*American Society of Plastic Surgeons*

▶ **POSITION STATEMENT**

Issued February 03, 2026

# Position Statement on Gender Surgery for Children and Adolescents

**Summary:** The clinical management of children and adolescents presenting with gender dysphoria or gender incongruence has undergone rapid change, and ASPS wishes to offer guidance to members providing gender surgery services for this population. This ***position statement*** discusses the views of the American Society of Plastic Surgeons (ASPS) on breast/chest, genital, and facial gender surgery for individuals under the age of 19.

## BACKGROUND AND RATIONALE

### Clinical and Policy Evolution

Over the past two decades, the clinical management of children and adolescents presenting with gender dysphoria or gender incongruence has undergone rapid change. Treatment models have increasingly included psychological assessment, social transition, endocrine interventions such as puberty blockers and cross-sex hormones, and surgical procedures.

During this period, clinical practice progressed amid growing patient demand and an evolving understanding of the evidence base, particularly with respect to long-term outcomes in pediatric and adolescent populations. More recently, a number of international health systems and professional bodies initiated formal re-examinations of earlier clinical practice assumptions in response to changes in patient presentation and a growing uncertainty about the benefits of medical and surgical interventions. Systematic reviews and evidence reassessments have subsequently identified limitations in study quality, consistency, and follow-up alongside emerging evidence of treatment complications and potential harms.

### ASPS's Understanding of the Evidence Base and Related Ethical Considerations

In August 2024, ASPS communicated to members that the Society had not endorsed any external organization's clinical practice guidelines or recommendations for the treatment of children or adolescents with gender dysphoria.[1] At that time, ASPS recognized that the evidence base informing medical and surgical interventions in this population was limited and characterized as low quality/low certainty (i.e., there was limited confidence that the intervention's reported effects reflected the true effects).[2] This understanding was informed by new systematic reviews published in Europe[3-4] as well as the 2024 *Independent Review of Gender Identity Services for Children and Young People: Final Report* commissioned by NHS England and authored by Dr. Hilary Cass.[5]

ASPS's understanding has continued to evolve in light of additional comprehensive evidence reviews, including the 2024 *Plastic and Reconstructive Surgery* article *Mastectomy for individuals with gender dysphoria younger than 26 years: a systematic review and meta-analysis*[6] and the 2025 report from the U.S. Department of Health and Human Services (HHS) titled *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices*.[7] These reviews have not resolved earlier uncertainties regarding treatment benefit; in some areas they have contributed to a clearer understanding of potential harms, while also highlighting limitations of the available evidence, including gaps in documenting long-term physical, psychological, and psychosocial outcomes. For an evidence summary, ASPS directs members to *Appendix 4* of the HHS report, which details the types of interventions (medical, surgical, psychological), reported outcomes, magnitude and direction of effects, and overall certainty of evidence available in the published literature.

Relevant to ASPS's position and understanding of the larger patient assessment process, both the Cass Review and the HHS report emphasize that the natural course of pediatric gender dysphoria remains poorly understood. Available evidence suggests that a substantial proportion of children with prepubertal onset gender dysphoria experience resolution or significant reduction of distress by the time they reach adulthood, absent medical or surgical intervention[8-9] Evidence regarding adolescent-onset presentation, which has become increasingly common since the mid-2010s, is more limited but similarly does not allow for confident prediction of long-term trajectories.[5,10] Importantly, clinicians, even those with extensive experience, currently lack reliable methods to distinguish those whose distress will persist from those whose distress will remit.[11] The HHS report underscores that this uncertainty has significant ethical implications: when the likelihood of spontaneous resolution is unknown and when irreversible interventions carry known and plausible risks, adhering to the principles of beneficence and non-maleficence (i.e., promoting health and well-being while avoiding harm) requires a precautionary approach.

The concept of "patient values and preferences" has been cited as sufficient rationale for the treatment of children and adolescents in the face of very low/low certainty evidence; however, high-quality research on patient values and preferences is missing in this area of medicine. For example, it is unclear whether fully informed patients and their caregivers would endorse the current values and preferences framework that places a higher value on achieving more favorable aesthetic effects in adolescence and places a lower value on avoiding potential harm from early pubertal suppression.[12]

Respect for emerging adolescent autonomy is also cited as a rationale for the provision of care in the face of low certainty evidence. However, patient autonomy is more properly defined as the right of a patient to accept or refuse appropriate treatment; it does not create an obligation for a physician to provide interventions in the absence of a favorable risk–benefit profile, particularly in adolescent populations where decision-making capabilities are still developing.[7] In pediatric contexts, the threshold for intervention must be higher and safeguards more stringent.

Overall, and consistent with long-standing frameworks in medical ethics, including those articulated by Beauchamp and Childress in 2019[13] and the American Academy of Pediatrics Committee on Bioethics in 2016[14], ASPS recognizes that surgeons should offer treatments that are medically indicated and supported by an expectation that the anticipated benefits outweigh potential harms. The patient education and informed consent process, which incorporates patient values and preferences and acknowledges emerging autonomy, operates within – not independently of – this evidentiary threshold.[15]

**Purpose and Scope of this Statement**

This document is not a clinical practice guideline. ASPS has not undertaken a formal guideline development process, including independent systematic evidence assessment, consensus panels, or strength-of-recommendation determinations.

Instead, given the current state of the evidence and variability in legal and regulatory environments, the ASPS/PSF Board of Directors determined that a position statement, rather than a clinical practice guideline, was the most appropriate mechanism at this time.

The ASPS/PSF Board of Directors issues this position statement to provide professional guidance to ASPS members in a rapidly evolving and controversial clinical area; to clarify ASPS's interpretation of the current evidence base as it relates to the integration of surgical care into a larger care pathway; to support members in navigating informed consent, patient selection, institutional policy, and medico-legal risk; and to articulate principles that prioritize patient welfare, scientific integrity, and professional self-regulation.

## ▶ ASPS FOUNDATIONAL PRINCIPLE: RESPECT FOR PATIENT DIGNITY AND COMPASSIONATE CARE

The ASPS Code of Ethics holds that *"all patients should be treated with full respect for human dignity. ASPS Members should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion."*[16] ASPS affirms the inherent dignity of every patient and supports the rights of all individuals to privacy and humane medical care. This includes pediatric and adolescent patients who present with gender dysphoria, those who identify as transgender and gender non-conforming, and those who experience regret, cease treatment, or later detransition. Recognition of patient dignity is not contingent upon pursuit of a specific clinical pathway.

This position statement does not seek to deny or minimize the reality of any patient's distress, and it does not question the authenticity of any patient's experience. Instead, ASPS affirms that truly humane, ethical, and just care, particularly for children and adolescents, must balance compassion with scientific rigor, developmental considerations, and concern for long-term welfare.

## ▶ ASPS POSITION

Consistent with ASPS's August 2024 statement that the overall evidence base for gender-related endocrine and surgical interventions is low certainty, and in light of recent publications reporting very low/low certainty of evidence regarding mental health outcomes, along with emerging concerns about potential long-term harms and the irreversible nature of surgical interventions in a developmentally vulnerable population, ASPS concludes there is insufficient evidence demonstrating a favorable risk-benefit ratio for the pathway of gender-related endocrine and surgical interventions in children and adolescents. **ASPS recommends that surgeons delay gender-related breast/chest, genital, and facial surgery until a patient is at least 19 years old.**

## ▶ ADDITIONAL CONSIDERATIONS FOR ASPS MEMBERS

### RESPECT FOR THE PROFESSIONALISM OF PLASTIC SURGEONS

This position statement is not a retroactive judgment but a forward-looking response to evolving evidence. It is intended to support continued learning and ethical practice within the specialty.

ASPS affirms its confidence in the competence, professionalism, and ethical intent of its members. Plastic surgery has a long tradition of responsible surgical innovation, guided by a commitment to improving patient outcomes, alleviating suffering, and advancing the field through clinical judgment and ongoing outcomes evaluation.

### OPPOSITION TO CRIMINALIZATION OF MEDICAL CARE

ASPS affirms that the regulation of medical care is best achieved through professional self-regulation, rather than criminal law or punitive legislative approaches. Although ASPS members may hold differing viewpoints on specific issues related to gender-related medical and surgical care for adolescents or adults, the Society remains united in its support for a regulatory environment that allows physicians to exercise independent professional judgment, guided by the best available evidence, established ethical frameworks, and patient welfare.

Nevertheless, ASPS advises Members to remain aware of state laws concerning transgender and gender-diverse individuals that may impact their practices. Policy trackers available online summarize state restrictions, stakeholders impacted, categories of penalties, and the status of litigation.[17]

## SHARED RESPONSIBILITY IN MULTIDISCIPLINARY CARE

Plastic surgeons are integral members of multidisciplinary care pathways and share responsibility for patient selection, informed consent, and risk-benefit counseling, particularly in clinical contexts where assessment protocols, upstream endocrine interventions, and long-term outcomes remain uncertain or contested. Because the evidence base for this care pathway is very low/low certainty and increasingly suggestive of potential harm and long-term complications, downstream surgical decision-making carries heightened ethical, clinical, and legal risk.

Plastic surgeons should maintain a working understanding of the current limits of evidence regarding social transition, puberty suppression, and cross-sex hormones; how prior medical/hormonal interventions may themselves influence physical and cognitive development, psychosocial functioning, and surgical care and risk; and the degree to which patient goals, expectations, and decision-making capacity have been evaluated in light of developmental stage and uncertainty of long-term outcomes.[6,18,19,20,21,22]

In addition to substantial uncertainty about the long-term benefits and harms of medical interventions such as puberty blockers and cross-sex hormones, the 2025 HHS report and the 2024 Cass Review emphasize that additional uncertainties remain regarding the natural history of pediatric gender dysphoria and the ability to predict persistence at the individual level. These uncertainties are interdependent and cumulative. Diagnostic assessment, psychosocial support, endocrine intervention, and surgery form a connected clinical pathway rather than a series of independent steps. Outcomes observed after surgery cannot be confidently attributed to surgery itself rather than to prior medical treatment, psychosocial factors, or the natural trajectory of the condition. As a result, surgical interventions inherit the foundational uncertainties present earlier in the continuum of care.

In this context, plastic surgeons cannot rely on the presence of a prior medical intervention, referral, or letter of support as a proxy for surgical indication or adolescent readiness. Psychological and psychiatric assessments play an essential role in multidisciplinary care, but surgeons retain an independent professional responsibility to understand how uncertainty in diagnosis, natural history, and the effects of prior treatment may bear directly on surgical risk-benefit assessment.

With respect to consent from minors, with or without aligned consent from parents/guardians, plastic surgeons should be aware that medical decision-making competence among minors is a matter of debate, particularly when patients are experiencing distress and considering treatments with lifelong consequences.[7,23,24] Surgeons share responsibility for determining whether a minor is developmentally able to understand the nature, irreversibility, and long-term implications of the proposed surgical intervention. This includes assessing whether the adolescent patient can meaningfully engage with information about uncertainty, alternative approaches, and the possibility that distress or perceived identity may evolve over time.[15]

When evidence regarding benefit is limited, natural history is uncertain, and fully informed consent a challenge, ASPS believes that plastic surgeons should adopt a posture of heightened caution, enhanced documentation, and explicit uncertainty disclosure, recognizing that their role is not simply technical but ethical. Shared decision-making in this setting not only requires multidisciplinary input, but clear surgeon judgment regarding whether proceeding with irreversible surgery is consistent with the patient's long-term welfare.

## EVIDENCE STANDARDS AND SAFEGUARDS FOR CHILDREN AND ADOLESCENTS

ASPS acknowledges that many plastic surgical clinical recommendations and standards rely on lower levels of evidence compared to those of other medical specialties. However, ethical decision-making in medicine does not depend on evidence quality alone, but on the relationship between evidence uncertainty, anticipated benefit, potential harm, and patient vulnerability.

Established principles of biomedical ethics dictate that physicians should offer interventions only when there is a reasonable expectation that anticipated benefits outweigh potential harms, with proportionately greater caution required as uncertainty and risk increase.[13,25] This ethical calculation differs materially when interventions are irreversible, expected benefits are uncertain, potential harms may be lifelong, and patients are minors with evolving preferences and identities who have been diagnosed with a condition of unknown stability.

As a result, ASPS understands that there is an ethical distinction between gender-related surgical interventions for minors (e.g., mastectomy, vaginoplasty) and other plastic surgical procedures occasionally performed on adolescents (e.g., breast reduction, gynecomastia surgery) that is not explained by the level of evidence alone, but by the interaction between the uncertainty of the evidence and the ethical risk across several dimensions.

1. **Clarity of indication and uncertainty of natural history.** Procedures such as breast reduction or gynecomastia surgery address objective physical conditions, and their indications are not dependent on predicting future identity development or evolving embodiment goals. In contrast, gender-related surgical interventions depend on assumptions about the persistence of gender dysphoria over time, and there are currently no validated methods that allow clinicians to reliably distinguish children and adolescents whose distress will persist from those whose distress will resolve without medical or surgical intervention.[11]

2. **Claimed primary benefit.** Breast reduction and gynecomastia surgery are typically justified by relief of observable physical symptoms (e.g., pain, functional limitations) with mental health improvement understood as a potential secondary benefit. In contrast, gender-related surgical interventions in minors are typically justified as providing psychological or psychosocial benefits (e.g., improved mental health/functioning).[26] These outcomes are harder to define, measure, and attribute causally, particularly when co-occurring psychological and endocrine interventions take place. As a result, surgeons are correct to raise the ethical threshold for performing these procedures since the evidence of benefit is either insufficient or very low/low certainty.

3. **Direction of uncertainty and ethical implications.** In procedures such as breast reduction, uncertainty typically concerns the degree of benefit and tradeoff, rather than whether benefit exists at all. In contrast, for gender-related surgical interventions in minors, uncertainty currently extends to whether the intervention provides meaningful benefit across key outcomes, including mental health and psychosocial functioning, or if it may instead contribute to harm, particularly in combination with other co-occurring medical/hormonal interventions.

4. **Irreversibility and long-term medical dependency.** While breast reduction is also considered irreversible and carries the potential for harm (e.g., loss of nipple sensation, inability to breastfeed), it does not typically result in lifelong medical dependency or foreclose on broad future developmental pathways. In contrast, gender-related surgical interventions permanently shape sexual function, fertility, embodiment, and future medical needs. They carry more profound and enduring consequences.

5. **Relationship to adolescent development and capacity for informed consent.** Breast reduction and gynecomastia surgery address physical pain or functional limitations but do not typically require an adolescent to engage in complex, long term, identity-linked decision making under conditions of uncertainty. In contrast, gender-related surgery procedures intervene directly in the processes of identity formation and psychosexual development. These are areas of ongoing maturation during adolescence that warrant particular ethical caution as surgeons assess adolescent medical decision-making capacity.

6. **Urgency framing and ethics of delay.** Breast reduction and gynecomastia surgery are not presented as "life-saving," and patient and parental counseling does not imply that deferral of these procedures creates a risk of catastrophic outcome. In contrast, pediatric gender-related interventions are sometimes characterized as "life-saving," including claims that withholding or delaying the intervention

substantially increases suicide risk.[27,28] Because the best available evidence indicates suicide deaths are fortunately rare[29,30] and the incremental impact of surgery on suicide prevention is unknown[31], ethical decision-making should not be driven by crisis claims. Instead, the ethically appropriate posture for plastic surgeons is greater caution.

Taken together, these factors demonstrate why greater uncertainty about the evidence is ethically tolerable in some areas of pediatric plastic surgery but not in others. This reasoning extends further to address critiques of the Cass Review that compare interventions for gender dysphoria to those used in pediatric critical care.[32] While the two may share low/very low certainty evidence for the relevant interventions, the characteristics of pediatric and neonatal sepsis, brain injuries, organ failure, and cancer crises diverge sharply from surgical interventions for gender dysphoria along the dimensions outlined above. When uncertainty concerns not just the magnitude of benefit but the existence of benefit in and of itself, and when potential harms are irreversible and identity-defining, the principles of beneficence and non-maleficence require a more precautionary approach.[13,14,25]

**International Policy Context**

ASPS notes that several countries, including Finland[3], Sweden[4], and the United Kingdom[5], have recently revised national policies to recommend that gender-related endocrine and surgical interventions for minors occur only within structured research settings or above the age of legal majority. These policy shifts reflect shared concerns about evidence limitations and long-term outcomes.

**Appraisal of Existing Clinical Practice Guidelines**

ASPS members should be aware that recent independent evidence assessments have raised concerns about the methodological trustworthiness of commonly referenced U.S.-based clinical practice guidelines related to gender-related care for children and adolescents and reinforce why ASPS has not endorsed any external guideline for the treatment of minors with gender dysphoria.

The UK's 2024 Cass Review commissioned two systematic reviews appraising more than 20 international clinical practice guidelines, including the World Professional Association for Transgender Health (WPATH) Standards of Care (Version 8), the Endocrine Society guidelines, and policy guidance from the American Academy of Pediatrics (AAP). Those appraisals found that these documents did not meet accepted criteria for high-quality, trustworthy clinical practice guidelines, citing limitations in developmental rigor, transparency, conflict of interest management, and the linkage between evidence certainty and strength of recommendations.[33,34] None of the three leading U.S. guidelines/practice statements were recommended for clinical implementation by the Cass Review or the 2025 HHS report.

**Commitment to Ongoing Review**

ASPS commits to ongoing review of emerging evidence and to revisiting this position as higher-quality data become available. Should the evidence base evolve to demonstrate clear benefit with acceptable risk, ASPS will reassess its recommendations accordingly.

***This position was approved by the ASPS/PSF Board of Directors on January 23, 2026.***

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