Chapter 11
Medical Treatment for Children with Gender Dysphoria: Conceptual and Ethical Issues

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Abstract There are various treatment approaches available for children and adolescents with gender identity disorder (GID). This chapter offers an overview of these, with a focus on bringing to light their underlying assumption and treatment goals. After such an account, the chapter focuses on the combined approach, which involves early medical treatment for children and adolescents with GID. This treatment has raised and may raise important ethical and legal concerns: this chapter disentangles and analyzes such concerns. The conclusion is not only that there is nothing unethical with providing transgender children and adolescents with early medical treatment but that it may be unethical not to do so.

11.1 Introduction

In this chapter, I discuss the treatments that can be offered to children and adolescents with so-called gender identity disorder (GID) and the conceptual and ethical issues that these treatments present. I use the terms "children and adolescents" in a deliberately undetermined way. Children may achieve puberty at different ages, and given that there is not a clear demarcation line between childhood and adolescence, I will use the two terms to refer to the category of minors who may apply for, and be eligible for, early medical treatment.

There have been, and there still are, different treatments available for transgender minors; not all of these involve medical interventions. The differences among these treatments often reflect underlying theoretical assumptions and treatment goals.

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I will provide an account of these approaches and then analyze the ethical issues surrounding medical treatment for gender dysphoria in children and adolescents.

For the sake of clarity, I will make explicit my assumptions here: transgenderism is not to be regarded as pathological or psychopathological (Giordano, 2012). For this reason, I will tend to use the terms transgender children, gender minorities, children with gender dysphoria, or atypical gender over the psychiatric classification of GID (it should be noted that the next edition of the Diagnostic and Statistical Manual of Mental Disorders—DSM-5—due to be published in 2013, amending the term GID in gender dysphoria) (APA). It follows that attempting to "correct" atypical gender identification by seeking to align perceived gender with the gender of assignment is typically not a legitimate goal of healthcare intervention. *Successful* therapy is the one that helps the sufferer to achieve a quality of life that is good *for him/her*, or to minimize his/her suffering, whatever the preferred gender/s may be.

11.2 Brief Overview of Therapies Available

11.2.1 Behavioral and Psychoanalytic Therapies

One of the first approaches used with children with atypical gender identity development has been behavioral therapy. Through negative and positive reinforcements, behavioral therapy aims to reduce cross-gender identification. This therapy has received a vast amount of criticism: it implies that cross-gender behavior is a type of deviance and that it is good to try to amend it. Moreover, behavioral therapies for transgender people proved to be largely unsuccessful [for further details on this approach, see Moller, Schreier, Li, and Romer (2009)].

More used, but no less controversial, have been psychoanalytic therapies. Freud argued that sex and gender identity become stable with the resolution of the Oedipus complex (sometimes called Electra complex for girls).[1] The resolution of these conflicts leads the child to identify with the same sex parent. At this point, the child acquires a stable sex and gender identity. If this process is inhibited by traumatic experiences, sex and gender identification are likely to be hindered. Therefore, when people show problems in sex and gender identification, according to Freud's theory, it is highly likely that the Oedipus complex has not been resolved appropriately (Roberts, Brett, Johnson, & Wassersug, 2008).

The Freudian theory of sex and gender development has been widely criticized. Golombok, in particular, noticed that gender identification occurs in children much earlier than the stage at which Freud postulated the resolution of the Oedipus

[1]Electra is another mythological figure in ancient Greece, which inspired various works, the most famous of which are probably the tragedies *Electra* by Sophocles and Euripides. Here, Electra plans the murder of her mother's lover, who killed her father. Sometimes the term "Oedipus complex" is also used for girls.

complex to occur. Moreover, children raised in atypical families—in fatherless settings, for example, or brought up by gay or lesbian couples—have a sex and gender identification that is comparable to those raised by one woman and one man (Golombok, Cook, Bish, & Murray, 1995; Golombok & Fivush, 1994; Golombok, MacCallum, & Goodman, 2001; Golombok, Murray, Brinsden, & Addalla, 1999; Golombok, Spencer, & Rutter, 1983; Golombok, Tasker, & Murray, 1997). If gender identification depended on the resolution of the complexes hypothesized by Freud, this would be highly unlikely, if not impossible.

Despite the fact that Freud's interpretation of gender development has had limited success, the (perhaps more raw) idea that transgenderism results from situations of family conflicts that the child elaborates through rejection of their gender of assignment has instead had more traction. There is, however, no evidence that transgenderism is monocausal or that upbringing has a large role in its development (Gaffney & Reyes, 2009).

It should be noted that, within the traditional psychoanalytic framework, *successful* therapy is the one that brings the person back within the binary *male or female* polarity. There has been a proliferation of cases in the literature allegedly "cured" with psychoanalysis. The assumption in these cases is that, structurally, the development of gender, when appropriate, will lead a child to mature into a man or into a woman, in a stable way across time, depending on the biological sex, provided that the family is functional enough to promote *adequate* adjustment (Haber, 1991).

The model does not account for the fact that biological sex itself is not straightforward; according to some researchers, there are not two but at least four or five sexes in humans [for a review of the literature on this research, see Giordano (2012)]. Moreover, in considering gender variance as pathological, at the best as an adaptation to a dysfunctional setting, this approach assumes what needs to be demonstrated (that transgenderism is indeed pathology) and risks basing clinical practice on this unsubstantiated assumption.

Of course, any therapy, and not just psychoanalysis, will have underlying assumptions relating to what a good life is, to what the good for the individual is, or to how it should be understood. However, it is desirable that the assumptions and goals be made explicit in order for patients to be able to make an informed choice as to whether or not they can share them, or, eventually, negotiate assumptions and goals that are agreeable to them. Unless there is an alignment of values between the healthcare professional and patient, it may be difficult to assess therapeutic "success."

There are several types of psychotherapies available, in addition to psychoanalysis, and psychotherapy is invariably advised for (and requested by) patients with an atypical gender identity development who want to transition. However, psychotherapy alone does not seem to offer sufficient help to transgender people, including children and adolescents (Kreukels & Cohen-Kettenis, 2011). Whereas there is high emotional distress in these children and higher levels of anxiety are noted than in control groups (Wallien, Van Goozen, & Cohen-Kettenis, 2007), it is now more frequently acknowledged that emotional distress is a consequence of their gender

identity rather than its cause (Moller et al., 2009). Usually transgender children will need a broader range of interventions, other than psychological support, in order to express more fully who they are and thus to achieve a satisfactory quality of life.

11.2.2 Etherapy and Distance Counseling

Online therapy (e-therapy) and distance counseling may counteract the isolation and marginalization that some transgender people may experience, especially in areas in which specialized healthcare provision is lacking. However, there is insufficient evidence to establish the advantages and disadvantages of this approach for this category of patients. Some of the possible advantages and risks are discussed in the Standards of Care published by the World Professional Association for Transgender Health (Coleman et al., 2012).

11.2.3 Combined Approach

A combined approach includes administration of medical therapies as well as psychotherapy, social intervention, and family work (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; De Vries & Cohen-Kettenis, 2012; Di Ceglie, 2009). The main aim of this approach is to alleviate distress and improve the child's quality of life and not to reduce cross-gender behavior or realign the child's perceived gender with the gender of assignment. Combined therapy for gender dysphoria includes three stages:

1. Stage 1: Fully reversible interventions (administration of medical therapies that suspend pubertal development) (Wylie, Fung, Boshier, & Rotchell, 2009).
2. Stage2: Partially irreversible interventions (administration of masculinizing/feminizing hormones).
3. Stage 3: Irreversible interventions (surgery) (Green, 2007).

I will focus on Stage 1, as it involves the administration of medication to minors and as it has raised acute ethical and legal dilemmas (Houk & Lee, 2006). I will concentrate on the ethical issues surrounding early medical treatment, but, where pertinent, I will offer some considerations relating to the laws regulating the treatment of minors, as these may apply to our case. These laws are likely to vary significantly in different countries, and my focus will be on the law in England and Wales, but this may provide one example of a set of answers to some of the pressing issues arising during the clinical encounter between a transgender minor and healthcare professionals. A fuller analysis of the legal issues has been provided elsewhere (Giordano, 2012).

11.2.4 Stage 1 Treatment: A Brief Description

The first stage of treatment generally involves the administration of drugs that cause a temporary suspension of pubertal development. This treatment, where provided, is offered in cases in which gender dysphoria is diagnosed as profound and highly likely to persist. The endogenous production of estrogen in girls and testosterone in boys is temporarily suppressed. Gonadotropin-releasing hormone analogues (GnRHa) are the most effective available drugs, subject to a range of caveats that I shall sketch in a moment. GnRHa act on the pituitary gland and inhibit the pituitary hormone secretion.[2] These drugs are sometimes called "blockers." These could be given to early adolescents just after the onset of puberty, before the substantial development of secondary sex characteristics. This is around what is known as Tanner Stage 2 or 3 (Marshall & Tanner, 1969, 1970). During the first and second stage of treatment, some children will have what is sometimes called a real-life experience (Levine, 2009). This involves adopting the role of the other gender in order to experience the congruence with presumed innate gender identity. During the first stage of treatment, the child normally also receives psychological support. Sessions with the psychologist are meant to help the patient make a conscious and thoughtful, well-informed decision as to whether or not to proceed with the actual first step of gender reassignment, cross-sex hormones. The child/adolescent might decide to transition and eventually to later begin cross-sex hormones. Alternatively, she/he may wish to revert to the gender of assignment and interrupt therapy. By resuming the endogenous sex hormone production, the pubertal development is thought to restart as normal. For this reason, blockers are regarded as a *reversible intervention*.

Puberty-suppressing drugs can be regarded as, at least to some extent, a *diagnostic tool*, as one of their most important functions is to enhance understanding of the nature, degree, and persistence of the child's discomfort (Cohen-Kettenis, 1998; Delemarre-van de Waal & Cohen-Kettenis, 2006).

11.2.5 Stage 1: Benefits and Risks

Temporary suppression of pubertal development has the following advantages:

1. It immediately reduces the patient's suffering (Cohen-Kettenis & Pfäfflin, 2003).
2. It improves the precision of the diagnosis. Adolescents are given more time to explore their self and their gender, without the distress of the changing body (Cohen-Kettenis & Pfäfflin, 2003).

[2] I am grateful to Professor Mike Besser for this specification.

3. It can also help identifying children who are false positives (Delemarre-van de Waal & Cohen-Kettenis, 2006).
4. It reduces the invasiveness of future surgery. In female to male, it would avoid, for example, breast removal; in male to female, it would avoid painful and expensive treatment for facial and body hair; moreover, the voice will not deepen, and the nose, jaw, and cricoid cartilage (Adam's apple) will be less developed. This will avoid later thyroid chondroplasty to improve appearance and cricothyroid approximation to raise the pitch of the voice (Cohen-Kettenis & Pfäfflin, 2003).
5. Better psychosocial adaptation appears to be associated with early physical intervention (Cohen-Kettenis & Pfäfflin, 2003). "Early intervention not only seemed to lead to a better psychological outcome, but also to a physical appearance that made being accepted as a member of the new gender much easier, compared with those who began treatment in adulthood" (Kreukels & Cohen-Kettenis, 2011).

With regard to the risks, a major concern is the impact of GnRHa on development. Administration of GnRHa slows the pubertal growth spurt. This can represent an advantage for male to female children, as it makes it more likely for them to achieve an ultimate height within the normal female range. However, the obvious question is whether reduction of the rate of growth has any side effects on bone formation and metabolism (Haraldsen, Haug, Falch, Egeland, & Opjordsmoen, 2007). GnRHa inhibit the production of endogenous sex hormones and thereby impact on the bone mass growth. Later administration of cross-sex hormones can increase bone mass, but long-term effects on bone mass development and sitting height are unclear. Data thus far provided by the Departments of Medical Psychology and Pediatrics in Amsterdam show that later administration of cross-sex hormones makes it possible to manipulate overall height and achieve *quasi* normal height (Cohen-Kettenis & Delemarre-van de Waal, 2005).

Another concern is the effect of GnRHa on the brain. Males and females show different brain development, especially in the amount of gray matter. There is now ample evidence that brain maturation continues well into adolescence; however, the exact role of pubertal sex hormones in this process remains to be discovered (Delemarre-van de Waal & Cohen-Kettenis, 2006; Kreukels & Cohen-Kettenis, 2011).

Additional concerns regarding blockers are their effects on reproductive capability. Specialists in Belgium have explored these effects (De Sutter, 2009). The use of GnRHa in early puberty might prevent the storage of sperm (for male to female children) and of ova (for female to male children) for future reproductive purposes. However, spermatogenesis in males can be restored by interrupting treatment. A boy whose puberty has been suppressed before spermatogenesis has occurred could decide to stop treatment long enough for spermatogenesis to start, once he is a bit older, if he wishes to collect and store sperm for reproductive purposes (this of

course would mean that he would have to accept the masculinizing effects of endogenous testosterone on his body). He can then continue with treatment for transition to female gender.

In female to male patients, ova may be collected and stored at the time of oophorectomy. The collection of ova has little impact on the already formed ova, but it is still not clear what the fertility success rates may be. Male to female patients do face an additional problem in that the genital tissue available for the later creation of a vagina will be less than would otherwise have been, if puberty is suppressed early, but this problem could be resolved with appropriate surgical intervention (Coleman et al., 2012).

Because of the potential risks of these medications, there has been a controversy internationally on the time at which medical treatment should be initiated. Some clinicians insisted that patients should wait until puberty was well on its way, or even completed. This seemingly "cautionary" approach, however, had the important disadvantage of denying transgender people the important benefits of early treatment (see above). In addition to this, Fenner and Mananzala (2005) make further considerations relating to the risks of *not receiving treatment*:

> First, it [being rejected at clinics …] alienates [sufferers] from medical providers […]. Because of this increased distrust, many may not return for primary care, HIV testing, STD treatment and other essential care […] These denials also create a necessity […] to seek this care out elsewhere. For many, this care is the only way to express their gender fully so that they can seek employment, attend school, and deal with every day interactions in their new gender. […] For many young people [medical treatment] feels like a life or death need, and they will do whatever is necessary to get this treatment. Many, when rejected at a clinic […], buy their hormones from friends or on the street, injecting without medical supervision at dosages that may not be appropriate and without monitoring by medical professionals. This opens them up to high risk for HIV, hepatitis, and other serious health concerns. Additionally, many youth have difficulty raising money to buy these hormones illegally because they do not have parental support for their transition and face severe job discrimination as young transgender applicants. For many, criminalized behaviour such as prostitution is the only way to raise the money. Doing this work makes them vulnerable to violence, trauma, HIV, and STD infection, and entanglement in the […] justice system (Fenner & Mananzala, 2005).

The clinical evidence gathered so far shows that for children with serious and persistent gender dysphoria, the best outcome is provided by starting treatment with puberty suppressant medications as soon as pubertal changes occur, at Tanner Stage 2 or 3. International clinical guidelines provide similar advice (Houk & Lee, 2006; Imbimbo et al., 2009; Moller et al., 2009; Murad et al., 2010). The reaction to pubertal changes is still used to assess the extent and persistence of the child's gender variance, and thus, a delicate balance needs to be drawn between making an accurate diagnosis and ensuring that no preventable harm is inflicted to the children by waiting too long.

The debate on early medical treatment has raised important ethical questions and has revealed weighty ethical concerns. It is to those that I now turn.

11.3 Ethical Concerns: Playing God or Fiddling with Nature?

Intervening in the spontaneous development of puberty may seem morally unacceptable—as *playing god* or as interfering (where the interference is perceived as inherently undue) with "nature."

This objection is problematic for a number of reasons, not the least of which is that "playing god" would of course only be considered by either those who believe in god or the agnostic. Perhaps more importantly, those who use this line of reasoning should provide a cogent account of what they mean by "nature." But even leaving aside these terminological and conceptual problems, the appeal to "nature" (which I use in inverted commas due to its vagueness) still fails on other grounds.

Firstly, it is not clear why "natural" developments should not be interfered with, when the purpose of the interference is to alleviate suffering or ameliorate people's lives. Medicine, and perhaps the whole apparatus of science and without exaggeration probably the whole of human knowledge, aims at understanding better and hopefully ameliorating the *status quo*, the allegedly "natural" course of events. Many of the choices and actions that most people would reasonably regard as morally decent have a similar purpose: stopping our children from running into incoming traffic is an interference with "nature," and so it is to call an ambulance if we saw a person in need. One cannot coherently argue that any similarly decent behavior, aimed at preventing or reducing the ill health or misfortunes that "naturally" occur to our fellows and to ourselves and which indeed represents interferences with the "natural" course of events, is immoral without proving that the most basic moral attitudes, like compassion and desire to prevent harm, are utterly deplorable or wicked. David Hume, in an essay published in 1783, wrote:

> If I turn aside a stone which is falling upon my head, I disturb the course of nature, and I invade the peculiar province of the Almighty, by lengthening out my life beyond the period which by the general laws of matter and motion he had assigned it … any why not impious, say I, to build houses, cultivate the ground, or sail upon the ocean? In all these actions we employ our powers of mind and body, to produce some innovation in the course of nature; and in none of them do we any more (Hume, 1783).

The appeal to god or "nature" has a long and not praiseworthy history. John Stuart Mill, for example, pointed out how the appeal to "nature" was used in his times to justify the subjection of women as well as the subjection of black people in America. Women were regarded as "naturally" suited for domestic roles, black people as "naturally" inferior, and the appeal to "nature" was used in the attempt to justify what was, effectively, slavery in both cases. The idolatry of "nature" has been used ad hoc in the attempt to justify various forms of violence or to deny important goods to others.

Secondly, doctors interfere with "nature," or, more precisely, with spontaneous developments, all the times, and we all do. Doctors treat people in the hope of delaying death, and thus they, rightly so, unscrupulously interfere with the course of "nature." Malignant tumors are spontaneous developments, which doctors treat routinely, and no serious objections are raised against governments that fund cancer research.

One may object that comparing cancer with puberty is preposterous: illnesses are not "spontaneous" developments in the same way that pubertal development is. This objection does not account for what a "spontaneous pubertal development" may mean to a transgender child. Developing in a body that is perceived as alien is simply not an option for many transgender children; the sequel associated with puberty is grim for many transgender children, and some would rather take their life than develop in the "natural" body (Fenner & Mananzala, 2005). For these children, the spontaneous development of puberty is no less fatal than a malignant illness. In fact, this objection assumes that some processes are "illnesses" and others are not. From this epistemological claim, the objection draws normative conclusions, such as that it is ethical or even obligatory to interfere with illnesses and unethical to intervene with "natural" developments. But the epistemological assumption is not valid, and neither are the normative conclusions justified. How people define what is a disease, an illness, an abnormal state, a disadvantaged state, and an unbearable state is open to serious debate (Symposium on Disability, 2001).

Any epistemological claim that some conditions are "spontaneous" or "natural" or "normal" and others are "illnesses" should be explained, especially when the purpose of the epistemological claim is to deny people important benefits that they claim for themselves.

But even if a convincing definition of what "illness" is and is not could be provided, the normative implications proposed do not logically follow. Ageing is associated with various adverse effects on our health, yet it is not generally regarded as wrong to interfere with this process of spontaneous development in order to ameliorate people's quality of life. Or should doctors refuse on ethical grounds to prescribe calcium or estrogens to postmenopausal women to counteract the spontaneous bone mineral density loss? Should hip replacements be banned on moral grounds? Should fitness instructors on ethical grounds refuse to prescribe weight-bearing exercise to older clients with osteoporosis? Would we be morally repugnant if we exercised in order to delay the spontaneous process of ageing?

If it is right to intervene to delay ageing at one end of "spontaneous development" (towards the end of life), to ameliorate a person's quality of life, or to minimize his/her suffering, it should be right to delay ageing at the other end (towards its beginning) for the same purposes.

One could here object further that, even if it is "natural," ageing causes tangible hideous effects on one's health and safety. So, the objection may go; it is not ageing per se that doctors interfere with but the illnesses associated with it. Giving pubertal suppressant medications is instead an interference with the development per se, and not with its hideous effects.

This objection does not stand up to close scrutiny. It is unclear how one can logically or practically separate an interference with ageing per se from an interference with its effects. Coronary bypass artery surgery, for example, is likely to delay death and thus affects both the process of ageing and the diseased organ. Conceptually separating ageing per se, the spontaneous (and allegedly benign) process, from the hideous effects of it, seems patent nonsense. More importantly, it is obviously true that ageing usually carries with it adverse effects on people's health and that people

who age may suffer age-related diseases: but who says that a transgender child suffers less than a person with osteoarthritis? Or should doctors be invested with the power of deciding whose suffering deserves alleviating?

It may be easier for many of us to relate to the suffering of an ageing person than to the suffering of a transgender person, simply because many of us will age, and only a few of us will experience gender dysphoria. But the suffering that we are unlikely to experience ourselves is not for that reason less painful to the ones concerned or less worthy of our own concern.

Insofar as interference with what is thought of as a "spontaneous" or "natural" development is likely to alleviate suffering and promote well-being, there is a strong prima facie reason in favor of interfering.

11.4 Is It Unethical to Make Choices That Affect the Future of a Child?

Having established that it is not *interfering* per se that is unethical, it may be further argued that gender identity development is a complex and still scarcely understood process, and some healthcare professionals may be reluctant to interfere medically with it because of the long-term unforeseeable consequences that this may have. Some may wonder whether, without medical treatment, the child may eventually feel comfortable with his/her body.

In addressing these concerns, we should first note that many types of interventions (not only medical) in the life of a child represent important interferences with his/her future. Sending them to school, raising them as a part of one culture or religion, and many others are choices made at a certain point in time that produce long-term consequences: they open up some options and foreclose others. Not taking any action also interferes with the person's future: for example, not sending our children to school also has long-term consequences. Sometimes worse consequences result from taking *no action*. Indeed, it could be argued that there is no such a thing as *no action* and that any choice, including the choice not to intervene, is still *doing something*. From this point of view, refusal of treatment is not simply *taking no action* but making a choice that has consequences. This explains why in some countries deciding not to treat can be an offense (omission of treatment).[3]

A decision (in our case, to treat or not to treat, to treat in a determined way at a certain point in time or in a different way later) finds its moral justification in the foreseeable consequences that that decision is likely to produce. The choice with the best foreseeable consequences for the patient is, prima facie, the one to be preferred. Of course, a forecast of the foreseeable consequences is open to failure: nobody (doctors are no exception) can see into the future. It is, for example, possible that we

[3] In Italy, for example, Articles 328, 591, and 593 of the Penal Code, respectively, *Omission or Refusal of Official Acts*, *Abandonment of the Incapacitated*, and *Omission of Rescue*.

judge early treatment as beneficial for a particular child and that that child is a "desister" that she/he decides to interrupt therapy; it is even possible that gender dysphoria would have subsided spontaneously even without treatment. It is thus possible that some of those whose dysphoria has subsided *after* the initiation of treatment might have been "desisters" anyway, even without treatment. It would be impossible, however, to know whether in these cases the treatment and support received has helped those allegedly false positives to adapt to their gender or whether they would have adapted in the same way without treatment. In fact, "desisters" may also benefit from early treatment. Early suspension of puberty may allow the child the time to explore his/her gender without the fear of growing in the "wrong" body and may actually *prevent* the later provision of more irreversible treatments (such as hormones) to false positives. If treatment is withheld, instead, or postponed, the child who is a "persister" will incur certain and preventable harm. This means that, whereas in other situations it may be prudent to defer medical treatment until the child is older, delaying treatment of even a few months in cases of gender dysphoria may have hideous consequences.

One could ask whether it is possible that some of the children who receive early treatment may proceed to transition and whether, if they were not treated at all, their condition may have subsided spontaneously. This less appealing possibility is quite remote as, where early treatment is provided, this follows a careful selection process and careful diagnosis. Early treatment is offered to children who suffer significant distress and who manifest strong and persistent dysphoria; their progress and levels of satisfaction are monitored carefully over time, before more irreversible treatments are provided.

Certain forecasts are outside the boundaries of medicine: medicine is about probabilities, not indisputable deductions. Thus, the only way in which doctors and patients can proceed is to balance probabilities and evaluate likely outcomes, both on grounds of careful assessments of each individual patient and of the evidence available.

11.5 Who Decides on What Is in the Best Interests of a Patient?

Whereas the best interests of patients should in principle be served, doctors may still wonder how these should be understood and who should make a judgment. There is a wide agreement that medical decisions regarding children should promote their welfare. For example, the British Medical Association (BMA) states: "The welfare of children and young people is the paramount consideration in decisions about their care" (BMA, 2011). In England and Wales, Section 1 of the Children Act 1989 states that the welfare of the child must be the "paramount consideration."[4]

[4]Online at http://www.legislation.gov.uk/ukpga/1989/41/section/1. Last accessed 15 November 2011.

In English jurisprudence, it has been established that best interests are not to be regarded narrowly as *medical* interests only, as previously understood.[5] Best interests must encompass ethical, social, moral, emotional, and welfare considerations.[6] In *A Hospital NHS Trust v. S and others,* it was stated: "When considering the best interests of a patient, it is […] the duty of the court to assess the advantages and disadvantages of the various treatment and management options, *the viability of each such option and the likely effect each would have on the patient's best interests and, I would add, his enjoyment of life* […] any likely benefit of treatment has to be balanced and considered in the light of any additional suffering the treatment option would entail"[7] (my emphasis). The professional's opinion needs to be *reasonable and responsible*; has to have a logical basis, it has to be grounded on an evaluation of the comparative risks and benefits and must be defensible.[8] Doctors are not the sole judges of the patient's best interests.

When it is not immediately evident what is in a patient's best interests, or when there is a dispute between the parties (e.g., the family and patient on the one hand and the healthcare professionals on the other), in England it will be up to the courts to determine the patient's best interests and no longer up to the doctors alone. The judgment will be made according to the established view that best interests encompass not only medical interests but also the person's present and past feelings, wishes, beliefs, and values. In all cases, and thus in cases of younger minors as well, best interests will be assessed in light not only of medical evidence but also of the nonmedical evidence relating to the patient's overall condition. In the UK, the General Medical Council (which, it should be mentioned here, is not the law in the UK) also states that the child's best interests are not confined to clinical interests but include, among other factors, the views and values of the child, of the parents, and an evaluation of the choice, if there is more than one, which will least restrict the child's future options (GMC, 2007).

These provisions may set out principles that can guide the judgment of clinicians in the interaction with transgender minors. Doctors are not clairvoyants: all that can be expected of them is to make a careful assessment of each individual applicant, by involving, wherever possible and appropriate, the family, in order to understand the history and the extent of the child's discomfort and to make a prediction that is as accurate as possible of how the child will feel if treated and if not treated, based on the facts available at the time. In the clinics that adopt a combined approach, generally the child is seen by a team of specialists, as gender dysphoria encompasses endocrinological, psychological, and social issues. (It should be noted that WPATH in 2011 has taken a flexible approach and contemplates the possibility that individual healthcare professionals be involved with patients with gender dysphoria.)

[5] *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118, [1957] 1 WLR 634.
[6] *A v. A Health Authority* [2002] 1 FCR 481, [2002] Fam 213 at para 43; see also *Re A (medical treatment: male sterilisation)* [2000] 1 FCR 193; *A Hospital NHS Trust v. S and others* [2003] Lloyd's Rep Med 137, (2003) 71 BMLR 188 at para 47.
[7] *A Hospital NHS Trust v. S and others* [2003] Lloyd's Rep Med 137, (2003) 71 BMLR 188 at para 47.
[8] *Bolitho v. City and Hackney HA* [1998] AC 232 at 242, HL.

WPATH also allows for individual health professionals to adapt the clinical guidelines to suit the needs of the individual patient. These departures, WPATH warns, should be recognized as such, explained to the patient, and documented through informed consent (Coleman et al., 2012). If the specialists, after careful evaluation, regard the dysphoria as strong and likely to persist, and if deferring treatment seems on balance of probabilities the most risky option, then there are grounds for considering early treatment as being in the best interests of the child. Determination of best interests should also be based on best available clinical evidence and on published research (evidence-based medicine). If healthcare professionals assess the child's best interests in this manner and it appears that initiating treatment seems, on balance, in the best interests of the particular child, they should be able to commence treatment and their conduct will be most likely irreprehensible.[9]

11.6 At What Age Can Children Decide?

The age at which a child may participate directly in the therapeutic process, and may even consent to treatment without the knowledge of their parents, will be regulated by the laws in force in each individual country. In England and Wales, minors aged 16 and 17 have a right, as stated by the Family Law Reform Act 1969, to consent to medical treatment. For those below the age of 16, the famous case known as *Gillick* would apply. The court in that case established that a child under sixteen can give an effective consent to medical treatment, provided that she/he had reached "sufficient understanding and intelligence to be capable of making up his own mind in the matter requiring decision."[10] This is known as the *Gillick* test, or *Gillick* competence test. Generally, the more serious the decision, the greater the capacity required of the minor.[11] It should be noted that if the treatment is offered only within a research study, *Gillick* may not apply [for more see Giordano (2012)]. Should parents oppose treatment that is deemed to be in the best interests of the child, the consent of the child who has *Gillick* capacity is normally valid in England. In any case, it should be borne in mind that, even with young minors or infants, parents, or those with parental authority, in England do have a right to make decisions on behalf of their children only insofar as their decision is not detrimental to the child's best interests; for example, Jehovah's witnesses do not have a right to refuse whole blood transfusions on behalf of their children. Should the parents' decisions be detrimental to their children's best interests, these decisions can be overhauled.

The legal provisions relating to consent in minors are likely to vary significantly in different countries. However, it is generally recognized that the child's capacity

[9] *Re J* (A Minor) (Child in Care: Medical Treatment) [1992] 2 All ER 614.
[10] Gillick v. West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 at 409 e-h per Lord Fraser and at 422 g-j per Lord Scarman; See also R v. D (1984) 2 A11 ER 449.
[11] *Re S* (A Minor) (Consent to Medical Treatment) [1994] 2 FLR 1065; *Re E* (A Minor) (Wardship: Medical Treatment) [1993] 1 FLR 386.

to consent to medical treatment "does not depend on the age of the child, but on subjective features of the child in respect to the particular treatment proposed" (Jones, 2006). The British Medical Association (BMA) states:

Children and young people can expect:

- To be kept as fully informed as they wish, and as is possible, about their care and treatment.
- Health professionals to act as their advocates.
- To have their views and wishes sought and taken into account as part of promoting their welfare in the widest sense.
- To be the individual who consents to treatment when they are competent to do so.
- To be encouraged to take decisions in collaboration with other family members, especially parents, if this is feasible.
- To be able to expect that information provided will remain confidential unless there are exceptional reasons that require confidentiality to be breached (BMA, 2011).

In international documents, similar points are made. For example, the Convention on the Rights of the Child, adopted in 1989 by the UN General Assembly, states that the child has a right to have his/her views accorded due weight in relation to the child's maturity (UNICEF, 1989, Article 12).

Thus, whereas the laws in different countries may diverge, it is an important principle of ethics and good clinical practice that children are not automatically assumed to lack capacity and that a therapeutic relationship be based on taking seriously into consideration the child's opinions about his/her own care. Including children in the therapeutic process should be the norm, and they should not be regarded as incompetent just because they do not agree with the physicians. Importantly, doctors should not judge the capacity of a child solely on the basis of his/her age. Because the decision either to suspend puberty or to transition involves both significant others and others at large, it would probably be difficult for a child to initiate the process of medical treatment for gender dysphoria without support, even if she/he had the legal capacity to do so. Perhaps for this reason, international guidelines generally insist on the importance of family participation (Coleman et al., 2012). On the other hand, it must be recognized that children who apply to this medical treatment often have a long-term history of gender dysphoria and may have gained significant self-awareness, maturity, and capacity to make decisions on this subject matter.

11.7 Gender Dysphoria Is a Psychiatric Issue, Not a Medical Issue

The idea that transsexualism is a psychiatric or psychological problem, and therefore should not be treated medically, is one that has run through literature (Raymond, 1994). The literature has traditionally dealt principally with adults, but the point is one of relevance in the case of children as well. I have argued

elsewhere that there are no sound epistemological grounds to regard gender dysphoria as a psychological or psychiatric disorder (Giordano, 2012). But even assuming for the sake of the argument that transgenderism was purely psychological, psychological treatment has a poor outcome. Why should doctors insist in using a form of therapy that has proven largely unsuccessful on its own? Pharmacological treatment is routinely used to treat the so-called symptoms of the many so-called psychiatric disorders, disorders for which no biological or somatic cause has been found. Lithium carbonate is regularly used to treat bipolar disorder, a psychiatric syndrome whose causes are unknown. It is not clear why, even if one assumed that transsexualism was a psychological or psychiatric disorder, transsexuals should not be treated in the same way as other "psychiatric" patients. There are further issues relating to whether gender dysphoria is appropriately regarded as a mental illness and to the goals of psychiatric interventions in general and in this specific case. For reasons of space and consistency, these cannot be analyzed here. For our current purposes, it is however important to remind that the fact that a condition is classified as a psychiatric disorder is not per se a good reason to refuse effective medical intervention.

11.8 Gender Dysphoria Is a Social Issue, Not a Medical Issue

Another objection raised against medical treatment for transgenderism is that the suffering associated with it is caused not by atypical gender per se but by questionable gender stereotypes and prejudice. A masculine femininity and a feminine masculinity are not foreseen in the sociocultural context of many Western countries, and this is why, according to this argument, nonconforming individuals end up seeking medical treatment, when they could and should, in principle, live their gender liminalities undisturbed. It is society that needs to change. By changing people's bodies, rather than society, a twofold harm results: a mutilation of individuals, who are exposed to the risks and pains of extensive surgery, and a reinforcement of the oppressive stereotypes that are the very cause of their suffering (Raymond, 1994).

Raymond (1994), for example, argues that trans-surgery is a form of sexual politics and medical treatment for gender dysphoria is akin to the Nazi's "medical" practices, and even worse than those, in that the transgender has so strongly internalized the gender stereotypes that has become willing to seek and consent to the mutilating procedures.

Indeed, social responses to transgenderism are, to a significant extent, responsible for the suffering of gender minorities. Social ostracism, bullying, or even open violence is a sadly common experience for gender minorities, and social ostracism often begins early in the life of the transgender (GIRES, 2008; Grossman & D'Augelli, 2006; Wallien, Veenstra, Kreukels, & Cohen-Kettenis, 2010): in societies in which the gender divide is less marked, transgender people suffer less (Connolly, 2003). One could indeed argue that it is society that should change and not individuals. This, in itself, appears a sound argument, but on further scrutiny, it turns out to be untenable.

This seemingly appealing claim is based in fact on a number of other, less transparently expressed, and less logically cogent arguments. Disentangling these "hidden" arguments helps us see why none of them stands logical scrutiny.

11.8.1 Transgenders Embrace the Gender Stereotypes That Are Responsible for Their Suffering

Part of the argument presented above is that when the gender dysphoric seeks medical alteration of their appearance, they are embracing the very gender stereotypes that are responsible for their discomfort. Raymond writes:

> Through hormonal and surgical means, transsexuals reject their 'native' bodies, especially their sexual organs, in favour of the body and the sexual organs of the opposite sex. They do this mainly because the body and the genitalia, especially, come to incarnate the essence of their rejected masculinity and desired femininity. Thus transsexualism is the result of socially prescribed definitions of masculinity and femininity, one of which the transsexual rejects in order to gravitate toward the other (Raymond, 1994).

This view needs to be balanced against the fact that many transsexuals seem to go well beyond the "classic" gender divide "male/female." Many transsexuals do not transition fully: many transwomen seek breast implants and leave their genitals as they are. Many live in the other gender without any surgery, and many embrace different segments of genders in their identity. The reasons for these choices may be diverse. However, by ignoring what happens to a significant segment of the transcommunity, Raymond offers an account that is partial and perhaps even methodologically questionable.

Moreover, this argument does not account for the experience of children: some children express their atypical gender very early in life. At the age of 3 or 4, sometimes atypical gender is already clearly manifested. The child generally has a marked preference for toys and play, clothes, and activities that are typical of the other gender and may identify himself/herself with the other gender openly. It is difficult to speculate that at this stage the discomfort is due to the desire to conform with internalized gender stereotypes. I will come back to this later.

11.8.2 Transgender Treatment Is Responding with Medical Means to a Social Problem

The other side of the argument is that providing transgender people with medical treatment is responding with medicine to a problem that is social, and not medical, in nature. This other side of the argument is incomplete.

It is not clear, to start with, that gender dysphoria is solely or mainly a social problem, even if social responses can exacerbate the suffering significantly and may

cause a whole range of additional problems for transgender people (bullying in schools, acceptance by peers, discrimination in employment, lack of clarity regarding to legal rights, and so on). Yet, studies suggest that there are important biological factors implicated in gender development, both typical and atypical. Gender identity development does not solely depend on social factors and reinforcements: biological and cognitive factors are also implicated in the process. It is, thus, at best simplistic to assume that, whereas biological factors are implicated in typical gender identity development, no biological factors are involved in atypical gender development (Giordano, 2012).

But even if there were no identifiable biological bases for gender dysphoria, this would not necessarily say much about the ethics of providing medical care. It is normal clinical practice to offer medical treatment for conditions of suffering that appear solely determined by social variables or norms (even by morally dubious social norms, as we shall see later in this chapter). Children whose growth is deemed to be retarded or excessive routinely receive endocrinological treatment[12] purely on psychological grounds (Drop, de Waal, & de Muinck Keizer-Schrama, 1998). Treatment for "bat ears" in children, circumcision in male infants and children (still legal in England), or "corrective" surgery for many forms of the so-called disorders of sex development (DSDs) are other examples of invasive medical treatment administered purely for social reasons [for an account of DSDs, see Giordano (2012)], and the list could be expanded significantly.

Of course, this raises another conceptual issue relating to how "medical conditions" can be differentiated from "social constructs," and it is possible that this is a chicken-and-egg problem. Philosophers have widely debated the issue, with unsurprisingly unsatisfactory results (Giordano, 2011). The debate has been prompted partly by disability right activists who have argued that their "different abilities" *become* "disabilities" in a given prejudicial and discriminatory social context. I will not dwell on the intricacies of this debate here: suffice it to say for the current purposes that there is no consensus as to what "an illness" is. The fact that such a consensus has not been reached has at least one important normative implication: "illness" is too vague a concept to be used as a ground for healthcare provision. It cannot be argued that what makes it appropriate or ethical to offer clinical care in one case and not in another is the fact that in one case there is an "illness" and in the other there isn't, without at least a sound and solid characterization of illness. Absent this, it must follow that, even if it were true that transgender people are to a large extent made to suffer by mistaken social stereotypes, it does not follow that *therefore* they ought not to receive medical help.[13]

[12]I owe this important observation to Professor Peter Clayton.

[13]There might be ethical and pragmatic issues of resource allocation, which could explain why the state might not publicly fund some treatments for transgender people (or for the infertile, or for the intersex, or for the person who is dissatisfied with his/her physical appearance, and so on). However, pragmatic concerns relating to how to allocate resources and how to prioritize people's needs are not principled reasons to deny medical treatment.

11.8.3 Medicine Should Not Reinforce Bad Social Stereotypes

The other part of the argument in question is that by providing transgender treatments, the medical profession bears the responsibility of reinforcing the social stereotypes that cause transgenderism in the first place. Raymond (1994) writes: "there are many ethical objections to alleviating individual gender suffering at the expense of reinforcing, qualitatively and quantitatively, sex-role conformity."

Indeed, medical treatments that appear to reinforce social stereotypes seem dubious. Think of skin bleaching and nose filing for black people: there is something distasteful with a doctor who bleached the skin of a black woman in order to "make her more acceptable" socially or "more attractive." But, distaste apart, this raises an important ethical question: why should people, including gender minorities, be turned into martyrs of ideals? By suggesting that individuals should bear avoidable suffering because to alleviate their suffering would harm society, Raymond proposes what she reproaches the Nazis for doing: turning individuals into martyrs of the social good (of course, of one particular idea of what such a good is).

In principle, nobody should be allowed to suffer if his/her suffering can be alleviated. If this principle had to be abridged, it should be only on very stringent grounds and perhaps in exceptional circumstances. If gender minorities had to be refused medical care on the ground that their problem is social and not medical in nature, they would be jeopardized twice: once because they suffer from a social wrong in the first instance and the second time because they are denied medical care in the name of that society that harmed them.

Of course, by using the example of suspect "cosmetic" surgery, I did not wish to equate transgender treatment with skin bleaching or nose filing, neither do I wish to trivialize the suffering of people with atypical gender. I purposely raised the example of medical interventions that are clearly provided to release the stress caused solely by social stereotypes or, even prejudice, to emphasize how, even in such cases, it would be at least dubious to deny people who wanted treatment. Even more so for the transgender, whose condition is not solely caused by dubious social norms, or by beauty imperatives, but by a complex array of biological, social, and cognitive factors, which all together contribute to the development of gender.

Gender identity development is a complex process, and science has not disentangled the way in which it occurs, both in typical and atypical cases: we know that a stable gender is generally acquired around the age of 6 or 7 (Gross, 2010), that children with an atypical gender sometimes manifest this very early in childhood, and that gender identity is generally not amenable to external command. Some children may have a strong gender identification, whether or not matching with the assigned gender, very early and well before puberty; others may be unsure about their gender identity, and, in some cases, gender identity can be malleable until puberty. However, even in those cases, perceived gender identity is resilient: others will not normally be able to "convince" a child that she/he is of the gender that those others may want to attribute to him/her. This all suggests, at least, that it is not clear that the transgender person suffers solely or mainly because of mistaken social

stereotypes: the discomfort may appear arguably a long time before those stereotypes are even known to the child, and a child may well oppose typical gender stereotypes.

In conclusion, the argument that transsexualism is a social problem and therefore should not be treated medically is flawed. It is not clear that gender variance is solely the product of gender stereotypes, and even if it were (a claim that cannot be substantiated given the complexities involved in gender development), this would not imply that medical treatment should not be offered. Of course, there is no reason to believe that one type of intervention (medical) should exclude others (social and familial).

Other important concerns relate to the experimental nature of pubertal suppressant medications.

11.9 Experimenting on Children Is Unethical

The administration of puberty suppressant medications is to some extent experimental. The impact of GnRHa on bone formation and its effects on the brain, as we saw earlier, is under scrutiny, and it may be questioned whether it is ethical to offer children a treatment whose side effects have not been fully established.

The ethical issue is twofold here. Firstly, one can ask whether genuine consent can be provided in cases of experimental treatment: how can a person consent to a treatment without clear information relating to the side effects? Secondly, one could ask whether, even if the person could give valid consent in the face of uncertainties, it would be ethical to expose patients, especially children, to unknown risks.

11.9.1 Can Genuine Consent Be Given to Experimental Treatments?

One of the core features of valid consent to any medical intervention is information. However, valid consent to a medical intervention can still be given even if its side effects have not been fully established—and it's this that prevents all medical research involving human beings being unethical from the start, whether research participants are children or adults. In order to give valid consent, the patient or research participant must receive as complete information as possible about treatment and has to be informed about the potential risks and benefits, even if these risks have not been fully established. Patients should be aware that they are able to withdraw their consent to continuation of involvement with the therapy or research project, if this treatment is provided within a research protocol, and never be subjected to any inhuman or degrading treatment or avoidable and unwanted harm or injury (World Medical Association, 2008). Once all available material information

has been provided, the prospective patient or research participant will consider the potential risks of treatment with its potential benefits and make a decision as to whether to consent to treatment or refuse it.

The laws of each country, as well as established international guidelines, provide clear advice as to how to ensure that valid informed consent is gathered in cases of minors who apply for innovative or experimental treatment or for participation of minors in medical research. The CIOMS guidelines, for example, have specific articles offering advice as to how to proceed with minors (CIOMS, 2002). In England, the Clinical Trials Regulation, Schedule 1, Part 4 establishes the conditions and principles of research that apply in relation to a minor. These implement in national law the Directive, 2001/20/EC of the European Parliament and of the Council on the approximation of the laws, regulations, and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use, issued on the 4th of April 2001 (Directive, 2001/20/EC). Article 4 states:

In addition to any other relevant restriction, a clinical trial on minors may be undertaken only if:

(a) The informed consent of the parents or legal representative has been obtained; consent must represent the minor's presumed will and may be revoked at any time, without detriment to the minor.
(b) The minor has received information according to its capacity of understanding, from staff with experience with minors, regarding the trial, the risks and the benefits.
(c) The explicit wish of a minor who is capable of forming an opinion and assessing this information to refuse participation or to be withdrawn from the clinical trial at any time is considered by the investigator or where appropriate the principal investigator.
(d) No incentives or financial inducements are given except compensation.
(e) Some direct benefit for the group of patients is obtained from the clinical trial and only where such research is essential to validate data obtained in clinical trials on persons able to give informed consent or by other research methods; additionally, such research should either relate directly to a clinical condition from which the minor concerned suffers or be of such a nature that it can only be carried out on minors.
(f) The corresponding scientific guidelines of the Agency have been followed.
(g) Clinical trials have been designed to minimise pain, discomfort, fear and any other foreseeable risk in relation to the disease and developmental stage; both the risk threshold and the degree of distress have to be specially defined and constantly monitored.
(h) The Ethics Committee, with paediatric expertise or after taking advice in clinical, ethical and psychosocial problems in the field of paediatrics, has endorsed the protocol.
(i) The interests of the patient always prevail over those of science and society (Directive, 2001/20/EC).

Thus, whereas special caution needs to be taken, providing experimental treatment to children, or enrolling children in research, is not in principle unethical, nor it is unlawful in many countries.

11.9.2 Is It Ethical to Expose Children to Unknown Risks?

The other question is whether it may be ethical to expose people, especially minors, to unknown side effects of experimental treatments, which could affect their future, even if their consent was valid. Children and adolescents might be believed to have greater difficulty than adults in foreseeing how they will feel in the future, due to their limited capacity at long-term judgment and their more scanty knowledge of their self and because gender identity may still be fluctuating during adolescence. It may be even questioned how a child can know before the age of puberty that they are transgender: only once gender has fully developed, one may believe and may reach the conclusion that that gender is mistaken for them.

Although these concerns are understandable, children may show marked gender dysphoria well before the onset of puberty. Their perceived gender may mismatch with the assigned gender very early in life; the incongruence may continue through childhood, and by the time a child is about to hit puberty, she/he may know enough about himself/herself to make a decision as to whether she/he wishes to begin medical treatment or not. While many children with gender dysphoria will be "desisters," that is, their dysphoria will subside, for the majority of those who continue to experience it after the onset of puberty, gender dysphoria is most likely to continue in adulthood (Reed, Rhodes, Schofield, & Wylie, 2009). The evidence collected thus far shows that for children with marked and persistent gender dysphoria, early treatment is both beneficial and benign. Effects of GnRHa are reversible and, based on the data collected to date, associated with no severe or uncontrollable side effects (see earlier in this chapter). Masculinizing and feminizing hormones have effects that are more difficult to reverse; however, Stage 2 treatment should in principle be administered after Stage 1 treatment and after a careful assessment of how the child reacts to the first phase of treatment. This is an additional reason why Stage 1 treatment is so important: it may prevent the treatment of false positives, of those children who may have some gender dysphoria, but who will not transition.

On the contrary, *not being treated* early may be devastating for most children and adolescents with profound and persistent gender dysphoria, and will force those who go on to transition into unnecessary mutilating surgery and other preventable harm (see earlier in this Chapter). The certain and real side effects of *not receiving treatment* might, for many, outweigh the potential risks of this treatment (Fenner & Mananzala, 2005; Kreukels & Cohen-Kettenis, 2011). Patients, including minors, can make an informed and rational choice to take the potential risks of treatment, including those who have not been fully established, when the alternative is on balance of probabilities much worse for them. They may have sufficient knowledge of themselves to have the capacity to consent to medical treatment before puberty is

well under way [for more on the determination of legal capacity in minors, see Giordano (2012)].

It may be worth reporting here another argument against early treatment that has been produced in the literature. During adolescence, it has been suggested, the ratio of gray to white matter in the prefrontal brain area changes, and there are increases in connectivity between this area and other areas of the brain, as well as an increase in dopaminergic activity in prefrontal striatal limbic pathways. These, it is argued, may lead to increased likelihood of making impulsive choices or engaging in risky behavior. It should, however, be noted that this potentially increased predisposition to impulsive choices may lead the young adolescent who does not receive medical care to engage in risky behavior out of despair. Young people who are denied medical care might try to obtain the medications through illegal sources and may even become suicidal. Moreover, the wish to change gender never occurs abruptly, and it is a long-term issue for those who eventually are referred to the specialists. It is thus highly unlikely that the wish to undergo treatment for gender dysphoria may be caused by the variations in the central nervous system suggested here (Kreukels & Cohen-Kettenis, 2011).

11.10 What Are the Responsibilities of the Doctors?

The arguments developed so far have wide implications relating to the doctors' responsibilities. In judging whether or not to treat, healthcare professionals should evaluate what is likely to happen to the person who applies for treatment if she/he does not receive treatment, and not only what is likely to happen if she/he does receive treatment. In other words, healthcare professionals should take into consideration the consequences of their omissions as well as those of their actions. This might seem to go beyond professional obligations: clinicians might feel that they must assess the clinical benefits and risks *of therapies*, but that they are not responsible for what happens to people outside their clinics. Thus, for example, they may believe that they are responsible if they administer a drug, with the result that bone development or brain development is impaired, and that they are not equally responsible if the adolescent, against his/her professional advice, gets hormones in the streets or takes his/her life, having been refused medical care.

The extent to which all of us, including healthcare professionals, are responsible for the implications of our choices further down the line, or for what other people decide to do also as a result of our own choices (here including our own omissions), is open to debate. However, it is a mistake to believe that we bear no responsibility whatsoever for any of these implications. Omitting to treat, or deferring treatment, is not a morally neutral option. Deferring treatment may mean alienating minors from healthcare services, subjecting them to preventable mutilating surgery later on,

and exposing them to the risk of body dissatisfaction (they will have to bear forever with the consequences of having fully grown in a body that they perceived as alien to them) and to preventable bullying and social discrimination due to an ambiguous appearance, which could have been prevented with early treatment. In order to avoid all of this, children may feel that they have no other option but to obtain medications off the illegal market, running the risk of entanglement with street life and with the juvenile justice system (Fenner & Mananzala, 2005). Suicidal ideation and suicide attempts are much higher in transchildren who have not been able to access early treatment than in those who have been medically treated early (Spack, 2008).

Doctors, generally speaking, do not have an obligation (at least under English law) to treat just because a person wants treatment, even if that person has the capacity to consent to treatment. Healthcare professionals (similarly to many other professionals) are entitled to refuse or withdraw their services based either on moral or on clinical judgment (but we need to remember that in other countries omitting to treat can be a criminal offense) (Giordano, 2012).[14] The doctor's and patient's opinions as to whether a certain treatment is harmful or beneficial may diverge, and this may happen in the case of administration of early treatment for gender dysphoria. These are precisely the instances in which the healthcare professional should also ponder the risks and benefits of treatment versus nontreatment, because failing to act is not necessarily the safest option or a morally neutral one. When we know that if we fail to do something, the consequences of our omissions are serious and potentially fatal for others, we have a moral responsibility for those consequences.

11.11 Conclusions

This chapter has provided an overview of the available treatment for children with gender dysphoria. Clinical evidence shows that the most promising approach involves the administration of medication to children soon after the start of puberty. I have analyzed some of the most important ethical and, where pertinent, legal issues surrounding the provision of medical treatment to people with gender dysphoria, children in particular. The arguments explored in this chapter all point toward the conclusion that denying early medical care may mean exposing children to preventable harm, and thus, not only in principle is there nothing unethical about providing early medical treatment to transgender minors, but it may indeed be unethical to deny what is, for many, the only means to achieve a satisfactory life.

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[14]This legal right has some limits under English law.

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