DOCTORS FOR AMERICA

The *Caring* Clinician's Guide

Prepared for Doctors for America by student attorneys under the supervision of a licensed attorney pursuant to D.C. App. R. 48 in Spring 2025.

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The *Caring Clinician's Guide* ("Guide") was researched and written by student attorneys based in the District of Columbia during the 2025 Spring Semester.

This Guide was prepared for Doctors for America ("DFA") under the supervision of a licensed attorney pursuant to DC Rule 48. To learn more about DFA, please visit their website and review their mission statement **here**.

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Please be advised that this Guide was last substantively updated on **April 19, 2025.** Readers should remain mindful that laws can and often do change quickly. A non-exhaustive list of external resources, summaries of pending litigation, and other relevant supplemental material that may be helpful for readers to consult can be found in the Guide's Appendix.

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EXECUTIVE SUMMARY

Access to gender affirming care is essential to the overall well-being and positive development of individuals diagnosed with gender dysphoria. Substantial clinical evidence shows that gender affirming care is a safe and effective treatment for gender dysphoria, for adults and minors alike. Doctors for America ("DFA") firmly believes in a patient's right to choose a treatment plan that is best suited for them and their individual circumstances, guided by healthcare providers and—in the case of minors—their parents or guardians. DFA does *not* believe that politicians have a place in the exam room. Unfortunately, Congress and conservative states across the country have invited themselves in and have severely restricted, and even criminalized, safe, patient-preferred medical treatments for gender-affirming care; just as they did with reproductive healthcare. With the rise in state prohibitions or severe restrictions on gender affirming care, doctors are facing an increasingly difficult, and legally precarious, landscape. While clinicians have an ethical duty to provide adequate care to their patients, clinicians must also grapple with potential legal consequences. This Guide is intended to serve as a resource for clinicians in Washington, DC providing gender affirming care to patients in the District or elsewhere. **This Guide does not provide legal advice, and clinicians are encouraged to seek legal counsel that can better assess their individual circumstances.**

This Guide includes four major components. **First,** the Guide provides a roadmap for how best to use the Guide. This section reminds readers of why gender affirming care is critical to patients, summarizes recent state and federal actions restricting access to gender affirming care, and provides an overview of interstate "shield laws." Additionally, this section discusses the role of licensure and its impacts on telemedicine. **Second,** the Guide provides a legal risk analysis for DC doctors providing gender affirming care to patients who reside in DC. Although this is a lower-risk activity, this section offers important insights into how recent federal actions may implicate institutions that receive federal funding. Given DC's unique dependence on Congress to approve locally adopted legislation, this section will also discuss how that relationship may impact future legislation within the District. **Third,** the Guide analyzes risks for DC clinicians who provide gender affirming care to patients who live outside of the District. Given the number of states with severe restrictions on the provision of gender affirming care (and consequences for violating these restrictions), this activity is considered higher risk; but DC's shield law may offer some protection. **Fourth,** the Guide discusses HIPAA and advises clinicians on maintaining strong data protection practices, which is increasingly of concern for telemedicine providers. This section also offers a toolkit for clinicians committed to advocating for preserving access to gender affirming care. **Lastly,** the Guide provides clinicians five final recommendations for how they advocate locally and nationally and assess their own circumstances.

This Guide is not intended to be an exhaustive resource on how clinicians can support patients in need of gender affirming care. Rather, it is one of many tools that clinicians can rely on in deciding how best to care for their patients.

I. INTRODUCTION

A. Who This Guide Is For and How Best to Use It

Summary: *This Guide is intended to support DC clinicians, who provide gender affirming care to DC patients (meaning patients who are in DC). But this Guide may also be helpful for DC clinicians who provide care to patients located outside of DC. Regardless of the clinician's practice and circumstances, this Guide is not intended to serve as legal advice. All clinicians are advised to consult individually with an attorney before providing gender affirming care to patients located outside of DC.*

Gender affirming care[1] is under attack, at both the state and federal level. The onslaught of efforts to restrict patients' access to this life-saving care[2] creates a legal landscape that is both ever-changing and increasingly complicated for clinicians to navigate.[3] Although DC clinicians live and practice within a place that is supportive of gender affirming care,[4] DC clinicians must still understand how DC law interacts with the laws of other states and federal law—especially if clinicians choose to provide care to patients living outside of DC. This is particularly important given the nature of DC's relationship with its neighbors, Maryland and Virginia. Local clinicians may consider themselves "DMV Providers" instead of "DC Providers." **This Guide acknowledges this reality but is limited to an analysis of DC and federal law only.**

> **"It's like anything else in medicine. We put on PPE, and we make sure the scene is safe before we respond to an emergency. This Guide is our PPE."**
>
> *Dr. Christine Petrin, DFA Board President*

This Guide is intended to support DC clinicians by discussing the District of Columbia's "shield law"—the "Human Rights Sanctuary Amendment Act of 2022"—and analyzing how this law can protect clinicians if they provide gender affirming care to patients, both in and outside of the District. Although this Guide is meant to be a resource for clinicians by helping them better understand the law, its nuances, and its relationship with other state and federal laws, this Guide should be used for educational purposes only. Clinicians, like their patients, practice within diverse sets of circumstances that can affect how the shield law is applied. **Thus, any clinician who chooses to provide gender affirming care should consult an attorney for individualized legal advice before doing so.** Additionally, this Guide includes an analysis of other laws and actions that have prohibited or restricted gender affirming care. Because this analysis addresses sensitive issues of criminal and civil liability, **it is important that this information be held closely and used by DFA members only.**

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[1] For the purposes of this Guide, gender affirming care is an inclusive term that refers to mental health support, puberty blockers, hormone therapies, and, for adults, gender affirming surgery.

[2] *See* Amy E. Green, Jonah P. DeChants, Myeshia N. Price, & Carrie K. Davis, *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. Adolescent Health 643, 647 (2022) (link); *see also* Laura E. Kuper, Sunita Stewart, Stephanie Preston, May Lau, & Ximena Lopez, *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*, 145 Pediatrics 1, 5–9 (2020) (link).

[3] Lindsey Dawson & Jennifer Kates, *Policy Tracker: Youth Access to Gender Affirming Care and State Policy Restrictions*, KFF (updated Nov. 26, 2024) (link).

[4] *See, e.g.*, *District of Columbia's Equality Profile*, Movement Advancement Project (last visited Feb. 24, 2025) (link).

This Guide also recognizes that not every clinician will be able to continue providing gender affirming care. But that does not mean a clinician is left without options to support their colleagues and patients. **Clinicians have a long history of being on the frontlines of social justice and health equity movements.** From the medical civil rights movement, in which clinicians called upon the American Medical Association[5] to end segregated healthcare,[6] to the Jane Collective, an underground network of medical students who provided safe abortions,[7] clinicians have used their expertise and experience to advocate on behalf of their patients and colleagues. **This moment is no different.** See **Part V** for additional recommendations on how you can still support this effort.

B. Why Gender Affirming Care Is Important

Summary: *Patients deserve to have the autonomy to choose care that is best for them. Gender affirming care is critical to the healthy development of trans and gender-diverse individuals, including both adolescents and adults. Despite the evidence that demonstrates the effectiveness of gender affirming care, over half of the states have restricted gender affirming care. The Trump Administration has taken similar steps and has attempted to limit gender affirming care nationally, by restricting the use of federal funds to support the care.*

WARNING: HHS Creates Gender Affirming Care Tip Line, Issues Guidance to Whistleblowers

On April 14, 2025, HHS created a tip line for individuals to report suspected "chemical and surgical mutilation" of children, and issued guidance on how individuals can report clinicians suspected of providing gender affirming care under the HIPAA whistleblower exception.[8] (See **Part IV.A**) The guidance explicitly claims that complaints related to the prescribing of puberty blockers to minors, in states where such prescriptions are prohibited, qualify for whistleblower protection. The creation of this tip line is a recent development, and the ramifications are unclear. **Implementation of the tip line should be monitored closely, and all clinicians should critically assess how this may impact their practice.**

The evidence is clear: gender affirming care supports healthy outcomes for transgender, intersex, and gender-diverse adults[9] and youth.[10] Not only is such care safe and effective, but it also affords patients the

[5] James L. Madara, *Reckoning With Medicine's History of Racism*, Am. Med. Ass'n (Feb. 17, 2021) (link).
[6] *See* Nat'l Libr. of Med., *The Medical Civil Rights Movement and Access to Health Care*, Nat'l Inst. of Health (Jan. 14, 2016) (link).
[7] *See* Elisabeth Heissner & Hannah Johnson, *The Jane Collective: Health Care For and By Women*, Chicago Hist. Museum (Jan. 21, 2025) (link).
[8] *Guidance for Whistleblowers on the Chemical and Surgical Mutilation of Children*, U.S. Dep't of Health & Hum. Servs. (last reviewed Apr. 14, 2025) (link); *see also Whistleblower Tips and Complaints Regarding the Chemical and Surgical Mutilation of Children*, U.S. Dep't of Health & Hum. Servs. (last reviewed Apr. 14, 2025) (link); *see also* S. Baum, *HHS Launches Snitch Form to Report Gender Affirming Care Providers*, Erin In The Morning (Apr. 15, 2025) (link).
[9] *See, e.g.*, Min Kyung Lee, Yuehwern Yih, Deanna R. Willis, Janine M. Fogel, & James D. Fortenberry, *The Impact of Gender Affirming Medical Care During Adolescence on Adult Health Outcomes Among Transgender and Gender Diverse Individuals in the United States: The Role of State-Level Policy Stigma*, 11 LGBT Health 111–21 (2023) (link).
[10] *See e.g.*, Diane Chen et al., *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, 388 New Eng. J. Med. 240 (2023) (finding hormone therapy safe and effective for treating gender dysphoria in transgender teens) (link).

ability to live their fullest, most authentic lives.[11] Gender affirming care leads to better mental-health outcomes in adulthood[12] and supports healthy mental and emotional development in minors.[13] And access to gender affirming care is even more essential for transgender people of color, who already face significant barriers to equitable healthcare.[14]

Yet, despite this evidence, twenty-seven state governments have restricted access to gender affirming care. Most notably, several states have barred gender affirming care for minors,[15] and others have made accessing care burdensome for adults.[16] It comes as no surprise that many of these laws were adopted after the Supreme Court ruled, in *Dobbs v. Jackson* (2022), that states have the authority to limit healthcare options for pregnant people.[17] And it seems likely that the Supreme Court will similarly hold that states have the authority to restrict healthcare options for transgender and gender-diverse people.[18]

> **"There is nothing like living comfortably in one's body. Being able to look into the mirror and being happy with the reflection I see has been magical. I no longer dislike the person looking back at me and that has made life worth living."**
>
> - Jessie Lee Ann McGrath,[19] a Los Angeles prosecutor, who came out as trans in 2015.[20]

With the new Trump Administration, the federal government is following conservative states' lead and has taken several steps to limit access to gender affirming care at the federal level. Of note, the Trump Administration issued two Executive Orders in the days following his Inauguration that aimed to restrict access to gender affirming care: "*Defending Women From Gender Ideology Extremism and Restoring*

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[11] *See, e.g.*, *id.*; *see also* Diana M. Tordoff, Jonathon W. Wanta, Arin Collin, Cesalie Stephney, David J. Inwards-Breland, & Kym Ahrens, *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 JAMA Network Open 220978 (2022) (finding same for use of puberty blockers in transgender teens) (link).

[12] *See, e.g.*, Jack L. Turban, Dana King, Julia Kobe, Sari L. Reisner, & Alex S. Keuroghlian, *Access to Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, 17(1) Plos ONE, e0261039 (2022) (link).

[13] Tordoff et al., *supra* note 11.

[14] Ilan H. Meyer, Taylor N.T. Brown, Jody L. Herman, Sari L. Reisner, & Walter O. Bockting, *Demographic Characteristics and Health Status of Transgender Adults in Select US Regions: Behavioral Risk Factor Surveillance System*, 107. Am. J. of Pub. Health, at 582–589 (2017) (link).

[15] Dawson & Kates, *supra* note 3; *see, e.g.*, Ala. Code § 26-26-4 (link) (prohibiting the use of hormone therapies, puberty blockers, and surgery for all minors); Ga. Code Ann. § 31-7-3.5 (link) (prohibiting gender affirming surgery and hormone therapies for minors); Iowa Code Ann. § 147.164 (link) (prohibiting use of hormones, puberty blockers, and surgery for minors).

[16] *See, e.g.*, Fla. Code Ann. § 456.52 (link) (allowing only licensed physicians to prescribe, administer, or perform gender affirming care, even for adults); Mo. Code Ann. § 208.152.15 (link) (prohibiting use of Medicaid funds for surgical or prescription gender affirming care, including adults); N.C. Gen. Stat. Ann. § 90-21.152(d) (link) (allowing clinicians to refuse gender affirming care to adult patients, allowing hospitals and facilities to restrict gender affirming care, including for adults).

[17] Dobbs v. Jackson Women's Health Organization, 597 U.S. 215 (2022) (link).

[18] *See* Adam Liptak & Emily Bazelon, *Supreme Court Seems Inclined to Uphold Tennessee Law on Transgender Care*, N.Y. Times (Dec. 4, 2024) (link). Note: This Guide occasionally cites The New York Times. Although this Guide relies on the publication and some of its reporting, the Guide's authors acknowledge the publication has a troubling history of publishing stories with a distinctly anti-trans tone. *See, e.g.*, Mary Yang, *'New York Times' Stories on Trans Youth Slammed by Writers—Including Some of Its Own*, NPR (Feb. 15, 2023, 5:28 PM) (link). By citing to the New York Times, the authors do not suggest they endorse the publication and how it has addressed trans stories. *See also* United States v. Skrmetti, No. 23-477, U.S. ___ (2023) (link); *see also* Appendix, Part B.

[19] Brief of Elliot Page et al. as Amici Curiae Supporting Petitioner, United States v. Skrmetti, 144 S. Ct. 2679 (Nos. 23-466, 23-477, 23-492) (link).

[20] David Ono, *Veteran L.A. Prosecutor Takes Courageous Step to Live Her True Identity as Transgender Woman*, ABC 7 (June 29, 2019) (link).

Biological Truth to the Federal Government,"[21] which banned the use of federal funds supporting "gender ideology," and "*Protecting Children From Chemical and Surgical Mutilation*," which banned federal funding to medical institutions which provide gender affirming care to minors.[22] We summarize these Orders in greater detail in the **Appendix**. But note that these orders have the devastating effect of limiting gender affirming care, even in states that have adopted laws that seek to protect patients and their care, because of hospitals' and medical schools' reliance on federal funding, including Medicare and Medicaid.[23] In addition to the Executive Orders, which have potential, enforceable ramifications, President Trump has also continued the dangerous rhetoric of comparing gender affirming care to child abuse.[24]

In short, the current reality is terrifying, dangerous, and potentially life-threatening. **This bleak reality reinforces what Doctors for America has firmly believed since its inception:** clinicians have the opportunity—and responsibility—to partner with their patients and ensure they have access to the care that is best for them.[25] This means clinicians should honor their patients' rights to bodily autonomy and uphold their professional duty to provide reasonably diligent care that supports their patient's choices to the fullest extent possible. This also means that healthcare systems should honor clinicians' ethical duty to continue providing care that patients need and deserve—even if it means risking potential retaliation from the federal government. We talk about this more in **Part II.D.**

C. Licensure, Registration, Certification, and Telemedicine

Summary: *The DC Board of Medicine regulates clinician licensure, for both in-person care and care via telemedicine. DC participates in the Interstate Medical Licensure Compact, allowing DC clinicians the ability to practice in multiple states, if the clinician chooses to be licensed in those states. To practice telemedicine in DC, clinicians must be licensed and must abide by all standards of care related to the practice, including those pertaining to prescription drugs. DC clinicians should be aware that all prescription drugs are monitored by DC, and some states may monitor certain medications to determine whether a clinician has provided restricted care to a patient.*

Medical licensure is overseen by state boards of medicine. Clinicians in each state typically have two paths to licensure: (1) applying directly to the state' board of medicine or (2) applying for an expedited license through the Interstate Medical Licensure Compact ("IMLC"),[26] which expedites clinician licensing across participating states when the clinician is already licensed in one.

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[21] Exec. Order No. 14,168, 90 Fed. Reg. 8615 (Jan. 30, 2025) (eliminating the use of "gender identity" by the federal government and ordering the sole use of "male" or "female" to categorize individuals) (link).
[22] Exec. Order No. 14,187, 90 Fed. Reg. 8771 (Feb. 3, 2025) (prohibiting medical institutions, which provide gender affirming care, from accessing federal funds) (link).
[23] *See* Elayne J. Heisler, Michele L. Malloy, Alison Mitchell, & Marco A. Villagrana, Cong. Rsch. Serv., RL31340, Sources of Federal Funding for Health Care Facilities: Frequently Asked Questions 6 (2024) (discussing availability of block grants that can support health facilities) (link); *see also* Jessica Farb, *Federal Health Care Spending*, U.S. Gov't Accountability Off. (last visited Mar. 17, 2025) (link).
[24] Proclamation, *National Child Abuse Prevention Month, 2025*, The White House (Apr. 3, 2025) (link) ("Sadly, one of the most prevalent forms of child abuse facing our country today is the sinister threat of gender ideology. . . . As President, I proudly signed Executive Order 14187 prohibiting schools from indoctrinating our children with transgender ideology, while also taking action to cut off all taxpayer funding to any institution that engages in the sexual mutilation of our youth.").
[25] Doctors for America, *Gender-Affirming Care Talking Points* (2024) (link).
[26] *See*, e.g., D.C. Code Ann. § 3-1271.03 (link).

Under the IMLC, a clinician may not obtain a license in another member state if that clinician (1) had been convicted or adjudicated by court for any offense, (2) had been disciplined by a licensing agency of any jurisdiction, (3) has had their "controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration," or (4) is actively under investigation by any licensing or law enforcement agency.[27] This means that any negative action taken against a clinician's license in a member state may render them ineligible for licensure through the IMLC in other member states. However, as we discuss in **Part II.A**, DC's shield law provides alternative routes to licensure for clinicians who were disciplined based on their provision of gender affirming care.

Telemedicine has dramatically increased access to medicine for patients across the country. In fact, in 2022, 54.9 percent of clinicians were in practices that used telemedicine to manage patients with chronic illnesses, 49.8 percent were in practices that used telemedicine to diagnose and treat, and 24.4 percent were in practices that provided after-hours care via telemedicine.[34]

Yet, as of December 2023, a clinician's ability to practice via telemedicine has been restricted in most states, with bans on telehealth services for doctors with out-of-state licenses.[35] As such, multi-state licensure is integral to protecting access to gender-affirming care. Not only must a clinician comply with state licensure laws and all relevant standards of care, but a clinician providing telemedical services needs to also ensure they are complying with relevant standards, rules, and laws related to identity verification, informed consent, confidentiality, privacy, and security.[36] This Guide discusses "best practices" related to digital security and data protection in greater detail in **Part IV.B**.

PDMPs as Law Enforcement Tools

Note that DC clinicians are obligated to abide by both DC *and* federal law when prescribing medication.[28] This means that DC clinicians' prescriptions will be tracked by the DC Prescription Drug Monitoring Program ("PDMP").[29] Although there is little risk that DC law enforcement will use the local PDMP to monitor DC clinicians' gender affirming care practices, there have been other states that have used their PDMPs to track pain-medications[30] and abortion medications.[31] Additionally, given testosterone's classification as a Schedule III controlled substance,[32] it may be subject to higher scrutiny in states with restrictive gender affirming care laws.[33]

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[27] D.C. Code Ann. § 3-1271.02(11) (link).
[28] *See generally* D.C. Mun. Regs. tit. 17, §§ 10300–316, 10399 (2019) (link).
[29] *Prescription Drug Monitoring Program*, DC Health (last visited Mar. 18, 2025) (link).
[30] *Prescription Drug Monitoring Programs*, The Action Lab at Ne. Univ. (last visited Mar. 18, 2025) (link).
[31] *See* Blake Dodge & Rebecca Torrence, *Abortion Pill Prescriptions are Now Being Tracked in Parts of the US—With Help from a Little-Known Tech Company*, Bus. Insider (Mar. 10, 2025, 5:01 AM) (link); *How Project 2025 Seeks to Obliterate Sexual and Reproductive Health and Rights*, Guttmacher Inst. (Oct. 2024) (link).
[32] *See* Katie McCreedy, Jule von der Heydt, Aanchalika Chauhan et al., *State Policies Regulating Law Enforcement Access to Prescription Drug Monitoring Program Testosterone Prescription Data*, 20 JAMA 1754–57 (2024) (link).
[33] *Cf.* Jennifer D. Oliva, *Expecting Medication Surveillance*, 93 Fordham L. Rev. 509, 526–28 (2024) (discussing possibility that PDMPs may be used to surveil patients receiving gender affirming care) (link).
[34] Tanya Albert Henry, *74% of Physicians Work in Practices That Offer Telehealth*, Am. Med. Ass'n (Dec. 20, 2023) (link).
[35] Caleb Trotter, *In 30 States, You Can't Use Telehealth with Out-of-State Doctors*, Pacific Legal Found. (Dec. 13, 2023) (link).
[36] D.C. Code Ann. § 3-1201.05(c)(2) (link). The DC Department of Health Care Finance ("DHCF") has provided guidance to doctors on which third-party applications are compliant with HIPAA (link).

D. What are State Shield Laws?

Summary: *Shield laws protect clinicians from out-of-state investigations and proceedings related to protected healthcare activity, such as abortion care and gender affirming care. The laws also protect patients from similar investigations, if they received care in states with enacted shield laws. For the purposes of determining applicable laws, it is important where the patient is located at the time of care, not where the clinician is located. Shield laws disrupt this common understanding and offer protection to clinicians for practicing protected care, regardless of where the patient is located. It is currently unclear how a federal court would resolve disputes between states with shield laws and those without.*

Patients seeking gender affirming care must grapple with the troubling reality that their healthcare may be criminalized, simply because of where they live. Consider Rylee, an eighteen-year-old from Indianapolis, who is considering moving to Illinois so that she can access the healthcare she needs to live authentically. Rylee came out as trans when she was fifteen and started hormone therapy when she turned eighteen.[37] Indiana, where Rylee currently lives, bans gender affirming care for those under eighteen,[38] but Rylee has grown concerned that the Trump Administration's Executive Order, which would ban care for those under nineteen,[39] will be fully implemented in her state.[40] Rylee feels as if her "trans experience has been dictated by [the Indiana] government"[41] and simply wants to live in a place where she can access the healthcare she needs to be her full, authentic self.

> **"I want to be able to start my life and do it in a place where I know I'm going to be accepted."**
>
> - *Rylee Schermerhorn*[42]

But not all patients can move to a new state and may need to seek care from clinicians elsewhere. In the wake of the large scale effort to restrict and criminalize reproductive health care,[43] twenty-three states, and the District of Columbia, have enacted "shield laws."[44] These shield laws are intended to protect patients, providers, and those assisting patients by offering them a safe harbor if they receive or provide care in a state where the procedures are legal. Although shield laws were really an invention out of necessity for abortion and other reproductive health care, seventeen states, and DC, have expanded these protections to gender affirming care.[45] In practice, the laws "shield" individuals from civil, criminal, and professional consequences that may be pursued in states with restrictive laws. For instance, the New York shield law—which was recently evoked by Dr. Margaret Carpenter (see Part III.C), a New York abortion provider,

[37] Violet Miller & Samantha Donndelinger, *Trans People Facing Gender-Affirming Care Bans Flee to Illinois, Shield Law States*, WBEZ Chicago (Mar. 14, 2025, 6:00 AM) (link).
[38] Ind. Code § 25-1-22-13(a) (link).
[39] Exec. Order No. 14,187, *supra* note 22 (defining "child" as an individual under nineteen-years-old).
[40] Miller & Donndelinger, *supra* note 37.
[41] *Id.*
[42] *Id.*
[43] *After* Roe *Fell: Abortion Laws by State*, Ctr. for Reproductive Rights (last visited Feb. 24, 2025) (link).
[44] *State Shield Laws: Protections for Abortion and Gender-Affirming Care Providers*, KFF (last updated Sept. 24) (link).
[45] *Shield Laws for Reproductive and Gender-Affirming Health Care: A State Law Guide*, UCLA Ctr. on Reproductive Health, L., & Pol'y (last updated Feb. 2025) (link).

who was criminally charged for violating Louisiana's anti-abortion statute[46]—protects clinicians who provide abortion care to out-of-state patients from extradition, arrest, and professional disciplinary actions.[47]

To be clear, if a clinician is protected by a state's shield law, the shield law does not limit what *another state* may attempt to do. In other words, the protection of a shield law is limited to care that occurs *within the protecting state's borders*. It is important to keep this in mind, especially if a clinician chooses to provide in-person care in a state that restricts gender affirming care, or travels to a state after violating its civil and criminal laws. Even if the clinician is a resident of DC, or any other state with a shield law, the "shield" cannot be applied in that instance. We discuss this more below in **Part III.B.**

Although most shield laws include protections for gender affirming care, the laws were designed to support clinicians providing abortion care to out-of-state patients, typically through medication abortions.[48] Although related,[49] abortion procedures are also very different from gender affirming care. Clinicians who support a patient with a medication abortion may care for that patient through initial recovery only.[50] However, clinicians who provide gender affirming care must establish a longer-term relationship with their patients. Clinicians must gauge how their patients respond to various treatments, such as by monitoring hormone levels through regular blood work.[51] Clinicians may continue to support patients as they transition socially, and as patients transition mentally.[52] For minor patients, clinicians may also support patients' families.[53] In short, gender affirming care is different from abortion care, and providing gender affirming care to a patient in another state will be more difficult—and ongoing—than abortion care via telemedicine.[54]

Before digging into these protections, it is important to briefly note *why* DC has the authority to protect its patients and clinicians from adverse consequences in other states. First, regulating health care and health

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[46] Pam Belluck & Emily Cochrane, *New York Doctor Indicted in Louisiana for Sending Abortion Pills There*, N.Y. Times (Jan. 31, 2025) (link); *see also* Physician Profile: Dr. Margaret Carpenter, Part III.C.

[47] *See* N.Y. Crim. Proc. Law § 570.17(2) (protecting against extradition) (link); N.Y. Crim. Proc. Law § 140.10(3-a) (protecting against arrest) (link); N.Y. Ins. Law § 3436-A (prohibiting malpractice insurers from taking adverse action) (link). *See generally*, Ryeaan Chaudhary, Nora M. Franco, Xingni Chen, Angela Kang, & Priscilla Kim, How New York's Telehealth Shield Law Protects Abortion Care (Columb. L. Sci., Health, & Info. Clinic, 2d ed., 2025) (link).

[48] *See* KFF, *supra* note 44 (noting that seventeen states, and DC, of the twenty-four jurisdictions that have shield laws, include protections for gender affirming care).

[49] *See* Juliana Kim, *How Gender-Affirming Care May be Impacted When Clinics that Offer Abortions Close*, NPR (Aug. 14, 2022 6:59 AM) (link); *see also* Rose Mackenzie & Arli Christian, *The Intertwined Future of Attacks on Abortion and Gender-Affirming Care*, ALCU (Jan. 18, 2023) (link).

[50] *See* Carrie N. Baker, *Telemedicine Abortion: What It Is and Why We Need It Now More Than Ever*, Ms. Magazine (Mar. 26, 2020) (link).

[51] *See* David A. Klein, Scott L. Paradise, & Emily T. Goodwin, *Caring for Transgender and Gender-Diverse Persons: What Clinicians Should Know*, 98 Am. Fam. Physician 645–53 (2018) (link).

[52] Patrick Boyle, *What is Gender-Affirming Care? Your Questions Answered*, AAMC News (Apr. 12, 2022) (link).

[53] *See* Carolyn Wolf-Gould, *Notes From a Gender Clinician*, Advocate (Mar. 21, 2025, 6:00 PM) (discussing her experience with a young girl and her mother, who was struggling managing external reactions to her daughter's gender identity) (link).

[54] That does not mean it cannot be done: several providers have a full-telemedicine model for gender affirming care, drastically increasing access for some patients. Consider local organizations like 360 Health X (link), or organizations that serve patients nationally, like Plume (link) and FOLX (link). However, Plume and FOLX both rely on patients completing their required labs within the patient's home state, which may create barriers for patients in more restrictive states. Additionally, it is important to note that Plume and FOLX do not treat patients younger than eighteen, which significantly reduces their legal exposure and makes them less reliant on a state's shield law.

care procedures is firmly within the police power of a state.[55] Even though DC is not itself a "state" (see Part II.E for why this matters), the District still has the reserved authority to regulate its clinicians and the care they may or may not provide.[56] This is why DC, and not the federal government, decides what clinicians must prove before they can be licensed to practice in the District. Second, **while states are within their right to criminalize conduct that occurs within their borders, a state cannot criminalize conduct that occurs elsewhere.**[57] In other words, a state cannot "reach into" another state to enforce its criminal laws. But this can be a complicated analysis for telemedicine, especially when the states' laws conflict with one another. See Part III.C.

If a DC clinician cares for a patient while the patient is in DC, it is undisputed that DC law applies, full stop. With telemedicine, on the other hand, if a DC clinician cares for a patient outside of DC, where DC law stops and another state's law begins is a harder question. Anti-gender affirming care states would argue this is an easy question: location is dependent on *where the patient* receives care, and it is irrelevant where the clinician is located. And there is some support for this argument.

Federal regulations provide that, for the purposes of telemedicine, a clinician is subject to the laws of the patient's state.[58] The DC Department of Health Regulation and Licensing Administration has also previously taken the position that the practice of a clinician's healthcare profession "occurs where the patient is located"[59] and the provider must meet any licensure requirement of the patient's state.[60] And some state courts have also held that telemedicine providers can be subject to a state's criminal law, even if they do not practice within that state.[61] But if a clinician is providing care that is otherwise protected by their home state (like DC or New York) and another state (like Louisiana or Texas) attempts to prosecute the clinician for that protected care, it is unclear how courts will resolve this conflict.[62]

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[55] The United States Supreme Court has recognized as much. *See, e.g.*, Jacobson v. Commonwealth of Massachusetts, 197 U.S. 11, 25 (1905) ("According to settled principles, the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.") (link).

[56] *See, e.g.*, D.C. Mun. Regs. tit. 17, § 4612 (prescribing standards of conduct for licensed physicians practicing with the District) (link).

[57] *See, e.g.*, Nielsen v. State of Oregon, 212 U.S. 315, 385 (1909) ("It is enough to decide, as we do, that, for an act done within the territorial limits of [] Washington, under authority and license from that state, one cannot be prosecuted and punished by [] Oregon.") (link); *cf.* Yellowhammer Fund v. Marshall, 733 F. Supp. 3d 1167, 1195 (M.D. Ala. 2024) (holding that Alabama cannot criminalize individuals, in other states, when they inform patients on how to access abortions in states where the procedure is lawful) (link).

[58] *See, e.g.*, Definitions relating to the dispensing of controlled substances by means of the Internet, 21 C.F.R. § 1300.04(i)(1) (emphasis supplied) ("The practice of telemedicine is being conducted while the patient is being treated by, and physically located in a [registered] hospital or clinic . . . by a practitioner acting in the usual course of professional practice, who is acting in accordance with applicable State law, and who is registered . . . in the State *in which the patient is located* . . . .") (link).

[59] See *Guidance on Use of Telehealth in the District of Columbia*, DC Health Regul. & Licensing Admin. (Mar. 12, 2020) (link).

[60] D.C. Mun. Regs. tit. 17, § 4618.1 (2017) (link).

[61] *See* Hageseth v. Superior Court, 59 Cal. Rptr. 3d 385 (Cal. Ct. App. 2007) (holding a Colorado physician is liable under California law that criminalizes the unlicensed practice of medicine with California) (link); *cf.* Walsh v. Chez, 418 F. Supp. 2d 781 (W.D. Pa. 2006) (holding an Illinois physician liable under Pennsylvania medical malpractice law because his conduct was sufficiently connected with the state, and therefore the state's laws applied) (link).

[62] A New York county clerk refused Texas's effort to file civil proceedings against Dr. Carpenter, citing the state's shield law. Pam Belluck, *New York County Clerk Blocks Texas Court Filing Against Doctor Over Abortion Pills*, N.Y. Times (Mar. 27, 2025) (link).

II. DC CLINICIANS CARING FOR DC PATIENTS

In the face of state and federal attacks on gender affirming care, DC clinicians are rightfully concerned with how these efforts to restrict care can affect their ability to practice in the District. The District of Columbia adopted its version of a shield law in 2022. The "Human Rights Sanctuary Amendment Act"[67] was enacted in direct response to the Supreme Court's *Dobbs* decision and the wave of restrictive abortion laws that followed shortly after,[68] and provides that "any person"[69] in DC is protected from out-of-state investigations and proceedings related to receiving or seeking an abortion, performing an abortion, providing contraception, and providing, consenting to, receiving, or facilitating gender affirming care, amongst other actions.[70] The D.C. Council also recognized the need to protect LGBTQ+ individuals and their right to obtain gender affirming care.[71] Underpinning the law is the Council's belief that **"fundamental bodily autonomy rights should be safe from any form of undue interference."**[72]

Four Functions of the DC Shield Law

1. ***Prohibits Government Resources for Investigations.*** Any DC officer or employee is prohibited from providing any information, expending any time or money, or other resource to support an out-of-state investigation of a patient receiving, or a clinician providing, gender affirming care.[63] *See Parts II.B and III.A.*
2. ***Prohibits DC Courts Supporting Investigations.*** The DC courts are prohibited from issuing out-of-state subpoenas, unless the subpoena is accompanied by a sworn statement that the subpoena is not intended to support an investigation seeking to impose liability for providing gender affirming care.[64] *See Part III.B.*
3. ***Prohibits Professional Consequences for Clinicians.*** The DC medical licensing board is prohibited from taking an adverse action against a DC clinician if another state has revoked, suspended, or restricted the clinician's practice after they have provided gender affirming care.[65] *See Part II.A.*
4. ***Creates Ability for Clinicians to Countersue.*** DC clinicians have a "**private right of action**" to sue out-of-state parties if they have been sued in another state after providing gender affirming care.[66] *See below*.

[63] D.C. Code Ann. §§ 2–1461.01(a), (a)(7) (link).
[64] D.C. Code Ann. § 13–443(a) (link).
[65] D.C. Code Ann. § 3–1205.14(e-1) (link).
[66] D.C. Code Ann. § 2–1461.02 (link).
[67] D.C. Law 24-257 (effective Feb. 23, 2023) (link).
[68] Council of the District of Columbia, Comm. on Gov't Operations and Facilities, Report on B24-0808, at 3 (Sept. 22, 2022) [hereinafter D.C. Council Committee Report] (link).
[69] The shield law defines "person" as "any individual." D.C. Code Ann. § 2–1461.01(c)(5) (cross-referencing D.C. Code Ann. § 2-1401.02(21)) (link). We interpret this definition to include all DC licensed clinicians practicing in DC, patients physically in DC, and medical students practicing in DC.
[70] D.C. Code Ann. §§ 2–1461.01(a)(1), (2), (4), (7) (link).
[71] D.C. Council Committee Report at 6.
[72] D.C. Council Committee Report at 7.

Private Right of Action

A right created by statute that allows an individual to file a lawsuit against another party. Here, if a clinician was sued in another state because they provided gender affirming care while in DC and the clinician was forced to pay damages, the DC shield law provides that the clinician can file a subsequent lawsuit against that party to recover the amount of damages they had to otherwise pay.

As noted above, the DC shield law is designed to protect DC clinicians who provide, or facilitate access to, gender affirming care to patients inside, and outside of, the District.[73] First, this section discusses how the DC shield law protects clinicians' professional licensure and ability to continue practicing in DC, regardless of what other states may do. Second, this section discusses how the shield law protects DC clinicians who provide in-person care to DC patients. Third, this section discusses how the shield law protects DC clinicians who provide care to DC patients via telemedicine. Fourth, this section offers additional insights on how a DC clinician, or healthcare facility, may violate DC non-discrimination laws if they cease providing gender affirming care to DC patients. Lastly, this section illustrates the complexities that DC clinicians must navigate, merely because they practice in a "quasi-state," with limited independence from Congress and the federal government.

A. Licensure and DC Shield Law Protections

Summary: *DC's shield law prohibits DC licensing boards from taking reciprocal adverse action against health professionals when the original adverse action was taken in response to the clinician's provision or facilitation of gender affirming care. DC law allows the mayor to expedite review of licensure, and similar, applications for clinicians who had their credentials revoked in other states based on participating in gender affirming care. However, the DC shield law does not prevent other states from suspending, revoking, or restricting a clinician's license elsewhere.*

Medical licensure in DC is overseen by the DC Board of Medicine. DC also has a reciprocity agreement with Maryland and Virginia. While DC's licensure law prohibits clinician's from practicing within the District without a license, Maryland- and Virginia-licensed clinicians are exempted from this rule if they (1) do not have an office within the District, (2) they pay DC's registration fee, and (3) the clinician's state allows DC clinicians of the same primary practice to provide medical care in their respective state.[74, 75]

When clinicians provide gender affirming care to an out-of-state patient, the patient's home state typically has the power to issue subpoenas, warrants, and extradition demands to pursue adverse actions against those clinicians. See Part III.B. However, **DC's shield law provides protection for clinician's licenses,**

[73] D.C. Code Ann. § 3-1201.05(a) (link). The law uses the same definition of "gender affirming care" as used in the DC Human Rights Act, which defines the care as "any social, psychological, behavioral, medical, or surgical intervention that is lawful in the District and is designed to support or affirm a person's gender identity or expression, including hormone therapy, behavioral healthcare, reproductive counseling, hair removal, speech therapy, facial reconstruction surgery, and gender affirmation surgery." *See* D.C. Code Ann. § 2-1401.02(12A) (link).

[74] D.C. Code Ann. § 3-1205.02(a)(4) (link).

[75] Clinicians who are not registered in DC are permitted to provide telemedicine to patients physically located in the District so long as they had a pre-existing practitioner-patient relationship either (a) the patient is only temporarily in DC or (b) the patient is a DC resident and telemedicine services do not exceed 120 days. D.C. Code Ann.§ 3-1201.05 (link). However, clinicians that practice over state lines through the reciprocity agreement would not be protected by DC's shield law.

registrations, and certifications in DC when that clinician's license may have been suspended or revoked in another state.

The DC shield law provides that licensing boards—including the Board of Medicine, the Board of Nursing, and the Board of Pharmacy, among others[76]—may not take "reciprocal adverse or disciplinary action" against a health professional if their license, registration or certification was revoked, suspended, or restricted in another state for providing, facilitating, or attempting to provide or facilitate gender affirming care to a client or patient.[77] This provision of the shield law, however, is only applicable if the provided care is lawful and the clinician is licensed to provide that care.[78] As a reminder, **gender affirming care is a lawful healthcare practice in DC.**

DC law further authorizes the Mayor to expedite the review of a licensure, certification, or registration application for any health professional who had their certification, license or registration suspended or revoked in a different state based solely on their provision, facilitation, or attempt to provide or facilitate gender affirming care.[79] Importantly, gender affirming care, in the context of this statute, refers to any medical or surgical interventions used to support or affirm an individual's gender identity, including, but not limited to, hormone therapy, facial reconstruction surgery, and gender affirmation surgery.[80]

What does this mean if you are licensed in another state? DC's shield law only comes into play if an adverse action has been taken against you in another state. While the statute protects your license, registration, or certification in DC, it does not protect against reciprocal action in other states where clinicians may be licensed.

If a clinician is licensed in multiple states and reciprocal action has been taken in more than one state, how much weight is a negative ruling given in later hearings? This is a bit complicated and partially depends on state participation in the IMLC. Under the IMLC, disciplinary action taken against a clinician in a non-principal license state may be deemed "conclusive as to matter of law and fact decided," allowing other boards to either (a) impose the same or lesser sanction or (b) pursue separate disciplinary actions.[81] However, if a clinician's license is revoked or suspended, any licenses that the clinician holds in all other member state boards are automatically suspended.[82] DC's shield law effectively supersedes this provision in DC by prohibiting disciplinary action, and providing for expedited review of credentials, if the suspension or revocation was based on the provision of gender affirming care that would be permitted under District law. However, if a clinician is licensed in other states that do not have shield laws that prohibit the same type of disciplinary action, then those state boards have the authority to take identical reciprocal action.

This is not to say that a non-participating state cannot take reciprocal adverse action against a clinician. Under federal law, all state medical boards must report adverse actions, including but not limited to

[76] D.C. Code Ann.§ 3-1202.01(1) (link).
[77] D.C. Code Ann. § 3-1205.14(e-1) (link).
[78] *Id.*
[79] D.C. Code Ann. § 3-1205.01a(a) (link).
[80] D.C. Code Ann. § 3-1205.14(e-1)(1)(B) (link).
[81] D.C. Code Ann. § 3-1271.10(c) (link).
[82] D.C. Code Ann. § 3-1271.10(d) (link).

suspensions and revocations, to the National Practitioner Data Bank ("NPDB").[83] However, while state medical boards retain access to the data bank, the availability of imposing reciprocal actions absent IMLC participation is dependent on state law. Remember that the IMLC is only one pathway to getting a license in another state, and each state's board of medicine can prescribe its own guidelines and penalties. For instance, Virginia, which does not participate in the IMLC, requires the medical board to suspend a medical license if that clinician has had their license restricted in another state.[84] In short, participation in the IMLC does not provide the only avenue of reciprocal adverse action; however, the IMLC streamlines the process of imposing punishments.

B. In-Person Care

While there is no specific provision in DC licensure law that expressly authorizes the provision of gender affirming care, a clinician's ability to provide in-person gender affirming care to DC residents (as well as non-DC residents present in DC) is based in a practitioner's affirmative duty to provide care. The implication that DC-licensed clinicians are authorized to provide in-person gender affirming care is further supported by DC's law preventing the District government from facilitating any investigations or proceedings that are aimed at limiting one's human right of bodily autonomy within DC.[85] Accordingly, the District is prohibited from providing information or resources "in furtherance of any interstate investigation or proceeding" for providing or facilitating gender-affirming care.[86] This law also established a private right of action for individuals who had judgments entered against them, "based in whole or in part" on their alleged provision or facilitation of gender affirming care.[87] See **Part I.C.** With this provision, if a DC clinician loses a lawsuit in another state, because they provided gender affirming care in DC, then the DC clinician can sue to recover damages from that out-of-state suit. In a sense, this provision provides DC clinicians with a legal 'tit-for-tat.'

C. Telemedicine to DC Patients

Summary: *Under current law, if a DC clinician provides gender affirming care via telemedicine to a DC resident or patient located in DC, the DC shield law should protect the clinician from any out-of-state investigation or legal proceeding related to that care.*

Providing telemedicine to patients has become an increasingly common practice, and one that may lead to increased access for some patients.[88] Clinicians who are licensed, registered, or certified to practice within the District are permitted to treat patients located in the District via telemedicine, with no additional requirements.[89] As long as a clinician provides telemedical services in a manner that complies with standards of care for in-person treatment, the clinician is permitted to provide any treatment via telemedicine that is

[83] 42 U.S.C. § 11132(a)(1)(A) (link).
[84] Va. Code Ann. § 54.1-2409(A) (link).
[85] D.C. Code Ann. § 2–1461.01 (link).
[86] *Id.*
[87] D.C. Code Ann. § 2–1461.02 (link).
[88] *See, e.g.*, Victor C. Ezeamii, Okelue E. Okobi, Hassana Wambai-Sani, Gamamedaliyanage S. Perera, Shakhnoza Zaynieva, Chinwe C. Okonkwo et al., *Revolutionizing Healthcare: How Telemedicine Is Improving Patient Outcomes and Expanding Access to Care*, Cureus (July 5, 2024) (link).
[89] D.C. Code Ann. § 3-1201.05(a) (link).

otherwise permitted in the District.[90] This includes prescribing medication via telemedicine,[91] and providing services reimbursed by Medicaid.[92] Local DC providers have incorporated telemedicine into their practices, and have acknowledged that it can be especially helpful for LGBTQ+ patients.[93] Even if a DC clinician is providing care to a DC patient, they may still be concerned with how other states' laws on gender affirming care will impact their ability to care for their patients.

The DC shield law prohibits any DC officer or employee from providing any information, expending any time or money, or using any property, equipment, or other resource to support an out-of-state investigation of a patient receiving, or a clinician providing, gender affirming care.[94] **If a DC clinician provides care to a patient in DC, there is very little risk that another state will pursue an investigation of the clinician and their practice.** However, if a clinician is licensed to practice in another state, such as through a reciprocity agreement, the clinician may have a greater risk of facing adverse consequences in that other state. We discuss this above in **Part I.C**. Regardless of actions taken by other states against a DC clinician's license, the DC shield law prohibits DC medical licensing boards from using those out-of-state proceedings to take adverse action against the clinician, if they complied with all DC standards of care.[95] See **Part II.A** for more.

D. Federal Funds and State Non-Discrimination Law

Summary: *This section discusses how DC non-discrimination statutes and the DC shield law may conflict with federal actions seeking to prohibit or penalize healthcare services otherwise protected by state law. Federal funding is relevant to gender affirming care providers in DC because the "Protecting Children" and "Defending Women" Executive Orders have already triggered legal challenges from states, arguing that a loss of federal funding based on providing gender affirming care is not only unconstitutional but would cause irreparable financial harm to life-saving institutions. Based on this argument, federal courts have ordered the federal government from enforcing the funding-related sections of the Executive Orders. This section also discusses how some states and DC have altered, suspended, or entirely ceased offering gender affirming care to comply with the Executive Orders and stave off debilitating federal funding losses.*

1. How President Trump's Executive Orders Impact State Medical Institutions & Funding

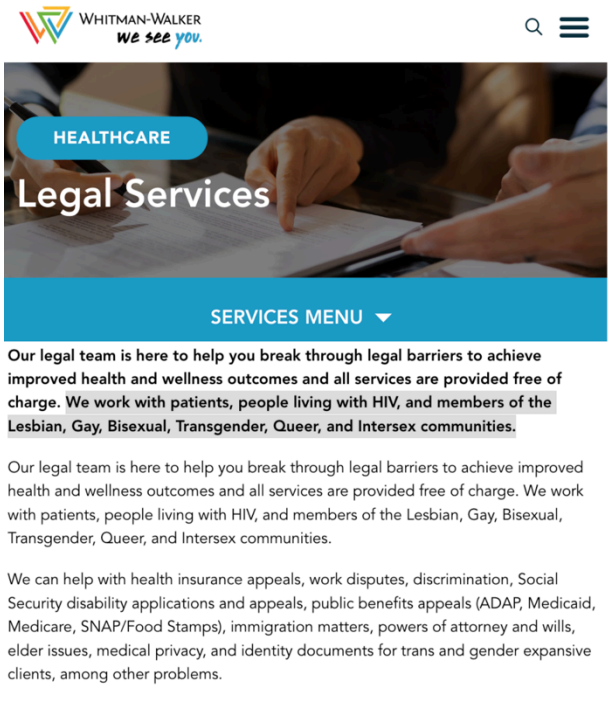
President Trump's "*Defending Women"* Executive Order was issued on the first day of his presidency. It states that, "[f]ederal funds shall not be used to promote gender ideology" and instructs federal agencies to assess "grant conditions and grantee preferences [to] ensure grant funds do not promote gender ideology."[96]

[90] D.C. Code Ann. § 3-1201.05(c)(1) (link).
[91] D.C. Code Ann. § 3-1201.05(d) (link).
[92] D.C. Mun. Regs. tit. 29, § 910.5 (link). As a quick aside, federal law currently prohibits DC from using its locally-raised Medicaid funds to support patients receiving an abortion. Planned Parenthood of Metro DC has more about the Dornan Amendment and how it has limited low-income DC patients' access to abortion health care for over 30 years (link). While Congress has not adopted a similar amendment focused on gender affirming care, future adoption is not outside the realm of possibility.
[93] *Health Services*, Metro Health (describing patients' abilities to contact providers via "chat, phone, and video call") (last visited Mar. 19, 2025) (link); *Home*, 360 Health X ("Virtual Services available everywhere") (last visited Mar. 19, 2025) (link).
[94] D.C. Code Ann. §§ 2–1461.01(a), (a)(7) (link).
[95] D.C. Code Ann. § 3–1205.14(e-1) (link).
[96] Exec. Order No. 14,168, § 3(g), 90 C.F.R. § 8615 (link).

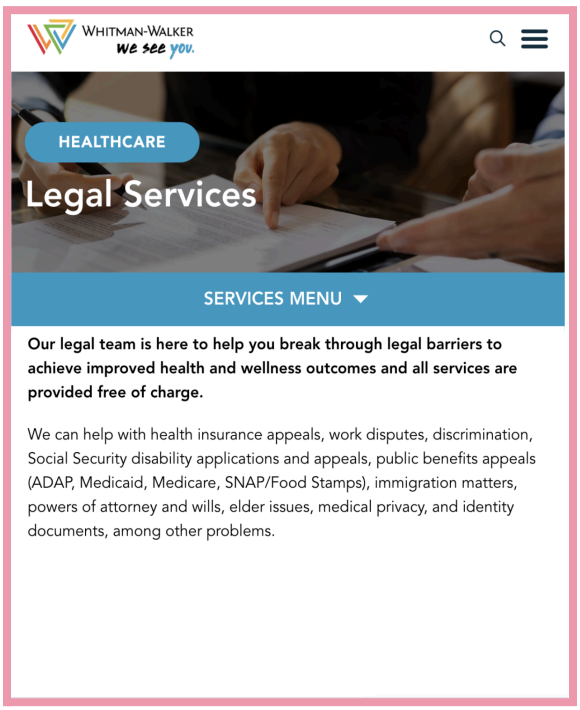
Crucially, the funds at stake include Medicare and Medicaid funding. The Office of Personnel Management ("OPM") issued a guidance memo to federal agencies regarding the Executive Order, further instructing that "each agency should take prompt actions to end all agency programs that use taxpayer money to promote or reflect gender ideology as defined in Section 2(f) of *Defending Women*."[97]

The Legality of Gender Affirming Care in DC (as of April 2025): Under current DC law, it is legal for clinicians to provide gender affirming care to patients. Furthermore, it would likely *violate* DC non-discrimination laws for a clinician to refuse medical services to a patient based on gender identity. However, DC's status as a "quasi-state"[98] complicates its ability to offer protection from federal intervention and limits its ability to enact new laws aimed at protecting gender affirming care services and the clinicians providing those services. Nonetheless, DC's laws, its prestigious hospitals, and the sizable receipts of federal funding ultimately serve as a double-edged sword: on one hand, they make the District of Columbia a high-value target for the federal government to scrutinize; on the other hand, the District is also a highly credible potential plaintiff to bring a legal challenge against the federal government.

A notable example of how the Executive Order is already impacting DC-based providers comes from DC's oldest health center specializing in LGBTQ+ care, **Whitman-Walker**,[99] which recently removed certain public links and statements from its website relating to gender affirming care, including references to the terms 'transgender' and 'intersex' on their legal services page (see images below).[100]



Whitman-Walker "Legal Services" on Dec. 7, 2024



Whitman-Walker "Legal Services" on Mar. 21, 2025

[97] Letter from Charles Ezell, Acting Dir. of U.S. Off. of Personnel Mgmt. (Jan. 29, 2025) (link).
[98] Part II.E of this Guide goes in-depth on DC's status as a quasi-state and implications of its local authority under "Home Rule."
[99] Sarah Y. Kim, *With gender-affirming care under threat, D.C. area providers worry about continuing services,* WAMU (Feb. 19, 2025) (link).
[100] *Compare* Legal Services, Whitman-Walker Clinic (Dec. 7, 2024) (link) *with*, Legal Services, Whitman-Walker Clinic (Mar. 21, 2025) (link).

Whitman-Walker is not an outlier. The decision to edit the public language on their website was likely an attempt to avoid (further) exposure to federal action and potentially to preserve eligibility for federal funding. britt walsh, Director of Transgender Care for Whitman-Walker, defended the decision, stating "[w]e could not take chances that we would not be able to continue services . . . [t]hat our [Federally Qualified Health Center] designation would be taken away, that we wouldn't make payroll. So we pulled things down from our website."[101]

Across the country, states and their respective health institutions are grappling with the same pressures while also striving for adherence to their state's non-discrimination laws. Below, the responses of three different states (New York, California, and Virginia) are examined to demonstrate how opposing interpretations of and approaches to the Executive Orders may affect medical students, medical institutions and their respective funding.

2. State Responses (So Far): New York, California, and DC's Neighbors (Maryland/Virginia)

Several state attorneys general have issued proactive statements, articulating the tension between some of President Trump's executive orders and state non-discrimination laws/constitutional protections. For example, California's Attorney General issued a statement seeking to assure residents that "families seeking gender-affirming care, and the doctors and staff who provide it, are protected under state laws like the Transgender, Gender Diverse, and Intersex ("TGI") Inclusive Care Act."[102] The New York Attorney General issued a similar statement, reminding clinicians and providers that "[r]egardless of the availability of federal funding" it would violate state law to "[withhold] the availability of services from transgender individuals based on their gender identity or their diagnosis of gender dysphoria, while offering such services to cisgender individuals."[103] The New York Attorney General also joined a coalition of thirteen state attorneys general who have asserted "their commitment to protecting access to gender-affirming care in the face of the Trump administration's recent Executive Order."[104]

Divergent approaches have been taken by DC's neighbors: Virginia and Maryland.

The Virginia Attorney General shared a letter with the University of Virginia and Virginia Commonwealth University informing them that his office would be "closely monitoring" compliance with President Trump's executive orders prohibiting gender affirming care. The letter specified that Virginia "[h]ospitals and institutions that continue to mutilate children place themselves at significant legal risk and face substantial financial exposure."[105]

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[101] Erin Reed, *No More Compliance: Historic LGBT Clinic Whitman-Walker's Erasing of Trans People a Step Too Far*, Erin In The Morning (Feb. 21, 2025) (link).

[102] Press Release, *Attorney General Bonta Issues Statement on President Trump's Executive Order Seeking to End Youth Access to Gender Affirming Care*, Office of Rob Bonta, California Attorney General (Jan. 30, 2025) (link).

[103] Letter from Letitia James, Attorney General of New York (Feb. 3, 2025) (link).

[104] Press Release, *Attorney General James and Coalition of 13 Attorneys General Issue Joint Statement on Protecting Access to Gender-Affirming Care,* Office of the New York Attorney General (Feb. 5, 2025) (link).

[105] Anna Bryson, Eric Kolenich, *VCU, UVa halt medical care for minors' gender transition, following Miyares directive*, Richmond Times-Dispatch (Jan. 31, 2025) (link).

Maryland has taken the opposite approach. On February 21, 2025 the Maryland Attorney General issued a press release, announcing and detailing the state's amicus brief[106] to support the plaintiffs in *PFlag v. Trump* (discussed below). The Attorney General stated that their filing supports the plaintiffs' argument challenging the Trump Administration's executive orders, and their argument "that there is considerable medical evidence showing that gender-affirming care improves the health outcomes for individuals with gender dysphoria." Importantly, the Attorney General also clarified that "[w]hile such care remains available in Maryland" the amicus brief is meant to demonstrate a "commitment to protecting access to [gender affirming care]" and underscoring the fact that "no federal law prohibits or criminalizes gender affirming care."[107]

Maryland's support for gender affirming care reflects a long-standing history within the state. In 1965, Johns Hopkins Hospital opened the nation's first gender medicine clinic ("The Gender Identity Clinic"), intentionally founded to provide gender affirming care. Unfortunately, the clinic was closed less than two decades later, and some medical experts have found overlap between the circumstances then and those we face today. Dr. Alex Keuroghlian, a clinical psychiatrist (affiliated with Massachusetts General Hospital, the Fenway Institute, and Harvard Medical School)[108] stated "[h]istory is repeating itself. . . . We're seeing the exact same tactics being used—defamation, sensationalist transphobia, intimidation of providers who want to offer this care."[109]

While The Gender Identity Clinic was never specifically re-opened, Johns Hopkins presently operates a robust Center for Transgender and Gender Expansive Health. As of today, the Center continues to offer "comprehensive, evidence-based and affirming care for transgender and gender diverse youth and adults that is in line with the standards of care set by [WPATH]."[110]

The tension between federal fund allocation and state non-discrimination laws is currently being litigated in several states. While no cases are currently active in DC, practitioners based in the District are subject to nationwide injunctions, like the one granted in *PFlag* v. *Trump.*

PFlag v. *Trump* (Status as of 3/4/2025: Nationwide Injunction)

On March 4, 2025, a federal judge in the District Court of Maryland granted PFLAG's request for a preliminary nationwide injunction.[111] Under the injunction, the Trump Administration cannot enforce Section 3(g) of Executive Order 14168 ("*Defending Women*") and Section 4 of Executive Order 14187 ("*Protecting Children*")." Specifically, the administration is restricted from "conditioning or withholding federal funding based on the fact that a healthcare entity or health professional provides gender affirming medical care to a

[106] Brief of PFLAG, Inc. as Amicus Curiae, PFLAG, Inc., et al. v. Trump, et al. Civil Action No. BAH-25-337 (Feb. 21, 2025) (link). The amicus brief was joined by the following additional states: Massachusetts, California, Colorado, Connecticut, Delaware, Hawai'i, Illinois, Maine, Minnesota, Nevada, New Jersey, New York, Oregon, Rhode Island, Vermont, Washington, and **the District of Columbia**.

[107] Press Release, Attorney General Brown Co-Leads Amicus Brief to Support Plaintiffs in PFLAG v. Trump (Feb. 21, 2025) (link).

[108] *See* Theresa Gaffney, *The story of the nation's first clinic for gender-affirming surgery*, STAT (Oct. 3, 2022) (link); *see also* Harvard Med. Sch., "Alex Keuroghlian" (Medical Education) (last visited Mar. 31, 2025) (link).

[109] Gaffney, *supra* note 108.

[110] Ctr. for Transgender and Gender Expansive Health, *Services and Appointments for Adults* at Johns Hopkins Medicine (last visited Mar. 30, 2025) (link).

[111] Memorandum Opinion, PLAG, Inc. et al. v. Donald Trump, et al. 1, Civil No. 25-337-BAH (Mar. 4, 20250) (link).

patient under the age of nineteen." The national scope of the injunction is highly relevant. For example, hospitals at the University of Virginia resumed gender affirming care that had previously halted.[112] Accordingly, this case is relevant to DC clinicians because, **under the nationwide injunction, DC hospitals cannot lose federal funding based on whether they provide gender-affirming healthcare services.**

The grant of the injunction also demonstrates that the court found that PFLAG was likely to succeed on the merits of their argument: that the plaintiffs would suffer irreparable harm without an injunction. The court also clarified that "a more limited injunction"—one only enforced on the plaintiffs rather than nationwide—"would allow the coercive impact of the challenged portions of the Executive Orders to persist and would effectively deny the named Plaintiffs the relief they seek."[113]

Injunction

A court order that requires a party to take (or not) certain actions while a lawsuit is still proceeding. Here, the injunction limits the Trump Administration's ability to enforce the Executive Orders. However, note that injunctions can be appealed before the lawsuit is completed.

Importantly, prior to the nationwide injunction the court issued an initial temporary restraining order ("TRO") against the Trump Administration. The TRO is noteworthy, because it demonstrates the speed at which courts can respond: PFLAG filed their amended complaint on February 11, 2025 and the TRO was issued on February 13, 2025.[114]

Washington, et al. v. Donald Trump, et al. (Current Status: Preliminary Injunction for Plaintiff States)

On February 14, 2025, a federal judge in the Western District Court of Washington issued a similar injunction against President Trump's "*Defending Women Against Gender Ideology*" Executive Order, but this injunction is limited in scope.[115] The plaintiffs argued that **the Executive Order threatens more than $1 Billion in lost funds** that were provided to the state health care facilities (*e.g.*, state-run medical hospitals, research institutions, etc.) from Congress *before* the Trump Administration took office and enforced the order.[116] The plaintiffs further alleged the Executive Order contradicts state law. The Washington injunction only applies to the plaintiff states (Washington, Minnesota, Oregon) and only prohibits enforcement of the Executive Order banning gender affirming care.[117]

This case is relevant to DC medical practitioners because the plaintiff states predicated their successful request for an injunction on state laws like the DC Human Rights Act. See the chart below for a direct analysis of DC's non-discrimination laws—and those of nearby Virginia and Maryland—as compared to the analogous laws of the plaintiff states (Washington, Minnesota, and Oregon).

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[112] Kate Andrews, *UVA Health resumes gender-affirming care after federal judge's order*, Virginia Bus. (Feb. 14, 2025) (link).
[113] *Id.* at 64.
[114] *See* Amended Complaint for Declaratory and Injunctive Relief, PFLAG v. Trump (Civil No. BAH024-337) (link); *See also* Order, PFLAG v. Trump (Civil No. BAH024-337) (link).
[115] *See* Complaint, Washington, et al. v. Donald Trump, et al. (case 2:25-cv-00127-JCC) (W.D. Wash. 2025) (link).
[116] *Id*.
[117] Order Granting Plaintiffs' Motion For Temporary Restraining Order, Washington, et al. v. Donald Trump, et al. (case 2:25-cv-00244-LK) (W.D. Wash. 2025) (link).

Comparative Non-Discrimination Laws

DC and Plaintiff States Challenging GAC-Related Executive Orders

	Considers and legally classifies gender identity, or gender expression as a protected characteristic.	**Prohibits** discrimination in the provision of health-related services, or public services generally on the basis of gender identity, expression.	**Requires** coverage of Medicaid (or state-equivalent) and commercial insurance to cover GAC.	**Prohibits** State Health Authority from denying medically necessary GAC.	**Establishes** legal enforcement of the WPATH Standards of Care for the Health of Transgender and Gender Diverse People as the "accepted standards of care"
DC	✔[118]	✔[119]	✔[120]	✔[121]	—
MD	✔[122]	✔[123]	✔[124]	✔[125]	—
VA	✔[126]	✔[127]	**[128]	✔[129]	—
WA	✔[130]	✔[131]	✔[132]	✔[133]	—
MN	✔[134]	✔[135]	✔[136]	✔[137]	—
OR	✔[138]	✔[139]	✔[140]	✔[141]	✔[142]

Accordingly, while it is likely that the federal government may target federal funding at facilities such as DC-based Children's National Hospital (discussed below), this chart demonstrates the synergy between DC's

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[118] D.C. Off. of Human Rts., *The 23 Protected Traits [under] DC Human Rights Act* (last updated Feb. 24, 2025) (link).
[119] D.C. Off. of Human Rts., *Non-Discrimination in the District's State Medicaid Program Based on Gender Identity or Expression* (Feb. 2014) (link).
[120] *Id*.
[121] *Id*.
[122] *See* Md. Code Ann., state gov't § 20–101 (2014) (link); *see also* Maryland Exec. Order 01.01.2007.16 ("Code of Fair Employment Practices . . . establishes zero tolerance for discrimination, retaliation, and harassment, which includes sexual orientation, genetic information, and **gender identity and expression**.") (emphasis added) (link).
[123] *Guidance to the LGBTQIA+ Community* at 2-3, Off. of Md. Att'y Gen. (2025) (citing Md. Code Ann., Health-Gen. § 15–151) (link).
[124] *Id*.
[125] *Id*.; *see also* Maryland Exec. Order No. 01.01.2023.08 ("Protecting the Right to Seek Gender-Affirming Treatment in Maryland") (link).
[126] Va. Code Ann. § 2.2-3900 (2021) ("Virginia Values Act" *formerly* Virginia Human Rights Act) (link); *see also* Va. Code Ann. §38.2-3449.1 ("Prohibited discrimination based on gender identity or status as a transgender individual") (link).
[127] *Id*.
[128] While it is illegal for Virginia Medicaid to not cover medically necessary care, there is no state-level law that ensures transgender residents will have access to *all* medically necessary transition-related care. *See* Equality Virginia, *FAQ: Health Insurance Protections for Transgender and Non-Binary Virginians* (Feb. 2022) (link).
[129] Virginia Values Act, *supra* note 126.
[130] Wash. Rev. Code §§ 49.60.030(1), .040(2), .040(29), .215.; *see also* Washington State Senate Committee Services, *Overview of the WA Law Against Discrimination, Ch 49.60 RCW, (WLAD)* (listing "sexual orientation/Gender identity/Sex" as one of twelve covered characteristics) (link).
[131] Wash. Rev. Code § 74.09.675 (2024) (link).
[132] *Id*.
[133] *Id*.
[134] In 2024, Minnesota Governor Tim Walz took executive action to classify the state as a "trans refuge" for residents. *See* Selena Simmons-Duffin, *Tim Walz's state became a 'trans refuge.' Here's what that means and how it happened*, NPR (Oct 1., 2024) (link).
[135] Minn. Stat. § 256B.0625, subdiv. 3a (2025) (link); *see also* Minn. Stat. § 62Q.585 (2024) (link).
[136] *Id*.
[137] *Id*.
[138] *See* Press Release, Oregon Legislature Adds Protected Class of "Gender Identity" to Oregon Statutes, Oregon Department of Justice (Jun. 25, 2021) (link).
[139] Or. Rev. Stat. § 659.875 (2023) (link).
[140] Or. Rev. Stat. § 414.769 (2023) (link).
[141] *Id*.
[142] Or. Admin. Rule 836-053-0441 (2025) (link).

laws and the laws of states who have successfully pursued injunctions to prevent the federal government from restricting fundings to hospitals where gender affirming care is provided.

3. Federal Funding For Gender Affirming Care (For Minors) In DC

Much like the plaintiffs in *Washington v. Trump*, DC has a strong factual background to demonstrate that its hospitals therein would suffer irreparable harm if severed from federal funding due to their offering of gender affirming care. To demonstrate the dependence on federal funding, as well as the vulnerability of clinical programs operating in DC, Children's National Hospital ("CNH") is used as a case study below.

Children's National Hospital ("CNH")

Children's National Hospital reports that it "receives more than 70% of its research funding from federal agencies, including 60% from the National Institutes of Health."[143] The funding contributes to the Hospital's renowned reputation as one of the top ten pediatric hospitals in the country and contributes to innovative research across specialties, which include neonatology, neurology and neurosurgery, cancer, nephrology, orthopedics, diabetes and endocrinology.[144] The hospital also has a history of being designated as the lead institute for certain federal grant programs. For example, in the wake of the global COVID-19 pandemic, CNH was selected as the lead institution amongst five hospitals provided $29 million in federal funds to research future pandemic readiness.[145]

Prior to the nationwide injunction issued by the Maryland District Court, (see above) CNH had publicly posted disclaimers on their website to inform parents and families that CNH is "pausing all puberty blockers and hormone therapy prescriptions for transgender youth patients, per an Executive Order issued by the White House."[146] The hospital's website duly notes it has a pre-existing policy of "[not] perform[ing] gender-affirming surgery for minors." Children's Hospital's public "Position On Care" statement also clearly states that their gender affirming care services require parental consent; that gender affirming surgeries are not provided to anyone under the age of eighteen; and that hormone therapy is not provided to prepubescent patients. These public statements pre-date the Trump Administration's Executive Order. However, CNH announced that further restrictions on gender affirming care would be enforced to comply with the Executive Order. Specifically, on January 30, 2025 (ten days after the Executive Order's announcement) CNH noted that they were "pausing all puberty blockers and hormone therapy prescriptions for transgender youth patients."[147]

It is unclear which services are restricted beyond the deliberate administration of puberty blockers and hormone therapy prescriptions. However, a non-exhaustive list of CNH's clinical programs and services that

[143] *About Us*, Children's Nat'l Hosp. (last visited Mar. 31, 2025) (link).
[144] Newsroom, *Children's National Hospital again ranked among the best in the nation by U.S. News & World Report*, Children's Nat'l Hosp. (Oct. 8, 2024) (link).
[145] Newsroom, *Five leading children's hospitals secure $29M in federal funding to enhance future pandemic readiness*, Children's Nat'l Hosp. (Jul. 19, 2022) (link).
[146] Newsroom, *Children's National Hospital Statement on Executive Order*, Children's Nat'l Hosp. (Jan. 30, 2025) (link).
[147] *Id.*

likely remain vulnerable include: the **Youth Pride Clinic** (Ages 12–21),[148] the **Gender Development Program** (Ages 12–21),[149] and the **Gender and Autism Program ("GAP")** (Ages 3–25).[150]

Children National's GAP program demonstrates the unique scope of services provided for gender diverse patients. GAP offers a novel clinical service dedicated to serving patients and families who are simultaneously seeking medical care for "autism-related neurodiversity, such as with executive function and self-advocacy needs" and "gender development."[151] The clinic clarifies that patients include those who "identify as transgender, nonbinary, questioning, [and] neurodivergent young people who have gender-related needs, but who do not use such identity terms."[152]

E. DC Home Rule Act and the Constitution's District Clause

Summary: *This section explains the DC Home Rule Act and how it impacts the local legislative process. Relatedly, this section addresses how Congress has the power to usurp local lawmaking authority under Article I of the U.S. Constitution (the "District Clause"), which has been invoked as recently as 2021 to overturn an unanimously passed "Crime Bill." In the event DC's local government attempts to pass additional laws aimed at protecting gender affirming care or insulating gender affirming care clinicians, the District Clause would likely be similarly invoked.*

1. DC's Complicated 'Quasi-State' Status

Since 1973, DC has operated under "Home Rule," which means that the local government has secured some degree of autonomy and ability to self-function separate from the federal government.[153] Under Home Rule, DC has a duly elected District Council government with authority and jurisdiction to pass laws for the betterment of DC residents, the same way cities across the country do. However, DC is uniquely vulnerable to federal usurpation because Article I of the U.S. Constitution includes an "Enclave" or "District Clause."[154] This clause permits Congress to obstruct the legislative agenda of DC's local government and overturn policy since it is both a city and the nation's capital.

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[148] Importantly, the Executive Order and Children's National operate under different age categorizations as it relates to gender affirming care. CNH captures "youth and young adults" within the age range of 12–21 whereas the Executive Order defines the term 'child' and 'children' to mean 'individuals under 19 years of age'. *Compare LGBTQ+ Care and Support,* Children's Nat'l Hosp. (Feb. 24, 2035) (link) *with* Exec. Order No. 14,187, 90 C.F.R. § 8771 (Feb. 3, 2025) (link).

[149] *LGBTQ+ Care and Support,* Children's Nat'l Hosp. (Feb. 24, 2035) (link).

[150] *Id.*

[151] *Gender and Autism Program*, Children's Nat'l Hosp. (last visited Mar. 31, 2025) (link).

[152] Notably, this DC's "GAP" clinic "the first clinical service dedicated to the needs of autistic gender-diverse/transgender youth" in the United States. A recent evaluation study of the program (based on data and evaluations of seventy-five consecutive GAP evaluations at CNH) found that the program "has proven a sustainable neuropsychology-based service with consistent referral flow and insurance authorizations" and that, critically, it found the program addressed the "desperate shortage of provided in [GAC] field" by training specialist clinicians. *See* John F. Strang, Abigail F. Fischbach, Sharanya Rao, Ann Clawson, & Megan Knauss et al., *Gender and Autism Program: A Novel Clinical Service Model For Gender-Diverse/Transgender Autistic Youth And Young Adults*. The Clinical Neuropsych. 1–37 (2024) (link).

[153] *See* Council of the District of Columbia, *DC Home Rule* (last visited Mar. 31, 2025) (link).

[154] U.S. Const., Art. I, § 8. clause 17 ("To exercise exclusive Legislation in all Cases whatsoever, over such District (not exceeding ten Miles square) as may, by Cession of particular States, and the Acceptance of Congress, become the Seat of Government of the United States, and to exercise like Authority over all Places purchased by the Consent of the Legislature of the State in which the Same shall be, for the Erection of Forts, Magazines, Arsenals, dock-Yards, and other needful Buildings")

While the District Clause has not been evoked within the context of laws or regulations related to gender affirming care, it has recently been evoked to temper another "hot issue" and contentious legal area: criminal law. Towards the end of his administration, President Biden cooperated with Congress to successfully overturn the DC "Crime Bill," even though it was unanimously passed by the District Council.[155]

How Congress Overturned the DC Crime Bill Under Biden

The DC Council first passed the "Revised Criminal Code Act" unanimously in 2021 after spending years on research and debating how to modernize their outdated criminal code. Modernization included eliminating archaic codes, but also introducing more progressive approaches to crime, including lowering the penalty for carjacking.

However, Mayor Bowser opted to veto the bill—a choice that Republicans in Congress leveraged after the bill was ultimately passed following a 12–1 override of the mayoral veto.

In 2023, using the District Clause, the Republican majority House of Representatives swiftly voted to veto DC's crime bill, with thirty Democrats joining their efforts, and the Senate soon followed.

2. How Congress May Interfere with DC Legislation Protecting GAC

The threat to Home Rule under Trump's Administration is, unfortunately, more severe. Shortly after the 119th Congress began, Republican Congressmembers (Senator Lee (R-UT) and Representative Ogles (R-TN)) introduced the "BOWSER Act," which would repeal the DC Home Rule Act.[156] The Act's title is a transparent nod to DC's Mayor (Muriel Bowser) and, if passed, would effectively invalidate the legislative autonomy of DC to pass and enforce its own policy decisions, including those affecting crime, health, safety, and medical care. Instead, residents—including medical professionals practicing in the District—would be principally controlled by and subjected to the federal laws and regulations passed by Congress, not the DC Council.

Importantly, adoption of the BOWSER Act would require passage in both the House of Representatives and the Senate; the latter would require achieving sixty votes in a chamber where Republicans currently occupy only fifty-three seats, assuming the Senate maintains its current filibuster rules.[157]

Recent intervention with the Crime Bill under President Biden and the political appetite for challenging DC Home Rule under President Trump demonstrates that Congress is, at the very least, monitoring the District Council's decision-making and willing to exercise oversight when it comes to salient issues. As the "*Defending Women*" and "*Protecting Children*" Executive Orders demonstrate, gender affirming care is certainly salient to the Trump Administration. This saliency is compounded by the current political makeup of the federal government: the Republican trifecta makes it even more likely that certain DC policies or initiatives—including laws concerning gender affirming care—may be subjected to staunch federal oversight and potential repeal.

[155] Susan Davis, *Congress Overturns D.C. Crime Bill with President Biden's Help*, NPR (Mar. 8, 2023, 7:30 PM) (link).
[156] Press, Rep. Ogles, Sen. Lee Introduce Bowser Act (Feb. 6, 2025) (link).
[157] *About Filibusters and Cloture*, U.S. Senate (last visited Mar. 31, 2025) (link).

More recently, a congressional threat was leveraged against DC's local budget in the 119th Congress's budget process. The final Continuing Resolution ("CR") passed in March 2025, included a provision that would siphon **$1 Billion in *local* funding** from the District of Columbia.[158] While the loss of these specific funds would not have necessarily impacted gender affirming care (or hospitals, generally) it did set an eerie precedent that Congress may alter the local DC budget, inadvertently or intentionally.[159]

If the DC Council were to enact new legislation seeking to protect gender affirming care and further shield clinicians from criminal and civil liabilities for providing medically necessary care, it is very possible that Congress would intervene and subsequently veto the legislation. **However, it is important to note that the existing DC shield law was approved by Congress, and is therefore a fully enacted law,** and seems likely that Congress would need to enact separate legislation to repeal the DC shield law.

[158] Aris Folley, *Congress Poised To Force $1b Cut To Local Dc Budget, Surprising Many Lawmakers,* The Hill (Mar. 13, 2025, 6:46 PM) (link).

[159] Many Republican members of Congress expressed that the provision impacting DC's budget may have passed as a "mistake" on behalf of lawmakers. *See* Jennifer Scholtes & Meredith Lee Hill, *Senate Passes Dc Budget Fix After House Gop Omission*, Politico (Mar. 14, 2025, 7:08 PM) (reporting quote from Sen. Mark Warner (D-VA), "If we allowed this mistake to take place, D.C. will lay off cops, it'll close schools, it'll shut down on trash removal — for those of us in the region who use metro, dramatic cutbacks.") (link). *See also* Ciara Wells, *Trump Calls for House to Pass DC's $1B Budget Fix*, WTOP (Mar. 28, 2025, 1:30 PM) (link).

III. DC CLINICIANS CARING FOR NON-DC PATIENTS

All trans and gender-expansive individuals deserve access to the healthcare that is best for them and their journey. And when states restrict access to gender affirming care, patients suffer. DC clinicians must decide whether they feel comfortable providing care to non-DC patients.[160] Ultimately, some clinicians may decide that they are not comfortable, but those clinicians can still support the movement. See **Part V** for some additional actions that *all* clinicians can take to support access to gender affirming care.

> **"Every second I wasn't on hormones after puberty was excruciating. The worst-case scenario here is that most major [hospitals] discontinue programs, and this health care is only accessible to very, very few wealthy kids."**
>
> - *Zelda, 17-year-old trans boy from Louisiana*[161]

While the DC shield law (and other District laws) protects DC clinicians who provide gender affirming care to DC patients, the extent of protection for DC clinicians who provide care to non-DC patients is less clear. **It is important to note that DC clinicians *must be physically in DC*, at the time they care for patients, to leverage the shield law.** If a clinician provides gender affirming care while beyond the District's borders, then the shield law cannot be used. Further, the District's status as a "non-state," with a heavy federal law enforcement presence,[162] complicates how the DC shield law can be invoked.

This part of the Guide attempts to offer some clarity for clinicians who may offer gender affirming care to patients residing outside of the District. **First**, this part offers clinicians with a checklist that they can use to evaluate their individual factors, which may inform whether they offer gender affirming care to non-DC patients. **Second**, this discusses how the shield law protects clinicians from out-of-state investigations. **Lastly**, this section will examine recent actions within the reproductive health care space that may shed light onto how the shield law will interact with gender affirming care prohibitions, including those at the federal level.

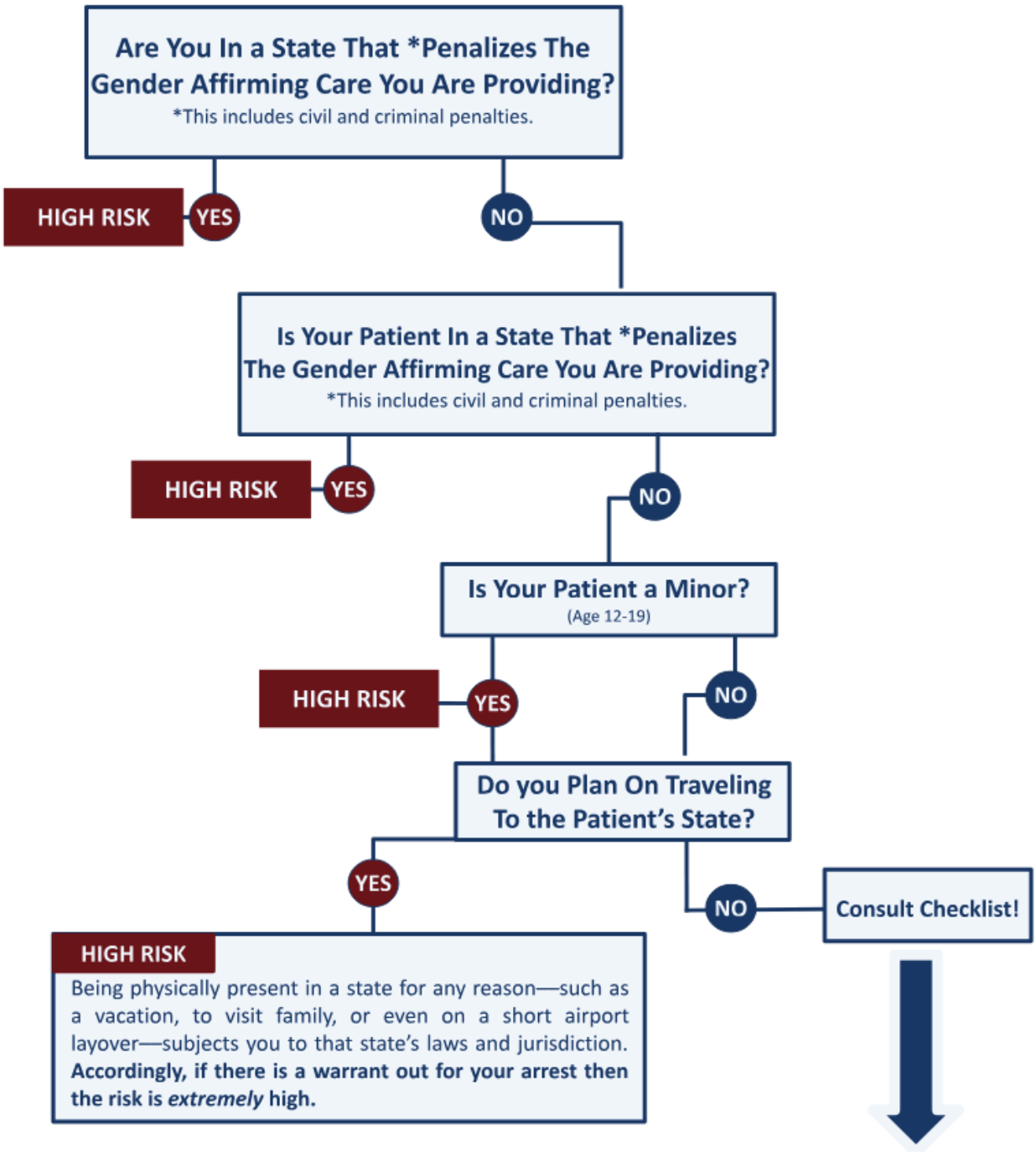
[160] *See, e.g.*, Natalie Dunlat, Caitline Troutman, & Ben Kieffer, *Ban on Gender-Affirming Care for Minors has Transgender Iowans Looking Out of State for Services*, Iowa Pub. Radio (Mar. 5, 2025, 5:48 PM) (link) (discussing some patients crossing state borders to neighboring shield law states, like Illinois and Minnesota, so they can continue accessing gender affirming care).

[161] Anya Kamenetz, *How Trans Teens Are Dealing With Trump 2.0, in Their Words*, The Cut (Feb. 28, 2025) (link).

[162] In addition to the Metropolitan Police Department ("MPD"), there are thirty-two federal law enforcement agencies that have jurisdiction to act in the District. (link)

A. Analyzing Your Risk Factors

There are several factors that clinicians should consider when evaluating the potential risk of the gender affirming care services they provide. The flowchart below is intended to identify some of the major factors that indicate high risk for potential civil or criminal penalties. **Please note that the flowchart (1) does not offer legal advice and (2) does not provide a comprehensive or exhaustive list of all factors a clinician should consider.**



✓ Risk Factor Checklist ✓

The flow chart demonstrates some of the key factors you should consider when evaluating the risk of the care you choose to provide to patients.

Importantly, as of March 2025, no DC-based clinicians, who provide gender affirming, have been criminally or civilly charged for providing care to patients.[163] Nonetheless, the threat to gender affirming care persists and future litigation may mirror the prosecution and investigation of Dr. Carpenter—who faces separate charges in Louisiana and Texas for providing telemedical care for patients seeking abortions post-*Dobbs*.

For these reasons, there are no "low risk" or "zero risk" assessments of providing gender affirming care to minors in the United States under the Trump Administration's current Executive Orders. Additionally, this flowchart is *not* exhaustive. There are many other factors you may consider based on your individual circumstances, your medical institution, and personal risk assessment.

Factors that may further elevate your risk include:

- ❑ **Any medical licensing regulations that may be relevant to out-of-state telemedicine services.**
- ❑ **Whether providing care to out-of-state patients requires them to pick up certain prescriptions in hostile states.**
- ❑ **Your personal involvement in mailing certain prescriptions** (Consult the Guide's Appendix for a discussion on how the *Comstock Act* and the *Food, Drug, and Cosmetic Act* are relevant to this assessment).[164]
- ❑ **Your and/or your institution's inability to protect your personal information (*e.g.*, name and address) from public databases.**
- ❑ **Your immigration status and whether you are here practicing under a visa.**

❑

[163] While not related to the applicability of a state's shield law, we do recognize that some clinicians have been sued simply because they provided gender affirming care. *See, e.g.*, Associated Press, *Texas Sues Doctors and Accuses Her of Violating Ban on Gender-Affirming Care*, CNN (Oct. 18, 2024, 1:52 AM) (link).

[164] *See* Appendix, Part A.

B. Out-of-State Investigations and the DC Shield Law's Protections

Summary: *The DC shield law does not prevent another state from issuing a subpoena or an arrest warrant. However, the DC shield law does prevent DC employees from assisting in executing those subpoenas or warrants, meaning they have limited effect for DC clinicians, while they are in DC. It is important to note that, because of how arrest warrants are typically written and shared, DC clinicians may still face the risk of arrest while in DC, even by DC law enforcement. DC clinicians can likely explain the situation and claim protection under the shield law, but DC clinicians should understand the risks involved. The presence of dozens of federal law enforcement agencies, which have limited authority to operate in DC, further complicates and increases the risk.*

As highlighted above, the DC shield law is focused on DC clinicians and only prohibits DC employees from assisting with out-of-state investigations. In other words, **the DC shield law says nothing about what other states may do, including whether they pursue civil or criminal investigations**. Dr. Carpenter's on-going cases provide good examples of this limitation. While the New York shield law protects Dr. Carpenter and her practice, the state's shield law did not stand in the way of Louisiana and Texas when those states chose to pursue investigations of her.[165] As DC clinicians consider their individual risks and determine whether they should provide gender affirming care to non-DC patients, the following sections are intended to answer questions that may be on their minds.

1. Can I be arrested in DC for providing gender affirming care to a non-DC patient?

Potentially, but the DC shield law could quickly end the detention. For crimes committed in another state, the state typically enters that warrant into the National Crime Information Center ("NCIC").[166] This is a national database that is accessible by state and federal law enforcement.[167] Police officers often search this database during traffic stops to determine if a stopped driver has an active arrest warrant.[168] If a Metropolitan Police Department ("MPD") officer discovers there is an active arrest warrant, issued by another state, the officer will likely arrest the individual and bring them to appear before the DC Superior Court (DC's local court system).[169] From there, the arrested individual can be extradited to the other state, where they will be subject to a criminal trial under the laws of that state.[170]

But the DC shield law appears to interrupt this process. The shield law provides that DC employees, including court staff, cannot support out-of-state investigations or proceedings related to protected healthcare activity, like gender affirming care. Thus, if a clinician were to demonstrate that their arrest is due to providing gender affirming care, DC employees would be required to stop supporting the investigation, including releasing the arrested clinician.

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[165] *But see* Pam Belluck, *New York County Clerk Blocks Texas Court Filing Against Doctor Over Abortion Pills*, N.Y. Times (Mar. 27, 2025) (link).
[166] Alejandra L. Carabello, Cynthia Conti-Cook, Yveka Pierre, Michelle McGrath, & Hillary Aarons, *Extradition in Post-Roe America*, 26 CUNY L. Rev. 1, 46 (2023) (link).
[167] *Law Enforcement Resources–National Crime Information Center (NCIC)*, FBI (last visited Mar. 18, 2025) (link).
[168] Carabello et al., *supra* note 166, at 46.
[169] D.C. Code Ann. § 23–701 (link).
[170] D.C. Code Ann. § 23–704(a) (link).

While this seems like a straightforward protection for DC clinicians, it is important to note that the NCIC system provides arresting officers with limited information. Arrest warrants do not have to include detailed information about the crime alleged or the circumstances surrounding it. For example, within the abortion context, a state could charge an abortion-providing clinician with homicide, infanticide, child abuse, or aiding and abetting any of those crimes.[171] For gender affirming care, states which have restricted the care have taken various approaches to how they describe the procedures. Some states describe this as "child genital mutilation,"[172] while others use terms like "gender reassignment surgery,"[173] and others go so far as to describe gender affirming care as medical "experimentation."[174]

As an example, if an MPD officer stops a DC clinician and discovers the clinician has an active out-of-state arrest warrant for allegedly committing "genital mutilation" or "child abuse," the MPD officer is highly likely to arrest the clinician. The clinician may ultimately be able to explain the situation when they appear in court, and a DC judge would likely find that the arrest warrant is based on conduct that is otherwise lawful in the District. In turn, the judge would likely release the clinician under the DC shield law. Regardless, the clinician still runs the risk of being arrested merely because another state has issued a warrant.

Foreign Clinicians May Face Additional Risks Given Immigration Status

If you are a clinician living and practicing here under a visa, it is strongly encouraged that you speak with an attorney before providing gender affirming care. The Trump Administration has already demonstrated they are willing to deport individuals after those individuals participated in protests or other civil disobedience.[175] It is unclear whether the DC shield law would provide protection for international clinicians.

2. Can federal law enforcement arrest me for providing gender affirming care to a non-DC patient?

Technically yes, but there are limitations. With DC being the nation's capital, the federal government, including federal law enforcement, has a large and noticeable presence in the District. Additionally, DC is not a state and thus has limited independence from the federal government. See Part II.E for more on this. Given the District's limited independence and the purported need for federal law enforcement to act independently within the District, MPD has entered into cooperative agreements with several federal law enforcement agencies.[176] As a general matter, each cooperative agreement provides (1) where the federal law enforcement agencies can act within the District; (2) whether the agencies can execute search or arrest warrants in the District; and (3) what procedures the agencies need to follow when searching or arresting individuals.

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[171] Carabello et al., *supra* note 166, at 46.
[172] Idaho Code Ann. § 18-1506B (link).
[173] S.C. Code Ann. § 44-42-310 (link).
[174] Mo. Code Ann. § 191.1720 (link).
[175] *See, e.g.*, *Alanea Cremen & Jordan Fischer*, *Judge Blocks Deportation of Georgetown Researcher Arrested by ICE Over Alleged Hamas Support*, WUSA 9 (Mar. 20, 2025, 11:05 PM) (link).
[176] *Cooperative Agreements*, Metro. Police Dep't (last visited Mar. 18, 2025) (link).

For instance, under the existing cooperative agreement with MPD, the Federal Bureau of Investigation ("FBI") has jurisdiction in the area surrounding the FBI's headquarters, and within that jurisdiction the FBI has the same powers of arrest as any MPD officer acting in the area.[177] If the clinician were stopped by an FBI agent on the corner of Tenth Street NW and E Street NW (part of the FBI's jurisdiction), the FBI agent would search the NCIC (see above) and could find that there is an active arrest warrant for the clinician. The FBI agent would likely arrest the clinician, just like an MPD officer, and bring the clinician to appear before the DC Superior Court. Again, the DC shield law would likely play a role in limiting the DC Superior Court staff's ability to order the clinician to remain in custody, but the shield law *does not limit* any actions taken by the FBI agent, or any other federal officer.[178] To add insult to the D.C-not-being-a-state-injury, local criminal charges are brought by a U.S. Attorney (an officer of the U.S. Department of Justice).[179] And the DC Council cannot enact legislation that limits or prohibits a U.S. Attorney from "penalizing conduct that [they] see as prohibited under federal or local law."[180] Given the Trump Administration's position on gender affirming care,[181] this is particularly concerning and should be strongly considered before a clinician provides care to an out-of-state patient.

3. If another state issues an arrest warrant, will I be extradited to that state?

It's unlikely. The DC shield law does not explicitly mention arrest warrants or extradition, unlike the New York shield law.[182] But the DC shield law prohibits any employee or officer from expending time or money, or any other resource, to support an out-of-state investigation or proceeding related to the DC clinician providing lawful gender affirming care. A police officer working with MPD is an employee of the DC government, and the statute appears to also include DC Superior Court employees. So, the shield law prohibits those individuals, who are otherwise necessary to arrest and extradite a fugitive, from arresting or extraditing, given that these actions would be related to an "investigation or proceeding."

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[177] *Cooperative Agreement: Federal Bureau of Investigation Police and MPDC*, Metro. Police Dep't (Effective Mar. 22, 2001) (link).

[178] *See* D.C. Council Committee Report, *supra* note 68, at 8 ("Nothing in [the shield law] serves to eliminate federal restrictions on health care, constrain interpretations of other federal laws, or otherwise limit the actions of the federal government.").

[179] U.S. Att'y Off., *About the District of Columbia*, U.S. Dep't of Justice (last visited Mar. 18, 2025) (link) ("It serves as both the local and the federal prosecutor for the nation's capital. On the local side, these prosecutions extend from misdemeanor drug possession cases to murders. On the federal side, these prosecutions extend from child pornography to gangs to financial fraud to terrorism. In both roles, the Office is committed to being responsive and accountable to the citizens of the District of Columbia.").

[180] *See* D.C. Council Committee Report, *supra* note 68, at 8 ("The nature of criminal law enforcement as currently practiced in the District may also limit the reach of [the shield law].").

[181] *See* Appendix, Part C.

[182] *See* N.Y. Crim. Proc. Law § 570.17(2) (protecting against extradition) (link); N.Y. Crim. Proc. Law § 140.10(3-a) (protecting against arrest) (link).

4. If another state investigates me, will I be forced to talk to prosecutors?

No, not if the state is engaged in an investigation or proceeding focused on the clinician providing lawful gender affirming care. Prosecutors often use a **deposition** to put witness and defendant testimony on the record before trial. The DC shield law prohibits District employees and officers, acting in their official roles, from expending any time or resources in supporting "any interstate investigation or proceeding," which seeks to impose civil or criminal penalties on DC clinicians who provide gender affirming care.[183] The shield law does not explicitly define who are considered "employees and officers," but other District laws and regulations suggest that this language is meant to include any individual employed by any branch of the DC government.[184] This would include District police officers, District government employees, and DC court employees. Said differently, if an individual works for the DC government, they cannot use their official roles and capacities to support out-of-state investigations or proceedings, including forcing clinicians to sit for depositions.

Deposition

An out-of-court, transcribed interview, taken under oath. Witnesses may have their attorney present during the interview, and the attorney can object to questions asked. The interview could be admitted as evidence during trial.

5. If another state investigates me, will I be forced to give up my patient records?

No, the DC shield law would help prevent other states from accessing your patient records. Law enforcement and prosecutors often use **subpoenas** to force witnesses and defendants into producing various documents. If another state wanted to force a clinician to give up their patient records, the state would need to issue a subpoena in the DC court system. But the shield law would block that subpoena from taking effect in DC.[185]

The law provides that if another state submits a subpoena to the DC Superior Court, the court cannot certify the subpoena unless the issuing state *affirms that the subpoena is not intended* to support a civil or criminal investigation related to the doctor providing gender affirming care.[186] If the issuing state fails to include this affirmation, then the DC Superior Court is prohibited from certifying the subpoena. Instead, the court staff will provide notice to the DC clinician who was the subject of the subpoena. According to the DC Council, this language was adopted to ensure that DC residents are made aware of any out-of-state investigations that may be occurring without their

Subpoena

A legal document that compels an individual to comply with the other party's request. Subpoenas are issued by a court and must be complied with, or an individual faces the risk of being held in contempt. Typically, subpoenas are used to force an individual to sit for a deposition (an out of court interview taken under oath) or produce various documents and records (known as discovery).

[183] D.C. Code Ann. § 2–1461.01(a), (a)(7) (link).
[184] *See* D.C. Mun. Regs. tit. 7, §199 (link).
[185] It is also important to note that DC recognizes a doctor-patient privilege, which means a clinician cannot be forced to disclose any confidential information related to the patient's care, unless the patient has consented to the disclosure. *See* D.C. Code Ann. § 14–307(b) (link).
[186] D.C. Code Ann. § 13–443(a) (link).

knowledge.[187] If another state is investigating a DC clinician providing gender affirming care to a non-DC patient, the shield law creates some significant barriers for the state to proceed with its investigation. For instance, consider how Seattle Children's Hospital relied on the Washington state shield law to justify its refusal to respond to a Texas subpoena for patient medical records.[188]

[187] *See* D.C. Council Committee Report, *supra* note 68, at 11. ("The Committee is concerned that some interstate investigations and proceedings might intrude on District residents' rights without District government officials even knowing that they are facilitating such investigations and proceedings.").

[188] Paul J. Weber, *Seattle Hospital Says Texas Attorney General Asked for Records About Transgender Care for Children*, Associated Press (Dec. 22, 2023 3:15 PM) (link); *see also* Briana Conner, *Texas Attorney General Ken Paxton, Seattle Children's Hospital Reach Settlement on Trans Care*, ABC 7 (Apr. 23, 2024) (link) (discussing settlement agreement in which Attorney General Paxton agreed to rescind the subpoena in return for the hospital withdrawing its business license within the state; discussing also that the hospital testified that the facility does not have staff that treated transgender youth from Texas, in person or remotely). Note that the parties settled before a judge could rule on whether the Washington shield law justified the hospital's refusal to respond.

C. Additional Risk Considerations

Summary: *In general, the risks for clinicians practicing gender affirming care in DC are higher than those practicing in democratically controlled states elsewhere because of the aforementioned friction between local autonomy and federal control under the District Clause (see Part II.E). For example, a DC Council law identical to Governor Hochul's "Protecting the Privacy of Providers and Strengthening New York's Shield Law" could be blocked by Congress, the same way the DC Crime Bill was vetoed by Congress in 2023.*

To date, no clinicians have been criminally or civilly charged in DC for providing gender affirming care. However, clinicians practicing in DC should remain mindful of the evolving legal landscape surrounding (1) out-of-state (extraterritorial) gender affirming care, (2) telemedicine services that include gender affirming care to patients living in states that criminalize the healthcare, and (3) potential liability under the Comstock Act, as discussed in the **Appendix, Part A**.

The scope of potential liability that a clinician providing gender affirming care to out-of-state patients may face is dependent on the laws of the state filing suit. The charges against Dr. Carpenter exemplifies this principle, as she faces *civil* charges in Texas and *criminal* charges in Louisiana for telemedicine care she provided to patients seeking abortions. A "Physician's Profile" is provided on the next page, featuring the perspective of a former patient and further context regarding Dr. Carpenter's reputation as health care advocate and medical doctor.

PHYSICIAN PROFILE Dr. Margaret "Maggie" Carpenter

Dr. Margaret "Maggie" Carpenter has built a career defined by an unwavering dedication to patient care.

Both as a physician and an advocate, Dr. Carpenter has spent years ensuring that critical medical care reaches those who need it most. This ethos has driven her to serve members of her immediate New York-based community (where she attended medical school!) and inspired her to travel abroad in order to spread care to underserved regions globally. More recently, Dr. Carpenter's patient-centric approach to practice has garnered national attention, particularly to her telemedicine services to pregnant patients post-*Dobbs*.

As of March 2025, Dr. Carpenter is the first and only doctor to be charged for violating state regulations post-*Dobbs*. She faces both civil and criminal charges in Texas and Louisiana for separate instances of care for young, pregnant patients in those states.

> **[Dr. Carpenter] listened to me, recognized my symptoms, and took the appropriate next steps. She operated only in the interest of helping me. Without Dr. Maggie's intervention at that time in my disease's progression, the cancer would have continued to spread; my chance of survival diminished … I credit her with helping to save my life.**
>
> - *Maya Gottfried, former patient*

The indictment of Dr. Carpenter affirmed long anticipated fears: that reproductive care post-*Dobbs* was subject to not only political hostility, but legal or professional liability as well. The indictment has also raised questions about the complicated position healthcare providers find themselves as "politics" increasingly enters the exam room and, in some cases, dictates the course of treatment. However, the attention has also brought forth stories and statements of support from Dr. Carpenter's community—including former patients.

Maya Gottfried wrote that Dr. Carpenter's vigilance saved her life. In her mid-thirties, Gottfried experienced a series of dismissive medical consultations that led to ineffective treatment plans for her persistent gastrointestinal symptoms. It wasn't until she met with Dr. Maggie that a proper diagnosis was reached. Dr. Carpenter requested she visit a specialist, where it was discovered that Gottfried had stage three colorectal cancer—an aggressive illness, but one that could be treated thanks to early detection.

For many, Dr. Carpenter embodies the highest ideals of medicine: placing patient well-being above all else. And she is not alone. Physicians at organizations like Doctors For America are speaking up about the evolving fears embedded within their profession as clinicians struggle to navigate shifting regulations and restrictions on care. Angel Foster, co-founder of Massachusetts Medication Abortion Access Project ("**MAP**") has urged: **"There will be some providers who will step out of the space, and some new**

providers will step in. But it has not changed our practice. It has not changed our intention to continue to practice.**"**[189]

[189] Rosemary Westwood, *After Historic Indictment, Doctors Will Keep Mailing Abortion Pills Over State Lines*, NPR (March 19, 2025, 5:00 AM) (link)

Louisiana Litigation Against Dr. Carpenter

a. **Background and Facts:** In January 2025, a grand jury in Baton Rouge, Louisiana handed down a criminal indictment against Dr. Carpenter (and her company, "Nightingale Medical, P.C.") for violating the state's near-total abortion ban. Dr. Carpenter is accused of prescribing abortion pills online to a pregnant teenager residing in Port Allen, Louisiana after being contacted by the teenager's mother. The mother has surrendered herself to local authorities; a criminal arrest warrant was issued against Dr. Carpenter on February 11, 2025.[190] Notably, mifepristone and misoprostol was recently reclassified by Louisiana as "controlled dangerous substances" increasing the regulation required for it to be prescribed.[191] This re-classification is important to clinicians providing gender affirming care as a similar tactic may be used to enhance the potential penalties for providing (or mailing)[192] certain prescription drugs related to a patient's treatment.

b. **Aggressive Prosecution Strategy:** Louisiana has signaled that its intention is to similarly prosecute other doctors engaged in similar telemedicine practices as Dr. Carpenter. Additionally, the Louisiana Attorney General warned that Dr. Carpenter "could be arrested in other places" noting that "[i]f New York won't cooperate, there are other states that will."[193]

c. **How Louisiana Discovered That The Service Was Provided:** The facts of this criminal dispute remain undeveloped. The general understanding is that the recipient of the abortion medication suffered a medical emergency sometime after ingesting and called 911—responding officers sometime thereafter discovered she had received the medication in the mail. Rather conflictingly, the arrest warrant states, in part, that "the accused [Dr. Carpenter] was present in this State at the time of the commission of said crime, and fled from Justice."[194]

Texas Litigation Against Dr. Carpenter

a. **Background and Facts:** On December 12, 2024 the Texas Attorney General filed suit against Dr. Carpenter for "violating Texas law by providing abortion-inducing drugs to Texans through telehealth." Texas asserts that Dr. Carpenter is not authorized to practice telemedicine in the state and therefore seeks an injunction preventing her from continuing to provide similar services in addition to seeking civil penalties in the amount of $250,000 or less and no less than $100,00 for "any and every violation" of Texas' Health and Safety code.[195]

b. **Court Ruling:** On February 13, 2025 the Texas District Court ordered Dr. Carpenter to pay $100,000 for violating Texas Health and Safety code §170A.005 ("Performance of Abortion") by prescribing abortion medication to a patient residing near Dallas. She was also ordered to pay a total of $13,200 in reasonable attorney fees and filing costs to the state. The court also granted a permanent

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[190] Governor Jeff Landry, Extradition Arrest Warrant for Maragret D. Carpenter, Exec. Dept. of the State of Louisiana (Feb. 11 2025) (link) [hereinafter *Carpenter Arrest Warrant*].

[191] Sara Cline and Kevin McGill, *Louisiana's New Law On Abortion Drugs Establishes Risky Treatment Delays, Lawsuit Claims*, Associated Press (Oct. 31, 2024) (link) (stating, "[p]rior to the reclassification, a prescription was still needed to obtain mifepristone and misoprostol in Louisiana. The new law reclassified the pills as "Schedule IV drugs," putting them in the same category as the opioid tramadol and other substances that can be addictive.")

[192] *See* Appendix, Part A for a discussion on how the federal Comstock Act is relevant for clinicians mailing prescriptions to patients.

[193] Lorena O'Neil, *Louisiana Attorney General Signs Off On Extraditing Ny Doctor In Abortion Pill Case*, La. Illuminator (Feb. 12, 2025) (link).

[194] *Carpenter Arrest Warrant*, *supra* note 190.

[195] Petition and Application for Temporary and Permanent Injunctive Relief, Texas v. Dr. Carpenter (Case No. 471-08942-2024) (S.D. Tex.) (link).

injunction against Dr. Carpenter, prohibiting her from "prescribing abortion-inducing drugs to Texas residents" and "practic[ing] medicine in the State of Texas without a license and registration."[196]

The Response of Dr. Carpenter's Home State (New York):

Governor Hochul has stood firm (thus far), continuing to assert that the state will not cooperate with extradition requests or otherwise aid in the prosecution of New York-based doctors. In a February 2025 press conference, the Governor explicitly stated she did not intend to acquiesce to the extradition order for Dr. Carpenter, saying the order would not be signed "now [or] ever."[197] The State Attorney General and Governor are also strengthening existing New York law to protect doctors treating out of state patients.[198] On Thursday, March 27, 2025 a county clerk in New York refused to file the judgment against Dr. Carpenter, stating, "[i]n accordance with the New York State Shield Law, I have refused this filing and will refuse any similar filings."[199]

[196] Final Order, Texas v. Dr. Margaret Carpenter (Cause No. 471-08943-2024) (S.D. Tex.) (link).

[197] Pam Belluck, Benjamin Oreskes, Emily Cochrane, *Abortion Provider Won't Be Extradited to Louisiana, N.Y. Governor Says*, N.Y. TIMES (Feb. 13, 2025) (stating, ""I will not be signing an extradition order that came from the governor of Louisiana — not now, not ever," Ms. Hochul said at a news conference on Thursday.") (link).

[198] Press Release, *Protecting Reproductive Freedom: Governor Hochul Signs Legislation Affirming New York's Status as a Safe Haven for Reproductive Health Care*, Gov. Kathy Hochul (New York) (link). Relatedly, on-going litigation in Alabama persists regarding the constitutionality of prosecuting residents who receive out-of-state abortions is being challenged as well. *See* Yellowhammer Fund v. Marshall, 733 F. Supp. 3d 1167 (M.D. Ala. 2024).

[199] Michael Hill, *NY County Clerk Refuses To File Texas' Fine For Doctor Accused Of Prescribing Abortion Pills*, Tex. Tribune (reporting from AP News) (Mar. 27, 2025) (link).

IV. HIPAA AND OTHER PRIVACY CONSIDERATIONS

A. HIPAA

Summary: *The HIPAA Privacy Rule creates baseline protections against the disclosure of protected health information ("PHI"), which DC law provides more stringent protections for patient health data. Clinicians are afforded discretion in disclosing patient information in response to judicial and administrative orders, as well as law enforcement requests. Despite HIPAA and DC law protections, access to gender affirming care remains critically at risk given the whistleblower exception and de-identification safe harbor.*

1. Protected Health Information and Permitted Disclosures Under HIPAA

The Health Insurance Portability and Accountability Act ("HIPAA") protects health information by providing patients with two substantive rights: (1) **access rights** that allow patients to view, and correct, personal health information records, and (2) **portability rights** that control the transfer and access of patient health information to parties other than the patient and their healthcare providers. The HIPAA Privacy Rule, which became effective in 2001, establishes privacy protections by limiting how protected health information ("PHI") can be used and disclosed by covered entities.[200]

Protected health information refers to any individually identifiable patient information that was created, used, or disclosed for a patient's healthcare diagnosis or treatment, including, but not limited to, payment information, contact information, health conditions and diagnoses, test and imaging results, prescriptions, and clinician notes. However, the Trump Administration's rescission of U.S. Department of Health and Human Services ("HHS") guidance on gender affirming care and patient privacy (issued during the Biden Administration) leaves the status of patient information related to gender affirming care in flux.[201] As some conservative states and organizations push the narrative that gender affirming care for minors constitutes child abuse,[202] **it is important to understand how, and when, clinicians can exercise discretion in disclosing PHI to law enforcement and third parties.**

Under the HIPAA Privacy Rule, covered entities are only required to disclose PHI to (1) individuals requesting access to their own records and (2) HHS when it is "undertaking a compliance investigation or review or enforcement action."[203] Covered entities are generally ***permitted*** to disclose PHI without patient authorization when such disclosure is "required by law."[204]

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[200] Office for Civil Rights (OCR), *Covered Entities and Business Associates*, U.S. Dep't Health and Hum. Servs. (Aug. 21, 2024) (link) (defining covered entity). For a discussion of whether free clinics are covered under HIPAA, *see* Ropes & Gray LLP, *HIPAA Frequently Asked Questions*, Americares (May 2014) (link).

[201] Meghan O'Connor, Simone Colgan Dunlap, & Kaitlyn Fydenkevez, *Trump Administration Rescinds HHS Guidance on Privacy of Gender Affirming Care Data*, Quarles & Brady LLP (Feb. 20, 2025) (link).

[202] In 2022, the Texas Attorney Gender, Ken Paxton, declared that all gender affirming procedures and treatments could "legally constitute child abuse under several provisions" of the Texas Family Code. Tex. Op. Att'y Gen. No. KP-0401 (2022) (link). While this opinion is not binding on courts, it mirrors the sentiment of many Republican officials who are actively trying to ban gender affirming care. Furthermore, an amicus brief submitted in United States v. Skrmetti similarly argues that gender affirming care for minors is medical child abuse. Brief for America's Frontline Doctors & Dr. Simone Gold as Amici Curiae Supporting Respondents, United States v. Skrmetti, pg. 10-29, No. 23-477, U.S. ___ (2023) (link).

[203] 45 C.F.R. § 164.502(a)(2) (link).

[204] 45 C.F.R. § 164.512 (link).

Of these disclosures, which depend on state law, **three stand out as particularly relevant to the provision of gender affirming care**, and each provide a different set of factors to consider in choosing the exercise one's disclosure discretion:

(1) **Abuse, neglect, or domestic violence disclosures.**[205] While HIPAA ***permits*** the disclosure of PHI to government authorities that manage and respond to abuse, neglect, and domestic violence reports, DC-licensed clinicians are **mandatory reporters** of child abuse and neglect.

(2) **Judicial and administrative proceeding disclosure.** Disclosures are ***permitted*** if they are provided in response to (a) court or administrative tribunal orders,[206] (b) subpoenas, discovery requests, or lawful processes,[207] or (c) third-party requests.[208] In light of DC's law preventing the District's government from assisting in interstate investigations, DC clinicians should take advantage of HIPAA's categorization of these disclosures as permitted rather than required, when possible.

(3) **Law enforcement disclosures.** Covered entities are ***permitted*** to disclose PHI to law enforcement "in compliance with and as limited by the relevant requirements of" (a) a court order, court-ordered warrant, subpoena, or summons issued by a judicial officer,[209] (b) a grand jury subpoena,[210] or (c) an administrative request that requires a response[211] so long as it satisfies a three-part test.[212] Similar to judicial and administrative proceedings disclosures, clinicians should take advantage of authority to decline access requests that may put patient privacy or access to gender affirming care within the District at risk.

HIPAA Privacy Rule Final Rule Excludes Gender Affirming Care

The HIPAA Privacy Rule to Support Reproductive Health Care ("Final Rule"), which went into effect in June 2024, provides additional protections for reproductive health care.[213] However, the Final Rule does not include gender affirming care, and DC law (particularly DC Code § 3-1205.14(e-1)) clearly delineates between reproductive care and gender affirming care. As such, clinicians should be aware that the Privacy Rule does not protect gender affirming care services from criminalization.

HIPAA creates baseline protections—a floor—by requiring only a narrow set of disclosures. However, many states, including DC, impose more restrictive regulations that offer additional protections. For example, in

[205] 45 C.F.R. § 164.512(c) (link).
[206] 45 C.F.R. § 164.512(e)(1)(i) (link).
[207] 45 C.F.R. § 164.512(e)(1)(ii) (link). Note that disclosure is only permitted if either (a) the patient was given notice of the access request or (b) there is assurance that reasonable efforts have been made to secure a qualified protective order.
[208] 45 C.F.R. § 164.512(e)(1)(iii) (link). Note that disclosure is only permitted if the third party demonstrates each of the following: (1) a good faith effort to provide written notice to the patient outlining the individual's right to object and (2) the time to raise the objection elapsed and either no objection was filed, or all objections were resolved.
[209] 45 C.F.R. § 164.512(f)(1)(ii)(A) (link).
[210] 45 C.F.R. § 164.512(f)(1)(ii)(B) (link).
[211] 45 C.F.R. § 164.512(f)(1)(ii)(C) (link).
[212] 45 C.F.R. §§ 164.512(f)(1)(ii)(C)(1)–(C)(3) (link). The three part test requires "(i) [that] the information sought is relevant and material to a legitimate law enforcement inquiry, (ii)) [that] the request is specific and limited in scope . . . [for] the purpose for which the information is sought; and (iii) de-identified information could not reasonably be used."
[213]

DC, clinicians are prohibited from disclosing confidential patient information without written consent, unless that disclosure is "required in the interest of justice" and the patient has been notified of the requested disclosure and given the opportunity to object.[214]

2. Beware of Nefarious Actors: The Whistleblower Exception and De-Identification Safe Harbor

WARNING: HHS Creates Gender Affirming Care Tip Line, Issues Guidance to Whistleblowers

On April 14, 2025, HHS created a tip line for individuals to report suspected "chemical and surgical mutilation" of children and issued guidance on how individuals can report clinicians suspected of providing gender affirming care under the HIPAA whistleblower exception.[215] The guidance explicitly claims that complaints related to the prescribing of puberty blockers to minors, in states where such prescriptions are prohibited, qualify for whistleblower protection. The creation of this tip line is a recent development, and the ramifications are unclear. **Implementation of the tip line should be monitored closely, and all clinicians should critically assess how this may impact their practice.**

While a clinician providing gender affirming care often worries most about the state- and federal-level regulations that encroach upon their ability to provide these services, a clinician's colleagues can pose just as great a risk. The HIPAA whistleblower exception allows covered entities to disclose PHI to an attorney or the government if they possess a good faith belief that another covered entity is engaged in unlawful conduct or the entity violated professional and/or clinical standards.[216] This exemption, however, does not require any de-identification or limit on the PHI disclosed, allowing broad disclosures that ignore patient privacy en masse.[217]

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[214] D.C. Code Ann. § 14–307 (link).

[215] *Guidance for Whistleblowers on the Chemical and Surgical Mutilation of Children*, U.S. Dep't of Health & Hum. Servs. (last reviewed Apr. 14, 2025) (link); *see also Whistleblower Tips and Complaints Regarding the Chemical and Surgical Mutilation of Children*, U.S. Dep't of Health & Hum. Servs. (last reviewed Apr. 14, 2025) (link); *see also* S. Baum, *HHS Launches Snitch Form to Report Gender Affirming Care Providers*, Erin In The Morning (Apr. 15, 2025) (link).

[216] 45 C.F.R. § 164.502(j) (link).

[217] There have been sanctions, however, against whistleblowers for carelessness. *See* United States ex rel. Alvord v. Lakeland Reg'l Med. Ctr., No. 10-52-T-17EAJ, 11-14 (M.D. Fla. Sept. 14, 2012) (sanctions imposed for unsealing medical records attached to complaint, resulting in disclosure of PHI, irrespective of whether unsealing was "inadvertent and for a brief period of time") (link).

Recent Weaponization of the Whistleblower Exception

Although the whistleblower exception was originally intended to authorize the reporting of patient fraud or abuse, this exception has recently been weaponized to circumvent patient privacy and interfere with clinicians' abilities to provide gender affirming care. For example, Dr. Eithan Haim attempted to claim protection under the whistleblower exception after he accessed patient PHI at Texas Children's Hospital. Dr. Haim believed the hospital was violating state law by continuing to provide gender affirming care to patients—arguing disclosure was necessary to fulfill his role as a mandatory reporter of child abuse—and he supplied a conservative activist with the PHI as evidence of wrongdoing. The U.S. Department of Justice ("DOJ") initially charged Dr. Haim with violating HIPAA, but all charges against him were dropped after President Trump issued his executive orders recognizing only two genders and "ending the weaponization" of DOJ. Given the disclosure was made to a reporter (notably not covered under HIPAA's whistleblower exception) and the false pretenses under which Haim obtained the PHI (which is punishable with up to $250,000 and 10 years' imprisonment)—both of which were included in the government's pretrial motion to preclude Ethan Haim from using the term "whistleblower" with the jury—the decision to drop charges is best described as selective pardoning in pursuit of President Trump's anti-transgender agenda.

Similar to the whistleblower exception, HIPAA also provides a de-identification safe harbor, in which eighteen identifiers are removed from a patient's health information such that it no longer qualifies as PHI and is therefore not protected.[218] This safe harbor can work as a backstop to the whistleblower exception, providing additional protections for providers who choose to disclose sensitive, albeit anonymized, treatment information in pursuit of ending their colleagues' provision of gender affirming care.

Whistleblower Activity Could Reveal Clinicians' GAC Practice

If a clinician's name could be used, either on its own or in conjunction with other available information, to identify a patient, it must be removed from PHI to be considered de-identified. If a clinician's name affords little opportunity for an individual to be identified by virtue of being that clinician's patient, then removal is not required. Since HIPAA protects the patient rather than the covered entity, clinicians need to be cautious of whistleblower activity that would allow disclosure of PHI that could reveal their participation in offering and providing gender affirming care.

[218] These factors include the patient's—and patient's relatives'—names, geographic identifiers smaller than a state, relevant dates (including birth date, admission date, and discharge date), phone numbers, medical record numbers, Internet Protocol (IP) addresses, biometric identifiers (like fingerprints), and photographs. 45 C.F.R. § 164.514(b)(2) (link).

B. Data Protection Practices

Action Checklist

- □ Verify your organization's electronic protection measures
- □ Use end-to-end encrypted platforms
- □ Reach out to helplines to strategize your personal privacy strategy
- □ Educate your clients about protecting their information on personal devices.

We live in a society where our data is exploited and monetized by third-parties. Additionally, with the rise in states criminalizing select healthcare procedures, like abortion and gender affirming care, there is a substantial risk that law enforcement could leverage a clinician or patient's data to determine whether a crime occurred. Clinicians have an existing ethical obligation to maintain client confidentiality, and that confidentiality likely extends to digital information. **Laws like HIPAA provide some degree of protection, but clinicians likely need to go beyond these obligations, especially if they are providing highly scrutinized and controversial care, like gender affirming care.** For instance, the HIPAA Privacy Rule aims to protect patient PHI by limiting disclosures of PHI, the whistleblower exception and de-identification safe harbor provide alternative routes for providers who oppose gender affirming care. But given the looseness of the "good faith" belief requirement, physicians are best positioned to protect their patients' access to gender affirming care by limiting data sharing—even with colleagues at their institution.

It is also important to check your organization's electronic medical record ("EMR") configuration for additional PHI protections, as well as offering these measures if they are compatible with your EMR provider and available by patient request. Functions like Epic's "Break the Glass"[219] are additional security features that restrict access to patient records, allowing access by colleagues only when provided with a valid reason (typically in an emergency), as well as creating an audit trail. These audit trails may be crucial in the context of whistleblowing because they can provide a timeline of access and aid in showing false pretenses in gaining access for later disclosure under the whistleblower exception.

If you choose to participate in online activism, it is important to protect your accounts and communications. You may choose to **use end-to-end encrypted messaging platforms**, like Signal, to communicate with your activist peers and even patients. Similarly, platforms like Jitsi Meet, support end-to-end encryption for video and audio conferencing.[220] Access Now, a New York-based nonprofit focused on digital civil rights, also provides a free, 24/7 Digital Security Helpline to assist individuals and activist groups strategize their digital security.[221]

As a clinician-activist, it is important to **remind your patients about what HIPAA does and does not cover**. While the health information that is collected by you and your organization is likely protected under HIPAA, any data collected by their personal devices and third-party applications are not. Anti-abortion groups have

[219] *See* University of North Carolina Health Care Privacy Office, *Monitoring Employee Access Within Epic*, UNC Healthcare (Mar. 2018) (link); *see also Break-the-Glass*, The University of Iowa (link); *see also* Office of HIPAA Compliance, *HIPAA Guidance: Epic's Break the Glass Function*, Central Michigan University (link).
[220] *Movement Technology post-US Election: Report Back*, May First Movement Tech. Coop. (link); *Jitsi Mett Security & Privacy*, Jitsi (link).
[221] *Digital Security Helpline*, Access Now (link).

weaponized the third-party doctrine—the idea that there is no reasonable expectation of privacy in data that individuals voluntarily provide to third parties—by buying abortion clinic location data from data brokers: data such as the groups of people who visited these clinics, how long they stayed, and even where they went after they left.[222] Some states have amended their consumer protection regulations to protect personal information collected, obtained, and often sold by third parties. Virginia's governor, for instance, signed an amended Consumer Protection Act, which requires opt-in consent from consumers before third parties can obtain, disclose, sell, or disseminate sexual health information.[223]

Personal devices collect—and disclose—far more information about ourselves than we could imagine. While it is always in our best interest to practice safe data protection practices, disabling location services on personal phones is imperative to keeping oneself safe when receiving gender affirming care in the current political and social climate.

C. Critical Information Literacy

With the ever-changing social, political, and legal atmosphere regarding the status of gender affirming care, there has been no shortage of organizations and research institutions that push a narrative of gender affirming care as unethical—some even likening it to child abuse.[224] Many of these organizations employ fact distortion techniques to misinform the public—as well as the legal and medical communities—on the importance of gender affirming care for minors' health and safety. With President Trump's recent directive to the National Institutes of Health to study "regret" among transgender individuals who received gender affirming care, it is increasingly important to critically evaluate the sources of research that you, your institution, and your patients rely on.[225]

Action Checklist

When evaluating an organization's credibility, consider the organization's:

- ☐ Motivations and biases
- ☐ External affiliations
- ☐ Sources of funding
- ☐ Control over common services related to a clinician's practice

When evaluating studies, it is important to consider the funding organization's motivations and biases to determine the source's credibility. **While some organizations vocalize their repulsion of gender affirming care for minors, others hide behind a facade of so-called objectivity.** For example, the Society for Evidence-Based Gender Medicine ("SEGM") submitted an amicus brief in support of neither party in *United States v. Skrmetti* (see **Appendix, Part B**), claiming to provide an objective view that highlighted the supposed transience of gender dysphoria and the Cass Review's assessment of research on gender affirming

[222] Joseph Cox, *Data Broker Is Selling Location Data of People Who Visit Abortion Clinics*, VICE Digital Publishing (May 3, 2022) (link).
[223] David Strauss, *Proposed State Privacy Law Update: March 31, 2025*, Husch Blackwell (Mar. 30, 2025) (link); *Virginia's New Sweeping Reproductive and Sexual Health Privacy Law May Affect All Companies Doing Business in the State*, Quarles (Apr. 2, 2025) (link);
[224] One brief submitted in support of Tennessee's ban specifically claimed that gender affirming surgery for minors is "criminal child abuse and medical batter." Brief for America's Frontline Doctors & Dr. Simone Gold as Amici Curiae Supporting Respondents, United States v. Skrmetti, pg. 10-29, No. 23-477, U.S. ___ (2023) (link).
[225] Ryan Adamczeski, *Trump Orders NIH to Study Gender Transition 'Regret.' Here's What We Already Know About It*, Advocate (Apr. 7, 2025) (link).

medicine.[226] Similarly, Genspect categorizes itself as a non-partisan group "committed to promoting a healthy, evidence-based approach to sex and gender."[227] Yet, they hosted "Detrans Awareness Day" in our nation's capital,[228] and have been designated as an anti-LGBTQ hate group by Southern Poverty Law Center since 2023.[229]

External affiliations can also provide insight into an organization's alignment with or position against gender affirming care. SEGM members, for instance, founded Therapy First (formerly Gender Exploratory Therapy Association ("GETA")), a conservative organization that advocates for gender exploratory therapy—a transgender therapy treatment analogous to conversion therapy for LGBTQIA+ individuals.[230]

Proof of funding or control over healthcare-related modalities, like EMR providers or telehealth platforms, could also inform a physician's decision to use one service over another. For instance, SpeakWithAnMD is affiliated with America's Frontline Doctors—who submitted an amicus brief in support of Tennessee's ban—and had been subject to criticism during the COVID era for overcharging, prescribing, and failing to deliver, non-FDA approved, anti-parasitic drugs to treat COVID-19.[231]

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[226] Brief for Society for Evidence-Based Gender Medicine (SEGM) as Amicus Curiae Supporting No Party But Suggesting Affirmance, United States v. Skrmetti, No. 23-477, U.S. ___ (2023) (link).
[227] *About*, Genspect USA (last visited Mar. 31, 2025) (link).
[228] *Detrans Awareness Day 2025*, Genspect USA (last visited Mar. 31, 2025) (link).
[229] *Anti-LGBTQ*, S. Poverty L. Ctr. (last visited Mar. 31, 2025) (link).
[230] Alejandra Caraballo, *The Anti-Transgender Medical Expert Industry*, 50 J.L. Med. & Ethics 687 (2022) (link); *Therapy First*, Wikipedia (last edited Mar. 26, 2025) (link).
[231] *See America's Frontline Doctors*, Wikipedia (last edited Jan. 31, 2025) (link); *see also* Vera Bergengruen, *How 'America's Frontline Doctors' Sold Access to Bogus COVID-19 Treatments—and Left Patients in the Lurch*, Time USA (May 19, 2021) (link).

V. FINAL RECOMMENDATIONS

This Guide has made unequivocally clear that gender affirming care is critically important. This Guide has also made the point that clinicians must consider their individual circumstances when deciding what is best for themselves and their patients. This may mean some clinicians will continue providing care to DC patients, while others may explore how they can provide care to non-DC patients via telemedicine. This could also mean that some clinicians will pursue opportunities to advocate for more equitable and just policies that enshrine patients' rights to access care they need. And other clinicians may choose to advocate with their hospital or clinic to ensure that their institutions remain committed to providing gender affirming care. Like patients, clinicians are best positioned to decide what choice makes the most sense to them. **This Guide does not suggest there is *one right way*.**

Five final recommendations for clinicians reading this Guide are provided below:

1. Offer your support to your patients and their families. First, remember that treating transgender and gender-diverse patients with respect, dignity, and compassion *is* gender affirming care. This includes talking to your patients and offering whatever immediate support you can. **This is a turbulent and terrifying time for transgender individuals and their families, and you—as their healthcare provider—can offer them a respite.** If you are unable to provide patients with the medical care they need, consider making a referral to another provider. Keep in mind that some states restrict clinicians from "facilitating" or "aiding and abetting" a patient's gender affirming care.[232] Additionally, remember the DC shield law protects DC clinicians who facilitate gender affirming care.[233]

2. Speak to your hospital/clinic leadership. In the face of threats from the federal government, healthcare institutions have already shown they may pull back on care they once offered to patients.[234] As a clinician, your story and the story of your patients[235] can be some of the most effective advocacy tools. **Remind your institution leadership why gender affirming care is important, why it is aligned with your institution's mission, and what ceasing care would mean for your patients.**[236] In the event your institution stops care, it may run the risk of violating DC's non-discrimination law.

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[232] *See e.g.*, Iowa Code Ann. § 147.164(2)(b) (link) (prohibiting a clinician from "aiding and abetting" a patient receiving gender affirming care). It is unclear whether a referral would be considered "facilitation," but courts typically require something more than simply giving an individual information that is otherwise available. *Cf. aid and abet*, Cornell L. Legal Info. Inst. (last reviewed Nov. 2024) (link) (discussing four required elements for an "aiding and abetting" criminal offense).

[233] D.C. Code Ann. § 2–1461.01(a)(7) (link).

[234] Jenna Portnoy, *After Trump Order, Hospitals Suspend Some Health Care for Trans Youth*, The Washington Post (Jan. 31, 2025) (link); Sarah Y. Kim, *With Gender-Affirming Care Under Threat, D.C. Area Providers Worry About Continuing Services*, WAMU (Feb. 19, 2025) (link).

[235] Doctors for America, *Advocacy Grand Rounds - Speaking Out Against Gender Affirming Healthcare Bans*, YouTube (Feb. 26, 2018) (link).

[236] *See, e.g.*, Alex Morris, *Trump Banned Gender-Affirming Care for Teens. Now, These Families Are in Chaos*, Rolling Stone Magazine (Feb. 20, 2025, 9:30 AM) (link); *see also* Elsie Carson-Holt, *'We're Living Through Hell': What Trump's Anti-Trans War Really Means*, The Nation (Feb. 21, 2025) (link).

3. Advocate for your colleagues and patients. As DFA members, you know advocacy is an effective and important tool for change: the same applies here. Some national organizations have spoken out against the Trump Administration (like the American Psychological Association, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians).[237] But other organizations have been silent (like the American Medical Association). **National leaders like the AMA need to speak up, and they need to hear from you.** Additionally, as highlighted in this Guide, several states have taken legal action against the federal government and have sought to prevent the government from enforcing President Trump's Executive Orders. And these states have seen initial success! This Guide has demonstrated that DC is similarly situated to these other states, suggesting that DC could also have a viable lawsuit against the Administration. The DC Attorney General decides who to sue on behalf of DC's public interest.[238] While DC residents do not have congressional representation, advocating to local leaders can be just as impactful in working towards policy changes that positively impact DC clinicians and patients.

4. Inventory your data privacy practices. Regardless of whether your circumstances allow you to advocate publicly, it is essential that you inventory your data privacy practices. **Review this Guide carefully and take all necessary steps to secure both your data and that of your patients**, like checking whether your telemedicine portal is HIPAA compliant and speaking with patients in secure, private locations. You may want to consider investing in telemedicine applications that use dual-encryption technology and rely on patient-messaging applications that have robust data privacy policies. Stay vigilant with whom you share patient information. And critically analyze "medical evidence" when offered by organizations advocating against gender affirming care.

5. Evaluate your evolving individual risks. It is unlikely that the national landscape for gender affirming care will be settled anytime soon. This means that a clinician's individual risks may continue to shift. Changes in the law may make it more difficult for a clinician to provide gender affirming care, but changes may also make it easier. Although clinicians have so many other responsibilities, **those that work with transgender patients have an extra duty of staying up to date** on what is happening at the federal level,[239] and the states in which their patients live (if not in DC).[240] Lean on your DFA community,[241] your colleagues, and other resources, to learn more about what is happening and what it may mean for you.

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[237] *See, e.g.*, Allia Vaez, *Major Medical Groups Push Back Against Trump Administration's 'Sex-Based Definitions,'* ABC News (Feb. 27, 2025 12:07 PM) (link).

[238] *About the Office of the Attorney General*, Attorney General for the District of Columbia, (last visited Feb. 27, 2025) (link).

[239] Lindsey Dawson & Jennifer Kates, *Overview of President Trump's Executive Actions Impacting LGBTQ+ Health*, KFF (last updated Mar. 26, 2025) (link).

[240] Lindsey Dawson & Jennifer Kates, *Policy Tracker: Youth to Gender Affirming Care and State Policy Restrictions*, KFF (last updated Mar. 19, 2025) (link).

[241] *News*, Doctors for America (last visited Feb. 27, 2025) (link).

VI. APPENDIX

A. Existing Federal Law Could be Used to Restrict Access to Medications

Although gender affirming is much more than hormone therapy and puberty blockers, medication plays a large part in helping individuals address the physical needs associated with gender dysphoria. Given the need for medication *as part of* a gender affirming care regimen, it is important to keep in mind how federal law may impact a clinician's ability to prescribe and send medication to a patient. There is justified concern that the Trump Administration could rely on two federal laws to severely restrict access to gender affirming medications: the Comstock Act and the Food, Drug, and Cosmetics Act ("FDCA").

1. Comstock Act's "obscenity" language leaves room for interpretation

The federal Comstock Act could be used to prohibit clinicians from mailing medications necessary for gender affirming care. The Comstock Act, adopted in 1873, was intended to address various "obscenities" in American society. The law criminalizes the mailing of "any drug, medicine, or thing which is advertised or described in a manner . . . for producing abortion, *or for any indecent or immoral use*."[242] While the Trump Administration has not publicly raised this as a possibility, there have been efforts to revive the law to prohibit the mailing of abortion-related medications.[243] And the law's language could be interpreted to restrict gender affirming care.

In recent history, the law has not been leveraged against clinicians who provide medication for abortion, so long as the medication is legal.[244] Instead, the law has been reserved for punishing individuals who mail illegal drugs.[245] The Biden Administration took the position that the "mere mailing" of abortion medications to another state is an "insufficient basis for concluding that the sender intends for [the medications] to be used unlawfully."[246] President Trump has previously said he would not enforce the Comstock Act to ban mail delivery of abortion medication, claiming that the "federal government should have nothing to do with this issue."[247]

Yet, the Trump Administration's position on gender affirming care has been much more forceful and, compared to its view on abortion, sees a far greater role for the federal government to play in restricting access to gender affirming care.[248] This position, plus the language the Administration has used to describe

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[242] 18 U.S.C. § 1461 (emphasis supplied) (link); *see also* Doctors for America & Lawyers for Good Government, *Comstock Act* (link).
[243] *See* Danielle Kurtzleben, *Why Anti-Abortion Advocates Are Reviving a 19th Century Sexual Purity Law*, NPR (Apr. 10, 2024 4:11 PM) (link).
[244] Although some states have made the act of an abortion illegal, the medications used in the abortion are still legal.
[245] *See, e.g.*, United States v. Gentile, 211 F. Supp. 383, 385 n.5 (D. Md. 1962) ("It seems clear under the authorities that in order to make out an offense under this paragraph the Government should be required to allege and prove that contraceptive devices are shipped and received with intent that they be used for illegal contraception or abortion or for indecent or immoral purposes.") (link).
[246] Application of the Comstock Act to the Mailing of Prescription Drugs That Can Be Used for Abortions, 46 Op. O.L.C. ___, 2 (2023) (link).
[247] Alice Miranda Ollstein, *'It's Not a Pro-Life Position': Anger After Trump Says No to Comstock*, Politico (Aug. 20, 2024, 4:56 PM) (link).
[248] *See* Appendix, Part C.

gender affirming care,[249] suggests that the federal government could turn to the Comstock Act to restrict mail delivery of gender affirming care medication.

But this is only a possibility. To be clear, the Trump Administration *has not* directed the Department of Justice to enforce the Comstock Act against clinicians who supply gender affirming medications, *nor has Congress* indicated it will legislate similarly. Thus, as of now, mailing gender affirming medication does not violate federal law. Pharmacists, and clinicians who send medications, should always check state and local mailing regulations before sending medications. It is also recommended that clinicians keep in mind the role of Prescribed Drug Monitoring Programs ("PDMPs") and the ability of law enforcement to track prescriptions through those state systems. We discuss this in **Part I.C.**

2. Amendment to the FDCA could limit off-label use of gender affirming medications.

Off-label use of medications is a common, widespread practice,[250] especially for minors given the lack of pediatric-specific research.[251] Clinicians prescribe medications for off-label use to treat a variety of patient conditions, including gender dysphoria. Off-label use does not mean the medications are experimental or ineffective.[252] Nonetheless, due to a recent change to the Food, Drug, and Cosmetics Act ("FDCA"),[253] the Food and Drug Administration ("FDA") could ban off-label use of certain medications *if* the Agency finds that the use "presents substantial deception or an unreasonable and substantial risk of illness or injury."[254]

This language is broadly written, and subject to interpretation by the FDA. Since the amendment was adopted in 2022, no federal court has ruled on how this new power can be used by the federal government. But, given the Trump Administration's position that gender affirming care for children is the equivalent to "maiming" and "mutilation,"[255] it is not outside the realm of possibility that the federal government may rely on the FDCA to limit off-label use of gender affirming medications.

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[249] *See, e.g.*, Exec. Order No. 14,168, 90 Fed. Reg. 8615 (2025) (emphasis supplied) ("The erasure of sex in language and policy has a corrosive impact not just on women but on the *validity of the entire American system*. Basing Federal policy on truth is critical to scientific inquiry, public safety, *morale*, and trust in the government itself.") (link); *see also* Exec. Order No. 14,187, 90 Fed. Reg. 8771 (2025) ("Across the country today, medical professionals are *maiming and sterilizing* a growing number of *impressionable children* . . . This dangerous trend will be *a stain on our Nation's history*, it must end.") (link).

[250] *See, e.g.*, Brief of Professors of Law, Medicine, and Public Health as Amici Curiae Supporting Petitioner, United States v. Skrmetti, 144 S. Ct. 2679 (Nos. 23-466, 23-477, 23-492) (link).

[251] *See* H. Christine Allen, M. Conor Garbe, Julie Lees, Naila Aziz, Hala Chaaban et al., *Off-Label Medication use in Children, More Common Than We Think: A Systematic Review of the Literature*, 8 J. Okla. State Med. Ass'n 776–83 (2018) (link).

[252] *See, e.g.*, Brief of Professors of Law, Medicine, and Public Health as Amici Curiae Supporting Petitioner, United States v. Skrmetti, 144 S. Ct. 2679 (Nos. 23-466, 23-477, 23-492) (link).

[253] Joel Zinberg, *The FDA Wants to Interfere in the Practice of Medicine*, Competitive Enter. Inst. (Jan. 12, 2023) (link).

[254] 21 U.S.C.A. § 360f(a)(1) (link).

[255] Exec. Order No. 14,187, 90 Fed. Reg. 8771 (2025) (link).

B. *U.S. v. Skrmetti*: Supreme Court Ruling Could Permit State Restrictions

The Legal Issue: Whether **Tennessee Senate Bill 1** ("SB1"),[256] which prohibits all medical treatments intended to allow "a minor to identify with, or live as, a purported identity inconsistent with the minor's sex" or to treat "purported discomfort or distress from a discordance between the minor's sex and asserted identity," violates the Fourteenth Amendment's Equal Protection Clause.

Procedural History: *Skrmetti* was initiated by a legal challenge brought by three transgender teenaged minors, their parents, and a Memphis doctor engaged in providing gender affirming care in Tennessee against Tennessee officials (including Attorney General Jonathan Skrmetti), seeking to stop the state from enforcing SB1. The U.S. Department of Justice, then under the Biden Administration, intervened to join the plaintiffs, arguing that SB1 violated federal law under the Fourteenth Amendment.[257]

- **District Court:** The plaintiffs were successful at the District Court, where a preliminary injunction was issued against SB1, prohibiting the law from being enforced. Specifically, the court found that SB1 "discriminates on the basis of sex and that transgender persons constitute a quasi-suspect class" and was therefore "facially unconstitutional."
- **U.S. Court of Appeals:** However, the Sixth Circuit Court of Appeals reversed the District Court's decision and allowed the ban to go into effect. The Sixth Circuit opinion reasoned, in part, finding that the Tennessee law "treat[s] similarly situated individuals evenhandedly" regardless of their identity.
- **U.S. Supreme Court:** The Supreme Court granted certiorari last June and held oral arguments on December 5, 2024. **The case is currently pending, and an official opinion is expected to be released by the Court sometime before or during June 2025.**

Oral Argument: Two advocates argued for the plaintiffs, former Solicitor General Elizabeth Prelogar and Chase Strangio of the American Civil Liberties Union.[258] Tennessee was represented by Matthew Rice, the state Solicitor General. The oral argument in *Skrmetti* signaled disagreement amongst the Justices on both key legal issues and factual findings presented. For example, the Justices signaled disagreement on:

(1) whether SB1 qualifies as a categorical ban on gender-affirming care,
(2) whether transgender individuals qualify as a suspect class, and
(3) whether SB1 presents and operates under a sex-based distinction (as opposed to a medical condition distinction or age distinction), thus triggering a higher degree of scrutiny.

Conservative justices also debated the veracity of medical evidence supporting gender affirming care for minors. For instance, Justice Alito paid particular attention to statistics provided by Tennessee, indicating higher rates of post-treatment infertility complications and patient regret. Those statistics were refuted by the plaintiffs in both their briefings and during their oral arguments, and by copious amounts of amicus briefs provided by medical professionals experienced with gender affirming care.[259]

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[256] S.B.1, 113th Gen. Assemb., Reg. Sess. (Tenn. 2024) (link).

[257] The Supreme Court heard oral arguments on this case in December 2025, before President Trump was inaugurated. On February 7, 2025, the Solicitor General's office notified the Court that the position taken by the Biden Administration "no longer represent[s] the United States' position." (link). The Solicitor General urged the Court to resolve the dispute and did not call for the court to dismiss the case. *See also* Adam Liptak, *Trump Administration Flips U.S. Position in Supreme Court Transgender Case*, N.Y. Times (Feb. 7, 2025) (link).

[258] Notably, Chance Strangio became the first (known) transgender advocate to argue before the Supreme Court. *See* Lindsay Whitehurt, *First transgender attorney to argue before the Supreme Court, challenging health care ban for minors*, AP News (Dec. 2, 2024, 9:48 AM) (link).

[259] A compelling brief was submitted in support of the plaintiffs by 17 medical experts with experience providing gender affirming care. Brief of Seventeen Healthcare Providers as Amici Curiae Supporting Petitioner, United States v. Skrmetti, 144 S. Ct. 2679 (Nos. 23-466, 23-477, 23-492) (link).

C. Summaries of Select Trump Administration Executive Orders, Agency Actions

1. EO 14168: Banning "Gender Ideology" and "Restoring Biological Truth"

On January 20, 2025 (the first day of the Trump Administration), President Donald Trump issued an Executive Order titled, "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government."[260] The Executive Order ("EO") declares that it is the policy of the United States federal government to only recognize two sexes, male and female, and further declares that the "sexes are not changeable and grounded in fundamental and incontrovertible reality." The EO is effective immediately.

Key Points from the Executive Order

- The federal government will enforce "sex-protective laws" in a manner that only recognizes "sex" as meaning either "male" or "female." This could mean provisions like Section 1557 of the Patient Protection and Affordable Care Act will not be enforced to prevent discrimination against transgender or gender-expansive individuals.[261] The federal government has also rescinded all guidance documents related to the rights of transgender and gender-expansive individuals.
- The federal government will only recognize "sex" as an identifier and will not use "gender" in place of sex. For instance, an individual will only be identified by their biological sex on federal government records (*e.g.* visas, passports, social security cards, etc.).
- The federal government will not rely on the Supreme Court's *Bostock v. Clayton County* opinion to enforce other anti-discrimination statutes on behalf of transgender and gender-expansive individuals. The federal government will abide by *Bostock* only as it relates to Title VII's employment discrimination prohibitions.
- The federal government will not house transgender inmates in spaces that correspond to their gender identity. Additionally, the federal government will no longer allow federal funds to be used to support gender affirming care for federal inmates, or other individuals.

Next Steps and Things to Watch Closely

The EO directs the Health and Human Services Secretary and the Attorney General to issue guidance on how the EO will be implemented across the federal government. The HHS Secretary is directed to publish guidance, by February 19, that expands on the "sex-based definitions" included in the order. The Attorney General is directed to publish guidance describing how sex-segregated spaces in the workplace and federal funded entities must conform with the order. There is no deadline for this guidance. Lastly, the White House Legislative Affairs Office is directed to present, by February 19, draft bill text to the president, that would codify the order's definitions.

[260] *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, The White House (Jan. 20, 2025) (link).

[261] Section 1557 of the Patient Protection and Affordable Care Act provides that an individual may not be discriminated against, or excluded from health programs or activities, on the basis of their race, color, religion, sex, national origin, age, or disability. *See* 42 U.S.C. § 18166 (link).

2. EO 14187: Prohibiting Federal Funds from Supporting "Chemical and Surgical Mutilation"

On January 28, 2025, President Donald Trump issued an Executive Order titled, "Protecting Children From Chemical and Surgical Mutilation."[262] The Executive Order ("EO") declares that it is the policy of the United States to "not fund, sponsor, promote, assist, or support" gender-affirming transition in individuals under the age of nineteen ("children").

Key Points from the Executive Order

- The EO uses "chemical and surgical mutilation" in place of "gender affirming care," to describe the use of puberty blockers, sex hormones, and surgical procedures.
- The EO attacks the World Professional Association for Transgender Health (WPATH) for lacking "scientific integrity" and orders any policies relying on WPATH guidance, in particular the "Standards of Care Version 8," to be rescinded or amended.
- The heads of every executive department and/or agency that provides research or educational grants are directed to end gender affirming care in institutions that receive federal research or education grants, including medical schools and hospitals.[263]
- The Secretary of Health and Human Services ("HHS") and the Attorney General are instructed to provide new guidance to protect whistleblowers. This means that any person, including doctors, who report gender-affirming care, would be protected, which may lead to complications with HIPAA.[264]
- The Secretary of Defense is instructed to exclude gender affirming care for children from TRICARE health insurance coverage.
- The Director of the Office of Personnel Management is instructed to include provisions in the Federal Employee Health Benefits and Postal Service Health Benefits to exclude coverage for all pediatric gender affirming surgeries and hormone treatments in 2026.
- The Department of Justice ("DOJ") is instructed to review 18 U.S.C. § 116 to strengthen protections against female genital mutilation.[265] This instruction includes coordinating the enforcement of the statute among all U.S. states and territories. The DOJ is also instructed to consult with Congress to create a private right of action for children and parents in connection with receiving gender affirming care.
- The DOJ is instructed to prioritize ending the practice of removing children from their parents' custody when their parents refuse to consent to gender affirming care. The EO recognizes a potential application of the Parental Kidnapping Prevention Act.

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[262] *Protecting Children from Chemical and Surgical Mutilation*, The White House (Jan. 28, 2025) (link).

[263] Already, some gender affirming clinics associated with public research institutions are pulling back on the services they provide minors. *See* Nick Pinto, *NYU Langone Is Canceling Gender-Affirming Care Appointments for Trans Kids, Parents Say*, Hell Gate (Jan. 31, 2025 10:21 PM) (link).

[264] Relatedly, the DOJ recently dropped all criminal charges against a former Texas surgeon for violating HIPAA, after he shared information about other doctors providing gender affirming care to patients. *See* Steve Alder, *DOJ Drops Charges Against Surgeon Who Exposed Continuing Transgender Care at Texas Children's*, The HIPAA Journal (Jan. 27, 2025) (link).

[265] The statute is a criminal ban on performing, aiding, or conspiring to perform female genital mutilation procedures on a person under eighteen years old. However, the statute expressly states that a surgical operation is not a violation if the operation was "necessary to the health of the person on whom it is performed." *See* 18 U.S.C. § 116(b)(1) (link). Furthermore, a federal district court previously ruled that the FGM statute was unconstitutional because the federal government does not have the authority to police local or state criminal activity. *See* United States v. Nagarwala, 250 F. Supp. 3d 613 (E.D. Mich. 2018) (link).

Next Steps and Things to Watch Closely

The EO directs the HHS Secretary to publish, within 90 days of the order, a review of existing literature on the best practices for assisting children with gender dysphoria. It also directs the Secretary to "increase the quality of data" to guide new practices for assisting children with gender dysphoria.[266] Furthermore, the EO references state Medicaid programs, which are also used to fund gender-affirming care for adults.[267] Although the EO is focused only on minors' access to gender affirming care, the reference to state Medicaid programs suggests that there may be a broader attack on gender affirming care in the future.

3. Proposed CMS Rule Could Limit Health Insurance Coverage of Gender Affirming Care

On March 10, 2025, the Trump Administration, via the Centers for Medicare and Medicaid Services ("CMS"), published a proposed rule related to gender affirming care.[268] The proposed rule would prohibit states from including "sex-trait modifications" within their essential healthcare benefits, starting in Plan Year 2026 (Jan. 1, 2026).[269] Public comment on the proposed rule closed on April 11, 2025, with over twenty-six thousand comments submitted. Per the Administrative Procedure Act, CMS must review the submitted comments and issue a response when it publishes the final rule. It is unclear when the final rule will be published.

Background on the ACA and "Essential Health Benefits"

Under the Affordable Care Act ("ACA"), states must operate their own healthcare insurance marketplaces, which offer insurance plans for individuals and small businesses.[270] States have flexibility in deciding what services these plans must cover, but federal law requires that they at least include "essential health benefits" ("EHBs").[271] These EHBs are services and procedures that are typically covered by employer-provided healthcare plans, so that healthcare coverage provided by the marketplace has some parity to that offered by private employers. In addition to EHBs, the ACA requires that state marketplace plans include other statutorily required services, such as emergency services, hospitalizations, maternity and newborn care, and mental health and substance abuse disorder services.[272] However, there are also services that state marketplace plans are prohibited from covering. Under existing CMS regulations, marketplace plans may not cover services such as non-pediatric dental services, routine non-pediatric eye exam services, and non-medically necessary orthodontia.[273] The rationale for these exclusions is that employer healthcare plans do not typically cover these services, so the state marketplace plans cannot be forced to cover them.

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[266] There are concerns that this push for additional studies will open the door for legitimizing studies like those included in the Brief of the American College of Pediatricians (link) or the Brief of America's Frontline Doctors and Dr. Simone Gold (link).

[267] Michael Zaliznyak, Eric E. Jung, Catherine Bresee, & Maurice M. Garcia, *Which U.S. States' Medicaid Programs Provide Coverage for Gender-Affirming Hormone Therapy and Gender-Affirming Genital Surgery for Transgender Patients?: A State-by-State Review, and a Study Detailing the Patient Experience to Confirm Coverage of Services*, 18 J. Sex. Med. 410, 410-422 (2021) (link).

[268] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 12942, 12985 (proposed Mar. 19, 2025) (to be codified at 445 C.F.R. pts. 147, 155, & 156) (link) [hereinafter *Proposed Rule*]; *see also* Arin Waller, *Trump is Trying to Deny Coverage for Trans Health Care. Here's How You Can Stop Him.*, LGBTQ NATION (Mar. 24, 2025) (link).

[269] *Proposed Rule*, *supra* note 268, at 12985.

[270] *See, e.g.*, *Affordable Care Act*, Wikipedia (last visited Apr. 9, 2025) (link).

[271] *Information on Essential Health Benefits (EHB) Benchmark Plans*, Ctrs. for Medicare & Medicaid Servs. (last modified Jan. 14, 2025, 3:10 PM) (link).

[272] *See* 42 U.S.C. § 18022 (link).

[273] 45 C.F.R. § 156.115(d) (link).

Proposed CMS Rule Would Add "Sex-Trait Modifications" to Excluded Services List

The proposed rule would prohibit states from including "sex-trait modification" as EHBs within their healthcare marketplace plans.[274] The proposed rule does not define "sex-trait modification"[275] but seems to integrate the understanding previously adopted by the Trump Administration's "Protecting Children from Chemical and Surgical Mutilation" Executive Order banning gender affirming care for children (see **Appendix, C.2**).[276] The Executive Order banned federal funding for procedures that result in the "chemical and surgical mutilation" of children, including puberty blockers, hormones, and surgical procedures that "attempt to transform an individual's physical appearance to align with an identity that differs from his or her sex or attempt to alter or remove an individual's sexual organs to minimize or destroy their natural biological functions." CMS acknowledges the ongoing litigation related to the Executive Order (see **Part II.D**) but declares that this rulemaking is independent of the Executive Order, and the proposed rule does not rely on the enjoined portions of the Executive Order.[277]

The proposed rule claims that the prohibition is justified for similar reasons, that other medical procedures are excluded from EHBs.[278] "Because coverage of sex-trait modification is not typically included in employer-sponsored plans, and EHB must be equal in scope to a typical employer plan, we propose to add 'sex-trait modification' to the list of [excluded items and services]."[279] However, research from KFF suggests that employer plans' coverage of gender affirming care is more common than the proposed rule suggests.[280] According to KFF's 2024 Employer Health Benefit Survey, 24 percent of large employers covered gender-affirming hormone therapy.[281] This compares to the near universal coverage of hormone therapy and other medically necessary surgeries for cisgender people.[282]

Although the proposed rule would prohibit states from including "sex-trait modification" in their EHBs, the proposed rule does not prohibit states from "voluntarily covering [the procedures] as a non-EHB."[283] However, if a state elects to cover "sex-trait modification," the state must defray the costs of that mandated coverage.[284]

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[274] The proposed rule recognizes that there may be some medical conditions, such as precocious puberty or therapies related to traumatic injuries, where "items and services that are also used for sex-trait modification may be appropriate." The proposed rule does not declare that such conditions are exempted from this exclusion and instead seeks comments on whether CMS "should define explicit exceptions to permit the coverage of such items and services . . . and what those conditions are . . . .").

[275] *Proposed Rule*, *supra* note 268, at 12987 ("Consistent with the other listed benefits that issuers must cover as an EHB at § 156.115(d), we are not proposing a definition of 'sex-trait modification.' However, we solicit comment on whether we should adopt a formal definition of 'sex-trait modification,' whether there are current issuer standards with regards to what is considered 'sex-trait modification,' and how such a definition could best account for the items and services currently covered or excluded as sex-trait modification by plans subject to the EHB requirement.").

[276] *Id.* at 12986.

[277] *Id.*

[278] *Id.* at 12987.

[279] *Id.* at 12986.

[280] Lindsey Dawson, Kaye Pestaina & Matthew Rae, *New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers*, KFF (Mar. 24, 2025) (link).

[281] *2024 Employer Health Benefits Survey*, KFF (Oct. 9, 2024) (link).

[282] *Transgender-Inclusive Healthcare Benefits (Criterion 2d)*, HRC Foundation (last visited Apr. 9, 2025) ("For example, coverage for routine care, hormone therapies and medically necessary surgeries is available to cisgender people . . . under virtually all employer-sponsored health insurance plans.") (link).

[283] *Proposed Rule*, *supra* note 268, at 12987.

[284] *Id.*

Proposed Rule Would Likely Increase Costs, Limit Access to Gender Affirming Care

KFF reports that, if the proposed rule were implemented as published, the impacts across the states would vary. Some healthcare plans might eliminate coverage, while other plans would cover the services outside the EHB package.[285] This could have a noticeable impact on access to gender affirming care. Additionally, any costs incurred for gender affirming care would not be required to count towards deductibles or out-of-pocket maximums, increasing direct costs to patients.[286]

[285] Dawson, Pestaina, & Rae, *supra* note 280.
[286] *Id.*

D. Additional Resources

This Guide is not meant to be an exhaustive resource for all questions or situations that a doctor may encounter as they consider providing (and continuing) gender affirming care. This section is intended to suggest additional resources that doctors (or their patients) may find helpful.

Policy, Legislation, and News Trackers

KFF: Overview of President Trump's Executive Actions Impacting LGBTQ+ Health (Link)
This is a living resource that tracks all actions taken by President Trump which impact LGBTQ+ health. The resource includes summaries of the actions and how the actions are likely to impact the community. The resource is organized by date issued.

KFF: Policy Tracker: Youth Access to Gender Affirming Care and State Policy Restrictions (Link)
This is a living resource that tracks all state actions related to gender affirming care. The resource includes a map view of enacted legislation, as well as a litigation tracker related to the state laws.

UCLA Law & Williams Institute: Shield Laws for Reproductive and Gender Affirming Health Care: A State Law Guide (Link)
This is a living resource that tracks state "shield laws." The resource includes a map of state statutes and includes a fact sheet for each state's law.

Erin in the Morning (Link)
Erin Reed is an independent, transgender journalist who reports on state and national LGBTQ+ legislation and executive actions. The website often breaks updates, including those related to actions taken by the Trump Administration.

National Partners & Mutual Aid

CenterLink (Link)
CenterLink is a member-based coalition focused on supporting the development of strong, sustainable, LGBTQ+ community centers. CenterLink also focuses on national grassroots organizing, coalition building, and social activism. The website offers a directory of LGBTQ+ community centers across the country.

Equality Federation (Link)
The Equality Federation is a coalition of state LGBTQ+ advocacy organizations. The Federation works closely with partners and stakeholders to build an active base of LGBTQ+ supports to advance pro-LGBTQ+ policies and defeat anti-LGBTQ+ policies from the ground up.

GLMA: Health Professionals Advancing LGBTQ+ Equality (Link)
GLMA is a national organization committed to ensuring health equity for LGBTQ+ communities and equality for LGBTQ+ health professionals. GLMA advocates for patients and providers and publishes various position statements.

Trans Lifeline (Link)

The Trans Lifeline has compiled a database of mutual aid organizations dedicated to supporting trans and gender-diverse individuals. This can be helpful for patients who need access to funding to continue their care, including funding for travel and postoperative care. *Them*, a publication dedicated to reporting on queer issues, has a similar database, organized by state (link).

Advocacy Tools

Doctors for America: Channeling Your Outrage Into Action (Link) (Link)

A DFA Advocacy Grand Rounds, featuring Greg Jackson, Dr. Joseph V. Sakran, and Kayla Hicks, a community-based violence prevention leader.

Doctors for America: Advancing Gender-Affirming Care—From Education to Legislation (Link)

A DFA Advocacy Grand Rounds, featuring Dr. Crystal Beal, Vivian Topping, and Dr. Myeshia Price.

Doctors for America: Beyond the Headlines—Advocacy, Policy, and the Road Ahead for Gender Affirming Care (Link)

A DFA Advocacy Grand Rounds, featuring Dr. Blair Peters and Alex Sheldon, executive director of GLMA.

Yale Law School: An Evidence-Based Critique of 'The Cass Review' on Gender-Affirming Care for Adolescent Gender Dysphoria (Link)

This is an empirical review of the Cass Review, which has been cited in various lawsuits related to gender affirming care. The authors find that the Review (1) did not recommend banning gender affirming care; (2) did not follow established standards for reviewing evidence and research; (3) failed to contextualize gender affirming care within other areas of pediatric medicine; (4) misinterpreted and misrepresented its own data; (5) repeated claims that have been disproven by evidence; (6) relied on systematic reviews that have serious methodological flaws; and (7) violated standard processes that typically lead to clinical recommendations.