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Paternalistic Restrictions on Gender-Affirming Health Care

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Abstract

Recently the UK and many US states have brought in policies and laws that limit or entirely prevent access to gender-affirming health care for trans adults and/or trans youth. These restrictions on trans access to gender-affirming care are justified on paternalistic grounds; that is, on the basis of the benefits to trans youth and trans adults of these restrictions. This paper argues that a state cannot permissibly limit trans people's access to gender-affirming health care on paternalistic grounds. First, the paper constructs and defends a weak antipaternalist principle (§2). Second, the paper argues that paternalistic restrictions on trans adults accessing gender-affirming care that have been implemented in Florida, Missouri, and the UK fall afoul of this weak antipaternalist principle (§3–5). Finally, the paper discusses the bans on trans teenagers accessing puberty blockers that have been implemented by the UK and twenty-five US states. It argues that the combination of (a) extant accounts of when paternalistic restrictions on teenagers accessing X can be justified even though restrictions on adults accessing X cannot be justified and (b) the argument made in the rest of the paper implies that these paternalistic bans on trans teenagers accessing puberty blockers are impermissible.

Keywords: transgender rights, paternalism, liberalism, puberty blockers, feminist political philosophy

1. Introduction

Gender-affirming health care (GAH) interventions change, or stop changes to, individuals' primary or secondary sex characteristics. Gender-affirming hormone replacement therapy (GAHRT) is a form of GAH that involves the prescription of hormones and/or hormone blockers. GAHRT enables trans and nonbinary people to change their secondary sex characteristics. GAHRT allows many trans men—and nonbinary assigned-female-at-birth people—to develop male secondary sex characteristics, including facial hair and a deeper voice. GAHRT allows many trans women—and nonbinary assigned-male-at-birth people—to develop female sex characteristics including breasts, a "feminine" (re)distribution of fat where fat builds up in the hips and cheeks rather than in other places, and a decrease in body hair

(Vincent 2018, 152). Puberty blockers are another form of GAH, which stop trans youth from developing the secondary sex characteristics associated with the sex they were assigned at birth. According to the American Medical Association (2021), GAHRT and puberty blockers are medically necessary for many trans and nonbinary adults and youth. Many studies have shown that GAHRT for trans and nonbinary people can lead to a reduction in depression and negative experiences of gender dysphoria (Nolan et al. 2023; Green et al. 2021; Almazan and Keuroghlian 2021; Chen et al. 2023). Almost 90 percent of trans and nonbinary people are either on a regime of GAHRT or hope to begin such a regime (Grassian 2022 24; James et al. 2016, 99). And this is unsurprising, since very many trans people have a strong persistent desire to have different sex characteristics from those that they endogenously developed or are set to endogenously develop (Vincent 2018; Coleman et al. 2022; see also §3 and note 7 below).

Recently many states have limited access to GAHRT and puberty blockers. The UK and twenty-five US states have banned puberty blockers and GAHRT for trans youth. Several states and countries have also adopted significant limits on adult access to GAHRT. For instance, Missouri has adopted a bill making trans adults wait three years to access GAHRT, and Florida has banned 80 percent of GAHRT for trans adults in the state (Wilchins 2024; see also §5.C below). These limits on trans access to GAH are mostly implemented based on the paternalistic rationale that these limits supposedly *benefit* the trans people who seek to access GAH. Is it justifiable for states to limit access to GAH on such paternalistic grounds? Even if a paternalistic restriction on someone's doing something would benefit them, it does not follow that it is permissible, legitimate, or justified. For instance, a state cannot legitimately prohibit us from marrying someone even if it is clear that the marriage would be all-things-considered bad for us. Other paternalistic state limits on actions (e.g., seat belt laws) are plausibly justified and permissible. Are paternalistic limits on GAH paternalistic limits of the former impermissible kind or the latter impermissible kind? Although there is much discussion of limits on access to GAH in the literature, there has been little, if any, focus on the legitimacy of paternalistic justifications of limits on access to GAH (Ashley 2022; Wenner and George 2021; Cosker-Rowland 2022; and Beattie 2022). Furthermore, it is particularly important to assess whether such paternalism is legitimate in the context of GAH because it is clear that limits on access to GAH cannot be justified on other nonpaternalistic grounds (such as grounds concerning harms to others).

Section 2 discusses permissible paternalism. It argues that we should accept a weak antipaternalist principle on which state actions can be paternalistically justified only if (a) they involve a relatively minimal infringement on the freedom, autonomy, or will of those targeted by the paternalistic action or (b) these actions provide a serious reduction to the likelihood of death or serious injury for those targeted by the

paternalism. Section 2 argues that there are good reasons to accept this weak antipaternalist principle, that it is relatively uncontroversial, and that there is no reason to reject it.

Sections 3 and 4 argue that this attractive weak antipaternalist principle implies that significant paternalistic limits on adult access to GAHRT cannot be justified. Section 5 argues that this case against significant limits on adult access to GAHRT has implications for the limits on adult access to GAHRT that have been implemented in the UK and the US, which have been justified on paternalistic grounds. Section 5 also discusses the implications of weak antipaternalism for Alessandra Lemma and Julian Savulescu's (2023) recent argument for a psychotherapy requirement on access to GAHRT.

Although significant limits on adult access to GAHRT cannot be paternalistically (or otherwise) justified, significant limits on youth access to GAH may be paternalistically justified. Section 6 discusses whether this is so. It focuses on laws and policies that stop trans teenagers from accessing puberty blockers. It discusses several accounts of when and/or why a paternalistic restriction on children ϕ-ing is justified and permissible even though a similar paternalistic restriction on adults ϕ-ing could not be justified or permissible. I argue that none of these accounts show that although it is not justified or permissible to (a) stop all adults from accessing hormone blockers, it is justified or permissible to (b) stop all teenagers from accessing hormone blocking puberty blockers. Sections 2–5 argue that (a) is impermissible. In this case, it follows that (b) is impermissible too. So, the bans on puberty blockers in twenty-five US states and the UK are impermissible and unjustified.

Before moving on to the argument of the paper, two questions need to be answered. The first question is, why does this paper discuss both GAH for adults and GAH for teenagers? It does this for several reasons. First, states are overriding medical professionals and medical guidelines and adopting paternalistically justified restrictions on access to GAH for both adults and teenagers. Second, this paper argues that there is a bridge from the justified conclusion that paternalistic restrictions on adult access to GAHRT are impermissible to the conclusion that paternalistic restrictions on teenage access to puberty blockers are impermissible. Finally, some of the paternalistic restrictions on access to GAH that have been implemented, and which are discussed in this paper, concern both adults and teenagers, such as Florida's restrictions in Senate Bill 254 (SB 254), which are discussed in both section 5.C and section 6 below, and Nebraska's restrictions, which are discussed in section 5.D.

The second question is, why does this paper discuss restrictions on GAH in both the UK and the US when the medical and legal systems in the UK and the US are very different? This paper discusses the UK and US restrictions as examples of what kinds of paternalistic limits on access to GAH are impermissible, and as examples of the practical implications of this paper's arguments. The differences between the UK

and the US do not stop us from being able to diagnose state limits on access to GAH as impermissible paternalism in both jurisdictions.

2. Impermissible Paternalism

Paternalism, at a minimum, involves someone or some entity coercing some agent A, or prohibiting or deterring A from doing something, without their consent, on the basis that this coercion or prohibition is in A's best interest (Dworkin 2020). For instance, a state that forces children to go to school to ensure that they get an education acts paternalistically toward them. Although paternalism toward children is often justified, permissible, or right, paternalism toward adults is often thought to be wrong, unjust, or illegitimate. One reason for this is that to treat adults paternalistically is often thought to involve an insult to them—namely, that they are incapable of promoting their own good. Many definitions of paternalism, such as Jonathan Quong's (2011, 80) and Seana Shiffrin's (2000, 218), hold that A acts paternalistically toward B only if A acts in a way that is motivated by a negative judgment about B's ability to act in their own interests. On this kind of view there is a strong reason to refrain from acting paternalistically because paternalism involves doing a form of expressive harm to the person targeted by this paternalism: paternalistic actions communicate the view that those subject to this paternalism do not have the requisite rational capacities to look after their own interests and so must have their own interests looked after by others, contrary to their own will and consent.

Many paternalistic state actions seem to be unjustified actions that a state should not take. It seems illegitimate for a state to entirely prohibit people from eating junk food, going mountain climbing, getting tattooed, having a hysterectomy, driving cars or motorcycles, boxing, kayaking through rapids, swimming alone at night, or marrying someone who will clearly be bad for them on the basis that these things could result in damage to peoples' interests (Flanigan 2017, xiii). A state that adopted such bans would seem to overreach and encroach on people's autonomy and liberty in an illegitimate or unjustified way. Some hold that paternalistic action by a state toward adults is always wrong and unjustified. This view is often attributed to John Stuart Mill and is often understood to be one of the main ideas articulated in Mill's harm principle, according to which someone's freedom can be restricted only in order to prevent harm to others (Brink 2022, §3.6). Other philosophers including Richard Arneson (1980), Michael Cholbi (2013), and Joel Feinberg (1986) have also argued that paternalism, or paternalistic state action, toward adults is always unjustified or wrongful.[1]

[1] For discussion, see Birks (2018, 137).

But some paternalistic state actions toward adults do seem justified and permissible, such as a state forcing everyone to wear seat belts while driving cars and to wear motorcycle helmets when riding motorcycles.[2] But these paternalistic laws have two features. First, these laws provide a serious reduction in individuals' chances of death or serious injury: requiring drivers and passengers to wear seat belts and motorcyclists to wear helmets makes them far less likely to die or be very seriously injured in a car/motorcycle crash. Second, these laws' infringements on individual freedom, autonomy, and/or will is minimal; these laws do not fundamentally interfere with how someone lives their life or what kind of activities they can engage in and experiences they can have. Requiring that someone wear a seat belt while they are in a car does not fundamentally interfere with the kinds of activities that someone can engage in; in contrast, banning someone from mountain climbing or eating junk food does interfere with the kinds of things that someone can do (Weston 2023, 64).

Given that the most plausibly justified or permissible paternalistic state actions that interfere with what adults can do have these two features, and that impermissible paternalism does not, we can endorse an antipaternalist principle that distinguishes between paternalistic actions that have such features and those that do not; namely, *weak antipaternalism*.

> *Weak antipaternalism:* Paternalism can serve as a justification for a legitimate and permissible state action concerning adults' self-regarding actions only if (a) the action's infringement on the freedom, autonomy, or will of those targeted by the paternalistic state action is minimal or (b) the action either on its own or in combination with similar actions provides a serious reduction to the likelihood of death or serious injury of those targeted by the paternalistic state action.

Hereafter, any reference to "weak antipaternalism" is a reference to this principle.

Weak antipaternalism holds that motorcycle helmet and seat belt laws can be justified, since these policies satisfy both (a) and (b). It might seem that we should hold that paternalistic state actions are permissible only if they satisfy *both (a) and (b).* But that may be a controversial claim. Bans on smoking (for those who do not currently smoke), such as the ban recently implemented by New Zealand, do not satisfy (a): such bans are not obviously a minimal encroachment on those banned from smoking. Yet we may think that these policies are permissible, since such smoking bans do have feature (b): they significantly reduce the likelihood of death or serious injury of those they ban from smoking.

[2] Unless they need to not wear a helmet to conform with their religious beliefs, as Sikhs do (Billingham 2017).

State actions that seem to be impermissible paternalism fail to satisfy both (a) and (b). For instance, banning all adults from ever mountain climbing would constitute impermissible state paternalism. Such a ban would involve a significant encroachment on mountain climbers' freedom, and mountain climbing with precautions does not seriously increase one's chance of death or serious injury. A blanket ban on driving would stop many people from doing many different things and so would involve a massive infringement on people's autonomy and freedom without seriously reducing most drivers' risk of death or serious injury. So, by the lights of weak antipaternalism such a ban would be impermissible.[3]

Although it is plausible that state seat belt and motorcycle helmet requirements are justified and permissible, and weak antipaternalism fits with and explains why this is so, weak antipaternalism should not be controversial even to those who are opposed to *all paternalistic state restrictions on adults* including seat belt laws. For weak antipaternalism only states a *necessary condition* on paternalistic state action being permissible or justified—namely, that such action must satisfy (a) or (b). It does not hold that satisfaction of (a) or (b) is *sufficient* for such state paternalism to be justified; that is a further question that goes beyond weak antipaternalism. Opponents of all paternalistic restrictions can agree with weak antipaternalism but still hold that state actions that satisfy (a) or (b) are still not permissible or justified, all things considered.

3. Paternalistic Limits on Adult Access to Gender-Affirming Health Care

Gender-affirming health care (GAH) interventions change, or stop changes to, individuals' primary or secondary sex characteristics through gender-affirming hormone replacement therapy (GAHRT) and/or hormone suppression or other procedures such as surgeries. GAHRT brings bodily changes. Assigned male at birth (AMAB) people on GAHRT who take estrogen and suppress their testosterone generally experience breast growth, the softening of skin, muscle atrophy from the

[3] It might seem that bans on taking out a subprime mortgage or significant restrictions on gambling are permissible forms of paternalism that breach weak antipaternalism and so this principle is not so weak after all. But financial ruin might well be thought to constitute a serious injury, in which case such bans and restrictions would not breach weak antipaternalism. Alternatively, weak antipaternalism could be revised to be made in terms of "serious harm or injury," and financial ruin is a serious harm. All the arguments that I make in the rest of this paper appear to be sound even if we understand this principle in this slightly broader way. For instance, the arguments that I make in §3–4 that GAHRT is not likely to lead trans people to experience serious injury generalize to show that GAHRT is not likely to lead trans people to experience serious harm.

chest and other places, thinning of body hair, some thickening and (re)growth of hair on the head, a change of fat distribution in which (relatively) more fat builds up in the cheeks of the face—making one's face look more feminine—and in the thighs and backside, and fat no longer builds up primarily in the belly (Vincent 2018, esp. 154). The prescription of testosterone causes the opposite fat distribution changes, and the opposite changes in terms of muscle growth and skin softening. Testosterone causes the growth of facial hair, causes one's voice to break (and so to deepen), it can also cause a loss of hair on one's head and emotional changes (Vincent 2018, 178–82; Plemons 2017, esp. 39–42).

Almost 90 percent of trans and nonbinary people seek GAHRT (Grassian 2022, 24; James et al. 2016, 99). Many trans people's gender identities are tied up with their sense that they should have different sex characteristics or bodily features. For instance, many trans men's, and some nonbinary assigned female at birth people's, gender identity is tied up with their sense that they should not have breasts and/or should have facial hair; many trans women's gender identity is tied up with their sense that they should have breasts, should not have facial hair, or should otherwise not look like a man; some nonbinary AMAB people also have such experiences. Many trans people want gender-affirming health care because they want, need, or judge that they should have the bodily changes that it brings and/or because they feel devastating gender dysphoria, sadness, depression, anxiety, or despair, because they do not have these bodily features (Cosker-Rowland 2022, 833–34). Many studies have demonstrated a link between (a) depression, anxiety, and suicidal ideation in trans people and (b) a lack of trans access to GAHRT; several studies, including a randomized controlled trial, have found that GAHRT lowers depression, suicidal ideation and suicide attempts in trans people (Nolan et al. 2023; Green et al. 2021; Almazan and Keuroghlian 2021; and Chen et al. 2023). Many trans people also want gender-affirming health care because it helps one to be treated as the gender that matches one's gender identity or to not be treated as the gender one was assigned at birth: for instance, not having breasts and having facial hair helps one not be perceived as a woman; having breasts and having the feminine distribution of fat that feminizing GAHRT brings helps trans women to be perceived and treated as women rather than as men (Serano 2016, 31; Bornstein 2016, 30–32; Cosker-Rowland 2022, 833–34). Many trans people, especially those who did not realize they were trans until later in life, find it very difficult to come out as trans or live as the gender that matches their gender identity without first having GAHRT. For instance, some trans women feel that they are unable to express their gender identity without being on a regime of GAHRT; e.g., they are unable to come out as a woman to others or to dress or express themselves in the feminine ways that they want to by wearing feminine clothing or makeup because they feel that they will look wrong—or will put

themselves at significant risk of being assaulted on the street—if they do this before they have begun a course of HRT (National Blood Clot Alliance 2023).[4]

> Recall the weak antipaternalism principle discussed above:
>
> *Weak antipaternalism:* Paternalism can serve as a justification for a legitimate and permissible state action concerning adults' self-regarding actions only if (a) the action's infringement on the freedom, autonomy, or will of those targeted by the paternalistic state action is minimal or (b) the action either on its own or in combination with similar actions provides a serious reduction to the likelihood of death or serious injury of those targeted by the paternalistic state action.

Limiting trans and nonbinary adults' access to GAHRT by forbidding them from accessing it or by requiring trans and nonbinary adults to wait several months before being able to access it lacks both (a) and (b) and therefore constitutes illegitimate or impermissible paternalism. Stopping someone from accessing GAHRT is anything but a minimal limit on their freedom, autonomy, or will. If someone is unable to access GAHRT for months or years, then they may suffer severe daily (or hourly) gender dysphoria. Stopping someone from accessing GAHRT may endanger their mental health, and may stop them from being able to live and express themselves as the gender they take themselves to be. Stopping someone from accessing GAHRT also seems to provide a significant restriction on their bodily autonomy: there is a pill or other medication they could take that could allow them to have a body that they want to have and are strongly motivated to have. So restricting someone from accessing GAHRT for (e.g.) years or at least six months on paternalistic grounds does not satisfy (a).

Limiting trans adults' access to GAHRT does not result in a serious lowering of the chances of death or serious injury of those who seek and would otherwise access GAHRT. Some studies have found that trans women taking oral estrogen have a higher risk of blood clots than people who are not trans women. And some studies have found that older trans women who have been on hormone replacement therapy, specifically those taking estradiol, for a long period of time have a higher risk of stroke,

[4] I was on GAHRT for over a year before taking any real steps toward a social gender transition as a trans woman. I have encountered many trans women who have taken a similar approach in trans support groups. A search of Reddit for "hormones before social transition" found many posts with people discussing not feeling comfortable socially transitioning before taking hormones and further commenters explaining similar experiences.

though not of death, than people who are not trans women (Masumori and Nakatsuka 2023). But these studies do not show that limiting trans women's access to GAHRT can be permissible paternalism in virtue of satisfying (b) for several reasons.

First, the World Professional Association of Transgender Health (WPATH), the world's foremost body of medical professionals engaged in trans health care, argue that these studies are insufficient to show that GAHRT is responsible for increased health risks to trans women. This is because many studies have shown that many minority groups have increased risks of cardiovascular disease and stroke that are at least partially the result of "structural factors such as access to care, socio-economic status, and allostatic load related to minority stress" (Coleman et al. 2022, S145). And trans and gender diverse "people often experience social, economic, and discriminatory conditions similar to other minority populations with known increased cardiovascular risk" (S110). WPATH therefore advises that medical professionals assess trans patients for cardiovascular and blood-clot risks and work with patients to help them minimize risks—for instance, by helping trans patients to reduce other factors that increase cardiovascular risk, such as helping them to stop smoking, eat healthily, and exercise (Coleman et al. 2022, S112, S145).

Second, we have unfettered access to many things, such as junk food, excessive amounts of fatty food, alcohol, driving, overworking, and failing to exercise, which are correlated with cardiovascular risks similar to those that long-term GAHRT for trans women and other AMAB people is alleged to have (Heart Foundation 2024; Pelc 2022; Ding et al. 2014). It seems that our access to these things should not be significantly restricted. Limiting access to GAHRT on these grounds would also be more intrusive than limits on access to all of these things except, perhaps, overworking. This may lead us to think that we should not understand "a serious reduction to the likelihood of death or serious injury" in (b) in such a way that it permits significant limits on trans women and other AMAB people accessing estradiol on the basis of stroke risk. For if such significant limits are permissible paternalism, then significant limits on access to alcohol, junk food, and overworking are also permissible paternalism, and significant limits on access to alcohol, junk food, and overworking are not permissible paternalism. So, given weak antipaternalism, significant paternalistic restrictions and bans on trans women and assigned male at birth people's access to GAHRT are impermissible.

There is little evidence that GAHRT causes significant health risks for trans men and assigned-female-at-birth (AFAB) nonbinary people. The most significant risk of GAHRT for trans men and AFAB people appears to be the possibility of heightened blood pressure, which could lead to an increased risk of heart attacks and stroke (Delgado-Ruiz, Swanson, and Romanos 2019). But this risk can be monitored, and treatment can be adjusted in light of it. Furthermore, many diets (e.g., those high in junk food or cholesterol) and many other actions that could not be permissibly

paternalistically significantly restricted (e.g., overworking, driving a lot) have similar cardiovascular risks, as discussed above.

Some argue that the rate of regret regarding GAH justifies deterring, or restricting, adults from accessing GAHRT because it shows that GAHRT is not in many adults' best interests, despite what they might believe when they attempt to access GAHRT. There is little systematic evidence of regret rates regarding GAH, however, and what evidence there is seems to show that regret rates are as low as regret rates for other kinds of medical procedures; for instance, the most systematic study that has been conducted found a regret rate of less than 6 percent for GAH (see §6.E below). So, policies that stop trans people from accessing GAHRT for months or years on paternalistic grounds are impermissible because they do not have features (a) or (b) that are required for permissible paternalism according to weak antipaternalism.

4. Objections

I have encountered two important objections to this argument. A first objection concerns diagnostic regulations. Diagnostic regulations are regularly practiced in medicine and, whatever their justification, do not seem to be forms of impermissible paternalism (cf. Flanigan 2017). For instance, guidelines for the prescription of ADHD medications standardly require 2–3 hours of time with a psychiatrist (which may take several sessions) before an ADHD diagnosis can be given to a patient and they can be prescribed medications for their ADHD (e.g., Australasian ADHD Guideline Development Group 2022). Whatever the exact justification of such diagnostic regulations (paternalistic or nonpaternalistic),[5] they seem to be not impermissible or impermissible instances of paternalism but only responsible medicine. Might significant restrictions on trans people accessing GAHRT be justified on similar grounds? If these significant restrictions could be justified on similar grounds, then these significant restrictions could be justified in the following way: they are necessary because in order to practice responsible medicine, someone needs to be diagnosed with gender incongruence or gender dysphoria before being given access to GAHRT, and a thorough responsible diagnosis of gender incongruence or gender dysphoria takes significant time.[6]

I do not want to dispute the following claim:

> *Appropriate diagnostic requirements are permissible.* If a certain form of evidence gathering or testing of a patient is a necessary or appropriate means for them to be diagnosed with a medical condition,

[5] Some ADHD medications are part of a class of illegal recreational drugs; restrictions on the latter may be paternalistic or other-regarding.

[6] Thanks to two referees for pushing me on this issue.

> and they need to be diagnosed with that medical condition in order to be given access to a particular medication, then it is permissible to require that form of evidence gathering or testing before a patient is given access to that medication.

But it could not be necessary or appropriate to stop trans people accessing GAHRT for several months or years in order to diagnose them with gender incongruence or gender dysphoria. Several months or years are not necessary for psychiatrists to diagnose people with other conditions such as ADHD, bipolar, or schizophrenia. And the conditions someone needs to meet in order to be diagnosed with gender incongruence or gender dysphoria do not seem to be conditions that would require more time to diagnose than these other conditions. For instance, someone will be diagnosed with gender dysphoria by a psychiatrist if the psychiatrist believes that they have had (i) a strong desire to be treated as a gender other than that which they were assigned at birth for at least six months and (ii) a strong desire to be that gender for at least six months.[7] It would be hard to see why a psychiatrist would need more than a few hours to ascertain that someone satisfies (i) and (ii) if they only need a few hours to ascertain that someone has had symptoms of ADHD, across a range of areas of their life, in both their adulthood and childhood, that are not better explained by some condition other than ADHD. Indeed, most psychiatrists do not need more than one appointment to take themselves to be in a position to diagnose someone with gender incongruence or gender dysphoria (Gender Care 2020) Furthermore, many organizations, including the World Professional Association for Transgender Health (WPATH), and many trans health professionals in the US and Australia, take an informed consent approach to enabling trans people to access GAHRT, which does not require any form of diagnosis (Coleman et al. 2022, esp. S32 and S110–S127;

[7] Or if they meet two out of four other conditions—or one of these four other conditions and one of (i) and (ii)—which include (iii) desiring to be rid of some of their sex characteristics due to their incongruence with their experienced gender for at least six months and (iv) desiring some of the sex characteristic associated with another gender for at least six months due to this incongruence (American Psychiatric Association 2022). Similarly, in the UK access to GAHRT is contingent upon being found to satisfy the *ICD-11*'s definition of gender incongruence, which involves a "persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender" (WHO 2015; see also NHS 2022b).

Spanos et al. 2021). So, the idea that any diagnosis could be necessary or appropriate to enable someone to access GAHRT is disputed by trans health professionals and, among others, the world's main body for transgender health. Therefore, restricting trans people from accessing GAHRT for months or years cannot be justified as part of appropriate or necessary diagnostic requirements.

An alternative line of response to this first objection would be to argue that diagnostic restrictions in general must satisfy weak antipaternalism, and they generally do, such as in the case of the diagnostic restrictions regarding ADHD and access to medications for ADHD: these restrictions are not significant impingements on autonomy and/or prevent significant injury or unnecessary harm. But, as I've argued, significant restrictions on access to GAHRT do not satisfy weak antipaternalism.

A second objection to my argument concerns life-altering and irreversible changes. Weak antipaternalism only claims that paternalistic state action is impermissible when it does not provide a serious reduction in the likelihood of serious injury of those targeted by the paternalistic state action. But proponents of limits on access to GAHRT often claim that (1) GAHRT creates life-altering or irreversible changes (see §5.B and §6 below), and it might be claimed that (2) life-altering or irreversible changes constitute (or are likely to constitute) serious injuries. If (1) and (2) hold, then significant restrictions on access to GAHRT do not breach weak antipaternalism.[8]

There are reasons to contest (1): it is not entirely clear that the changes that GAHRT leads to are irreversible or life-altering in the relevant sense. But I want to concentrate on contesting (2) here. Many life-altering and irreversible changes are clearly beneficial: having a child is life-altering and irreversible but is clearly beneficial for many and does not constitute a serious injury. Other life-altering and irreversible changes do constitute serious injuries: Gerald Dworkin (1972, 80) mentions becoming addicted to drugs that destroy one's mental or physical capacities. And it might well be that a state can permissibly restrict our ability to take such drugs on paternalistic grounds. One way to distinguish between these cases may be in terms of whether there is good reason to believe that someone who undergoes the life-altering and irreversible change is likely to be seriously injured or not. Many people who become addicted to drugs that destroy their mental or physical capacities seem to have been seriously injured by having these capacities destroyed. In contrast, many parents' well-being is enhanced by having children. So, although (2) is false, we might be able to make a related valid claim:

[8] Thanks to a referee for this objection.

> (2*) A life-altering or irreversible change should be treated as likely to lead to a serious injury *when it is likely to lead to a significant cost to one's well-being*.

But a trans person's undergoing a course of GAHRT is not at all likely to lead to a significant cost to their well-being. Multiple studies show that GAHRT significantly improves trans people's well-being (Nolan et al. 2023; Green et al. 2021; Almazan and Keuroghlian 2021; Chen et al. 2023) and, as I argued, in section 3, there is no reason to believe that people who undertake a course of GAHRT are at all likely to regret it. So, restrictions on trans adults' access to GAHRT cannot be justified on the grounds that GAHRT leads to life-altering or irreversible changes that are likely to lead to a serious injury to them.

5. Implications

5.A. Missouri

In April 2023 Missouri adopted an emergency rule requiring that trans and nonbinary adults must have three years of evidence of gender dysphoria documented by a medical professional prior to accessing GAHRT (Fentem 2023). This limit on adult access to GAHRT was explicitly adopted on the basis of paternalistic considerations; namely, that (trans) people who wish to access GAHRT will be better informed if they are required to wait three years and accumulate three years of documented evidence of their gender dysphoria before they are permitted to access GAHRT (Fentem 2023).

Given the argument in the previous sections, Missouri's limit is impermissible, illegitimate, and unjustified because it breaches weak antipaternalism. It is (a) a significant infringement on trans adults' freedom, autonomy, and wills and (b) it is not an infringement that serves to seriously reduce trans adults' chances of death or serious injury. So, by the lights of weak antipaternalism it is impermissible paternalism. And, as I argued in section 4, a three-year requirement is not a necessary or appropriate diagnostic requirement for someone to be diagnosed with gender dysphoria. Therefore, even if diagnostic requirements are a form of permissible paternalism, Missouri's requirement is not permissible or legitimate paternalism.

5.B. United Kingdom

Until at least 2018 many trans adults in the UK were required to satisfy a "real life experience" requirement (RLE) before accessing GAHRT. RLE requirements require trans people to publicly live as the gender that matches their gender identity for months by *inter alia* being out to everyone in their working and home lives as that gender, using a name that is associated with that gender, and dressing in ways that are (stereotypically) associated with that gender. For instance, until at least 2018 trans women in the UK had to live as women for several months before accessing

GAHRT (Pearce 2018, 65–68, 94, 148). The supposed justification of this was "to ensure that, possibly irreversible hormone treatment is not undertaken without there being a completely coordinated comprehensive care approach which has the ability to meet the changing needs of our service users flexibly and safely" (Leeds and York Partnership NHS Foundation Trust 2012; quoted in Pearce 2018, 189). This is a paternalistic justification, ensuring that patients do not have access to making potentially irreversible changes that may be against their interests. Such RLE requirements significantly limit the freedom, autonomy, and will of trans people; particularly pertinent in this context is that, as I explained in section 3, many trans people may strongly desire to be on GAHRT but may be extremely uncomfortable with living publicly as a gender other than that which they were assigned at birth prior to having GAHRT. And such RLE requirements do not avert any significant risk of injury or death. So, such RLE requirements are impermissible by the lights of weak antipaternalism. Furthermore, such lengthy RLE requirements are not necessary in order to diagnose someone with gender dysphoria or gender incongruence since, as I argued in section 4, no more than one or two meetings are necessary or appropriate requirements for such a diagnosis. Therefore, such RLE requirements are impermissible.

5.C. Florida

In 2023 Florida passed Senate Bill 254 (SB 254).[9] This bill banned all GAH for children. But SB 254 also banned 80 percent of GAHRT for trans and nonbinary adults in the state because most GAHRT for trans and nonbinary adults in Florida is provided by nurse practitioners and SB 254 bans nurses from providing GAHRT. Soft paternalism regarding X is designed to make it more difficult for those subject to paternalism regarding X to access X. For instance, prior to the reversal of *Roe v. Wade*,[10] Texas made it more difficult for people to access abortions by restricting the clinics that could provide abortions, and the putative justification for this law was that it promoted the well-being of women seeking abortions (because, it was claimed that, abortions frustrate their well-being). So, Texas tried to paternalistically deter people from having abortions by restricting who could provide an abortion (Mayans and Vaca 2018, 30–31). Similarly, Florida seems to have attempted to make it more difficult for trans adults to access GAHRT by severely curtailing its availability within the state.

[9] S.B. 254, Treatments for Sex Reassignment, 2023–2024 Leg., Reg. Sess. (Fla. 2023). This bill was blocked in mid-2024, but the block was overruled in August 2024 (Associated Press 2024).

[10] *Roe v. Wade*, 410 U.S. 113 (1973); *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022).

The sponsors of SB 254 justified the bill on paternalistic grounds—namely, the supposed bad consequences of GAH for those who have it (Sexton 2023). So, Florida's ban on 80 percent of GAHRT for trans adults is a paternalistic attempt to deter trans and nonbinary adults from accessing GAHRT and therefore falls within the scope of weak antipaternalism. And this ban significantly impacts the freedom, autonomy, and will of trans Floridians; it makes many trans Floridians unable to access GAHRT, which significantly impacts their freedom, autonomy, and will. Therefore, these limits on access to GAHRT do not meet the first clause, (a), of weak antipaternalism's bar for legitimate paternalistic state action. And given that such limits on access to GAHRT cannot meet the second clause (b) of this weak antipaternalist constraint, Florida's soft paternalistic restriction on trans and nonbinary adults' access to GAHRT falls afoul of the weak antipaternalist constraint too.

5.D. Psychotherapy Requirements

Other limits have been proposed on access to GAHRT. For instance, Lemma and Savulescu (2023) propose that trans and nonbinary people be required to engage in psychotherapy before being given access to a regime of GAHRT. Lemma and Savulescu are not entirely clear about the details of this psychotherapy requirement. Some weak version of this requirement may not fall afoul of weak antipaternalism. For instance, a requirement that before being enabled to access GAHRT, a trans or nonbinary person has one or two sessions of psychotherapy, scheduled for the week after their appointment with a doctor requesting HRT, may not breach weak antipaternalism. This would not constitute a significant impingement on anyone's autonomy, freedom, or will. And this would not be a requirement greater than the therapy requirements that those seeking IVF or an abortion are subject to in many jurisdictions. Yet more significant therapy requirements would breach this weak paternalism requirement. For instance, Nebraska recently released guidelines requiring anyone below the age of nineteen to have at least forty hours of therapy for a maximum of two hours per week (so at least five months of therapy) not in a gender-affirming context prior to accessing GAHRT (Reed 2023). A psychotherapy requirement along these lines that required several months of psychotherapy prior to initiation of GAHRT and that was applied to all trans adults seeking GAHRT would breach weak antipaternalism. And such a requirement could not be justified as necessary or appropriate for diagnostic reasons for, as I argued in section 4, no more than a few hours, and definitely not five months, are necessary or appropriate for someone to be diagnosed with gender incongruence or gender dysphoria. Therefore, significant psychotherapy requirements are impermissible.

6. Paternalistic Limits on Teenage Access to Puberty Blockers

The UK and twenty-five US states have banned puberty blockers and all GAH for trans minors (Simons-Duffin and Fung 2024; Triggle 2024). The justifications for these bans on puberty blockers are paternalistic. For instance, signing Alabama's ban on GAH for minors into law, Alabama governor Kay Ivey said, "We should especially protect our children from these radical, life-altering drugs and surgeries when they are at such a vulnerable stage in life" (Alfonseca 2023). As discussed briefly in section 5.C, Florida's ban on trans minors accessing GAH has a paternalistic rationale. Are these paternalistic bans on trans teenagers' access to puberty blockers permissible? I will focus on whether it is permissible for a state to ban trans teenagers who have been diagnosed with gender incongruence/dysphoria from accessing puberty blockers; these are the only subset of trans minors that WPATH recommends be prescribed puberty blockers (Coleman et al. 2022, S48). I will make the following argument:

(1) Paternalistic bans on adults accessing hormone blockers are impermissible forms of paternalism.
(2) No plausible account of when it can be permissible to ban teenagers from accessing X even though it is impermissible to ban adults from accessing X implies that although it is impermissible to ban adults from accessing hormone blockers, it is permissible to ban teenagers from accessing hormone blockers (puberty blockers).

It follows from (1) to (2) that bans on teenagers accessing puberty blockers are impermissible.[11] Sections 2–5 argued for (1). In this section I will argue for (2).

6.A. Settled Preferences

There are several different accounts of why it is easier to justify paternalistic restrictions on children's actions than on adults' actions. A first way of differentiating adults' rights against paternalism from children's rights against paternalism is in terms of their settled preferences: adults have settled preferences but children lack them (Feinberg 1986, 115; Mill 1869, ch. 5; Schapiro 1999, 729; Grill 2019, 125–26). This is an intuitive rationale in the case of GAH too. For part of the paternalistic case against

[11] We may also need a further premise such as: if paternalistic bans on adults accessing X are impermissible, then other-things-equal paternalistic bans on teenagers accessing X are impermissible. This is very plausible since in all the cases where such bans on teenagers are plausibly permissible, other things are not equal for the kinds of reasons discussed below.

allowing trans teenagers to access GAH, which we see in both Alabama's and Florida's justifications of these bans, is that GAH is life-altering and trans youth are not in a position to know that they have a settled preference for being a gender different from that which they were assigned at birth or having sex characteristics different from those which they would form through endogenous puberty.

But even if a difference between children and adults in terms of settled preferences could justify paternalistic limits on youth access to some forms of GAH, it could not justify paternalistic limits on access to puberty blockers. For there is no evidence that puberty blockers lead to life-altering changes. Puberty blockers just give trans teenagers time to assess whether they wish to (i) have the somewhat irreversible changes that endogenous puberty brings, giving them secondary sex characteristics associated with the gender they were assigned at birth, or they wish to (ii) have the somewhat irreversible changes that GAHRT brings, giving them the secondary sex characteristics associated with a gender that they were not assigned at birth. Puberty blockers themselves do not cause a significant risk of harm and so do not lead to life-altering changes for that reason. Long-term puberty suppression has been found to lead to a decrease in bone density. But puberty blockers' long-term effects on bone density have only been shown to increase the risk of hip fracture by 0.3 percent and to increase the risk of other fractures by 1 percent (Ashley 2022, 149; Pang et al. 2020; Beattie 2022, 73). More generally, the jurisdictions that have banned puberty suppression for trans and nonbinary youth still allow puberty suppression for (cis) children for the purpose of preventing precocious puberty (NHS 2022a; Thorn 2023). There is no reason to believe that a child's experiencing precocious puberty involves greater harm to them than their being forced to go through a puberty that gives them sex characteristics they strongly desire not to have. So, the jurisdictions that have prevented trans and gender diverse teenagers from accessing puberty blockers seem committed to the view that puberty blockers are relatively safe. And several systematic reviews have found that puberty blockers themselves are reasonably safe (Bragge et al. 2024; Queensland Health 2024; Ashley 2022, 149).[12] So the difference between adults and teenagers regarding settled preferences cannot justify banning puberty blockers when it is impermissible to ban adults from accessing hormone suppressors.

6.B. Prudence

A second, related account of why paternalistic restrictions on children's actions can sometimes be justified when similar restrictions on adults' actions could

[12] Even reviews generally unfavorable to puberty blockers, such as the UK's *Cass Review*, which is the review that led the NHS to ban puberty blockers, do not hold that evidence shows that puberty blockers harm trans youth (Cass 2022, 15).

not be concerns a (supposed) difference in adults' and children's typical capacities for prudence. For instance, Grill (2019, 127) says,

> What children will, or want, may often be quite myopic. Young children are often quite spontaneous, oblivious to what will be important to them in the next moment, much less in the next year. Many adolescents are easily overwhelmed by strong impulses and feelings, which they may be experiencing for the first time. Adolescents also typically lack a sense of proportion and may have a strongly inflated or deflated view of themselves. This all means that children may on average be less prudent than adults, which means that they will more often make choices that are suboptimal or even harmful from a long-term prudential perspective. This, in turn, may give us stronger reason to interfere with them against their will and for their good.

This is a plausible account of why a state sometimes has stronger reasons to adopt paternalistic limits on children's actions than on adults' actions. But this justification of paternalistic restrictions on children's actions does not seem to justify preventing all teenagers from accessing puberty blockers. Puberty blockers give trans teenagers time to figure out and get the requisite sense of proportion. Furthermore, this kind of justification would not seem to justify bans on access to puberty blockers when expert doctors and a teenager's parents agree that puberty blockers are appropriate for them because the teenager has been found to have gender incongruence/dysphoria—and accordingly has been found to have wanted to be a different gender, to be treated as a different gender, and/or to have different sex characteristics for a significant period of time. Yet bans on puberty blockers in twenty-five US states and the UK apply in such circumstances.

6.C. Securing Future Possibilities

Third, paternalistic restrictions on children's actions are sometimes thought to be permissible when and because they secure children a large set of possibilities for their future, secure their future autonomy, or promote the well-being of their future selves; this is why it is permissible for liberal states to mandate compulsory education for instance (Grill 2019, 131, 126; Feinberg 1986, 326). But puberty blockers seem to facilitate rather than clampdown on such future opportunities (Wenner and George 2021). So, a future autonomy-based justification of paternalistic action toward children cannot be employed in support of a blanket ban on puberty blockers for trans minors. Furthermore, the future well-being of trans youth who, as adults, live as a gender different from that which they were assigned at birth would seem to be promoted by puberty blockers. Trans adults who have not had puberty blockers and

wish to treat their gender dysphoria may need expensive surgery, such as a mastectomy, or hours of expensive and painful laser hair removal or electrolysis, to counteract the effects of their endogenous puberty, while other effects of endogenous puberty, such as broader shoulders for those who were assigned male at birth, cannot be counteracted. These changes make it the case that trans adults who have gone through endogenous puberty, and have not had puberty blockers, find it harder to be treated as the gender that matches their gender identity. Travers (2021) accordingly argues that trans youth who do not have access to puberty blockers "endure more financial hardship, physical pain and mental anguish later in life" than trans youth who have access to puberty blockers, and that trans youth who do not have access to puberty blockers "becom[e] much more vulnerable to discrimination and violence" than trans youth who do have access to them (see also Travers 2018).

6.D. The Caretaker View

A fourth view is that children can be paternalistically prohibited from ϕ-ing by the state when it knows that if they were adults they would choose to not-ϕ. In an important book on children's rights, David Archard (2004, 78) discusses this view as the caretaker thesis: "The caretaker, if you like, chooses for the child in the person of the adult which the child is not yet but will eventually be." Given that trans adults experience large benefits from having blocked their endogenous puberty, that many trans adults bemoan that they did not block their endogenous puberty, and that there are few costs to puberty blockers, we might well think that adults would prefer that their teenage selves had blocked their puberty if they experienced persistent gender dysphoria as a child and in their teens. Furthermore, Archard (2004, 84) holds that the caretaker thesis implies that "the good caretaker must strive both to realise the child's particular nature *and* to safeguard her 'open future.'" And it seems that puberty blockers speak to both these requirements on the good caretaker: they preserve a child's open future, and they respect their particular nature by not forcing them to go through a puberty at odds with their experiences of gender dysphoria.

6.E. An Objection

I have been arguing that

> (2) no plausible account of when it can be permissible to ban teenagers from accessing X even though it is impermissible to ban adults from accessing X implies that although it is impermissible to ban adults from accessing hormone blockers, it is permissible to ban teenagers from accessing hormone blockers (puberty blockers).

And I have already established that

> (1) paternalistic bans on adults accessing hormone blockers are impermissible forms of paternalism.

And it follows from (1) and (2) that bans on teenagers accessing puberty blockers are impermissible.

One objection that is often made to defenses of the prescription of puberty blockers is that most trans children who experience persistent gender incongruence or gender dysphoria do not turn into trans or nonbinary adults. Proponents of bans or restrictions on puberty blockers often point to studies that they claim show that only 15–40 percent of trans children who experience gender dysphoria or gender incongruence continue to experience gender dysphoria or gender incongruence later in their lives (Baron and Dierckxsens 2022, 604; Steensma et al. 2011; Steensma et al. 2013; Wallien and Cohen-Kettenis 2008).

There is good reason, however, to contest that this data is correct and is genuinely relevant to the argument that I have been making regarding trans teenagers. Some of these studies do not show this 15–40 percent figure. For instance, Madeleine Wallien and Peggy Cohen-Kettenis's (2008) study only shows that 43 percent of their participants who experienced gender dysphoria in their childhood did *not* continue to experience gender dysphoria later in their lives, rather than showing that only 15-40 percent continued to experience gender dysphoria later in their lives. The other studies that are cited concern whether children below the age of twelve continue to have gender dysphoria later in their teens. Such studies appear to be irrelevant to the question of whether puberty blockers may be prescribed to trans teenagers who have gender dysphoria because such studies do not show anything about whether teenagers who experience gender dysphoria or gender incongruence after the age of twelve will continue to have this experience later in life.[13] Additionally, studies of trans children who have socially transitioned to another gender found that only 7.3 percent had socially retransitioned to a different gender five years later (Olson et al. 2022). Similarly, a recent study of all the children that went through the only gender clinic in Western Australia found that out of the 548 teenagers referred to the clinic between the beginning of 2014 and the end of 2020, only 5.3 percent (29 teenagers) detransitioned or came to reidentify with the gender they were assigned at birth; and of those 29 teenagers, 27 reidentified with the gender they were assigned at birth very early in the assessment process. Unlike the patients in other studies, these patients were all referred to the clinic as teenagers: the mean age for those assigned male at birth who were referred to the clinic was

[13] Beattie (2022, 74) notes other problems with these studies.

13.88 years old; the mean age for those who were assigned to the clinic who were assigned female at birth was 15.81 years old (Cavve et al. 2024). So, it seems that there is reason to believe that in fact over 90 percent of trans teenagers diagnosed with gender incongruence or dysphoria continue to experience this later in their lives.

Furthermore, Cameron Beattie (2022, 73) makes the plausible argument that even if it were true that only 15–40 percent of trans teenagers' gender incongruence or dysphoria persisted into adulthood, prohibiting puberty blockers on this basis would be a mistake because puberty blockers (a) will still significantly benefit this 15–40 percent of trans children who turn into trans adults, (b) will not significantly harm those trans children who do not turn into trans adults, and (c) would in fact still benefit those trans children who do not turn into trans adults at the time by diminishing their negative experiences—and keeping their options open for the future.

7. Conclusion

There is a recent international trend toward limiting trans and gender diverse adults and teenagers' access to gender-affirming health care. These limits are almost uniformly justified on paternalistic grounds. This paper has shown that this trend involves impermissible state paternalism and that this trend should be condemned and, if possible, reversed. Some paternalistic state actions are impermissible, such as banning or very significantly restricting all adults from getting tattoos, eating junk food, or going mountain climbing. Other forms of state paternalism are plausibly justified and, at least, permissible, such as requiring all adults to wear seat belts when they are driving. Section 2 gave a plausible principle, *weak antipaternalism*, that explains the difference between these impermissible and plausibly permissible forms of paternalism. Sections 3–5 argued that many limits on trans adults' access to GAHRT that have been implemented in the UK and US fall afoul of this weak antipaternalist principle and so are impermissible forms of paternalism. Section 6 discussed existing accounts of when paternalistic restrictions on teenagers' accessing X can be permissible even though similar paternalistic restrictions on adults accessing X are impermissible. It argued that none of these accounts can be used to ground an asymmetry between paternalistic restrictions and bans on adult access to hormone blockers, which were argued to be impermissible in sections 3–5, and paternalistic restrictions and bans on teenage access to puberty blockers. In this case, paternalistic bans on trans teenagers accessing puberty blockers, which have been implemented in twenty-five US states as well as the UK, are impermissible.

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