Table 11. Personal, work, and client-related burnout and stress among providers

BURNOUT ITEM	M (SD)	SD	AVERAGE PERCENTAGE OF TIME YOU FELT THIS WAY
PERSONAL BURNOUT			
How often do you feel tired?	3.75	0.88	69%
How often are you physically exhausted?	3.30	0.99	57%
How often are you emotionally exhausted?	3.65	0.86	66%
How often do you think: "I can't take it anymore"?	2.44	1.12	36%
How often do you feel worn out?	3.47	0.92	62%
How often do you feel weak and susceptible to illness?	2.49	1.06	37%
WORK-RELATED BURNOUT			
Is your work emotionally exhausting?	3.47	0.93	62%
Do you feel burnt out because of your work?	3.11	0.91	53%
Does your work frustrate you?	2.83	0.96	45%
Do you feel worn out at the end of the working day?	3.53	0.95	63%
Are you exhausted in the morning at the thought of another day at work?	2.68	1.15	42%
Do you feel that every working hour is tiring for you?	2.20	1.07	30%
Do you have enough energy for family and friends during leisure time?*	3.10	0.90	52%
CLIENT BURNOUT			
Do you find it hard to work with clients/patients?	2.01	0.82	25%
Do you find it frustrating to work with clients/patients?	1.99	0.74	24%
Does it drain your energy to work with clients/patients?	2.36	0.88	34%
Do you feel that you give more than you get back when you work with clients/patients?	2.36	0.98	34%
Are you tired of working with clients/patients?	1.92	2.00	23%
Do you sometimes wonder how long you will be able to continue working with clients/patients?	2.36	1.02	34%

Note: *reverse coded in computing averages

Participants were, on average, somewhat satisfied with their jobs (M = 3.6, SD = 1.0), where 1 = poor, 2 = moderate, 3 = good, 4 = very good, and 5 = excellent. With regard to burnout, participants experienced the most burnout in their personal and work lives. On average, participants felt personally burned out or experienced work burnout approximately half of the time (55%, SD = 20 and 49%, SD = 18, respectively). The least amount of burnout was experienced in their actual interactions with clients. On average, participants experienced client burnout 29% of the time (SD = 16).

Participants often spoke about their exhaustion and burnout in open-ended responses. Said one:

> *I don't know where to begin. I feel exhausted much of the time and also feel compelled to keep going. I often want to stop working completely or go into another area of my field entirely that requires nothing of controversy in the scope of practice. The increase of needs feels crushing, and I want to disappear—to walk away and just blend into the fog, "live a carefree life," and be left alone to do creative and rejuvenating things.*
>
> *I often think about working less hours/shorter shifts because the days are long and often emotionally draining.*
>
> *My work is draining and never-ending, so it tends to have a "piling on" feeling as far as fatigue and stress goes.*

Support from coworkers and institutions. We asked respondents how supported they felt as a provider of GAC by their employers. Although most participants felt very supported (62%) or somewhat supported (20%) by their employers, 12% did not feel this way. More specifically, 7% said they received ambivalent/mixed support, 4% said they felt not very supported, and 1% said they felt not at all supported. Six percent did not answer the question because it was not applicable to them (e.g., because they were self-employed and/or their own "boss").

Some participants provided more detail about the lack of support they felt from their institutions or coworkers around providing gender-affirming care specifically or LGBTQ-supportive care more broadly. When reflecting on their relationships with their coworkers, one provider explained, "The [Federally Qualified Health Center] I work for is not [focused on LGBTQ+ patients] although the majority of patients I see are LGBTQ identified. Leadership is trying to be supportive, but the majority of staff I work with day to day struggle with the very basics of trans care." Another provider shared, "We advertise a gender equity clinic, but our staff and support staff show the opposite—many microaggressions and blatant homophobia and transphobia." Describing the challenges presented by the lack of a supportive institution, one provider said, "My department is very supportive; the hospital is overall much less responsive. Despite harassment in our public facilities, [and] bomb and death threats, there has been little effective follow-up." One focus group participant said, "They still say they support the [gender] program and want the programs to happen. They would just like for us to be as quiet about it as possible."

Additional challenges as a transgender provider. As noted above, 44% of respondents were transgender or nonbinary. Transgender and nonbinary providers sometimes detailed additional sources of stress related to their status as transgender or nonbinary GAC providers specifically, such as suspicion and doubt from clients, colleagues, and the public at large. Indeed, 100% of these participants said that being transgender or nonbinary made providing GAC more complicated, sharing various examples such as:

> *[I feel] doubted more by the academic/medical community as if my support for this care is only personal/subjective.*
>
> *I think that knowing that I am nonbinary makes some parents discount my expertise, training, years of experience ... and just see me as personally biased.*

> *I gave a talk not too long ago, and I was asked by someone—one of the attendees—if I was transgender, and the reason I bring this up is because the attendee could not wrap their mind around that this is standard of care. They thought it only was an interest of people with a certain sociopolitical opinion, it wasn't something that everybody needs to know. I just want to kind of put it out there. That's the elephant in the room.*

ACTIONS TAKEN IN RESPONSE TO RECENT LEGISLATION

We asked respondents about actions they or their institutions had taken in response to the changes in the legislative environment for GAC. This included changes to staff and employer practices, changes to the scope of responsibilities, changes in approach to care, changes to visibility as a provider, and actions taken by providers in their personal lives.

Changes in employer actions related to provision of GAC. Many providers reported changes in employer practices, such as related to the visibility of GAC services. See Table 12. Overall, 65% reported one or more actions that enhanced the visibility and feasibility of GAC provision, including increasing staff who provide GAC and increasing visibility around the provision of GAC. Another 47% reported actions aimed to support the well-being and safety of GAC providers, such as encouraging staff to access stress-reduction and well-being resources or taking measures to increase cybersecurity and physical security in the workplace. This includes over a quarter (28%) of providers who reported that their employer had increased security in their building to manage existing or possible threats.

By contrast, 27% of participants reported that their employer had taken one or more actions to reduce the visibility around the provision of GAC. Some of these can be viewed as protective, such as reducing GAC providers' visibility online, whereas others were more restrictive, asking providers not to wear signifiers of trans inclusion and limiting providers' ability to present GAC-related research. Ultimately, 25% reported at least one "protective" action, and 10% reported at least one "restrictive" action.

Smaller numbers of participants reported outside challenges to the provision of GAC-related care, such as threats and cuts to funding.

Table 12. Changes in staffing and employer practices

ITEM	%
EMPLOYER ACTIONS RELATED TO REDUCE VISIBILITY AND FEASIBILITY OF GAC	
Protective	
My employer has made efforts to DECREASE the visibility of GAC PROVIDERS (e.g., online)	20%
Because so many of my pediatric colleagues at other institutions have received threats, my organization preemptively took down my picture.	
Our media and communications departments actively discourage participating in almost all media requests.	
We have a Communications Director who monitors any staff engagements outside of the office where we might be representing our organization. They both approve our participation and assess any potential danger.	
We have our clinician bios password protected on our website and give prospective clients the password. This was after a video of a training that a clinician did about writing letters for gender-affirming surgery was picked up and shared by LibsofTikTok.	

ITEM	%
Our clinic chose to take names off of our webpage, which I did not agree with. That was not my decision to make. But … nobody was really finding me through our webpage, I would say. It was definitely more patient word of mouth, a number of other national online directories, and then again, national work in other organizations. So, I wasn't as—I didn't push back on them taking down my information from the webpage because it was more the other people felt unsafe, and I was like, "I will do what you all feel you need to for your safety." This isn't going to affect me necessarily. (focus group participant)	
My employer has made efforts to DECREASE the visibility of the GAC SERVICES we provide (e.g., online)	14%
One of our programs for youth does not advertise these services due to safety concerns.	
Services are unchanged, but we are less public about specific services or providers on institution-wide online pages.	
They have made efforts to make our LGBTQ+ services less visible and talk less about issues facing our community.	
We have experienced changes in organizational structuring to reduce the visibility of GAC services (e.g., those services are subsumed under a different area or subspecialty)	3%
Restrictive	
We have fewer opportunities to present publicly about gender-affirming care	8%
The way the hospital has responded to this in terms of our doing presentations and talks and doing things internationally, which I used to do quite often, is to be very, very cautious about where and with what kind of support from the hospital and backup. (focus group participant)	
My employer has interfered with my ability to publish or present GAC-related research or other material	4%
We are discouraged from wearing or displaying signifiers of trans inclusion (e.g., pronoun pins, flags) in community spaces/ outside of our workplace	1%
We have reduced the number of staff who work in GAC	0%
EMPLOYER ACTIONS RELATED TO ENHANCE VISIBILITY AND FEASIBILITY OF GAC	
My employer has made efforts to INCREASE the visibility of GAC SERVICES we provide (e.g., online)	40%
My employer (part of a group practice) has increased visibility of gender-affirming related care within website, ads, and other avenues. They have also increased visibility of providers in the practice who offer these services. Self-care for providers has been more encouraged with recent changes that are being made.	
We have increased our visibility and offerings through on-campus signage and on our website, more coordination with other LGBTQ organizations on campus; we've had more staff and student affairs speaking engagements to spread the word about our GAC offerings (primarily hormones).	
My employer has made efforts to INCREASE the visibility of our GAC PROVIDERS (e.g., online)	26%
We have been encouraged to wear signifiers of trans inclusion in community spaces	29%
We have increased the number of staff who work in GAC	28%
EMPLOYER ACTIONS RELATED SUPPORT THE SAFETY AND WELL-BEING OF GAC PROVIDERS	
We have been encouraged to take advantage of individual or group support resources to reduce stress and enhance well-being	34%
We have increased security in our building/s	28%

ITEM	%
We have contracted with companies who search the Dark Web for any mention of our organization. All of our staff are enrolled in an employer-paid anti-doxing program. We now have locked doors at all entrances, a video system for buzzing patients into clinical areas, and the ability to shut off elevator access to our clinic. We have alarm buttons in each room. Now that our security is tightened, we will begin to publish our address (previously only PO Box number) and the bios of our providers.	
OTHER CHANGES IN RESPONSE TO RECENT LEGISLATION	
We have had to apply to new funding streams and grants to provide GAC	13%
We have had budget cuts that have affected our ability to provide GAC	4%
Our services have held pretty steady, but we experienced layoffs for budget shortfalls unrelated to GAC, and that affected the whole agency	

Changes to scope of services. As noted above in Table 12, 13% of respondents also indicated that they have had to apply to new funding streams and grants to provide GAC, and 4% have had budget cuts that have affected their ability to provide GAC. We also asked providers about any changes in the scope of services they or their employers were providing in response to recent legislation. Similar percentages of providers said that they increased the types or scope of GAC they provided (12%) or reduced the types or scope of GAC they provided (9%) as a result of recent legislation. In addition, 8% said their job responsibilities had changed, and 23% said they were now working with external organizations to coordinate access to GAC. See Table 13, below.

Table 13. Changes to scope of practice and responsibilities

ITEM	%
We have REDUCED the types or scope of gender-affirming services provided—e.g., only doing hormones, referring to other places for certain types of care	9%
Examples given include reduction in services provided to youth, especially surgery ("Surgeons are no longer doing gender-affirming top surgery on patients under age 18, have to refer out to different institutions or private practice"); no longer doing surgery at all.	
We have INCREASED the types or scope of gender-affirming services provided	12%
Examples given: new programs, dedicated meetings/appointments to meet the needs of out-of-state clients (n = 4); more streamlined process "to prioritize seeing refugee patients traveling to our state to see GAC"; hiring more providers, including those coming from hostile states (n = 2); now providing laser hair removal; created specialty fellowships (e.g., facial reconstruction, urological reconstruction) for surgeons; trained providers in placing/providing hormone implants (e.g., Testopel); training all primary care providers to provide gender-affirming care; ensuring that campus partners have "increased access to binders, packers, trans tape"; organizing groups and retreats for trans patients	
We have worked with grassroots/advocacy organizations to coordinate access to GAC (e.g., to facilitate access to hormone treatments, providers in 'safe states')	23%
My job responsibilities have changed	8%
Examples: more case management for out-of-state cases (n = 2); opened a solo practice for GAC; changed jobs to be in a less hostile state; more time doing legislative advocacy, media relations, and trainings (n = 3); increased caseload due to providers leaving	
The biggest change has been my role in educating my fellow care providers about care bans and restrictive legislation that impact us as providers and our patients.	
We have been doing more to train providers/staff in how to be more LGBTQ+ affirming and have been recognized by our hospital/org as an LGBTQ+-affirming practice	

Changes in approach to care. Many participants reported that their approach to providing care to transgender patients had changed as a result of recent legislation. Over half (57%) said their approach to counseling youth, adults, and families had changed. Most emphasized that greater legal obstructions to care and greater worries about future access to care had created shifts in their approach to care and how they counseled transgender clients. Clients were now more worried about legal access to care in the future. In turn, GAC providers described spending more time discussing risks, protections, and safety, including potential moves out of the state or country and how to protect their personal information. For example, many said they were more likely to be proactive and direct in counseling clients not to look at colleges or jobs in states with restrictive laws. As one focus group participant shared:

> *Once somebody's in high school, I will say ... "What are you thinking about after high school," and this may be with a 9th grader who's going, "I don't know," but I'll be like, "You need to think about this now because this is going to dictate what you're going to do later on and these are the resources." We're always providing families with resources at every stage, "What happens when you graduate from high school?" or "How do you choose a college or an apprenticeship program?" or whatever you're going to do next. It's never too soon to start thinking about that.*

Some emphasized that they spent more time discussing how to obtain documentation, how to be safe in public (e.g., carry pepper spray; carry birth certificates of children in red states), and strategies for maintaining access to GAC (e.g., implants vs. injections):

> *I am more likely now than I would have been several years ago to be quite blunt in my feedback, especially to parents of trans youth, about the risks that they will likely have to navigate depending on geography, political outcomes, and factors such as types of engagement with medical systems, disclosure privilege, etc.*

> *I have added a discussion about laws/politics to all my new hormone consultation visits. I frequently discuss the current state of laws and politics with patients. I encourage everyone 18 and over to vote for candidates that will protect gender-affirming care. Our state doesn't currently restrict access to care for minors, but we do talk about safety when traveling or visiting other states that do have restrictions.*

> *Now a lot more of therapy sessions are focusing on ... supporting folks in obtaining all needed documentation if they are needing to move states/out of the country.*

Providers also described taking more care to acknowledge, validate, and address the harms of anti-transgender rhetoric, as well as to express solidarity with their patients. Many said they no longer provided "blanket assurances" regarding the future (e.g., guaranteeing continued access to care) amid the current political landscape and were more likely to acknowledge uncertainty. One provider said, "I have no idea how insane and harmful things could get if ... our providers/org is prosecuted for providing care for out-of-state patients." Another provider said, "I no longer say we are going to be ok in [state]; I am less certain about what a different administration could do at the federal level." Still, another provider said, "I try to be more thoughtful about the impact on young people and their families, not focusing too much on "it gets better" or "toxic positivity."

GAC providers also spent much more time discussing community support and resources in the service of hope, connection, and resilience. They emphasized mutual aid, community organizations, and developing relationships with others, encouraging their clients to "identify who their allies are" and to "lean on community" as well as encouraging "connection to community and stories of hope, resilience, and resistance." For example:

> *I provide reassurance of strength in numbers, more people are out as trans, lean on your community, provide support network resources.*

> *I focus on helping them find additional resources for support, offer advocacy support and encourage their involvement in advocacy work, promote the building strengthening of ties with others in the trans and larger queer community, provide education, and work with them to build and fortify their sense of self-efficacy and personal value.*

Changes to visibility as a GAC provider. Nearly half (47%) of participants had sought to become more visible as a GAC provider; just 14% had sought to become less visible as a provider over the past few years. Among those who sought to increase their visibility, some explained their reasoning and actions, often emphasizing that they felt compelled to visibly assert their affirming stance (e.g., online) because of their privileged identities:

> *My identities appear to be in alignment with majority identities (White, straight passing). It is important to me to visibly display that I am a provider of gender-affirming care.*

> *I now wear my values more. I appear het[erosexual] because I'm a cis[gender] (ish) woman married to a cis[gender] man, so I put it on my clinic's website that I'm queer and bi, which I would not have done before.*

> *I think it is important to use my privilege to maintain a level of visibility that is at minimum clear to other queer people, especially queer and trans young adults.*

> *I have begun using they/them pronouns in clinic and professionally.*

Among those who sought to reduce their visibility, some further explained this decision and the actions they took to do so. Most of these providers emphasized concerns about the privacy of their families, and most took steps to reduce their online visibility specifically:

> *I'm cautious around my identity as a parent, worried my child may be targeted.*

> *I have paid for my online information to be removed/limited for the safety of myself, my partner, and my family.*

> *I only list my professional address [online] and my spouse does not follow my professional pages, and I don't identify anyone in my family on any social media pages.*

For some, visibility was complex. They sought to reduce their vulnerability in the personal realm while continuing to be visible professionally. One provider explained, "I am protecting my home and personal privacy while giving more talks and writing more publications." Another provider shared, "I am less visible as a trans person in my home community due to the safety of my family. I am still visible as a trans provider of affirming care." Yet another provider shared:

While I have worked to make myself more visible as a provider of gender-affirming care due to the need, I have also found myself focusing on becoming less visible in my personal life (e.g., out in the community) to reduce the risk of harassment and/or violence from others. The latter causes profound shame and distress, as I am proud to be trans and do not feel it is something I should feel any need to hide or otherwise obscure.

A focus group participant shared:

I need to be judicious about where I'm putting myself out there and what groups I'm going to because I've got a family, and I don't need people burning the rainbow flags on my lawn. And that's been expressed by a lot of [similar providers], especially [those with] little kids. They're like, "Yeah, I just need to pull back on what I'm doing," So, a lot of people are still doing the work, but they're pulling back on their visibility, pulling back on how much they talk about how much advocacy they do because they just don't want to get caught up and they don't want their families to get caught up and punished for what they're doing.

Another focus group participant spoke to the complexity of visibility and safety and making different choices at home and work related to visible signifiers of queer and transgender inclusion:

There are times when I feel safe, and I also need to be aware of my privilege. There are times that I feel very unsafe, and then I feel guilty about the privilege that I have. But sitting in my porch [with] my neighbor right next door wearing I heart Trump in big, huge, bold letters, that doesn't feel safe for me. And I'm the only home that's Democratic, and I'm the only queer person in the entire cul-de-sac, let alone probably most of my neighborhood. So I don't have flags out front. I don't have "All are welcome here" out front. I do in my office. Two weeks ago, we put cameras all around the exterior of our home. That's not something I ever thought that I would have to do in my community. And ... at [my office now], there's no security. I could jump through that window, and I know how to get out if I needed to get out, and I also know that I have many parents of my clients who are wildly frustrated with me, and so in those ways, I also don't feel safe.

Table 14. Changes to visibility as a GAC provider

ITEM	%
I have sought to become more visible as a GAC provider	47%
I have sought to become less visible as a GAC provider	14%

When [our hospital was attacked online], immediately all sorts of information came down from our website as people were being doxxed, and this went on for several months. There was truly no security in the building in which we were housed, so they had to do an extraordinary amount of security measures with the elevators and checking people in downstairs. They had screens and plexiglass up. It was really stressful for staff, but particularly for our non-clinical staff—our front desk staff ... They had to do incredible engineering to make this a safer place. (focus group participant)

Actions taken by providers personally. We also asked respondents about actions they had taken in their personal lives in response to the changes in the legislative environment for GAC.

Participants reported taking various actions to help them personally deal with the rise in recent legislation over the past few years. Close to or more than half of participants were seeking support from family and friends (59%), setting boundaries between work and home (51%), exercising/ meditating (48%), and engaging in advocacy work (51%).

Many also reported taking actions to protect their safety. Over one-third (39%) were trying to decrease their personal visibility online, and 30% removed private information about themselves or their family on the internet. Yet only 20% were considering leaving their job. See Table 15.

Figure 11. Proactive and protective actions to manage well-being

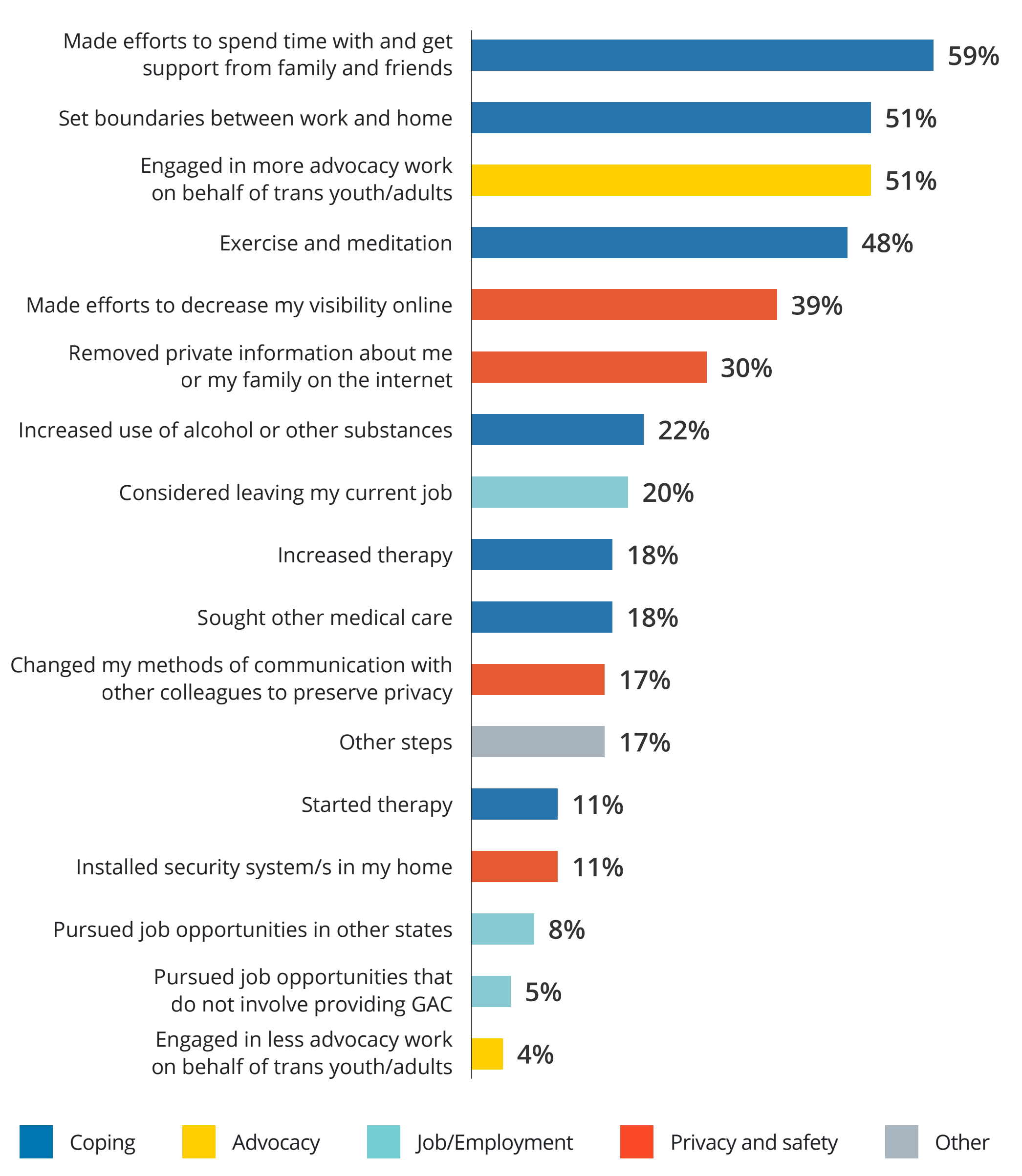


Table 15. Proactive and protective actions to manage well-being

ITEM	%
COPING	
Made efforts to spend time with and get support from family and friends	59%
Set boundaries between work and home (e.g., not checking email at home, taking weekends and evenings off)	51%
I try to maintain a healthy work/life balance.	
I'm definitely more protective of my time off. And I've had to set boundaries with certain people who are friends and advocates where I'm just like, "The sky is falling yesterday, the sky is falling tomorrow. Tonight, I need to take a break. So trust me, I'm not the only one doing this work, you're not the only one doing this work, we should stop acting like we're the only ones doing this work. (focus group participant)	
Exercise and meditation	48%
I've taken general steps to improve my health and well-being, such as diet and exercise.	
Started therapy	11%
Increased therapy (e.g., in time, number, or type)	18%
Sought other medical care	18%
Increased use of alcohol or other substances	22%
Initially increased use of alcohol, have majorly cut back since then, and focused on self-care to be able to do this work sustainably.	
ADVOCACY	
Engaged in more advocacy work on behalf of trans youth/adults	51%
At my age and after so many years on the front lines and behind the scenes, working for health equity, access to care, and social justice advocacy for LGBTQI folx, I refuse to stand down in fear or be silent.	
I do a lot of advocating on behalf of my clients. The schools around me are not safe. [So, I go to the school committee meetings]. (focus group participant)	
Engaged in less advocacy work on behalf of trans youth/adults	4%
JOB/EMPLOYMENT	
Considered leaving my current job	20%
Pursued job opportunities in other states	8%
Pursued job opportunities that do not involve providing gender-affirming care	5%
PRIVACY AND SAFETY	
Removed (or hired services to remove) private information about me or my family on the Internet	30%
Made efforts to decrease my visibility online (e.g., only use first name on social media; get off social media)	39%
Changed information and descriptions of my services on online professional and advertising websites (not removed) so there is less overt naming of the gender work	
Changed my methods of communication with other colleagues (e.g., private messaging service, use of non-employer email address) to preserve privacy	17%
Installed security system/s in my home	11%
OTHER STEPS	
Other steps to improve my health/well-being, protect myself/my family, or shift my professional role/focus	17%

ITEM	%
Meet with attorneys	
Engage with financial and legal advisors to learn how to reduce personal risk in the event of legal action	
Reduce work hours	
I am underemployed as part of the struggle to achieve a personally healthy life and mitigate effects of systemic oppression, specifically anti-trans, anti-human shifts in U.S. politics. I would gladly continue providing specifically trans- and queer-affirming care if I could feel safe living in the community and could control the number of hours worked	
Reduced my hours from 40 to 30	
Insurance changes	
I have begun to shift my practice away from taking insurance for services, in an effort to ensure that I can continue to provide care without restriction in case legislation in my state changes	
Other	
Started new psychiatric medications; seeking connections with other therapists in my state that provide GAC; moved to Northeast.	

Providers who are at increased risk of threat due to the care they provided or particularly vulnerable because of their own identity were more likely to take protective action. Providers who served youth were more likely than those who served adults only to take steps to remove their personal information online (34% versus 12%), X^2 (1, 133) = 4.73, p = .021. They were also more likely to install security systems than those who served adults only (14% versus 0%), X^2 (1, 133) = 3.91, p = .036). We also found that transgender respondents were somewhat more likely than cisgender respondents to take steps to remove their personal information online (38% versus 24%), X^2 (1, 133) = 3.02, p = .061.

THINKING ABOUT THE FUTURE

Continued provision of GAC. Participants shared concerns related to the future provision of GAC amid the rise in legislation limiting access to care.

Some voiced worries about further restrictions on care and the impact on their clinics and jobs. Many of these concerns were related to funding and other resources. Providers recognized that state or federal funding restrictions could hamper their ability to provide competent care, particularly for youth. A few worried that if their employer faced severe funding problems or legal challenges, their GAC services would shut down, effectively eliminating their jobs. Resource challenges, more generally, were also cited as a threat to the future of GAC. Others worried that if the federal government adopted laws and policies restricting access to care and targeting providers, their positions would "disappear." Others worried that their state, community, or clinic would be unable to manage a continued influx of out-of-state patients and about their own personal capacity to continue to provide care amid such high demand and related stress ("I worry about how my emotional capacity to do this care is going to tank and potentially burning out"). Some, too, voiced worries about an escalation of mental health challenges and increased suicidality among transgender people as a result of further restrictions on and denial of GAC.

Some providers noted that they were considering changes in their professional life or practice because of concerns about their future capacity to provide GAC, including evaluating and taking on other potential sources of income. And some participants spoke about ways in which their status as transgender providers created additional concerns for them related to job security. Specifically, they wondered about whether they would be subjected to additional or particular scrutiny or hostility because of their status as a transgender person providing GAC. See Table 16.

Table 16. Worries about the future of gender-affirming care

THEME	SAMPLE QUOTES
Restrictions on state/ federal funding for care (e.g., executive orders discontinuing federal funding for GAC)	*Many of our payments come from Medicare, and our clinic struggles financially as is. [My] concern is that we would close or be unable to continue to offer [GAC] if this occurs.*
	Will our clinic lose funding? Will our patients lose access to health insurance overall?
	I work for a health care system that serves a lot of underserved in our community. We have a larger number of Medicaid patients. Financially, we are struggling. I'm not sure that the whole organization will do much to fight back if federal funding is pulled. I have been continuing as usual until we hear otherwise.
	I think that if the hospital was threatened with lawsuits or other significant potential for financial loss, I suspect they would cut, limit, or discontinue the gender program.
Lack of resources/general funding challenges	*[State] has theoretical legal protections for access to care, and most major medical systems except a Christian one offer gender-affirming care. However, resources are insufficient, everyone is underinsured, and a majority of those who need it continue to struggle to access care often for financial reasons.*
	Funding is hard to come by for any clinic … we lack resources.
	The anti-trans sentiment has led to] reduced donations and funding for trans programs and organizations.
Inability to manage continued influx of out-of-state patients	*Will we get more patients traveling to us from out of state? We can hardly keep up with demand now.*
	I worry that our community will not be able to support the influx of people needing gender-affirming care as they flee from states that are less trans-friendly. I care for myself as a professional by not overextending or pushing my professional boundaries or limits to work.
	There is strain due to demand with lack of providers (i.e., more clients/patients than available doctors/other professionals).
Escalation of client mental health challenges due to inability to access care	*I have SO MANY concerns that I don't know where to begin. I think the best summary is that I'm afraid people who need life-affirming care won't be able to get it, and they will be more miserable for longer, be at risk of getting grey market care, or we will lose them to suicide and violence. I don't know how this will affect the way I provide care. I will have to make decisions as the hits come.*
	I am afraid that folks will lose access to life-saving care, and suicides will increase.

THEME	SAMPLE QUOTES
Adjustments to professional life in anticipation of potential threats to the future of GAC	*Because a big part of my practice is helping people connect to gender-affirming care, I don't know what to expect, but I'm making some adjustments to my sources of income.*
	If I am banned from providing gender-affirming care, I'll still do it but under the mask of "regular" mental health care. What type of mental health care I do with my clients is confidential.

Job security. Related to the future of GAC, participants were asked about their sense of job security. Fourteen percent of respondents were very (6%) or somewhat (8%) worried about job security, and 15% were unsure. Yet, most participants were not at all (44%) or not very (29%) worried about job security.

Providers who saw adults only were somewhat less likely to be worried about their jobs: 88% of those who saw adults only were not at all or not very worried, versus 71% of those who saw youth, X^2 (1, 133) = 2.70, p = .078. Likewise, cisgender providers were somewhat less likely to be worried about their jobs than transgender providers: 78% of cisgender providers were not worried, compared to 67% of transgender providers, X^2 (1, 133) = 2.21, p = .099.

Advice to future health professions students. Asked what they would tell a student thinking of entering the field of GAC, participants offered a range of sentiments. Most emphasized the rewards of providing such care, although some also emphasized the challenges alongside such rewards. Some offered specific advice related to getting support and setting boundaries. The themes are summarized in Table 17.

Table 17. Advice to future health professions students

THEME	QUOTES
This is an incredibly rewarding and meaningful profession	*I find it to be the most rewarding part of my day. Watching people become who they are and watching them become their whole selves.*
	I would tell a student that providing gender-affirming care is incredibly rewarding, meaningful, and provides a service that is essential for gender-diverse patients. The happy moments when someone finally feels affirmed, when someone starts to have gender euphoria on gender-affirming hormone treatment, the relief and improvement of dysphoria after gender-affirming surgeries, the relief when pubertal changes are paused, and being able to provide a safe and affirming space to my patients continues to push me forward and encourage me to continue taking care of my patients.
	One of the greatest joys I have is being able to include questions to youth such as "What brings you euphoria" vs. just dysphoria and including joy and celebration, especially given there may be less spaces that are available for this joy.

THEME	QUOTES
It will be challenging **and** rewarding	*It is highly rewarding work with a lot of stress in the current climate*
	It's difficult practicing in a politically hostile climate, and at the same time, the work is rewarding
	This work is equally rewarding and demanding. It will crush you weekly and then you'll feel so accomplished the next day.
	Working as an RN in a gender-affirming program is incredibly rewarding because it is one of the rare parts of medicine where patients mostly feel happy and empowered by receiving medical care, and it's a beautiful experience to witness and support a person's self-actualization. Simultaneously, there is anger, heartbreak, and frustration at both the private insurance system on the whole, which is designed for profit and not for patient needs, and at the specific anti-trans laws that are ramping up across the country, especially targeting young trans people.
Do this work in community with others (for support, to avoid burnout)	*I would tell them that this work is very rewarding and needed, but it can be isolating if you don't have adequate support. I would also tell them that finding colleagues who are supportive of your specialty, and ideally also are gender-affirming care providers, is also super important.*
	Actively seeking community and support is a huge way to stay connected, stay grounded, and avoid burnout
	Be especially mindful of their self-care and diligent in engaging in a healthy self-care routine. I would also highly recommend connecting with other gender affirming care providers, as they can be a valuable source of support professionally and will likely understand some of the challenges you experience. Building community with others who provide gender-affirming care can also help you feel less alone.
	Make sure you have a good social support network, watch your online presence/ security, and reach out to current providers to network and learn.
Be mindful that this work is challenging, and uncertain, especially given the political climate	*I think they would need to think very carefully and weigh potential consequences. Even now if you live in a "safe" state, we know that is subject to change. If a student is fully committed and would like to make this their work, I would not want to discourage them but also be realistic. This work will likely always be politically charged. The patient loads are heavy in terms of the amount of mental and social support needed ... aka, it's not just writing a prescription and see you in a year. Many cases are extremely complicated, and the medical care is constantly evolving. What we did a year ago is not the same thing we are doing now. You have to be open to change and uncertainty.*
	It's harder than you think it will be. Not the medicine--that part is fine. But the increased scrutiny of pediatric gender medicine is so, so hard.
Set boundaries to avoid burnout	*I would encourage them to make sure they keep a focus on boundaries and self-care as they enter the field to avoid burnout.*
Do multiple types of practice (not just GAC) to avoid burnout	*Make sure you have lots of skills, not just gender-affirming care skills; do not pigeonhole yourself.*

Benefits and challenges of being a GAC provider. Participants were asked to reflect on the best and most challenging aspects of being a GAC provider. Participants identified the best aspects as being able to help people become themselves, working with like-minded colleagues, helping and caring for other people, and having autonomy in their work. The hardest aspects included the current sociopolitical and legal climate around GAC, transphobia, challenges presented by the health care system as a whole, administrative burdens, and burnout. See Table 18.

Table 18. Best and most challenging aspects of being a gender-affirming care provider

BEST	HARDEST
Helping people become themselves; supporting clients in their growth:	**The sociopolitical/legislative context, transphobia:**
Seeing people grow and self-actualize.	*Additional burden of sociopolitical landscape and increased scrutiny from society and institution on gender-affirming care.*
Getting to see my patients thrive, feeling like I help people every day.	*Concern that something will happen to our patients, politically or personally. Some of our patients seem very vulnerable, and I worry the world will hurt them.*
I find it very fulfilling and receive great joy from it - I feel it is a great honor to be able to be present and take part in my patients' flourishing and embodiment of gender euphoria.	*Holding space for the ambiguity and pain in recent and current legislative attacks and transphobia.* *Navigating the unknown future of the change in political environment.*
Seeing my patients visibly change into their true selves over the period of about 2 years, and seeing them become so much happier in their bodies.	*Seeing the toll that the current sociopolitical climate has on my patients. Worrying about the ability to provide this care. Responding to parents or other caregivers who have gotten immersed in misinformation and having to argue for the care that is evidence-based.*
The patients. Especially the youth; they really inspire me. They deal with a lot for being so young and to see them grow into themselves is beautiful. So many people have this aha moment of self-actualization, and that makes it all worth it.	*Constant threats and disparaging comments from politicians and media, feeling restricted to live and work in certain states.*
Working with/training colleagues who believe in this work:	**The health care system as a whole:**
Getting to teach ... students about GAC. Getting to work with predominantly queer and trans colleagues in a very safe space.	*20-minute visits, American fee-for-service medicine, and the industrial complex*
Getting to work alongside like-minded providers who are proud to do this work, even if it's challenging.	*Lack of time seeing patients*

BEST	HARDEST
I feel great job satisfaction. I know I am making a difference, and I love interacting with my patients as well as my coworkers. I love that the clinic I work in is staffed with like-minded people, all working towards the same mission. Our values align, and it feels so safe to work here. I don't have to worry about arguing with a coworker who doesn't believe in trans care.	*The for-profit health care marketplace model that prioritizes profits over patient wellness and providers*
	I believe that the American healthcare system is currently collapsing, so navigating a collapsing system as a provider is terrible. The work is endless.
The wonderful team I get to work with day to day, all with shared dedication to trans youth/families.	*Our profit-driven capitalist healthcare system that is steeped in racism and patriarchy and unaffordable for the vast majority of people*
Helping members of my community:	**Administrative burden:**
Directly caring for my community, providing care that is difficult to find, seeing my clients succeed.	*Administrative tasks including things like prior authorizations and insurance issues*
Getting to work so intimately with my community.	*Having to sit on a computer all day long, the hours, all the insurance BS.*
I love that my job allows me to focus on my community, and working mostly with young adults is an honor to watch folks get to know themselves and grow.	*Hours spent going in circles with insurance companies.*
	Paperwork
	Training, hours, electronic health records
Working with and alongside my community, supporting resilience and celebrating joy.	*The paperwork! The sheer volume of work is overwhelming. I could give 24 hours a day, and there would always be people/patients/ managers wanting me to give more.*
Financial and professional freedom/autonomy:	**Burnout:**
It allows me relative financial and time freedom and the ability to be in my own supportive community while I work.	*Burnout ... I love the work that I do, but it is exhausting. I have to wear multiple hats in my work, and it is hard to hear the worst parts of people's experiences ... I try to be intentional about my mental and physical health, but it is hard.*
Ability to practice with autonomy	*Emotionally draining, high burnout.*
I get to see clients grow and thrive. Since I started my private practice, I have had more life/work balance and get to have a deeper impact on my long-term clients.	*My clinical work is demanding of my time, mental energy, emotional intelligence, and executive functioning. There are not enough hours in the day to see my clients, document, consult with providers, attend departmental meetings, supervise, conduct research, teach, and then also be a son, brother, uncle, friend, and dog dad.*

CONCLUSION

In recent years, the provision of GAC has become heavily politicized. Although the evidence base continues to support access to care, and both patients and providers report positive outcomes from the care, efforts to curtail access to treatments, particularly for minors, have directly impacted providers. Our sample of providers--located predominantly in states that still permitted access to care at the time of the survey--have experienced increased demand and increased administrative burden, including issues with insurance coverage. Many also report safety concerns, including online harassment as a result of their provision of care, and physical safety threats. Many providers have taken action in response to the change in political climate, such as taking steps to protect their personal safety and changing the way they discuss care with clients.

Notably, providers remained devoted to providing high-quality care to their patients to the best of their ability. Many expressed a desire to increase their ability to help clients access care by increasing their visibility as providers, staffing, or other capacity. While many respondents found the provision of GAC “rewarding and challenging,” most were not inclined to decrease care or services. However, even in protective environments, providers worried about the future of access to GAC.

Understanding the burdens and rewards of providing gender-affirming care is important in a swiftly changing legislative environment. Such providers are under significant stress, even as they seek to provide care to communities that are themselves marginalized—often while inhabiting marginalized identities themselves. Workplaces should develop policies and procedures that place the safety and well-being of their employees—including gender-affirming care providers—at the forefront. Likewise, workplaces and providers should actively advocate for the health and well-being of their clients, regardless of (but mindful of) the politicized nature of their care.

AUTHORS

Abbie E. Goldberg, Ph.D., is an Affiliated Scholar at the Williams Institute and a Professor in the Department of Psychology at Clark University, where she also serves as Director of Women's & Gender Studies.

Elana Redfield, J.D., is the Arnold D. Kassoy Scholar of Law and Federal Policy Director at the Williams Institute.

ACKNOWLEDGMENTS

The authors would like to thank Christy Mallory, Interim Executive Director and Legal Director at the Williams Institute, and Laurel Sprague, Research Director at the Williams Institute, for their review and feedback on this report. The authors would also like to thank Brad Sears, Rand Schrader Distinguished Scholar of Law and Policy at the Williams Institute, for his help with survey design and Nicholas Rodriguez for assistance with survey logistics.

SUGGESTED CITATION

Goldberg, A.E., Redfield, E. (2025). *The Experiences of Gender-Affirming Care Providers*. Los Angeles, CA: The Williams Institute, UCLA School of Law.

ABOUT THE WILLIAMS INSTITUTE

The Williams Institute is dedicated to conducting rigorous, independent research on sexual orientation and gender identity law and public policy. A think tank at UCLA Law, the Williams Institute produces high-quality research with real-world relevance and disseminates it to judges, legislators, policymakers, media, and the public. These studies can be accessed at the Williams Institute website.

FOR MORE INFORMATION

The Williams Institute, UCLA School of Law
(310) 267-4382
williamsinstitute@law.ucla.edu
williamsinstitute.law.ucla.edu

METHODS

DATA COLLECTION

Data collected in fall 2024 (September-December 2024) were drawn from an online survey developed by the first author in collaboration with scholars of public policy, law, and clinical practice with transgender populations. It was constructed using the Qualtrics software application.

Two separate focus groups, each with four GAC providers in states without bans, helped to inform the development of the survey. About half of the focus group participants were mental health providers, and about half were medical providers. Focus groups focused on the experiences of providing GAC in states without bans. More specifically, they discussed changes in the experience of providing GAC over the past few years, experiences of (non)support from employers, workplace climate, attacks from the broader public, well-being, advocacy, and future plans related to their career. They looked at how their identities impacted their response to the politicization of GAC and the provision of care, mental and physical health, and the upcoming presidential election and associated stress. Focus group participants were invited to offer feedback on the survey, which was also informed by the literature, news articles, and media reports, as well as the insights and observations of the research team and associated scholars.

The anonymous survey was pilot-tested for ease of use and functionality by four members of the target population prior to survey launch. Feedback was also sought from scholars and practitioners. The suggestions of both groups led to changes in the survey. The anonymous survey was approved by the Human Subjects Board at Clark University and disseminated widely via professional and personal contacts and listservs, with cautionary advice not to post on public social media out of concerns for data integrity.

PRIVACY AND DATA PROTECTION

The data collected for this report are anonymous. We, the researchers, have no access to information about participants' identities. We did not ask for identifying information (e.g., birth dates), nor did participants report it.

DATA CLEANING AND PREPARATION

A total of 155 surveys were started, and 22 were not included because they were either incomplete (n = 12) or completed by providers in states that had passed legislation (n = 13). Our final sample was 133. Of note is that 88% completed the survey prior to the November 2024 election; 12% completed it after.

DATA ANALYSIS

We used descriptive statistics and qualitative content analysis in this report. We also conducted a limited number of chi-square tests. In presenting quotes, we have edited minor spelling and grammar errors to increase readability. The majority of quotes come from open-ended questions in the survey; however, some quotes come from focus group participants. We have indicated this accordingly.

EXHIBIT B

Journal of Adolescent Health 73 (2023) 672–678

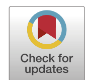
ELSEVIER

JOURNAL OF
ADOLESCENT
HEALTH

www.jahonline.org

Original article

Adolescent Providers' Experiences of Harassment Related to Delivering Gender-Affirming Care



Landon D. Hughes, Ph.D. [a,b,*], Kristi E. Gamarel, Ph.D., Ed.M. [c,d], Arjee J. Restar, Ph.D., M.P.H. [e,f], Gina M. Sequeira, M.D., M.S. [g,h], Nadia Dowshen, M.D., M.S.H.P. [i,j], Katelyn Regan, L.C.S.W. Med [j], and Kacie M. Kidd, M.D. [k]

[a] *Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute, Boston, Massachusetts*
[b] *Department of Epidemiology, Harvard T.H. Chan School of Public Health, Boston, Massachusetts*
[c] *Department of Health Behavior and Health Education, University of Michigan School of Public Health, Ann Arbor, Michigan*
[d] *Population Studies Center, Institute for Social Research, University of Michigan, Ann Arbor, Michigan*
[e] *Department of Epidemiology, University of Washington School of Public Health, Seattle, Washington*
[f] *Department of Behavioral and Social Sciences, Yale School of Public Health, New Haven, Connecticut*
[g] *Department of Pediatrics, University of Washington, Seattle, Washington*
[h] *Craig-Dalsimer Division of Adolescent Medicine, Children's Hospital of Philadelphia, Philadelphia, Pennsylvania*
[i] *Perelman School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania*
[j] *Gender & Sexual Development Program, Children's Hospital of Philadelphia, Philadelphia, Pennsylvania*
[k] *Department of Pediatrics, West Virginia University School of Medicine, Morgantown, West Virginia*

Article history: Received March 24, 2023; Accepted June 26, 2023
Keywords: Transgender; Adolescent; Health personnel; Providers; Laws and statutes; Gender dysphoria; Gender affirmation; Violence and harassment

A B S T R A C T

Purpose: The politicization of adolescent gender-affirming care has occurred alongside targeted harassment (e.g., threats of violence, doxing, bomb threats) of adolescent gender-affirming care providers across the United States. This study sought to explore their experiences of targeted harassment.
Methods: From October to December 2022, mental and physical health gender-affirming care providers from across the United States completed a survey including open-ended questions about the kinds of harassment they experienced (i.e., method and messages of harassment) and its impact on their lives and practices. Thematic analyses were used to analyze their responses.
Results: In total, 117 providers completed the survey and 70% shared that either they, their practice, or their institution had received threats specific to delivering gender-affirming care. The most common experiences were threats via social media or mailed letters. Several received death threats. Providers described how targeted harassment impacted their psychological well-being and required them to reassess clinic safety. Additionally, providers expressed the need for a more accurate representation of gender-affirming care in media and stronger advocacy from institutions and organizations emphasizing the importance of this care.
Discussion: Adolescent gender-affirming care providers are experiencing targeted harassment, significantly affecting their ability to deliver care to transgender and gender-diverse adolescents

IMPLICATIONS AND CONTRIBUTION

Gender-affirming care providers for adolescents have faced harassment through social media, mail, and phone, including deception, protests, and death and bomb threats. These threats' emotional and psychological impact may reduce access to care, underscoring the need to protect providers and ensure access for all transgender and gender-diverse adolescents.

Conflicts of interest: The authors have no conflicts of interest to declare.

* Address correspondence to: Landon D. Hughes Ph.D., Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute, 401 Park Drive, Suite 401 East, Boston, MA 02215.

E-mail address: lhughes@hsph.harvard.edu (L.D. Hughes).

1054-139X/© 2023 Society for Adolescent Health and Medicine. All rights reserved.
https://doi.org/10.1016/j.jadohealth.2023.06.024

and their families. Providers stressed the importance of receiving support from their institutions to ensure their safety. The ongoing sociopolitical climate related to gender-affirming care coupled with targeted harassment of those providing it will further limit access to this care.

© 2023 Society for Adolescent Health and Medicine. All rights reserved.

Gender affirmation refers to the social, psychological, legal, and medical affirmation of one's gender identity and is critical to the health and well-being of transgender and nonbinary adolescents (TNBA) [1]. For some TNBA, gender affirmation includes medical interventions, like puberty-blocking medications [2]. All major medical organizations support gender-affirming care for adolescents (e.g., the American Academy of Pediatrics, the Endocrine Society, the American Psychiatric Association, etc. [3,4]), as it has been shown to improve physical and mental health outcomes for TNBA that last into adulthood [5–12].

Despite evidence for gender-affirming care [5–12], TNBA face significant access barriers. These include a paucity of adolescent gender-affirming care providers (AGAPs), stigma, and a lack of affirming environments [13–15]. Furthermore, the politicization of gender-affirming care has coincided with new barriers to care, such as criminalizing the provision of gender-affirming care [16,17] and launching congressional inquiries and child welfare investigations [18]. In this climate, AGAPs face harassment and threats of violence [19–21], which can compound the challenges of providing healthcare to TNBA. For example, Hughes et al. (2021) found that in this climate, AGAPs reported fearing for their safety because they had received hate mail or had protestors show up at their clinics. Additionally, news outlets have reported direct threats to AGAPs, such as bomb [20] and death threats [19]. Despite these challenges, AGAPs are navigating threats of violence to ensure patients receive the care they need [22].

While prior research [21] and news reports [19,20,22] have identified threats, this study aimed to extend the literature by exploring AGAPs' experiences of targeted harassment, such as threats of violence, doxing, and bomb threats, and how they and their clinics have navigated and mitigated them. Other types of providers, such as abortion providers, have dealt with threats of violence while practicing (e.g., clinic protests, bomb threats, and physical threats of violence)[23]—we expected to find similar themes among AGAPs. Developing policies and interventions that support patients' and providers' safety and well-being requires first documenting AGAPs' experiences with threats of violence and harassment.

Methods

Data and sample

From October to December 2022, we surveyed AGAPs who offer gender-affirming healthcare to TNBA in the United States about their experiences of threats. We conveniently sampled AGAPs using professional listservs and contacting providers who had previously participated in similar studies [21]. We also used a snowball sampling approach in which participants were asked to share the survey link with their networks. Eligibility criteria included currently working as a physician, nurse practitioner (NP), physician's assistant, social worker, or mental health or behavioral health provider, and providing gender-affirming care (e.g., prescribing puberty blockers or offering mental health support) to TNBA under the age of 18. The survey was only available in English via Qualtrics. Consent was collected electronically.

There were ten open-ended questions and 30 multiple-choice questions related to harassment and demographic information. Participants were asked if they had personally experienced harassment as AGAP. Those who answered "yes" were asked open-ended questions about the impact of this harassment on their personal lives and practices. These participants were given a dropdown menu to select the modes of harassment they had experienced (see Table 1 for available options). Harassment types were chosen by reviewing news reports and prior literature [17,20–23]. All participants were asked open-ended questions about what they felt their practice or institution should do in response to harassment and what organizations could do to support AGAPs. A team of researchers and healthcare professionals with experience in adolescent transgender health created the survey. It was beta-tested by three healthcare providers with clinical expertise; changes from beta testing were aimed at tailoring the questions to be more inclusive of behavioral health providers. Participants did not receive compensation. The study was deemed exempt from further review by the University of Michigan Institutional Review Board (HUM00196292).

Analyses

Three team members (L.D.H., K.E.G., and K.M.K.) conducted an inductive thematic analysis of open-ended responses [24]. Themes were identified and refined through reiterative discussions, and the first author indexed and organized data. Discrepancies in interpretation were resolved through dialogue with the entire team until a consensus was reached.

Results

Table 2 outlines the demographics of the sample. One hundred forty people responded to the survey, of which 117 were eligible. All those eligible participated in the study, with the majority (65%) being physicians (MDs/DOs), followed by behavioral health providers (BHPs) (30%), and then NPs (5%). Most participants were White (74%) and identified as cisgender women (59%). Most providers were from the West and South. The median response time was nine minutes, with 75% of the sample completing the survey in 5–15 minutes. We had an 89% complete response rate across both open-ended and multiple-choice questions.

Escalating severity of threats

Table 1 describes the types of threats providers experienced. Information on the type of provider (i.e., mental or physical health) and census region is presented with illustrative quotes. Seventy percent reported that they or their clinic had

Table 1
Experiences with harassment and changes to practice

Mode of harassment	Behavioral health provider		Nurse practitioner		Physician (MD/DO)		Total	
	n	%	n	%	n	%	n	%
Social media posts	20	57%	3	50%	29	39%	52	44%
Phone call to your clinic	18	51%	3	50%	24	32%	45	38%
Protestors outside clinic or hospital	9	26%	0	0%	16	21%	25	21%
Emails	11	31%	2	33%	13	17%	26	22%
Letters or other mail to your work address	7	20%	1	17%	11	15%	19	16%
Bomb threat	3	9%	0	0%	2	3%	5	4%
Other	4	11%	3	50%	6	8%	13	11%
False reports to medical boards or other regulatory bodies	2	6%	1	17%	3	4%	6	5%
Phone call to your personal phone	1	3%	0	0%	1	1%	2	2%
Respondents experiences with threats								
Aware: aware of this targeted harassment to providers of gender-affirming care.	35	100%	5	83%	75	100%	115	98%
Personally experienced: personally experienced targeted harassment due to being an adolescent gender-affirming care provider.	15	43%	2	33%	33	44%	50	43%
Clinic experienced: respondents whose clinic or health system experienced targeted harassment due to providing adolescent gender-affirming care.	24	69%	4	67%	44	59%	72	62%
Clinic or personally experienced: respondents who personally experienced targeted harassment or their clinic or health system experienced targeted harassment.	25	71%	4	67%	53	71%	82	70%
Adapted to threats: reported limiting or changing the care you provide due to the experience or threat of targeted harassment.	6	17%	0	0%	16	21%	22	19%
Were the limits or changes you have made due to personal choice or practice/institutional decisions?*								
Personal choice	2	33%	0	n/a	8	50%	10	9%
Institutional decision	3	50%	0	n/a	8	50%	11	9%
Both a personal choice and institutional decision	1	17%	0	n/a	0	0%	1	1%

* note the n used to calculate these percentages were among those who reported limiting or changing the care they provided due to the experience or threat of targeted harassment.

experienced threats due to providing gender-affirming care. The most common threats experienced by participants were social media posts (44%), followed by phone calls to their clinic (38%). In addition, almost one-quarter reported receiving threatening emails, while 21% had had protestors show up at their clinic. For example, one Behavioral Health Provider from the South said, "[We've received] hundreds of harassing or threatening emails and calls to the clinic saying I should be '86d' [killed] and people saying they were going to videotape patients and providers coming in and out of the clinic." Another Behavioral Health Provider from the West said: "[We've experienced] phone calls and voicemails telling the clinic that we are killing children [along with] protesters outside the clinic and billboards placed close to the clinic."

The qualitative analyses showed that the harassment often contained religious language or misinformation about gender-affirming care. For example, one physician from the Midwest said: "A conservative political candidate tweeted a video of me giving a talk about gender-affirming care and stated me and my health system are experimenting on children. We also received a piece of mail at [the] clinic saying we were disobeying the lord and will be going to hell."

Several providers noted an escalation of the types of threats they received, often starting with online harassment and progressing into more severe and direct threats. For example, one provider stated:

> "Our program started with early social media harassment, then progressed to individualized phone calls…and later bomb threats to [our] children's hospital that we cannot confirm was directed at our program but aligned with the timing of other hospitals that experienced similar harassment." (Physician, West)

Five participants reported experiencing bomb threats and five experienced death threats that often came from online sources.

Impact of threats

Providers noted several ways threats of violence had affected them. Table 3 outlines exemplary quotes by themes related to the impact of threats.

Theme 1: physical safety and security measures. Providers took actions to ensure the physical safety of themselves and their patients in response to these threats. For example, providers discussed limiting their public internet profiles and installing security systems at their homes and clinics, including panic buttons. Furthermore, providers described how they contacted police of threats they received, created active shooter plans, and screened mail for hazardous material in response to threats. One provider mentioned driving different ways to work to ensure they were not being followed.

Theme 2: emotional/psychological safety. Providers stated that threats of violence taxed them mentally and emotionally. Many described themselves as "constantly on edge," waiting for something violent to happen to them or their patients. For example, one provider said:

> "It's caused me to fear for my safety, feel stress, and consider leaving my job. It has disrupted my sleep, caused panic

Table 2
Participant demographics (n = 117)

	M (SD)	
Age	41.40	(8.02)
	n	(%)
Gender identity*		
Cisgender women	69	59%
Cisgender men	17	15%
Nonbinary or genderqueer	10	9%
Trans men	5	4%
Trans women	2	2%
Other	2	2%
Race/Ethnicity*		
Non-Hispanic White	86	73%
Hispanic or Latinx	6	5%
Non-Hispanic Asian	4	3%
Non-Hispanic Black	4	3%
Biracial or other	3	3%
Current occupation		
Physician (MD/DO)	76	65%
Behavioral Health Providers	35	30%
Nurse practitioners	6	5%
Census region where providers practice†		
West	32	27%
South	28	24%
Northeast	23	20%
Midwest	17	15%
Gender-affirming care provided†		
Letter writing to support medical care	86	74%
Surgery referrals	82	70%
Prescribed hormones	72	62%
Prescribed menstrual suppressants	72	62%
Prescribed antiandrogens	71	61%
Prescribed puberty blockers	64	55%
Mental healthcare	48	41%

* Note all responses were optional, therefore some categories do not total to 100%.
† Greater than total n as participants are able to choose more than one option.

attacks, and made me lose my appetite. I've been late to work because I've feared entering the building in case someone was to target my work." (Behavioral Health Provider, East)

Providers often described that these threats affected their families. For example, one provider wrote:

"[Handling threats] is exhausting. I worry about how it impacts my partner and family because they are worried sick about me. I feel increased symptoms of burnout. It leads to feelings of sadness, despair, anger, etc." (Behavioral Health Provider, East)

Several providers accessed mental health services because of increasing threats and found therapists and counselors valuable in managing threats' psychological effects.

Theme 3: reconsidering practice. A few healthcare providers wrote that threats have made them reconsider providing gender-affirming care, while several noted that their colleagues had already stopped providing this care due to fear of legal action or threats. However, none of the participants reported that they had stopped providing care unless their employer had forced them to do so. Some reported feeling uncertain about providing a course of treatment that may not be sustainable due to the evolving legal landscape, for instance, starting puberty blockers that they may not be able to continue prescribing. Some providers explained how increased stress has led to burnout, making them consider leaving the profession altogether. For example, many mentioned the compounding effects of the COVID-19 pandemic and the politicization of gender-affirming care on providers. One wrote:

"Between COVID, the current harassing atmosphere of doing gender affirmative care, and personal reasons, we have experienced a mass exodus of providers doing gender affirmative care, especially behavioral health providers… Initially, it was felt things would get better after COVID, but at this point, it has been multiple years of this intensity at work which is not sustainable." (Physician, East)

Others reported feeling nervous about making evidence-based clinical decisions that may become political fodder or put themselves or their patients at risk. Several providers noted that they thoroughly screen patients and their families before accepting them as patients for fear that those contacting them may not be seeking care. For example, some providers reported they feared that individuals opposed to gender-affirming care would deceive them by posing as a parent to record providers to misconstrue their words for political purposes. For instance, a provider wrote, "I worry about 'secret shopper' patients who are only going to twist our discussions and interactions for incendiary aims, while I am just trying to provide what I think of as potentially lifesaving medical care." (Physician, prefer not to respond) This created feelings of needing to be wary of new patients.

While many providers described how threats have made them reconsider practicing, others stated that threats only solidified their resolve to provide care:

"This harassment has increased my passion for the work I do. It has highlighted the need for providers to offer gender-affirming care and has reinforced my decision to pursue this career path." (Behavioral Health Provider, West)

Theme 4: increased workload. Providers also noted that threats had increased their workload. Some participants said that threats had shut down some clinics, increasing the number of patients traveling to open clinics. Furthermore, they noted that new legal and safety concerns had complicated their workflow. For example, one participant said:

"Our pediatric care has been placed under a microscope which has caused undue stress and extra labor for our clinical team at a time where demand for gender-affirming care among youth has also increased." (Behavioral Health Provider, West)

The increasing demand for care and the need to implement safety measures had put additional strain on already stretched resources. Several participants described bomb threats as causing significant disruptions to their work. Another provider wrote, "Talk about security and safety has taken up so much space and capacity that I would love to be spending on patient care." (Behavioral Health Provider, West), while others noted that they had to personally track online threats against them as their employers are unable or unwilling to do so, "I have had to find my own death threats." (Behavioral Health Provider, East) Many providers described focusing on security as distracting from clinical work.

Theme 5: limits on access to care. Providers wrote that threats resulted in limited access to care because some clinics stopped advertising their services or paused accepting new patients.

Table 3
Impact of threats, exemplary quotes by theme

Theme and exemplary quotes
Theme 1. Physical safety and security measures
"I am concerned about my safety and it is upsetting that I have to dim my light and my ability to advocate for my patients because it may affect the safety of me, my colleagues, and my family." -Physician, South
"I worry about someone coming to our clinic with a firearm or approaching me in the parking garage. I no longer feel physically safe in the environment where I see patients and provide care. It has impacted my burnout as a mental health care clinician and decreased my ability to have boundaries and not take work stress home with me." -Behavioral Health Provider, West
Theme 2. Emotional/Psychological safety
"[I've experienced] increased anxiety, at times feelings of burn out/low motivation towards work/depression. It can make me irritable in personal relationships. I have since started in psychiatric care and therapy since I have been receiving such harassment." -Physician, East
"It is exhausting. I worry about how it impacts my partner and family because they are worried sick about me. I feel increased symptoms of burnout. It leads to feelings of sadness, despair, anger, etc." -Behavioral Health Provider, East
Theme 3. Reconsidering practice
"I know that some colleagues are also second guessing their policies not based on clinical care and patient experience, but with an eye to reducing scrutiny/criticism." -Behavioral Health Provider, West
Theme 4. Increased workload
"The threats have caused me to be busier and to provide additional services when I'm already at capacity." -Behavioral Health Provider, West
"The threats have consumed much of the time of our senior leadership rather than using their expertise to help the clinic in other ways." -Physician, East
Theme 5. Limits on access to care
"I've been sending new patient request emails to our security team for review which delays care for legitimate people seeking care." -Behavioral Health Provider, West
"[Threats have] reduced some providers' willingness to provide care meaning I am the only one willing to provide care in our area." -Physician, South

Additionally, providers described that some clinics in conservative areas had been shut down due to threats of violence. Moreover, many observed that threats have caused parents to be more afraid to access care. One said:

> "The clinic has to minimize itself and completely changed its name/visibility, and for a while we couldn't take new patients. We started again because one of our attendings fought the hospital, but we can't make it known publicly. It has also hurt trans kids who are under the impression the clinic is still closed and suffer mentally as they are under the impression that there is no one out there to give them care anymore." (Physician, South)

These factors resulted in longer wait times for adolescents seeking care, potentially causing harm to their mental health.

Recommendations for change

Participants described four ways advocates and organizations could protect providers and their patients.

First, providers felt large institutions, such as hospitals and professional organizations, should show more public-facing support for adolescent gender-affirming care. Additionally, they felt these groups should educate policymakers and advocate for protective policies, set up peer educational programs to combat misinformation, and directly support providers with safety training and continuing education credits. One said:

> "I feel the American Academy of Pediatrics has taken this on as a priority and I am aware that they are developing tools and resources to help with provider wellbeing as well as safety that make me very optimistic. My local hospital is struggling around security measures and safety best practices so I think such resources and guidance will go a long way." (Physician, East)

In addition to the American Academy of Pediatrics, providers mentioned the World Professional Organization for Transgender Health, the Society for Adolescent Health and Medicine, and the National Association for Social Workers as influential organizations that should advocate for TNBA and providers.

Second, providers emphasized the visibility and representation of TNBA in the media and mainstream society to promote acceptance and understanding. Providers viewed threats as originating from a lack of knowledge about their work, misinformation, and misunderstanding of the importance of gender-affirming care. For example, one provider wrote:

> "Sometimes parents are repeating misinformation as fact and providers have to find ways to hear the concerns, and calmly direct families to correct information even when the parents approach is offensive or hostile." (Behavioral Health Provider, West)

Providers discussed the need for more training on safely engaging with hostile family members who may believe misinformation about gender-affirming care.

Third, providers felt that patients would suffer most from these threats and that organizations should directly support TNBA and their families in accessing care, including paying for medical and travel costs and providing security when accessing facilities. Providers highlighted involving a patient's family and community in care, as it is critical to building a supportive network for patients.

Finally, providers emphasized the importance of research on the needs and experiences of TNBA when accessing care, including more evidence-based approaches to care. This included studying the long-term use of gender-affirming medications and the barriers patients face when accessing care. One participant described the role of research in helping the public to understand the importance of gender-affirming care, "I would also like to see more funding and support for research efforts around gender-affirming care for a stronger literature base to combat the misinformation." (Behavioral Health Provider, West)

Discussion

Given the increasing number of threats faced by AGAPs [19,20,25,26], we sought to understand the threats AGAPs are experiencing, how AGAPs are adapting to these threats, and what steps they believe should be taken to maintain access to gender-affirming care. Understanding the experiences of AGAPs navigating threats is critical to solutions centered on their needs and supporting patients' access to gender-affirming care [2]. The major themes we identified in the data were an escalation of the severity of threats of violence against providers of gender-affirming care, the impact of these threats on providers and their patients, and recommendations for change.

This study expanded prior work documenting that AGAPs experienced threats of violence [21] to identify the types of threats and their effects on providers. Findings highlighted numerous threats to providers' emotional and physical safety. Personal harassment included death threats, bomb threats, and threats to their patients, which have been described in recent news reports [19,20,22]. However, our findings extend prior work to demonstrate the impact of these threats on AGAPs, which included the need for increased personal and clinic security measures, the psychological toll and their impact on the provision of care and an increased workload.

In the past year, hundreds of anti-trans bills have been introduced by state and federal legislators [27]. Overall, providers wrote that the changing sociopolitical climate and experiencing threats had led some of their colleagues to stop providing gender-affirming care to TNBA. Providers discussed fearing that individuals would show up not looking for care but for political reasons—to record them and misconstrue their words for political purposes. These fears appear justified as news reports have confirmed that a far-right activist group has had associates pretending to be parents seeking medical care for their children and secretly recording providers [28].

Further limitations on access to gender-affirming care for adolescents, such as providers pausing accepting new patients, closing clinics, or making it more difficult to find their services, will likely exacerbate difficulties in finding providers with expertise in supporting TNBA [14,15,29]. This has the potential to exacerbate existing racial and socioeconomic inequities in access to care, leading to poor outcomes for TNBA, for whom access to care has become even more difficult [30].

These results demonstrate the importance of a multifaceted approach to supporting TNBA, including public advocacy and health system-level support for AGAPs and their patients. First, hospitals and other institutions must evaluate their level of preparedness to respond to threats and boost security measures, particularly those identified by providers themselves (e.g., installing panic buttons in clinics, screening mail for hazardous material, etc.) to safeguard providers and patients. Second, the leadership of hospitals and other institutions must do their due diligence of holding gender-affirming care as part of the medical community's and patient's interest, and visibly denounce transphobia, especially in states where anti-trans bills have been introduced in legislative chambers. This could include being active members of state medical advisory boards and partaking in policy comments and testimonies. Third, given the increased workload of providers, it is imperative for healthcare systems to institutionalize practices and policies that encourage train, incentivize, and mobilize more physicians and medical staff—namely physicians, NPs, physician's assistants, social workers, or mental health or behavioral health providers—to be competent in gender-affirming medical care. Lastly, as threats have shut down clinics in conservative areas and providers begin to refer and move patients from one clinic to another safer clinic, health insurers need to remain flexible with their policies, including telehealth coverage, to accommodate this shift.

Future research should consider how to support providers and TNBA navigating structural stigma when accessing care by working directly with TNBA and their families. Results could be used to create programs that buffer the effects of laws banning care for TNBA and create a system of providers knowledgeable in gender-affirming care for adolescents. Examples of possible intervention include medical-legal partnerships that have developed in other settings that aid providers and families navigating legal precarity when accessing care [31].

Limitations

This study has several limitations. We relied on a limited sample of AGAPs recruited through email listservs and referrals. The sample comprises mostly non-Hispanic White cisgender women and cannot be generalized to all AGAPs. Future research must include the perspectives of providers from other racial and ethnic groups and trans and other gender-diverse providers. Additionally, respondents were only from the United States and were not representative of those in other countries.

Furthermore, some providers may have wanted to participate in this study but chose not to due to the sensitive nature of the survey; therefore, our sample included only those who felt comfortable completing the survey. With these limitations in mind, this work builds on that of Hughes et al. (2021) to capture the perspectives of AGAPs regarding the threats they face in the current sociopolitical environment. Results from this sample across the United States showed that the dangers AGAPs face have negatively impacted their clinical work and mental well-being and will limit access to gender-affirming care for TNBA.

Conclusions

Increasing threats of violence have significantly impacted provider safety and patient access to care. Our work highlights the importance of protecting providers and ensuring access to care for all TNBA and families seeking gender-affirming treatments. Study findings illustrate the stark reality for AGAPs who risk their physical and mental health to provide evidence-based care for this vulnerable population.

Acknowledgments

The authors would like to thank all of the providers who participated in this study. Listed above is everyone who contributed significantly to the work.

Funding Sources

Dr. Hughes' work was supported by the Graduate Student Research Grant Fund from the Rackham Graduate School at the University of Michigan and the Population Studies Center at the Institute for Social Research (T32AG000221). Dr. Dowshen, Dr. Gamarel, and Dr. Restar were supported in part by the

Adolescent Trials Network for HIV Interventions (UM2MH132134), and the Stoneleigh Foundation also supports Dr. Dowshen's work. Dr. Kidd is supported by the National Institute of General Medical Sciences (U54GM104942). The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

References

[1] Reisner S, Radix A, Deutsch MB. Integrated and gender-affirming transgender clinical care and research. JAIDS J Acquir Immune Defic Syndr 2016; 72:S235–42.
[2] Coleman E, Radix AE, Bouman WP, et al. Standards of care for the health of transgender and gender diverse people, Version 8. Int J Transgend Health 2022;23:S1–259.
[3] Rafferty J, Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence, Section on Lesbian, Gay Bisexual, Transgender Health Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence. Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. Pediatrics 2018; 142:e20182162.
[4] Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-Dysphoric/gender-Incongruent Persons: An endocrine society* clinical practice guideline. J Clin Endocrinol Metab 2017;102:3869–903.
[5] Coleman E, Bockting W, Botzer M, et al. Standards of care for the health of Transsexual, transgender, and gender-Nonconforming people, Version 7. Int J Transgend 2012;13:165–232.
[6] Turban JL, King D, Carswell JM, et al. Pubertal suppression for transgender youth and risk of suicidal ideation. Pediatrics 2020;145:e20191725.
[7] de Vries ALC, Steensma TD, Doreleijers TAH, et al. Puberty suppression in adolescents with gender identity disorder: A Prospective Follow-up study. J Sex Med 2011;8:2276–83.
[8] Costa R, Dunsford M, Skagerberg E, et al. Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. J Sex Med 2015;12:2206–14.
[9] Allen LR, Watson LB, Egan AM, et al. Well-being and suicidality among transgender youth after gender-affirming hormones. Clin Pract Pediatr Psychol 2019;7:302–11.
[10] Salas-Humara C, Sequeira GM, Rossi W, et al. Gender affirming medical care of transgender youth. Curr Probl Pediatr Adolesc Health Care 2019;49:100683.
[11] van der Miesen AIR, Steensma TD, de Vries ALC, et al. Psychological Functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. J Adolesc Health 2020;66:699–704.
[12] de Vries ALC, McGuire JK, Steensma TD, et al. Young Adult psychological outcome after puberty suppression and gender reassignment. Pediatrics 2014;134:696–704.
[13] Gridley SJ, Crouch JM, Evans Y, et al. Youth and caregiver perspectives on barriers to gender-affirming health care for transgender youth. J Adolesc Health 2016;59:254–61.
[14] Pampati S, Andrzejewski J, Steiner RJ, et al. "We deserve care and we deserve competent care": Qualitative perspectives on health care from transgender youth in the Southeast United States. J Pediatr Nurs 2021;56:54–9.
[15] Eisenberg ME, McMorris BJ, Rider GN, et al. "It's kind of hard to go to the doctor's office if you're hated there." A call for gender-affirming care from transgender and gender diverse adolescents in the United States. Health Soc Care Community 2020;28:1082–9.
[16] To create the Arkansas save adolescents from experimentation (Safe) Act. AR: Little Rock; 2021.
[17] Gordon CM. Caught in the middle: The care of transgender youth in Texas. Pediatrics 2022;149:e2022057475.
[18] Perez J. Texas judge halts Abbott's transgender investigation order. Politico. 2022. Available at: https://www.politico.com/news/2022/03/11/texas-judge-abbott-transgender-investigation-order-00016802. Accessed December 22, 2022.
[19] Sands L. Man charged with threatening doctor caring for trans patients, LGBTQ kids. The Washington Post. 2022. Available at: https://www.washingtonpost.com/nation/2022/12/04/lgbtq-children-boston-doctor-threats/. Accessed December 22, 2022.
[20] Moghe S. Woman faces federal charge for calling in a false bomb threat to a Boston hospital providing gender-affirming care. CNN. 2022. Available at: https://www.cnn.com/2022/09/15/us/boston-hospital-bomb-threat-gender-affirming-care/index.html. Accessed December 22, 2022.
[21] Hughes L, Kidd KM, Gamarel KE, et al. "These laws will be devastating": provider perspectives on legislation banning gender-affirming care for transgender adolescents. J Adolesc Health 2021;69:976–82.
[22] Southwick R. Threats and harassment: 24 hospitals targeted for providing gender-affirming care. Chief healthcare executive. 2022. Available at: https://www.chiefhealthcareexecutive.com/view/two-dozen-hospitals-targeted-for-providing-gender-affirming-care-report. Accessed December 22, 2022.
[23] McLeod C, Pivarnik K, Flink-Bochacki R. Individual abortion providers' experiences with targeted harassment in the United States. Contraception 2022;107:42–7.
[24] Thomas DR. A general inductive approach for analyzing qualitative evaluation data. Am J Eval 2006;27:237–46.
[25] Gluck F, Friedman A, Shoup C. GOP legislative leaders say they'll introduce ban to end gender-affirming care for minors in Tennessee. Tennessean. 2022. Available at: https://www.tennessean.com/story/news/2022/10/21/nashville-protest-rally-gender-affirming-care-minors-tennessee-capitol/69579695007/. Accessed December 22, 2022.
[26] Rummler O. Political pressure led to shutdown of Texas' largest gender-affirming care program. The Texas Tribune. 2022. Available at: https://www.texastribune.org/2022/03/11/texas-genecis-closure-transgender/. Accessed December 22, 2022.
[27] Trans legislation tracker. Available at: https://translegislation.com/.
[28] Klibanoff E, Nguyen A. Austin doctors who treated trans kids leaving Dell Children's clinic after AG Paxton announces investigation. The Texas Tribune. 2023. Available at: https://www.texastribune.org/2023/05/13/austin-dell-childrens-gender-affirming/. Accessed June 20, 2023.
[29] Kidd KM, Sequeira GM, Paglisotti T, et al. "This could mean death for My child": Parent perspectives on laws banning gender-affirming care for transgender adolescents. J Adolesc Health 2020;68:1082–8.
[30] Goldenberg T, Jadwin-Cakmak L, Popoff E, et al. Stigma, gender affirmation, and primary healthcare use among black transgender youth. J Adolesc Health 2019;65:483–90.
[31] Gamarel KE, Jadwin-Cakmak L, King WM, et al. Improving access to legal gender affirmation for transgender women involved in the criminal–legal system. J Correct Health Care 2023;29:12–5.

EXHIBIT C

October 3, 2022

The Honorable Merrick Garland
Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue, N.W.
Washington, DC 20530

Dear Attorney General Garland,

On behalf of the American Academy of Pediatrics, the American Medical Association, and the Children's Hospital Association, collectively representing more than 270,000 physicians and more than 220 children's hospitals across the country, we write to urge you to investigate the organizations, individuals, and entities coordinating, provoking, and carrying out bomb threats and threats of personal violence against children's hospitals and physicians across the U.S.

From Boston to Akron to Nashville to Seattle, children's hospitals, academic health systems, and physicians are being targeted and threatened for providing evidence-based health care. These attacks have not only made it difficult and dangerous for institutions and practices to provide this care, they have also disrupted many other services to families seeking care. In one hospital, a new mother was prevented from being with her preterm infant because the hospital's Neonatal Intensive Care Unit was on lockdown due to a bomb threat. Children's hospitals across the nation have substantially increased security in addition to working with local and federal law enforcement, both on their main hospital campuses as well as across their ambulatory delivery sites, in order to ensure the safety of patients, families, and medical staff who work there. In addition, some providers have needed 24/7 security. Children's hospitals and their medical staffs continue to face increased threats via social media – including to their personal accounts. Coupled with harassing emails, phone calls, and protestors at health care sites, there is elevated and justifiable fear among families, patients, and staff.

These coordinated attacks threaten federally protected rights to health care for patients and their families. The attacks are rooted in an intentional campaign of disinformation, where a few high-profile users on social media share false and misleading information targeting individual physicians and hospitals, resulting in a rapid escalation of threats, harassment, and disruption of care across multiple jurisdictions. Our organizations have called on technology companies to do more to prevent this practice on digital platforms, and we now urge your office to take swift action to investigate and prosecute all organizations, individuals, and entities responsible.

Attacks against health care institutions that threaten violence, intimidation, and physical harm have left hospitals, staff, and their communities shaken. Providers of evidence-based gender-affirming health care and their colleagues are facing increased stress and fear on top of the conditions they have faced while working on the frontlines of a global pandemic for nearly three years. Families seeking care at these institutions as well as our those providing their care fear for their personal safety in the wake of these attacks.

Our organizations are dedicated to the health and well-being of all children and adolescents. We are committed to the full spectrum of patient care–from prevention to critical care. We stand with the physicians, nurses, mental health specialists, and other health care professionals providing evidence-based health care, including gender-affirming care, to children and adolescents.

On behalf of the patients and families we serve and the physicians we represent, we thank you for your attention to our request.

Sincerely,

American Academy of Pediatrics

American Medical Association

Children's Hospital Association

EXHIBIT D

ONLINE HARASSMENT, OFFLINE VIOLENCE

UNCHECKED HARASSMENT OF GENDER-AFFIRMING CARE PROVIDERS AND CHILDREN'S HOSPITALS ON SOCIAL MEDIA, AND ITS OFFLINE VIOLENT CONSEQUENCES

Last Updated 12/8/22

EXECUTIVE SUMMARY

- Anti-equality, online extremists are leading a proactive and coordinated campaign of hate against hospitals and medical providers who offer gender-affirming care for transgender, non-binary and questioning youth.
- Social media posts from accounts like Libs of TikTok and Matt Walsh kick off a cycle of harassment and stigma, with the ultimate goal of inciting violence and shutting down access to lifesaving and medically necessary gender affirming care:
    - Hate speech accounts post an inflammatory message full of disinformation about gender affirming care and call out a specific hospital or doctor by name.
    - The doctor and hospital almost immediately begin receiving a barrage of harassing and threatening messages online.
    - Offline, doctors and hospitals named in social media harassment campaigns face harassment and threats at their homes and workplaces. In the most extreme examples, doctors face death threats and hospitals face bomb threats, halting care for all patients
    - Extremist politicians looking to rile up the most extreme members of their base join in spreading the same transphobic rhetoric from their platforms, in some cases going so far as to introduce legislation to regulate children's hospitals and gender-affirming care providers.
    - Hospitals halt gender-affirming services or remove online resources and websites in order to protect the safety of their patients and staff.
- In an informal exploration across Facebook and Twitter, we identified 24 different hospitals and providers, across 21 states, who were directly attacked online following harassing, inflammatory and misleading posts from Libs of TikTok, Matt Walsh, and other right-wing accounts. Especially egregious posts/ attacks include:
    - Following a series of social media posts from right-wing provocateur Libs of TikTok that claimed Boston Children's Hospital's (BCH) Gender was performing hysterectomies on minors and thus the hospital "needs to be shut down," BCH has received three separate bomb threats, forcing temporary lockdowns and evacuations. The most recent bomb threat, from November 16th, specifically targeted BCH's gender affirming care clinic, as well as individual physicians, claiming bombs had been placed in both the clinics and three doctors' homes.
    - One investigative report from October found that 20 different children's hospitals had been named and targeted in online harassment campaigns in recent months, forcing 17 to remove or alter resources and content from their websites on gender-affirming care services. Five

HUMAN RIGHTS CAMPAIGN FOUNDATION

additional hospitals who had not been specifically targeted also chose to remove or alter information. Several hospitals and clinics have had to halt services or shut down altogether.

- In the wake of the November mass shooting at LGBTQ+ club Club Q in Colorado Springs where 5 people were killed while attending a drag show, the founder of Gays Against Groomers, an anti-trans hate group which equates gender affirming care with child abuse, stated on Tucker's Carlson's show that "shootings like the one at Club Q in Colorado Springs, Colo., would continue until the "evil agenda" of gender-affirming health care was put to an end."

- Despite this danger, social media companies have failed to act and stop the proliferation of violent rhetoric. Despite repeated violations of social media companies' own content policies,the most prominent accounts behind these campaigns have been allowed to remain active and committed to spreading extremist hate, receiving little more than a slap on the wrist in the form of temporary bans, rather than permanent deplatforming. With Elon Musk taking over Twitter, the spread of anti-trans rhetoric and hate speech, including that which targets doctors and hospitals, is likely to only proliferate — already, the frequency of tweets using anti-LGBTQ+ slurs on Twitter is up by around 60%.

- Given the rise in coordinated hate speech, and the real-world violence it is engendering against doctors, hospitals, and the LGBTQ+ community at large, it is necessary for everyone — not just social media platforms — to work to stop this cycle of disinformation, violence and hate. Pro-equality politicians and LGBTQ+ allies alike need to speak out, and push for policies both online and offline that forcefully fight back against the tide of extremism.

INTRODUCTION

On August 11, 2022, the social media account Libs of TikTok posted a false claim to their 1.4 million Twitter followers and 55,000 Facebook accounts that Boston Children's Hospital (BCH) was providing hysterectomies to transgender minors. Libs of TikTok, an account run by conservative activist Chaya Raichik, is just one of a growing number of extreme right-wing hate accounts that have been waging a war on the LGBTQ+ community and its allies, routinely posting transphobic and homophobic lies, misinformation, and conspiracies. These false claims were quickly debunked by Politifact on August 12th, but Libs of TikTok doubled down and claimed Politifact was lying.

Libs of TikTok's followers quickly followed that account's lead, and began harassing BCH and its staff, who experienced an unprecedented barrage of online harassment every time a new lie was posted. Over the five days following the initial post, Libs of TikTok tweeted or retweeted more than a dozen posts about BCH, saying that the hospital "needs to be shut down." But much of the harassment BCH received came from Libs of TikTok's thousands of followers, who began their own attacks on BCH's social media accounts, calling for doctors to be "put in camps" or subjected to "Nuremberg type trials and punishments." Other posts accused doctors of being pedophiles or "groomers" who mutilate children's bodies, ors issued threats that "a day of reckoning is coming" for doctors, where they would be "prosecuted for Child Abuse…[and for holding an] ideology does not belong in an American society." To date, many of these posts remain online months later, despite being in direct violation of Twitter and Meta's policies on abusive behavior/targeted harassment and hateful conduct.

As a result of this sustained harassment, BCH was forced to take down educational videos and resources about gender-affirming care and remove information about these services from their website.

As online attacks intensified, offline harassment and violent threats began as well. In a statement issued by BCH on August 16th, the hospital noted that harassment had moved from "a large volume of hostile internet activity" to "phone calls, and harassing emails," leading the hospital to begin "working with law enforcement to protect or clinicians, staff, patients, family, and the broader

BCH community." On August 17th, U.S. Attorney for Massachusetts Rachel S. Rollins issued a statement as well, calling the threats "disturbing to say the least" and reiterated the Department of Justice's commitment to "ensure equal protection of transgender people under the law;" meanwhile, "federal agents began monitoring threats" against the hospital.

This coordinated campaign of harassment culminated on August 30th, 2022, when BCH received a bomb threat, leading law enforcement to temporarily place the hospital on lockdown. On August 31st, the Fenway Institute's National LGBTQIA+ Health Education Center received threatening voicemails and death threats against a doctor on staff who was co-affiliated with BCH. Less than two weeks later, another series of bomb threats were made online against BCH starting on September 9th, leading to enhanced police presence in the area. A third bomb threat led the hospital to temporarily shut down again on November 16th, with the threat delivered via email by a sender who said "they were targeting the hospital because they opposed its Gender Multispecialty Service (GeMS) program" which provides gender-affirming care to transgender youth. No bomb was found in either incident. To date, two arrests have been made in connection with these threats. However, BCH has continued to receive "dozens" more threats, as reported by the FBI's Boston Division, along with "harassing phone calls and e-mails, individual death threats, and threats of mass casualty attacks."

What occurred in Boston is just one example of coordinated campaigns of hate, violence, and harassment being waged both online and offline against health care providers and children's hospitals simply for providing age-appropriate, best practice, medically necessary medical care to transgender youth. What has emerged is a clear pattern of online harassment against gender-affirming care providers and clinics, and offline violence against the same, driven by hate speech that has proliferated unchecked on social media. Taking a page from the extreme right-wing anti-abortion playbook, campaigns have been targeting dozens of specific pediatricians and children's hospitals involved in providing gender affirming care to transgender youth. In each case, initial attacks from large accounts like Libs of TikTok are quickly taken up by their increasingly radicalized followers, in what has been likened to stochastic terrorism, wherein "someone is inspired to act violently in the name of something they perceive as wrong from messages they receive that are designed to inspire such action."

As a result, health care providers and children's hospitals following best-practice guidelines are now in the crosshairs of targeted social media harassment campaign which has begun to translate into offline, real-world violence.

CYCLE OF ONLINE HATE AND STIGMA

We are currently witnessing a relentless cycle of online hate and stigma which is translating to offline harassment and violence. This cycle will only worsen in the absence of intervention by social media platforms. The cycle typically follows the same five steps:

1. **Hate speech accounts such as Libs of TikTok or Matt Walsh, a known anti-trans extremist at the alt-right news site The Daily Wire, post an inflammatory message full of disinformation about gender affirming care and call out a specific hospital or doctor by name.**
2. **The doctor and hospital almost immediately begin receiving a barrage of harassing and threatening messages.**
3. **Offline, doctors and hospitals named in social media harassment campaigns face harassment and threats at their homes and workplaces. In the most extreme examples, doctors face death threats and hospitals face bomb threats, halting care for all patients.**

4. **Extremist politicians looking to rile up the most extreme members of their base join in spreading the same transphobic rhetoric from their platforms, in some cases going so far as to introduce legislation to regulate children's hospitals and gender-affirming care providers.**

5. **Hospitals halt gender-affirming services or remove online resources and websites in order to protect the safety of their patients and staff.**

STAGE 1: EXTREME HATE SPEECH ACCOUNTS TARGET A SPECIFIC CHILDREN'S HOSPITAL OR PROVIDER

In the first stage, hate speech accounts such as Libs of TikTok or Matt Walsh, a known transphobe at the alt-right news site The Daily Wire, post an inflammatory message full of disinformation about gender affirming care and call out a specific hospital or doctor by name.

The first stage of this cycle of harassment and violence begins with a targeted social media campaign that names and attacks an individual doctor or hospital for offering gender affirming care. The campaign spreads misinformation about the best practice, age-appropriate medical care these doctors and hospitals provide.

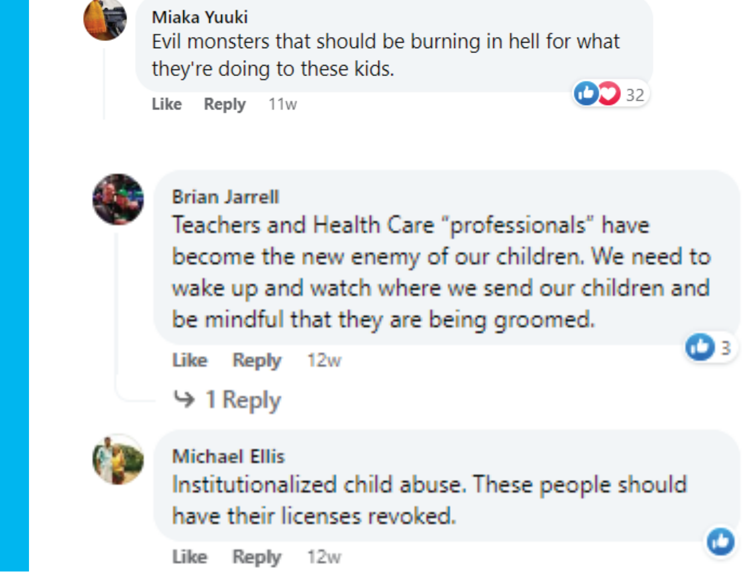
Gender affirming care for transgender and non-binary people is supported by every credible medical, psychological, and pediatric organization, including the American Medical Association (AMA), the American Academy of Pediatrics (AAP), the American Psychological Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP). Gender clinics at children's hospitals and health care providers who provide gender affirming care to youth offer a range of safe, effective, age-appropriate health care options delivered in consultation with patients and their families. For younger transgender and non-binary patients, this largely includes providing mental health care. It may also include social support for their families as they navigate changes in their child's gender expression. This can include changes to the child's name, pronouns, clothing or hairstyle to better match their sense of self and improve their psychological well-being. Older youth work with therapists, health care providers and their parents or caretakers to determine the best treatment plan. This may include fully reversible puberty blockers which have been safely used for decades.

Despite the realities of what gender affirming care *is*, anti-trans activists continue to wage a war of disinformation, harassment and stochastic terrorism on pediatricians and children's hospitals — with new hospitals targeted and harassed almost daily. Over the Summer and Fall of 2022, Libs of TikTok, Matt Walsh, and other right-wing hate accounts targeted at least 20 children's hospitals, as well as numerous individual doctors, simply for doing their job and providing best-practices medical care, some examples of which are noted below (See Appendix for additional examples of the sort of harassment, violent threats, and hate speech hospitals and providers encountered on social media between August and November 2022).

On August 12th, Libs of TikTok posted a video to Twitter and Facebook decrying the Children's Hospital of Pittsburgh for putting out "promotional videos on puberty blockers." Puberty blockers, which include FDA approved medications that are the gold standard treatment given to cisgender youth experiencing endocrine disorders, are fully reversible treatments that pause puberty and physical changes associated with pubertal development. They allow youth more time to continue exploring and understanding their gender identity with their families, their doctors and their therapists. This pause prevents the extreme distress that results from an unwanted puberty, a condition that leads to high rates of depression, self-harm and suicidality when left untreated.

Libs of TikTok, however, ignored the truth about the safety, efficacy, and reversibility of puberty blockers, and instead shared this post to claim that it is harmful care being recklessly provided by doctors that puts children at risk. On Twitter, the post was retweeted over 3,300 times, and on Facebook, it

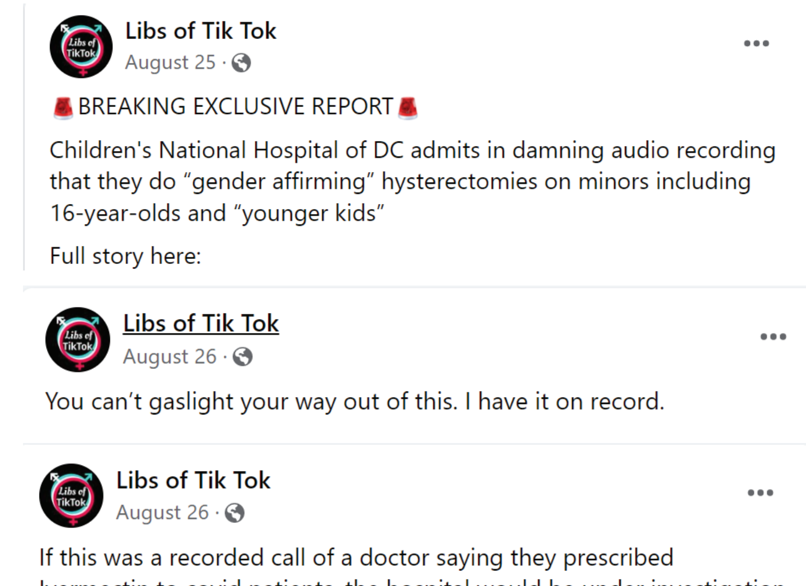
was shared over 200 times. Comments on both the original post and on the Children's Hospital's social media accounts are filled with vile attacks, insults, threats, and accusations.



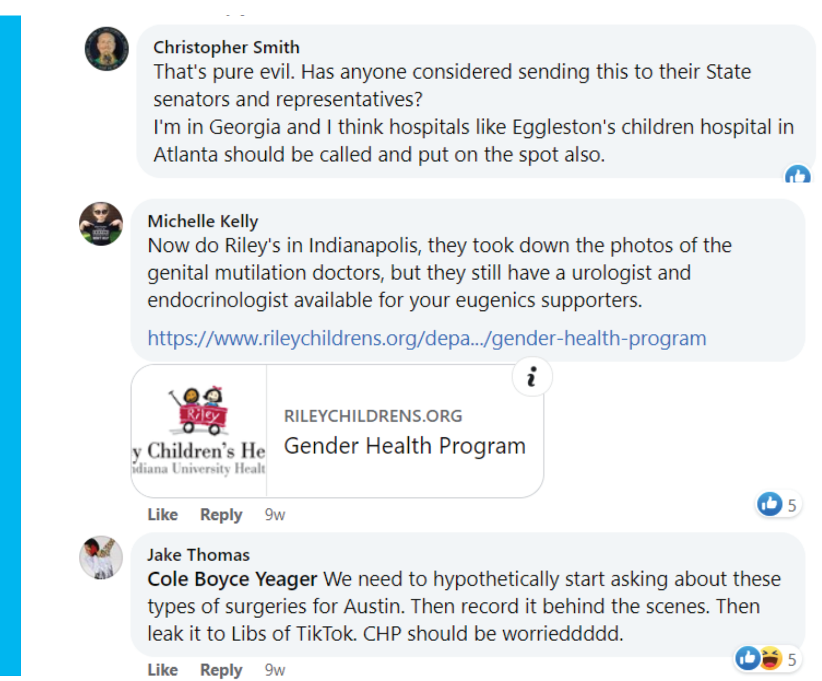
Between August 18 and August 23, Raichik went on the warpath, posting about eight different hospitals — including four different hospitals on August 18 alone:

- August 18: Children's Mercy Hospital (Kansas City, MO)
- August 18: OHSU Doernbecher Children's Hospital (Portland, OR)
- August 18: Children's Hospital and Medical Center Omaha (Omaha, NE)
- August 18: Yale Pediatric Gender Clinic (New Haven, CT)
- August 19: Ann & Robert H. Lurie Children's Hospital (Chicago, IL)
- August 19: Kaiser Permanente (California)
- August 22: Seattle Children's Hospital (Seattle, WA)
- August 23: Children's Hospital of Philadelphia (Philadelphia, PA)

On August 25th, Libs of TikTok posted a video on Twitter and Facebook from a conversation she had with a switchboard operator at Washington DC's Children's National Hospital, in which the operator mistakenly stated that the hospital would perform hysterectomies on minors. Though the hospital immediately issued a statement correcting the record and noting they do not perform gender-affirming surgery on youth under age 18, Libs of TikTok continued to post more and more inflammatory lies about the hospital, including falsely disputing the hospital's claims.



In the comments of the Libs of TikTok posts, users urged Libs of TikTok to begin similar investigations into other children's hospitals, so they could be "put on the spot."



On September 20, Matt Walsh tweeted a thread about his so-called "investigation" into Vanderbilt University's Transgender Health Clinic, making false and inflammatory claims that doctors at Vanderbilt "castrate, sterilize, and mutilate" transgender youth by offering puberty blockers and hormone therapy and/or performing gender-affirming surgery—while ignoring reality that Vanderbilt does not even perform these surgeries on minors.

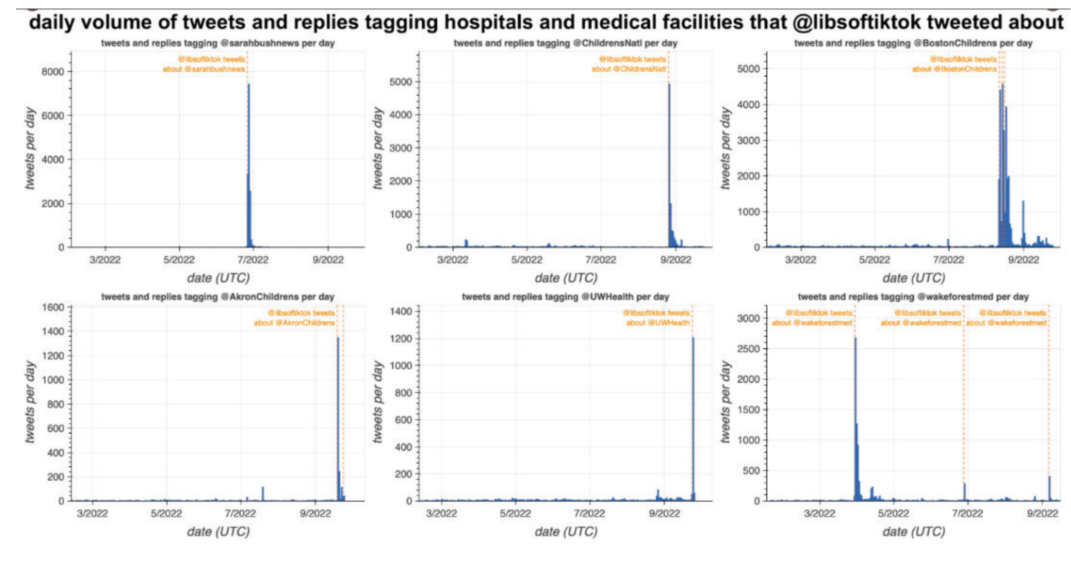
On November 9th, Seth Dillon, the CEO of right-wing satire site The Babylon Bee, made the inflammatory claim that it was, in fact, children's hospitals and doctors who were committing violence by performing gender-affirming surgeries—including falsely claiming these surgeries were provided on "young girls." He then encouraged the campaigns of harassment and violence of hospitals and doctors to continue, praising them for "reducing this violence and leading to laws that criminalize it."

Violence occurs at children's hospitals whenever a young girl has her healthy breasts or uterus surgically removed. Thankfully, our efforts are successfully reducing this violence and leading to laws that criminalize it.

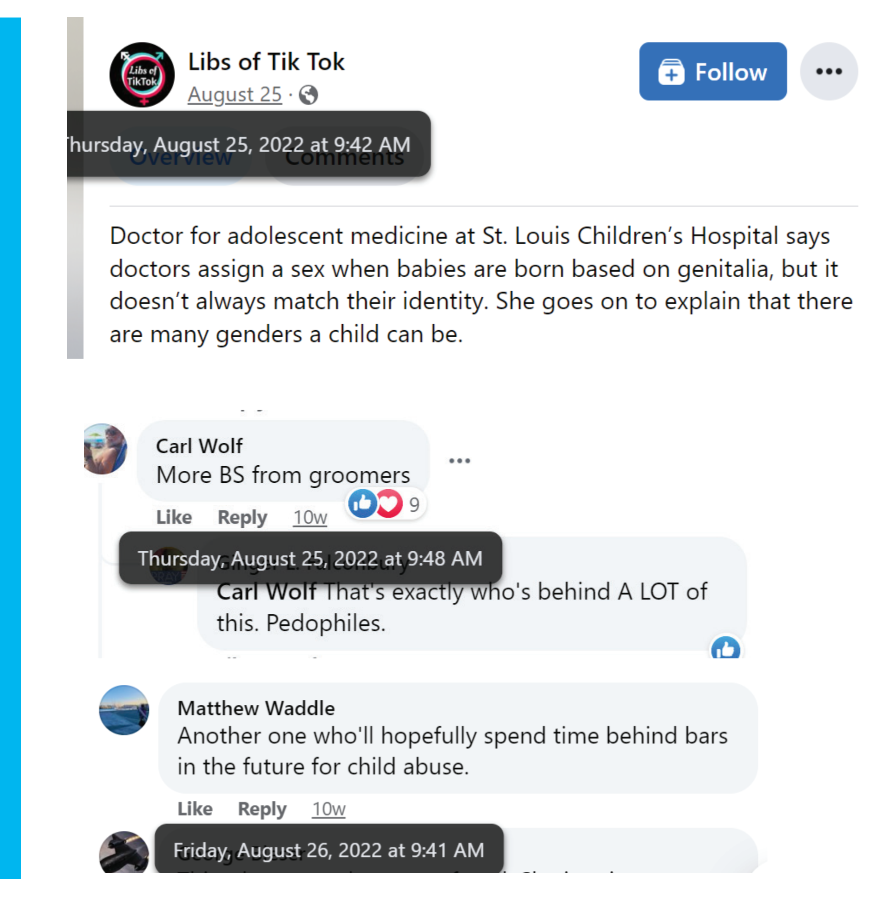
STAGE 2: CHILDREN'S HOSPITALS AND PHYSICIANS TARGETED IN POSTS BEGIN RECEIVING ONLINE HARASSMENT AND THREATS

In the second stage, the doctor and hospital almost immediately begin receiving a barrage of harassing and threatening messages.

Almost immediately, any doctor or hospital tagged or named in a post will receive a huge spike in engagement on their social media channels—virtually all of it negative, threatening, or harassing in nature. A Twitter user tracked engagement after each of Libs of TikTok's tweets and found that the daily volume of Tweets engaging with hospital accounts went from essentially zero, to in the thousands, after being named in an attack by Libs of TikTok:



For example, at 4:36PM on August 24th, Libs of TikTok tweeted a video from an adolescent medicine doctor at St. Louis Children's Hospital and the Washington University Transgender Center, where she explains the difference between biological sex, gender, and gender identity; Libs of TikTok posted the same video to her Facebook account at 9:42AM on August 25th. Within minutes of the first Tweet, the doctor began to receive hateful and threatening messages via Twitter and her work email.



Fwd: A criticism

Get Outlook for iOS

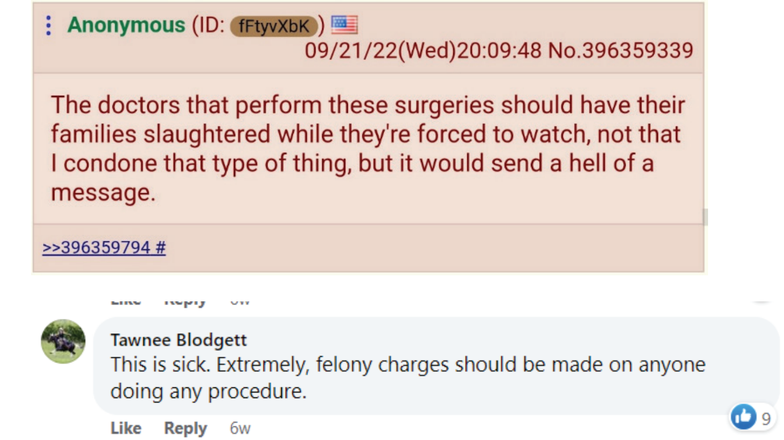
From: Tengu Yama <Tengu_Yama@live.com>
Sent: Wednesday, August 24, 2022 11:00 PM
To: [redacted]
Subject: A criticism

A pediatrician who advocates for the mutilation and sterilization of young children. All to pad her pockets. You're an evil, vile cunt. And you'll end up paying for these sins. Betraying the Hippocratic Oath all for some extra shekels in your pocket. Enjoy your just deserts you evil fucking whore.

In another example, less than 24 hours after Matt Walsh tweeted his false claims and misrepresentations about Vanderbilt on September 21, various Twitter accounts associated with Vanderbilt began receiving harassing and threatening messages, using much of the same phrasings and lies from Walsh's thread.

Post blurred to hide the composite image of names and faces of Board of Directors

Users on other social media message boards such as 4chan and Facebook began similarly calling for the deaths and imprisonment of physicians at Vanderbilt.



On September 23, Libs of TikTok posted a thread attacking University of Wisconsin for having a gender services program, including targeting the co-director, Dr. Katherine Gast, by name. Within hours, threatening Tweets began popping up, specifically naming Dr. Gast and threatening her directly.

STAGE 3: ONLINE HARASSMENT CAMPAIGNS BEGIN TO MOVE INTO OFFLINE THREATS, HARASSMENT, AND VIOLENCE

In the third stage, doctors and hospitals named in social media harassment campaigns face harassment and threats at their homes and workplaces. In the most extreme examples, doctors face death threats and hospitals face bomb threats, halting care for all patients.

In this stage, online harassment campaigns increasingly move off social media platforms, leading to real-world consequences. Doctors begin facing death threats on their personal phones and at their homes, hospitals face bomb scares, and providers are muzzled and driven underground.

Since the “first known protest of gender-affirming pediatricians” in December 2020, multiple hospitals nationwide have faced in person protests at their clinics, leading at least one clinic to close its doors for good. However, increasingly, hospitals and doctors across the nation have been experiencing offline, real-world harm as a result of online campaigns waged against them. For instance:

- A plastic surgeon in Miami who has been targeted by Libs of TikTok had false complaints filed against her to the Federal Trade Commission and Florida medical boards by anti-trans activist organizations, in an attempt to have her and her clinic shut down.

- One pediatrician in the Midwest received a threatening voicemail and was then "*accosted in my apartment building by someone who had seen the Libs of TikTok post and berated me in the lobby calling me a groomer and a pedophile that mutilates children. She suggested out loud that I "f*ck my dog" who I was walking at the time. Hitting every imaginable trope.*"
- Another pediatrician on the West Coast told HRC they have had protestors show up at their clinic with the pediatrician's face depicted on their posters, as well as received threats that their "*body will be tied to the back of a care and driven all over Los Angeles*" and that "*I am considered "enemy #1 and people should take a gun and shoot me.*"
- Speaking to NBC News, Dr. Gast at University of Wisconsin (see above) noted she faced an almost immediate "scary and overwhelming" backlash after Libs of TikTok's thread, with both her and her family having their personal information leaked online, and her clinic receiving "harassing phone calls."
- After being targeted in a post by Libs of TikTok, the Children's Hospital of Pittsburgh begins receiving harassing, hateful, and threatening messages, leading the hospital to be forced to begin "operating with enhanced security measures."
- A Time article published in 2021 notes several incidents of doctors and hospitals across the country who experienced similar forms of harassment to those detailed in this report. This included pediatricians and children's hospitals having fake complaints filed against them to their medical boards and experiencing protests at their clinics, while doctors reported receiving threatening letters at their homes, harassing phone calls on their personal phone numbers, and having their identities impersonated online.
- On November 20th, mere hours after a deadly shooting at Club Q, a gay nightclub in Colorado Springs, left at least 5 LGBTQ+ people dead and 25 injured, Matt Walsh rejected claims that his campaign of anti-trans hate speech and attacks on gender affirming care providers could have played a role in motivating the shooting. Instead, he tweeted that "leftists" were trying to "blackmail us unto accepting the castration and sterilization of children" and vowed to double down on his opposition to gender affirming care.

Leftists are using a mass shooting to try and blackmail us into accepting the castration and sexualization of children. These people are just beyond evil. I have never felt more motivated to oppose everything they stand for, with every fiber of my being. Despicable scumbags.

7:11 PM · Nov 20, 2022 · Twitter Web App

7,677 Retweets **1,021** Quote Tweets **42K** Likes

- Two days later, on November 22nd, the founder of Gays Against Groomers, an anti-transgender hate group which equates gender affirming care with child abuse, went on Tucker Carlson's show and claimed shootings like the one at Club Q in Colorado Springs, Colo., would continue until the "evil agenda" of gender-affirming health care was put to an end.

Attacks have gotten so severe that on October 3, 2022 the American Academy of Pediatrics (AAP), American Medical Association (AMA) and Children's Hospital Association (CHA) sent a letter to Attorney General Merrick Garland and the Department of Justice (DOJ) sent a letter to Attorney General Merrick Garland and the Department of Justice (DOJ) urging an investigation into the "*organizations, individuals, and entities coordinating, provoking, and carrying out bomb threats and threats of personal violence against children's hospitals and physicians across the U.S.*"

STAGE 4: RIGHT WING POLITICIANS JOIN IN THE ATTACKS ON HEALTHCARE PROVIDERS AND CHILDREN'S HOSPITALS,

In the fourth stage, right-wing politicians looking to rile up the most extreme members of their base join in spreading the same transphobic rhetoric from their platforms, in some cases going so far as to introduce legislation to regulate children's hospitals and gender affirming care providers.

Alongside campaigns of harassment and intimidation, the lies and disinformation in these posts are picked up by extreme right-wing politicians, often without doing any fact checking of their claims — or actively ignoring when these lies have been debunked by credible sources. These politicians use this rhetoric to justify passing anti-trans policies and calling for investigations into doctors and hospitals, which limit the ability of doctors to provide safe, age-appropriate, life-saving medical care — and the ability of transgender youth and adults to access this care.

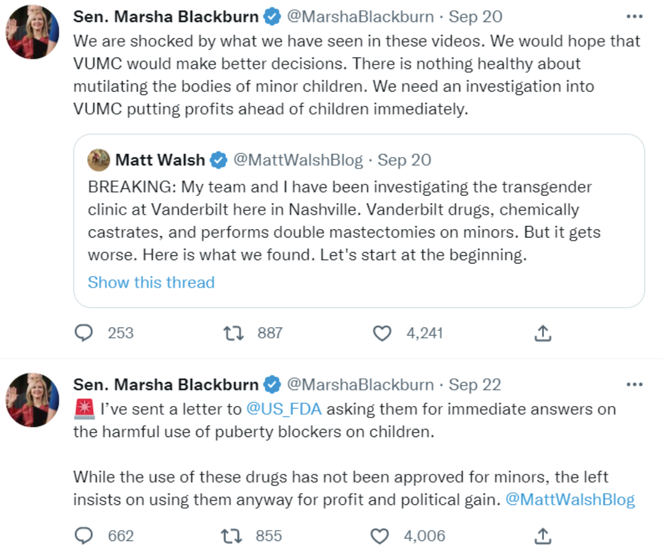
- **The very same day as Matt Walsh's first tweet about Vanderbilt's gender clinic**, the Tennessee Governor called for an investigation into the Vanderbilt clinic. Within 48 hours, Matt Walsh announced on Twitter that several state legislators in Tennessee were writing a bill with the goal of not only shutting down Vanderbilt's clinic, but making gender affirming care illegal statewide—while, at the same time, Tennessee Senator Marsha Blackburn had called for the FDA to investigate provision of puberty blockers in an attempt to end its provision nationwide.

MAJOR UPDATE: I have met with Tennessee Rep William Lamberth and Sen Jack Johnson. We are working on a bill to shut down Vanderbilt's child gender transition program and ban the practice in the state. Tennesseans do not want this barbarism in our state. We will put a stop to it.

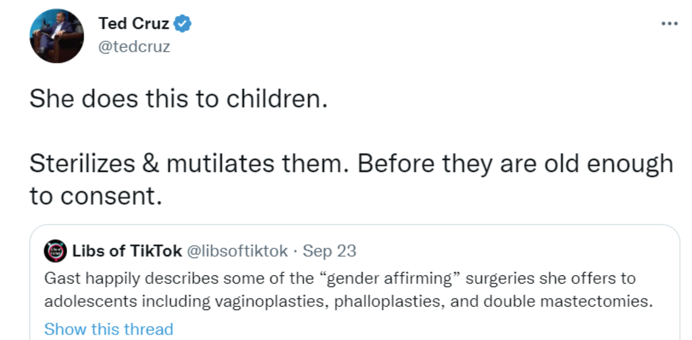
4:29 PM · Sep 21, 2022 · Twitter for iPhone

The governor of Tennessee is calling for an investigation into Vanderbilt after my report this afternoon. Legislators on the state and national level have also responded. We are not going to let up. We will shut this down.

9:37 PM · Sep 20, 2022 · Twitter for iPhone



- **On September 20,** Florida Gov. Ron DeSantis' spokesperson also applauded Matt Walsh for targeting Vanderbilt Children's Hospital, and said it was a "necessary first step to raise consciousness."
- **On September 23**—just a day after the political attacks on Vanderbilt—Texas Senator Ted Cruz retweeted one of Libs of TikTok's tweets about Dr. Gast at University of Wisconsin, echoing some of the most egregious lies about gender affirming care. Cruz previously called Libs of TikTok a "fabulous account" after they spread disinformation about Boston Children's Hospital.



  - Politicians and candidates for the 2022 Midterms in multiple states, including Pennsylvania, Ohio, Florida, Georgia, and South Carolina, praised Libs of TikTok and repeated many of her claims, including introducing bills to ban gender-affirming care for minors, and incorporating her anti-trans messaging into their political platform.On August 19, Georgia Representative Marjorie Taylor Greene introduced a national bill that would "make it a felony to perform any gender affirming care on a minor"
  - On September 3, failed Arizona gubernatorial candidate Kari Lake said her opponent was "actively encouraging performing double mastectomy, surgery and hysterectomy surgeries on our young girls. They are actively pushing to castrate our boys," and that she would ban those procedures in Arizona.

- On September 16, Florida Senator Marco Rubio issued a campaign ad, claiming the "radical left" will "indoctrinate children and try to turn boys into girls."
- **On September 19**, American Principles Project started a $450,000 ad campaign in support of Blake Masters, the Arizona GOP Senate candidate for the 2022 Midterms, that claimed Mark Kelly and Joe Biden were "pushing dangerous transgender drugs and surgeries on kids — taking away parental rights."
- On September 23, Doug Mastriano, the 2022 failed gubernatorial candidate for Pennsylvania, announced his intention to introduce a statewide bill that would prohibit gender affirming surgeries for children—surgeries which are largely only done on those age 16 and older—claiming he "can't stand by as medical providers across the country cave to the pressures of militant leftists committed to distorting the concept of gender so that it defies the bounds of science and logic. Mastriano later accused Children's Hospital Of Philadelphia of kidnapping homeless transgender youth to perform gender experiments on them.

STAGE 5: GENDER-AFFIRMING CARE AND RESOURCES ARE HALTED OR REMOVED AND, IN SOME INSTANCES, HEALTH CARE IS DISRUPTED FOR ALL PATIENTS

In the fifth and final stage, hospitals are forced to halt gender-affirming services or remove online resources and websites in order to protect the safety of their patients and staff.

The aim of these harassment campaigns has been to block access to gender-affirming care and resources for transgender and non-binary youth and their families. In doing so, they have risked the health, safety, and well-being of not only trans youth and their families, but also all other children and families attending the same clinics and hospitals. As of October 3, all but three of the at least 20 children's hospitals which have been targeted by right wing campaigns have had to modify the information publicly available on gender affirming care services they offer, including removing or altering websites, informative resources, and contact information for clinics and providers. For example,

- On August 30th, Boston Children's Hospital had to temporarily lock down their entire hospital for 90 minutes, leaving patients' families stranded outside, after receiving a bomb threat, two weeks after an online harassment campaign began against them. At the time of the threat, federal agents were already "moderating threats made against [the hospital] and its employees" following a campaign of harassment initiated by Libs of TikTok.
  - On September 9th, a second bomb threat was called in, while on November 16, a third bomb threat from a person claiming bombs were placed in both the Gender Multispecialty Service (GeMS) transgender health clinic and the homes of three doctors, once again forced BCH again into lockdown and partial evacuation.
- Vanderbilt University Transgender Health Clinic had to temporarily shut down their websites, and move all in-person appointments to telehealth within 24 hours of Matt Walsh's Tweet. Vanderbilt University Transgender Health Clinic had to temporarily shut down their websites, and move all in-person appointments to telehealth within 24 hours of Matt Walsh's Tweet.
- The University of Wisconsin was forced to temporarily shut down and password protect their websites, within days of being inundated with attacks.
- In Chicago, Lurie Children's Hospital was forced to cancel transgender youth support groups, and then move them online, after the hospital and its providers began receiving online threats and harassment following Tweets from Libs of TikTok and other right-wing allies.

- On September 26, Republican Rep. Nancy Mace accused her opponent, Democrat Dr. Annie Andrews, of "child abuse" for supporting "'gender affirming therapy.' As a result of these attacks, Dr. Andrews was forced to take immediate unpaid leave from MUSC Shawn Jenkins Children's Hospital in order to protect herself and her colleagues, risking disruption to her patients' care.

It has not just been gender-affirming care that has been interrupted: When hospitals are forced to go into lockdown and hire extra security, it impacts access to care for all children and their families.

- As noted in the letter sent to the DOJ "In one hospital, a new mother was prevented from being with her preterm infant because the hospital's Neonatal Intensive Care Unit was on lockdown due to a bomb threat."
- On September 28, The University of Oklahoma - the only hospital in the state that offered gender affirming care to transgender and non-binary youth - was pressured into halting some gender-affirming care services, after the governor and state legislature threatened to withhold federal Covid relief funds for all services in the entire hospital if they did not cease providing it. Had the hospital refused, they would have lost over $108 million in funds to cover "cancer care, pediatric behavioral health care and other infrastructure."
  - This bill was authorized in a special session of the state legislature, just two weeks after UnWokablePod tweeted about University of Oklahoma's gender-affirming treatment services and was retweeted by Libs of TikTok.

THROUGHOUT IT ALL, SOCIAL MEDIA COMPANIES ALLOW THIS RHETORIC TO CONTINUE, AND SPREAD, UNMODERATED AND UNCHECKED.

All of these steps begin and continue as a result of social media companies allowing the rhetoric to spread, and remain, online — even when in violation of their own policies. Without intervention from social media companies, this will just lead to more hate speech, more threats, and more violence.

Hate speech and harassment campaigns against pediatricians and children's hospitals start online from a small number of 'super-spreader' instigator accounts, then grow exponentially as moderators refuse to remove even the most egregious of posts. As of this writing on November 8, 2022, all Tweets and Facebook posts included above remain live, despite all of them being in violation of Twitter and Meta's policies on abusive behavior/targeted harassment and hateful conduct. Many are also in violation of both platforms' much-publicized decision to ban the use of the vulgar term "groomer" - a slur which has recently seen a resurgence in an attempt to demonize LGBTQ+ people, culture and gender-affirming care.

Libs of TikTok has received several temporary bans from Twitter and Facebook, but to little effect. Facebook banned Libs of TikTok in August amidst their online attacks on Boston Children's Hospital, but the account was reinstated almost immediately. Twitter issued a one-week ban of the account in late August after their attacks on BCS and Children's National Hospital in DC — but left the account up in 'read only mode' rather than hide its Tweets. Once the account was restored, Raichik continued her attacks on gender-affirming care providers and children's hospitals, leading to another temporary suspension in September. On her very first day back on Twitter after her second ban, she posted a thread attacking Barbara Bush Children's Hospital in Maine for having a gender clinic for transgender youth, including calling out at least one provider by name.

And rather than apologize or revise her conduct or content, Raichik and the Libs of TikTok account have doubled down, reveling in the attention a temporary suspension brings, and vowing that *"No matter how many times they try censoring and silencing us, we're never gonna stop the work we've started. We're not going anywhere."*

And with Elon Musk now in control of Twitter as of October 28, 2022, it is likely this will only get worse. Twitter's (now former) Head of Safety and Security admitted there was a "surge in hateful conduct" in the immediate aftermath of Musk assuming control. A recent study from Montclair State University confirmed this, finding that in just the first twelve hours after Musk took the reigns, there were almost 5,000 hate speech filled Tweets — translating to almost 400 tweets an hour, about 5 times higher than the seven-day average in the week leading up to Musk's takeover. And one of Musk's first actions was to ask Twitter's content moderation team to "to review Twitter's hateful conduct policy, according to the people, specifically a section that says users can be penalized for 'targeted misgendering or deadnaming of transgender individual'" — a response met with taunting Tweets celebrating this change from both Matt Walsh and Libs of TikTok. Since then, the majority of Twitter executives have quit, Twitter's content moderation team has been unable to effectively do their job, and Elon Musk has been unbanning hate accounts, including two which were initially banned for their anti-transgender hate speech.

CONCLUSION

The five points of this cycle illustrate the insidious strategy used by right-wing extremists to spread fear and create hate by any means available to them. Accounts like Libs of TikTok engage in stochastic terrorism, waging violent hate and harassment campaigns, spreading lies, disinformation, and violence, while ignoring science, medicine, and research. They sit safely behind their keyboards while transgender and non-binary people must live with the consequences of their violent rhetoric, and medical providers live in fear for the "crime" of supporting transgender and gender non-conforming people. We already know what this story looks like - we've seen it in attacks on abortion clinics including bombings, arson and murders. We've seen it in Pizzagate, in QAnon, and in the election denialism that led to the January 6th attacks.

Social media companies have a responsibility to act and to not be bystanders while angry mobs intimidate LGBTQ+ people and our allies into silence. But given their reticence to act—and, in the case of Twitter, the dangerous overtuning of policies designed to prevent hate and disinformation on the platform—responsibility has to expand beyond social media companies. Elected leaders need to forcefully speak out against anti-LGBTQ+ violence and hate speech, less the political conversation be dominated by those who seek to stoke and encourage these campaigns of harassment and violence against young people, their families, doctors and hospitals. The DOJ needs to follow through on the request from medical associations to act swiftly and "investigate the organizations, individuals, and entities coordinating, provoking, and carrying out bomb threats and threats of personal violence." LGBTQ+ allies need to call out disinformation and hate speech when they encounter it both online and offline, including speaking up in support of gender affirming care providers and hospitals, so doctors know there are people out there in their communities who stand in solidarity with them — not just people seeking to harm them.

We can all imagine a better future — one where truth is valued more than the loudest voice in the room. But now we all must act to make that vision a reality.

hrc.im/OnlineHateReport

Appendix

HUMAN RIGHTS CAMPAIGN FOUNDATION™

CALLS TO ACTION

- **Watch HRC's video**

- **Learn more our gender-affirming care in the Human Rights Campaign's gender-affirming care fact sheet, explainer, or gender-affirming care explainer video.**

- **Read recent research on the spread of online hate speech and offline violence against the LGBTQ+ community, including**

  A. The Human Rights Campaign and CCDH's report "Digital Hate: Social Media's Role in Amplifying Dangerous Lies About LGBTQ+ People."

  B. GLAAD's report on protests and "significant threats" drag events faced in 2022

  C. CCDH's report "The Musk Bump: Quantifying the rise in hate speech under Elon Musk."

- **Social media users should counteract online hate speech and harassing or violent content**

  A. Report harassing and abusive posts.

  B. Elevate and share posts from gender-affirming care experts, and transgender advocates and allies.

  C. Speak out and post messages of support and solidarity for gender-affirming care providers

  D. Share accurate information and educate others about gender-affirming care, to counteract the spread of misinformation and lies

  E. For more tips, review the United Nations' guide, "Engage—how to deal with hate speech?", or the CCDH report "Don't Feed the Trolls How to Deal with Hate on Social Media."