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"Death threats and despair": A conceptual model delineating moral distress experienced by pediatric gender-affirming care providers☆

Ari S. Gzesh [a,c,d,*], Dana Prince [b], Scott K. Jelinek [c,d], Amy Hillier [d], Shanna K. Kattari [e], Jama Shelton [f], Megan S. Paceley [g]

[a] University of Pennsylvania School of Social Policy & Practice, United States
[b] Joseph and Morton Mandel School of Applied Social Sciences, Case Western Reserve University, United States
[c] Craig-Dalsimer Division of Adolescent Medicine, Children's Hospital of Philadelphia, United States
[d] Leonard Davis Institute of Health Economics, University of Pennsylvania, United States
[e] University of Michigan School of Social Work, United States
[f] Hunter College Silberman School of Social Work, United States
[g] University of Connecticut School of Social Work, United States

ABSTRACT

Gender-Affirming Care Providers (GACPs) for children and adolescents function within an intricate socio-political landscape that necessitates navigating legislative restrictions, institutional betrayals, and overarching societal prejudices. This manuscript presents a conceptual model that captures the multifaceted factors inducing moral distress among these professionals, including social workers, counselors, nurses, and physicians. Employing a system dynamics lens, our model delineates the complex interplay of legislative, societal, and institutional pressures with individual experiences, coping mechanisms, and resilience-building endeavors. While underscoring the pronounced challenges confronting pediatric GACPs—ranging from societal oversight to the long-term implications of decisions made during adolescence—we also highlight the pivotal role of identity concordance in enhancing patient-provider interactions. Shared identities between transgender and gender-diverse patients and providers can act as catalysts for fostering trust, bridging communication gaps, and serving as affirming representations of societal acceptance and success. Based on these insights, we offer robust recommendations including comprehensive institutional training, technological safeguards against online harassment, community alliances for multifaceted support, and intensified nationwide advocacy campaigns emphasizing the evidence-based nature of gender-affirming care. Through this comprehensive exploration, our aim extends beyond merely outlining challenges; we spotlight potent avenues for intervention, positive change, and reinforced support structures for GACPs. In sum, this paper contributes a profound understanding of the dynamics influencing GACPs, offering a clarion call for proactive measures to support these professionals and their patients in today's challenging socio-political environment.

1. Introduction

The landscape of physical and mental healthcare is inextricably tied to a mosaic of societal norms, legislative enactments, and institutional directives. We contend that within this nexus, gender-affirming care emerges as a poignant exemplar of the tensions between ethics, personal conviction, and external determinants. As gender-affirming care has become increasingly recognized as vital and life-affirming for many transgender and gender-diverse (TGD) individuals, so too has it become a focal point for debate, controversy, and misunderstanding.

The challenges faced by providers of gender-affirming care are numerous. Legislative restrictions, institutional betrayals, and societal transphobia collectively coalesce to create an environment rife with barriers. For these providers, navigating the tightrope of external

pressures and the intrinsic drive to deliver compassionate, effective care can lead to profound moral distress—a distress augmented by the stark realization of the potential harm to their patients caused by these barriers. As one provider shared with the first author, navigating this legislative landscape felt like "death threats and despair."

Yet, to perceive this issue merely as a binary of care versus obstruction is to oversimplify a deeply multifaceted dynamic. Many gender-affirming care providers are not simply passive recipients of external pressures, but are active advocates, educators, and innovators, seeking solutions within and beyond the confines of traditional healthcare systems. Their journey is further nuanced when catering to pediatric and adolescent patients, a demographic that introduces additional layers of complexity due to the involvement of guardians, long-term implications of early decisions and interventions, the threat of the involvement of child protective services, state policies imposing sanctions on gender-affirming care providers, and heightened societal scrutiny.

This manuscript presents a conceptual model that depicts the myriad and dynamic factors influencing moral distress among gender-affirming care providers of children and adolescents. Through a system dynamics lens, we endeavor to map the intricate interplay of legislative, societal, and institutional forces with individual experiences, coping strategies, and resilience-building efforts. Our aim is not just to delineate challenges but also to highlight avenues for positive change and intervention.

2. Background

2.1. Moral distress

The concept of moral distress refers to uncertainty, conflict, and/or constraints that challenge clinical providers to act within their professional ethics and guidelines. Moral distress is often associated with burnout or compassion fatigue, but it is much more specific, involving an ethical dilemma or moral event that results in value incongruence and/or compromised integrity, taking the form of emotional, psychological, or physical pain or disequilibrium. Moral distress is generally associated with negative feelings, but some scholars have described its potential for dialogue, improved communication, clarity in decision-making processes, as well as personal growth (Fantus, et al., 2017).

Moral distress emerged from the field of nursing, but has also been identified within allied professions including social work, psychology, psychiatry, and medicine (Austin, et al., 2010; Bernhardt, Forgetta, & Sualp, 2020; Fantus et al., 2017; Kherbache et al., 2022; Lamiani et al., 2017). The COVID-19 pandemic drew attention to moral distress of frontline healthcare workers (Riedel, et al., 2022); as in the case with COVID-19, moral distress may develop over time rather than involving a single event. While manifesting as distress among individual professionals, it often reflects larger structural inequities. As Epstein and Hamric (2009) explained, "repeated experiences of moral distress indicate deeper, systemic problems of poor communication, inadequate collaboration, and perceived powerlessness resulting from hierarchical structures" (p. 338). Some even view moral distress as the inevitable outcome of an inhumane health care system (Doggett, 2023).

McCarthy and Gastmans (2015) identified four sources of moral distress experienced by providers: clinical situations, working conditions, structural conditions, and internal moral sources. Mabel et al. (2022) distinguish between types of moral distress including *moral conflict* (i.e., difference in moral perspective), *constraint* (i.e., barriers to providing appropriate care), *dilemma* (i.e., multiple conflicting values), *uncertainty* (i.e., best course of treatment is not clear), and *tension* (i.e., challenges communication honestly about options).

2.2. Gender-affirming care

2.2.1. Scope of services

Gender-affirming care (GAC) is defined by the World Health Organization (WHO) as including social, psychological, behavioral, and medical interventions "designed to support and affirm an individual's gender identity" when it conflicts with sex assigned at birth (Gender incongruence, 2024). Politicians promoting bans on GAC typically conceptualize it narrowly as medical intervention, such as puberty blockers, hormones, and surgery (Cicero, 2023), but GAC can also include counseling, assistance navigating social transitions, family support groups, and voice therapy, among other services. GAC involves providers across multiple professional backgrounds who commonly look to the World Professional Association of Transgender Health's (WPATH) Standards of Care (SOC)–first published in 1979–for recommendations about medical and surgical GAC (Ramos, et al., 2023).

Although the prevalence of need for GAC is difficult to ascertain, a recent Pew study estimates as much as 5% of youth identify with a different gender than their sex assigned at birth (Brown, 2022). While terminology in this constantly-evolving field continues to shift, sex and gender are distinct concepts: sex is assigned at birth based on physical or chromosomal features, and typically encompasses male, female, or intersex; in contrast, gender identity and expression exists on a continuum that may fall along a binary (man vs. woman) but can also encompass anything in between and beyond (i.e., agender, genderqueer, nonbinary, etc.).

GAC is predicated on the belief that every individual is entitled to live in the gender that is most authentic to their sense of self (Ehrensaft, 2016), an assertion undergirded by the standards of care promoted by many professional medical organizations, including the WHO, the American Academy of Pediatrics, American Academy of Child & Adolescent Psychiatry, and WPATH (Poteat et al., 2023). Despite the need for unfettered access to GAC, many TGD individuals experience discrimination when attempting to acquire healthcare; in a national survey of almost 28,000 transgender respondents, over a third of individuals who sought care over the past year were harassed, refused treatment, and/or needed to educate their providers about transgender healthcare (James, et al., 2016). Another study found that 47% of transgender adults experienced some form of mistreatment or discrimination from a provider (Medina, 2021).

2.2.2. Barriers to access and current legislative landscape

There are many barriers to access for TGD patients seeking GAC, particularly in pediatrics. Various scholars have categorized these barriers in differing ways, such as structural, interpersonal, and anticipation barriers (Carrillo, et al., 2011; Warner & Mehta, 2021). Physical access to care constitutes a significant structural barrier. The increase in the number and capacity of gender clinics in major cities in the U.S. has supported access by primarily urban and suburban TGD youth (TGDY) and families, but even among those with private health insurance and physical access, the supply of GAC has not kept up with demand, leading to long wait times (Henderson, et al., 2022). Rural TGDY, especially in the Midwest, face geographic barriers to care (Gandy, et al., 2021; Tillewein et al., 2023). Similarly, those in southern states face particular geographic, structural, cultural, and interpersonal barriers (Griffin, et al., 2019; Johnson et al., 2019) that have only increased with the state restrictions concentrated in the Southeast (Borah, et al., 2023). When comparing the number of TGD children, number of gender clinics, and equality scores in gender identity laws, the Midwest and South rank well below the Northeast (Weixel & Wildman, 2022). Families with TGD children are choosing to move and/or seek GAC in other states (Hennessy-Fisk, 2023; Sable-Smith, et al., 2023; Kidd et al., 2021). State bans have caused 25.3% of US families to drive 8+ hours to procure GAC, up from 1.4% pre-bans (Borah, et al., 2023).

The surge of anti-LGBTQ + bills introduced in state legislatures creates additional barriers to GAC, which was already limited/

contested. The ACLU has been tracking nearly 500 anti-LGBTQ + bills introduced in 48 states in 2023 (ACLU, 2023), including 130 of which specifically restricted healthcare. Legislative bans exacerbate health disparities among TGDY of color (Goldenberg, et al., 2019) who already experience higher rates of violence, discrimination, lower quality of care, economic insecurity, and mental health issues and may not have the resources to relocate to another state (Azevedo, Taylor, & Matthews, 2023). As McNamara et al. (2023) explained, "state of residence is now a primary social determinant of health for TGDY, with racially and ethnically diverse people facing the worst vulnerabilities" (McNamara, et al., 2023, p. 408).

The most obvious consequences of anti-trans legislation are restricted access to care where laws have gone into effect, or where the advent of potential restrictions results in providers withholding services (Melhado, 2023; Muoio, 2022; Twenter, 2023). Even the prospect of anti-trans legislation has generated fear among TGDY and their families, concerned that restrictions will worsen mental health and increase suicidal ideation, deny them autonomy over medical decision-making due to government overreach, and further politicize medical care (Hughes, et al., 2023; Kidd et al., 2021). Interpersonal barriers are extant in provider-patient relationships, particularly when there is a lack of provider sensitivity, attitude, or acumen. In turn, these negative interactions exacerbate anticipation barriers, which may cause TGD to seek out informal means of garnering hormone replacement therapy (HRT) outside of health systems.

2.3. Moral distress and gender affirming care: what makes GAC especially fraught

Many aspects of pediatric GACcontribute to provider moral distress compared with other forms of healthcare, even before legislative restrictions. From a clinical perspective, GAC is distinct because it involves physical and mental health considerations requiring multidisciplinary teams with differing professional training and, potentially, different codes of ethics. Conflict and uncertainty may make it difficult to reach consensus about appropriate care (Gerritse et al., 2018; Shuster, 2021). Some gender clinics coordinate care across services including primary care, counseling, psychiatry, endocrinology, and surgery, but uncoordinated care characterizes many other health systems (Gridley, et al., 2016). While some providers have received specialty training, many have not, leading to a lack of trained providers as well as frustration from those with expertise working with colleagues who are not knowledgeable in or comfortable providing GAC (Gridley, et al., 2016).

The widely accepted WPATH Standards of Care (SOC) are intended to "provide clinical guidance for health professionals" in order to provide TGD patients with "safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment" (Coleman, et al., 2022, p. S5). But while the SOC provides guidelines, it still leaves much room for discretion and disagreement about the best medical course of action. Under the WPATH SOC model, patients must undergo a clinical health assessment, and a mental health specialist trained in these standards must provide a letter confirming a diagnosis of gender dysphoria and mental health stability in order to access hormones. Access to surgery involves a mental health and physical health assessment (Coleman, et al., 2022).

Historically, WPATH standards were designed with a binary conceptualization of gender. Version 8 of the SOC includes a chapter dedicated to GAC for nonbinary people, reflecting a paradigm shift in transgender care (Coleman et al., 2022; Motmans et al., 2019). But there has been less research and training for providers about HRT dosing for nonbinary people, increasing the likelihood of barriers and uncertainty among providers about initiating GAC (Konnelly, 2021; Shuster, 2021). While the SOC are widely followed, the Informed Consent model–more frequently used in community settings–provides an alternative, eliminating the required mental health assessment and letter. Rather, it focuses instead on the role of clinicians effectively communicating the risks and benefits of treatment as well as treatment alternatives (Cavanaugh et al., 2016; Solanki et al., 2023). The Endocrine Society has its own guidelines; while WPATH SOC no longer requires 'real-life experience in the identified gender role,' the Endocrine Society has maintained this step even before a mental healthcare provider completes their assessment (Shuster, 2021). These differences may contribute to uncertainty and conflict in clinical decision-making.

Access to and insurance coverage of medical care generally requires a diagnosis of "gender dysphoria," potentially contributing to ambivalence among providers because not all TGD experience gender dysphoria (Dube, et al., 2024; Kumar et al., 2022) and because the diagnosis pathologizes and stigmatizes gender identities incongruent with sex assigned at birth (Motmans, et al., 2019). Ambivalence around specific gender-related diagnoses (e.g. "gender dysphoria" or using other types of insurance codes to implement care) may contribute to provider ambivalence; at the same time, providers recognize that not all TGD experience gender dysphoria, and the practice of diagnosis may contribute to distress. Providers following the SOC may also resist or resent being put in the role of gatekeeper, struggling to "balance their roles helping trans clients and maintaining a sense of professional obligation to make 'reasonable' decisions" (Shuster, 2021, p. 111). As Kumar et al., (2022) explained, TGD people face the paradox of having to exhibit distress about gender incongruence while "simultaneously maintaining an appearance of mental capacity and fitness that would not disqualify them from receiving care" (p. 2). In so doing, TGD may demonstrate "performative pathology, which entails the demonstration of etiology necessary for dysphoria diagnoses while avoiding corollary disempowerment" (Gzesh, 2022, p. 71). This paradox may cause providers to worry that TGD people are withholding information about their mental health, in order to be approved for GAC.

2.4. Pediatric GAC special considerations

Providers may also experience ambivalence about the diagnosis because they question the certainty of TGDY regarding their gender identity and commitment to medical or surgical interventions. Beans Velocci, historian of knowledge production about sex, gender, and sexuality, explained how this is rooted in the history of GAC and the near-obsession of endocrinologist Harry Benjamin with patient regret, revenge, and liability (2021). While often overstated in the press, particularly in regard to "detransitioning" (Singal, 2023), lack of scientific research on the long-term implications of puberty blockers and hormone use may further contribute to provider uncertainty (Kimberly, et al., 2018). Even when there is consensus between providers and TGDY, parents may express doubts, resistance, and outright refusal to allow their child to undergo a medical transition (Grossman, Park, Frank, & Russell, 2019; Andrzejewski et al., 2020).

While holding all of these clinical considerations, providers are also aware of the time-sensitive nature of medical interventions and the possible life-and-death implications for denial of care. For youth who have not completed puberty and are desperate to avoid development of secondary sex characteristics associated with their sex assigned at birth, the timing of puberty-blockers is essential, yet may be complicated by lengthy deliberations between providers and parents (Clark, et al., 2020) or state-level age restrictions. Delaying care is associated with a number of comorbidities (Kimberly, et al., 2018), and providers must exercise their clinical judgment in the face of overwhelming research about the negative impact of denial of care on the mental health of TGD people and increase in suicidal ideation (Green, et al., 2022); 42% of LGBTQ youth seriously considered attempting suicide in the past year, including more than half of TGDY (Trevor Project, 2023a). At the same time, 29% of TGDY reported not feeling safe to go to the doctor or hospital when they were sick or injured, and 86% indicated that recent policy debates and legislative restrictions have negatively impacted their mental health (Trevor Project, 2023b). In contrast, research has consistently shown

that health disparities for TGDY diminish when they have access to gender-affirming care (Chew, et al., 2018; de Vries et al., 2014; Mahfouda et al., 2019; Tordoff et al., 2022; Turban et al., 2020), creating further pressure on providers facing uncertainty or conflict with caregivers or other clinicians.

Structural constraints may preclude intervention, even with clear consensus among the provider, patient and parents about the need and form of that care. Institutional policies within clinics and healthcare systems create additional constraints to providing affirming care, including intake forms, electronic medical records, pronoun use, and availability of all-gender bathrooms (Bhaat et al., 2022). These factors, known to impact the experience and willingness of TGD people to seek care, may be or seem beyond the ability of providers to control. Feeling responsible for shifting the underlying cisnormativity and transphobia (Heng, et al., 2018) of their institution in order to protect TGD patients may feel overwhelming. An additional source of moral distress may include the realization that gender dysphoria reflects and may be triggered by social context, not simply an individual's internal conflict between gender identity and sex assigned at birth (Galupo, et al., 2020). Providers may worry about the lack of community-level and school supports for TGDY to support social and medical transitions (Sequeira et al., 2023).

In response, providers may feel compelled to engage in advocacy efforts to change attitudes, systems, and laws (Cicero, 2023). Some may want to speak to the media to help educate the public and address scientific misinformation and the "coordinated disinformation campaign" about GAC, but worry about harassment and face restrictions from their institutions about speaking publicly (Hughes et al., 2023; McNamara et al., 2023). Providers may sense deep ambivalence within their professions about the appropriate role of advocacy among clinicians (Lynne-Joseph, 2023). Even when they are motivated to be public advocates, they may not have received training in order to speak to the press, testify at legislative hearings, or write op-eds with confidence (McNamara, et al., 2023).

Inevitably, the current socio-political and legal landscape of GAC increases anxiety for providers who may have already been facing moral dilemmas on multiple layers. At the extreme, providers face criminal prosecution or losing their ability to practice if they defy state laws prohibiting GAC (Hughes et al., 2021). Short of that, many have experienced harassment through social media, mail, phone, protests, and death and bomb threats (Carlisle, 2022); Hughes et al. (2023) found that 70% of the providers whom they surveyed reported that they, their practice, or umbrella institution had received threats related to delivering GAC. "These threats' emotional and psychological impact may reduce access to care, underscoring the need to protect providers and ensure access for all transgender and gender diverse adolescents'' (Hughes, et al., 2023, p. 1). Sequeira et al. (2023) quoted a provider about the impact of community and institutional biases:

I don't feel like I can be a good advocate or an outspoken advocate in my state, because it will just grow this large target on my back and potentially put me in physical harm but also professional harm (p. S63).

Providers may also worry about the larger implications of politicians interfering in clinical decision-making (McNamara, et al., 2023) and politics eclipsing healthcare beyond GAC (Kraschel et al., 2023). Providers must attend to their own worsening mental health, including increased risk for suicidality, as legislation calls on them to defy current standards of care (Hughes et al., 2023). Beyond their own safety, providers must also consider the safety of their patients, families, and clinic staff (McNamara, et al., 2023), potentially having to close down their clinics or reduce their visibility, thereby further limiting access to GAC (Hughes et al., 2021; Hughes et al., 2023).

3. Conceptualization

3.1. Utility of system dynamics theory for understanding provider moral distress

As illustrated, the moral distress experienced by GACP is shaped by complex, interconnected, multi-level factors including restrictive and punitive legislation, transphobia and ageism, bias, stigma, and others. Various frameworks (e.g. social and environmental determinants of health, ecological systems theory) demonstrate how social phenomena are informed by multiple, interacting, "levels" or system contexts (e.g. family, neighborhood, school). Systems thinking and system dynamics theory is based on the field of engineering's development of control theory and nonlinear dynamic systems (Meadows, 2008; Sterman, 2002). Hallmarks of this systems approach include modeling of dynamic changes in system behavior over time, conceptualization of nonlinear relationships, and dynamic feedback systems (e.g. reinforcing and balancing loops) (Hovmand, 2014; Proctor et al., 2011). System dynamic approaches include development of informal causal maps, also called causal loop diagrams (CLDs), to identify key factors operating within a system and driving system behavior.

3.2. Methodology and explication of model

There are several approaches to generating a causal loop diagram (CLD). One approach, that we applied to develop our conceptual model of moral distress among GACP, involves developing a "seed structure" – or the initial conception of the system grounded in empirical evidence. For our purposes, we began by drawing our own understanding of system functioning for GACP. This seed structure was grounded in the professional and personal experiences of the first author (Author1), a gender-expansive social worker with extensive practice and lived experience in harm reduction and mental health promotion among TGDY. Another author (Author3) is an adolescent medicine physician providing GAC, while the other five (Author2, Author4, Author5, Another6, and Author7) are associate professors of social work with research and clinical/practice experience serving TGD populations. All seven scholars, who are majority White, hold a diverse set of identities across gender, sexual orientation, disability status, career experience, and geographic locations within the U.S., which helped elucidate how these forces interact to affect GACP.

After generating the initial seed structure, we culled scientific literature to identify common constructs associated with moral distress, and worked these constructs into an initial visual diagram (Hovmand, 2014; Prince et al., 2022). Next, we applied principles of community-based system dynamics, which emphasizes the perspectives of community members to direct intervention and policy change. This meant tapping into the "mental models'' individuals hold about how a system is functioning. This approach acknowledges that knowledge accumulates in nodes (within individuals or clusters of individuals), and yet this knowledge is often invisible (Hovmand, et al., 2007; Schoech et al., 2001). In terms of GACP, concentrated nodes of specialized knowledge exist but are rarely made visible to the wider service system. For example, GACP have become adept at finding 'workarounds' for behavioral, mental and physical health insurance billing that can assist TGDY and their families in receiving affirming care. Through showing our seed structure to GACP providers, we were able to both verify and refine our conceptual model. The first, second, and third authors iterated on the CLD, condensing constructs and pathways. Fig. 1 shows the final CLD generated from extant research and community member mental models.

To address the intricacies of this dynamic problem while ensuring the conceptual model remains pragmatic for action-oriented implementation science, we grouped crucial constructs and demonstrated their interconnections using arrows. This conceptual causal loop diagram maps out the interwoven factors that contribute to moral distress
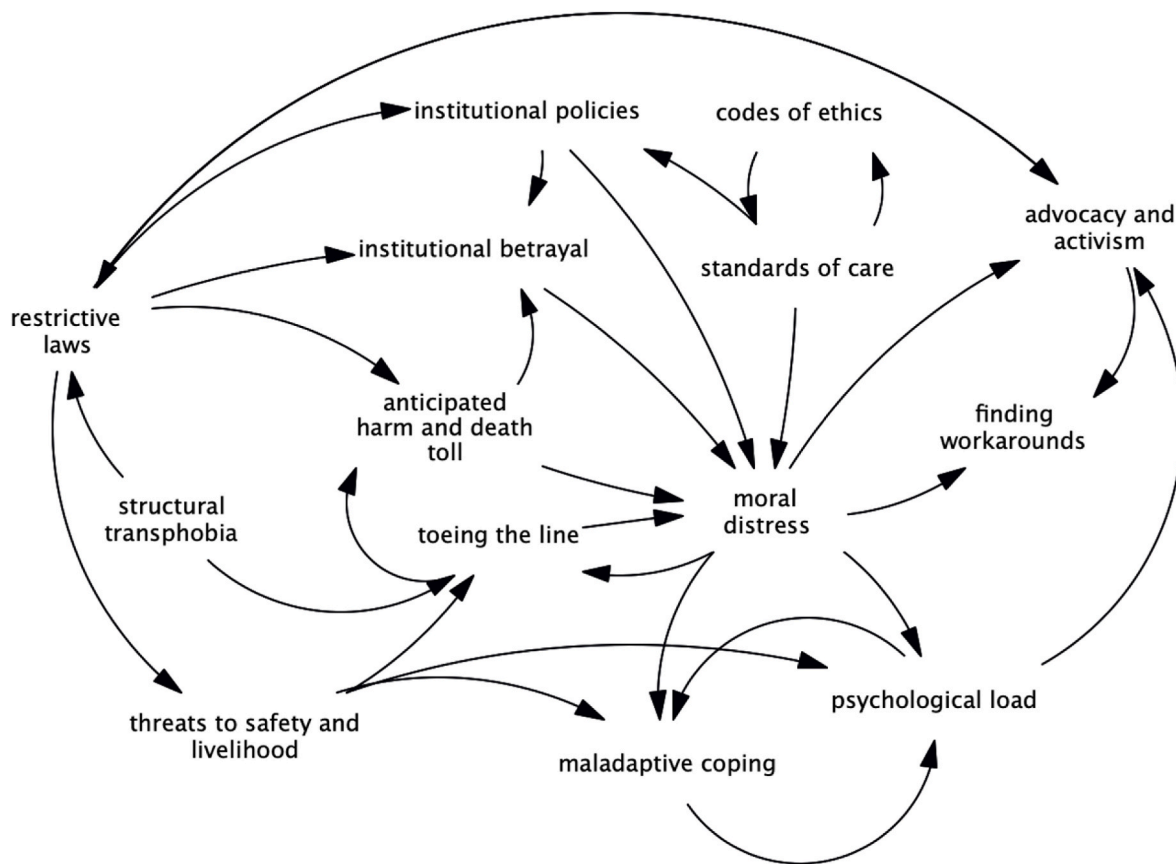
Fig. 1. Causal loop diagram (CLD) *Conceptual model for understanding provider moral distress.*

experienced by GACP. By clearly identifying the mechanisms compounding moral distress, we are better positioned to pinpoint potential interventions.

A primary driver of this system is structural transphobia, which is characterized by transphobic laws, policies, and attitudes that function to restrict access to GAC (Price, et al., 2023). Transphobia exacerbates minority stress (Meyer, 2003) through multiple feedback loops; internalized (i.e. feeling shame regarding one's identity) and interpersonal (i. e. discrimination enacted through social dynamics) forms of transphobia have been shown to compound behavioral, cognitive, and affective processes underlying TGD individuals' risks for mental health disorders (Blosnich, et al., 2016; Du Bois et al., 2018; Valentine & Shipherd, 2018).

Structural transphobia shapes both restrictive state laws and subsequent institutional policies, reifying transphobia and gender binary bias into regulatory practice. The codification of transphobia not only threatens the safety and livelihood of providers, but can also have broader societal repercussions, such as restrictive school and workplace policies, threats to the safety of TGD people and their families, and restrictions on gender expression and enforcement of binary gender ideologies. Patient care may become subsumed by threats to providers' safety and livelihood. Safety threats, both perceived and actual, encompass targeted harassment such as threats of violence, doxing, death threats, and even bomb threats. Consequently, these threats sometimes drive care providers towards self-preservation behaviors (Hughes et al., 2023). For some, this might mean leaving their professional roles or relocating out of state. Such drastic actions can lead to emotional and financial strain on individual providers and their families, as well as limited care for TGD people in these states.

In an ideal healthcare landscape, institutional policies would derive from universally accepted standards of care. These standards should be anchored in codes of professional ethics. However, the current

legislative climate fosters varying interpretations or even outright rejection of these best practices. The loop of ethics informing standards of care becomes skewed, hampered by these restrictive legislations. This misalignment is not without consequence. When laws hinder therapeutic and medical best practices, care providers often experience institutional betrayal, which in turn, culminates in moral distress. Institutional betrayal is defined as action or inaction, on behalf of a trusted and powerful institution, that exacerbates the impact of traumatic experiences through violation of trust and dependency (Smith & Freyd, 2014).

The mere anticipation of potential harm emanating from these policies, both at state and institutional levels, contributes to psychological burden on providers. Notably, the psychological burden of GACP may already be quite high; the additional input of hostile laws can lead to overflow of the provider's already saturated system. System overwhelm may in turn increase negative affective states including desperation, powerlessness, shame, and hopelessness. Providers grappling with such profound emotional turmoil might resort to maladaptive coping strategies like self-harm, substance use, aggression, or debilitating mental health problems. Socially, they might grapple with isolation, alienation, or rejection.

Amidst this grim backdrop, advocacy emerges as a beacon of hope. Its relationship with institutional policies and state laws is reinforcing: as restrictive measures intensify, the drive for advocacy gains momentum. Advocacy not only informs standards of care but also exerts influence on institutional policies. Often, these efforts draw inspiration and strength from community-based solutions. When faced with institutional betrayal, providers— reeling from the associated moral distress and burnout—may foray beyond traditional healthcare systems to harness community support. Examples of these community solutions range from crowdsourcing hormones from unofficial suppliers, sharing information on affirming providers, or establishing external supervision

groups.

Providers, navigating this challenging landscape, may develop system "workarounds," like creative diagnoses codes or circumventing insurance policies, such as using "endocrine disorder, unspecified," "painful menses," or "breast hypertrophy" to ensure insurance coverage of gender-affirming medications or procedures, rather than just Gender Dysphoria/Gender Identity Disorder (Cruz & Paine, 2021). Conversely, some may opt for "toeing the line," adhering rigidly to the given mandates, for fear of reprisal or out of sheer exhaustion.

While this model underscores the triggers of moral distress, it also highlights potential intervention avenues. Strengthening advocacy efforts can equip providers to educate the public, demystifying GAC using evidence-based arguments. If institutions pivot from betrayal to support, providers would be better fortified to face targeted harassment and continue offering vital care. We discuss two areas of consideration: the unique role of pediatric GAC (physical and mental health), and the issue of "identity concordance" or how TGD and queer providers face additional threats (and hold knowledge on resistance). Finally, we conclude with recommendations for a way forward.

4. Discussion

4.1. Unique aspects of moral distress for pediatric providers

Pediatric GACPs navigate a landscape that, while sharing similarities with TGD adult care, presents heightened challenges and opportunities. These challenges have the potential to amplify as well as potentially mitigate the experience of moral distress due to four unique dimensions. First, pediatric care, especially in sensitive areas such as gender affirmation, is subject to heightened scrutiny and oversight from society, institutions, and legislation. The public, at times driven by misinformation or prejudice, can influence legislative decisions that disproportionately affect minors' patient care. While potentially contributing to a sense of powerlessness, this can also strengthen resolve to advocate for young patients' needs. Second, pediatric providers must manage the dynamic tension of multiple stakeholder decision-making inclusive of the best interests of the youth, the wishes of caregivers, and, in a growing number of states, restrictive institutional or state laws and policies. Navigating this role can exacerbate provider moral distress, particularly when the chosen (or imposed) course of action is not in the best interests of the youth. Adopting a strengths-based approach can help providers communicate more effectively with caregivers and highlight how GAC can promote wellbeing of both the youth and their family. Third, given the long-term implications of decisions made during the developmental period of adolescence on later life outcomes and adjustment, providers may experience prolonged ethical dilemmas. The pressure of ensuring both the present and future wellbeing of the adolescent, set against a backdrop of societal pressures and restrictive policies, can accentuate moral distress; providers may experience heightened emotional investment and a sense of being accountable to both the present and future of the youth in their care. Witnessing the distress of these young individuals, especially when they are denied access to essential care due to legislative or institutional barriers, can deepen the feelings of hopelessness and powerlessness among providers. However, this same instinct, when channeled through strengths-based communication, can nurture trust, resilience, and a sense of agency in the young individual. Finally, pediatric providers may engage in advocacy and educational efforts within their institutions, peer groups, and with other stakeholders. While this may provide a source of shared commitment, values, and solace in the work, it may also lead to increased exposure to hostile perspectives on GAC, increasing the psychological load. Taken together, given the evolving nature of an adolescent's identity and the shifting societal, legal, and medical landscapes they will face, providers may grapple with the anxiety of anticipating future challenges for their patients. This anticipation of future harm and expected death toll can contribute significantly to moral distress.

In the context of our conceptual model, these unique challenges can intensify the experience of moral distress for pediatric GACPs. While the underlying factors such as legislative restrictions, institutional betrayals, and societal transphobia affect both adult and pediatric providers, pediatric GACPs experience these pressures in a magnified, more intricate manner due to the vulnerabilities and complexities associated with younger patients. They also have the opportunity to utilize resilience-building strategies that prioritize the strengths and potential of each young patient. The balance of these dual forces—challenge and resilience—defines the unique experience of pediatric GACPs.

4.2. Identity concordance in GAC

The value of shared lived experiences between patients and providers cannot be overstated, especially within the realm of GAC. Though the topic is under-researched and as yet does not include TGD identities, existing literature suggests that provider-patient gender concordance can positively impact patient outcomes (Lau, et al., 2021). Similarly, racial concordance between patient and provider is associated with relatability, trustworthiness, cultural understanding and comfort (Moore, et al., 2022). Identity concordance between TGD patients and providers offers a unique bridge of understanding, often transcending the typical patient-provider dynamic and possessing the potential to enhance overall patient experience. TGD providers who have navigated similar life experiences may possess enhanced empathy and understanding related to the challenges, fears, and aspirations TGD patients face. This shared identity can foster deeper trust, encouraging patients to be more open about their concerns and needs. Positive role models promote resilience among TGD people (Matsuno & Israel, 2018). For many TGD patients, seeing a TGD provider serves as living proof of potential success and societal acceptance, instilling hope and confidence in patients.

Identity concordance can reduce miscommunication, facilitating more effective care strategies. Communication barriers often arise from misunderstanding or a lack of knowledge about TGD experiences and linguistic practices. TGD people may use various terms to describe their sexual and reproductive anatomy; Klein and Golub (2020) suggest TGD patients want providers to ask for preferred anatomical terms before discussing sexual and reproductive health, however only 27% of survey participants had ever been asked this question. TGD providers can be more attuned to addressing the health disparities TGD individuals often face due to societal, systemic, and healthcare biases, ensuring they are actively addressed in care plans. Moore et al. (2022) suggest high patient satisfaction ratings among racially concordant patient-provider dyads could be a result of patient perception regarding the provider's ability to understand the systemic issues impacting patient health. However, identity concordance is not a replacement for comprehensive training and cultural humility. While it offers many benefits, all healthcare providers, irrespective of their individual identities, should be equipped with the knowledge and skills to provide high-quality GAC.

5. Recommendations and implications for practice

The experiences of GACPs, as illustrated by Hughes et al. (2023), emphasizes an urgent need for reinforced support systems for these professionals amidst escalating threats in an often-hostile socio-political environment. Their findings spotlighted the vulnerability of these professionals, and call for immediate and robust interventions to ensure their safety against threats of violence, doxing, and other forms of harassment. Several avenues for intervention emerge.

1. **Reinforcing Institutional Policies & Training**: Building upon the recommendations from Hughes et al. (2023), institutions must provide overt support to GACPs. Comprehensive training, based on the models suggested by Chong et al., (2021) and Ricklefs et al. (2023),

should be integrated into institutional frameworks. Such training could encompass:

○ Recognizing and addressing targeted harassment.
○ Best practices in gender-affirming care.
○ Embedding ethical considerations and resilience-building in care provision, which involves routinely training providers on updated guidelines, fostering case-based discussions, and establishing mentorship for navigating complex dilemmas. Resilience-building encompasses workshops on stress management, mentorship programs, and feedback mechanisms to equip providers with coping strategies and support against challenges.

2. **Physical Safety Protocols:** To protect GACPs, institutions should augment the security of clinic spaces by conducting routine safety drills and installing panic buttons and monitored surveillance systems. Institutional public relations departments should proactively monitor social media to preempt potential threats, liaising with local authorities to ensure swift responses.

3. **Innovative Technological Safeguards**: Protecting GACPs in the digital realm is paramount. Institutions should adopt encrypted communication platforms, allowing providers to share resources, experiences, and offer peer support. Additionally, considering the doxing risks, proactive measures like employing services like DeleteMe can ensure that providers' personal information remains inaccessible, curtailing online harassment avenues.

4. **Fostering Community Alliances & Peer Support:** Building on insights from Ricklefs et al. (2023) and the psychological toll noted by Hughes et al. (2023), it is evident that community collaboration and emotional support are intertwined. Providers and community leaders must unite to co-create protective spaces and robust mechanisms to counteract harassment. This synergistic effort should encompass community watch groups, dedicated helplines, and collaborative platforms to share best practices. Moreover, these alliances should prioritize establishing sanctuaries where challenges can be shared, advice sought, and emotional support accessed, addressing both the external threats and the internal distresses faced by GACPs.

5. **Legal Support**: Collaborate with legal entities to provide pro bono or subsidized legal support for care providers. This legal umbrella can prove crucial, especially for those navigating the maze of restrictive state laws.

6. **Advocacy & Public Awareness**: Professional organizations should spearhead multidisciplinary nationwide campaigns emphasizing that GAC is medically necessary and evidenced-based. The stature and credibility of these organizations act as a shield, diverting undue attention from individual providers who might otherwise be targeted. With resources to facilitate media training and press releases, these entities can leverage their influence to shift public perspectives, and counteract restrictive legislations.

By identifying these interstices and subsequently deploying targeted interventions, we hope to not only alleviate the moral distress of gender-affirming care providers but also to fortify the entire ecosystem supporting them, and their patients. This multi-pronged approach seeks to address the issue from various angles, optimizing the chances for tangible, positive change and galvanizing a fervent call to action.

CRediT authorship contribution statement

Ari S. Gzesh: Writing – review & editing, Writing – original draft, Visualization, Methodology, Formal analysis, Conceptualization. **Dana Prince:** Writing – review & editing, Writing – original draft, Methodology, Conceptualization. **Scott K. Jelinek:** Writing – review & editing, Writing – original draft, Conceptualization. **Amy Hillier:** Writing – review & editing, Writing – original draft. **Shanna K. Kattari:** Writing – review & editing, Writing – original draft, Conceptualization. **Jama Shelton:** Writing – review & editing, Writing – original draft, Conceptualization. **Megan S. Paceley:** Writing – review & editing, Writing –

original draft, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Further reading

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