

October 19, 2026

Robert F. Kennedy, Jr.
Secretary
United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: HHS Final Request for Information Regarding Sex-Rejecting Procedures on Minors

Dear Secretary Kennedy:

I am a private citizen, not affiliated with any of the organizations addressed by the above referenced request. However, I have been involved in care supervised by the documents at the root of the issues you seek to address.

HHS has sent demand letters to medical organizations¹ that had direct or indirect impact on gendered care, for minors and adults. There are specific accusations against specific organizations but generally the letters assert that HHS² has documented substantial evidence of harm for minors from sex-rejecting procedures that the organizations have supported and provided. The evidence addressed patients from heterogeneous cohorts, with differing clinical presentations and treatment pathways. The guidelines at issue for that care impact adults also.

I do not intend to address the specific allegations against any organization, but rather address the concerns that prompted the HHS to investigate the care category. The published letters to the organizations requesting current positions, proposed changes, and timelines gave the impression it was open to some discussion on the topic.

In the Author's Note to *The Problem with Distress*³, I wrote:

It [this book] was written because something fundamental has become difficult to say in the field of gender-related care: that medicine exists to understand before it acts.

¹ Endocrine Society; American Psychiatric Association; American Medical Association; American Psychological Association; WPATH; American Academy of Pediatrics

² U.S. Department of Health and Human Services, *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices*, November 19, 2025, <https://opa.hhs.gov/gender-dysphoria-report>.

³ Coyle, T.C. (2026). *The Problem with Distress: Why Patients Deserve Diagnosis Before Intervention*

This work argues for something deceptively simple: that patients—especially developing ones—deserve diagnosis before intervention and to be understood as individuals rather than processed as categories.

I was a patient (not a minor) during the periods when DSM-3 and HBGDA SOC-3/4 existed in the 1980s and 1990s. I have been a patient during the period when DSM-5 and SOC-8 have been formally in place. I participated in commenting on the proposed drafts of SOC-7 and SOC-8 when they were open for public comment. I have published works that address the medical issues, the changing medical landscape and impacted populations being treated by the organizations highlighted.

My submission addresses the three subjects raised in your requests: current position, proposed changes, and timing. I offer these responses independently, rather than on behalf of any organization.

1. Current position

Medical intervention should depend on identification of a specific clinical presentation and an individualized assessment of whether the proposed intervention is justified. Neither an identity assertion, distress alone, nor a request for treatment establishes eligibility. Medical intervention for minors is exceptional. My proposals retain the possibility of intervention for minors under the specified diagnostic and clinical requirements. They distinguish temporary puberty suppression during assessment from subsequent testosterone or estrogen treatment, and establish separate requirements for surgery.

2. Proposed changes

I offer two connected proposals for evaluation. The Proposed Addition to DSM identifies a distinct clinical presentation through persistent internal self-body incongruence, specific bodily concerns, corresponding physical-change goals, and explicit exclusions. It is an additional construct, rather than a revision of the existing Gender Dysphoria diagnosis.

The Standards of Care, Draft Revision, 2026 establishes additional requirements for considering and supervising treatment. These include longitudinal assessment, independent clinical recommendations, informed consent and parental permission where applicable, medical monitoring, and long-term follow-up. Diagnosis alone does not establish that an intervention is appropriate.

The accompanying Grounding of the Proposed Addition to DSM identifies relevant empirical findings, clinical guidance, historical precedents, and the author's proposed modifications.

3. Timing

The proposed documents are available now for evaluation and discussion. Institutional review, revision, and adoption require participation and decisions beyond my authority; I cannot

responsibly forecast their completion. I request an opportunity to begin that process through substantive engagement with HHS and the professional organizations.

Interpreting the Evidence

Gender-related distress is a presenting concern; it does not establish that patients share the same condition or require the same treatment. That distinction matters when interpreting evidence.

“Minors” identifies an age category, not a uniform clinical population. Findings concerning treatment benefits and harms must be examined for their applicability to the developmental history, clinical presentation, and intervention under consideration. The HHS Review recognizes variation among patients; the question is whether its broad conclusions adequately distinguish among clinical presentations and treatment pathways. Uncertainty about benefit across a heterogeneous population does not, by itself, establish that withholding intervention is appropriate for every identifiable subgroup. The potential consequences of providing, deferring, or withholding intervention must all receive consideration.

Clearer identification does not itself establish treatment benefit. It makes it possible to examine whether particular patients benefit, experience harm, or require a different approach—and to revise care accordingly. The proposals’ immediate value is to give HHS and the responding organizations specific diagnostic distinctions and clinical requirements to evaluate.

I request written acknowledgment of receipt, substantive consideration of the accompanying proposals, and identification of an appropriate contact or process for further discussion.

Sincerely,

Tracy C. Coyle

About the author:

I am 68; as an adult I was provided medical care under earlier editions of DSM and HBIQDA SOC. I have been actively involved with this topic for more than 40 years. Amongst others, I have authored three books relevant to this topic:

Coyle, T.C. (2022) *Life Change: Discussions in the Trans Community [discussions from 1989-1990]*

Coyle, T.C. (2023) *Gender Incongruent: Understanding Us*

Coyle, T.C. (2026) *The Problem with Distress: Why Patients Deserve Diagnosis Before Intervention*

Other works can be found on my website: <https://tracycoyle.com>

Attachments:

1. Proposed Addition to DSM
2. Standards of Care, Draft Revision, 2026
3. Grounding of the Proposed Addition to DSM

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